2023

COMMUNITY HEALTH NEEDS ASSESSMENT

HealthPark Medical Center Service Area (Market Area 4)
Lee County, Florida

Sponsored by
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Prepared by PRC

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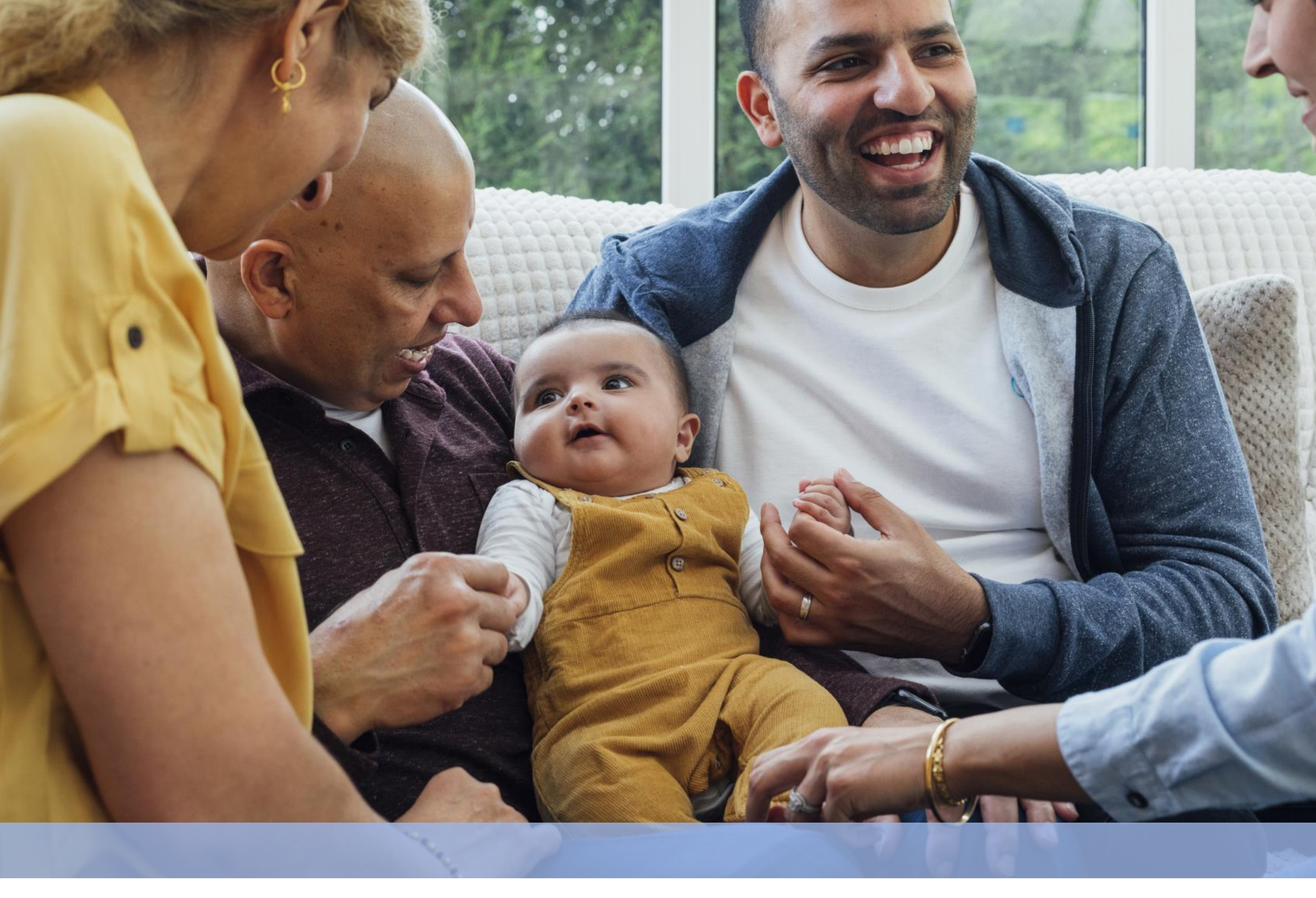


INTRODUCTION

PROJECT OVERVIEW

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2007, 2011, 2014, 2017, and 2020, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of HealthPark Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment — part of a larger, countywide assessment effort by Lee Health — was conducted on behalf of HealthPark Medical Center by PRC, Inc., a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

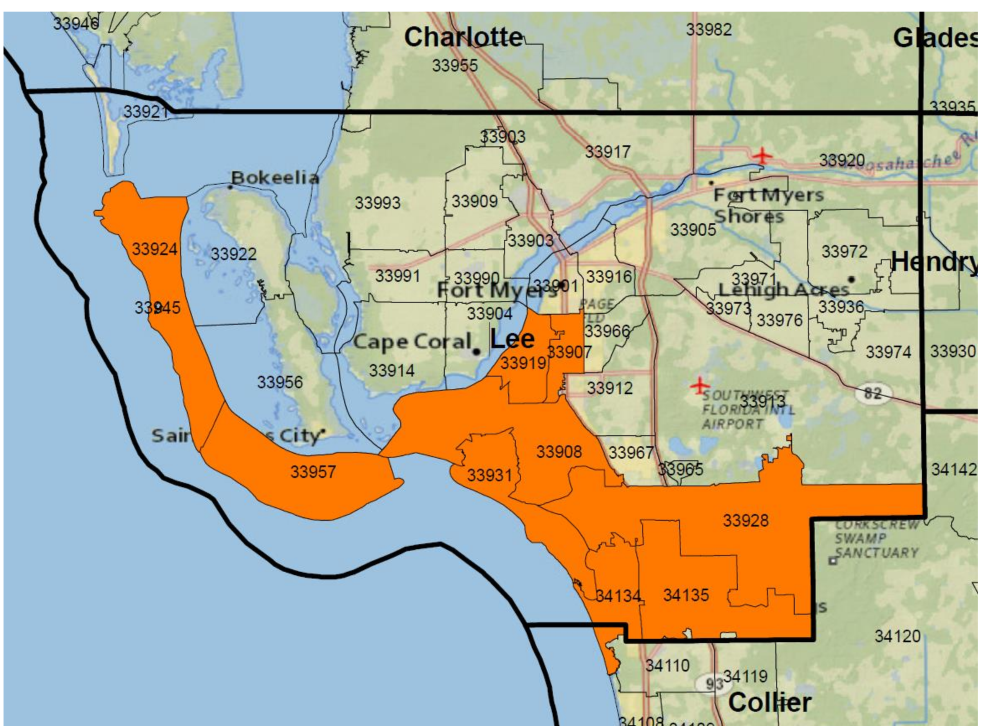
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Lee Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “HPMC Service Area” in this report) is defined as each of the residential ZIP Codes comprising Market Area 4 in southwest Lee County, including 33907, 33908, 33919, 33931, 33924, 33957, 33928, 34134, and 34135. This community definition, determined based on the ZIP Codes of residence of recent patients of HealthPark Medical Center, is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 251 individuals age 18 and older in the HPMC Service Area. All administration of the surveys, data collection, and data analysis was conducted by PRC.

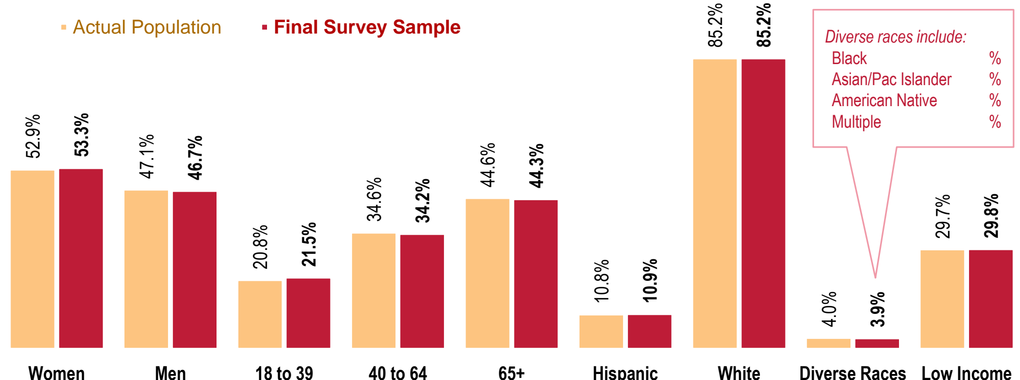
For statistical purposes, the maximum rate of error associated with a sample size of 251 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the HPMC Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(HPMC Service Area, 2023)



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2023 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. "White" reflects those who identify as White alone, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented throughout the county as part of this process. A list of recommended participants was provided by Lee Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Note that key informant input was drawn from a more regional administration that included all of Lee County. In all, 80 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	8
Public Health Representatives	5
Other Health Providers	14
Social Services Providers	26
Other Community Leaders	27

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Abuse Counseling & Treatment, Inc.
- Alvin A. Dubin Alzheimer's Resource Center
- Arthrex
- B & I Contractors, Inc.
- BJM Consulting, Inc.
- Cafe of Life, Inc.
- Center for Progress and Excellence
- Charlotte Behavioral Health Care
- Child Care of Southwest Florida, Inc.
- Children's Network of SWFL
- Chris-Tel Construction
- Collaboratory
- Community Assisted Supported Living
- Community Cooperative
- David Lawrence Center
- Deaf and Hard of Hearing Center
- District Eight Health Planning Council
- D-Signed Nutrition, LLC
- Edison National Bank
- F.I.S.H. of Sanibel-Captiva, Inc.
- Florida Department of Health – Lee County
- Florida Gulf Coast University
- Golisano Children's Hospital
- Golisano Children's Hospital/ Pediatric ENT
- Guardian ad Litem Foundation
- Harry Chapin Food Bank
- Healthy Start of Southwest Florida
- Hodges University
- HOPE Clubhouse
- Hope HealthCare Services
- Interfaith Charities of South Lee
- LARC, Inc.
- LCH Board of Directors
- Lee Community Healthcare
- Lee County
- Lee County Government
- Lee County Medical Society
- Lee Economic Development Office
- Lee Health
- Lee Health Foundation
- Lee Physician Group
- March of Dimes
- Markham Norton Mosteller Wright & Co. PA
- McGriff Insurance Services
- Millennium Physician Group
- Minnesota Twins Baseball
- Park Royal Hospital
- Physicians Primary Care
- Physicians Primary Care Ob-Gyn
- Physicians Primary Care, Community Health Improvement (CHI) Committee
- Premier Mobile
- PricewaterhouseCoopers LLP
- Priority Marketing
- Private Practice, Community Health Improvement (CHI) Committee
- Quality Life Center
- SalusCare, Inc.
- Shell Point Retirement Community
- Stevens Construction, Inc.
- Stillwell Enterprises
- Studio+
- The Heights Center, Inc.
- The Lee County Coalition for a Drug-Free Southwest Florida
- The Sanibel Captiva Trust Company
- United Way Lee, Hendry, Glades
- Valerie's House
- Village of Estero

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Lee County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level (Lee County) data.

Benchmark Data

Trending

Similar surveys were administered in the HPMC Service Area in 2007, 2011, 2014, 2017, and 2020 by PRC on behalf of HealthPark Medical Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Florida Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

HealthPark Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, HealthPark Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. HealthPark Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	25
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	116
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	123

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Barriers to Access – Appointment Availability – Difficulty Finding a Physician – Lack of Transportation ▪ Primary Care Physician Ratio ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cancer Prevalence
DIABETES	▪ Diabetes Deaths ▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ Alzheimer’s Disease Deaths ▪ Increasing Confusion/Memory Loss
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Distracted Driving

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Low Food Access ▪ Difficulty Accessing Fresh Produce ▪ Sugar-Sweetened Drinks ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults]
ORAL HEALTH	▪ Dental Insurance Coverage
RESPIRATORY DISEASE	▪ Asthma Prevalence [Adults]
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Use of Marijuana ▪ Use of Prescription Opioids ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Smokeless Tobacco Use

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Use
3. Diabetes
4. Access to Health Care Services
5. Nutrition, Physical Activity & Weight
6. Disabling Conditions
7. Heart Disease & Stroke
8. Infant Health & Family Planning
9. Cancer
10. Injury & Violence
11. Oral Health
12. Tobacco Use
13. Respiratory Diseases

Hospital Implementation Strategy

HealthPark Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, HPMC Service Area results are shown in the larger, gray column.
- The columns to the right of the service area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the HPMC Service Area compares favorably (☀), unfavorably (☂), or comparably (☁) to these external data.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2007 (or earliest available data). Note that survey data reflect the ZIP Code-defined HPMC Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect county-level (Lee County) data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

	HPMC Service Area	HPMC vs. BENCHMARKS			
SOCIAL DETERMINANTS		vs. FL	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	4.8 [County-Level Data]	6.2	4.0		
Population in Poverty (Percent)	12.1 [County-Level Data]	13.1	12.6	8.0	
Children in Poverty (Percent)	18.7 [County-Level Data]	18.2	17.1	8.0	
No High School Diploma (Age 25+, Percent)	10.2 [County-Level Data]	11.0	11.1		
Unemployment Rate (Age 16+, Percent)	2.9 [County-Level Data]	2.3	3.3		10.8
% Worry/Stress Over Rent/Mortgage in Past Year	36.6		45.8		
Population With Low Food Access (Percent)	37.0 [County-Level Data]	25.1	22.2		
% Food Insecure	27.0		43.3		17.7

better similar worse

	HPMC Service Area	HPMC vs. BENCHMARKS			
OVERALL HEALTH		vs. FL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	18.0	14.7	15.7		15.1

better similar worse

ACCESS TO HEALTH CARE	HPMC Service Area	HPMC vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	18.8	22.6	8.1	7.6	26.2
% Difficulty Accessing Health Care in Past Year (Composite)	52.6		52.5		28.1
% Cost Prevented Physician Visit in Past Year	14.9	14.0	21.6		10.1
% Cost Prevented Getting Prescription in Past Year	13.6		20.2		12.3
% Difficulty Getting Appointment in Past Year	38.1		33.4		13.3
% Inconvenient Hrs Prevented Dr Visit in Past Year	11.7		22.9		9.8
% Difficulty Finding Physician in Past Year	27.4		22.0		7.9
% Transportation Hindered Dr Visit in Past Year	10.7		18.3		2.9
% Language/Culture Prevented Care in Past Year	1.4		5.0		1.3
% Stretched Prescription to Save Cost in Past Year	17.7		19.4		16.5
Primary Care Doctors per 100,000	92.9 [County-Level Data]	108.0	107.3		
% Have a Specific Source of Ongoing Care	71.4		69.9	84.0	81.1
% Routine Checkup in Past Year	76.4	76.9	65.3		78.9
% Two or More ER Visits in Past Year	15.4		15.6		6.2
% Rate Local Health Care "Fair/Poor"	16.7		11.5		11.8
% Have Heard of Healthy Lee Community Initiatives	19.2				13.2

better similar worse

CANCER	HPMC Service Area	HPMC vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	**121.0** [County-Level Data]	139.0	146.5	122.7	142.5
Lung Cancer Deaths per 100,000 (Age-Adjusted)	**29.5** [County-Level Data]	32.7	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	**16.7** [County-Level Data]	18.4	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	**11.6** [County-Level Data]	16.0	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	**10.1** [County-Level Data]	12.4	13.1	8.9	
Cancer Incidence per 100,000 (Age-Adjusted)	**428.2** [County-Level Data]	460.5	449.4		
Lung Cancer Incidence per 100,000 (Age-Adjusted)	**51.1** [County-Level Data]	56.1	56.3		
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	**113.9** [County-Level Data]	122.3	128.1		
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	**80.8** [County-Level Data]	97.9	109.9		
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	**30.2** [County-Level Data]	36.0	37.7		
% Cancer	**15.9**	13.3	7.4		15.9
% Wear Sunscreen on Sunny Summer Days	**18.9**				21.9
% [Women 50-74] Breast Cancer Screening	**80.9**	79.2	64.0	80.5	87.7
% [Women 21-65] Cervical Cancer Screening	**72.0**	76.7	75.4	84.3	78.3
% [Age 50-75] Colorectal Cancer Screening	**94.1**	72.5	71.5	74.4	84.2

better similar worse

DIABETES	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	17.2 [County-Level Data]	20.6	22.6		13.5
% Diabetes/High Blood Sugar	12.1	11.8	12.8		13.3
% Borderline/Pre-Diabetes	16.9		15.0		9.5
Kidney Disease Deaths per 100,000 (Age-Adjusted)	4.6 [County-Level Data]	9.6	12.8		7.2

better similar worse

DISABLING CONDITIONS	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	40.4		38.0		30.9
% Activity Limitations	29.3		27.5		18.2
% High-Impact Chronic Pain	23.9		19.6	6.4	
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	16.5 [County-Level Data]	19.1	30.9		10.2
% [Age 45+] Increasing Confusion/Memory Loss	19.8				11.9
% Caregiver to a Friend/Family Member	22.7		22.8		20.9

better similar worse

HEART DISEASE & STROKE	HPMC Service Area	vs. FL	vs. US	vs. HP2030	TREND
		HPMC vs. BENCHMARKS			
Heart Disease Deaths per 100,000 (Age-Adjusted)	110.9 [County-Level Data]	142.1	164.4	127.4	137.7
% Heart Disease	13.5	7.6	10.3		10.7
Stroke Deaths per 100,000 (Age-Adjusted)	24.9 [County-Level Data]	41.2	37.6	33.4	20.9
% Stroke	4.9	3.6	5.4		2.6
% High Blood Pressure	46.3	33.5	40.4	42.6	36.4
% High Cholesterol	47.9		32.4		39.5
% 1+ Cardiovascular Risk Factor	97.2		87.8		83.5

better similar worse

INFANT HEALTH & FAMILY PLANNING	HPMC Service Area	vs. FL	vs. US	vs. HP2030	TREND
		HPMC vs. BENCHMARKS			
No Prenatal Care in First 6 Months (Percent of Births)	7.7 [County-Level Data]	7.4	6.1		6.6
Teen Births per 1,000 Females 15-19	20.8 [County-Level Data]	18.4	19.3		
Low Birthweight (Percent of Births)	8.2 [County-Level Data]	8.7	8.2		
Infant Deaths per 1,000 Births	5.7 [County-Level Data]	5.8	5.5	5.0	6.2
% Would Not Want Newborn Vaccinated	17.6				

better similar worse

INJURY & VIOLENCE	HPMC Service Area	HPMC vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	70.7 [County-Level Data]	58.8	51.6	43.2	42.6
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	15.2 [County-Level Data]	14.7	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)	68.3 [County-Level Data]	68.9	67.1	63.4	
% [Age 45+] Injured as the Result of a Fall in Past Year	18.5				
% Texted While Driving in the Past Month	28.9				16.6
% [Those w/Pools] Pool Has Safety Features	88.9				88.8
Homicide Deaths per 100,000 (Age-Adjusted)	6.2 [County-Level Data]	7.0	6.1	5.5	7.6
Violent Crimes per 100,000	339.7 [County-Level Data]	433.9	416.0		
% Victim of Violent Crime in Past 5 Years	2.8		7.0		1.0
% Victim of Intimate Partner Violence	13.2		20.3		11.8

better similar worse

MENTAL HEALTH	HPMC Service Area	HPMC vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	19.7		24.4		9.2
% Diagnosed Depression	27.2	14.7	30.8		17.1
% Symptoms of Chronic Depression	39.7		46.7		20.8

MENTAL HEALTH (continued)	HPMC Service Area	vs. FL	vs. US	vs. HP2030	TREND
		HPMC vs. BENCHMARKS			
% Typical Day Is "Extremely/Very" Stressful	13.9		21.1		8.9
Suicide Deaths per 100,000 (Age-Adjusted)	14.9 [County-Level Data]	14.3	13.9	12.8	15.5
Mental Health Providers per 100,000	87.3 [County-Level Data]	114.3	146.6		
% Have Ever Sought Help for Mental Health	37.1				
% Receiving Mental Health Treatment	19.5		21.9		13.4
% Unable to Get Mental Health Services in Past Year	7.4		13.2		

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	HPMC Service Area	vs. FL	vs. US	vs. HP2030	TREND
		HPMC vs. BENCHMARKS			
% "Very/Somewhat" Difficult to Buy Fresh Produce	28.6		30.0		12.8
% 7+ Sugar-Sweetened Drinks in Past Week	24.7				17.3
% No Leisure-Time Physical Activity	27.8	26.8	30.2	21.8	22.6
% Meet Physical Activity Guidelines	27.7	27.0	30.3	29.7	27.3
Recreation/Fitness Facilities per 100,000	10.1 [County-Level Data]	12.3	11.9		
% Overweight (BMI 25+)	63.8	64.1	63.3		59.5
% Obese (BMI 30+)	27.4	28.4	33.9	36.0	19.0

better similar worse

ORAL HEALTH	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% Have Dental Insurance	61.9		72.7	75.0	54.0
% Dental Visit in Past Year	65.3	61.2	56.5	45.0	70.5

better similar worse

RESPIRATORY DISEASE	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	26.2 [County-Level Data]	35.1	38.1		32.7
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	6.1 [County-Level Data]	9.1	13.4		5.4
COVID-19 Deaths per 100,000 (Age-Adjusted)	37.5 [County-Level Data]	56.4	85.0		
% Asthma	11.3	7.3	17.9		6.2
% COPD (Lung Disease)	9.0	7.5	11.0		9.2

better similar worse

SEXUAL HEALTH	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	324.2 [County-Level Data]	612.5	379.7		
Chlamydia Incidence per 100,000	404.9 [County-Level Data]	465.7	481.3		
Gonorrhea Incidence per 100,000	148.5 [County-Level Data]	189.9	206.5		

better similar worse

SUBSTANCE USE	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	17.6 [County-Level Data]	12.0	11.9		12.2
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	14.1 [County-Level Data]	13.1	12.5	10.9	
% Excessive Drinking	22.5	22.6	34.3		20.8
% Drinking & Driving in Past Month	5.4	2.0			2.9
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	37.6 [County-Level Data]	25.9	21.0		10.2
% Used an Illicit Drug in Past Month	4.2		8.4		2.2
% Used Marijuana in the Past Month	15.3				8.0
% Used a Prescription Opioid in Past Year	19.7		15.1		11.4
% Ever Sought Help for Alcohol or Drug Problem	6.6		6.8		1.9
% Personally Impacted by Substance Use	40.2		45.4		34.6

better similar worse

TOBACCO USE	HPMC Service Area	HPMC vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% Smoke Tobacco Products	**14.1**				
% Someone Smokes at Home	**8.6**		17.7		7.3
% Use Vaping Products	**9.9**	5.7	18.5		6.6
% Use Smokeless Tobacco	**4.0**	2.3			0.7

better similar worse

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

Total Population
(Estimated Population, 2017-2021)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Lee County	752,251	781.01	963
Florida	21,339,762	53,653.42	398
United States	329,725,481	3,533,041.03	93

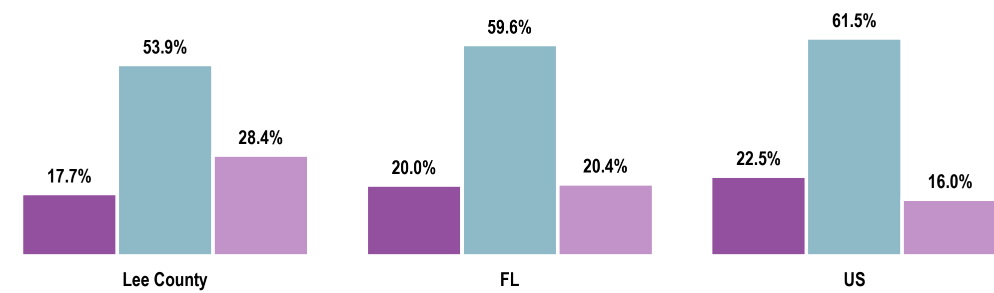
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]

Total Population by Age Groups
(2017-2021)

▪ Age 0-17 ▪ Age 18-64 ▪ Age 65+

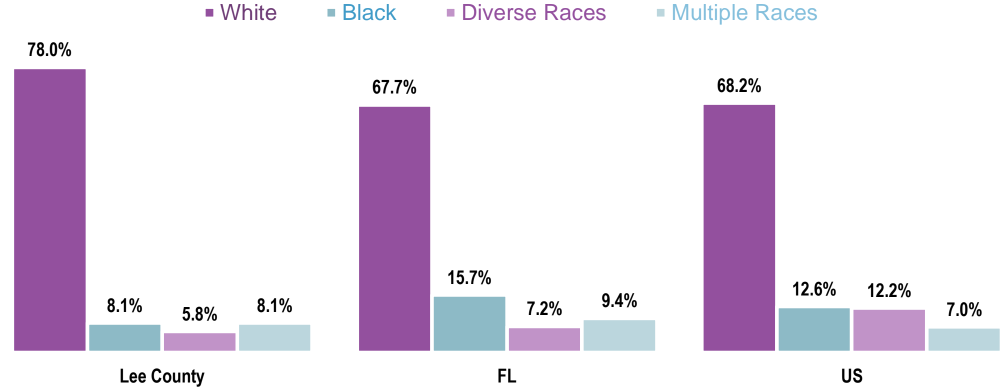


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Race & Ethnicity

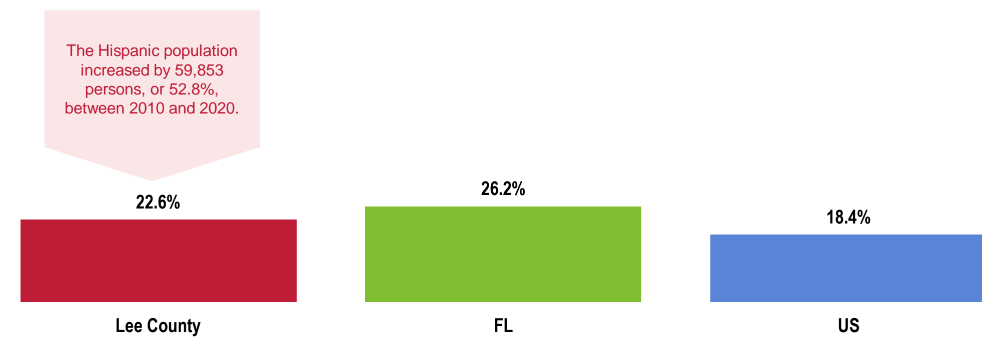
Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The following charts illustrate the racial and ethnic makeup of our community. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

