Community Health Improvement Plan 2026 - 2028

Prepared by the Florida Department of Health in Orange County

and

Healthy Orange Collaborative

Mission:

The Florida Department of Health works to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

January 1, 2026 – December 31, 2028

Florida HEALTH

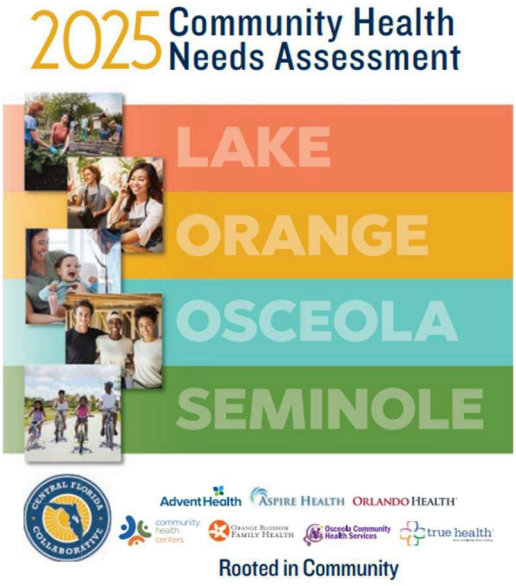
TABLE OF CONTENTS

EXECUTIVE SUMMARY

Driving Community Health Improvement in Orange County: A Detailed Process

The health outcomes and associated quality of life within a community are profoundly determined by social, economic, and environmental factors. Recognizing this complexity of factors, the routine assessment of key community health indicators is not only core to public health practice but remains a critical, foundational component of the broader Community Health Improvement Plan (CHIP) process.

Phase 1: The Community Health Needs Assessment (CHNA)

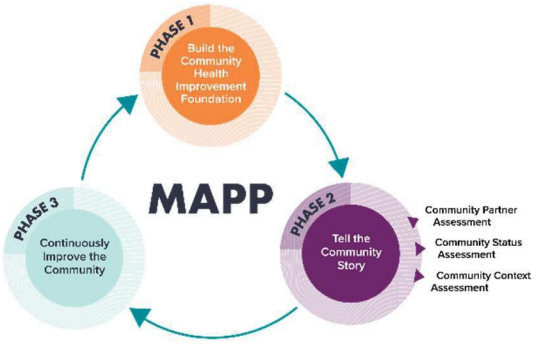


In 2025, the Florida Department of Health in Orange County (DOH-Orange) was part of the Central Florida Collaborative Community Health Needs Assessment (CHNA). This was a major collaborative effort, involving local hospitals, surrounding county health departments, and a diverse range of other stakeholders and community partners.

The collaboration partnered with Crescendo Consulting Group to facilitate the expert collection, analysis, and evaluation of community data. The CHNA had a comprehensive methodology that included a mixed method approach consisting of the following components:

- **Data Analysis**: In-depth review of dozens of validated primary and secondary data sources. Information was tabulated and parsed to identify disparities and other insights whenever possible.
- **Primary Qualitative Research:** This component included 30 focus group discussions and 106 key stakeholder interviews.
- **Survey Research:** The community survey engaged nearly 2,600 respondents and provided insights by county on a breadth of key CHNA issues.
- **Access Audit:** Over 45 “mystery shopper” calls were conducted during the Access Audit to illuminate real-life customer service and access to care issues.
- **Prioritization Process:** The Central Florida Collaborative leadership and approximately 12 to 15 stakeholders in each county participated in a modified Hanlon Method*, an evidence-based approach which objectively takes into consideration explicitly defined criteria and feasibility factors. The needs prioritization process was conducted at the regional level and at the county level. *(Hanlon Method*- Appendix 1)*

Phase 2: Strategic Planning Frameworks: (Mobilizing for Action through Planning and Partnerships (MAPP) and Florida's State Health Improvement Plan (SHIP)



The Community Health Needs Assessment (CHNA) is a core component and outcome of the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning framework. Essentially, MAPP is the comprehensive process that guides a community in conducting its CHNA and then using the results to take action.

MAPP as the Framework for the CHNA

MAPP is a community-driven strategic planning process designed to help communities assess their public health needs and resources, prioritize issues, and develop a collective community health improvement plan (CHIP).

- **CHNA is part of the MAPP process:** Conducting the CHNA is a critical phase within the broader MAPP framework. In MAPP 2.0, this work is encapsulated in Phase 1: Build the CHI Foundation, which results in a comprehensive community assessment.
- **MAPP utilizes multiple assessments for a comprehensive CHNA:** MAPP provides structure and tools for a thorough assessment, ensuring the CHNA is comprehensive by incorporating diverse data. The MAPP framework assessments typically includes:
    - **Community Themes and Strengths Assessment / Community Context Assessment:** Gathers qualitative information on how residents perceive their quality of life, concerns, and community assets.
    - **Community Health Status Assessment / Community Status Assessment:** Provides quantitative data on health outcomes, behaviors, and social determinants of health.
    - **Forces of Change Assessment (FOC):** Identifies external factors (like legislation, technology, or demographics) that impact the community's health.
- **MAPP ensures the CHNA is community-driven:** The MAPP process emphasizes mobilizing partnerships and community engagement throughout the planning phases, which ensures the resulting CHNA reflects the needs and priorities of a broad range of stakeholders and community members.

Florida's State Health Improvement Plan (SHIP)

To drive health improvement and enhance the performance of Florida’s public health system, leadership across the State of Florida assembled a diverse group of partners to create a practical roadmap. This culminated in the development of a five-year Florida State Health Improvement Plan (SHIP) 2022-2026. This plan is targeted for a strategic collective action to enhance public health. The SHIP serves as the state-level blueprint that informs DOH-Orange's CHIP.

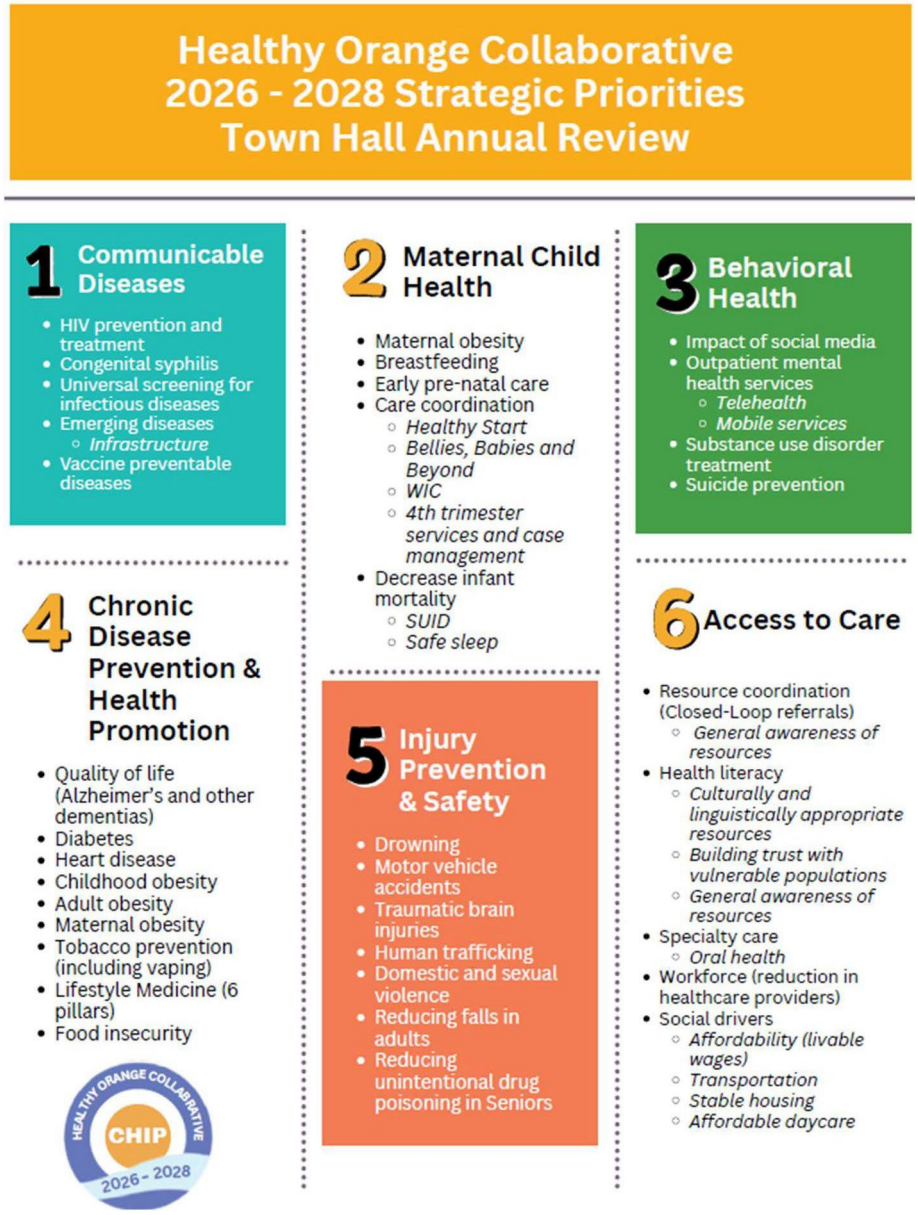
Phase 3: CHIP Development and Approval

The comprehensive data collection and assessment phase led directly into the development and formal adoption of the Community Health Improvement Plan (CHIP) for DOH-Orange:

- **October 2025: Steering Committee Implementation**
  - DOH-Orange implemented a Healthy Orange Collaborative Steering Committee composed of community partners from diverse sectors.
  - The primary function of this committee was to develop data-driven strategies for implementing evidence-based, targeted, and integrated efforts to improve the community's health.
  - Based on the CHNA and MAPP findings, the committee proposed six priority areas for the CHIP 2026-2028: Communicable Diseases, Maternal Child Health, Behavioral Health, Chronic Disease Prevention & Health Promotion, Injury Prevention & Safety, and Access to Care.
- **October 2025: Annual Review / Town Hall Meeting**
  - DOH-Orange engaged over 70 community health partners in a dedicated Annual Review / Town Hall meeting of the Healthy Orange Collaborative.
  - During this meeting, partners discussed and refined the specific goals, strategies, and objectives corresponding to each of the six priority groups.
- **November 2025: Priority Finalization Meeting / Final Review**
  - The CHIP facilitator convened all six priority groups in separate meetings to finalize the specific activities for each strategy and objective.
  - The draft CHIP 2026-2028 was sent to all the collaborative partners and the Steering Committee for final review.
- **December 2025: Formal Approval**
  - The Performance Management Council (PMC) at DOH-Orange formally approved the CHIP 2026-2028.

