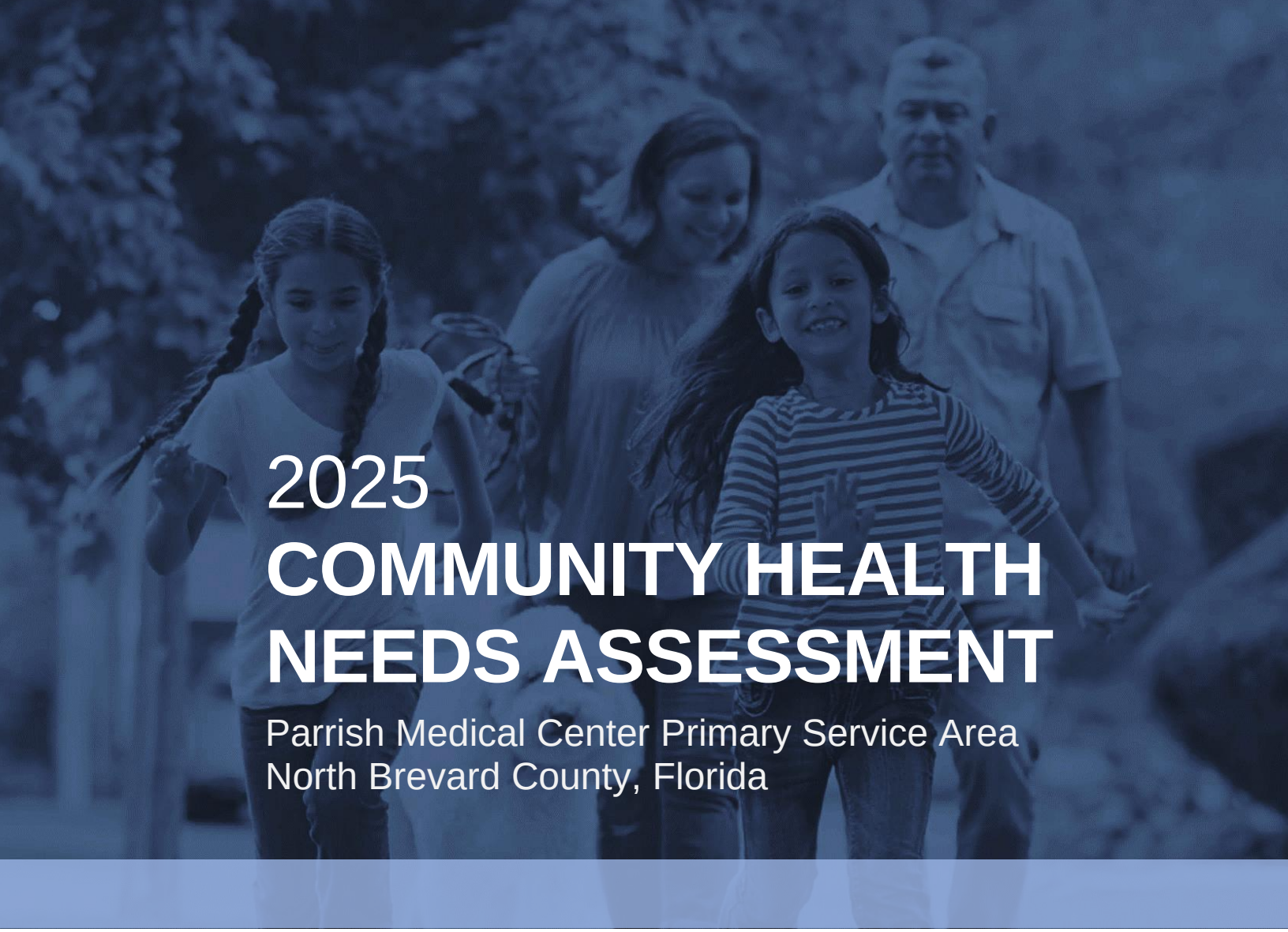


2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Parrish Medical Center Primary Service Area
North Brevard County, Florida

Sponsored by
PARRISH MEDICAL CENTER

PARRISH HEALTHCARE

2024-0581-02

Prepared by
www.PRCExcellence.com

TABLE OF CONTENTS

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 2016, 2019, and 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the primary service area of Parrish Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment was conducted on behalf of Parrish Medical Center by Professional Research Consultants, Inc. (PRC), 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.

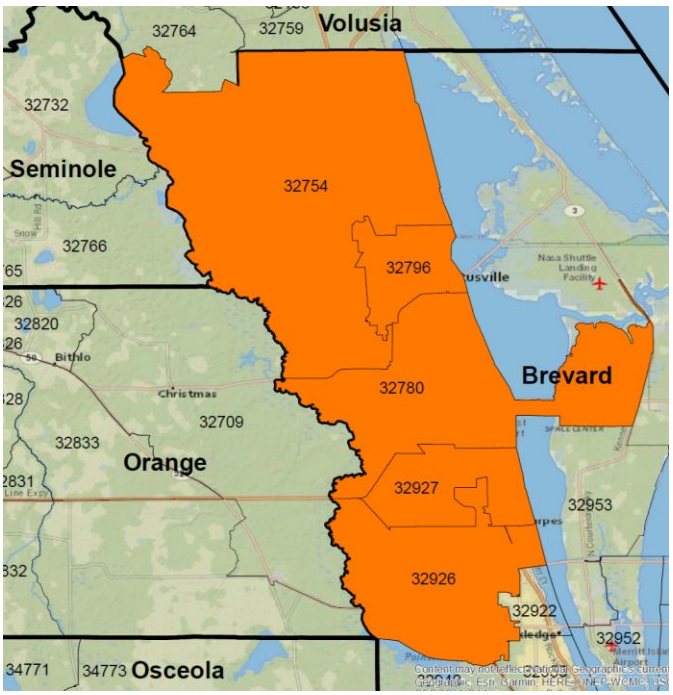
PRC Community Health Survey

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 Parrish Medical Center 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 “Primary Service Area” or “PSA” in this report) is defined as each of the residential ZIP Codes comprising the primary service area of Parrish Medical Center in North Brevard County, Florida, including: 32754, 32796, 32780, 32927, and 32926. This community definition, which includes those ZIP Codes generating the majority of inpatient admissions, 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.

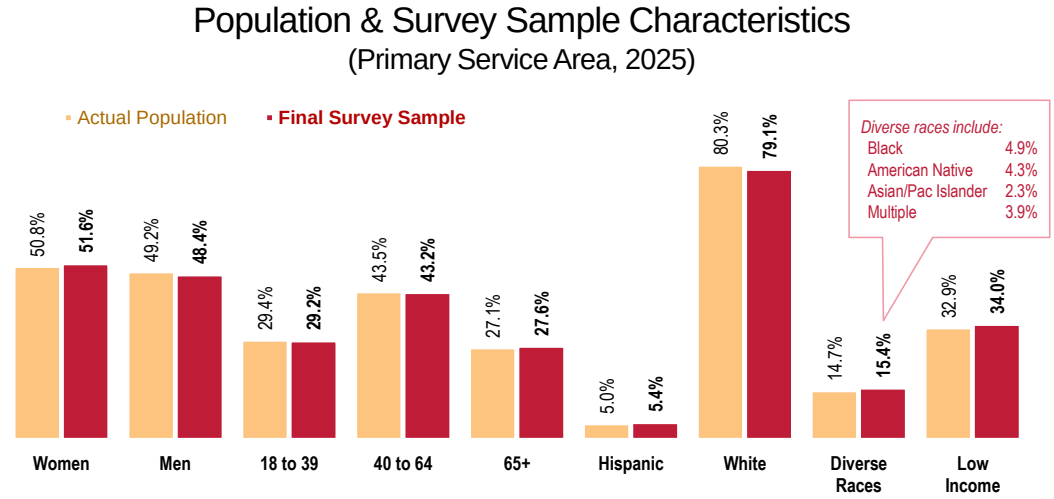
The sample design used for this effort consisted of a random sample of 300 individuals age 18 and older in the Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary Service Area as a whole. 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 300 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 Primary 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.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 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. Race reflects those who identify with a single race category, 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 as part of this process. A list of recommended participants was provided by Parrish Medical Center; 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. In all, 74 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
Public Health Representatives	6
Health Care Providers	2
Social Services Providers	14
Community Leaders	52

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.

- 211 Brevard
- Brevard Prevention Coalition
- Central Florida Treatment Center
- Charlie Health
- Circles of Care
- Community of Hope
- Curative Care
- Early Learning Coalition of Brevard County
- Florida Health
- Florida Tobacco
- Government Analyst II
- Groups Recovery
- Healthy Start Coalition of Brevard
- HFH Supportive Housing
- Hope Community Church
- Hope for North Brevard
- Indian River Church
- Jess Parrish Medical Foundation
- Life Safety Specialist
- Lifepointe Ministries
- Love INC Brevard
- North Brevard Charities
- North Brevard County Hospital District Board of Directors
- Parrish Medical Center
- Port St. John Foundation
- Riverview Pilot Club
- Space Coast Health Center
- Titusville Chamber of Commerce

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 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 data for the entirety of Brevard County.

Benchmark Data

Trending

Similar surveys were administered in the Primary Service Area in 2016, 2019, and 2022 by PRC on behalf of Parrish Medical Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available (note that because ZIP Code 32926 was added in 2019, it is not included in the 2016 results). 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

Parrish 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, Parrish 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. Parrish 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	24
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	108
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	10
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	11
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)	112

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	▪ Barriers to Access – Cost of Prescriptions – Cost of Physician Visits – Appointment Availability – Lack of Transportation – Culture/Language ▪ Routine Medical Care (Children) ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths – Including Lung Cancer, Prostate Cancer, Female Breast Cancer, Colorectal Cancer Deaths ▪ Lung Cancer Incidence
DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Heart Disease Prevalence ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ High Blood Cholesterol Prevalence
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Homicide Deaths ▪ Intimate Partner Violence

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Difficulty Accessing Fresh Produce ▪ Meeting Physical Activity Guidelines ▪ Access to Recreation/Fitness Facilities
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Asthma Prevalence [Adults]
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Cirrhosis/Liver Disease Deaths ▪ Excessive Drinking ▪ Unintentional Drug-Induced Deaths ▪ Illicit Drug Use ▪ Use of Prescription Opioids ▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Cigarette Smoking ▪ Cigarette Smoking in the Home ▪ Use of Vaping Products

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. CANCER
4. NUTRITION, PHYSICAL ACTIVITY & WEIGHT
5. HEART DISEASE & STROKE
6. ACCESS TO HEALTH CARE SERVICES
7. DISABLING CONDITIONS
8. TOBACCO USE
9. INJURY & VIOLENCE
10. INFANT HEALTH & FAMILY PLANNING
11. RESPIRATORY DISEASES

Hospital Implementation Strategy

Parrish 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, Primary Service Area results are shown in the larger, gray column.

The columns to the right of the Primary 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 Primary Service Area compares favorably (), unfavorably (), or comparably () to these external 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.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2016 (or earliest available data). Note that 2016 survey data does not include ZIP Code 32926, which was added to the Primary Service Area in 2019.

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 data for the entirety of Brevard County.

SOCIAL DETERMINANTS	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	**1.4** [County-Level Data]	6.2	3.9		
Population in Poverty (Percent)	**9.9** [County-Level Data]	12.6	12.4	8.0	
Children in Poverty (Percent)	**13.3** [County-Level Data]	16.9	16.3	8.0	
No High School Diploma (Age 25+, Percent)	**6.9** [County-Level Data]	10.4	10.6		
Unemployment Rate (Age 16+, Percent)	**3.7** [County-Level Data]	3.6	4.0		8.7
% Unable to Pay Cash for a $400 Emergency Expense	**35.8**		34.0		15.4
% Worry/Stress Over Rent/Mortgage in Past Year	**43.0**		45.8		37.0
% Unhealthy/Unsafe Housing Conditions	**20.9**		16.4		6.3
Population With Low Food Access (Percent)	**41.8** [County-Level Data]	25.1	22.2		
% Food Insecure	**38.4**		43.3		15.2
		better	similar	worse	

OVERALL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	**20.4**	19.1	15.7		19.8
		better	similar	worse	

ACCESS TO HEALTH CARE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**12.8**	15.4	8.1	7.6	8.5
% Difficulty Accessing Health Care in Past Year (Composite)	**52.9**		52.5		42.8
% Cost Prevented Physician Visit in Past Year	**24.0**	12.9	21.6		16.5
% Cost Prevented Getting Prescription in Past Year	**25.1**		20.2		15.7
% Difficulty Getting Appointment in Past Year	**30.9**		33.4		20.3
% Inconvenient Hrs Prevented Dr Visit in Past Year	**16.3**		22.9		15.0
% Difficulty Finding Physician in Past Year	**21.3**		22.0		15.5
% Transportation Hindered Dr Visit in Past Year	**22.3**		18.3		5.4
% Language/Culture Prevented Care in Past Year	**5.9**		5.0		1.7
% Stretched Prescription to Save Cost in Past Year	**20.3**		19.4		16.0
% Difficulty Getting Child's Health Care in Past Year	**16.6**		11.1		
Primary Care Doctors per 100,000	**72.3** [County-Level Data]	73.0	74.9		
% Have a Specific Source of Ongoing Care	**65.9**		69.9	84.0	72.9
% Routine Checkup in Past Year	**71.5**	78.9	65.3		72.7
% [Child 0-17] Routine Checkup in Past Year	**82.5**		77.5		
% Two or More ER Visits in Past Year	**22.2**		15.6		13.2

ACCESS TO HEALTH CARE (continued)	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% Rate Local Health Care "Fair/Poor"	21.5		11.5		20.1
		better	similar	worse	

CANCER	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	272.5 [County-Level Data]	213.1	182.5	122.7	296.6
Lung Cancer Deaths per 100,000	67.2 [County-Level Data]	47.6	39.8	25.1	
Female Breast Cancer Deaths per 100,000	35.5 [County-Level Data]	28.4	25.1	15.3	
Prostate Cancer Deaths per 100,000	33.3 [County-Level Data]	24.5	20.1	16.9	
Colorectal Cancer Deaths per 100,000	22.3 [County-Level Data]	18.6	16.3	8.9	
Cancer Incidence per 100,000	497.8 [County-Level Data]	452.4	442.3		
Lung Cancer Incidence per 100,000	65.4 [County-Level Data]	54.4	54.0		
Female Breast Cancer Incidence per 100,000	129.9 [County-Level Data]	121.3	127.0		
Prostate Cancer Incidence per 100,000	97.7 [County-Level Data]	97.0	110.5		
Colorectal Cancer Incidence per 100,000	37.5 [County-Level Data]	35.1	36.5		
% Cancer	11.1	15.1	7.4		15.0
% [Women 50-74] Breast Cancer Screening	81.5		64.0	80.5	76.8
		better	similar	worse	

CANCER (continued)	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	67.1		75.4	84.3	76.5
% [Age 45-75] Colorectal Cancer Screening	75.6		71.5	74.4	79.4
		better	similar	worse	

DIABETES	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	32.1 [County-Level Data]	35.1	30.5		30.5
% Diabetes/High Blood Sugar	14.5	12.5	12.8		13.9
% Borderline/Pre-Diabetes	15.0		15.0		8.7
Kidney Disease Deaths per 100,000	19.3 [County-Level Data]	16.4	16.9		20.0
		better	similar	worse	

DISABLING CONDITIONS	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	49.1		38.0		48.0
% Activity Limitations	38.3		27.5		26.2
% High-Impact Chronic Pain	27.8		19.6	6.4	30.6
Alzheimer's Disease Deaths per 100,000	31.9 [County-Level Data]	29.4	35.8		31.7
% Caregiver to a Friend/Family Member	24.9		22.8		28.5
		better	similar	worse	

HEART DISEASE & STROKE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	265.3 [County-Level Data]	226.2	209.5	127.4	292.3
% Heart Disease	14.3	8.4	10.3		8.8
Stroke Deaths per 100,000	87.6 [County-Level Data]	72.7	49.3	33.4	65.5
% Stroke	7.2	3.6	5.4		5.8
% High Blood Pressure	49.2	35.9	40.4	42.6	45.8
% High Cholesterol	42.1		32.4		30.9
% 1+ Cardiovascular Risk Factor	87.7		87.8		86.4
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	33.5 [County-Level Data]	31.5	22.3		21.1
Teen Births per 1,000 Females 15-19	13.9 [County-Level Data]	16.0	16.6		
Low Birthweight (Percent of Births)	8.3 [County-Level Data]	8.8	8.3		
Infant Deaths per 1,000 Births	6.1 [County-Level Data]	6.0	5.6	5.0	5.8
		better	similar	worse	

INJURY & VIOLENCE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	**86.1** [County-Level Data]	78.7	67.8	43.2	64.7
Motor Vehicle Crash Deaths per 100,000	**16.8** [County-Level Data]	16.4	13.3	10.1	
Homicide Deaths per 100,000	**6.4** [County-Level Data]	6.6	7.6	5.5	5.1
% Victim of Violent Crime in Past 5 Years	**4.6**		7.0		
% Victim of Intimate Partner Violence	**24.5**		20.3		13.0
		better	similar	worse	

MENTAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**24.5**		24.4		13.7
% Diagnosed Depression	**29.3**	16.3	30.8		19.6
% Symptoms of Chronic Depression	**40.3**		46.7		27.3
% Typical Day Is "Extremely/Very" Stressful	**26.6**		21.1		11.9
Suicide Deaths per 100,000	**21.1** [County-Level Data]	15.5	14.7	12.8	23.0
Mental Health Providers per 100,000	**191.5** [County-Level Data]	205.7	313.6		
% Receiving Mental Health Treatment	**22.9**		21.9		
% Unable to Get Mental Health Services in Past Year	**14.8**		13.2		5.5
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**36.4**		30.0		19.9
% No Leisure-Time Physical Activity	**32.0**	25.4	30.2	21.8	28.0
% Meet Physical Activity Guidelines	**18.4**	31.5	30.3	29.7	16.4
% [Child 2-17] Physically Active 1+ Hours per Day	**39.4**		27.4		
Recreation/Fitness Facilities per 100,000	**10.6** [County-Level Data]	12.8	12.3		
% Overweight (BMI 25+)	**64.0**	65.7	63.3		65.1
% Obese (BMI 30+)	**38.8**	30.1	33.9	36.0	30.4
% [Child 5-17] Overweight (85th Percentile)	**44.5**		31.8		
% [Child 5-17] Obese (95th Percentile)	**28.9**		19.5	15.5	
		better	similar	worse	

ORAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS			
		vs. FL	vs. US	vs. HP2030	TREND
% Have Dental Insurance	**68.3**		72.7	75.0	59.3
% Dental Visit in Past Year	**53.8**	61.2	56.5	45.0	57.1
% [Child 2-17] Dental Visit in Past Year	**69.7**		77.8	45.0	
		better	similar	worse	

RESPIRATORY DISEASE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	**68.5** [County-Level Data]	50.2	43.5		86.0
Pneumonia/Influenza Deaths per 100,000	**16.8** [County-Level Data]	13.0	13.4		19.2
% Asthma	**19.5**	8.5	17.9		8.5
% [Child 0-17] Asthma	**13.0**		16.7		
% COPD (Lung Disease)	**11.5**	6.8	11.0		13.3
		better	similar	worse	

SEXUAL HEALTH	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**326.9** [County-Level Data]	626.0	386.6		
Chlamydia Incidence per 100,000	**298.1** [County-Level Data]	480.4	495.0		
Gonorrhea Incidence per 100,000	**96.3** [County-Level Data]	199.3	194.4		
		better	similar	worse	

SUBSTANCE USE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	**22.0** [County-Level Data]	15.3	15.7		17.8
Cirrhosis/Liver Disease Deaths per 100,000	**28.9** [County-Level Data]	17.0	16.4	10.9	
% Excessive Drinking	**22.3**	16.1	34.3		10.0
Unintentional Drug-Induced Deaths per 100,000	**38.1** [County-Level Data]	32.5	29.7		22.3
% Used an Illicit Drug in Past Month	**12.7**		8.4		3.1
% Used a Prescription Opioid in Past Year	**28.8**		15.1		21.1
% Ever Sought Help for Alcohol or Drug Problem	**6.5**		6.8		4.3
% Personally Impacted by Substance Use	**50.4**		45.4		44.4
		better	similar	worse	

TOBACCO USE	Primary Service Area	PRIMARY SERVICE AREA vs. BENCHMARKS vs. FL	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	**31.6**	10.5	23.9	6.1	15.7
% Someone Smokes at Home	**25.2**		17.7		13.1
% Use Vaping Products	**18.6**	7.6	18.5		11.1
		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]

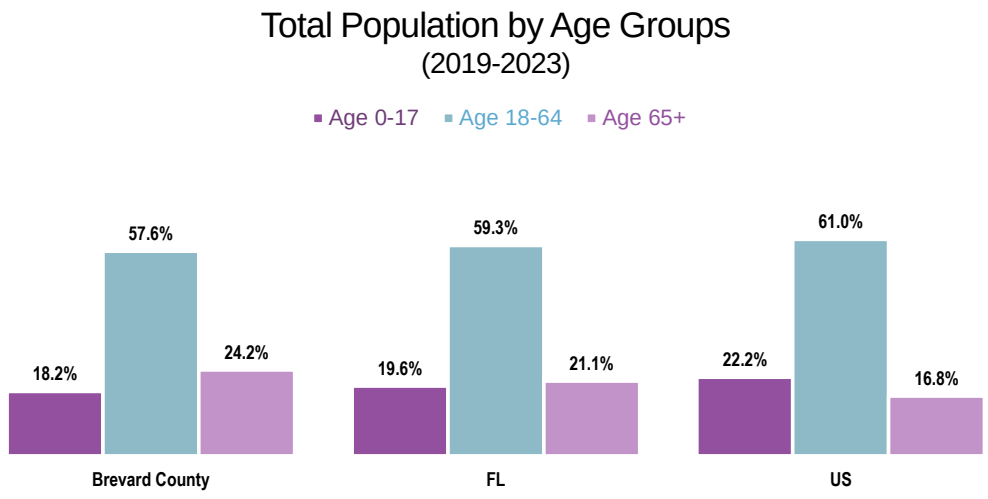
Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Brevard County	620,533	1,014.97	611
Florida	21,928,881	53,654.21	409
United States	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 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]



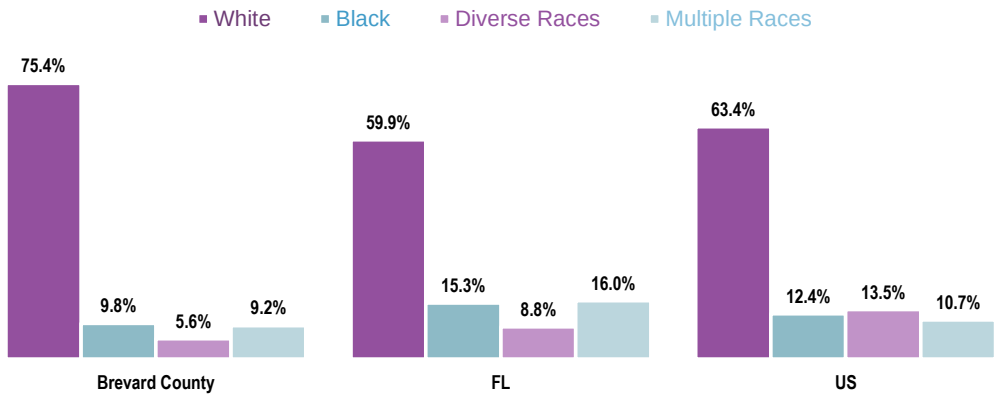
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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]

Total Population by Race Alone
(2019-2023)

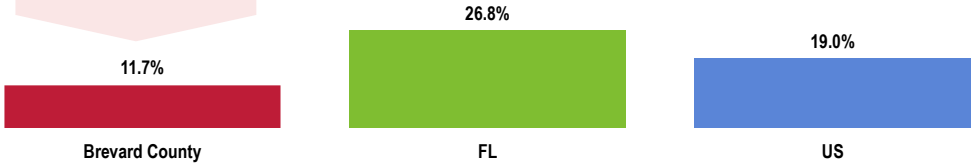


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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

Hispanic Population
(2019-2023)

The Hispanic population increased by 23,965 persons, or 54.5%, between 2010 and 2020.



