# Community Health Improvement Plan 2021 - 2025

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Revised February 2023

## *Florida Department of Health in Orange County*

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Governor

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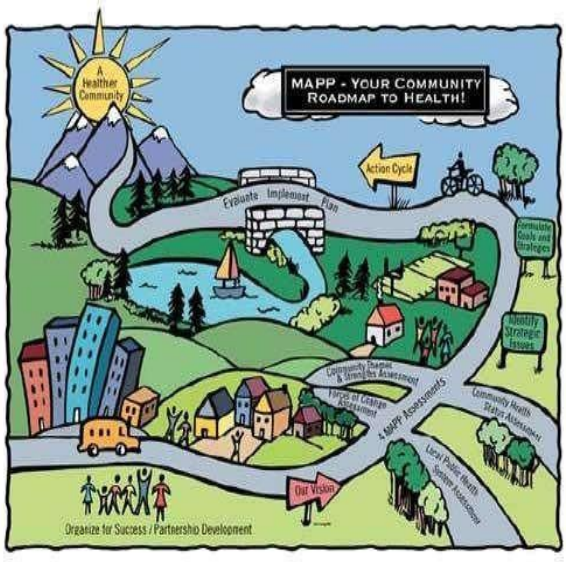
# EXECUTIVE SUMMARY

The health of a community and associated outcomes is determined by various social, economic and environmental factors. As such, routine assessment of key community health indicators is core to public health and remains as a critical component to the broader community health improvement planning process. In 2019, the Florida Department of Health in Orange County (DOH-Orange) participated in a collaborative effort with hospitals and surrounding county health departments as well as other stakeholders and community partners to develop a comprehensive Community Health Needs Assessment (CHNA) APPENDIX A: Community Health Needs Assessment. A community health needs assessment is a process that uses both qualitative and quantitative methods to systematically collect and analyze health data to identify current trends and opportunities for improvement. Health data utilized for the CHNA included factors addressing health risks, quality of life, social determinants, inequity, mortality, morbidity, community assets, forces of change and how the public health system provides the ten essential public health services. The regional public health collaboration partnered with the consulting services of Strategic Solutions, Inc. to facilitate collection, analysis and evaluation of community data.

In 2022 to drive health improvement and enhance the performance of Florida's public health system, leadership across the State of Florida assembled a diverse group of partners from various organizations to create a practical roadmap that enables and informs meaningful action. This collaborative process was deployed to promote inclusion and foster shared ownership of an actionable plan, which included compiling an assessment of the state's health, identifying priority health areas and defining goals and objectives for advancing the health of Floridians. This process culminated in the development of Florida's State Health Improvement Plan (SHIP), which serves as a five-year blueprint for driving efficient and targeted collective action to enhance public health.

In 2020, DOH-Orange engaged over one hundred community health partners and in 2022, the Performance Management Council at DOH Orange approved the State Health Improvement Plan (SHIP) to be incorporated in the 2021-2025 DOH Orange Community Health Improvement Plan (CHIP). The community-driven strategic planning process for improving community health, developed by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO), Mobilizing for Action through Planning and Partnership (MAPP), was the accredited framework utilized to develop the CHIP. APPENDIX B: MAPP Process.



Facilitation of the MAPP and overall CHIP Performance and Quality Improvement, with support from several partnering agencies was conducted by the DOH Orange, along with Florida Department of Health (FDOH) agencies in collaboration with Strategic Solutions, Inc. In 2019 Orange County developed a Community Health Assessment (CHA). The Mobilizing for Action through Planning and Partnerships (MAPP) methodology was followed to develop the 2019 CHA. The 2022 CHA comprises four assessments:

1. A Community Health Status Assessment was released in October 2022 which helped to identify key community problems via data review.
2. Community Themes and Strengths Assessment included 30 focus group discussions and 105 key stakeholder interviews. The community survey engaged over 4,000 respondents and provided insights by county on a host of key CHNA issues.
3. The Local Public Health System Assessment was conducted to understand the performance and abilities of community health system.
4. A Forces of Change Assessment was conducted with community leaders to understand threats and opportunities that might lie ahead.

We utilized the 2022 CHNA and the 2022- 2026 SHIP Plan as the basis to initiate engagement and discussion with our community partners in development of the 2021–2025 CHIP. As part of the FDOH integrated public health system, a new CHNA and CHIP are required every 3-5 years by all 67 county health departments in Florida. Implementation of the CHIP is systematically monitored and evaluated with participation from dedicated community health partners. Measures of success and CHIP priority action plans are reviewed and analyzed quarterly to promote plan progression, effectiveness of processes and to foster community health partnerships APPENDIX F: Annual Evaluation Report. The following diagram shows the selected 5-year CHIP priority areas:

| Health Priority | Rank |
|---|---|
| Access to Care | 1 |
| Health Equity (Minority Health) | 3 |
| Healthy Weight Nutrition and Physical Activity | 2 |
| Substance Abuse Behavioral and Mental Health | 4 |
| Injury Prevention and Safety | 5 |
| Chronic Disease | * |

| | |
|---|---|
| Built Environment | 6 |
| Health Literacy | 7 |
| Senior Health | 8 |
| Sexually Transmitted Disease | 9 |

# SELECTED PRIORITIES

A survey was conducted with over thirty community partners and internal departments to determine health priorities. The survey along with the CHA, Local Public Health System Assessment (LPHSA), Forces of Change and Community Strengths and Themes, along with leadership input was used to determine priorities and objectives for each. The selected priorities are listed below:

1. Health Equity
2. Behavioral Health
3. Access to Care
4. Injury Prevention and Safety
5. Healthy Weight, Nutrition, & Physical Activity

# COMMUNITY HEALTH IMPROVEMENT PROCESS

Long term positive health outcomes are not the result of happenstance. Strategic collection and assessment of key health data provides communities with critical information to determine the greatest local and national threats to health in addition to awareness of emerging health issues. Collaboration of community partners in the development, monitoring and evaluation of action plans that support prioritized health related issues establishes accountability towards obtaining measurable health improvements and quality outcomes.

Community health improvement planning is a long-term, systematic effort that addresses health problems based on the results of community health assessment activities, local public health system assessment and the community health improvement process. The resulting *Community Health Improvement Plan* (CHIP) is used by health and other government, educational and human service agencies, in collaboration with community partners, to set priorities, coordinate action plans and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It defines the vision for the health of the community through a collaborative process and addresses the strengths, weaknesses, opportunities and challenges that exist in the community to improve the health status of that community.

Based on the data provided in the *Community Health Needs Assessment* APPENDIX A:

Community Health Needs Assessment, DOH-Orange collaborated with local community health partners in more than four planning sessions. Beginning in June 2020, we initiated a community-wide strategic planning process for improving community health utilizing the MAPP model. Developed by NACCHO, the MAPP framework is an accredited approach towards the creation and implementation of a community health improvement plan that focuses on long-term strategies that address multiple factors that affect the health of a community.

## MAPP Process Adaptation for COVID-19:

DOH-Orange decided that we would use online meetings and online survey tools to minimize face to face meetings. If face to face meetings were required, we decided to meet one on one with selected community partners and use Microsoft teams for follow up meetings. Large community partner meetings, which are typically conducted, were deemed a threat to safety and therefore avoided altogether.

**Initial Assessment of Community Partner Priorities:** The initial assessment meetings were conducted with over 20 key community partners. These meetings generated a list of health objectives and priorities based on feedback from the partners. These perspectives were further confirmed by a review of the 2019 Community Health Needs Assessment report.

**Department Prioritization:** DOH-Orange took a strategic approach to the CHIP as a tool to move toward a culture of accountability for services provided by its teams and community partners. Objectives that show Orange County in the 4$^{th}$ quartile were prioritized. Community Leadership was consulted, and their priorities were considered and ultimately 10 objectives were selected.

The resulting *2021-2025 Orange County Community Health Improvement Plan* is designed to use existing resources wisely, consider unique local conditions and needs, assess policy changes required to obtain goals, and form effective partnerships for action.

