2014-16 Community Health Plan

Florida Hospital Waterman conducted a Community Health Needs Assessment (CHNA) in 2013. With oversight by a community-inclusive Community Health Needs Assessment Committee, the Assessment looked at the health-related needs of our broad community as well as those of low-income, minority and underserved populations[i]. The Assessment includes both primary and secondary data.

The Community Needs Assessment Committee, hospital leadership and the hospital board reviewed the needs identified in the Assessment. Using the Priority Selection processes described in the Assessment, the Committee identified the following issues as those most important to the communities served by our hospital. The hospital Board approved the following priorities and the full Assessment.

1. Colon Cancer
2. Breast Cancer
3. Obesity
4. Heart Disease
5. Access to Care

With a particular focus on these priorities, the Committee helped ___ develop this Community Health Plan (CHP) or "implementation strategy[ii]." The Plan lists targeted interventions and measurable outcome statements for each effort. Many of the interventions engage multiple community partners. The Plan was posted by May 15, 2014 at the same web location noted below.

Florida Hospital Waterman's fiscal year is January-December. For 2014, the Community Health Plan will be deployed beginning May 15, 2014 and evaluated at the end of the calendar year. In 2015 and beyond, the Plan will be implemented and evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be posted annually and attached to our IRS Form 990.

If you have questions regarding this Community Health Plan or Community Health Needs Assessment, please contact Steven Jenkins, Community Benefit Manager, at steven.jenkins@ahss.org.

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[i] The full Community Health Needs Assessment can be found at www.floridahospital.com/waterman under the Community Benefit heading.

[ii] It is important to note that this Community Health Plan does not include all Community Benefit activities. Those activities are noted on Schedule H of our Form 990.

Florida Hospital Waterman

2014-2016 Community Health Plan

OUTCOME GOALS						OUTCOME MEASUREMENTS								
CHNA Priority	**Outcome Statement**	**Target Population**	**Strategies/Outputs**	**Outcome Metric**	**Current Year Baseline**	**Year 1 Outcome Goal - #**	**Year 1 Actual**	**Year 2 Outcome Goal - #**	**Year 2 Actual**	**Year 3 Outcome Goal - #**	**Year 3 Actual**	**Hospital $**	**Matching $**	**Comments**
Colon Cancer	Increase education and awareness of the benefits of colon cancer prevention to more than 75% of population	Adults, age 50+	Promote education through paid and earned media; health and wellness classes held at CREATION Health	Communication reach via earned and paid media through communication distribution and media affidavits	0	Communication reaching > 20% of PSA		Communication reaching > 40% of PSA		Communication reaching > 75% of PSA		Staff time, media costs, advertising ($15,000 per year)	N/A	
	Increase distribution of free FOBT kits to more than 250 community members	Adults, age 50+, Focus on low income/minority populations	Increase total number of FOBTs distributed to the community through health fairs and outreach to churches and community groups	Number of FOBT kits distributed	156	175		200		250		Staff and procedural time - $12 per FOBT screening	N/A	Current screening compliance rates: Lake 58.1%, Florida 56.4%, US 61.8%, 2020 Goal 70.5%
	Increase number of gastroenterology providers in the market to 10	Adults, age 50+	Recruit new providers to the primary service area	Number of providers in the primary service area	8	1				1		TBD	N/A	
	Educate 150 health care providers in regarding cancer patient navigator services	Health care providers	Introduce and operationalize cancer coordinator/patient navigator	Number of providers (physicians and extenders) educated - 150 identified providers	0	24 provider education sessions		75 providers educated (total)		150 providers educated (total)		Existing staff time - physician relations. $5,000 materials per year	N/A	

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
Breast Cancer	Increase participation (including screening rates) in Pink Army by 25%	Women, age 40+	Engage women to get take part in Pink Army campaign to increase awareness, education and compliance with screening mammograms	Increase number of women engaged in the Pink Army	2013 enlistees: 2,039; Engaged: 14%; Resulting mammos: 69	Increase number enlistees by 10% ; Increase percentage of engaged participants to 16%; Increase resulting mammos to 75		Increase number enlistees by 10% ; Increase percentage of engaged participants to 18%; Increase resulting mammos to 80		Increase number enlistees by 10% ; Increase percentage of engaged participants to 25%; Increase resulting mammos to 100		Annual advertising and campaign costs - $45,000	N/A	
	Provide and promote discounted screening mammograms; educating more than 75% of the population	Women, age 40+, uninsured	Provide and promote low cost screening mammograms	Communication reach via earned and paid media through communication distribution and media affidavits	N/A	Communication reaching > 20% of PSA		Communication reaching > 40% of PSA		Communication reaching > 75% PSA		Annual promotion costs - $7,000	N.A	
Obesity	Conduct 2 sessions of Fitness for Life Class through CREATION Health per year	Adults	Provide and promote health and wellness courses through CREATION Health Center	Total number of sessions held, number of participants	2; 13	2; 40		2; 50		2; 75		CREATION Health Grant		Overweight and obesity rates in Lake County 2010: 67.9%; 65.0% in Florida
				Percentage of "graduate" who report greater knowledge of healthy eating skills										

