2022 AdventHealth Lake Placid

Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

Table of Contents

Introduction 3
Letter From Leadership 3
Executive Summary 4
About AdventHealth 7

Community Overview 8
Community Description 9
Community Profile 9

Process, Methods and Findings 16
Process and Methods 17
- Community Input 17
- Secondary Data 18

The Findings 19

Priorities Selection 22
Prioritization Process 23
Members of the Prioritization Session 23
CHNAC Members 26
Available Community Resources 31
Priorities Addressed 34
Priorities Not Addressed 36

Community Health Plan 39
Next Steps 39
2020 Community Health Plan Review 40
2019 Community Health Needs Assessment Comments 42

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

Adventist Health System/Sunbelt, Inc. d/b/a AdventHealth Lake Placid will be referred to in this document as AdventHealth Lake Placid or “the Hospital”. AdventHealth Lake Placid in Lake Placid, Florida conducted a community health needs assessment from July 2022 to November 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 Collaborative

AdventHealth Lake Placid serves the same community as two other AdventHealth hospitals, AdventHealth Sebring and AdventHealth Wauchula. The hospitals shared service area covers Highlands and Hardee Counties. The hospitals partnered with The Florida Department of Health in Highlands County and in Hardee County to complete the community health needs assessment. This group, referred to as “the Collaborative”, met 13 times in 2021-2022. They reviewed the primary and secondary data and helped to identify the top needs in the community.

Community Health Needs Assessment Committee

AdventHealth Lake Placid 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 the 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 Lake Placid in collaboration with the Collaborative collected both primary and secondary data, in partnership with Conduent Healthy Communities Institute (HCI), an independent agency specializing in the data collection and assessment process.

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 nine aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://highlands.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.
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.

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?

Following the prioritization of needs by the community and the Collaborative, the CHNAC reviewed data specific to the community the Hospital serves and voted unanimously for the Hospital to address the same needs that had been selected.
See Prioritization Process for more.

Priority Issues to be Addressed

The priority issues to be addressed are:

1. Access to Healthy Foods (and Diabetes Prevention)
2. Access to Quality Health Care
3. Behavioral Health (Mental Health & Substance Misuse)

See Priorities Addressed for more.

Approval

On December 15, 2022, the AdventHealth Lake Placid 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 Lake Placid 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 Lake Placid 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 Lake Placid

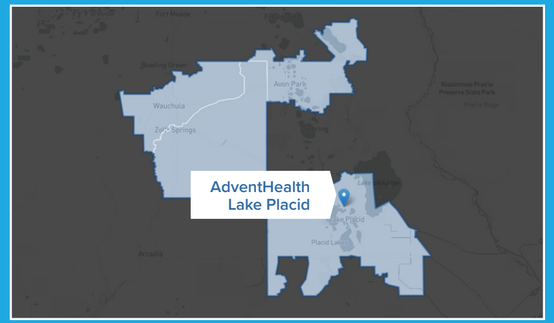
AdventHealth Lake Placid is a 33-bed Hospital that opened in 1981 to better serve the members of Highlands County. In 2021, AdventHealth Lake Placid saw 12,095 total ED visits and has received national recognition in patient safety, Ultrasound and computed tomography (CT) and Emergency Department (ED). To better meet the health needs of Highlands County, the Hospital offers a Wellness Center, along with educational classes, to the community. Key Service lines include, ER, ICU and the Medical Surgical Unit. AdventHealth Lake Placid is on the leading edge of technology in Highlands County, being the only Hospital to utilize virtual and room sterilization technology. The Hospital has been recognized and received an "A" from the Leapfrog Group in patient safety. For more information, visit www.AdventHealthLakePlacid.com.

COMMUNITY OVERVIEW

Community Description

Located in Highlands County, Florida, AdventHealth Lake Placid 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 Highlands and Hardee Counties. The Hospital has an overlapping PSA with both AdventHealth Sebring and AdventHealth Wauchula. As the Hospitals have a large, shared service area, they often work in collaboration when addressing community needs. According to the 2020 Census, the population in the AdventHealth Lake Placid community has decreased 2.5% in the last ten years to 64,751 people.

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

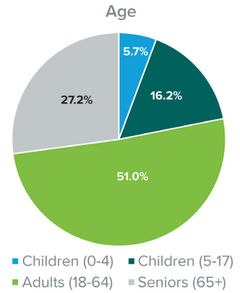
Age and Sex

The median age in the Hospital's community is 43.9, higher than that of state, which is 42.2, and that of the US, 38.2.

Males are the majority, representing 51.3% of the population. Senior aged women, 65 and older, are the largest demographic in the community at 14.9%. Middle aged men, 40-64, are the second largest demographic group at 14.1%.

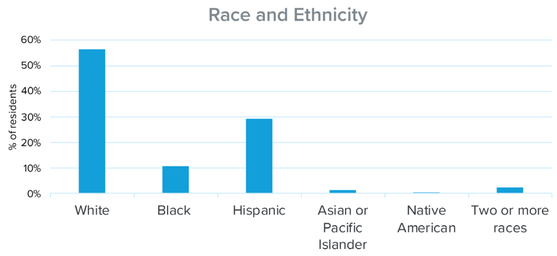
Children are 21.9% of the total population in the community. Infants, those zero to four, are 5.7% of that number. The community birth rate is 44.6 births per 1,000 women aged 15-50, which is lower than the US average of 51.9, and that of the state, 48.3. In the Hospital's community, 34.3% of children aged 0-4 and 32.3% of children aged 5-17, live in poverty.

Seniors, those 65 and older, represent 27.2% of the total population in the community. Females are 53.3% of the total senior population.



