Community Health Improvement Plan 2021 - 2025

Florida Department of Health in

Orange County

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General and Secretary of Health

Raul Pino, MD
Health Officer, Florida Department of Health in Orange County

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CONTRIBUTORS

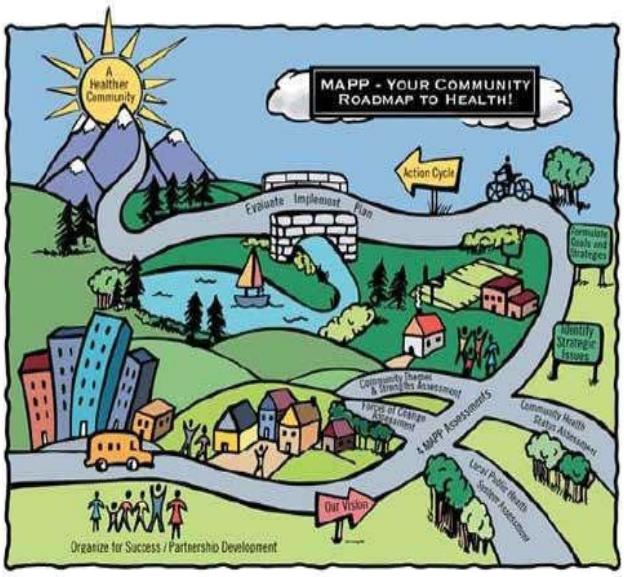
1. **AdventHealth:** *Elizabeth Aulner, Stephanie Arguello*
2. **Aspire Health:** *Shannon Robinson*
3. **Shepherd's Hope:** *Abby Seelinger, Pam Gould*
4. **Community Health Centers, Central Florida:** *Alicia Coonce, Debra Andree, Maureen Ferguson*
5. **Second Harvest:** *Karen Broussard, Amanda Sintes-Yallen, Rachel Stankiewitch*
6. **University of Florida Extension:** *Angela Corona, Kimberly A. McMahon*
7. **Health Choice Network:** *Bakari Burns*
8. **Hebni Nutrition:** *Celines Martinez, Glen Providence*
9. **My True Health:** Jafet Rios, Sheyla Almedina
10. **Primary Partners:** Jane Simon
11. **Oviedo Medical Research:** Karen Kolin
12. **Health Council of East Central Florida:** Ken Peach
13. **My Florida Families:** Kristie Gray
14. **Orlando Health**: Lanie Fox-Ackerman, Sara Osbourne, Lauren Popeck
15. **Mental Health Association of Central Florida:** Dr. Marni Stahlman
16. **West Orange Healthcare District:** Lesa Boettcher, Tracy Swanson
17. **Healthy Start Orange:** Linda Southerland, Elaine Cauthen
18. **Seniors First:** Marsha Lorenz
19. **Simeon Resource and Development Center for Men, Inc:** Larry Williams
20. **Nemours Children's Hospital:** Martha Santoni, Dr. Wanda Donham, Dr. Bruce Brown
21. **Feeding Children Everywhere:** Tiffany Burris-Kobashigawa, Rick Whitted, Ezekiel Brooks
22. **Metro Plan Orlando:** Sarah Larsen
23. **Home Physicians Group:** Sandra Yochem
24. **Humana:** Wendy Roman, Dr. Robert DeMarco
25. **Primary Care Access Network (PCAN):** Rebecca Sayago
26. **Grace Medical Home:** Dr. Stephanie Garris
27. **Florida State University:** Dr. Alexandra Nowakowski

28. **Florida Department of Health, Orange County:** Dr. Raul Pino, Jim Pate, Chait Renduchintala, Ellis Perez, Arthur Howell, Audrey Alexander, Evelyn Dillard, Manovna Narcisse, Ana Piedrahita, Anthony Ramos, Rossie Bonefont, Marlene Andreoli, Justin Mitchell, Patricia Gaige, Dona Walcott, Annette Thomas.

EXECUTIVE SUMMARY

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

In 2020, DOH-Orange engaged over one hundred community health partners in the development of the 2021-2025 Orange 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 Process.