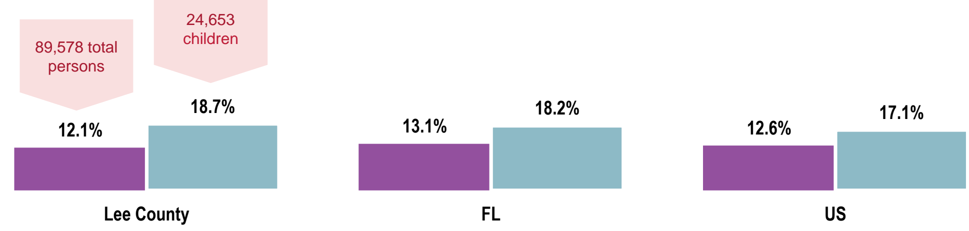
Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]

Percent of Population in Poverty
(2017-2021)
Healthy People 2030 = 8.0% or Lower

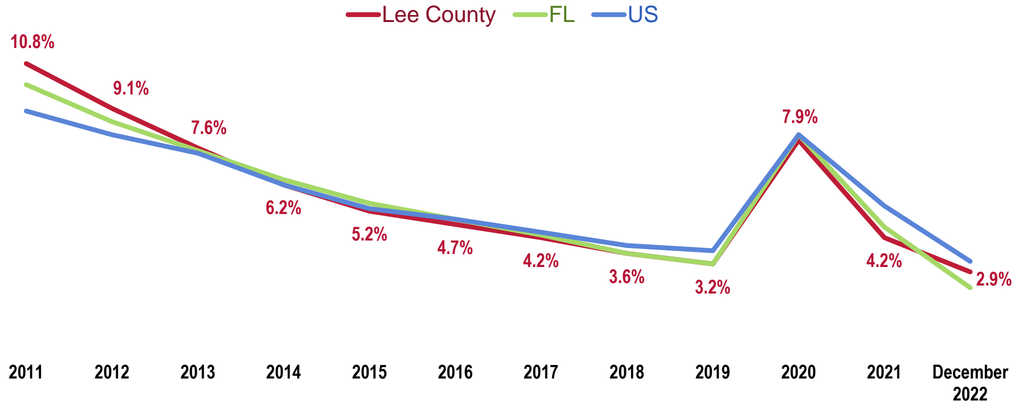


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]

Unemployment Rate
(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)

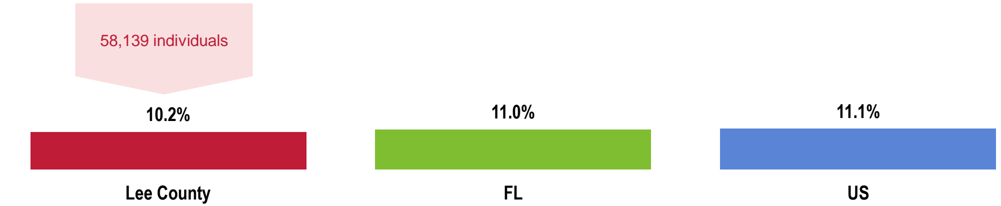


Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2017-2021)

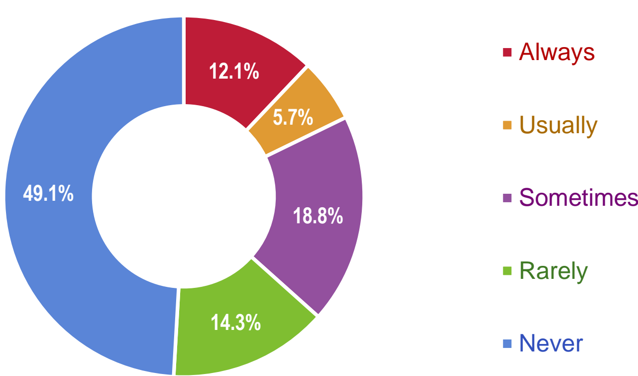


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

PRC SURVEY ▶ **"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"**



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: • Asked of all respondents.

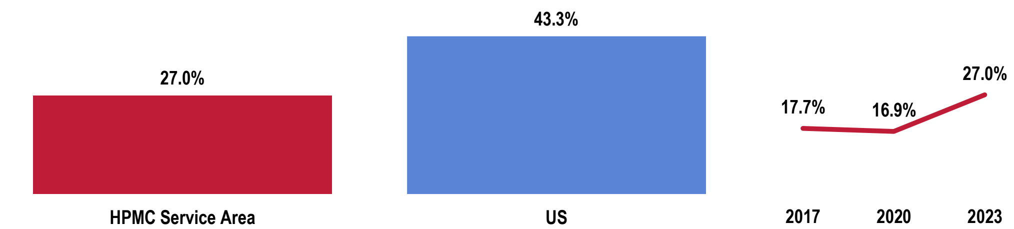
Food Insecurity

PRC SURVEY ▶ **"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.**

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

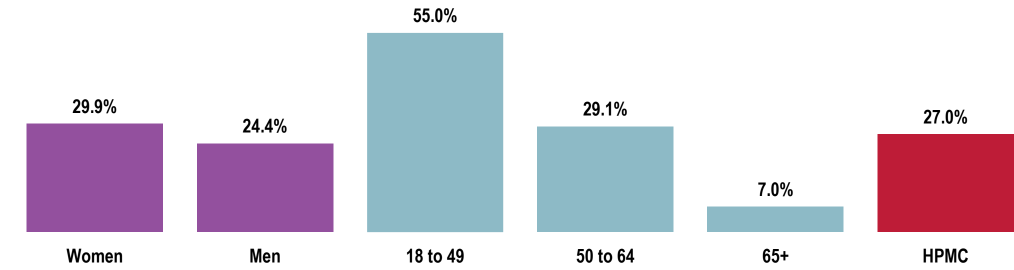
Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(HPMC Service Area, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health* as a problem in the community:

Perceptions of Social Determinants of Health as a Problem in the Community
(Among Key Informants; Lee County, 2023)

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Housing

> Without stable affordable housing and access to income as well as medical benefits, individuals struggle to access regular follow up care. It is difficult to focus on taking your medications, attending appointments and such when you are too busy trying to figure out where you are going to be able to sleep that is safe or how you will get your next meal. Many times, individuals end up with extended stays in hospitals, emergency rooms, and inpatient mental health and substance use treatment facilities due to lack of housing or access to income to support themselves in the community. – Social Services Provider
>
> Housing environment due to Hurricane Ian; Health behaviors due to lack of education, lack of proper health care, social and environmental factors. – Community Leader
>
> Housing supply at a premium affordability, growing influx of illegal immigrants without appropriate integration in fiscal and educational and health resources Lack of sufficient primary care providers – Community Leader
>
> There have been increased housing challenges since COVID-19 that were exacerbated by Hurricane Ian. Many families were displaced as a result of these tragedies. This has increased stress on families and patients. – Physician
>
> We had a shortage of affordable housing to begin with, after Hurricane Ian the housing shortage became worse, and many families had to leave the area or move in with other family members. Young people cannot afford to have their own housing. – Social Services Provider
>
> Affordable housing, too much expected in down payments for people renting, middle class is being pushed out of housing market, more resources need to be available to show children FASFA and what kind of funding is available for college and post high school. – Social Services Provider
>
> High-cost housing, no community college, racial discrimination, immigration policies – Physician
>
> Affordable housing in Lee County is in short supply. Young people with children struggle to find an affordable place to live. I suspect many have to choose between rent/mortgage and food, health care and prescription medications. The cost of health care creates the haves and have nots. As a practical matter there has been and continues to be one hospital system in Lee County. – Community Leader
>
> Individuals experiencing issues of housing, food and transportation go without health care, which to them is a luxury. Basic needs have to be met before one puts their focus on staying healthy or seeking a means to stay healthy. – Other Health Provider
>
> Affordable housing is nonexistent. Our education system is under attack for political agendas, discrimination is being encouraged and promoted by external forces. Healthcare access is being restricted by removing eligibility classifications and restricting the professional practice of healthcare professionals (Women's Health is under attack). Lee Health residents with the greatest risk factors and social determinants are being isolated and intimidated to not seek care in the moments needed. Therefore, patients are presenting more acutely ill and failing health. – Other Health Provider
>
> Barriers to affordable housing continue to be a challenge. The wait list for people who need housing continues to expand. The school literacy rate is something that should be a concern. The more we bureaucratize our schools has resulted in lower test scores, a decrease in the percentage of graduates seeking higher education and consequently household income is not keeping pace with the economy. – Social Services Provider
>
> The cost of housing is very high here, which limits hiring the staff needed. Affordable housing is one of the major issues in recruitment. – Community Leader

> Unaffordable housing, substandard State College, pollution along beaches and Caloosahatchee River. Still much racial discrimination in our community – Physician
>
> The basis of health comes from feeling safe and meeting basic needs. The housing crisis in our area is adding stress to our families which in turn leads to poor health. Families are making choices between putting a roof over their head or eating healthily, buying prescriptions, or keeping utilities. – Community Leader
>
> The cost of housing is higher than what can be covered by the local wages. – Community Leader
>
> The cost of housing continues to rise (ownership and rentals) as wages lag behind, there is limited affordable housing available for those in need, discrimination of persons of color, those who identify as LGBTQ+ and others who are labeled 'minorities' and/or underserved are experiencing even more restrictions, discrimination and stigma making access to necessary social determinants of heath nearly impossible. – Social Services Provider
>
> Housing costs and rents far exceed financial resources for significant numbers of the population. Lee County is addressing this with new multifamily condos and apartments, but regional growth is exceeding build rate. – Other Health Provider
>
> Minimal affordable housing, inflation, lack of affordable services. – Other Health Provider
>
> No affordable housing. – Other Health Provider

Impact on Quality of Life

> Social determinants of health pose major challenges in Lee. Socioeconomic disparities, limited healthcare access, affordable housing issues, educational barriers, food insecurity, & environmental factors contribute to poor health outcomes. Income inequality, unemployment, & lack of education impact residents' ability to afford healthcare & access quality services. A shortage of healthcare providers further exacerbates the problem. Affordable housing scarcity & homelessness create unstable living conditions & increased health risks. Educational challenges, with high dropout rates & low literacy levels, hinder health literacy & decision-making. Food deserts & inadequate nutrition contribute to chronic conditions. Environmental factors like natural disasters & climate change impact physical & mental health. Addressing these challenges requires a comprehensive approach, with collaboration between healthcare, housing, education, & community orgs to promote health equity & improve well-being – Public Health Representative
>
> When folks don't have their basic needs met, they are at risk for decline in health, MASLOW. A big issue now is discrimination due to our elected officials. It is unthinkable that our state government is discriminating against people due to their orientation – and yet it is happening. It is completely inhumane. – Social Services Provider
>
> When basic human needs are not met, human beings suffer. There is food insufficiency, housing issues (insurance rates, lack of affordable housing, hurricane-impacted housing issues), and chronic employment issues. Human beings who do not have their basic human needs met cannot live healthy and happy lives. Helping people navigate and secure healthy social determinants of health will bring down mental health and addiction rates, as well as acute medical issues, crisis calls, and other emergent needs. – Other Health Provider

Cost of Living

> Social determinants are among the leading contributors to health in Lee County, as in most of the country. This is a localized phenomenon. Many communities in Lee County have limited access to nutritious food, high costs of living relative to income (i.e., rent/occupancy cost vs. incomes), long working commute times, etc. – Social Services Provider
>
> The cost of living has increased to a level that is barely sustainable for a lot of Lee County residents. I believe they will put off their health care, not obtain necessary medications and eat unhealthily because they can't afford to do things in any other way. The cost of living is an issue and then add Hurricane Ian on top of it. I believe there is access to education; however, transportation, and the ability to purchase textbooks and computers are challenging for many. Social security for seniors is not enough to sustain them but it is all the income that many of our seniors have. – Other Health Provider
>
> Lack of appropriate compensation, sky rocketing cost of housing as well as cost of living are major contributors to community access to medical care and education. Economic factors make education, especially for adults with families, a true hardship. Cost of living and housing increases are a growing problem for seniors who need help with aging in place, cost of medical treatment and prescription drug costs. – Social Services Provider
>
> Hospitalization is unaffordable without public assistance. Florida did not expand Medicaid for low-income adults. Those people are ineligible for ACA. Housing costs have skyrocketed. Many people are struggling with day-to-day expenses to keep a roof over their (and their families) heads. Medical care is a luxury they cannot afford. – Social Services Provider

Access to Care/Services

> Lack of services in minority communities, stigma, cost of housing in Lee County – Social Services Provider
>
> Cost is prohibitive. – Social Services Provider
>
> These are a major problem for many communities. We need to focus on addressing barriers to care in underserved populations and this isn't currently being addressed by many. – Public Health Representative
>
> Interferes with access and contributes to illness – Physician

Income/Poverty

> Due to low income and education, individuals can't afford decent housing, so many end up in a bad environment and are discriminated against because of where they live. – Public Health Representative
>
> 98% of the families in our community are below the poverty level, the community is predominantly comprised of minorities, and some are undocumented. Our community struggles with almost all the social determinants of health (poverty, transportation, education, safe affordable housing, access to healthcare, food security, etc.) – Social Services Provider

Vulnerable Populations

> Deaf individuals fall under the category of "limited clientele". It is one of several disabilities that is categorized as a "severe disability", which also includes: blindness, lack of voice to communicate, paraplegic, quadriplegic, and severe intellectual disability. This limited clientele designation considers any of those disabilities to fall under low to moderate income, which is already an additional barrier. – Social Services Provider

Segregation

> A recent consulting study found that we were the most segregated community they have ever worked in. Segregated by race, age, gender, seasonality, etc....There are very few public commons that bring people together. I think that is why art and music walks are so popular, people are starved to see people not like themselves. Housing is creating a new generation of overcrowding and living in non-traditional shelters and commute times are putting new stresses on workers who are spending more time in their car than with their kids. – Community Leader

Water Quality

> Water quality, this is the only place where I can't drink from the tap due to the taste. It may test okay, but the taste and clarity is awful and I am not on well water. – Social Services Provider

Impact of Hurricane

> Stress due to issues related to Hurricane Ian, as to proper housing, loss of jobs and income, recovery grants and/or insurance monies taking way too long to be sustainable. – Community Leader

Co-Occurrences

> SDH are the underlying concerns of all larger issues. It's systemic. – Social Services Provider

Awareness/Education

> Lack of education and prevention. Lack of early detection – Social Services Provider

Economy

> Economic stability, neighborhood and built environment and social and community context. – Other Health Provider

Lack of Coordination

> Lack of coordination among community serving entities. – Community Leader

Transportation

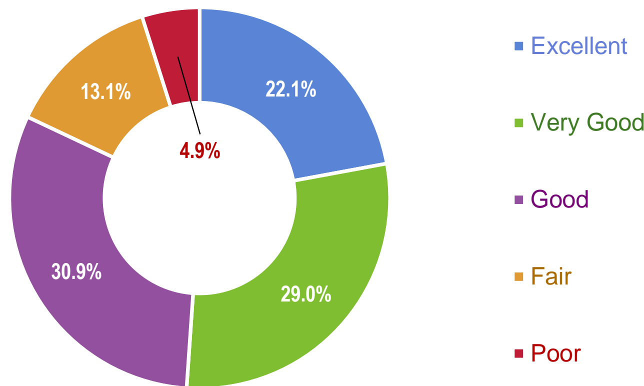
> Lack of transportation and affordability – Community Leader

HEALTH STATUS

Overall Health

PRC SURVEY ▶ "Would you say that in general your health is: excellent, very good, good, fair, or poor?"

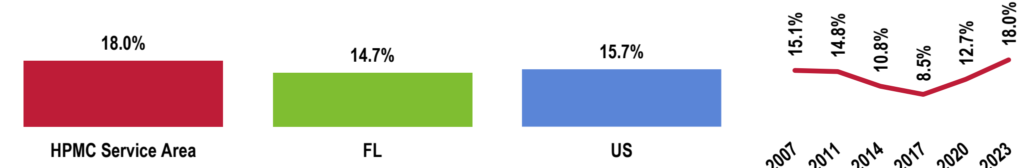
Self-Reported Health Status
(HPMC Service Area, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

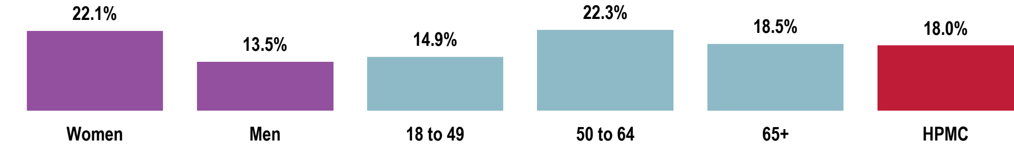
Experience "Fair" or "Poor" Overall Health

HPMC Service Area



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(HPMC Service Area, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

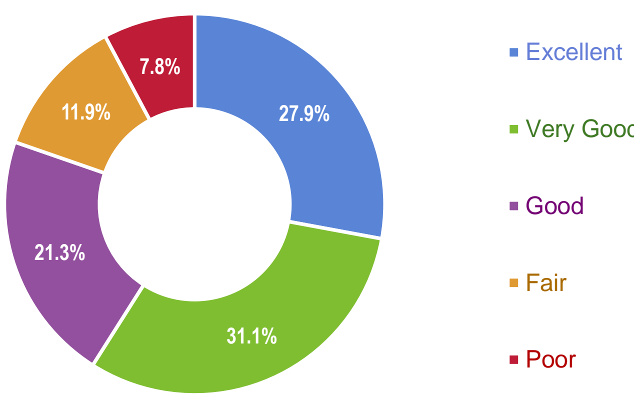
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

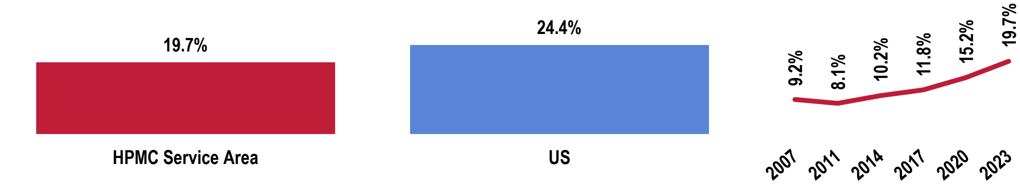
PRC SURVEY ▶ "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health

HPMC Service Area



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.

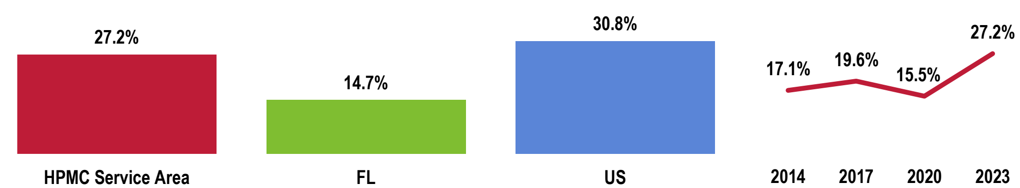
Depression

Diagnosed Depression

PRC SURVEY ▶ "Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

HPMC Service Area



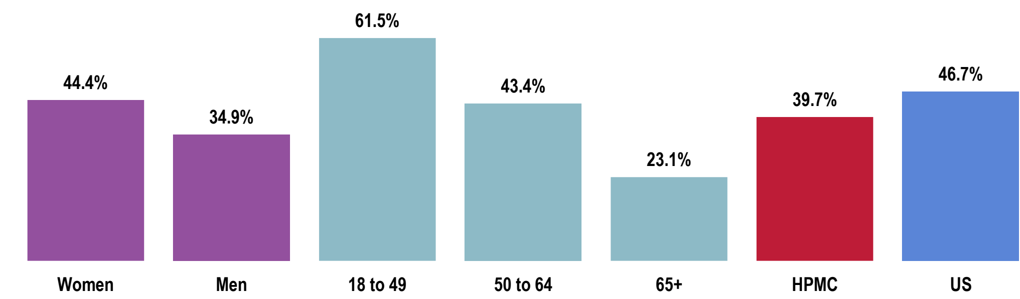
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 80]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ▶ "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(HPMC Service Area, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

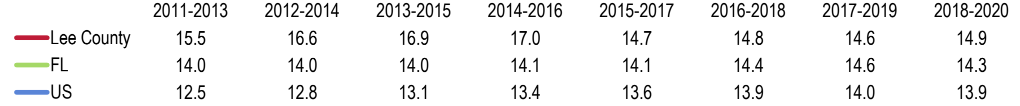
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



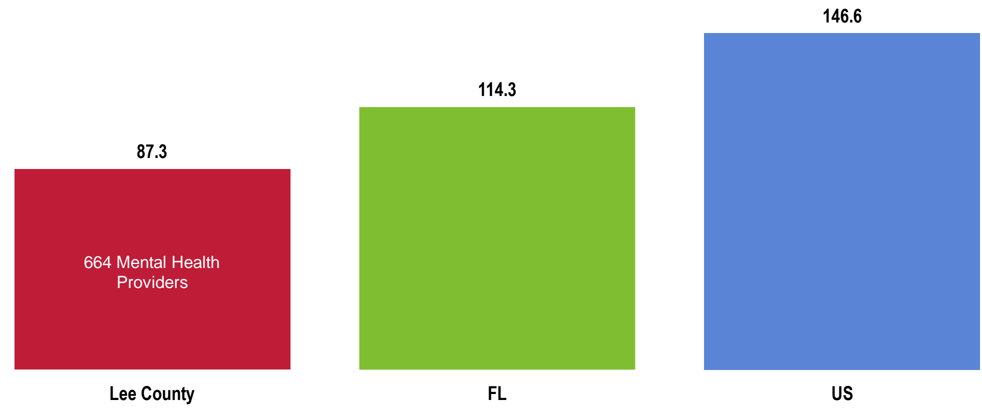
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	15.5	16.6	16.9	17.0	14.7	14.8	14.6	14.9
FL	14.0	14.0	14.0	14.1	14.1	14.4	14.6	14.3
US	12.5	12.8	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Mental Health Treatment

Note that this indicator only reflects providers practicing in Lee County and residents in Lee County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

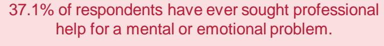


Sources: • Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

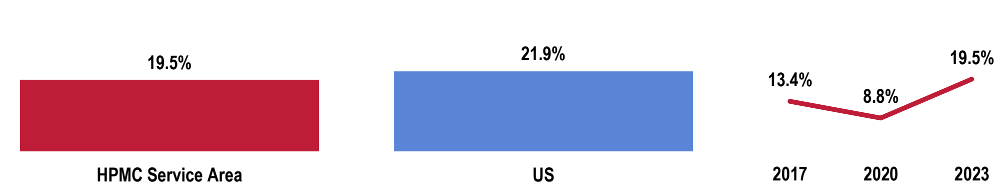
Notes: • This indicator reports the rate of the county population to the number of mental health providers, including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ▶ "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

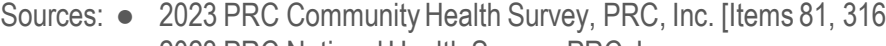


HPMC Service Area



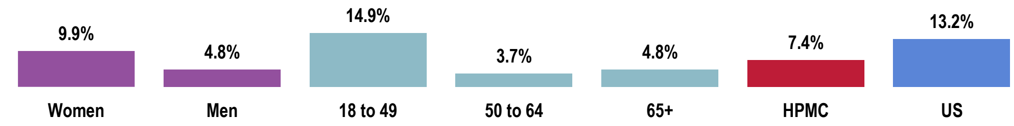
Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Items 81, 316]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.