The sequence of the CHNA, alignment with MAPP and SHIP, establishment of the Steering Committee, the town hall/implementation meeting, priority finalization meeting, and the final PMC approval constituted the rigorous process for formally establishing this foundational CHIP.

Presented in the organizational chart below is the strategic priority document that defines our core priorities, and the specific topics used to formulate our goals and objectives:



SELECTED PRIORITIES

1. Communicable Diseases
2. Maternal Child Health
3. Behavioral Health
4. Chronic Disease Prevention & Health Promotion
5. Injury Prevention & Safety
6. Access to Care

COMMUNITY HEALTH IMPROVEMENT PLAN PROCESS

Achieving long-term positive health outcomes demands strategic efforts. Communities must proactively collect and assess key health data to gain critical, real-time insights into the greatest local and national threats, as well as awareness of emerging health issues. Furthermore, collaboration among diverse community partners is essential for developing, monitoring, and evaluating effective action plans. This joint effort establishes accountability and is the mechanism for achieving measurable health improvements and high-quality outcomes.

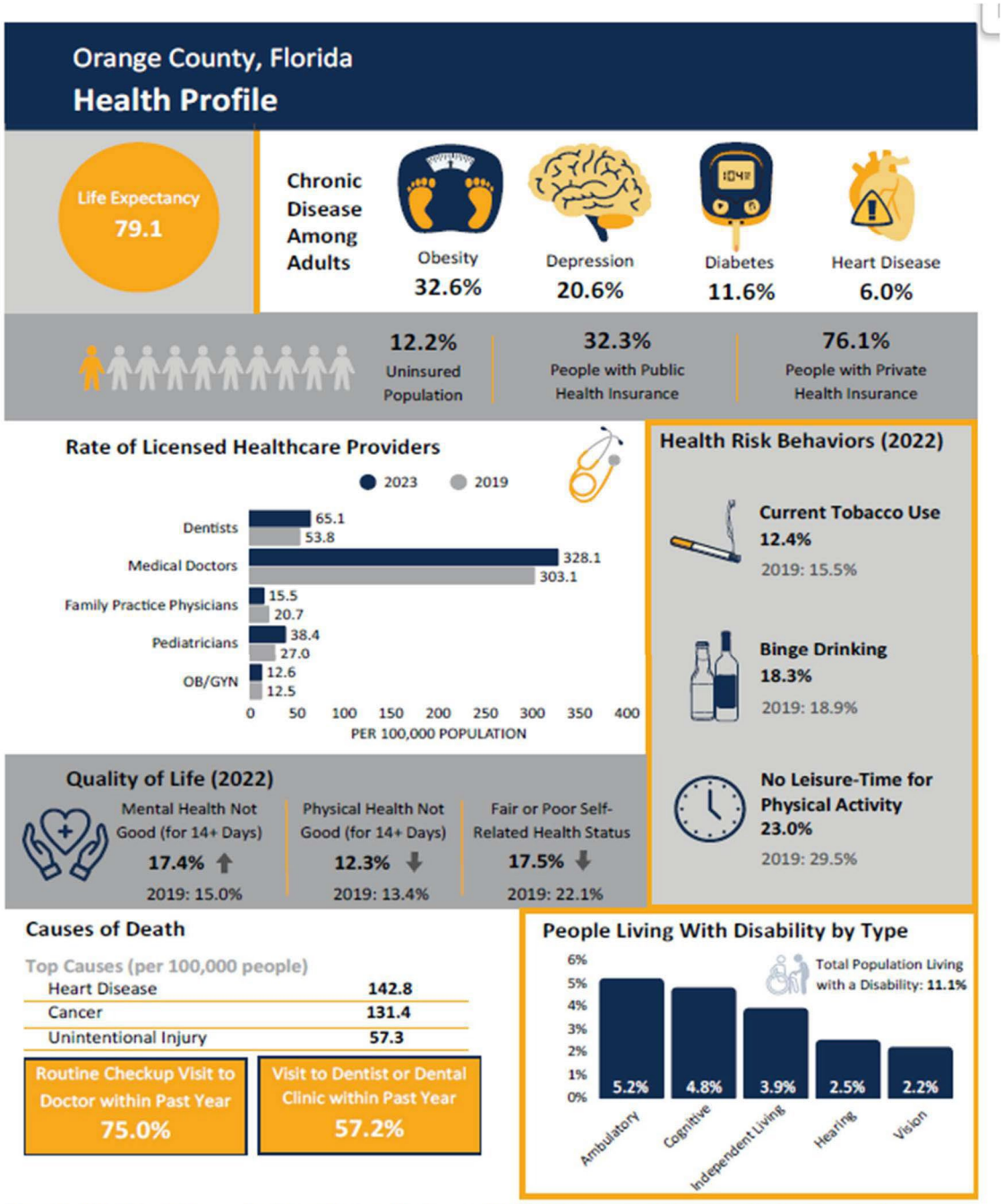
The Community Health Improvement Plan (CHIP)

Community Health Improvement Planning is the systematic, long-term effort dedicated to solving identified health problems. This planning process is fundamentally grounded in the findings of comprehensive community health assessments. The resulting Community Health Improvement Plan (CHIP) serves as the essential strategic roadmap. In Orange County, this collaboration is called the Healthy Orange Collaborative. The collaborative consists of a wide array of stakeholders and partnerships with community groups to set priorities, coordinate actions, and target limited resources effectively.

Importantly, the CHIP defines a collaborative vision for the community's health. By identifying and addressing the strengths, weaknesses, opportunities, and challenges (SWOT) that exist locally, the CHIP provides the necessary framework for developing policies and defining the specific actions required to promote and improve the overall health status of the community.

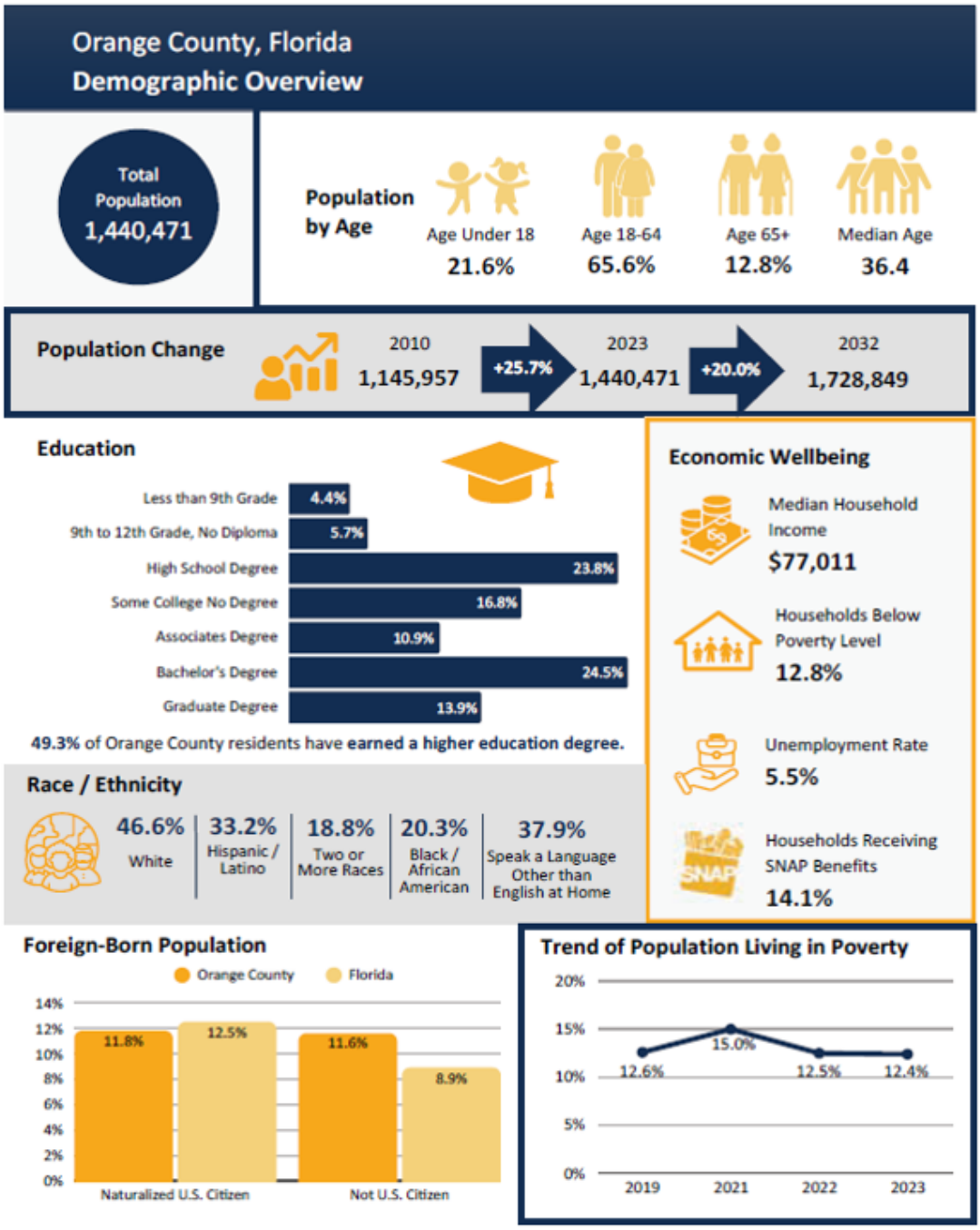
2025 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) ORANGE COUNTY FINDINGS

Major findings from the 2025 Community Health Needs Assessment for Orange County are shown below:



Sources: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates | Florida Behavioral Risk Factor SurveillanceSystem | Florida Department of Health, Division of Public Health Statistics & Performance Management. Florida HealthCHARTS, CountyHealth Dashboard Health Resource Availability

Regional Secondary Data



Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Qualitative Summary: Orange County Community Health Needs Assessment

Summary of the strengths, key themes, and pressing needs identified in a Community Health Needs Assessment for Orange County.

