2022 AdventHealth Waterman Community Health Needs Assessment

AdventHealth

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Letter From Leadership

It is my honor to serve as CEO of AdventHealth' s Central Florida Division – North Region, which includes Lake, Flagler and Volusia counties. From the city of Mount Dora overlooking Lake Dora to the sunny beaches of Palm Coast and the bustling neighborhoods of Deltona, we are on a journey together to build healthy communities.

Thank you for taking the time to review the 2022 Community Health Needs Assessment. It is the culmination of a yearlong collaborative process spearheaded and resourced by a steering committee of leaders from community-based organizations, along with community leaders (health equity champions), who ensured we were including voices from all populations. Your health equity champions in Lake, Volusia and Flagler worked closely with the community – they reviewed materials, identified focus groups, and helped to prioritize the health needs of the areas we serve. This publication includes a summary of the focus groups, the Community Health Survey, stakeholder interviews and an analysis of population-health data.

The 2022 Community Health Needs Assessment will serve as a guide as we work together with community partners, organizations and our health equity champion in developing Community Health Plans for the communities from Astor to Clermont, Palm Coast to New Smyrna Beach, Daytona Beach to DeBary, DeLand and Deltona so every person has an opportunity to attain full health potential. Together our collective vision will maximize efforts through collaboration, driving our communities to success.

Thank you again for your interest in the 2022 Community Health Needs Assessment.

Audrey Gregory, Ph.D.
President and CEO
Central Florida Division North Region

Executive Summary

Florida Hospital Waterman, Inc. dba AdventHealth Waterman will be referred to in this document as AdventHealth Waterman or “The Hospital”. AdventHealth Waterman in Tavares, 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 Community Health Needs Assessment was completed as a collaborative process with the Central Florida Collaborative, which included Lake, Orange, Osceola and Seminole county health care providers, Federally Qualified Health Centers and the Florida Department of Health for Lake, Orange, Osceola and Seminole counties. The full report from the Central Florida Collaborative can be found here: **https://www.adventhealth.com/community-health-needs-assessments**.

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Waterman took part in the Central Florida Collaborative, referred to as the Collaborative, to help guide the Hospital through the assessment process. The Collaborative served as the Community Health Needs Assessment Committee (CHNAC). The Collaborative included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations. The Collaborative worked with Crescendo Consulting Group to complete the CHNA process.

The Collaborative met several times throughout 2021 - 2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.
See the Prioritization Process section for a list of Collaborative members.

Data

AdventHealth Waterman, in collaboration with the Collaborative, collected both primary and secondary data. The primary data included community surveys, stakeholder interviews and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data were compiled and analyzed to identify the top 15 aggregate issues.
See the Process and Methods section for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the Collaborative 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.

Prioritization Process

The Collaborative participated in a prioritization process that consisted of two rounds of online surveying and one facilitated discussion session per county (Lake, Orange, Osceola & Seminole) followed by one full Collaborative facilitated discussion.
See Priorities Selection for more.

The Collaborative and the Hospital also considered four factors during prioritization.

A. Alignment: Does this issue align with our mission, strategy, public-health or community goals?

B. Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?

C. Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?

D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?

Priority Issues to be Addressed

The priority issues to be addressed are:

1. Behavioral Health: Drug and Substance Use
2. Early Childhood Education
3. Community Engagement on Available Resources and Services

See the Priorities to be Addressed and the Priorities Not Addressed sections for more.

Approval

In September 2022, the AdventHealth Waterman 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 Waterman will work with the Collaborative 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

System Description

AdventHealth Waterman 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.

AdventHealth hospital facilities participated in this assessment, including AdventHealth Orlando, a major tertiary referral hospital for Central Florida and much of the southeast, the Caribbean and South America. These eight facilities have service areas encompassing parts of each county in the Central Florida region with a total of 2,953 beds, including acute care, pediatric care, organ transplant, NICU levels II and III, comprehensive rehabilitation, adult psychiatric care and much more. While these AdventHealth facilities are located in Lake, Orange, Osceola and Seminole counties, their primary service areas extend into Brevard, Flagler, Polk and Volusia counties.

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. 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. 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.

Facility Description

AdventHealth Central Florida Division is represented in the Central Florida Collaborative by AdventHealth Altamonte Springs, AdventHealth Apopka, AdventHealth Celebration, AdventHealth East Orlando, AdventHealth Kissimmee, AdventHealth Orlando, AdventHealth Waterman, AdventHealth Winter Garden and AdventHealth Winter Park. The AdventHealth system in Central Florida is comprised of 37,000 skilled and compassionate caregivers working in physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers to provide individualized, wholistic care.

AdventHealth Waterman is a 300-bed acute-care community hospital located in Central Florida, was established in 1938 and has been the cornerstone of health care excellence in Lake County. A Grade-A Safety hospital since 2013, hospital services include: 24-hour emergency department and pediatric emergency services, award winning and comprehensive heart program, including open heart and thoracic surgery, comprehensive Cancer Institute, including leading cancer treatment technologies, certified Joint Replacement Center, Community Primary Health Clinic, critical care services, award winning advanced diagnostic imaging services, including 3D mammography, computerized tomography (CT), magnetic resonance imaging (MRI), ultrasound and nuclear medicine), digestive health care, home care services, inpatient and outpatient rehabilitation services, laboratory services, sports medicine, surgical services including minimally invasive and robotic assisted surgeries, urology, 24-bed Women and Children's Center, wound and hyperbaric medicine and spiritual care.

COMMUNITY OVERVIEW

Description

Located in Lake County, Florida, AdventHealth Waterman defines its community as Lake County. The Central Florida Collaborative selected county level data in order to capture the needs of residents throughout the wide service area covered by the participating agencies and the Hospital service area.