## KEY MAPP FINDINGS

### Community Health Needs Assessment (CHNA)

The Central Florida Collaborative (CFC) worked with its assessment partner Crescendo Consulting Group (CCG) to formalize and deploy a highly inclusive Community Health Needs Assessment (CHNA). The *CHNA* provided a "snapshot in time" of the demographics, employment, health status, health risk factors, health resource availability and quality of life perceptions. DOH-Orange conducted the CHNA in collaboration with two area hospitals (Orlando Health and AdventHealth), Aspire Health Partners, True Health, Orange Blossom Family Health Center, Osceola Community Health Services, DOH-Osceola, DOH- Seminole, DOH-Lake, and DOH-Orange. Data from the U.S. Census Bureau, including the American Community Survey, Florida CHARTS, Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Data (BRFSS), County Health Rankings, and hospital utilization data was employed in the Community Health Needs Assessment.

Major findings from the CHNA for Orange County and other official sources (US Census) show:

In 2021:

- Current population 1,429,908
- Median household income $64,833
- 36.7% have a bachelor's degree or higher
- 15.0% of the population live below the federal poverty level
- 19.5% of the children under 18 live in poverty in Orange County
- 12.9% of the population is without health insurance and this number is expected to increase due to COVID-19
- 33.0 % of the population is Hispanic or Latino
- 19.9 % of the population is Black
- Source https://data.census.gov/cedsci/profile?g=0500000US12095

In 2020, the leading causes of death were:

- Heart Disease
- Cancer
- Unintentional Injury
- Stroke
- COVID-19
- Chronic Lower Respiratory Disease

Source
https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.LeadingCausesOfDeathProfile

Social determinants of health are defined as conditions in which people are born, grow, live, work and age. The CHNA identified opportunities for improvement related to social determinants of health in areas such as economic stability, education, social and community context, health and health care and neighborhood and built environments. Social determinants of health affecting Orange County residents include:

- Lack of affordable and adequate housing and homelessness
- Lack of access to affordable food
- Lack of good paying jobs, jobs with advancement options, job training and living wages
- Lack of transportation
- Adverse Childhood Experiences (ACEs)
- Increased need of behavioral and mental health services and lack of knowledge on where to go for help

Identified health inequities among specific demographic groups present an opportunity to focus services on population specific issues. For example, the following health inequities were identified in Orange County:

- Infant mortality per 1,000 births in Orange County is highest among Blacks (15.5) compared to Whites (3.8) and Hispanics (5.5).
- Women who identify as Black/African American made up the highest percentage of women who received no prenatal care (4.8%).
- Births to women who were obese during pregnancy is highest among Blacks (34.9%) compared to (23.9%) for Hispanics and (22.0%) for Whites.
- Heart disease has been identified a leading cause of death at the rate of 150.6 per 100,000 in Orlando that is significantly higher than the 2020 Health People Goals which is 103.4 per 100,000 people.
- Age adjusted mortality in the Black community at 390.2 per 100,000 is significantly higher than for Hispanics at 209.7 and whites at 319.8. In this plan, we focus on improving outcomes for the Black Community in our Health Equity Priority.
- The CHA reports reduction in homeownership rates from 60.7% in 2000 to 54.5% in 2017. Consequently, the number of children who are homeless and housing insecure have increased. We have identified Behavioral Health, specifically tobacco use in children and young adults as a focus area.

## Local Public Health System Assessment (LPHSA)

*The Local Public Health System Assessment (LPHSA)* serves as a snapshot of where the health department and public health system are relative to the National Public Health Performance Standard, and to progressively move towards refining, and improving outcomes for performance across the public health system.

On 16 March 2016, 53 community partners from 37 different organizations participated in an assessment. The self-assessment was structured around the Model Standards for each of the 10 Essential Public Health Services; 30 Model Standards which served as quality indicators that are organized into 10 Essential Public Health Service areas in the instrument and address the three core functions of Public Health; Priority of Model standards questionnaire, and a Local Health Department contribution, which was completed internally by Florida Department of Health in Orange County employees. After a thorough discussion of the Essential Services and its Model Standards, participants evaluated the public health system and voted on its performance *(Optimal Activity, Significant Activity, Moderate Activity, Minimal Activity, No Activity)*

| Optimal Activity (76-100%) | Moderate Activity (26-50%) |
|---|---|
| ***ES 2: Diagnose and Investigate*** | ***ES1: Monitor Health Status*** |
| Identification/Surveillance | Community Health Assessment |
| Emergency Responses | Current Technology |
| Laboratories | Registries |
| ***ES 5: Develop Policies and Plans*** | ***ES 3: Inform, Educate, and empower*** |
| Emergency Plan | Health Education and Promotion |
| ***ES 6: Enforce Laws & Regulations*** | Health Communication |
| Review Laws | ***ES: 4 Mobilize Community Partnerships*** |
| **Significant Activity (51-75%)** | Constituency Development |
| ***ES 3: Inform, Educate, and Empower*** | Community Partnerships |
| Risk Communication | ***ES 5: Develop Polices and Plans*** |
| ***ES 5: Develop Polices and Plans*** | CHIP/Strategic Planning |
| Government Presence | ***ES 7: Link People to Health Services*** |
| Policy Development | Assure Linkage |
| ***ES 6: Enforce Laws & Regulations*** | ***ES 8: Assure Workforce*** |
| Improve Laws | Workforce Assessment |
| Enforce Laws | Leadership Development |
| ***ES 7: Link People to Health Services*** | ***ES 9: Evaluate Service*** |
| Personal Health Service Needs | Evaluation of Population Health |
| ***ES 8: Assure Workforce*** | Evaluation of Personal Health |
| Workforce Standards | Evaluation of LPHS |
| Continuing Education | **Minimal Activity (1-25%)** |
| ***ES 10: Research/Innovations*** | None of the Essential Services scored in the Minimal/No Activity range |
| Foster Innovation | **No Activity (0%)** |
| Academic Linkages | |
| Research Capacity | |


Source: Centers for Disease Control, and Prevention

Based on the responses provided by participants, an average was calculated by combining all the scores from each model standard performance measure. The average score was then recorded in the National Public Health Performance Standards database, where it then generated the average score to each Essential Service and overall. The following chart provides a composite summary of how the Model Standards performed in each of the 10 Essential Services. This gives a sense of the Local Public Health System's greatest strengths and weakness. The table summarizes our findings.

## Forces of Change

The *Forces of Change Assessment* focuses on identifying forces such as legislation, technology and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: "What is occurring or 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?" The Forces of Change Assessment is one of the steps in the Mobilizing for Action through Planning and Partnerships (MAPP) process that the Florida Department of Health in Orange County follows.

Based on the *Forces of Change Assessment, the* following key findings were identified using data from the primary and secondary research. Prioritization exercises conducted for this CHNA by leaders representing Orange County resulted in these top priorities:

- Health Equity: Infant Mortality (In the black population)
- Health Equity: Reduction in HIV and AIDS (in the black population)
- Health Equity: Mammograms, Cervical and Prostrate Testing (Cancer prevention)
- Behavioral Health: Tobacco use and Vaping (in youth)

- Healthy Weight, Nutrition & Physical Activity: Diabetes Rates and Hospitalization
- Healthy Weight, Nutrition & Physical Activity: Heart Disease and Hypertension
- Healthy Weight, Nutrition & Physical Activity: Maternal Weight, Childhood Obesity and Healthy Eating
- Access to Care (Specialized Care for Specific Conditions): Asthma
- Access to Care (Specialized Care for Specific Conditions): Vaccinations
- Access to Care (Specialized Care for Specific Conditions): Hospital Readmissions and Hospital Acquired Infections

## Community Themes & Strengths

The *Community Themes and Strengths Assessment* gathers thoughts, opinions and perceptions of community members to develop a meaningful understanding of impactful issues.

These themes were gathered from informal conversations with selected partners, surveys and in group settings in virtual meetings attended by many community partners. Broad themes were discussed, input was solicited from participants and categorized for analysis. These themes were considered during the selection of priorities and objectives.

