# Community Health Improvement Plan

## July 2023 - June 2026

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HealthySeminole

Eat Well • Live Well • Play Well

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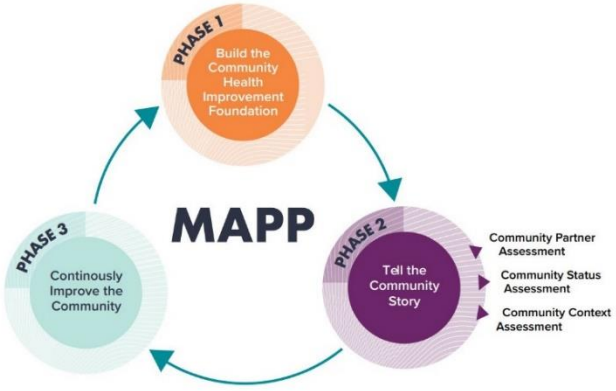
*Austin Long and community attendees*

**Dr. Velma H. Williams Westside Community Center**
*Britt Henderson and community attendees*

**Improving Oviedo Neighborhoods (ION)**
*Ben Williams, Patrick Kelly and community attendees*

# EXECUTIVE SUMMARY

The 2023-2026 Community Health Improvement Plan (CHIP) for Seminole County is a strategic document that outlines the vision, goals, objectives, and strategies to address the most pressing health needs of the community. The CHIP is based on the findings and recommendations of the 2022 Community Health Needs Assessment (CHNA) *(Appendix A: CHNA)*, conducted by the Central Florida Collaborative (CFC), a partnership of mental and health care providers, public health agencies community members in Lake, Orange, Osceola, and Seminole Counties with its assessment partner Crescendo Consulting Group. The CHNA used a comprehensive and participatory methodology that involved multiple sources of data, stakeholder input, and equity champions to identify and prioritize the health issues affecting Seminole County.



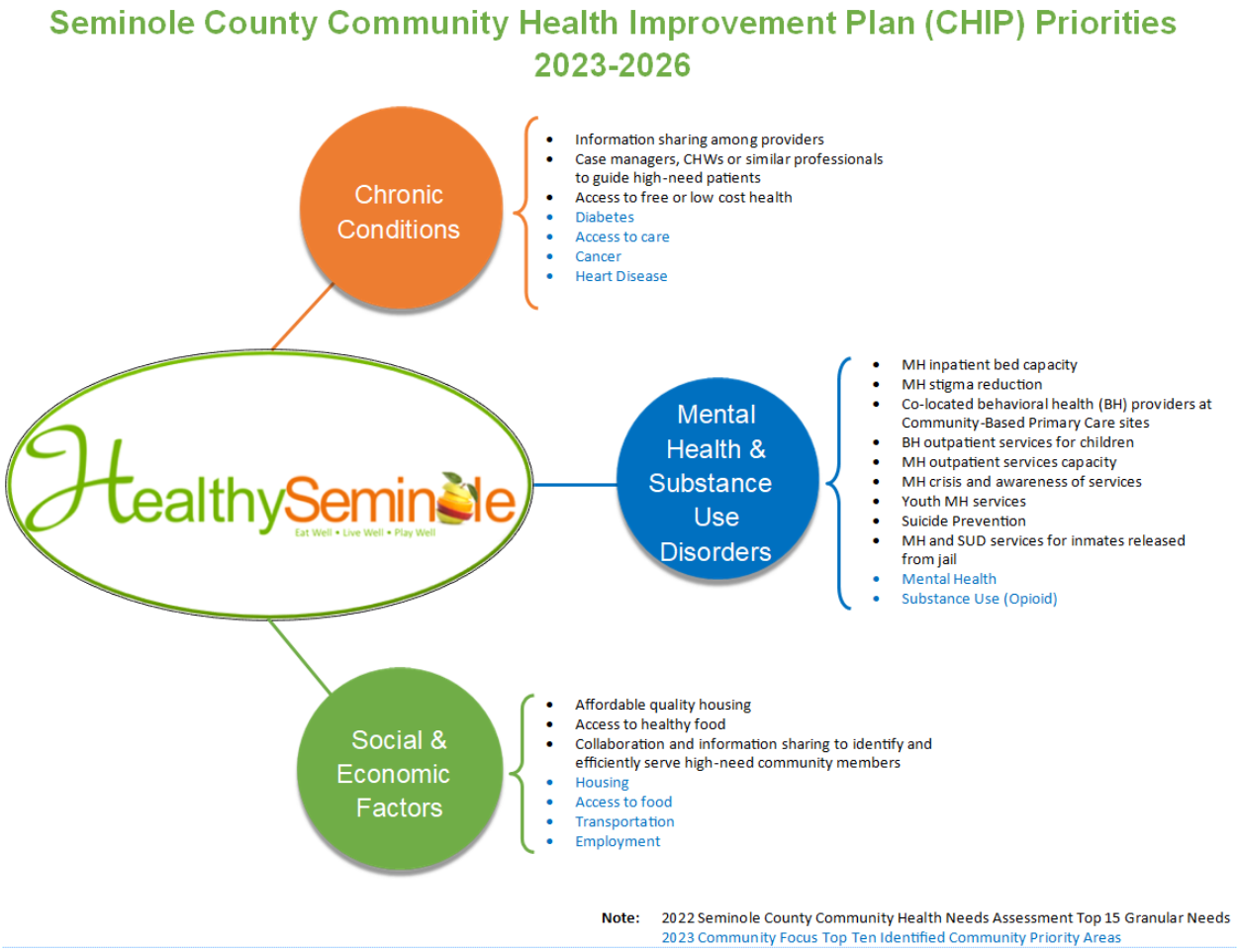

In 2023, the Florida Department of Health in Seminole County (DOH-Seminole) engaged over one hundred community health partners in the development of the 2023-2026 Seminole County Community Health Improvement Plan (CHIP). The community-driven strategic planning process for improving community health, developed by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Healthy Officials (NACCHO), Mobilizing for Action through Planning and Partnership (MAPP), was the accredited framework utilized to develop the CHIP (*Appendix B: MAPP*).

Combining the 2022 Seminole County CHNA top 15 granular priorities and top ten priorities identified through community dialogues, then comparing with the State Health Improvement Plan (SHIP) priority areas and the Healthy People 2030 intuitive topics (*Appendix D: Alignment Table*), providing a national and state-level guidance and benchmarks for improving the health of the population, three overarching priorities for Seminole County were identified, which are: Chronic Conditions, Mental Health and Substance Use Disorder, and Social and Economic Factors (See Seminole County CHIP priorities diagram).

The CHIP provides a framework and a roadmap for action to address the health needs and priorities of Seminole County. It outlines the vision, mission, values, and guiding principles of the Community Health Improvement process, as well as the goals, objectives, and activities for each priority area. The CHIP also identifies the roles and responsibilities of the CHIP partners, stakeholders, and community members, as well as the resources and opportunities for collaboration and alignment. The CHIP is intended to be a living document that will be monitored, evaluated, and updated with participation from dedicated community health partners. Measures of success and CHIP priority area

action plans are reviewed and analyzed at least quarterly to promote plan progression, effectiveness of processes and to foster community health partnerships (*Appendix F: Annual Evaluation Report*).

The CHIP reflects the voice and vision of the community and demonstrates the commitment and dedication of the Healthy Seminole Collaborative members and other partner organizations to improve the health and well-being of Seminole County. The CHIP is a call to action for all sectors and individuals to join forces and work together to make Seminole County a healthier and happier place to live, work, and play.



# COMMUNITY HEALTH IMPROVEMENT PROCESS

A Community Health Improvement Plan (CHIP) is a long-term, systematic effort that addresses health problems based on the results of community health assessment activities, community partnership assessments and the community health improvement process. The resulting 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. 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.

The 2023-2026 Seminole County Community Health Improvement Plan was developed following the Mobilizing for Action through Planning and Partnerships (MAPP) model. The CHIP started by conducting four community dialogues held in different locations in the county between December 2022 and February 2023. During these sessions, the 2022 Community Health Needs Assessment (CHNA) results of were shared, and a prioritization exercise was conducted. Then, on April 6, 2023, the Healthy Seminole Collaborative members identified three priorities for the CHIP: Chronic Conditions; Mental Health and Substance Use Disorders; and Social and Economic Factors. These CHIP priorities were identified after priorities from the 2022 CHNA and community dialogues priorities were combined and grouped in themes that were in alignment with the State Health Improvement Plan priorities and the Healthy People 2030 intuitive areas. During this session the implementation of the Community Partner Assessment (CPA) survey was discussed, and a first activity to develop plan goals and objectives for each of the CHIP priority areas was conducted.

On June 1st, the CPA survey was extended for two more weeks due to low response rate, and the collaborative members received a Design Thinking Crash Course to introduce an innovation approach for the next CHIP implementation cycle.

