2022 AdventHealth Zephyrhills

Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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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 wholistic 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

Florida Hospital Zephyrhills, Inc. d/b/a AdventHealth Zephyrhills will be referred to in this document as AdventHealth Zephyrhills or "the Hospital". AdventHealth Zephyrhills in Zephyrhills, 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 Zephyrhills took part in 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 the Florida Department of Health in 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 Zephyrhills 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 five times in 2021 - 2022.

A list of CHNAC members can be found in Prioritization Process.

Data

AdventHealth Zephyrhills 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 Priorities Addressed 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 14, 2022, the AdventHealth Zephyrhills 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 Zephyrhills 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 Zephyrhills 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 Zephyrhills

AdventHealth Zephyrhills is a 149-bed acute care hospital and is a member of the faith-based AdventHealth System, providing a connected network of care in nearly a dozen states with more than 50 hospitals and hundreds of care sites. Since 1985, the hospital has provided award-winning care with a mission to extend the healing ministry of Christ. The hospital offers a wide variety of services to include heart care, orthopedics, women's health, surgical care, digestive health, robotic technology, a 24/7 emergency room with online scheduling 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 www.AHZephyrhills.com.

COMMUNITY OVERVIEW

Community Description

Located in Pasco County, Florida, AdventHealth Zephyrhills defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes five zip codes across mainly Pasco County and a small part of Hernando County. The Hospital shares a PSA with AdventHealth Dade City and serves the same community.

According to the 2020 Census, the population in the AdventHealth Zephyrhills community has grown 7.3% in the last ten years to 92,104 people. This reflects a similar percentage of growth as seen in the United States since the last Census but half the amount seen in 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. Data are reported for the Hospital's PSA, also referred to as the community, unless listed for a specific county. 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

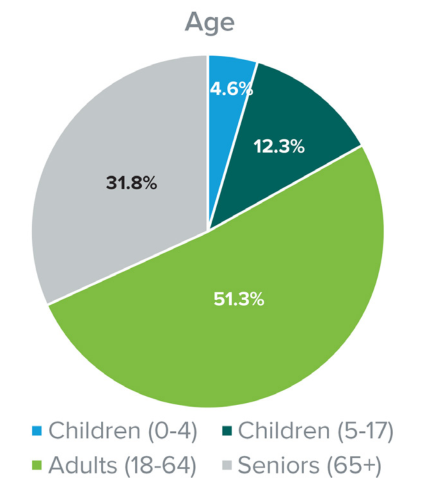
Age and Sex

The median age in the Hospital's community is 50.8, higher than that of the state, which is 42.2 and the US, 38.2.

Females are the majority, representing 51.6% of the population. Senior aged women, 65 and older, are the largest demographic in the community at 17.2%. Middle aged women, 40-64, are the second largest demographic group at 15%.

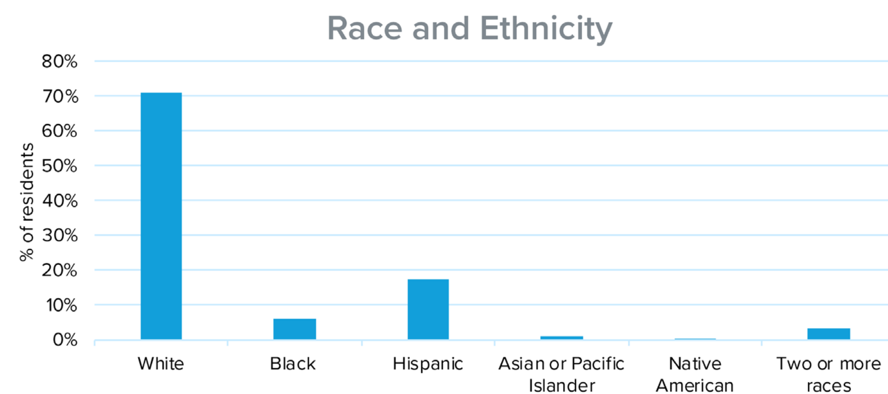
Children are 16.9% of the total population in the community. Infants, those zero to four, are 4.6% of that number. The community birth rate is 56.9 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and that of the state, 48.3. In the Hospital's community, 28.6% of children aged 0-4 and 27.6% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 31.8% of the total population in the community. Females are 53.8% of the total senior population.



