AdventHealth Sebring
2020-2022
COMMUNITY HEALTH PLAN

Adventist Health System/Sunbelt, Inc.
d/b/a AdventHealth Sebring
Approved by the Hospital Board on: April 30, 2020
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Extending the Healing Ministry of Christ

AdventHealth

2020-2022 COMMUNITY HEALTH PLAN

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Acknowledgements

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

We are especially grateful for the internal and external partners who helped guide the development of the community health plan, which will enable our teams to continue fulfilling our mission of *Extending the Healing Ministry of Christ*.

OVERVIEW

Adventist Health System/Sunbelt, Inc. d/b/a AdventHealth Sebring, will be referred to in this document as AdventHealth Sebring or "The Hospital."

Community Health Needs Assessment Process

AdventHealth Sebring in Sebring, Florida, AdventHealth Wauchula in Wauchula, Florida and AdventHealth Lake Placid in Lake Placid, Florida or the "Hospitals," share the same defined community and completed their Community Health Needs Assessment (CHNA) process together as a collaboration in 2019. The assessment identified the health-related needs of the community including low-income, minority and other underserved populations.

In order to ensure broad community input, AdventHealth Sebring, AdventHealth Wauchula and AdventHealth Lake Placid created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospitals 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 throughout 2018-2019. The members reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospital, and helped develop the Community Health Plan (CHP) to address the priority issues.

The CHP lists targeted interventions and measurable outcomes for each priority issue noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

Priority Issues to be Addressed

The priority issues to be addressed include:

1. Mental Health (Behavioral Health)
2. Transportation
3. Cardiovascular Disease
4. Education (Social Determinant of Health)

See Section 3 for goals, objectives and next steps for each priority selected to be addressed.

Priority Issues not to be Addressed

The priority issues that will not be addressed include:

1. Poor Dental Health
2. Tobacco Use
3. Obesity/Overweight/Obese

See Section 4 for an explanation of why the Hospital is not addressing these issues.

Board Approval

On April 30, 2020, the AdventHealth Sebring Board approved the Community Health Plan goals, objectives and next steps. A link to the 2020 Community Health Plan was posted on the Hospital's website prior to May 15, 2020. The Community Health Plan can be found at https://www.adventhealth.com/community-health-needs-assessments.

Ongoing Evaluation

AdventHealth Sebring Board's fiscal year is January – December. Implementation of the 2020 CHP begins upon its approval by the Board. The first annual evaluation will begin from the date of implementation through the end of the calendar year. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information

Learn more about the Community Health Needs Assessment and Community Health Plan for AdventHealth Sebring at https://www.adventhealth.com/community-health-needs-assessments.

CHP PRIORITY 1

Mental Health

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. Suicide is the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. In the AdventHealth Sebring Primary Service Area (PSA), the rate of death due to self-harm (suicide) is 19 (per 100,000 population), which is higher than the state rate of 14 (per 100,000 population). Furthermore, 25% 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. Seventeen percent of the Medicare-fee-for-service PSA population are depressed.

The Hospitals will collaborate on the initiatives below and aim to establish new partnerships with local community organizations, leaders and stakeholders. Through these partnerships, the Hospitals will implement strategies that will reduce the stigma associated with mental health by increasing public awareness with mental health education and training opportunities. These are regional initiatives, which appear on multiple Community Health Plans. However, the projected and reported numbers below are specific to AdventHealth Sebring.

Goal	**To increase education and awareness related to mental health by engaging public schools, community members, organizations, and stakeholders.**
Objective	Partner with Champion for Children Advocacy Center to raise awareness of the impact of mental health in youth and adults residing in the Hospital's PSA by creating and implementing two local social media campaigns from a baseline of zero local social media campaigns by the end of year three (December 31, 2022).