According to the 2020 Census, the population in Lake County has grown by nearly 19% in the last ten years to 383,956 people. This is almost triple the amount of growth in the United States since the last Census.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the County level service area, also referred to as the community, unless listed for a specific county. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.

Community Profile

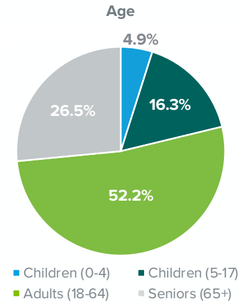
Age and Sex

The median age in the Hospital's community is 46.9, higher than that of the state, which is 42.0 and the U.S., 38.1.

Females are the majority, representing 51.5% of the population. Adults ages 20-64 years are the largest demographic in the community at 52.2%.

Children, ages 0-19 years are 21.2% of the total population in the community. Infants, those zero to four, are 4.9% of that number. The community birth rate is 9.7 births per 1,000 women. This is below the statewide average of 10.3 births per 1,000 women. The life expectancy for Lake County residents is 78.1 years, which is lower than the state (79.4) but higher than the U.S. (77.8).

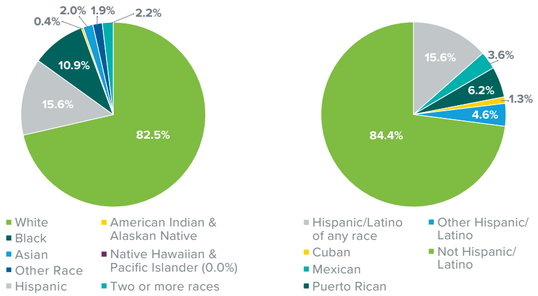
Seniors, those 65 and older, represent 26.5% of the total population in the community. Lake County has a much higher percentage of seniors than Orange, Osceola and Seminole counties and the state. While all age groups have unique and ever-changing health needs, older populations are more likely to require more health care services. In 2019, the average annual cost of individual health care was approximately $7,180 for ages 45 to 54, compared to approximately $13,050 for those 65 and over.



Race and Ethnicity

Lake County presents less racial diversity than other counties in the Collaborative, with most (82.5%) residents identifying as White. Approximately 30.3% of residents in Lake County identify as an ethnic minority. In comparison to national and state figures, the percentage of people who do not speak English is lowest in Lake County (4.7%).

Race in Lake County



Ethnicity in Lake County

Economic Stability

Income

The median household income in the Hospital's community is $55,792. This is below the median for both the state and the U.S ($57,703 and $64,994 respectively). The Black/African American population in Lake County presents the lowest median household income ($44,681) across all races in the county but is higher than the state and U.S for Blacks/African Americans. Workplace inequalities can have negative health consequences as those who are unemployed have reported feelings of depression, anxiety, low self-esteem, demoralization and stress. Lake County has a 6.1%

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 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 for example 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.

unemployed civilian labor force rate, which is higher than that of both Florida and the U.S. (both at 5.4%) and represents preCovid-19 pandemic rates. Racial and ethnic minorities living in poverty often present more adverse health outcomes compared to the White population in Lake County. Residents of impoverished communities are at increased risk for mental illness, chronic disease, higher mortality and lower life expectancy. In Lake County, a higher percentage of minority populations are living in poverty - which is also reflected in the lower median household income per year. In the community, the population living in poverty is 11.1% which is lower than the state and the U.S., at 13.3% and 12.8% respectively, however, significant disparities exist for the Black/African American and Hispanic/Latino populations in Lake County compared to Whites or Asians living in poverty.

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] For 2021, the percentage of the population in Lake County that was food insecure was 13.9% which was slightly lower than that of the state (13.3%). The percentage of food insecure children in the community was 20.9%, higher than the 19.1% for the state.

Increased evidence is showing a connection between stable and affordable housing and health[2], showed the food insecurity rate in the Hospital's community as 16%. When households are cost burdened or severely cost burned, 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%. The burden is more extreme for renters. In the Hospital's community, 13% of households are considered severely cost burdened and 14% of households experienced severe housing problems. The total number of housing units in Lake County in 2019 was 157,039. Housing in Lake County in 2020 remained a challenge even though the percentage of severely cost-burdened households (i.e., those spending 50% or more of their income on direct housing costs) are lower than the Florida average, 13% and 17%, respectively. Additionally, fewer homes in Lake County have severe housing problems. The percentage of people living in mobile homes is much higher in Lake County (18.5%) than in Florida (8.9%) and the United States (6.2%).[2]

1 Food Insecurity - Healthy People 2030 | health.gov
2 Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)

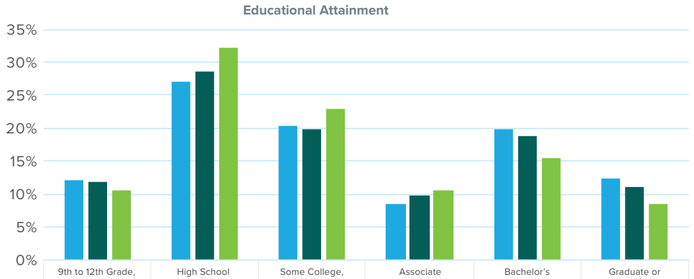
Housing Challenges in Lake County

	Severe Housing Cost Burdened	Severe Housing Problems
Lake County	13%	14%
Florida	17%	19%

Education Access and Quality

Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.[3] 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 a 92.1% high school graduation rate, which is higher than the state. The percentage of residents that have obtained a high school diploma or higher in Lake County is 90.0%, which is higher than Florida and the U.S. both at a rate of 88.5%. Despite the statistics, racial and ethnic minorities in Lake County may face unique barriers to higher education. Black/African American and Hispanic/Latino individuals have lower college enrollment and graduation rates compared to White individuals. Latino individuals are most likely to attend college part-time, which reduces their odds of graduating.[4]

Educational attainment and unemployment rates in Lake County vary across each race and ethnicity, but those who identify as Hispanic/Latino present greater disparities. Childcare services, especially for children with special needs was recognized in the top 15 community needs from information gathered in the community survey and stakeholder interviews. The community survey results also highlighted educational needs and access to and cost of childcare as top needs.