Finally, on July 20th, the final proposed plan items were displayed in posters around the room, and the collaborative members were asked to indicate their contribution to any plan item by placing their organization names next to it. This process resulted in a comprehensive and inclusive CHIP that reflects the voice and vision of the community and the commitment and dedication of the CHIP partners.

# KEY MAPP FINDINGS

## Community Health Needs Assessment

The CHNA had a comprehensive methodology that included a mixed method approach consisting of the following components:

- Incorporation of a team of Equity Champions – ten individuals or organizations who represented multiracial or other minority communities. They assisted with the following objectives:
    - Reviewing research instruments for cultural appropriateness.
    - Participating in stakeholder interviews.
    - Participating in the prioritization process and strategy development discussions.
    - Providing guidance regarding the most effective ways to engage unique community members (e.g., via interviews, surveys, or other methods).
- Data analysis: In-depth review of dozens of validated data sources. Information was tabulated and parsed to identify disparities and other insights.
- Digital research: This included a review of health-related online search terms with the intent to identify new or emerging health trends.
- Primary qualitative research: This component included 30 focus group discussions and 105 key stakeholder interviews.
- Survey research: The community survey engaged over 4,000 respondents and provided insights by county on a breadth of key CHNA issues.
- Access Audit: Over 45 “mystery shopper” calls were conducted during the Access Audit to illuminate real-life customer service and access to care issues.
- Prioritization process: The Central Florida Collaborative leadership and approximately 12 to 15 stakeholders in each county participated in a modified Delphi Process to incorporate quantitative and qualitative insight to the final needs prioritization exercise at a county level. The process also included a series of county-level, focused meetings, as well as an “all service area” meeting.

2022 Seminole County CHNA top 15 granular issues within top five needs:

**Increase system capacity**

3. Mental health outpatient services capacity
7. Mental health inpatient bed capacity

**Enhance Mental Health (including substance use disorder) outreach and treatment**

4. Mental health crisis services and community awareness of available resources
9. Behavioral health outpatient services for children
13. Youth mental health services
14. Suicide prevention

15. Mental health and substance use disorder transition care for inmates being released from jail

**Streamline access to care**

11. Access to free or low-cost health care services for all residents

**Refine primary care and specialized medical care (e.g., chronic conditions) services**

2. Information sharing among providers

5. Case managers, Community Health Workers, and similarly credentialed professionals to guide high-need patients

6. Mental health stigma reduction

8. Co-located case managers and behavioral health providers at community-based primary care sites

10. Integrated community collaborations (e.g., schools, Criminal Justice System, health care providers and Public Health Departments) to share information and ultimately identify and more efficiently serve high-need community members

**Address housing and other social determinants**

1. Support for additional affordable, quality housing – affects recruitment and retention of culturally diverse and informed providers, as well as access to free or low-cost health care for families.

12. Access to healthy food

**Data limitations**:

The dramatic changes in 2020 due to the COVID-19 pandemic may have impacted some of the traditional projection tools, source data and data collection methods. For example, the American Community Survey (ACS), which provides detailed population and housing information revised its messaging, altered their mailout strategy and made sampling adjustments to accommodate the National Processing Center's staffing limitations.[1]

Additionally, in-person interviews were limited to telephone and virtual formats. Although some interviews were conducted face-to-face, the decision to conduct most interviews via telephone or virtually may have impacted some of the traditional in-person dynamics.

## Community Partnership Assessment

In April-June 2023 DOH-Seminole invited 42 community organizations using Healthy Seminole Collaborative participants' distribution list to complete a Community Partnership Assessment (CPA) survey. We received 21 completed surveys. Below is a summary of analysis of the CPA survey based on suggested themes in MAPP 2.0.

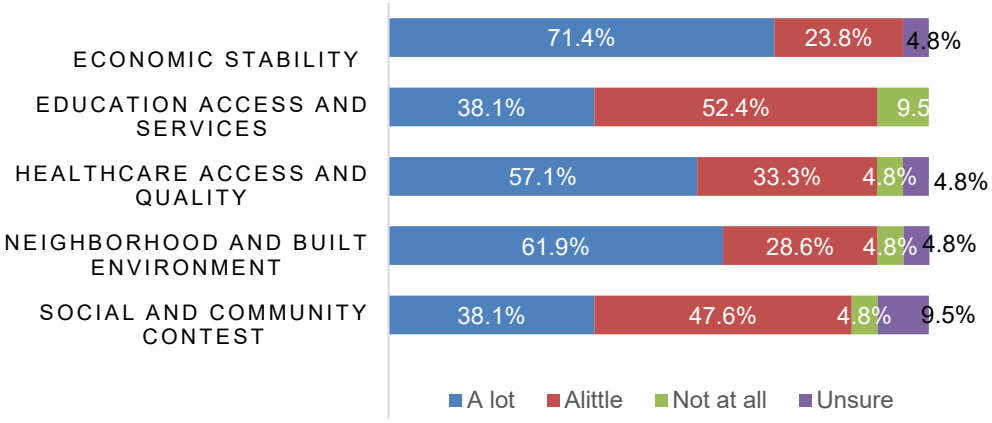
[1] U.S. Census Bureau.

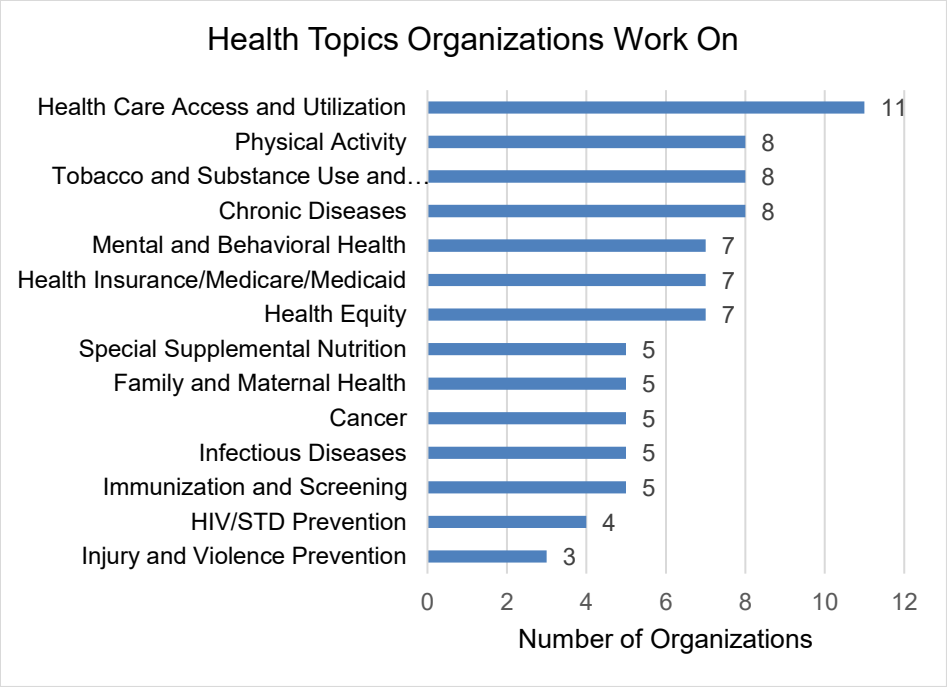
**Community Strengths**
Seminole County is filled with a variety of organizations that are supporting community health and well-being. There is a strong desire among partners to collaborate and learn from each other to continue to improve. Many organizations are engaged in health equity work and others express a desire to begin this work. Seminole County has partners working on the 10 Essential Public Health Services and the health issues identified through the Community Health Assessment. Population served includes, underserved, low-income individuals, victims of domestic violence, abused children, seniors, housing insecure, substance-use disorder, survivors of human trafficking, ALICE (asset limited income constrained, employed) population, pregnant women, disabled, transportation disadvantaged, LGBTQIA, transgender, immigrants, refugees, unsheltered and unemployed.

**Organizational Capacities**
Many of the organizations struggle with capacity and it prevents them from doing the upstream work that they would like to do. However, partners recognize that collaboration and networking can help expand capacity to continue to address health inequities within the community. Many organizations are physically located in neighborhood/s of target populations. Access to care is granted through working closely with community organizations from priority populations; most receive referrals and clients.

In regards Cultural Competency, organizations address it, by hiring staff from specific racial/ethnic groups that mirror priority populations, have staff/interpreters that speak the language/s of priority populations, which supports leadership development, and languages offered through language lines.

**Social Determinants of health**
71% of organizations reported working a lot on economic stability; 62% in neighborhood and built environment; 57% in healthcare access and quality; and 38% in social and community context.