Race and Ethnicity

In the Hospital's community, 71.1% of the residents are non-Hispanic White, 6.2% are non-Hispanic Black and 17.4% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 1.2% of the total population, while 0.3% 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.

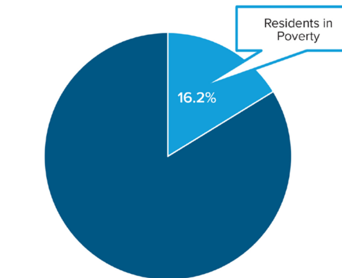
Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.

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

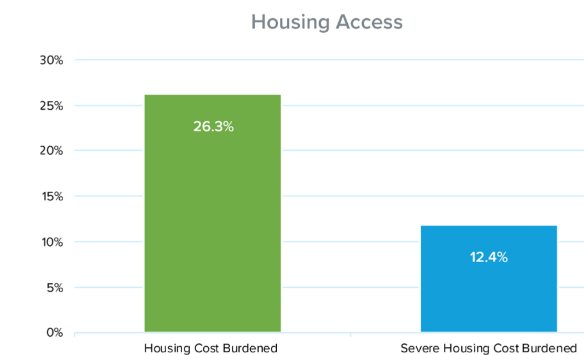


The median household income in the Hospital's community is $46,992. This is below the median for the state and that of the U. S. The poverty rate in the community is 16.2%, which is higher than the state and national rate.

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 2020[2] showed the food insecurity rate in the Hospital's community as 17.6%.

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 the 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

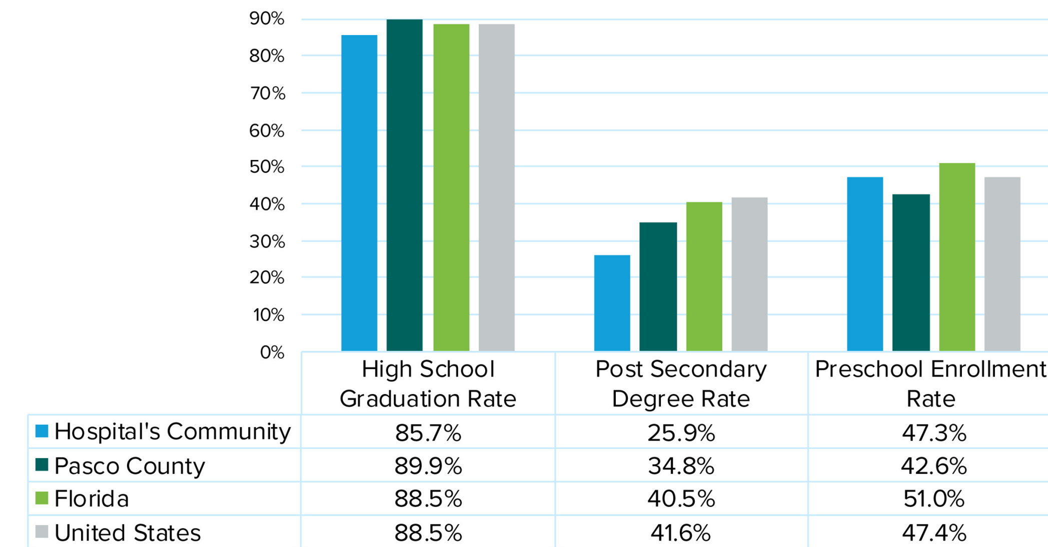
Education Access and Quality

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 lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is an 85.7% high school graduation rate, which is lower than the state and national rate. The rate of people with a post-secondary degree is also 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.