	9th to 12th Grade, No Diploma	High School Graduate (Includes Equivalency)	Some College, No Degree	Associate Degree	Bachelor's Degree	Graduate or Professional Degree
United States	12.0%	27.0%	20.4%	8.5%	19.8%	12.4%
Florida	11.8%	28.6%	19.9%	9.8%	18.9%	11.0%
Lake County	10.5%	32.1%	22.8%	10.6%	15.4%	8.6%

3 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)
4 Healthy People 2030, Enrollment in Higher Education

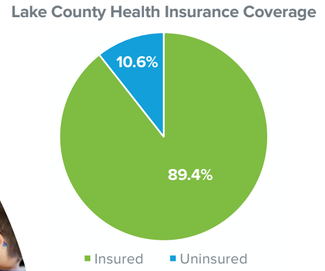
Health Care Access and Quality

From the U.S. Census Bureau, 2016-2020 American Community Survey (ACS) 5-Year Estimate, 89.4% of residents had health insurance coverage, whether private insurance, public insurance, or both. 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. 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.[5]

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, or particularly for those experiencing transportation challenges.

Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. Over three-quarters of the population had health insurance but when looking at utilization of health care services and immunizations, numbers of utilization were low. In the Hospital's community, 13.6% of people report not being able to see a doctor in the past year due to the cost. Over 22% of Lake County residents who identified as Hispanic/Latino ethnicity could not see a doctor at least once in the past year due to cost – nearly double the percentage of Non-Hispanic/Latino White residents (11.5%). The need for recruitment and retention of culturally diverse and informed providers who demographically reflect the community was identified by stakeholders and focus group participants. Under 50% of the population of Lake County received immunizations for the flu and pneumonia. In the community survey, dental care was identified as the second most important health need for children in the Collaborative service area.

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



Utilization of Health Care Services by Adults

2019	Lake County
Adults who could not see a doctor at least once in the past year due to cost	13.6%
Adults who have a personal doctor	73.2%
Adults who said their overall health was good to excellent	78.7%
Had a medical checkup in the past year	79.0%
Visited a dentist or a dental clinic in the past year (2016)	57.2%
Immunizations	
Received a flu shot in the past year	40.0%
Have ever received a pneumonia vaccination	43.5%

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 access food 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.[6]

The impact of the neighborhood and built environment on health and well-being cannot be emphasized enough. For example, there are many available references showing the benefits of living near a park or "green space.[7] In Lake County, 21.3% of residents live within 0.5 miles of a park. This is lower than Florida's 40.1%. Many people in the United States live in neighborhoods with high rates of violence, unsafe air or water and other health and safety risks. Racial and ethnic minorities and people with low incomes are more likely to live in places with these risks. In addition, some people are exposed to things at work that can harm their health, like secondhand smoke or loud noises.[8]

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

7 For example, see https://www.nrpa.org/our-work/Three-Pillars/health-wellness/ParksandHealth/fact-sheets/parksimproved-mental-health-quality-life/

8 Healthy People 2030. Neighborhood & Built Environment

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.[9] When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. National research shows that people more connected to family, friends and others have fewer mental health challenges and generally better health. Also, they also have higher self-esteem and are better at engaging others. People can connect through work, community clubs or others to build their own relationships and social support. 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.

The Collaborative survey results show that most people agree that they have social connections in their lives. In the community, only 4.5% of respondents to the Collaborative survey disagreed that they are happy with their friendships and relationships. Nearly one in seven residents (13.1%) stated that they do not have enough people in their lives to ask for help. One in nine residents (11.7%) indicate that relationships and friendships are not as satisfying as they would want them to be. These factors can create barriers to feeling connected in the community.

Mental Health & Behavioral Health (Drug & Substance Use)

Mental health including drug and substance use were identified as top needs from primary and secondary data for Lake County. In 2019, suicide rates were highest in those who identify as White, 22.5 per 100,000, slightly higher compared to Lake County total (20.0). This changed in 2020, those who identified as non-Hispanic/Latino had the highest rate of suicide at 19.9 per 100,000, slightly higher than the Lake County total (17.8).[10]

Mental health including suicide was a top need identified by survey participants, stakeholders and focus groups. Illegal Drug Use/Abuse of Prescription Medications and Alcohol Abuse/Drinking Too Much was identified as the top risky behavior within Lake County through the community survey. From the community survey, 55.9% of participants believe illegal drug use and prescription medicine abuse is an unmet need in Lake County. In addition, support for family members of a person being treated for substance use disorder was also recognized by stakeholders and focus group participants.

In the community survey, mental and behavioral health was identified as the most important health need for children in the Collaborative service area. Suicide prevention was also identified on the survey as one of the top health needs for children in the Collaborative service area. The community surveys, stakeholder interviews and focus groups also identified a need for mental health outpatient service capacity, mental health crisis services and community awareness of available resources and mental health care for senior services. From the survey, adults who needed mental health care but did not receive it said that the reasons for unmet need was due to being unable to pay for care, unable to schedule an appointment when needed, lack of awareness about navigating the system and finding a doctor/counselor.

