



UF Health Shands COMMUNITY HEALTH NEEDS ASSESSMENT 2022 Report



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COMMUNITY HEALTH NEEDS ASSESSMENT At a Glance

7 County CHNA Region



Alachua
Bradford
Columbia
Levy
Marion
Putnam
Suwannee

UF Health Shands

Secondary Data



Adolescent
Health



Cancer



Chronic
Conditions

Primary Data/Community Input

Key Informant Interviews:

16



Community
Partners &
Organizations

20



Interviews
Conducted

Significant Health Need Topic Quotes



High number of African Americans with cancer that have no access to early detection and diagnosis.

– Key Informant



You're living sick with conditions that they're afraid to even go to the doctor, if they even have a doctor.

– Key Informant



We have classes closing every day, teachers walking out and no affordable or available mental health care for teens.

– Key Informant



Introduction & Purpose

UF Health Shands is proud to present its 2022-2024 Community Health Needs Assessment (CHNA), which comprehensively addresses the health needs of the communities it serves. The assessment covers the seven-county primary service areas (PSA) utilized in previous CHNAs, namely Alachua, Bradford, Columbia, Levy, Marion, Putnam, and Suwannee counties. In 2018, these counties accounted for approximately 67% of inpatient admissions and 84% of emergency department visits. This report specifically focuses on UF Health Shands and its affiliated entities within the seven-county service region. This includes Shands Teaching Hospital and Clinics, Inc (STHC), which encompasses Select Specialty Hospital-Gainesville, LLC (SSH) and Archer Rehabilitation, LLC d/b/a UF Health Rehab Hospital (Archer Rehab). SSH operates a 48-bed long-term acute care hospital within STHC's primary hospital facility. Furthermore, Archer Rehab, a 60-bed rehabilitation facility, is located approximately one mile from STHC's main hospital campus.

This CHNA report provides an overview of the process and methods used to identify and prioritize health needs as federally required by the Affordable Care Act.

CHNA Purpose

The purpose of this CHNA is to offer a deeper understanding of the health needs across the UF Health Shands seven-county region and guide the hospital's planning efforts to address needs in actionable ways with community engagement. Findings from this report will be used to identify and develop efforts to address disparities, improve health outcomes and focus on social determinants of health to improve the health and quality of life of residents in the community.

This report includes a description of:

- The community demographics and population served
- The process and methods used to obtain, analyze and synthesize primary and secondary data
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups
- The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs

UF Health Shands Hospital

UF Health Shands is a private, not-for-profit hospital system affiliated with the University of Florida. It is part of UF Health, a world-class academic health center and part of one of the nation's top 10 public research universities, with main campuses in Gainesville and Jacksonville as well as community hospitals in Leesburg and The Villages®. UF Health Shands is based in Gainesville.

UF Health Shands has more than 1,000 expert UF College of Medicine and many community physicians along with more than 11,000 nursing and support staff that provide comprehensive high-quality patient care, from primary care and family medicine to subspecialty tertiary and quaternary services for patients with highly complex medical conditions. It features a teaching hospital, UF Health Shands Hospital, five specialty hospitals — UF Health Shands Cancer Hospital,

UF Health Shands Children's Hospital, UF Health Psychiatric Hospital, UF Health Heart & Vascular Hospital and UF Health Neuromedicine Hospital; a network of outpatient rehabilitation centers; and a home health agency. UF Health Shands is affiliated with more than 100 UF Health Physicians primary care and specialty medical practices located throughout North Central Florida. UF Health Shands Hospital is also home to a state-designated Level I trauma center, a Level IV neonatal intensive care unit, a regional burn center and an emergency air and ground transport program.

Acknowledgments

The development of 2022 CHNA was a collective effort that included key members from UF Health Shands and input gathered from community residents and organizations in UF Health Shands seven county service region. UF Health Shands CHNA project members included Robert Thornton, Vice President of Finance and Paul Lipori, Director of Financial Planning and Analysis. Additional supporting members included David R. Nelson, Senior Vice President for Health Affairs, UF & President, UF Health, Colleen Koch, M.D., Dean of UF College of Medicine, and Marvin A. Dewar, M.D., J.D., Senior Associate Dean UF College of Medicine and Chief Executive Officer UF Health Physicians.

UF Health Shands Executive Team
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Traci Spray d'Auguste , <i>Chief Operating Officer</i>
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James J. Kelly, Jr. , CPA, <i>Senior Vice President, Chief Financial Officer</i>
Michele Lossius , M.D., <i>Chief Quality Officer</i>

Consultants

UF Health Shands commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2022 CHNA. Conduent HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. The following HCI team members were involved in the development of this report: Corinna Kelley, MPH – Public Health Consultant; Elizabeth Bobo, MPH, MA, CHES – Account Manager; Cushanta Horton, MPH, MBA – Public Health Analyst; George Nguyen-Research Assistant; and Courtney Wiggins – Public Health Project Coordinator. To learn more about Conduent HCI, please visit www.conduent.com/community-population-health.

Evaluation of Progress Since Prior CHNA

UF Health Shands completes its CHNA every three years. An important piece of this three-year cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Implementation Strategy (Figure 1). By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next assessment.

Figure 1. The CHNA Cycle



Priority Health Needs from Preceding CHNA

UF Health Shands identified needs for fiscal years 2019-2021 included several factors and behaviors that stand out as recurring, common areas of concern (Table 1).

UF Health Shands decided to continue with the two original broad strategic goals as the focus of the 2019 community health improvement workplan:

- Residents will be able to *access* comprehensive primary care and preventive services
- Promote *wellness* among residents

The following community outreach efforts were coordinated by UF Health Communications for the period July 2019 through May 2022 that map specifically to implementation items outlined in the 2019 CHIP. These initiatives included hosting seminars, webinars and town halls on various topics and participating in community events.

Summary of Initiatives

Table 1. 2019-2021 CHNA Health Topics

CHNA Health Topics	
Accidental death (motor vehicle accidents, pedestrian accidents)	Low rates (shortage) of mental health providers
Alcohol use	Low rates (shortage) of dentists
Asthma	Mental health
Cardiovascular disease	Obesity
Diabetes	Physical inactivity
ED visits due to dental reasons	Poverty
Food insecurity	Sexually transmitted infections (STI's)
High blood pressure	Substance abuse
Hospitalization and ED visits due to alcohol-related causes	Suicide
Infant mortality	Teen pregnancy
Insurance status (continued high rates of uninsured)	Tobacco use
Kidney Disease	Violent crime

- Hosted community pediatric injury prevention webinar and provided injury prevention education at community events
- Hosted COVID-19 vaccine, flu vaccine and importance of routine pediatric vaccinations webinars, seminars, and town halls.
- Hosted webinars and seminars about heart disease prevention and treatment.
- Taught Hands-Only CPR and early heart attack warning signs to community groups.
- Hosted webinars and seminars about cancer risk factors, screening, and treatment for various types of cancer; and participated in community events and provided information about cancer screening guidelines.
- Hosted webinars about prenatal care, including information about COVID-19 risks and COVID-19 vaccinations for pregnant or breastfeeding mothers.
- Opened newly refurbished burn clinic, expanding capacity.
- Added new ambulatory pharmacy at SpringHill.
- Successfully advocated for Tobacco Free Florida passage in Alachua County.

Details Mapped to Implementation Items

- Educate public about Trauma prevention using Trauma Injury Prevention Specialist
 - We hosted a pediatric injury prevention webinar and provided injury prevention education and information at three community events.
- Educate and encourage residents to increase community vaccination rates
 - We hosted five COVID-19 vaccine webinars, one seminar about the benefits of the flu vaccine, and one webinar about the importance of routine childhood vaccinations.
- Increase access to cardiovascular risk management and education
 - We hosted five webinars and two seminars about heart disease prevention and treatment.
 - We provided information about heart health and early heart attack warning signs, and taught Hands-Only CPR at six community events.
- Increase cancer screening and detection
 - We hosted two webinars and one seminar about cancer risks factors, screening, and treatment; topics focused on pancreatic cancer, breast cancer and kidney cancer.
 - We participated in two community events and provided information about women's cancer screening guidelines and pediatric brain tumors.
- Increase access to prenatal and postnatal care
 - We hosted five webinars about prenatal care, including information about COVID-19 risks and COVID-19 vaccinations for pregnant or breastfeeding mothers.

Community Feedback

The 2019 Community Health Needs Assessment Reports and Implementation Plan were made available to the public via the website [Social Mission & Community | UF Health, University of Florida Health](#). To collect comments or feedback, there is a Contact US page with phone number and email of Communications Team members. No comments had been received on the preceding CHNA at the time this report was written.

Demographic Profile

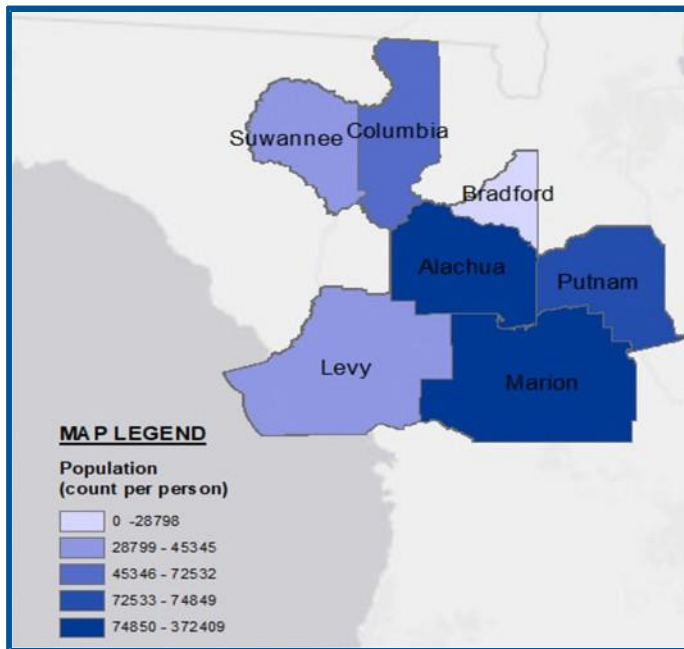
The following section explores the demographic profile of UF Health Shands. The demographics of a community significantly impact its health profile. Different racial, ethnic, age and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Demographic Profile

Population

According to the 2021 Claritas Pop-Facts population estimates, the UF Health Shands Primary Service Area has an estimated population of 908,877 in 2021 which represents 4% of Florida’s total population. Figure 2 shows population size by county within the UF Health Shands service area. The darkest blues represent zip codes with the largest population. Geographically, there are 6,089 total square miles in the service area, or 11% of the total landmass of Florida, according to the U.S. Census Bureau American Community Survey 2015-2019 5-year estimates. The geography encompasses a mix of urban and rural areas. Population density for this entire area, estimated at 139.21 persons per square mile, is greater than the national average population density of 90.19 persons per square mile, but less than the state density of 371.64 persons per square mile.

Figure 2: Population Size by Zip Code



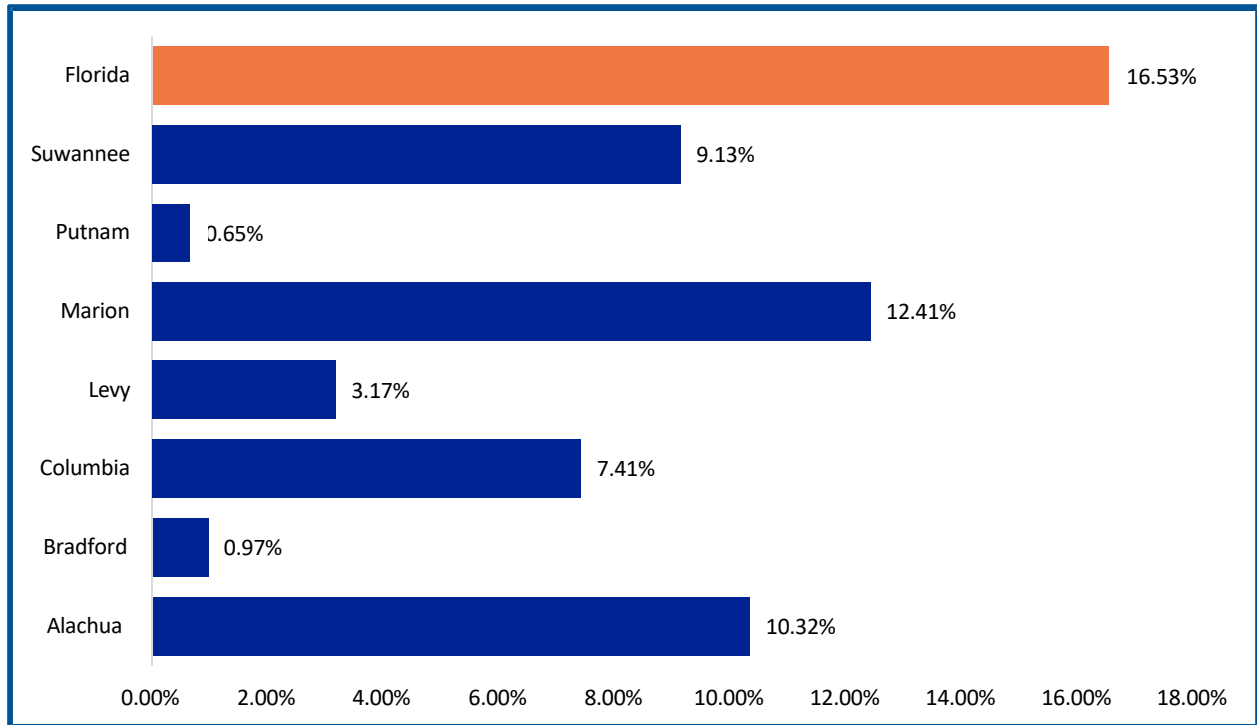
Data Source: 2021 Claritas Pop-Facts®, U.S. Census Bureau 2019

Table 2. Population Size by County

Total Population	
CHNA Region	908,877
Alachua	272,851
Bradford	28,798
Columbia	72,532
Levy	42,093
Marion	372,409
Putnam	74,849
Suwannee	45,345
Florida	21,908,282
United States	328,239,523

Figure 3 shows the population of the counties in the UF Health Shands primary service area was projected to grow between 0.65% and 12.41% from 2010-2021. Marion County was projected to have the greatest growth, at 12.41%, followed by Alachua County, at 10.32%. Bradford and Putnam counties were projected to see the slowest growth, both under 1%.

FIGURE 3. POPULATION CHANGE 2010-2021



Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

Gender

The total population mix by gender is similar to Florida and the United States overall. Bradford County stands out, with males being more prevalent than females. This is due to the presence of several state correctional facilities (prisons) in the county.