Race and Ethnicity

In the Hospital's community, 56.3% of the residents are non-Hispanic White, 10.6% are non-Hispanic Black and 29.1% 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 2.3% 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.

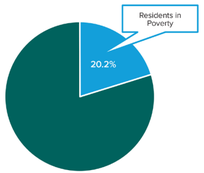
Neighborhood and Built Environment: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

Income

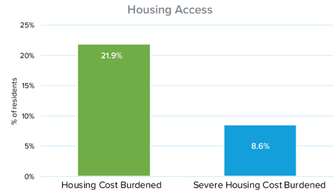
The median household income in the Hospital's community is $42,318. This is below the median for the state and that of the US. The poverty rate in the community is 20.2%, which is higher than the state and national rate.



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 18%.

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

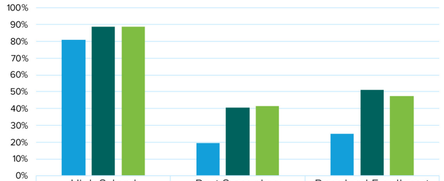
Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.[4] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in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

In the Hospital's community, there is an 80.7% 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.[5]

In the Hospital's community, 24.9% of 3-4-year-olds were enrolled in preschool. This is lower than the state (51%) rate and the national rate (47.4%). There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



	High School Graduation Rate	Post Secondary Degree Rate	Preschool Enrollment Rate
Hospital's Community	80.7%	19.5%	24.9%
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

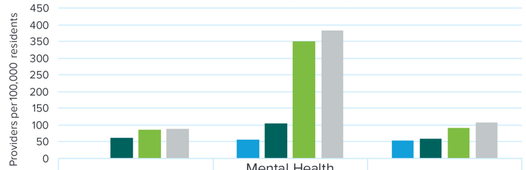
In 2020, 12.3% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability 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.

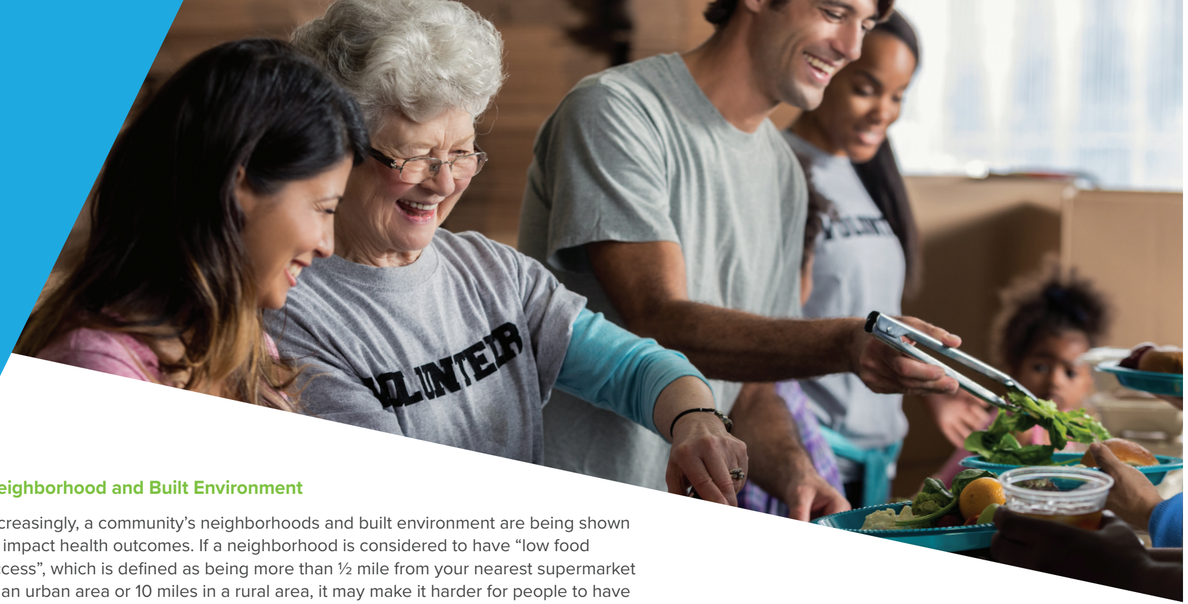
Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. In the Hospital's community, 77.3% of people report visiting their doctor for routine care.

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

Providers per Capita



	Primary Care	Mental Health Providers (2021)	Dentists (2022)
Hospital's Community	N/A	55.8	54.8
Highlands County	62	104.4	58.4
Florida	86.5	350.7	91.5
United States	89.1	381.9	106.4



Neighborhood and Built Environment

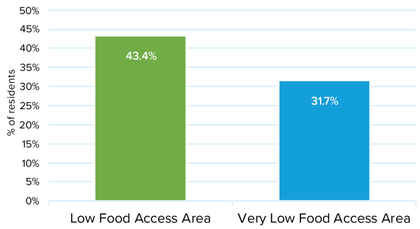
Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder 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, 43.4% of the community lives in a low food access area, while 31.7% 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 accessing health care, healthy food and maintaining employment. In the community, 5% 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

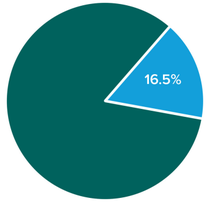
People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through 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, 16.5% 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 23.3% of seniors (age 65 and older) report living alone and 5% 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.

To guide the assessment process and create a wholistic and collaborative approach the Hospital partnered with AdventHealth Sebring and AdventHealth Wauchula, two facilities which also serve the same community, and the Florida Department of Health in Highlands and Hardee Counties, where the hospitals are located. The group, known as “the Collaborative”, consulted and worked with the community and those who represent the interests of medically underserved, low-income and minority community members throughout the assessment and prioritization process. The Collaborative also 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://highlands.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

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.