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

10 Florida Department of Health. Bureau of Vital Statistics

Process, Methods and Findings

Process and Methods

The Process

The health of people living in the same community can be very different because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Collaborative solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. The Collaborative also collected publicly available data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form the Central Florida Collaborative to guide the assessment process. During data review sessions, community members of the Collaborative provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

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, stakeholder interviews, and focus groups.

Community Health Survey

- A total of 4,284 surveys were collected with 3,456 from Lake, Orange, Osceola and Seminole counties.
- Lake – 266, Orange – 822, Osceola – 1729, Seminole – 639
- Provided in English, Haitian Creole, Spanish, Portuguese and Vietnamese to anyone in the community and accessible through web links and QR codes.
- Links and QR codes were shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to electronic mailing lists, they maintained and when possible shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Interviews

- Interviews were scheduled with 101 community stakeholders who were asked to provide input on health and barriers to health that they were seeing in the community.

Focus Groups

- Focus groups were held with 30 groups of community stakeholders to gain input on health and barriers to health in the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income, and/or who are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

The Central Florida Collaborative served as the CHNAC. The Collaborative provided their expertise and knowledge regarding the community throughout the process.

The Collaborative consisted of organizations representing the community, public health, low income, minority, and other underserved populations. The following chart contains members of the Central Florida Collaborative who provided strategic leadership throughout the CHNA and/or served as stakeholders.

Name	Organization	Services Provided	Populations Served
Elizabeth Aulner, Program Manager, Community Health	AdventHealth Central Florida Division South Region	Healthcare	Social Vulnerability Index zip codes Lake, Orange, Osceola & Seminole
Rebecca Desir, Program Manager, Community Health	AdventHealth Central Florida Division South Region	Healthcare	Social Vulnerability Index zip codes Lake, Orange, Osceola & Seminole
Renee Furnas, Manager, Community Relations	AdventHealth Central Florida Division	Healthcare	Social Vulnerability Index zip codes Lake, Orange, Osceola & Seminole
Sarah Hawkins, Program Manager, Community Health	AdventHealth Central Florida Division South Region	Healthcare	Social Vulnerability Index zip codes Lake, Orange, Osceola & Seminole
Stephanie Arguello, Director, Community Health	AdventHealth Central Florida Division South Region	Healthcare	Social Vulnerability Index zip codes Lake, Orange, Osceola & Seminole
Babette Hankey, President & Chief Executive Officer	Aspire Health	Behavioral Healthcare	Provide behavioral health care to residents of service area
Christine Suehle, Chief of Staff	Aspire Health	Behavioral Healthcare	Provide behavioral health care to residents of service area
Katherine Schroeder, Vice President Outpatient Services	Aspire Health	Behavioral Healthcare	Provide behavioral health care to residents of service area
Scott Griffiths, Chief Administrative Officer	Aspire Health	Behavioral Healthcare	Provide behavioral health care to residents of service area
Zachary Hughes, Vice President of Innovation and Technology	Aspire Health	Behavioral Healthcare	Provide behavioral health care to residents of service area
Debra Andree, MD, President & Chief Executive Officer	Community Health Centers	Healthcare	Provides medical care to low income and uninsured residents.
Maureen (Molly) Ferguson, Director of Government Relations and Grant Management	Community Health Centers	Healthcare	Provides medical care to low income and uninsured residents.
Aaron Kissler, MPH, Administrator, County Health Officer	Florida Department of Health – Lake County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Melaine Chin, Health Consultant	Florida Department of Health – Lake County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Chaithanya Renduchintala, CHIP Manager	Florida Department of Health – Orange County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Dhanya Varghese, CHIP Facilitator	Florida Department of Health – Orange County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Ellis Perez, Program Manager, Community Health	Florida Department of Health – Orange County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Raul Pino, MD, MPH, Director of the Florida Department of Health in Orange County	Florida Department of Health – Orange County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Ana McDougall, Senior Health Operations Manager	Florida Department of Health – Osceola County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Jeremy Lanier, QI Liaison	Florida Department of Health – Osceola County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Vianca McCluskey, Administrator, County Health Officer	Florida Department of Health – Osceola County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.

Name	Organization	Services Provided	Populations Served
Ana Scuteri, Community & Population Health Division Director	Florida Department of Health – Seminole County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Donna Walsh, Administrator, County Health Officer	Florida Department of Health – Seminole County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Patricia Mondragon, Quality Improvement/ Accreditation Consultant	Florida Department of Health – Seminole County	Healthcare / Public Health	Provides medical care to low income and uninsured residents.
Bakari Burns, MPH, MBA, President & Chief Executive Officer	Orange Blossom Family health	Healthcare	Provides medical care to low income and uninsured residents.
Daniella Sullivan, Health Services Administrator	Orange County Government	County Leadership	Orange County Residents
Nicole Virtue, Program Manager	Orange County Government	County Leadership	Orange County Residents
Yolanda G. Martínez, EdPhD., PhD., Director, Health Services Department	Orange County Government	County Leadership	Orange County Residents
Alyson Olinzock, Manager, Community Benefit	Orlando Health	Healthcare	Provides medical care to low income and uninsured residents.
Debbie Ruiz, Community Benefit, Admin	Orlando Health	Healthcare	Provides medical care to low income and uninsured residents.
Lainie Fox Ackerman, AVP, External Affairs and Community Benefit	Orlando Health	Healthcare	Provides medical care to low income and uninsured residents.
Mary Hignight, Community Benefit Specialist	Orlando Health	Healthcare	Provides medical care to low income and uninsured residents.
Sara Osborne, Sr. Director, Community Benefit	Orlando Health	Healthcare	Provides medical care to low income and uninsured residents.
Belinda Johnson-Cornett, Chief Executive Officer	Osceola Community Health Services	Healthcare	Provides medical care to low income and uninsured residents.
Raquel Berberena, Director of Community Relations	Osceola Community Health Services	Healthcare	Provides medical care to low income and uninsured residents.
Kelly Welch, Program Manager, Community Services	Seminole County Government	County Leadership	Seminole County Residents
Janelle Dunn, Chief Executive Officer	True Health	Healthcare	Provides medical care to low income and uninsured residents.
Michelle Mangum, Director of Government Affairs	True Health	Healthcare	Provides medical care to low income and uninsured residents.
Sheyla Almedina, Director of Operations	True Health	Healthcare	Provides medical care to low income and uninsured residents.

