AdventHealth Lake Placid

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

Adventist Health System/Sunbelt, Inc. d/b/a AdventHealth Lake Placid
Approved by the Hospital Board on: October 24, 2019
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Extending the Healing Ministry of Christ

AdventHealth

2019 Community Health Needs Assessment

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Acknowledgements

This report was prepared by Kimberly Williams and Sara Rosenbaum, with contributions from members of the AdventHealth Lake Placid Community Health Needs Assessment Committee representing health leaders in our community and AdventHealth Lake Placid leaders.

A special thanks to Florida Department of Health in Highlands County for their expertise and support in the collection and analysis of the data.

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

1. EXECUTIVE SUMMARY

Goals

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, AdventHealth Wauchula in Wauchula, Florida, and AdventHealth Sebring in Sebring, Florida completed their Community Health Needs Assessment together as a collaboration in 2019. The three Hospitals share the same defined community and conducted the process together.

The goals of the assessment were to:

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

Community Health Needs Assessment Committee

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

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

Data

AdventHealth Lake Placid collected both primary and secondary data. AdventHealth Lake Placid accessed primary data shared by the Florida Department of Health in Hardee County and the Hardee County Health Care Task Force and primary data collected by the Hospital. Primary data included stakeholder interviews, community surveys, and community meetings. In addition, AdventHealth Lake Placid collaborated with Florida Department of Health in Highlands County and the Living Well in Highlands County to develop a joint community survey to better understand the needs of the community.

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

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

Community Asset Inventory

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

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

Selection Criteria

Using the data findings and the Community Asset Inventory, the CHNAC narrowed the list of 8-12 issues to 4 priority issues.

The CHNAC used a priority selection tool that uses clearly defined criteria to select the top issues to address. *See Section 10 for the Priority Selection Report.*

The priority selection criteria included:

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

Priority Issues to be Addressed

The priority issues to be addressed included:

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

2. Transportation
    a. Goal 1: To increase community partnerships with local transportation systems, local leaders, and local businesses to develop new strategies for improving access to transportation.
    b. Goal 2: To increase access to culturally appropriate nutritious food options in food desert or low income/low access areas by implementing the Food is Health program. The Food is Health Program is a community program for people who don't have the means or transportation to add fresh vegetables and fruits to their diet..

3. Cardiovascular Disease
    a. Goal 1: To increase access to health education, early intervention programs, and resources related to cardiovascular disease.
    b. Goal 2: To decrease tobacco use in adults and youth community members.

4. Education (Social Determinant of Health)
    a. Goal 1: To increase partnerships with local school – based programs to better understand the problem of educational attainment as a social determinant of health.
    b. Goal 2: To implement strategies to support community efforts to address the problem of educational attainment as a social determinant of health.

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

Approvals

On October 24, 2019, the AdventHealth Lake Placid Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2019 Community Health Needs Assessment was posted on the Hospital's website as well as https://www.adventhealth.com/community-health-needs-assessments prior to December 31, 2019.

Next Steps

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

2. ABOUT: ADVENTHEALTH LAKE PLACID

TRANSITION TO ADVENTHEALTH

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

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

About AdventHealth Lake Placid

AdventHealth Lake Placid is a 50-bed Hospital that opened in 1981 to better serve the members of Highlands County. In 2018, AdventHealth Lake Placid saw 13,276 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 Highland County, being the only Hospital to utilize virtual and room sterilization technology.

3. CHOOSING THE COMMUNITY

AdventHealth Lake Placid defined its community as its Primary Service Area (PSA) from which 75-80% of its patients come. This includes portions of Highlands and Hardee counties and the zip codes 33825 - Avon Park, 33852 - Lake Placid, 33870 – Sebring, 33872 – Sebring, 33873 – Wauchula, 33875 – Sebring.

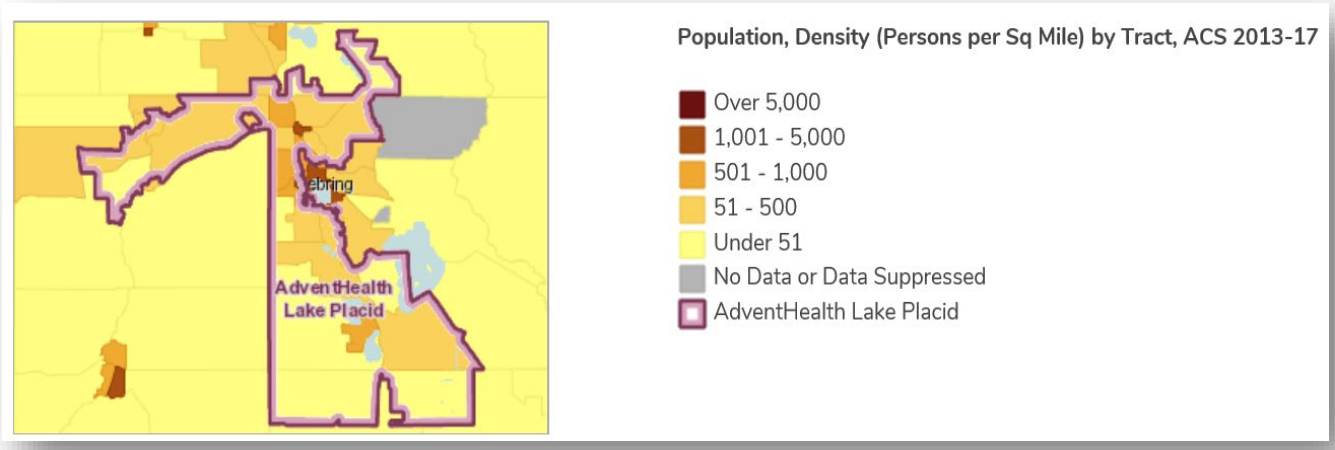
4. COMMUNITY DESCRIPTION AND DEMOGRAPHICS

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

A total of 87,256 people live in the 933 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2013-17 5-year estimates. The population density for this area, estimated at 93.48 persons per square mile, is greater than the national average population density of 90.88 persons per square mile.

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
AdventHealth Lake Placid	87,256	933	93.48
Hardee County, FL	27,326	637.79	42.84
Highlands County, FL	100,177	1,016.59	98.54
Polk County, FL	652,256	1,796.76	363.02
Florida	20,278,447	53,634.01	378.09
United States	321,004,407	3,532,315.66	90.88

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



COMMUNITY DEMOGRAPHICS

Female 50.71%

Male 49.29%

AGE	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+
%	4.81%	14.57%	6.41%	10.03%	10.03%	10.44%	12.45%	31.26%

RACE	Caucasian	African-American	Asian	Native American /	Native Hawaiian	Other Race	Multiple Races
%	81.24%	9.24%	1.67%	0.24%	0.01%	5.59%	2%

ETHNICITY	Hispanic or	Non-Hispanic
%	22.77%	77.23%

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

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

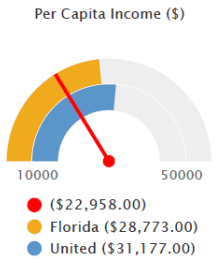
DATA INDICATOR	DESCRIPTION	ADVENTHEALTH LAKE PLACID SERVICE AREA	FLORIDA AVERAGE
Poverty	% Population in Poverty (Below 100% FPL)	19.5%	15.46%
Unemployment Rate	Unemployment Rate	7.7%	3.1%
Violent Crime	Violent Crime Rate (Per 100,000 Pop.)	310.2	444.7
Population with No High School Diploma	% Population Age 25+ with No High School Diploma	17%	12.42%
Insurance	Uninsured Adults-% Without Medical Insurance	23.23%	18.44%
Insurance	Uninsured Children-% Without Medical Insurance	7.78%	6.58%
Food Insecurity Rate	Food Insecurity Rate	15.7%	13.4%
Population with Low Food Access	% Population with Low Food Access	35.83%	25.7%
Use of Public Transportation	% Population Using Public Transit for Commute to Work (Age 16+)	3.62%	2%
Alcohol Consumption	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	15.6%	17.1%
Tobacco Usage	% Population Smoking Cigarettes (Age-Adjusted)	22.4%	18.9%

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

Income - Per Capita Income

The per capita income for the AdventHealth Lake Placid primary service area is $22,958.00. This includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in the Hospital primary service area is the average (mean) income computed for every man, woman, and child in the specified area.

Report Area	Total Population	Total Income ($)	Per Capita Income ($)
AdventHealth Lake Placid	87,257	$2,003,223,338.00	$22,958.00
Hardee County, FL	27,326	$509,426,300.00	$18,642.00
Highlands County, FL	100,177	$2,306,087,400.00	$23,020.00
Polk County, FL	652,256	$14,727,282,200.00	$22,578.00
Florida	20,278,447	$583,486,218,200.00	$28,773.00
United States	321,004,407	$10,008,063,515,700.00	$31,177.00



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

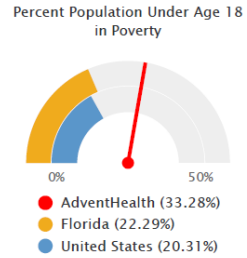
Per Capita Income by Race Alone

Report Area	White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Hardee County, FL	$20,582.00	$9,147.00	$27,197.00	$15,810.00	$0.00	$10,117.00	$9,467.00
Highlands County, FL	$25,043.00	$15,058.00	$27,360.00	$16,569.00	$0.00	$9,557.00	$12,343.00
Polk County, FL	$24,514.00	$14,937.00	$28,937.00	$23,695.00	$51,501.00	$13,624.00	$10,654.00
Florida	$31,765.00	$17,901.00	$31,415.00	$22,993.00	$23,509.00	$18,653.00	$17,231.00
United States	$34,221.00	$21,117.00	$36,158.00	$18,822.00	$22,685.00	$17,051.00	$17,948.00