TABLE 3. POPULATION BY GENDER

	Male	Female	% Male	% Female
CHNA Service Area	445,550	463,327	49%	51%
Alachua	131,914	140,937	48%	52%
Bradford	15,933	12,865	55%	45%
Columbia	37,718	34,814	52%	48%
Levy	20,572	21,521	49%	51%
Marion	178,740	193,669	48%	52%
Putnam	37,065	37,784	50%	50%
Suwannee	23,608	21,737	52%	48%
Florida	10,706,704	11,201,578	49%	51%
United States	161,657,323	166,582,200	49%	51%

Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

Age

The total population by age group for the region varies significantly across counties. The two largest counties in the service area, Alachua, and Marion, have increased variations in age demographics. The Alachua County population, which includes the University of Florida, trends to a younger demographic (19% of population ages 18-24) than the state of Florida (8% ages 18-24). Marion County, which includes the City of Ocala and several large retirement communities, has a significantly higher proportion of 65+ residents (30.1% ages 65 or older) than the overall defined CHNA service region (23% ages 65+), Florida (20.9% ages 65+) or the United States (16.5% ages 65+).

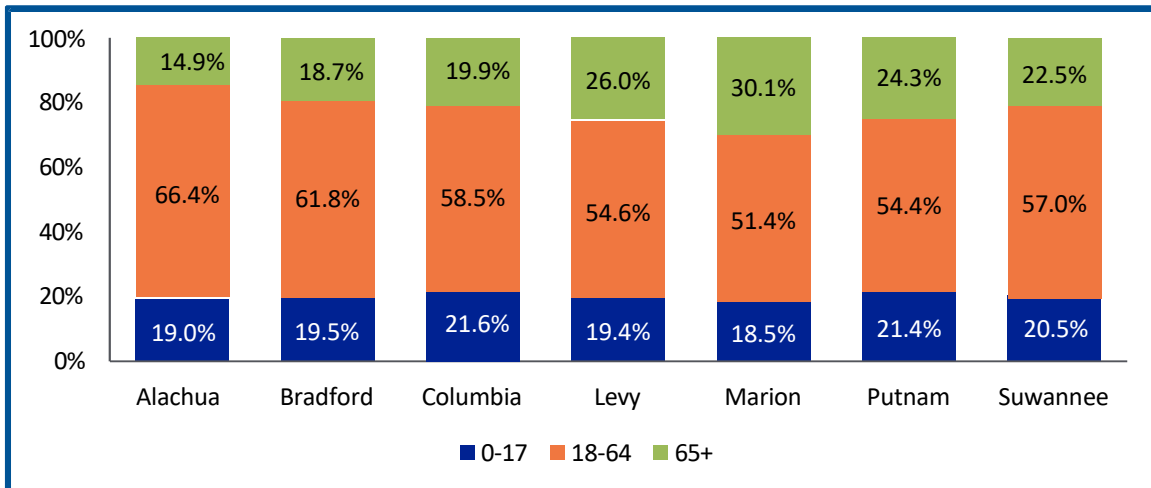
TABLE 4. POPULATION BY AGE GROUP

	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
CHNA Service Area	47,445	127,038	98,718	115,576	97,901	96,098	114,192	211,909
Alachua	14,056	36,908	51,524	43,656	31,740	26,326	28,031	40,610
Bradford	1,560	4,066	2,388	4,339	3,825	3,536	3,699	5,385
Columbia	4,302	11,366	6,658	9,246	8,590	8,303	9,650	14,417
Levy	2,170	6,006	2,903	4,520	4,153	4,794	6,590	10,957
Marion	18,512	50,259	25,971	39,815	37,083	39,717	48,896	112,156
Putnam	4,409	11,573	5,610	8,271	7,451	8,202	11,158	18,175
Suwannee	2,436	6,860	3,664	5,729	5,059	5,220	6,168	10,209
Florida	1,165,417	3,153,779	1,796,374	2,764,003	2,666,451	2,717,390	2,920,424	4,724,444

Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

Figure 4 shows UF Health Shands population by age group. As shown, between 18.5%- 21.6% of the population are infants, children, or adolescents (ages 0-17); 51.4%-66.4% are 18 to 64, and 14.9%-30.1% are age 65 and older.

FIGURE 4. POPULATION BY AGE GROUP, PERCENT DISTRIBUTION



Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

TABLE 5. POPULATION BY AGE GROUP, PERCENT DISTRIBUTION

	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
CHNA Service Area	5%	14%	11%	13%	11%	11%	13%	23%
Alachua	5%	14%	19%	16%	12%	10%	10%	15%
Bradford	5%	14%	8%	15%	13%	12%	13%	19%
Columbia	6%	16%	9%	13%	12%	11%	13%	20%
Levy	5%	14%	7%	11%	10%	11%	16%	26%
Marion	5%	13%	7%	11%	10%	11%	13%	30%
Putnam	6%	15%	7%	11%	10%	11%	15%	24%
Suwannee	5%	15%	8%	13%	11%	12%	14%	23%
Florida	5%	14%	8%	13%	12%	12%	13%	22%

Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities must be healthy. Most of the service region is White, with 75% of the residents being White. Levy has the largest White population at 84.5% (non-Hispanic), 9.2% Hispanic or Latino, 9% Black or African American (non-Hispanic), and less than 1% Asian (non-Hispanic). Alachua County has 6.3% of residents (17,286 people) reported as Asian. Within the CHNA service area, Alachua County has the largest proportion of Asians.

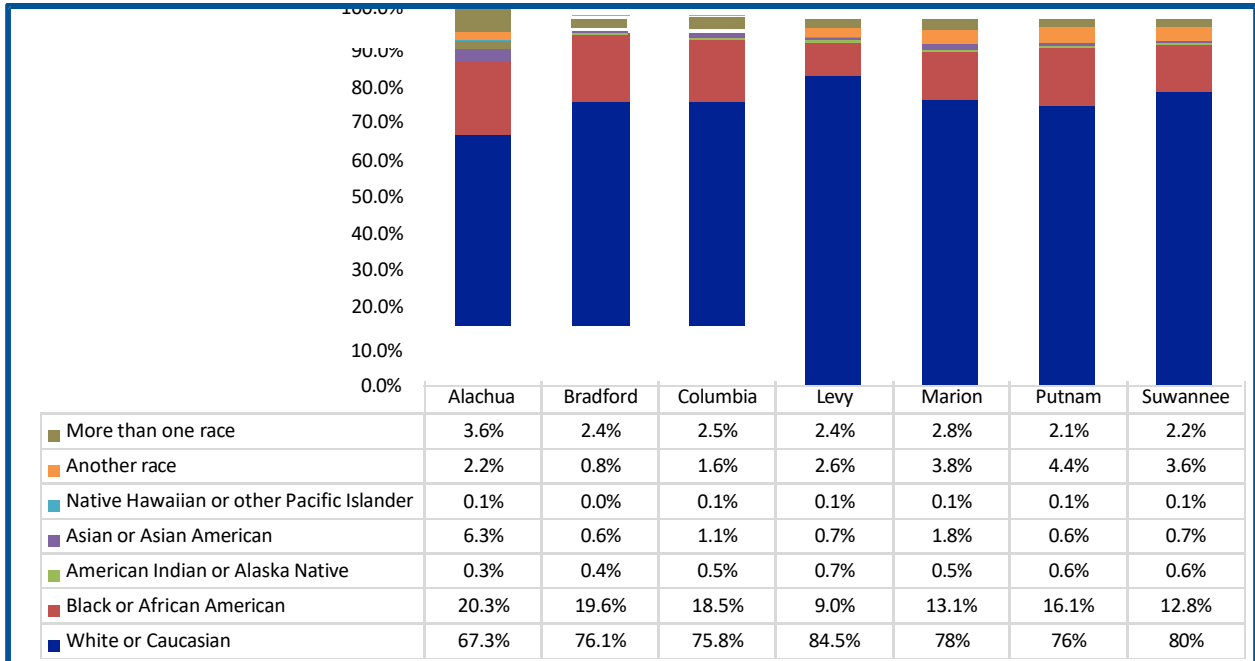
The proportion of Blacks/African Americans in each county ranges from 9% in Levy to 20.3% in Alachua. The proportion of the population identifying as “Another Race” also ranges from 0.8% in Bradford to 4.4% in Putnam County.

TABLE 6. POPULATION BY RACE

	White	Black	Asian	American Indian/ Alaska Native	Native Hawaiian / Pacific Islander	Another Race	More than one Race
Alachua	183,671	55,241	17,286	429	162	5,880	9,693
Bradford	21,906	5,656	171	67	12	240	693
Columbia	54,988	13,395	766	169	60	1,178	1,774
Levy	35,585	3,804	285	142	37	1,102	999
Marion	290,093	48,938	6,768	796	204	14,209	10,481
Putnam	57,005	12,016	471	206	94	3,258	1,544
Suwannee	36,334	5,817	296	137	30	1,625	984
Florida	15,877,105	3,572,369	645,401	42,560	16,470	1,014,911	691,364
United States	235,377,662	41,234,642	17,924,209	2,750,143	599,868	15,910,192	10,763,902
CHNA Region	679,582	144,867	26,043	1,946	599	27,492	26,168

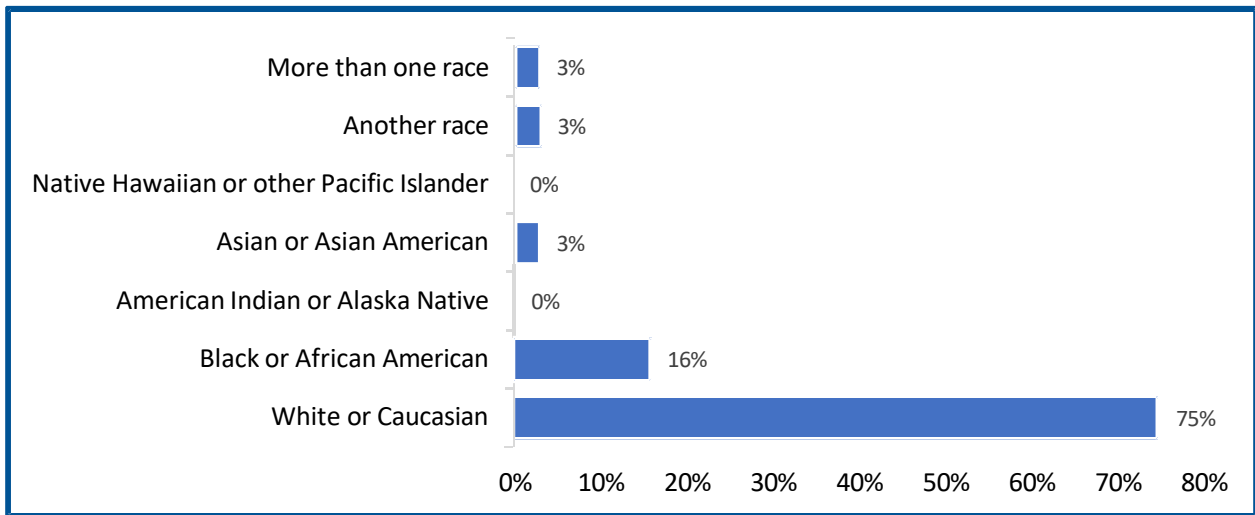
Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

FIGURE 5. POPULATION BY RACE, PERCENT DISTRIBUTION



Data Source: 2021 Claritas Pop-Facts®

FIGURE 6. CHNA REGION POPULATION BY RACE, PERCENT DISTRIBUTION



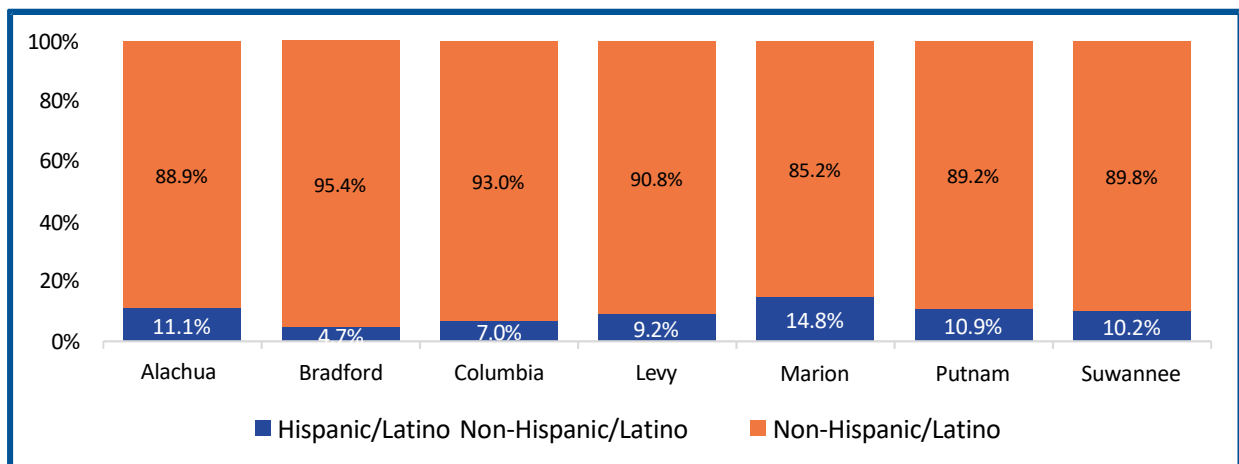
Data Source: 2021 Claritas Pop-Facts®

TABLE 7. POPULATION BY ETHNICITY

	Non-Hispanic	Hispanic
CHNA Region	800,415	108,462
Alachua	242,517	30,334
Bradford	27,459	1,339
Columbia	67,432	5,100
Levy	38,233	3,860
Marion	317,321	55,088
Putnam	66,727	8,122
Suwannee	40,726	4,619
Florida	15,850,215	6,058,067
United States	266,252,191	58,445,603

Data Source: 2021 Claritas Pop-Facts®, American Community Survey 2015-2019

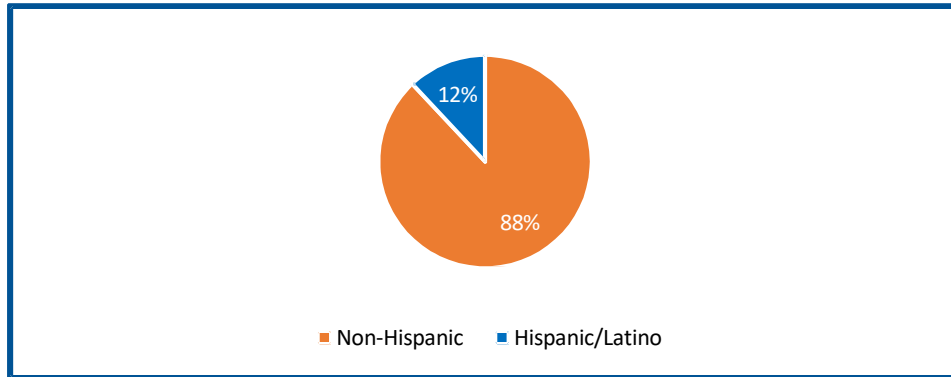
FIGURE 7. POPULATION BY ETHNICITY, PERCENT DISTRIBUTION



Data Source: 2021 Claritas Pop-Facts®

Compared to Florida or the United States, the defined service area has a lower population of Hispanic residents. The service area reflects a 12% Hispanic or Latino population versus 27.7% for Florida and 17.8% for the United States.