Secondary Data

To inform the assessment process, the Collaborative collected existing health-related and demographic data about the community from publicly available sources. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations, including:

- American Community Survey
- Community Commons
- County Health Rankings and Roadmaps
- FLHealthCHARTS
- Florida Office of Data Dissemination and Transparency
- KIDS COUNT
- Health Equity Data Analysis, HEDA, system (University of Minnesota)
- ESRI/ArcGIS/Business Analyst Online
- Kaiser Family Foundation
- Carnegie Mellon University COVID-19 Delphi Project (daily chronic disease, behavioral health and community lifestyle tracking data)
- Google Trends
- CPD Maps/UDS Maps
- The Surveillance, Epidemiology and End Results (SEER) Program database
- Law Enforcement Assisted Diversion (LEAD)
- “Family Matters” report on multigenerational living
- U.S. Department of Housing and Urban Development, CHAS Database
- Other proprietary and internally developed databases

The Findings

There were 15 aggregate needs found in the assessment process that rose to the top for Lake County.

Behavioral Health: Drug and Substance Use:

- Community services to reduce illegal drug use and abuse or misuse of prescription medications
- Support for family members of a person being treated for substance use disorder

Early Childhood Education

- Childcare services, especially for children with special needs

Community Engagement in Available Resources and Services:

- Social Support, Social Integration, Community Engagement
- Recruitment and retention of culturally diverse and informed providers who demographically reflect the community
- Dental care for children, especially those from low income or other priority communities
- Access to free or low-cost healthcare services for all residents
- Access to primary care services

Mental Health:

- Youth mental health services
- Suicide prevention initiatives in middle and high schools
- Mental health outpatient services capacity
- Mental health crisis services and community awareness of available resources
- Mental health care for senior services
- Suicide prevention

Housing and Income

- Affordable, quality housing

PRIORITIES SELECTION

Prioritization Process

The Collaborative and the Hospital through data review and discussion narrowed down the needs of the community. Community Partners in the Collaborative represented the broad range of interests and needs, from public health needs to the economic needs, for underserved, low-income and minority people in the community. The Collaborative met on a monthly basis to review and discuss the collected data and select the top community needs.

For a full list of members of the Central Florida Collaborative which includes community members, public health experts and hospital representation please see page 18-21.

Members of the Central Florida Collaborative included:

AdventHealth Team Members

- Stephanie Arguello,
  Director, Community Health,
  AdventHealth Central Florida Division South Region
- Elizabeth Aulner,
  Community Health Program Manager,
  AdventHealth Central Florida Division South Region
- Rebecca Desir,
  Community Health Program Manager,
  AdventHealth Central Florida Division South Region
- Renee Furnas,
  Community Relations Manager,
  AdventHealth Central Florida Division
- Sarah Hawkins,
  Community Health Program Manager,
  AdventHealth Central Florida Division South Region

Public Health Experts

- Melaine Chin,
  Florida Department of Health in Lake County
- Aaron Kissler,
  Florida Department of Health in Lake County
- Jeremy Lanier,
  Florida Department of Health in Osceola County
- Vianca McCluskey,
  Florida Department of Health in Osceola County
- Ana McDougall,
  Florida Department of Health in Osceola County
- Patricia Mondragon,
  Florida Department of Health in Seminole County
- Ellis Perez,
  Florida Department of Health in Orange County

Public Health Experts (continued)

- Raul Pino, MD, MPH,
  Florida Department of Health in Orange County
- Chaithanya Renduchintala,
  Florida Department of Health in Orange County
- Ana Scuteri,
  Florida Department of Health in Seminole County
- Dhanya Varghese,
  Florida Department of Health in Orange County
- Donna Walsh,
  Florida Department of Health in Seminole County

The Collaborative participated in a prioritization process based on the Delphi method that consisted of two rounds of online surveying and three facilitated discussion sessions. The needs were then evaluated by hospital leadership using AdventHealth priority criteria, which considered four factors:

- **A. Alignment:** Does this issue align with public health or community goals?
- **B. Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?
- **C. Resources:** Are there existing effective interventions and opportunities to partner with the community to address this issue?
- **D. Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community?