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 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.

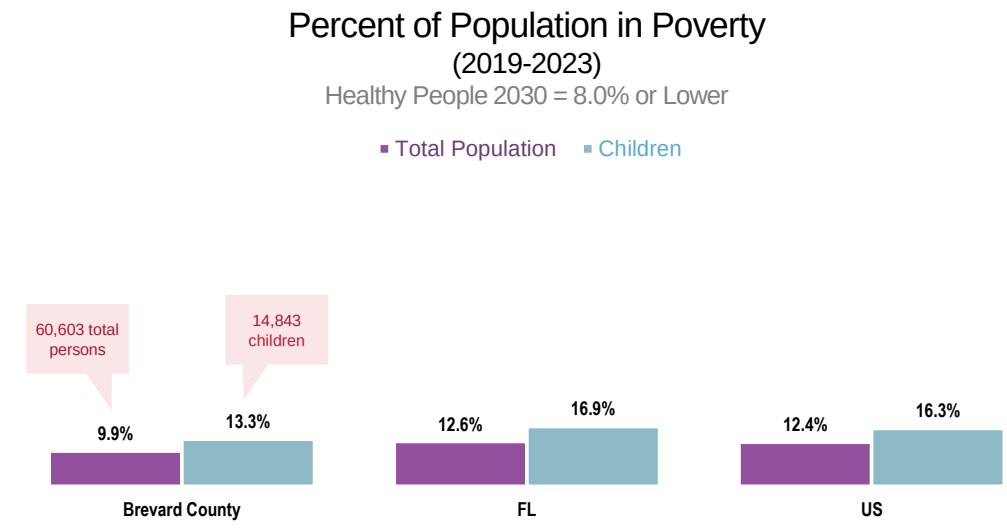
– Healthy People 2030 (https://health.gov/healthypeople)

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.

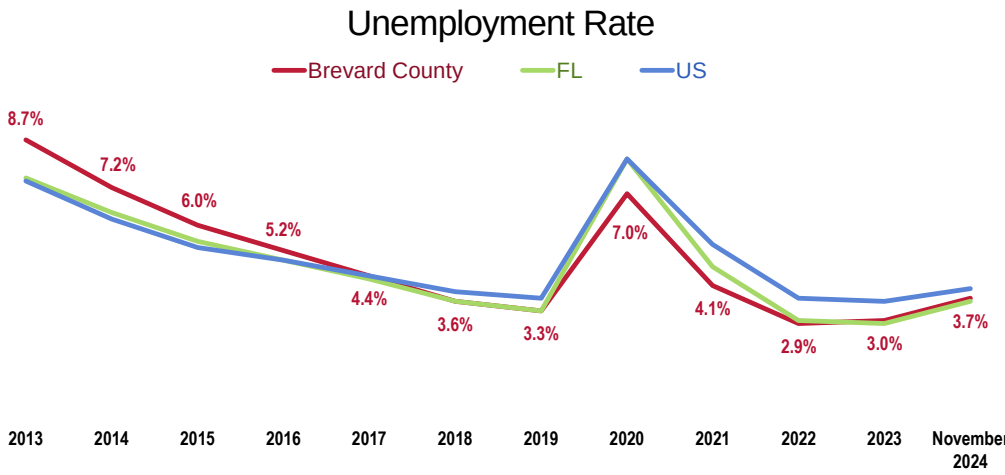
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 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]



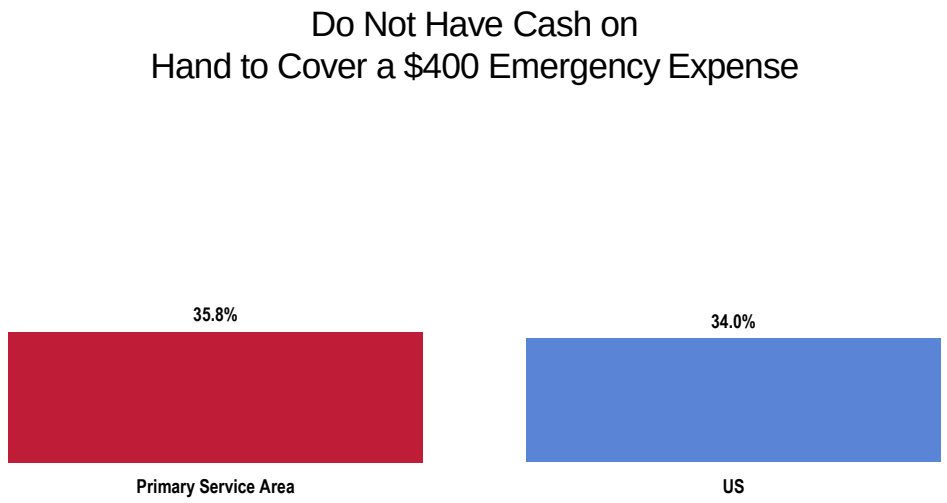
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

PRC SURVEY ► "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following details "no" responses in the Primary Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

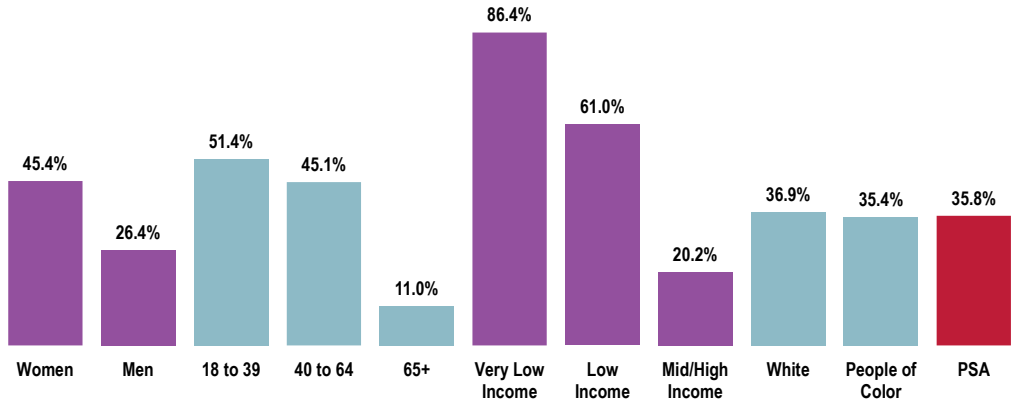


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

(Primary Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

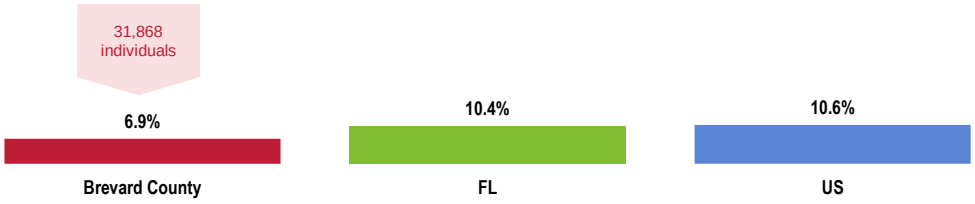
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. “White” reflects those who identify as White alone, without Hispanic origin. “People of Color” includes those who identify as Hispanic or as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races.

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; 2019-2023)



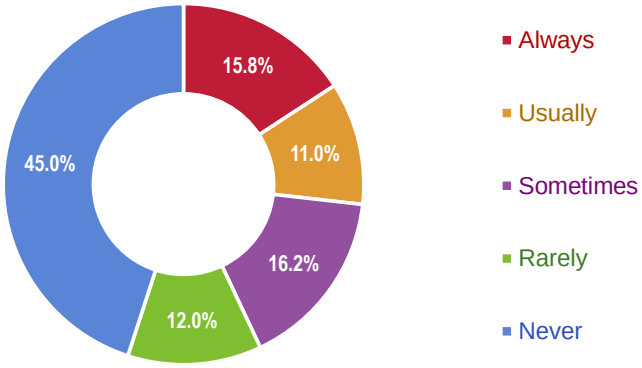
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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?"

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Primary Service Area, 2025)



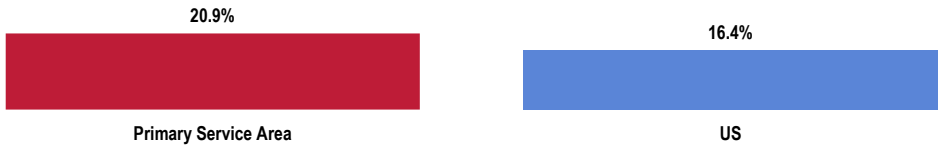
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ► "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year

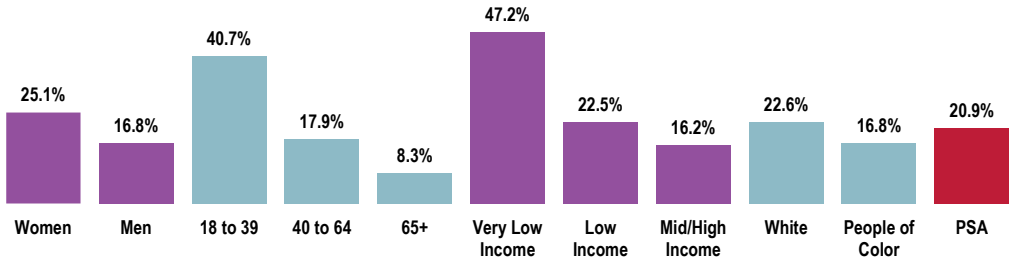


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Primary Service Area, 2025)

Among homeowners	15.0%
Among renters	36.8%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

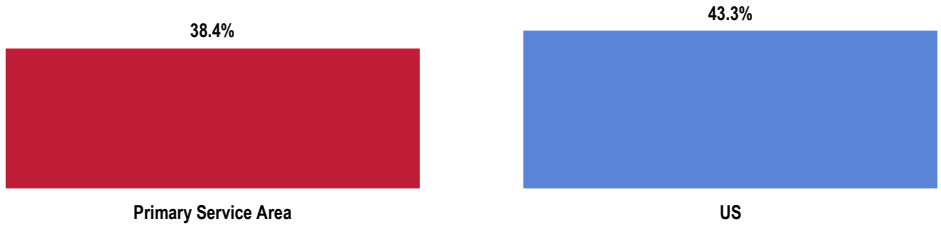
Food Insecurity

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.

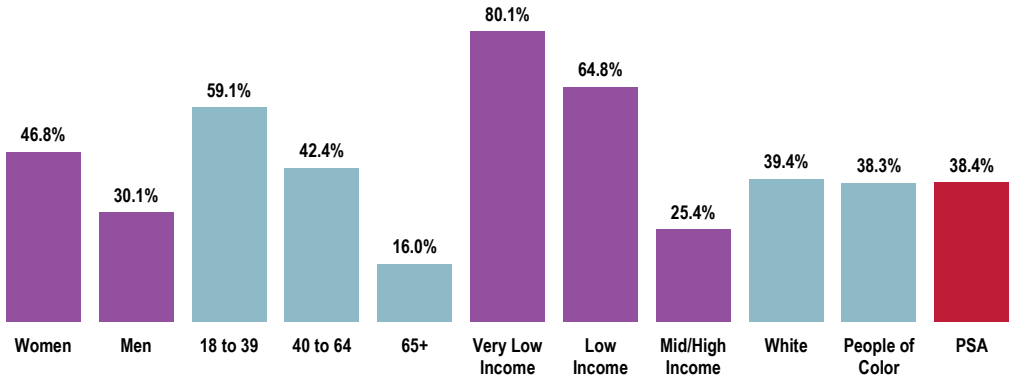
Food Insecure



Sources:
- 2025 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 Insecure
(Primary Service Area, 2025)

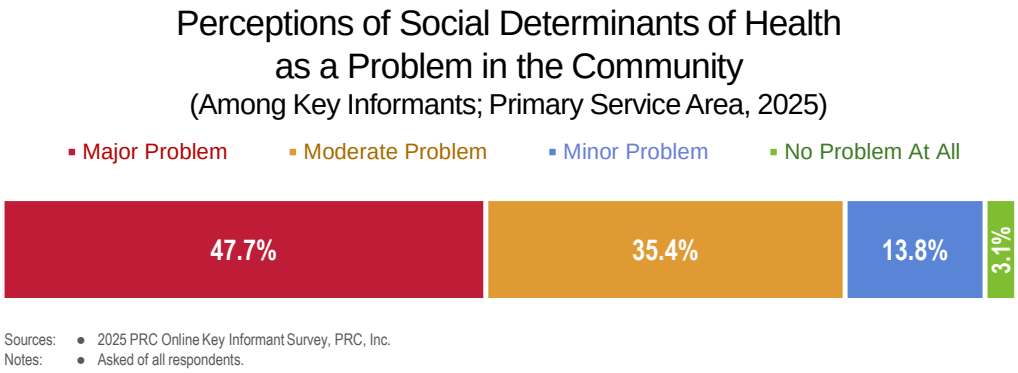


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 98]

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 (including Housing)* as a problem in the community:



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

Affordable Housing

> If you can afford to live in a nice neighborhood, you benefit from fresher air - away from street fumes or smoke stacks. You benefit from advantageous conditions such as more green spaces, better security, off street parking, walking trails and parks that are safe to use nearby. Each of these features contribute to better health. Racial prejudice is a big factor in our town. The level of bias reflected in the way minority students are treated in public schools here damages our young people and their chances for career and financial success. There is a severe shortage of safe affordable housing for lower middle class and poverty level citizens. It's difficult to tie together the whole picture, but these and other factors put heavy burdens on many of our citizens and causes ongoing hardships with poor health outcomes. — Community Leader
>
> Without proper housing or income, one's mental health begins being impacted which then impacts their physical self as well. — Social Services Provider
>
> This is a tough one. Our community suffers from many problems. There is a lack of affordable housing for everyone, not just seniors. Our children suffer when their parents are unemployed. Many become homeless and live in their cars. In fact, there are many who are employed and live in their cars due to not being able to afford housing. Our environment is not a very healthy one. Drugs in the streets. — Community Leader
>
> Housing resources are very limited and with the cost of rent being so high, it is hard for people to afford to stay housed. We have had numerous clients that are/were unhoused, and it is difficult to find available housing resources to provide them within Brevard County as a whole, but especially North Brevard. — Social Services Provider
>
> Unaffordable housing, low paying jobs in comparison to housing costs, health care and access to health care, issues with DCF and other federal programs. — Social Services Provider
>
> We do not have a robust affordable housing stock; income and education are lacking, the water is polluted. — Community Leader
>
> Limited low-income housing. Difficulty getting through to Florida My Access helpline. Lack of responsiveness from local agencies. — Community Leader
>
> Mental/Anxiety- attainable housing and rent rises are a big issue here in Brevard, causing individuals and families high stress and in some cases, homelessness. — Social Services Provider

Unhoused Population

> We have homeless people living in the woods are on the 405. Many people cannot afford rent. — Community Leader
>
> We have a large population of homeless people - including elderly people and children. Food insecurity is a real problem as well as affordable housing. — Community Leader
>
> When people don't have a stable and safe place to live and a steady job they are just trying to survive. They are not spending time educating themselves they are just trying to find where the next meal will be and getting from point a to b. — Public Health Representative
>
> Homelessness is on the rise- rent is out of reach for many, the income of many can't keep up with the cost of living. — Social Services Provider
>
> Homelessness, education about services locally available, stigma about receiving help. — Community Leader

Low Income

> Low pay. — Community Leader
>
> Socioeconomic poverty. — Community Leader
>
> Social determinants of health, such as income, education, housing, and access to healthcare, are major challenges in Brevard County. Economic instability affects many residents, with 14% uninsured and over 30% lacking $400 for emergencies. Housing insecurity is another issue, as 34.3% of residents struggle with housing costs. Limited public transportation makes healthcare and job access difficult, especially for lower-income individuals. Additionally, disparities in education and employment contribute to poor health outcomes. These factors create barriers to essential services, worsening health conditions and deepening inequities in the community. Addressing them requires targeted policies and community programs to improve access to resources and support. — Public Health Representative
>
> There is poverty. — Community Leader

Access to Care for Underinsured and Uninsured

> We have a large population of persons who do not have insurance and/or who are underinsured. Transportation is a barrier to many people. Housing prices have escalated and there is very limited housing resources in this North end of the County. The rates of unhoused persons are increasing and will only get worse with the shutdown of many Federal programs. Additionally, with the introduction of HB 1365 - persons who are unhoused cannot even stay in the parks and have nowhere to go. This is increasing the transient nature of these persons making it more difficult for us to provide resources and services to them. — Health Care Provider
>
> We don't have enough medical support for low income families to go to. — Community Leader

Economy

> Inflation, politics, insurance companies, no one is proactive rather just reactive and often it is too late...the problem did not start over night, and it will not be solved without more outspoken, bold advocates, those willing to think outside of the box and considering a new approach to public programs and systematic approaches. — Community Leader

Limited Educational Attainment

> Many individuals are lacking a high school degree, let alone college or trade school. This leads to earning a lower income and subsequently struggles with housing and a safe environment. — Social Services Provider

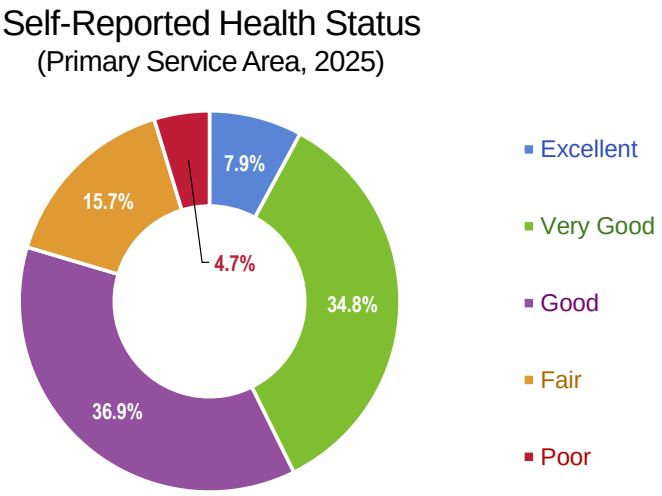
Aging Population

> More help for our seniors. — Community Leader

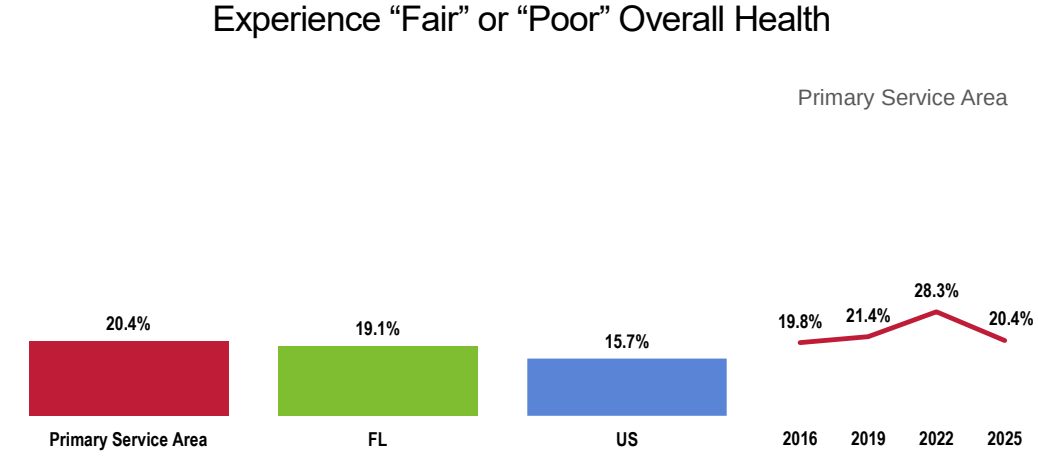
HEALTH STATUS

Overall Health

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

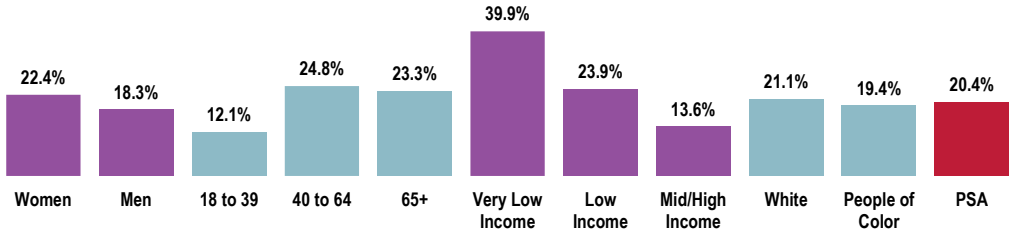


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 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): 2023 Florida data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Primary Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

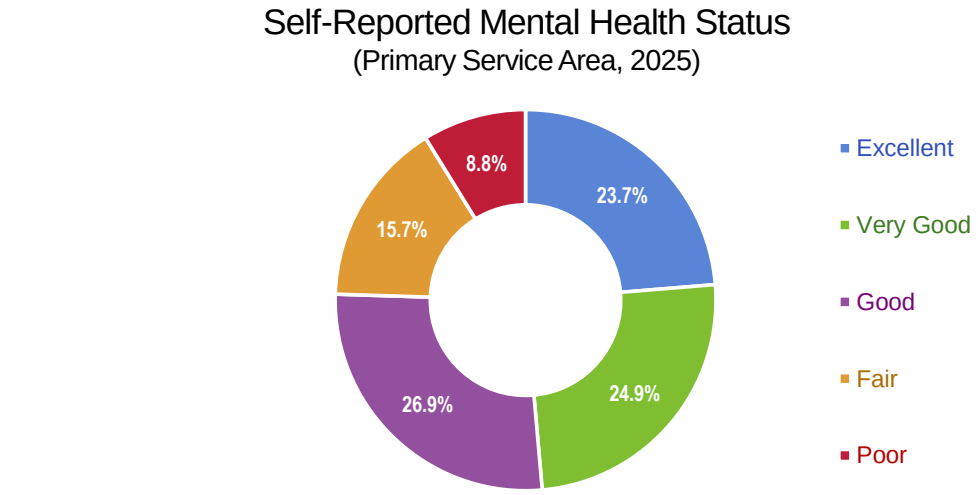
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

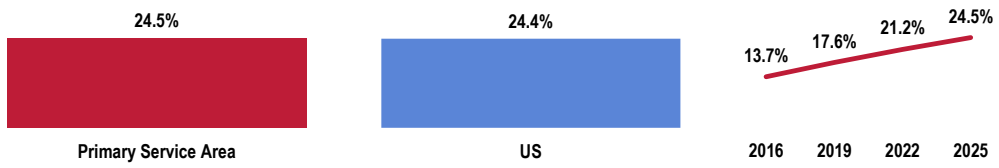
PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Primary Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

