



20 AdventHealth 22 Carrollwood

Community Health Needs Assessment

Extending the Healing
Ministry of Christ

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Letter From Leadership

At AdventHealth, our mission of Extending the Healing Ministry of Christ goes beyond our walls. We are committed to addressing the needs of the communities we serve with a holistic focus – one that strives to heal and restore the body, mind and spirit.

Every three years, AdventHealth hospitals complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our communities best. This in-depth look at the overall health of the community as well as barriers to care helps us better understand each area’s unique needs, so we can address the issues that matter most.

AdventHealth is blessed to serve communities across the United States. In big cities and small towns, our promise of wholeness is constant. We believe all people deserve to feel whole, and we are committed to meeting them wherever they are on that journey and supporting them along the way.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. It is through open dialogue and constant collaboration with these key partners that AdventHealth will bring wholeness to all communities we serve.

In His Service,

Terry Shaw
President and CEO
AdventHealth



Executive Summary

University Community Hospital, Inc. d/b/a AdventHealth Carrollwood will be referred to in this document as AdventHealth Carrollwood or “the Hospital”. AdventHealth Carrollwood in Tampa, Florida conducted a community health needs assessment from August 2021 to June 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

The All4HealthFL Collaborative

In order to ensure broad community input, AdventHealth Carrollwood partnered with the All4HealthFL Collaborative, referred to as the Collaborative, to help guide the Hospital through the assessment process. The Collaborative included representation from AdventHealth, BayCare Health System, Bayfront Health St. Petersburg, Moffitt Cancer Center, Johns Hopkins All Children’s Hospital, Lakeland Regional Health, Tampa General Hospital and DOH - Hillsborough, Pinellas, Pasco and Polk counties. This included intentional representation from those serving low-income, minority and other underserved populations.

The Collaborative met seven times in 2021 - 2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.
A list of Collaborative members can be found in Process, Methods and Findings.

Community Health Needs Assessment Committee

AdventHealth Carrollwood also convened a Community Health Needs Assessment Committee (CHNAC). The purpose of the CHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The CHNAC made this decision by reviewing the priority needs selected by the Collaborative, the internal Hospital resources available, the unique demographic data of the community the Hospital serves, when different from county level data, and local resources existing in the community. With this information the CHNAC was able to determine where the Hospital could most effectively support the community. The CHNAC met seven times in 2021 - 2022.
A list of CHNAC members can be found in Prioritization Process.

Data

AdventHealth Carrollwood in collaboration with the Collaborative collected both primary and secondary data. The primary data included community surveys and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top six aggregate issues. To read more about the county level findings and data highlighted in the report, please visit <https://www.all4healthfl.org/>.
See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC understand existing community efforts to address the identified issues from aggregate primary and secondary data and to prevent duplication of efforts.
See Available Community Resources for more.

Selection Criteria

The Collaborative held a prioritization meeting with community organizations and community members to rank the needs based on the data. The criteria used for prioritization during the meeting was also the same used by the CHNAC.
See Prioritization Process for more.



Each need was ranked individually using the following criteria on a scale of 1 to 3:

A. Scope and Severity: What is the magnitude of each health issue?

B. Ability to Impact: What is the likelihood for positive impact on each health issue?



Priority Issues to be Addressed

The priority issues to be addressed are:

1. Access to Health and Social Services
2. Behavioral Health (Mental Health & Substance Misuse)

See *Priorities Addressed for more*.

Approval

On December 15, 2022, the AdventHealth Carrollwood Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

Next Steps

AdventHealth Carrollwood will work with the Collaborative and the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

About AdventHealth

AdventHealth Carrollwood is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care.

More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

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

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture, having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth Carrollwood

AdventHealth Carrollwood 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 nationally recognized and award-winning care, evidenced by earning its 13th consecutive Grade A from the Leapfrog Group for Patient Safety. The hospital provides a wide variety of services including heart care, spine and orthopedics, bariatrics, wound care, robotic technology, two 24/7 emergency rooms with online scheduling, in Carrollwood and Westchase and much more. With a focus on whole-person care, skilled and compassionate caregivers provide individualized care for body, mind and spirit. To learn more about the hospital's services, visit [AdventHealthCarrollwood.com](https://www.AdventHealthCarrollwood.com).