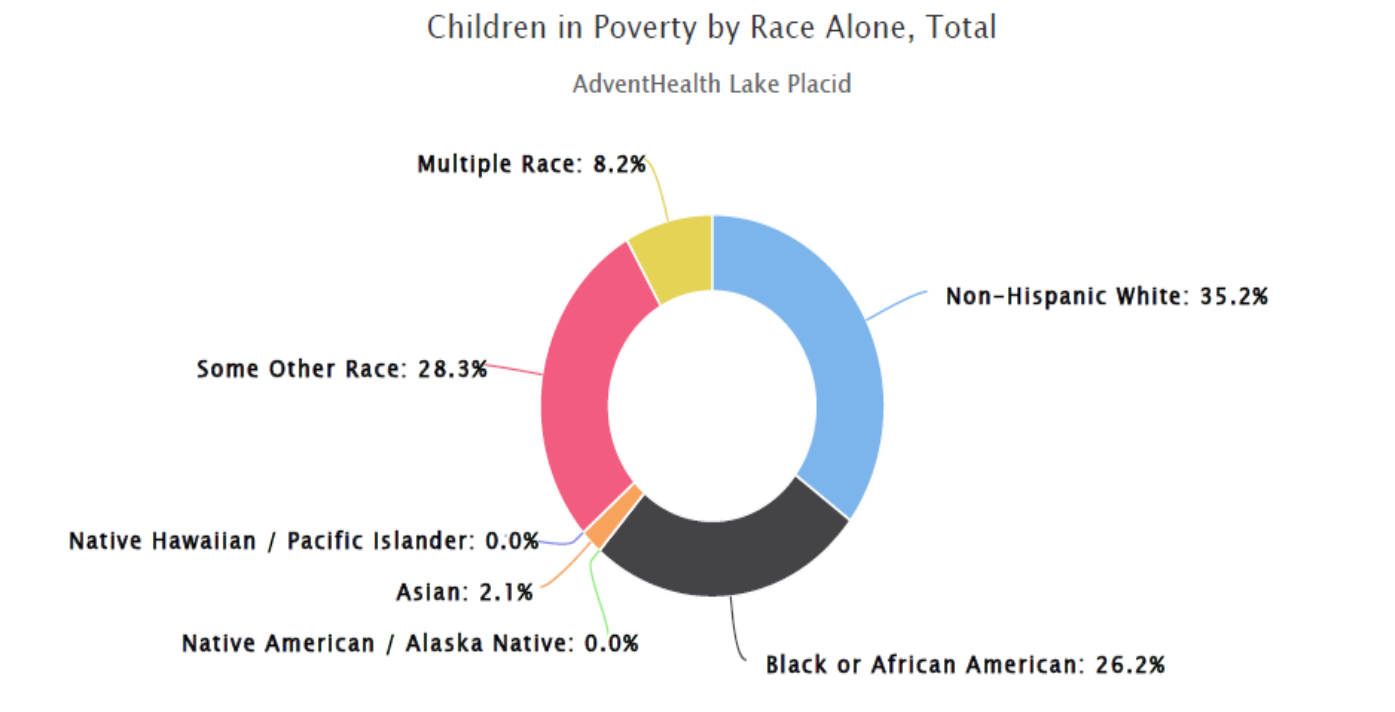
Households living with income below the Federal Poverty Level (FPL)

In the AdventHealth Lake Placid primary service area, 33.28% or 5,568 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL), which is higher than the state percentage. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
AdventHealth Lake Placid	84,668	16,730	5,568	33.28%
Hardee County, FL	25,481	7,207	2,810	38.99%
Highlands County, FL	98,712	17,295	5,455	31.54%
Polk County, FL	638,716	144,967	39,203	27.04%
Florida	19,858,469	4,044,879	901,772	22.29%
United States	313,048,563	72,430,017	14,710,485	20.31%



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


Children in Poverty by Race Alone, Total
AdventHealth Lake Placid
Multiple Race: 8.2%
Non-Hispanic White: 35.2%
Some Other Race: 28.3%
Native Hawaiian / Pacific Islander: 0.0%
Asian: 2.1%
Native American / Alaska Native: 0.0%
Black or African American: 26.2%

5. COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

A Community Health Needs Assessment Committee (CHNAC) was formed to help AdventHealth Lake Placid conduct a comprehensive assessment of the community. The committee included representation from the Hospital, public health officials and the broad community as well as representation from low-income, minority and other underserved populations. The committee met regularly throughout 2018-2019. Current CHNAC members include:

Community Members

Name	Title	Organization	Description of Services	Low-Income	Minority	Other Underserved Populations
Aisha Alayande	Executive Director	Drug Free Highlands	Coalition for substance abuse education and reduction	X	X	X
Paul Blackman	Sheriff	Highlands County Sheriff's Office	Sheriff's Department			X
Kelly Brooks	General Manager	MV Transportation	Transportation Disadvantaged Community Transportation Coordination for Highlands & Hardee Counties	X	X	X
Carly Carden	Marketing and Business Development Manager	Peace River Center	Domestic violence shelter, group home, psych. services, behavioral health services, rape recovery, substance abuse treatment			X

Charlene Edwards	Executive Director	Healthy Start Coalition of Hardee, Highlands and Polk Counties	Promotes and supports all healthy pregnancies, babies and families through community partnerships	X	X	X
Don Elwell	County Commissioner - Highlands County	HCBCC	Highlands County Commissioner			X
Ingra Gardner	Director	Nu-Hope Elder Care Services, Inc.	Non-profit, lead agency providing state and federal funded services to seniors			X
Tiffany Green	Board Chair	Highway Park Neighborhood Council	Works to restore and preserve the community through advocacy, education, health and other programs for all	X	X	
Ken Harley	Program Manager	Heartland Regional Transportation Planning Organization	Coordinates transportation plans for the 6 county Heartland Region			X
Tessa Hickey	Director of Nursing	Florida Department of Health - Highlands	Local health department, improves health status by preventing epidemics, protects against environmental hazards, encourages healthy behaviors, responds to disasters	X	X	X

Pricilla Preece	Executive Director	Samaritan's Touch Care Center	Provides free primary and specialized medical, dental and vision care to uninsured families with income at or below 200% of Fed. Poverty Guidelines	X		X
Pastor Robert Shannon	Pastor	Wings of Faith Christian Worship Center	Church pastor		X	
Marybeth Soderstrom	Engagement & Mobility Manager	Heartland Regional Transportation Planning Organization	Coordinates transportation plans for the 6 county Heartland Region	X		
Melissa Thibodeau	Executive Director	Heartland Rural Health Network	Health education for youth, ages 11-19, also integrates Community Health Workers into chronic disease management services	X	X	X
Amanda Tyner	Community Program Administrator	Highlands County Department of Health	Local health department			X
Denise Williams	County Veteran Service Officer	Highlands County Veteran Services Office	Assists veterans in application for additional benefits through the VA, and for disability compensation, non-service-connected pensions, home loan certificates of eligibility and	X	X	X

			VA medical enrollment			
Nancy Zachary	Director of Health	RCMA	Provides child care and child and parent education for migrant and other rural, poor families	X	X	
Denise Collazo	Health Center Administrator, Avon Park	Central Florida Health Care	FQHC, primary care medical home for insured, uninsured, underinsured and migrants	x	x	x

AdventHealth Lake Placid Members

The following AdventHealth Lake Placid Team members provided leadership throughout the process:

- **Terri Bryant**, Administrative Director, Transitional Services; Case Management
- **Denise Grimsley**, VP & Administrator-Wauchula
- **Melissa Helms**, CREATION Life Nurse; Community Health Education
- **Randy Surber**, President/CEO
- **Linda Lynch**, Director of Pastoral Care; Chaplaincy
- **Rebecca McIntyre**, Home Health/Wellness Director; Home Health & Wellness Centers
- **Rosalie Oliver**, CFO
- **Sara Rosenbaum**, CREATION Life Community Specialist, Community Health Education
- **Kimberly Williams**, Director of Community Benefit; West Florida Region, Community Benefit Support
- **Amber Windsor-Hardy**, Community Health Coordinator/Community Benefits; West Florida Region, Community Benefit Support

6. PUBLIC HEALTH

AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid, share the same defined community and therefore conducted the CHNA process together. Public health was represented throughout the Community Health Needs Assessment.

Highlands County Public Health
Living Well in Highlands County is a collaboration between the Florida Department of Health in Highlands County and local community partners/organizations interested in identifying the health needs of the community. AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid are an active part of Living Well in Highlands County. The Administrator and Community Programs Manager lent their expertise to assist in developing key strategies to deploy the Community Health Needs Assessment Survey and participated in the priority selection and asset inventory process. The mission of Living Well in Highland County is to identify and address health issues

important to Highlands County residents through planning and community partnerships by engaging the community today for a healthier tomorrow. http://highlands.floridahealth.gov/ .

The following Highlands County employees provided public health leadership throughout the process:

- **Mary Kay Burns, RN, BSN, MBA,** Administrator, Florida Department of Health in Highlands County
- **Amanda L. Tyner, MPH** Community Programs Administrator, Florida Department of Health Highlands County

Hardee County Public Health

The Hardee County Health Care Task Force is a collaboration between the Florida Department of Health in Hardee County and local community partners/organizations interested in identifying the health needs of the community. AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid are an active part of the Hardee County Health Care Task Force. The expertise of their Operations Manager and Community Health Educator, assisted in the CHNA process through their participation in the priority selection and asset inventory process.

Hardee County public health representatives from the Florida Department of Health in Hardee County and the Hardee County Health Care Task Force actively participated in the Community Health Needs Assessment (CHNA) process with AdventHealth Sebring.

The Hardee County Health Care Task Force (HCTF) is comprised of a diverse group of public, private, non-profit, social services, and government entities that make up the public health system in Hardee County. The HCTF (http://hardee.floridahealth.gov/index.html) works together to produce a Community Health Assessment (CHA for Hardee County) to provide a snapshot in time of the community strengths, needs, and priorities. The Hardee County CHA is separate from the AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid CHNA.

The following Hardee County employees provided leadership throughout the process:

- **Kristin Casey,** Operations Manager, Florida Department of Health in Hardee County
- **Stefania Sweet, MPH** Community Health Educator, Florida Department of Health in Hardee County

7. PRIMARY AND SECONDARY DATA SOURCES

Primary Data

a. Florida Department of Health in Highlands County worked together to design the 2019 Community Health Needs Survey and launched a county-wide effort to engage the community to participate in the survey. The survey asked questions which aimed to better understand feedback from community members related to barriers to accessing care (including dental care, mental health care), challenges to accessing care for children's health (including care for special needs children), health behaviors, and other social determinants of health. The Florida Department of Health in Hardee County shared results from primary data collected from community surveys with the Community Health Needs Assessment Committee (CHNA).

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

c. Stakeholder interviews/surveys were conducted by sending out a link to members of our Community Health Needs Assessment Committee CHNAC and completed on-line. As needed, reminders were sent out to CHNAC members to complete the on-line questionnaire.