FIGURE 8. CHNA REGION POPULATION BY ETHNICITY, PERCENT DISTRIBUTION

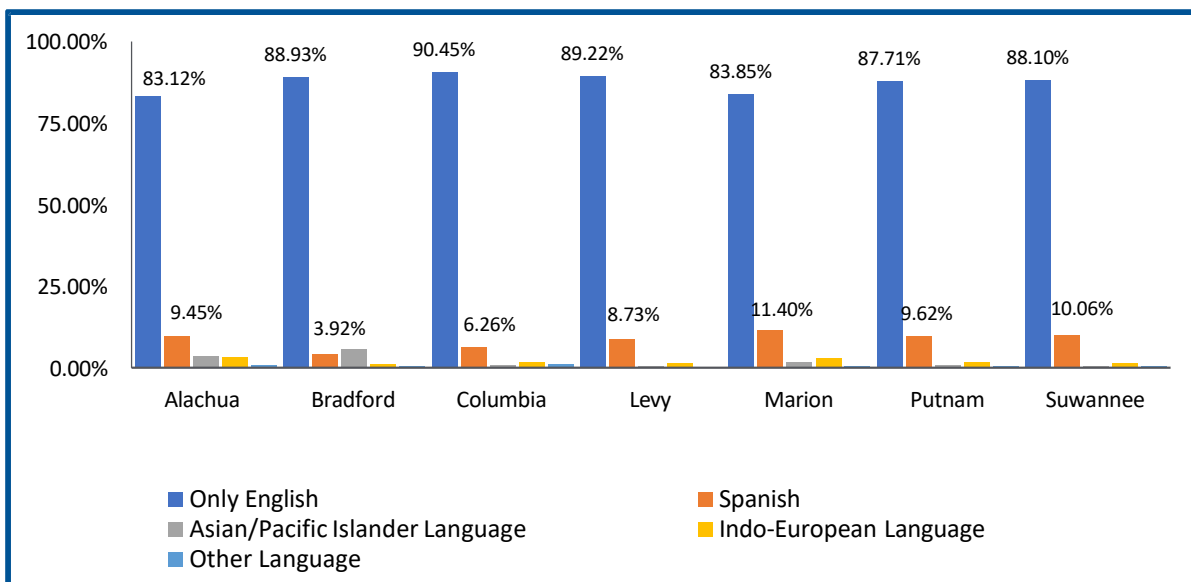


Data Source: 2021 Claritas Pop-Facts®

Language and Immigration

Understanding countries of origin and languages spoken at home can help inform the cultural and linguistic context for the health and public health system. Language is an important factor to consider for outreach efforts to ensure that community members are aware of available programs and services. Figure 9 shows the percentage of the population age 5 and older by language spoken at home. The most common language spoken at home among all counties is English (83.1%-90.5%). Spanish is the second most common. Marion County has the highest proportion of population age 5 and older speaking Spanish, at 11.4%, and Bradford County has the smallest proportion, at 3.9%. The percentage of residents who speak Spanish at home is lower compared with the state of Florida (14.4%) and the U.S. (13.5%).

FIGURE 9. LANGUAGE OTHER THAN ENGLISH AT HOME (PERSONS 5+)



Data Source: 2021 Claritas Pop-Facts®

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health of UF Health Shands service area that contain the 76 community impact ZIP codes.

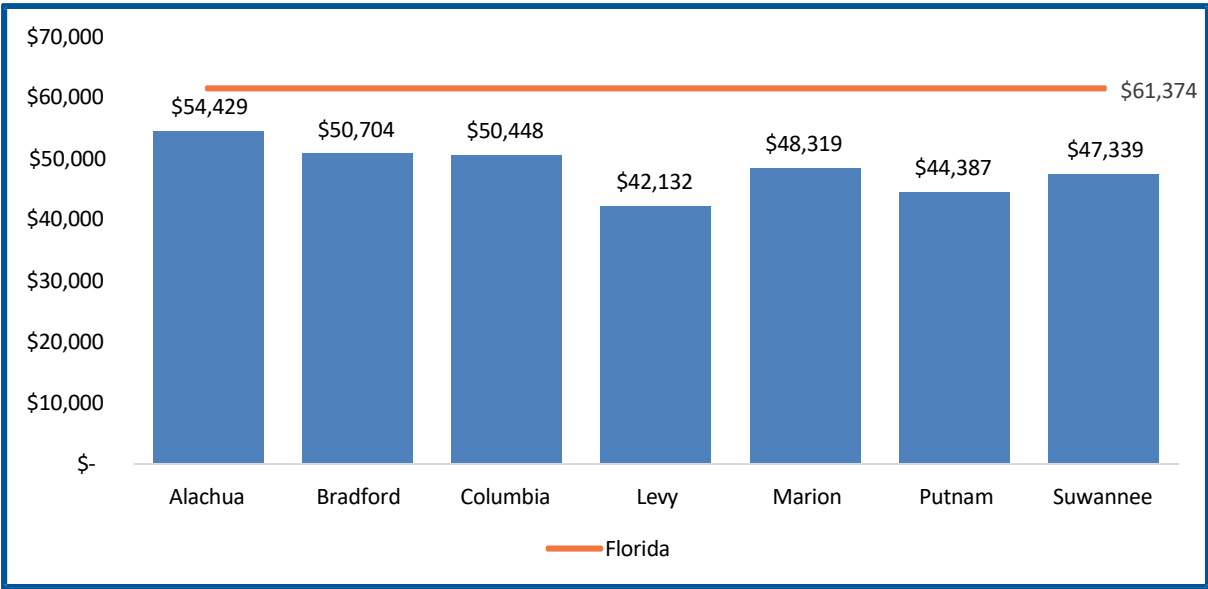
Social determinants are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. It should be noted that county-level data can sometimes mask what could be going on at the ZIP code level in many communities. While indicators may be strong at the county level, ZIP code level analysis can reveal disparities.

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one’s ability to work.

Figure 10 shows the median household income values for all seven counties overall and by race/ethnicity compared with state and national benchmarks. Levy County has the lowest median income, at \$42,132. Alachua County (\$54,429) followed by Bradford County (\$50,704) and Columbia County (\$50,448) have the highest median income within the service area. All seven counties’ median income is lower than the state’s value of \$61,374. However, there are disparities by race/ethnicity. American Indian and Native Hawaiian have the lowest income in Putnam and Suwannee, at \$14,999. This is less than Florida’s median income of \$61,374 and the lowest compared with other racial groups across other counties.

FIGURE 10. MEDIAN HOUSEHOLD INCOME



Data Source: 2021 Claritas Pop-Facts®

TABLE 8. MEDIAN HOUSHOLD INCOME BY RACE/ETHNICITY

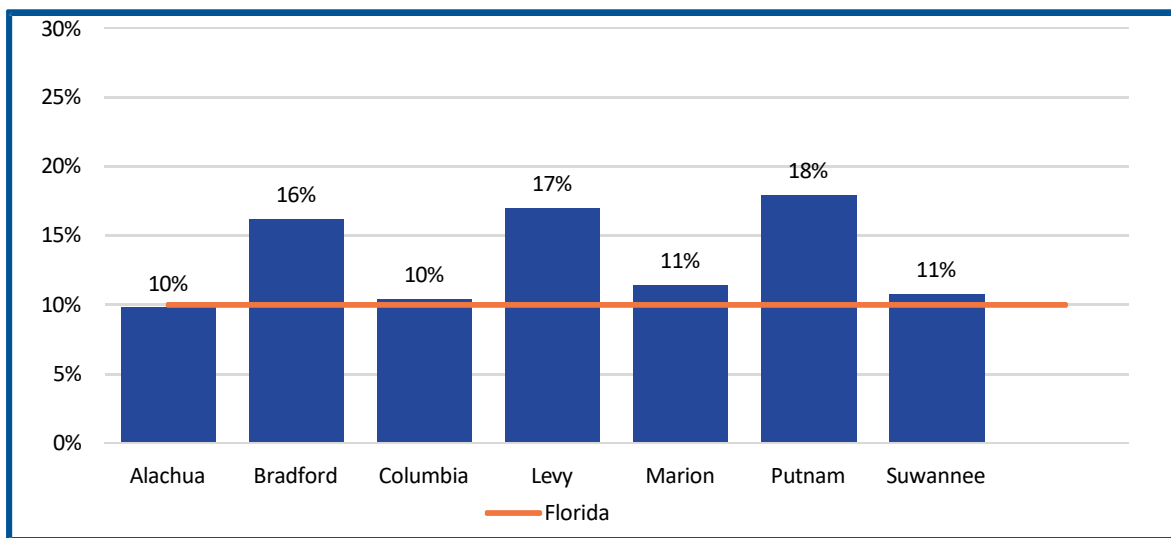
Race/Ethnicity	Alachua	Bradford	Columbia	Levy	Marion	Putnam	Suwannee	Florida
White	\$61,730	\$57,864	\$54,553	\$42,821	\$49,968	\$48,365	\$50,332	\$64,978
Black/African American	\$34,499	\$29,409	\$41,749	\$29,521	\$38,368	\$27,071	\$23,944	\$45,331
Asian	\$60,854	\$87,500	\$32,564	\$30,000	\$76,793	\$119,922	\$24,688	\$79,066
American Indian/Alaskan Native	\$41,111	\$57,422	\$21,923	\$41,750	\$50,425	\$26,143	\$14,999	\$52,947
Native Hawaiian/Pacific Islander	\$30,000	\$25,000	\$42,500	\$30,000	\$46,250	\$14,999	\$14,999	\$58,912
2+ Races	\$51,439	\$16,266	\$38,063	\$38,576	\$44,613	\$51,674	\$57,169	\$59,706
Some Other Race	\$54,717	\$51,667	\$25,000	\$90,840	\$38,645	\$34,105	\$25,377	\$50,697
Non-Hispanic/Latino	\$55,495	\$49,902	\$50,281	\$43,000	\$48,892	\$44,758	\$47,508	\$63,344
Hispanic/Latino	\$45,739	\$81,173	\$52,363	\$31,521	\$44,333	\$40,323	\$46,061	\$54,841

Data Source: 2021 Claritas Pop-Facts®

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases. Figure 11 shows how four counties (Alachua, Columbia, Marion, and Suwannee) within the UF Health Shands service area are near Florida’s percentage of families living in poverty, at 10%. Bradford (16%), Levy (17%) and Putnam (18%) are higher than Florida’s value.

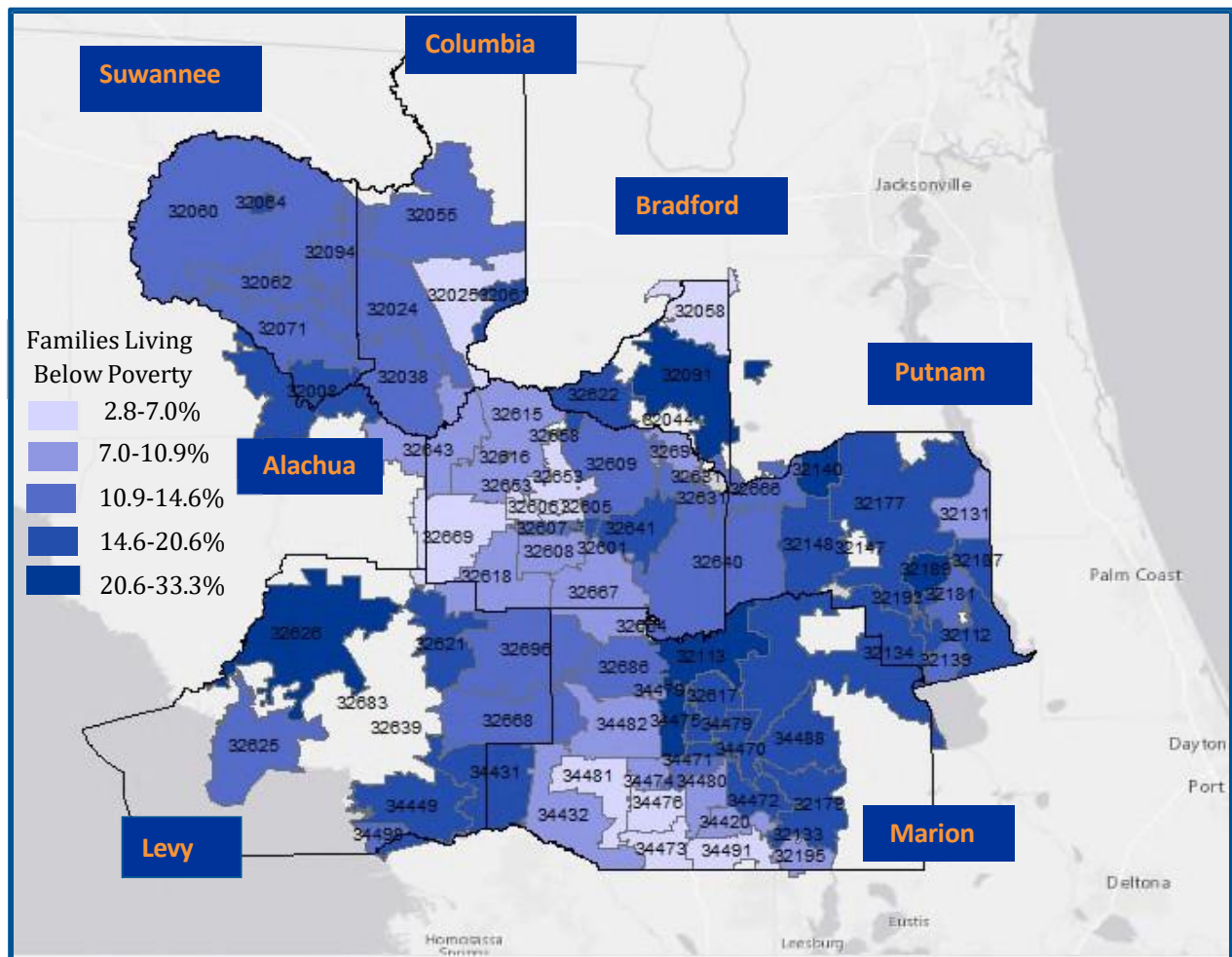
FIGURE 11. FAMILIES LIVING UNDER FEDERAL POVERTY LEVEL



Data Source: 2021 Claritas Pop-Facts®

The map in Figure 12 shows families living in poverty by ZIP code. The darker the purple, the higher the poverty rate. ZIP codes 32091, 32626, 32113, 32189 and 32140 are ZIP codes with the highest rate of families living below poverty, with a range from 20.6%-33.3%.