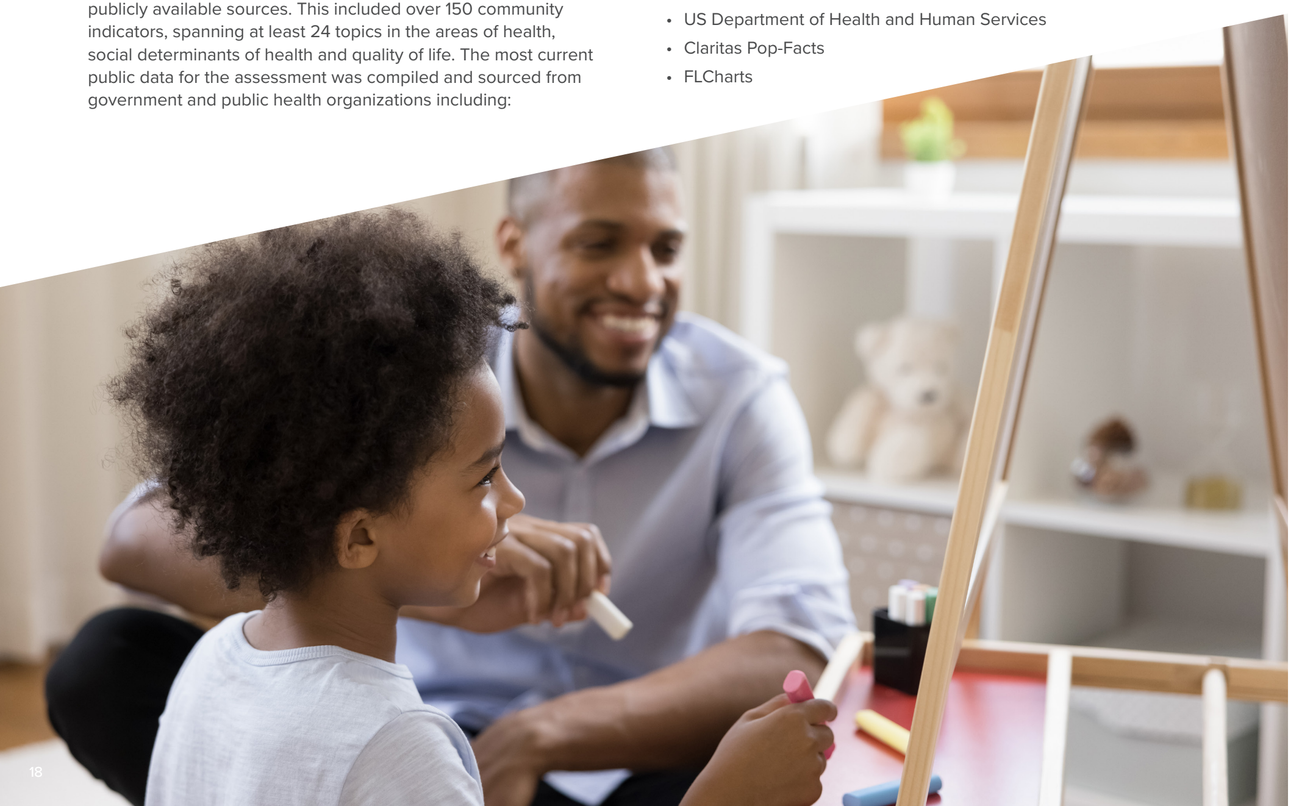
Focus Groups

- Five joint 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 community stakeholders, Black/African Americans, Hispanic/Latinos, Older Adults and Parents of Children. Members or representatives of these communities were selected to participate in the focus group discussions.

Secondary Data

To inform the assessment process, Conduent 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
- FLCharts



The Findings

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

Access to Healthy Foods

Access to healthy foods was a priority found in the assessment. A lack of food access can lead to food insecurity. Food insecurity is a lack of available financial resources for the purchase of food. Individuals who experience food insecurity often consume a diet that is not nutrient-rich and lacks the nutrition needed to sustain a healthy life. A nutrient-poor diet is typically higher in calories and saturated fat and often linked to the development of chronic disease, such as diabetes, hypertension and heart disease.

Access to Quality Health Care

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.

Children's Health

Children's health needs are unique in that both their bodies and minds are continually growing and shaping in ways that need extra care and nourishment. Health issues affecting children include food insecurity, dental care, medical care and mental health needs.

Diabetes

Diabetes is a disease indicated by having high levels of uncontrolled sugar in the blood. Diabetes is the eighth leading cause of death in the United States. When diabetes goes untreated it can lead to more serious health issues such as vision loss, heart disease, stroke, nerve and kidney diseases.

Economy

A healthy economy in a community can ensure better health outcomes because a strong economy can mean more jobs, better income and greater access to health insurance coverage through employee-related benefits. Financial stress can result in poor health outcomes including physical, mental and relationship strains resulting in an overall reduced quality of life.

Mental Health and Mental Health Disorders

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.

Older Adult Health

Older adults are at higher risk for chronic health problems such as diabetes, osteoporosis and Alzheimer's disease. In addition, 1 in 3 older adults fall each year and falls are a leading cause of injury for this age group. Physical activity can help older adults prevent both chronic disease and fall-related injuries. Older adults are also more likely to go to the hospital for some infectious diseases. Making sure older adults get preventive care and supportive community services can help them stay healthy.

