2022 AdventHealth Ocala

Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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Letter From Leadership

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

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

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

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

In His Service,

Terry Shaw
President and CEO
AdventHealth

▌Executive Summary

Florida Hospital Ocala Inc., d/b/a AdventHealth Ocala Inc. will be referred to in this document as AdventHealth Ocala or "the Hospital". AdventHealth Ocala in Ocala, Florida conducted a community health needs assessment from April 2022 to November 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.

- Assess and understand the community's health issues and needs.

- Understand the health behaviors, risk factors and social determinants that impact health.

- Identify community resources and collaborate with community partners.

- Publish the Community Health Needs Assessment.

- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

The Collaborative

In order to ensure broad community input, AdventHealth Ocala partnered with the Florida Department of Health in Marion County to conduct the community health needs assessment. To guide the assessment process, a steering committee was formed 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. This steering committee is referred to here as "the Collaborative". The Collaborative included intentional representation from those serving low-income, minority and other underserved populations.

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

Community Health Needs Assessment Committee

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

Data

The Collaborative collected both primary and secondary data for the assessment. The Collaborative contracted WellFlorida, an independent agency, to aid in the data collection and assessment process. Primary data included a community survey and provider surveys. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top six aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://marion.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.
See Process, Methods and Findings for data sources.

Community Asset Inventory

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

Selection Criteria

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

The Collaborative and the CHNAC considered four factors during prioritization:

- Importance and Urgency: Issue severity, burden to large or priority populations, is it of great community concern, is there a focus on equity?

- Impact: Potential effectiveness, is this cross cutting or targeted reach, is there an ability to demonstrate progress?

- Feasibility: What is the community capacity, political will and acceptability to the community?

- Resource Availability: Financial cost, staffing, stakeholder support, time needed?

Priority Issues to be Addressed

The priority issues to be addressed are:

1. Access to Care

2. Behavioral Health (Mental Health & Substance Misuse)

3. Wellness and Primary Prevention

4. Healthy Aging

See Priorities Addressed for more.

Approval

On December 15, 2022, the AdventHealth Ocala 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 Ocala will work with the Collaborative and the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

▌ About AdventHealth

AdventHealth Ocala is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

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

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

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

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

AdventHealth Ocala

AdventHealth Ocala is a 385-bed full-service community hospital that opened in 1898. In August 2018, AdventHealth Ocala became a part of the AdventHealth network. The facility is 640,000 square feet and sits on 15 acres. Within the hospital network there are three 24/7 ER facilities, one onsite and two offsite, to better meet the needs of Marion County. The onsite ER has both an adult and children's emergency department that has over 50 combined beds with the ability to treat many conditions and injuries. The two offsite ERs, AdventHealth TimberRidge ER and AdventHealth Belleview, are 24-hour full-service emergency departments and the TimberRidge location was the first offsite ER in the state of Florida. The hospital offers many inpatient services including, labor and delivery through The Baby Place®, Orthopedic unit, comprehensive cardiovascular surgery unit and a wound care center. AdventHealth Ocala is accredited by The Joint Commission and has received recognition from the American Heart Association and American Stroke Association. They are accredited by the American College of Cardiology in Chest Pain, Heart Failure, Cardiac Cath Lab, Electrophysiology, Transcatheter Valve Certified and awarded the HeartCARE™ Center designation. They are also a Certified Advanced Primary Stroke Center as well as a Center of Excellence in Robotic Surgery.

COMMUNITY OVERVIEW

▊ Community Description

Located in Marion County, Florida, AdventHealth Ocala defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes sixteen zip codes across mainly Marion County and a small part of Levy County.

According to the 2020 Census, the population in the AdventHealth Ocala community has grown 16.4% in the last ten years to 317,010 people. This is more than twice the percentage of growth seen in the United States since the last census and slightly more than the amount seen in the state of Florida. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the Hospital's PSA, also referred to as the community, unless listed for a specific county. The Collaborative conducted the CHNA with a county-level approach, therefore county-level data are included throughout the CHNA report in addition to Hospital PSA-level data. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.

AdventHealth Ocala

## ▊ Community Profile

Age and Sex

The median age in the Hospital's community is 46.8, higher than that of the state, which is 42.2, and the US, 38.2.

Females are the majority, representing 52.2% of the population. Middle aged women, 40-64, are the largest demographic group at 15.1%. Senior aged women, 65 and older, are the second largest demographic in the community at 14.3%.

Children are 19.4% of the total population in the community. Infants, those zero to four, are 5.2% of that number. The community birth rate is 48.8 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and that of the state, 48.3. In the Hospital's community, 31.6% of children aged 0-4 and 26.3% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 28.1% of the total population in the community. Females are 53.8% of the total senior population.

Age

- 5.2%
- 14.2%
- 28.1%
- 52.5%

■ Children (0-4)   ■ Children (5-17)
■ Adults (18-64)   ■ Seniors (65+)
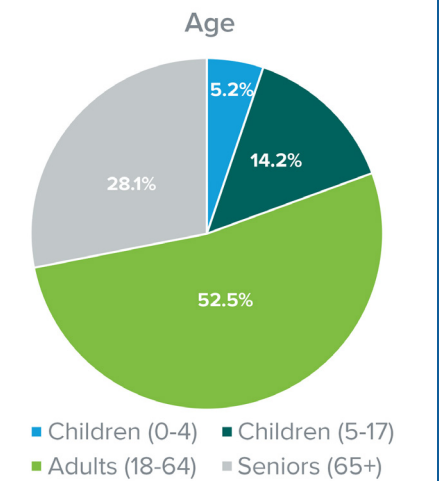
Race and Ethnicity

In the Hospital's community, 65% of the residents are non-Hispanic White, 12.3% are non-Hispanic Black and 16.3% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 1.8% of the total population, while 0.3% are Native American and 3.9% are two or more races.