FIGURE 12. FAMILIES LIVING UNDER FEDERAL POVERTY LEVEL MAP BY ZIP CODE



Data Source: 2021 Claritas Pop-Facts®, ArcGIS Map

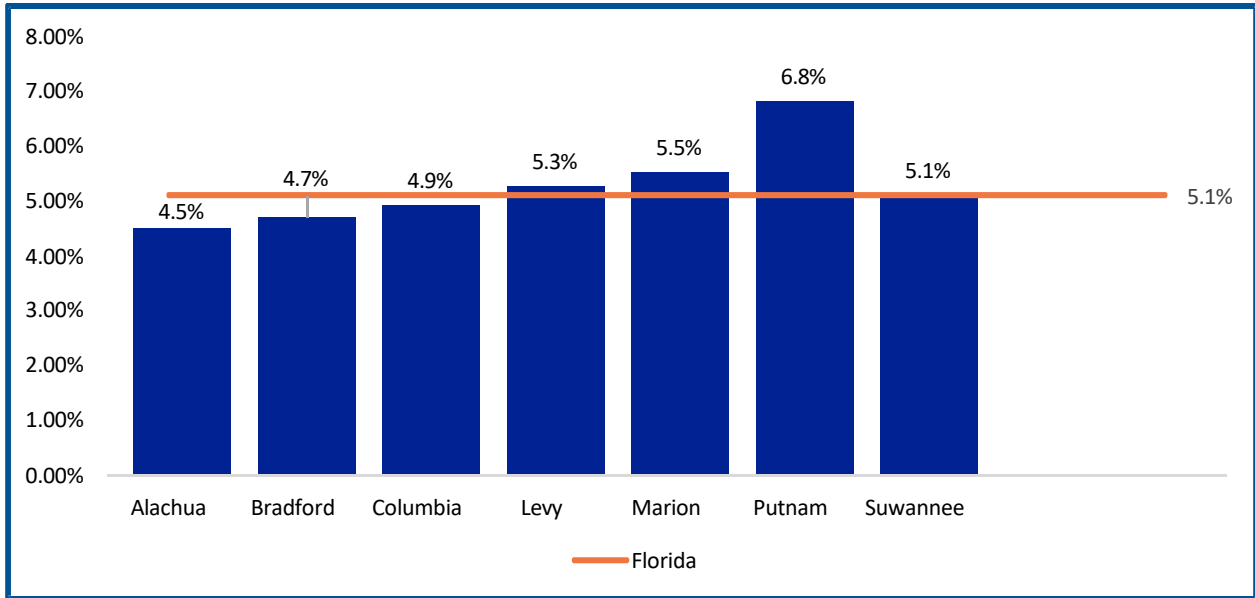
Employment

A community’s employment rate is a key indicator of the local economy. An individual’s type and level of employment impacts access to health care, work environment and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.

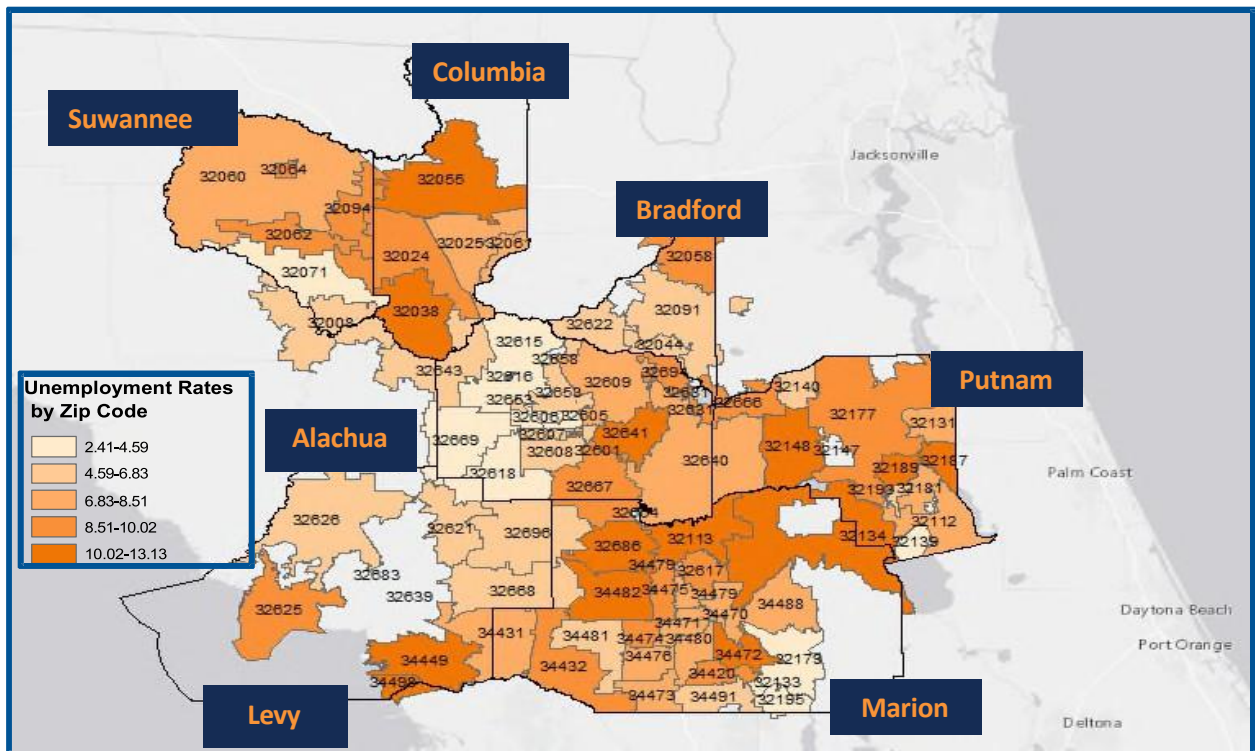
Type of employment and working conditions can also have increased impacts on health. Work-related stress, injury and exposure to harmful chemicals are examples of ways employment can lead to poorer health.

FIGURE 13. CHNA SERVICE UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE (NOVEMBER 2021)



Data Source: US Bureau of Labor Statistics, November 2021

FIGURE 14. UNEMPLOYED WORKERS IN CIVILIAN LABOR FORCE MAP BY ZIP CODE



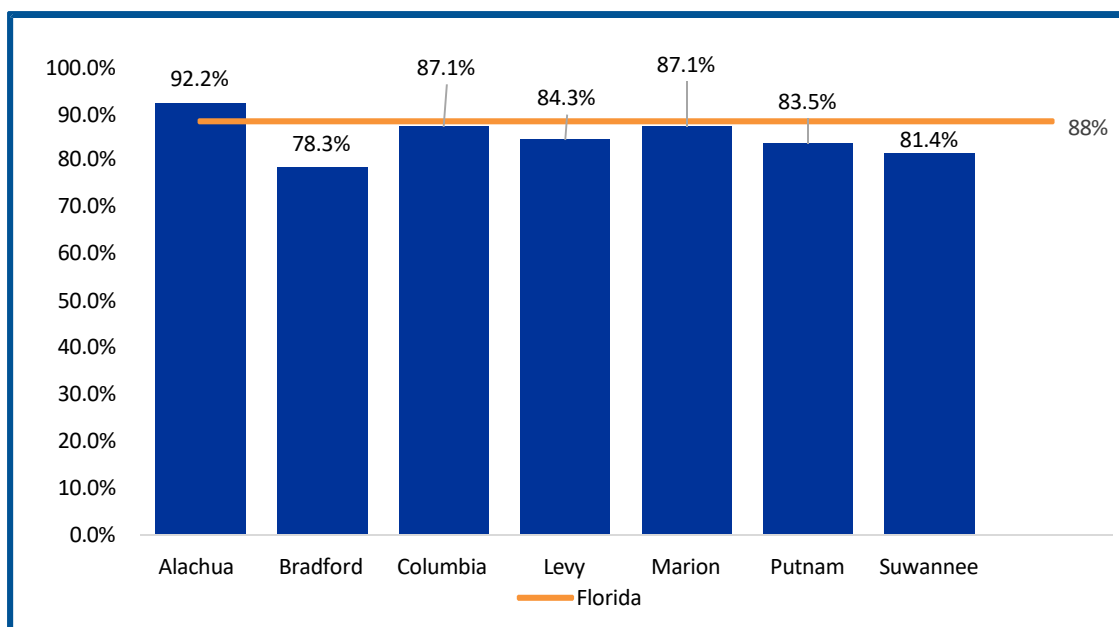
Data Source: US Bureau of Labor Statistics, November 2021, ArcGIS Map

Education

Education is an important indicator for health and well-being across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, experience better health outcomes and practice health-promoting behaviors.

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.

FIGURE 15. POPULATION 25+ WITH HIGH SCHOOL DEGREE OR HIGHER

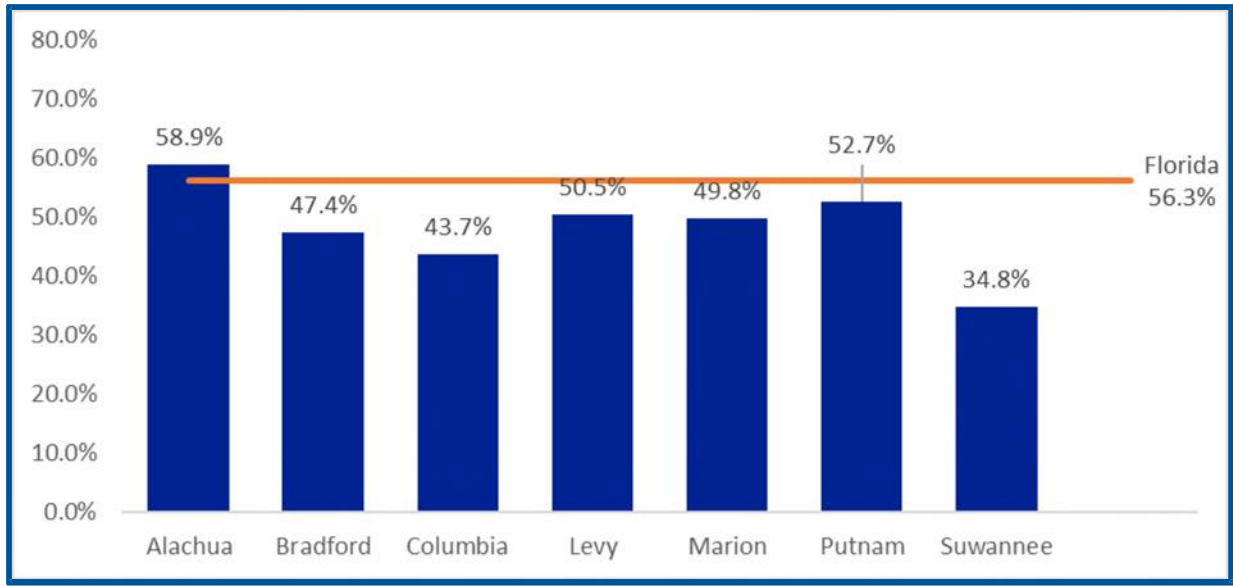


Data Source: 2021 Claritas Pop-Facts®

Housing

Safe, stable, and affordable housing provides a critical foundation for health and well-being. Exposure to health hazards and toxins in the home can cause damage to an individual or family's health. When families must spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress and mental health problems, and an increased risk of disease. In Figure 16, all counties except Alachua are below Florida's percentage of 56.3% for renters who spend 30% or more of their income on rent.

FIGURE 16. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT



Data Source: 2021 Claritas Pop-Facts®

Disparities and Health Equity

Identifying disparities by race/ethnicity, gender, age, and geography helps to inform and focus priorities and strategies. Understanding disparities also help us better understand root causes that impact health in a community and inform action toward health equity. Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities¹. National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black, Indigenous, or People of Color, individuals living below the poverty level, and LGBTQ+ communities.

Primary and secondary data revealed community health disparities based on race/ethnicity, particularly among the Black and Hispanic communities. The assessment also found ZIP codes/cities/municipalities with disparities related to health and social determinants of health. It is important to note that while much of the data is presented to show differences and disparities in data by population groups, differences within each population group can be as great as differences between different groups. For instance, Asian or Asian and Pacific Islander encompasses individuals from over 40 different countries with very different languages, cultures and history in the U.S. Information and themes captured through key informant interviews have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Race/Ethnic & Age Disparities

The Index of Disparity analysis shows which subgroup (e.g., race/ethnicity, age, or gender) has a significant difference between the subgroup's value and the overall indicator value. A significant difference is defined as two values with non-overlapping confidence intervals. Only significant differences in which a subgroup is worse than the overall value is identified. Confidence intervals are not available for all indicators. In these cases, there is not enough data to determine if two values are significantly different from each other.

Secondary data reveal that different race and ethnic groups are disparately impacted for African Americans/Black, Hispanic populations, and older adults. These important gaps in data should be recognized and considered for implementation planning to mitigate the disparities often faced by age groups, gender, race, or ethnicity.

¹ Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

TABLE 9. INDICATORS WITH RACE/ETHNIC, GENDER & AGE DISPARITIES

Health Topic	Indicator	County	Disparity Category
Maternal, Fetal & Infant Health	Teen Birth Rate	Alachua, Bradford	Race
	Infant Mortality Rate	Columbia, Marion, Putnam, Suwannee	Race
	Repeat Teen Births	Bradford, Columbia, Levy, Suwannee	Black
Older Adults	People 65+ Living Below Poverty	All Counties	Race, Age
Mental Health	Suicide	Bradford	Race
Cancer	Death due to Prostate Cancer	Alachua, Bradford, Putnam	Race
	Melanoma Incidence Rate	Alachua, Bradford, Columbia, Marion, Putnam	Race, Gender
	Death due to Oral Cancer	Bradford	Race
	Prostate Incidence Rate	Bradford, Columbia	Race
Cancer & Women's Health	Cervical Incidence Rate	Bradford, Putnam, Suwannee	Race
	Death due to Lung Cancer	Columbia	Race
	Death due to Breast Cancer	Putnam, Suwannee	Race
Oral Health	Oral Cavity & Pharynx Cancer Incidence Rate	Levy, Putnam	Race
Other Chronic	Death Rate due to Kidney Disease	Alachua, Marion	Race

Primary Data

Key informant participants mentioned that the Black/African American and rural communities are more likely to be negatively impacted by poverty, which contributes to poor health outcomes. Key informants did not specifically call out a particular race or ethnic group in the community as struggling more with social determinants of health but stated that minorities seem to be more negatively impacted by issues like poverty which contributes to poor health outcomes. Additionally, older adults were the age group that key informants brought up the most as having more barriers to accessing health care and services compared to younger populations. They also mentioned low-income families struggling to access services.

Geographic Disparities

Geographic disparities were identified using the Health Equity Index® (formerly SocioNeeds Index) and Food Insecurity Index. These indices have been developed by the Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need or food insecurity. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. For both indices, counties, zip codes and census tracts with populations over 300 are assigned index values ranging from zero to 100, where higher values are estimated to highest need. Understanding which communities have greater need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of highest socioeconomic need correlated with poor health outcomes. Based on the HEI index, 76 zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 17. Fourteen ZIP codes have a ranking of 5, which indicates the highest level of socioeconomic need (as indicated by the darkest shades of blue). The following are the top three zip codes: 34475 (Marion), 32611 (Alachua) and 32189 (Putnam). Table 10 provides the index values for each ZIP code. See Appendix B for more detailed methodology for the calculation of HEI Values.