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

1. A community Health Status Assessment that was conducted between September 2018 and June 2019 which helped to identify key community problems via data review.
2. Community Themes and Strengths Assessment was conducted from October 2018 to May 2019 from nine focus groups, 18 individual interviews, 1,240 community survey participants, 86 intercept survey participants and 11 key informant survey participants.
3. The Local Public Health System Assessment was conducted to understand the performance and abilities of community health system.
4. A Forces of Change Assessment was conducted with community leaders to understand threats and opportunities that might lie ahead.

We utilized the 2019 CHA as the basis to initiate engagement and discussion with our community partners in development of the 2021–2025 CHIP. As part of the FDOH integrated public health system, a new CHNA and CHIP are required every 3-5 years by all 67 county health departments in Florida. Implementation of the CHIP is systematically monitored and evaluated with participation from dedicated community health partners. Measures of success and CHIP priority action plans are reviewed and analyzed quarterly to promote plan progression, effectiveness of processes and to foster community health partnerships APPENDIX F: Annual Evaluation Report. The following diagram shows the selected 5-year CHIP priority areas:

Health Priorities From the Community Health Needs Assessment		
Health Priority	**Rank**	**Score**
Access to Care	1	160
Health Equity	3	146
Healthy Weight Nutrition and Physical Activity	2	121
Substance Abuse Behavioral and Mental Health	4	86

Chronic Disease	*	112
Built Environment	5	67
Health Literacy	6	69
Senior Health	7	73
Sexually Transmitted Disease	8	53

SELECTED PRIORITIES

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

1. Access to Care
2. Health Equity
3. Behavioral Health
4. Healthy Weight Nutrition and Physical Activity

- Chronic Disease Management was ranked high by our community. We have not created a separate priority for this area. Based on discussion with our internal services teams and community partners, these objectives have been rolled up under other priorities as listed below:
- Access to Care
    - Reduce hospital visits due to complications of respiratory diseases by 25% in Orange County by 12/31/2025
    - Increase the number of women aged 50-74 who had a mammogram in the past 2 years in Orange County by 12/31/2025
- Health Equity
    - Reduction of 20 per 100,000 in newly diagnosed cases of AIDS in the Black population by 12/31/2025
- Healthy Weight, Nutrition and Physical Activity
    - Decrease preventable Hospitalizations under 65 from Diabetes by 5% among

Orange County residents by 12/31/2025

The community believes we have addressed major areas of concern and opportunities for improvement with this approach to priorities as it allows us to develop cross disciplinary teams to address policy and local system improvements effectively.

COMMUNITY HEALTH IMPROVEMENT PROCESS

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

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

Based on the data provided in the *Community Health Needs Assessment* APPENDIX A: Community Health Needs Assessment, the Florida Department of Health in Orange County (DOH-Orange), collaborated with local community health partners in more than four planning sessions. Beginning in June 2020, we initiated a community-wide strategic planning process for improving community health utilizing the Mobilizing for Action through Planning and Partnerships (MAPP) model. Developed by the National Association of County and City Health Officers (NACCHO), the MAPP framework is an accredited approach towards the creation and implementation of a community health improvement plan that focuses on long-term strategies that address multiple factors that affect the health of a community.

MAPP Process Adaption for COVID-19:

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

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

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

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

KEY MAPP FINDINGS

Community Health Needs Assessment (CHNA)

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

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

In 2020:

- Current population 1,321,194
- Median household income $54,335
- 33.8% have a Bachelor's degree or higher
- 16.1% of the population live below the federal poverty level
- 22.5% of the children under 18 live in poverty in Orange County
- 14.5% of the population is without health insurance and this number is expected to increase due to COVID-19
- 30.9 % of the population is Hispanic or Latino
- 19.9 % of the population is Black
- Source https://data.census.gov/cedsci/profile?g=0500000US12095

In 2019, the leading causes of death were:

- Cancer
- Heart Disease
- Unintentional Injury
- Stroke
- Chronic Lower Respiratory Disease
- Diabetes

Source
http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.LeadingCausesOfDeathProfile

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

- Lack of affordable and adequate housing and homelessness
- Lack of access to affordable food