Strengths

- Strong Community Collaboration: Orange County is characterized by a cooperative spirit among community members and organizations.
- Robust Communication Networks: Strong communication facilitates cross-sector collaborations and effective problem-solving.
- Progress and Resilience: Notable achievements include improvements in telehealth access, infrastructure, law enforcement training, and economic development, all contributing to a healthier community.
- Shared Goals: The community is united by common goals of progress and well-being, promoting continuous growth.

Key Themes

- Trust in Healthcare Providers: This is central to improving access. Trust operates on both interpersonal (finding comfortable providers) and systemic levels. A lack of trust influences individuals' willingness to seek care, particularly for marginalized groups.
- Representation and Cultural Competency:
    - Many community members, especially from minoritized backgrounds, emphasized the need for healthcare providers to better reflect the populations they serve.
    - Racial, socioeconomic, and language barriers affect outcomes, making cultural competency critical.
    - It is important to incorporate diverse voices to inform health interventions.

Identified Needs and Barriers

1. Access to Affordable Healthcare

- Cost Barrier: High cost is a major barrier, especially for the uninsured/ underinsured. Even those with insurance face high out-of-pocket costs, particularly for dental and mental health.

- System Challenges: Challenges include limited access to specialists, complicated healthcare systems, and a lack of local providers leading to increased wait times.
- Delayed Care: Delayed access to primary care forces reliance on emergency services for non-emergent needs, resulting in poor health outcomes and increased expenses.
- Culturally Competent Care: A lack of culturally competent providers who understand the unique needs of those new to the country and medically underserved communities is a key issue. This discomfort can deter individuals from seeking future care.
- Language Barrier: These issues are exacerbated for those whose primary language is not English or who are unfamiliar with the U.S. healthcare system.

2. Awareness of Services and Resources

- Information Gaps: There is a need for improved awareness of available healthcare and community-based services.
- Contributing Factors: Information overload, language barriers, and a lack of central resource hubs make access difficult.
- Dissemination Strategy: A strong call exists for information to be disseminated in multiple languages through trusted community channels (e.g., faith leaders).
- Vulnerable Group: New Floridians are especially at risk of not knowing what services are available.

3. Behavioral Health

- Substance Use Concerns: Growing concerns about substance use are reported.
- Treatment Gaps: Inadequate substance use treatment options, including crisis care, lead to extended wait times.
- Resource Deficiencies: The behavioral health system, especially for those on Medicaid, lacks critical resources for crisis care and inpatient facilities.
- System Overload: The system is overwhelmed, resulting in gaps in care.
- Stigma: Internalized and external stigma around mental health and substance use prevents individuals from seeking care and inhibits the funding of services.

4. Financial Stress

- Cost of Living: The rising cost of living and lack of livable wages are significant concerns.
- Impossible Choices: This financial stress often results in residents having to choose between paying for basic needs and healthcare.

5. Housing and Transportation

- Housing Insecurity: Housing insecurity, particularly among seniors and youth, exacerbates other challenges. Homelessness is noted as rising, and affordable housing remains a critical need.
- Transportation Barriers: Public transportation is cited as inadequate for the growing population. Challenges limit access to healthcare, healthy food, and employment opportunities.
- Opportunities for Improvement: Enhancing public transportation, walkability, and bike-ability could improve overall community access to resources.

Community Survey Highlights

The purpose of the community survey was to enable participation of people living throughout the service area to share their perspectives on the greatest needs affecting their community.

Methodology:

The community survey was made available online and via print copies in English, Spanish, Haitian Creole, Portuguese and Chinese. The questionnaire included closed-ended, need- specific questions for community members to provide input and demographic questions. Invitations to participate were distributed by partners through channels including the Central Florida Collaborative, social media, flyers and email listservs among other methods.

There were 870 responses from Orange County out of 2,376 total responses from the four-county region of Lake, Orange, Osceola and Seminole counties.

CHNA Results

Community needs were identified at regional and county levels through analysis of primary and secondary data. In Orange County, 32 needs emerged. A modified Hanlon Method*, an evidence-based prioritization technique, was used to assess needs across counties and the Central Florida Collaborative region, considering defined criteria and feasibility factors.

The Top 15 Orange County Community Needs by Social Drivers of Health are listed below:

Top 15 Community Needs by Social Driver of Health

Economic Stability

- Affordable housing, including for older adults
- Food security
- Jobs with livable wages
- Affordable childcare services

Healthcare Access and Quality

- Improved care coordination among healthcare providers
- Programs for chronic disease prevention and education
- Maternal and prenatal care, including more OB/GYN providers
- Impact of social media on the mental health of children
- Access to outpatient mental health services
- Substance use treatment services

Neighborhood and Built Environment

- Transportation, especially to medical appointments and public transportation

Social and Community Context

- Improved health literacy resources
- General awareness of resources, including prenatal care services for new residents[88]
- Linguistically and culturally appropriate healthcare services and resources
- Building trust with medically underserved populations

STRATEGIC PRIORITY AREAS

Utilizing the results of the 2025 Community Health Needs Assessment and the MAPP (Mobilizing for Action through Planning and Partnerships) process, the Steering Committee identified six strategic priority areas for the Orange County Community Health Improvement Plan (CHIP). The Healthy Orange Collaborative partners participated in the implementation, monitoring, and evaluation framework for the CHIP, including establishing the specific goals, strategies, objectives, and activities for each priority area. This focused work is expected to strengthen the public health infrastructure and ultimately promote the health, well-being, and quality of life for all Orange County residents.

The 2026-2028 CHIP priorities, goals, strategies, objectives and activities are overviewed in the sections below.

(Note: The FLHealthCHARTS Data Source link for each objective will need to be changed to view Orange County data.)

PRIORITY 1: MATERNAL CHILD HEALTH

Maternal Child Health (MCH) is a critical public health discipline focused on improving the well-being of women and infants. The health of a community's mothers and children is a strong predictor of its future social, economic, and overall health vitality. Adrian Lawson and Suhaah Nadir (DOH-Orange) will serve as the internal lead for this priority area, while Jarred McCovery (AdventHealth Central Florida) will act as the external community liaison. The priority group will meet quarterly via Microsoft Teams to monitor progress on all listed SMART objectives and activities.

Goal MCH1:	**Strengthen and improve coordination between maternal health services and early childhood programs. *(SHIP Goal MCH3)***
Strategy MCH1.1:	Use “Closing the Loop” referral tools to ensure seamless connection between perinatal and postpartum services.
Objective MCH1.1.1	By December 31, 2028, increase the percentage of Orange County mothers initiating prenatal care in the 1st trimester from 66.1% (2023) to 73%. *(SHIP Objective MCH3.1)* **Organization(s) Responsible**: DOH-Orange, Nemours Children’s Health, AdventHealth, Orlando Health, University of Central Florida, Fetal Alcohol Spectrum Disorders Clinic, Healthy Start Orange, Community Health Centers, Inc. **Data Source:** Births to Mothers Initiating Prenatal Care in the 1st Trimester

Activity MCH1.1.1.1	Partner with hospitals, Federally Qualified Healthcare Centers (FQHCs), *(Community Health Centers Inc., True Health, Orange Blossom Family Health),* and obstetric clinics to implement warm referrals for newly pregnant patients to early prenatal care by utilizing "Closing the Loop" referral tools.
Activity MCH1.1.1.2	Incorporate health literacy interventions and navigation support to overcome barriers by sustaining the language line systems and providing education material in multiple languages.
Activity MCH1.1.1.3	Increase enrollment in and awareness of Presumptive Eligibility for Pregnant Women (PEPW) through health literacy interventions and navigation support.
Objective MCH1.1.2	By December 31, 2028, decrease the number of births to mothers who were overweight at time pregnancy occurred from 29.4% (2024) to 26.0%. **Organization(s) Responsible:** DOH-Orange, Nemours Children's Health, AdventHealth, Orlando Health, The Foundation for a Healthier West Orange, Healthy Start Orange.[4] **Data Source**: Births to Mothers Who Were Overweight at Time Pregnancy Occurred
Activity MC1.1.2.1	Provide nutrition and physical education activities for 1,000 pregnant women per year to reduce the risk of gestational diabetes and adverse birth outcomes.
Objective MCH1.1.3	By December 31, 2028, decrease infant mortality rates per 1,000 live births from 5.7% (2021) to 4.5%. *(SHIP Objective ISV1.1)* **Organization(s) Responsible:** DOH-Orange, Nemours Children's Health, AdventHealth, Orlando Health, The Foundation for a Healthier West Orange, Healthy Start Orange, Community Health Centers, Inc. **Data Source:** Infant Mortality (Aged 0-364 Days)
Activity MCH1.1.3.1	Decrease the percentage of very low birth-weight infants by engaging mothers in programs that increase health literacy knowledge. *(SHIP Objective MCH2.1)*
Activity MCH1.1.3.2	Increase the proportion of infants who are put to sleep on their backs by providing safe sleep education and prevent Sudden Unexpected Infant Death (SUID) to 1000 clients per year by all community partners combined. *(SHIP Objective ISV1.1)*
Activity MCH1.1.3.3	Implement preventative interventions during the Fetal & Infant Mortality Review (FIMR) process with Healthy Start Coalition - Community Action Group, hospitals, and community partners to develop policies that support the implementation of evidence-based practices to reduce infant mortality by using the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Objective MH1.1.4	By December 31, 2028, increase the proportion of Orange County mothers who initiated breastfeeding from 89.9% (2023) to 94%. **Organization(s) Responsible**: DOH-Orange, Nemours Children's Health, AdventHealth, Orlando Health, Florida Breastfeeding Coalition, Healthy Start Orange. **Data Source:** Mothers Who Initiate Breastfeeding
Activity MCH1.1.4.1	Provide lactation support and peer counseling through WIC, Healthy Start, and community coalitions through care coordination and home visiting programs.
Activity MCH1.1.4.2	Increase maternity hospital awareness and participation of the Maternity Practices in Infant Nutrition and Care (mPINC) survey to drive improvements in breastfeeding support and adherence to the "Ten Steps to Successful Breastfeeding".

Policy and system level changes needed to address identified causes of Maternal Child Health:

Effective policy and system-level changes to address health gaps and challenges in Maternal Child Health (MCH) must focus on barriers and addressing the Social Drivers of Health (SDoH). The strategy requires a dual approach: making impactful changes within the healthcare system and enacting broader policies that impact the economic and social well-being of women and infants.