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
	Increase participation and completion rate in employee/ community weight loss programs by 5% each year	Adults, Employees	Encourage healthy eating and weight loss through employee and family programs	Total number of participants who complete the program	266, 55 complete	Increase completion rate by 5%		Increase completion rate by 5%		Increase completion rate by 5%		CREATION Health Grant		
				Percentage of "graduates" who report greater knowledge of healthy eating skills		85%		88%		90%				
	Provide a minimum of 1,000 free BMI screenings in the community over the next three years	Adults	Provide community BMI screenings and education	Total number of people screened	250	500 total BMI screenings		750 total BMI screenings		1,000 total BMI screenings		Staff costs - approximate < $5 prescreening		
				Percentage of people with BMIs > 40% who are referred to a physician or healthy eating programs		90%		92%		95%				
Heart Disease	Educate and motivate community through 1,500 heart disease risk screenings and assessments	Adults	Provide community heart disease screenings and health assessment including BP and cholesterol	Total number of screenings	N/A	250 screenings		500 screenings		750 screenings		Approximate $15.50 per screening		Lake County hypertension and high total cholesterol rates are significantly higher than FLA and national averages

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
				Percentage of people found to be at high risk who are referred to a physician for follow-up care		90%		92%		95%				
	Increase traffic to online education and health assessment by 5% for the next three years	Adults	Free online education and assessment tool	Total number of participants	TBD	Increase total number of participants by 5%		Increase participation by 5%		Increase participation by 5%		$7,000 development and $1,000 annual; $35,000 annual promotion costs		
	Support providing 2,500 free blood pressure screenings in the community	Adults	Sponsor free blood pressure screening kiosks at local Publix Supermarkets	Total number of screenings	0	Provide 2,500 screenings		Increase total number of participants by 5%		Increase total number of participants by 5%		$1,600 per month; $2,500 startup costs		
	Financially incentivize non-smoking among employees and family members	Employees and families	Screen and provide health insurance premium discounts for non-smoking employees and family members	Smoking rates among employees and	TBD	Decrease smoking rate by 5%		Decrease smoking rate by 5%		Decrease smoking rate by 5%		Discount price - TBD		
			Promotion of smoking cessation programs	Distribution of smoking cessation program education to smokers identified through employment screening	N/A	Distribute materials to 70% of identified smokers		Distribute materials to 80% of identified smokers		Distribute materials to 90% of identified smokers		$250 for materials		

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
Diabetes	Provide and promote diabetes education course	Adults newly diagnosed with diabetes	Introduce diabetes education course covered by insurance with scholarships available	Total number of classes held; Total number of class participants	N/A	Hold 6 classes with 75 participants		Hold 10 classes with 125 participants		Hold 10 classes with 150 participants		Program start-up costs; Class costs	No other providers are offering diabetes education classes	
	Provide 225 free glucose screenings and diabetes education to identified audiences	African-American, Hispanic Adults	Screen identified audience for elevated glucose levels	Total number of screenings	N/A	Provide 50 free screenings		Provide 75 free screenings		Provide 100 free screenings		Screening costs	Focus on churches and community centers	
				Percentage of people with elevated glucose levels who are referred to diabetes education classes		90%		92%		95%				
				Percentage of people with elevated glucose levels who are referred to a physician		90%		92%		95%				
Access to Care	Maintain number of patients visits provided through the Family Health Clinic around 3,000 per year	Residents living below 130% of the poverty level	Provide free health services to resident of Lake County	Total number of clinic visits	3,143	Retain total number of patient visits > 3,000		Retain total number of patient visits > 3,000		Retain total number of patient visits > 3,000		$112 per visit		
	Increase total number of primary care providers in Lake County by adding additional providers	Lake County residents	Recruit new providers to the area	Number of newly recruited providers	Current number of providers	Increase providers		Increase providers		Increase providers		Cost to recruit new providers		

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
	Transition at least 20% of patients identified as low-income without a primary care provider to the Primary Health Clinic	ER patients without a primary care provider and eligible for care through Primary Health Clinic	Outreach and assistance to schedule and see the patient through the Primary Health Clinic	Conversion rate of identified patients to Primary Health Clinic	40.51%	Maintain at least 20% conversion rate		Maintain at least 20% conversion rate		Maintain at least 20% conversion rate		$112 per visit; program and tracking costs		
	Establishment of transitional care program to reduce avoidable patient readmissions	Identified patients at risk for readmission with AMI, CHF, pneumonia	Clinical outreach and follow up with patients before discharge	Percentage of readmissions among identified patients	30%	< 20%		< 18%		< 16%		Programs Cost		