Prevention and Safety

Healthy People 2030 focuses on preventing intentional and unintentional injuries. Unintentional injuries are the fourth leading cause of death in the United States. Under the topic area of Prevention and Safety, accidents and injury prevention were identified as important health concerns to address. Many unintentional injuries are caused by motor vehicle crashes and falls, whereas many intentional injuries are related to gun violence and physical assaults.

Substance Use and Misuse

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.

PRIORITIES SELECTION

Prioritization Process

The Collaborative invited participants from numerous collaborating organizations, as well as other community partners, to narrow down the needs of the community to a list of three based on the findings from the assessment. This virtual prioritization session, on October 26, 2022, included a presentation highlighting the findings from the data and the needs that were identified. The invited participants represented a broad cross section of experts and organizational leaders with extensive knowledge of the health needs in the community. They represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

Members of the Prioritization Session

Community Members

Julie Richardson, Children's Advocacy Center

Nancy Zachary, RCMA

Cynthia Acevedo, Healthy Families/HCBCC

Michelle Cathey, Heartland Rural Health Network

Lenora White, CareerSource Heartland

Anna Richard, Hope for Highlands/ Champion for Children Foundation

Courtney Green, Director of Adult Education and Technical Dual Enrollment, South Florida State College

Arthur Conover, Assistant Veterans Services Officer, Highlands County Veteran Services; Highlands County Board of County Commissioners

Bernadette Hansen, Mental Health Counselor, Children's Advocacy Center

Public Health Experts

Tessa Hickey, Director of Nursing, DOH-Highlands

Jennifer Roth, Interim Administrator, DOH-Highlands

Pamela Crain, Health Educator, DOH-Highlands

AdventHealth Team Members

Alyssa Smith, Community Health Coordinator

Alison Grooms, Community Health Coordinator

Kimberly Williams, Director of Community Benefit

Dottie Robinett, Executive Assistant

Amberhope Montero, Community Specialist (AdventHealth Sebring)

Christen Johnson, Vice President

Hannah Miller, Intern

Linda Lynch, Director of Pastoral Care

Andrew Roquiz MD, Physician

Jason Dunkel, CEO

Following the data presentation, participants then discussed the identified needs, how the needs were impacted by the social determinants of health and the resources available to address the needs. Following discussions, the participants completed the prioritization using an online activity to rank the needs.

Each need was prioritized individually using the following criteria:

Scope and Severity: How big an issue is each health issue?

- *How many people in the community are or will be impacted?*
- *How does each need impact health and quality of life?*
- *Has the need changed over time?*

Ability to Impact: Do you feel the groups taking on this work will be able to have a positive impact on each health issue?

- *Do the hospitals, health departments or community organizations have the knowledge, experience or resources to address the health need?*
- *Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?*
- *Can we create clear goals to address the health need? Are those goals achievable in the next few years?*

Rank	Need	Cumulative Score
1	Mental Health & Mental Disorders	37
2	Access to Quality Health Care	37
3	Children's Health	33.5
4	Access to Healthy Foods	33.5
5	Diabetes	33
6	Substance Use & Misuse	31.5
7	Older Adult Health	30.5
8	Prevention & Safety	29.5
9	Economy	28.5

The Collaborative supported the ranking of needs prioritized during the exercise and chose to focus on the top three; Access to Quality Health Care, Access to Healthy Foods (including Diabetes Prevention) and Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse) The Collaborative did choose to include some of the other interconnected needs that had been identified in the assessment in their final top three priorities.

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.

Having reviewed the selections and the supporting data from the Collaborative, the CHNAC voted unanimously for the Hospital to address the same needs that had been selected by the Collaborative. Through a unified approach in addressing the same needs as the Collaborative, the belief is that the Hospital will have a greater impact in addressing the needs of the community.

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 serve and ensure their voices were at the table.

Name, Title	Organization	Services Provided	Populations Served
Nancy Christensen, Vice President	AdventHealth Medical Group	Health care	Provides primary care and specialty medical services to the general population
Dottie Robinett, Executive Assistant	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services
Jason Dunkel, Chief Executive Officer	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services
Randy Suber, Former Chief Executive Officer	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services
Rosalie Oliver, Vice President Chief Financial Officer	AdventHealth West Florida Region	Health care	Serves the general population through hospital health care and emergency department services
Terri Bryant, Former Director of Case Management Terri Bryant, Former Director of Case Management	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services
Bobbie Clark, Wellness Center Supervisor	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services and through wellness activities
Amberhope Montero, CREATION Life Community Health Specialist	AdventHealth Sebring, Lake Placid and Wauchula	Health care and health education programs	Serves the general population through hospital health care, emergency department services and community health education
Linda Lynch, Director of Pastoral Care	AdventHealth Sebring, Lake Placid and Wauchula	Health care and pastoral care	Serves the general population through hospital health care, emergency department services and pastoral care
Becky McIntyre, Home Health/ Wellness/Diabetes/CREATION Life Director	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services

Name, Title	Organization	Services Provided	Populations Served
Cathy Albritton, Marketing Director	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care and emergency department services
Sara Rosenbaum, Former CREATION Life Community Specialist	AdventHealth Sebring, Lake Placid and Wauchula	Health care	Serves the general population through hospital health care, emergency department services and community health
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
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
Kimberly Williams, Community Benefit Director	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
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
Justin Allen, Senior Vice President/Chief Performance and Customer Operations Officer	Patient Engagement Advisors	Health care	Focus on inpatients within hospitals
Lisa Adams, Care 360 Director of Engagement	Patient Engagement Advisors	Health care	Focus on inpatients within hospitals