Objective	Increase the number of Mental Health First Aid USA certification training classes provided for free to community members residing in the Hospital's PSA by three certification classes from a baseline of zero certification classes by the end of year three (December 31, 2022).
Goal	**To increase community-level partnerships to enhance existing efforts currently addressing factors that impact mental health in youth and adults.**
Objective	Provide vouchers to cover the costs of household supplies for homeless adults residing in the Hospital's PSA who receive housing services at Peace River Center (PRC) from a baseline of zero vouchers to three by the end of year three (December 31, 2022).
Objective	Increase awareness of Hospital sponsored community benefit programs and resources available to uninsured/underinsured adults and youth residing in the Hospital's PSA through a partnership with Peace River Center (PRC), by providing three informative in-service presentations to Crisis Response Outreach Counselors at PRC from a baseline of zero presentations by the end of year three (December 31,2022).
Objective	Increase the amount of paid staff time for Hospital staff/team members to volunteer with community organizations addressing mental health from a baseline of zero hours to 300 hours by the end of year three (December 31, 2022).

Hospital Contributions

- Community benefit staff to collaborate with Champion for Children Advocacy Center to create and implement local social media campaigns.
- Cover costs of household supplies for adults receiving housing services at Peace River Center.
- Provide community benefit staff to manage, implement and evaluate community strategies and partnerships.
- Provide financial assistance to sponsor printing costs for community resource tool kit guides on mental illness and substance misuse.
- Provide free Mental Health First Aid certification classes to Highlands County community members (cover cost of training materials, certifications, meals, staff training, etc.).
- Cover costs associated with training community benefit staff as Mental Health First Aid USA instructors.

- Community benefit staff to work with the AdventHealth Care 360 Transition[1] Specialist to track and report referrals to internal and external resources to address mental health. Transition Specialists connect patients with health care resources and services needed for a successful recovery before leaving the hospital.
- Community benefit staff to actively participate in community meetings with partners addressing mental health.
- Community benefit staff and members of the Hospital leadership teams to actively serve on community boards associated with addressing mental health.
- Provide Hospital paid staff time of four hours per quarter to participate in volunteer activities addressing mental health.

Community Partners

- Champion for Children Advocacy Center to host Mental Health First Aid training classes for children and families in the Hospital's PSA.
- Peace River Center to provide housing services, including supplies, to the homeless in the Hospital's PSA.
- Strengthen collaborative relationships with local sites (churches, community centers, schools) to support community efforts to address suicide/depression/mental health.

[1] AdventHealth's Care 360 Transition teams assist the patient by conveniently connecting the patient with health care resources and services needed for a successful recovery before leaving our hospital.

CHP PRIORITY 2

Transportation

A poor transportation system prevents those who do not own a car or have reliable transportation from accessing health care. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. Furthermore, a lack of access to public and private transportation also means limited access to grocery stores and supermarkets selling healthy foods. Such challenges affect individuals and families' ability to purchase and consume affordable healthy foods. In the AdventHealth Sebring Primary Service Area (PSA), 3% (1,026 persons) of the population are currently using public transportation as their primary means of transportation to work. Furthermore, 27% of the population (28,585 persons) aged 18 years and older do not have a regular healthcare provider, which is higher than the state average (25%).

The Hospitals aim to establish new partnerships with local community organizations, leaders and stakeholders to create and implement strategies that will improve access to transportation by increasing awareness of the issue and opportunities to address it. The Hospital will also address this priority through the AdventHealth Food is Health® signature program. The Food is Health® program is provided at no cost for community members who do not have the means or transportation to include fresh vegetables and fruits in their diet. Food is Health® reaches into communities to improve the overall health and wellness of adults living in food deserts or low-income/low-access areas. The Food is Health® program is a regional initiative, which appears on multiple Community Health Plans. The Hospitals will work collaboratively on initiatives to improve transportation challenges impacting Highlands and Hardee Counties communities. These are regional initiatives, which appear on multiple Community Health Plans. However, the projected and reported numbers below are specific to AdventHealth Sebring.

Goal	**To increase community partnerships with local transportation systems, leaders, and businesses to develop new strategies for improving access to transportation.**
Objective	Decrease transportation challenges (barriers) among vulnerable adults residing in the Hospital's PSA by creating and implementing two new collaborative strategies from a baseline of zero strategies by the end of year three (December 31, 2022).