Using these criteria, AdventHealth leadership reviewed the 15 priorities from the Collaborative and made the decision to group multiple needs together so similar or related needs could be addressed under one priority. Ultimately, three of these groups were chosen as final priorities. The groups of needs are outlined below:

Behavioral Health: Drug and Substance Use

- Community services to reduce illegal drug use and abuse or misuse of prescription medications.
- Support for family members of a person being treated for substance use disorder

Early Childhood Education

- Childcare services, especially for children with special needs

Community Engagement in Available Resources and Services

- Social Support, Social Integration, Community Engagement
- Recruitment and retention of culturally diverse and informed providers who demographically reflect the community.
- Dental care for children, especially those from low income or other priority communities.
- Access to free or low-cost healthcare services for all residents.
- Access to primary care services

Mental Health

- Youth mental health services.
- Suicide prevention initiatives in middle and high schools.
- Mental health outpatient services capacity.
- Mental health crisis services and community awareness of available resources.
- Mental health care for senior services
- Suicide prevention

Housing & Income

- Affordable, quality housing

The three groups chosen as AdventHealth Waterman's priorities are:

1. **Behavioral Health: Drug and Substance Use**
2. **Early Childhood Education**
3. **Community Engagement on Available Resources and Services**

Priorities Addressed

The final three priorities were selected based on the community need, availability of existing resources and alignment with system approaches. A list of existing community resources can be found in the Available Community Resources section of this document on page 36. **The final three priorities for AdventHealth Waterman include:**

Priority 1: Behavioral Health: Drug and Substance Misuse

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. 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.

Lake County Need:

In Lake County, Fentanyl deaths increased 310% from 2013 to 2019 and Methamphetamine deaths increased 335% from 2013 to 2019.[11] Between 2018 and 2020, Lake County has presented the highest rate of opioid prescriptions within the service area (Lake, Orange, Osceola & Seminole Counties).[12] Community services to reduce illegal drug use and abuse or misuse of prescription medications and support for family members of a person being treated for substance use disorder were also recognized as top needs within Lake County. Awareness of and the need to address substance misuse, as well as a growing fentanyl crisis, has been increasing in the country. By addressing alcohol and drug misuse as a priority, the Hospital can align with local, state and national efforts for resources to create better outcomes opportunities over the next three years.

11 Florida Drug-Related Outcomes Surveillance & Tracking (FROST) System
12 Florida Department of Health Bureau of Community Health Assessment Division of Public Health Statistics and Performance Management Substance Use Dashboard

Priority 2: Early Childhood Education

Early childhood education describes the period of learning that takes place from birth to 8 years old. There are several types of early education programs, including those that are federal, state or privately funded. Early childhood, particularly the first 5 years of life, impacts long–term social, cognitive, emotional, and physical development. Healthy development in early childhood helps prepare children for the educational experiences of kindergarten and beyond.

Lake County Need:

The data showed that the percentage of youth ready for kindergarten at entry was 56% in Lake County, which is still higher than that of the state (50%).[13] The Hospital prioritized early childhood education because of the foundation it provides for better health and long-term outcomes for all residents. Childcare services, especially for children with special needs was identified as a top need in the Lake County data review.

Priority 3: Community Engagement in Available Resources and Services

Social support stems from relationships with family members, friends, colleagues, and acquaintances. Social capital refers to the features of society that facilitate cooperation for mutual benefit, such as interpersonal trust and civic associations. Individual social support and cohesive, capital-rich communities help to protect physical and mental health and facilitate healthy behaviors and choices. People with greater social support, less isolation, and greater interpersonal trust live longer and healthier lives than those who are socially isolated. Neighborhoods richer in social capital provide residents with greater access to support and resources than those with less social capital. Additionally, neighborhoods with lower social capital may be more prone to violence than those with more social capital and often have limited community resources and role models.

13 Florida Department of Education, FLKRS Statewide Results

Lake County Need:

Data in the assessment highlighted how complicated the health care system can be to understand and navigate, even for those who work within the industry. Many stakeholders discussed how disconnected different parts of the health care system are, leading to a lack of care coordination between different providers and a low awareness in the community of what services and resources are available. Word-of-mouth tends to be the best method to share information, especially in priority populations. Social support, social integration, community engagement, recruitment and retention of culturally diverse and informed providers who demographically reflect the community and dental care for children, especially those from low income or other priority communities were also identified as top needs within Lake County. The Hospital hopes to improve the health of the community by increasing community engagement and awareness of the resources and services available that improve health and by connecting residents to them.

Priorities Not Addressed

Mental Health

There is a growing need in Lake County to increase the available resources addressing mental health needs. The assessment found the percentage of adults reporting poor mental health is slowly increasing statewide, however in Lake County the percentage remained the same from 2016-2019 (12.5%).[14] In Lake County adults under 45 have the highest report of poor mental health. Lake County also lags behind the statewide average for both mental health providers and adult psychiatric beds.[15] From the community survey, stakeholder interviews, focus groups and primary data

14 Florida Behavioral Risk Factor Surveillance System
15 Florida Department of Health Bureau of Community Health Assessment. Division of Public Health Statistics & Performance Management's Suicide and Behavioral Health Profile, 2020

youth mental health services, suicide prevention initiatives in middle and high schools, mental health outpatient services capacity, mental health crisis services and community awareness of available resources, mental health care for senior services, and suicide prevention were identified as top needs. The mental health needs of the community are significant, but the Hospital did not perceive the ability to have a measurable impact on these needs within the three years allotted for the Community Health Plan.

Housing and other social determinants

Housing in Lake County in 2020 remained a challenge even though the percentage of severely cost burdened households (i.e., those spending 50% or more of income on direct housing costs) is lower than the Florida average, 13% and 17%, respectively. Additionally, fewer homes in Lake County have severe housing problems.[16] Workplace inequalities among racial and ethnic minorities can have negative health consequences as those who are unemployed have reported feelings of depression, anxiety, low self-esteem, demoralization and stress.[17] The Hospital did not perceive the ability to have a measurable impact on these needs within the three years allotted for the Community Health Plan.

16 County Health Rankings: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-transit/severe-housing-problems.
17 Healthy People 2030, Employment.