CHNAC Members continued

Name, Title	Organization	Services Provided	Populations Served
Dianna Feo, Business Operations Manager	CareerSource Heartland	Workforce programs	Employment services and skills training for job seekers of the general population
Ann Martin, Chief Programs Officer	CareerSource Heartland	Workforce programs	Employment services and skills training for job seekers of the general population
Bethany Coz, Tobacco Program Director	Central Florida Area Health Education Center (AHEC)	Health education and prevention programs	Health education and tobacco prevention programs for general public
Denise Collazo, Health Center Administrator	Central Florida Health Care-Avon Park	Health care	Federally qualified health center that provides health services to low-income, uninsured and underinsured adults and children
Elizabeth Silva, PCMH Navigator	Central Florida Health Care	Health care	Federally qualified health center that provides health services to low-income, uninsured and underinsured adults and children
Carissa Marine, Chief Executive Officer	Champion for Children Foundation	Parent and caregiver programs	Provides abuse and neglect prevention programs for children and families of the general population
Anna Richard, Director of Children's Services	Champion for Children Foundation	Parent and caregiver programs	Provides abuse and neglect prevention programs for children and families of the general population
Maria Pearson, Director	Drug Free Hardee	Substance use prevention programs	Provides education and advocacy for substance use prevention for families and youth of the general population
Stefania Sweet, Community Health Programs Manager	DOH - Hardee	Health care and public health	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Deja Sparkman, Community Health Liaison	DOH - Hardee	Health care and public health	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Rosa Ontiveros, Minority Health/Health Equity Liaison	DOH - Hardee	Health care and public health	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Pamela Crain, Community Programs Manager	DOH - Highlands	Health care and public health	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Tessa Hickey, Director of Nursing	DOH – Highlands	Health care and public health	Provides health care services and health education programs with a focus on low-income, underserved, underinsured and uninsured populations
Noey Flores, Hardee County Commissioner	Hardee County Board of County Commissioners	County leadership	Carriers out the policies and enforces regulations for the general population of Hardee County
Jill Vaillancourt, Executive Director	Hardee Help Center	Food pantry and homeless services	Provides food and other services to the homeless and at-risk populations
Cynthia Acevedo, Program Director	Healthy Families Highlands County	Parent and caregiver programs	Provides parent and caregiver programs to the general population
Charlene Edwards, Executive Director	Healthy Start Coalition of Hardee, Highlands and Polk County	Pregnant women, children and family development programs	Provides prevention and healthy development programs for pregnant women, children and families
Aisha Alayande, Executive Director	Heartland Core Wellness	Health/wellness and youth substance use prevention	Prevention education programs regarding substance use targeted for youth
Marybeth Soderstrom, Engagement and Mobility Manager	Heartland Regional Transportation Planning Organization	Transportation	Provides transportation services to low-income residents
Larry Moore, iMAD Program Director	Heartland Rural Health Network	Health care and public health	Focus on rural, minority adults and teens by providing health care services, health education and employment readiness skills
Melissa Thibodeau, Executive Director	Heartland Rural Health Network	Health care and public health	Focus on rural, minority adults and teens by providing health care services, health education and employment readiness skills
Valeria Rivera, Project Director	Heartland Rural Health Network	Health care and public health	Focus on rural, minority adults and teens by providing health care services, health education and employment readiness skills
Ingra Gardner, Director of Community Programs	Highlands County Board of County Commissioners	County leadership	Carriers out the policies and enforces regulations for the general population of Hardee County
Denise Williams, County Veteran Services Officer	Highlands County Veteran Services Office	Veteran's services	Provides resources and programs for veterans residing in Highlands County

CHNAC Members continued

Name, Title	Organization	Services Provided	Populations Served
Debbie Slade, Director	Nu-Hope Elder Care Services	Senior services	Congregate meals, independent living resources and health education for senior citizens of Highlands County
Carly Carden, Marketing and Business Development Manager	Peace River Center	Mental health, behavioral health, crisis and victim services programs	Mental health, crisis services and victim services for the general population and low-income children ages 5 to 18
Nancy Zachary, Director of Health	Redlands Christian Migrant Association (RCMA)	Migrant family services and early childhood education	Provides early childhood education and care services specifically for migrant children and families
Bill Stephenson, Executive Director	Samaritan's Touch Care Center	Health care	Provides primary and specialty care services for low-income, uninsured and underinsured populations
Tina Walker, Operations Director	Samaritan's Touch Care Center	Health care	Provides primary and specialty care services for low-income, uninsured and underinsured populations
Kamille Manalo, Panther Youth Partners Coordinator	South Florida State College	Workforce programs	Employment readiness and skills training programs specifically targeted for youth
Courtney Green, Director of Adult Education and Technical Dual Enrollment	South Florida State College	Education programs	Adult education programs for the general population seeking to complete their G.E.D. or technical skills
Mercedes McNew, Administration Secretary	The Ruth E. Handley Children's Advocacy Center	Children's trauma programs	Programs to reduce trauma to child abuse victims and prevention programs for families needing support
Bernadette Hansen, Licensed Mental Health Counselor	The Ruth E. Handley Children's Advocacy Center	Children's trauma programs	Programs to reduce trauma to child abuse victims and prevention programs for families needing support
Sarah Beth Rogers, Manager	The Ruth E. Handley Children's Advocacy Center	Children's trauma programs	Programs to reduce trauma to child abuse victims and prevention programs for families needing support
Mabel Castillo, Program Manager of The Florida Center in Avon Park	Tri-County Human Services	Mental and behavioral health programs	Mental health and behavioral health programs for adults and low-income children ages 5-18
Deanne Shanklin, Highlands County Coordinator	United Way of Central Florida	Higher education and workforce development	Education, employment support, community improvement, disaster services and volunteer programs focused on serving the underserved populations