Maternal Child Health

The goals, strategies, objectives, and activities for the Maternal Child Health (MCH) priority were developed and finalized during the Healthy Orange Collaborative Town Hall meeting in October 2025. The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

Maternal Child Health Community Partners

Name	Organization
Penny Smith Arthur Howell Adrian Lawson Joy Bayley	DOH-Orange
Nancy Molello	Nemours Children's Health

Jessica Tam	Orlando Health
Jarred McCovery Nadine Walker	AdventHealth
Dr. Tara Williams	Florida Breastfeeding Coalition
Dr. Fayshonda Cooks Ojeleye Olajumoke Jean Davis Dr. A'Naja Newsome	University of Central Florida
Kristal Pollick	Fetal Alcohol Spectrum Disorders Clinic
Arelys Allen Thelisha Thomas	Healthy Start Orange
Tracy Swanson Jeanni Trout	The Foundation for a Healthier West Orange
Pascale Vincent	Center for Multicultural Wellness and Prevention
Yentl Lega	Aetna Better Health of Florida
Ebony Davis-Martin Dr. Roshni Patel	Community Health Centers, Inc.

PRIORITY 2: BEHAVIORAL HEALTH

Behavioral Health (BH) focuses on mental and emotional well-being. It enables individuals to realize their potential, effectively cope with life's normal stressors, work productively, and contribute meaningfully to their community. Donna Walsh (DOH-Orange) will serve as the internal lead for this priority area, while Marni Stahlman (Mental Health Association of Central Florida) and Yaberci-Perez Cubillan (Aspire Health) will serve as the external community liaisons. The priority group will meet quarterly via Microsoft Teams to monitor progress on all listed SMART objectives and activities.

Goal BH1:	**Reduce the impact of mental, emotional, and behavioral health disorders *(SHIP Goal MW1.1)***
Strategy BH1.1:	Implement evidence-based community interventions to reduce preventable hospitalizations due to mental health disorders and behaviors.
Objective BH1.1.1	By December 31, 2028, decrease the number of emergency department visits by residents of all ages from mental disorders from 740.9 (2024) to 700.0.

	Organization(s) Responsible: Mental Health Association of Central Florida, Central Florida Cares Health System Inc., Aspire Health, Victim Service Center of Central Florida, La Amistad Behavioral Health Services, University Behavioral Center, Central Florida Behavioral Hospital, Palm Point Behavioral Health, AdventHealth, Orlando Health, Community Health Centers, Inc. **Data Source:** Emergency Department Visits from Mental Disorders
Activity BH1.1.1.1	Increase access to 24/7 Mobile Crisis Response Teams (MCRTs) to provide immediate on-site assessment, de-escalation, and non-hospital referrals during community mental health crises through brand recognition and education.
Activity BH1.1.1.2	Increase collaboration with community partners to coordinate services for individuals experiencing a mental health crisis who do not require inpatient psychiatric hospitalization through care coordination.
Activity BH1.1.1.3	Connect with outreach and early intervention programs which target high-risk populations (e.g., individuals with a history of frequent hospitalizations, uninsured/underinsured groups, specific age demographics) with proactive mental health screenings, education, and outpatient treatment services.
Objective BH1.1.2	By December 31, 2028, decrease the number of residents involuntary examinations (Baker Act) from 10,756 (2023) to 10,000 examinations. *(SHIP Objective MW1.3)* **Organization(s) Responsible**: Mental Health Association of Central Florida, Central Florida Cares Health System Inc., Aspire Health, Victim Service Center of Central Florida, La Amistad Behavioral Health Services, University Behavioral Center, Central Florida Behavioral Hospital, Palm Point Behavioral Health, AdventHealth, Orlando Health. **Data Source:** Baker Act Involuntary Examinations
Activity BH1.1.2.1	Provide 1,000 residents every year with access to mental health counseling among community partners.
Activity BH1.1.2.2	Provide 1,000 residents with mental health concerns every year with access to telemedicine services among community partners.
Activity BH1.1.2.3	Provide access to transportation for mental health services among community partners through entity-based services.
Objective BH1.1.3	By December 31, 2028, decrease the number of hospitalizations by residents of all ages from mood and depressive disorders from 7,885 (2024) to 7,000. **Organization(s) Responsible**: Mental Health Association of Central

	Florida, Central Florida Cares Health System Inc., Aspire Health, Victim Service Center of Central Florida, La Amistad Behavioral Health Services, University Behavioral Center, Central Florida Behavioral Hospital, Palm Point Behavioral Health, AdventHealth, Orlando Health. **Data Source:** Hospitalizations From Mood and Depressive Disorders
Activity BH1.1.3.1	Reduce the percentage of adolescents/young adults who feel sad or hopeless over the last year through mental health counseling. *(SHIP Objective MW2.2)*
Activity BH1.1.3.2	Increase connections to care for patients presenting with mood/ depressive disorder crises by providing a referral before the patient leaves the emergency department.
Activity BH1.1.3.3	Establish partnerships with community mental health centers to promote after-hours and weekend tele-psychiatry service through social media and community awareness campaigns awareness.
Strategy BH1.2:	Implement evidence-based[4] community interventions to reduce mortality related to suicide and drug overdose deaths.
Objective BH1.2.1	By December 31, 2028, decrease age-adjusted rate of suicide deaths per 100,000 from 10.1% (2024) to 9.0%. **Organization(s) Responsible:** Central Florida Cares Health System Inc, University of Central Florida Police Department, Aspire Health Department of Veterans Affairs. **Data Source:** Deaths from Suicide
Activity BH1.2.1.1	Provide Question, Persuade, and Refer (QPR) Suicide Prevention training to 1,000 vulnerable individuals of Orange County.
Activity BH1.2.1.2	Collaborate with the Veterans Administration to provide veterans who are suicidal and managing emotional or mental health crises with support. *(SHIP Objective MW 4.3)*
Objective BH1.3.1	By December 31, 2028, decrease drug overdose deaths for opioids in Orange County per 100,000 from 21.7 (2024) to 20.0. **Organization(s) Responsible**: Orange County Drug-Free Coalition. **Data Source:** Substance Use Dashboard
Activity BH1.3.1.1	Distribute and train the community on the use of Naxolone (Narcan) in an Opioid crisis through Florida's State Opioid Response Project. *(SHIP Objective MW3*.4)

Policy and system level changes needed to address identified causes of Behavioral Health:

Policy and system-level changes to address behavioral health must focus on three core areas: achieving true parity between mental and physical health, fully integrating care models, and addressing the Social Drivers of Health (SDoH).

Behavioral Health

The goals, strategies, objectives, and activities for the Behavioral Health (BH) priority were developed and finalized during the Healthy Orange Collaborative Town Hall meeting in October 2025. The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community 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
Marni Stahlman	Mental Health Association of Central FL	Trinity Schwab Nikaury Munoz	Central Florida Cares
Catherine Raley Sheri Baeza	Victim Service Center of Central FL	Babette Hankey John Wolf Yabercia Perez-Cubillan Kristen Lewandowski Megan Guck Shannon Hutchison	Aspire Health
Sara Osborne	Orlando Health	Benita Harris	University of Central Florida Police Department
Shannon Gravitte Mari Torres-Luengas	AdventHealth	Dr. Thomas Hall Michailah Marshall	Orange County Drug-Free Coalition
Windy McCarthy	La Amistad Behavioral Health Services, University Behavioral Center, Central Florida Behavioral Hospital,	Dr. Kara Boyer Nyssa Tai Teresa Brown	Department of Veterans Administration

	Palm Point Behavioral Health		
Michael Viola Donna Walsh	DOH-Orange	Yentl Lega	Aetna Better Health of Florida
Ebony Davis-Martin	Community Health Centers, Inc.		

PRIORITY 3: ACCESS TO CARE

Access to Care (AC) is the timely use of health services necessary to achieve the best possible health outcomes. In a county setting, barriers like affordability, transportation, unstable housing, and lack of affordable childcare directly determine, and often degrade, the overall health status of the entire population. Beth Paterniti will serve as the internal lead for this priority area, while Sandi Vidal (Central Florida Foundation) and Sara Osborne (Orlando Health) will act as the external community liaison. The priority group will meet quarterly via Microsoft Teams to monitor progress on all listed SMART objectives and activities.

Goal AC1:	**Improve access to high-quality healthcare services for the life span of all people**
Strategy AC1.1	Improve access to care by addressing barriers to care through community engagement.
Objective AC1.1.1	By December 31, 2028, decrease emergency department visits by Orange County residents from 550,860 (2024) to 500,000. **Organization(s) Responsible**: Primary Care Access Network (PCAN), Grace Medical, Blue Cross Blue Shield, True Health, Community Care Plan, Orange Blossom Family Health, University of Central Florida, AdventHealth, Orlando Health, Community Health Centers, Inc. **Data Source:** Emergency Department Visits
Activity AC1.1.1.1	Establish ER diversion and primary care navigation services at local emergency room facilities through the Primary Care Access Network (PCAN) Navigator Program and Federally Qualified Healthcare Centers (FQHCs).
Activity AC1.1.1.2	Enhance community education initiatives related to access to services and resources that address Social Drivers of Health (SDoH) needs through FindHelp and Unite Us and other “Closing the Loop” referral tools with partner organizations.
	By December 31, 2028, increase the percentage of adults who had a medical checkup in the past year from 75.2% (2019) to 80%.