Secondary Data: Hospital Utilization Data

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

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

Secondary Data: The Engagement Network

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

DATA SOURCES:

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

8. COMMUNITY COLLABORATION

The AdventHealth Lake Placid, AdventHealth Sebring, and AdventHealth Wauchula Community Health Needs Assessment is the product of a cross county-wide collaborative process with the Florida Department of Health in Highlands County and the Florida Department of Health in Hardee County.

Living Well in Highlands County is a collaboration between the Florida Department of Health in Highlands County and local community partners/organizations interested in identifying the health needs of the community. AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid are an active part of Living Well in Highlands County.

The Hardee County Health Care Task Force is a collaboration between the Florida Department of Health in Hardee County and local community partners/organizations interested in identifying the health needs of the community. AdventHealth Sebring, AdventHealth Wauchula, and AdventHealth Lake Placid are an active part of the Hardee County Health Care Task Force.

Collaborators

- **Living Well in Highlands County Collaboration** collectively worked together with the CHNAC to provide resources and strategies to complete a county-wide Community Health Needs Assessment.
- **The Hardee County Health Care Task Force** collectively worked together with the CHNAC to provide resources to complete a county-wide Community Health Needs Assessment.

9. DATA SUMMARY

Primary and Secondary Data: High Level Findings

Primary and secondary data was collected, analyzed, and shared with the Community Health Needs Assessment Committee (CHNAC) it was categorized into top 8-10 priorities per source of data. These results are listed by source in the tables below.

Primary and secondary data was presented to the CHNAC. Each committee member received copies of the reports. AdventHealth Lake Placid financial department provided admission data for inpatient and the Emergency Department including diagnosis, payer source and zip codes for 2019.

1. Top 11 Priorities for AdventHealth Lake Placid Primary Service Area determined from Secondary Data provided by The Engagement Network/ Secondary Needs Assessment Tool					
1	Adults with no medical insurance	**5**	Children living in poverty	**9**	Population with no leisure time physical activity
2	Age 18+ with no social/emotional support	**6**	Low food access	**10**	Adult obesity and overweight
3	Teen births – double the Florida rate	**7**	Mothers with late or no prenatal care – double state average	**11**	Adults high cholesterol
4	Adults with no medical insurance	**8**	Adults with no regular doctor		

2. Top 8 health priorities determined by Secondary Data collected from the most recent local Health Department needs assessment					
1	Cost of health care	**5**	Lack of dental care		
2	Low cost healthy food	**6**	Heart disease and stroke		
3	Lack of specialized physicians	**7**	Overweight/Obesity		
4	Cancer	**8**	Tobacco use		

3. Top 6 health priorities determined by Secondary Data from other local sources (DOH County Health Status and Health Equity profile – CHARTS)					
1	Child food insecurity rate of 25%	**5**	Stroke Hospitalization rates rising		
2	Households recognized case public assistance or food stamps 25%	**6**	Congestive Heart Failure Hospitalization rates rising		
3	15% of population without health insurance				
4	25% adults sedentary				

Primary and Secondary Data: Aggregate Community Health Needs

At a subsequent CHNAC meeting, the results of the Florida Department of Health in Highlands County's top 10 health needs were reviewed, and the committee was then provided with the top 8 - 10 health priorities specific to AdventHealth Lake Placid's primary service area. The committee discussed in an open forum as they compared the overarching top 11 health needs of the County with the top 8-10 health needs specific to the communities nearest the Hospital (our primary service areas).

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

Top 7 Priorities

	Priority Issue	Ethnic Group	Age Group	Specific Geographic Area
1	*Mental Health*	Underserved, low – income populations	Adults age 18 and older	33825, 33870, 33872, 33852
2	*Transportation*	Underserved, low – income, populations	Adults age 18 and older	33825, 33870, 33872, 33852
3	*Cardiovascular Disease*	Underserved populations, community	Adults age 18 and older	33825, 33870, 33872, 33852
4	*Education*	Underserved, minority, low-income populations, community focus.	Adults age 25 and older	33825, 33870, 33872, 33852
5	*Poor Dental Health*	Underserved, minority, low-income populations, community focus.	Adults age 18 and older and children	33825, 33870, 33872, 33852
6	*Tobacco Use*	Underserved, minority, low-income populations, community focus.	Adults age 18 and older	33825, 33870, 33872, 33852
7	*Obesity/Overweight/Obese*	Underserved, minority, low-income populations, community focus.	Adults age 18 and older	33825, 33870, 33872, 33852

10. COMMUNITY ASSET INVENTORY

In order to help AdventHealth Lake Placid's CHNAC determine the community health priorities where they could make a meaningful difference, the Hospital conducted a Community Asset Inventory related to the top 10 identified community health needs. The inventory was designed to help the CHNAC narrow the 10 needs to the four (4) priority issues. Appendix C includes the full Asset Inventory.

COMMUNITY ASSET INVENTORY		
Top Issues Defined by Primary/Secondary Data	**Current Community Programs**	**Current Hospital Programs**
Mental Health	*Champion for Children Advocacy Center, Drug Free Zone (schools), Red Ribbon Week, Acting Out (youth sharing), Youth/Adult Mental Health 1st Aid program (partner with Heartland for Children), Health Start Edinburgh screening, Mental Health First Aid, Adult Day Care, Crisis Stabilization Unit, Domestic Violence Safe House and DV Program, Outpatient Counseling and Psychiatry, Rape Recovery Program, Substance Use Treatment, Wellness Clinic Services, Children's Services- Resiliency Team, Home to Stay, Behavioral Health Services, Community Action Team, Housing services- group homes, Peace River Apartments, Mobile Crisis Response Team and Crisis Hotline, Recovery Services- Adult Case Management, Supported Employment, Supportive Housing and Psychosocial Rehabilitation Program services, School based mental/behavioral health services, Telehealth for Substance Abuse Counseling, Short Term Residential Treatment Center, Strengthening Families program, Farfrom PSAs*	*Depression Support Group, Grief Support Group*
Transportation	*Community Transportation Group*	*Small fund for ER/ IP patients discharged to home without transportation access*
Cardiovascular Disease (Obesity/Overweight)	*Morning Mile Program, Community gardens, Food distribution sites, Nutrition (healthy eating) and diabetes education classes, Home Delivered Meals/ nutrition education/ nutrition counseling, Congregate Meal Primary Care for those without insurance at or below 200% FPG, Food Pantry, Diabetes Education, Chronic*	*Community Garden, Food is Health, CHIP, Pre-Diabetes education/Diabetes education, Free Community Health Lectures, Cardiac Nutrition class, Tobacco Cessation class, Eating Healthy on a Budget class, Healthy Eats class, Cardiac Support Group, Stroke Support*

	Disease Care Clinics, Nutritional Counseling	*Group, Diabetes Support Group, Walking paths*
Education	*Enabling Services (bilingual), School health (public schools), "Farfrom" programs - prevention education programs, Back Chat "town hall", Aunt Bertha, Family Fundamentals, a Success By 6 parent resource center, Education on sexual health In-school/After-school (iMAD program), Workshop on Social Emotional Learning, Founders Day and Health Fair, RCMA Head Start (3-5 years), Early Head Start (6 weeks - 3 years), Migrant Head Start (6 weeks - 5 years), VPK, Parenting education for enrolled families, Panther Youth Partners Program*	*Wellness Center, CREATION Life Ministry*
Tobacco Use	*AHEC Tobacco Cessation Classes, Florida Department of Health SWAT Program, Behavioral Health Services*	*Tobacco Cessation class (in partnership with AHEC)*
Poor Dental Health	*Congregate Meal* *Primary Care for those without insurance at or below 200% FPG*	*No dental services provided*
Obesity/Overweight/Obese	*Morning Mile Program, Community gardens, Food distribution sites, Nutrition (healthy eating) and diabetes education classes, Home Delivered Meals/ nutrition education/ nutrition counseling,*	*Community Garden, Food is Health, CHIP, Pre-Diabetes education/Diabetes education, Free Community Health Lectures, Cardiac Nutrition class, Tobacco Cessation class, Eating Healthy on a Budget class, Healthy Eats class*

11. PRIORITY SELECTION

Priority Selection using the RATING & PRIORITIZING KEY HEALTH ISSUES WORKSHEET

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

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

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

Step 1: List Key Issues
Step 2: Rate Against Selection Criteria (1= lowest priority; 2= medium; 3= high; 4=highest)
Step 3: Total Rating Averages/Voting

RATING & PRIORITIZING KEY HEALTH ISSUES							
Step 1: List Key Issues	**Step 2:** Rate Against Selection Criteria (1= lowest priority; 2= medium; 3= high; 4=highest)						**Step 3:** Total Rating
	RELEVANT *How important is the issue?*		**IMPACTFUL** *What will we achieve by addressing this issue?*		**FEASIBLE** *Can we adequately address this issue?*		
	• Size of problem (ex. % population) • Severity of problem (ex. Cost to treat, lives lost) • Urgency to solve problem; community concern • Linked to other important issues		• Availability of solutions/proven strategies • Builds on or enhances current work • Significant consequences of not addressing issue now		• Availability of resources (staff, community partners, time, money) to address issue • Political capacity/will • Community/social acceptability • Appropriate socio-culturally • Can identify easy, short-term wins		
Mental Health	12	+	10	+	15	=	37
Heart Disease	15	+	11	+	19	=	45
Education	10	+	10	+	19	=	39
Transportation	18	+	17	+	10	=	45
Poor Dental Health	17	+	10	+	8	=	35
Tobacco Use	12	+	9	+	9	=	30
Obesity/Overweight/Obese	15	+	10	+	10	=	35