**Health Behaviors and Outcomes**

Health is not only absence of sickness, but it also includes the systems, environment and resources that have a critical impact on health outcomes. Every partner has a role in connecting those they serve with the resources that impact health behaviors and outcomes. The survey respondents highlighted the following as the impact of their work in communities they served:

- Prevention of abuse/neglect.
- Promotion of strong and economically self-sufficient families.
- Linkage and referral of substance users to various resources to improve their recovery capital and chances of sustained recovery.
- Provision of affordable housing.
- Improved access to healthcare and reduction in disparities in health status.
- Advocating rational healthcare policies on behalf of underserved.
- Provision of patient centered medical care.
- Assistance with domestic violence.
- Assistance with food insecurities.

## Community Context Assessment

This assessment was conducted at the four-county service area. The process involved substantial onsite data gathering, local knowledge and expertise and outreach efforts for community engagement. The primary qualitative approach engaged policy leaders, key stakeholders throughout the four-county area, non-profit organization representatives, health care consumers, the criminal justice system, diversity representatives, people

experiencing homelessness and others. The qualitative techniques used included:

- Equity Champions - Diversity Group Outreach
- Stakeholder One-to-One Interviews (105 interviews)
- Focus Group Discussions (30 focus group discussion)

The combination of individual interviews and focus group discussions provided an in-depth perspective of high-level topics impacting the general four-county service area.

**Strengths**
Many individuals who participated in the qualitative research highlighted positive aspects of living and working in the Central Florida region. The growing diversity of the population was mentioned by numerous stakeholders in all four counties. One stakeholder noted, “With diversity comes interesting things to do that we didn’t use to have. It’s also attracting younger, highly educated, diverse individuals; so, now there is a breadth of thought leaders.”

The Central Florida region is home to numerous non-profit organizations throughout the four counties. A majority of the stakeholders agreed that many organizations are very collaborative and have developed supportive partnerships over the years with a goal to break down silos. A stakeholder said, “Passion for helping people has brought people together.”

Many stakeholders commented on the positive economic impact of the local theme parks and tourism industry. There was also consensus that the weather is generally nice year-round with many opportunities for outdoor activities and recreation.

**Top Challenges**
Challenges and barriers were identified at three levels: (1) Policy, Advocacy and System, (2) Community and (3) Individual.

**Policy, Advocacy and System Level**
Many of the challenges identified through the qualitative research were issues at a state or national level and require policy and regulatory change within state and federal laws or system-wide regulations to reduce the impact felt by individual community members. Some of the most common comments relate to:

- Complex Health Care System including staffing shortages.
- Financial Issues including the fact that many have no realistic access to health insurance without Medicaid expansion.
- Non-profit Organization Funding and Sustainability Challenges.
- Workforce development and staffing challenges.

**Community Level**
Community-level challenges are a step below system-level challenges, but there is an overlap between system-, community- and individual-level challenges. Community-level

challenges generally affect the wider population as a whole and not just select individuals within a community. Many of the community-level challenges are interrelated. The clusters of community-level challenges include:

***Rapid Population Growth in Central Florida***
The rapid population growth in Central Florida was identified as one of the top challenges in the qualitative research by many stakeholders. In addition, there is a lack of infrastructure to handle the growth and a lack of affordable housing.

***Behavioral Health***
Driven by the opioid epidemic and COVID-19 pandemic, the acuity of behavioral health in the community has increased significantly in the Central Florida region and across the country. One silver lining of the COVID-19 pandemic is that people tend to be somewhat more candid about mental health issues and are breaking through some of the stigmatization found in specific populations.

Chronic understaffing and an opioid epidemic that is not going away anytime soon exacerbate these behavioral health challenges.

Many other stakeholders also identified the importance of assisting with housing, transitions, nutrition and other basic needs to help people experiencing a mental health condition maintain some stability in the community.

***Health Care Access is Not Equitable Across the Region***
Stakeholders identified a variety of potential barriers and challenges people may experience when it comes to accessing health care services. Common barriers include lack of transportation or inadequate public transportation system, lack of health insurance or the ability to pay and mistrust of the health care industry. The COVID-19 pandemic has intensified the need to build trust in the health care industry in many priority populations[2] given the increasing prominent role of public health information and leaders.

***Awareness of Community Services***
There is a consensus among various stakeholders that community-wide awareness of what services and resources are available is low. Word of mouth tends to be the best method to share information, especially in priority populations.

**Individual Level**
Many of the identified challenges and barriers at the system and community level trickle down, and they impact the community residents who make up the over 2.8 million people who live in the Central Florida region. Some of the key individual challenges include:

[2] Priority populations include communities historically underrepresented, such as Black/African American communities, Hispanic/Latino communities, members of the LGBTQ+ community and others.

***Affordable Housing Crisis***
The affordable housing crisis is one of the top challenges impacting the Central Florida region and across the country. The lack of affordable housing is a root cause driver of many other needs and challenges in the community. As one stakeholder said, “Housing burden leads to a chain reaction to bad health care.”

***Chronic Disease***
Many barriers exacerbate increasing chronic disease rates, especially in more outlying rural communities in Central Florida. Transportation issues, including challenges getting to a grocery store or a health clinic, present another barrier.

Other stakeholders identified the lack of prevention and education programs, especially in the region’s youth population as another contributing factor to high chronic disease rates in the community. Health literacy and culturally appropriate health information were also identified as challenges for the increasingly diverse communities of Central Florida.

***The Wage Gap***
The recent increases in wages are closer to the living wage needed for one adult with no children living in the Greater Orlando area. However, with inflation and the continuing rise of housing-related costs, the new wages may still not be enough for many hospitality and tourism workers to live in a safe, non-cost-burdened home.

***Access to Care***
Throughout the qualitative research process, many challenges, and barriers to accessing health care and social services in the Central Florida region were identified. Many of the top barriers have been identified in the sections above. A list recapping the most common barriers for individuals includes:

- Transportation gaps and inefficiencies with the public transportation system.
- Lack of health insurance or the financial ability to pay for services, including insurance copays.
- Long wait times to see providers.
- Lack of awareness of resources, services, and providers in the community
- Health literacy and health information not available in multiple languages
- Mental health stigma.

**Additional Community Engagement Activities**
Four Community Dialogue sessions were hosted in the cities of Oviedo, Sanford, and East Altamonte Springs. The sessions engaged residents and community leaders to provide input on a summary of findings from our 2022 Community Health Needs Assessment and participate in a prioritization exercise to help the Healthy Seminole Collaborative identify areas the upcoming 2023-2026 Community Health Improvement Plan should focus its efforts on.

During the priority exercise, a total of 30 areas were listed for participants to vote on areas of low, medium, or high priority. After counting all high priority votes the resulting ranking of areas is displayed in the table below.

| # | AREAS |
|---|---|
| 1 | MENTAL HEALTH (INCLUDES SUICIDE) |
| 2 | HOUSING |
| 3 | ACCESS TO FOOD |
| 4 | TRANSPORTATION |
| 5 | SUBSTANCE USE: OPIOID |
| 6 | DIABETES |
| 7 | ACCESS TO CARE |
| 8 | EMPLOYMENT |
| 9 | CANCER |
| 10 | HEART DISEASE |
| 11 | PRENATAL CARE |
| 12 | INCOME – POPULATION LIVING IN POVERTY |
| 13 | NUTRITION |
| 14 | STROKE |
| 15 | MATERNAL MORTALITY |

| # | AREAS |
|---|---|
| 16 | PHYSICAL ACTIVITY |
| 17 | INFANT MORTALITY |
| 18 | SUBSTANCE USE: ALCOHOL |
| 19 | SUBSTANCE USE: SMOKING |
| 20 | ALZHEIMER |
| 21 | EDUCATIONAL ATTAINMENT |
| 22 | DENTAL HEALTH |
| 23 | INTENTIONAL INJURIES: HOMICIDES |
| 24 | OTHER DISEASES AND SEXUAL HEALTH: HIV & AIDS |
| 25 | OTHER DISEASES AND SEXUAL HEALTH: SEXUALLY TRANSMITTED DISEASES |
| 26 | OTHER DISEASES AND SEXUAL HEALTH: HEPATITIS |
| 27 | COVID-19 |
| 28 | CHRONIC LOWER RESPIRATORY DISEASES |
| 29 | ASTHMA |
| 30 | UNINTENTIONAL INJURY |




Meetings/Locations of Community Dialogue sessions: Healthy Seminole Collaborative, Improving Oviedo Neighborhoods, Dr. Velma D. Williams Westside Community Center and Boys and Girls Club – East Altamonte Branch respectively.

# PRIORITY AREAS

Through the MAPP process the top three priority areas were selected by Healthy Seminole Collaborative participants for action planning, monitoring and evaluation. The Seminole 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 Seminole County residents.

The selected 2020-2023 CHIP priorities, goals, objectives, and activities are listed below.