In the Hospital's community, 47.3% of 3-4-year-olds were enrolled in preschool. This is lower than the state (51%) rate and similar to the national rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.[5]



	High School Graduation Rate	Post Secondary Degree Rate	Preschool Enrollment Rate
Hospital's Community	85.7%	25.9%	47.3%
Pasco County	89.9%	34.8%	42.6%
Florida	88.5%	40.5%	51.0%
United States	88.5%	41.6%	47.4%

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

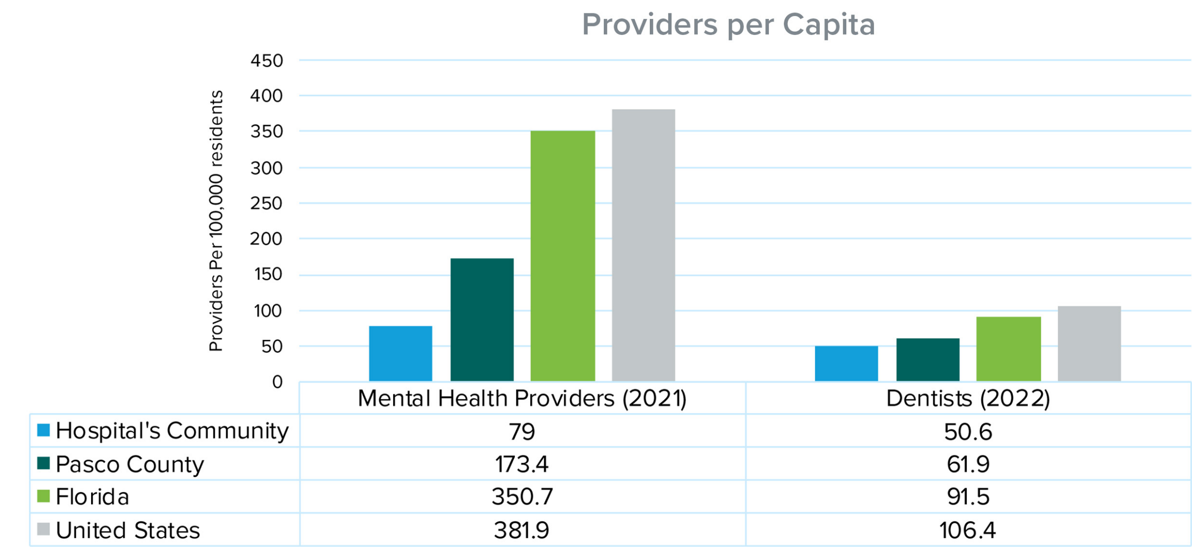
Health Care Access and Quality

In 2020, 12.6% 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]