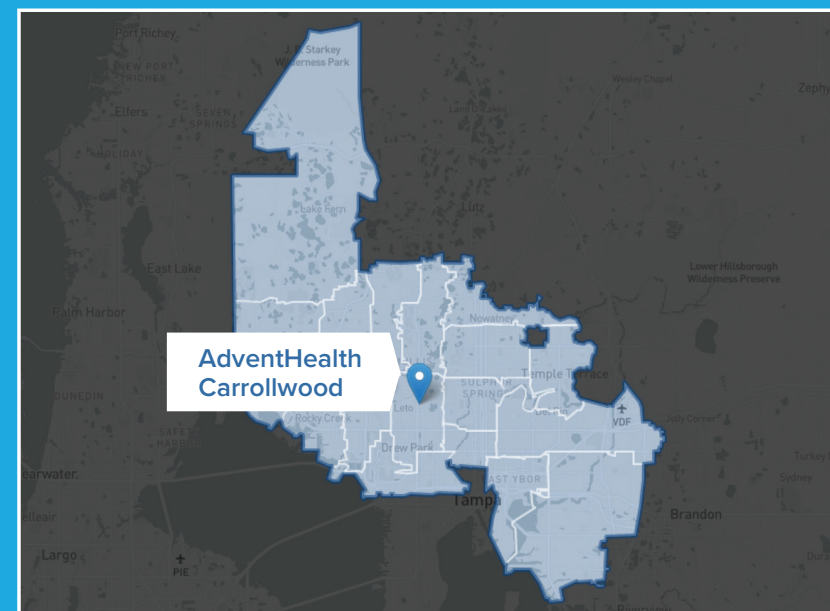


COMMUNITY OVERVIEW

Community Description

Located in Hillsborough County, Florida, AdventHealth Carrollwood defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 17 zip codes across Hillsborough County.

According to the 2020 Census, the population in the AdventHealth Carrollwood community has grown 12.3% in the last ten years to 549,780 people. This reflects a larger percentage of growth than in the United States since the last Census, but less than that of the state of Florida. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. The Collaborative conducted the CHNA with a county-level approach, therefore county-level data are included throughout the CHNA report in addition to Hospital PSA-level data. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

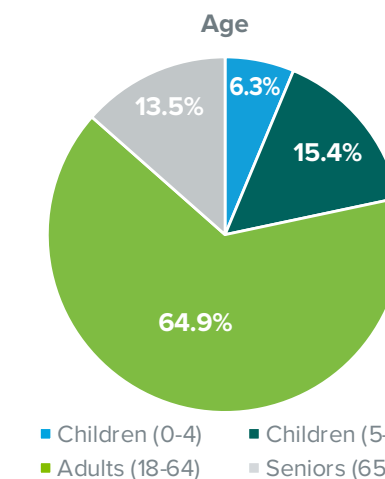
Age and Sex

The median age in the Hospital's community is 36.8, less than that of the state which is 42.2 and the US, 38.2.

Females are the majority, representing 51.2% of the population. However young adult males, 18-39, are the largest demographic in the community at 16.9%. Young adult females are the second largest demographic group at 16.8%.

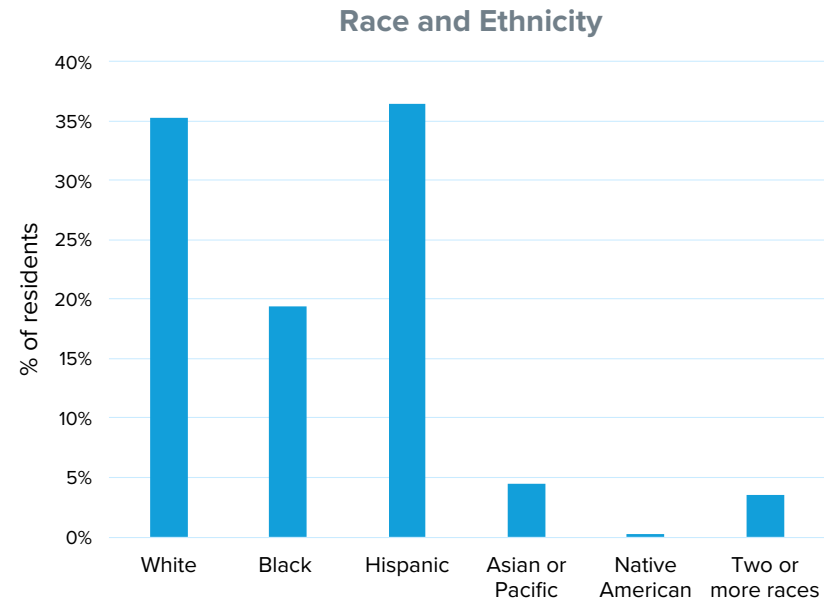
Children are 21.6% of the total population in the community. Infants, those zero to four, are 6.3% of that number. The community birth rate is 50.7 births per 1,000 women aged 15-50, this is lower than the US average of 51.9 but higher than that of the state, 48.3. In the Hospital's community, 24.8% of children aged 0-4 and 24.1% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 13.5% of the total population in the community. Females are 56.1% of the total senior population.



Race and Ethnicity

In the Hospital's community, 35.3% of the residents are non-Hispanic White, 19.4% are non-Hispanic Black and 36.4% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 4.5% of the total population, while .2% are Native American and 3.5% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

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



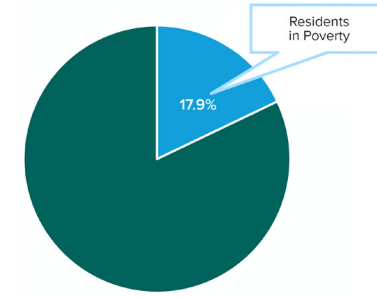
The Healthy People 2030 place-based framework outlines five areas of SDOH:

- Economic Stability:** This includes areas such as income, cost of living, food security and housing stability.
- Education Access and Quality:** This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.
- Health Care Access and Quality:** This includes topics such as access to health care, access to primary care and health insurance coverage.
- Neighborhood and Built Environment:** This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.
- Social and Community Context:** This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