## MENTAL HEALTH AND SUBSTANCE USE DISORDERS PRIORITY

According to the Centers for Disease Control and Prevention (CDC), mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental and emotional well-being empowers individuals to realize their own abilities, cope with the normal stresses of life, work productively and contribute to their communities. Prevention and early intervention strategies that work to reduce and treat mental health and substance use disorders are essential for ensuring optimal mental and physical health.

| **Goal MH1:** | **Prioritize and improve overall wellness by increasing awareness and promoting community resilience for mental, emotional and behavioral health.** |
|---|---|
| **Objective MH1.1:** | By December 31, 2024, increase the number of community events that Healthy Seminole Collaborative agencies participate in promoting mental, emotional, and behavioral health awareness and resources by 40% from those that occurred in 2022. |
| | **Contributing Organization(s)**: DOH-Seminole (OHPE), Seminole County Sheriff's Office (SCSO), and Tobacco Free Seminole |
| **Activity MH1.1.1** | By December 31, 2023, gather the total number of outreach events that Healthy Seminole Collaborative partner agencies participated in, |

| | |
|---|---|
| | promoting mental, emotional, and behavioral health awareness and resources in 2022. |
| **Activity MH1.1.2** | Promote and track community outreach events with community partners at every Healthy Seminole Collaborative meeting. |
| **Activity MH1.1.3** | Create tracking tool to capture community outreach events minimally including the date, time, location, approximate number of residents reached, and information disseminated at each outreach event. |
| **Objective MH1.2:** | By July 1, 2024, develop a method to assess outreach participant learning to be used by Healthy Seminole Collaborative agencies at outreach events from 0 in 2022. |
| | **Contributing Organization(s)** UCF - Department of Health Sciences, College of Health Professions and Science |
| **Activity MH1.2.1** | Develop a standardized skills assessment to measures outreach participant learning by July 15, 2024. |
| **Activity MH1.2.2** | Deploy the standardized skills assessment to all Healthy Seminole Collaborative agencies by July 31, 2024. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| **Goal MH2:** | **Prioritize and improve overall wellness by increasing awareness and promoting community resilience for process and substance use disorders.** |
|---|---|
| **Objective MH2.1:** | By December 31, 2024, increase the number of community events that Healthy Seminole Collaborative agencies participate in, promoting process and substance use disorders awareness and resources by 40% from those that occurred in 2022. |
| | **Contributing Organization(s)**: DOH-Seminole, SCSO, and Recovery Connections of Central FL |
| **Activity MH2.1.1** | By December 31, 2023, gather the total number of outreach events that Healthy Seminole Collaborative partner agencies participated in, promoting process and substance use disorders awareness and resources in 2022. |
| **Activity MH2.1.2** | Promote and track community outreach events with community partners at every Healthy Seminole Collaborative meeting. |
| **Activity MH2.1.3** | Create tracking tool to capture community outreach events minimally including the date, time, location, approximate number of residents reached, and information disseminated at each outreach event. |
| **Objective MH2.2:** | By July 1, 2024, develop a method to assess outreach participant learning to be used by Healthy Seminole Collaborative agencies at outreach events from 0 in 2022. |
| | **Contributing Organization(s)**: UCF - Department of Health Sciences, College of Health Professions and Science |
| **Activity MH2.2.1** | Develop a standardized skills assessment to measures outreach participant learning by July 15, 2024. |

| | |
|---|---|
| **Activity MH2.2.2** | Deploy the standardized skills assessment to all Healthy Seminole Collaborative agencies by July 31, 2024. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| **Goal MH3:** | **Increase Seminole County resident access to community services through collaborative partnerships.** |
|---|---|
| **Objective MH3.1:** | By October 1, 2024, create a collaborative grant application plan with a minimum of five participating Healthy Seminole Collaborative agencies from 0 in 2022. |
| | **Contributing Organization(s)**: Seminole County Government – Community Health, Christian HELP, and East Central Florida Regional Planning Council (ECFRPC) |
| **Activity MH3.1.1** | By October 1, 2023, identify a minimum of three Healthy Seminole Collaborative, Mental Health & Substance Use Disorder subcommittee members who have experience in grant writing. |
| **Activity MH3.1.2** | By March 1, 2024, identify at least one viable grant to serve Seminole County residents. |
| **Activity MH3.1.3** | By October 1, 2024, submit identified grant application. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| **Goal MH4:** | **Increase Seminole County incarcerated resident access and participation in Seminole County Problem Solving Courts** |
|---|---|
| **Objective MH4.1:** | Increase Seminole County incarcerated resident access and participation in Seminole County Problem Solving Courts. |
| | **Contributing Organization(s)**: Seminole County Resource Management-Grants, and 18th Judicial Circuit-Seminole County |
| **Objective MH4.2:** | By October 1, 2024, Veteran's Court will serve 25 participants. |
| | **Contributing Organization(s)**: Seminole County Resource Management-Grants, and 18th Judicial Circuit-Seminole County |
| **Objective MH4.3:** | By October 1, 2024, Mental Health Court will serve 25 participants. |
| | **Contributing Organization(s)**: Seminole County Resource Management-Grants, and 18th Judicial Circuit-Seminole County |
| **Activity MH4.3.1** | By November 30, 2023, Memorandums of understanding will be established with Court Partners to provide treatment and auxiliary services to the participants. |
| **Activity MH4.3.2** | Ongoing, Provide interested participants admission assessments within 60 days of inquiry. |
| **Activity MH4.3.3** | Ongoing, Sign eligible and willing participants within 30 days of assessment. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| Goal MH5: | Enhance Diversion Programs for Adults that without intervention could qualify for State Hospitalization |
|---|---|
| Objective MH5.1: | By October 1, 2024, 14 Seminole County Residence will be provided wrap around services through the Reinvestment Grant deterring them from State Hospitalization. |
| | **Contributing Organization(s)**: Seminole County Resource Management-Grants and ASPIRE Health Partners |
| Activity MH5.1.1 | By October 1, 2023, Memorandums of understanding will be established with between Seminole County and ASPIRE Health Partners. |
| Activity MH5.1.2 | Ongoing, screen at least 40 citizens monthly for eligibility for programing. |
| Activity MH5.1.3 | Ongoing, provide evidenced based treatment wrap around services for at least 90-days to enrolled participants. |
| Activity MH5.1.4 | Provide committee with quarterly reports on project progress in meeting objectives. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| Goal MH6: | Enhance Juvenile Diversion and Treatment Services |
|---|---|
| Objective MH6.1.: | By October 1, 2024, provide prevention programming in the form of evidenced-based practice SNAP (Stop Now and Plan) to 20 new participants through the Reinvestment Grant. |
| | **Contributing Organization(s)**: Seminole County Resource Management-Grants, and SCSO-Juvenile Justice Division |
| Activity MH6.1.1 | By October 1, 2023, Memorandums of understanding will be by October 1, 2023, Memorandums of understanding will be established with between Seminole County and SCSO. |
| Activity MH6.1.2 | Ongoing, provide evidence-based mental health and substance abuse intervention services through the SNAP program model to 20 participants. |
| Activity MH6.1.3 | Less than 25% of Juvenile Program participants will be arrested while receiving services. |
| Activity MH6.1.4 | A minimum of 50% of Juvenile Program participants shall demonstrate a decrease in civil citations received while receiving services. |
| Activity MH6.1.5 | Provide committee with quarterly reports on project progress in meeting objectives. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

Development of the Mental Health and Substance Use Disorders priority goals, strategies, objectives, and activities were completed during the CHIP planning sessions by the community partners identified below, who have agreed to support implementation of plan items. Partners who were not directly contributing to the progress of the objectives listed above, still provide input from their subject matter expertise, and updates on additional activities carried in support of the overarching priority goal(s) at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

| NAME | ORGANIZATION |
|---|---|
| Justin Mrotz | Action Church |
| Elizabeth Aulner | AdventHealth |
| Marissa Gore | Aspire |
| Nikaury Munoz | Central Florida Cares |
| Ana Scuteri | DOH-Seminole |
| Heather Haskett | |
| Paula Koehler | |
| Patricia Mondragon | |
| Jennifer Grant | Early Learning Coalition |
| Arvinder Sodhi | Gratus |
| Anna Kesic | Impower |
| Jessica Hixon | |
| Marcie Dearth | |
| Kevin Carraro | Lakewood Center |
| Donna Gray | League of Women Voters of Seminole County |
| Leslie Grubl | |
| Tamara Dowling | Lit Path |

| NAME | ORGANIZATION |
|---|---|
| Madeline Lee | NAMI |
| Pernell Bush | No Limit Health and Education |
| Mark Huhgson | Recovery Connections of Central Florida |
| Meredith Bekemeyer | Rescue Outreach Mission |
| Chris Ham | |
| Alison Catalfamo | |
| Bradley Justin | |
| Clifford Harris | Seminole County Sheriff's Office |
| Lisa Zucker | |
| Michele Smith | |
| Nicole Strother | |
| Omar Mestre | |
| Kelly Welch | Seminole Co. Gov Community Health |
| Amanda Hamer | Seminole Co. Gov Grants |
| Melanie Santiago | Tobacco Free Seminole |
| Dr. Michael Rovito | UCF |
| James Jackson | UniteUs |