Data from Community Conversations, Consumer Surveys and Stakeholder Interviews were collected, and the following themes identified:

| |
|---|
| **Chronic Conditions** |
| ○ Obesity and overweight |
| ○ Cancer |
| ○ Hypertension/high blood pressure |
| ○ Cardiovascular diseases |
| ○ Diabetes |
| **Access to Care** |
| ○ Availability of specialty medical care |
| ○ Inappropriate use of the emergency department |
| ○ Uninsured |
| ○ Screening for cancer |
| ○ Navigating the health care system |

| | |
|---|---|
| | ○ Dental hygiene/dental care |
| ▯ | **Health Equity for the Black community** |
| ▯ | **Lack of exercise/physical health** |
| | ○ Inactivity due to physical pain or poor emotional health |
| | ○ Need more and better bike and pedestrian friendly infrastructure |
| ▯ | **High prevalence of substance use in youth** |
| ▯ | **Food insecurity including access to quality, nutritious foods** |
| ▯ | **Poverty/low wages** |
| | ○ Need more affordable housing |
| ▯ | **Transportation is a systemic issue** |

# PRIORITY AREAS

Through the MAPP process, ten priority areas were identified and prioritized for Orange County. The top three prioritized areas were selected by MAPP participants for action planning, monitoring and evaluation. The Orange County Community Health Improvement Planning Committee designated a lead partner for each priority area and will work with other dedicated community health partners to implement, monitor and evaluate each action plan activity quarterly using a reporting tracking tool to promote plan progression, effectiveness of processes and foster community health partnerships APPENDIX F: Annual Evaluation Report. Implementation of the action plans will ultimately strengthen the public health infrastructure, enhance planning, research and the development of community health partnerships, and promote and support the health, well- being and quality of life for Orange County residents. The proposed 2021-2025 CHIP priorities, goals, strategies, objectives and activities are discussed in the sections below.

## PRIORITY 1: MINORITY HEALTH

Healthy People 2020 defines health equity as “The attainment of the highest level of health for all people. Achieving healthy equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” Audrey Alexander, DOH-Orange, will serve as the internal lead for this priority area. The priority group will meet via teams on a quarterly basis to monitor progress on all SMART objectives listed in the table below.

| Goal MH1: | **Reduce Infant Mortality in Orange County *(SHIP Goal MCH3)*** |
|---|---|
| **Strategy MH1.1:** | Improve access to care, nutrition, health literacy and practices before, during, and after pregnancy, by providing culturally sensitive education and support in local communities. |
| **Objective MH1.1.1** | By December 31, 2025, decrease infant mortality for all races in Orange County per 1000 live births from 5.8 (2021) to 5.2 *(SHIP Objective MCH3.1)*<br><br>**Organization(s) Responsible**: DOH-Orange- Bellies Babies & Beyond Program, Healthy Start Coalition of Orange County, FIMR (Fetal-Infant Mortality Review) Committee, Nemours Hospital, AdventHealth, Orlando Health, Winnie Palmer Hospital for Women & Babies<br><br>**Data Source:**<br>https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=InfantDeath.DataViewer&cid=0053 |
| **Activity MH1.1.1.1** | Decrease the percentage of very low birth-weight infants born under 2500 grams (5.5lbs) from 1492 (2021) to 1300 infants by engaging patients in programs that increase health literacy knowledge. *(SHIP Objective MCH2.1)* |
| **Objective MH1.1.2** | By December 31, 2025, decrease infant deaths from Sudden Unexpected Infant Death (SUID) per 1000 live births from 14 (2021) to 9 *(SHIP Objective ISV1.1)*<br><br>**Organization(s) Responsible:** DOH-Orange- Bellies Babies & Beyond Program, Healthy Start Coalition of Orange County, FIMR (Fetal-Infant Mortality Review) Committee, Nemours Hospital, AdventHealth, Orlando Health, Winnie Palmer Hospital for Women & Babies<br><br>**Data Source:**<br>https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=InfantDeath.DataViewer&cid=0711 |
| **Activity MH1.1.2.1** | Implement Cribs for Kids in Orange County hospitals and request all the hospitals to be Safe Sleep Bronze Level certified. |
| **Activity MH1.1.2.2** | Increase the proportion of infants who are put to sleep on their backs by providing safe sleep education and prevent SUID to 1000 or more people per year by all community partners combined. *(SHIP Objective ISV1.1)* |
| **Objective MH1.1.3** | By December 31, 2025, interview the same mothers to increase the proportion of infants to exclusively breastfeed through 6 months of age to 42.4% (6-month target), and to continue breastfeeding through 12th month of age to 54.1% (12-month target) from 35% in 2018.<br><br>**Organization(s) Responsible**: DOH-Orange- Bellies Babies & Beyond Program, Healthy Start Coalition of Orange County, Nemours Hospital, AdventHealth, Orlando Health, Winnie Palmer Hospital for Women & Babies<br><br>**Data Source:** |

| | |
|---|---|
| | https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/increase-proportion-infants-who-are-breastfed-exclusively-through-age-6-months-mich-15 |
| **Activity MH1.1.3.1** | Increase the percentage of maternity service hospitals with 100% of written breastfeeding policy elements identified on the Maternity Practices in Infant Nutrition and Care survey by assessing maternity care practices and encourage hospitals to make improvements that better support breastfeeding *(SHIP Objective MCH2.5)* |
| **Strategy MH1.2:** | Reduce the prevalence of STDs in the black community |
| **Objective MH1.2.1** | By December 31, 2025, reduce newly diagnosed cases of HIV in the Black population per 100,000 from 146 (2021) to 110.<br><br>**Organization(s) Responsible**: Area 7 HIV/AIDS Program Office, Contracted Providers- DOH- Orange<br><br>**Data Source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0471 |
| **Activity MH1.2.1.1** | Refer at a minimum 1500 people per year to PrEP services by all EHE service providers. |
| **Activity MH1.2.1.2** | Increase HIV testing to 1500 people per year by EHE contracted providers. |
| **Activity MH1.2.1.3** | Increase HIV testing through home testing to a minimum of 1,000 people by Area 7. |
| **Activity MH1.2.1.4** | Reduce the rate of congenital syphilis from 86.5 per 100,000 live births (2021) to 80.1 by collecting data reports from Area 7. *(SHIP Objective MCH 2.3)* |
| **Objective MH1.2.2** | By December 31, 2025, reduce newly diagnosed cases of AIDS in the Black population per 100,000 from 62 (2021) to 51.<br><br>**Organization(s) Responsible**: Area 7 HIV/AIDS Program Office, Contracted Providers DOH-Orange<br><br>**Data Source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0141 |
| **Activity MH1.2.2.1** | Counsel on AIDS to 1500 or more people per year by all community partners combined. |
| **Activity MH1.2.2.2** | Referral to treatment and care 400 or more people per year by EHE contracted provider and Area 7. |

**Policy and system level changes needed to address identified causes of health inequity:**

Developing tracking systems that can track clients across various service organizations. Health data sharing, aggregation and application of evidence-based methods to improve planning of activities.