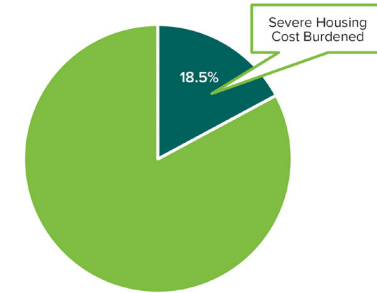
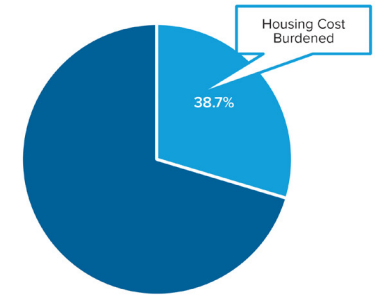
Income

The median household income in the Hospital's community is \$57,832. This is below the median for the state and the US. The poverty rate in the community is 17.9%, which is higher than the state and the national rate.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.¹ Feeding America estimates for 2020², showed the food insecurity rate in the Hospital's community as 15.8%.



Increased evidence is showing a connection between stable and affordable housing and health.³ When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.

¹ Food Insecurity - Healthy People 2030 | health.gov

² Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)

³ Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

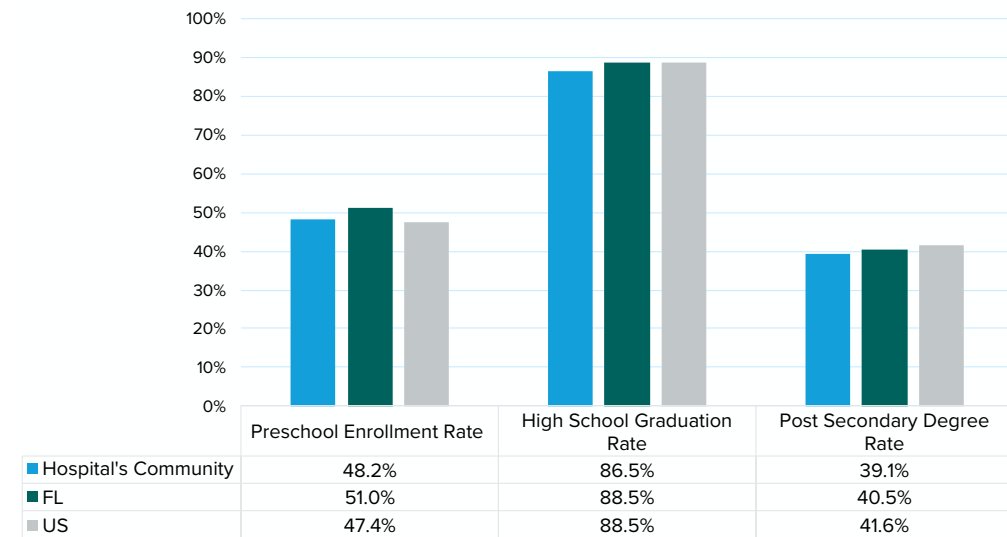
Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.⁴ Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is an 86.5% high school graduation rate, which is lower than the state and national rates. The rate of people with a post-secondary degree is lower in the Hospital's community than both that of the state and the nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.⁵

In the Hospital's community, 48.2% of 3–4-year-olds were enrolled in preschool. This is lower than the state (51%) and slightly higher than the national (47.4%) rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



⁴ The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

⁵ Early Childhood Education! Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

Health Care Access and Quality

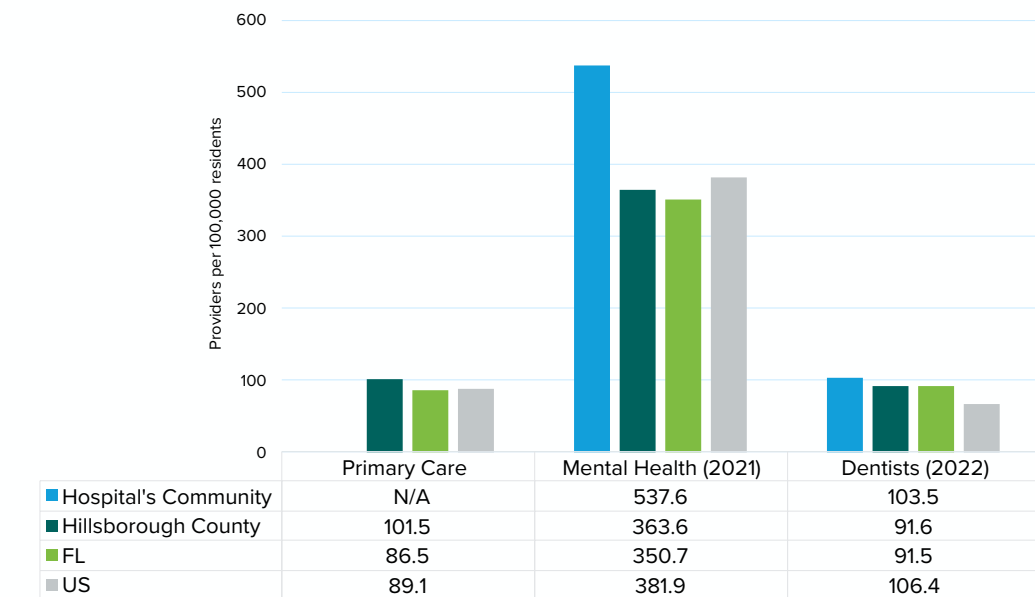
In 2020, 14.9% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.⁶

Accessing health care requires more than just insurance, there also need to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 76.3% of people report visiting their doctor for routine care.