PRC SURVEY ▶ "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services
When Needed in the Past Year
(HPMC Service Area, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 82]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of
Mental & Emotional Health as a Problem in the Community
(Among Key Informants; Lee County, 2023)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All

Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Access to care, both for crisis intervention and baseline psychiatric care. – Social Services Provider

Minimum of a six-month waiting list to get any kind of care from a mental health provider. Lack of mental health providers that are free and accessible. Fallout from COVID and Hurricane Ian, and schools are still a warzone with bullying. – Social Services Provider

Limited resources for CBT, day programs, and inpatient treatment. Limited access to affordable medications. – Other Health Provider

It's an epidemic on its own. There is a lack of quality resources and the waitlists for community-based services are long. – Social Services Provider

Access to a qualified provider for care. – Physician

Lack of access to care. Not enough agencies or mental health professionals to provide services. – Social Services Provider

Lack of treatment programs and inpatient facilities. – Other Health Provider

Very limited availability of mental health treatment and services. Florida has among the lowest funding levels for mental health of any state. Salus Care, Lee County's only in-patient mental health facility was closed altogether for months following Hurricane Ian and has only recently reopened with limited capacity. – Social Services Provider

A complete lack of comprehensive resources in Lee County. – Other Health Provider

Mental health is a challenge around the country and we in Lee County are no exception. There is a shortage of inpatient psychiatric beds, as well as pediatric mental health inpatient and outpatient facilities. – Physician

Access to care, wait times for outpatient therapy and psychiatry. Family education and support services, housing, wrap around services. Lack of knowledge around the Baker Act within the health and human services systems. Mental health, first aid training awareness, free counseling, licensed providers in network with major insurance companies. – Other Health Provider

Assistance, what we have is limited and if they are not suicidal or homicidal, they won't help them. – Social Services Provider

Access, or the length of time before access. – Other Health Provider

No advanced services available. – Community Leader

Access to providers, psychiatrists in particular, and coordinating care between psychiatrist/primary care physicians and therapists. For a person with mild depression, trying to coordinate care can be difficult, imagine a person with a more complicated/serious mental health condition, it is really on the person to be their own care coordinator. – Social Services Provider

Lack of treatment resources, especially for children and teens. Stigma against treatment, lack of recognition of mental health issues in families, lack of resources for the uninsured, and very limited public transportation. – Social Services Provider

The lack of residential treatment centers for those suffering from mental health issues who are homeless. – Social Services Provider

Access and desire to be treated. – Physician

Dealing with and having space for people with substance abuse. – Community Leader

Access to help. There are not enough services, care providers, housing, and programs. – Social Services Provider

Lack of access to services, lack of providers accepting insurance, lack of crisis care, increased Baker Acts of children and adolescents without matching resources and facilities. – Community Leader

Access to inpatient and outpatient services, especially clinicians, therapists, and physicians. – Community Leader

Lack of access to professional help, and stigma of seeking help. – Social Services Provider

The access to mental health services over the past ten years has decreased. Additionally, the quality of services has been on the decline as well. – Social Services Provider

Availability of treatment centers and clinicians. – Community Leader

Access to care. – Community Leader

Lack of Providers

There are not enough providers compared to the need for mental health treatment. Waitlists of over a year are unacceptable for people seeking treatment for their mental health problems. Not just adults, children are impacted as well, sometimes worse. Wrap around care is also needed in this community. The providers for mental health treatment need to talk to other providers to ensure their clients find housing, clothes, food, etc. – Public Health Representative

There are not enough providers, especially for the uninsured. It's Saluscare or nothing and their services are limited due to the amount of people that need help. The state of Florida does very little to address this issue. It would look bad for tourism to admit the truth. Most people with mental health issues are not able to manage their own care without some kind of support system. There is still a stigma, though it has improved, that needing help makes a person weak or unworthy. – Social Services Provider

Lack of mental health providers. There are a multitude of small non-profit agencies providing service, but only one or two larger non-profit providers. – Community Leader

Lack of providers and access to care. Also, SalusCare being down for eight months. – Community Leader

Not enough providers. They don't take health insurance in most cases. – Community Leader

Insufficient number of providers. Lack of long-term placement for those with chronic needs. – Community Leader

Easily accessible mental health counseling. There are not enough providers and not enough support groups in the area. Also, it is not affordable for half of our families. – Community Leader

Affordable Care/Services

Payment. – Social Services Provider

Cost. – Other Health Provider

Indigent individuals cannot afford mental health services. There is a long wait to get into mental health services. Being able to afford the medication prescribed is an ongoing issue. Maintaining housing with mental health issues. Affordable housing for those who are limited with employment options. – Other Health Provider

Affordable access to both psychiatry and counseling services. – Physician

Lack of access to affordable or covered services to help them. – Physician

Awareness/Education

Lack of education and prevention. Lack of early detection. – Social Services Provider

There is a general lack of education and awareness to this issue. We are underrepresented on a per capita basis by access to qualified professionals and offices, especially those that take insurance and have growing problems with school aged children lashing out, suicides, road rage and other forms of social misbehavior. – Community Leader

Lack of adequate awareness, even within the medical community, but primarily a lack of services. – Physician

Lack of conversation around it, which leads to a lack of access, partnerships and outcomes that work. If we don't normalize mental health and bring in experts to help us support it, we will continue to see growth in those impacted by such issues. – Other Health Provider

Denial/Stigma

Stigma remains a significant challenge to accessing services. Also, work force shortages, lack of insurance parity, lack of outreach to underserved populations and inadequate reimbursement rates. – Social Services Provider

Denial by the patient and/or family. Lack of qualified providers. Lack of means to pay providers. Not enough beds to house those in need of 24-hour care. Insufficient state and federal funding provided to our area due to bureaucracy of allocation. – Community Leader

Hard to get people to admit it, and consequences can be dangerous for the individual and community. – Community Leader

First, accepting the fact that you have a mental health issue. Then, finding a provider that looks like you and being able to afford services. – Public Health Representative

Impact Due to Hurricane

Recent Hurricane Ian has devastated the community and exacerbated existing mental health issues for all people, including children. Lack of housing or damaged housing is adding stress to families and creating mental health concerns. – Social Services Provider

Mental health problems of depression and PTSD have increased since the area was devastated by Hurricane Ian. In our community, there is no easy access to help. – Social Services Provider

Access to Care for Uninsured/Underinsured

Uninsurable and lack of inpatient beds. – Community Leader

Lack of insurance coverage, more funding and better available resources. – Other Health Provider

Affordable Housing

Lack of access to affordable housing, lack of access to financial and medical benefits. – Social Services Provider

Grief

Grief is all over the community and there are very few stable revenue streams for organizations supporting children and families grieving. Valerie's House is here for families and growing to keep up with the numbers of children grieving. More funding needs to be available to address grief therapy. Grief when not dealt with head on will lead to substance abuse and violence amongst those grieving. – Social Services Provider

Homelessness

Shelter is nonexistent and has a major impact on overall health needs. – Social Services Provider

Comorbidities

Depression, anxiety, insomnia, bipolar disorder, dysthymia. – Physician

Diagnosis/Treatment

> Many have undiagnosed issues. Check out the nightly news or social media for examples. Our country is devolving. Too much stress. – Community Leader

Funding

> Funding is a major problem associated with mental health. With money, we could have a better system of care and wrap around services for these issues. Currently, mental health is criminalized, and we rely on the law enforcement and court systems to deal with people who have major mental health problems. There should be a system of care associated with mental health from infancy through senior living in which everyone is familiar, has access, and is effective. – Community Leader

Language Barrier

> Access to interpreters for mental health counseling. – Social Services Provider

Transportation

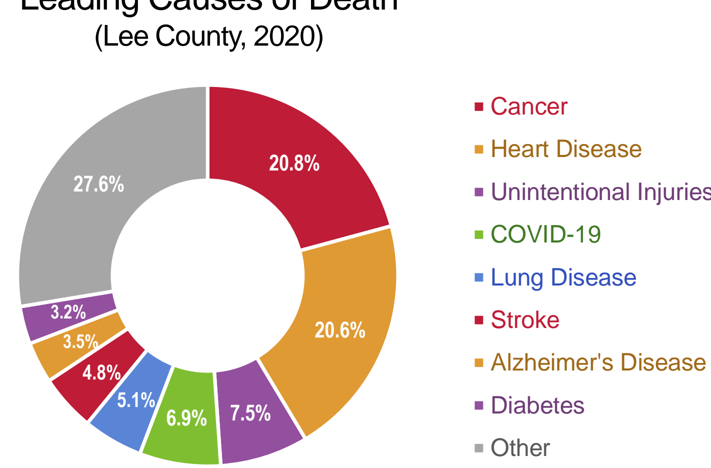
> Transportation and access to technology. – Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes: • Lung disease includes deaths classified as chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Florida and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Lee County. [COUNTY-LEVEL DATA]

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Lee County	FL	US	Healthy People 2030
Cancers (Malignant Neoplasms)	121.0	139.0	146.5	122.7
Heart Disease	110.9	142.1	164.4	127.4*
Unintentional Injuries	70.7	58.8	51.6	43.2
Falls [Age 65+]	68.3	68.9	67.1	63.4
Unintentional Drug-Induced Deaths	37.6	25.9	21.0	—
COVID-19 (Coronavirus Disease) [2020]	37.5	56.4	85.0	—
Lung Disease (Chronic Lower Respiratory Disease)	26.2	35.1	38.1	—
Stroke (Cerebrovascular Disease)	24.9	41.2	37.6	33.4
Alcohol-Induced Deaths	17.6	12.0	11.9	—
Diabetes	17.2	20.6	22.6	—
Alzheimer's Disease	16.5	19.1	30.9	—
Motor Vehicle Deaths	15.2	14.7	11.4	10.1
Suicide	14.9	14.3	13.9	12.8
Cirrhosis/Liver Disease	14.1	13.1	12.5	10.9
Homicide	6.2	7.0	6.1	5.5
Pneumonia/Influenza	6.1	9.1	13.4	—
Kidney Disease	4.6	9.6	12.8	—

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

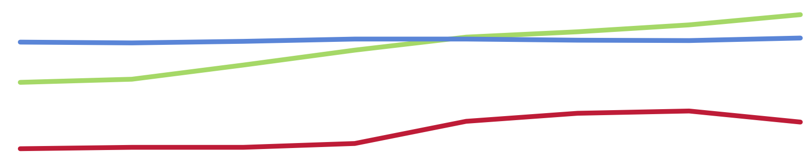
Heart Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	137.7	136.0	139.4	132.3	124.7	113.9	110.7	110.9
FL	152.0	151.4	150.3	149.1	147.3	145.0	143.0	142.1
US	171.3	169.6	168.9	167.5	166.3	164.7	163.4	164.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 33.4 or Lower



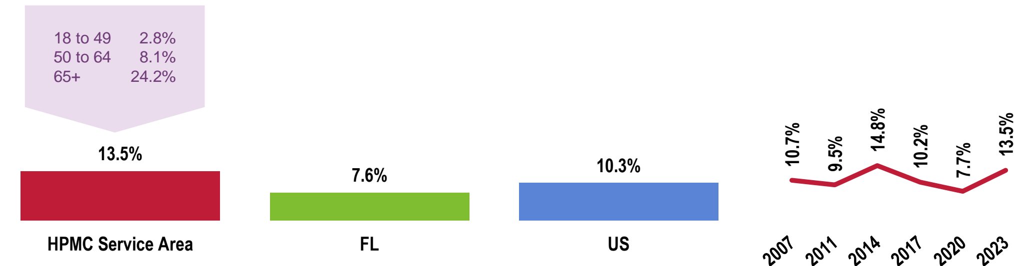
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	20.9	21.1	21.1	21.7	25.0	26.2	26.6	24.9
FL	30.9	31.4	33.6	35.8	37.8	38.6	39.6	41.2
US	37.0	36.9	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease



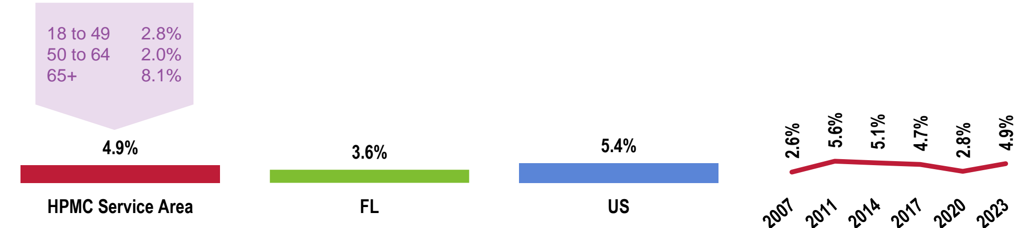
Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke

HPMC Service Area



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 23]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.

Cardiovascular Risk Factors

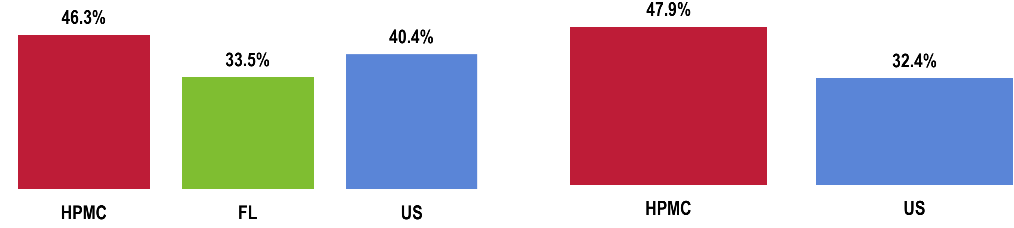
Blood Pressure & Cholesterol

PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

PRC SURVEY ▶ "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure
Healthy People 2030 = 42.6% or Lower

Prevalence of High Blood Cholesterol

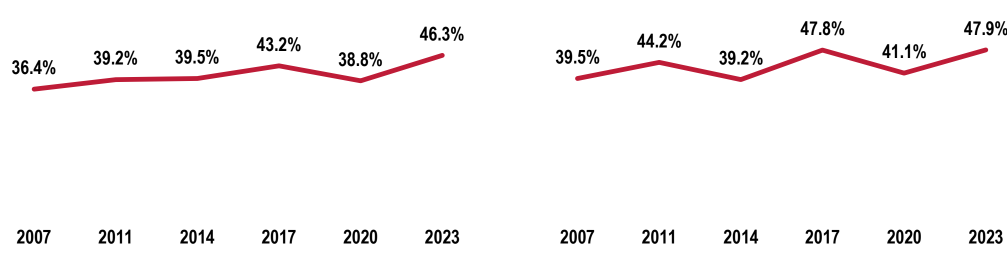


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: ● Asked of all respondents.

Prevalence of
High Blood Pressure
(HPMC Service Area)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(HPMC Service Area)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

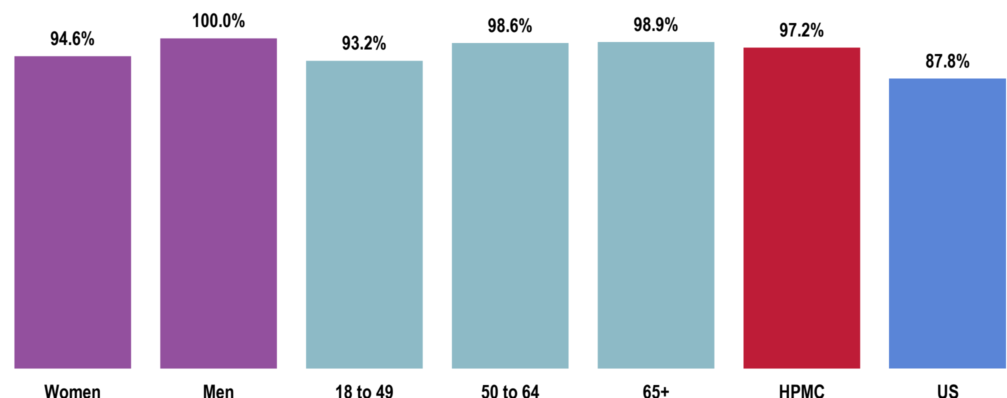
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

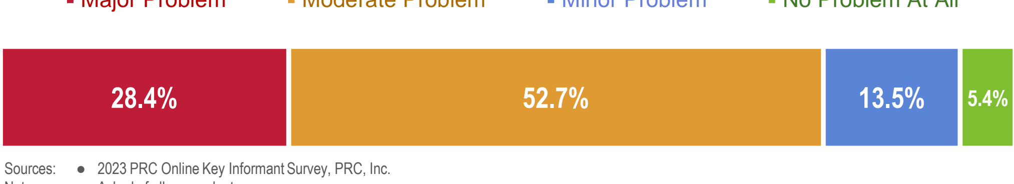
The following chart reflects the percentage of adults in the HPMC Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 100]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Reflects all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> More than 70% of individuals utilizing the mobile clinic are affected by hypertension, diabetes, or obesity. – Other Health Provider
>
> According to the Florida Department of Health's Bureau of Vital Statistics, in Lee County in 2021, heart disease and stroke combined as the highest percentage of total deaths in Lee County. While a focus of physical activity has been started with a few committees more work can be done to lower the scores with this mostly preventable cause of death. – Public Health Representative
>
> All patients have a cardiovascular disease diagnosis or have a family history of cardiovascular disease. – Physician
>
> I've learned this from a community discussion about the health of Lee County citizens, and both of these occurring above national averages. – Social Services Provider
>
> It's the number-one killer of women. – Community Leader

Aging Population

> Demographics, older population, they are at higher risk. – Physician

> We care for the age bracket where it happens more than other geographical areas, the 55-65% on Medicare. – Physician
>
> It is the number one killer overall and our aging population puts more people at risk, along with the other risk factors of diabetes and obesity. – Physician
>
> Age of our population. – Community Leader
>
> The age and wellness of our community. – Community Leader

Access to Care/Services

> Demand and volume outweigh current organizational resources and infrastructure. – Other Health Provider
>
> I work with the senior population, and we hear of waiting to see cardiologists for 6 plus months – even for those declining while in AFIB. Many are flying to other cities around the country to access care (e.g., pacemaker) then return home and try to put together a hybrid care team with out of town and local providers. This works for seniors with standard Medicare, for those in an HMO type Medicare plan with only local access, I imagine they are at higher risk of health decline with limited local health access. We often suggest that clients move back home with extended family support or to a state with expanded Medicaid and better access to care. – Social Services Provider
>
> Lack of access to care and education on prevention measures. – Public Health Representative
>
> Access to medical care in the deaf community is also difficult due to lack of transportation. – Social Services Provider

Comorbidities

> They are related to main health issues and death. – Other Health Provider

Co-Occurrences

> Due to the increase in obesity, there is an increase in hyperlipidemia, hypertension, heart disease and stroke. – Physician

Diagnosis/Treatment

> Many do not receive primary care. Hypertension and hyperlipidemia are uncontrolled. Also, comorbidities like diabetes are uncontrolled. No access to affordable healthy food. Substance abuse, tobacco abuse, and alcohol use also increase the risk of cardiovascular disease. – Other Health Provider

Lifestyle

> A healthy life is closely related to a healthy heart. Heart disease is a leading cause of death in our county. Heart disease and stroke are major causes of disability and significant contributors to increases in health care costs. – Other Health Provider

Disease Management

> Uncontrolled and untreated hypertension, hyperlipidemia, and diabetes. – Social Services Provider

Cancer

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Lee County. [COUNTY-LEVEL DATA]

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	142.5	140.5	139.5	135.4	131.2	128.2	125.1	121.0
FL	158.6	155.9	153.1	150.1	147.8	144.8	142.2	139.0
US	166.2	162.7	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Lung cancer is by far the leading cause of cancer deaths in Lee County. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

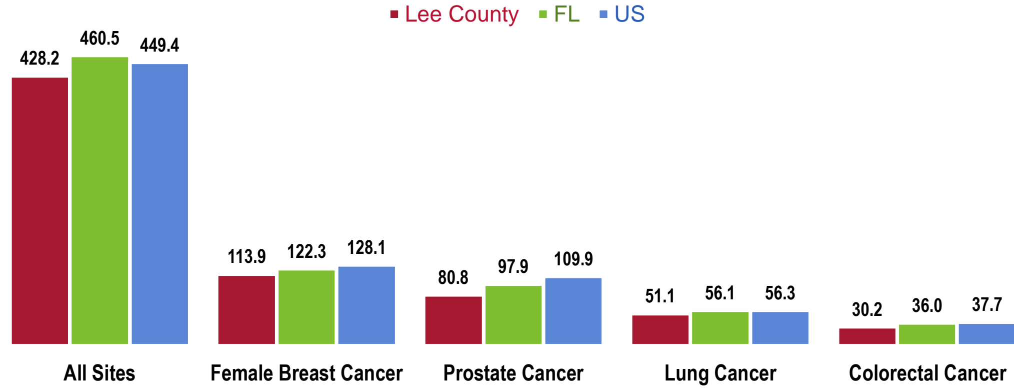
	Lee County	FL	US	HP2030
ALL CANCERS	121.0	139.0	146.5	122.7
Lung Cancer	29.5	32.7	33.4	25.1
Female Breast Cancer	16.7	18.4	19.4	15.3
Prostate Cancer	11.6	16.0	18.5	16.9
Colorectal Cancer	10.1	12.4	13.1	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2015-2019)



Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

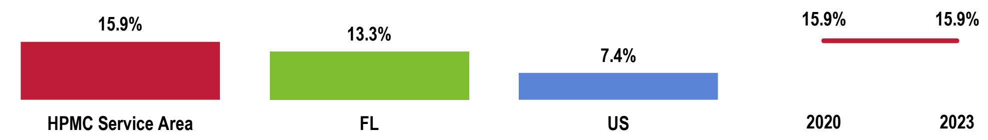
Notes:
- This indicator reports the age-adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population.

Prevalence of Cancer

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with cancer?"

Prevalence of Cancer

HPMC Service Area

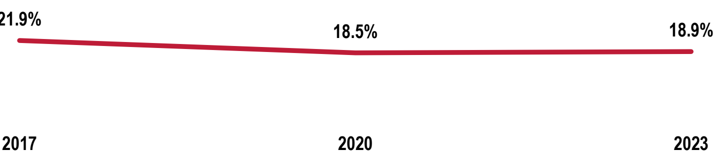


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 24]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Use of Sunscreen

PRC SURVEY ▶ "When you go outside on a sunny summery for more than one hour, how often do you use sunscreen or sunblock? Would you say: always, nearly always, sometimes, seldom, or never?"

Always Wear Sunscreen When Outside on a Sunny Summer Day for More Than 1 Hour
(HPMC Service Area)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: ● Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC SURVEY ▶ "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ▶ "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

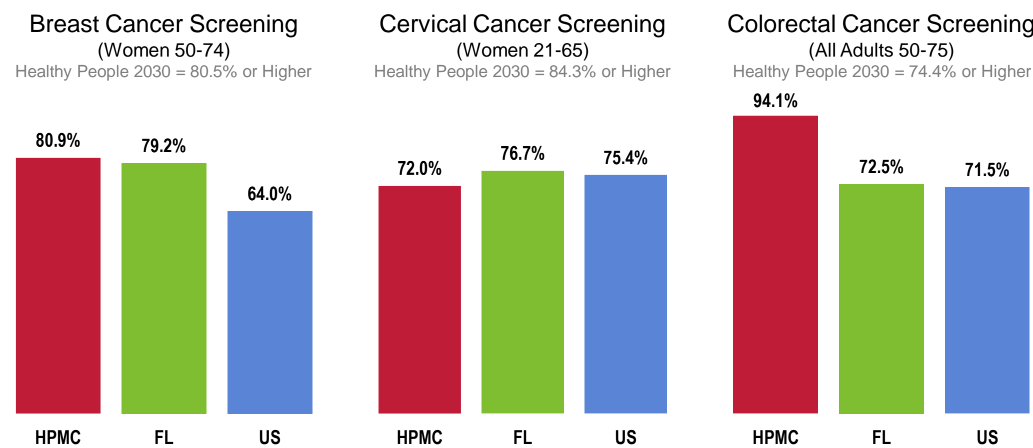
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ▶ "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

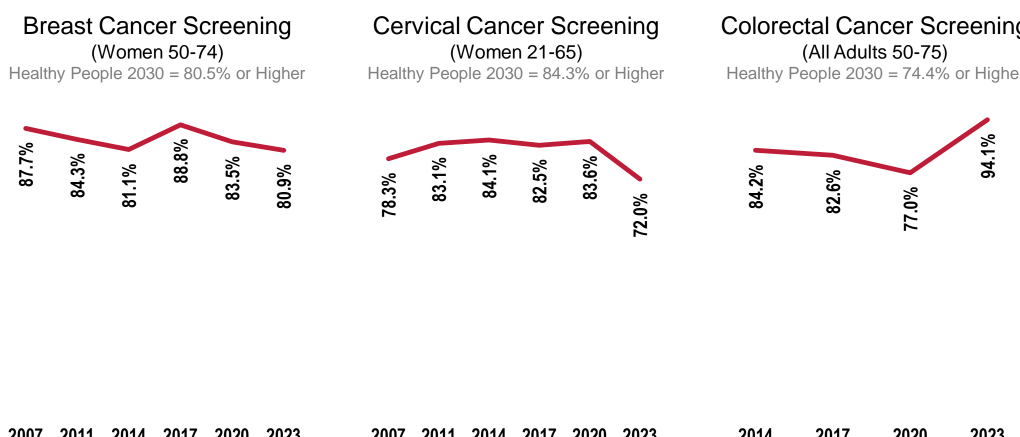
PRC SURVEY ▶ "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

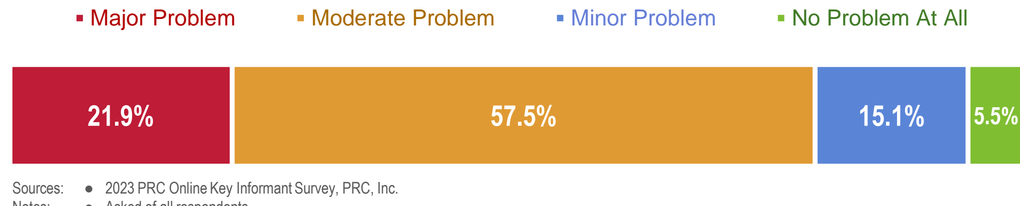


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> So many people are diagnosed with it, so we always need to keep on top of it. We have a new leader in cancer care, and it will help greatly in meeting the needs. – Community Leader
>
> Demographics and age distribution. – Physician
>
> Cancer is a growing problem throughout the world. Cases of breast cancer, prostate cancer and lung cancer are increasing rapidly. – Physician
>
> According to the Florida Department of Health's 2021 Bureau of Vital Statistics data of Lee County, 20.45% of all deaths that occurred in 2021 were caused by cancer. That is one in five deaths that are cancer. CANCER is the leading cause of death in Lee County. If a person truly cared about saving the most lives in Lee County targeted interventions towards cancer would have the largest impact. To put this in perspective, In Lee County in 2021, 9,411 lives were lost to all causes, cancer was 1,925 of that number. Similarly, cancer and heart disease have been the leading causes of death in the nation and Lee County for several years however, the data displays a lack of success in any intervention in lowering these fatalities. – Public Health Representative

Diagnosis/Treatment

> Because people in my community do not seek medical care until things get really bad, so if it's cancer, their chances of survival are low. – Public Health Representative
>
> Personal, family and friends have all had issues and the local treatment is subpar. Most people who can afford it will travel out of the area for treatment. – Community Leader
>
> Cancer goes often times undiagnosed, misdiagnosed or caught in late stages. Maybe additional screenings can be covered by all insurances during annual screenings to increase prevention. – Other Health Provider