Race and Ethnicity
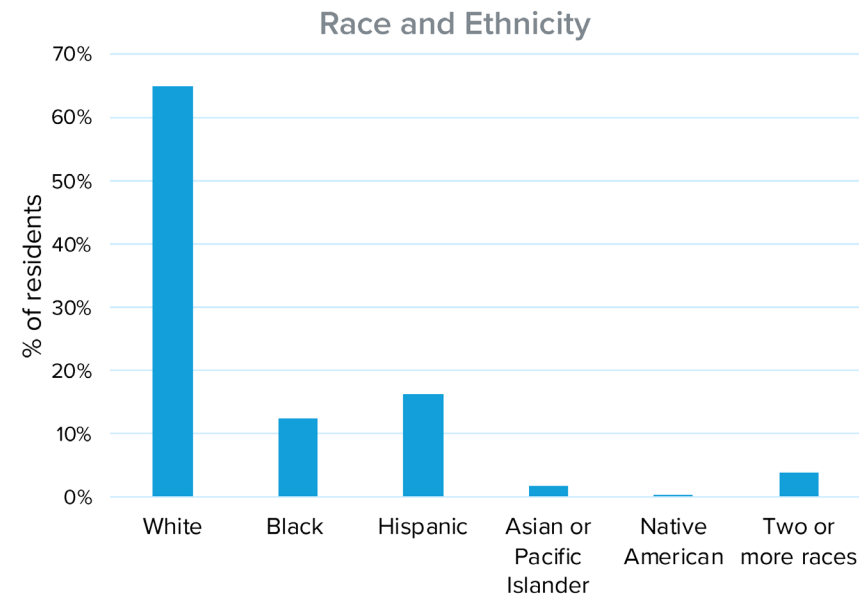
Social Determinants of Health

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

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

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

Economic Stability: This includes areas such as income, cost of living, food security and housing stability.

Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

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

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

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

Economic Stability

Income

The median household income in the Hospital's community is $50,522. This is below the median for the state and that of the US. The poverty rate in the community is 15.1%, which is higher than the state and national rate.
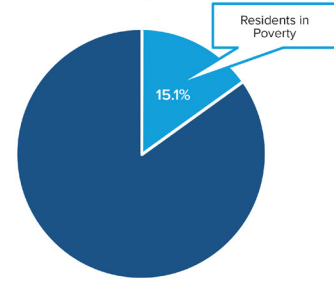
Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[1] Feeding America estimates for 2020[2] showed the food insecurity rate in the Hospital's community as 16%.
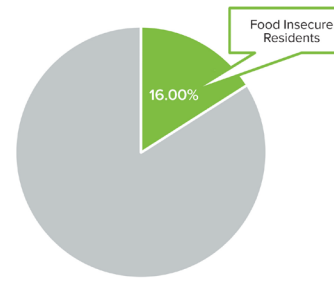
Increased evidence is showing a connection between stable and affordable housing and health.[3] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.
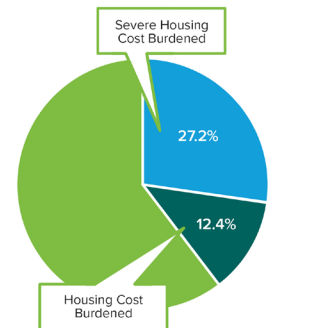
1 Food Insecurity - Healthy People 2030 | health.gov
2 Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
3 Severe housing cost burden* | County Health Rankings & Roadmaps

Residents in Poverty — 15.1%

Food Insecure Residents — 16.00%

Severe Housing Cost Burdened — 12.4%
Housing Cost Burdened — 27.2%

Education Access and Quality

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

In the Hospital's community, there is an 88.3% high school graduation rate, which is slightly lower than the state and national rate. The rate of people with a post-secondary degree is lower in the Hospital's community than both that of the state and the nation.