⁶ Health Insurance and Access to Care (cdc.gov)

Providers Per Capita



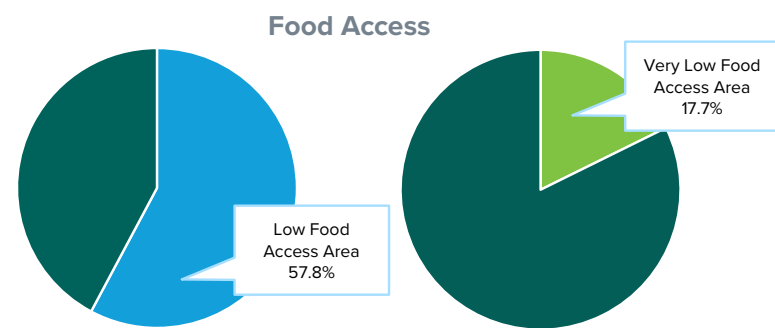


Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to maintain a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.⁷ In the Hospital's community, 57.8% of the community lives in a low food access area, while 17.7% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 9.1% of the households do not have an available vehicle.



⁷ A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

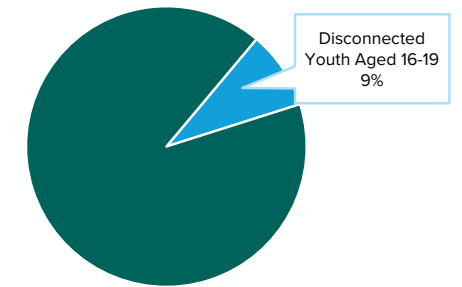
Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.⁸ When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 9% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 26% of seniors (age 65 and older) report living alone and 9.3% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

⁸ Social and Community Context - Healthy People 2030 | health.gov

Disconnected Youth





Process, Methods and Findings

■ Process and Methods

The Process

The health of people living in the same community can be very different because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, input was solicited directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. Publicly available data was also collected and reviewed. This data helped to inform how the community fared across health, social determinants of health and quality of life indicators, compared to other communities in Florida and the US.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form the All4HealthFL Collaborative to guide the assessment process. The Collaborative is a regional effort through which health systems and departments of health spanning four counties work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment. The Collaborative included representation for Hillsborough County from the Hospital, BayCare Health System, Johns Hopkins All Children's Hospital, Moffitt Cancer Center, Tampa General Hospital and DOH - Hillsborough. The Collaborative worked with Conduent Healthy Communities Institute (HCI), an independent agency to aid in the data collection and assessment process. To read more about the county level findings and data highlighted in the report, please visit <https://www.all4healthfl.org/>

All4HealthFL Collaborative Members

Individuals on the Collaborative represented large and specialty health care systems; as well as the Florida Department of Health in Hillsborough County (DOH - Hillsborough County), all sharing a unified vision of creating impactful community health improvement. As part of this shared vision, Collaborative members recognized the value of the voices of the community and the necessity of trusted relationships in these communities to affect real change. Collaborative members serving as stewards for the Hillsborough community included:

- Kimberly Williams, Director of Community Benefit, AdventHealth
- Amber Windsor-Hardy, Program Manager, AdventHealth
- Alison Grooms, Community Health Coordinator, AdventHealth
- Lisa Bell, Director of Community Benefit, BayCare
- Leah Gonzalez, Community Benefit Coordinator, BayCare
- Jamie Laraia, Community Benefit Specialist, BayCare
- Colleen Mangan, Community Benefit Analyst, BayCare
- Krista Cunningham, Community Outreach Coordinator, BayCare
- Dr. Leslene Gordon, Community Health Director, DOH Hillsborough County
- Allison Nguyen, Program Manager, DOH Hillsborough County
- Olga Tomasello, Health Educator Consultant, DOH Hillsborough County
- Chedeline Apollon, Senior Human Services Program Specialist, DOH Hillsborough County
- Stephanie Sambatakos, Community Health Improvement Supervisor, John Hopkins All Children's Hospital
- Dr. Nathanael Stanley, Data Analyst and GIS Specialist, Moffitt
- Tamika Powe, Director of Community Benefit, Tampa General

Community Input

The Collaborative collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. This was collected through a community survey and focus groups.

Community Survey

- Provided in English, Spanish and Haitian Creole to anyone in the community and accessible through weblinks and QR codes.
- Surveys were shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists, they maintained and when possible shared on their own social media channels.
- Paper surveys were given to community partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.
- Survey responses were tracked and monitored by ZIP code, age, gender, race and ethnicity to ensure targeted outreach for at-risk populations.