FIGURE 17. HEALTH EQUITY INDEX

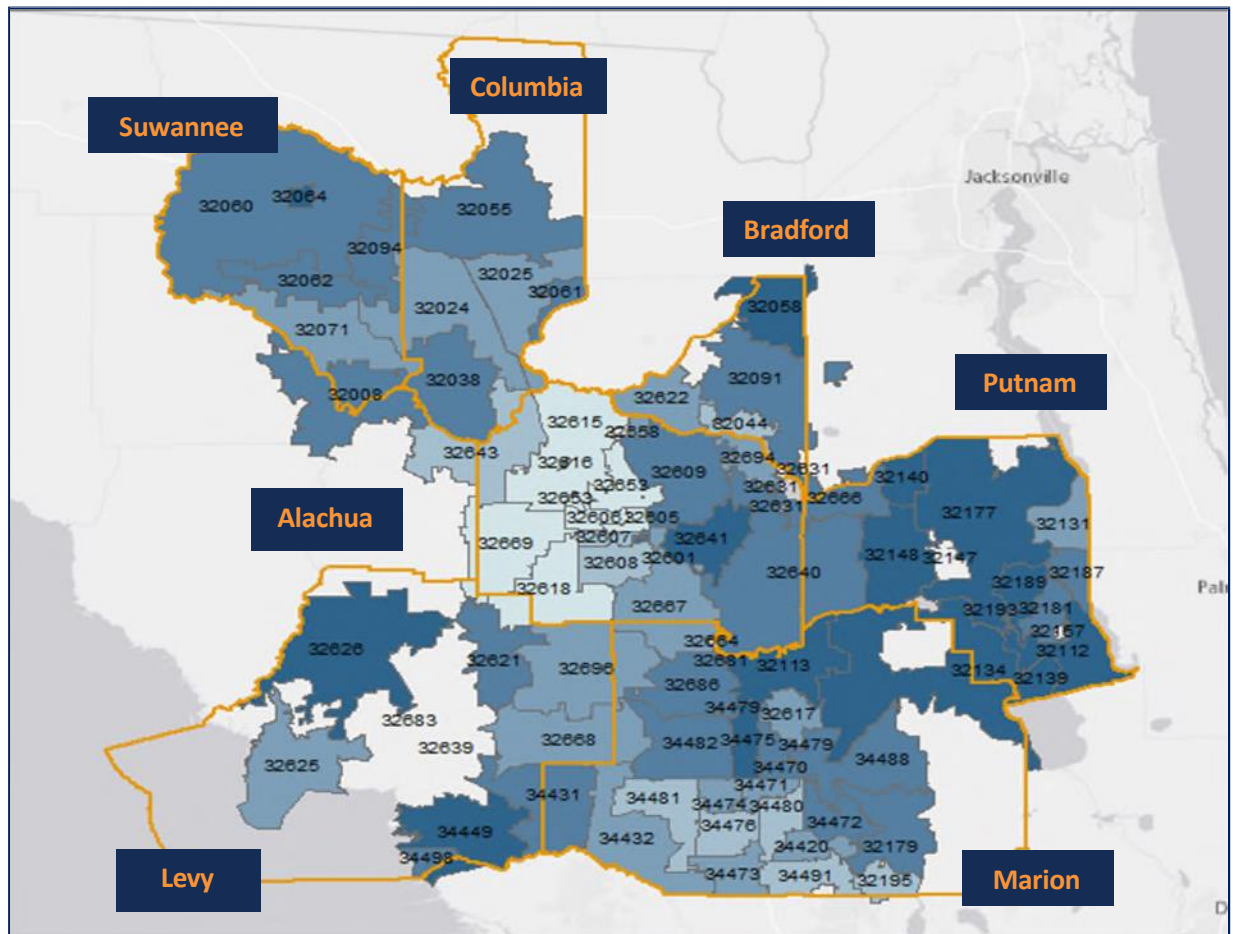


TABLE 10. HEALTH EQUITY INDEX VALUES BY ZIP CODE

Zip Code	County	Health Equity Value	Rank
34475	Marion	97.60	5
32611	Alachua	95.70	5
32189	Putnam	94.10	5
32112	Putnam	93.80	5
32148	Putnam	93.50	5
32113	Marion	92.60	5
32139	Putnam	92.10	5
32058	Bradford	92.10	5
34449	Levy	92.00	5
32064	Suwannee	91.80	5
32626	Levy	91.20	5
32641	Alachua	90.60	5
32134	Marion	90.50	5
32177	Putnam	88.80	4
32140	Putnam	87.60	4
32193	Putnam	87.50	4
32187	Putnam	86.50	4
34482	Marion	85.70	4
32621	Levy	85.40	4
34498	Levy	84.80	4
34488	Marion	84.30	4
34472	Marion	84.10	4
32060	Suwannee	83.40	4
32609	Alachua	82.30	4
32091	Bradford	82.30	4
32094	Suwannee	81.80	4
32179	Marion	81.80	4
32181	Putnam	81.60	4
32062	Suwannee	81.30	4
32008	Suwannee	81.20	4
34431	Marion	81.00	4
32640	Alachua	80.80	4
32640	Putnam	80.80	4
32686	Marion	80.80	4
32603	Alachua	80.20	4
34470	Marion	79.90	3
34479	Marion	79.30	3

Zip Code	County	Health Equity Value	Rank
32666	Putnam	78.50	3
32055	Columbia	78.40	3
32061	Columbia	78.30	3
32038	Columbia	77.40	3
32696	Levy	74.20	3
32631	Alachua	73.50	3
32025	Columbia	72.40	3
34420	Marion	72.20	3
32625	Levy	71.90	3
34432	Marion	71.20	3
32071	Suwannee	71.00	3
32601	Alachua	69.20	2
32622	Bradford	69.20	2
32668	Levy	68.00	2
32617	Marion	65.70	2
32694	Alachua	64.30	2
32024	Columbia	63.30	2
34471	Marion	61.50	2
34474	Marion	61.30	2
32131	Putnam	60.70	2
32667	Alachua	60.30	2
32667	Marion	60.30	2
34473	Marion	59.40	2
32044	Bradford	55.50	2
32607	Alachua	54.60	2
34491	Marion	54.60	2
34481	Marion	51.80	2
34476	Marion	49.60	1
32195	Marion	48.90	1
34480	Marion	46.60	1
32608	Alachua	44.50	1
32643	Alachua	43.30	1
32615	Alachua	34.10	1
32618	Alachua	29.00	1
32653	Alachua	23.60	1
32669	Alachua	14.80	1
32605	Alachua	13.00	1
32606	Alachua	10.80	1

TABLE 11. FOOD INSECURITY INDEX VALUES BY ZIP CODE

Zip Code	Index	Rank	County
34475	97.6	5	Marion
32641	95.4	5	Alachua
32064	92.4	5	Suwannee
32609	88.4	5	Alachua
32148	87.4	5	Putnam
32626	87.1	5	Levy
32621	87	5	Levy
32177	86.9	5	Putnam
32091	86.8	5	Bradford
32139	86.6	5	Putnam
32058	85.5	5	Bradford
34470	84.5	5	Marion
32112	83.7	5	Putnam
32113	83.4	5	Marion
32179	83.4	5	Marion
34488	83.1	5	Marion
32055	82.2	5	Columbia
32025	81.1	5	Columbia
32008	80.9	5	Suwannee
32189	79.8	4	Putnam
32060	78.6	4	Suwannee
32181	78.5	4	Putnam
32038	78.4	4	Columbia
32044	77.6	4	Bradford
32696	77.2	4	Levy
34472	77.2	4	Marion
32617	76.1	4	Marion
32061	75.7	4	Columbia
32187	75	4	Putnam
32640	73.4	4	Alachua, Putnam
32094	72.5	4	Suwannee
32071	71.9	4	Suwannee
34449	71.6	4	Levy
32134	71.1	4	Marion
32601	71.1	4	Alachua
34479	70.4	4	Marion

Zip Code	Index	Rank	County
32140	70.3	4	Putnam
32607	69.5	4	Alachua
34431	69.1	4	Marion
34474	66.7	3	Marion
32062	65.9	3	Suwannee
34420	65.6	3	Marion
34471	65.2	3	Marion
32024	64.4	3	Columbia
32622	63.8	3	Bradford
34498	61.6	3	Levy
32668	61.3	3	Levy
32694	61	3	Alachua
32193	60.8	3	Putnam
34482	60.6	3	Marion
32131	60.5	3	Putnam
32686	59.6	3	Marion
32603	58	3	Alachua
34432	57.1	3	Marion
34473	55.4	3	Marion
32666	53.2	2	Putnam
34480	52.8	2	Marion
32608	52.2	2	Alachua
32643	48.5	2	Alachua
32667	47.2	2	Alachua, Marion
32625	44.8	2	Levy
32618	44.1	2	Alachua
32631	43.4	2	Alachua
32615	41.7	2	Alachua
32195	38.5	2	Marion
34491	36.6	1	Marion
32653	33	1	Alachua
34476	31.9	1	Marion
34481	31.3	1	Marion
32669	27.8	1	Alachua
32605	21.8	1	Alachua
32606	20.5	1	Alachua
32611	15.9	1	Alachua

Methodology: Primary & Secondary Data

Overview

Multiple types of data were collected and analyzed to inform this Community Health Needs Assessment (CHNA). Primary data consisted of key informant interviews while secondary data included indicators spanning health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of the health needs in UF Health Shands' seven-county CHNA region.

Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed from a community indicator database developed by Conduent Healthy Communities Institute (HCI). The database, maintained by researchers and analysts at HCI, included over 150 community indicators, spanning at least 24 topics in health, determinants of health and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared with data from other communities and from national targets, as well as to previous time.

HCI's Data Scoring Tool® systematically summarizes multiple comparisons and ranks indicators based on the highest need.

For each indicator, Alachua, Bradford, Columbia, Levy, Marion, Putnam, and Suwannee County values were compared to a distribution of Florida and U.S. counties, state and national values, Healthy People 2030, and trends, as shown in Figure 19. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcomes and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Table 11 shows the health and quality of life topics scoring results for UF Health Shands' seven-county region. Topics that received a score of 1.50 or higher were considered a health need. Eight health topics emerged across the region that scored at or above the 1.50 threshold in data scoring. These health topics include Maternal, Fetal & Infant Health, Older Adults, Mental Health & Mental Disorders, Cancer, Women's Health, Adolescent Health, Tobacco Use, and the Economy. Please see Appendix A for the full list of health and quality of life topics, including the list of national and state indicators that are categorized into and included in the secondary analysis for each topic area.

FIGURE 19. SECONDARY DATA SCORING

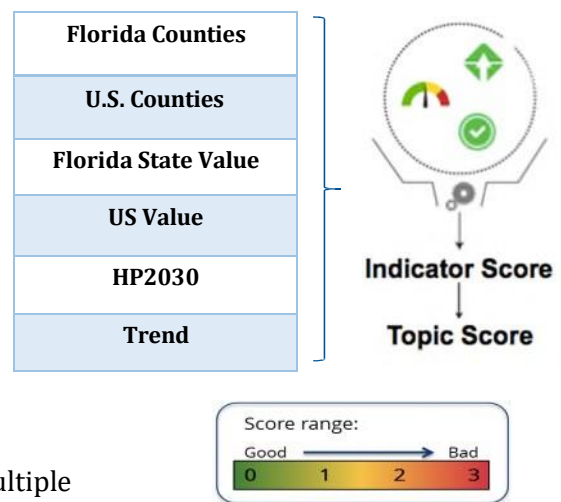


TABLE 11. SECONDARY DATA SCORING

Health Topics	Alachua	Bradford	Columbia	Levy	Marion	Putnam	Suwannee	Regional Score
Maternal, Fetal & Infant Health	1.68	2.13	2.12	2.08	1.84	2.08	2.23	2.02
Wellness & Lifestyle	1.16	2.10	2.10	2.18	2.02	2.24	2.15	1.99
Weight Status	1.49	1.94	1.99	1.93	1.72	2.03	2.14	1.89
Oral Health	1.38	2.10	1.82	2.08	1.62	2.01	1.98	1.85
Heart Disease & Stroke	1.41	1.90	1.97	1.88	1.86	1.94	1.94	1.84
Diabetes	1.44	2.23	1.97	1.36	1.72	2.19	1.97	1.84
Older Adults	1.57	2.01	1.77	1.81	2.01	2.06	1.61	1.83
Other Conditions	1.42	2.03	1.89	1.89	1.88	2.29	1.33	1.82
Mental Health & Mental Disorders	1.54	2.15	1.77	1.92	1.54	1.93	1.80	1.81
Cancer	1.70	1.73	1.99	1.67	1.61	1.73	1.86	1.75
Women's Health	1.75	1.50	2.07	1.74	1.71	1.69	1.81	1.75
Prevention & Safety	1.58	1.58	1.81	1.65	1.82	2.01	1.31	1.68
Adolescent Health	1.67	1.55	1.65	1.71	1.55	1.80	1.58	1.64
Sexually Transmitted Infections	2.09	1.36	1.91	1.57	1.39	1.87	1.29	1.64
Children's Health	1.45	1.53	1.65	1.75	1.56	1.63	1.76	1.62
Health Care Access & Quality	1.00	1.76	1.31	2.02	1.51	1.84	1.90	1.62
Tobacco Use	1.58	1.50	1.69	1.65	1.50	1.64	1.65	1.60
Respiratory Diseases	1.58	1.49	1.59	1.60	1.54	1.58	1.57	1.56
Physical Activity	1.31	1.49	1.55	1.47	1.65	1.70	1.64	1.54
Alcohol & Drug Use	1.46	1.25	1.70	1.32	1.66	1.55	1.29	1.46
Immunizations & Infectious Diseases	1.46	1.21	1.56	1.39	1.33	1.45	1.49	1.41
Quality of Life Topics	Alachua	Bradford	Columbia	Levy	Marion	Putnam	Suwannee	Regional Score
Education	1.35	1.88	1.58	2.02	1.92	2.02	1.87	1.81
Community	1.43	1.84	1.69	2.01	1.75	1.97	1.77	1.78
Economy	1.52	1.88	1.53	1.86	1.57	1.94	1.59	1.70
Environmental Health	1.51	1.42	1.46	1.43	1.58	1.57	1.48	1.49

Primary Data Collection & Analysis

To ensure the perspectives of community members were considered, input was collected from residents of the community served by UF Health Shands. Primary data used in this assessment consisted of key informant interviews. These findings expanded upon information gathered from the secondary data analysis to inform this Community Health Needs Assessment.

To help inform an assessment of community assets, community members were asked to list and describe resources available in the community. Although not reflective of every resource available in the community, the list can help UF Health Shands expand and support existing programs and resources. This resource list is available in Appendix D.

Key Informant Interviews

Twenty key informant interviews were conducted to gain a deeper understanding of health issues impacting the residents of the community served by UF Health Shands. Community members

invited to participate were recognized as having expertise in public health, special knowledge of community health needs, representing the broad interests of the community served by the hospital, and/or being able to speak to the needs of medically underserved or at-risk populations.