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

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

- Infant mortality per 1,000 births in Orange County is highest among Blacks (15.5) compared to Whites (3.8) and Hispanics (5.5).
- Births to mothers with less than high school education is highest among Blacks (16.5%) compared to Hispanics (13.6%) and Whites (9.6%).
- Births to women who were obese during pregnancy is highest among Blacks (34.9%) compared to (23.9%) for Hispanics and (22.0%) for Whites.
- Heart disease has been identified a leading cause of death at the rate of 150.6 per 100,000 in Orlando that is significantly higher than the 2020 Health People Goals which is 103.4 per 100,000 people.
- Age adjusted mortality in the Black community at 390.2 per 100,000 is significantly higher than for Hispanics at 209.7 and whites at 319.8. In this plan, we focus on improving outcomes for the Black Community in our Health Equity Priority.
- The CHA reports reduction in homeownership rates from 60.7% in 2000 to 54.5% in 2017. Consequently, the number of children who are homeless and housing insecure have increased. We have identified Behavioral Health, specifically tobacco use in children and young adults as a focus area.

Local Public Health System Assessment (LPHSA)

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

Source: Centers for Disease Control, and Prevention

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

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

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

Forces of Change

The *Forces of Change Assessment* focuses on identifying forces such as legislation, technology and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: “What is occurring or might occur that affects the health of our community or the local public health system?” and “What specific threats or opportunities are generated by these occurrences?” The Forces of Change Assessment is one of the steps in the Mobilizing for Action through Planning and Partnerships (MAPP) process that the Florida Department of Health in Orange County follows.

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

- Health Equity: Infant Mortality (In the black population)
- Health Equity: Reduction in HIV and AIDS (in the black population)
- Health Equity: Mammograms, Cervical and Prostrate Testing (Cancer prevention)
- Behavioral Health: Tobacco use and Vaping (in youth)
- Healthy Weight, Nutrition & Physical Activity: Diabetes Rates and Hospitalization
- Healthy Weight, Nutrition & Physical Activity: Heart Disease and Hypertension
- Healthy Weight, Nutrition & Physical Activity: Maternal Weight, Childhood Obesity and Healthy Eating
- Access to Care (Specialized Care for Specific Conditions): Asthma
- Access to Care (Specialized Care for Specific Conditions): Vaccinations
- Access to Care (Specialized Care for Specific Conditions): Hospital Readmissions and Hospital Acquired Infections

Community Themes & Strengths

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

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

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

• **Chronic Conditions**
○ Obesity and overweight
○ Cancer
○ Hypertension/high blood pressure
○ Cardiovascular diseases
○ Diabetes
• **Access to Care**
○ Availability of specialty medical care
○ Inappropriate use of the emergency department
○ Uninsured
○ Screening for cancer
○ Navigating the health care system
○ Dental hygiene/dental care
• **Health Equity for the Black community**
• **Lack of exercise/physical health**
○ Inactivity due to physical pain or poor emotional health
○ Need more and better bike and pedestrian friendly infrastructure
• **High prevalence of substance use in youth**
• **Food insecurity including access to quality, nutritious foods**
• **Poverty/low wages**
○ Need more affordable housing
• **Transportation is a systemic issue**

PRIORITY AREAS

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

PRIORITY 1: HEALTH EQUITY

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

Goal HE1:	**Improve overall health status of the black community**
Strategy HE1.1:	Improve access to care, nutrition, health literacy and practices during pregnancy by providing culturally sensitive education and support in local communities.
Objective HE1.1.1:	Decrease infant mortality rates by 5% among black infants in Orange County by 12/31/2025 at the rate of 1% each year
	Organization(s) Responsible: DOH-Orange, Healthy Start Coalition of Orange County, Nemours Hospital Data Source: http://www.flhealthcharts.com/charts/DataViewer/InfantDeathViewer/InfantDe%20athViewer.aspx?indNumber=0053
Activity HE1.1.1.1	Programs to increase health literacy knowledge by a minimum of 2 points. 500 per year or more people per year by all community partners combined