Health Care Access and Quality

Health care access and quality were identified as top needs from the CHNA. This priority area included recruitment and retention of culturally diverse and informed providers who demographically reflect the community, dental care for children, especially those from low income or other priority communities, access to free or low-cost healthcare services for all residents, and access to primary care services. While there is a need for access to care, due to existing resources, scope and ability to have a measurable impact within the three years allotted for the Community Health Plan, this priority was not selected.

COMMUNITY HEALTH PLAN

Next Steps

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

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

Priority 1: Access to Care: Cost of Care, Insurance & Medication for Cancer

In the 2019 CHNA, the Hospital selected to address Access to Care: Cost of Care, Insurance & Medication for Cancer. The Hospital exceeded its set metric to increase the number of uninsured women who receive a mammogram by a minimum of 25% more than twofold with a 250% increase in participants screened. Additionally, if an abnormality was identified, women received appropriate follow up imaging and diagnostic work-up. Development of a streamlined process for identifying women prior to imaging exam furthered the ease of access to care, expedited insurance coverage, scheduling appointments, provider consults and education. Of the 114 uninsured women screened, 43 were eligible for funding and care coordination through Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). Although the Hospital has completed the objective, it will continue to utilize the program. Under this priority the Hospital also sought to improve the timely administration of chemotherapy for identified uninsured/underinsured cancer patients treated at AdventHealth Waterman annually in accordance with the national standard of treatment initiation within 48 hours to 8 weeks. The Hospital met this metric by referring 10 uninsured patients with a cancer diagnosis to an independent party, Health Fund Solutions (HFS), to obtain insurance to cover their cost of care. Of the 10 patients referred seven obtained coverage with an average 8-day turnaround and started their treatment within 30 days. The Hospital also exceeded its set metric of two community outreach, education, prevention and screening activities with the three activities completed. Additionally, the Hospital exceeded its second metric of 10 individuals per activity with a total of 41 individuals for all activities and provided access to care resources 100% follow up to those identified to be at risk for cancer. Through collaboration with facility physician liaisons, radiation oncologists and nurse navigators the Hospital surpassed its goal to educate 150 health care providers regarding navigator services and other resources for uninsured/self-pay patients by providing in person visits to provider offices and providing one-on-one education on available nurse navigation services for uninsured and underinsured patients diagnosed with cancer.

Priority 2: Prevention: Screenings, Well Visits & Behavioral Risk Factors

Focusing on all ethnicities and age groups, this issue was selected because data showed that this issue ranked as the number one top priority needing to be addressed in Lake County and the focus put on prevention will aid in the over-all health and well-being of the community. The Hospital fell short of its set metric of >50% people reached with an undetermined number reached. As the needs in the community have changes as a result of COVID-19 the Hospital will realign this objective to better address the needs that have been exacerbated as a result of the pandemic. In 2021, the Hospital will continue to identify a new objective to support this goal and increase awareness and education about preventative measures which combat chronic disease. The Hospital progressed on its set metric of 500 assessments with 59 completed. As part of the Hospital's commitment to care and recognition of the access and transportation challenges that exist with our community, we have adopted a one-stop shop approach to assessments and screenings. By providing a litany of diagnostic services in one visit, community members are able to better understand their overall health and understand their needs for follow up care. To accomplish this, the Hospital provides a health risk assessment to individuals to flag any areas that may require a deeper dive. Upon receiving the results of the assessment, additional screenings are provided for cancer, diabetes, obesity and heart disease. Through this approach we are able to identify the chronic conditions in our community that can have the most lasting impact and direct individuals to the appropriate avenue of care. Outcome numbers for these assessments and screenings are aggregated across the objectives and do not represent unique individuals. Over the course of 2021, 59 individuals received health assessments, of these 41 received an additional level of diagnostic care through screenings for chronic diseases. The Hospital met its set metric of two prevention screening and assessment activities with three activities completed. Additionally, the Hospital surpassed its second metric of 90% of participants referred with 100% of participants referred to free programs offered in the community. This objective was surpassed on through a screening and assessment activity held for residents in two (2) low-income housing communities and one (1) local food distribution site. With the assistance of community partners 59 low-income and/or impoverished individuals were screened for chronic disease and provided with the necessary resources to access care within the community.

Priority 3: Diabetes: Type II

Focusing on all ethnicities ages 18+, this condition was selected because data shows that diabetes is one of the leading chronic diseases in Lake County, and the percentage of adults with diagnosed diabetes in Lake County is higher than the state average. The Hospital progressed on its set metric of 100 screenings with 59 being screened. Additionally, the Hospital exceeded its second metric of 90% of participants referred to free programs with 100% participants referred. As part of the Hospital's commitment to care and recognition of the access and transportation challenges that exist with our community, we have adopted a one-stop shop approach to assessments and screenings. By providing a litany of diagnostic services in one visit, community members are able to better understand their overall health and understand their needs for follow up care. To accomplish this, the Hospital provides a health risk assessment to individuals to flag any areas that may require a deeper dive. Upon receiving the results of the assessment, additional screenings are provided for cancer, diabetes, obesity and heart disease. Through this approach we are able to identify the chronic conditions in our community that can have the most lasting impact and direct individuals to the appropriate avenue of care. Outcome numbers for these assessments and screenings are aggregated across the objectives and do not represent unique individuals. Over the course of 2021, 59 individuals received health assessments, of these 41 received an additional level of diagnostic care through screenings for chronic diseases. The Hospital progressed on its set metric of 100 assessments with 59 completed. Additionally, the Hospital exceeded its second metric of 90% of participants referred to free programs with 100% participants referred.