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

In the Hospital's community, 36.1% of 3-4-year-olds were enrolled in preschool. This is lower than the state and the national rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.
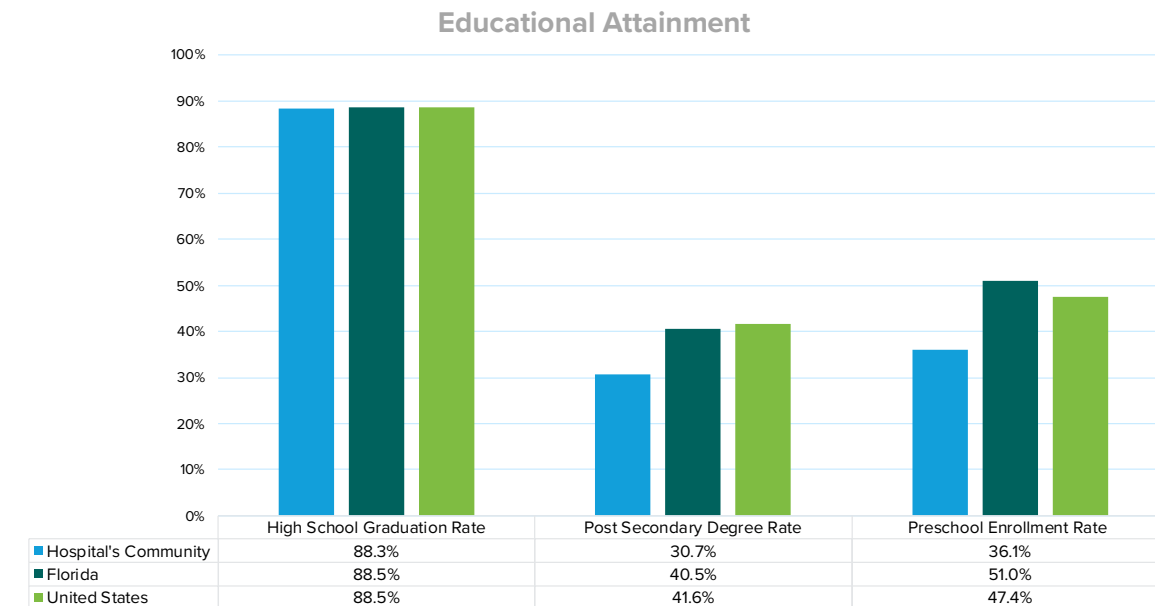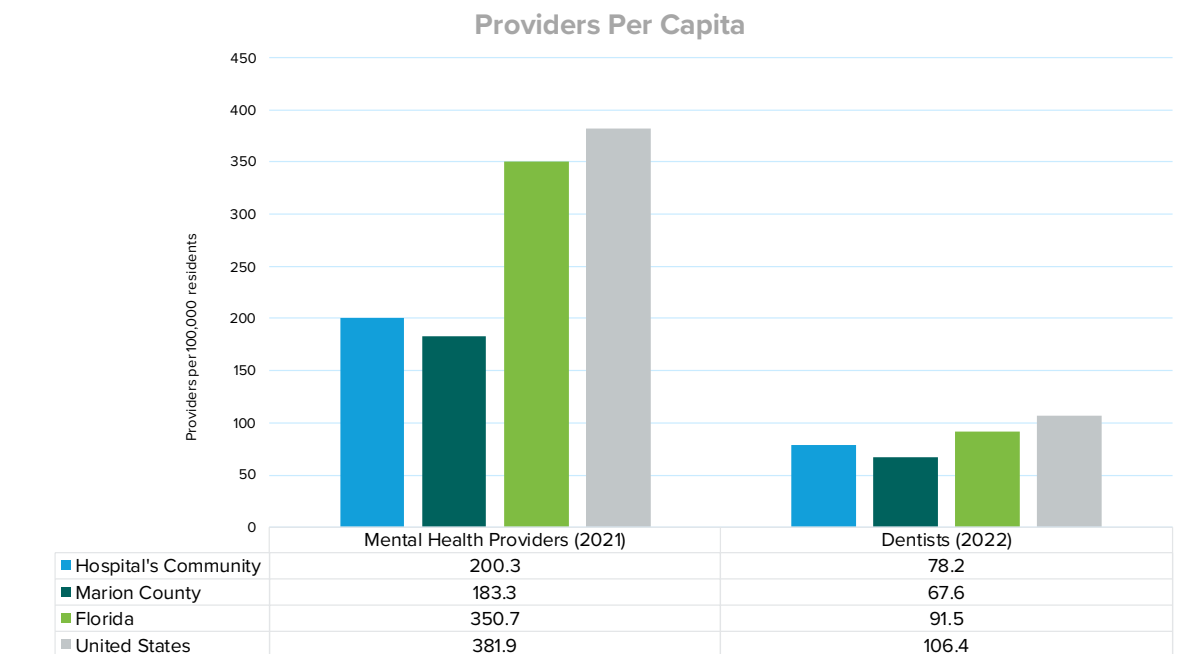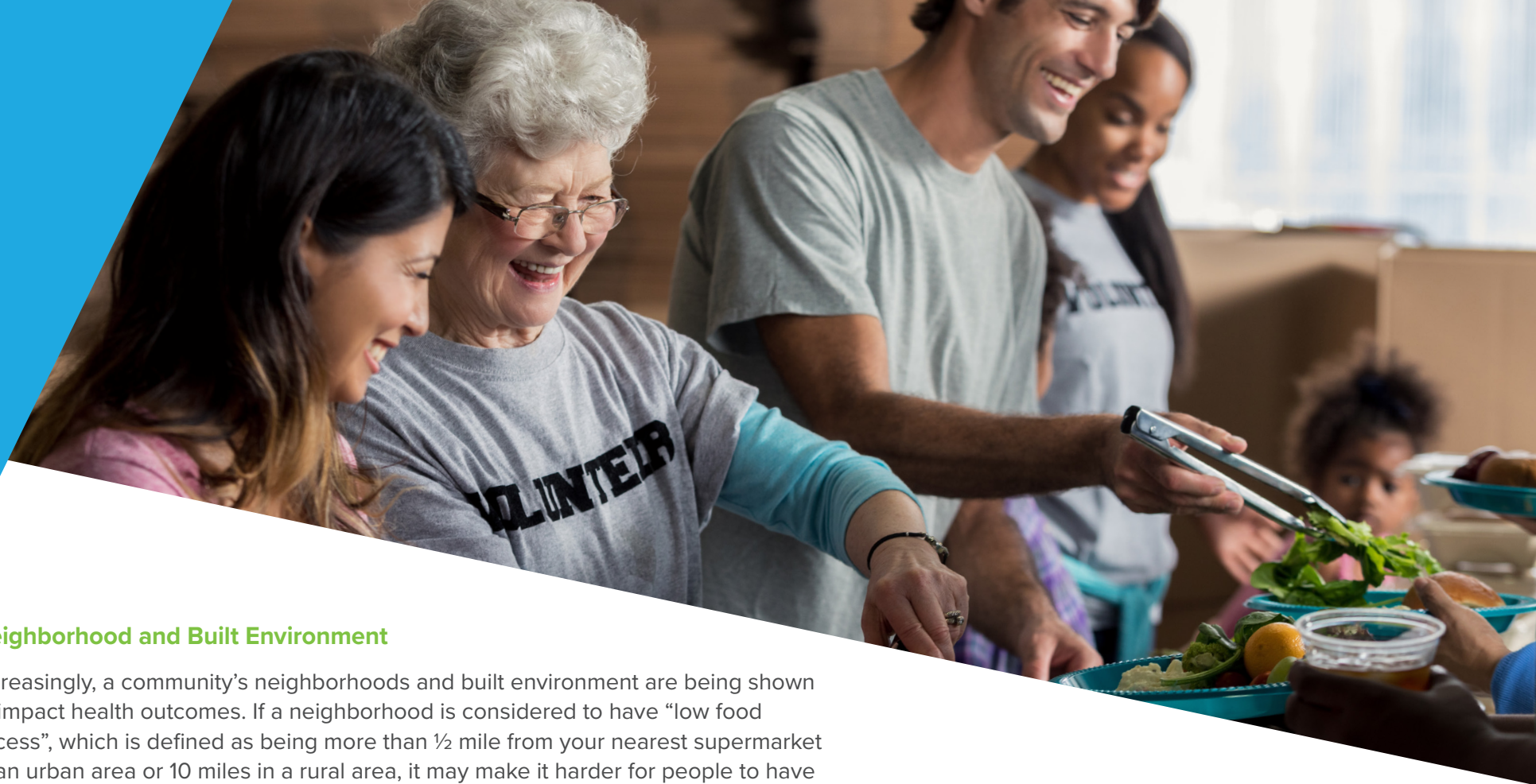
Health Care Access and Quality