Focus Groups

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

Secondary Data

To inform the assessment process, HCI collected existing health related and demographic data about the community from publicly available sources. This included over 150 community indicators, spanning at least 24 topics in the areas of health, social determinants of health and quality of life. The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Center for Disease Control and Prevention
- US Dept of Health and Human Services
- Claritas Pop-Facts



The Findings

There were six issues found in the assessment process that rose to the top. To identify top needs, HCI reviewed and compared the findings across all three data sets; the community survey, focus groups and the secondary data. There were six needs which overlapped across all three data sets.



Access to Health and Social Services:

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



Behavioral Health (Mental Health and Substance Misuse):

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

Substance use disorders can involve illicit drugs, prescription drugs, alcohol or tobacco. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.



Cancer:

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



Exercise, Nutrition and Weight:

Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.



Nutrition can be defined as a substance that is taken into the body as food, which influences health while healthy eating means eating a variety of foods that give you nutrients you need to maintain your health, feel good and have energy. Many people in the United States don't eat a healthy diet, which could be because some people

don't have the information needed to choose healthy foods or don't have access to healthy foods or can't afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at an increased risk for obesity, heart disease, type 2 diabetes and other health problems.

Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual's body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.



Cardiovascular: Heart Disease and Stroke:

The term “heart disease” refers to several types of heart conditions. The most common type of heart disease in the United States is coronary artery disease (CAD), which affects the blood flow to the heart. Decreased blood flow can cause a heart attack. Sometimes heart disease may be “silent” and not diagnosed until a person experiences signs or symptoms of a heart attack, heart failure or an arrhythmia.

Stroke is a disease that affects the arteries leading to and within the brain. It is the fifth leading cause of death and a leading cause of disability in the United States. A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts (or ruptures). When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it and brain cells die.



Immunizations and Infectious Diseases:

Vaccination is the act of introducing a vaccine into the body to produce immunity to a specific disease. It uses your body's natural defenses to build resistance to specific infections and makes your immune system stronger. Vaccines train your immune system to create antibodies, just as it does when it's exposed to a disease. However, because vaccines contain only killed or weakened forms of germs like viruses or bacteria, they do not cause the disease or put you at risk of its complications.



PRIORITIES SELECTION

■ Prioritization Process

The Collaborative narrowed down the needs of the community to a list of three priorities with input from 61 participants from collaborating organizations, as well as other community partners. These participants represented a broad cross section of experts and organizational leaders with extensive knowledge of the health needs in the community. They were seen to represent the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

Participants joined a two-hour virtual prioritization session, which included a presentation highlighting the findings from the data and the needs that were identified. The participants then were placed in smaller groups where they discussed the needs and how the needs were impacted by the social determinants of health. Following discussions, participants ranked the needs via an online prioritization process.



Each need was ranked individually using the following criteria:

- **A. Scope and Severity:** What is the magnitude of each health issue?
- **B. Ability to Impact:** What is the likelihood for positive impact on each health issue?

Needs were scored from 1 to 3. The higher the score, the higher a priority the participants considered it. The needs were scored as follows.

Need	Cumulative Score
Access to Health and Social Services	173
Behavioral Health (Mental Health & Substance Misuse)	172
Exercise, Nutrition and Weight	167.5
Heart Disease and Stroke	146
Immunizations and Infectious Diseases	133
Cancer	132.5

The Collaborative supported the ranking of needs prioritized during the exercise and chose to focus on the top three; Access to Health & Social Services, Behavioral Health (Mental Health & Substance Misuse) and Exercise, Nutrition & Weight.

Following the Collaborative's selection, the Hospital convened a Community Health Needs Assessment Committee (CHNAC) to review the priorities selected by the Collaborative and to identify the needs the Hospital would select. The CHNAC reviewed the data behind the Collaborative's priorities and the unique demographic data of the community the Hospital serves, when different from county level data. The CHNAC also considered the Hospital's PSA-level secondary data, local community resources available, as well as the Hospital's current resources and strategies to find ways to prioritize and address the needs most effectively. The CHNAC followed the same process and criteria as the Collaborative for prioritization and selection.

The following health needs were chosen as priorities:

Access to Health & Social Services

Behavioral Health (Mental Health & Substance Misuse)

CHNAC Members

Members serving on the CHNAC were selected to provide their expertise and knowledge regarding the unique communities served by the Hospital. These individuals were looked to represent the interests of the populations they served and ensure their voices were at the table.

Name	Organization	Services Provided	Populations Served
Brittany Garner, Programs Manager	The Phoenix	Sober living programs	Specific focus on individuals who are sober from drugs and alcohol by providing active lifestyle programs that foster friendships and healthy living for a sober life
Matt Spence, Chief Programs Officer	Feeding Tampa Bay	Food pantry and food distribution services	Provides food for low-income populations and those in need
Gene Earley, Director	Hillsborough County Health Care Services	Health care	Provides healthy living programs and health care assistance to individuals in need in Hillsborough County
Stephanie Brown-Gilmore, Director	Tampa Housing Authority	Housing services	Housing services for low-income residents of Tampa
Debbie DeWitt, Manager Contracts Administration	Hillsborough County Health Care Services	Health care	Provides healthy living programs and health care assistance to individuals in need in Hillsborough County
Caitlyn Peacock, Executive Director	Tampa Bay Network to End Hunger	Food security programs and education	Provides solutions and programs for food insecure and low-income residents of the Tampa Bay area
Teresa Kelly, Executive Director	Health Council of West Central Florida (HCWCF)	Health education, health consultancy and assessment, planning and advisory services	Serves the general population of Hillsborough, Hardee, Highlands, Manatee and Polk Counties by representing the health care concerns of these residents.
Dr. Jeffrey Johnson, Director of Support Services	United Way Suncoast	Community improvement programs	Education, employment support, community improvement, disaster services and volunteer programs focused on serving the underserved populations
Dr. Sheron Brown, Executive Director	Tampa Bay Healthcare Collaborative	Health care collaborative	Promote and advance health equity to serve those who are negatively impacted by unfair barriers to having their best health possible by increasing awareness, building capacity and fostering collaborations
Dr. Rohit Patel, Physician/Hospitalist	AdventHealth Medical Group	Health care	Provides primary care and specialty medical services to the general population
Chedeline Apollon, Senior Human Services Program Specialist	DOH - Hillsborough	Health care and health education programs	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations