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL ADDRESS		
Relevance	**Impact**	**Feasibility**
1. Mental Health		
In the AdventHealth Lake Placid primary service areas (PSA), the rate of death due to self – harm (suicide) is 20.5 (per 100,000 population), which is higher than the state rate of 14 (per 100,000 population). Furthermore, 25% (16,345 persons) of the adults in the PSA population self-report that they receive insufficient social and emotional support all or most of the time, which is higher than the state rate (21%). 17% of the Medicare-fee-for-service PSA population are depressed.	Mental Health First Aid and other support groups. Severe emotional, behavioral, and physical health problems of our community members, decreased enjoyment of life.	The community has a strong network of existing mental health/behavioral health resource available. Peace River Center, Telehealth for Substance Abuse Counseling, Short Term Residential Treatment Center.
2. Heart Disease		
In the AdventHealth Lake Placid primary service area (PSA), 9.1% (7,820) of adults aged 18 and older have coronary heart disease or angina (heart related chest – pain). This percentage is higher than the state percentage of 5.6%. Coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.	Nutrition (healthy eating) and diabetes education classes, Home Delivered Meals/ nutrition education/ nutrition counseling Increased poor health, Increase in ED visits, increased mortality from heart disease	Food is Health, CHIP, Free Community Health Lectures American Diabetes Association,
3. Education		
In the AdventHealth Lake Placid primary service area, there are 10,986 persons aged 25 and older without a high school diploma (or equivalency) or higher. This represents 17% of the total population aged 25 and older and is higher than the state average of 12.42%. Educational attainment is a social determinant of health and is linked to health outcomes.	Food is Health Program, GED program support for helping educational attainment, Poor health outcomes from a lack of understanding health overall, lack of resources to find employment, low health literacy and other Social Determinants of Health.	Pre-Diabetes education/Diabetes education, AdventHealth Lake Placid Wellness Center, CREATION Life Ministry
4. **Transportation**		
In the AdventHealth Lake Placid primary service area (PSA), approximately 23% of the total population (42,799 persons) age 18 years and older do not have a healthcare provider, which is higher than the state average (18%). A poor transportation system prevents those who do not own a car or have reliable transportation from accessing healthcare. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use.	Invite transportation organizations to sit on the CHNAC and discover ways to work together. Difficulty accessing health care – doctor appointments, routine checkups, health education. Leads to overall poor health.	Transportation Access Community Transportation group

RATIONALE FOR PRIORITY ISSUES THE HOSPITAL WILL NOT ADDRESS		
Relevance	**Impact**	**Feasibility**
1. Poor Dental Health		
The rate of qualified dentist in the primary service area is lower than the state rate. This has a negative effect on access to dental care. In the AdventHealth Lake Placid primary service area, the access to dentists' rate (per 100,000 pop.) is 36 (in 2015 year), as compared to the state rate of 56.	Florida Department of Health in Highlands County, Federally Qualified Health Centers Many oral diseases can be prevented with routine care and regular dental checkups.	Lack of enough qualified dentist in PSA. Florida Department of Health, local colleges, American Dental Association, Dental hygienists' programs, Partner to bring incentive programs to attract qualified dentist to the PSA.
2. Tobacco Use		
In the AdventHealth Lake Placid primary service area, an estimated 13,180 of adults age 18 or older self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease. In the Hospital PSA, 22.5% of adults are currently smoking cigarettes, which is higher than the state percentage of 19%.	AHEC, Florida Department of Health, Increase in cardiovascular disease, cancer incidence/mortality, and poor quality of health in community members	Tobacco Cessation Classes, Health Education Drug Free Highlands, AHEC, Florida Department of Health
3. Obesity/Overweight		
In the AdventHealth Lake Placid primary service area, approximately 33% of adults aged 20 and older (21,741 persons) self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. The state percentage is 27%. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.	Food distribution sites, Home Delivered Meals/ nutrition education/ nutrition counseling, Congregate Meal Primary Care for those without insurance at or below 200% FPG, Food Pantry	Nutrition (healthy eating) and diabetes education classes, Food is Health, CREATION Health, AdventHealth Sebring Wellness Center, CREATION Life Ministry

12. PRIORITY ISSUES TO BE ADDRESSED

The following 4 issues **WILL** be addressed for the following reasons below:

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

Priority #1: Mental Health
Description of the problem: The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability for adults, children, and adolescents. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide. Mental health disorders are the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. In the AdventHealth Lake Placid primary service areas (PSA), the rate of death due to self – harm (suicide) is 20.5 (per 100,000 population), which is higher than the state rate of 14 (per 100,000 population). Furthermore, 25% (16,345 persons) of the adults in the PSA population self-report that they receive insufficient social and emotional support all or most of the time, which is higher than the state rate (21%). This indicator is relevant because social and emotional support is critical for navigating the challenges of daily life as well as for good mental health. 17% of the Medicare-fee-for-service PSA population are depressed.

Priority #2: Heart Disease
Description of the problem: Coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks. In the AdventHealth Lake Placid primary service area (PSA), 9% (7,820 persons) of adults aged 18 and older have coronary heart disease or angina (heart related chest – pain). Additionally, the rate of death due to heart disease per 100,000 population is 151 (289 average annual deaths from 2012 – 2016), which is higher than the state rate of 150 and 22% (13,180 persons) of the PSA population smoke cigarettes (higher than the state rate of 19%). Tobacco use is also linked to cardiovascular disease.

Priority #3: Education
Description of the problem: In the AdventHealth Lake Placid primary service area, 17% (10,986 persons) of the population aged 25 and older do not have a high school diploma (or equivalency) or higher and is higher than the state average of 12%. Educational attainment is a social determinant of health and is linked to health outcomes. Additionally, improving health literacy may be a useful strategy for reducing disparities in health related to education.

Priority #4: Transportation
Description of the problem: A poor transportation system prevents those who do not own a car or have reliable transportation from accessing healthcare. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. In the AdventHealth Lake Placid primary service area (PSA), 3.62% (1,022 persons) of the population are currently using public transportation as their primary means of transportation to work. Additionally, approximately 30% of the population (22,810 persons) age 18 years and older do not have a regular healthcare provider, which is higher than the state average (25%).

13. PRIORITY ISSUES THAT WILL NOT BE ADDRESSED

The following 3 issues **WILL NOT** be addressed for the following reasons below:

Potential challenges or barriers to addressing the need exist such as:

(1) The issue should not be addressed as an individual problem but will be indirectly impacted positively by first addressing multiple issues selected priority areas above by the Hospital CHNAC.

(2) The CHNAC did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time.

Priority #1: Poor Dental Health
Description of the Problem: Many oral diseases can be prevented with routine care and regular dental checkups. The health of the teeth, the mouth, and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Lack of access to dental care for all ages remains a public health challenge. In the AdventHealth Lake Placid primary service area, the access to dentists' rate (per 100,000 pop.) is 36 (in 2015 year), as compared to the state rate of 56.
Reason(s) priority was not selected: The CHNAC did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time.

Priority #2: Tobacco Use
Description of problem: In the AdventHealth Lake Placid primary service area, an estimated 13,180 of adults age 18 or older self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease. In the Hospital PSA, 22.5% of adults are currently smoking cigarettes, which is higher than the state percentage of 19%.
Reason(s) priority area was not selected: The CHNAC felt the issue should not be addressed as an individual problem. Therefore, interventions to address tobacco use will be wrapped into the priority area of heart disease.

Priority #3: Obesity/Overweight/Obese
Description of the Problem: In the AdventHealth Lake Placid primary service area, approximately 33% of adults aged 20 and older (21,741 persons) self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. The state percentage is 27%. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.
Reason(s) priority area was not selected: The CHNAC felt the issue should not be addressed as an individual problem. Therefore, interventions to address Obesity/Overweight/Obese will be wrapped into the education priority area. The Community Health Needs Assessment Committee (CHNAC) will approach this area of need more comprehensively, as other barriers contribute to negative health outcomes in this area of priority.

14. NEXT STEPS

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

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

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

15. WRITTEN COMMENTS REGARDING 2016 NEEDS ASSESSMENT

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

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

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

Priority #1: Heart Disease

2016 Description of the Issue: Number two cause of death in the Primary Service Area (PSA). The service area also presents a higher than state average rate of high blood pressure and cholesterol.

2019 Update: The interventions include offering free, evidence-based Stanford Chronic Disease Self- Management Program (CDSMP) 6-week class series, to educate participants regarding chronic disease self-management. A second intervention included implementing a Complete Health Improvement Program (CHIP) class series, a lifestyle enrichment program designed to reduce disease risk through better health habits and appropriate lifestyle modifications.

- Free, evidence-based Stanford Chronic Disease Self- Management Program (CDSMP) 6-week class series were held to educate participants regarding chronic disease self-management both on site at the Hospital and in community settings outside of the Hospital (local health department locations, community senor centers, library locations, churches, etc.). In addition, efforts to recruit participants included partnering with other agencies to allow referrals to the class series with splitting expenses in half with the agency to share the costs associated with running the program.
- Complete Health Improvement Program (CHIP) class series, a lifestyle enrichment program designed to reduce disease risk through better health habits and appropriate lifestyle modifications was also offered. Goals included lowering cholesterol, hypertension and blood sugar levels, reducing excess weight through improved dietary choices, enhancing daily exercise, increasing support systems and decreasing stress in an evidence-based program. The program exceeded expectations of 50% of participants who experience improved biometric indices (program measures blood sugar levels, cholesterol, blood pressure, BMI and weight) by reaching 90%.

Priority #2: Diabetes

2016 Description of the Issue: Higher than state average of diabetes rates, and lower than average access to diabetes self-management and Pre-diabetes education programs.

2019 Update: Morning Mile program a before-school walking/running program sponsored by the American Diabetes Association, that gives children a chance to start each day in an active way. The intervention was a pilot program, to include Title 1 Schools in the Morning Mile (walking) program in collaboration with the American Diabetes Association (ADA). Additionally, AdventHealth Sebring offered free, 3-hour Pre-diabetes classes at the Hospital and in the community.

- In partnership with our local community partners, we are also offering diabetes self-management education. AdventHealth Sebring exceeded its goal of 20 classes by implementing 22 pre-diabetes classes. Success in this outcome can be attributed to working closely with our local community partners to promote the classes in the community setting.

Priority #3: Obesity/Nutrition

2016 Description of the Issue: 41% of residents in the PSA have low food access (food desert). 31.9% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) in the "overweight" category. 34.7% of adults aged 20 and older self-report that they have a BMI in the "obese" category.

2019 Update: Sponsored free CREATION Health class series to the community, provided trained staff members to teach the series, and implemented the Food is Medicine (FIM) program. FIH is a free program for community members who don't have the means or transportation to add fresh vegetables and fruits into their diet.