Objective AC1.1.2	**Organization(s) Responsible**: Primary Care Access Network (PCAN), Grace Medical, Blue Cross Blue Shield, True Health, Community Care Plan, Orange Blossom Family Health, University of Central Florida, AdventHealth, Orlando Health, Community Health Centers, Inc. **Data Source:** Adults Who Had a Medical Checkup in the Past Year (BRFSS)
Activity AC1.1.2.1	Increase patient enrollment and utility at FQHCs through PCAN collaboration, community events, and enrollment educational sessions.
Activity AC1.1.2.2	Increase community organization engagement in opportunities to provide knowledge of referral platforms and culturally and linguistic resources through FindHelp and United Us and other “Closing the Loop” referral tools with partner organizations.
Activity AC1.1.2.3	Increase transportation access to primary care entities through screening questions, hospital navigators, and educational resources.
Objective AC1.1.3	By December 31, 2028, decrease the number of people (aged 0-64 years) who are uninsured from 171,685 (2023) to 168,685. **Organization(s) Responsible:** DOH-Orange, Primary Care Access Network (PCAN), Grace Medical, Blue Cross Blue Shield, True Health, Community Care Plan, Orange Blossom Family Health, Florida Impact. **Date Source:** Population Uninsured (Aged 0-64 Years)
Activity AC1.1.3.1	Connect with PCAN organizations for assistance with accessing health insurance options for individuals seen through the CACs at the FQHCs. Sharing information on connecting with navigator services under the Covering Florida Program at the University of South Florida.
Activity AC1.1.3.2	Enhance collaborative engagement with faith-based entities and community organizations through educational and promotional opportunities.
Activity AC1.1.3.3	Increase health plan engagement in strategies to educate residents on coverage and benefits through the case managers by using campaign and educational materials.
Activity AC1.1.3.4	Increase enrollment in and awareness of Florida KidCare programs. *(Medicaid for Children, MediKids, Florida Healthy Kids, and the Children's Medical Services (CMS) Health Plan)* for children.

Policy and system level changes needed to address identified causes of Access to Care:

The necessary policy and system-level changes to address barriers to Access to Care (AC) should focus on addressing the Social Drivers of Health, eliminating financial barriers, growing the healthcare workforce, and improving service delivery infrastructure.

Access to Care

The goals, strategies, objectives, and activities for the Access to Care (AC) priority were developed and finalized during the Healthy Orange Collaborative Town Hall meeting in October 2025. The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

Access to Care Community Partners

Name	Organization	Name	Organization
Mari Torres-Luengas Rebecca Desir	AdventHealth	Sandi Vidal	Central Florida Foundation
Sara Osborne Alyson Olinzock	Orlando Health	Dr. Debra Andree Kathy Jo Bailey Molly Ferguson Ebony Davis-Martin	Community Health Centers, Inc.
Rebecca Sayago	Primary Care Access Network	Stephanie Garris	Grace Medical Home
Gloria San Miguel	Blue Cross Blue Shield	Dr. Fayshona Cooks Dr. Tracy Macintosh	University of Central Florida
Karla Radka	Senior Resource Alliance	Amy Pont Cindy Johnston Evelyn Corrales-Randle	Community Care Plan
Gisella Suarez Beth Paterniti	DOH-Orange	April Johnson	Center for Multicultural Wellness and Prevention
Ilein Santiago Janelle Dunn Lasonja Houston Sheyla Almedina	True Health	Asheena Moses	Florida Impact
Damontie Graham	Aetna Better Health of Florida	Abby Rice	Shepherd's Hope

PRIORITY 4: INJURY PREVENTION & SAFETY

Injury Prevention & Safety (IPS) is crucial as most injuries are preventable, not accidental. By reducing the incidence of injuries such as bike, motorized vehicle crashes, pedestrian safety, drowning, falls, violence, and overdoses, communities can significantly lower death rates, emergency room visits, and hospitalizations and improve the overall quality of life for residents. Mary Vogel (DOH-Orange) will serve as the internal lead for this priority area, while Brent Moore (Children's Safety Village) will act as the external community liaison. The priority group will meet monthly during the Safe Kids Coalition to monitor progress on all listed SMART objectives and activities.

Goal IPS1:	**Reduce the rate of preventable injuries within Orange County**
Strategy IPS1.1	Increasing injury intervention strategies such as sharing effective solutions and implementing prevention programs is key to keeping residents in Orange County safe.
Objective IPS1.1.1	By December 31, 2028, reduce unintentional injury deaths per 100,000 from 45.7% (2024) to 41%. **Organization(s) Responsible:** DOH-Orange, Children's Safety Village, Orange County Sheriff's Office, Orlando Health, MetroPlan Orlando, Senior Resource Alliance, Orange County Board of County Commissioners **Data Source:** Deaths From Unintentional Injury
Activity IPS1.1.1.1	Reduce drowning deaths in children aged 1-5 years by promoting drowning prevention campaigns, events, and following county regulations.
Activity IPS1.1.1.2	Reduce deaths of children aged 19 years and under from motor vehicle accidents (MVA) by promoting MVA prevention campaigns, events, and following county regulations. *(SHIP Objective ISV1.3)*
Activity IPS1.1.1.3	Reduce serious injuries and fatalities from micromobility crashes involving children aged 19 years and under by promoting prevention campaigns, events, and following municipality regulations.
Activity IPS1.1.1.4	Reduce the rate of deaths related to traumatic brain injury (TBI) for youth aged 19 years and under by promoting TBI literacy, prevention campaigns, and events. (*SHIP Objective ISV1.5)*
Activity IPS1.1.2.5	Reduce injury-related fatalities from unintentional drug poisonings by providing prevention safety education and implementing community partner initiatives. *(SHIP Objective ISV2.1)*
Activity IPS1.1.2.6	Reduce injury-related fatalities from falls in adults aged 60 years or older by providing prevention safety education and implementing community partner initiatives. *(SHIP Objective ISV2.2)*

Objective IPS1.1.2	By December 31, 2028, reduce non-fatal injury hospitalizations by Orange County residents from an age adjusted rate of 512.53 (2024) to 500.0. **Organization(s) Responsible:** Victim Service Center of Central Florida, Harbor House, Department of Children's and Families **Data Source:** Non-Fatal Injury Hospitalizations
Activity IPS1.1.2.1	Increase human trafficking reports for individuals aged 18 and under by promoting awareness of the Florida Abuse Hotline (1-800-962-2873) and the USF TIP Lab's state data collection. *(SHIP Objective ISV3.2)*
Activity IPS1.1.2.2	Increase the number of victim referrals related to domestic and sexual violence by promoting safety education and implementing community partner initiatives. *(SHIP Objective ISV3.3)*
Activity IPS1.1.2.3	Reduce injury-related falls in adults aged 60 years or older by providing prevention safety education and implementing community partner initiatives. *(SHIP Objective ISV2.2)*

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

Effective Injury Prevention & Safety requires a multifaceted approach involving both policy and system-level changes aimed at addressing the identified root causes of injury. This approach moves beyond simply educating individuals to creating safer environments and mandates.

Injury Prevention and Safety

The goals, strategies, objectives, and activities for the Injury Prevention & Safety (IPS) priority were developed and finalized during the Healthy Orange Collaborative Town Hall meeting in October 2025. The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

Injury Prevention & Safety Community Partners

Name	Organization	Name	Organization
Brent E. Moore	Children's Safety Village	Lina Chico	Orlando Health
Catherine Raley	Victim Service of Central Florida	Karla Radka	Senior Resource Alliance

Karie Arch	Harbor House	Amy Cooper	AdventHealth
Carissa Johns	Orange County Sheriff's Office	Katelyn Lee Michaela Robinson Stephanie Scialpi	Department of Children and Families
Sarah Larsen	Metroplan Orlando	Mary Vogel Ronique Bain	DOH-Orange
Dr. Maria Vazquez	Orange County Public Schools (OCPS)	Byron Brooks	Orange County Board of County Commissioners

PRIORITY 5: CHRONIC DISEASE PREVENTION & HEALTH PROMOTION

Chronic Disease Prevention & Health Promotion (CDPHP) targets the most significant sources of illness, death, and healthcare expenditure. It addresses the fundamental fact that chronic diseases, such as heart disease, diabetes, and cancer, are among the leading causes of death and disability. By focusing on primary prevention, these efforts aim to prevent the development of these conditions by promoting early interventions and healthy behaviors such as better nutrition, physical activity, and avoiding tobacco products. Arthur Howell (DOH-Orange) will serve as the internal lead for this priority area, while Aurelia Roehrig (American Heart Association) will act as the external community liaison.

Goal CDPHP1:	**Reduce the rate of health conditions and hospitalizations mediated by chronic diseases**
Strategy CDPHP 1.1:	Increase the health status of targeted groups by improving health outcomes.
Objective CDPHP 1.1.1:	By December 31, 2028, decrease the number of hospitalizations from diabetes by Orange County residents from 3,968 (2024) to 3,300. *(SHIP Objective 4.2)* **Organization(s) Responsible:** Second Harvest Food Bank, U.S. Hunger, American Heart Association, Hebni Nutrition, Orlando Health, AdventHealth, DOH-Orange, Community Health Centers, Inc. **Data Source:** Hospitalizations From Diabetes
Activity CDPHP 1.1.1.1	Improve hospital discharge care coordination for patients due to a diabetes-related event through educational seminars.

Activity CDPHP 1.1.1.2	Offer diabetes self-management education classes in various community locations. Classes cover essential skills: Know Your Numbers, glucose monitoring, medication adherence, healthy eating, physical activity.
Activity CDPHP 1.1.1.3	Collect food insecurity screening data needs across the county from organizational based systems.
Activity CDPHP 1.1.1.4	Provide 2,000 or more residents with a voucher for a healthy food box and fresh produce each year.
Activity CDPHP 1.1.1.5	Support a minimum of 1,000 students and children each year through obesity prevention efforts including policy, systems, and environmental change efforts. Efforts will include the implementation and maintenance of school gardens, implementation of healthy childcare center policies, and farm to school/Early Care and Education (ECE) initiatives.
Objective CDPHP 1.1.2:	By December 31, 2028, decrease the number of hospitalizations from coronary heart disease by Orange County residents from 4,544 (2024) to 4,000. **Organization(s) Responsible:** American Heart Association, U.S. Hunger, Second Harvest Food Bank, Hebni Nutrition, DOH-Orange, Shepherd's Hope. **Data Source:** Hospitalizations From Coronary Heart Disease
Activity CDPHP 1.1.2.1	Offer workshops and educational seminars on topics directly linked to overall health and the six pillars of lifestyle medicine such as nutritious eating, stress management/mental well-being, regular physical activity, and the importance of adequate sleep.
Activity CDPHP 1.1.2.2	Provide on-site basic health screenings, including blood pressure checks, BMI assessment, blood glucose and cholesterol testing, and vision/hearing checks through community engagement health fairs.
Activity CDPHP 1.1.2.3	Utilize Health Related Social Needs (HRSN) screenings to identify upstream risk factors that contribute to the development of coronary heart disease.
Objective CDPHP 1.1.3:	By December 31, 2028, decrease the number of emergency department (ED) visits for asthma among children and adolescents aged 0–17 years from 2,125 (2024) to 2,000. **Organization(s) Responsible**: DOH-Orange. **Data Source:** Emergency Department Visits From Asthma (Aged 0-17)