Name	Organization	Services Provided	Populations Served
Tara Spiller, Public Health Nutrition Consultant	DOH - Hillsborough	Health care and health education programs	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Kirit Shah, Founder	Free Clinic of Tampa Bay	Health care	Provides medical services for insured and uninsured adult patients with a focus on those underinsured and low-income.
Abraham Marrero, Consultant/ Director of Special Projects	Patient Engagement Advisors	Health care	Focus on inpatients within hospitals
Natasha Pierre, Community Leader for Mental Health/Chief Executive Office	The Set Mind (formerly with NAMI Tampa)	Mental health programs and services	Focus on lifestyle programs for empowering women
Justin Allen, Senior Vice President/Chief Performance and Customer Operations Officer	Patient Engagement Advisors	Health care	Focus on inpatients within hospitals
Angelica Domena, Supervisor Care 360	Patient Engagement Advisors	Health care	Focus on inpatients within hospitals
Ellen Snelling, Chair	Hillsborough County Anti-Drug Alliance/Tampa Alcohol Coalition	Substance use education	Focus on providing substance use education and resources to adults and youth struggling with addiction
Maria Russ, Supervisor of Health Services	Hillsborough County Public Schools, School Health Services	Public education services	Focuses on the youth in the public school district of Hillsborough County by providing health services within the schools
Eric Hubert, Business Development Manager	Crisis Center of Tampa Bay	Behavioral health, mental health and crisis intervention programs	Provides behavioral health, crisis and trauma support services to youth and adults in the Tampa Bay area
Dr. Sharad Patel, Physician/Surgeon	AdventHealth Medical Group	Health care	Provides primary care and specialty medical services to the general population

Name	Organization	Services Provided	Populations Served
Erika Skula, Chief Executive Officer	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Shane Cimock, Executive Director of Marketing	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Latasha McFarlane, Director of Case Management	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Romel Charles, Chaplain	AdventHealth Carrollwood	Health care and pastoral care	Serves the general population through hospital health care, emergency department services and pastoral care
Jennifer Desroches, Care Management	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Peggie Ireland, Performance Measure Coordinator	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Sonja Gonzalez, Care Manager	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Kelly Presnell, Assistant Director of Marketing	AdventHealth West Florida Division	Health care	Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services
Mazi Ferguson, Interim Director	University of South Florida's Office of Community Engagement and Partnerships	Education and connection programs	Provides connection, resources and education on community engagement for the general population
Kimberly Williams, Director of Community Benefit	AdventHealth West Florida Division	Health care	Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services but community benefit programs are focused on low-income, minority, underserved populations
Amber Windsor-Hardy, Community Health Program Manager	AdventHealth West Florida Division	Health care	Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services but community benefit programs are focused on low-income, minority, underserved populations
Alison Grooms, Community Health Coordinator	AdventHealth West Florida Division	Health care	Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services but community benefit programs are focused on low-income, minority, underserved populations

Name	Organization	Services Provided	Populations Served
Alyssa Smith, Community Health Coordinator	AdventHealth West Florida Division	Health care	Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services but community benefit programs are focused on low-income, minority, underserved populations
Marcellina Adonis, Executive Director	Calvary Community Clinic	Health care	Provides health care services for the uninsured, unemployed, underserved and low-income populations
Grace Glenn, Executive Director	Grace Community Medical Center	Health care	Provides health care services for underserved members of the population
Samuel Olarte, Tobacco Treatment Specialist	Gulfcoast North Area Health Education Center (AHEC)	Substance use peer support	Health education and tobacco prevention programs for general public
Veronique Polo, Community Relations Manager/Community Benefit Champion	AdventHealth Carrollwood	Health care	Serves the general population through hospital health care and emergency department services
Marisol Sanchez, President	Guided Path Haven	Trauma assistance programs	Provides food, clothing and Medicaid assistance for victims of domestic violence and those suffering from homelessness
Sharon Hall, Program Manager	Mothers Against Drunk Driving	Substance use education and outreach programs	Outreach programs to serve the families of victims of drunk driving fatalities



Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address..