Access to Care/Services

> Skin cancer (in the Sunshine State) is a big issue. Try to get a dermatology appointment in this state in under four months. Many dermatologists are not accepting new patients. As Florida is a top retirement state, statistically, there are more people with cancer issues. – Community Leader
>
> Limited access to infusion centers for chemotherapy. No radiation center in the area. Access to screening methods is limited. – Physician

Aging Population

> Lee County has an aging population, and many residents do not have access to screenings and early detection. – Social Services Provider

Impact on Quality of Life

> In my personal experience I see more tragic consequences (life-changing conditions and death) for cancer victims than heart/stroke victims, but heart/stroke seems to get more attention. During the past 30 days a coworker's wife passed away from cancer. Treatments have progressed but most just extend life at the expense of quality of Life, whereas many who have heart/stroke issues are able to have surgeries which provide good outcomes. – Community Leader

Lack of Coordination

> Developing service line. Challenges in coordinating partnerships with community independent groups to bridge care gaps. – Other Health Provider

Lifestyle

> While there are many oncologists in the area, not enough is being done on lifestyle and diet prevention and complementary treatments. – Other Health Provider

Prevention/Screenings

> Lack of early detection and lack of prevention education and awareness. – Social Services Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

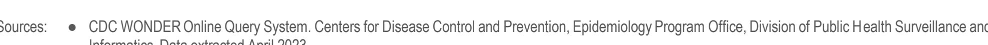
Age-Adjusted Respiratory Disease Deaths

Lung Disease

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the charts that follow. [COUNTY-LEVEL DATA]

Lung Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	32.7	32.8	32.5	31.1	32.3	31.6	28.9	26.2
FL	38.9	38.8	38.8	38.1	38.5	38.0	37.0	35.1
US	42.0	41.7	41.8	41.3	41.0	40.4	39.6	38.1



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza

Pneumonia and influenza mortality is illustrated here. [COUNTY-LEVEL DATA]

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

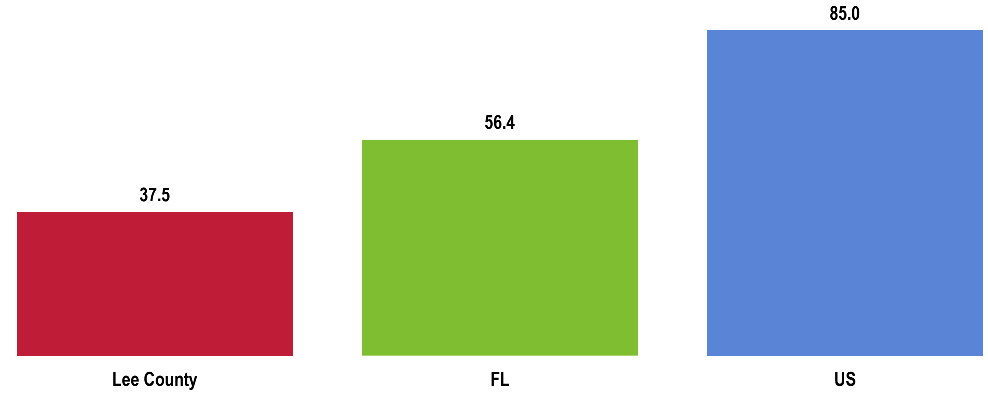
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	5.4	4.9	4.9	5.0	5.3	5.9	6.1	6.1
FL	9.1	9.2	9.3	9.3	9.3	9.5	9.1	9.1
US	15.3	15.2	15.4	14.6	14.3	14.2	13.8	13.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted COVID-19 (Coronavirus Disease) Deaths

Age-adjusted mortality for COVID-19 is illustrated in the following chart. [COUNTY-LEVEL DATA]

COVID-19: Age-Adjusted Mortality
(2020 Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

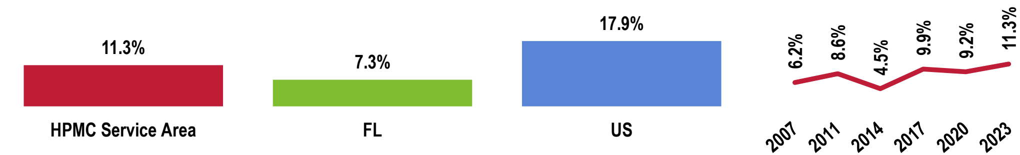
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ▶ "Do you currently have asthma?"

Prevalence of Asthma

HPMC Service Area



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

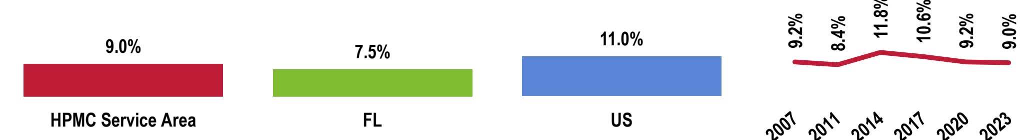
Notes:
- Asked of all respondents.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ▶ "Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

HPMC Service Area

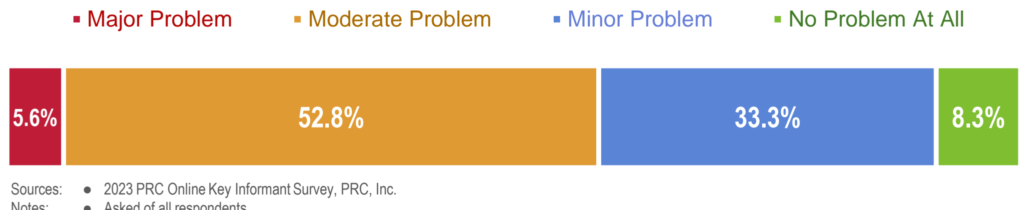


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Environmental Contributors

> Allergens and tobacco abuse. – Physician
>
> Pollution and allergies. Some people don't have the resources to get treated and their condition can progress. – Other Health Provider

Aging Population

> The general age of the population creates additional exposure. – Community Leader

Awareness/Education

> Many premature babies that have respiratory issues. Lacking education for preventing respiratory illness. – Public Health Representative

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

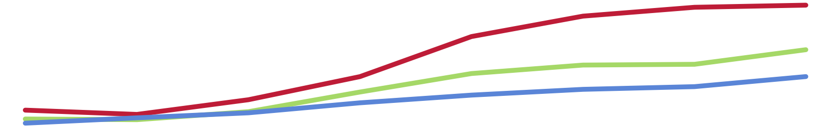
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

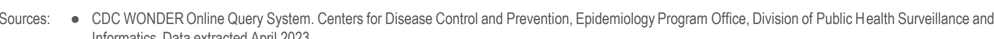
Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

Unintentional Injuries: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	42.6	41.5	45.4	51.6	62.3	67.7	70.1	70.7
FL	40.3	40.1	42.2	47.5	52.4	54.7	54.9	58.8
US	39.2	40.6	41.9	44.6	46.7	48.3	48.9	51.6



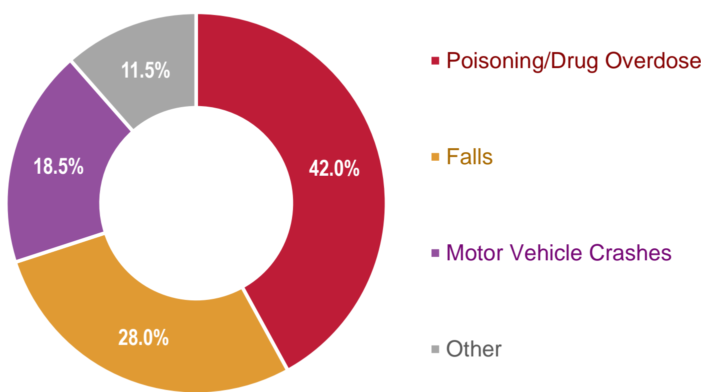
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the area include the following: [COUNTY-LEVEL DATA]

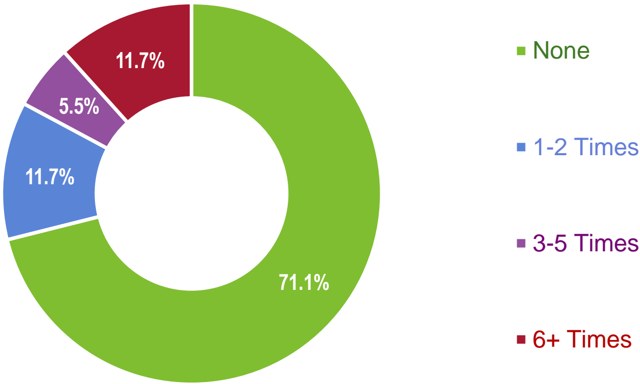
RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

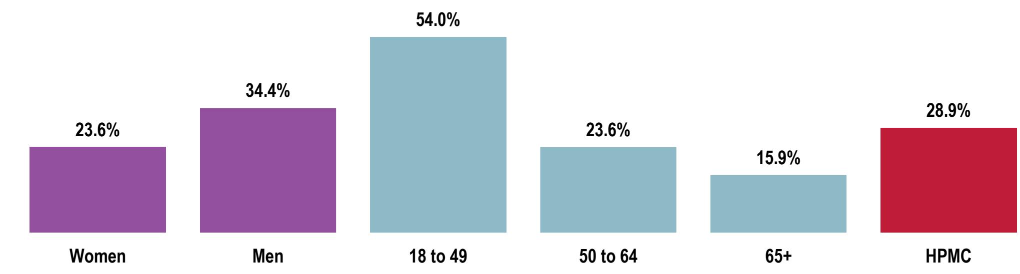
Distracted Driving

PRC SURVEY ▶ "In the past 30 days, how many times would you say that you either sent or read text messages or email while driving and the vehicle was moving?"



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: • Asked of all respondents.
• Texting while driving includes sending or reading a text message or email while driving and the vehicle was moving.

Texted While Driving in the Past Month
(HPMC Service Area, 2023)



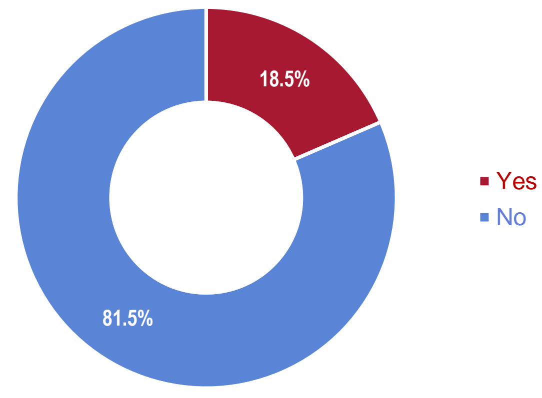
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● Texting while driving includes sending or reading a text message or email while driving and the vehicle was moving.

Falls

PRC SURVEY ▶ [Age 45+] **"In the past 12 months, were you injured as the result of a fall?"**

In this case, the injury limited regular activities for at least a day or caused you to go see a physician.

Injured as the Result of a Fall in the Past 12 Months
(Adults Age 45 and Older; HPMC Service Area, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of all respondents age 45+.

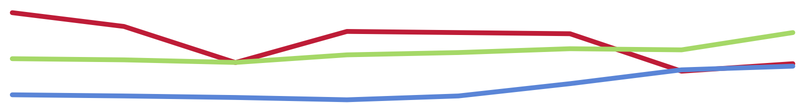
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Homicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	7.6	7.2	6.2	7.1	7.0	7.0	6.0	6.2
FL	6.3	6.3	6.2	6.4	6.5	6.6	6.6	7.0
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

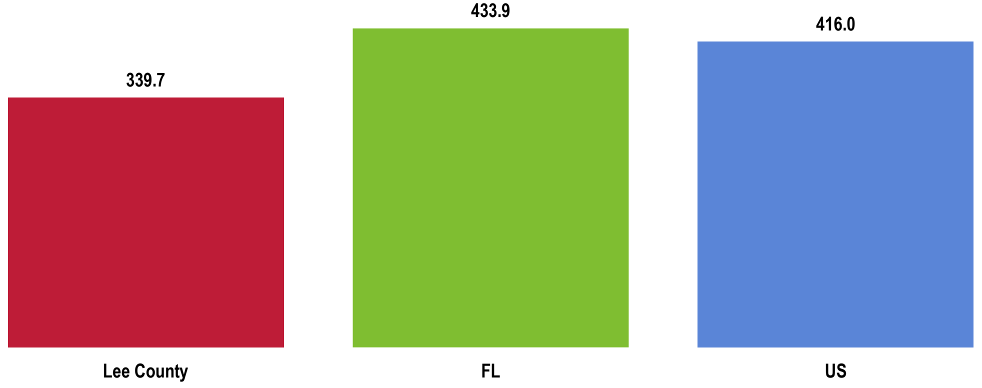
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]

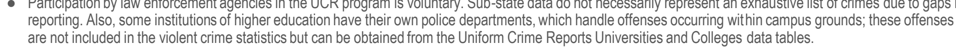
Violent Crime Rate
(Reported Offenses per 100,000 Population, 2015-2017)



Lee County FL US

Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

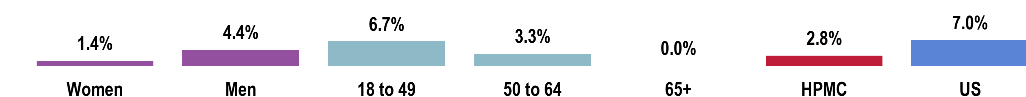
Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.



Violent Crime Experience

PRC SURVEY ▶ "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(HPMC Service Area, 2023)



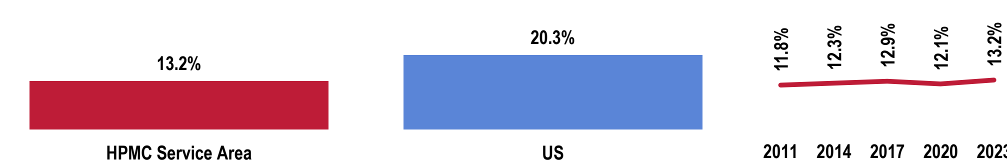
Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 32]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

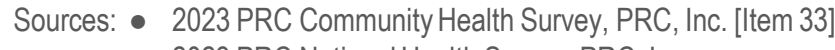
Intimate Partner Violence

PRC SURVEY ▶ "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

HPMC Service Area

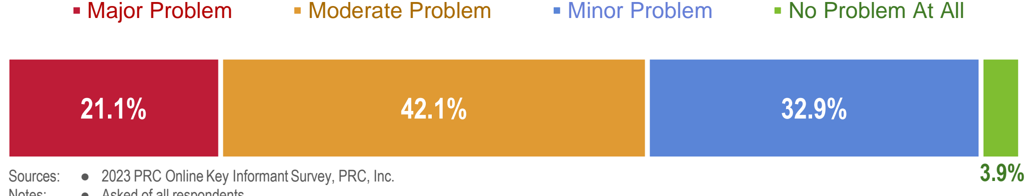




Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 33]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Increased violence nationwide. – Social Services Provider
>
> Recent stats indicate so. Additionally, with the changes in the economy and further oppression of persons of color and other underserved, this contributes to the rise in injury and violence. – Social Services Provider
>
> There is much violence going on today, which leads to injuries in our society as a whole. My community is impacted as well. – Public Health Representative
>
> Unintentional Injuries have been the third leading cause of death in Lee County for many years. These are preventable with many types of interventions. A further drill down of the types of injuries that are most prevalent should be looked at and interventions should be aligned with these causes. – Public Health Representative

Suicide Rates

> Suicide and homicidal incidents have increased since COVID. The ED's are maxed with individuals who are injured or perceived to be violent (threats, mental health, addiction issues, actualized violence). As basic emotional and housing needs are unmet, violence and injury will increase. – Other Health Provider
>
> Suicide as well as homicide and other violent crimes are increasing in our community because of the quick growth that we are seeing in addition to culture shifts around law enforcement offices. Specifically in the community, losing Chief Diggs was a major loss in connection to the community. – Public Health Representative

Affordable Housing

> The area is over-populated for the infrastructure. That includes affordable housing, roadways, parks & rec, and green spaces. A lack of the same leads to anger, road rage and accidents – leading to both violence and injuries. There are plenty of jobs in SW Florida, but they are not jobs that will support even one person independently, much less a family. – Social Services Provider

Automobile Accidents

> Automobile accidents. – Physician

Awareness/Education

> Lack of education and prevention. Lack of early detection. – Social Services Provider

Accidents

> Gun violence and access to guns. Pedestrian and cyclist injuries and death due to accidents with vehicles as a result of poor community design. Low walkability and bike trails. – Community Leader

Income/Poverty

> Communities are still dangerous, people growing up in poverty, lack of families staying intact, lack of fathers in the home, single parents, teen pregnancies, lack of understanding or access to birth control, drugs, and lack of hope. – Social Services Provider

Language Barrier

> When a deaf person is injured, the barriers they face are the communication access to understand their options. – Social Services Provider

Coping Skills

> Diminishing of coping skills with a highly complex and stressful national political narrative. Society as a whole has lost its civility, respect, and is more focused on isolation, violence, fracturing communities and disfranchising individuals. – Other Health Provider

Prevention/Screenings

> Better access to prevention resources in our county, such as biking and pedestrian safety, distracted driving, drowning prevention, drug and alcohol abuse, fire safety and burn prevention, gate/gang, and violence prevention. – Other Health Provider

Diabetes

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

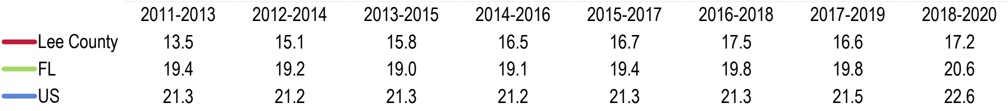
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	13.5	15.1	15.8	16.5	16.7	17.5	16.6	17.2
FL	19.4	19.2	19.0	19.1	19.4	19.8	19.8	20.6
US	21.3	21.2	21.3	21.2	21.3	21.3	21.5	22.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

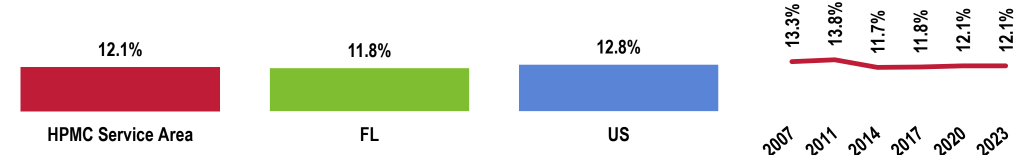
Prevalence of Diabetes

PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ▶ "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

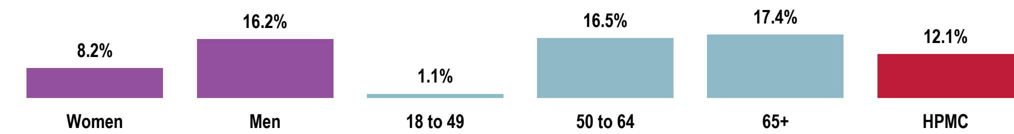
Another 16.9% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(HPMC Service Area, 2023)

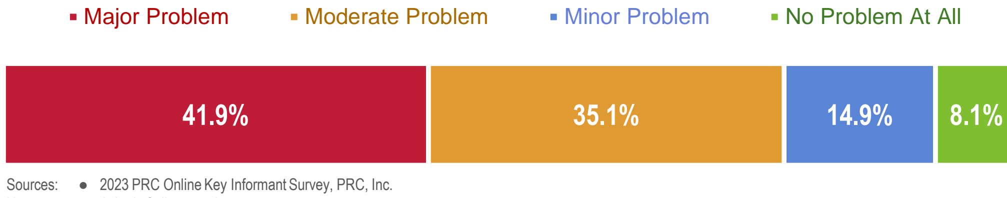


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 106]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Medications/Supplies

> Access to affordable medications and access to healthy food. – Other Health Provider
>
> The cost of insulin and other medications, such as hyperglycemic medications. Access to healthcare. Cultural dietary habits. Hispanic meals traditionally contain rice and beans, which are high in starch. – Social Services Provider
>
> Affordability of good medication, including insulin. Also, access to an endocrinologist if it's really needed. – Physician
>
> Access to affordable medications, especially if they have comorbidities. – Physician
>
> Affordable insulin. – Social Services Provider
>
> Unable to get the glucose machine and testing strip or pay for insulin. Lack of podiatry for the uninsured. – Other Health Provider

Awareness/Education

> Poor access to diabetes education. NCH only has one outpatient dietitian or CDE for all outpatient services. Insurance coverage is limited for this service. Cost and coverage for newer diabetes medications and treatments. – Other Health Provider
>
> Lack of education and prevention. Lack of early detection. – Social Services Provider
>
> Lack of education or motivation to eat better. Possibly lack of access to healthier and affordable foods. – Social Services Provider
>
> The failure to understand the life altering and potentially life ending realities of uncontrolled diabetes. – Social Services Provider
>
> Knowledge of how to prevent or deal with it. Access to healthy foods. – Social Services Provider
>
> Education and access to appropriate care, especially for lower income households. – Community Leader

Nutrition

> Poor diet and inactivity, which leads to obesity and higher blood sugars. – Community Leader
>
> Changing diet and lifestyle. Cost of treatment. – Social Services Provider
>
> Terrible eating habits. – Community Leader
>
> Healthy habits. – Other Health Provider
>
> Inadequate diet choices, lack of education, food deserts and poor food options. Worsening obesity epidemic. – Physician

Access to Care/Services

> Accessing a provider and medication and education. – Public Health Representative
>
> Access to care specifically for diabetes supplies and support for management of the disease by endocrinologists and diabetic educators. – Physician
>
> Access to specialists and the high cost of insulin and other diabetes medicines. – Social Services Provider
>
> Under resourced to match community demands for health management. – Other Health Provider

Access to Affordable Healthy Food

> Access to quality food. No fresh market. Expensive quality food and lack of education on nutrition. – Physician
>
> Access to affordable healthy food, basic economics of cheaper food providing excess calories, and also the price of insulin. – Community Leader

Built Environment

> Lack of sidewalks in most neighborhoods, lack of access to parks and green spaces where people can walk and exercise physical activities, lack of access to community pools, limited to no encouragement for people to become more active. Many people, including children, are overweight. – Social Services Provider

Disease Management

> Lack of compliance with recommended lifestyle changes to manage diabetes, resulting from competing priorities. Aging population on a fixed income that choose nutritionally poor foods due to lower cost. – Public Health Representative

Prevention/Screenings

> Need a greater focus on preventative care and lifestyle adjustments. Growing obesity issues. Endocrine subspecialty availability. I suspect these services are stretched. – Physician

Insufficient Physical Activity

> Need to find ways of engaging in more physical activities and ways to better manage their diet. – Other Health Provider

Lack of Providers

> Access to endocrinologists. – Other Health Provider

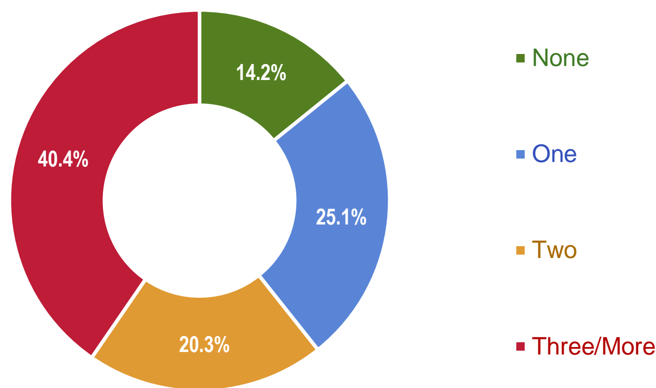
Disabling Conditions

Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

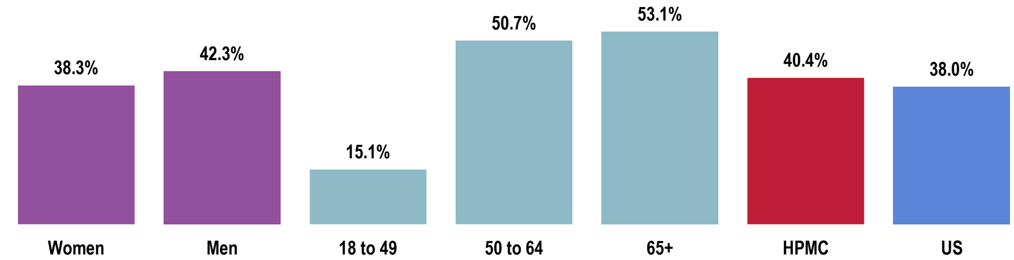
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Have Three or More Chronic Conditions
(HPMC Service Area, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

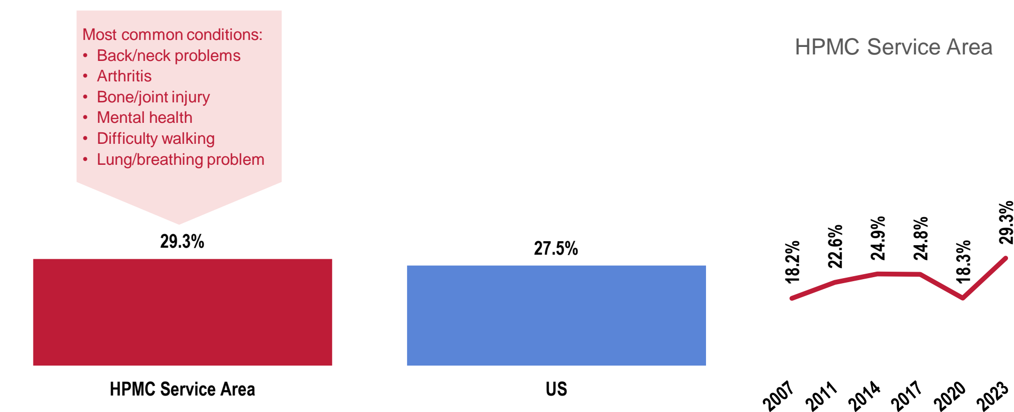
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

PRC SURVEY ▶ **"Are you limited in any way in any activities because of physical, mental, or emotional problems?"**

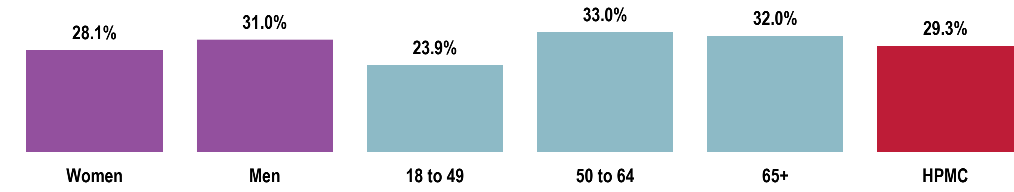
PRC SURVEY ▶ [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem
(HPMC Service Area, 2023)

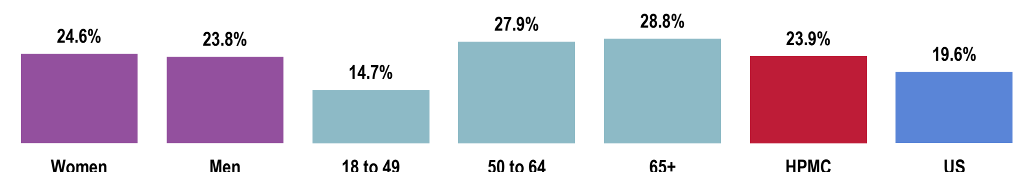


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ▶ "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(HPMC Service Area, 2023)
Healthy People 2030 = 6.4% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

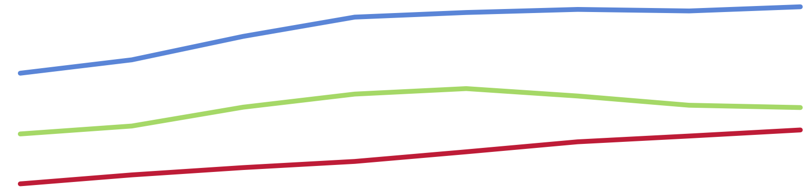
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]

Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	10.2	11.2	12.1	12.8	13.9	15.1	15.8	16.5
FL	16.0	17.0	19.2	20.7	21.3	20.5	19.4	19.1
US	23.1	24.7	27.4	29.7	30.2	30.6	30.4	30.9

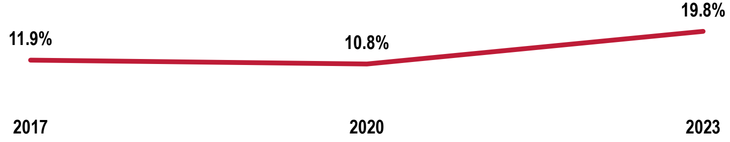
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Confusion/Memory Loss

PRC SURVEY ▶ "During the past 12 months, have you experienced confusion or memory loss that is happening more often or getting worse?"