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 Quality Healthcare	• Samaritan's Touch Care Center: provides free medical and mental health care to Highlands County and serves the low-income and low-access populations • Champion for Children Foundation helps with limited healthcare costs for children including medical, mental health, vision, dental and hearing • Dr, William Chen with Chen Dental, a local dentist that offers free dental services • Heartland Rides programs for transportation disadvantaged individuals • Central Florida Health Care's dental program • Nu Hope Elder Care services • Department of Health Highlands County Primary Care services for adults and children	• AdventHealth Whole Health Hub to find resources in community • AdventHealth's Life after Cancer course • AdventHealth's Chronic Disease Self-Management course • AdventHealth's Community Sports Clinic
Access to Healthy Foods (and Diabetes Prevention)	• Ridge Area Seventh Day Adventist Church offers free community garden goods weekly • Avon Park Seventh Day Adventist Church offers a 6-week Reversing Diabetes program every year in the third quarter • Department of Health Highlands Women, Infants and Childrens nutrition programs • Nu Hope Elder Care Services • Department of Health Highlands Healthy Start Coalition • Department of Health Highlands County Diabetes education programs (Closing the Gap Diabetes Self-Management classes) • Department of Health Highlands' Tools for Health blood pressure monitoring instruments	• AdventHealth's Lifestyle and Longevity Series for community members • AdventHealth's free Diabetes Education classes • AdventHealth's free Food is Health® program • AdventHealth's free Diabetes Prevention classes offered at the Wellness Center • AdventHealth's Community Cooking class • AdventHealth's Gestational Diabetes class • AdventHealth's Eat'n like Eden class • AdventHealth's Cardiac Nutrition class

Top Issues	Current Community Programs	Current Hospital Programs
Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse)	• Avon Park Seventh Day Adventist Church offers an 8-week Depression Recovery program annually during the first quarter • Samarita's Touch Care Center's free mental health counseling • Champion for Children Foundation's help with children's mental health needs • Peace River Center Mobile Crisis Unit • Peace River Center offers free Mental Health First Aid classes • Peace River Center's Victim Services offers free counseling for survivors of sexual assault for ages 12 and up • Tri County Human Services program to strengthen families that provides prevention resources for substance abuse or at-risk kids • Heartland for Children offers free Mental Health First Aid classes	• AdventHealth pastors and faith community initiatives • AdventHealth's free Mental Health First Aid program • AdventHealth's Nedley Depression and Anxiety Recovery Seminar • AdventHealth's Nedley Optimize Your Brain course
Children's Health	• Florida Department of Children and Families (DCF) Medicaid Assistance programs for pregnant women, parents and caretaker relatives of children • Highlands County Department of Health's Women, Infants and Children (WIC) program • Redlands Christian Migrant Association (RCMA) Early Head Start program • Highlands County Department of Health's Healthy Start program • Highlands County Board of County Commissioners Healthy Families program • Children's Advocacy Center • Champion for Children Foundation	• AdventHealth offers a community sports clinic once per year in an underserved area of the community • Dr. Andrew Roquiz with AdventHealth offers a free 6-week series for children called Neal Nedley's Optimize Your Brain at the Walker Memorial Academy
Older Adult Health	• Highlands County Department of Health programs and services • Central Florida Health Care's primary care services • Nu-Hope Elder Care • Senior Connection Center • Samaritan's Touch Care Center • Heartland Rides programs for the transportation disadvantaged	• AdventHealth Lake Placid in partnership with the Alzheimer's Association offers the 10 Warning Signs of Alzheimer's Disease program • AdventHealth Lake Placid in partnership with the Alzheimer's Association offers the Brain Bus program • AdventHealth Lake Placid in partnership with the Senior Connection Center offers free fitness classes for seniors
Prevention and Safety	• Nu Hope Elder Care Services • Champion for Children Foundation • Highlands Community Services • Highlands County Department of Health • Highlands County Sheriff's Office prevention programs	
Economy	• Florida Department of Children and Families' Temporary Cash Assistance program • CareerSource Heartland's Career Services program • Florida Division of Vocational Rehabilitation Services • Ridge Area ARC community services • South Florida State College's adult education and career services	

Priorities Addressed

Access to Healthy Foods (and Diabetes Prevention)

Access to quality healthy food was a top need prioritized during the assessment. In Highlands County, one-third of residents live in an area where there is low access to a grocery store, which can make having a healthy, nutrient-dense diet more challenging. Also, almost a fifth (17.9%) of community survey respondents shared they were worried that they would run out of food before they had money to buy more. Respondents also expressed concern about increasing food prices and the lack of healthy food options in local neighborhoods.

During the prioritization process, the decision was made to address diabetes through the access to healthy foods priority. An individual's quality of life when living with diabetes is heavily influenced by how well they can manage their blood sugar and eating well is key to blood sugar management. By improving access to healthy food, an impact can be made for those with diabetes as well. According to secondary data, diabetes in the Medicare population in Highlands County is at 30%, which is a slightly higher percentage than that of the state (27.8%) and the US (27%). Eighteen percent (18%) of adults in the county have been diagnosed with diabetes, this is more than one and a half times the rate seen for the state (11.7%). The age adjusted death rate due to diabetes in the county is also slightly higher in the county (27.8 per 100,000) than in the state (23.2/100,000) and the nation (24.8/100,000). The Hospital will align with community partners and county efforts, when possible, to create targeted strategies which improve access and health outcomes for Highlands County residents.