Activity HE1.1.1.3	Safe sleep education provided to 1000 or more people per year by all community partners combined. 100 qualified caregivers a year will be educated by (DOH-Orange)
Activity HE1.1.1.4	Promote and support breastfeeding 2500 or more women per year by all community partners combined. 100 qualified caregivers a year, DOH- OC 1200 pregnant black women per year via WIC program, DOH-OC
Activity HE1.1.1.5	Bellies, Babies and Beyond Program: car seat safety, Educational programs, baby showers once a quarter (educational), distribution of car seats, safety skill demonstration. 1000 or more people per year by all community partners combined. 6-week program on baby safety. partners – Orange County Healthy Start, AdventHealth and/or Orlando Health. WIC program 500 people a year.
Strategy HE1.2:	Reduce the prevalence of STDs in the black community
Objective 1.2.1	Reduction of 20 per 100,000 in newly diagnosed cases of HIV in the Black population by 12/31/2025 from 69 per 100,000 in year 2019 by 4 per 100000 (or percent) per year.
	Organization(s) Responsible: Immunology, Community Health FDOH (Justin/Dona, Willie Brown) Data Source: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0471
Activity HE1.2.1.1	Referral to counseling and testing 1500 or more people per year by all community partners combined.
Activity HE1.2.1.2	Increase HIV services testing PREP (120 per year DOH-Orange, immunology)
Objective HE1.2.2:	Reduction of 20 per 100,000 in newly diagnosed cases of AIDS in the Black population by 12/31/2025 from 87 per 100,00 in year 2019 by 4 per 100000 (or percent) per year.
	Organization(s) Responsible: DOH-Orange Data Source: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0141
Activity HE1.2.2.1	Counsel on STDs and birth control 1500 or more people per year by all community partners combined.
Activity HE1.2.2.2	Referral to counseling and testing and care 500 or more people per year by all community partners combined.

Activity HE1.2.2.3	Increase AIDS services/testing PREP (120 people a year, DOH-Orange, Immunology)

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

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

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

Health Equity

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

Health Equity Community Partners

Name	Organization	Name	Organization
Dr. Martha Santoni	Nemours Children's Hospital		
Tiffany Burris-Kobashigawa	Feeding Children Everywhere		
Ellis Perez	DOH-Orange, Community Health		
Rossie Bonefont	DOH-Orange, WIC		
Larry Williams	Simeon Resource and Development Center for Men, Inc		
Aulner Elizabeth	AdventHealth		
Angela Corona	UF/IFAS Extension Family Nutrition Program		

PRIORITY 2: BEHAVIORAL HEALTH – Includes Mental Illness and Substance Abuse

Mental and emotional well-being enables individuals to realize their own abilities, cope with the normal stresses of life, work productively and contribute to his or her community. Ellis Perez,

DOH-Orange, will serve as our department leader for this priority area. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below.

Goal BH1:	**Reduce Tobacco Use in Youth and adults**
Strategy BH1.1:	Expand anti-tobacco initiatives and health literacy related to tobacco usage.
Objective BH1.1.1:	Increase the percentage youth who commit to not initiate any tobacco product by 2.5% in Orange County by 12/31/2025 at the rate of 0.5 % a year from current baseline of 87.3 % in 2020
	Organization(s) Responsible: DOH-Orange and FSU (Dahlia Scafe, Shannon, Dr.Hall) Data Source: http://www.flhealthcharts.com/charts/YouthTobacco/YTDataViewer.aspx?bid=5

Activity BH1.1.1.1	Tobacco program within Community Health has initiatives related to increasing the number of pledges by 300 a year DOH- Orange, Community Health
Activity BH1.1.1.2	Various Tobacco programs on Education on Prevention 1000 or more people per year by all community partners combined
Activity BH1.1.1.3	Recruit more youth in the Students Working Against Tobacco program; implement tobacco cessation 300 or more Students per year by all community partners combined
Activity BH1.1.1.4	FSU COM does some work on this with the AHECs. FAP addresses vape use in its AFS and AFH programs 200 per year will be reached via this program
Activity BH1.1.1.5	Community forums with pediatric experts; kidshealth.org; 50 or more pediatric per year by all community partners combined
Objective BH1.1.2:	Increase tobacco cessation in Orange County by 2025 by 5 % from a baseline of 59.3% in 2016 at the rate of by 1 % each year starting in 2021
	Organization(s) Responsible: DOH-Orange Community Health and AdventHealth (Maria, Wendy, Martha, Dr. Hall, Sara) Data source: http://www.flhealthcharts.com/charts/Brfss/DataViewer.aspx?bid=9
Activity BH1.1.2.1	Offer tobacco cessation classes; community forums with pediatric experts; kidshealth.org; one-page handouts/ outreach 500 a year and commitment from 250 people a year, DOH-Orange Community Health.
Activity BH1.1.2.2	Tobacco program within Community Health has initiatives related to reducing this number 500 or more people per year by all community partners combined