Experienced Increasing Confusion/Memory Loss in Past Year
(Adults Age 45 and Older; HPMC Service Area, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 318]

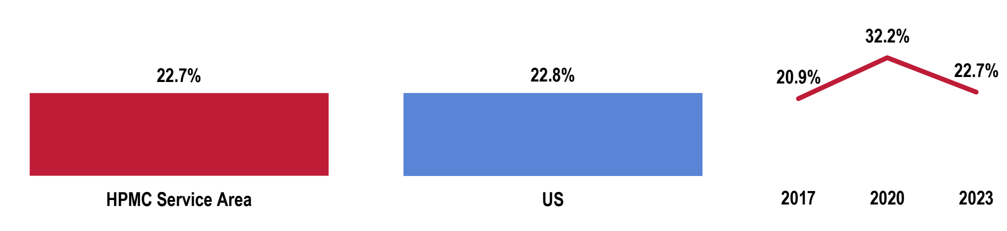
Notes: • Asked of all respondents age 45 and older.

Caregiving

PRC SURVEY ▶ "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

Act as Caregiver to a Friend or Relative
with a Health Problem, Long-Term Illness, or Disability

HPMC Service Area



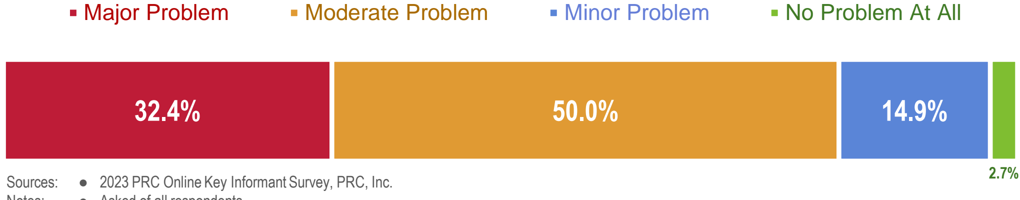
Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 85]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:

Perceptions of Disabling Conditions as a Problem in the Community
(Among Key Informants; CCH Service Area, 2023)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> Demographics and older aged population, greater prevalence of the above disabling conditions. – Physician
>
> Older people with chronic pain. Many exhaust conventional therapy without relief. Limited access to certain medications for pain management. Cost of medications and doctor visits. Chronic pain leads to poor sleep and depression, which leads to more drugs. – Other Health Provider
>
> Age alone increases the incidence of these conditions and 29% of Lee County's population is over 65. – Public Health Representative

Many of these affect seniors – there is a limited safety net for this population who are low to mid income. There are barriers to accessing Medicaid and then even if the person has that support, there are few places that accept it or have capacity. It is a safety issue for those who wander (in car or on foot or scooter), and for those who drive. The driver's test for seniors is expensive. If a person with dementia is lost and found and reported to police, there is nowhere to bring the person except their home (if they have one) – only to have the occurrence likely repeat itself. For senior caregivers of a person with dementia or other disabling condition, care or supported living options are unaffordable leaving the senior caregiver at risk of decline physically and emotionally. – Social Services Provider

Because of the age of our population in Lee County and the influx of snowbirds for four or five months of the year. – Community Leader

I think because of the aging population and the incidence of workplace accidents because of the size of the construction and homebuilding industry pain and mobility are significant problems. I haven't looked at the number of pain management offices we have or medical marijuana dispensaries we have per capita, but they are certainly well represented. – Community Leader

Age of the population of Lee County. – Community Leader

Chronic pain, spinal stenosis in the geriatric population, specifically with little access to medications due to contraindication, such as renal function or efficacy, controlled substance laws changing, and injections conflict with value-based payment models. – Physician

An aging population with a lack of access to healthcare. – Social Services Provider

Access to Care/Services

Under resourced. – Other Health Provider

Excellent care is hard to find. – Community Leader

Limited access to services, limited access to health care for the uninsured, very limited public transportation, stigma concerning mental health and substance abuse, limited resource for non-English speaking citizens. – Social Services Provider

It is not the disabling condition, but the lack of accommodations that are required by ADA law to be provided but are not. – Social Services Provider

Alzheimer's/Dementia

Dementia, it is a major problem and there are not any decent places of care. Their staff are not properly trained to care for these patients. Laws don't allow for proper care training and no one supervises the care, or it is limited with the supervision. – Social Services Provider

Alzheimer's. – Community Leader

Dementia inpatient services that are affordable. – Community Leader

Affordable Care/Services

Many suffer with these conditions because they don't have a primary care provider or finances to access medical care needed. They are treated badly when seeking care for these conditions. – Public Health Representative

Awareness/Education

Lack of education and prevention. Lack of early detection. – Social Services Provider

Comorbidities

Chronic pain. Dementia. Trauma and accidents. Vision and hearing loss. – Physician

Diagnosis/Treatment

Often times people diagnosed with these conditions depend on other people and might not receive the appropriate care or treatment. – Other Health Provider

Impact on Quality of Life

Disabling problems like diabetes, hypertension, and obesity can have a significant impact on our community. These chronic conditions can affect individuals of all ages, races, and socioeconomic backgrounds, and can lead to a range of physical and mental health challenges. Diabetes is a chronic condition that affects the way the body processes blood sugar. It can lead to a range of complications, including nerve damage, kidney damage, and vision loss. In our community, we see many individuals who struggle with diabetes, and we recognize the importance of providing education and support to help them manage their condition and prevent complications. Hypertension, or high blood pressure, is a common chronic condition that affects many individuals in our community. Left untreated, hypertension can lead to a range of complications, including heart disease, stroke, and kidney damage. By providing access we limit the burden on our healthcare infrastructure and strengthen family – Other Health Provider

Incidence/Prevalence

> As I see the number of assisted living options explode, one knows this is becoming a more difficult problem for our community. We also still have a large uninsured or under-insured population who is at risk for these conditions. Plus, the overall age of our community increases the likelihood of all of these conditions. – Physician

Income/Poverty

> People with disabling conditions predominantly have low to very low income. Consequently, they do not have access to medical services due to lack of insurance or being underinsured, such as those on Medicaid. – Social Services Provider

Resources for Developmental Disabled Individuals

> Individuals with intellectual and developmental disabilities have few resources and yet have unique needs. They are more prone to obesity, diabetes and other health issues. They also have extremely limited access to dental care. Few dentists take Medicaid and many have to travel to Sarasota for care. There is a long wait. Many go without dental care and therefore it turns into other health related issues. There are over 1,100 residences in Lee County that we know of that have IDD diagnosis. – Social Services Provider

Accessible/Affordable Senior Assisted Living

> Accessible and affordable senior assisted living. – Community Leader

Cost of Hearing Aids

> Lack of affordable hearing aids for the elderly and those on a fixed income. – Social Services Provider

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

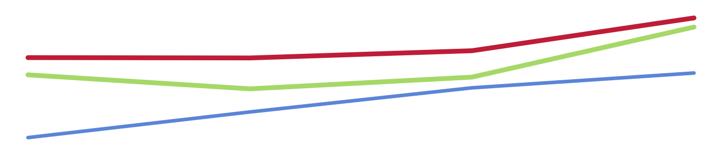
– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of Lee County women who did not receive prenatal care during the first six months of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services. [COUNTY-LEVEL DATA]

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births)



	2008-2010	2011-2013	2014-2016	2017-2019
Lee County	6.6%	6.6%	6.8%	7.7%
FL	6.1%	5.7%	6.0%	7.4%
US	4.3%	5.0%	5.7%	6.1%

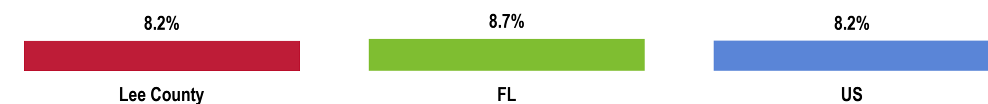
Sources: • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).
Note: • This indicator reports the percentage of women who do not obtain prenatal care before their seventh month of pregnancy (if at all).

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2014-2020)



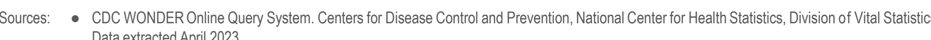
Lee County	FL	US
8.2%	8.7%	8.2%

Sources: • University of Wisconsin Population Health Institute, County Health Rankings.
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	6.2	5.8	5.8	5.9	5.9	5.8	5.8	5.7
FL	6.2	6.1	6.2	6.2	6.2	6.1	6.0	5.8
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

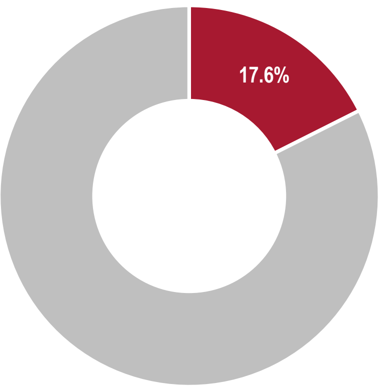
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2023.
• Centers for Disease Control and Prevention, National Center for Health Statistics.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • This indicator reports deaths of children under 1 year old per 1,000 live births.

Newborn Vaccinations

PRC SURVEY ▶ **"Thinking about childhood vaccinations, if you had a new baby, would you want to get all of the recommended vaccines?"**

PRC SURVEY ▶ [Those who would not want vaccines] **"What is the main reason you would not get all the recommended vaccines?"**

Would Not Want My Newborn
to Receive All Recommended Vaccinations
(HPMC Service Area, 2023)



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 325]
Notes: ● Asked of all respondents.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

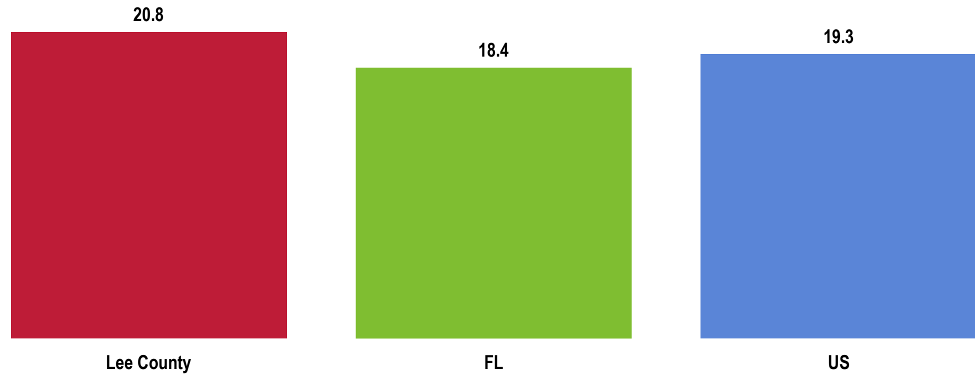
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines teen births in Lee County, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]



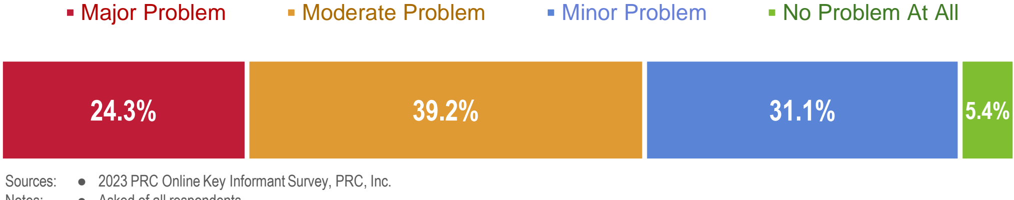
Sources: • Centers for Disease Control and Prevention, National Vital Statistics System.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes: • This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:

Perceptions of Infant Health & Family Planning as a Problem in the Community
(Among Key Informants; Lee County, 2023)



Sources: ● 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> New residents who arrive in SW Florida pregnant are not able to make a timely appointment with an OB due to a lack of physicians. Family planning/birth control is available at no/low cost, but people do not know that and don't know where to find it. Our teen pregnancy rate is much too high and could be reduced with education and birth control options. – Social Services Provider
>
> Lack of access to healthcare and resources. – Social Services Provider
>
> Limited pediatrician access. Very limited early childhood education facilities, and with costs prohibitive to many families, planning is limited culturally and politically. – Other Health Provider
>
> We have several deaf clients who have recently given birth to babies. All of them needed specialized equipment for their newborn such as a flashing light baby monitor that vibrates to alert them when the baby is crying. Our agency provides access to this equipment and training to deaf clients, something all doctor's offices with deaf patients should know, and refer to us. So many things that hearing parents have access to for their newborns that deaf people do not. We can help. – Social Services Provider
>
> Anecdotally, we hear about family experiences with low-birth-weight babies and young mothers who have not accessed Ob-Gyn care in a timely manner. I also imagine we have an above average of misuse of both prescription and nonprescription drugs that must affect pregnant mothers. – Community Leader
>
> Limited resources for the uninsured, very limited public transportation, limited access to safe family planning, and stigma against family planning in some communities. – Social Services Provider
>
> Population from rural areas have less access to such services or lack access to proper education. – Other Health Provider
>
> Access to care and early intervention is not available to all community members. – Social Services Provider

Awareness/Education

> Lack of education and prevention. Lack of early detection. – Social Services Provider
>
> There aren't many options for educating new mothers outside of their OBGYN offices before they give birth to their baby. While in the hospital and even after discharge, they have the support of pediatricians, headstart, and others, it just seems like many new mothers are going into the birthing process without much knowledge. Education is needed to inform them of their options for birth and what to expect. – Public Health Representative

Government/Policy

> Women's care and recent state and federal decisions forces families. Increase in infant diagnosis and problems. – Social Services Provider
>
> The current political environment seems to limit the providers from making their services well known to the community. – Community Leader

Affordable Care/Services

> We have few resources and high costs. Florida ranks as number 42 out of 50 in states for baby health. Recent federal rulings have made family health worse. – Social Services Provider

Impact on Quality of Life

> Developmental delay, pregnancy complications, and prenatal care. – Physician

Transportation

> Pregnant women lack access to maternal and prenatal health care largely due to lack of transportation. – Community Leader

Unplanned Pregnancies

> We still have many teens and others with unplanned pregnancies. – Public Health Representative

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

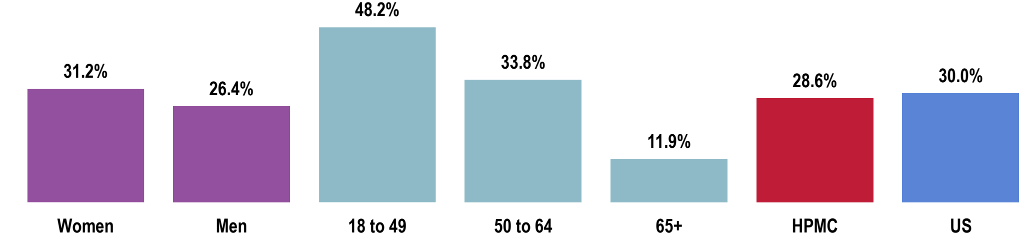
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Fresh Produce

PRC SURVEY ▶ "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(HPMC Service Area, 2023)



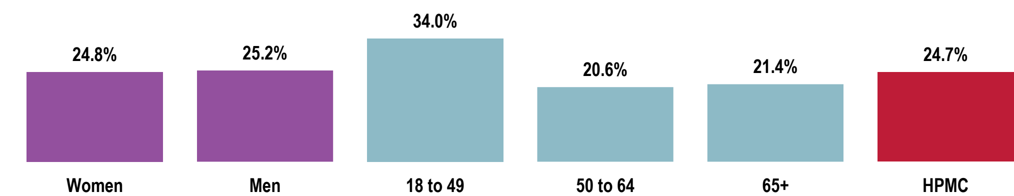
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Sugar-Sweetened Beverages

PRC SURVEY ▶ **"During the past seven days, how many servings of sugar-sweetened beverages did you have?"**

These beverages include soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, or sweet tea and do not include "diet" drinks.

Had Seven or More Sugar-Sweetened Beverages in the Past Week
(HPMC Service Area, 2023)

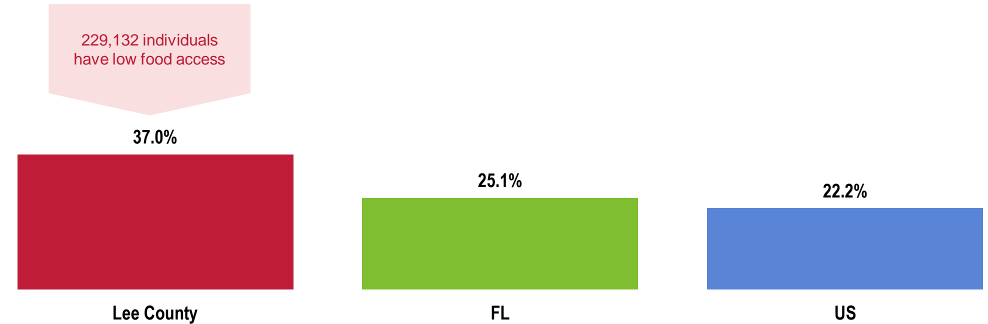


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 328]
Notes: ● Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]

Population With Low Food Access
(2019)



Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).

● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).
Notes: ● Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

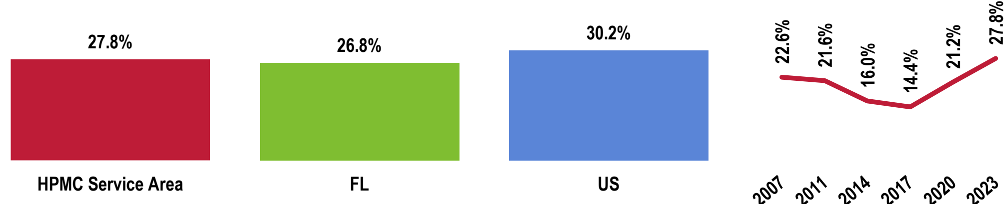
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ▶ "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;

- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ▶ "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ▶ "And during the past month, how many times per week or per month did you take part in this activity?"

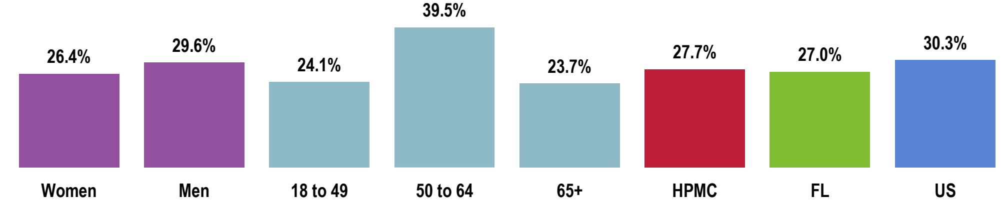
PRC SURVEY ▶ "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ▶ "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

Meets Physical Activity Recommendations
(HPMC Service Area, 2023)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

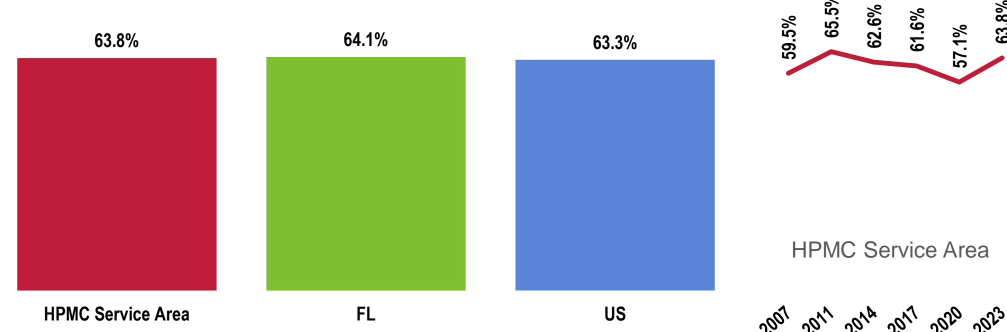
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC SURVEY ▶ “About how much do you weigh without shoes?”