Priority 4: Obesity (Adult & Children)

Focusing on all ethnicities and all age groups, this condition was selected because data shows the proportion of obese adults in Lake County is higher than the Healthy People 2020 goal, and there is a strong community concern about the impact of obesity on both children and adults. The Hospital progressed on its set metric of 500 of assessments with 59 completed. As part of the Hospital's commitment to care and recognition of the access and transportation challenges that exist with our community, we have adopted a one-stop shop approach to assessments and screenings. By providing a litany of diagnostic services in one visit, community members are able to better understand their overall health and understand their needs for follow up care. To accomplish this, the Hospital provides a health

risk assessment to individuals to flag any areas that may require a deeper dive. Upon receiving the results of the assessment, additional screenings are provided for cancer, diabetes, obesity and heart disease. Through this approach we are able to identify the chronic conditions in our community that can have the most lasting impact and direct individuals to the appropriate avenue of care. Outcome numbers for these assessments and screenings are aggregated across the objectives and do not represent unique individuals. Over the course of 2021, 59 individuals received health assessments, of these 41 received an additional level of diagnostic care through screenings for chronic diseases. The Hospital progressed on its set metric of 1000 participants by the end of year three with 808 reached. A virtual Healthy Lifestyle presentation was given to four local Boys and Girls clubs across Lake County reaching 171 children. Participants received multi forms of education on the benefits of healthy eating and active lifestyles, including but not limited to, through participation in interactive games, songs and a presentation from a pediatrician and registered dietician. All participants received a holiday healthy gift box consisting of fruit, nuts, vegetable juice, activity games and were encouraged to continue to choose healthy foods and maintain an active lifestyle for optimal health and weight.

Priority 5: Cardiovascular Disease

Focusing on all ethnicities and age groups, this condition was selected because data shows that even though there is a decrease in mortality, heart disease is still the second leading causes of death in Lake County. The Hospital progressed on its set metric of 100 participants screened with 59 participants screened. Additionally, the Hospital exceeded its second metric of 90% of participants referred to free resources with 100% participants referred. As part of the Hospital's commitment to care and recognition of the access and transportation challenges that exist with our community, we have adopted a one-stop shop approach to assessments and screenings. By providing a litany of diagnostic services in one visit, community members are able to better understand their overall health and understand their needs for follow up care. To accomplish this, the Hospital provides a health risk assessment to individuals to flag any areas that may require a deeper dive. Upon receiving the results of the assessment, additional screenings are provided for cancer, diabetes, obesity and heart disease. Through this approach we are able to identify the chronic conditions in our community that can have the most lasting impact and direct individuals to the appropriate avenue of care. Outcome numbers for these assessments and screenings are aggregated across the objectives and do not represent unique individuals. Over the course of 2021, 59 individuals received health assessments, of these 41 received an additional level of diagnostic care through screenings for chronic diseases. The Hospital progressed on its set metric of 100 participants screened with 59 participants screened. Additionally, the Hospital exceeded its second metric of 90% of participants referred to free resources with 100% participants referred. The Hospital met its set metric of >50% people reached by identifying new ways to connect and educate the on early heart attack care during a pandemic. Aligned with the standards for the national Chest Pain Center accreditation (by the Society of Chest Pain Centers) Early Heart Attack Education (EHAC) flyers and handouts were posted in locations accessible by the public throughout the AdventHealth Waterman facility, all employees had required mandatory cheat pain education, including EHAC care to effectively communicate to visitors and patients, additionally, EHAC was presented through media outlets reaching over 50 percent of the targeted audience.

2020 Community Health Plan 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, 2022, and have not received any written comments.

Available Community Resources

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

For an up-to-date list of resources in your community, please visit: **WholeHealthHub.org**

Top Issues	Current Community Programs	Current Hospital Programs
Basic Needs Assistance	• Camp Boggy Creek • Central Florida Hope Center • Central Healthy Start • Haven Lake and Sumter • Lake Cares Food Pantry • Lake Community Action Agency • Lifestream • LovExtention • New Vision for Independence • Salvation Army • United way • We Care Lake and Sumter	• Community Health Improvement Program • Community Health Screenings • Pre-Natal & Birth Care Classes • Smoking Cessation Program • Spiritual Ambassadors Program • Support Groups • Whole Health Hub (Wholehealthhub.org)
Children and Youth Organizations (Including Education Access and Quality)	• Boys and Girls Club of Central Florida • Department of Children and Families • Early Learning Coalition • Get Fit Lake • Healthy Start Coalition • Lake -Sumter Children's Advocacy Center • Lifestream • Take Stock in Children • WIC • YMCA of Central Florida	• Master Teacher's Program
Mental & Behavioral Health (Including Drug & Substance Misuse)	• Be Free Lake • Hand in Hand • Lifestream • Lutheran Services Florida • Milestone's Counseling	• AdventHealth Emergency Room • Screen, Engage, & Treat for Success Program (SETS) • CREATION Life
Life Skills/Job Training	• Clermont Hope Center • Find Feed Restore • Forward Paths • Lake Cares • Lifestream • New Vision for Independence • Thrive	• Dedicated Education Unit (DEU) Program

Top Issues	Current Community Programs	Current Hospital Programs
Clinics and Other Healthcare Providers (Including Access to Care)	• Community Health Centers • Florida Department of Health in Lake County • Florida Department of Health in Orange County • Florida Department of Health in Osceola County • Florida Department of Health in Seminole County • Lifestream • St. Luke's Free Medical and Dental Clinic	• AdventHealth Community Primary Health Clinic • AdventHealth Emergency Room • AdventHealth Physician Network
Housing and Homelessness	• Christian Cares Center • Find Feed Restore • Habitat for Humanity • Mid Florida Homeless Coalition • New Beginnings • The Open Door • Veteran's Affairs	

AdventHealth

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

CNHA Approved by the Hospital Board on: September 22, 2022

For questions or comments please contact:
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