**Alignment & Resources:** APPENDIX D: CHIP Alignment & APPENDIX E: Assets & Resources

### Minority Health

Development of the Minority Health goals, strategies, objectives and activities were completed during the CHIP planning sessions by the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities. Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

### Minority Health Community Partners

| | |
|---|---|
| Arthur Howell<br>Charnae Debose<br>Clifford Youngblood<br>Evelyn Dillard<br>Penny Smith<br>Quenesha Lennon | DOH- Orange |
| Brian Postlewait | Homeless Services Network CF |
| Bridget Monroe | Alzheimer's Dementia Resource Ctr. |
| Brooke Schmoe | The Midwife Bus |
| Martha Santoni | Nemours Hospital |
| Deanna Wathington<br>Vicky Smith | Common Sense Childbirth |
| Debra Moffa<br>Olivia Smith<br>Tanya Adams | Ability Housing |
| Thelisha Thomas<br>Arelys Caraballo-Colon | Healthy Start Coalition of Orange County/ FIMR (Fetal-Infant Mortality Review) Committee |
| Erick Sanchez | American Heart Association |
| Glen Providence | Hebni Nutrition Consultants |
| Jason Doll | Zebra Youth |
| Griselda Payne<br>Neza Xiuhtecutli | Florida Farmworkers Association |
| Jeff Hayward | HFUW |
| Kelsey Williams | Covenant House |
| Kisha Gaines | Civic Communications |
| Lajuana Raines | OC Sheriff's Office |
| Larry Williams | SR&DCM |

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|---|---|
| Marcia Romero | People Who Make a Difference |
| Maureen Ferguson | Community Health Centers |
| Peggie Burgess | Center for Change |
| Sarah Larsen | Transportation Planner<br>Metro Plan Orlando |
| Sara Osborne | Orlando Health<br>Winnie Palmer Hospital for Women & Babies |
| Elizabeth Aulner<br>Rebecca Desir<br>Nadine Walker<br>Krista Jackson<br>Samantha Miller | Advent Health |
| Susan Makowski | United Against Poverty |
| Tatiana Thomas | Covenant House |
| Tracy Harris | Libby's Legacy |
| Vicky Smith | Common Sense Childbirth |
| Ken Terrell<br>Chad Stowers | Crew Health |
| Bryan DuBac | Miracle of Love |
| Andre Antenor | Positive Assistance |
| Jiovanna Allen | Midway Specialty |
| Mulan Williams | Divas in Dialogue |

## PRIORITY 2: BEHAVIORAL HEALTH

Mental and emotional well-being enables individuals to realize their own abilities, cope with the normal stresses of life, work productively and contribute to his or her community. Beth Paterniti from DOH-Orange will serve as the internal lead for this priority area. Marni Stahlman, Mental Health Association of Central Florida, will serve as the external community liaison. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below.

| | |
|---|---|
| **Goal BH1:** | **Reduce the impact of mental, emotional, and behavioral health disorders** ***(SHIP Goal MW1.1)*** |
| **Strategy BH1.1:** | Implement evidence- based community interventions to reduce preventable hospitalizations due to mental health disorders and behaviors |
| **Objective BH1.1.1** | By December 31, 2025, decrease the number of adults aged 18 years and older with involuntary examinations (Baker Act) from 11,975 (2021) to 10,700 examinations *(SHIP Objective MW1.3)* |

| | |
|---|---|
| | **Organization(s) Responsible**: Mental Health Association of Central Florida, Central Florida Cares Health System Inc., Aspire Health, Victim Service Center of Central Florida, University of Central Florida, College of Medicine<br><br>**Data Source:**<br>https://www.usf.edu/cbcs/bakeract/documents/usf_barc_fy_20_21_annual_report.pdf |
| **Activity BH1.1.1.1** | Provide 400 adults every year with access to mental health counseling among community partners. |
| **Activity BH1.1.1.2** | Provide 500 adults with mental health concerns every year with access to telemedicine services among community partners. |
| **Activity BH1.1.1.3** | Provide access to transportation for mental health services among community partners as needed. |
| **Activity BH1.1.1.4** | Distribute and train the community on the use of Naxolone (Narcan) in an Opioid crisis through Florida's State Opioid Response Project. *(SHIP Objective MW3.4)* |
| **Objective BH1.1.2** | By December 31, 2025, decrease the number of children aged 17 years and younger with involuntary examinations (Baker Act) from 18.73% (2021) to 15.5% *(SHIP Objective MW2.1)*<br><br>**Organization(s) Responsible**: Mental Health Association of Central Florida, Central Florida Cares Health System Inc., Aspire Health, Victim Service Center of Central Florida, University of Central Florida, College of Medicine<br><br>**Data Source:**<br>https://www.usf.edu/cbcs/bakeract/documents/usf_barc_fy_20_21_annual_report.pdf |
| **Activity BH1.1.2.1** | Increase the percentage of children every year (aged 3-17 years) with a mental/behavioral condition who receive treatment or counseling. *(SHIP Objective MW2.3)* |
| **Activity BH1.1.2.2** | Reduce the percentage of adolescents/young adults who feel sad or hopeless over the last year through mental health counseling. *(SHIP Objective MW2.2)* |
| **Objective BH1.1.3** | By December 31, 2025, increase the number of new identified partners that can distribute an approved and current Early Detection, Early Diagnosis concern and awareness campaign for Alzheimer's Disease and related dementias *(SHIP Objective AD 1.2)*<br><br>**Organization(s) Responsible:** Alzheimer's Dementia Resource Center<br><br>**Data Source:**<br>https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=8687 |
| **Activity BH1.1.3.1** | Reach out to community partners to determine which organizations provide Alzheimer's and related dementia awareness training. *(SHIP Objective AD 1.1)* |
| **Objective BH1.1.4** | By December 31, 2025, reduce the proportion of middle and high school students in Orange County who report currently using any tobacco product from 20.1% (2020) to 16.1% *(SHIP Objective CD1.1)* |

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|---|---|
| | Organization(s) Responsible: Tobacco Free Florida, TFF CIVIC Communications (CIVCOM)<br><br>Data Source: https://www.flhealthcharts.gov/Charts/LoadPage.aspx?l=rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=0446 |
| **Activity BH1.1.4.1** | Establish more tobacco use screening and cessation referral systems at organizations and health systems in Orange County. |
| **Activity BH1.1.4.2** | Implement a comprehensive tobacco-free policy in Orange County K-12 Schools, which will include all 15 provisions recommended by the Public Health Law Center and American Heart Association. Allow accessibility of a SWAT Chapter available to all middle and high school students in Orange County. |
| **Objective BH1.1.5** | By December 31, 2025, decrease age-adjusted rate of suicide deaths per 100,000 from 9.3% (2021) to 8.5%.<br><br>**Organization(s) Responsible:** Central Florida Cares Health System Inc, Mental Health Association of Central Florida, Nemour's Children's Hospital, Victim Service Center of Central Florida, CHEARS LLC, DOH- Orange<br><br>**Data Source:** https://www.flhealthcharts.gov/Charts/LoadPage.aspx?l=rdPage.aspx?rdReport=Death.DataViewer&cid=0116 |
| **Activity BH1.1.5.1** | Provide Question, Persuade, and Refer (QPR) Suicide Prevention training to 1,000 vulnerable individuals of Orange County. |
| **Activity BH1.1.5.2** | Develop a model to identify up to 10,000 high risk individuals based on gender and age to facilitate suicide coordination among partners. |
| **Activity BH1.1.5.3** | Establish partnership with the Veterans Administration to provide veterans who are suicidal and managing emotional or mental health crises with support. *(SHIP Objective MW 4.3)* |

**Policy and system level changes needed to address identified causes of Behavioral Health:** Implement an Alzheimer's, tobacco/vaping, and suicide support with the Veterans Administration objective with 3 participating organizations by June 30, 2025.