- CREATION Health (CH) class series were sponsored in 1 local faith congregation identified by existing professional relationships with the Chaplain at the Hospital. St. James Catholic Church, The Ridge SDA Church, Avon Park SDA Church, Wauchula SDA Church, and the Filipino American SDA Church sent 1 delegate each to the CREATION Health "Train the Trainer" Seminar hosted by the Mission and Ministry/Community Development departments. Delegates received a CH Leadership kit value at $350. The CH Kit contains CH Seminar Topic Power Point, CH Topic Videos, CH Leadership Manual, Small Group Discussion Guide, Seminar Personal Study Guide, and Participant Pre-Post Self Assessments. The Hospital also sponsored free pre- and post-bio-metric screenings (blood pressure, blood sugar, and body mass index) and nursing services for all CH programs implemented in local congregations.
- We exceeded our goal of 30 program graduates, with an actual number of 41 graduates in 2018. Additionally, we exceeded the goal of 80% participants self-reporting improved lifestyle choices as measured by CREATION Health self-assessment form by reach 100% with this metric.
- AdventHealth Sebring and AdventHealth Lake Placid partnered with local community organizations to address the nutritional needs of those in communities designated as food deserts or low income/low access with the Food is Health program (formally known as Food is Medicine). This is accomplished by increasing health and lifestyle educational opportunities, biometric screenings, and access to healthy produce and dry goods. In year 2, a total of 133 fresh produce vouchers were distributed to participants. With 48% of participants showing a decrease in blood sugar, which exceed the 10% of participants goal. Reduction in BMI was not reported.

Priority #4: Access to Care (Mental Health Services)

2016 Description of the Issue: PSA is a designated Health Professional Shortage Area (HPSA)

2019 Update: Strategies implemented aim to increase community awareness and availability of local mental health care services for uninsured and underinsured individuals in the community. In 2018, the Hospital started two grief support group and depression support groups.

- Strategies implemented to increase community awareness and availability of local health care services for un/underinsured individuals included continuing the CREATION Health Ministry Outreach program, providing discounted home-supply prescriptions for low-income patients discharged from hospital care, providing monetary support to the Samaritan's Touch free clinic and providing their clinic with in-kind lab and imaging services for Samaritan's Touch patients.
- Each year, AdventHealth Sebring and AdventHealth Lake Placid continue to exceed outcome goals in each of the above-mentioned strategies to increase access to primary care in the designated primary service areas (PSA).
- Volunteer participation in the CREATION Health Ministry Outreach program continues to increase each year, with a total of 65 volunteers participating in this strategy. Monetary support for this strategy exceeds Year 2 outcomes goals in each category.

Priority #5: Access to Care (Primary Care)

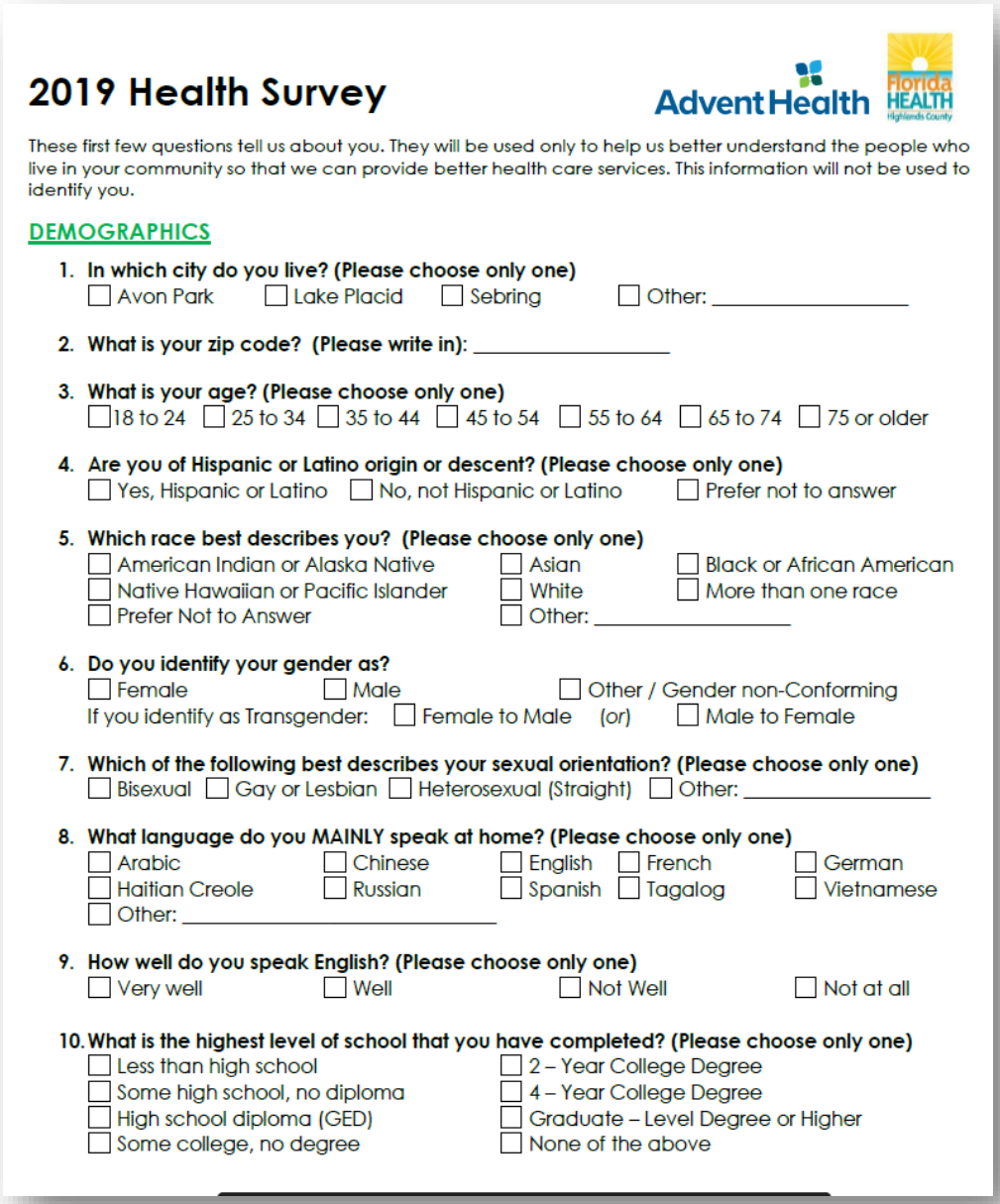
2016 Description of the Issue: PSA is a designated HPSA

2018 Update: Strategies for this priority include increasing community awareness of availability of local health care services for the un/under-insured by continuing the CREATION Health Ministry Outreach program, providing monetary support by offering discounted home-supply prescriptions for low-income patients discharged from Hospital care, and supporting the Samaritan's Touch free clinic and providing the clinic with in-kind lab and imaging services for Samaritan's Touch patients.

- In 2018, the Hospital started two grief support group and depression support groups. Support groups were hosted on site at AdventHealth Sebring and AdventHealth Lake Placid.

APPENDIX A:
PRIMARY DATA SURVEY
& PRIMARY DATA RESULTS

2019 Community Health Needs Survey Results



2019 Health Survey

AdventHealth

Florida HEALTH Highlands County

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

DEMOGRAPHICS

1. **In which city do you live? (Please choose only one)**
   ☐ Avon Park ☐ Lake Placid ☐ Sebring ☐ Other: _____

2. **What is your zip code? (Please write in):** _____

3. **What is your age? (Please choose only one)**
   ☐ 18 to 24 ☐ 25 to 34 ☐ 35 to 44 ☐ 45 to 54 ☐ 55 to 64 ☐ 65 to 74 ☐ 75 or older

4. **Are you of Hispanic or Latino origin or descent? (Please choose only one)**
   ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino ☐ Prefer not to answer

5. **Which race best describes you? (Please choose only one)**
   ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
   ☐ Native Hawaiian or Pacific Islander ☐ White ☐ More than one race
   ☐ Prefer Not to Answer ☐ Other: _____

6. **Do you identify your gender as?**
   ☐ Female ☐ Male ☐ Other / Gender non-Conforming
   If you identify as Transgender: ☐ Female to Male (or) ☐ Male to Female

7. **Which of the following best describes your sexual orientation? (Please choose only one)**
   ☐ Bisexual ☐ Gay or Lesbian ☐ Heterosexual (Straight) ☐ Other: _____

8. **What language do you MAINLY speak at home? (Please choose only one)**
   ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German
   ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese
   ☐ Other: _____

9. **How well do you speak English? (Please choose only one)**
   ☐ Very well ☐ Well ☐ Not Well ☐ Not at all

10. **What is the highest level of school that you have completed? (Please choose only one)**
    ☐ Less than high school ☐ 2 – Year College Degree
    ☐ Some high school, no diploma ☐ 4 – Year College Degree
    ☐ High school diploma (GED) ☐ Graduate – Level Degree or Higher
    ☐ Some college, no degree ☐ None of the above

Community surveys were completed in collaboration with the Living Well in Highlands County Collaboration. Surveys were administered in paper format as well as completed online. Surveys were offered in both English and Spanish languages.

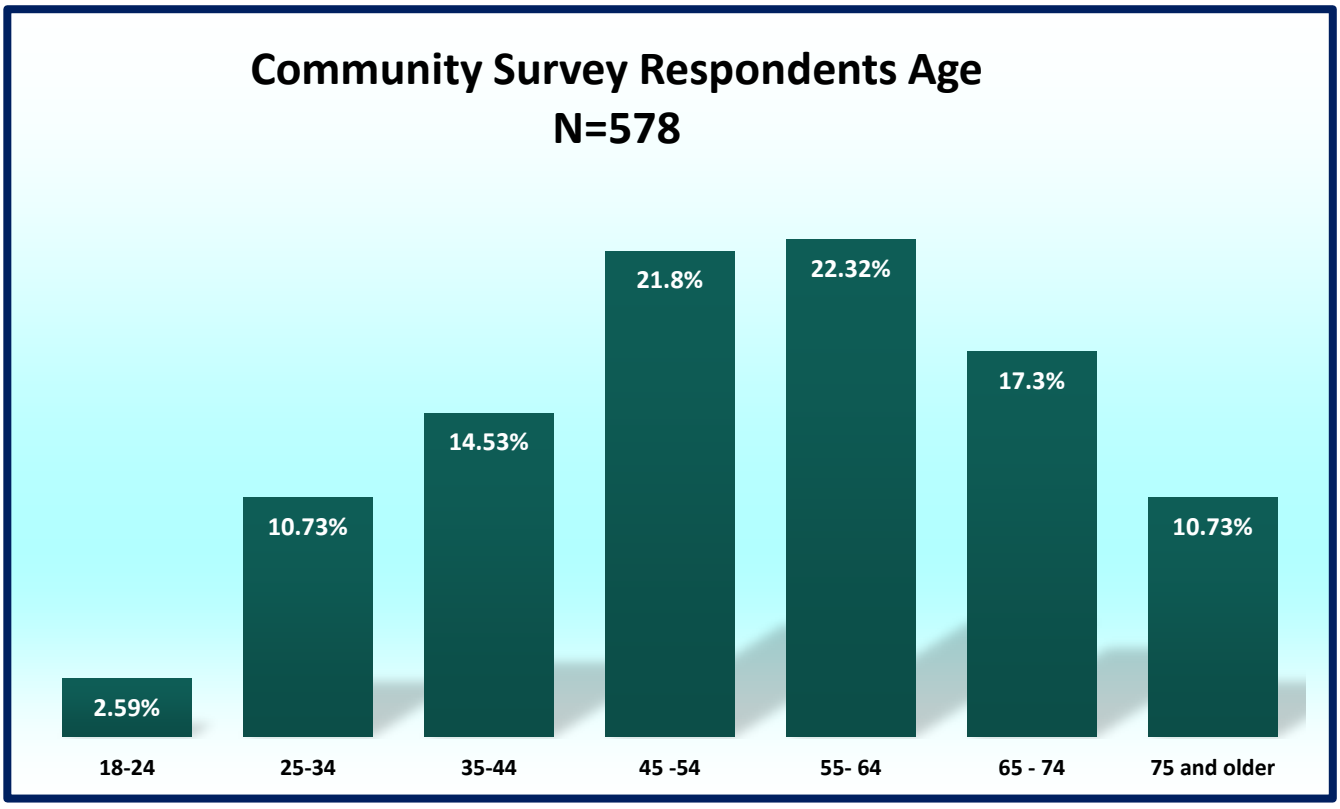
The aggregate results are shown below.