In 2020, 11% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[6]

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

Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. In the Hospital's community, 80.1% of people report visiting their doctor for routine care.

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

Educational Attainment

	High School Graduation Rate	Post Secondary Degree Rate	Preschool Enrollment Rate
Hospital's Community	88.3%	30.7%	36.1%
Florida	88.5%	40.5%	51.0%
United States	88.5%	41.6%	47.4%

Providers Per Capita

Providers per 100,000 residents

|	Mental Health Providers (2021)	Dentists (2022)
Hospital's Community	200.3	78.2
Marion County	183.3	67.6
Florida	350.7	91.5
United States	381.9	106.4

Neighborhood and Built Environment

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

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[7] In the Hospital's community, 56.6% of the community lives in a low food access area, while 35% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to accessing health care, healthy food and maintaining employment. In the community 4.9% of households do not have an available vehicle.

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

Food Access

Low Food Access Area

56.6%

Very Low Food Access Area

35%
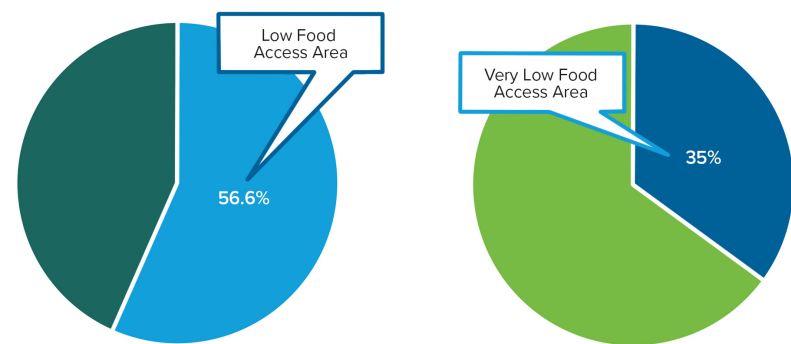
Social and Community Context

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

In the community, 10% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 24.6% of seniors (age 65 and older) report living alone, and 2% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

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

Disconnected Youth

10.0%
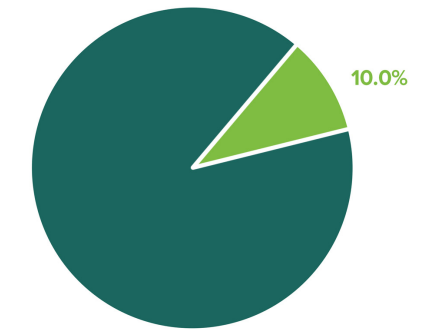
Process, Methods and Findings

▌ Process and Methods

The Process

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

The Hospital partnered with the Florida Department of Health in Marion County to conduct the community health needs assessment. To guide the assessment process, a steering committee was formed 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. This steering committee, referred to here as "the Collaborative", is a county level effort through which health care providers, the department of health and social service providers work to identify and address community health needs through a unified and targeted approach. The Collaborative worked with WellFlorida, an independent agency, to aid in the data collection and assessment process. To read more about the county level findings and data highlighted in the report, please visit https://marion.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

The Collaborative Members

Individuals on the Collaborative represented the Hospital, the Florida Department of Health in Marion County (DOH-Marion) and more than 100 invited members, who guided the process and assured that the health needs and issues of all Marion County residents were considered, all sharing a unified vision of creating impactful community health improvement. As part of this shared vision, Collaborative members recognized the value of the voices of the community and the necessity of trusted relationships in these communities to affect real change. Members are listed below.