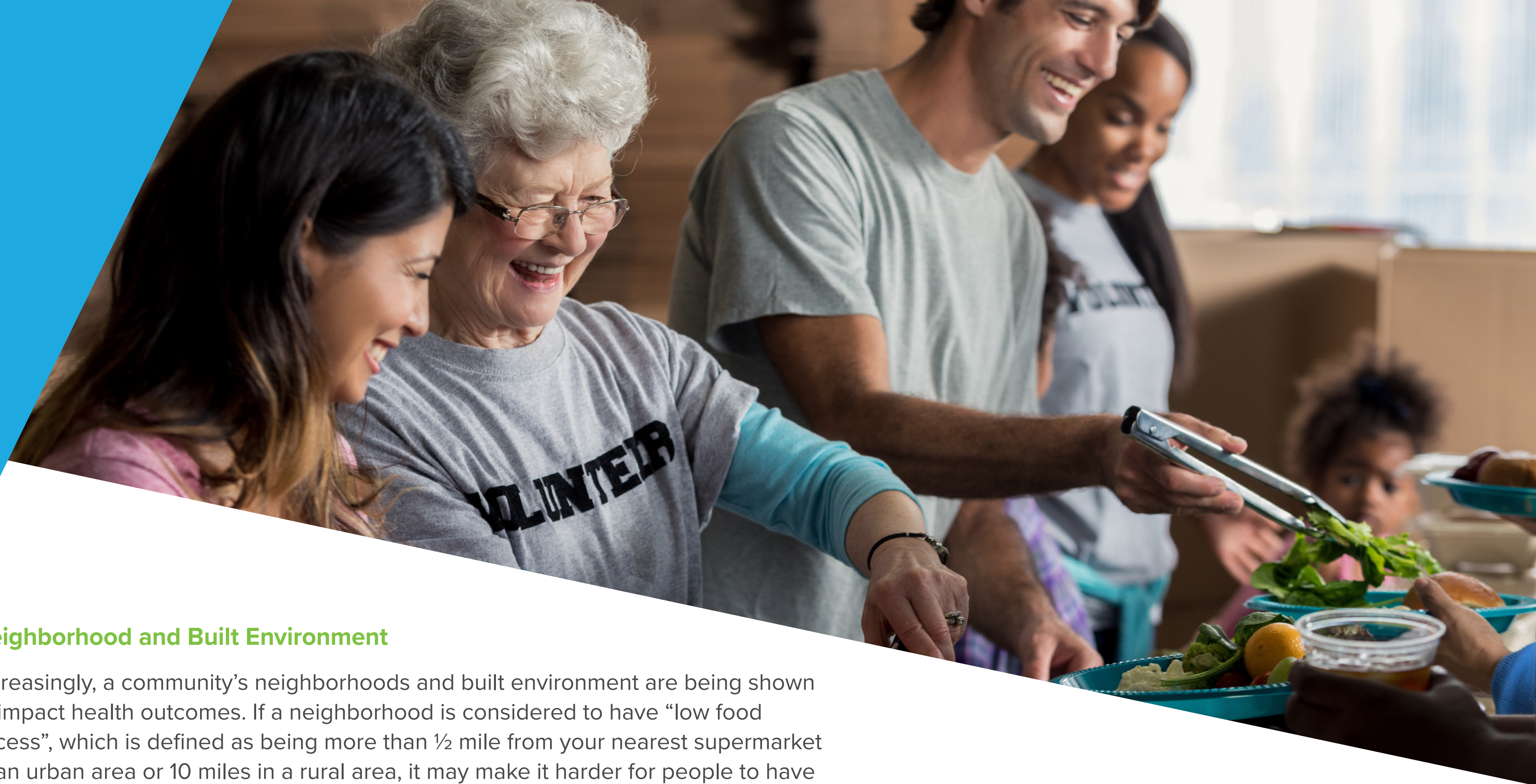
Accessing health care requires more than just insurance, there also needs to be available health care professionals to provide care. When more providers are available in a community, access can be easier, particularly for those experiencing transportation challenges.

Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. In the Hospital's community, 79.3% of people report visiting their doctor for routine care.

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



	Mental Health Providers (2021)	Dentists (2022)
Hospital's Community	79	50.6
Pasco County	173.4	61.9
Florida	350.7	91.5
United States	381.9	106.4



Neighborhood and Built Environment

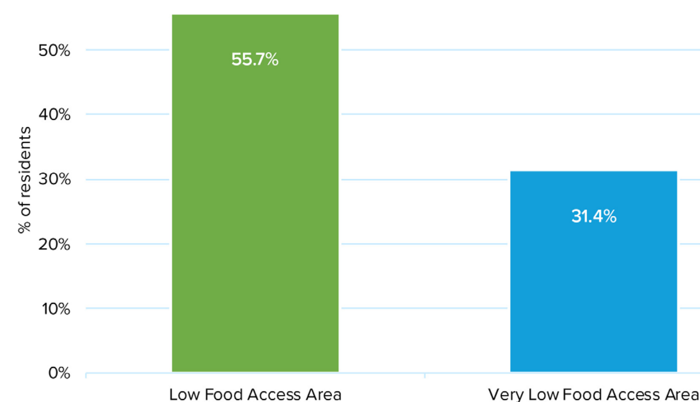
Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have 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, 55.7% of the community lives in a low food access area, while 31.4% 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 accessing health care, healthy food and maintaining employment. In the community, 6% of households do not have an available vehicle.