## SOCIAL AND ECONOMIC FACTORS PRIORITY

Social and economic factors impacting health are the conditions in the environments where people live, work, and play that influence health throughout the lifespan. These factors, including but not limited to income, employment, housing, literacy skills and transportation have a major impact on people's ability to lead long, healthy lives.

| **Goal SEF1:** | **Improve awareness of quality services that empower all Seminole County residents to make informed decisions for the optimal health.** |
|---|---|
| **ObjectiveSEF1.1:** | By June 30, 2026, establish a (one) catalog with Smart Sheets of resources available from partners in multiple languages from zero in 2022. |
| | **Contributing Organization(s)**: DOH-Seminole (OHPE and School Health), Seminole County Government – Community Health, The Sharing Center, and Family Outreach Community Center |
| **Activity SEF1.1.1** | By July 1, 2023, procure Smart Sheets through FDOH. |
| **Activity SEF1.1.2** | By December 31, 2023, partners will report if they have access to Culturally and Linguistically Appropriate Services (CLAS) and language line. |
| **Activity SEF1.1.3** | By July 1, 2024, partners will conduct an assessment of client language needs. |
| **Objective SEF1.2:** | By June 30, 2025, increase access to care through mobile health services to at least three identified communities in need. |
| | **Contributing Organization(s)**: DOH-Seminole (CIMHS), Family Outreach Community Center and Central FL Black Nurses Association (CFBNA) of Orlando |
| **Activity SEF1.2.1** | By September 30, 2023, identify active mobile units, services, and capacity. |
| **Activity SEF1.2.2** | By December 31, 2023, identification of communities in need based on immigration status, race, ethnicity. |
| **Activity SEF1.2.3** | By December 31, 2023, create a plan to situate mobile unit services in alignment with identified community needs. |
| **Activity SEF1.2.4** | By December 31, 2024, share plan with partners and community. |
| **Objective SEF1.3:** | By June 30, 2024, develop two educational materials and opportunities to learn and understand the need for healthy and affordable housing. |
| | **Contributing Organization(s)**: Seminole County Government – Community Health, DOH-Seminole, ECFRPC and Bright Community Trust |
| **Activity SEF1.3.1** | Create material to educate policy makers about the need for healthy and affordable housing. |

| | |
|---|---|
| **Activity SEF1.3.2** | Create material to educate residents about the need for healthy and affordable housing. |

**Policy and system level changes needed to address identified causes of health inequity:** Support development of healthy and affordable housing policies from the Live Local Act

| **Goal SEF2:** | **Strengthen partnership.** |
|---|---|
| **Objective SEF2.1:** | By May 31, 2026, increase the number of community stakeholders who engage with the Healthy Seminole Collaborative and its communication channels from 42 in 2023 to at least 5 additional members annually. |
| | **Contributing Organization(s)**: DOH-Seminole (OPQI, SH), The Sharing Center, Bright Community Trust and Recovery Connections of Central Florida |
| **Activity SEF2.1.1** | By October 31, 2023, identify organizations from the public health system who are relevant to current CHIP priorities and are not participating in collaborative. |
| **Activity SEF2.1.2** | By May 31, 2026, strengthen networks and partnerships with community leaders and stakeholders leading healthy housing, food, or community initiatives to increase opportunities for collaborating to complete objectives. |
| **Objective SEF2.2:** | By December 31, 2023, 80% of Healthy Seminole Collaborative partner agencies will join at least one referral platforms commonly used in Seminole County. |
| | **Contributing Organization(s)**: DOH-Seminole (OHPE, CIMHS), CFBNA of Orlando and DCF |
| **Activity SEF2.2.1** | By September 30, 2023, identify platforms most collaborative members used for connecting community with services. |
| **Activity SEF2.2.2** | By December 31, 2023, educate on benefits of selected platforms to collaborative agencies who are not enrolled in any of the selected platforms. |
| **Objective SEF2.3:** | Support regional Vision Zero plans to ensure safety of Seminole County residents as they travel. |
| | **Contributing Organization(s)**: MetroPlan, City of Oviedo, ECFRPC and Orlando DOH-Seminole (SH) |
| **Activity SEF2.3.1** | Collaborate with Seminole County and local municipalities as they develop their Vision Zero plans. |
| **Activity SEF2.3.2** | Author letters of support for any jurisdictions who adopt Vision Zero Plans. |

**Policy and system level changes needed to address identified causes of health inequity:** Vision Zero safety action plan.

| Goal SEF3: | Decrease a gap in infant health outcomes. |
|---|---|
| **Objective SEF3.1:** | Reduce the black-white infant mortality gap from 3.1 (2021) to two or less times higher by December 31, 2025. |
| | **Contributing Organization(s)**: Healthy Start Coalition of Seminole County and DOH-Seminole (OHPE, FHB) |
| **Activity SEF3.1.1** | By December 31, 2025, address the black-white infant mortality gap by creating 1 doula training program to serve Seminole County residents. |
| **Activity SEF3.1.2** | By December 31, 2025, address the black-white infant mortality gap by creating 1 nurse home visiting program to serve Seminole County residents. |
| **Activity SEF31.3** | By December 31, 2025, develop a Community Action Group plan based on recommendations from the Fetal Infant Mortality Review (FIMR) Case Review Team. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

Development of the Social and Economic Factors priority goals, strategies, objectives, and activities were completed during the CHIP planning sessions by the community partners identified below, who have agreed to support implementation of plan items. Partners who were not directly contributing to the progress of the objectives listed above, still provide input from their subject matter expertise, and updates on additional activities carried in support of the overarching priority goal(s) at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

| NAME | ORGANIZATION |
|---|---|
| Vincent Dyer | Bike/Walk Central Florida |
| Traci Blue | Bright Community Trust |
| Constance Brown | Central Florida Black Nurses Association of Orlando |
| Ben Williams | City of Oviedo - Improving Oviedo Neighborhoods (ION) |
| Rod Love | Community Synergy Group Inc. |
| Anna Archambault | Department of Childrens and Families |
| Traci Klinkbeil | |
| Stephanie Jackson | DOH-Seminole |
| Maria Quintero Urdaneta | |
| Gigi Rivadeneyra | |

| NAME | ORGANIZATION |
|---|---|
| Ken Peach | Health Council of East Central Florida |
| Carmen Guzman | Healthy Start Coalition in Seminole County |
| Magdalena Pedrosa | |
| Patricia Genao | HOPE Helps |
| Tony Hernandez | Iglesia Vida Nueva/ Family Outreach Community Center |
| Sarah Larsen | MetroPlan Orlando |
| Alyson Olinzock | Orlando Health |
| Mark Thompson | Picnic Project |
| Lucie Vital | Positive Assistance |
| Chantel Reed | Seminole Co. Gov. |

| NAME | ORGANIZATION |
|---|---|
| | |
| Enid Santiago | |
| Claudia Tejada | |
| Luis Nieves-Ruiz | East Central Florida Regional Planning Council |

| NAME | ORGANIZATION |
|---|---|
| | Community Health |
| Matthew Borchelt | The Sharing Center |
| Jafet Rios | True Health |
| | |

## CHRONIC CONDITIONS PRIORITY

Cancer, heart disease, stroke, diabetes, and illnesses related poor lifestyle choices are among the most common health problems affecting people of all ages, socioeconomic statuses, and ethnicities. Risk factors – lack of physical activity, poor nutrition, tobacco use, excessive alcohol use, the environment, and social and economic factors – cause much of the illness, suffering and early death related to chronic diseases and conditions.

| **Goal CC1:** | **Promote the attainment and maintenance of health through nutrition, physical activity, and supportive lifestyle behaviors.** |
|---|---|
| **Objective CC1.1:** | By June 30, 2026, increase A1c screening opportunities for clients to assess their average amount of glucose in the blood over the past 2-3 months from 300 in 2022 to 450. |
| | **Contributing Organization(s)**: True Health, DOH-Seminole (CIMHS) and AdventHealth |
| **Activity CC1.1.1** | Increase percentage of green and yellow Supporting Wellness at Pantries (SWAP) ranked food distributed to pantries in Seminole County from 65% in 2022 to 70% annually by December 31, 2025. |
| **Activity CC1.1.2** | Create awareness of nutrition education classes opportunities available to Seminole County residents. |
| **Activity CC1.1.3** | Provide diabetes medication educational sessions to improve diabetes medication adherence. |
| **Objective CC1.2:** | By June 30, 2026, increase physical activity by promoting walking and biking at locations across Seminole County. |
| | **Contributing Organization(s)**: MetroPlan Orlando, DOH-Seminole (OHPE), and UF/IFAS Extension |
| **Activity CC1.2.1** | By September 30, 2023, identify different sidewalks and trails that will be constructed during the timeline of the CHIP. |
| **Activity CC1.2.2** | Host a ribbon cutting educational event at two (2) trails/sidewalks/pedestrian facilities in Seminole County. |
| **Activity CC1.2.3** | Disseminate information about asthma, high blood pressure and heart disease at ribbon cutting to raise awareness on benefits of physical activity. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

| Goal CC2: | Expand access to preventive and self-management services for Chronic conditions. |
|---|---|
| **Objective CC2.1:** | Increase number of effective patient referrals to more specialized providers. |
| | **Contributing Organization(s)**: Seminole Co Gov (Community Health); DOH-Seminole (CIMHS, OHPE); CFBNA of Orlando, UF/IFAS Extension, Orlando Health and AdventHealth |
| **Activity CC2.1.1** | Promote chronic management classes. |
| **Objective CC2.2:** | By June 30, 2025, increase the annual number of cervical cancer screenings to Seminole county women 50 years and older residents from 26 in Fiscal Year 22-23 to 80. |
| | **Organization(s) Responsible**: DOH-Seminole (Breast and Cervical Cancer Early Detection Program) |
| **Activity CC2.2.1** | Increase cancer screening referrals made by DOH-Seminole Community Integrated Mobile Health Services unit. |

**Policy and system level changes needed to address identified causes of health inequity:** No changes identified at this time.