Community Partners

Rob Balmes, Ocala/Marion County Transportation Planning Organization

Jesse Blair, Ocala Fire Rescue

Ann Burnett, FreeD.O.M. Clinic USA

Sarah Catalanotto, Suwannee River Area Health Education Center (AHEC)

Greg Davis, Marion County Public Schools

Ashley Gerds, Community Foundation Ocala/Marion County

Michael Harris, Marion County Hospital District

Lynn Irish, Salvation Army

Cassandra Jackson, Marion Senior Services

Angela Juaristic, Ocala Housing Authority

David Kuhn, MD, Trinity Clinic

Erin Jones, Ocala/Marion County Chamber & Economic Partnership

Sarah Lambert, Marion County Parks and Recreation

Robin Lanier, The Centers/SMA Healthcare Ocala

Jessica Majoros, Marion County Parks and Recreation

Cheryl Martin, Marion County Community Services

Jennifer Martinez, Marion Senior Services

Beth McCall, Marion County Children's Alliance

Community Partners *Continued*

Rod McGinnes, College of Central Florida Emergency Medical Services (EMS)

Andrew Montick, WellFlorida Council

Beth Nelson, United Way of Marion County

Erin Peterson, Healthy Start of North Central Florida

John Podkamorski, National Alliance on Mental Illness (NAMI) Marion

Brenda Rabadan, Marion County Hospital District

Caron Reid, Community Partnership School

Chip Rich, Marion County Community Services

Frances Santiago, Langley Health Services

Andrea Simmons, Marion County Public Schools

Clint Smith, Marion County Sheriff's Office

Kenetta Sutton-Wilson, Suwannee River Area Health Education Center (AHEC)

Loretha Tolbert-Rich, Marion County resident

Helen Urie, Marion County Community Services

Shelly Vickers, Healthy Start of North Central Florida

Maclyn Walker, Heart of Florida Health Center

Alicia Wood, University of Florida (UF) Health

Heather Wyman, Heart of Florida Health Center

AdventHealth Team Members

Thomas Agrusti, AdventHealth

Gregory Cain, AdventHealth Ocala

Laura Eatmon, AdventHealth Ocala

Neelie Harmon, AdventHealth Ocala

Kristy Hodson, AdventHealth Ocala

Chad Houchin, AdventHealth Ocala

Natalie McComb, AdventHealth Ocala

Bradley McLarty, AdventHealth Ocala

Julie Paradiso, AdventHealth Ocala

Trish Price, AdventHealth Ocala

Michael Torres, MD, AdventHealth Ocala

Kimberly Williams, AdventHealth

Amy Wise, AdventHealth Care360

Public Health Experts

Craig Ackerman, DOH-Marion

Lisa Bonitatis, DOH-Marion

Kelly Conklin, DOH-Marion

Monica DaSilva, DOH-Marion

Sherry Duncan, DOH-Marion

Mary Anne Jackson, DOH-Marion

Christy Jergens, DOH-Marion

Mark Lander, DOH-Marion

Randy Ming, DOH-Marion

Violeta O'Connor, DOH-Marion

Tracey Sapp, DOH-Marion

Jonathan Spann, DMD, DOH-Marion

William Thompson, DOH-Marion

Community Input

The Collaborative, in partnership with WellFlorida, collected input directly from the community and from health care and social service providers working in organizations addressing the needs and interests of the community. This was collected through a community survey, a provider survey and a Forces of Change assessment.

Community Survey

- Individuals were asked to provide information about community health issues and the healthcare system from the perspective of Marion County residents.

- Surveys were provided in English and Spanish to anyone in Marion County and accessible through weblinks and QR codes.

- Surveys were shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists they maintained and when possible shared on their own social media channels.

Provider Survey

- Participants were asked to provide input on health and barriers to health that they were seeing in the community.

- Surveys were sent to individuals working from healthcare and community partners who provide healthcare and social services in Marion County. Healthcare providers included professionals such as physicians, dentists and advanced registered nurse practitioners; community partners included social service workers, counselors and others who provide community-based services.

- 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.

Forces of Change Assessment

Convened by the Collaborative, a group of community leaders met in the summer of 2022 to review the preliminary data from the assessment process. The group was asked to consider the following questions for discussion:

What is occurring or what might occur that affects the health of our community or the local public health system? **and**

What specific threats or opportunities are generated by these occurrences?

Discussions began with brainstorming to identify the possible forces that may hinder or help the community in its quest for improvement in community health outcomes. The goal of discussion was to identify forces – such as trends, factors and events – that are or will be influencing the health and quality of life of the community and the work of the community to improve health outcomes.

Secondary Data

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

- US Census Bureau
- Center for Disease Control and Prevention
- US Department of Health and Human Services
- FloridaHealthCharts

▌ The Findings

There were six needs found in the assessment process that rose to the top. To identify the top needs, WellFlorida led the Collaborative through a data review and discussion session. The Collaborative discussed the issues and findings from the community survey, the provider survey and in the Forces of Change assessment, to create a list of issues which they believed accurately reflected the areas of concern for Marion County residents.

A facilitated consensus process moved the discussion from creating the list of issues to identifying the common themes within them. Through the consensus process, these themes were consolidated into six broad topic areas which had shared themes and related impacting SDOH factors.

Access to Care

Many people face barriers that prevent or limit access to needed health care and social services, which may increase the risk of poor health outcomes and health disparities. Access to health care is the timely use of personal health services to achieve the best possible health outcomes. Two important factors in accessing care involve having an adequate number of providers in a community and adequate health insurance coverage.