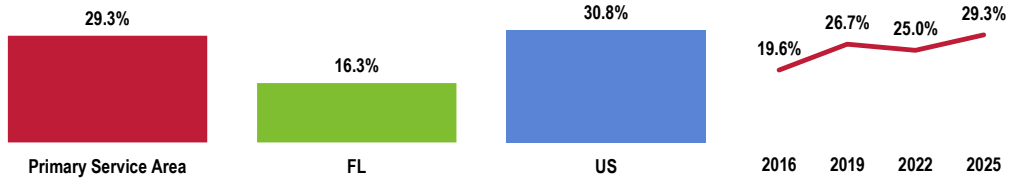
Depression

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

Primary Service Area



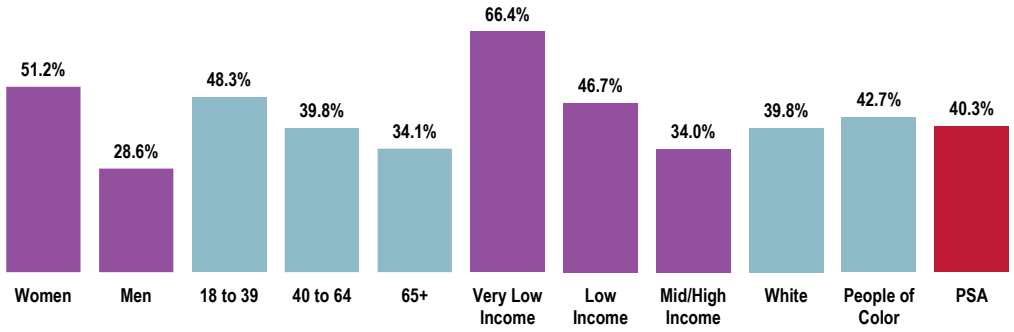
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, 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
(Primary Service Area, 2025)



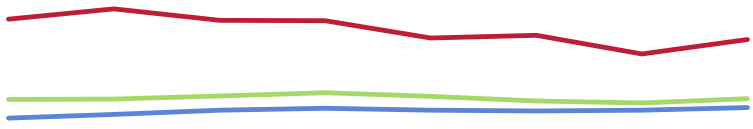
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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 mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

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



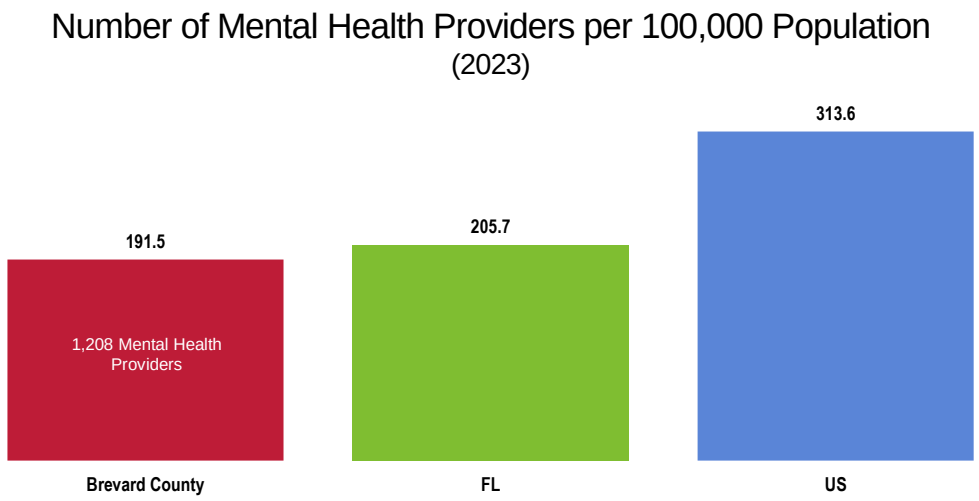
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	23.0	24.0	22.9	22.9	21.2	21.5	19.7	21.1
FL	15.4	15.5	15.8	16.1	15.7	15.3	15.1	15.5
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- 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 within Brevard County and residents within Brevard County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

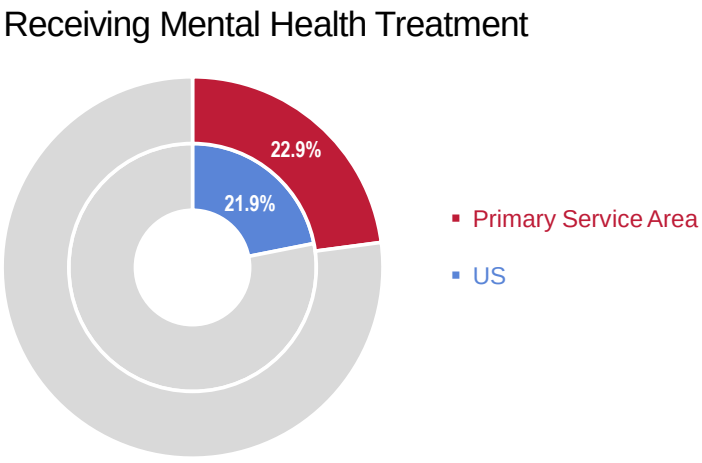
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]



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 February 2025 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.

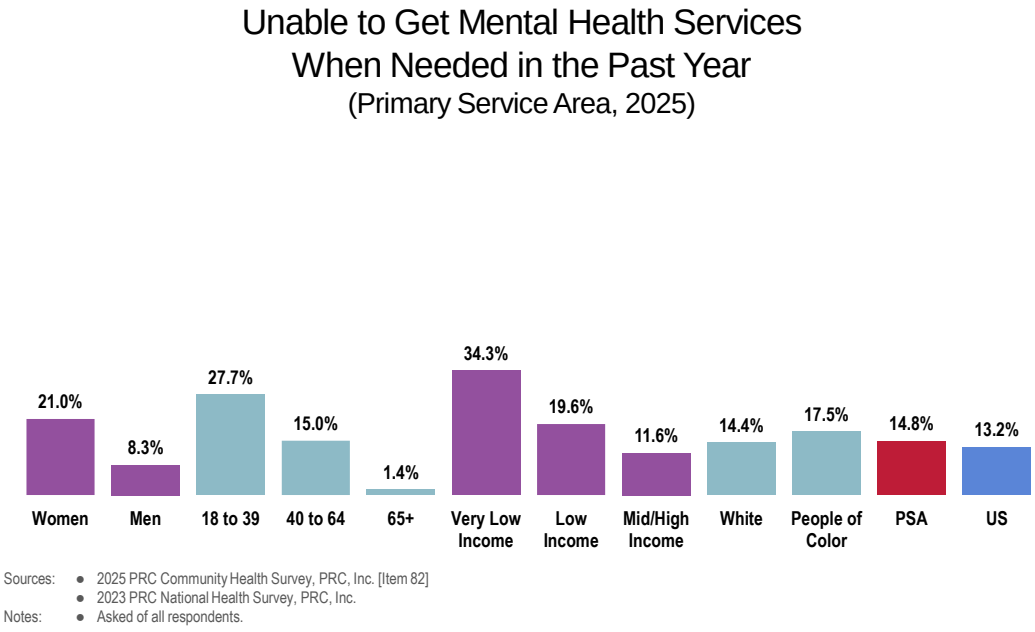
PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

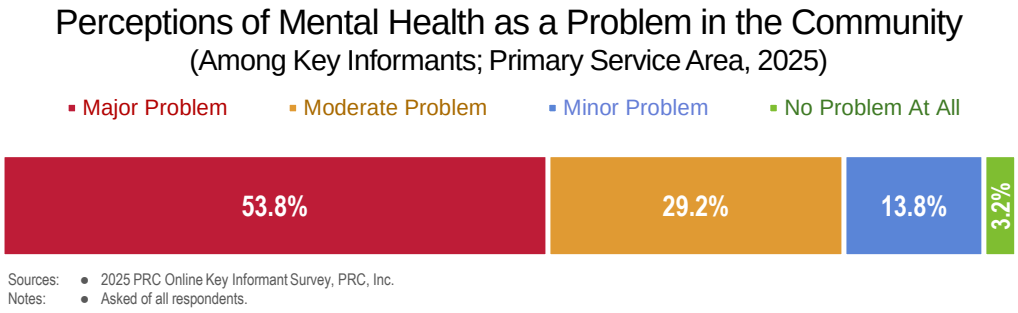
Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

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



Key Informant Input: Mental Health

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



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

Access to Care/Services

> Access to psychiatrist. Access to therapy for uninsured and persons on Medicaid. — Health Care Provider
>
> Not enough facilities, or treatment centers or medical professionals for that field. — Community Leader
>
> Finding accessible directions to get help, even starting the process, for someone with mental health issues. — Community Leader
>
> We have one place in North Brevard but only open to a few mental problems. — Community Leader
>
> North Brevard residents with MHI seem to be largely ignored. I don't see much outreach to help folks. — Community Leader
>
> Low level of community outreach brings mental health care to underserved neighborhoods. We need store front clinics in places like churches and coffee houses, with paid licensed counselors or at least trained mental health workers under supervision from a licensed counselor or social worker. We need people culturally attuned to various ethnicities, available for people living on the streets and immigrant’s populations. Just throw a dart at any age group, children and youth, young adults employed and unemployed, or older adults, all need more support and better access. — Community Leader
>
> There is a lack of resources available for assisting with mental health. Many individuals struggle to access medication or therapy due to copays. There are also a lot of undiagnosed individuals in our community due to stigma and lack of understanding regarding mental health. — Social Services Provider
>
> They aren't getting the help they need. There are not enough services available. Especially low or no cost options. — Community Leader
>
> The community's access to mental health care, which includes cost, medical coverage, treatment and providers availability. The system's inability to properly address mental health issues. — Social Services Provider

Denial/Stigma

> They refuse to seek help. They can't afford to go to appointments or prescriptions. They don't know where to go that is affordable. — Public Health Representative
>
> They are discriminated against and judged, people are fearful of those with mental illness because of pre-conceived notions and societies' narrative. — Community Leader
>
> We have to address the stigma and get people help before they self-medicate and develop a substance use disorder. As with access to care, transportation, insurance, income / cost play a role. — Public Health Representative
>
> Anxiety and Fear. Unable to cope with life situations. — Community Leader

Lack of Providers

> Not enough counselors or psychologists. — Community Leader
>
> Lack of counselors. — Community Leader
>
> Lack of providers in the area, affordability of services, insurance barriers. — Health Care Provider
>
> Not enough counselors especially for children. — Community Leader

Unhoused Population

> There are many homeless people and addicts that the primary problem is mental health. — Social Services Provider
>
> I don't believe there are a lack of service providers. However, accessibility may be an issue. Many "clients" are unhoused, and the county has very little accommodation for such people. They end up in the streets and have nowhere to go once "treated". Lack of housing complicates detox and recovery efforts. There can be no long term treatment without stability. — Community Leader
>
> Programs for the homeless. — Community Leader

Affordable Care/Services

> Families/individuals are faced with a variety of insecurities i.e. housing, food, economic; with those challenges come mental health stressors. Challenges with mental health include: the lack of affordable care or the stigma to going to a LMHT/group. — Social Services Provider
>
> Inability to have affordable mental health. — Community Leader
>
> Affordable treatment services for those without insurance and a stable living environment. — Social Services Provider

Incidence/Prevalence

> Brevard County faces significant mental health challenges, with rising depression rates (24.3% in 2019) and 27% of residents rating their mental health as “fair” or “poor.” Access to care is limited, with 555 residents per mental health provider, leading to long wait times. Financial barriers also exist, as 14% of residents lack health insurance, making treatment inaccessible. Socioeconomic factors, including housing instability and food insecurity, further worsen mental health struggles. Stigma remains a major issue, discouraging people from seeking help. Addressing these challenges requires expanding mental health services, improving insurance access, and fostering community support. — Public Health Representative

Follow Up/Support

> For those in the community who are challenged, often do not have anyone to help them or speak out for them when trying to find help. This does not apply only to seniors but also to veterans and just ordinary people. I guess what I am trying to say is we need more advocates for those who cannot help themselves. — Community Leader

Awareness/Education

> I feel that mental health is a big issue on our area. People don't understand how important their health is. — Community Leader

Alcohol/Drug Use

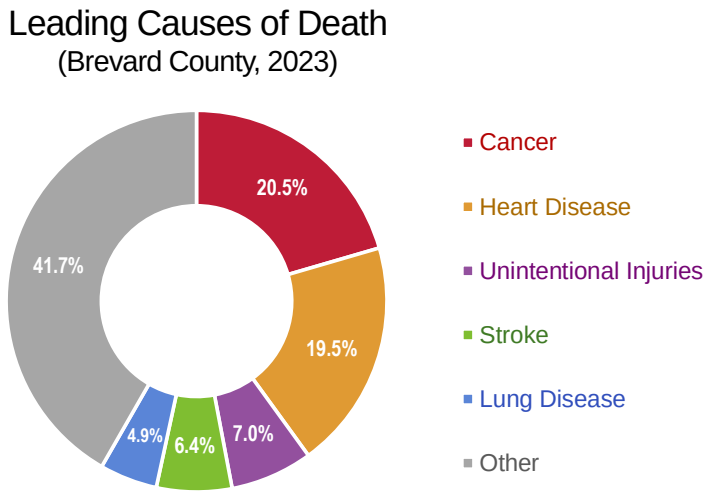
> Drug use and depression. — Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines 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 February 2025.

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

Death Rates for Selected Causes

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

Here, 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.

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

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	Brevard County	Florida	US	Healthy People 2030
Cancers (Malignant Neoplasms)	272.5	213.1	182.5	122.7
Heart Disease	265.3	226.2	209.5	127.4*
Stroke (Cerebrovascular Disease)	87.6	72.7	49.3	33.4
Unintentional Injuries	86.1	78.7	67.8	43.2
Lung Disease (Chronic Lower Respiratory Disease)	68.5	50.2	43.5	—
Unintentional Drug-Induced Deaths	38.1	32.5	29.7	—
Diabetes	32.1	35.1	30.5	—
Alzheimer's Disease	31.9	29.4	35.8	—
Cirrhosis/Liver Disease	28.9	17.0	16.4	10.9
Alcohol-Induced Deaths	22.0	15.3	15.7	—
Suicide	21.1	15.5	14.7	12.8
Kidney Disease	19.3	16.4	16.9	—
Motor Vehicle Deaths	16.8	16.4	13.3	10.1
Pneumonia/Influenza	16.8	13.0	13.4	—
Homicide	6.4	6.6	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- 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.

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.

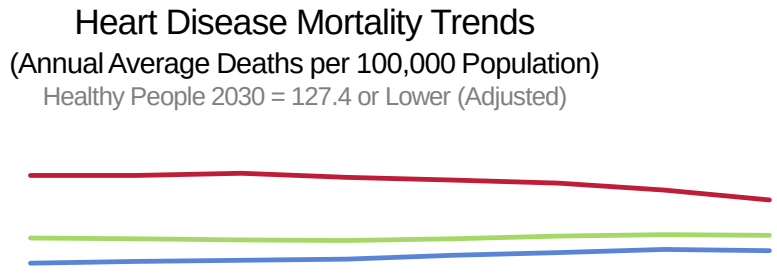
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they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

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

Heart Disease & Stroke Deaths

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	292.3	292.3	294.8	290.1	287.4	284.1	276.2	265.3
FL	223.1	222.3	221.2	220.5	222.4	225.4	227.0	226.2
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

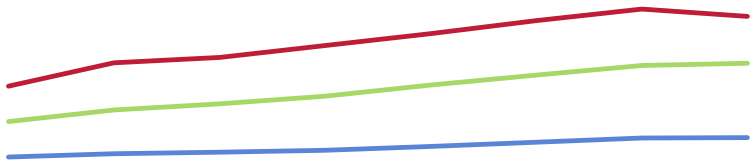
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	65.5	72.9	74.6	78.3	82.1	86.2	89.8	87.6
FL	54.3	58.0	59.9	62.3	65.9	69.0	72.0	72.7
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

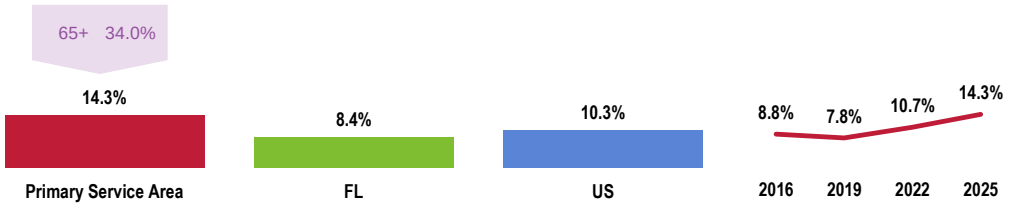
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Primary Service Area



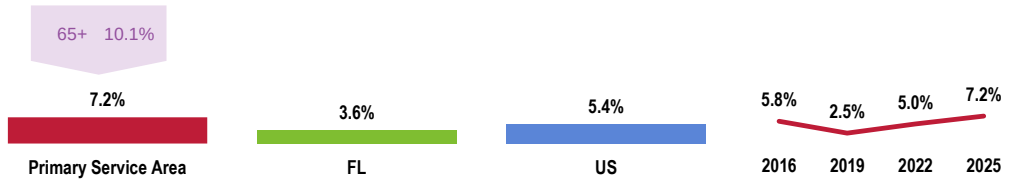
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Florida data.
- 2023 PRC National Health Survey, PRC, 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

Primary Service Area



Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

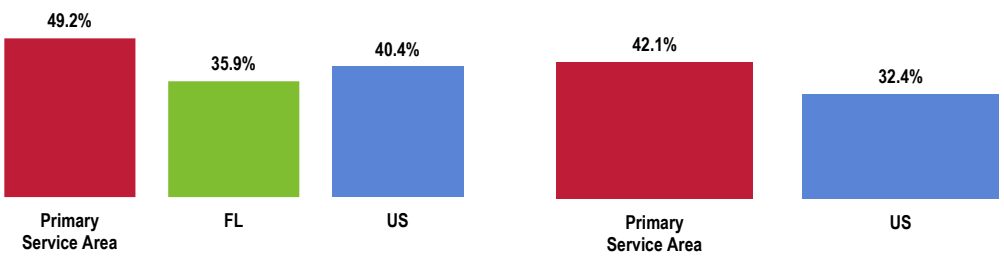
PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

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

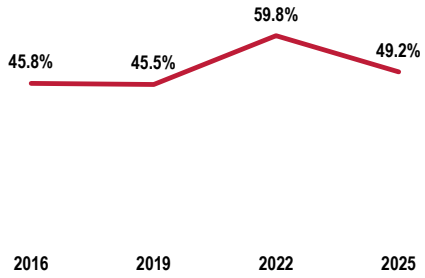


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

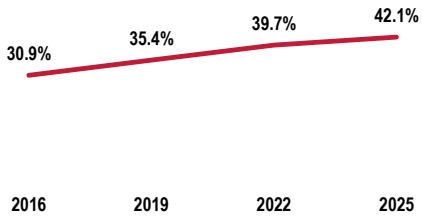
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure
(Primary Service Area)

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol
(Primary Service Area)



Sources:
- 2025 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:

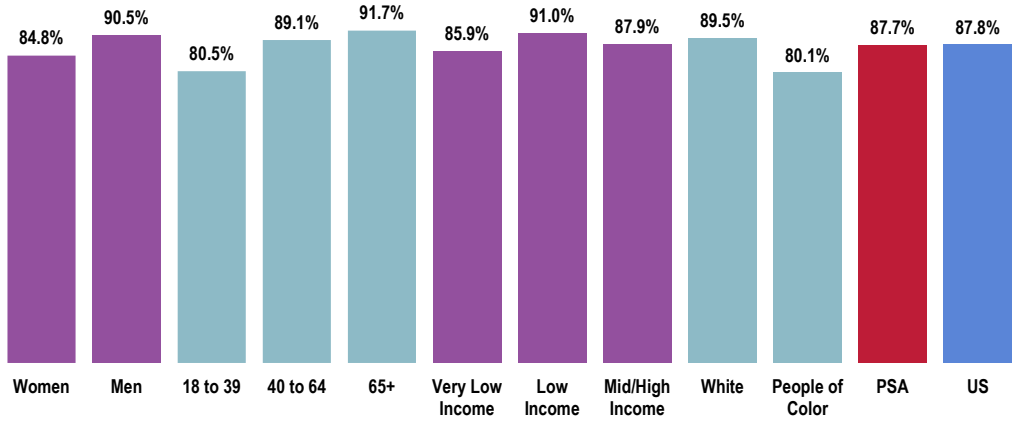
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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 Primary Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

Exhibit One or More Cardiovascular Risks or Behaviors
(Primary Service Area, 2025)

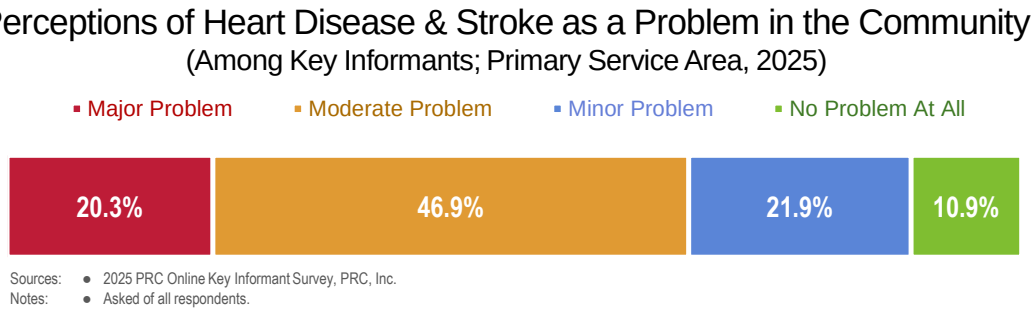


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

Incidence/Prevalence

> Heart disease and stroke are major health concerns in Brevard County, contributing significantly to deaths. In 2023, the county's stroke death rate was 44.1 per 100,000, similar to Florida's average. Heart disease remains a leading cause of death statewide. Several factors contribute to these issues, including an aging population, unhealthy lifestyles (smoking, poor diet, inactivity), socioeconomic challenges limiting healthcare access, and delayed diagnoses. Addressing these conditions requires public health efforts focused on prevention, improved healthcare access, and education to reduce risk factors and improve overall community health. — Public Health Representative
>
> Heart disease is a growing problem with women. More community programs directed at women are essential. — Community Leader
>
> Very common in our neighborhood. — Community Leader

Lack of Specialists

> More cardiologists are needed. With a high rate of people dying of heart disease, more than just one or two heart doctors are needed. Also, more specialty heart doctors are needed. Gives people a choice when seeking help. — Community Leader
>
> Limited cardiologists. — Community Leader

Lifestyle

> Poor diet and lack of access to affordable healthy foods as well as sedentary lifestyles contribute more to it. Stressors of life add to the higher probability. — Community Leader
>
> Negligence, lifestyle, education, folks not being aware of symptoms. — Community Leader

Vulnerable Populations

> Many of our citizens live with stressful conditions and are very hard-working, holding down two or three minimum-wage or less jobs, just to hold onto their mortgages and make their car payments. Health pathways such as eating properly, getting enough sleep, and keeping stress low by exercising and having time for hobbies is not an option for a significant number of people in the work force here. — Community Leader

Affordable Medication/Supplies

> The ability to purchase items to reduce the risk of heart disease and stroke is difficult for individuals in the community. There is also a great deal of substance use, specifically tobacco, that can make this issue even worse. — Social Services Provider

Cancer

ABOUT CANCER

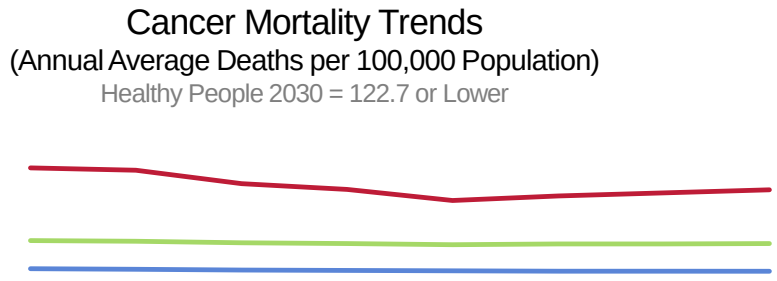
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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)

Cancer Deaths

The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	296.6	293.9	279.4	273.0	260.6	265.5	269.1	272.5
FL	216.4	215.7	214.2	213.3	211.8	212.8	212.5	213.1
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- 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. [COUNTY-LEVEL DATA]

Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

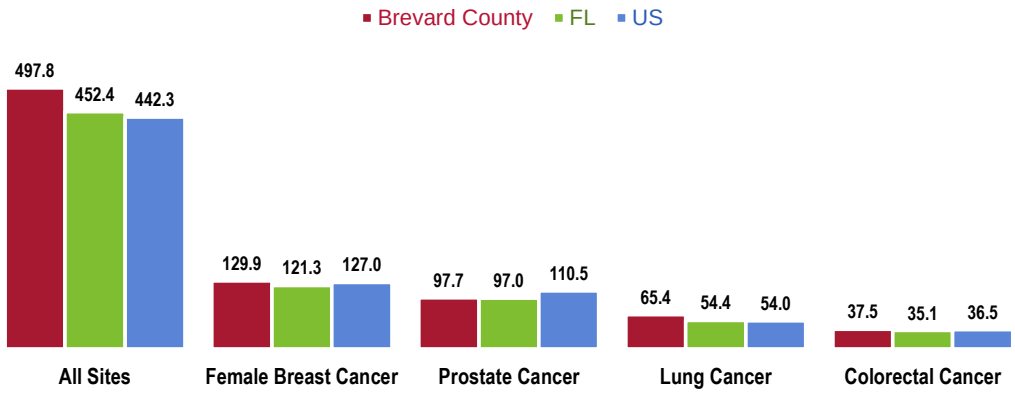
	Brevard County	Florida	US	HP2030
ALL CANCERS	272.5	213.1	182.5	122.7
Lung Cancer	67.2	47.6	39.8	25.1
Female Breast Cancer	35.5	28.4	25.1	15.3
Prostate Cancer	33.3	24.5	20.1	16.9
Colorectal Cancer	22.3	18.6	16.3	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- 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. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Incidence per 100,000 Population, 2016-2020)

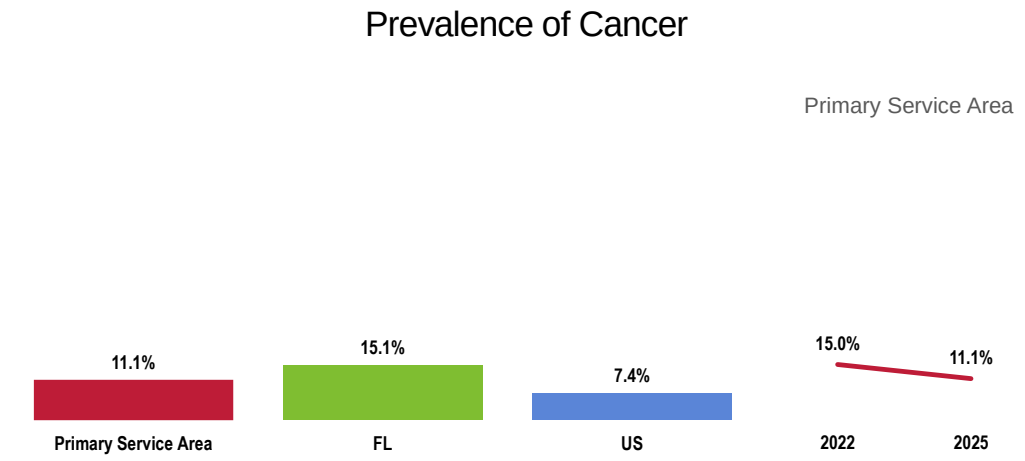


Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

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



Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

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 45 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?"**

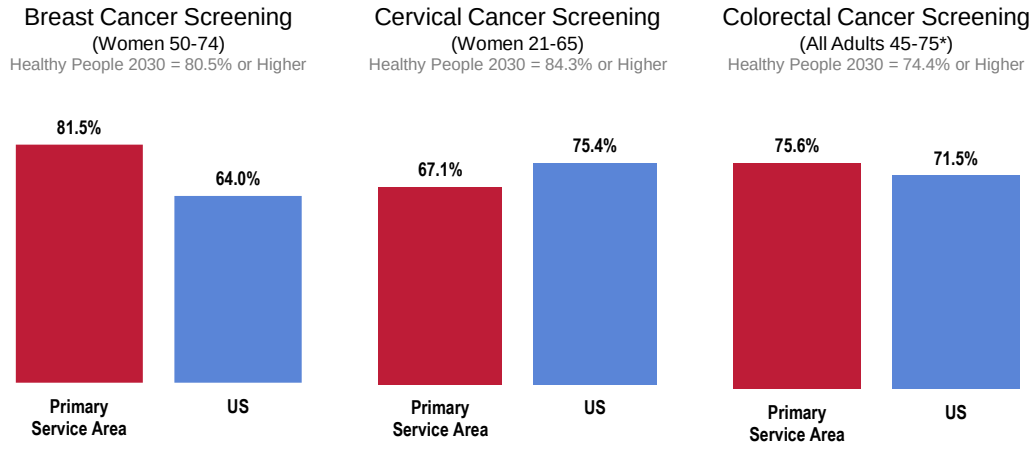
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

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?"

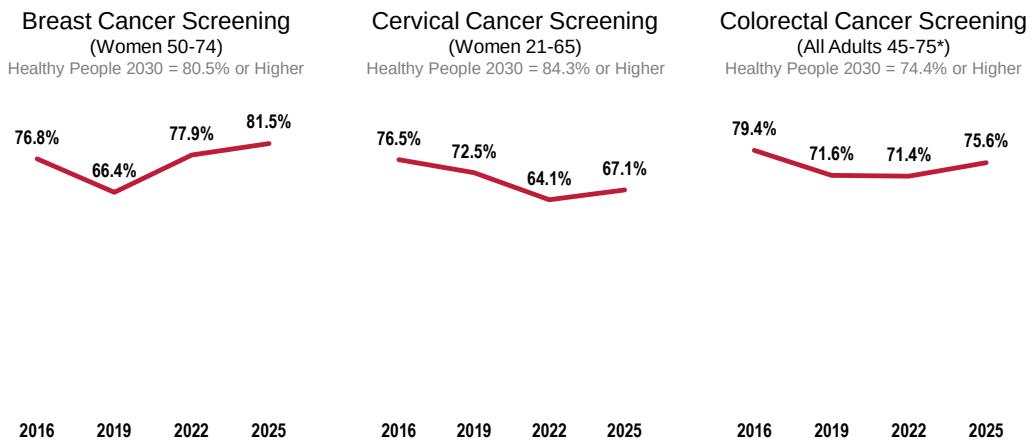
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 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.
- *Note that national data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

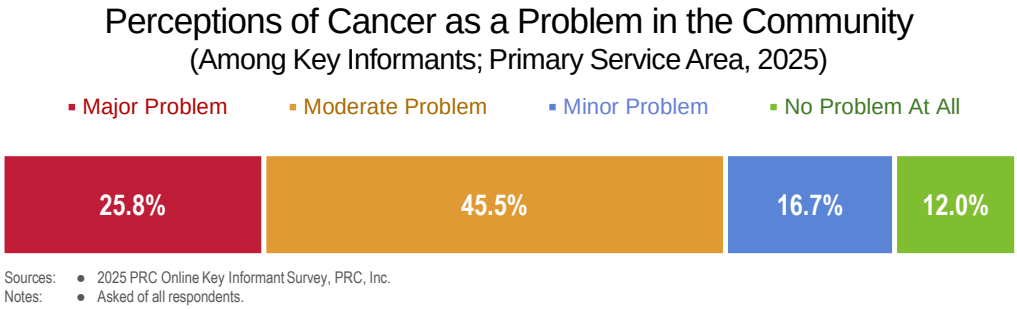


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- *Note that past data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

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



Sources:
- 2025 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

> We seem to have a growing number of people getting cancer though I don't have any data to back this up. Perhaps I have this impression because of increased awareness, testing, and advertising. — Community Leader
>
> Quite a few people that I know, including myself, have or have had cancer of various types. Fortunately, there are a number of areas available to get treatment. — Community Leader
>
> Cancer seems to be more common than ever before. I hear about it more often affecting more of our population. — Community Leader
>
> According to FL Charts, the cancer rate (2021) was 521.6 as compared to the State as a whole (471.0). — Public Health Representative
>
> Have met or know of several folks who have cancer, and we have a need for medical professionals for cancer treatment in our community without patients having to seek treatment out of town. — Community Leader

Access to Care/Services

> Many cancer patients in this community seek treatment help outside of the North Brevard community. — Community Leader
>
> Increased diagnosis in community with extreme medical costs and denial from insurance. — Community Leader
>
> There is limited local access to cancer specific health care. — Community Leader

Awareness/Education

> Lack of education on what can increase your chances of cancer. Not having the means to see a provider for annual exams that screen for cancer. — Public Health Representative
>
> Not familiar with new resources. Wrong diagnosis. — Community Leader
>
> Not as well-known specialists. — Community Leader

Diagnosis/Treatment

> People are not screening as part of their health plan. Many don't see a physician until there's a very obvious problem. — Community Leader

Lack of Specialists

> No or very few oncologists. — Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

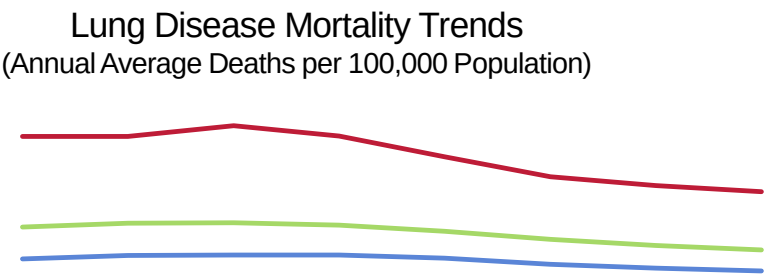
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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)

Respiratory Disease Deaths

Lung Disease Deaths

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]



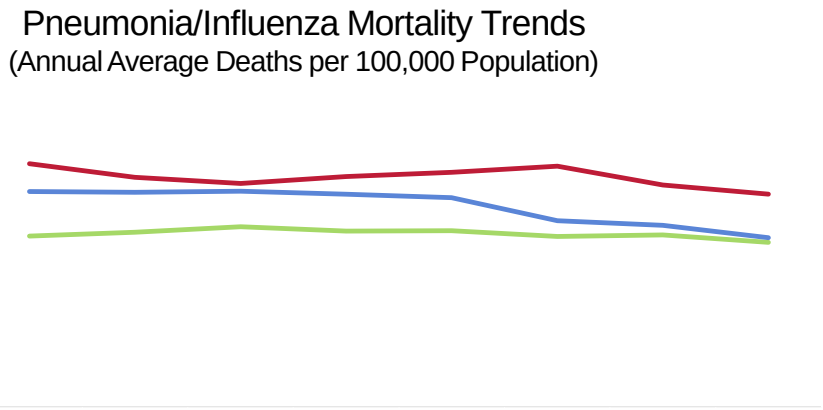
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	86.0	85.9	89.3	86.1	79.5	73.2	70.5	68.5
FL	57.3	58.6	58.7	58.0	56.1	53.5	51.6	50.2
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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.

Pneumonia/Influenza Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	19.2	18.1	17.6	18.2	18.5	19.0	17.5	16.8
FL	13.5	13.8	14.2	13.9	13.9	13.5	13.6	13.0
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	13.4

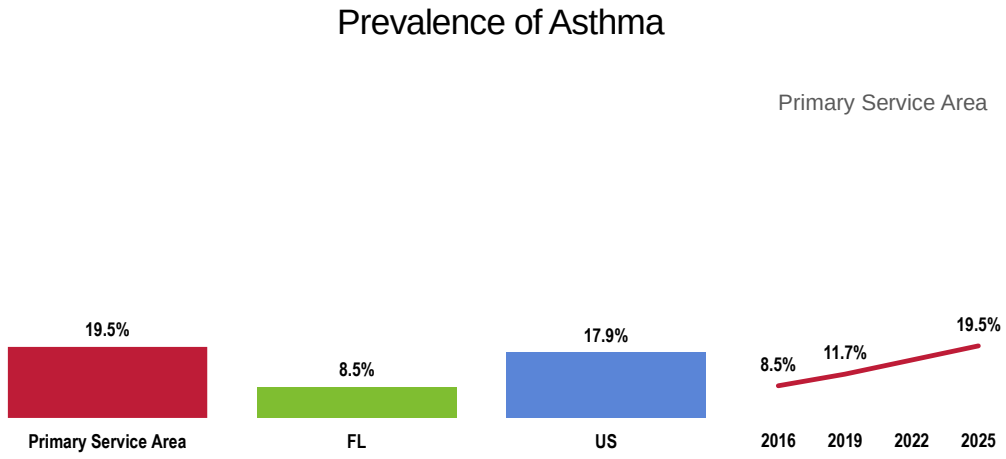
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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.

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"



Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "Has a doctor, nurse, or other health professional ever told you that this child had asthma?"

Prevalence of Asthma in Children (Children 0-17)

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

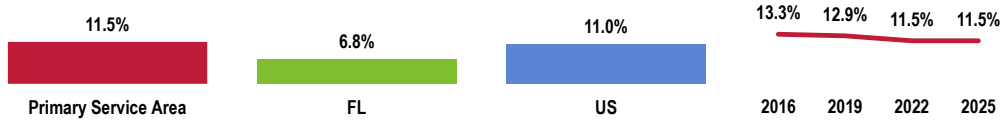
Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► "Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Primary Service Area

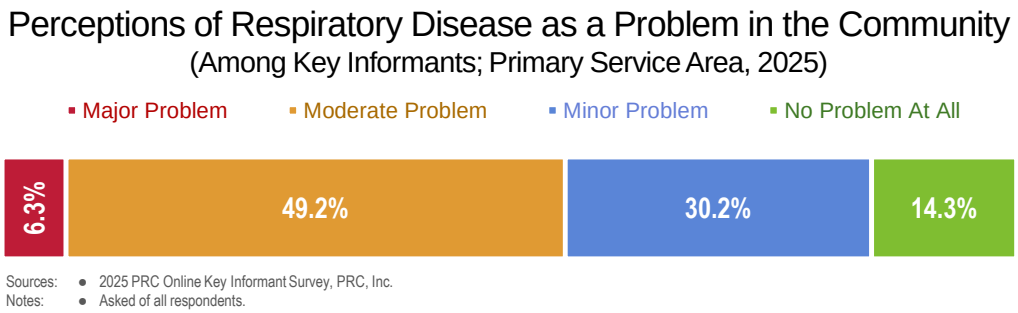


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, 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:

Aging Population

> Many older people do not have opportunities to get any help other than their doctors. — Community Leader

Incidence/Prevalence

> Rise in post-COVID and COPD. — Community Leader

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.

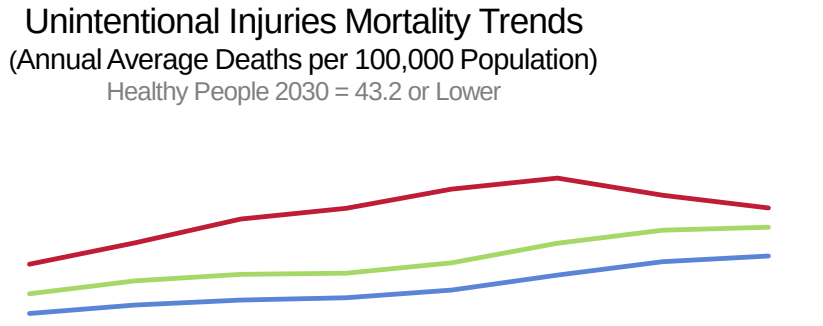
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	64.7	72.8	81.8	85.8	93.1	97.3	90.7	86.1
FL	53.5	58.4	60.9	61.3	65.3	72.6	77.6	78.7
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

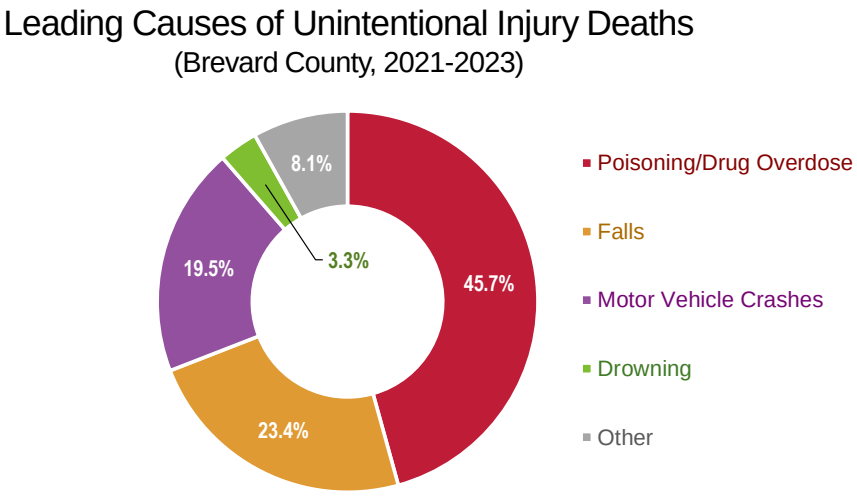
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

Leading Causes of Unintentional Injury Deaths

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

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]



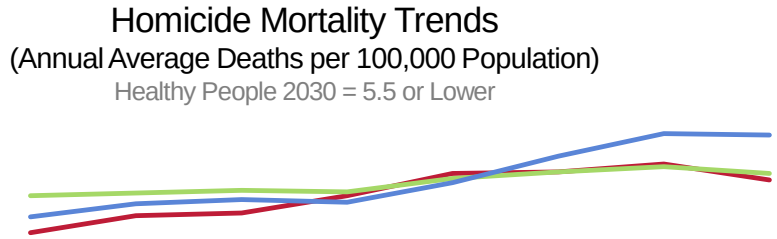
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Intentional Injury (Violence)

Homicide Deaths

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	5.1	5.5	5.6	6.0	6.6	6.6	6.8	6.4
FL	6.0	6.1	6.2	6.1	6.5	6.6	6.8	6.6
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

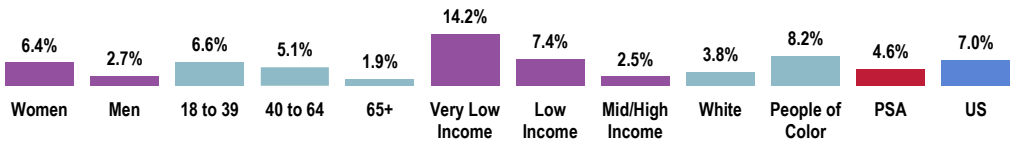
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

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
(Primary Service Area, 2025)



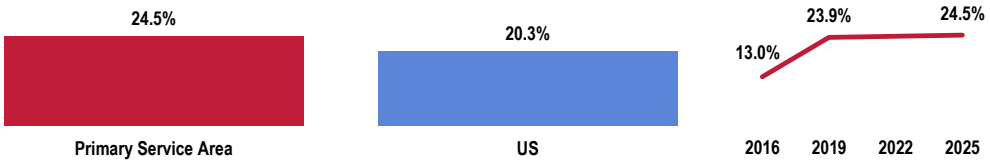
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

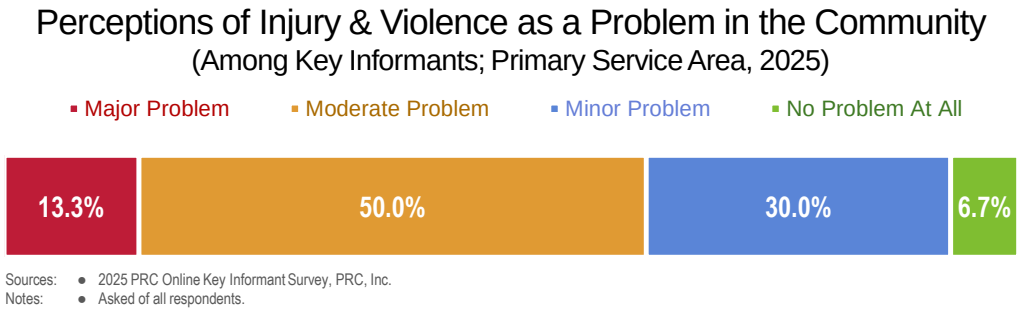
Primary Service Area



Sources: ● 2025 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

> Violence is on the news nightly. — Community Leader
>
> We see it all the time violence and mental health issues are on the rise. — Community Leader
>
> Too much shooting and injury, crime. — Community Leader

Alcohol/Drug Use

> People are under the influence. And people make stupid decisions. — Public Health Representative

Gun Violence

> Alot of gun violence. — Community Leader

Diabetes

ABOUT DIABETES

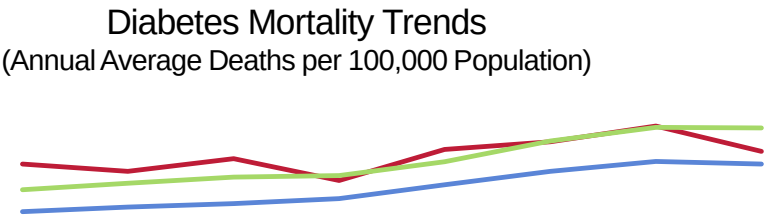
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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)

Diabetes Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	30.5	29.6	31.2	28.4	32.3	33.3	35.3	32.1
FL	27.3	28.1	28.9	29.1	30.8	33.4	35.1	35.1
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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.

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

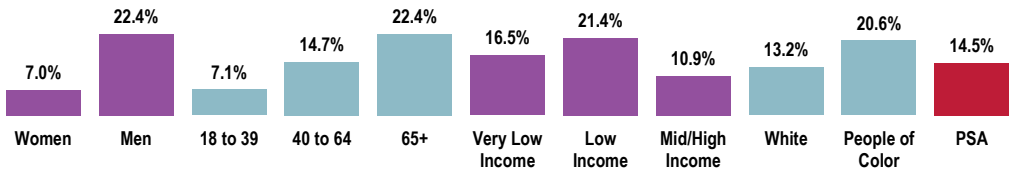
Another 15.0% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Primary Service Area

Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Prevalence of Diabetes
(Primary Service Area, 2025)

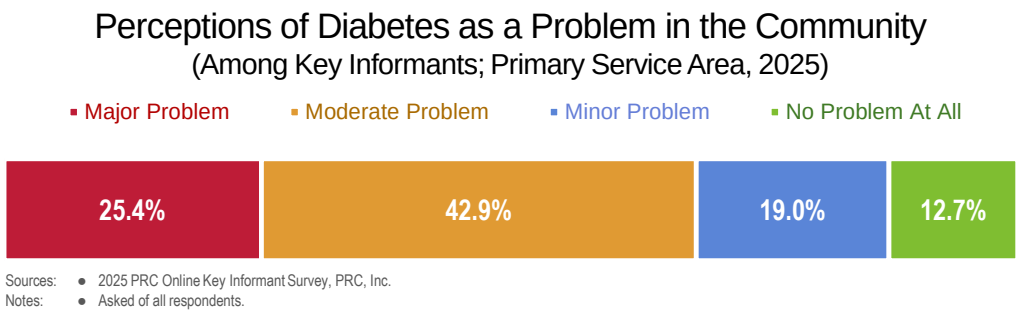


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]

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:



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

Affordable Medication/Supplies

> Access to the medical equipment to monitor and the medications to help treat. On a larger scale, buying foods that will assist with reducing the risk and the worsening of existing diabetes is more difficult to accomplish. — Social Services Provider
>
> Getting medicine at a reasonable cost. — Community Leader

Awareness/Education

> Education, transportation to appointments, funding to purchase medical supplies. — Public Health Representative
>
> Lack of training about how to take care of and nutrition. We used to have it at the hospital now we don't. — Community Leader

Access to Affordable Healthy Food

> Quality affordable nutrition. — Social Services Provider
>
> Access to fresh food, expense related to fresh food vs processed foods and sugary foods. — Community Leader

Nutrition

> Appropriate nutrition, access to prescriptions. — Social Services Provider
>
> Having to deal with diet issues and access to insulin etc. It also seems to be a precursor to other ailments such as eye problems, circulatory problems etc. — Community Leader

Vulnerable Populations

> Among poor people and non-English speaking people especially, they do have access to enough medical support and counseling to understand their disease. Unless you are a Veteran or have excellent insurance, the comprehensive approach to managing diabetes is not available. Example: They may not have money to pay for necessary meds; they may not be able to get to the doctor's office for the frequent labs and checkups that help; they may not have money or access to the proper healthy foods needed, as parts of our community are in a "food desert" because people without transportation cannot get to grocery stores but have to rely on the nearest gas station or fast-food store that they can get to by walking. Also, because diabetes is made worse by such conditions as alcohol abuse, kidney disease, and heart disease, the price paid for ignoring or denying diabetes too often leads to severe wound infections or amputations, and the quality of life takes a downward dive. — Community Leader

Access to Care/Services

> Limited treatment centers. — Community Leader

Incidence/Prevalence

> Growing population of diabetics in the community. — Community Leader

Obesity

> Obesity. — Community Leader

Disabling Conditions

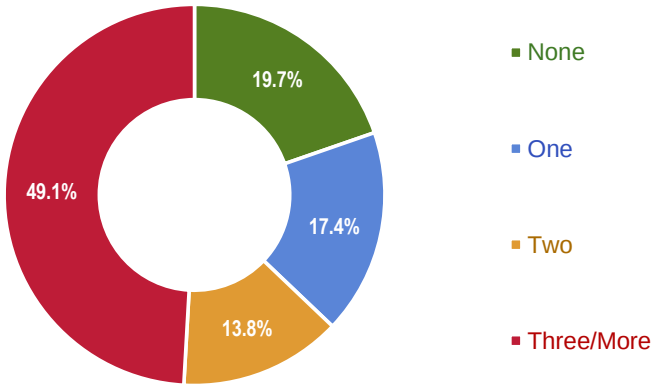
Multiple Chronic Conditions

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.