Activity CDPHP 1.1.3.1	Increase the number of referrals in the Asthma Home Visiting Program to assess asthma triggers and provide education.
Objective CDPHP 1.1.4	By December 31, 2028, reduce the proportion of middle and high school students in Orange County who report using cigarettes, Cigars, Electronic Vapor Products or Hookah in the past 30 Days from 6.5% (2024) to 5.8%. *(SHIP Objective CD1.1)* **Organization(s) Responsible:** Tobacco Free Florida, TFF CIVIC Communications (CIVCOM) **Data Source:** Florida Youth Tobacco Survey Data *Definition for Tobacco Products: any product containing nicotine, such as vape products, cigarettes, cigars, hookah, or smokeless products.*
Activity CDPHP 1.1.4.1	Implement a comprehensive tobacco-free policy in Orange County K-12 Schools, which will include all 15 provisions recommended by the Public Health Law Center and American Heart Association. Allow accessibility of a SWAT Chapter available to all middle and high school students in Orange County.
Objective CDPHP 1.1.5	By December 31, 2028, decrease the number of hospitalizations from Alzheimer's Disease from 182 (2024) to 165. **Organization(s) Responsible:** Alzheimer's Dementia Resource Center **Data Source:** Hospitalizations From Alzheimer's Disease
Activity CDPHP 1.1.5.1	Increase the number of identified partners that have distributed an approved and current Early Detection, Early Diagnosis concern, and awareness campaign. *(SHIP Objective AD 1.1)*
Activity CDPHP 1.1.5.2	Offer educational workshops and seminars for caregivers on topics directly related to preventing hospitalization for the person with Alzheimer's Disease.
Activity CDPHP 1.1.5.3	Increase promotional material to educate community on new blood tests that detect proteins associated with the disease and established tests like cognitive assessments, brain imaging (MRI, CT, PET scans), and the linkage between hearing loss & Alzheimer's.

Policy and system level changes needed to address identified causes of Chronic Disease Prevention & Health Promotion:

Addressing the root causes of Chronic Disease Prevention & Health Promotion requires shifting the focus from individual behavior to implementing upstream policy and system-level changes that shape the environments where people live, learn, work, and age.

These changes directly address the Social Drivers of Health (SDoH), which are the primary drivers of chronic disease.

Chronic Disease Prevention & Health Promotion

The goals, strategies, objectives, and activities for the Chronic Disease Prevention & Health Promotion (CDPHP) priority were developed and finalized during the Healthy Orange Collaborative Town Hall meeting in October 2025.The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

Chronic Disease Prevention & Health Promotion Partners

Name	Organization	Name	Organization
Rebecca Desir Mari Torres-Luengas	AdventHealth	Arthur Howell Suhaah Nadir Unnati Shah Valeria Ruiz	DOH-Orange
Angela Corona Claire White	Second Harvest Food Bank of Central Florida	Glen Providence Maya Sumair	Hebni Nutrition
Aurelia Annunziata	American Heart Association	Corissa McClellan	U.S. Hunger
Gloria Harris	Fit 2 Dance	Leroy Johnson	The Sharing Center
Kisha Gaines Stephen Schaefer	TFF Civic Communications	Barbara Mills	Alzheimer's Dementia Resource Ctr.
Abby Rice	Shepherd's Hope	Ebony Davis-Martin	Community Health Centers, Inc.

PRIORITY 6: COMMUNICABLE DISEASES

Communicable diseases continue to challenge public health due to their potential for rapid transmission and adverse community impact. The CHIP takes a collaborative, cross-sector approach to strengthen disease surveillance, support timely identification, and implement swift, coordinated responses that protect the health of all Orange County residents. Mitchell Michalak (DOH-Orange) will serve as the internal lead for this priority area. Andre Antenor (Positive Assistance) will serve as the external community liaison. The priority group will meet during the quarterly Area 7 meeting to monitor progress on all SMART objectives and activities listed in the table below.

Goal CD1:	**Reduce the risk of outbreaks, epidemics, and pandemics by controlling the rapid spread of Communicable Diseases.**
Strategy CD1.1:	Reduce the prevalence of communicable diseases to create a healthier and more resilient community.
Objective CD1.1.1	By December 31, 2028, increase the proportion of persons with HIV (PWH) who are linked to care within 30 days from 78.7% (2024) to 85%. **Organization(s) Responsible**: QLatinx, Area 7 HIV/AIDS Program, AdventHealth, Orlando Health, University of Florida, CTL MOA Approved Providers. **Data Source:** Persons with HIV (PWH) Continuum **See case definition**
Activity CD1.1.1.1	Conduct targeted community outreach campaigns, including social media and local events, to increase awareness and reduce stigma associated with PrEP.
Activity CD1.1.1.2	Partner with community-based organizations to offer free, confidential rapid HIV testing.
Activity CD1.1.1.3	Facilitate an emergency department-based HIV screening initiative to expand HIV testing and linkage to care.
Activity CD1.1.1.4	Ensure that individuals in high-priority populations who are newly diagnosed with HIV are linked through the Rapid Start program to medical care within 7 days of diagnosis by community care coordination services.
Objective CD1.1.2	By December 31, 2028, decrease the rate of congenital syphilis per 100,000 resident births from 91.7 (2023) to 50.0. **Organization(s) Responsible**: DOH-Orange STD Program, AdventHealth, Orlando Health, CTL MOA Approved Providers **Data Source:** Syphilis, Congenital
Activity CD1.1.2.1	Develop a coordinated, and rapid response protocol between the health department, birthing hospitals, and obstetrical providers to ensure that any pregnant person who screens positive for syphilis is immediately treated.

Activity CD1.1.2.2	Partner with various community partners to promote adherence to universal syphilis screening guidelines through education and awareness.
Objective CD1.1.3	By December 31, 2028, decrease the number of acute Hepatitis C cases from 165 (2024) to 130. **Organization(s) Responsible**: DOH-Orange STD Program, AdventHealth, Orlando Health, CTL MOA Approved Providers. **Data Source:** Hepatitis C, Acute
Activity CD1.1.3.1	Increase education and awareness of the risk factors for Hepatitis C infection and transmission through community partner initiatives.
Activity CD1.1.3.2	Increase access to testing and treatment through community-based screening and referrals across mobile clinics, health fairs, and public and private healthcare sites.
Objective CD1.1.4	By December 31, 2028, increase the percentage of immunization levels in Kindergarten from 85.4% (2025) to 95%. **Organization(s) Responsible**: DOH-Orange. **Data Source:** Immunization Levels in Kindergarten
Activity CD1.1.4.1	Conduct public awareness and education campaigns on vaccine safety and benefits.
Activity CD1.1.4.2	Partner with community groups and health care systems to ensure access to vaccines through mobile clinics, health fairs, and public and private healthcare sites.
Objective CD1.1.5	By December 31, 2028, increase the percentage of children fully immunized: Expanded Immunization Series (aged 2 years) from 76.8% (2024) to 95%. **Organization(s) Responsible**: DOH-Orange **Data Source:** Children Fully Immunized: Expanded Immunization Series (Aged 2 Years)
Activity CD1.1.5.1	Conduct public awareness and education campaigns on vaccine safety and benefits.
Activity CD1.1.5.2	Partner with community groups and health care systems to ensure access to vaccines through mobile clinics, health fairs, and public and private healthcare sites.
Objective CD1.1.6	By December 31, 2028, engage with two new community partners to increase response and preparedness capacity to emerging infectious diseases through multiple modes of surveillance. **Organization(s) Responsible**: DOH-Orange, Orange County Utilities, Orange County Health Services, University of Florida, AdventHealth, Orlando Health.

	Data Source: CDC's National Wastewater Surveillance System (NWSS)
Activity CD1.1.6.1	Increase the awareness regarding the utility of wastewater-based epidemiology and its integration into traditional surveillance streams through coordinated communications campaigns with community partners
Activity CD1.1.6.2	Timely reporting of forecasting models and early detections in surveillance to key stakeholders for coordinated outbreak or emerging infectious disease responses.

Policy and system level changes needed to address identified causes of Communicable Diseases:

Addressing the identified causes of communicable disease emergence and transmission requires comprehensive policy and system-level changes that transcend individual interventions. These changes focus on strengthening public health infrastructure, improving community collaboration, and addressing upstream social drivers of health.

Communicable Diseases

The goals, strategies, objectives, and activities for the Communicable Diseases (CD) priority were developed during the Healthy Orange Collaborative Town Hall meeting in October 2025 and finalized in November 2025 through a virtual meeting with Communicable Disease priority partners. The community partners listed below have accepted responsibility for implementing these strategies and completing the assigned objectives and activities. Community Partners are held accountable at quarterly meetings where progress toward goals, objectives and activities are discussed, including strategies to mitigate barriers to success.

Communicable Diseases Partners

Name	Organization	Name	Organization
Dr. Amelia Thompson	AdventHealth	Beth Paterniti Alvina Chu Alelia Munroe Kara Williams Willie Brown Mitchell Michalak Kelly Bastien Dean Hutchins William Haubenestel Gisella Suarez	DOH-Orange
Sara Osborne	Orlando Health	Gabriella Rodriguez	QLatinx

Dr. Joseph H. Bisesi	University of Florida	Dr. Ed Torres	Orange County Utilities
Dr. Raul Pino	Orange County Health Services		

Counseling Testing Linkage (CTL) Memorandum of Agreement (MOA) Approved Providers *

CAN Community Health, Inc.*	26Health, Inc*
Community Health Centers, Inc.*	Crew Community Health, Inc.*
Pineapple Healthcare, Inc.*	Harmony Healthcare Orlando, Inc.*
Curative Care Center*	Orange County Health Services*
Park Place Behavioral Health Center*	Access Health Plus*
Hope And Help*	Bliss CARES, Inc.*
Sunshine Specialty Health Outreach Foundation, Inc.*	Midway*
AUM Internation Foundation*	STEPS*
Aguilar Salud, Inc.*	The LGBT+ Center Orlando*
Unconditional Love (Comprehensive Healthcare)*	Community Care Resources*
Care First Foundation, Inc. dba Comprehensive Health Center of Orlando*	IMG Helps (Healthy MD)*
Healthcare Unity Group, Inc.*	Embrace Health, Inc.*
OIC Inspired, Inc.*	Invested Health Center, Inc.*
Miracle of Love*	Positive Assistance*

Appendix 1: Hanlon Method

The 2025 Central Florida Collaborative Community Health Needs Assessment utilized a modified Hanlon Method, which is an evidence-based technique which objectively takes into consideration explicitly defined criteria and feasibility factors. The process was conducted in two phases. The first phase was a pre-session survey where Central Florida Collaborative partners and others invited to participate in the process ranked each community for magnitude of need, severity of need and feasibility of addressing the need in their community. Based on the three criteria rankings, a priority score was calculated.