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

Food Access



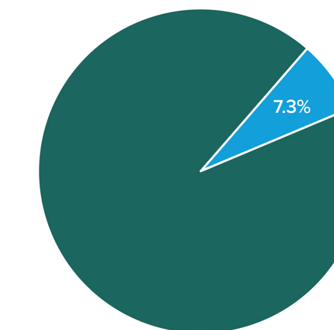
Social and Community Context

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, 7.3% 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 24.3% of seniors (age 65 and older) report living alone and 2% 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, the state 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 Pasco County from the Hospital, BayCare Health System, Johns Hopkins All Children's Hospital, Moffitt Cancer Center and the Florida Department of Health in Pasco County. 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; the Florida Department of Health in Pasco County (DOH-Pasco), 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 Pasco community included:

Community Partners

Kimberly Williams, Director of Community Benefit, AdventHealth

Alyssa Smith, Community Health Coordinator, AdventHealth

Thomas Agrusti, 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

Catherine Deasaro, Community Outreach Coordinator, BayCare

Megan Carmichael, Program Manager, DOH-Pasco

Tom Panagopoulos, Minority Health & Health Equity Liaison, DOH-Pasco

Marina D'Amato, Health Educator Consultant, DOH-Pasco

Dr. Nathanael Stanley, Data Analyst and GIS Specialist, Moffitt Cancer Center

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

- Surveys were 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 Department 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 the 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.

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals.

Lack of health insurance coverage may negatively affect health since uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations and well-child visits that track developmental milestones.

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.

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 89 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, 58 participants completed the prioritization using an online activity to rank the needs.

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	158
Behavioral Health (Mental Health & Substance Misuse)	155
Exercise, Nutrition and Weight	144.5
Heart Disease and Stroke	126.5
Immunizations and Infectious Diseases	126.5
Cancer	112.5

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 relied on to represent the interests of the populations they served and ensure their voices were at the table.

Name, Title	Organization	Services Provided	Populations Served
Amanda Markiewicz, Chief Programs Officer	Sunrise of Pasco County Domestic and sexual Violence Center	Shelter	Victims of violence, recently homeless
Ray Pichette, Senior Pastor	East Pasco Adventist Church	Space for mental health support groups, mission & ministry, food pantry	Low-income and food insecure
Nick Deford, Pastor	First Church of the Nazarene	Mission & ministry, food pantry	Low-income and food insecure
Kimberly Poe, Executive Director of Elementary Schools	Pasco County Schools	Education	Elementary school aged youth
Cheryl Pollock, Director of Community Services & Business development	Premier Community HealthCare	Health care services & dental health	Low-income, uninsured/underinsured populations
Manuel Mayor, Community Programs & Resource Development Manager	Premier Community HealthCare	Health care services & dental health	Low-income, uninsured/underinsured populations
Shari Bresin, Family and Consumer Sciences Agent	UF/IFAS Cooperative Extension Pasco County	Nutrition & finance education	Low-income and food insecure
Mark Trujillo, Market Development Professional	Humana	Mental health advocacy	General population
Debbie Proulx, Executive Director	NAMI Pasco	Mental health advocacy	General population