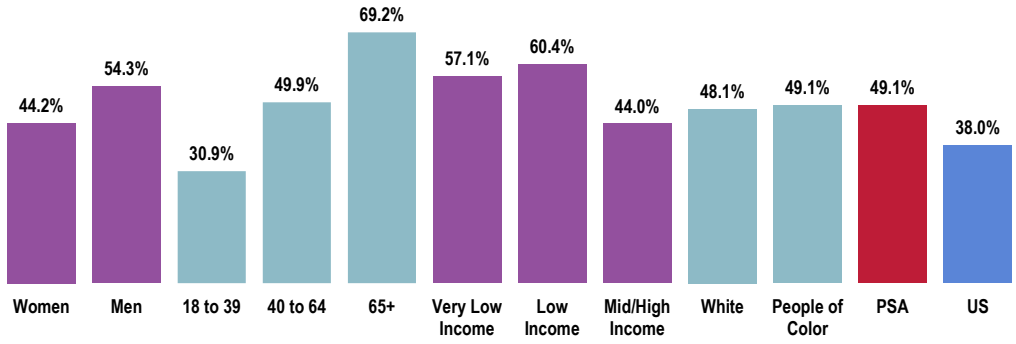
Number of Chronic Conditions
(Primary Service Area, 2025)



Sources:
- 2025 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/or stroke.

Have Three or More Chronic Conditions
(Primary Service Area, 2025)



Sources:
- 2025 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

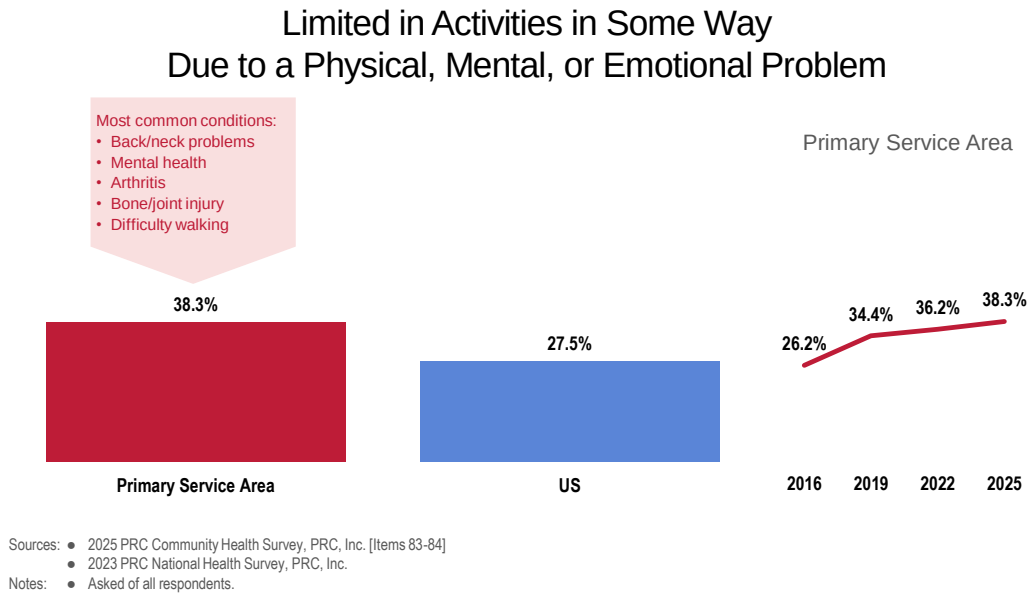
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

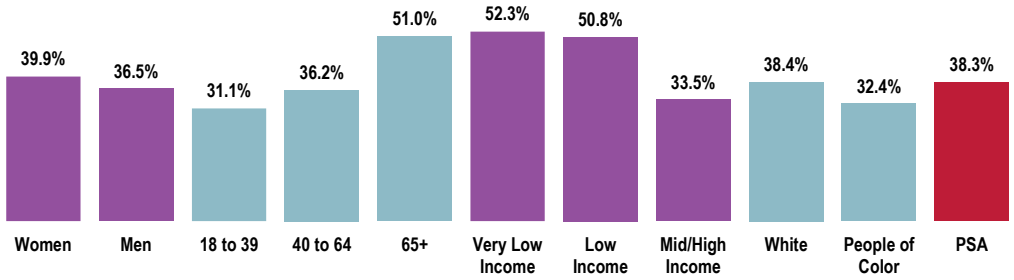
PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

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



Sources: ● 2025 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
(Primary Service Area, 2025)

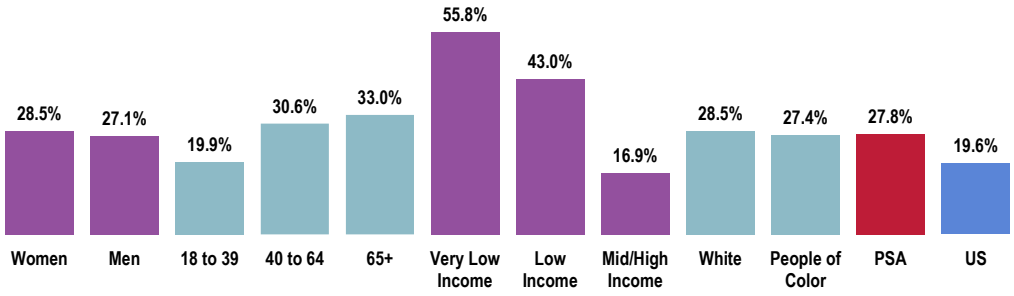


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

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
(Primary Service Area, 2025)
Healthy People 2030 = 6.4% or Lower



Sources: • 2025 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

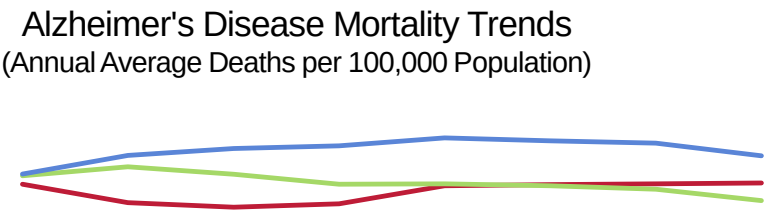
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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)

Alzheimer's Disease Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	31.7	29.1	28.5	29.0	31.5	31.7	31.8	31.9
FL	33.0	34.2	33.2	31.8	31.8	31.6	31.0	29.4
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

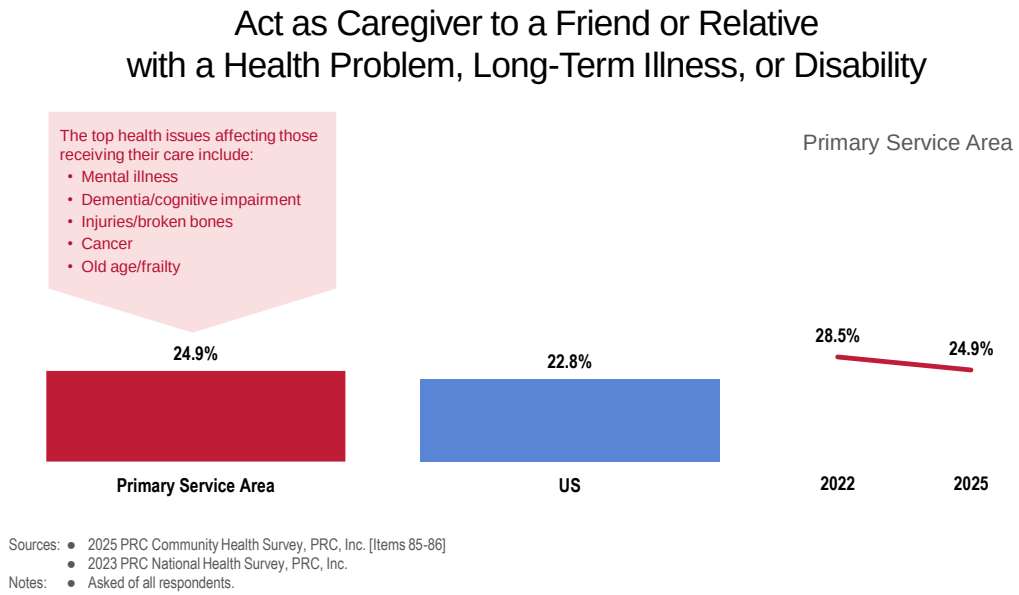
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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.

Caregiving

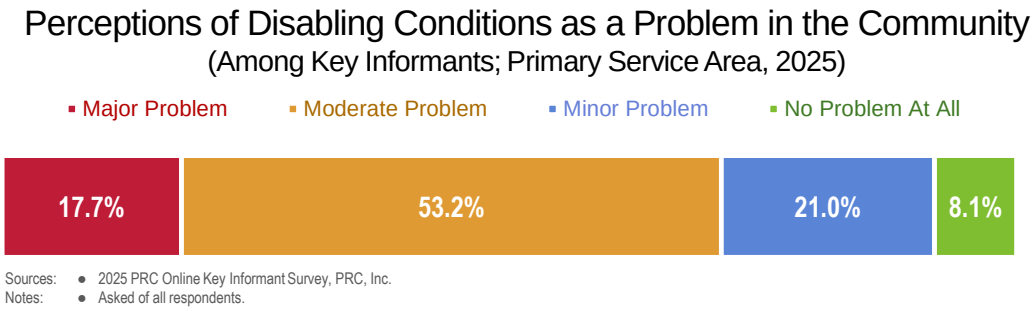
PRC SURVEY ► "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

PRC SURVEY ► [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Key Informant Input: Disabling Conditions

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



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

Aging Population

> I do believe the problem relates to where to go to seek help. In a community with growing aging population, I believe more people are needed to help guide the aged seeking help. — Community Leader
>
> North Brevard County has a high population of elderly who are prone to these issues. — Community Leader
>
> We have a high number of elderly and limited income in our community. People with these types of health care conditions with no access to an advocate or resources to help them prevent and/or resolve some of the medical issues that will accompany these types of conditions. — Community Leader

Incidence/Prevalence

> I have encountered many people who have been diagnosed with these conditions. — Public Health Representative
>
> I have witnessed people living on the streets who have disabling conditions such as cerebral palsy, post-traumatic brain injuries affecting speech and cognitive functions, and untreated or under-treated conditions such as dementia, blindness, deafness. Also, I have met lifelong residents living on the streets who were born with mental retardation and have no support services available. I have met an elderly woman living in her car who is attempting to undergo cancer treatment, with no support other than the kindness of the people trying to provide the treatments. I know a person with severe dementia who is unable to manage his finances, yet is attempting to provide care for his housemate who has severe chronic medical conditions. I could list dozens of examples of disabling conditions that I have witnessed personally. The reason these are problems is that the level of suffering affects quality of life for us all. — Community Leader

Affordable Care/Services

> The cost alone is a major issue. Not only do individuals have multiple doctors (multiple copays) and multiple medications or assistive devices, but may need additional care or assistance from individuals and this is often not even covered by insurance. — Social Services Provider

Alcohol/Drug Use

> Addiction and treatment for chronic pain. — Community Leader

Family Support

> There needs to be more support and housing for families with physical limitations. — Community Leader

Arthritis

> Arthritis and other skeletal problems that affect mobility. — Community Leader

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.

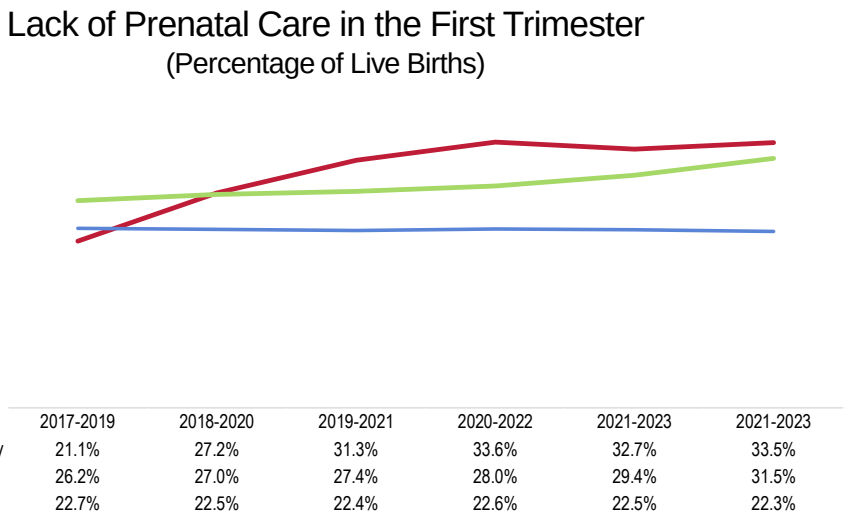
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– 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 women who did not receive prenatal care during their first trimester 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]



	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023	2021-2023
Brevard County	21.1%	27.2%	31.3%	33.6%	32.7%	33.5%
FL	26.2%	27.0%	27.4%	28.0%	29.4%	31.5%
US	22.7%	22.5%	22.4%	22.6%	22.5%	22.3%

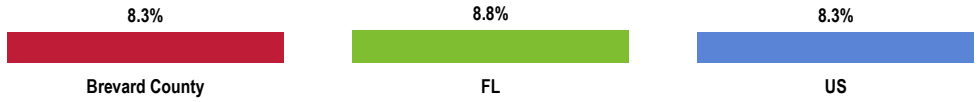
Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: ● This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

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, 2016-2022)



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 1 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

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Brevard County	5.8	5.6	5.7	5.7	6.1
FL	6.2	6.2	6.2	6.1	6.0
US	5.9	5.9	5.8	5.7	5.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2025.
● 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.

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.

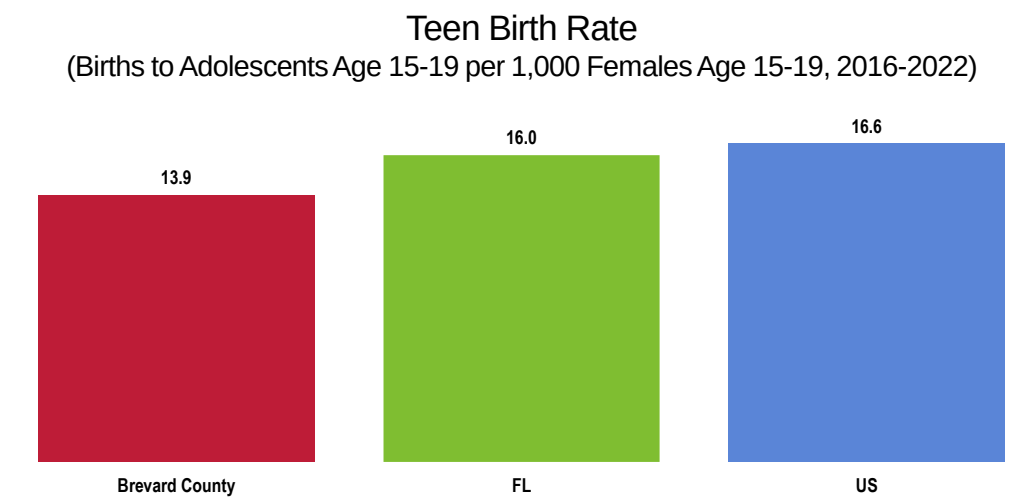
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

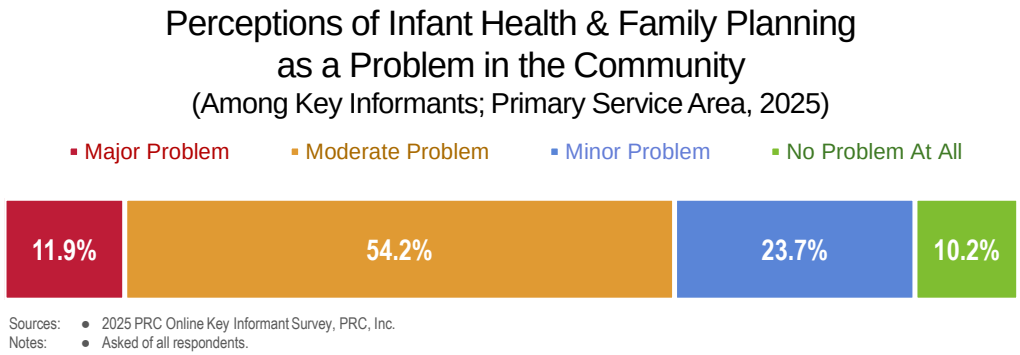


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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:



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

Access to Care/Services

> I think there are not many options for free or low cost birth control, or classes to teach how to use it. — Social Services Provider
>
> In the past, like 20 years ago, the Public Health Department used to have outreach groups and community workers who provided information on and support for infant health and family planning. That doesn't appear to be available now. Also, some NPOs offer information that is not culturally aware or that is religiously biased and not medically accurate. If you can afford good health insurance, you can get access to good support through your medical plan/physician. But even then, family planning information is not necessarily integrated in an optimal way. For example, women may be given information but somehow men are not involved. — Community Leader

Maternal Mortality

> Our 2023 severe maternal morbidity rate is one of the highest in the state (per FL Charts) and it's climbing. — Public Health Representative

Affordable Care/Services

> Families are not able to afford and care for family needs. It's rampant in our community. — Community Leader

Substance Use

> Substance Use during pregnancy and while raising a child. — Social Services Provider

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

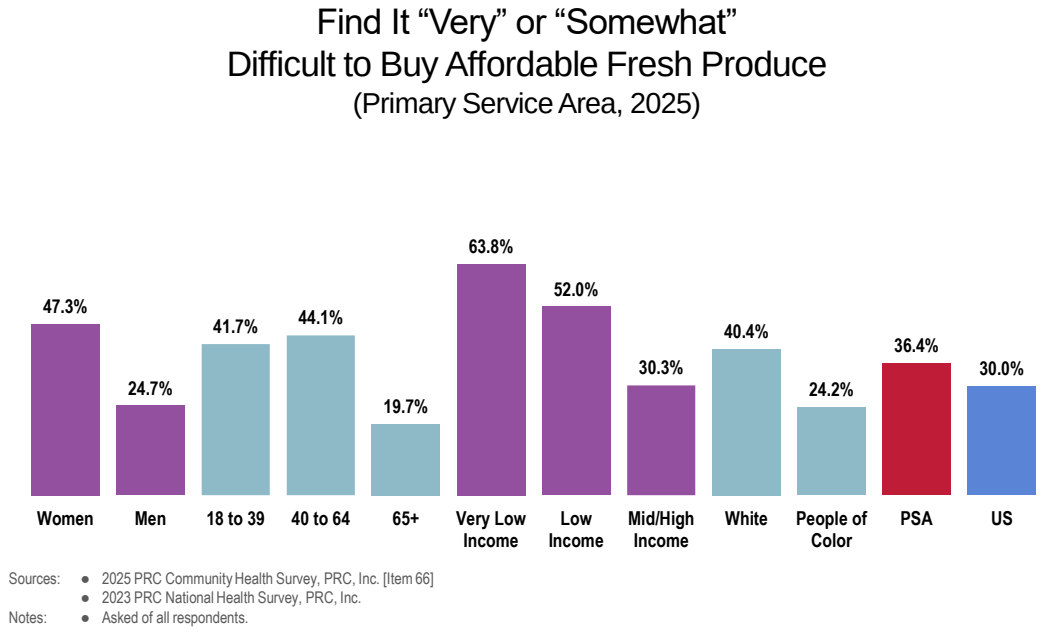
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy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

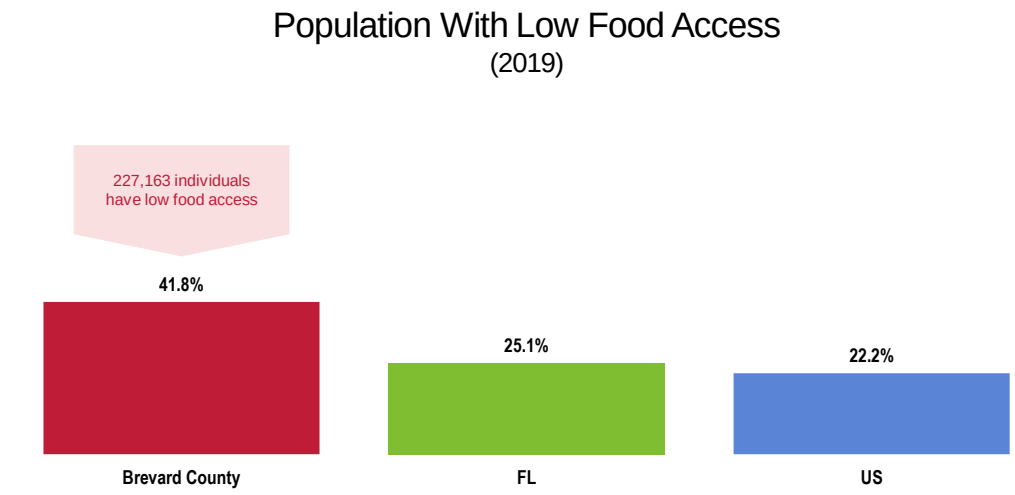


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

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]



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 February 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

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.

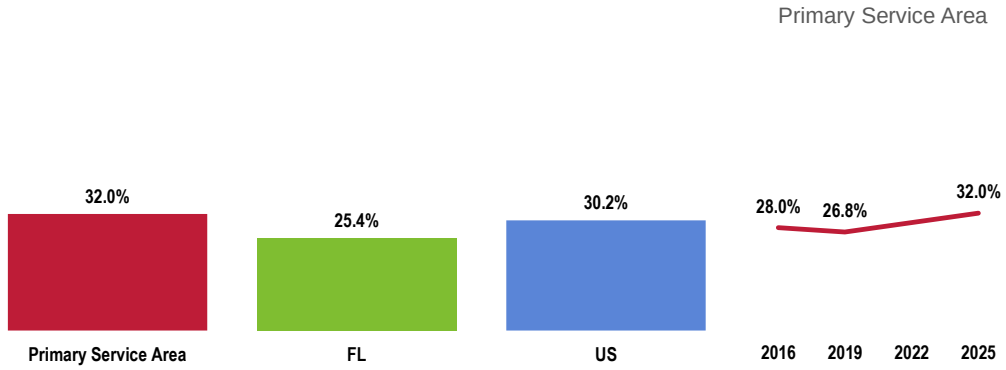
– Healthy People 2030 (https://health.gov/healthypeople)

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:
- 2025 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): 2023 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.