Top Issues	Current Community Programs	Current Hospital Programs
Access to Health and Social Services	<ul style="list-style-type: none"> Gracepoint partnership with PCP Walmart Health Tampa Family Health Centers (representative onsite for quick follow up appointments and guidance for uninsured patients) Tampa Bay Healthcare Collaborative Family Healthcare Foundation Calvary Community Clinic Suncoast Community Health Centers, Inc. Palm River Community Health Center 	<ul style="list-style-type: none"> Team member volunteerism Mammography Bus
Behavioral Health (Mental Health and Substance Misuse)	<ul style="list-style-type: none"> Gracepoint Tampa Family Health Centers Walmart Health Veterans Counseling Veterans Tampa Fire education programs Tampa Bay Thrives University of South Florida National Alliance on Mental Illness (NAMI) Hillsborough Drug Abuse Comprehensive Coordinating Office (DACCO) The Phoenix Tampa Tri-County Central Office Alcoholics Anonymous program Hillsborough The Salvation Army Florida Adult Rehabilitation Center (ARC) Cove Behavioral Health Tampa Funcoast Area Narcotics Anonymous Moffit Cancer Center Forever Free Cessation Clinic Sober Living America Families First Florida 	<ul style="list-style-type: none"> Mental Health First Aid classes Team member volunteerism

Top Issues	Current Community Programs	Current Hospital Programs
Exercise, Nutrition and Weight	<ul style="list-style-type: none"> Feeding Tampa Bay UF/IFAS Extension of Hillsborough County DOH - Hillsborough - health promotion and education UACDC food pantry and community garden Soaring City UP Tampa Family Health Centers (community garden) Tampa Family YMCA Community Recreation Services Barksdale Active Adult Center 	<ul style="list-style-type: none"> AdventHealth Food is Health® Team member volunteerism
Cancer	<ul style="list-style-type: none"> American Cancer Society programs including Relay for Life, Road to Recovery, Reach to Recovery, Cancer Survivors Network and the 24/7 Cancer Helpline Moffitt Cancer Center Tampa Family YMCA Livestrong program Tampa Bay Community Cancer Network 	<ul style="list-style-type: none"> Women's Health and Cancer Prevention Event Prostate and colorectal screenings for men
Heart Disease and Stroke	<ul style="list-style-type: none"> American Heart Association programs including CPR, Life's Essential 8, You're the Cure, Well-Being Works Better Tampa Family YMCA'S Blood Pressure Self-Monitoring 	<ul style="list-style-type: none"> AdventHealth's free Community Hands-Only CPR classes Health fairs and health screenings offered to the public Early heart attack care AED deployment
Immunizations and Infectious Disease	<ul style="list-style-type: none"> DOH - Hillsborough's free or low-cost vaccinations Children's Board of Hillsborough County's Family Resource Center Palm River Community Health Center Cove Behavioral Health free HIV testing and health education to general public Tampa Family Health Centers Suncoast Community Health Centers All Woman's Health Center 	



Priorities Addressed

The priorities addressed include:

Access to Health and Social Services

Access to Health & Social Services was a top health need identified from both the community survey and focus group discussions. Thirty-six percent (36%) of community survey respondents ranked Access to Health Care as a pressing quality of life issue. Reasons that prevented survey respondents from getting medical care they needed included: unable to schedule an appointment when needed, unable to afford to pay for care, cannot take time off work, doctors' offices that do not have convenient hours. Other barriers included: Medicaid changes, higher than anticipated co-payments, COVID-19 restrictions and long wait times to see a medical provider.

Adults without health insurance and a usual source of health care are top areas of concern related to health care access & quality in Hillsborough County. The percentage of adults without health insurance in Hillsborough County is (23%), which falls in the worst (25%) of counties in the nation. Focusing on access to care will help align local efforts and resources to create targeted strategies to improve access for Hillsborough County residents.

Behavioral Health (Mental Health & Substance Misuse)

Mental health and substance misuse were identified as top health needs from the secondary data, community survey and focus groups. About 31% of survey respondents have been diagnosed with depression or anxiety. Thirty percent (30%) of community survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. In Hillsborough County, deaths due to drug poisoning and opioid overdose have been an increasing concern,

specifically for white males. Secondary data showed an increased trend in the percentage of 6th-12th grade students who have used electronic vaping in the 30 days prior to the survey. Awareness and the need to address behavioral health has been growing in the country and locally. By including behavioral health as a priority, the Hospital can align to local, state and national efforts for resource collaboration and to create better outcome opportunities over the next three years.



Priorities Not Addressed



Heart Disease and Stroke

Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. Although 36% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease. The Hospital did not select this as a priority as there are already several other community organizations actively addressing this need in the community who are better positioned to make an impact.



Immunizations and Infectious Diseases

Immunizations and Infectious Diseases did not come up as a top issue through community feedback. The syphilis incidence rate in Hillsborough County (22.9 cases per 100,000 population) in 2020 was over the US value (11.9 cases per 100,000 population) and the Florida value (16.2 cases per 100,000 population). There are opportunities to impact through prevention education, however, the Hospital 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.



Cancer

During the assessment, cancer was not mentioned in focus groups and was ranked low in the community survey. Seventeen percent (17%) of survey respondents ranked cancer as a pressing health issue and 10% reported being told by a medical provider that they have been diagnosed. Secondary data warning indicators showed county values at or slightly above Florida and US values for cervical cancer incidence rate, melanoma incidence rate and cancer within the Medicare population. Cancer was not selected by the Hospital as a top priority to address during the upcoming three-year Community Health Plan as there are others already addressing this need.