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

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

Behavioral Health (Mental Health & Substance Misuse)

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

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

Education

Education, the idea of imparting knowledge or skills to another, was a theme heard across many needs voiced in the community. This was in reference to the need for more community education on available social services for chronic disease management and to the impact of early childhood education on long term outcomes.

Safety

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

Aging

The most often mentioned barrier identified in the built environment was transportation. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities. Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes.

Built Environment (Transportation)

The most often mentioned barrier identified in the built environment was transportation. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities. Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes.

PRIORITIES SELECTION

▍Prioritization Process

The Collaborative narrowed down the needs of the community to a list of four priority areas through a facilitated discussion and debate until a consensus was reached among the group. The Collaborative used the criteria below to evaluate and prioritize the list of six to the final four selected.

1. **Importance and Urgency:** Issue severity, burden to large or priority populations, is it of great community concern, is there a focus on equity?

2. **Impact:** Potential effectiveness, is this cross cutting or targeted reach, is there an ability to demonstrate progress?

3. **Feasibility:** What is the community capacity, political will and acceptability to the community?

4. **Resource Availability:** Financial cost, staffing, stakeholder support, time needed?

During the discussion, the Collaborative chose to address two of the needs under one priority. This decision was made because of the related themes of the needs, many of which can be addressed through a singular approach. The Collaborative chose to address education and safety through a unified priority known as Wellness and Primary Prevention. The complete list is included here and includes not only the priorities selected but also targeted areas that can be used when developing strategic interventions to address the priority.

Access to Care, addressing:
- Primary care
- Provider shortages
- Barriers to care including financial, physical, cultural and attitudinal
- Health literacy

Behavioral Health, focusing on:
- Mental health services across the lifespan
- Substance misuse prevention and treatment
- Mental wellness and community-based strategies for prevention

Wellness and Primary Prevention, with emphasis on:
- Community safety and injury prevention
- Life skills education
- Healthy behaviors and responsible health decision-making

Healthy Aging, with a focus on:
- Supportive care and services for the aging population

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

The CHNAC followed the same process and criteria as the Collaborative for data review and needs prioritization. Having reviewed the selections and the supporting data from the Collaborative, the Hospital chose to address the same needs. Through a unified approach in addressing the same needs as the Collaborative, the belief is that the Hospital will have a greater impact in addressing the needs of the community.

CHNAC Members

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

Name, Title	Organization	Services Provided	Populations Served
Jamie Ulmer, CEO	Heart of Florida Health Center	Health Care	Focused on uninsured populations with special programs
Mike Taeka, CEO	The Vines Behavioral Health Hospital	Behavioral Health Care	Focused on populations with behavioral health challenges
Ann Burnett, Executive Director	FreeD.O.M. Clinic USA	Dental Health	Provides free or low cost dental care to uninsured residents of Marion County
Mark Lander, Administrator	Florida Department of Health of Marion County	Local Government	Provides various community health programs and administers local community health policies
Beth Nelson, Director of Community Impact	United Way	Volunteerism support and community outreach	Connects organizations to non-profits in the area for volunteer opportunities and advocates for various at-risk populations
Craig Ackerman, Operations Director	Florida Department of Health of Marion County	Local Government	Provides various community health programs and administers local community health policies
Heather Wyman, Health Education Coordinator	Heart of Florida Health Center	Health Care	Focused on uninsured populations with special programs
John Podkamorski, Executive Director	NAMI Marion	Behavioral Health	Behavioral health advocacy group and provides support groups for individuals and facilities with behavioral health challenges
Jennifer Martinez, Executive Director	Marion Senior Services	Food and Nutrition	65+ community
Lamar Rembert, Principal	Howard Middle School	Education	Middle school aged students
Peter Lee, City Manager	City of Ocala	Local Government	Oversees operations and community partnerships within Ocala city limits

Name, Title	Organization	Services Provided	Populations Served
Bradley Mclarty, Wellness & Cardio Pulmonary Rehab Manager	AdventHealth	Health Care	Manages operations for cardiac and pulmonary rehabilitation patients along with wellness activities within the wellness center
Natalie McComb, Marketing Manager	AdventHealth	Marketing	Local population
Joe Johnson, CEO	AdventHealth	Administration	Local population
Ashley Dowler, Director of Rehabilitation Services	AdventHealth	Administration	Local population
Greg Cain, Director of Mission and Ministry	AdventHealth	Mission and Ministry	Local population
Jenna Krager, Executive Director	AdventHealth Ocala Foundation	Philanthropy	Low-income and food insecure populations
Curt Bromund, Executive Director	Marion County Hospital District	Health care and community health services	Local adult population
Chad Christianson, CEO	Ocala Health	Health Care	Local adult population
Alicia Wood, CFO	UF Health	Health Care	Local adult population
Sarah Catalanotto, Executive Director	Suwanee River Area Health Education Center	Smoking cessation and continuing education	Adults living in local counties
Robin Lanier, VP	SMA Healthcare	Behavioral Health	Adult population
Rick Bourne, CEO	Hospice of Marion County	Hospice and end of life care	65+ community
Beth Mccall, Executive Director	Marion County Children's Alliance	Advocacy	Youth