Survey Results – Respondent Demographics

A total of 578 residents from AdventHealth Sebring, and AdventHealth Lake Placid primary service areas participated in the collaborative Community Health Needs Assessment (CHNA) survey. Roughly 80% of community residents who participated in the survey were female and approximately 20% were male.

- **578 Total Respondents** from Highlands & Hardee County
- **79.06% Female**
- **83.70% White**
- **9.17% Hispanic or Latino**
- **6.23% African American**

Below, graph 1. shows the age ranges of survey participants. Nearly half of the respondents were between the ages of 45 to 64 years of age.



Graph 1. CHNA survey participation by age in Highlands County, Florida

SURVEY DEMOGRAPHIC INFORMATION

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

HEALTH INSURANCE STATUS

How do you pay for most of your health care?	
I pay cash / I don't have insurance	5.19%
TRICARE/Veteran's Administration	2.42%
Medicaid PPO	3.28%
Medicare HMO	18.17%
Medicare PPO	0.865%
Commercial Health Insurance (HMO, PPO)	64.88%
Some other way	5.19%

EMPLOYMENT STATUS

Employed, working full–time	67.5%
Student	0.87%
Employed, working part–time	5.02%
Retired	22.0%
Not employed, looking for work	1.00%
Disabled, not able to work	1.35%
Not employed, NOT looking for work	1.56%

SURVEY DEMOGRAPHIC INFORMATION		
Primary Service Area Represented in Survey Data	33825 - Avon Park, 33852 - Lake Placid, 33870 – Sebring, 33872 – Sebring, 33873 – Wauchula, 33875 – Sebring	
Languages Spoken	95.2% English 3.29% Spanish	0.34% French 0.69% Tagalong 0.52% Other:
Household Size *(Including yourself, how many people currently live in your home?)*	84.8% 1-3 20.10% 4-5 3.00% 6+	
Household Annual Income	11.24% Less than $25,000 20.1% $25,000-$49,999 22.66% $50,000-$74,999 14.88% $75,000-$99,999	7.61% $100,000-$124,999 4.33% $125,000-$149,999 5.90% $150,000 and up 13.32% Prefer not to answer
Gender	79.06% Female	19.9% Male
Highest Education Level	0.69% Some High School 14.7% High School Graduate 25.1% Some College 16.44 % Associate Degree	18.69% Bachelor's Degree 23.2% Graduate Degree 0.69% Other: Less than high school, 0.17% Vocational school completed
Ethnicity	9.17% Hispanic	88.7% Non-Hispanic 2.10% Prefer not to answer
Race	83.7% White 6.23% African-American 0.35% Hawaiian/Pacific Islander 2.82% Prefer not to answer	1.70% Asian 2.60% Multiple Races 2.25 % Other
Are you a caregiver to an adult family member who cannot care for themselves in your home?	5.71% Yes	94.10% No
How many CHILDREN (under age 18) currently live in your home? Please choose only one:	None 69.70% 1 10.9% 2 11.4% 3 5.71%	4 1.38% 5 0.52% 6 or more 0.35%

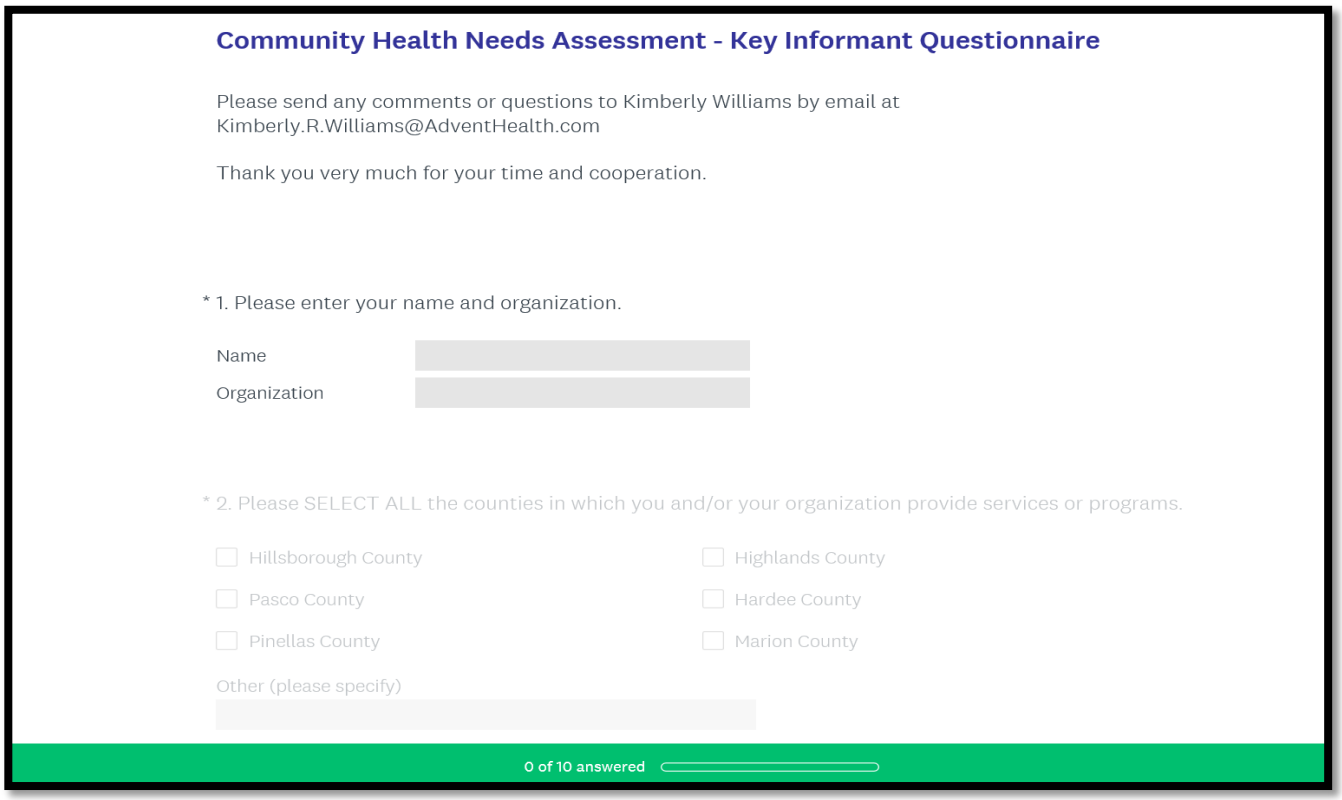
SOCIAL DETERMINANT QUESTIONS		
In the past 12 months, I worried about whether our food would run out before we got money to buy more.	6% Often True 13 % Sometime True	72% Never True 9% No Answer
In the past 12 months, the food that we bought just did not last, and we did not have money to get more.	4% Often True 12 % Sometime True	73% Never True 11% No Answer
In the past 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?	22% YES	67% NO 11% No Answer
In the past 12 months, how many times did you eat fast food? Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout or drive-through.	42% 1 -2 times 11% 3-4 times	4% 5+ times 43% No Answer
In the past 12 months has your utility company shut off your service for not paying your bills?	2% YES	85% NO 13% No Answer
Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed? (Please choose only one)	15% YES	73% NO 12% No Answer
What is the MAIN reason you didn't get the medical care you needed? (Please choose only one)	63% Can't afford it / Costs too much 16% I don't have health insurance	21% I had trouble getting an appointment
Has there been any time in the past 2 years when you were living on the street, in a car, or in a temporary shelter?	0.2% YES	88% NO 11.8% No Answer
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	5% YES	83% NO 12% No Answer
I feel safe in my own neighborhood.	76% Agree 9% Disagree	5% Not Sure 10% No Answer
I am happy with my friendships and relationships.	83% Agree 4% Disagree	3% Not Sure 10% No Answer
I have enough people I can ask for help at any time	75% Agree 11% Disagree	4% Not Sure 10% No Answer
My relationships are as satisfying as I would want them to be.	77% Agree 8% Disagree	4% Not Sure 11% No Answer

STAKEHOLDER SURVEY RESULTS

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

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

STAKEHOLDER INTERVIEW QUESTIONS



Community Health Needs Assessment - Key Informant Questionnaire

Please send any comments or questions to Kimberly Williams by email at Kimberly.R.Williams@AdventHealth.com

Thank you very much for your time and cooperation.

* 1. Please enter your name and organization.