**Alignment & Resources:** APPENDIX D: CHIP Alignment & APPENDIX E: Assets & Resources

**Behavioral Health – Includes Mental Illness and Substance Abuse**

Development of Behavioral Health – Includes Mental Illness and Substance Abuse goals, strategies, objectives and activities that were completed during the CHIP planning sessions by the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities. Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

**Behavioral Health Community Partners**

| Name | Organization | Name | Organization |
|---|---|---|---|
| Donna Wyche | Orange County Government | Trinity Schwab<br>Nikaury Munoz | Central FL Cares Health |
| Heather Thomas | Orange County Government | Katherine Schroeder | Aspire Health |
| Larry Williams | Simeon Resource and Development Center for Men, Inc | Kisha Gaines<br>Stephen Schaefer<br>Kristina Zachry | TFF Civic Communications |
| Marni Stahlman | Mental Health Association of Central FL | Bridget Monroe<br>Edith Gendron | Alzheimer's & Dementia Resource Center |
| JoEllen Revell<br>Kaylyn Palmer | Victim Service Center | Michael Viola | DOH- Orange |

## PRIORITY 3: ACCESS TO CARE

Dr. Annette Thomas and Joy Bayley from DOH-Orange will serve as the internal leads for this priority area. Sandi Vidal, Central Florida Foundation and Sara Osborne, Orlando Health, will serve as the external community liaisons. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below.

| **Goal AC1:** | **Improve access to high-quality health care services for the life span of all people** |
|---|---|
| **Strategy AC1.1** | Reduce readmission rates by providing services such as access to health care, home care, education and health literacy for selected health conditions |
| **Objective AC1.1.1** | By December 31, 2025, improve the access to care of residents by increasing medical checkups in the past year from 75.2 (2019) to 80%.<br><br>**Organization(s) Responsible**: Primary Care Access Network/ Covering Central Florida, Grace Medical, Senior Resource Alliance, Health Council of East Central Florida, Care- A- Medix, Blue Cross Blue Shield, DOH-Orange, True Health, Community Care Plan<br><br>**Data Source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=BRFSS.Dataviewer&bid=0059 |
| **Activity AC1.1.1.1** | Increase the number of Orange County adults that have insurance coverage by 3%. Partners will enroll 1,000 additional adults that will be covered by insurance each year. |
| **Activity AC1.1.1.2** | Decrease the number of uninsured children in Orange County from 19,251 (2023) to 14,438 through enrollment events. |

| | |
|---|---|
| **Activity AC1.1.1.3** | Create check points along the healthcare pathway to identify potential drug interactions in adults over 65. 100 high risk adults per year will be identified by all community partners combined. |
| **Activity AC1.1.1.4** | Increase the number of Orange County residents with special health care needs that have a medical home through various clinical partners. *(SHIP Objective MCH1.1)* |
| **Activity AC1.1.1.5** | Care-A-Medix service focuses on keeping at least 25 seniors out of the hospital per year by providing in-home visits. |
| **Activity AC1.1.1.6** | Increase the percentage of kindergarten and 7th grade immunizations in Orange County to 95% through various vaccination events. |
| **Activity AC1.1.1.7** | Increase the percentage of residents aged six-months and older who receive an annual flu vaccine through various vaccination events. *(SHIP Objective TED3.2)* |
| **Activity AC1.1.1.8** | Encourage municipal water systems lacking fluoridation to implement this action to increase fluoridated public water in Orange County to 98%. *(SHIP Objective CD7.2)* |
| **Strategy AC1.2** | Improve screening for targeted groups to reduce cancer rates |
| **Objective AC1.2.3** | By December 31, 2025, increase the number of women aged 50-74 who had a mammogram in the past 2 years from 77.8% (2016) to 83% *(SHIP Objective CD1.2)*<br><br>**Organization(s) Responsible:** People Who Make a Difference, Libby's Legacy, Advent Health, University of Central Florida, College of Medicine, DOH- Orange<br><br>**Date Source:**<br>http://www.flhealthcharts.com/charts/Brfss/DataViewer.aspx?bid=0111 |
| **Activity AC1.2.3.1** | Increase the number of referrals clinics receive by accepting 1000 or more patients per year |
| **Activity AC1.1.3.2** | Provide transportation/access to health care facilities 500 or more people per year by all community partners combined. |
| **Activity AC1.1.3.3** | Provide breast cancer screenings to 200 or more patients per year by all community partners combined. |

**Policy and system level changes needed to address identified causes of health inequity:**

Local policy changes anticipated are:

To improve access to care, care coordination and continuum of care between hospital, outpatient, counseling and home-based care, partners will develop a process to facilitate data sharing, when possible, to streamline services and coordinate efforts. Care for uninsured and under insured patients will be significantly improved if patient level service utilization is shared amongst partners, if such sharing can be done in compliance with patient privacy laws.

**Alignment & Resources:** APPENDIX D: CHIP Alignment & APPENDIX E: Assets & Resources

**Access to Care – Includes Outpatient services and Cancer Screening**

Goals, strategies, objectives and activities were completed during the CHIP planning sessions by the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities. Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

## Access to Care Community Partners

| Name | Organization | Name | Organization |
|---|---|---|---|
| Elizabeth Aulner | AdventHealth | Sandi Vidal | Central Florida Foundation |
| Sara Osborne | Orlando Health | Thelisha Thomas<br>Elaine M.<br>Arelys Caraballo-Colon | Healthy Start Coalition of OC |
| Jane Simon | Alliance Community Health | Stephanie Garris | Grace Medical Home |
| Rebecca Sayago<br>Anne Packham | Primary Care Access Network/ Covering Central Florida | Molly Ferguson | Community Health Center |
| Gloria San Miguel | Blue Cross Blue Shield | Marcia Romero | People Who Make a Difference |
| Patrick Odoyo | Senior Resource Alliance | Dr. Dexter Hadley | University of Central Florida, College of Medicine |
| Evelyn Dillard<br>David Overfield<br>Gissella Suarez | DOH- Orange | Tracy Harris | Libby's Legacy |
| Ilein Santiago | True Health | Stephanie Williams-Louis | Community Care Plan |
| Ken Peach | Health Council of East Central Florida | Marcus Prevot | Care-A-Medix |

## PRIORITY 4: INJURY PREVENTION AND SAFETY

Every year, people suffer preventable unintentional injuries from falls, motor vehicle crashes and intentional injuries such as human trafficking incidents, domestic and sexual violence. Injuries happen every day, but most are preventable. Unnati Shah and Dahlia Scafe from DOH-Orange will serve as the internal leads for this priority area. Brent Moore, Children's Safety Village will serve as the external community liaison. The priority group will meet in person monthly at the Safe Kids Orange County Meeting at Children's Safety Village to monitor progress on all the SMART objectives listed in the table below.

| | |
|---|---|
| **Goal IPS1:** | Reduce the rate of preventable injuries within Orange County |
| **Strategy IPS1.1** | Increasing injury intervention strategies such as sharing effective solutions and implementing prevention programs is key to keeping residents in Orange County safe. |
| **Objective IPS1.1.1** | By December 31, 2025, reduce unintentional injury deaths per 100,000 from 62.0% (2021) to 53.0%<br><br>**Organization(s) Responsible: Florida Asthma Program and Collation, Children's Safety Village, Orlando Police Department, Orange County Fire Rescue, Orange County Sheriff's Office, Orlando Health, True Health, Epilepsy Association, University of South Florida, College of Public Health, FL Department of Health Central Office**<br><br>**Data Source:**<br>https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=9755<br><br>https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0692<br><br>https://www.flhealthcharts.gov/Charts/LoadPage.aspx?l=rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0531<br><br>https://www.flhealthcharts.gov/Charts/LoadPage.aspx?l=rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0524 |
| **Activity IPS1.1.1.1** | AFS and AFH programs help to reduce hospital readmissions for at least 20 children with asthma per year. *(SHIP Objective CD5.2)* |
| **Activity IPS1.1.1.2** | Reduce drowning in children aged 1-5 years from 3.4% (2020) to 2.5% by promoting drowning prevention campaigns, events, and following county regulations |
| **Activity IPS1.1.1.3** | Reduce deaths of children aged 19 years and under from motor vehicle accidents (MVA) from a rate of 14.7 (2021) to 13.5% by promoting MVA prevention campaigns, events, and following county regulations. *(SHIP Objective ISV1.3)* |

| | |
|---|---|
| **Activity IPS1.1.1.4** | Reduce the rate of deaths related to traumatic brain injury (TBI) for youth aged 19 years and under from 9.6% (2021) to 9.0 by promoting TBI literacy, prevention campaigns and events. (*SHIP Objective ISV1.5)* |
| **Objective IPS1.1.2** | By December 31, 2025, reduce non-fatal injury hospitalizations in the vulnerable population from an age adjusted rate of 571 (2021) to 490.<br><br>**Organization(s) Responsible: Victim Service Center of Central Florida, Harbor House, University of South Florida, Orange County Fire Rescue, Department of Children's and Families**<br><br>**Data Source:**<br>https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.NonFatalInjuryHospitalizationsProfileDASHBOARD |
| **Activity IPS1.1.2.1** | Increase the ratio of total human trafficking reports to verified human trafficking cases for those aged 18 years and under that are reported to the Florida Abuse Hotline by promoting safety education and spreading information on the Hotline initiatives. *(SHIP Objective ISV3.2)* |
| **Activity IPS1.1.2.2** | Increase the number of victim referrals related to domestic and sexual violence by promoting safety education and implementing community partner initiatives. *(SHIP Objective ISV3.3)* |
| **Activity IPS1.1.2.3** | Reduce injury-related fatalities from falls in adults aged 60 years or older by providing prevention safety education and implementing community partner initiatives. *(SHIP Objective ISV2.2)* |
| **Activity IPS1.1.2.4** | Reduce injury-related fatalities from unintentional drug poisonings in adults ages 20-64 by providing prevention safety education and implementing community partner initiatives. *(SHIP Objective ISV2.1)* |

**Policy and system level changes needed to address identified causes of Injury Prevention and Safety:**

Injuries and violence contribute to lost productivity, poor mental health, years of potential life loss and premature death.