CHNAC Members continued

Name, Title	Organization	Services Provided	Populations Served
Karla Grimsley, CEO	Interfaith Emergency Services	Emergency Shelter and Food	Homeless population
James Henningsen, President	College of Central Florida	Education	Local adult population
Diane Gullet, Superintendent	Marion County Public Schools	Education	Local youth population
Rob Balmes, Director	Ocala Marion TPO	Transportation	Local adult population
Donnie Mitchell, Program Grant Manager	Housing Finance Authority of Marion County	Housing	Local adult population
Cheryl Martin, Director	County Community Services	Housing	Local adult population
James Haynes, Director	Ocala Community Development Services	Housing	Local adult population
Gwendolyn Dawson, CEO	Ocala Housing Authority	Housing	Local adult population
Amanda Robbins, Senior Director of Procurement	Signature Brands	Business /Employment	Local adult population
Rusty Skinner, CEO	Career Source Citrus Levy Marion	Business /Employment	Local adult population
Tom Chase, CEO	Langley Health Services	Health Care	Local adult population
Jesse Blair, EMS Captain	City of Ocala EMS	Emergency Response Services	Local Population, high risk populations

▍Available Community Resources

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

Top Issues	Current Community Programs	Current Hospital Programs
Access to Care	• College of Central Florida Dental Program (low-cost dental services) • FreeD.O.M Clinic USA • Heart of Florida Health Center • Langley Health Services (FQHC) • Florida Department of Health in Marion County • Brother's Keeper (ministry of Blessed Trinity Church)	• Pediatric orientation • Support groups for weight loss and diabetes management • Team member volunteerism
Behavioral Health (Mental Health and Substance Misuse)	• Heart of Florida Health Center • Langley Health Services (FQHC) • Beacon Point • Suwannee River AHEC (smoking cessation) • National Alliance on Mental Illness • The Vines Behavioral Health Hospital • Ora Clubhouse	• AdventHealth sponsored Mental Health First Aid • Team member volunteerism
Wellness and Primary Prevention	• Active Marion Project (Marion County Hospital District) • Fitness and Nutrition in Schools (FANS) • Florida Department of Health in Marion County	• AdventHealth Food is Health(R) • Prestige 55 program • Support groups for weight loss and diabetes management • Pediatric Orientation • Team member volunteerism
Healthy Aging	• Marion Senior Services • YMCA Active Older Adults Classes (low impact, gentle yoga, fall prevention, Osteo-Pilates)	• Healthy Home program • Prestige 55 program
Transportation	• Brother's Keeper (ministry of Blessed Trinity Church) • Interfaith Emergency Services (gas vouchers for medical appointments) • The Center of Hope (Salvation Army Ocala) • Marion Transit Services	

▮ Priorities Addressed

The priorities addressed include:

🗒 Priority 1:
Access to Care

Over half (54%) of community survey respondents ranked access to health care as the most important factor contributing to a healthy community. An important factor in access to care involves having an adequate number of providers in a community. The rate of primary care providers in Marion County is 59.9 (per 100,000 population) compared to the Florida rate of 72.2. Marion County has a rate of dental providers at 43.1 compared to Florida at 60.8. Similarly, the rate for mental health providers in Marion is 104.2 compared to the Florida rate of 169.0. 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. The percentage of adults aged 18-64 that do not have health insurance coverage in Marion County is 20.5%, slightly higher than the state of Florida at 19.4%. Focusing on access to care will help align local efforts and resources to create targeted strategies to improve access for Marion County residents.

🧠 Priority 2:
Behavioral Health (Mental Health & Substance Misuse)

In the Hospital's community, 18.7% of residents have depression, while 14.3% of the residents reported poor mental health. Survey respondents (51.9%) ranked drug abuse as the behavior with the greatest negative impact on overall health. One of the most concerning trends is drug overdose deaths, which have increased significantly over the past few years, currently at a rate of 62.8 (per 100,000 population) and one of the highest rates for counties in Florida. Marion County also sees a higher percentage of adults who currently smoke, with 18.3% of adults in Marion County compared to 14.8% for the state of Florida. Awareness and the need to address behavioral health has been growing in the country and locally. By including behavioral health as a priority, the Hospital can align to local, state and national efforts for resource collaboration and to create better outcome opportunities over the next three years.

🛡 Priority 3:
Wellness and Primary Prevention

Prevention means intervening before health effects occur, through measures such as vaccinations, altering risky behaviors (poor eating habits, tobacco use) and limiting substances known to be associated with a disease or health condition. The committee chose to focus on wellness and primary prevention in the areas of community safety and injury prevention, life skills education and healthy behaviors and responsible health decision-making. Unintentional injury is the third leading cause of death in Marion County. The age-adjusted death rate for unintentional injury in Marion County is more than double that of the state, scoring in at 73.5 deaths per 100,000 population compared to just 34.9 for the state. Although a lower percentage of adults are overweight in Marion County compared to the state (31.8% versus 37.6%), a greater percentage are obese (35.0% versus 27.0%). On the related topic of physical activity, over two thirds of adults are sedentary in Marion County, with only 30.2% meeting muscle strengthening recommendations.

🧍 Priority 4:
Healthy Aging

Demographic data reflects that Marion County has an older population than the state of Florida as a whole, with 28.9% of the population being over the age of 65 compared to Florida at 20.5%. Older adults are at higher risk for chronic health problems like diabetes, osteoporosis and Alzheimer's disease. Physical activity can help older adults prevent both chronic disease and fall-related injuries. Making sure older adults get preventive care and supportive community services can help them stay healthy. Providing services for patients and families affected by Alzheimer's disease emerged as an important topic to address in the Hospital's community. The data shows that 12.4% of the population aged 65 and older in Marion County received a probable diagnosis of Alzheimer's disease. Also pertinent for an older community, data shows that falls are the leading cause of emergency department and hospital visits in Marion County. Loneliness and isolation, which have a negative impact on overall health, were identified by 14.6% of community survey respondents. This theme also emerged during prioritization conversations. In Marion County, 30.4% of residents aged 65 and older live alone, compared to 24.4% for the state.