Name

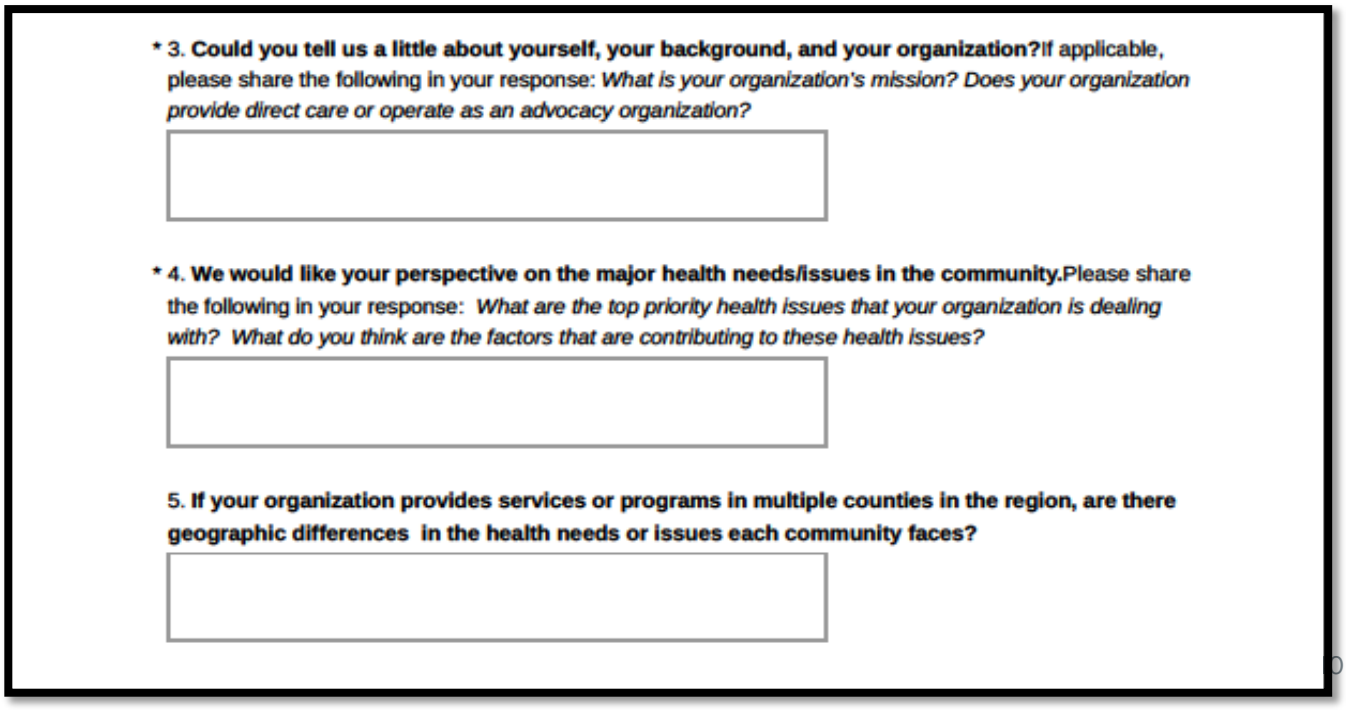
Organization

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

- Hillsborough County
- Pasco County
- Pinellas County
- Highlands County
- Hardee County
- Marion County

Other (please specify)

0 of 10 answered



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

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

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

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

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

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

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

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

STAKEHOLDER SURVEY RESULTS

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

1. Lack of Public Transportation
2. Behavioral Health (Substance Use Disorders, Mental Health, Crisis Care)
3. Access to Healthcare (Lack of Health Insurance, Poverty)
4. Infant Mortality Rates (Birth Disparities among Black Moms)
5. Obesity, Nutrition, and Diabetes (Adults and Children)

Some key quotes from Community Stakeholders are provided below:

Health Topics	
Lack of Public Transportation	"Highlands County faces more transportation-related issues due to the fact that it is geographically larger and those services that are available are spread out. Hardee have fewer resources than Highlands County when it comes to other factors." "There's a lack of transportation, lack of health insurance coverage, and a stigma of being seen at the Health Department." "Lack of transportation (no public transportation)." "The elder and the low-income communities are impacted greatly by the lack of transportation." "Driving distance for specialty care services."
Behavioral Health (Substance Use Disorders, Mental Health, Crisis Care)	"Lack of health insurance (low income, low employment opportunities), low health literacy (not sure why, lower educational levels?)." "Lack of mental health facilities (not a money-maker), lack of specialized physicians (rural area, little in the way of things to do, poor schools…keep physicians away or here for only a short time until their children get old enough for school)." "Denial of a mental health issue, social stigma surrounding mental health issues, lack of support from family to seek help, etc." "We are seeing a large population of indigent patients who need services. We are seeing increased needs in mental health and victim services. The top priority health issue we deal with is mental health and crisis care."
Access to Healthcare (Lack of Health Insurance, Poverty)	"Lack of transportation, lack of cultural sensitivity, lack of LGBTQIA support in the community, language barriers, lack of services being offered, lack of health insurance, cost of services even with insurances, lack of understanding of how to utilize health insurance, wait times for getting in to doctors, and location of services." "Mental health, poor diet and lack of exercise, lack of healthcare education/understanding (how to easily and properly access and navigate the healthcare system - like seeing your primary healthcare provider to prevent health issues to include oral health and use the ER strictly for emergencies)." "Lack of knowledge, lack of transportation, lack of proper insurance coverage, lack of trust in government healthcare providers." "Poor public transportation and a lack of/poor health insurance at TOP of list." "The lower the income, the more affected the individuals seem to be. Also, the level of education seems to have an effect as well as the environment."

	“To a very small extent, the Highway Park Neighborhood Council addresses some healthcare issues by having an annual health fair. This is very surface however.” “We see in the migrant worker population - Lack of transportation, cost barriers, and a lack of knowledge about programs designed to help them.” “Lack of access to specialty care.”
Infant Mortality Rates (Birth Disparities among Black Moms)	“Lack of public transportation and legal status for the Hispanics. Also, important to mention is the lag time in getting pregnant women into care in their first trimester. Some Providers do not accept appointments early in a woman's pregnancy and ask them to wait until they have missed 2-3 menses.” “Birth Disparities among our Black moms and infants and white moms/infants. Black infants are 2.5 times more likely to die than white infants.” “Black infants die at a much higher rate than white infants. We are working with the 7 social determinants of health to address this issue.”
Obesity, Nutrition, and Diabetes (Adults and Children)	" Obesity, both adult and childhood, diabetes, hypertension, mental health issues.” “Childhood Obesity and adverse childhood experiences are the priority health issues for Highlands and Hardee Counties. I think lack of education and resources are major contributors, as well as lack of transportation.”
Vaccinations	"Hepatitis A – education of proper prevention and vaccination needed.”

APPENDIX B:
SECONDARY DATA REPORT

AdventHealth Lake Placid
Needs Assessment Report - Quick Facts

Location
AdventHealth Lake Placid (Service Area)

Demographics

Data Indicator	Indicator Variable	Location Summary	State Average
Population Age 65+	Total Population	87,257	20,278,447
	Population Age 65+	27,277	3,926,889
	Percent Population Age 65+	31.26%	19.36%
Population Age 0-18	Total Population	87,257	20,278,447
	Population Age 0-17	16,913	4,111,582
	Percent Population Age 0-17	19.38%	20.28%
Population Age 18-64	Total Population	87,257	20,278,447
	Population Age 18-64	43,067	12,239,976
	Percent Population Age 18-64	49.36%	60.36%
Total Population	Total Population	87,256	20,278,447
	Total Land Area (Square Miles)	933	53,634.01
	Population Density (Per Square Mile)	93.48	378.09
Change in Total Population	Total Population, 2000 Census	75,641	15,982,378
	Total Population, 2010 Census	86,740	18,801,310
	Total Population Change, 2000-2010	11,099	2,818,932
	Percent Population Change, 2000-2010	14.67%	17.64%
Female Population	Total Population	87,257	20,278,447
	Female Population	44,247	10,364,086
	Percent Female Population	50.71%	51.11%
Hispanic Population	Total Population	87,256	20,278,447

	Non-Hispanic Population	67,386	15,263,432
	Percent Population Non-Hispanic	77.23%	75.27%
	Hispanic or Latino Population	19,870	5,015,015
	Percent Population Hispanic or Latino	22.77%	24.73%
Male Population	Total Population	87,257	20,278,447
	Male Population	43,010	9,914,361
	Percent Male Population	49.29%	48.89%

Social & Economic Factors

Data Indicator	Indicator Variable	Location Summary	State Average
Violent Crime	Total Population		
	Violent Crimes	260	89,934
	Violent Crime Rate (Per 100,000 Pop.)	**310.2**	444.7
Population with No High School Diploma	Total Population Age 25+	64,751	14,396,066
	Population Age 25+ with No High School Diploma	10,986	1,787,348
	Percent Population Age 25+ with No High School Diploma	**17%**	12.42%
Poverty - Population Below 100% FPL	Total Population	84,668.88	19,858,469
	Population in Poverty	16,496.32	3,070,972
	Percent Population in Poverty	**19.5%**	15.46%
Insurance - Uninsured Adults	Total Population Age 18 - 64	42,799	12,071,750
	Population with Medical Insurance	32,857	9,845,200
	Percent Population with Medical Insurance	76.8%	81.56%
	Population Without Medical Insurance	9,942	2,226,550
	Percent Population Without Medical Insurance	**23.23%**	18.44%
Insurance - Uninsured Children	Total Population Under Age 19	17,128	4,291,510
	Population with Medical Insurance	15,795	4,009,046
	Percent Population with Medical Insurance	92.2%	93.42%
	Population Without Medical Insurance	1,333	282,464
	Percent Population Without Medical Insurance	**7.78%**	6.58%

Income - Per Capita Income	Total Population	87,257	20,278,447
	Total Income ($)	$2,003,223,338.00	$583,486,218,200.00
	Per Capita Income ($)	**$22,958.00**	$28,773.00
Unemployment Rate	Labor Force	33,209	10,365,951
	Number Employed	30,650	10,047,379
	Number Unemployed	2,558	318,572
	Unemployment Rate	**7.7%**	3.1%
Lack of Social or Emotional Support	Total Population Age 18+	69,462	14,682,954
	Estimated Population Without Adequate Social / Emotional Support	16,345	3,127,469
	Crude Percentage	23.5%	21.3%
	Age-Adjusted Percentage	**24.8%**	21.2%
Teen Births	Female Population Age 15 - 19	2,305	597,095
	Births to Mothers Age 15 - 19	142	21,555
	Teen Birth Rate (Per 1,000 Population)	**61.59**	36.1
Food Insecurity Rate	Total Population	86,191	20,946,045
	Food Insecure Population, Total	13,541	2,806,770
	Food Insecurity Rate	**15.7%**	13.4%
Poverty - Children Below 100% FPL	Total Population	84,668	19,858,469
	Population Under Age 18	16,730	4,044,879
	Population Under Age 18 in Poverty	5,568	901,772
	Percent Population Under Age 18 in Poverty	**33.28%**	22.29%