Activity BH1.1.2.3	Tobacco program on Prevention 1000 or more people per year by all community partners combined
Activity BH1.1.2.4	Referral to FL DOH Quit Smoking Line **1000** or more people per year by all community partners combined **100 – DOH referrals**
Activity BH1.1.2.5	Recruit more youth in the Students Working Against Tobacco program; implement tobacco cessation 300 youth per year, DOH-Orange
Activity BH1.1.2.6	"FSU COM does some work on this with the AHECs. FAP addresses tobacco use in its AFS and AFH 250 people a year will be reached.

Policy and system level changes needed to address identified causes of Behavioral Health: Local policy changes anticipated are: New policy to identify and refer individuals into the Opioid Diversion Program. By June 30, 2025, increase from 2 to 5 the number of smoke free policies in postsecondary schools, and higher education institutions in Orange County by providing technical assistance.

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

Behavioral Health – Includes Mental Illness and Substance Abuse

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

Behavioral Health Community Partners

Name	Organization	Name	Organization
Dr. Xan Nowakowski	Representing Florida Asthma Program		
Dr. Stephanie Garris	Grace Medical Home		
Larry Williams	Simeon Resource and Development Center for Men, Inc		
Dr. Martha Santoni	Nemours Children's Hospital		
Ellis Perez	DOH-Orange, Community Health		

PRIORITY 3: ACCESS TO CARE

Rossie Bonefont, DOH-Orange, will serve as our department leader for this priority area. Sarah Larsen with Metro Orlando will serve as the community leader on this priority group. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below.

Goal AC1:	**Reduce readmission rates in Orange County Hospitals**
Strategy AC1.1:	Reduce readmission rates by providing in home services such as access to food, home care, education and health literacy for selected health conditions
Objective AC1.1.1:	Reduce age adjusted hospitalization due to asthma from 94 per 100,000 to 84 per 100000 by 2025 at the rate of 2 per 100000 per year in Orange County By 12/31/2025
	Organization(s) Responsible: East Central Florida Planning Council, AdventHealth and DOH-Orange, (Elizabeth, Pam, Annette Thomas) Data Source: http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=9755
Activity AC1.1.1.1	Increase the number of Orange County residents that have insurance coverage by 3%, 1000 additional people will be covered by insurance each year.
Activity AC1.1.1.2	Increase the number of Orange County residents that have a medical home by 1%. 1400 additional people will have access to Medical Homes
Activity AC1.1.1.3	Adults over 65 years work with the senior services landscape to improve adverse drug events. Create check points along the healthcare pathway to identify potential drug interactions. 100 high risk adults per year will be identified by all community partners combined
Activity AC1.1.1.4	Monitoring the health of vulnerable women and their babies 300 per year, DOH-WIC program
Activity AC1.1.1.5	Care-A-Medix service focuses on keeping seniors out of the hospital. (Health Council of East Central Florida) 25 seniors out of hospital per year
Activity AC1.1.1.6	AFS and AFH programs help to reduce hospital readmissions for kids with asthma. (FSU) 20 children per year
Strategy AC1.2:	Improve screening for targeted groups to reduce cancer rates

Objective AC1.2.1:	Increase the number of women **aged 50-74 who** had a mammogram in the past 2 years in Orange County by 5 % before 12/31/2025 from a baseline of 77.8% in 2016 at the rate of 1 %each year
	Alternate: Prostrate, Cervical other Cancer Screenings (Manovna & Stephanie) Date Source http://www.flhealthcharts.com/charts/Brfss/DataViewer.aspx?bid=0111
Activity AC1.2.1.1	Referral to clinics 1000 or more people per year by all community partners combined
Activity AC1.1.1.2	Provide transportation/access to health care facilities 500 or more people per year by all community partners combined
Activity AC1.1.1.3	Encourage mammograms for Care-A-Medix clients when visiting their homes for chronic care. 100 per year
Activity AC1.1.1.4	Breast cancer screenings 200 or more people per year by all community partners combined.