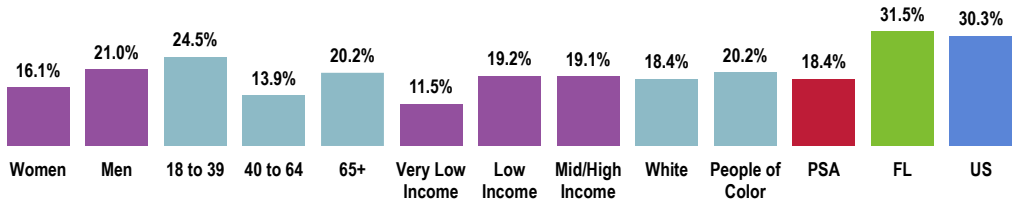
Respondents were also asked about strengthening exercises:

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

(Primary Service Area, 2025)

Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 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): 2023 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 both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

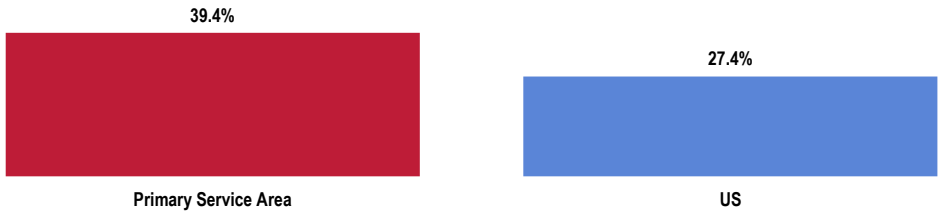
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

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

PRC SURVEY ► "During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Children 2-17)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

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

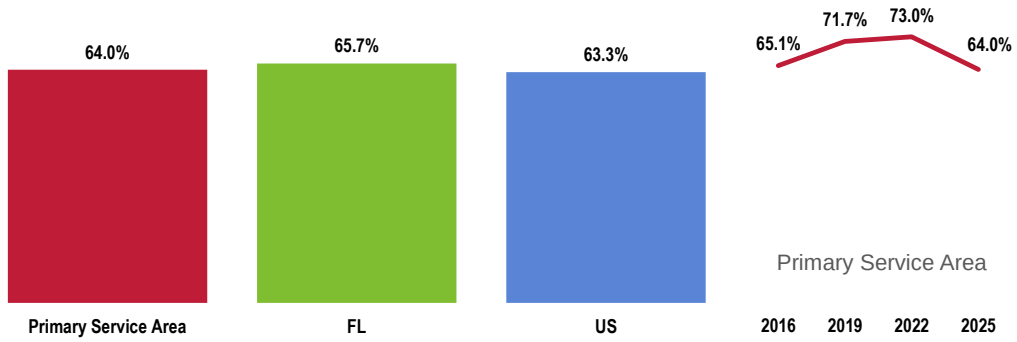
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

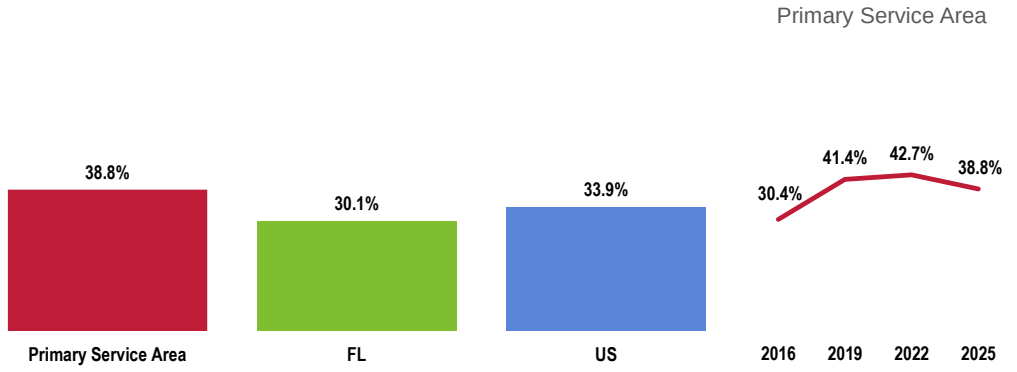


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, 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

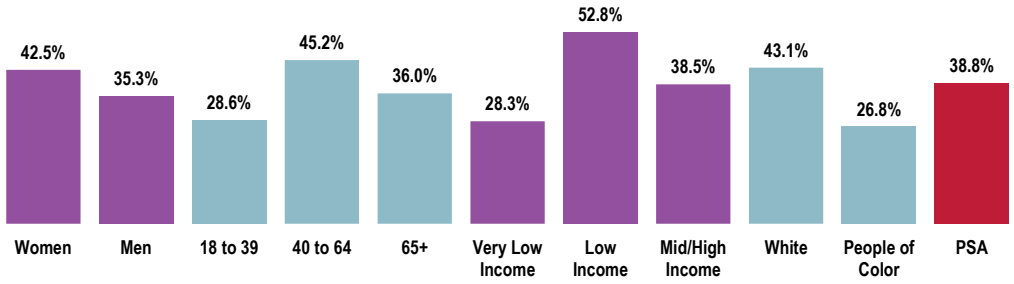
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 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): 2023 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
(Primary Service Area, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 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.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight — <5th percentile
- Healthy Weight — ≥5th and <85th percentile
- Overweight — ≥85th and <95th percentile
- Obese — ≥95th percentile

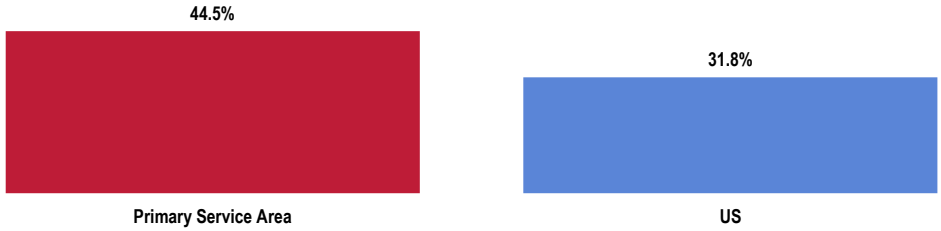
– Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ► "How much does this child weigh without shoes?"

PRC SURVEY ► "About how tall is this child?"

Prevalence of Overweight in Children
(Children 5-17)



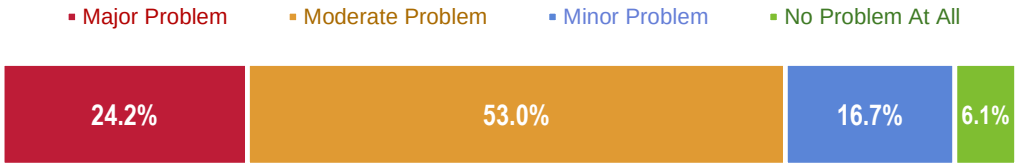
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

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; Primary Service Area, 2025)



Sources:
- 2025 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:

Lifestyle

> People are depressed, overworked, underpaid, eat trash food, don't want to make time, don't want to spend money are nutritional food and gym memberships. They lack motivation. — Public Health Representative
>
> Again, the general problem is overeating and a lack of exercise due to the sedate lifestyles so many people have. — Community Leader
>
> Motivating and engaging individuals to regularly participate in physical activity and better nutrition. — Social Services Provider
>
> People are not eating right or exercising to maintain their lifestyle. — Community Leader

Awareness/Education

> There is a lack of knowledge in the community, but there are also monetary considerations. Many individuals utilize food banks which does not have as nutritious items so that they are shelf stable. — Social Services Provider
>
> We need to set up more nutritional classes for the poorest neighborhoods and for our seniors. — Community Leader
>
> Lack of understanding importance, budget to purchase healthier food options, lack of understanding what is healthier food options. — Community Leader

Access to Affordable Healthy Food

> "Healthy" foods are often more expensive and incomes do not support. We have several food pantries that give out foods. However, the nutritional value of the items distributed is low. The area is not very "walkable" and there are limited resources in this area. We do have a Y and several gyms. Food, I believe is the major issue. — Community Leader
>
> The many NPO and church food pantries indicate the ongoing struggle for food security on our town. Many who are disabled or handicapped in some way must walk or wheel themselves to nearby fast food places or gas station store and try to find eatables on sale. I think people would be surprised at the wide age spectrum of people who come to Under the Bridge ministry, for example, to get a good meal. . . Young single mothers with infants and children, stroke victims in wheelchairs, old men and women with multiple health issues such as asthma, heart conditions, diabetes, and cancer. — Community Leader

Affordable Care/Services

> The biggest challenge is that there are not many opportunities, cost is high, and insurance and/or health care benefits do not cover programs that would be helpful in these areas. — Community Leader

Insufficient Physical Activity

> Not enough encouragement to get out and walk. No program/group making it fun enough and attractive enough to bring people out of the air conditioned house with the TV and 100s of TV and streaming services. — Community Leader

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.

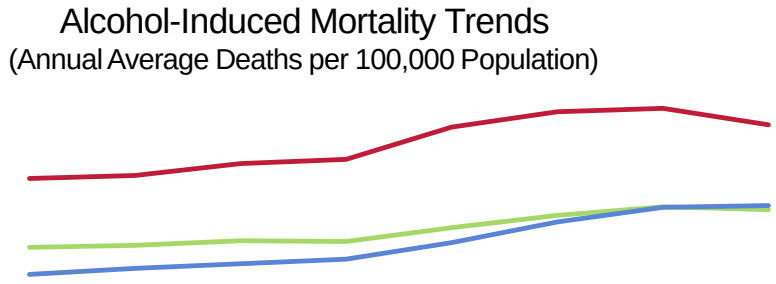
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Alcohol-Induced Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	17.8	18.0	19.0	19.3	21.9	23.1	23.3	22.0
FL	12.4	12.5	12.9	12.8	13.9	14.9	15.6	15.3
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

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.

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.

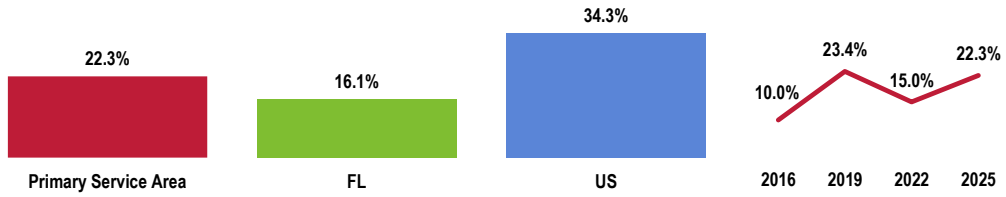
PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

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

Primary Service Area



Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

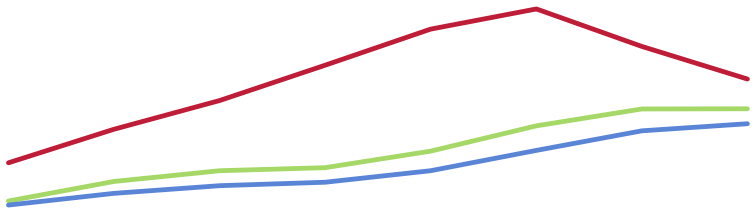
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more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

Drugs

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 mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Brevard County	22.3	28.6	34.0	40.7	47.6	51.4	44.3	38.1
FL	15.0	18.7	20.7	21.3	24.5	29.2	32.4	32.5
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

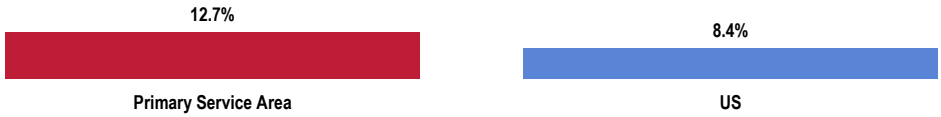
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

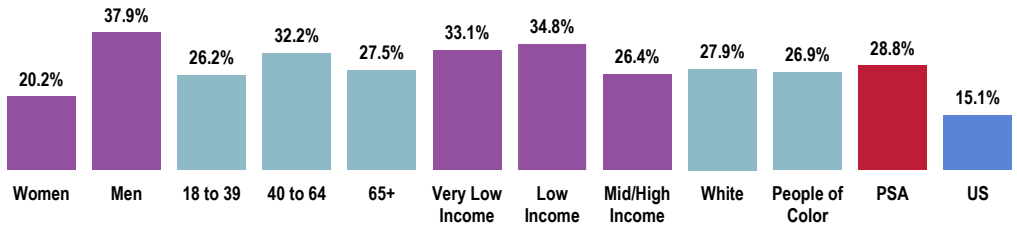
Notes:
- Asked of all respondents.

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
(Primary Service Area, 2025)



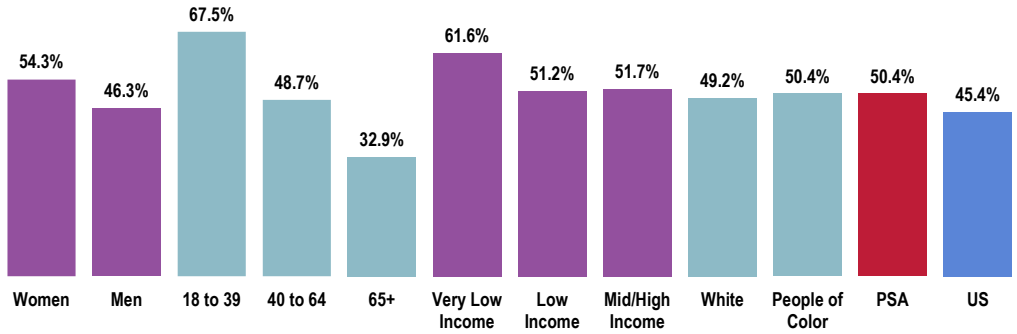
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

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)
(Primary Service Area, 2025)

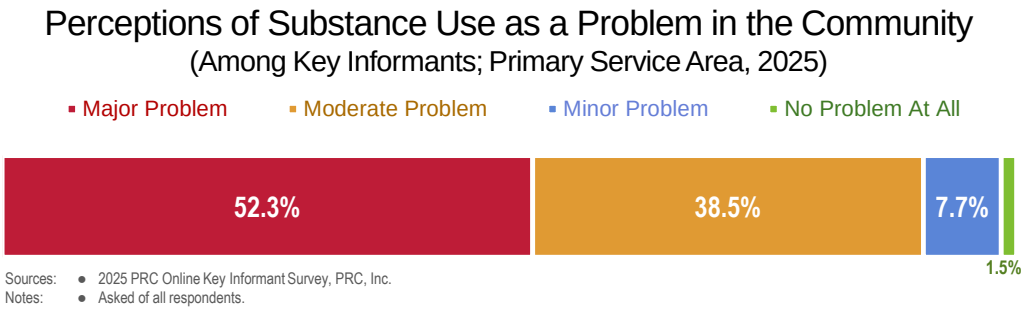


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

Access to Care/Services

> The number of facilities available is insufficient to cover the area under review. — Social Services Provider
>
> There are very few treatment centers and limited levels of care. In particular for low income or individuals with Medicaid. — Community Leader
>
> No substance abuse clinic. — Community Leader
>
> We have nothing to help people in this area. Low income and poor mental health availability. — Community Leader
>
> More counselors. — Community Leader
>
> We don't have enough treatment centers to address the need and we do not have the re-entry support services for clients and their families when the user leaves a treatment program. — Community Leader
>
> Lack of inpatient facilities that are local. A lack of inpatient programs for the uninsured/underinsured. — Health Care Provider

Denial/Stigma

> Stigma, not wanting to get help, lack of real prevention efforts, cost / income, underinsured / uninsured. — Public Health Representative
>
> Stigma and confidentiality concerns. Denial, lack of support. Fear of the unknown. — Community Leader
>
> Stigma, affordability and accessibility. — Community Leader
>
> The fact that no one wants a Drug Rehab Center in their community. — Community Leader
>
> The stigma. Everyone has their own beliefs about substance use, even the individuals who use substances, which makes asking for help more difficult. — Social Services Provider

Insurance Issues

> Insurance. — Public Health Representative
>
> Insurance/financial resources. — Social Services Provider
>
> Lack of insurance- fear of being arrested. — Social Services Provider

Awareness/Education

> Lack of awareness. — Social Services Provider
>
> Encouraging individuals to avail themselves of the available community resources. Generally, this means immediate availability for assessment and treatment services as it's important to capitalize on an individual's willingness to inquire about services. But most importantly, a community awareness of the services that are available and how to easily access them assists the referral process. — Social Services Provider

Culture

> Missing a moral commitment to staying away from drugs. Ignorance, people not knowing that marijuana and cocaine are much stronger today than twenty years ago. There is a large number of mentally ill people as a result of drug and or alcohol addiction. Also, it is very expensive and almost impossible to get needed help when addicted. There are groups out there with the goal of helping addicts and their families, but the long term ability to stay away from addictive substances is almost impossible. This is an issue for police, hospitals, doctors, teachers, lawyers, families and the addicts themselves. Our minister says that the biggest problem he hears about among his souls is an addiction of some kind. Access to drugs must be too easy. Police must be able to help as much as possible and be totally supported by local government, families, and churches. — Community Leader

Funding

> Funding - our agencies need financial resources to be able to manage the caseload. — Community Leader

Affordable Care/Services

> Income. — Community Leader
>
> Cost, stigma. — Community Leader

Faith

> Lack of faith. — Community Leader

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.

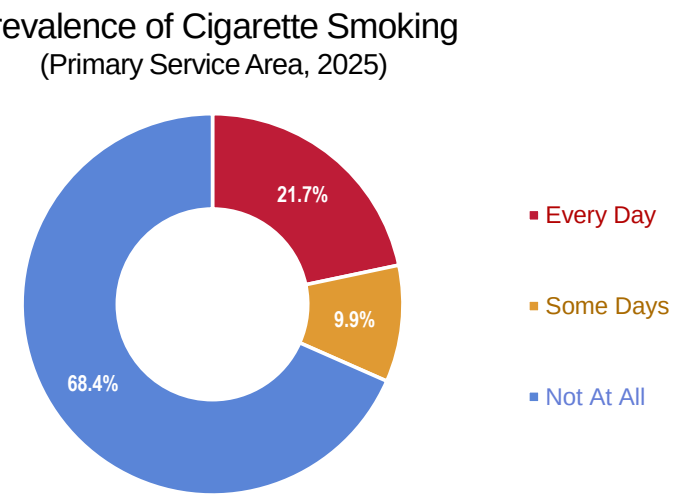
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including 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)

Cigarette Smoking

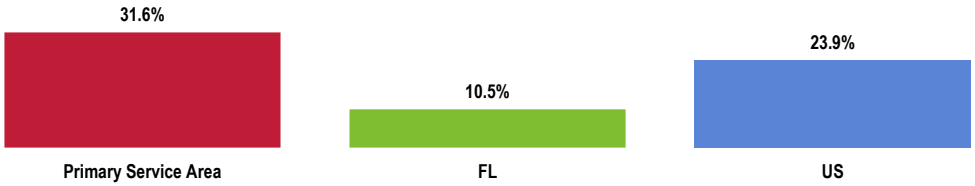
PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower



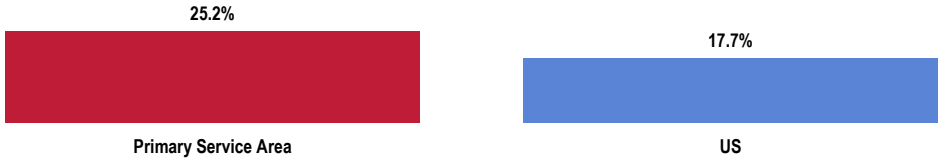
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes 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?"

Member of Household Smokes at Home



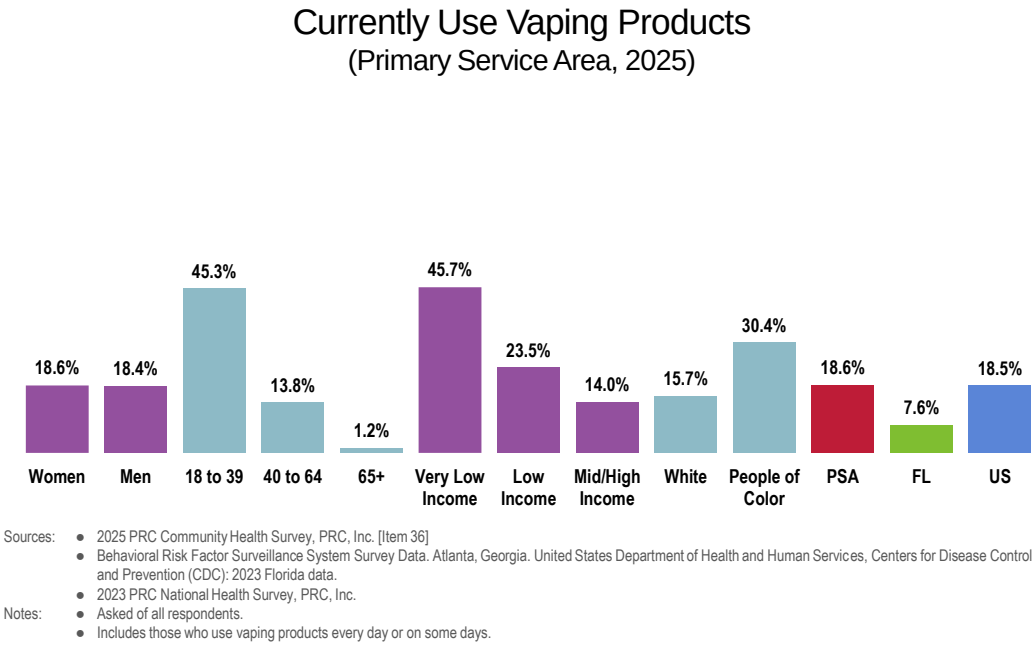
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

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.")

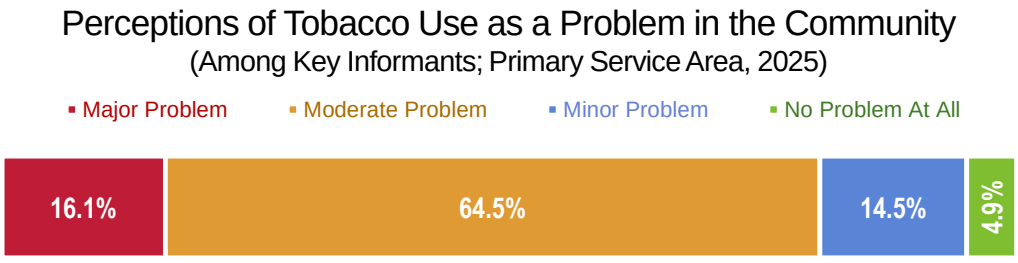


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Tobacco Use

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



Sources:
- 2025 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:

E-Cigarettes

> Vaping to be exact. Vaping shops are everywhere. — Public Health Representative
>
> Vaping is all over the place. — Community Leader

Vulnerable Populations

> Our community is full of individuals who have high stress due to low income and physically demanding jobs. Tobacco is easy to get and legal, which leads many individuals to use it for the relaxing effects that nicotine can have. — Social Services Provider

Awareness/Education

> I feel people don't understand that they are risking their health. Also the health of those around them. — Community Leader

Incidence/Prevalence

> It's a major issue in most communities. North Brevard isn't any different. — Community Leader

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).