Access to Quality Health Care

Access to quality health care was a top need identified when surveying the community. More than half (60%) of community survey respondents reported accessing care in the emergency department for non-emergency needs. Almost a quarter (24%) shared that they needed dental care in the last 12 months but did not receive the care they needed. Community members cited barriers such as cost or financial concerns, lack of trust in the providers, lack of insurance or limited coverage, inability to take time off work for appointments, lack of awareness or difficulty navigating the healthcare system and language barriers for non-English speakers when trying to sign up for insurance or complete paperwork.

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. Highlands County falls within the lower 25% of counties in both the state and in the US for adults who do not have any kind of health insurance coverage. Highlands County also has a lower rate of primary care providers in the area compared to the state (57 providers per 100,000 versus 73 providers per 100,000). Focusing on access to quality health care will help align local efforts and resources to create targeted strategies to improve access for Highlands County residents.

Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse)

In Highlands County, 27% of community survey respondents reported having been diagnosed with a depressive disorder or anxiety disorder. Secondary data found in the assessment also showed the age-adjusted death rate due to suicide in Highlands County is 25.2 per 100,000, this is almost twice that of the state (13.1 per 100,000) and the US (13.5 per 100,000). The assessment also found more than ten percent (12.1%) of survey respondents were unable to access mental health resources when needed in the last 12 months. The top reasons cited were inability to pay for care, inability to schedule an appointment when needed and inability to take time off work for appointments.

Substance use and misuse also emerged as a top concern, reflected in both primary and secondary data sources. Teen vaping was cited as the highest area of concern for tobacco use in the county from primary data. Secondary data showed the rate of drug and opioid-involved deaths as 35.4 per 100,000 in Highlands County, higher than both the rate in the state (26.7 per 100,000) and the nation (23 per 100,000). The death rate due to drug poisoning in Highlands County is also slightly higher than the state and national rate.

Awareness and the need to address behavioral health issues, including mental health, mental health disorders, substance use and substance misuse, has been growing in the country. By including this topic area as a priority, the Hospital will work collaboratively with community partners to create better outcome opportunities over the next three years.

Priorities Not Addressed

Economy

In Highlands County 12.9% of families reported living below the poverty level in the primary data findings. This percentage is higher than both the state (9.3%) and national (9.1%) values. Seven percent of respondents reported being worried that they may not have stable housing in the next two months. Community respondents shared that job availability is scarce and low wage jobs are not appealing. They also expressed concern for rising food prices and housing costs and limited social security funds.

While a strong economy is important in the overall health needs of the community, the CHNAC did not perceive this priority area as one that could be easily addressed within the three-year CHP cycle. It was voted the lowest in the ability to impact category in the prioritization meeting. Therefore, the Hospital will not work to address this priority area in the upcoming CHP.

Older Adult Health

The primary data collection revealed that respondents felt aging problems, such as difficulty getting around, dementia and arthritis, were top concerns. They also shared that there were no specialists, such as neurologists, in rural areas that encompass Highlands County and that specialists such as these are needed as individuals age. Transportation challenges were also shared as an area of concern for this population, specifically those who are mobility challenged. Respondents also expressed a concern for common stereotypes faced by older adults and inequalities they experience when accessing care.

Older Adult Health ranked seventh among the other topic areas in the secondary data analysis with a score of 1.97 but was ultimately not selected as one of the top three priority areas to address in the next three-year plan. Participants in the prioritization selection meeting felt the top three priority areas chosen were significant and easier to address with the resources available and therefore, the Hospital will not be addressing Older Adult Health directly in the upcoming CHP.

Prevention and Safety

Prevention and Safety was identified as a significant health need in the secondary data analysis but scored as one of the lowest out of all the topic areas. Primary data collection results determined Highlands County residents were particularly concerned with distracted driving (including texting, eating and talking on the phone while driving). This activity was noted as a risky behavior that is harmful to the overall health of the community.

Prevention and Safety ranked eighth out of nine total significant health needs identified from both primary and secondary data sources but was not voted as a top priority to address by the CHNAC in the upcoming three-year Community Health Plan.

Children's Health

Children's Health ranked third out of the nine topic areas of health concern. The areas of concern under this topic included child food insecurity, health insurance coverage and medical care and mental health care. The rate of food insecurity among children in Highlands County (24.3%) is higher than that of the state (17.1%) and US (14.6%). Highlands also shows a lower percentage of children with health insurance at 91.7% compared to 92.4% in the state and 94.3% in the US. Over 16% of caregivers of children responded not being able to access mental or behavioral health for their children when needed. From the primary data findings many caregivers expressed concern for lack of pediatric providers available, especially specialists, in the area. They also shared a need for increased education and communication for parents and cultural competency among healthcare workers.

Children's health is of utmost importance, but the Collaborative decided that instead of focusing on it as a stand-alone priority area, instead children would be a target population group to focus on among all the priority areas.

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.

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.

Mental Health (Behavioral Health)

In the 2019 assessment, mental health was identified 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 higher than the state rate. The assessment also found a slightly higher percentage of the Medicare-fee-for-service population were depressed compared to the state average. The assessment also found a quarter of the adults in the community reported receiving insufficient social and emotional support all or most of the time. 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 behaviors and suicide.

The Hospital focused its efforts on increasing education and building community level networks for mental health support. As part of this effort, in 2021 four team members completed the Mental Health First Aid instructor certification. Having received the certification, the team members are now providing classes training community members on how to help someone who may be experiencing a mental health or substance use challenge. The Hospital completed one community class by the end of 2022. 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.

Transportation

The Hospital also selected transportation as a priority in the assessment. In the Hospital's community, almost 4% of the population use public transportation as their primary means of travel to work. A lack of reliable transportation or an inadequate public transportation system prevents those who do not own a car or have consistent transportation from accessing health care which can result in rescheduled or missed appointments and delayed care. Transportation barriers can also create challenges for people to find healthy food when living in low food access areas impacting their overall health.