Goal AC2:	**Achieve herd immunity to COVID-19 by June 2022**
Strategy AC2.1:	Combine an appropriate target take rate, along with exposures resulting in immunity to approach level required for “herd immunity”
Objective AC2.1.1:	Achieve a 70% Orange County immunity rate via a combination of vaccine administration and immunity through exposure by June 2022.
	Organization(s) Responsible: DOH-Orange, Community Partners
Activity AC2.1.1.1	Ensure points of distribution of vaccine in all orange county zip codes by September 2021
Activity AC2.1.1.2	Monthly tracking of positive case rate (exposure to) of COVID-19 in Orange County
Activity AC2.1.1.3	Monthly tracking of number of vaccinations give in Orange County.

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

Local policy changes anticipated are:

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

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

Access to Care – Includes Outpatient services and Cancer Screening

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

Access to Care Community Partners

Name	Organization	Name	Organization
Elizabeth Aulner	AdventHealth		
Ken Peach	Health Council of East Central Florida		
Tiffany Burris-Kobashigawa	Feeding Children Everywhere		
Sandra Yochem	Greater Orlando Community Coalition		
Jane Simon	Alliance Community Health		
Rebecca Sayago	Primary Care Access Network		

PRIORITY 4: HEALTHY WEIGHT, NUTRITION & PHYSICAL ACTIVITY

Overweight and obesity are increasingly common conditions in the United States and in Florida. The accumulation of excess fat is a serious medical condition that can cause complications such as metabolic syndrome, high blood pressure, atherosclerosis, heart disease, type 2 diabetes, high blood cholesterol, cancers and sleep disorders. Arthur Howell, DOH-Orange, will serve as our department leader for this priority area. The priority group will meet via teams on a quarterly basis to monitor progress on all the SMART objectives listed in the table below

Goal HW1:	**Reduce rate of health conditions mediated by poor nutrition practices**
Strategy HW1.1:	Increase health status of targeted groups by improved access to nutrition and health literacy
Objective HW1.1.1:	Decrease Hospitalizations from or with Diabetes by 5% among Orange County residents by 12/31/2025 from a baseline of 3,069.7 in 2019 by 1% a year
	Organization(s) Responsible: DOH-Orange, AdventHealth, Second Harvest Food Bank, Feeding Children Everywhere, Ellis Perez, Peggie burgess, Tiffany, Rachel SH Data Source: http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndData Viewer.aspx?cid=0334
Activity HW1.1.1.1	identify patients with 1. poorly controlled diabetes 500 2. frequent ER visits 3. and food insecurity 1000 or more people per year by all community partners combined.
Activity HW1.1.1.2	Provide 1000 or more people a voucher for a healthy food box and fresh produce each year.
Activity HW1.1.1.3	1000 or more participants will receive quarterly monitoring and education visits with a healthcare provider.
Activity HW1.1.1.4	500 or more people will be provided training to improve healthy cooking knowledge and skills.
Activity HW1.1.1.5	By December 31, 2023, 90% of CHIC program participants will receive quarterly nutrition education and biometric screenings.
	Decrease the rate of Adults who are overweight 5% in Orange County by 12/31/2025 from 34.8% in 2016 by 1% per year