A total of 14 organizations participated in the process, including the Florida Department of Health in Alachua County, social service organizations, local businesses, and health care organizations. Table 12 lists the organizations that participated in these discussions.

These discussions took place between November 2021 and December 2021. Due to the ongoing COVID-19 pandemic, each discussion was conducted virtually by phone and/or webinar. A questionnaire was developed to guide each interview and focus group discussion. Discussion topics included (1) the biggest perceived health needs in the community, (2) barriers of concern and (3) the impact of health issues on vulnerable populations. Interviewees were also asked about their knowledge of health topics where there were data gaps in the secondary data. The list of questions included in the key informant interview discussions can be found in Appendix C.

TABLE 12. LIST OF ORGANIZATIONS PARTICIPATING IN INTERVIEWS

County	Organizations
All Counties	
	United Way of North Central Florida
	Meridian Behavioral Health
	Healthy Start Coalition North Central Florida
	Suwannee River AHEC, Inc
	Rural Women’s Health Project
Combined Counties	
	Center for Independent Living of North Central Florida
	ACORN Clinic
Putnam County	
	Florida Department of Health Putnam County
	Brain Baby Makers
Alachua County	
	Eldercare of Alachua County
	University of Florida
	Florida Department of Health Alachua County
	Archer Family Health Care UF Health
	First Baptist Church

Key Informant Analysis Results

The project team captured detailed transcripts of the key informant interviews. The text from these transcripts was analyzed using the qualitative analysis tool Dedoose®². Text was coded using a pre-designed codebook, organized by themes, and analyzed for observations. Figure 20 summarizes the main themes and topics that emerged from these discussions.

² Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Sociocultural Research Consultants, LLC www.dedoose.com

The findings from the qualitative analysis were combined with findings from the secondary data and survey analysis and are incorporated throughout this report in more detail.

FIGURE 20. KEY THEMES FROM QUALITATIVE DATA

Top Health Concerns/Issues	Barriers to Care	Most Negatively Impacted Populations
<ul style="list-style-type: none"> • Chronic Conditions • Healthcare Access & Quality • Mental Health & Mental Disorders • Oral Health 	<ul style="list-style-type: none"> • Awareness • Cost • COVID-19 • Fear or stigma • Limited # of providers • Limited or no health insurance • Navigating the health care system • No specialty care • Office Hours • Transportation 	<ul style="list-style-type: none"> • African American • Children • Older Adults • Geographic/Rural communities: Putnam, Suwanee, East Gainesville

Data Considerations

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. Each data source used in this assessment was evaluated based on its strengths and limitations during data synthesis and should be kept in mind when reviewing this report.

For primary and secondary data, immense efforts were made to include as wide a range of community health indicators and key informant experts as possible. Although the topics by which data are organized cover a wide range of health and quality of life areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Secondary data were limited by the availability of data, with some health topics having a robust set of indicators, while others were more limited. Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source. There is also variability in the geographic level at which data sets are available, ranging from census tract or ZIP code to statewide or national geographies. Whenever possible, the most relevant localized data is reported. Due to variations in geographic boundaries, population sizes, and data collection techniques for different locations (hospital service areas, ZIP codes and counties), some datasets are not available for the same time spans or at the same level of localization. The Index of Disparity³, used to analyze disparities for the secondary data, is also limited by data availability — some secondary data sources do not include subpopulation data and others only display values for a select number of race/ethnic groups. Lastly, persistent gaps in data systems exist for certain community health issues.

For the primary data, the breadth of findings is dependent upon who was willing and able to participate in key informant interviews. Some organizations hesitated to participate in interviews, stating that UF Health Shands does not have a history of close involvement with community-based organizations or direct community outreach.

³ Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280

Data Synthesis & Prioritization

Data Synthesis

To gain a comprehensive understanding of the prioritized health needs, the findings from primary and secondary data were analyzed for areas of overlap. A total of nine health needs were identified from both data sources. The Venn Diagram in Figure 21 displays the results of the primary and secondary data synthesis. Two topics were found across both key informant interviews and secondary data sources — Mental Health & Mental Disorders and Older Adults. Five health topics were considered within the secondary data — Adolescent Health, Cancer, Maternal Fetal & Infant Health, Tobacco, and Women’s Health. Two topics were considered within the key informant interviews — Chronic Conditions, and Oral Health. Figure 21 shows the overlapping evidence of need.

Primary data from key informant interviews as well as Secondary data findings identified nine areas of greater need. Figure 22 shows the final nine health needs, listed in alphabetical order, that were included for prioritization based on the synthesis of all forms of data collected for UF Health Shands CHNA.

FIGURE 21. PRIMARY & SECONDARY DATA SYNTHESIS

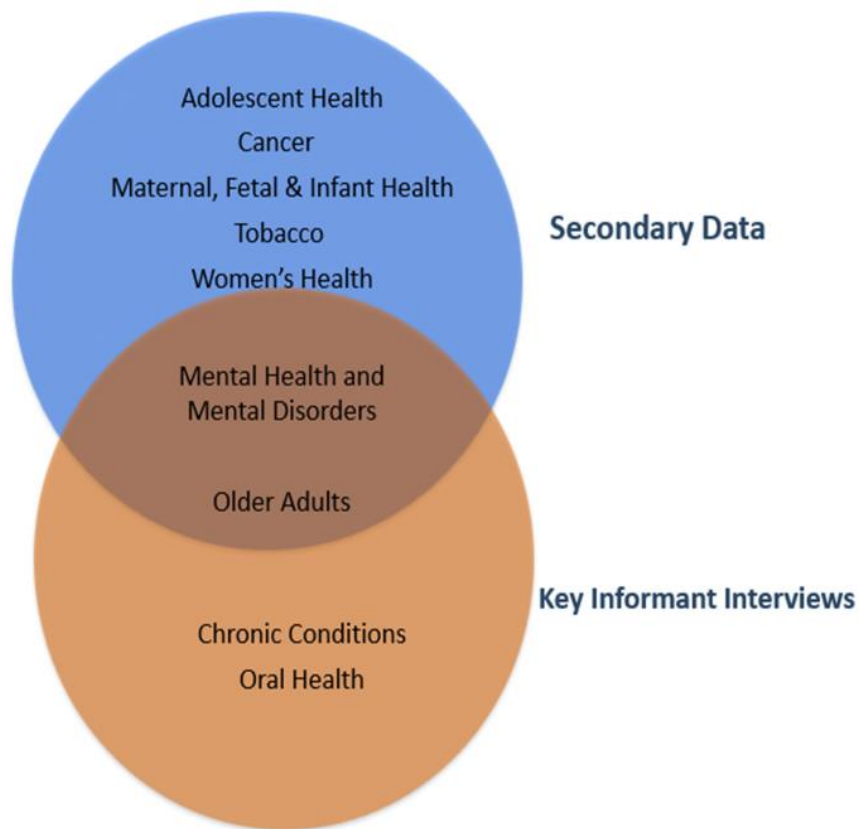
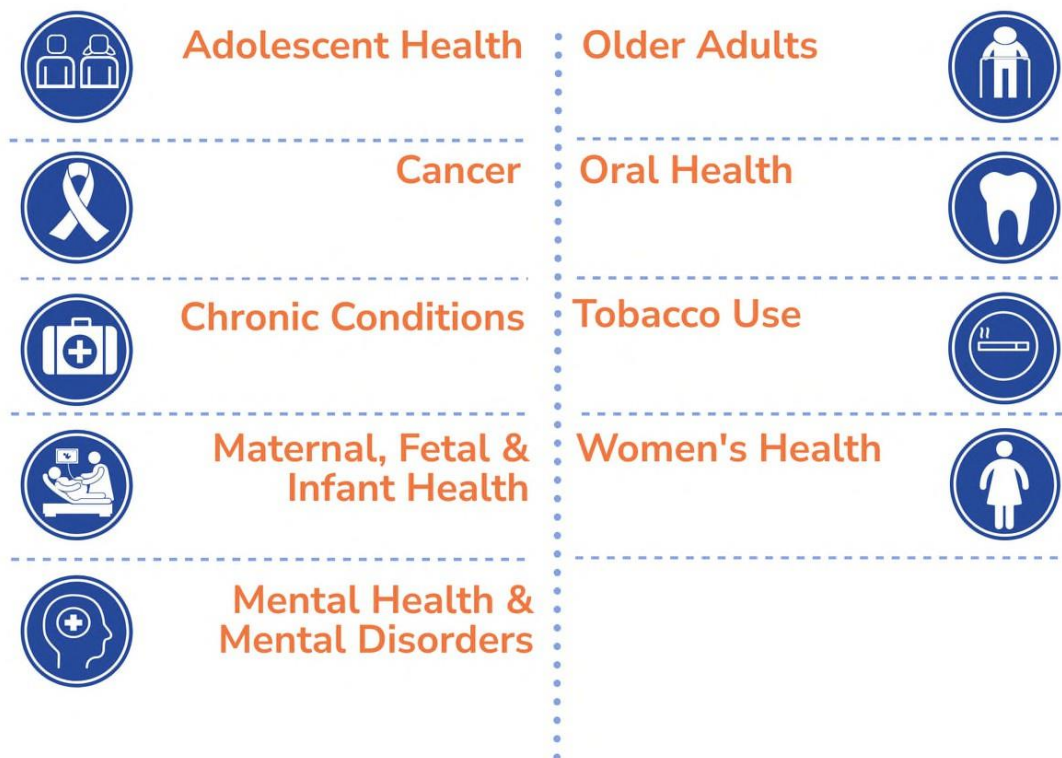


FIGURE 22. HEALTH NEEDS



Prioritization

To better target activities to address the most pressing health needs in the community, UF Health Shands Hospital convened a group of hospital leaders to participate in a presentation of data on health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise to assign a score to each health need based on a set of criteria. The process was conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

Leadership at UF Health Shands Hospital reviewed the scoring results of the community needs alongside additional supporting evidence and identified three priority areas to be considered for subsequent implementation planning.

Process

An invitation to participate in the UF Health Shands CHNA data synthesis presentation and virtual prioritization ranking activity was provided for attendees on March 8, 2022. A total of seven individuals representing UF Health Shands attended the virtual meeting and completed the online prioritization activity.

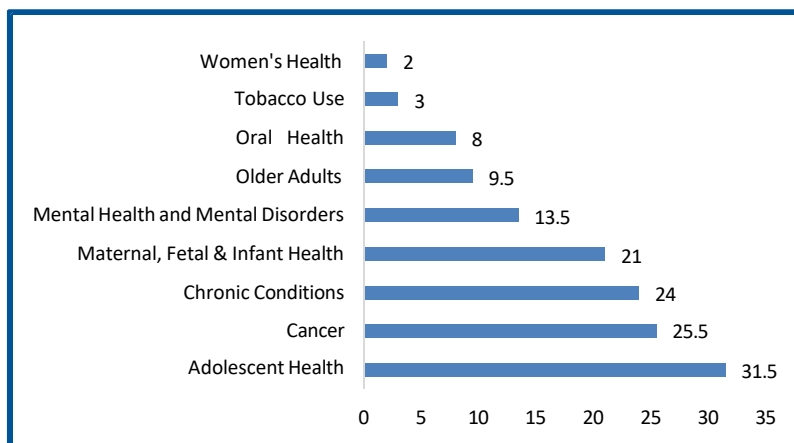
The criteria for prioritization included:

- Scope & Severity gauges the magnitude of each health issue
- Ability to Impact: the perceived likelihood of positive impact on each health issue

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. For example, participants assigned a score of 1-3 to each topic based on whether the magnitude was (1) least concerning, (2) somewhat concerning or (3) most concerning. Along a similar line, participants assigned a score of 1-3 to each topic based on (1) least ability to impact, (2) some ability to impact or (3) most ability to impact. In addition to considering the data presented by HCI in the presentation and on the prioritization cheat sheet, participants were encouraged to use their judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health topic and criterion. Numerical scores for the two criteria were equally weighted and averaged to produce an aggregate score and overall ranking for each health topic. The aggregate ranking can be seen in Figure 23.

FIGURE 23. AGGREGATE RESULTS OF ONLINE PRIORITIZATION ACTIVITY (N=7)



The ranked order of health needs that results from the prioritization process was shared with UF Health Shands CHNA project leads. The CHNA project leads reviewed the scoring results of the community needs with their leadership and determined to prioritize based on the same set of criteria used in the scoring exercise. The three priority health areas that will be considered for subsequent implementation planning are, Adolescent Health, Cancer, and Chronic Conditions.

Geographic Level of Analysis

The data scoring tables under each prioritized health topic are reflective of the average data score for UF Health Shands' seven county CHNA region. The chart below shows the average data score for each prioritized health need within the seven-county region. See Table 13 below for regional scores.

TABLE 13. (2022) PRIORITIZED HEALTH NEEDS REGIONAL SCORE

Health Topic	Regional Score
Adolescent Health	1.64
Cancer	1.75
Chronic Conditions	1.82

Prioritized Health Needs

The following section provides detailed descriptions of the prioritized health needs, including the health issues and description of population groups with greater needs and factors that contribute to those needs. The three prioritized health needs are presented in the order of how they ranked in the prioritization process.

2022 Prioritized Health Needs



**ADOLESCENT
HEALTH**



CANCER



**CHRONIC
CONDITIONS**

Prioritized Health Topic #1: Adolescent Health

Adolescent Health

Secondary
Data Score: **1.64**



Key Themes from Community Input



- Lack of knowledge on female reproductive screenings and prevention of sexually transmitted infections.
- Need for access to healthy eating and physical activity.
- Need for affordable mental health services for teens.

Warning Indicators



- Teens who are obese: High School Students
- Teen Birth Rate: 15-19
- Teens who use electronic vaping: Lifetime & within past 30 days
- Teens without Sufficient Physical Activity

Secondary Data

Based on the secondary data scoring results, Adolescent Health was identified as a top health need across all UF Health Shands' seven county region. Using HCI's Secondary Data scoring technique, Adolescent Health had a regional score of 1.64. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are seen in Table 14. See Appendix A for the full list of secondary data scoring results for Adolescent Health for each of the seven counties in UF Health Shands CHNA region.