Name, Title	Organization	Services Provided	Populations Served
Ano Kashumba, APRN, Executive Director	Pioneer Medical Group	Primary care/health care	Low-income, uninsured/underinsured populations
Steffan Davis, Community Impact & Allocations Manager	United Way Pasco	Volunteerism connection and advocacy	Provides volunteer opportunities with local non profits to businesses
Megan Carmichael, Project Manager	Florida Department of Health Pasco	Local government	Administers local health programs and enacts local health policies
Don Anderson, CEO	Pasco Homeless Coalition	Emergency housing and advocacy	Homeless populations
Thomas O'Conner Bruno, COO	Pasco Homeless Coalition	Emergency housing and advocacy	Homeless populations
JaLem Robinson, Director of Community Collaboration	Metropolitan Ministries	Emergency housing and advocacy, food pantry/soup kitchen	Homeless populations/low-income
Phillip Williams, Pastor	Glorious Church of God in Christ – Lacoochee	Mission and ministry, food pantry	Low-income and food insecure
Brenda Borjas, Nutrition Educator	UF/IFAS Extension	Nutrition & finance education	Low-income and food insecure
Andrea Vogel, MSN	AdventHealth	Quality and safety improvement	Oversees quality and safety policies and procedures at hospitals
Megan Kohan, Director of Finance	AdventHealth	Financial administration	Oversees spending and allocations at hospitals
Doug Higgins, Director of Mission and Ministry	AdventHealth	Mission and ministry	Oversees community outreach and faith-based projects
Amanda Maggard, CEO	AdventHealth	Administration	Provides direction over all hospital functions
Diane Reith, Director of Case Management	AdventHealth	Administration	Oversees case management operations at hospitals
Katie Duncan, Marketing Manager	AdventHealth	Marketing	Promotes service lines at hospital and sponsors local initiatives

CHNAC Members continued

Name, Title	Organization	Services Provided	Populations Served
Kimberly Williams, Director of Community Benefit	AdventHealth	Community benefit	Underserved, living in poverty, low access
Thomas Agrusti, Community Health Coordinator	AdventHealth	Community benefit	Underserved, living in poverty, low access
Alyssa Smith, Community Health Coordinator	AdventHealth	Community benefit	Underserved, living in poverty, low access
Alison Grooms, Community Health Coordinator	AdventHealth	Community benefit	Underserved, living in poverty, low access

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	• Family Resource Center of East/West Pasco • Holiday Inspire Hope Boxes • Unite Us platform • School-based mobile dental bus • Meals on Wheels • Pasco Schools (flu vaccines, vision and health screenings available in schools, dental van provides sealants at Title I schools, dental services from Premier at Cox Elementary, connect families with Florida Kids Care for health insurance) • Aunt Bertha (findhelp.org) • Healthcare navigators	• AdventHealth mammogram bus • AdventHealth team member volunteerism • AdventHealth Faith Community initiatives
Behavioral Health (Mental Health and Substance Misuse)	• Pasco County Parks and Recreation mental health initiatives (Stomp Out Suicide Race) • BayCare mobile mental health resources • Bobby White Foundation (resources for suicide prevention and loss survivors) • Tampa Bay Thrives • Coordinated Opioid Recovery Program (CORE) • Pasco Schools (in-school counseling, referrals to counseling in community, mental health curriculum, Youth At Risk staffings that bring community partners to a problem-solving team to address individual student cases) • Pasco Alliance for Substance Addiction and Prevention (ASAP)	• Mental Health First Aid classes sponsored by AdventHealth • Substance Misuse Taskforce • AdventHealth team member volunteerism
Exercise, Nutrition and Weight	• Meals on Wheels • Metropolitan ministries meal site- www.metromin.org • Fun Bites healthy concessions • Healthy Living Coach program • PACE-EH initiative in Holiday area • KidShape • Helping Hands Food Pantry at Atonement Lutheran Church • Healthy for Life program • Pasco Schools (District Student Wellness Policy, USDA National School Breakfast and Lunch programs, Provision 2 Breakfast Program (all students have access to free breakfast at schools with 50% or greater free/reduced lunch) • YMCA Veggie Van	• AdventHealth Food is Health(R) • AdventHealth team member volunteerism • CREATION Life program