Objective	Establish a new transportation taskforce in Hardee/Highlands County to co-host at least two community summits (with AdventHealth Wauchula and AdventHealth Lake Placid) from a baseline of zero summits to increase awareness of the impact of transportation accessibility on community health and wellness and employment sustainability for community members residing in the Hospital's PSA by the end of year three (December 31, 2022).
Goal	**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.**
Objective	The Food is Health® program will support a series of three nutrition education class series among low income families in the PSA from a baseline of one by the end of Year 3 (December 31, 2022).
Objective	The Food is Health® program will distribute 120 produce vouchers (valued at $10 each) to program participants from a baseline of 40 by the end of Year 3 (December 31, 2022).
Objective	The Food is Health® program will build and maintain partnerships with local community organizations serving low income/low access communities by engaging six community partners from a baseline of three by the end of Year 3 (December 21, 2022).
Objective	The Food is Health® program will increase the number of participants among low-income families in the PSA to 30 from a baseline of 11 by the end of Year 3 (December 31, 2022).
Objective	The Food is Health® program will increase the number of health screenings among adults living in food deserts or low income/low access communities to 45 from a baseline of 13 by the end of Year 3 (December 31, 2022).

Hospital Contributions

- Provide community benefit staff to manage, implement and evaluate the Food is Health® program.
- Community outreach nurse teams to provide free biometric screenings for Food is Health® program participants.
- Cover costs to provide free produce for Food is Health® program participants.
- Community benefit staff to actively participate in community meetings with partners addressing food security.
- Community benefit staff and Hospital leadership teams to actively serve on community boards associated with addressing food security.

Community Partners

- McCracken Farms, a local produce vendor, to provide culturally appropriate nutritious food options among program participants.
- Collaborative relationships with local sites (churches, community centers, schools) to host Food is Health® classes.

CHP PRIORITY 3

Cardiovascular Disease

Coronary heart disease is a leading cause of death in the U.S. and is also related to diabetes, high blood pressure, high cholesterol and heart attacks. According to the American Heart Association adults with diabetes are two to four times more likely to die from heart disease than adults without diabetes. In the AdventHealth Sebring Primary Service Area (PSA), 9% 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 is 156 per 100,000 population (370 average annual deaths from 2012 to2016), which is higher than the state rate of 150. Tobacco use is also linked to cardiovascular disease, in the PSA 22% of the population smoke cigarettes (higher than the state rate of 19%).

The Hospitals will collaborate on the initiatives below and are committed to working with local community organizations and stakeholders to implement effective strategies to reduce the burden of cardiovascular disease by providing health education in the community, increasing access to health screenings and connecting community members to resources to help manage blood pressure and cholesterol. These are regional initiatives, which appear on multiple Community Health Plans. However, the projected and reported numbers below are specific to AdventHealth Sebring.

Goal	**Improve access to health education, early intervention programs and resources related to cardiovascular disease.**
Objective	Increase the number of Hospital-sponsored American Heart Association (AHA) community CPR out-of-hospital bystander classes for adults and youth from a baseline of zero to two by the end of year three (December 31, 2022).
Objective	Partner with Florida Department of Health in Highlands County to provide patient referrals at discharge to enroll in free Diabetes Self-Management Education and Support (DSMES) classes by creating an internal referral system to refer 100 underinsured/uninsured adults residing in the Hospital's PSA from a baseline of zero by end of year three (December 31, 2022).
Objective	Increase the amount of paid time for the Hospital staff/team members to volunteer with community organizations addressing heart disease and stroke from a baseline of zero hours to 200 hours by the end of year three (December 31, 2022).
Goal	**Decrease tobacco use in adults and youth community members.**

Objective	Increase knowledge of free tobacco cessation programs and tobacco prevention/treatment resources for patients at discharge by partnering with Central Florida Area Health Education Center (AHEC) to provide continuing education classes to 50 team members (treating patients with tobacco use) from a baseline of zero by the end of year three (December 31, 2022).
Objective	Provide patient referrals at discharge to enroll in free AHEC tobacco cessation programs and receive free intervention therapies to quit smoking tobacco. Through a partnership with AHEC, create an internal referral system to link adults residing in the Hospital's PSA, providing resources for 18 patients from a baseline of zero by end of year three (December 31, 2022).
Objective	Increase access to tobacco cessation classes in adults residing in the Hospital's PSA by five classes from a baseline of zero by the end of year three (December 31, 2022).