Development of the Chronic Conditions priority goals, strategies, objectives, and activities were completed during the CHIP planning sessions by the community partners identified below, who have agreed to support implementation of plan items. Partners who were not directly contributing to the progress of the objectives listed above, still provide input from their subject matter expertise, and updates on additional activities carried in support of the overarching priority goal(s) at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

| NAME | ORGANIZATION |
|---|---|
| Cynthia Hawley | AdventHealth |
| Anthony Maldonado | Bueno Pharmacy |
| Ethel Smith | DOH-Seminole |
| Sarah Wright | |
| Sebastian Rosa | |
| Sarah Larsen | MetroPlan Orlando |

| NAME | ORGANIZATION |
|---|---|
| Sara Osborne | Orlando Health |
| Rene Gomez | Second Harvest Food Bank |
| Rebecca Eiland | Seminole Co. Gov. Community Health |
| Lydia Galeas | |
| Joseph Lebert | True Health |
| Wanda Adorno | University of Florida IFAS |

# APPENDIX A: Community Health Needs Assessment

## Overview and Operational Framework

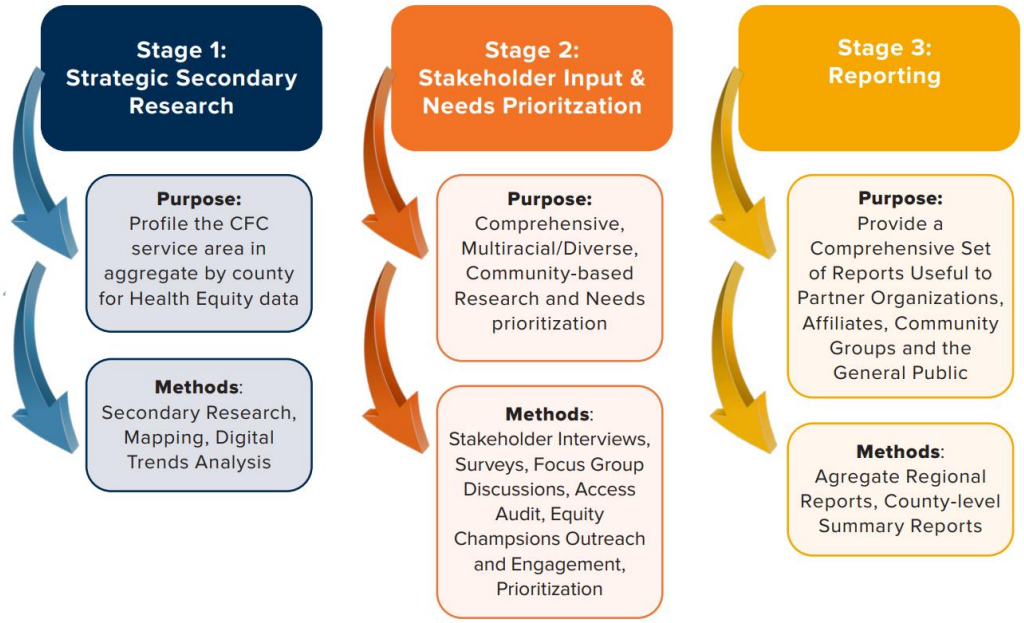
The Central Florida Collaborative worked with its assessment partner, Crescendo Consulting Group (CCG), to formalize and deploy a highly inclusive assessment framework. The approach was structured to be welcoming to priority communities and others, steeped in best practices, and designed to triangulate insights. At the conclusion of the process, the CFC developed a succinct, prioritized list of community needs. To do this, the methodology included a mixed modality approach – quantitative, qualitative, and technology-based techniques – to learn about the human stories and voices while weaving them with the best available data.

### Methodology

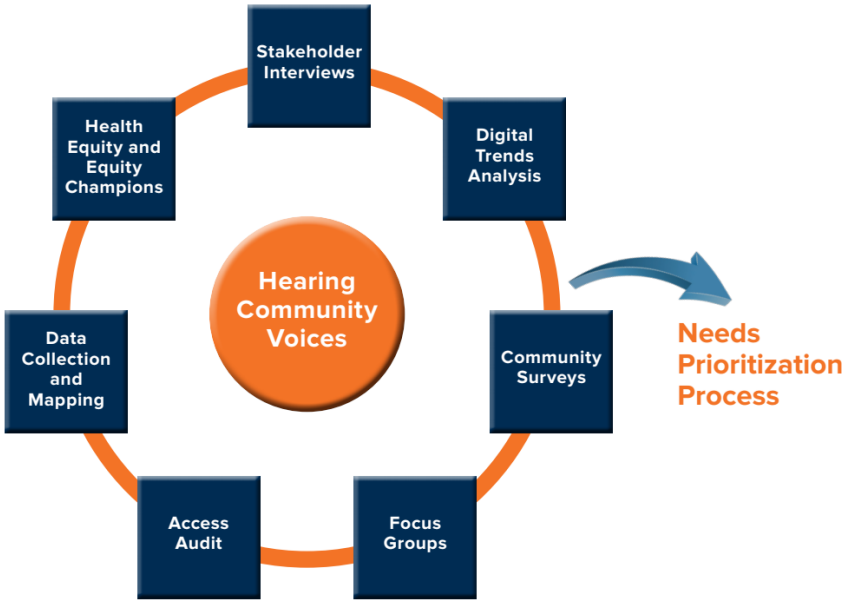
Crescendo engaged community partners, used data analytics, and invited others to join the discovery process to help create a positive cycle of change. The assessment activities meet the following goals:

- Identifying resources, strengths, and barriers to improving health outcomes.
- Developing a deeper understanding of community access to care challenges, including those faced by minority communities.
- Enabling partners to collaborate around the opportunities for population health improvement.

The following illustrates the three-stage approach used to support the project goals:



**Operational Framework**
Below is a graphic illustrating how the mixed-modality research methodology used stakeholder interviews, focus group discussions, a large sample community survey and an access audit to ensure community voices were combined and fed into the prioritization process.




Based on the results of the mixed-modality approach, an extensive list of 50 unique needs in each county was developed. The CFC deployed a Modified Delphi Technique to prioritize the needs resulting in 2022 Seminole County CHNA top 15 granular issues and top five priorities.

## Additional CHNA secondary data highlights

A sample of findings are listed below.

- The total population in Seminole County has grown approximately 10% over the last 10 years and it is projected to reach that same percentage by 2024. Florida experienced a near 12% increase in population between 2010 and 2019, the second-largest increase in population after Texas.
- Overall diversity continues to increase. For example, the percent of Hispanic/Latino Seminole County residents has increased from 16.2% in 2010 to 21.4% in 2019.
- The percent of adults with a college degree in Seminole County is notably above the U.S. and statewide average.

- In Seminole county, approximately 28% or more of the Black/African American community live in poverty, which is the same as the state level and approximately one percentage point or more above the U.S.
- Approximately one out of six homeowners across Seminole County are housing cost burdened, meaning that ownership costs exceed 30% of the household income.
- Similar to the nation, heart disease and cancer (of all types) were the leading causes of death in Seminole County between 2017 and 2019, followed by unintentional injuries.
- Rates for a majority of the leading causes of death have declined over the last 20 years. However, death rates due to Alzheimer's Disease have increased from 15.1 deaths in 1999-2001 to 19.9 deaths in 2017-2019 per 100,000 people.
- In 2019, over 33.2% of the adult population in Seminole County had high blood pressure, which is slightly lower than statewide (33.5%).
- The 2018-2020 death rate from unintentional falls in Seminole County (15.0 deaths per 100,000 population) is nearly 50% higher than the state rate. In addition, an increase of 3.3 percentage points was observed when compared to 2017-2019 death rate.
- Over the five-year reporting period (2015-2019), the percentage of the total population who do have health insurance has increased. Compared to the State (87.3%), Seminole County has a higher percentage of population who do have health insurance (90.3%). Hispanic/Latino population continues to show the lowest percentage when compared to other races.
- Preliminary research indicates that as a result of the COVID-19 pandemic, there is a high probability of an increased burden of mental health issues in the post-pandemic era.
- Approximately one in eight service area adults reported notable mental health challenges in 2019; this number likely increased dramatically in 2020 and 2021.
- With 358.5 total mental health providers per 100,000 population, Seminole County was the only one in the CFC service area who was not currently classified as a mental health professional shortage area.
- Fentanyl deaths have skyrocketed in Seminole County over 400% from 2013 to 2019.
- Similarly, overdoses from methamphetamines increased by 300% or more in Seminole County from 2013 to 2019.