Exercise, Nutrition and Weight

In Hillsborough County, 30.2% of adults are obese, and 68.8% of adults are overweight. This is higher than the state values, although not significantly. Additionally, the percentage of children with low access to a grocery store is 6%, which falls in the worst 50% of counties in both Florida and the US. This indicator shows the percentage of children living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area. Although Exercise, Nutrition and Weight was selected as one of the top three health priorities of concern, the CHNAC did not select it as one of the top two priorities to address in the upcoming three-year Community Health Plan as the Hospital is not positioned to directly address this.





COMMUNITY HEALTH PLAN

Next Steps

The Hospital will work with the Collaborative and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

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

A link to the Community Health Plan will be posted on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2023.



2020 Community Health Plan Review

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

Priority 1: Diabetes

In the 2019 assessment, diabetes was identified as a priority. In the Hospital's community, a higher percentage of adults had been diagnosed with diabetes compared to the state rate. Diabetes is the seventh leading cause of death in the US and more than 80 million people were found to be pre-diabetic. When diabetes goes untreated it can lead to more serious health issues such as vision loss, heart disease, stroke, nerve and kidney diseases.

As part of the effort to address this, the Hospital has launched the AdventHealth Food is Health® program in the community. The AdventHealth Food is Health® program is an AdventHealth West Florida Division program which increases access to health education and healthy foods to improve the overall health of the communities the Hospital serves. Through collaboration with community partners, the program connects with low income/low access communities and provides free health education, health screenings and produce vouchers which are used to purchase fresh fruits and vegetables. Since adopting the plan, the Hospital has partnered with several community organizations to expand the services the program can offer and provide more locations within the community. By the end of 2021, the Hospital held five of their planned classes, providing education to 222 participants and giving 1,039 produce vouchers. Recognizing the impact of nutrition on diabetes, the Hospital also established a paid program for employees to volunteer at local organizations focusing on food access and insecurity. By the end of 2021, 209 volunteer hours had been served.

Priority 2: Mental Health

Mental health was also identified as a priority in the 2019 assessment. 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 aged 25 to 34. In the Hospital's community, the rate of death due to self-harm (suicide) is 12.9 per 100,000 population. The assessment also found a higher percentage of the Medicare-fee-for-service population were depressed compared to the state average. 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.

The Hospital focused its efforts on increasing education and building community level networks for mental health support. As part of this effort, four team members completed the Mental Health First Aid instructor certification. These team members are now providing classes in the community for individuals to learn how to help someone who may be experiencing mental health or substance use challenges. By the end of 2021, 16 community members became certified as a Mental Health First Aider. The Hospital also partnered with the local NAMI chapter to provide Ending the Silence presentations in local schools. These presentations provide middle and high school students education on how to recognize individuals living with a mental health condition and action steps on how to help during a mental health crisis. By the end of 2021, 42 youth had attended the presentations.

Priority 3: High Blood Pressure

High blood pressure was also a priority in the 2019 assessment. The assessment found in the Hospital's community almost one-third of individuals had been diagnosed with high blood pressure, a higher percentage than that of the state. High blood pressure is 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 and because of this it is referred to as the "silent killer".

The Hospital has addressed the priority through two targeted ways; increasing access to medication and education. As part of this effort, the Hospital has identified a local clinic which serves the uninsured, with whom they plan to partner, to provide financial assistance to help cover the costs of blood pressure medications to reduce the financial burden to uninsured adults in need of medication. Also, recognizing smoking is related to high blood pressure, the Hospital has established a referral network with the Gulfcoast North Area Health Education Center (GNAHEC) to connect 50 patients with tobacco cessation classes and free intervention therapies to quit smoking in 2021.

Priority 4: Access to Health Care

In the 2019 assessment, access to health care was also chosen as a priority. 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. The assessment found that more than one-fourth of adults in the community do not have a primary care provider and almost one-fifth do not have health insurance.

One of the ways the Hospital has worked to address access to health care in the community is through a partnership with The Family Healthcare Foundation and the workshop "Navigating the Healthcare Plan". The cost of health care can be a deterrent to many individuals who need care when they do not have insurance. This can lead to delayed care and even higher financial costs when care is sought. The workshop provides health education to uninsured community members to help them understand how to enroll in affordable health insurance, how to best utilize it and how to find a primary care provider. In 2021, the workshops officially began, and 27 community members attended the workshop.

Priority 5: Substance Misuse

The Hospital also chose substance misuse as a priority in the assessment. In the Hospital's community it was found that almost one-fifth of adults aged 18 and above drank excessively, at a percentage higher than the state. 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.

As part of its efforts to address the priority, the Hospital has connected with organizations which specialize in substance misuse to create a network of resources for patients in need during discharge. The Hospital also established a paid program for employees to volunteer at local organizations focusing on substance misuse. In 2021, 35 volunteer hours were served.



■ 2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy on our Hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.





**University Community Hospital, Inc. d/b/a
AdventHealth Carrollwood**

CHNA Approved by the Hospital Board in December 15, 2022

For questions or comments please contact:
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