Hospital Contributions

- Provide community benefit staff to manage, implement and evaluate community strategies and partnerships.
- Community benefit staff to work with the AdventHealth Care 360 Transition Specialist, Case Management Department and AHEC staff to track and report referrals from Hospital to smoking cessation classes.
- Community benefit staff to actively participate in community meetings with partners addressing tobacco use.
- Community benefit staff and the Hospital leadership teams to actively serve on community boards associated with addressing tobacco use.
- Provide Hospital paid staff time of four hours per quarter to participate in volunteer activities addressing tobacco use.

Community Partners

- American Heart Association to expand community benefit strategies to increase community awareness of the negative impacts of tobacco use on heart health (youth vaping crisis initiative and advocacy efforts).
- Strengthen collaborative relationships with local sites (churches, community centers, schools) to support community efforts to address tobacco use.

- Central Florida Area Health Education Center (AHEC) Tobacco Free Florida Smoking Cessation Program to provide free education and resources (patches and other quit aids) for smoking cessation.

CHP PRIORITY 4

Education (Social Determinant of Health)

In the AdventHealth Sebring Primary Service Area (PSA), 17% (14,018 persons) of the population aged 25 and older do not have a high school diploma (or equivalency) or higher, which is more 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.

The Hospitals will collaborate on the initiatives below and are committed to working with local community organizations and stakeholders to implement effective strategies, gain new partnerships, and develop new initiatives. By addressing the impact of education attainment as a social determinant of health we work together to empower and strengthen our communities. These are regional initiatives, which appear on multiple Community Health Plans. However, the projected and reported numbers below are specific to AdventHealth Sebring.

Goal	**To increase partnerships with local school-based programs to better understand the problem of educational attainment as a social determinant of health.**
Objective	Partner with local community school and/or college programs to develop, implement and evaluate a community-based professional development program (interviewing skills, resume writing, basic computer skills, mentoring) for underserved adults residing in the Hospital's PSA by providing three community workshops from a baseline of zero by the end of year three (December 31, 2022).
Objective	Establish new partnerships with local community organizations to identify education access barriers in underserved adults residing in the Hospital's PSA from a baseline of zero organizations to two by the end of year three (December 31, 2022).
Goal	**To support community efforts to address the problem of educational attainment as a social determinant of health.**
Objective	Provide education vouchers to cover the costs of General Educational Development (GED) materials (textbooks, registration fees and tests) for adults residing in the Hospital's PSA from a baseline of zero vouchers to three vouchers by the end of year three (December 31, 2022).
Objective	Increase the amount of paid time for the Hospital staff/team members to volunteer with community organizations addressing education (as a social determinant of health) from a baseline of zero hours to 150 hours by the end of year three (December 31, 2022).

Hospital Contributions

- Provide community benefit staff to manage, implement and evaluate community strategies and partnerships.
- Cover cost of education vouchers for General Educational Development (GED) materials (textbooks, registration fees and tests) for adults.
- Community benefit staff to actively participate in community meetings with partners addressing education attainment.
- Community benefit staff and the Hospital leadership teams to actively serve on community boards associated with education access.
- Provide Hospital paid staff time of four hours per quarter to participate in volunteer activities addressing education attainment.

Community Partners

- Strengthen collaborative relationships with local sites (churches, community centers, schools) to support community efforts to address education attainment.

PRIORITIES THAT WILL NOT BE ADDRESSED

The Community Health Needs Assessment also identified the following priority health needs that will not be addressed. These specific issues and an explanation of why the Hospital is not addressing them, are listed 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.

1. Poor Dental Health
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 Sebring Primary Service Area (PSA), the access to dentists rate (per 100,000 pop.) is 36.5 (in 2015 year), as compared to the state rate of 56.

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.

2. Tobacco Use
In the AdventHealth Sebring PSA, an estimated 16,314 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% of Adults are currently smoking cigarettes, which is higher than the state percentage of 19%.

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.

3. Obesity/Overweight/Obese
In the AdventHealth Sebring PSA, approximately 33% of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30 (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.

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.