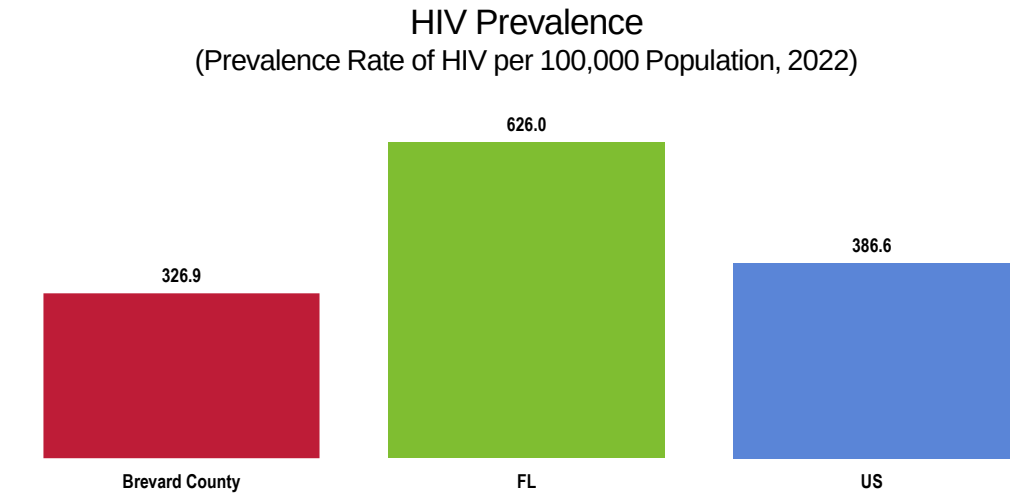
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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]



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 February 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

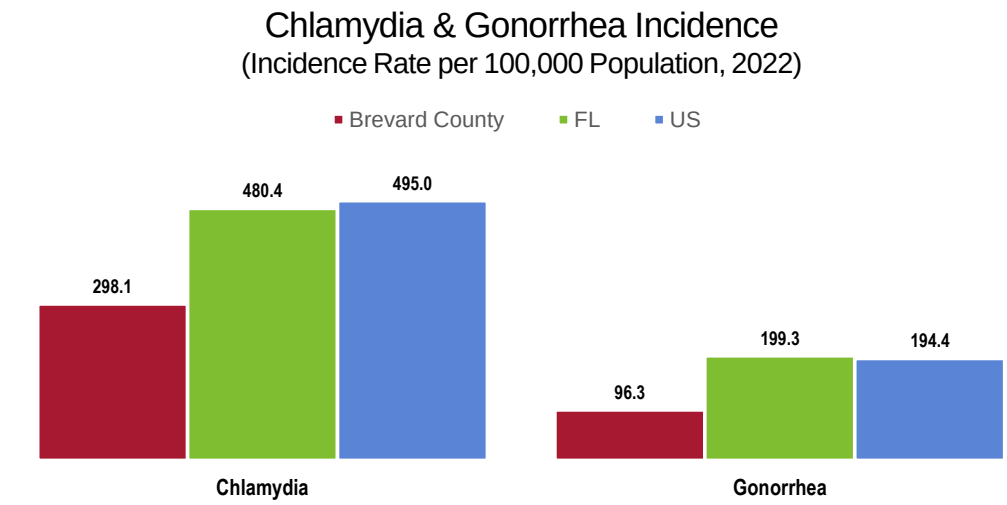
Chlamydia

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.

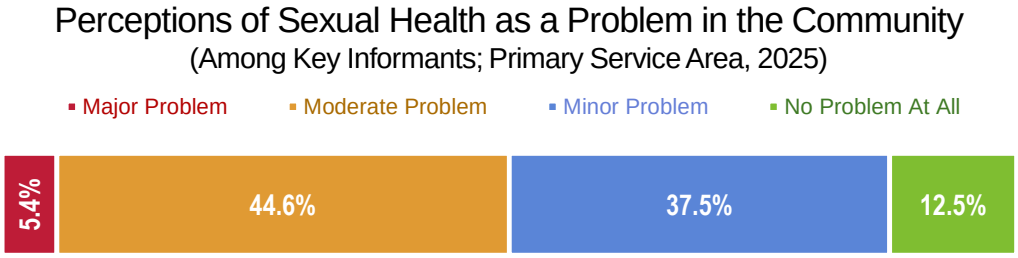
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



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 February 2025 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:



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

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 another state-sponsored program)**, 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)

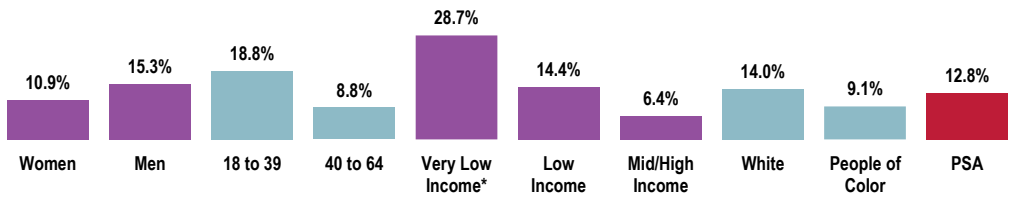
Healthy People 2030 = 7.6% or Lower

Primary Service Area

Sources:
- 2025 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): 2023 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; Primary Service Area, 2025)
Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 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.
- * Use caution when interpreting the results, as the sample falls below n=50.

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?"

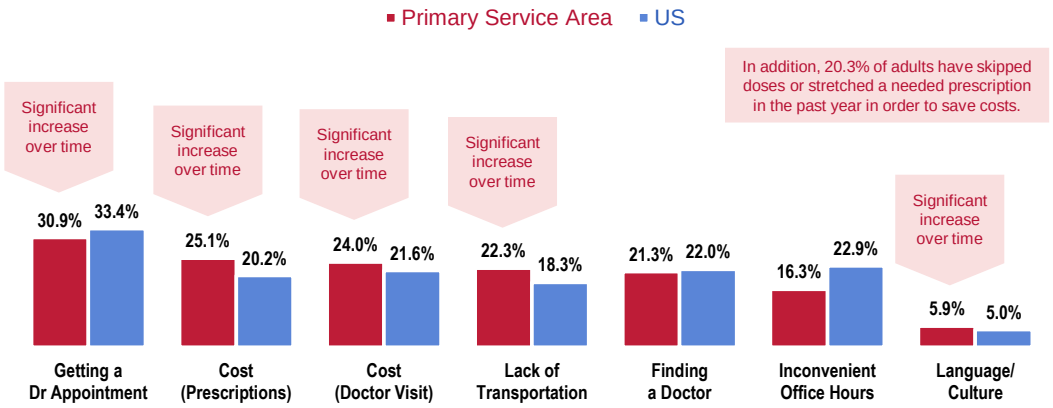
PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

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

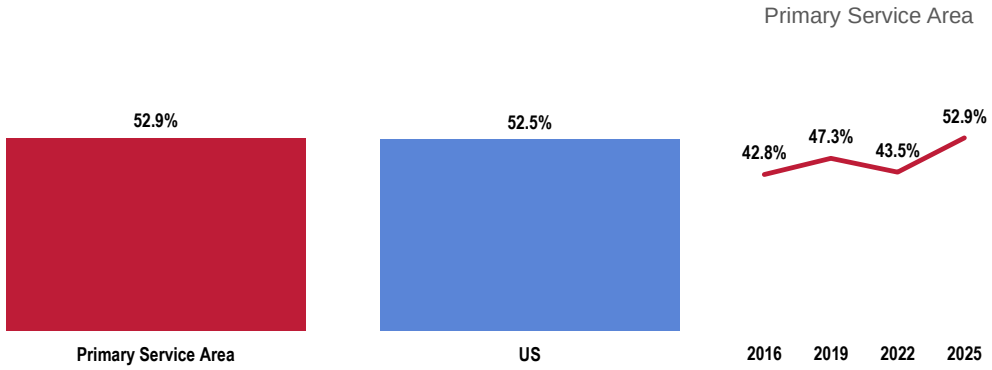


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

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.

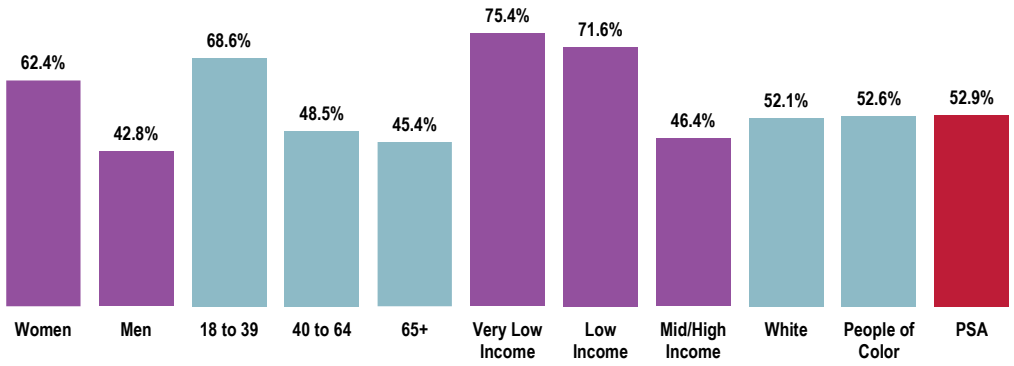
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2025 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
(Primary Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

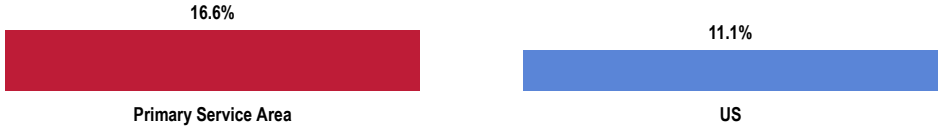
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care for this child but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

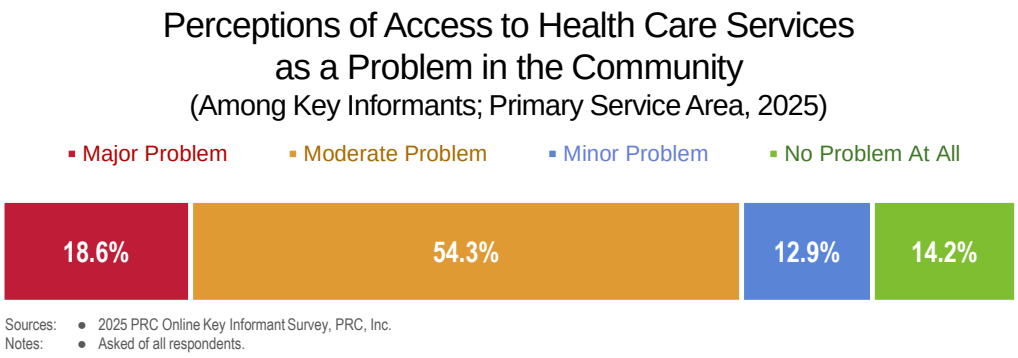


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

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:



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

Access to Care/Services

> There is an overall lack of available services. There is a lack of insurance coverage for individuals to access what is available. There is also a lack of knowledge of available services. — Community Leader
>
> No immediate help facility. — Community Leader
>
> Lack of insurance and providers, access to care, health literacy. — Public Health Representative
>
> The long wait to see qualified medical professionals. — Community Leader

Transportation

> Transportation, health insurance, navigating the health care system, especially for individuals who don't understand how to use smart phones, apps or don't have access to internet. — Public Health Representative
>
> Transportation as well as just knowing where and what is available. — Community Leader
>
> Transportation, underinsured or uninsured, income / cost, language / culture, office hours. — Public Health Representative

Emergency Room Care

> Long waits especially in ER. Big turnover in staff. — Community Leader
>
> The ER does not do an adequate job in taking care of emergencies other than minor problems. — Community Leader
>
> Homeless people/low income without insurance go to the area emergency room for help and are forced to wait for help while people with insurance receive help first. — Community Leader

Follow Up/Support

> Complete healing involves the physical, mental, emotional and spiritual aspects of the patient. There's a need for better spiritual support to complement the healing process for physical, mental and emotional healing. — Community Leader
>
> Lack of follow through on the patient's part. No phone, no transportation, impaired executive functioning, mental illness, no insurance, just to name a few. — Social Services Provider

Affordable Care/Services

> Accessing healthcare in Brevard County is challenging, mainly due to high costs. A 2022 health assessment found 54.7% of residents struggled with access, up from 45.8% in 2019. The uninsured rate also increased to 17.2%. Financial constraints are a major factor, with many delaying or skipping care. Over 30% of residents lack $400 for emergencies, and 34.3% worry about housing costs, further limiting healthcare affordability. These economic insecurities make cost the biggest barrier to healthcare access in the county. — Public Health Representative

Lack of Providers

> Not enough doctors. — Community Leader

> Proactive/preventative healthcare and its practice. — Community Leader

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.

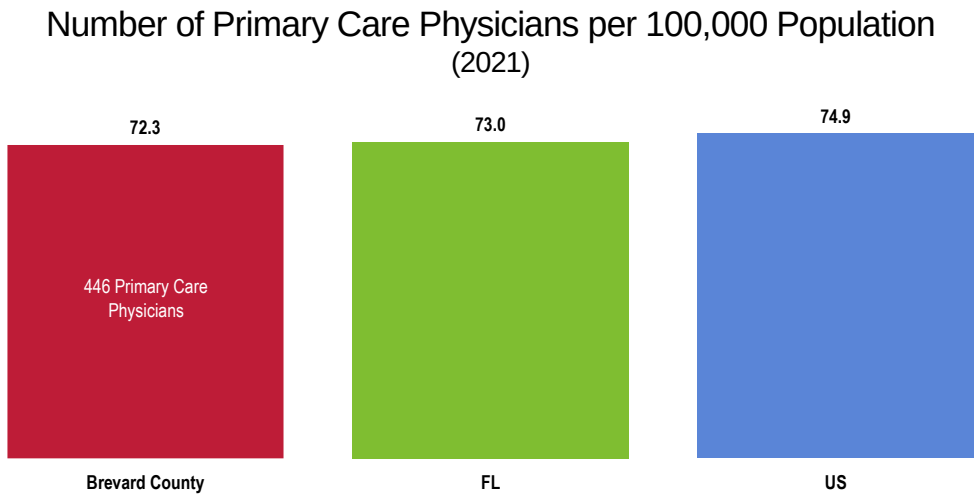
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– 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. [COUNTY-LEVEL DATA]

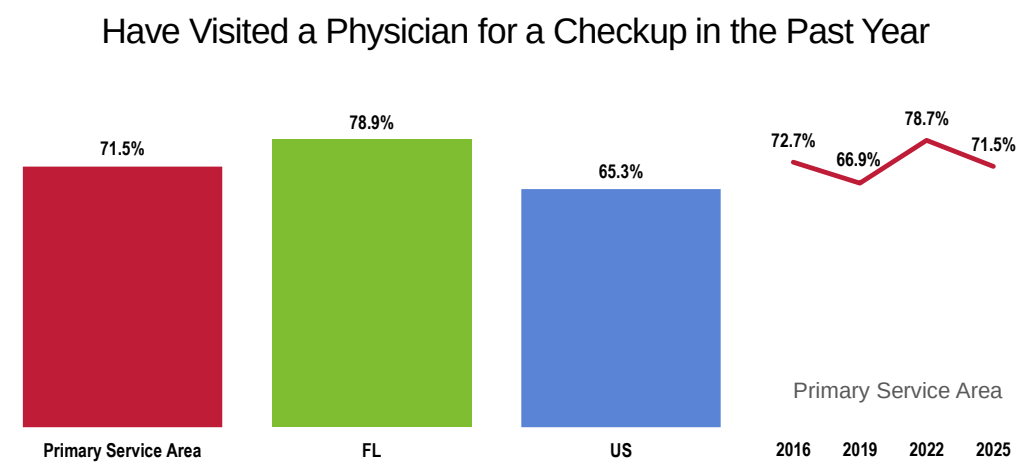


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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

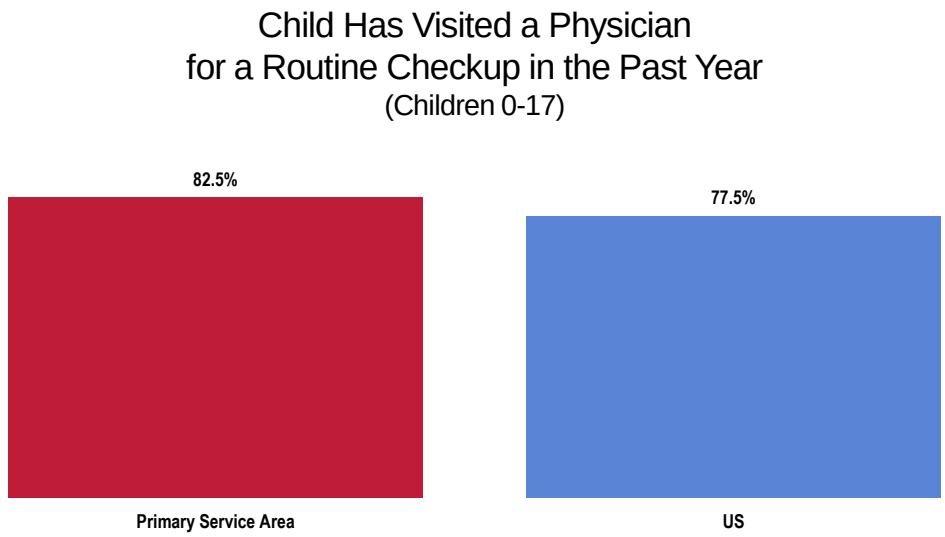
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2025 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): 2023 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

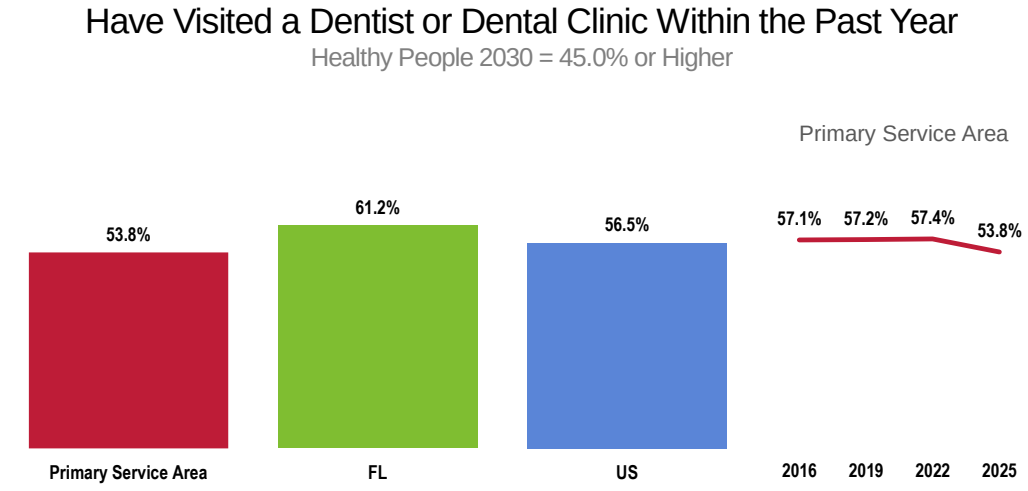
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

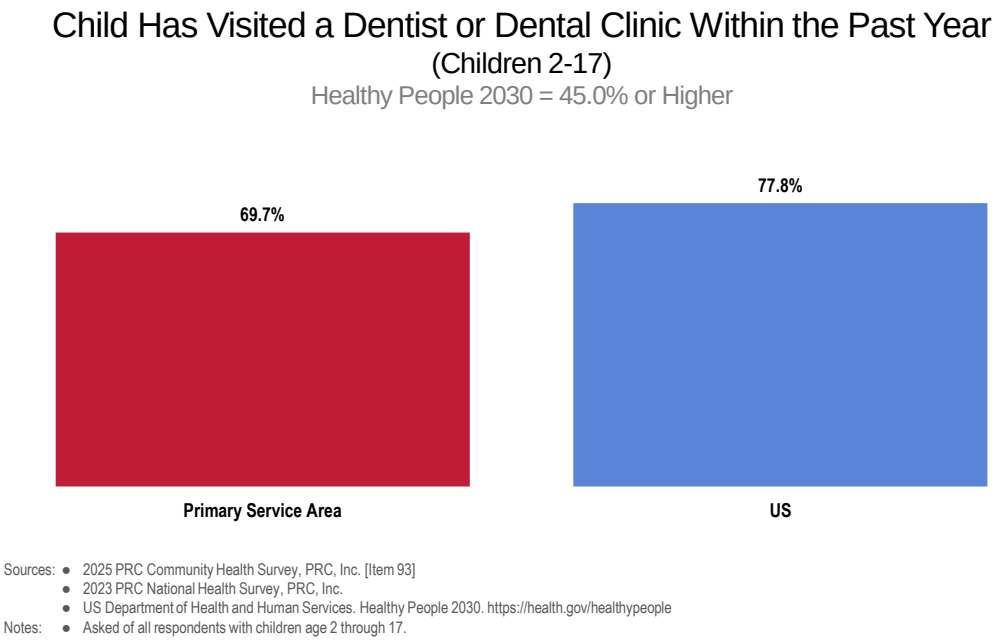
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2025 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): 2022 Florida data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

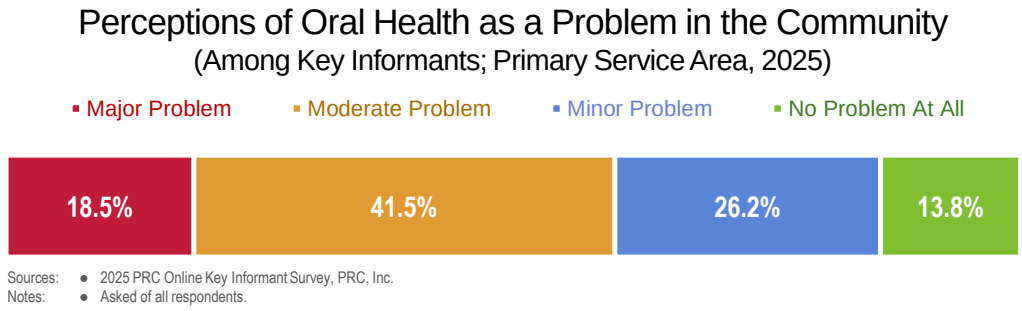
Notes:
- Asked of all respondents.