PRC SURVEY ▶ “About how tall are you without shoes?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

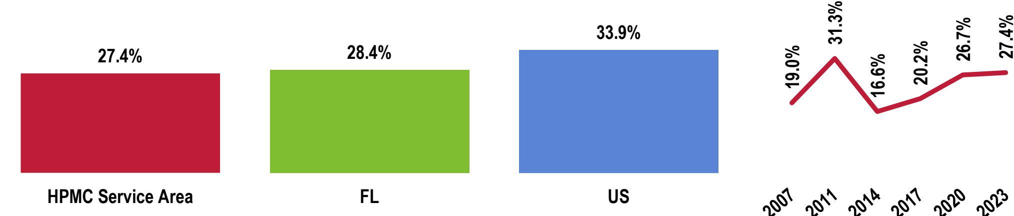


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Based on reported heights and weights, asked of all respondents.
● The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

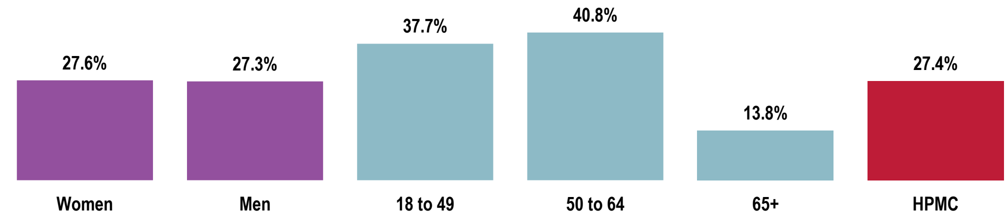
Healthy People 2030 = 36.0% or Lower



Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: ● Based on reported heights and weights, asked of all respondents.
● The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Prevalence of Obesity
(HPMC Service Area, 2023)
Healthy People 2030 = 36.0% or Lower

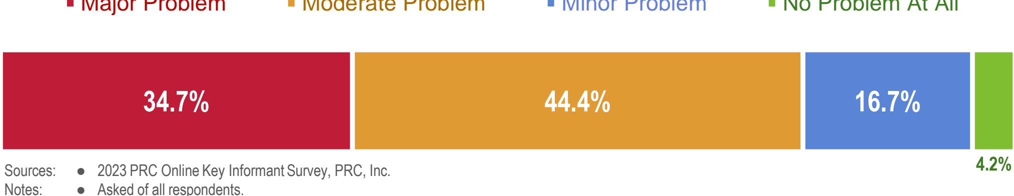


Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 112]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Based on reported heights and weights, asked of all respondents.
• The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Among Key Informants; Lee County, 2023)



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

Ample education and clinicians. – Community Leader

Lack of education and access to good and affordable food choices. – Physician

Lack of knowledge and interest in changing habits. – Physician

Education and ability to make time with schedules to understand the importance of physical activity. – Community Leader

Education provided in schools. – Other Health Provider

Education and being able to afford better choices for nutrition. – Public Health Representative

Access to Care/Services

Access to nutritionists, if covered by their insurance, or if are willing to self-pay, is limited. Insurance does not cover exercise physiologists to help guide patients. – Physician

Access to exercise equipment/programs. Parks should have exercise stations and the public educated on access and use. Free/low-cost gym throughout the county that provide nutrition education. Lee County could create a campaign that residents across the county could join in. – Social Services Provider

No place to go for lessons. Too few dieticians and too costly. – Physician

Access to Affordable Healthy Food

Lack of access to fresh food, fruits, and vegetables in low socioeconomic areas. Lack of parks and outdoor spaces throughout the county. The parks have become a hangout space for homeless people and families don't feel safe going there. Lack of public pools for families who do not have access to water and water sports and activities. Many people are overweight. – Social Services Provider

Individuals are unable to pay for meals that are more nourishing, so they end up eating unhealthy food because it's cheaper. – Other Health Provider

These aren't a priority for many in the community. Food access, especially healthy foods, is a huge problem in our community. There are many food deserts in our county. – Public Health Representative

Obesity

Again, growing epidemic of obesity and sedentary lifestyle. – Physician

Individuals who are overweight are more prone to workout injuries. Some challenges of nutrition are inadequate maternal or child health practices, inadequate access to health services, climate change and food insecurity. – Other Health Provider

Overweight or obese. Limited parks. Limited walking area. Gyms are not affordable. – Physician

Insufficient Physical Activity

The lack of physical activity and the impact on people's lives. – Social Services Provider

Lack of fun and interesting ways for children to stay active. Not all children like or play sports. Generational, parents' sedentary and unhealthy lifestyle is passed down. – Social Services Provider

Lifestyle

Choices. – Other Health Provider

Many have unhealthy lifestyles, such as poor nutrition, low levels of physical activity, and are overweight. About 60% of Lee County is a food desert, in which healthy food is difficult to find. – Social Services Provider

Income/Poverty

Low income and low access to foods, such as the food deserts. Additionally, we have food swamps of quick service foods located in heavily populated areas, with little access to fresh, healthy options. – Public Health Representative

Lack of Providers

There doesn't seem to be enough providers. Again, if they exist, there is very little outreach to make the general public aware. – Community Leader

Language Barrier

Any classes that are offered anywhere, personal training, nutrition, etc., they all need to be marketed to the deaf community so we can provide an interpreter for this important outreach. – Social Services Provider

Substance Use

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Alcohol-Induced Deaths

The following chart outlines age-adjusted, alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	12.2	13.1	14.7	15.5	15.2	15.7	15.8	17.6
FL	10.7	11.0	11.4	11.8	11.6	11.6	11.4	12.0
US	9.9	10.3	10.6	10.8	10.8	10.9	11.1	11.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

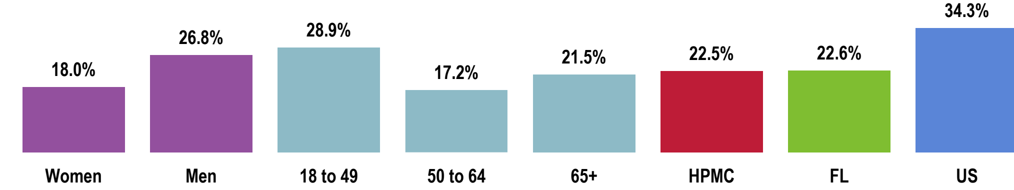
- HEAVY DRINKING ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

PRC SURVEY ▶ **"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"**

PRC SURVEY ▶ **"On the day(s) when you drank, about how many drinks did you have on average?"**

PRC SURVEY ▶ **"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5** (if male)**/4** (if female) **or more drinks on an occasion?"**

Engage in Excessive Drinking



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

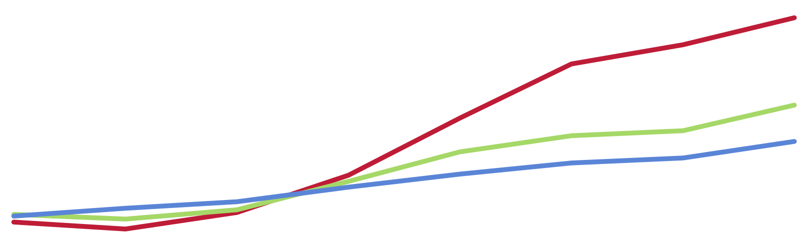
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Lee County	10.2	9.3	11.5	16.5	24.2	31.4	34.0	37.6
FL	11.2	10.6	11.9	15.7	19.6	21.8	22.5	25.9
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2023.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

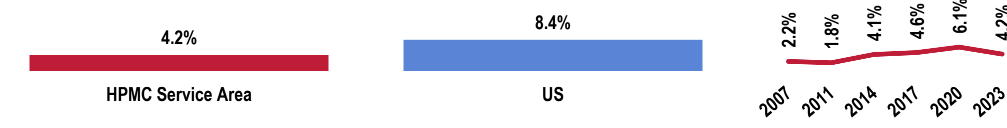
Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

PRC SURVEY ▶ "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

HPMC Service Area



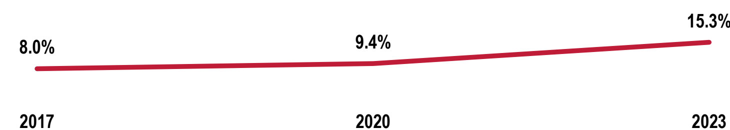
Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 40]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Use of Marijuana

PRC SURVEY ▶ "In the past 30 days, have you used marijuana?"

Marijuana Use in the Past Month
(HPMC Service Area, 2023)



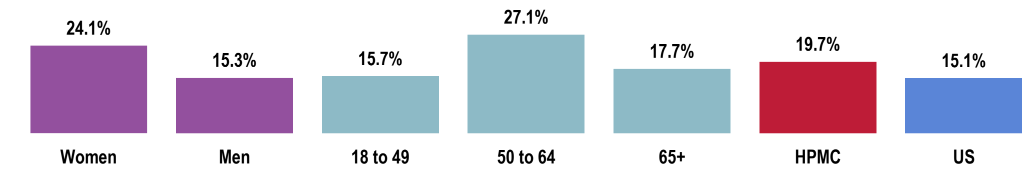
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: ● Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ▶ "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(HPMC Service Area, 2023)

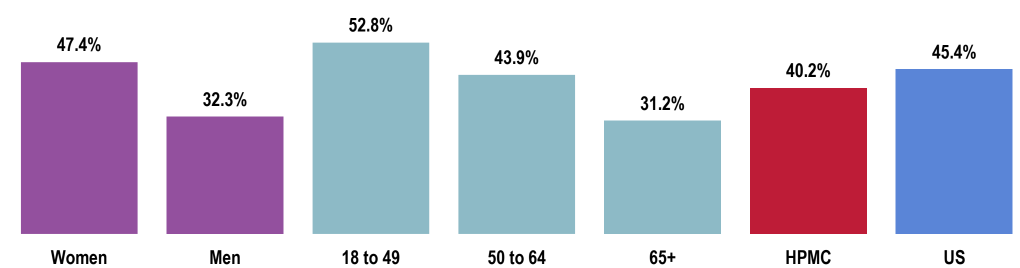


Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ▶ "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected
by Substance Use (by Self or Someone Else)
(HPMC Service Area, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 43]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:

Perceptions of Substance Use as a Problem in the Community
(Among Key Informants; Lee County, 2023)

▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All

Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Lack of available service. Lack of trust of the people and services. Lack of knowledge of service available. – Other Health Provider

When considering treatment needs, as with health care needs more broadly, rural areas continue to be disproportionately disadvantaged with a lack of basic services and underutilization of available services when compared to urban contexts. – Other Health Provider

Not enough centers, stigma, and cost. – Social Services Provider

Lack of IOP services, residential, and halfway houses. – Other Health Provider

Lack of facilities and lack of funding. – Social Services Provider

Greatly under resourced. – Other Health Provider

Lack of treatment resources, especially for children and teens, stigma against treatment, lack of recognition of mental health/substance use issues in families, lack of resources for the uninsured, very limited public transportation, lack of understanding of recovery/relapse – Social Services Provider

Insurance, peer support, family education, awareness within the primary care and medical settings, screenings, lack of crisis intervention teams, and law enforcement not being trained on Narcan. – Other Health Provider

Choices. – Other Health Provider

Limited treatment and limited providers that take insurance. – Community Leader

Lack of beds, providers, and programs. – Community Leader

Denial/Stigma

Denial of patient and/or family members. Insufficient treatment centers with an adequate number of providers and/or beds. – Community Leader

Admitting that there is a problem, and the profit made by selling drugs. – Community Leader

Stigma, financial resources to maintain MAT, transportation, and affordable housing. – Social Services Provider

Alcohol abuse is not seen as a problem. Our retired population focuses too much on drinking. Many of our recreational activities focus on dining and alcohol. – Physician

Stigma and discrimination, early identification, funding, parity, knowledge of resources, understanding of the disease model, and disease model focused treatment. – Social Services Provider

Social bias and programs. – Community Leader

Awareness/Education

Lack of education and prevention. Lack of early detection. – Social Services Provider

Knowledge of resources available. – Social Services Provider

Lack of education and communication access. – Social Services Provider

Talking about it, access, partnerships, and funding. – Other Health Provider

Lack of Providers

Not enough providers. – Public Health Representative

Lack of clinicians and high turnover at community mental health centers. Low Medicaid rates, and many don't accept Medicaid due to this reason. – Social Services Provider

Lack of treatment providers who have funding to cover individuals without income or healthcare, lack of treatment providers/facilities who accept Medicare or Medicaid, limited access to Marchman receiving facilities, no locked residential treatment facilities to assist with involuntary court ordered treatment, lack of intensive outpatient treatment program availability, lack of accountability for non-compliance with court ordered treatment under Marchman system. – Social Services Provider

Affordable Care/Services

There are not enough affordable programs available. – Public Health Representative

Access to affordable care in self-pay or insurance-pay models of care. – Physician

Diagnosis/Treatment

The current Mental Health and Substance Abuse System is comparative to socialized medicine. We have a provider in Lee County who has continued to underperform and does not have the incentive to work for their customer. For example, they operated their crisis stabilization unit for several months without a psychiatrist consistently present. The same agency runs the substance abuse treatment in Lee County who suffered the same outcome. They did not ensure proper clinicians were in-house to treat their patients. Recently, Lee County has endeavored to expand its provider network. However, this is a symptom of a problem that has been emergent for several years. – Social Services Provider

Drug rehab. – Other Health Provider

Disease Management

Willingness to seek help and access and affordable programs. – Physician

Lack of desire and ease of obtaining various drugs. – Community Leader

Vulnerable Populations

> I believe there is a large, undisclosed substance abuse challenge among older adults; not sure if this is a growing or stable trend in the younger population. Primary care physicians may be inadequately trained or without enough time to fully address this issue during screening encounters: for general population; for perinatal care; for older adults; for those with mental health issues. Addictionologists are scarce. – Physician

Alcohol/Drug Use

> Methadone, opioid, benzo, alcohol. – Physician

Co-Occurrences

> I believe that the community members that abuse do so in order to cope with the stress of their current living conditions. I believe we must improve the overall quality of life in the community in order to see improvement. – Social Services Provider

Funding

> Lack of funding by the State of Florida. The public health unit is underfunded. – Community Leader

Lack of Coordination

> Coordinated care and predominate treatment being in a for-profit arena. – Social Services Provider

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

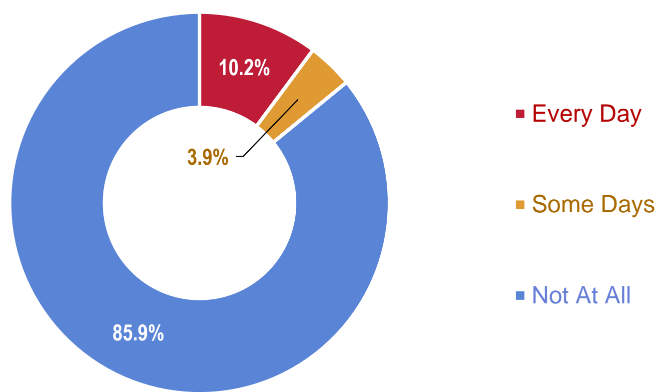
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Tobacco Smoking

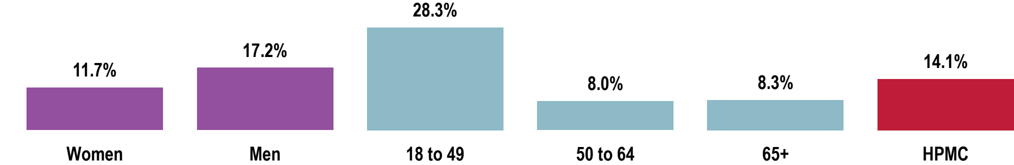
PRC SURVEY ▶ "Do you currently smoke tobacco products every day, some days, or not at all?" ("Currently Smoke Tobacco" includes those smoking "every day" or on "some days.")

Prevalence of Tobacco Smoking
(HPMC Service Area, 2023)



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: • Asked of all respondents.

Currently Smoke Tobacco Products
(HPMC Service Area, 2023)



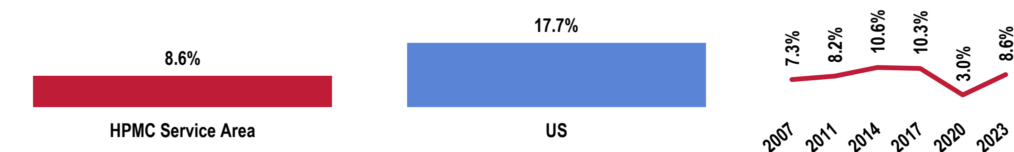
Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 307]
Notes: • Asked of all respondents.
• Includes those who smoke tobacco products every day or on some days.

Environmental Tobacco Smoke

PRC SURVEY ▶ "In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents.

Member of Household Smokes at Home



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 35]
- 2023 PRC National Health Survey, PRC, Inc.

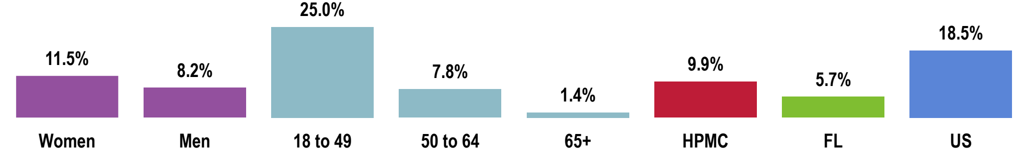
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ▶ "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(HPMC Service Area, 2023)



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Use of Smokeless Tobacco

PRC SURVEY ▶ "Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"

("Currently Use Smokeless Tobacco" includes use "every day" or on "some days.")

Currently Use Smokeless Tobacco
(HPMC Service Area)

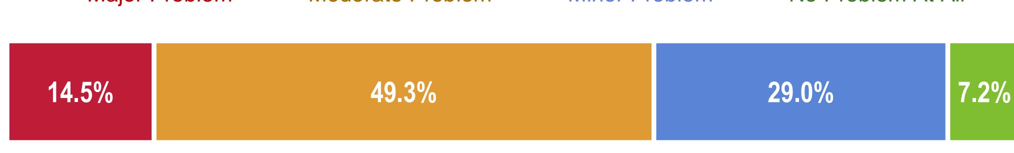
Sources: ● 2023 PRC Community Health Survey, PRC, Inc. [Item 309]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
Notes: ● Reflects the total sample of respondents.
● Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community
(Among Key Informants; Lee County, 2023)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: ● 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

At least 85% have had some form of use of tobacco product at one point in their life. – Physician

I work construction and see frequent use. Way too many people in the company use tobacco often. – Community Leader

Teen/Young Adult Usage

Many teens are still smoking, vaping, dipping, and finding ways to use tobacco to calm themselves down. – Social Services Provider

Access to Care/Services

Lack of resources to help people quit. – Social Services Provider

Awareness/Education

> Lack of education. – Social Services Provider

Co-Occurrences

> Many turn to tobacco to cope with other issues. – Public Health Representative

E-Cigarettes

> Vaping is on the rise, especially amongst the younger population. – Physician

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

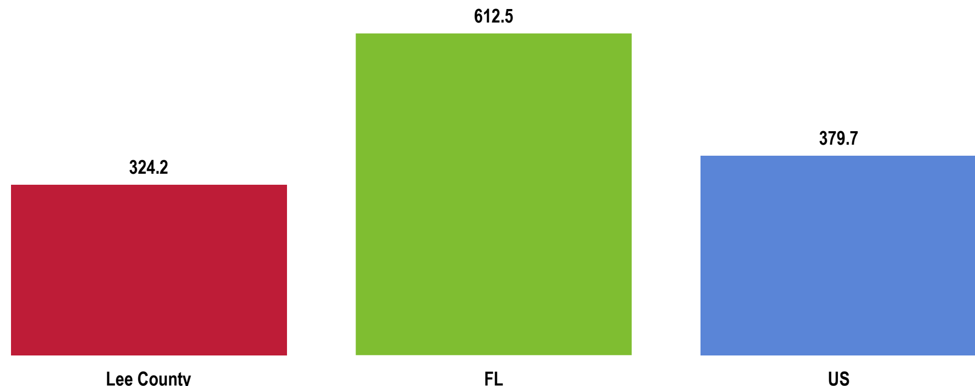
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]

HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2020)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

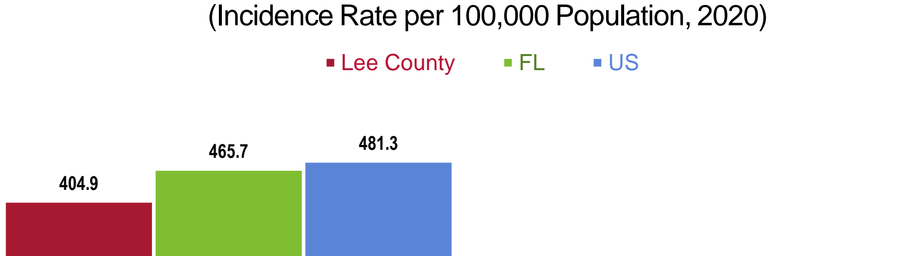
Chlamydia

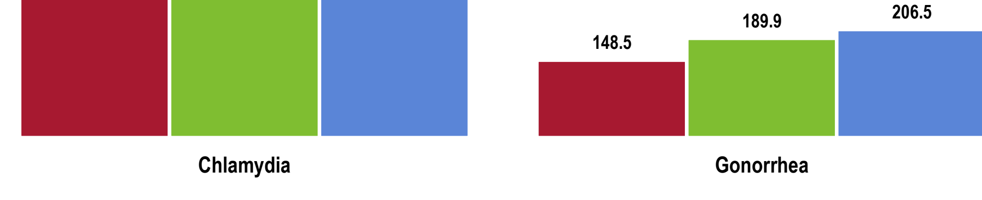
Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



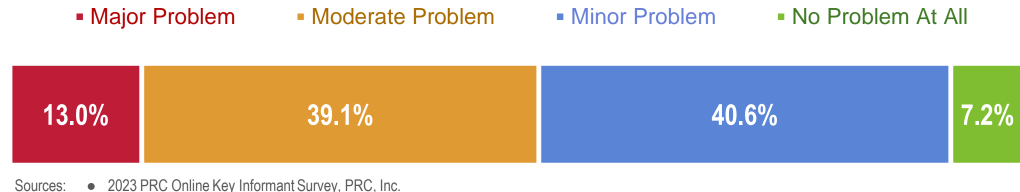


Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:

Perceptions of Sexual Health as a Problem in the Community
(Among Key Informants; Lee County, 2023)



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I imagine it is an issue in most communities, but with both our young population and aging population, there appear to be spikes in this area. – Community Leader
>
> We have a high rate of STIs. – Public Health Representative

> According to the Florida Department of Health Bureau of Communicable Diseases, from 2016 to 2021 Lee County has seen a 15% increase in the age adjusted rate of bacterial STDs. Similarly, syphilis, gonorrhea, and chlamydia have seen increases during this time period as well. – Public Health Representative
>
> Patients presenting for testing and treatment to our unit. – Other Health Provider

Awareness/Education

> Lack of education and prevention. Lack of early detection. – Social Services Provider

Affordable Medications/Supplies

> Prep is not abundantly available. – Physician

Comorbidities

> Sexually transmitted infections, adolescent pregnancy and family planning and contraception methods. – Other Health Provider

Denial/Stigma

> Stigma against discussion about sexual health, lack of treatment options, and lack of recognition of importance of sexual health of older adults. – Social Services Provider

ACCESS TO HEALTH CARE

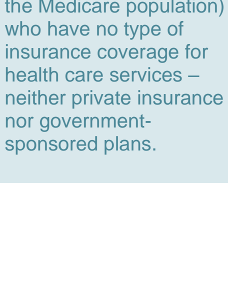
ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage



Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

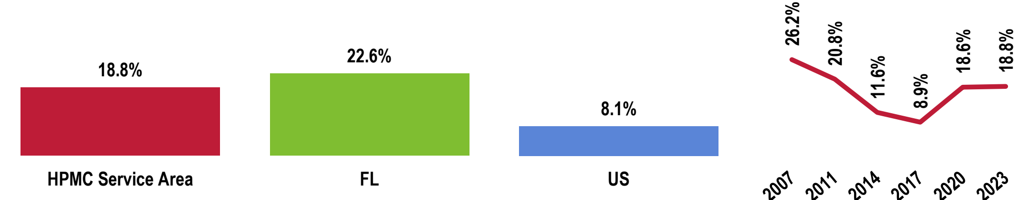
Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

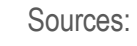
PRC SURVEY ▶ "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ▶ "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

HPMC Service Area

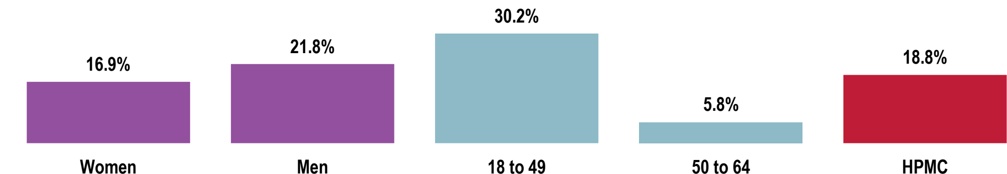




Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; HPMC Service Area, 2023)
Healthy People 2030 = 7.6% or Lower



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 117]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"**

PRC SURVEY ▶ **"Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"**

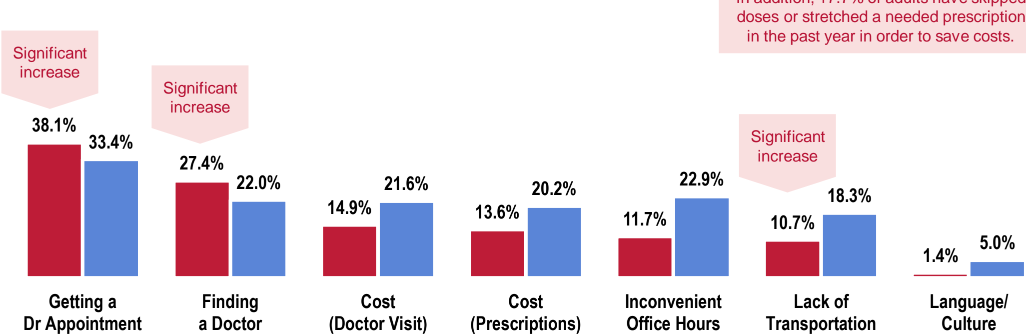
PRC SURVEY ▶ **"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"**

Also:

PRC SURVEY ▶ **"Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"**

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

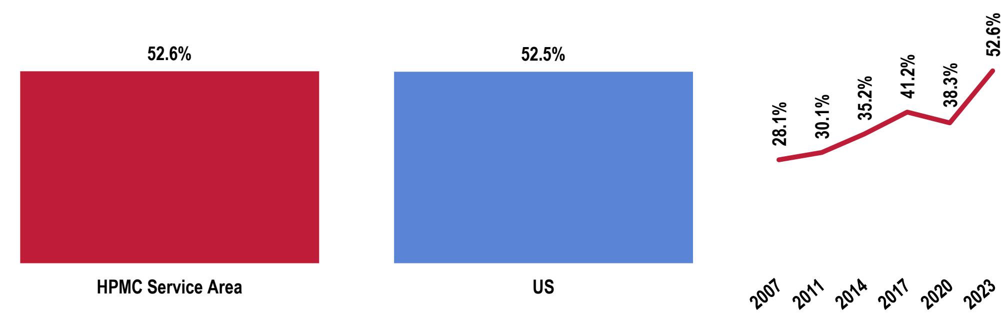


Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Items 6-13]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

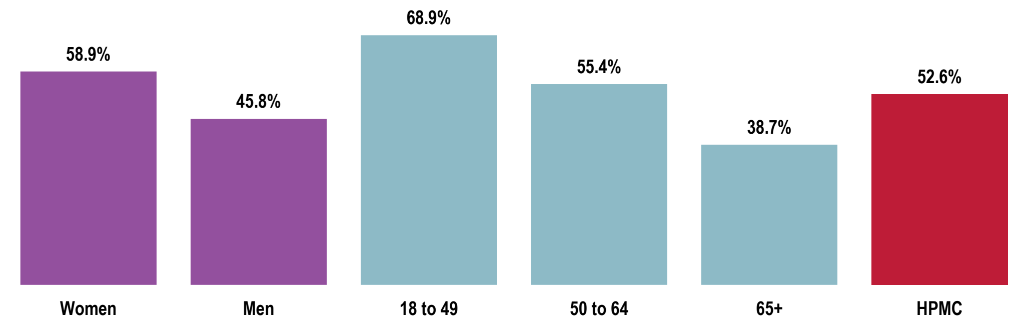
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 119]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(HPMC Service Area, 2023)