The second phase of the process was an in-person (Regional Needs Prioritization) or virtual (County Needs Prioritization) meeting. During the meeting, participants broke into small roundtable discussions to conduct the PEARL-E test for each of the community needs. The PEARL-E Test helps screen out community needs based on the following feasibility factors:

- **P**ropriety - Is addressing this community need suitable given community goals and values?
- **E**conomics - Does it make economic sense to address this community need? Are there potential economic consequences if it is not addressed?
- **A**cceptability - Will the community support efforts to address this community need? Is it wanted and culturally appropriate?
- **R**esources - Are resources (funding, staff, facilities, etc.) available or potentially available to address this community need?
- **L**egality - Are there legal or policy barriers to implementing solutions for this community need?
- **E**quity - Does addressing this community need promote equity by reducing health disparities and improving outcomes for underserved or marginalized populations?

At the end of each meeting, the participants voted for their top 15 needs. The needs that received the most votes were the top 15 community needs for each county.

Appendix 2: Healthy Orange Collaborative Steering Committee Agenda and Charter

Agenda

Florida Department of Health in Orange County
901 West Church Street, Orlando, FL 32805, 4th Floor Auditorium
September 29, 2025 – 9:00 a.m.- 11:00 a.m.

Meeting Purpose: Convene strategic partners to develop data-driven strategies for implementing evidence-based, targeted and integrated efforts to improve the health of the Orange County community.

Topic	Lead	Time	Summary of Key Points, Decisions & Action Items
▪ Welcome & Introductions	Dr. Robert Karch Director	9:00 a.m.	
▪ 2025 Orange County Community Health Needs Assessment (CHNA) Review	Donna Walsh Dhanya Lotfallah	9:15 a.m.	
▪ Activity - CHNA Prioritization	Jeff Feller Health Council	9:30 a.m.	
▪ Discussion - Health Care Partner Collective Impact & Model Practices	Group AdventHealth	10:30 a.m.	
- Strategic Partner Focus Group Charter & Purpose	Donna Walsh		
▪ Next Steps - Orange County Community Health Improvement Plan Session – October 7, 2025	Donna Walsh Dhanya Lotfallah	10:45 a.m.	
- Scheduled Meetings			
▪ Closing Comments/Adjourn	Dr. Karch	11:00 a.m.	

Healthy Orange Collaborative Steering Committee Charter 2026-2028

Purpose: The Community Health Planning Strategic Partners Focus Group comprises partners from diverse sectors to serve as a Community Health Improvement Plan Steering Committee. The primary function of the Community Health Improvement Plan Steering Committee is to develop data-driven strategies for implementing evidence-based, targeted and integrated efforts to improve the health of our community.

Primary Functions:

Leadership

- Prioritize health issues.
- Review and approve the Orange County Community Health Assessment and Improvement Plan.
- Review progress and oversee revisions to the plan annually.

Champion

- Advocate for Orange County Community Health Improvement Plan activities in their respective agencies and organizations, and across the county.

Activities:

- Set priorities for the Orange County Community Health Improvement Plan in alignment with the Orange County Community Health Assessment and State Health Improvement Plan.
- Discuss, revise and approve the Orange County Community Health Improvement Plan.
- Designate others to serve on Priority Area Workgroups.
- Review progress and consider revisions to the plan, at least annually.
- Regularly attend Steering Committee meetings.
- Nominate and select Steering Committee members.
- Nominate and select Steering Committee Chair.

Member Commitment:

- The term of service for Steering Committee members is the duration of the Orange County Community Health Improvement Plan.
- Any member of the Steering Committee may resign by submitting notice in writing or email to Steering Committee Chair.
- The Steering Committee shall meet twice annually for the duration of the plan.
- Decisions will be based either by consensus or majority vote of the members present at the meeting.

11/24/2025

Appendix 3: CHIP Annual Review/Town Hall Meeting Agenda

Community Health Improvement Plan
Annual Review Meeting Agenda

Details: Convene community partners to develop data-driven strategies for implementing evidence-based, targeted and integrated efforts to improve the health of the Orange County community.

Date and Time: October 7th, 2025

Address: 6101 Lake Ellenor, Orlando, FL 32809

Facilitator: Dhanya Lotfallah

Meeting Objectives:

1. Conduct a comprehensive review of the progress made in the last year toward achieving the goals and activities outlined in the Community Health Improvement Plan
2. Engage community members in discussions about the CHIP, gathering their feedback, ideas, and concerns to inform the plan's ongoing development and implementation of the 2026-2029 plan.

TIME	TOPIC	PRESENTER
9:00AM	*Welcome and Introductions*	Dr. Robert Karch
9:15AM-9:45AM	*Vision*	Dhanya Lotfallah
9:15AM-9:45AM	*CHIP Development, Priority Areas, and Progress*	Dhanya Lotfallah
9:15AM-9:45AM	*CHIP Implementation*	Dhanya Lotfallah
9:15AM-9:45AM	*Population(s) at Risk*	Dhanya Lotfallah
9:15AM-9:45AM	*Environmental Resiliency*	Dhanya Lotfallah
9:15AM-9:45AM	*Policy or Law Review*	Dhanya Lotfallah
9:15AM-9:45AM	*Key Accomplishments*	Dhanya Lotfallah
10:00AM-12:00PM	*CHIP 2026-2029 Planning*	Jeff Feller
	BREAK- Working Lunch	
12:30PM 2:30PM	*CHIP 2026- 2029 Planning Continued*	Jeff Feller
2:30PM-3:20PM	*Priority Group Reports*	Jeff Feller- Priority Group Presenter
3:20PM-3:25PM	*Partner Updates/Highlights*	Dhanya Lotfallah
3:25PM-3:30PM	*Media/Communication*	Dhanya Lotfallah
	ADJOURN	

CHIP Annual Town Hall Participants from Left to Right: Beth Paterniti, DOH-Orange; Jeff Feller, WellFlorida Council: Dr. Robert Karch, DOH-Orange; Christine Abarca, WellFlorida Council; Shelly Persaud, Dhanya Lotfallah & Donna Walsh, DOH-Orange.

CHIP Annual Town Hall Participants

Appendix 4: CHIP/SHIP/Healthy People 2030 Alignment

2025 CHNA Prioritized Need	Orange County CHIP Objectives & Activities		SHIP	Healthy People 2030
Economic Stability				
Affordable housing, including older adults	1. Activity AC1.1.2.1	1. Increase patient enrollment and utility at FQHCs through PCAN collaboration, community events, and enrollment educational sessions.		
Food Insecurity	1. Activity CDPHP 1.1.1.3	1. Collect food insecurity screening data needs across the county from organizational based systems.	1. SHIP Objective 4.2	1. NWS- 01
Jobs with livable wages				
Health Care Access and Quality				
Improved care coordination among healthcare providers	1. Activity BH1.1.1.2 2. Activity CDPHP 1.1.1.1 3. Activity CD1.1.2.1	1. Increase collaboration with community partners to coordinate services for individuals experiencing a mental health crisis who do not require inpatient psychiatric hospitalization through care coordination. 2. Improve hospital discharge care coordination for patients due to a diabetes-related event through educational seminars. 3. Develop a coordinated, and rapid response protocol between the health department, birthing hospitals, and obstetrical providers to ensure that any	2. SHIP Objective 4.2	2. D-06 3. STI-04

		pregnant person who screens positive for syphilis is immediately treated.		
Programs for chronic disease prevention and education	1. Objective CDPHP 1.1.1 2. Objective CDPHP 1.1.2 3. Objective CDPHP 1.1.3 4. Objective CDPHP 1.1.4 5. Objective CDPHP 1.1.5	1. By December 31, 2028, decrease hospitalizations from diabetes per 100,000 from 3,968 (2024) to 3,300. 2. By December 31, 2028, decrease hospitalizations from coronary heart disease per 100,000 from 4,544 (2024) to 4,000. 3. By December 31, 2028, decrease the number of emergency department (ED) visits for asthma among children and adolescents aged 0–17 years by 2,125 (2024) to 2,000. 4. By December 31, 2028, reduce the proportion of middle and high school students in Orange County who report using cigarettes, Cigars, Electronic Vapor Products or Hookah in the past 30 Days from 6.5% (2024) to 5.8%. 5. By December 31, 2028, decrease the number of hospitalizations from Alzheimer's Disease from 182 (2024) to 165.	1. SHIP Objective 4.2 4. SHIP Objective CD1.1	1. D-06 2. HDS-04 3. RD-04 4. TU-06, TU-08, TU-07, TU,05 5. DIA-02
Maternal and prenatal care, including more OB/GYN providers	1. Objective MCH1.1.1 2. Objective MCH1.1.2 3. Objective MCH1.1.3 4. Objective MCH1.1.4	1. By December 31, 2028, increase the percentage of Orange County mothers initiating prenatal care in the 1st trimester from 66.1% (2023) to 73%. 2. By December 31, 2028, decrease the number of births to mothers who were overweight at time pregnancy occurred	1. SHIP Objective MCH3.1 3. SHIP Objective ISV1.1	2. MICH-08 3. MICH-02 4. MICH-16

		from 29.4% (2024) to 26.0%. 3. By December 31, 2028, decrease infant mortality rates deaths per 1,000 live births from 5.7% (2021) to 4.5%. 4. By December 31, 2028, increase the proportion of Orange County mothers who initiated breastfeeding from 89.9% (2023) to 94%.		
Impact of social media on the mental health of children	1. Activity BH1.1.3.1	1. Reduce the percentage of adolescents/young adults who feel sad or hopeless over the last year through mental health counseling.	1. SHIP Objective MW2.2	1.MHMD-06
Access to outpatient mental health service	1. Activity BH1.1.1.3 2. Activity BH1.1.2 3. Activity BH1.1.2.2	1. Connect with outreach and early intervention programs which target high-risk populations (e.g., individuals with a history of frequent hospitalizations, uninsured/underinsured groups, specific age demographics) with proactive mental health screenings, education, and outpatient treatment services. 2. Provide 1000 residents every year with access to mental health counseling among community partners. 3. Provide 1000 residents with mental health concerns every year with access to telemedicine services among community partners.	3. SHIP Objective MW1.3	2. MHMD- 04
Substance use treatment services	1. Objective BH1.3.1	1. By December 31, 2028, decrease drug overdose deaths for opioids in Orange County per	1. SHIP Objective MW3.4	1. IVP-20