PRC SURVEY ► [Children Age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



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:

Affordable Care/Services

> Dentists are expensive and many in our community can't afford to see a dentist. — Social Services Provider
>
> I personally went without dental care for about 10 years, until my Medicare Plan offered some services. At least now I can have my teeth cleaned. It is simply way too overpriced to afford. — Community Leader
>
> Dental is very expensive and most have no dental insurance including myself. — Community Leader

Access to Care for Underinsured and Uninsured

> Lack of dental insurance, lack of resources or ability to access available resources, lack of knowledge about oral health, substance use. — Social Services Provider

Access to Care/Services

> We are scheduling months out - that alone tells me we have an issue. — Public Health Representative

Awareness/Education

> I don't feel people realize that there are places out there that will help them. — Community Leader

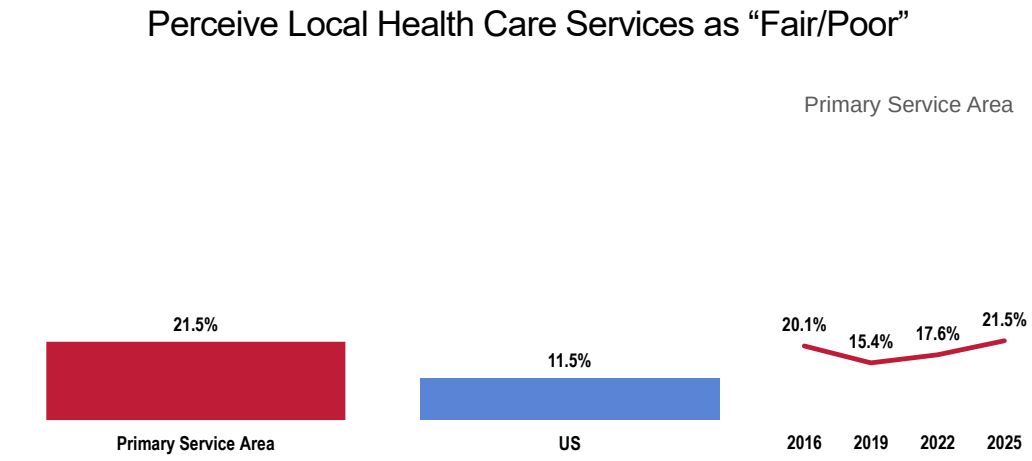
Co-Occurrences

> Oral health is directly related to self-esteem, heart health and productivity and confidence. — Community Leader

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?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
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
- Brevard County Community Action Agency
- Brevard Health Alliance
- Circles of Care
- Emergency Services
- Florida Department of Children and Families
- Florida Department of Health
- Grove Church
- Parrish Medical Center
- Primary Access to Health Clinic
- Recovery Connections of Central Florida
- Space Coast Health Centers

Cancer

- Advent Health
- American Cancer Society
- American Medical; Association
- Brevard Cancer Center
- Brevard Skin and Cancer
- Cancer Support Groups
- Cancer Treatment Center
- Community Clinic
- Health First Cancer Institute
- Parrish Health Alliance
- Parrish Healthcare Cancer Team
- Parrish Medical Center
- Relay for Life

Diabetes

- Brevard Health Alliance
- Diabetes Resource Group
- Doctors' Offices
- Health Departments
- Parrish Medical Center
- Space Coast Health Centers
- Support Groups

Disabling Conditions

- Brevard Health Alliance
- Central Florida Treatment Centers
- Coastal Physical Therapy
- Disabled American Veterans
- Joe's Club
- Lifepointe Ministries
- Medicaid
- No One Hungry
- North Brevard Charities
- Parrish Medical Center
- Recovery Advocacy Service Empowerment Project
- Recovery Connections of Central Florida
- Space Coast Health Centers
- St. Francis Reflections

Heart Disease & Stroke

- American Heart Association
- Brevard County Fire Rescue
- Complete Cardiology
- Doctors' Offices
- Florida Department of Health
- Health First Cardiac Rehabilitation
- Heart Care Centers –Titusville
- Parrish Healthcare Primary Stroke Center
- Parrish Medical Center

Infant Health & Family Planning

- Beta Pregnancy Center
- Brevard Department of Health
- Brevard Health Alliance
- Doctors' Offices
- Early Learning Coalition
- Head Start
- Health Departments
- Healthy Start of Brevard
- Space Coast Health Centers

Mental Health

- 211
- Brevard CARES
- Brevard County Natl Alliance on Mental Illness
- Brevard Health Alliance

- Brevard Health Alliance Behavioral Health Services
- Brevard Outpatient Alternative Treatment
- Catholic Charities
- Central Florida Treatment Centers
- Children's Center
- Circles of Care
- Housing for Homeless
- Joe's Club
- Lifetime Counseling Center
- North Brevard Health Partnership
- Palm Pointe
- Parrish Medical Center
- Space Coast Health Centers

Nutrition, Physical Activity & Weight

- Doctors' Offices
- Fitness Centers/Gyms
- Health Food Stores
- No One Hungry
- North Brevard Charities
- Parks and Recreation
- Parrish Medical Center
- Planet Fitness
- PSJ Sports
- Space Coast Health Centers
- YMCA

Oral Health

- Brevard Department of Health
- Brevard Health Alliance
- Florida Department of Health
- Health Departments

Respiratory Diseases

- Urgent Care

Social Determinants of Health

- 211
- AA/NA
- Adoption Center
- Brevard County Commission on the Status of Women
- Brevard County Housing Authority
- Brevard Homeless Coalition
- CareFour
- Children's Home Society of Florida
- Community Clinic
- Community of Hope
- Eckerd Connects
- Emergency Services
- Family Promise
- Food Banks/Pantries
- Grove Women's Recovery Center
- Health Departments
- Housing Authority
- Housing for Homeless
- Lifepointe Ministries
- My Access
- National Veterans Homeless Support
- No One Hungry
- North Brevard Charities
- North Brevard Health Partnership
- Parrish Medical Center
- Royal Oak Ministries
- Space Coast Health Centers
- Under the Bridge Ministries
- Women's Center

Substance Use

- 211
- AA/NA
- Beacon Recovery Center
- Brevard County Help Line
- Brevard County Prevention Coalition
- Central Florida Treatment Centers
- Churches
- Circles of Care
- Farm in Steward
- Glass House
- Groups Recover Together
- Grove Church
- Indian River Church
- New Way Recovery's Journey to Save Lives
- Overcomers
- Palm Pointe
- Park Avenue Baptist Church
- Parrish Medical Center
- Premier Addiction Recovery
- Project New Hope
- Space Coast Health Centers
- Walkabout Ministries

Tobacco Use

- Florida Quit Line
- Florida Tobacco

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit 2022-2024

Over the past three years, Parrish Healthcare, the nation's first and still only Joint Commission Integrated Care Certified system, has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

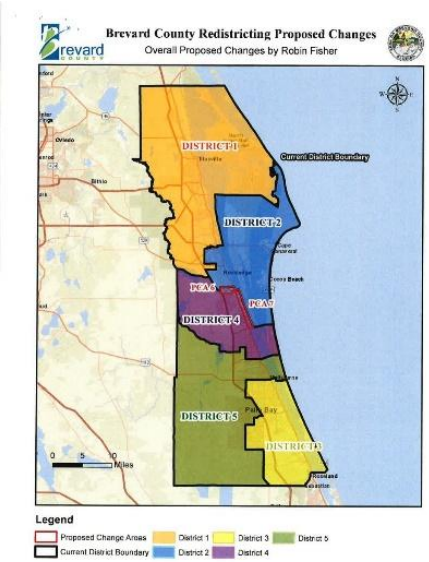
- Over $64.2 million in community benefit, (includes but not limited to charity care, community building, and benefit initiatives)
- More than $1.3 million in community contributions and other financial assistance programs (includes cash, in-kind donations/sponsorships)
- $62.9 million Uncompensated Care (care provided to uninsured, homeless, most vulnerable persons who may not otherwise have received care).

CBISA Report 2022-2024

Category	Encounters
Community Health Education	31,544
Health Support Services	1,120
Community Health Improvement Services	43,474
Health Professions Education	1,474
Cash and In-Kind Donations	230,598
Community Building Activities	720
Total Encouters	308,930

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

North Brevard Community Snapshot



Social Vulnerability Index:
High Risk; 75th to 95th percentile

The Social Vulnerability Index information is based on the CDC data related to 4 social vulnerabilities: Socioeconomic Status, Household Characteristics, Racial & Ethnic Minority Status, Housing Type & Transportation. In this analysis, Social Vulnerability means: Risk = (Vulnerability-Resources) * Volume. To mitigate risk, a population must have the same magnitude of resources as it does vulnerability.)

Population **99,329**	**Poverty Level** **25.6**
% Uninsured **10.5%**	**% Medicaid/Medicare** **70.5%**

Addressing Significant Health Needs

Parrish Healthcare conducted its last Community Health Needs Assessment (CHNA) in 2022 and reviewed the health priorities identified through that assessment. Considering the top-identified needs — as well as hospital resources and overall alignment with the health system's mission, goals and strategic priorities — it was determined at that time that Parrish Healthcare would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Health Care Services
- Heart Disease & Stroke
- Diabetes

Strategies for addressing these needs were outlined in Parrish Healthcare's Implementation Strategy available online at parrishhealthcare.com. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Parrish Healthcare to address these significant health needs in our community.

Planned Actions

Planned Actions	Community Need Impact Areas			
	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Maintain Joint Commission Integrated Care Certification.	✓	✓	✓	✓
Maintain national quality accreditations (e.g. Baby-Friendly, Primary Stroke, CoC, NCQA)	✓	✓		✓
Utilize community outreach mechanisms to raise awareness and educate the North Brevard county adult population about available resources.	✓	✓	✓	✓
Rank in the top 10% in the nation for quality and safety as measured by CMS, LeapFrog, and other national health ranking agencies	✓	✓	✓	✓
Operate Parrish Medical Group (PMG) primary and specialty care providers; nationally certified as a medical home; expand network of providers to improve availability of appointments and provider ratios.	✓	✓	✓	✓

Planned Actions Continued

Utilize care navigator program to offer interventions and care coordination to remove barriers and improve adherence to the self-management regimen.	✓	✓	✓	✓
Affiliate with strategic clinical partners (e.g. Cleveland Clinic) to provide access to tertiary and quaternary care	✓	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, Cleveland Clinic, etc.).	✓	✓	✓	✓
Utilize evidence-based state, regional and national resources such as Vizient Southeast to develop policies, protocols, and training for care partners (employees, medical staff, volunteers); e.g. behavioral health screenings, SDOH screenings, zero harm policy, etc.	✓	✓	✓	✓
Continue to serve as the area's lowest cost, highest quality provider	✓	✓	✓	✓
Offer financial assistance to qualified patients and help patients with no insurance to qualify for Medicaid, Medicare or other means of coverage.	✓	✓	✓	
Affiliate with most commercial insurances plans and participate in Medicare and Medicaid and continue to qualify as a Disproportionate Share Hospital.	✓	✓	✓	
Utilize evidence-based health screenings and risk assessments within community, primary care, hospital, and post-acute settings.	✓	✓	✓	
Partner with MedFast Urgent Care to provide quality alternative for non-emergency care needs.	✓	✓	✓	
Partner with Space Coast Health Centers, a federally qualified look-alike for improved access to primary, specialty and behavioral health care to the medically underserved.	✓	✓	✓	
Continue to support Peer Recovery program within the Emergency Department for persons ready to address their substance abuse condition.	✓	✓	✓	
Offer Occupational Health and Employee Wellness Programs focused on primary care assignments, health coaching and preventative wellness screenings	✓	✓	✓	
Operate appropriate complement of outpatient centers, programs, and services.	✓	✓	✓	
Implement chronic care management and remote patient monitoring program to support post-acute disease management.	✓	✓	✓	
Partner with key charitable and civic organizations aligned with addressing the key areas of priority (e.g. Children's Advocacy Center, Rotary Clubs, Parks and Rec, Junior Achievement, Boys & Girls Club, Eckerd Connects, etc.)	✓	✓	✓	
Were the initiatives implemented? Yes/No/Partially	Yes	Yes	Yes	Yes

Impact of Activities

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Increased the proportion of North Brevard adult population who complete an age, gender, condition-specific health risk assessment/screening and receive referrals to needed resources. ✓ PMG Providers complete nearly 32,000 early detection screenings from 2022-2024, representing an increase of more than 2,000 from 2022. ✓ Partnered with HealthAware to deploy free Health Risk Assessments and Care Navigation Services for Heart, Diabetes, Stroke, Diabetes, Breast Cancer, Colon Cancer, Joint Health and Sleep Health. Visit https://www.parrishhealthcare.com/patients-visitors/health-risk-assessment/. Investment in additional marketing and promotion to raise awareness and completion rates. ✓ Parrish Healthcare Care Navigators follow up with those scoring “at risk” for a chronic condition and make referrals accordingly. ❖ 385 patients referred to specialists	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Improved community perception of access to providers/services. ✓ Improved Google Rating from 2.8 to >4 Star and rising for Parrish Medical Center and Parrish Medical Group. ✓ Provider star rating transparency. Each provider has his/her personal star rating as rated by patients displayed within their profile allowing consumers to make informed decisions about where to seek care. Average rating for PMG providers is > 4 stars. ✓ All Parrish Medical Group primary care physician members are certified Patient Centered Medical Home. This puts PMG in the top 20 percent of all primary care providers in the nation regarding quality, cost and access. ✓ Parrish earns, maintains and publicizes numerous other quality- of-care accreditations and certifications from National Committee for Quality Assurance (NCQA), The Joint Commission, Commission on Cancer, American College of Surgeons to name a few. ✓ A list of hospital-credentialed physicians is located on our website and is promoted through investments in advertising and community outreach resources. More tens of millions of media impressions are achieved annually.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Increased early detection of disease among population served. ✓ Parrish Healthcare maintains a 4 .5 Star HEIDS rating indicating Parrish Medical Group Primary Care Providers are completing the necessary age-specific early detection screenings and immunizations in accordance with best-practices, as examples: ✓ PMG Providers complete nearly 32,000 early detection screenings from 2022-2024, representing a more than 2,000 increase from 2022.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Reduced avoidable hospital readmissions among population served. ✓ National hospital readmission rates are between 15% and 20%. Parrish Healthcare's readmissions rates are below the national average at 13.8%. Achieved through effective logistics center (Mission Control), Case Management and Care Transitions process, procedures and resources.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Reduced avoidable emergency room visits among population served. ✓ Deployed a multi-pronged Emergency Department process improvement initiative in collaboration with Team Health, Space Coast Healthcare Centers (federally qualified clinic) and Parrish Medical Group, to ensure patients are receiving the care in the right care setting and have an assigned medical home. ✓ Our process improvement initiate aligns with the requirements of the Nonemergent Care Access Plan Bill (CS/SB 7016—Health Care), and will result in in our plan to reduce the burden on the Emergency Department when patients rely on it as a substitute for primary care and/or urgent care. The plan will outline our strategy for educating and redirecting such patients to suitable primary care resources, in compliance with the CS/SB 7016.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Improved access to primary care and specialty care in North Brevard. ✓ Post Pandemic we lost approximately 70 providers; we have successfully replaced them and added additional providers specializing in OB/GYN, Interventional Cardiology, Interventional Radiology, Gastroenterology, Urology, among others. ✓ Structured a new relationship with Health First to enhance access to care countywide. ✓ Affiliate with most major health insurance companies and provide uninsured patient's assistance in enrolling with a health plan ✓ Provided the start up funding, approximately one million dollars, for Space Coast Healthcare Centers, a federally qualified clinic to provide access to care for persons uninsured or underinsured. ✓ Increased primary care visits by more than 50,000 visits from 2022 to 2024 and increase specialty care visits by nearly 8,000 in that same time period. ✓ Name among the nation's top 14% of Maternity care Access hospitals by U.S. News and World Report; special recognition of hospitals that serve communities that depend on them for access to vital maternity services. Without essential hospitals like Parrish Medical Center, the community would be in danger of becoming a maternity care desert.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Improved access to chronic disease-management programs/services in North Brevard. ✓ Implemented Remote Monitoring Chronic Care Navigation program within Parrish Medical Group Primary Care Practices in 2024. Hired a navigator and invested in equipment to be placed in patient's home for convenience and real-time intervention of worsening symptoms preventing unnecessary emergency department visit or hospitalization. ✓ Our Population Health and Care Navigation activities from 2022-2024 resulted in persons with one or more chronic conditions, without an assigned primary care provider, or with little to no health insurance gaining access to needed programs and services. ❖ 2,255 patients enrolled in our Care Navigation program ❖ 454 patients previously unassigned successfully assigned to a primary care provider ❖ 568 patients assisted in scheduling important follow-up appointments ❖ 111 patients enrolled in substance use recovery services, including but not limited to Narcotics Anonymous, Alcoholics Anonymous, Detoxification (Meant for alcohol and/or or substances), inpatient programs, and Medication-Assisted Treatment ❖ Over 1,264 patients achieved an average A1C reduction of 1%. ✓ Provide the area's only Diabetes Care Navigator program, complete with diabetes education, access to supplies for the underserved and support group facilitation.	✓	✓	✓	✓

Impact of Activities	Community Need Impact Areas			
Expected Results/Impact	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Increase patients with identified SDOH reporting improvement. ✓ **97.3%** of hospitalized patients screened for SDOH.	✓	✓	✓	✓

Summary of Impact Achieved

We Believe in Our Community

North Brevard County Hospital District d/b/a Parrish Medical Center is proud to be Brevard County's only independent, **PUBLIC**, not-for-profit community medical center, since 1958. It is an honor to be designated as a public, not-for-profit, health system. It means that every dollar earned is a dollar invested in programs, services, technology, and health professionals dedicated to improving the health and wellbeing of our North Brevard community members. Decisions about the health priorities in which to invest available resources are made based on the results of the comprehensive community health needs assessment, specific to North Brevard, that Parrish conducts every three years with input from a community health advisory committee and other community stakeholder groups.

As North Brevard's independent, public, not-for-profit community health system we do not answer to corporate investors or shareholders. We answer to the citizens of North Brevard. We are proud to summarize our community impact and the many impactful ways we are fulfilling our not-for-profit mission—And, doing so, with **ZERO TAX DOLLARS FOR MORE THAN 30 YEARS**. Whereas, other hospitals across the state with taxing authority have levied billions of dollars of taxes on their citizens over the years, Parrish Healthcare, has not. The following summary is not intended to be an all-inclusive catalogue of our vast community benefit initiatives, programs and services, but will provide a snapshot of our impact.

Addressing Health Equity and Social Determinants of Health

❖ Addressing Food Insecurity and Feeding People in Need

Parrish Healthcare, annually, donates hundreds of pounds of hams and turkeys to feed upwards of 600 families during the holidays. Donations are made to local charities, food pantries and churches all dedicated to providing hunger relief and serving meals to people in need during the holidays.

❖ Access to Clean Water

Parrish Healthcare's Parrish Medical Center sits on the banks of the Indian River Lagoon. The health of the lagoon has broad impact to access to clean water to our community and beyond. Parrish Healthcare supports the Brevard County Marine Resource Council and the Save Our Indian River Lagoon Projects in partnership with scientists, economists, environmentalists and multiple government agencies. Local projects planned to meet water quality targets and improve the health, productivity, aesthetic appeal, and economic value of the lagoon.

❖ Community Asset Mapping

We are leading the effort to create a community asset map for North Brevard. Community asset mapping is a strength-based approach to community development. Through this initiative we are identifying and documenting the organizations, individuals, and citizen associations existing within our North Brevard communities that serve as positive resources in address social determinants of health. In doing so, we are able to identify gaps and develop plans to close those gaps and address community needs.

❖ Essential Access Hospital for Maternity Care

U.S. News & World Report, the global authority in hospital rankings and consumer advice, named Parrish Medical Center a Maternity Care Access Hospital. U.S. News' Best Hospitals for Maternity Care ratings recognize hospitals offering essential maternity services to underserved communities. The **Maternity Care Access Hospital** designation recognizes essential hospitals serving communities that would be in danger of becoming maternity care deserts if they were to stop providing crucial maternity care services. Additionally, Parrish Healthcare is recognized by Florida Blue, the state's Blue Cross Blue Shield plan, with a Blue Distinction® Centers+ (BDC+) for **Maternity Care** designation. The program plays a key role in the Blue Cross Blue Shield Association's (BCBSA) National Health Equity strategy aimed at reducing racial health disparities.

❖ Uniting to Count and Support Homeless Persons in North Brevard

Parrish Healthcare collaborated with the Brevard Homeless Coalition, North Brevard Charities, LifePointe Ministries and Under the Bridge Ministries to help coordinate and participate in the annual Point in Time (PIT) Count. This was part of a national annual initiative, held during the last full week in January, to gain a snapshot of homelessness and service gaps in communities across America. In North Brevard, dozens of volunteers from the five organizations, and several other supporting local organizations, dedicated January 23-29, 2025, to this endeavor to get as accurate a count as possible.

❖ Providing Mental Health and Substance Use Disorder Lifelines

For people on the path of recovery from a mental health diagnosis or addictions, Parrish Healthcare, in partnership the Space Coast Healthcare Centers, offers several programs to assist including access to mental health services with on-site psychiatrist; access to a behavioral health specialist; and Peer Recovery Specialists (PRS) to help guide the journey. The path to recovery is made easier when a person walking it knows they are not alone, and that with them is someone who has shared experiences and has recovered from them.

❖ High Value- Low Cost - Health Care Provider

According to the Florida Center for Health Information and Transparency, a service of the Agency for Health Care Administration, Parrish Medical Center provides high quality health care at the lowest costs in the area and lower lengths of stay. The report validates that we are a high value provider of health care. For details please visit https://www.parrishhealthcare.com/about-us/quality-safety/ or visit www.floridahealthfinder.gov. For example, following are a few highlights from this report (2022):

Cost of care

- Diabetes - PMC is 36% lower than state average
- Heart Failure - PMC is 43% lower than state average
- Childbirth- PMC is 38% lower than state average
- Cancer – PMC is 35% lower than state average
- Orthopedics – PMC is 44% lower than state average

Readmission

- Heart Failure- PMC is 50% lower than state average
- Pneumonia- PMC is 33% lower than state average

Advancing Medicine Through Innovation and Technology

❖ First U.S. Cleveland Clinic Connected Member

After passing a rigorous review of Parrish Medical Center's operations, quality and service excellence, Cleveland Clinic has accepted Parrish Medical Center as the first domestic member of Cleveland Clinic Connected. As a Cleveland Clinic Connected member, Parrish Medical Center clinicians will be able to access educational opportunities either at Cleveland Clinic or through distance learning, as well as best practices and protocols that are used at Cleveland Clinic locations worldwide.

❖ Brevard's first hospital to provide atrial fibrillation patients with same-day ablations

Same-day ablations enable patients to be treated as outpatients. This reduces costs and allows patients to quickly receive relief and return home. We studied and reviewed the advantages of same-day ablation and concluded that it is a procedure with significant benefits for patients seeking freedom from AFib and were the first hospital in Brevard to offer this service. A cardiac ablation procedure uses heat or cold energy to create tiny scars in the heart to block irregular electrical signals and restore a typical heartbeat. The procedure is used to correct heart rhythm problems (arrhythmias). In same-day ablation, a surgeon uses catheters—thin, flexible tubes—inserted into the heart via veins or arteries, to apply the heat or cold that stops the errant electrical signals causing AFib.

❖ First in Brevard to Use VELYS Robotic-Assisted Solution Technology

Parrish Healthcare is first in Brevard to use and offer the VELYS™ Robotic-Assisted Solution—advanced technology designed for digital precision and accuracy in total knee replacement. Every knee is different, as is every patient requiring a knee replacement procedure. Patients are often looking for the latest technology as they aim for improved outcomes, increased movement and shortened recovery time. The VELYS™ Robotic-Assisted Solution technology helps surgeons perform a knee replacement with the use of data that's tailored to each patient's anatomy. This technology helps ensure predictable results to improve outcomes, increase mobility and help patients recover faster.

Community Health Education

Our family of Care Partners helped our community learn how to be and stay healthy by providing health screenings, workshops, seminars, as well as digital and printed resource materials across Brevard County.

- Nearly **309,000** community encounters with our workshops, classes, seminars, health fairs, and support groups.
- Our digital, print, and broadcast health content—resulted in **tens of millions of impressions**, assuring access to relevant health information to the community we serve.
- Personalized health portals providing access to communicate with physicians, schedule appointments, prescription refills, and lab results.

Community Support Groups

- Amputee Support Group of Titusville
- A.W.A.K.E Sleep Support
- Cancer and Survivor Support Group
- Caring for Caregivers Support Group
- Diabetes Support Group
- Early Steps Community Play Date
- Fearless Café
- Five Wishes
- Kidney Smart Class
- Mom's Support Group
- Stroke and Heart Survivors Support Group
- Tools to Quit Smoking Now

Reaching Out for Improved Quality of Life

We are proud to have the opportunity to support with financial and in-kind donations, as well as participation in fundraising and awareness events with the following community partners:

- Aging Matters
- American Cancer Society
- American Heart Association
- Big Brothers Big Sisters
- Brevard Indian Medical and Dental Association
- Boy Scouts of America
- Boyz to Men
- Brevard Achievement Center
- Children's Advocacy Center
- Healing in Motion Van Transportation
- Junior Achievement
- LEAD Brevard
- Local churches, schools and sports leagues
- March of Dimes
- Moore Heritage Cultural Center, plus other local cultural events and organizations
- National Veteran's Homeless Support
- North Brevard Charities
- North Brevard Coalition of Human Services
- North Brevard NAACP
- Pilot Club
- Prevent of Brevard
- Promise in Brevard
- Sentinels of Freedom
- Space Coast Economic Development Commission
- Titusville Area Chamber of Commerce
- Titusville Rotary Club
- The City of Titusville
- United Way
- Women's Center
- YMCA Family Center