# 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.
- Stronger public health infrastructure, partnerships, and leadership.

The recently updated methodology MAAP 2.0 follows a three-phase model as shown in the image below.


There are three assessments in phase two of the MAPP Process:

**Community Partner Assessment:** Replacing the Local Public Health Systems Assessment (LPHSA) from MAPP 1.0, this assessment provides a structure for all community partners to look critically at their (1) individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities.

**Community Status Assessment:** The Community Status Assessment (CSA) is a community-driven quantitative data assessment aimed at understanding the community's status. It helps communities move upstream and identify inequities beyond health behaviors and outcomes, including their association with social determinants of health and systems of power, privilege, and oppression.

**Community Context Assessment:** The Community Context Assessment (CCA) is a qualitative data assessment tool aimed at harnessing the unique insights, expertise, and perspectives of individuals and communities directly impacted by social systems to improve the functioning and impact of those systems.

Source: National Association of County & City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnerships (MAPP) - NACCHO

# APPENDIX C: County Profile


Seminole County is located in East Central Florida just north of Orlando. With an estimated population of 470,856 (2020 Decennial Census), according to the U.S. Census Bureau. Seminole County is also the most densely populated county in Central Florida with a total land area of 309.4 square miles. The county is comprised of seven cities and six unincorporated areas represented by 26 zip codes and 86 census tracts as of the 2010 Decennial Census. The median household income is $80,550 and 11.5% of Seminole 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 has the ability to define their access to affordable housing, healthcare, higher education opportunities and food. According to the US bureau of Labor Statistics, 3.0% of the population is unemployed (as of October 2023).

The life expectance at birth is 80.5 which is slightly higher than the state rate of 77.5 years. The racial makeup of the county consists of Whites (75.8%), Blacks/African Americans (12.0%), Asian (4.5%), and Other (7.7%). The Hispanic/Latino of any race accounts for 21.4% of the population. More than half (51.7%) of the population in Seminole County are female and 48.3% are male. Overall, the age distribution of Seminole County shows a higher percentage of younger population with a median age of 39.2 in 2019; only 15.2% are 65 years and above.

Seminole 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. Over five percent of the adult population in Seminole County have not attained a high school diploma. This is lower than the State (11.8%). 94.3% of the Seminole County adult population have earned a high school diploma or greater which is 4% higher than the State.

Mental Illness and substance abuse issues impact the social and mental health of Seminole County citizens. The mental health provider ration is 670 people per one mental health provider in Seminole County which is equivalent to the ratio seen across the State.

# APPENDIX D: CHIP Alignment

Both National and State health improvement priorities were considered during the development of the 2020-2023 Seminole County Community Health Improvement Plan. The following diagram provides a visual representation of these alignments.

| 2023-2026 Seminole CHIP | 2023-2026 DOH-Seminole Strategic Plan | 2017-2021 DOH Agency SHIP | Healthy People 2030 |
|---|---|---|---|
| Chronic Conditions | - Effective Agency Processes<br>- Healthy Thriving Lives | Chronic Diseases and Conditions | - Health Conditions<br>- Health Behaviors<br>- Populations |
| Mental Health and Substance Use Disorders | - Emerging Health Threats | Mental Wellbeing and Substance Abuse prevention | - Health Behaviors<br>- Populations |
| Social and Economic Factors | - Healthy Thriving Lives | Social and Economic Conditions Impacting Health | - Health Conditions<br>- Settings and Systems<br>- Social Determinant of Health |

# APPENDIX E: Assets & Resources

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

| Basic Needs Assistance | | |
|---|---|---|
| **Organization** | **Contact Information** | **Services Overview** |
| **Arab American Community Center** | 407-985-4550<br>aaccflorida.org | Eligibility/Insurance, employment Services, Immigration/Refugee Services, Legal Services, Abuse, Domestic Violence |
| **Catholic Charities of Central Florida** | 407-658-1818<br>cflcc.org | Access to Care, Behavioral Health, Emergency Services, Immigration/Refugee Services, Human Trafficking Services, Elder Services |
| **Center for Multicultural Wellness and Prevention** | 407-648-9440<br>cmwp.org | Housing and Homeless Services, HIV/AIDS, Mental Health, Access to Care, Chronic Disease |
| **Christian Service Center of Central Florida** | 407-425-2523<br>christianservicecenter.org | Food Assistance, Housing and Homeless Services, Emergency Services |
| **Community Hope Center** | 321-677-0245<br>hope192.com | Housing and Homeless Services, Employment Services, Food Assistance, Legal Services |
| **Harvest Time International** | 407-328-9900<br>harvesttime.org | Food Assistance, Emergency Services |
| **Heart of Florida United Way** | 407-835-0900<br>hfuw.org | Resource Connection |
| **Second Harvest Food Bank of Central Florida** | 407-295-1066<br>feedhopenow.org | Food Assistance |
| **The Salvation Army** | 407-423-8581<br>salvationarmyorlando.org | Housing and Homeless Services, Emergency Services |
| **The Sharing Center** | 407-260-9155<br>thesharingcenter.org | Food Assistance, Housing and Homeless Services |
| **United Against Poverty/ UP Orlando** | 407-650-0774<br>communityfoodoutreach.org | Emergency Services, Mental Health, Education, Food Assistance |
| **Florida Department of Health** | | |
| **Organization** | **Contact Information** | **Overview** |
| **Florida Department of Health in Seminole County** | 407-665-3000<br>seminole.floridahealth.gov | Cancer, Dental, Women's Health, HIV/AIDS, STI, Primary Care, Immigration/ Refugee Services, Chronic Disease, Child Services |
| **Federally Qualified Health Center (FQHC)** | | |
| **Organization** | **Contact Information** | **Overview** |
| **True Health** | 407-322-8645<br>mytruehealth.org | Primary Care, Eligibility/Insurance, Pediatric Care, Women's Health, Laboratory, Dental |

| Children and Youth Organizations | | |
|---|---|---|
| **Organization** | **Contact Information** | **Overview** |
| **Boys and Girls Club of Central Florida** | 407-841-6855<br>bgccf.org | Youth Engagement |
| **Boys Town Central Florida** | 407-588-2170<br>Boystown.org/locations/central-Florida/programs | Housing and Homeless Services (Youth), Mental Health (Youth) |
| **Central Florida Urban League** | 407-842-7654<br>cful.org | Youth Engagement |
| **Children's Home Society of Florida** | 407-846-5220<br>chsfl.org/ | Child Services, Mental Health |
| **Department of Children and Families** | 1-800-962-2873<br>reportabuse.dcf.state.fl.us | Report child abuse, child services |
| **Embrace Families** | 321-207-8200<br>embracefamilies.org | Child Services |
| **Give Kids the World** | 407-396-1114<br>gktw.org | Children with critical illnesses and their families |
| **Healthy Start Coalition** | Seminole: healthystartseminole.org | Education and care coordination to pregnant women and families of children under the age of three |
| **Kids House** | 407-324-3036<br>kidshouse.org | Abuse (Child), Mental Health (Youth), Child Services |
| **New Hope for Kids** | 407-331-3059<br>Newhopeforkids.org | Mental Health, Grief Counseling, Children with critical illnesses |
| **YMCA of Central Florida** | 407-896-9220<br>ymcacentralflorida.com | Youth Engagement |
| **Zebra Coalition** | 407-228-1446<br>zebrayouth.org | Housing and Homeless Services, Mental Health for youth ages 13-24 LGBTQIA+ |
| **Mental & Behavioral Health** | | |
| **Organization** | **Contact Information** | **Overview** |
| **Aspire Health Partners** | 407-245-0045<br>aspirehp.org | Mental Health, Substance Use, HIV/AIDS |
| **Devereux** | 1-800-338-3738 Ext. 77130<br>devereux.org | Mental Health, Substance Use, Chronic Disease (Diabetes), Child Services |
| **IMPOWER** | 407-304-3444<br>impowerfl.org | Child Services, Mental Health (Youth), Behavioral Health (Youth) |
| **Mental Health Association of Central Florida** | 407-898-0110<br>mhacf.org | Substance Use, Mental Health |
| **National Alliance on Mental Illness (NAMI)** | 407-253-1900<br>namiflorida.org | Mental and Behavioral Resources |
| **Orlando Behavioral Health** | orlandobehavioral.com | Mental Health, Substance Use |
| **Park Place** | 407-846-0068; 407-846-0023; 321-402-0690<br>ppbh.org | Mental Health, Substance Use |