		100,000 from 23.6 (2023) to 20.0.		
Neighborhood and Built Environment				
Transportation, especially to medical appointments and public transportation	1. Activity BH1.1.2.3 2. Activity AC1.1.2.3	1. Provide access to transportation for mental health services among community partners through entity-based services. 2. Increase transportation access to primary care entities through screening questions, hospital navigators, and educational resources.	1. SHIP Objective MW1.3	
Social and Community Context				
Improved Health literacy resources	1. Activity AC1.1.1.2	1. Enhance community education initiatives related to access to services and resources that address Social Drivers of Health (SDoH) needs through FindHelp and Unite Us and other “Closing the Loop” referral tools with partner organizations.		1. HC/HIT-R01
General awareness of resources, including prenatal care services for new residents*	1. Objective MCH1.1.1 2. Activity MCH1.1.1.1	1. By December 31, 2028, increase the percentage of Orange County mothers initiating prenatal care in the 1st trimester from 66.1% (2023) to 73%. 2. Partner with hospitals, Federally Qualified Healthcare, community health centers, obstetric clinics to implement warm referrals for newly pregnant patients to early prenatal care by utilizing “Closing the Loop” referral tools.	1. SHIP Objective MCH3.1	1. MICH-08
Linguistically and culturally appropriate	1. Activity MCH1.1.1.2	1. Incorporate health literacy intervention and navigation support to	1. SHIP Objective MCH3.1	1. HC/HIT-R01

healthcare services and resources	2. Activity AC1.1.2.2	overcome barriers by sustaining the language line systems and providing education material in multiple languages. 2. Increase community organization engagement in opportunities to provide knowledge of referral platforms and culturally and linguistic resources through Find Help and United Us and other “Closing the Loop” referral tools with partner organizations.		
Building trust with vulnerable populations	1. Objective AC1.1.3 2. Objective IPS1.1.2	1. By December 31, 2028, decrease the number of people uninsured from 171,685 (2023) to 168,685. 2. By December 31, 2028, reduce non-fatal injury hospitalizations in the vulnerable population from an age adjusted rate of 512.5 (2021) to 500.0.	2. SHIP Objective ISV3.2	1. AHS-01

APPENDIX 5: Assets and Resources

Healthy Orange Loop – Where Community and Resources Meet to Close the Loop on Health

HealthyOrangeLoop.org is your one-stop connection to free or reduced-cost health, wellness and more in Orange County. "Support Made Simple" – Start Your Search Here:

Social Services | HealthyOrangeLoop.org

If you or someone you know is in crisis, call or text 988 to reach the Suicide and Crisis Lifeline, chat with them online via their website, or text HOME to 741741 (multiple languages available). If this is an emergency, call 911.

Maternal Child Health

Organization	Website Resource
DOH-Orange	https://orange.floridahealth.gov/
Nemours Children's Health	https://www.nemours.org/
Orlando Health	https://www.orlandohealth.com/
AdventHealth	https://www.adventhealth.com/
Florida Breastfeeding Coalition	https://www.flbreastfeeding.org/
University of Central Florida	https://www.ucf.edu/
Fetal Alcohol Spectrum Disorders Clinic	https://www.thefloridacenter.org/what-we-do/fetal-alcohol-spectrum-disorders-clinic/
Healthy Start Coalition of Orange County	https://healthystartorange.org/
Foundation for a Healthier West Orange	https://fhwo.org/
Center for Multicultural Wellness and Prevention	https://cmwp.org/
Aetna Better Health of Florida	https://www.aetnabetterhealth.com/florida/index.html
Community Health Centers, Inc.	https://www.chcfl.org/

Behavioral Health Community Partners

Organization	Website Resource
Mental Health Association of Central FL	https://mhacf.org/
Victim Service Center of Central FL	https://victimservicecenter.org/
Central Florida Cares	https://centralfloridacares.org/https://www.orlandohealth.com/
Orlando Health	https://www.orlandohealth.com/
AdventHealth	https://www.adventhealth.com/
La Amistad Behavioral Health Services, University Behavioral Center, Central Florida Behavioral Hospital, Palm Point Behavioral Health	https://lamistad.com/
DOH-Orange	https://orange.floridahealth.gov/
Community Health Centers, Inc.	https://www.chcfl.org/
Aspire Health	https://aspirehealthpartners.com/
University of Central Florida Police Department	https://police.ucf.edu/
Orange County Drug-Free Coalition	https://www.orangecountyfl.net/FamiliesHealthSocialSvcs/DrugFreeCoalition.aspx
Department of Veterans Administration	https://www.floridavets.org/
Aetna Better Health of Florida	https://www.aetnabetterhealth.com/florida/index.html

Access to Care Community Partners

Organization	Website Resource
AdventHealth	https://www.adventhealth.com/
Orlando Health	https://www.orlandohealth.com/
Primary Care Access Network	https://www.pcanorangecounty.com/
Blue Cross Blue Shield	https://www.floridablue.com/
Senior Resource Alliance	https://www.seniorresourcealliance.org/
DOH-Orange	https://orange.floridahealth.gov/

True Health	https://www.mytruehealth.org/
Aetna Better Health of Florida	https://www.aetnabetterhealth.com/florida/index.html
Central Florida Foundation	https://cffound.org/
Community Health Centers, Inc.	https://www.chcfl.org/
Grace Medical Home	https://www.gracemedicalhome.org/
University of Central Florida	https://www.ucf.edu/
Community Care Plan	https://ccpcares.org/
Center for Multicultural Wellness and Prevention	https://cmwp.org/
Florida Impact	https://floridaimpact.org/
Shepherd's Hope	https://www.shepherdshope.org/

Injury Prevention and Safety Community Partners

Organization	Website Resource
Children's Safety Village	https://childrensafetyvillage.org/
Victim Service of Central Florida	https://victimservicecenter.org/
Harbor House	https://www.harborhousefl.com/
Orange County Sheriff's Office	https://www.ocso.com/en-us/
Orlando Health	https://www.orlandohealth.com/
Senior Resource Alliance	https://www.seniorresourcealliance.org/
AdventHealth	https://www.adventhealth.com
Department of Children and Families	https://www.myflfamilies.com/
Metroplan Orlando	https://metroplanorlando.gov/
DOH-Orange	https://orange.floridahealth.gov/

Chronic Disease Prevention & Health Promotion Partners

Organization	Website Resource
AdventHealth	https://www.adventhealth.com/
Second Harvest Food Bank of Central Florida	https://feedhopenow.org/
American Heart Association	https://www.heart.org/
Fit 2 Dance	https://fittodance2.com/
TFF Civic Communications	https://tobaccofreeflorida.com
Shepherd's Hope	https://www.shepherdshope.org/

DOH-Orange	https://orange.floridahealth.gov/
Hebni Nutrition	https://www.hebninutrition.org/about-us
U.S. Hunger	https://ushunger.org/
The Sharing Center	https://thesharingcenter.org/
Alzheimer's Dementia Resource Ctr.	https://adrccares.org/
Community Health Centers, Inc.	https://www.chcfl.org/

Communicable Diseases Partners

Organization	Website Resource
AdventHealth	https://www.adventhealth.com/
Orlando Health	https://www.orlandohealth.com/
DOH-Orange	https://orange.floridahealth.gov/
QLatinx	https://www.qlatinx.org/

APPENDIX 6: Quarterly Evaluation Report

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

DOH-Orange utilizes the Performance Improvement and Management System (PIMS) for CHIP monitoring. Priority objectives are prepopulated into the system and quarterly data is collected from the community partners and entered by the CHIP facilitator.
Quarterly data collection allows for frequent monitoring of CHIP activities and provides opportunities to review progress of the plan.

OVERALL CHIP OBJECTIVE PROGRESS

	SMART Objective	Baseline Date	Baseline Data	Data Type (percent, rate, count)	Target Date	Target Data	January-September 2025 Status
2	List the SMART objectives from your current plan. Add new objective at the end, if needed.	Provide the year of initial data (from the SMART objective).	Provide the initial data (from the SMART objective).	Will data be reported as a percent, rate, or count?	Provide the year the objective is targeted to be complete (from the SMART objective).	Provide the data target (from the SMART objective).	For this reporting period, was the objective on track, not on track, complete, or discontinued?
3	By December 31, 2025, decrease infant mortality for all races in Orange County per 1000 live births from 5.8 (2021) to 5.2	1/1/2021	5.8 (2021)	Rate	12/31/2025	5.2	On Track
4	By December 31, 2025, decrease infant deaths from Sudden Unexpected Infant Death (SUID) per 1000 live births from 14 (2021) to 9 (SHIP Objective ISV1.1)	1/1/2021	14 (2021)	Rate	12/31/2025	9	On Track
5	By December 31, 2025, interview the same mothers to increase the proportion of infants to exclusively breastfeed through 6 months of age to 42.4% (6-month target), and to continue breastfeeding through 12th month of age to 54.1% (12- month target) from 35% in 2018	1/1/2021	35% (2018)	Percent	12/31/2025	42.4% (6-month target), 54.1% (12-month target)	On Track
6	By December 31, 2025, reduce newly diagnosed cases of HIV in the Black population per 100,000 from 146 (2021) to 110.	1/1/2021	146 (2021)	Rate	12/31/2025	110	On Track
7	By December 31, 2025, reduce newly diagnosed cases of AIDS in the Black population per 100,000 from 62 (2021) to 51.	1/1/2021	62 (2021)	Rate	12/31/2025	51	On Track
8	By December 31, 2025, decrease the number of adults aged 18 years and older with involuntary examinations (Baker Act) from 11,975 (2021) to 10,700 examinations (SHIP Objective MW1.3)	1/1/2021	11,975 (2021)	Count	12/31/2025	10,700	On Track

A Town Hall meeting is held annually to assess the CHIP progress and to review and revise the plan as needed.