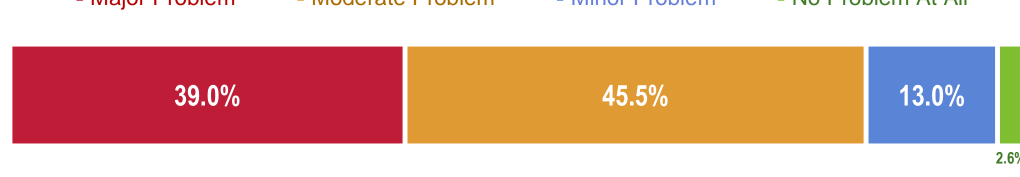


Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

Perceptions of Access to Health Care Services as a Problem in the Community
(Among Key Informants; Lee County, 2023)



Sources: • 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lack of Providers

There are not enough physicians and other medical professionals in SW Florida to serve the ever-growing population – especially in specialty fields. New patients (and in some cases current patients) must wait months to get an appointment, leaving no option other than using an urgent care center or emergency room for minor health issues. In addition, there are not enough physician groups/medical centers that accept Medicaid and/or use a sliding fee scale for payment. We have a large number of uninsured/underinsured families who cannot afford any preventative medical services. – Social Services Provider

It is difficult to get in to see a specialist – cardiology and cardio subspecialties in particular – you have to have connections. There are no neurology subspecialists dealing with Parkinson's and dementia related disorders. Mental health continues to be an issue but telehealth access through vendors and insurers has made a significant impact on access here. – Social Services Provider

Adequate number of providers to see the increasing population in our county. – Physician

Physician shortage across most specialties. Older population requiring more care. Cost of living increases make it difficult for our employees. – Physician

> Not enough providers, specialists in particular, and that gets even more challenging for Medicaid or uninsured individuals. – Public Health Representative
>
> There is a significant influx of people to Lee County and there has been difficulty in maintaining an adequate increase in physicians and providers to meet this need, especially in certain hard to fill specialties. – Physician

Access to Care/Services

> Persons with extremely low and low income cannot get access that is readily available. Persons who have mental health, substance abuse or dual diagnosis cannot get access to outpatient and inpatient services on a consistent basis consequently disrupting any possibility of continuity of care. – Social Services Provider
>
> Access to care, not just primary care either. – Physician
>
> In Cape Coral, it would be available hospital rooms and access to Emergency Room services. – Community Leader
>
> Too long of a wait to see a new primary care provider or specialty doctor. Too few doctors. Too little time spent with patients to assess issues, resulting in misdiagnosis and patient frustration. Cost of medications. Not enough lifestyle disease prevention programs. – Other Health Provider
>
> Limited access to primary and specialty practices. Appointment scheduling is delayed months. Immediate access is rarely available. – Other Health Provider
>
> The distribution of health care facilities is unevenly distributed around the county, with a bias for South- and South-Central Lee. – Community Leader
>
> The ability to get appointments with physicians in a timely manner. – Physician

Affordable Care/Services

> Lack of resources for low-income families and those with English language impairment. Sometimes lack of transportation plays a major role in them reaching a provider/specialist. Stigma related to mental health is a big barrier in getting the appropriate treatments beside high co-payments. – Other Health Provider
>
> Affordability, transportation limitations, access to supportive services to implement preventative care versus the need for emergency services. – Social Services Provider
>
> Ability to access affordable and quality healthcare. – Social Services Provider
>
> Affordable healthcare. Access to physicians and healthcare providers. Insurance and lack of participating physicians. – Social Services Provider

Transportation

> Few people in our community had cars, and those that did lost them in Hurricane Ian. Even though we can see Golisano Children's Hospital, how does a mother walk with three small children to seek medical attention? Many families in our community do not have medical / dental insurance and therefore cannot afford health care. One of the boys in our community broke his arm during the Hurricane. He was seen at the ER and told to see a Lee Health Pediatric Orthopedist to have the arm set. I drove the boy and his mother to the office. Initially they were refused treatment because they had no insurance. I had to ask to speak to the office manager. It was agreed that if I paid a reduced fee that they would treat the boy, what would have happened if I had not been there to act as an advocate for the patient, and I had been able to pay the fee? – Social Services Provider
>
> Transportation and being unaware of what's available and being afraid of those providing care. – Public Health Representative
>
> Transportation, funding and insurance for people. – Social Services Provider
>
> Transportation is an issue for many, which restricts access to care. – Community Leader

Access to Care for Uninsured/Underinsured

> In our community, we see a wide range of patients who face significant challenges when it comes to accessing healthcare. Some of the most pressing challenges we see include the uninsured, undocumented, and underinsured populations. For the uninsured and undocumented, access to healthcare can be a significant challenge. Without insurance or proper documentation, these individuals may not be able to access the medical care they need. This can result in delayed diagnoses, untreated conditions, and a lack of preventative care. For these individuals, our mobile health services can be a lifeline, providing them with access to medical care and support that they may not be able to access elsewhere. For the underinsured, high deductibles and copays can be a significant barrier to accessing healthcare. Even with insurance, these individuals may not be able to get the care they need. – Other Health Provider
>
> There is access for people who have no coverage, and it is the working people who don't have enough coverage. Also, there are not enough providers in the community. – Social Services Provider

Awareness/Education

> We are not actively discussing mental health and addiction treatment in our community. It appears to be an 'us vs them' problem, even as the numbers continue to rise among all residents. We need a full view of service capacity, gaps in service, and marketing around mental health and addiction. There is not enough access to support the need, with silos that prevent patients from accessing care. – Other Health Provider
>
> Community education. What is available, where it is available, how much it costs, what is a deductible, co-pay, coinsurance, OOP, etc. How do you find a provider who accepts Medicare/Medicaid? How do you establish a patient care coordinator (medical home)? Why go to an ER versus a walk-in clinic. – Community Leader

Multiple Factors

> Outpatient therapy is in network with all insurances including Medicare and Medicaid. Residential treatment options in network with managed Medicare & Medicaid plans. Baker Act receiving for youth. Mental Health halfway housing or group homes. Mobile assessment teams for mental health crisis. All police should carry and be able to administer Narcan nasal spray to victims of overdosing, as it is not policy with our local sheriff's department and a big reason for such high fatal overdoses. More oversight on not-for-profit organizations who receive funding for peer support services that peer specialists are trained and certified as well as meeting with individuals in crisis stabilization units and emergency departments to promote the continuum of care in Lee County. – Other Health Provider

Language Barrier

> Hospitals, emergency rooms, and doctors' offices NOT providing a live interpreter to a deaf person. Providing a VRI (video remote interpreter) is not the same thing and does not provide equal communication access for all. As the only Deaf & Hard of Hearing Center providing resources for five counties, including Lee, Collier, Charlotte, Hendry, and Glades counties we hear our share of community needs from our deaf and hard-of-hearing clients. These are the 2 biggest complaints. 1. An interpreter was not provided. 2. The VRI machine provided was not adequate. Specific comments include: It froze up. It would not connect to the internet. The nurse/doctor/tried it five times and still couldn't get it connected to the internet. It connected, but the connection was not good. The connection was so slow I couldn't understand the interpreter on the screen. – Social Services Provider

Access to Specialty Care

> Not one specific issue. With 1,000 people moving to Florida each day, finding a health care professional without a referral is very difficult. Dermatology may be the toughest. Getting an appointment during season is very tough with snow birds setting up appointments a year in advance. – Community Leader

Mental Health Treatment

> Mental health services. – Community Leader

Not Enough Coordination of Resources

> Not enough coordination of resources. – Social Services Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

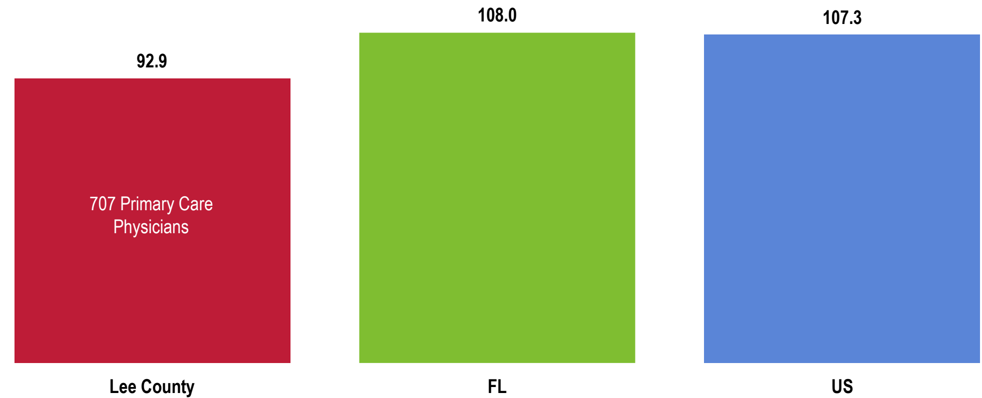
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

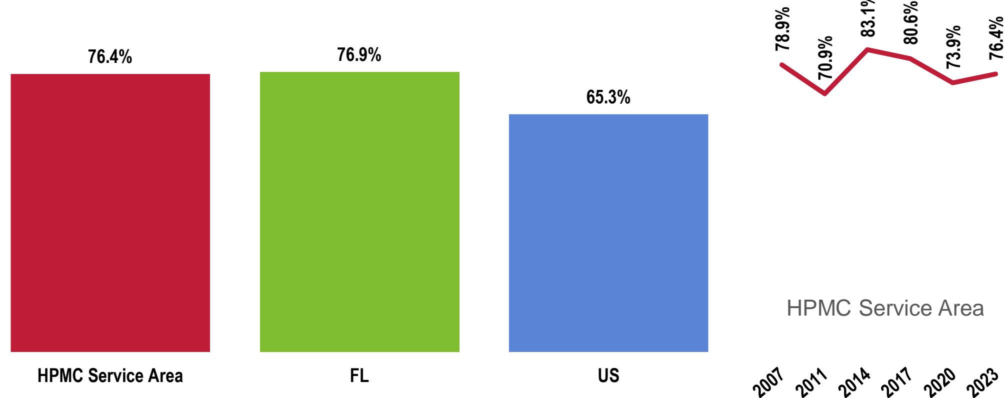


Sources: • Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2023 via SparkMap (sparkmap.org).

Notes: • Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

PRC SURVEY ▶ "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

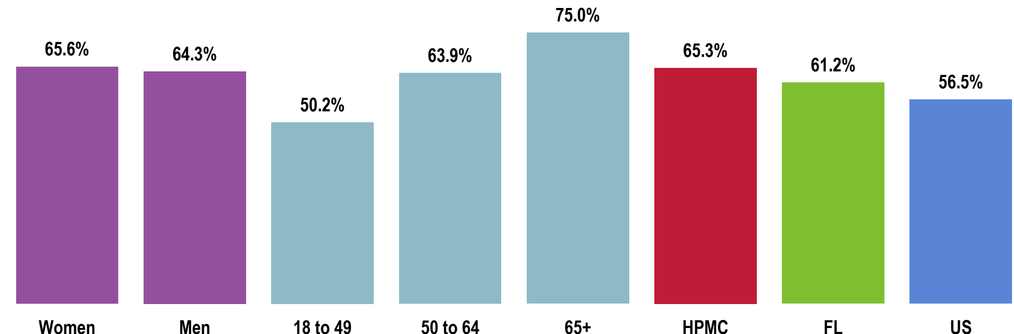
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

PRC SURVEY ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher

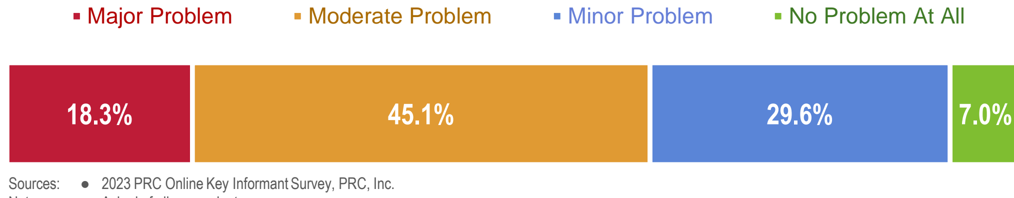


Sources:
- 2023 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care for Uninsured/Underinsured

> Lack of access to dental care due to insurance or income. – Social Services Provider
>
> So many people don't have coverage and poor oral health leads to other problems in the future. – Social Services Provider

Affordable Care/Services

> Lack of free dental care. Fluoride varnish availability in the office. – Physician
>
> Dental care is so important to a person's overall health. Many people, especially seniors, will forgo dental care due to financial reasons. While places like Family Health Centers offer care based on income – they have trouble staffing and retaining dentists. It would be great to have a focus on affordable dental care and increased access. – Other Health Provider

Incidence/Prevalence

> Almost every day we see one or more patients with tooth decay or dental abscess seeking care. – Other Health Provider
>
> Some of the major common diseases that impact our oral health include cavities, periodontal disease, and oral cancer. – Other Health Provider

Access to Care for Medicare/Medicaid Patients

> Access to dental care is limited especially for patients on government covered plans, such as Medicaid and Medicare. – Physician

Awareness/Education

> Lack of awareness for oral health. It doesn't seem to be a priority until there's a problem and is seen as unaffordable. – Public Health Representative

Co-Occurrences

> Poor dental health can lead to deterioration of body systems, poor body image, and chronic pain. – Community Leader

Lack of Providers

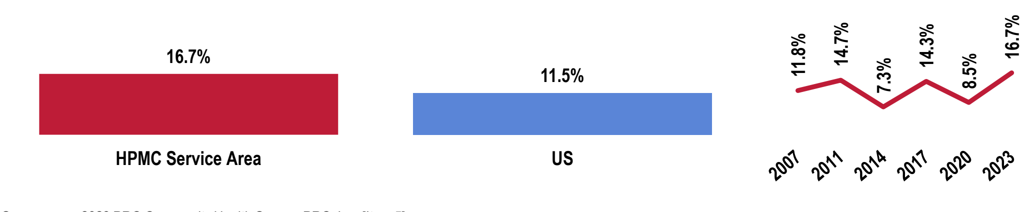
> Lack of dentists in general, and lack of dentists who take Medicaid. – Social Services Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ▶ "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"

Perceive Local Health Care Services as "Fair/Poor"



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Item 5]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

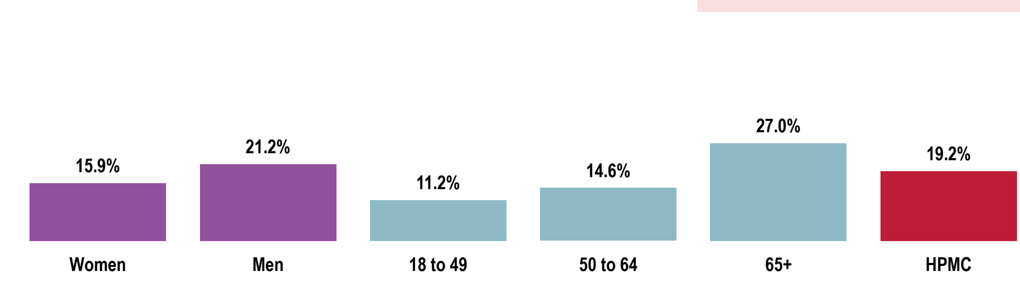
Awareness of Healthy Lee

PRC SURVEY ▶ "Before today, had you ever heard of Healthy Lee or any of its community outreach efforts?"

PRC SURVEY ▶ [Those who have heard of Healthy Lee] **"Has Healthy Lee impacted your lifestyle decisions?"**

Aware of Healthy Lee and Its Community Outreach Efforts
(HPMC Service Area, 2023)

Among those aware of Healthy Lee, 24.8% say it has impacted their lifestyle decisions.



Sources: • 2023 PRC Community Health Survey, PRC, Inc. [Items 319-320]
Notes: • Asked of all respondents.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

211
Blue Star Health
Cape Coral Hospital
Center for Progress and Excellence
Centerstone
Community Assisted Supported Living
Community Grants
Community Health Clinics
Complex Care Center
David Lawrence Center
Dispatch Health
Doc in the Box
Doctor's Offices
Dubin Center
Elite DNA
Employed Physician Network
Empowerment Center
Family Health Centers
Federally Qualified Health Centers
Florida Gulf Coast University
Florida Lions Eye Clinic
Florida State University
Free Standing Emergency Room
HCA
Healthy Lee
Insurance Companies
Kimmie's Recovery Zone
Lee Charity Care
Lee Community Health
Lee County Department of Health
Lee Health
Lee Tran
McGregor Clinic
Medical Society Referral
Medicare/Medicaid
Millennium Physician Group
Neighborhood Health Clinic
Non-Profit Organizations
North Collier Hospital
Park Royal Hospital
Physician Residency Programs
Premier Mobile Health Services
Project Hope
Qualified Interpreters
Resource Guides
SalusCare
Source of Light and Hope Center
Social Security Office
Telehealth Services
The Heights Center
Transitional Heart Care Clinic
United Way
Urgent Care
Valerie's House
We Care

Cancer

21st Century Oncology
American Cancer Society
Cancer Organizations
Cleveland Clinic
Community Screenings
Doctor's Offices
Family Health Centers
Fitness Centers/Gyms
Florida Breast Cancer Foundation
Florida Cancer Specialists
Genesis
GenesisCare Cancer Centers
Infusion Center
Komen Foundation
Lee Cancer Care
Lee County Department of Health
Lee Health
Lee Health Regional Cancer Center
Lee Memorial Hospital
MD Anderson
Medicare/Medicaid
Moffitt Cancer Center
North Collier Hospital
Partners Breast Health
Premier Mobile Health Services
Radiation Center
Regional Cancer Center

School System
Screening Centers
Sloan Kettering
Southwest Florida Proton
The Heights Center

Diabetes

American Diabetes Association
American Heart Association
Community Cooperative
Doctor's Offices
Drug Company Assistance Programs
Dunbar Lee Community Center
Educational Services
Family Health Centers
Fitness Centers/Gyms
Florida Blue Retail Center
Florida Health Department
Florida Lions Eye Clinic
Florida State University
Golisano Children's Hospital
Good RX
Harry Chapin Food Bank
Harry Chapin SNAP Educational Classes
Healthy Lee
Insurance Companies
Lee Community Health
Lee County Department of Health
Lee County Department of Human Services
Lee Health
Lee Health Solutions
Lee Physician Group
Local Employers
Millennium Physician Group
Nutrition Services
Online Diabetic Education
Parks and Recreation
Premier Mobile Health Services
Providence Family Life Center
SalusCare
The Heights Center
United Way
Walmart

Disabling Conditions

Alvin Dubin Alzheimer's
Amavida Living
Area Agency on the Aging
Assisted Living Facilities
Baker Senior Center
Center for Independent Living
Community Cooperative
Cypress Cove
Deaf and Hard of Hearing Center
Dementia Care and Cure Initiative - FDOEF
Dementia Facilities
Doctor's Offices
Dubin Center
Health Fairs
Healthy Lee
Home Health Services
Hope Healthcare
Hope Program of All inclusive Care for the Elderly
Lee Health
Lee Physician Group
Lighthouse of Southwest Florida
National Programs
Organizations Specialized in Helping Those in Need
Premier Mobile Health Services
Programs/Services for Deaf/Hard of Hearing
Providence Family Life Center
Rehab Center
Rehabilitation Services
Shell Point
Southwest Florida Council of the Blind

Heart Disease & Stroke

American Heart Association
American Red Cross
American Stroke Association
Cardiac Rehab
Community Programs
Doctor's Offices
Family Health Centers
Fitness Centers/Gyms
Florida Health Department
HCA
Healthy Lee
Imaging Center
Lee County Department of Health
Lee Health
Lee Health Solutions
Lee Memorial Hospital
Nutrition Services
Premier Mobile Health Services
Public Service Announcements
Rapid Diaresis Program
Rehabilitation Services
United Way

Infant Health & Family Planning

- Bright Horizons
- Doctor's Offices
- Early Steps
- Family Court
- Family Health Centers
- Family Planning
- Federally Qualified Health Centers
- Florida Gulf Coast University
- Florida Health Department
- Florida Kid Care
- FutureMakers
- Head Start
- Health Department
- Healthy Start
- Hospitals
- Lee County Department of Health
- Lee Health
- March of Dimes
- Planned Parenthood
- Public Service Announcements
- Sunshine Health
- Women, Infants, and Children

Injury & Violence

- 911 Crisis Line
- Abuse Counseling and Treatment
- Behavioral Health Coalitions
- Behavioral Health Services
- BERT
- Board Of County Commissioners
- City Gate Church
- Center for Progress and Excellence
- Department of Human and Veteran Services
- Drug Court
- Florida Department Of Transportation
- Impact Fees
- Law Enforcement
- Lee County Department of Health
- Lee County Injury Prevention Coalition
- Lee County Sheriff's Office
- Lee EMS
- Lee Health
- Lee Tran
- Parks and Recreation
- Pickup the Ball
- Quality Life Center
- Rehabilitation Services
- School System
- Streets Alive
- Urban Planners

Mental Health

- 988 Emergency Number
- Behavioral Health Coalitions
- Behavioral Health Services
- Bob Janes Center
- Center for Progress and Excellence
- Centerstone
- City/County Leaders
- Community Assisted Supported Living
- Community Screenings
- County Jail
- David Lawrence Center
- Deaf Women's Support Group
- Doctor's Offices
- Elite DNA
- Employers Employee Assistance Program
- Family Health Centers
- Federally Qualified Health Centers
- Florida Assertive Community Treatment Team
- Florida Gulf Coast University Community Counseling Center
- Golisano Children's Hospital
- Health Department
- Healthy Lee
- Healthy Minds
- Home Base SWFL
- Hope Clubhouse
- Hope Healthcare
- Hospitals
- Insurance Companies
- Kids Minds Matter
- Law Enforcement
- Lee Behavioral Health
- Lee County HVA
- Lee County Veterans and Human Services
- Lee Health
- Mental Health Services
- National Alliance on Mental Illness
- National Suicide Prevention Hotline
- Organizations in Lee County
- Park Royal Hospital
- Patty's Place
- Premier Mobile Health Services
- Royal Palm Hospital
- SalusCare
- State/County/City Governments
- Telehealth Services
- The Sterling Center
- Trevor Project
- United Way
- Valerie's House
- Vitrus Health
- White Sands

Nutrition, Physical Activity & Weight

- Caloosahatchee Regional Park
- Centennial Park
- Crunch Gym
- Doctor's Offices
- Eat Local Lee
- Fitness Centers/Gyms
- Florida Gulf Coast University
- Florida Health Department
- Food Policy Council
- Fresh Access Bucks
- Fresh From Florida
- Harry Chapin Food Bank
- Healthy Lee
- Lakes Regional Park
- Lee County Department of Health
- Lee County Schools
- Lee Health
- Lee Health Life Center
- Lee Health Solutions
- Lee Physician Group
- Linear Park
- Markets
- Parks and Recreation
- Programs Sponsoring Walks/Activities
- School System
- Terry Park
- Youth Men's Christian Association

Oral Health

- Dental Offices
- Family Health Centers
- Florida SouthWestern College
- Program of All-inclusive Care fir the Elderly
- Project Dentist
- Salvation Army

Respiratory Diseases

- Doctor's Offices
- Family Health Centers
- Lee Health

Sexual Health

- Area Agency on the Aging
- Blue Star Health
- Educational Services
- Family Health Centers
- Florida Health Department
- Free Testing
- ICAN
- Lee Community Health
- Lee County Department of Health
- Lee Health
- McGregor Clinic
- Premier Mobile Health Services
- Sexual Trauma and Offender Program
- Source of Light and Hope Center

Social Determinants of Health

- ARP Funding for Housing
- Bright Community Trust
- Brighter Bites
- Cape Coral Caring Center
- Community Assisted Supported Living
- Community Cooperation Ministries Inc
- Community Development Block Grant
- Centerstone
- Church
- Collaboratory
- Community Cooperative
- Community Housing and Resources
- Department of Human and Veteran Services
- Disability Services
- Doctor's Offices
- Dunbar Clinic
- Employers
- Family Health Centers
- FISH of Sanibel-Captiva, Inc
- Florida Blue
- Food Pantries
- Good Samaritan Clinic
- Goodwill
- Habitat for Humanity
- Health Planning Council of Southwest Florida
- Housing and Urban Development
- Housing Authority
- Lee County Department of Human Services
- Lee County Schools
- Lee County Veterans and Human Services
- Lee Health
- Lee Housing Authority
- Mount Hermon Church
- Naples Community Hospital
- Premier Mobile Health Services
- Programs/Services for Deaf/Hard of Hearing
- Providence Family Life Center
- Quality Life Center
- Rapid Care Clinics
- SalusCare
- Salvation Army
- School System

- Senior Friendship
- Senior Housing Projects
- The Heights Center
- Uber
- United Way

Substance Use

- Abuse Counseling and Treatment
- Addiction Medicine
- AIM Target
- Alcoholics Anonymous/Narcotics Anonymous
- Behavioral Health Services
- Centerstone
- Children's Network of Southwest Florida
- City/County Leaders
- David Lawrence Center
- Doctor's Offices
- Drug Free Southwest Florida
- Elite DNA
- Florida Treatment Center
- Fort Myers Addiction Treatment Center
- Healthy Start
- Kimberly Center
- Kimmie's Recovery Zone
- Lee Health
- LPG Addiction Medicine
- Meetings
- Methadone Clinic
- Operation PAR
- Park Royal Hospital
- Private Rehab Facilities
- SalusCare
- SAMHSA National Helpline
- St. Matthew's House
- Suboxone
- The Sterling Center
- TLS
- Treatment Centers
- United Way
- Veterans Affairs
- White Sands

Tobacco Use

- Cigarette Taxes
- Educational Services
- Lee County Department of Health
- Quit Florida

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Lee Health has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $702 million in community benefit, excluding uncompensated Medicare.
- More than $528 million in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Lee Health conducted its last CHNA in 2020 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals, and strategic priorities — it was determined at that time that Lee Health would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Healthcare Services
- Cardiovascular & Respiratory Diseases
- Mental Health & Substance Use Disorder
- Nutrition, Physical Activity, & Weight

Strategies for addressing these needs were outlined in Lee Health's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Lee Health to address these significant health needs in our community.