**Injury Prevention and Safety Activity**

Development of the Injury Prevention and Safety goals, strategies, objectives and activities were completed during the CHIP planning sessions with the Health Officer, Performance Management Council, and the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities. Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

**Injury Prevention and Safety Community Partners**

| Name | Organization | Name | Organization |
|---|---|---|---|
| Dr. Alexandra Nowakowski | Florida Asthma Program and Collation | Brent E. Moore | Children's Safety Village |
| JoEllen Revell | Victim Service Center of Central Florida | Dr. Karen Liller<br>Dr. Claudia Parvanta<br>Rheese McNab | USF College of Public Health |
| Katie Arch | Harbor House | Danielle Campbell | Orlando Police |
| Ilein Santiago | True Health | Michelle Forsyth<br>Patricia Long | Orange County Fire Rescue |
| Mike Sheehan | Epilepsy Association | Courtney Gleaton | Orlando Health |
| Sue Aboul-Hosn/ David Martine | Department of Children's and Families | Rhonda Jackson | FL Department of Health Central Office |
| Carissa Johns | Orange County Sheriff's Office | Samantha Miller | AdventHealth |

## PRIORITY 5: HEALTHY WEIGHT, NUTRITION & PHYSICAL ACTIVITY

Overweight and obesity are increasingly common conditions in the United States and in Florida. The accumulation of excess fat is a serious medical condition that can cause complications such as metabolic syndrome, high blood pressure, atherosclerosis, heart disease, type 2 diabetes, high blood cholesterol, cancers and sleep disorders. Rossie Bonefont, DOH-Orange, will serve as our internal lead for this priority area. Angela Corona, Second Harvest Food Bank of Central Florida, will serve as the external community liaison. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below

| | |
|---|---|
| **Goal HW1:** | **Reduce rate of health conditions mediated by poor nutrition practices** |
| **Strategy HW1.1:** | Increase health status of targeted groups by improved access to nutrition and health literacy |
| **Objective HW1.1.1:** | By December 31, 2025, decrease hospitalizations from diabetes per 100,000 from 2,867 (2021) to 2,100 *(SHIP Objective 4.2)*<br><br>**Organization(s) Responsible**: DOH-Orange, AdventHealth, Second Harvest Food Bank, U.S. Hunger, UF/IFAS Extension Family Nutrition Program |

| | |
|---|---|
| | **Data Source:** https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0344 |
| **Activity HW1.1.1.1** | Provide 500 or more people living with diabetes a voucher for a healthy food box and fresh produce each year. |
| **Activity HW1.1.1.2** | Provide training to 500 or more people to improve healthy cooking knowledge and skills. |
| **Objective HW1.1.2:** | By December 31, 2025, increase the number of health care practices implementing food insecurity screenings and decrease the food insecurity rate from 11.2% (2019) to 9.5%.<br><br>**Organization(s) Responsible:** Second Harvest Food Bank, American Heart Association<br><br>**Data Source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndRateOnly.Dataviewer |
| **Activity HW1.1.2.1** | Develop a system to understand the food insecurity screening baseline in Orange County. |
| **Activity HW1.1.2.2** | Support 10 health care practices annually incorporating food insecurity screenings and referral processes in their setting. |
| **Objective HW1.1.3:** | By December 31, 2025, decrease the overall rate of overweight adults from 34.7% (2019) to 29.8%.<br><br>**Organization(s) Responsible**: Grace Medical, U.S. Hunger, Second Harvest Food Bank, AdventHealth, American Heart Association<br><br>**Data Source:** http://www.flhealthcharts.com/Charts/Brfss/DataViewer.aspx?bid=5 |
| **Activity HW1.1.3.1** | Provide 1,000 or more adults a voucher for a healthy food box and fresh produce each year. |
| **Activity HW1.1.3.2** | Provide nutrition education or physical activity classes to 1000 adults |
| **Activity HW1.1.3.3** | Support 1000 or more adults through policy, systems, and environmental change efforts, inclusive of: healthy pantry strategies and implementation of new fresh food access points in the community. |
| **Objective HW1.1.4:** | By December 31, 2025, decrease the rate of overweight students in middle and high school from 17.1% (2022) to 15.5%.<br><br>**Organization(s) Responsible**: U.S. Hunger, UF/IFAS Extension Family Nutrition Program, DOH- Orange, Second Harvest Food Bank<br><br>**Data source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=SurveyData.YTS.Dataviewer&cid=0009 |

| | |
|---|---|
| **Activity HW1.1.4.1** | Support 1000 or more students and children each year through policy, systems, and environmental change efforts, inclusive of: implementation and maintenance of school gardens, implementation of healthy childcare center policies, and farm to school/ECE initiatives. |
| **Objective HW1.1.5:** | By December 31, 2025, decrease the number of births to overweight mothers from 28.3% (2021) to 26.0%.<br><br>**Organization(s) Responsible**: Second Harvest Food Bank, DOH- Orange, FitMoms2B, American Heart Association<br><br>**Data source:** https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=Birth.DataViewer&cid=607 |
| **Activity HW1.1.5.1** | Provide 250 or more pregnant or postpartum mothers a voucher for a healthy food box and fresh produce each year. |
| **Activity HW1.1.5.2** | Provide nutrition education activities and physical education activities for 500 pregnant women per year. |

**Policy and system level changes needed to address identified causes of Healthy Weight, Nutrition & Physical Activity:**

We have discussed improvement of sidewalks, construction of bike lanes and walking trails to encourage residents to exercise.

**Alignment & Resources:** APPENDIX D: CHIP Alignment & APPENDIX E: Assets & Resources

## Healthy Weight, Nutrition & Physical Activity

Development of the Healthy Weight, Nutrition & Physical Activity goals, strategies, objectives and activities were completed during the CHIP planning sessions by the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities. Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

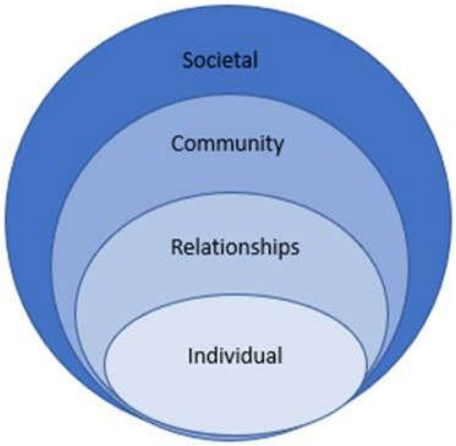
| Name | Organization | Name | Organization |
|---|---|---|---|
| Elizabeth Aulner | AdventHealth | Jennifer Blue<br>Unnati Shah<br>Rossie Bonefont | DOH- Orange |
| Ken Peach | Health Council of East Central Florida | Stephanie Garris | Grace Medical Home |
| Tiffany Burris-Kobashigawa | Feeding Children Everywhere | Glen Providence<br>Celinas Martinez | Hebni Nutrition |

| | | | |
|---|---|---|---|
| Angela Corona | Second Harvest Food Bank of Central Florida | Kimberly McMahon<br>Patrick Zayas | UF/ IFAS Extension Family Nutrition Program |
| Jane Simon | Alliance for Community Health | Matt Danner<br>Rick Whited<br>Sarah Dasilva | U.S. Hunger |
| Gloria Harris | Fit 2 Dance | Jean Davis | FitMoms2B-UCF |
| Lesa Boettcher | COO Healthy West Orange | Erick Sanchez | American Heart Association |
| Stephanie Garris | Grace Medical Home | | |

# APPENDIX A: Community Health Needs Assessment

## Public Health Framework

The Social-Ecological Model of Health (SEM) is used to holistically describe four social levels of influence that explain the complex interaction between individuals and the social context in which they live, work and play.