As part of the effort to address this, the Hospital has launched the AdventHealth Food is Health® program in the community. The 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. The Hospital planned for one class by the end of 2022.

Cardiovascular Disease

The Hospital also chose cardiovascular disease as a priority in the assessment. In the Hospital's community 9% of adults had been told they have coronary heart disease or angina. The assessment also found a slightly higher rate of death due to heart disease in the community than compared to the state rate. Heart disease 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. Smoking is also a major risk factor for cardiovascular disease. It was found that 22% of adults in the community smoke.

In part, the Hospital has focused on increasing education and access to cessation classes to address this priority. The Hospital has formed a partnership with the Central Florida Area Health Education Center (AHEC) to support a number of tobacco education and cessation initiatives. This includes establishing a referral network to connect patients with tobacco cessation classes and free intervention therapies to quit smoking. The work with AHEC was part of a collaborative effort between the Hospital, AdventHealth Sebring and AdventHealth Wauchula, all of which serve the same community. The Hospital supported AHEC through marketing efforts, referrals and by hosting two classes on the campus. The Hospital also developed and launched a paid volunteer program through which team members can volunteer at local organizations which are addressing the priority.

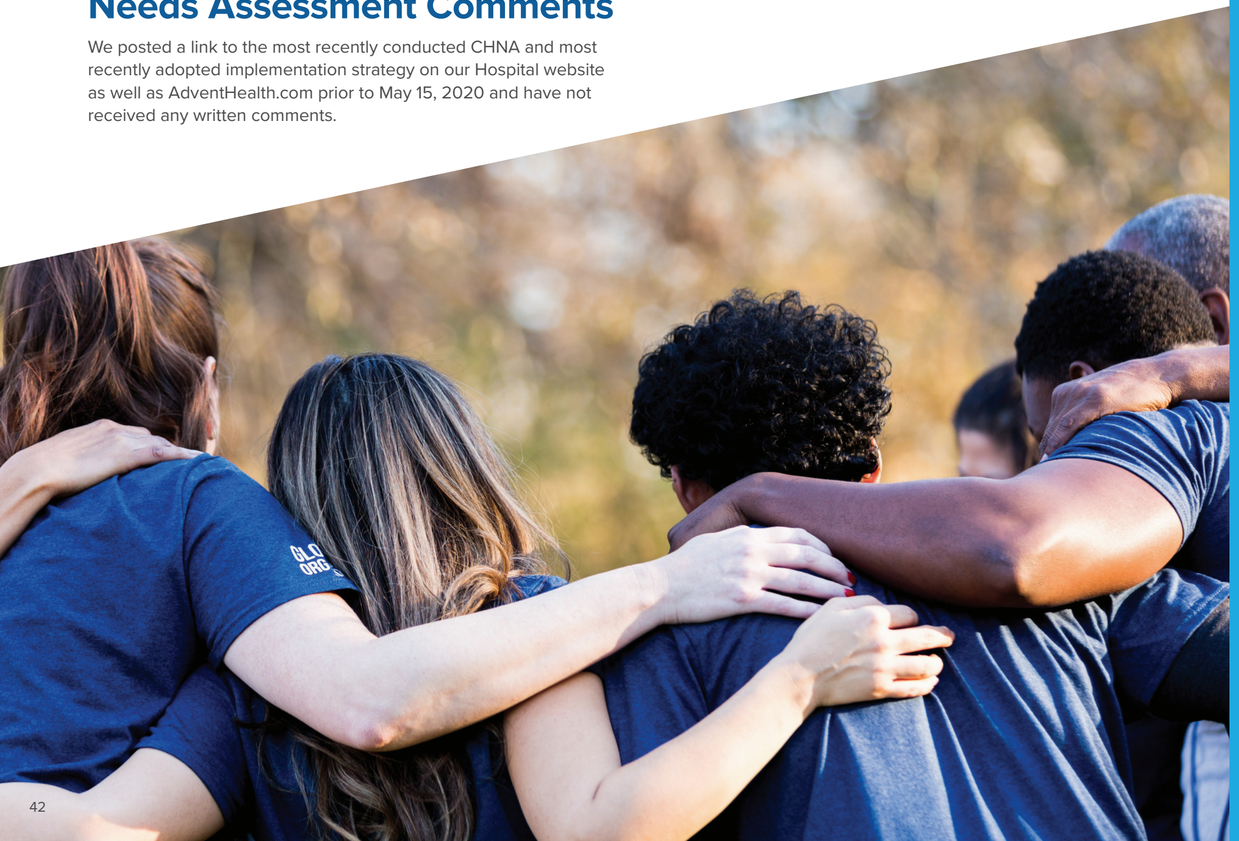
Education (Social Determinant of Health)

Education was also chosen as a priority in the assessment. Educational attainment is a social determinant of health. Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities. 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, 17% of the population was found to not have a high school diploma or equivalency.

Efforts to address education were part of a collaborative effort between the Hospital, AdventHealth Sebring and AdventHealth Wauchula, all of which serve the same community. The Hospital has focused on building partnerships with community organizations which support the priority. Through these efforts, the Hospital has partnered with South Florida State College and donated funds to help pay for the cost of the General Educational Development (G.E.D.) exam for those community members unable to afford the cost of the test.

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.



AdventHealth

Adventist Health System/Sunbelt Inc.,
d/b/a AdventHealth Lake Placid

CHNA Approved by the Hospital Board on December 15, 2022

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

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