| Life Skills/Job Training | | |
|---|---|---|
| **Organization** | **Contact Information** | **Overview** |
| **Adult Literacy League** | 407-422-1540<br>adultliteracyleague.org | Education |
| **Career Source of Central Florida** | 407-531-1222<br>careersourcecentralflorida.com | Employment Services |
| **Center for Independent Living** | 407-623-1070<br>cilorlando.org | Disabled Adults, Employment Services |
| **Central Florida Employment Council** | 407-834-4022<br>cfec.org | Employment Services |
| **Division of Vocational Rehabilitation** | 407-846-5260; 407-897-2725<br>rehabworks.org | Employment Services, Disabled Adults |
| **Employ Florida** | 1-800-438-4128<br>employflorida.com | Employment Services |
| **Goodwill Industries of Central Florida, Inc.** | 407-857-0659<br>goodwillcfl.org | Employment Services, Education |
| **Clinics and Other Healthcare Providers** | | |
| **Organization** | **Contact Information** | **Overview** |
| **Grace Medical Home** | 407-936-2785<br>gracemedicalhome.org | Primary Care, Dental, Mental Health, Laboratory, Chronic Disease, Housing and Homeless Services |
| **Healthcare Access Alliance** | 407-952-9233<br>healhaccessall.org | Primary Care, Resource Connection |
| **Hispanic Health Initiatives** | 386-320-0110<br>hhi2001.org | Chronic Disease (Diabetes), Food Assistance, Cancer, Primary Care |
| **Hope and Help Center of Central Florida** | 407-645-2576<br>hopeandhelp.org | HIV/AIDS, STI, Primary Care |
| **Planned Parenthood** | 407-246-1788<br>plannedparenthood.org | Women's Health, HIV/AIDS, STI |
| **Shepherd's Hope** | 407-876-6701<br>shepherdshope.org | Primary Care |
| **The Orlando Veterans Affairs Medical Center** | 407-631-1000<br>orlando.va.gov | Veteran Services, Employment Services, Primary Care, Mental Health |
| **Housing/Homelessness** | | |
| **Organization** | **Contact Information** | **Overview** |
| **Central Florida Commission on Homelessness** | 321-710-4663<br>www.cfchomelessness.org | Housing and Homeless Services |
| **Coalition for the Homeless of Central Florida** | 407-652-5300<br>Centralfloridahomeless.org | Housing and Homeless Services |
| **Covenant House** | 1-800-441-4478<br>covenanthousefl.org | Housing and Homeless Services |
| **Dave's House** | 407-457-1282<br>daveshouseevents.org | Housing and Homeless Services |

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| **Family Promise of Greater Orlando** | 407-893-4580<br>familypromiseorlando.org | Housing and Homeless Services |
| **Habitat for Humanity** | habitatorlandoosceola.org<br>habitatseminoleapopka.org | Housing and Homeless Services |
| **Homeless Services Network of Central Florida** | 407-893-0133<br>hsncfl.org | Housing and Homeless Services |
| **Hope Helps, Inc.** | 407-366-3422<br>hopehelps.org | Housing and Homeless Services |
| **IDignity** | 407-792-1374<br>idignity.org | Housing and Homeless Services |
| **Orlando Union Rescue Mission** | 407-423-3596 Ext. 2100/2105<br>ourm.org | Housing and Homeless Services, Food Assistance |
| **Rescue Outreach Mission of Central Florida** | 407-321-8224<br>rescueoutreachcfl.org | Housing and Homeless Services, Food Assistance |
| **Samaritan Resource Center** | 407-482-0600<br>samaritanresourcecenter.org | Housing and Homeless Services |
| **Wayne Densch Center** | 407-599-3900<br>abilityhousing.org/wayne-densch-center | Housing and Homeless Services, Mental Health, Substance Use |
| **Resources Phone Numbers and Crisis Lines** | | |
| **Resource** | **Contact Information** | **Overview** |
| **Adverse Childhood Experiences (ACEs)** | www.acesconnectioninfo.com | PACEs Connection is a social network that recognizes the impact of a wide variety of adverse childhood experiences (ACEs) in shaping adult behavior and health, and that promotes trauma-informed and resilience-building practices and policies in all families, organizations, systems and communities. |
| **Crisis Text Line** | Text HOME to 741741<br>https://www.crisistextline.org/ | Crisis Text Line provides free, 24/7 support via text message. We're here for everything: anxiety, depression, suicide, school. |
| **Findhelp.org** | https://www.findhelp.org/ | Search and connect to support for financial assistance, food pantries, medical care and other free or reduced-cost help. |
| **Lesbian, Gay, Bisexual and Transgender (LGBT) National Help Center** | 1-888-843-4564<br>https://www.glbthotline.org/ | Serving the lesbian, gay, bisexual, transgender, queer and questioning community by providing free & confidential peer-support and local resources. |
| **National Domestic Violence 24 Hr. Hotline** | 1-800-787-3224 | Hotline for domestic violence and abuse. |

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|---|---|---|
| **National Drug Abuse** | 1-800-662-4357 (HELP)<br>https://www.samhsa.gov/ | Support, information, advice, & referrals to address substance use and mental health |
| **National Elder Abuse Resources** | 1-855-500-3537 (ELDR)<br>https://ncea.acl.gov/ | The NCEA provides the latest information regarding research, training, best practices, news and resources on elder abuse, neglect and exploitation to professionals and the public. |
| **National Human Trafficking Hotline** | 1-888-373-7888 | Abuse, Domestic Violence, Human Trafficking Services |
| **National Sexual Assault** | 1-800-656-4673 (HOPE)<br>https://www.rainn.org/ | Support, information, advice, & referrals to address sexual assault |
| **National Suicide Prevention Lifeline** | 1-800-273-8255<br>https://suicidepreventionlifeline.org/ | The Lifeline provides 24/7, free and confidential support for people in distress and prevention and crisis resources. |
| **United Way 211** | Dial 211<br>https://www.hfuw.org/gethelp/ | Local resources to address financial assistance, health programs, crisis support and more. |
| **Veterans Crisis Line** | 1-800-273-8255<br>https://www.veteranscrisisline.net/ | 24/7 confidential crisis support for veterans and their loves ones. |

# APPENDIX F: Annual Evaluation Report

DOH Seminole leads the plan performance using a tracking tool in excel to assist the development, implementation, and performance management of the Strategic and Operational Planning process from beginning to end. At every subcommittee meeting, members provide progress updates on plan items. Meeting minutes are recorded by subcommittee liaisons and revised by subcommittee chairs. Final notes are shared with Priority areas, goals, objectives and activities are entered into the system, following extensive community input, and task leaders are assigned to maintain documentation towards progress.

Sample of performance tools in excel tracking tool

| Objective/Activity | Baseline | Contributing Org.(s) | Performance Year 1 | Performance Year 2 | Performance Year 3 | Trend[1] | Status[2] |
|---|---|---|---|---|---|---|---|
| Objective/Activity description | Baseline data | Organizations accepting responsibility | Performance data on year 1 | Performance data on year 2 | Performance data on year 3 | ▲ | On Track |

## Trends Descriptions and Status Descriptions

**[1]Trend Descriptions:**

- ▲ = Data trend is upward and in the desired direction for progress.
- ▼ = Data trend is downward and in the desired direction for progress.
- ▲ = Data trend is upward and in the undesired direction for progress.
- ▼ = Data trend is downward and in the undesired direction for progress.

**[2]Status Descriptions:**

- **On Track =** Objective progress is exceeding expectations or is performing as expected at this point in time.
- **Not on Track =** Objective progress is below expectations at this point in time.
- **Decision Required =** Objective is at risk of not completing/meeting goal. Management decision is required on mitigation/next steps.
- **Completed =** Objective has been completed or has been met and the target date has passed.
- **Not Completed =** Objective has not been completed or has not been met and the target date has passed.
- **Removed** = External factors prevented action towards completion of objective

In an effort to continually educate the community about factors impacting public health, The Florida Department of Health in Seminole County maintains a community intelligence platform called *MySidewalk*. The site is open to the public and is updated as new information become available. The intent of this platform is to drive progress through data. It allows data and information to tell the story of how the work of community engagement, health care, health promotion and education impact community health.

# APPENDIX G: Secondary Data Analysis

The Central Florida Collaborative team used data from diverse sources to develop demographic and lifestyle profiles of each county. The team also developed Equity Profiles which provide highly detailed insight to data variations based on gender, race, ethnicity and other community characteristics. Sources include, but were not limited to, the following:

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