Health and well-being are shaped not only by behavior choices of individuals, but also by complex factors that influence those choices. The SEM provides a framework to help understand the various factors and behaviors that affect health and wellness. This model can closely examine a specific health problem in a setting or context.

### PRIMARY

- Consumer Surveys
- Provider Surveys
- Stakeholder In-Depth Interviews
- Community Conversations
- Collaboration County-Level Themes

### SECONDARY

- U.S. Census Bureau
- Florida CHARTS
- County Health Rankings
- Hospital Utilization Data
- Healthy People 2020
- American Community Survey
- U.S. Department of Health & Human Services
- Hospital Claims Data
- Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDCP BRFSS)

In order to promote identification and prioritization of specific areas for improvement, CHNA data outcomes were reviewed with Community Health Improvement participants. The community survey conducted for the CFC included over 4,000 total responses. There were 822 responses from Orange County residents. The Prioritization Process Summary used secondary data analysis and qualitative research. The community survey generated a list of approximately 50 granular needs. The needs were then prioritized by a group of Orange County leaders using the Modified Delphi method (i.e., a three-stage mixed qualitative and quantitative) process. The results of the prioritization process yielded a rank-ordered set of prioritized needs falling into five specific categories. The top 15 granular needs were then folded under the five specific categories. Please see the results below.

**Top Five Needs**

- Increase system capacity
- Enhance mental health (including substance use disorder) outreach and treatment
- Streamline access to care

- Refine primary care and specialized medical care (e.g., chronic conditions) services
- Address housing and other social determinants

After the CHNA data was released leads from the departments and community partners ranked the priorities and objectives. Based on this ranking four priorities were identified. Meetings were conducted for each priority area and for each objective within a priority area. Activities were identified for each SMART health objective. Measures for each activity and community partner are listed in our plan. During the period 2021 to 2025 we will track progress on each activity and objective on a quarterly basis or more frequently. We will track participants in programs and activities. For objective selection we compared Orange County data against the performance of the State of Florida as a whole, as well as Healthy People 2020 (HP2020) objectives. Florida Health Charts is used as the primary data source of all our objectives. Over the next five years our efforts are focused on closing the gap between Orange County and the State of Florida on selected SMART objectives. Data highlights included the following:

| **County Health Rankings**<br>Source: County Health Rankings-2020 | **Rank**<br>DOH-Orange County |
|---|---|
| **Health Outcomes** | 7 |
| Length of Life (Mortality) | 5 |
| Quality of Life (Morbidity) | 17 |
| **Health Factors** | 21 |
| Health Behaviors | 14 |
| Clinical Care | 30 |
| Socioeconomic | 14 |
| Physical Environment | 52 |

# APPENDIX B: MAPP Process

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning framework for improving public health. MAPP helps communities prioritize their public health issues, identify resources for addressing them, and implement strategies relevant to their unique community contexts.

MAPP helps communities use broad-based partnerships, performance improvement and strategic planning in public health practice. This approach leads to the following:

- Measurable improvements in the community's health and quality of life;
- Increased visibility of public health within the community;
- Community advocates for public health and the local public health system;
- Ability to anticipate and manage change effectively; and
- Stronger public health infrastructure, partnerships and leadership

There are four assessments that inform the entire MAPP Process:

**Community Themes and Strengths Assessment** provides qualitative information on how communities perceive their health and quality of life concerns as well as their knowledge of community resources and assets.

**Local Public Health System Assessment** is completed using the local instrument of the National Public Health Performance Standards program (NPHPSP). The NPHPSP instrument measures how well public health system partners collaborate to provide public health services based on a nationally recognized set of performance standards.

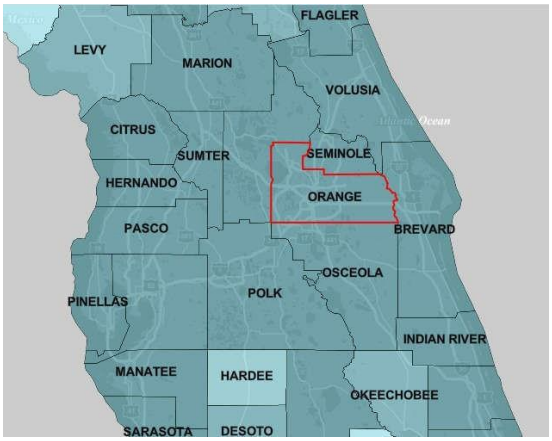
**Community Health Status Assessment** provides quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other measures that reflect a broad definition of health.

**Forces of Change Assessment** provides an analysis of the positive and negative external forces that impact the promotion and protection of the public's health.

Source: National Association of County & City Health Officials (NACCHO)
http://archived.naccho.org/topics/infrastructure/mapp/upload/MAPPfactsheet- systempartners.pdf

# APPENDIX C: County Profile (Orange County, FL)

Orange County is located in the central portion of the U.S. state of Florida. As of the 2020 census, the population was 1,429,908, making it Florida's fifth most populous county. Orange has a total land area of 1,003 square miles. The county is comprised of 15 cities and 31 unincorporated areas and represented by 79 zip codes as of the 2021 Decennial Census. The median household income is $64,833 and 15.0% of Orange County residents are living in poverty. Median household income is the most widely used measure for income since it is less impacted by high and low incomes. A family's income can define their access to affordable housing, healthcare, higher education opportunities and food. 2.6% of the population is unemployed (as of November 2022).




The life expectancy at birth is 79.9% which is slightly higher than the state rate of 79.5% years. The racial makeup of the county consists of Whites (69.9%), Blacks/African Americans (20.6%), and Other (9.6%). More than half (50.9%) of the population in Orange County are female. Overall, the age distribution of Orange County shows a higher percentage of younger population; only 12.3% are 65 years and above.

Orange county residents with higher education are more likely to have jobs that provide sustainable incomes and health promoting benefits such as health insurance, paid leave and retirement. 88.5% percent of the people over 25 in Orange County have attained a high school diploma and 33.8% have a bachelor's degree, this is at par with the State of Florida attainment (88%).

Mental illness and substance abuse issues impact the social and mental health of Orange County citizens. Mental health providers in Orange County, FL see an average of 507 patients per year. This represents an 8.32% decrease from the previous year (553 patients). Primary care physicians in Orange County, FL see an average of 1,207 patients per year. This represents a 1.07% decrease from the previous year (1,220 patients).