Objective HW1.1.2:	**Organization(s) Responsible**: AdventHealth, Second Harvest Food Bank, Feeding Children Everywhere (Evelyn, Kim) Data source: http://www.flhealthcharts.com/Charts/Brfss/DataViewer.aspx?bid=5
Activity HW1.1.2.1	"We provide an online food distribution platform, featuring boxes of fresh produce and healthy shelf-stable food shipped directly to the front-door of identified populations within days; along with data analytics & impact reports of those served." 30000 meals per year by all community partners combined
Activity HW1.1.2.2	Provide 300 patients participating in a pilot program partnership with Grace Medical food boxes every other week for 3 months, and 1 box every month for 9 months (15 total boxes) in addition to nutrition education.
Activity HW1.1.2.3	Fund healthy school teams, mini school grants for healthy school teams, fund the upgrade to an LPN or RN in our partner schools that can impact 10,000 students per year
Activity HW1.1.2.4	1. Offer nutrition education to our clients Nutrition Education to adults 1000 adults 2. Walking Classes, Access to care 1500 people
Activity HW1.1.2.5	provide 317 chronically ill patients food boxes at participating locations every other week for 1 year (24 boxes per person)
Activity HW1.1.2.7	"PSE Support: implementation and maintenance of school gardens and community gardens, promoting healthy choices in pantries, childcare center policies, farm to school and ECE, support facilitation of fresh food access points in community," 1000 or more beneficiaries a year
Objective HW1.1.3:	5% decrease in the number of births to overweight mothers by 12/31/2025 by 1% a year from a baseline of 27.5% in 2019 **Organization(s) Responsible**: East Central Florida Planning Council, Humana and Second Harvest (Ana & Anthony, Wendy) Data source: http://www.flhealthcharts.com/Charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=607
Activity HW1.1.3.1	"We provide an online food distribution platform, featuring boxes of fresh produce and healthy shelf-stable food shipped directly to the front-door of identified populations within days; along with data analytics & impact reports of those served." 30000 meals per year by all community partners combined
Activity HW1.1.3.2	Nutrition education to adults 1000 per year nutrition education provided by our employees to our clients 200 per year Nutrition education activities and physical education activities. 1500 pregnant women per year – DOH-Orange WIC program

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

We have discussed improvement of sidewalks, construction of bike lanes and walking trails to

encourage residents to exercise.

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

Healthy Weight, Nutrition & Physical Activity

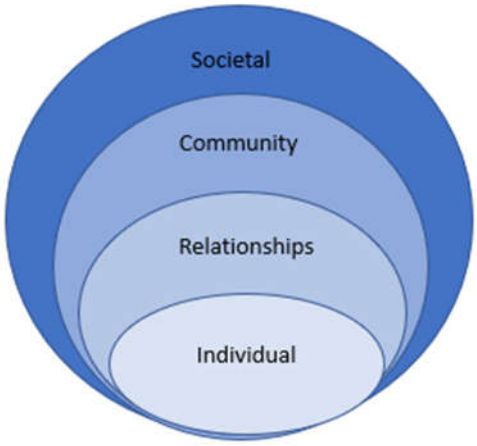
Development of the Healthy Weight, Nutrition & Physical Activity goals, strategies, objectives and activities were completed during the CHIP planning sessions by the community partners identified below, who have accepted responsibility for implementing strategies and completing objectives and activities.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

Name	Organization	Name	Organization
Karen Broussard	Second Harvest		
Elizabeth Aulner	AdventHealth Orlando		
Ken Peach	Health Council of East Central Florida		
Tiffany Burris-Kobashigawa	Feeding Children Everywhere		
Sandra Yochem	Greater Orlando Community Coalition		
Rebecca Sayago	Primary Care Access Network		
Rossie Bonefont	DOH-Orange WIC		
Angela Corona	UF/IFAS Extension Family Nutrition Program		
Jane Simon	Alliance for Community Health		

APPENDIX A: Community Health Needs Assessment

Public Health Framework

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



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

PRIMARY

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

SECONDARY

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

In order to promote identification and prioritization of specific areas for improvement, CHNA data outcomes were reviewed with Community Health Improvement participants. Due to Covid-19, in the interest of safety of the participants, initial meetings were conducted via teams. SMART Health objectives were identified. These objectives were shared via a survey along with Health Priorities. Leads from the departments and community partners ranked the priorities and objectives. Based on this ranking four priorities were identified. Open sessions were conducted for each priority area and for each objective within a priority area. Activities were identified for each SMART Health objective. Measures for each activity and community partner are listed in our plan. During the period 2021 to 2025 we will track progress on each activities and objective on a quarterly basis or more frequently. We will track participants in programs and activities. For objective selection we compared Orange County data against the performance of the State of Florida as a whole, as well as Healthy People 2020 (HP2020) objectives. Florida Health Charts is used as the primary data source of all our objectives. Over the next five years our efforts are focused on closing the gap between Orange County and the State of Florida on selected SMART objectives.Data highlights included the following:

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

County Health Rankings are published by the University of Wisconsin Population Health Institute and The Robert Wood Johnson Foundation to help counties understand what influences the current health of residents, (Health Outcomes) and the health of a county in the future (Health Factors). Health Outcomes, comprised of Length of Life and Quality of Life and Health Factors comprised of Health Behaviors (weighted at 30 percent), Clinical Care (20 percent), Social and Economic Factors (40 percent) and Physical Environment (10 percent). This results in a numerical ranking given to each county in a state.