TABLE 14. SECONDARY DATA WARNING INDICATOR SCORES

Adolescent Health Topic	County			County Value Compared to:		
Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Teens who are obese: High School Students	Alachua	17 percent	1.82	15.4 percent	N/A	N/A
	Bradford	27.1 percent	2.14			
	Columbia	24.2 percent	2.14			
	Levy	17.7 percent	1.97			
	Marion	17.2 percent	1.82			
	Putnam	23.2 percent	2.42			
	Suwannee	25.2 percent	2.42			
Teen Birth Rate: Age 15-19	Alachua	7.9 live births/ 1,000 females aged 15-19	0.56	16.2 live births/ 1,000 females aged 15-19	16.7 live births/ 1,000 females aged 15-19	N/A
	Bradford	31.2 live births/ 1,000 females aged 15-19	1.94			
	Columbia	27.6 live births/ 1,000 females aged 15-19	2.00			
	Levy	30.8 live births/ 1,000 females aged 15-19	2.50			
	Marion	28 live births/ 1,000 females aged 15-19	1.68			
	Putnam	26.9 live births/ 1,000 females aged 15-19	1.94			
	Suwannee	35.9 live births/ 1,000 females aged 15-19	2.25			

Adolescent Health Topic	County			County Value Compared to:		
Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Teens who use Electronic Vaping: Lifetime & within Past 30 Days	Alachua	25.8 percent	1.85	26.4 percent	N/A	N/A
	Bradford	25.7 percent	1.56			
	Columbia	34.1 percent	2.17			
	Levy	28.8 percent	1.61			
	Marion	26.9 percent	1.74			
	Putnam	29.4 percent	1.89			
	Suwannee	34.5 percent	2.17			
Teens without Sufficient Physical Activity	Alachua	78.6 percent	1.32	82.3 percent	N/A	N/A
	Bradford	82.8 percent	2.08			
	Columbia	76.3 percent	1.31			
	Levy	77.6 percent	1.33			
	Marion	84.6 percent	2.00			
	Putnam	85.6 percent	1.97			
	Suwannee	76.4 percent	1.31			

Barriers and Disparities: Adolescent Health

From the secondary data results, several indicators in this topic area raise concern for the UF Health Shands seven-county region. One of the indicators for Adolescent Health included high school teens who are obese. All the UF Health Shands seven-county region had higher rates of obesity in high school teens in comparison with Florida’s state value of 15.4%. Bradford County had the highest rate, at 27.1%, followed by Suwannee County, at 25.2%; Columbia County, at 24.2%; Putnam County, at 23.2%; Levy County, at 17.7%; Marion County, at 17.2% and Alachua County, at 17%. See Figure 24 for the Percentage of Teens Who Are Obese in High School.

Another indicator for Adolescent Health included teen birth rates for ages 15-19 (live births per 1,000 females). Teen birth rates for ages 15-19 (live births per 1,000 females) only Alachua County (7.9) was lower than the Florida State value of 16.2. The Figure 25 below shows Teen Birth Rate 15-19. Black/African females have higher rates of teen births than the Florida state value of 16.2 in all counties except for Suwannee County. Hispanic females have higher rates of teen births than the Florida state value of 16.2 in Bradford, Levy, Marion, Putnam, and Suwannee counties. White females have higher rates of teen births than the Florida state value of 16.2 in Bradford, Columbia, Marion, Putnam, and Suwannee counties.

FIGURE 24. PERCENTAGE OF TEENS OBESITY IN HIGH SCHOOL

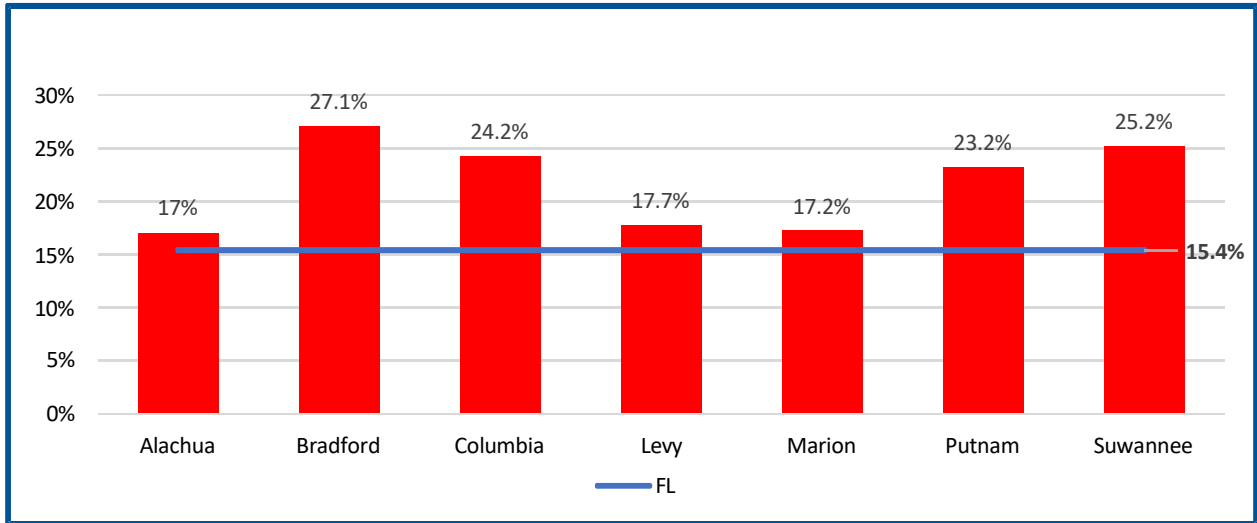
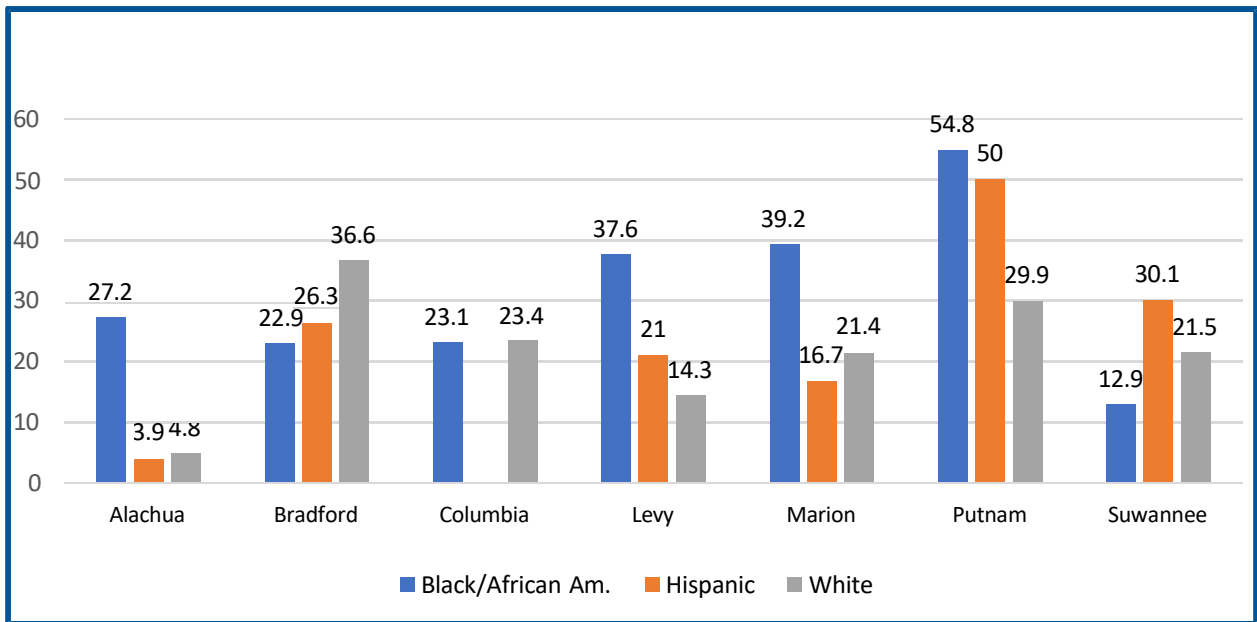


FIGURE 25. TEEN BIRTH RATE: 15-19 (LIVE BIRTHS/1000 FEMALES AGED 15-19)



“ We have classes closing every day,
 teachers walking out and no affordable
 or available mental health care for teens. ”

– Key Informant

Prioritized Health Topic #2: Cancer

Cancer

Secondary Data Score: **1.75**



Key Themes from Community Input



- Lack of knowledge and access on early detection screenings specifically for Hispanic and African American populations.
- No affordable treatment or resources.

Warning Indicators



- Cancer: Medicare Population
- **Melanoma Incidence Rate**
- **Age-Adjusted Death Rate due to Oral Cancer**
- Cervical Cancer Incidence Rate
- **Age-Adjusted Death Rate due to Prostate Cancer**

“ High number of African Americans with cancer that have no access to early detection and diagnosis. ”

– Key Informant

Secondary Data

Based on the secondary data scoring results, Cancer was identified as a top health need across all UF Health Shands’ seven-county region. Using HCI’s Secondary Data scoring technique, Cancer had a regional score of 1.75. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern. See Appendix A for the full list of secondary data scoring results for Cancer for each of the seven counties in the UF Health Shands CHNA region.

TABLE 15. SECONDARY DATA WARNING INDICATOR SCORES

Cancer Health Topic	County			County Value Compared to:			
	Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Cancer in Medicare Population		Alachua	9.3 percent	2.47	10.1 percent	8.4 percent	N/A
		Bradford	8.2 percent	1.31			
		Columbia	8.1 percent	1.58			
		Levy	7.8 percent	1.14			
		Marion	10.3 percent	2.53			
		Putnam	8.5 percent	1.64			
		Suwannee	7.5 percent	0.81			
	Alachua	24.6 cases/100,000 population	0.88		N/A	N/A	

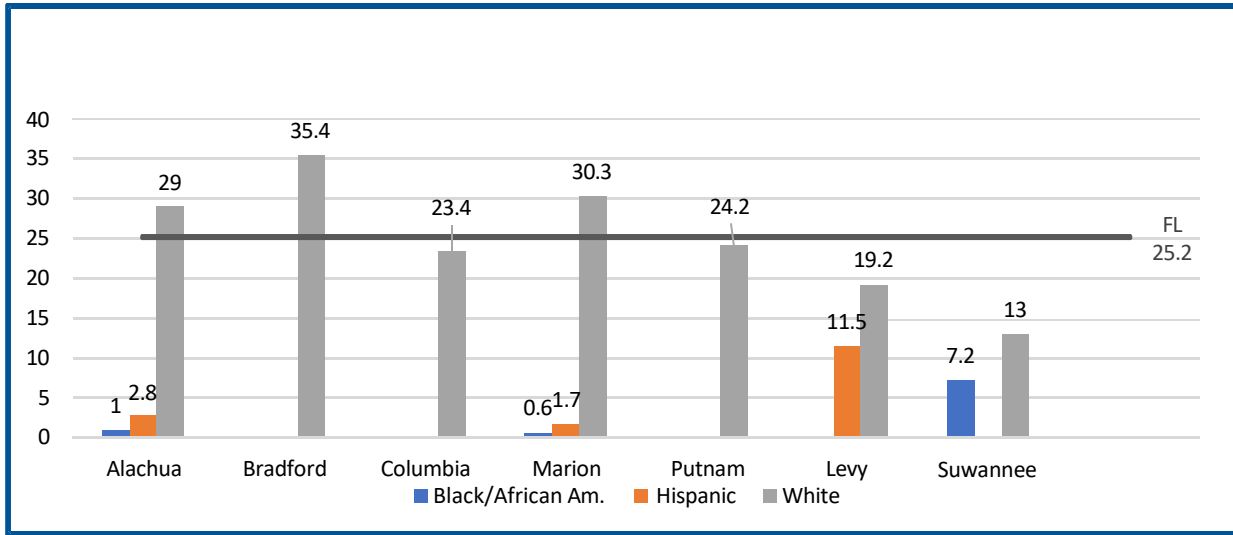
Melanoma Incidence Rate	Bradford	33.5 cases/100,000 population	2.42	25.2 cases / 100,000 population		
	Columbia	22.4 cases/100,000 population	1.17			
	Levy	17.7 cases/ 100,000 population	0.86			
	Marion	28 cases/100,000 population	1.71			
	Putnam	20.8 cases/100,000 population	1.03			
	Suwannee	16.1 cases/100,000 population	0.86			
Age-Adjusted Death Rate due to Oral Cancer	Alachua	3.3 deaths / 100,000 population	1.71	2.7 deaths/ 100,000 population	N/A	N/A
	Bradford	4.3 deaths/ 100,000 population	1.86			
	Columbia	6.3 deaths/ 100,000 population	2.42			
	Levy	4.5 deaths / 100,000	2.00			
	Marion	3.1 deaths/ 100,000 population	1.68			
	Putnam	3.8 deaths/ 100,000 population	1.69			
	Suwannee	8 deaths/ 100,000 population	2.42			
Cervical Cancer Incidence Rate	Alachua	10.2 cases/ 100,000 females	2.29	9 cases/ 100,000 females	N/A	N/A
	Bradford	3.2 cases/ 100,000 females	0.58			
	Columbia	11.4 cases/ 100,000 females	1.69			
	Levy	15.9 cases/ 100,000 females	2.14			
	Marion	11.4 cases/ 100,000 females	1.71			
	Putnam	13.5 cases/ 100,000 females	2.14			
	Suwannee	10.3 cases/ 100,000 females	1.97			

Cancer Health Topic	County			County Value Compared to:		
Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Age-Adjusted Death Rate due to Prostate Cancer	Alachua	9.9 deaths/ 100,000 males	2.03	7.4 deaths/ 100,000 males	N/A	16.9 deaths/ 100,000 males
	Bradford	11.7 deaths/ 100,000 males	2.06			
	Columbia	10.1 deaths/ 100,000 males	2.06			
	Levy	6.7 deaths/ 1,000 males	--			
	Marion	7.2 deaths/ 100,000 males	1.18			
	Putnam	10.2 deaths/ 100,000 males	2.06			
	Suwannee	7.7 deaths/ 100,000 males	1.56			

Barriers and Disparities: Cancer

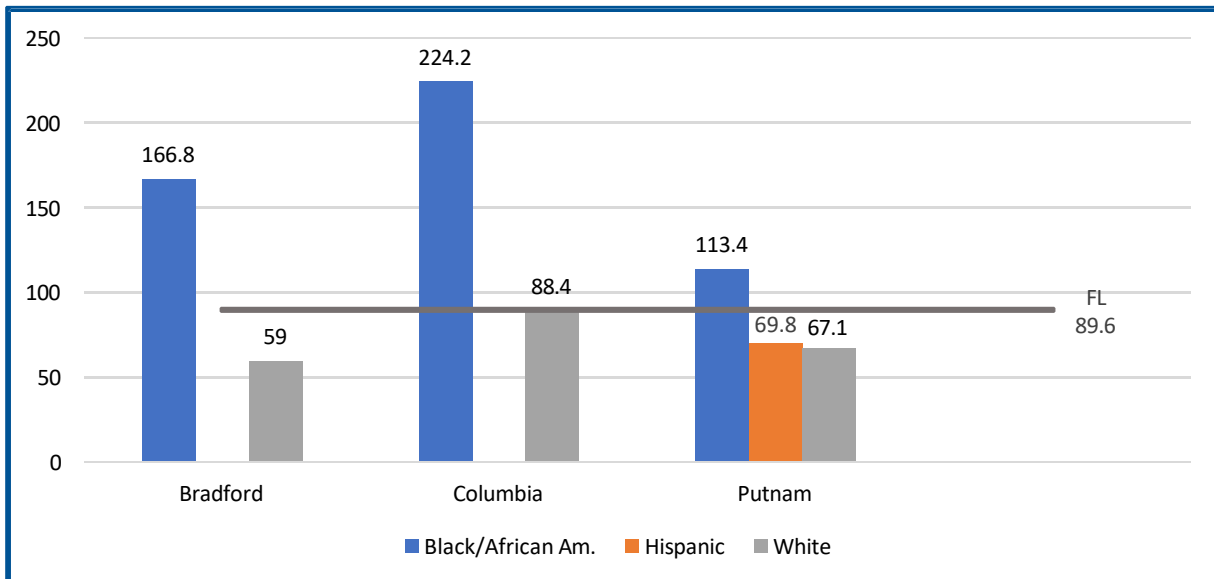
From the secondary data results, several indicators in this topic area raise concern for the UF Health Shands seven-county region. One of the indicators for Cancer included Melanoma Incidence Rates among the White population. Figure 26 shows a Number of Cases/100,000 Population of Melanoma in White populations compared with other racial groups. Alachua, Bradford and Marion counties had rates higher than Florida's rate of 25.2 cases per 100,000 population.