Top Issues	Current Community Programs	Current Hospital Programs
Cancer	• The Breast and Cervical Cancer Early Detection Program (BCCEDP) at the Florida Department of Health in Pasco County • American Cancer Society (Relay For Life, Road to Recovery, Reach to Recovery, Cancer Survivors Network, 24/7 Cancer Helpline) • YMCA LIVESTRONG Program • The LYN Fund (financial assistance for women battling cancer) • Tampa Bay Community Cancer Network	
Heart Disease & Stroke	• American Heart Association programs (Hands-Only CPR, Life's Essential 8, You're the Cure, Well-Being Works Better) • YMCA Blood Pressure Self-Monitoring Program	• AdventHealth Community Benefit Hands-Only CPR
Immunizations & Infectious Disease	• Florida Department of Health in Pasco County (free or low-cost vaccinations, HIV program) • Premier Community Healthcare	

Priorities Addressed

Access to Health and Social Services

More than one third (34%) of community survey respondents ranked Access to Health Care as a pressing quality of life issue. Focus group participants cited barriers such as transportation, cost of care and prescriptions, long referral wait times, provider shortages and inconvenient appointment times. Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals. The percentage of adults (aged 18-64) without health insurance in Pasco County is 21.6%. Pasco is in the worst 25% of all counties in the nation for this indicator. Focusing on access to care will help align local efforts and resources to create targeted strategies to improve access for Pasco County residents

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Behavioral Health (Mental Health & Substance Misuse)

Nearly 45% of the community and public health experts surveyed ranked mental health as the most pressing issue in Pasco County. In the Hospital's community, 19.7% have depression, while 18% of the residents report poor mental health. According to community survey respondents, 30% have been diagnosed with a depressive disorder or anxiety disorder.

Substance use emerged as a top concern, reflected in both primary and secondary data sources. One of the most concerning trends is with drug overdose deaths, which has increased significantly over the past few years, currently at a rate of 47.8 (per 100,000 population). Pasco County also sees a higher percentage of adults who currently smoke, with 21.6% of adults in Pasco County compared to 14.8% for the state of Florida. 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 outcomes 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 40% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease, these concerns can be addressed through the Access to Health and Social Services priority. 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. A secondary data indicator of concern includes the percentage of adults 65 and older with influenza vaccination, with the Pasco County value at 56.1%, which is lower than the state value (58.3%) and that of surrounding counties. Another secondary data warning indicator is the rate of Hepatitis B, Acute Infections, with Pasco County being significantly higher than that of the state, at 6.7 cases per 100,000 population and 2.5, respectively. There are opportunities to improve education on vaccination and prevention, but other community organizations, such as local health departments, have traditionally led these efforts. 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 identified as a top health concern by focus group participants nor community survey respondents. Nine percent (9%) of survey respondents ranked cancer as a pressing health issue and 16% reported being told by a medical provider that they have been diagnosed with cancer. Secondary data found in the assessment also showed there was a higher rate of cases for melanoma incidences in the county than in the state. Cancer was not selected as a priority as there are others already addressing this need.

Exercise, Nutrition and Weight

In the Hospital's community, secondary data comparisons between Pasco County and the state of Florida did not reveal opportunities for impactful change. Pasco is performing better than Florida in adults who are at a healthy weight, at 38.2% for Pasco and 32.8% for Florida. Data suggests that Pasco could improve in adults who consume at least five servings of fruits and vegetables, with Pasco at 15.9% and Florida at 18.3%. Both primary and secondary data sources reflected a need for focus on built environment, which can improve access to healthy foods and opportunities for physical activity. Focus group conversations also highlighted the challenges of rising costs of food.

The importance of strategies around exercise, nutrition and weight is significant, however the CHNAC shared that many related strategies can be included under Access to Health and Social Services, creating a stronger focus in that area which emerged as a priority for our community members and partners. Also, strategies around the built environment may not produce measurable results during the span of the Hospital's three-year community health plan.