Out of the 67 counties within the State of Florida, Orange ranks 7th in overall health outcomes and 7th in overall health factors. These rankings remain consistent with previous year's results. To continually educate the community about factors impacting public health, The Florida Department

of Health in Orange County invested in a community intelligence platform in 2020 called *MySidewalk*. We will go live with this platform in the second quarter of 2021. We will use survery123 tool to conduct GIS enabled surveys and acquire geospatial intelligence on the population we serve and optimize our activities and maximize impacts.

APPENDIX B: MAPP Process

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

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

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

There are four assessments that inform the entire MAPP Process:

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

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

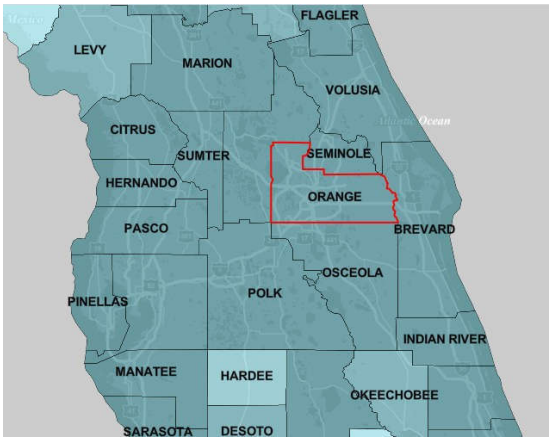
Community Health Status Assessment provides quantitative data on a broad array of health indicators, including quality of life, behavioral risk factors, and other measures that reflect a broad definition of health.

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

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

APPENDIX C: County Profile (Orange County, FL)

Orange County is located in East Central Florida just north of Osceola County. With an estimated population of 1,321,194 (as of July 1, 2018), according to the U.S. Census Bureau. Orange has a total land area of 1,003 square miles. The county is comprised of 15 cities and 31 unincorporated areas and represented by 79 zip codes as of the 2010 Decennial Census. The median household income is $54,335 and 12.3% of Orange County residents are living in poverty. Median household income is the most widely used measure for income since it is less impacted by high and low incomes. A family's income can define their access to affordable housing, healthcare, higher education opportunities and food. 6.0% of the population is unemployed (as of September 2018).



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

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

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

APPENDIX D: CHIP Alignment

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

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

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

APPENDIX E: Assets & Resources

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

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

APPENDIX F: Annual Evaluation Report

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

DOH Orange utilizes the VMSG (Vision, Mission, Services, and Goals) Dashboard which is a is a cloud-based, real-time, performance management system designed specifically to assist public health departments in the development, implementation and performance management of the Strategic and Operational Planning process from beginning to end. Priority areas, goals, strategies, objectives and action items are entered into the system, following extensive community input, and task leaders are assigned to maintain documentation towards progress.

Strategic Issue Area:

Goal:

Strategy:

Objective: SMART Objective which includes the baseline value, baseline year, target value and target date.

Objective % Done: **0** % Activities Sum: **0**

Status	Number	Activity Team	Activity	Performance Metric and Data Source	Status / Progress
	2.1.1.1				
	2.1.1.3				
	2.1.1.4				

Strategic Issue Area:

Goal:

Strategy:

Objective: SMART Objective which includes the baseline value, baseline year, target value and target date.

Objective % Done: **0** % Activities Sum: **0**

Status	Number	Activity Team	Activity	Performance Metric and Data Source	Status / Progress
	2.1.1.1				
	2.1.1.3				
	2.1.1.4				

APPENDIX G: Data Sources & References

DEMOGRAPHICS

- U.S. Census Bureau: State and County QuickFacts-Orange County, Florida. Accessed November 8, 2020
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- FDOH CHARTS - Transmittable Disease Cases & Morbidity. Accessed October 23rd, 2020.
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ADDITIONAL HEALTH INFORMATION

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