Lee Health is committed to enhancing healthcare standards for our community through the implementation of four key strategic pillars. These pillars serve as the foundation for our approach, encompassing multiple strategies that collectively work towards providing the best healthcare services. These Pillars are as follows:

Right Culture: Deliver a patient-focused experience through our engaged and service-driven team members.

Right Care: Provide safe, individualized care to promote an optimal quality of life for those we serve.

Right Time and Place: Deliver uniquely convenient and seamless care.

Right Cost: Improve the affordability of care and ensure ongoing financial viability.

Evaluation of Impact

Priority Pillars: Right Culture, Right Care	
Community Health Need	Improve health literacy outcomes and reinforce the importance of follow-up care
Goal(s)	Establish a comprehensive follow-up care support system. Develop and implement educational programs. Promote the use of web-based health education materials.

Strategy 1: Identify opportunities to promote follow-up in between provider visits.	
Strategy Was Implemented?	Yes
Target Population(s)	Patients who require follow-up care and support in between provider visits
Leading Partner(s)	Local Medical Providers Lee Physicians Group External Affairs Lee Virtual Health
Results/Impact	Improved patient adherence to treatment plans and overall health outcomes supported by personalized care plans. Better patient engagement, improved health management, and reduced healthcare disparities due to expanded Lifestyle Medicine certifications, dietitians in LPG offices, and Telehealth and Telemedicine.

Strategy 2: Promote web-based health education materials such as Healthy News Blog and Health Matters.	
Strategy Was Implemented?	Yes
Target Population(s)	Broader community to include those living in poverty
Leading Partner(s)	External Affairs
Results/Impact	Increased blogs and Health Matters segments, and enhanced community initiatives. • Vital health education materials made inclusive and relevant to diverse patient populations with the use of QR codes, telehealth, and enhanced outreach efforts to underserved communities.

Priority Pillars: Right Culture, Right Care	
Community Health Need	Leverage internal resources to reduce barriers to healthcare access for uninsured and underrepresented populations.
Goal(s)	• Enhance language services and cultural competency training. • Establish a comprehensive outreach program. • Build a more extensive healthcare system to reach more individuals.

Strategy 1: Prioritize cultural competency and reduction of language barriers throughout the provider network.	
Strategy Was Implemented?	Yes
Target Population(s)	Patients, residents, and visitors from diverse cultural backgrounds who may face language barriers when accessing healthcare services
Leading Partner(s)	External Affairs Human Resources Strategic Business FQHC Administration, Lee Physician Group Diversity, Equity, and Inclusion, Language Interpretation Services
Results/Impact	• Additional training for staff interpreters, improved connectivity for MARTTI devices, and Dual Role Interpreters, improved communication, and patient experience for individuals with limited English proficiency. • The establishment of a new Lee Community Healthcare(LCH) clinic site in Dunbar immediately following the use of a temporary mobile unit with exam rooms after Hurricane Ian, increased healthcare access and services for patients. • Six Lee Physician Group(LPG) clinics with Federally Qualified Health Center-Look Alike status: partnership with Premier Mobile for consistent medical treatment in multiple underserved areas further promoted cultural competency, and reduced language barriers.

Strategy 2: Leverage the Complex Care Center, Community Care Outreach, Care Management, Skilled Nursing Facilities Collaborative as resources for patients with low-access circumstances; position schedulers to assist patients with system navigation.	
Strategy Was Implemented?	Yes
Target Population(s)	Patients, residents, and visitors with low-access circumstances
Leading Partner(s)	Care Management Center For Care Transformation Healthy Life Center External Affairs Diversity, Equity, and Inclusion, Language Interpretation Services
Results/Impact	• Engaged transportation companies as free options for patients. Expanded supplies contributed Military Support Program to the Complex Care Center further optimized support for patients. • Barriers to care were decreased with new and enhanced community initiatives and partnership with Premier Mobile Health Services. • Increased collaboration with community partners. • Assistance with scheduling appointments and system navigation increased with Personal Health Advocates in the community.

Strategy 3: Support workforce development efforts within the System and community (e.g., nurse navigators).	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals within the healthcare workforce, including nurse navigators, as well as members of the community seeking career opportunities in the healthcare field
Leading Partner(s)	Workforce Planning Development, HR Recruitment and Employee External Affairs
Results/Impact	• Career development initiatives in collaboration with Lee County School District • Collaboration with local colleges and universities increased placement of interns, community classes for job development training, and other collaborative initiatives expanded workforce and enhanced access.

Strategy 4: Strategically deploy Family Medicine Residency Program and Lee Community Healthcare clinicians in underserved areas.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents and visitors in underserved areas
Leading Partner(s)	Local Medical Providers Lee Health Medical Staff Services Diversity, Equity, and Inclusion, Language Interpretation Services FQHC Administration, Lee Physician Group External Affairs
Results/Impact	• Disparities in healthcare access addressed with clinicians in underserved areas included medical residency, pharmacy interns, and other healthcare professionals. The integration of healthcare professionals in community-based settings, improved access.

Strategy 5: Support Marketing digital strategy for online appointment scheduling.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals accessing community-based settings and Lee Community Healthcare clinics
Leading Partner(s)	External Affairs Lee Virtual Health Healthy Life Center
Results/Impact	• Telehealth, Telehubs, MyChart, Findhelp and other community initiatives supported efforts of marketing, helping the community increase online appointment scheduling.

Strategy 6: Support use of telehealth services in community-based settings and Lee Community Healthcare clinics	
Strategy Was Implemented?	Yes
Target Population(s)	Underserved communities
Leading Partner(s)	Lee Virtual Health External Affairs
Results/Impact	• HRSA Award authorized telemedicine "hubs" in facilities serving underserved communities demonstrates progress in telemedicine capabilities.

Strategy 7: Support system-wide front door strategy and related initiatives.	
Strategy Was Implemented?	Yes
Target Population(s)	Healthcare providers, administrators, staff, and community involved in system-wide front door strategy and related community initiatives
Leading Partner(s)	Lee Physicians Group
Results/Impact	• 24 new clinicians, continued recruitment of PCP's and AP's. • Continued site reviews for new locations and expanded services. • Better alignment of efforts and resources optimized patient experience and outcomes. • Enhanced commitment to the safety and well-being of patients and staff increased provision of care at home promoted better health management.

Priority Pillars: Right Care, Right Cost	
Community Health Need	Support external partnerships to provide community-based care.
Goal(s)	• Establish collaborative health programs. • Strengthen outreach efforts. • Evaluate program effectiveness.

Strategy 1: Provide screenings, education, and referrals in partnership with community-based organizations (health fair, targeted wellness activities)	
Strategy Was Implemented?	yes
Target Population(s)	All individuals attending health fair events and targeted wellness activities
Leading Partner(s)	External Affairs Lee Health Medical Staff Services FQHC Administration, Lee Physician Group
Results/Impact	• Ongoing overview and enhancement of each tactic ensures continuous improvement and effectiveness in delivering screenings, education, and referrals, leading to improved health outcomes in the target population. • Successful launch of the Barbershop Wellness and Neighborhood Liaison Pilot Programs and the establishment of a mobile medicine program indicates expanded access to healthcare services and resources for underserved individuals, addressing health disparities. • Collaborative efforts with Choice Neighborhoods, Community Partnership Schools, nursing students, social services agencies, and college interns, demonstrate a holistic approach.

Priority Pillars: Right Culture, Right Care	
Community Health Need	Promote cardiovascular and respiratory health education within community-based health events.
Goal(s)	• Establish health education workshops. • Partner with community organizations to promote understanding.

Strategy 1: Increase stroke education resources at community-based health fairs and events.	
Strategy Was Implemented?	Yes
Target Population(s)	All community residents and visitors
Leading Partner(s)	Neuroscience Service Center External Affairs
Results/Impact	• Identification and distribution of giveaways and educational materials for stroke reenforced key stroke prevention messages and encouraged proactive health behaviors. • Expanded collaborative staff participation in community-based health fairs and events strengthened the promotion of stroke education resources and early intervention.

Strategy 2: Launch community campaign with employee/volunteer advocates to promote cardiovascular risk programs.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents and visitors at risk of cardiovascular diseases
Leading Partner(s)	Volunteer Services Community Faith Nursing External Affairs Cardiovascular Service Line, Heart & Vascular Institute
Results/Impact	• Collaboration with Nutrition/Community and the American Heart Association (AHA) for free blood pressure cuffs and educational materials added valuable resources to the campaign, facilitated access to screenings and educational materials that promoted cardiovascular health within the community.

Strategy 3: Leverage virtual community education opportunities such as Healthy Life Center virtual classes and Shipley Cardiothoracic Center's podcasts for heart health education.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals seeking heart health education
Leading Partner(s)	Healthy Life Center Local Medical Providers External Affairs Cardiovascular Service Line, Heart & Vascular Institute
Results/Impact	• Active podcasts from Shipley Cardiothoracic Center and Living the Healthy Life provided valuable heart health education to the target population, increased awareness and knowledge about cardiovascular health. • Expanded podcasts system-wide provided broader reach and impact, extending heart health education to a wider audience.

Strategy 4: Promote Mended Hearts Support Group for patients and families affected by cardiovascular conditions.	
Strategy Was Implemented?	Pending
Target Population(s)	Patients and families affected by cardiovascular conditions
Leading Partner(s)	Cardiac Rehabilitation External Affairs
Results/Impact	• Pending recertification of Mended Hearts due to COVID-19 pause followed by Hurricane Ian.

Strategy 5: Revitalize and promote Asthma Education Program at community-based health fairs and events.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals with asthma, particularly those from underserved communities
Leading Partner(s)	Lee Health Outpatient Services External Affairs
Results/Impact	• Gaps were addressed with additional office space; continued participation in health fairs and events.

Priority Pillars: Right Time and Place, Right Care	
Community Health Need	Strategically leverage community-based initiatives for increased awareness and intervention for cardiovascular and respiratory conditions.
Goal(s)	• Identify and collaborate with key community partners. • Develop tailored educational programs. • Connect with communities to promote healthy living.

Strategy 1: Partner with local businesses to provide health education materials at blood pressure monitoring stations.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals visiting local businesses that may benefit from educational materials on blood pressure monitoring
Leading Partner(s)	Lee Physician Group External Affairs
Results/Impact	• Blood pressure clinics included distribution of educational materials and blood pressure cuffs with teaching in local underserved community businesses and churches.

Strategy 2: Relaunch Barbershop/Beauty Salon Wellness programs for holistic health education and screenings in urban, low-income areas.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals in urban, low-income areas who frequent barbershops and beauty salons, with the aim of providing holistic health education and screenings
Leading Partner(s)	Nursing Community Care, Lee Health Solutions External Affairs Lee Health Medical Staff Services Lee Health Pharmacy
Results/Impact	• Successful launch of the Barbershop/Beauty Salon Wellness programs, operating one day per month with collaborative partners, provides valuable health education and screenings to the target population. • Efforts to recruit community volunteers from churches, fraternities, and sororities strengthened the program's outreach and support, promoting community engagement and sustainability.

Strategy 3: Support local community-based vaping and tobacco prevention education programs and initiatives targeting youth and young adults.	
Strategy Was Implemented?	Yes
Target Population(s)	Youth and young adults at risk of using vapor and tobacco products
Leading Partner(s)	Trauma External Affairs Lee Community Healthcare
Results/Impact	• Leveraging collaboration allowed for enhanced support and resources in implementing effective vaping and tobacco prevention education programs in the community, potentially reducing youth and young adult smoking rates. • HRSA (Health Resources and Services Administration) Award facilitated the streamlining of the referral process for smoking cessation services for Lee Community Healthcare patients through integration of Epic referrals to AHEC programs, promoting accessibility to cessation resources and supporting positive health outcomes in the community.

Priority Pillars: Right Care, Right Time and Place	
Community Health Need	Support care management as the primary champion in addressing social determinants of health related to cardiovascular and respiratory conditions.
Goal(s)	• Empower targeted interventions. • Expand educational opportunities. • Reduce instances of cardiovascular and respiratory conditions by addressing determinants of health.

Strategy 1: Leverage and elevate Community Care Outreach Program to address social determinants of health associated with increased cardiovascular risk.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals at risk of increased cardiovascular risk due to social determinants of health
Leading Partner(s)	Community Care, Lee Health Solutions External Affairs
Results/Impact	• Consistent co-facilitation of Barbershop Wellness and Lifestyle Medicine Pillars of Health provided ongoing support and resources to community members, promoting lifestyle changes and cardiovascular health. • Referrals to chronic disease workshops within Lee Health Solutions offer valuable support and education for managing chronic conditions and adopting healthier eating habits. • Improvements of dietary choices, education about local food pantries and cooking demonstrations with distribution of groceries have promoted better heart health and overall well-being.

Strategy 2: Share evidence-based Asthma Action Plans with patients upon diagnosis.	
Strategy Was Implemented?	Yes
Target Population(s)	Patients diagnosed with asthma
Leading Partner(s)	Lee Health Outpatient Services External Affairs
Results/Impact	• Evidence-based Asthma Action Plans have lead to improved asthma management and better health outcomes. • Smoking Cessation referrals in EPIC and direct outreach supports patients in quitting smoking.

Priority Pillars: Right Culture, Right Care, Right Time and Place	
Community Health Need	Improve ratio of mental health providers and services to regional need.
Goal(s)	• Increase behavioral health education. • Improve access to mental health services. • Ensure each community has support available.

Strategy 1: Increase behavioral health education opportunities at community-based events.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents and visitors who would benefit from increased availability of mental health programs and services through community collaborations
Leading Partner(s)	Behavioral Health Administration
Results/Impact	• Behavioral health education opportunities have increased in the community providing better access to mental health information and support.

Strategy 2: Increase programs and services for adult behavioral health.	
Strategy Was Implemented?	Yes
Target Population(s)	Adults seeking behavioral health services
Leading Partner(s)	Behavioral Health Administration
Results/Impact	• Collaboration with Home Base and veteran organizations, as well as NAMI Board of Directors participation, enhanced mental health support for veterans and families. • Identification of opportunities to integrate mental health services with VA (Veterans Affairs) services, further strengthened the support network and available resources for veterans and their loved ones. • Behavioral health education opportunities have increased in the community providing better access to mental health information and support.

Strategy 3: Launch fundraising strategy for adult and pediatric behavioral health services.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals in need of improved behavioral health services and funding support
Leading Partner(s)	Behavioral Health Administration Lee Health Foundation External Affairs Government Relations
Results/Impact	• Implementation of a pediatric fundraising strategy allowed for increased funding to improve pediatric behavioral health services, providing better support and resources for children and adolescents in need of mental health care. • Strategic discussions regarding adult behavioral health services enabled the exploration of various funding avenues and opportunities to bolster adult mental health programs.

Strategy 4: Promote legislative advocacy efforts to reinforce regional need for behavioral health services and funding in Southwest Florida.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals in need of improved behavioral health services and funding support
Leading Partner(s)	Behavioral Health Administration Government Relations
Results/Impact	• A State of Emergency drew attention to the urgent need for enhanced behavioral health services and funding in Southwest Florida. • Legislative initiatives addressing workforce shortages and reimbursement rates advocated for policy changes to positively impact the availability and quality of behavioral health services, making them more accessible and sustainable for the target population. • Collaboration between CEOs from surrounding counties to explore potential sustainable growth with mandated continued financial support created a unified approach to address the region's behavioral health needs, potentially leading to more significant investments and coordinated efforts in the area.

Strategy 5: Support community collaborations to increase program and service availability.	
Strategy Was Implemented?	Yes
Target Population(s)	Residents and visitors in the community who would benefit from increased availability of mental health services through community collaborations
Leading Partner(s)	Behavioral Health Administration External Affairs
Results/Impact	• Extensive support from Healthy Lee for behavioral health initiatives ensured comprehensive backing for mental health programs and services, strengthening their impact within the community. • Active support and involvement in community collaborations, such as Healthy Minds education and tabling's for NARCAN instruction and presentations, contributed to increased program availability, awareness, and accessibility for area universities, employers, and civic organizations, effectively promoting mental health on the frontlines and enhancing support for the LGBTQIA+ community.

Strategy 6: Support front door strategy with behavioral health integration in primary care.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals seeking primary healthcare services, with a focus on integrating behavioral health support and resources within the primary care setting
Leading Partner(s)	Behavioral Health Administration
Results/Impact	• Integration of behavioral health services in primary care practices with the inclusion of psychologists enhanced the accessibility of mental health support for patients, providing a more holistic and comprehensive approach to healthcare. • The explanation of behavioral health to primary care practices demonstrated a commitment to improving mental health services.

Priority Pillars: Right Care, Right Cost	
Community Health Need	Support initiatives to prevent substance use and identify support services for patients suffering from substance use disorders.
Goal(s)	• Create targeted intervention strategies. • Improve data collection and monitoring. • Strengthen the support system for individuals struggling with substance abuse.

Strategy 1: Monitor County data of drug-related deaths and near deaths.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals in the county who are at risk of drug-related deaths and near deaths due to substance use, their friends, family, physicians, and all community members
Leading Partner(s)	Behavioral Health Administration Trauma
Results/Impact	• Collaboration with first responders (EMS, Fire) and Drug-Free Coalition SWFL enabled a comprehensive case logging and data collection, which lead to a more accurate monitoring of drug-related incidents in the county. • Neonatal Abstinence Syndrome data tracking and analysis contributed to a better understanding of substance use impacts on newborns and helped implement appropriate intervention strategies to improve maternal and child health outcomes.

Strategy 2: Promote and support regional care management strategy with data-sharing platform.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals at risk of, or affected by substance use disorders, their friends and family
Leading Partner(s)	Behavioral Health Administration
Results/Impact	• Enhanced coordination and collaboration among stakeholders addressing substance use issues. • Implementation of the CM strategy and data-sharing platform facilitated effective education, early intervention, and prevention initiatives, which lead to improved outcomes for individuals impacted by substance use disorders in the region.

Strategy 3: Promote education and early intervention and prevention initiatives for substance use disorders.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals at risk of, or affected by substance use disorders, their friends and family
Leading Partner(s)	Behavioral Health Administration Trauma Lee Physician Group
Results/Impact	• Established a SUD Council and collaborated with Drug Free Lee Coalition for a coordinated approach to address substance use issues. • Accomplished data collection and sharing through Florida Health Charts/Substance Use Dashboard for evidence-based decision-making and targeted interventions. • Accomplished professional development for physicians and advanced practitioners through Reach Institute's Adult Behavioral Health/Addiction Course, enhancing care for individuals with substance use disorders. • Expanded the role of Clinical Psychologists at Lee Health for comprehensive behavioral health care and substance use-related management. • Increased availability of Narcan to save lives during opioid overdoses. • Recruited and hired of additional staff to strengthen resources for education, early intervention, and prevention of substance use disorders.

Strategy 4: Reinforce importance of peer support roles for patients with substance use disorders.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals dealing with substance use disorders, their family, and friends
Leading Partner(s)	Behavioral Health Administration Shipley Cardiothoracic Center External Affairs
Results/Impact	• Hired Certified Recovery Peer Specialists (CRPS) with an education/training component. This expansion enhanced the availability of peer support for patients, fostered a sense of understanding and empathy among individuals who have personally experienced recovery. • Involvement in conferences like "Mental Health on the Front Lines" allowed Lee Health to present on the importance of peer support, increasing awareness and knowledge about its benefits among healthcare professionals and the broader community. • Education programs for nursing staff on stress, burnout, and PTSD contributed to a more supportive environment for both patients and healthcare providers. • Lectures provided to Family Medicine/Internal Medicine resident physicians promoted a better understanding of peer support's significance. • Collaborations for seamless transitions between different levels of care and enhanced overall treatment effectiveness was accomplished. • The involvement of Peer Specialists in Addiction Medicine are stationed in each hospital ED.

Strategy 5: Expansion of substance use services relative to the intensive outpatient (IOP) and partial hospitalization (PHP).	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals dealing with substance use disorders, their family, and friends
Leading Partner(s)	Behavioral Health Administration
Results/Impact	Exploration and assessment of the need for expanded substance use services, included intensive outpatient and partial hospitalization programs, providing a comprehensive evaluation of the community's requirements. • Prioritization of inpatient beds as a primary focus for the Lee Health Substance Use Disorder (SUD) Council, reflected a commitment to addressing acute care needs in the context of substance use treatment. • Implementation of intensive outpatient services was the first step towards enhancing substance use services, and offered more accessible and flexible treatment options for individuals seeking support. • Plans to develop inpatient detox beds demonstrated a long-term commitment to expanding substance use services to cater to a wider range of patient needs, ensuring comprehensive care for those struggling with substance use disorders.

Priority Pillars: Right Culture, Right Care, Right Time and Place	
Community Health Need	Launch education initiatives for improved nutrition, physical activity, and weight outcomes.
Goal(s)	• Enhance community nutrition education. • Enhance physical activity. • Drive the community to healthy weight outcomes.

Strategy 1: Launch healthy cooking demonstrations alongside food distribution partners and events.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals participating in food distribution events, and partners promoting healthier cooking practice and good nutrition
Leading Partner(s)	Food and Nutrition Services Healthy Life Center External Affairs
Results/Impact	• Implementation of in-person cooking demonstrations with necessary precautions and the provision of pre-packaged samples, allowed participants to learn and experience healthier cooking techniques firsthand. Additionally, virtual classes provided accessibility and flexibility to a broader audience. • Strong support from UF IFAS (Institute of Food and Agricultural Sciences) and produce vendors ensured valuable resources and expertise were available for healthy cooking demonstrations. • Integration of the 5210 programs into EPIC enhanced its visibility and accessibility, reaching more individuals. • Community initiatives included collaboration with partners to offer valuable educational opportunities to adults and children, fostering healthy eating habits and nutritional awareness.

Strategy 2: Promote opportunities for parents and children to engage in community-based nutrition and physical activity programs.	
Strategy Was Implemented?	Yes
Target Population(s)	Parents and children in the community who are interested in engaging in nutrition and physical activity programs
Leading Partner(s)	Food and Nutrition Services External Affairs
Results/Impact	• Review and enhancement of food pantry resources lead to increased access to nutritious food options and heightened awareness of healthier choices. • Consistent collaboration with the CPS Wellness Committee, resulted in the successful implementation of various health-related initiatives. • Shared 5210 materials with community centers and food pantries; and placed in EPIC, providing parents and children with the knowledge and tools to make healthier nutrition and lifestyle choices. • Collaborated with the University of Florida's Institute of Food and Agricultural Sciences (UF IFAS), resulting in expanded Healthy Lee collaboration and momentum, as well as strengthened collaboration with the Lee County District School Board, further promoting opportunities for parents and children to engage in community-based nutrition and physical activity programs.

Strategy 3: Provide Nutrition Guidelines Education Lounges.	
Strategy Was Implemented?	Yes
Target Population(s)	Community center attendees and individuals relying on food pantries for their dietary needs
Leading Partner(s)	Food and Nutrition Services External Affairs
Results/Impact	• Shared 5210 materials with community centers and food pantries; and placed in EPIC, providing parents and children with the knowledge and tools to make healthier nutrition and lifestyle choices. • Accomplished and updated a list of food pantries.

Strategy 4: Reinvigorate 5210 campaign and resources.	
Strategy Was Implemented?	Yes
Target Population(s)	Community members who will benefit from increased awareness and education about the 5210 approaches to healthy living
Leading Partner(s)	Food and Nutrition Services External Affairs
Results/Impact	• Wide distribution of flyers, both digitally and in hard copies, ensured that 5210 educational materials reach a broad audience. • Integrated 5210 into community educational opportunities which lead to potential behavior change and improved well-being.

Priority Pillars: Right Care, Right Cost, Right Time and Place	
Community Health Need	Promote collaborative community-based initiatives for improved nutrition and exercise opportunities.
Goal(s)	• Improve community health and wellness. • Foster collaborative partnerships. • Increase access to health resources.

Strategy 1: Collaborate with community organizations to identify opportunities for accessible exercise facilities and programs	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals interested in participating in initiatives focused on improved nutrition, exercise, and physical activity
Leading Partner(s)	External Affairs
Results/Impact	• Engagement and involvement with various community centers and agencies, facilitated access to health and wellness programs for the target population. • Facilitated with multiple agencies a family sports day to introduce opportunities to use local facilities and programs

Strategy 2: Engage community partner organizations and local businesses to explore creation of healthy neighborhood stores.	
Strategy Was Implemented?	Strategy was modified to Healthy Eats
Target Population(s)	Broader community
Leading Partner(s)	Food and Nutrition Services External Affairs Lee Health Medical Staff Services Community Care, Lee Health Solutions
Results/Impact	• Healthy Eats delivers fresh food one time per month to financially qualified families. Nurse navigators identify and follow the participants. Food and nutrition services provides recipes. GME family practice offers a Healthy Habits clinic as follow up the families.

Strategy 3: Increase provider involvement in physical activity recommendation for improved health outcomes.	
Strategy Was Implemented?	Yes
Target Population(s)	Individuals seeking improved nutrition, exercise, and physical activity, with a specific focus on addressing obesity and behavioral health
Leading Partner(s)	Local Medical Providers Community Care Outreach, Lee Physician Group Lee Health Medical Staff Services External Affairs
Results/Impact	• Collaborated with Healthy Lee to address health disparities in target population. • Integration of the Graduate Medical Education (GME) program and Healthy Habits Clinic provides comprehensive healthcare services and promotes healthy lifestyle practices. • Placed 5210 materials in EPIC for providers to share, providing parents and children with the knowledge and tools to make healthier nutrition and lifestyle choices.