# APPENDIX D: CHIP Alignment

Both National and State health improvement priorities were considered during the development of the 2021-2025 Orange County Community Health Improvement Plan. The following diagram provides a visual representation of these alignments.

| 2021-2025 Orange CHIP | 2021-2025 DOH-Orange Strategic Plan | 2017-2021 DOH Agency SHIP | 2016-2020 DOH Agency Strategic Plan | Healthy People 2020 |
|---|---|---|---|---|
| **Minority Health** Goal: Improve access to care for identified Orange County residents who are less likely to receive quality and affordable services. | **Priority Area 2** Health Equity | **SHIP Priority 1** Health Equity | **Strategic Priority – Health Equity** Goal: Ensure Floridians in all communities will have opportunities to achieve healthier outcomes. | **LHI 1 Access to Health Services** AHS-3 Increase the proportion of persons with a usual primary care provider |
| **Behavioral Health (Includes Mental Illness and Substance Abuse)** Goal: Improve community awareness and engagement in mental health and substance abuse services. | **Priority Area 3** Long Healthy Life | **SHIP Priority 6** Behavioral Health – Includes Mental Illness & Substance Abuse | **Strategic Priority Long, Healthy Life** Goal: Increase healthy life expectancy, including the reduction of | **MHMD-1** Reduce the suicide rate. **MHMD-4.1** Reduce the proportion of adolescent aged 12-17 years who experience major depressive episodes (MDEs). |

| | | | | |
|---|---|---|---|---|
| **Healthy Weight, Nutrition and Physical Activity**<br>Goal: Strengthen the capacity of local agencies and health and human service providers to identify and refer Orange County residents to services which promote healthy weight, nutrition and physical activities. | | **SHIP**<br><br>**Priority 5**<br>Healthy Weight, Nutrition & Physical Activity | health disparities to improve the health of all groups. | **NWS-9**<br>Reduce the proportion of adults who are obese.<br><br>**NWS-10.4**<br>reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. |

# APPENDIX E: Assets & Resources

| ORANGE COUNTY COMMUNITY HEALTH ASSETS & RESOURCES | |
|---|---|
| • American Cancer Society<br>• American Diabetes Association<br>• American Heart Association<br>• American Lung Association<br>• Apopka Family Learning Center<br>• Aspire Health Partners<br>• Assisted Living Facilities<br>• Beta Center<br>• Boys & Girls Club of Central Florida<br>• Center for Change<br>• The Center for Disease Control and Prevention<br>• Center for Multicultural Wellness & Prevention<br>• Central Florida Commission on Homeless<br>• Central Florida Employment Council<br>• Central Florida Family Medicine<br>• Central Florida Partnerships on Health Disparities<br>• Central Florida Pharmacy Council<br>• Central Florida Urban League<br>• Central Florida YMCA<br>• Children's Home Society of Central Florida<br>• Christian Services Center of Central Florida<br>• City of Orlando Parks & Recreation<br>• Coalition for the Homeless of Central Florida<br>• Community Health Centers<br>• Community Vision<br>• County Chamber of Commerce<br>• Dental Care Assess Foundation<br>• Downtown Orlando Partnership<br>• Florida Department of Health in Orange County<br>• AdventHealth<br>• Florida Nurses Association | • Interfaith Hospitality Network Orlando<br>• La Amistad Residential Treatment Center<br>• Leadership Orlando<br>• Local Physicians<br>• Long Term Care Facilities<br>• Metro Orlando Economic Development<br>• Mission Fit Kids<br>• National Alliance on Mental Health<br>• National Association of County and City Health Officials (NACCHO)<br>• Nemours<br>• Orange Blossom Family Health<br>• Orange County Parks & Recreation<br>• Orange County Public library<br>• Orange County Public School System<br>• Orlando Health<br>• Orlando Union Rescue Mission Men's Division<br>• Orlando VA Medical Center<br>• Overeater Anonymous<br>• Park Place Behavioral HealthCare<br>• Pathways Drop in Center<br>• Primary Care Access Network (PCAN)<br>• Reduce Obesity in Central Florida<br>• Second Harvest Food Bank<br>• Seniors Resource Alliance<br>• Shepherds Hope<br>• The Center Orlando<br>• The Chrysalis Center, Inc<br>• The Collaborative Obesity Prevention Program<br>• The grove Counseling Center<br>• The Mental Association of Central Florida<br>• The National Kidney Foundation<br>• The Transition house<br>• True Health<br>• United Against poverty |

| | |
|---|---|
| • Florida State University College of Medicine<br>• Get Active Orlando<br>• Goodwill<br>• Grace Medical Home<br>• Harvest Time International, INC<br>• Health Central Hospital<br>• Healthy 100 Kids<br>• Healthy Central Florida<br>• Healthy Kids Today<br>• Healthy Orange Collaboration<br>• Hebni Nutrition Consultant's<br>• Hispanic Health Initiatives | • United Way 2-1-1<br>• University Behavioral Center<br>• University of Central Florida<br>• USA Dance<br>• Visionary Vanguard<br>• Wayne Densch Center<br>• Winter Park Health Foundation<br>• Workforce Central Florida<br>• 100 Black Men of Orlando |

# APPENDIX F: Annual Evaluation Report

**Florida Department of Health in Orange County Community Health Improvement Plan Progress Reporting Tool**

DOH Orange utilizes the Performance Improvement and Management System (PIMS). Priority objectives are prepopulated into the system and quarterly data is collected from the community partners and entered by the CHIP facilitator.

Default - Orange CHIP (Q1-Q4)
Orange CHIP

| Priorities | Objectives | Objective Lead | Performance Metrics | Series Status | | | | Data Notes |
|---|---|---|---|---|---|---|---|---|
| | | | | Q1-21 | Q2-21 | Q3-21 | Q4-21 | |
| 1: Health Equity | HE1.1.1: Decrease black infant mortality 2 per year in Orange County by 12/31/2025. | | Baseline Value | | | | | |
| | | | Quarterly Data | 0.00 | 0.00 | 0.00 | 10.00 | |
| | | | Target | | | | | |
| | | | Annual YTD | 0.00 | 0.00 | 0.00 | 10.00 | |
| | HE1.2.1: Reduction of 20 per 100,000 in newly diagnosed cases of HIV in the Black population by 4 per year from 191 to 171 by 12/31/2025. | | Baseline Value | | | | | |
| | | | Quarterly Data | 0.00 | 0.00 | 0.00 | 58.10 | |
| | | | Target | | | | | |
| | | | Annual YTD | 0.00 | 0.00 | 0.00 | 58.10 | |
| | HE1.2.2: Reduction of 20 per 100,000 in newly diagnosed cases of AIDS in the Black population by 4 per year from 88 to 68 by 12/31/2025. | | Baseline Value | | | | | |
| | | | Quarterly Data | 0.00 | 0.00 | 0.00 | 76.00 | |
| | | | Target | | | | | |
| | | | Annual YTD | 0.00 | 0.00 | 0.00 | 76.00 | |

# APPENDIX G: Data Sources & References

**DEMOGRAPHICS**

- U.S. Census Bureau: State and County QuickFacts-Orange County, Florida. Accessed November 8, 2020
- USA County Information-Orange County, Florida. http://www.usa.com/Orange-county-fl.htm. Accessed November 8, 2020
- Florida Legislature's Office of Economic and Demographic Research - Orange County Profile. Accessed November 2nd, 2020
- Orange County Crime Statistics. Florida Department of Law Enforcement Accessed November 2nd, 2020
- Florida Department of Education - Orange County School District Graduation Rates. Accessed October 23rd, 2020.

**HEALTH INFORMATION**

- Orange County FDOH CHARTS County Profile. Accessed October 23rd, 2020.
- County Health Rankings & Roadmaps 2020. http://www.countyhealthrankings.org/app/florida/2016/rankings/Orange/county/outcomes/overall/snapshot. Accessed February 25, 2020.
- Orange County FDOH CHARTS Pregnancy & Young Child Profile. Accessed February 24, 2020.
- Orange County FDOH CHARTS School-aged Child & Adolescent Profile. Accessed February 25, 2020
- FDOH Communicable Disease Frequency Report. Accessed October 23rd, 2020.
- FDOH CHARTS - Transmittable Disease Cases & Morbidity. Accessed October 23rd, 2020.
- Community Environmental Health Profile Report, Orange County. Florida Department of Health, Environmental Health Tracking Tool Accessed October 23rd, 2020.

**ADDITIONAL HEALTH INFORMATION**

- Florida Department of Health in Orange County. Demographic Report by Site.
- Florida Department of Health in Orange County. Annual Health Report 2020.
- Infant Mortality in Orange County, FL. by Census Tract
- Orange County Census Tracts with Greatest Number of Infant Deaths
- Infant Mortality Counts and Rates by Census Tract