Physical Environment

Data Indicator	Indicator Variable	Location Summary	State Average
Use of Public Transportation	Total Population Employed Age 16+	28,251	8,907,171
	Population Using Public Transit for Commute to Work	1,022	180,231
	Percent Population Using Public Transit for Commute to Work	**3.62%**	2%
Population with Low Food Access	Total Population	86,739	18,801,310
	Population with Low Food Access	31,076	4,831,135
	Percent Population with Low Food Access	**35.83%**	25.7%

Clinical Care

Data Indicator	Indicator Variable	Location Summary	State Average
Access to Dentists	Total Population, 2015	87,263	20,271,272
	Dentists, 2015	32	11,304
	Dentists, Rate per 100,000 Pop.	**36.3**	55.8
Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	35,835	5,497,252
	Estimated Population Ever Screened for Colon Cancer	23,664	3,628,186
	Crude Percentage	66%	66%
	Age-Adjusted Percentage	**51.3%**	61.5%
Cancer Screening - Mammogram	Total Medicare Enrollees	14,199	1,861,794
	Female Medicare Enrollees Age 67-69	1,080	161,850
	Female Medicare Enrollees with Mammogram in Past 2 Years	695	109,429
	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	**64.3%**	67.6%
Cancer Screening - Pap Test	Female Population Age 18+	60,077	11,566,352
	Estimated Number with Regular Pap Test	37,072	8,894,525
	Crude Percentage	61.7%	76.9%
	Age-Adjusted Percentage	**64.8%**	78.8%
Facilities Designated as Health Professional Shortage Areas	Primary Care Facilities	4	138
	Mental Health Care Facilities	5	125
	Dental Health Care Facilities	4	127
	Total HPSA Facility Designations	13	390
Lack of Prenatal Care	Total Births	95.78	906,594
	Mothers Starting Prenatal Care in First Semester	53.13	603,986
	Mothers with Late or No Prenatal Care	40.78	250,800
	Prenatal Care Not Reported	1.87	51,808
	Percentage Mothers with Late or No Prenatal Care	**42.6%**	27.7%
Federally Qualified Health Centers	Total Population	39,684	18,801,310
	Number of Federally Qualified Health Centers	4	406
	Rate of Federally Qualified Health Centers per 100,000 Population	**10.08**	2.16

Lack of a Consistent Source of Primary Care	Survey Population (Adults Age 18+)	84,807	14,671,272
	Total Adults Without Any Regular Doctor	22,810	3,638,104
	Percent Adults Without Any Regular Doctor	**26.9%**	24.80%
Preventable Hospital Events	Total Medicare Part A Enrollees	11,064	1,506,764
	Ambulatory Care Sensitive Condition Hospital Discharges	6,377	80,828
	Ambulatory Care Sensitive Condition Discharge Rate	**57.6**	53.6

Health Behaviors

Data Indicator	Indicator Variable	Location Summary	State Average
Alcohol Consumption	Total Population Age 18+	69,462	14,682,954
	Estimated Adults Drinking Excessively	6,792	2,334,590
	Estimated Adults Drinking Excessively (Crude Percentage)	11.6%	15.9%
	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	**15.6%**	17.1%
Physical Inactivity	Total Population Age 20+	68,645	15,678,149
	Population with no Leisure Time Physical Activity	22,390	3,874,964
	Percent Population with no Leisure Time Physical Activity	**30.4%**	23.6%
Tobacco Usage - Current Smokers	Total Population Age 18+	69,462.03	14,682,954
	Total Adults Regularly Smoking Cigarettes	13,179.57	2,642,932
	Percent Population Smoking Cigarettes (Crude)	19%	18%
	Percent Population Smoking Cigarettes (Age-Adjusted)	**22.4%**	18.9%

Health Outcomes

Data Indicator	Indicator Variable	Location Summary	State Average
Mortality - Lung Disease	Total Population	87,482	20,262,854
	Average Annual Deaths, 2007-2011	117	11,770
	Crude Death Rate (Per 100,000 Pop.)	133.79	58.09
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**57.25**	38.69
Mortality - Unintentional Injury	Total Population	87,482	20,262,854
	Average Annual Deaths, 2010-2014	60	10,873
	Crude Death Rate (Per 100,000 Pop.)	68.42	53.66
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**59.82**	47.69
Mortality - Heart Disease	Total Population	87,482	20,262,854
	Average Annual Deaths, 2010-2014	289	44,941
	Crude Death Rate (Per 100,000 Pop.)	330.16	221.79
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**151.01**	148.51
High Blood Pressure (Adult)	Total Population (Age 18+)	69,462	14,682,954
	Total Adults with High Blood Pressure	19,130	4,155,276
	Percent Adults with High Blood Pressure	**27.54%**	28.3%
Cancer Incidence - Lung	Estimated Total Population	16,881	2,771,859
	New Cases (Annual Average)	115	16,548
	Cancer Incidence Rate (Per 100,000 Pop.)	**68.3**	59.7
Mortality - Premature Death	Total Population	223,897	56,417,393
	Total Premature Death, 2014-2016	1,434	256,433
	Total Years of Potential Life Lost,2014-2016 Average	18,426	4,112,576
	Years of Potential Life Lost, Rate per 100,000 Population	**8,230**	7,290
Cancer Incidence - Prostate	Estimated Total Population (Male)	7,805	1,300,513
	New Cases (Annual Average)	50	12,667
	Cancer Incidence Rate (Per 100,000 Pop.)	**64.9**	97.4
Cancer Incidence - Breast	Estimated Total Population (Female)	7,102	1,330,172
	New Cases (Annual Average)	76	15,430

	Cancer Incidence Rate (Per 100,000 Pop.)	**108.2**	116
Cancer Incidence - Cervix	Estimated Total Population (Female)	3,798	1,048,314
	New Cases (Annual Average)	4	933
	Cancer Incidence Rate (Per 100,000 Pop.)	**11.5**	8.9
Cancer Incidence - Colon and Rectum	Estimated Total Population	16,125	2,653,116
	New Cases (Annual Average)	59	9,790
	Cancer Incidence Rate (Per 100,000 Pop.)	**36.8**	36.9
Obesity	Total Population Age 20+	68,629	15,687,277
	Adults with BMI > 30.0 (Obese)	21,741	4,162,381
	Percent Adults with BMI > 30.0 (Obese)	**32.8%**	26.6%
Overweight	Survey Population (Adults Age 18+)	82,477	14,014,811
	Total Adults Overweight	26,467	5,146,693
	Percent Adults Overweight	**32.1%**	36.7%
Diabetes (Adult)	Total Population Age 20+	68,621	15,705,775
	Population with Diagnosed Diabetes	10,859	1,715,434
	Population with Diagnosed Diabetes, Age-Adjusted Rate	**11.6%**	9.22%
Poor General Health	Total Population Age 18+	69,462	14,682,954
	Estimated Population with Poor or Fair Health	15,992	2,525,468
	Crude Percentage	23%	17.2%
	Age-Adjusted Percentage	**21.4%**	15.9%
Mortality - Suicide	Total Population	87,482	20,262,854
	Average Annual Deaths, 2010-2014	19	3,108
	Crude Death Rate (Per 100,000 Pop.)	22.15	15.34
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**20.54**	14
Mortality - Homicide	Total Population	87,482	20,262,854
	Average Annual Deaths, 2010-2014	4	1,216
	Crude Death Rate (Per 100,000 Pop.)	6.17	6
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**7.54**	6.4
Mortality - Cancer	Total Population	87,482	20,262,854

	Average Annual Deaths, 2010-2014	268	43,874
	Crude Death Rate (Per 100,000 Pop.)	306.22	216.53
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**154.95**	150.3
Mortality - Stroke	Total Population	87,482	20,262,854
	Average Annual Deaths, 2010-2014	68	10,871
	Crude Death Rate (Per 100,000 Pop.)	78.14	53.65
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**32.74**	35.48
High Cholesterol (Adult)	Survey Population (Adults Age 18+)	73,046	11,691,020
	Total Adults with High Cholesterol	35,204	4,898,256
	Percent Adults with High Cholesterol	**48.19%**	41.90%
Heart Disease (Adult)	Survey Population (Adults Age 18+)	86,131	14,681,551
	Total Adults with Heart Disease	7,820	822,348
	Percent Adults with Heart Disease	**9.1%**	5.6%
Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	16,302	2,222,669
	Beneficiaries with Depression	2,834	420,851
	Percent with Depression	**17.4%**	18.9%
Poor Dental Health	Total Population (Age 18+)	69,258	14,682,954
	Total Adults with Poor Dental Health	17,521	2,635,605
	Percent Adults with Poor Dental Health	**25.3%**	18%
Infant Mortality	Total Births	5,097	1,133,160
	Total Infant Deaths	43	7,932
	Infant Mortality Rate (Per 1,000 Births)	**8.4**	7
Low Birth Weight	Total Live Births	65,114	1,585,346
	Low Weight Births (Under 2500g)	5,281	137,925
	Low Weight Births, Percent of Total	**8.11%**	8.7%
Asthma Prevalence	Survey Population (Adults Age 18+)	86,287	14,756,311
	Total Adults with Asthma	10,054	1,841,437
	Percent Adults with Asthma	**11.7%**	12.5%

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

APPENDIX C: HOSPITAL UTILIZATION & EMERGENCY ROOM DATA

Below are the top 10 diagnoses for AdventHealth Lake Placid in 2018.

Emergency Department

1. Sepsis, unspecified organism
2. Ulcer of esophagus with bleeding
3. Alcoholic hepatitis without ascites
4. Gastrointestinal hemorrhage, unspecified
5. Other esophagitis
6. Unspecified cirrhosis of liver
7. Acute kidney failure, unspecified
8. Angiodysplasia of stomach and duodenum with bleeding
9. Candidal esophagitis
10. Food in esophagus causing other injury, initial encounter

Inpatient Admissions

1. Sepsis, unspecified organism
2. Ulcer of esophagus with bleeding
3. Alcoholic hepatitis without ascites
4. Gastrointestinal hemorrhage, unspecified
5. Other esophagitis
6. Unspecified cirrhosis of liver
7. Acute kidney failure, unspecified
8. Angiodysplasia of stomach and duodenum with bleeding
9. Candidal esophagitis
10. Hypertensive heart disease with heart failure