▍Priorities Not Addressed

Built Environment (Transportation)

During the assessment, transportation was often cited as a barrier to receiving care. On average 10% of community survey respondents shared that transportation kept them from accessing care and services when needed. During the Forces of Change assessment, transportation challenges were identified as an impacting factor for people in everything from accessing care to accessing nutritious foods for individuals living in food deserts. The committee decided that transportation, although a persistent problem in Marion County for a multitude of reasons, is being addressed as a countywide infrastructure and resource investment issue by county government. However, strategies to reduce transportation barriers to health care and social services will be considered in the community health improvement action plan.

COMMUNITY HEALTH PLAN

▌ Next Steps

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

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

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2023.

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.

Behavioral Health

In 2019, the Hospital chose behavioral health as a priority. In the Hospital's community, 15% of adults reported heavy alcohol consumption. Excessive drinking behavior patterns are determinants of future health and may be the cause of significant health issues, such as cirrhosis, cancers and untreated mental and behavioral health needs. The assessment also found almost one quarter of adult community members were current cigarette smokers. Smoking can cause a wide range of health issues including cancer, heart disease, diabetes, oral health diseases and harmful reproductive effects. Under the priority area of behavioral health, the Hospital also explored mental health data. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behaviors and suicide. In the Hospital's community, the percentage of the Medicare-fee-for-service population who were depressed was higher than the state average.

The Hospital focused its efforts on increasing access to behavioral health care for uninsured/underinsured patients who have an acute mental health episode or chronic mental health illness. To address the priority, the Hospital partnered with The Centers, which offers a wide variety of behavioral health care services designed to help people of all ages reach their highest level of functioning. Through this partnership, The Centers reserves five beds each day for uninsured patients, which includes coverage for up to three days funded by the Hospital. By the end of 2021, 155 patients had received coverage for 305 in-patient treatment days. The Hospital also developed and launched a paid volunteer program through which team members can volunteer at local organizations which are addressing mental health needs.

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

Obesity/Overweight/Obese, Lack of Physical Activity and Diabetes

The Hospital also chose obesity/overweight/obese, lack of physical activity and diabetes as a priority in the previous assessment. In the Hospital's community, 31% of adults are obese (BMI greater than 30), higher than the state average of 26.6%. Additionally, 37% of adults in the community are considered overweight (BMI between 25 and 30) and 30% of adults aged 20 and older self report no leisure time for physical activity. The assessment also found 10% of adults in the community had been diagnosed with diabetes.

As part of its efforts to address the priority, the Hospital focused on increasing access to education classes on diabetes and the impact of a healthy lifestyle. The Hospital has formed a partnership with the Florida Department of Health in Marion County to support their Diabetes Self-Management Education and Support (DSMES) classes. By the end of 2021, the Hospital funded six classes through the partnership. The Hospital also worked to establish a referral network to connect patients with the DSMES classes and is on track to refer 150 patients by the end of 2022.

Poor Dental Health and Uninsured/Underinsured (Lack of Medical Insurance)

In the 2019 CHNA, the Hospital addressed dental health and the lack of medical insurance as a priority. In the Hospital's community, the access to dentists rate is 38 per 100,000 population (in 2015), as compared to the state rate of 56. Many oral diseases can be prevented with routine care and regular dental checkups. The health of the teeth, the mouth and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being. Lack of access to dental care for all ages remains a public health challenge. The assessment also found 19% of adults and 6% of children in the community are uninsured.

Since adopting the plan, the Hospital has focused on increasing access to dental care providers and improving education on oral health. To support this work, the Hospital partnered with FreeD.O.M. Clinic, a free clinic sponsored by the Marion County Hospital District. To increase access, the Hospital is on track by the end of 2022 to recruit three volunteer dentists to staff mobile clinic events which are provided for low-income, uninsured and underinsured community residents. FreeD.O.M. Clinic and the Hospital also created a virtual training for community health workers on how to provide dental blocks, which provide a temporary solution to dental pain until recipients can secure dental appointments. By the end of 2021, six community health workers had completed the training and will be part of future mobile dental clinic events.

Low Food Access/Food Insecurity

Low food access/food insecurity was also a priority found in the assessment. A lack of food access can lead to food insecurity, when community members do not have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools. In the Hospital's community, 16.8% of the population has experienced food insecurity, as have 28% of those under 18.

As part of the effort to address this, the Hospital has launched the AdventHealth Food is Health® program in the community. The AdventHealth Food is Health® program is an AdventHealth West Florida Division program which increases access to health education and healthy foods to improve the overall health of the communities the Hospital serves. Through collaboration with community partners the program connects with low income/low access communities and provides free health education, health screenings and produce vouchers which are used to purchase fresh fruits and vegetables. Since adopting the plan, the Hospital has partnered with several community organizations to expand the services the program can offer and provide more locations within the community. In 2021, the Hospital held the first of their planned classes, provided 239 produce vouchers and established a paid program for employees to volunteer at local organizations focusing on food access and insecurity.

2019 Community Health Needs Assessment Comments

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

AdventHealth

**Florida Hospital Ocala Inc.,
d/b/a AdventHealth Ocala**

CHNA Approved by the Hospital Board on December 15, 2022

For questions or comments please contact:
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