FIGURE 26. MELANOMA INCIDENCE RATES (CASES/100,000 POPULATION)



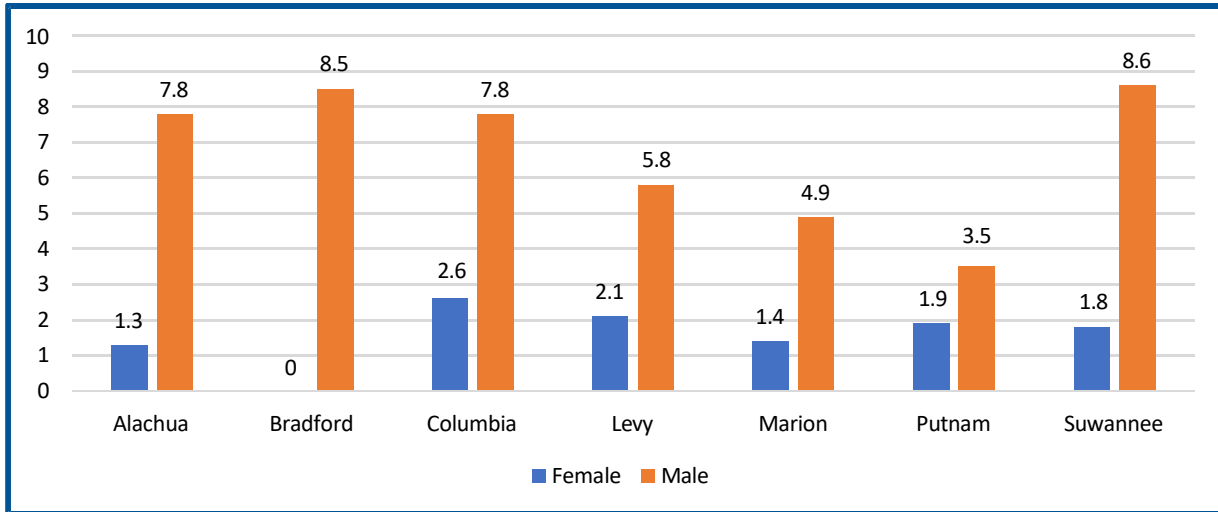
Another indicator for Cancer included prostate cancer incidence rates by race/ethnicity. Figure 27 shows the number of cases/100,000 population with prostate cancer by race/ethnicity in three counties. Bradford, Columbia, and Putnam had a large disparity among racial groups. Black men were 2-4 times as likely to be diagnosed with prostate cancer compared with whites. Although rates are suppressed for the Hispanic population in certain counties, this could be an opportunity to explore or educate the importance of screening among Hispanic males. Rates not showing up for Hispanic males in Bradford or Columbia could also mean that they are getting screened less compared with other racial groups.

FIGURE 27. PROSTATE CANCER INCIDENCE RATES (CASES/100,000 POPULATION)



Another indicator for Cancer included the death rate due to oral cancer. Figure 28 shows the age-adjusted death rate for oral cancer by gender by deaths/100,000 population. The chart shows that males across all seven counties are dying from oral cancer at increased rates compared with females.

FIGURE 28. AGE-ADJUSTED DEATH RATE DUE TO ORAL CANCER (DEATHS/100,000 POPULATION)



Prioritized Health Topic #3: Chronic Conditions

Chronic Conditions

Secondary Data Score: **1.82**



Key Themes from Community Input



- Other chronic conditions mentioned such as dementia, arthritis, asthma, COPD.
- Knowledge of health navigation to seek treatment was top concern.

Warning Indicators



- Chronic Kidney Disease: Medicare Population
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Atrial Fibrillation: Medicare Population
- **People 65+ Living Below Poverty Level**



I think there are a couple of contributing factors to chronic conditions such as knowledge about the disease process.



– Key Informant

Secondary Data

Based on the secondary data scoring results, Chronic Conditions was included as a top health need across all UF Health Shands' seven-county region within the older adult population. Using HCI's Secondary Data scoring technique, Chronic Conditions have a regional score of 1.82. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern seen in Table 16. See Appendix A for the full list of secondary data scoring results for Chronic Conditions for each of the seven counties in the UF Health Shands CHNA region.

TABLE 16. SECONDARY DATA WARNING INDICATOR SCORES

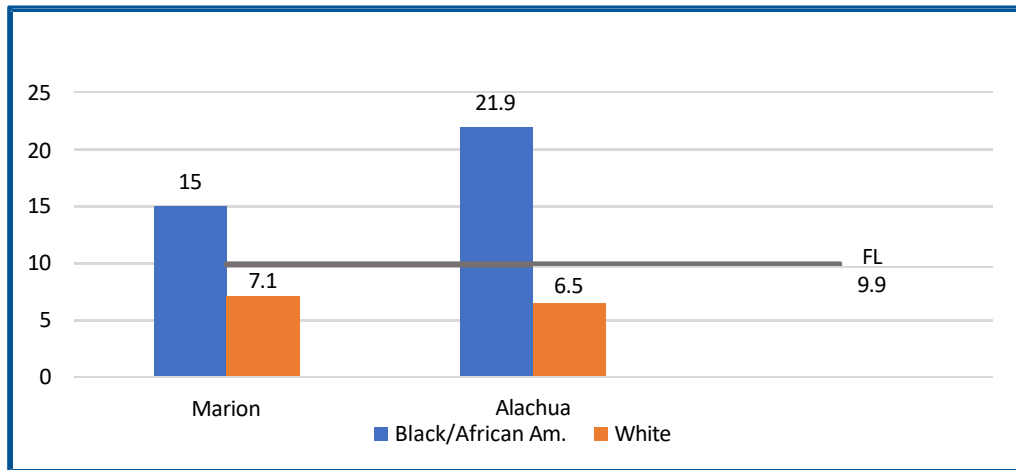
Chronic Disease Health Topic	County			County Value Compared to:		
Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Chronic Kidney Disease: Medicare Population	Alachua	26.3 percent	1.94	28.2 percent	24.5 percent	N/A
	Bradford	31.9 percent	2.92			
	Columbia	28.6 percent	2.58			
	Levy	27.7 percent	2.25			
	Marion	30.7 percent	2.82			
	Putnam	29.9 percent	2.58			
	Suwannee	26.4 percent	2.08			
Chronic Disease Health Topic	County			County Value Compared to:		
Indicator	Name	Value	Data Score	FL Value	U.S. Value	HP2030 Target
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	Alachua	37.2 percent	2.47	37.5 percent	33.5 percent	N/A
	Bradford	38.5 percent	2.31			
	Columbia	36.2 percent	1.92			
	Levy	34.3 percent	1.92			
	Marion	37.6 percent	2.65			
	Putnam	41.0 percent	2.75			
	Suwannee	32.8 percent	0.97			
Atrial Fibrillation: Medicare Population	Alachua	8.3 percent	1.12	10.1 percent	8.4 percent	N/A
	Bradford	9.4 percent	2.14			
	Columbia	8.7 percent	1.75			
	Levy	8.3 percent	1.14			
	Marion	10.5 percent	2.82			
	Putnam	9.6 percent	2.14			
	Suwannee	9.4 percent	2.25			

Barriers and Disparities: Chronic Conditions

From the secondary data results, there was one indicator of concern that included the death rate due to kidney disease. Figure 29 shows the age-adjusted death rate due to kidney disease by deaths/100,000 population by race/ethnicity. Individuals who have diabetes, high blood pressure

and a family history of kidney disease are at risk for developing chronic kidney disease. Most chronic disease rates in the UF Health Shands seven-county region were 2-3 times higher in Black populations compared with other groups. Marion and Alachua County saw the greatest disparity among Black/African Americans compared to Whites for individuals who died because of kidney disease.

FIGURE 29. AGE-ADJUSTED DEATH RATE DUE TO KIDNEY DISEASE (DEATHS/100,000 POPULATION)



Primary Data

Concerns related to other chronic conditions including dementia, arthritis, asthma, and COPD were mentioned in key informant interviews. Many comments were made about patient lack of knowledge on how to navigate the health care system to seek treatment and understand the profile of the disease or condition.

Non-Prioritized Health Needs

The following health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. However, UF Health Shands hospital will not focus on these topics in their Implementation Strategy.

Key themes from community input are included where relevant for each non-prioritized health need along with the secondary data score and warning indicators.

Non-Prioritized Health Need #1: Maternal, Fetal & Infant Health

Maternal, Fetal & Infant Health

Secondary Data Score: **2.02**



There is no birthing facility here (Putnam County) and the nearest facilities are 45 minutes to an hour away.

– Key Informant



Warning Indicators



- Preterm Births
- Mothers who Received Early Prenatal Care
- **Infant Mortality Rate**
- **Repeat Teen Births**

Non-Prioritized Health Need #2: Mental Health & Mental Disorders

Mental Health & Mental Disorders

Secondary Data Score: **1.81**



Key Themes from Community Input



- Top health issue from 2019 CHNA, Secondary Data & Key Informant Interviews.
- Availability, affordability and quality of Mental Health providers is a major concern in all counties.
- COVID-19 has impacted mental state of many residents.

Warning Indicators



- Alzheimer's Disease or Dementia: Medicare Population
- **Age-Adjusted Death Rate due to Suicide**
- Depression: Medicare Population
- Frequent Mental Distress

Licensed Mental Health

“ Providers are at full capacity, and they are completely unaffordable ”

if you have no insurance.

– Key Informant

Non-Prioritized Health Need #3: Older Adults

Older Adults

Secondary
Data Score:

1.83



Key Themes from Community Input



- Top health issue from Key Informant Interviews.
- COVID-19 has made it harder to get access to community resources and healthcare needs, they are fearful of getting infected and social isolation has resulted.
- Knowledge and navigation of healthcare system is needed.

Warning Indicators



- Chronic Kidney Disease: Medicare Population
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Atrial Fibrillation: Medicare Population
- People 65+ Living Below Poverty Level

“ Reliance on caregivers (older adults) relying on caregivers for transportation needs which effects access to care. ”

– Key Informant

Non-Prioritized Health Need #4: Oral Health

Oral Health

Secondary Data Score: **1.85**



Key Themes from Community Input



- No access to oral health in rural counties for adults.
- No affordable dental health care.
- Knowledge of importance of dental health.

Non-Prioritized Health Need #5: Tobacco Use

Tobacco Use

Secondary Data Score: **1.60**



.....
Smoking is just something you learn from
your family and just do it because you
have access to it at an early age.



– Key Informant
.....

Warning Indicators



- Adults who smoke
- Adolescents who Use Electronic Vaping: Lifetime & Past 30 days

Non-Prioritized Health Need #6: Women's Health

Women's Health

Secondary
Data Score: **1.75**



Key Themes from Community Input



- Ranked by survey respondents as the third most pressing quality of life issue (26.7%).
- 23.5% of respondents disagreed that people can access healthcare regardless of race, gender, sexual orientation, immigration status.

Warning Indicators



- Cervical Cancer Incidence Rate
- Age-Adjusted Death Rate due to Breast Cancer
- Pap Test in Past Year
- Breast Cancer Incidence Rate



Breast and cervical care is not promoted and there is late detection.



– Key Informant

Barriers to Care

A critical component in assessing the needs of a community includes identifying barriers to health care and social services, which can inform and focus strategies for addressing the prioritized health needs. Key informant participants were asked to identify any barriers to health care observed or experienced in the community. The following section explores those barriers that were identified through the primary data collection.

Transportation

Overall, there are many rural counties within the UF Health Shands seven-county CHNA region. Key informant participants who work and live within Putnam, Suwannee, Levy, Bradford, and Marion County mentioned a lack of transportation resources. Many residents of these counties rely on transportation from neighbors and relatives to get to and from appointments. There is also limited availability of providers within rural counties, which makes accessing care even more difficult if there are no transportation resources in the county to get residents to appointments outside the area.

Cost, Lack of Insurance, Underinsurance

In general, accessing affordable health care was a common barrier that was discussed whether due to overall cost or being underinsured or uninsured. Key informant participants mentioned limited insurance coverage due to no Medicaid expansion in the state of Florida. High costs of specialty care, oral health and mental health prevented many from seeking care when needed.

Navigating the Health System

Navigating the health system has been particularly difficult for older adults in every county, but more specifically for those in rural areas. Many key informant participants mentioned how new health system protocol and technology created in response to COVID-19 has created difficulty in accessing care and increased fear of returning to in-person visits. The older adult population has been hit the hardest, without adequate education on new telehealth technology and other issues with receiving medications and other educational resources. Those who live in rural areas are experiencing difficulties in accessing internet services or cannot afford a computer. In addition, fear and trust are barriers to accessing the health system. New protocols for patients going to in-person visits have made it difficult for patients seeking health and social services. Political influences on preventive measures for COVID-19 have created confusion among residents and increased fear and trust in the health care system.

Conclusion

This 2022-2024 Community Health Needs Assessment (CHNA), conducted for UF Health Shands, helps the hospital meet the federal requirement for charitable hospital organizations to conduct a community health needs assessment every three years [IRS Section 501(r) (3)].

This assessment used a comprehensive set of secondary and primary data to determine the nine health needs in the community served by UF Health Shands Hospital. The prioritization process identified three priorities to be considered for subsequent implementation planning: Adolescent Health, Cancer, and Chronic Conditions.

The findings in this report will be used to guide the development of the UF Health Shands Hospital Implementation Strategy, which will outline strategies to address identified priorities and improve the health of the community.

Appendices Summary

The following support documents are shared in a separate appendix available on the [UF Health Shands Needs Assessment Platform](#).

A. Secondary Data (Methodology, Index of Disparity and Data Scoring Tables)

A description of the Conduent HCI data scoring methodology, including a list of secondary data sources used in the analysis and county-level topic and indicator scoring results for the UF Health Shands seven-county CHNA region.

- [Alachua County](#)
- [Bradford County](#)
- [Columbia County](#)
- [Levy County](#)
- [Marion County](#)
- [Putnam County](#)
- [Suwannee County](#)

B. Community Input Assessment Tools

Data collection tools that were vital in capturing community feedback included key informant interview questions.

C. Community Resources and Potential Community Partners

This document highlights existing resources that organizations are currently using and available widely in the community and lists the organizations that participating in the key informant interviews.