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 prior to May 15, 2023.

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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.

Dental Health

In the 2019 CHNA, the Hospital addressed dental health as a priority. In the Hospital's community the access to dentists' rate is 33 per 100,000 population (in 2015), as compared to the state rate of 56. Many oral diseases can be prevented with routine care and regular dental checkups. The health of the teeth, the mouth and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Lack of access to dental care for all ages remains a public health challenge.

Since adopting the plan, the Hospital has focused on increasing access to dental care providers and improving education on the importance of dental care. To support this the Hospital partnered with Premier Community HealthCare Group, Inc., a non-profit organization and Federally Qualified Health Center (FQHC), in a pilot project to create a network of volunteer dentists to improve access to dental care providers. To support the pilot, the Hospital has aligned with the Florida Dental Association to recruit dentists. The Hospital is also allocating funding to help support the development of the network. To improve education on the importance of dental health, the Hospital has partnered with MORE HEALTH, Inc. to offer oral health training workshops to staff from local community agencies to increase access to oral health education for parents and youth. This includes training for 30 Pasco County school nurses.

Heart Disease

Heart disease was also a priority in the 2019 assessment. The assessment found in the Hospital's community the rate of death due to heart disease was higher than that of the state. Heart disease also is the leading cause of death in the US, responsible for one in four deaths annually. The major risk factors for heart disease are high blood pressure, high cholesterol, being overweight/obese and having an unhealthy diet. By managing blood pressure and cholesterol, eating a healthy diet and incorporating physical activity daily, the risk of developing heart disease could be greatly reduced.

The Hospital focused on increasing access to education on lifestyle and preventative care to address this priority. The Hospital partnered with Pioneer Medical Group to provide biometric screenings and health education at Pioneer's free mobile clinic events. This initiative provides community members with access to free biometric health screenings and primary care follow up to identify, treat and manage potentially unknown chronic conditions, including heart disease. By the end of 2021, 62 community members had been connected to follow-up care through the partnership.

Also recognizing smoking is a major cause of cardiovascular disease, 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.

Low Food Access (Social Determinant of Health)

Low food access was also a priority found in the assessment. In the Hospital's community, 26% live in areas with low food access. A lack of food access can lead to food insecurity, when community members do not have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.

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. In 2021, the Hospital held the first two of their planned classes, providing education to 30 participants and giving 147 produce vouchers. The Hospital also established a paid program for employees to volunteer at local organizations focusing on food access and insecurity.

Mental Health/Suicide/Depression

Mental health, suicide and depression were also identified in the 2019 assessment as a priority. Suicide is 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 suicide is 19 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, seven community members had completed the class. The Hospital also developed and launched a paid volunteer program through which team members can volunteer at local organizations which are addressing mental health needs.

Obesity/Overweight

Obesity became a priority in the 2019 assessment when it was found that in the Hospital's community, almost one third of adults are obese (BMI greater than 30), while 39% of adults are considered overweight (BMI between 25 and 30). Obesity can cause serious health complications including high blood pressure, high cholesterol, heart disease, osteoarthritis and some cancers. Obesity can be related to behavioral and/or genetic factors. Another contributing factor to obesity can be the built environment, for example where you live and if you have access to healthy food and the ability to exercise outside.

As part of its efforts to address this, the Hospital partnered with Premier Heath Care to create a local site in the community for the KidShape program. The KidShape program is a family-based intervention for overweight children which provides kids with an opportunity to exercise in a fun and engaging environment while developing healthy habits. Since adopting the plan, a community site was identified and established, and 26 children were enrolled into the KidShape program in 2021.

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.

Florida Hospital Zephyrhills Inc.,
d/b/a AdventHealth Zephyrhills

CHNA Approved by the Hospital Board on December 14, 2022

For questions or comments please contact:
wfd.communitybenefits@adventhealth.com

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