WINTER PARK MEMORIAL HOSPITAL
A Florida Hospital

2014-16 Community Health Plan

May 15, 2014

Florida Hospital Winter Park conducted a tri-county Community Health Needs Assessment (CHNA) in 2013 in collaboration with Orlando Health, Aspire Health Partners (formerly Lakeside Behavioral Health Center), the Orange County Department of Health, and the Health Council of East Central Florida. With oversight by a community-inclusive Community Health Impact Council that served as the hospital's 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 collaborative first reviewed and approved the Community Health Needs Assessment. Next, 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, hospital leadership and the Council identified the following issues as those most important to the communities served by Florida Hospital Winter Park. The hospital Board approved the priorities and the full Assessment.

1. Obesity
2. Diabetes
3. Chronic Disease Management

With a particular focus on these priorities, the Council helped Florida Hospital Winter Park 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 Winter Park's fiscal year is January – December. For 2014, the Community Health Plan will be deployed beginning May 15 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 Verbelee Nielsen-Swanson, Vice President of Community Impact, at Verbelee.Nielsen-Swanson@flhosp.org.

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

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

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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**
Obesity/ Chronic Disease Management/ Healthy Central Florida Initiatives	Continue to support "walking school bus" program through Healthy Central Florida in cooperation with the Winter Park Health Foundation	Children from schools enrolled in interventions	Promote through Winter Park Consortium schools via "Walk and Roll" every Monday and Wednesday	Number of children who participate in program	412	450		500		550		$290,000	$290,000 (Winter Park Health Foundation)	Staff support and promotion/ marketing
	Facilitate walking programs that aid in increasing leisure time physical activity	Eatonville, Maitland, and Winter Park residents	"Walk and talk with the Mayor", "Walk with a doc," "Mayors Sole Challenge", and "Maitland Walks"	Number of residents who participate in walking interventions	490	705		820		925		$290,000	$290,000 (Winter Park Health Foundation)	Staff support; promotion/ marketing
	Increase the likelihood of medication adherence among uninsured patients	Uninsured and underinsured patients	Provide prescription medications at little to no cost to the patient	Total cost of prescription medications disbursed to patients	$45,071	$45,000		TBD		TBD				
	Engage Florida Hospital Medical Group (FHMG) providers to continue meaningful use measures and create CERNER automation to refer obese patients into weight management practice	Patients of the 5 FHMG primary care practices in the primary service area (PSA)	Build an automated flag into the medical record that prompts referral into weight management program for all patients with BMI over 30	Proportion of patient encounters that include a referral into weight management	0	10% increase from baseline		10% increase from year 1		10% increase from year 2		Hospital providing personnel and software maintenance		
	Support and create opportunities for increased quality of life for residents of Eatonville, Maitland, and Winter Park	Residents of Eatonville, Maitland, and Winter Park	Healthy Central Florida to support, draft, and influence policy changes that support community development such as smoke-free resolutions	Number of adopted policies that support community health	5	Continue to support the implementation of resolutions already passed		Continue to support the implementation of resolutions already passed		TBD		Leadership and support		
	Provide opportunities for increasing social capital and physical activity	All residents of Central Florida	Annual 5k and 10k races	Number of persons who participate	18,000	Increase annually by 1%		Increase annually by 1%		Increase annually by 1%				

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	**Create awareness for international walk to school day and national bike to school day	Children who attend Lake Sebelia school	Promote through Winter Park Consortium schools via "Walk and Roll" every Monday and Wednesday	Number of children who participate in program	412	450		500		550		$290,000 to Healthy Central Florida from Florida Hospital	$290,000 to Healthy Central Florida from Winter Park Health Foundation	Staff support and marketing
	Increase knowledge of and accountability for physical activities	Eatonville, Maitland, and Winter Park	3 days a week for 30 minutes a day for 3 months; including online and social media accountability check points	Number of participants	TBD	TBD		TBD		TBD				
	Provide services designed to meet the needs of geriatric patients with a chronic illness	Geriatric patients in the primary service area (PSA)	Geriatric residency program, through longevity medicine institute	Number of patients aged 70 or older seen in the geriatric emergency department	0	1,216		TBD		TBD		TBD		
	Provide services designed to meet the needs of geriatric patients with a chronic illness	Geriatric patients in the PSA	Health navigators for patients 65 and older on an inpatient, outpatient, and emergency department (ED) level	Number of geriatric patients who receive education from a health navigator	0	TBD		TBD		TBD				
	Support efforts to reduce heart related conditions through the funding of research and programs	Residents of the primary service area	Provide support and board membership to the American Heart Association	Value of support	$100,000	$100,000		$100,000		$100,000		$100,000		
			Encourage employee participation in the annual Heart Walk	Number of FH walkers	500	600		650		675				
	Increase opportunities for leisure time physical activity in a social setting	Residents of the primary service area	Annual Healthy 100 sponsored community Run for Rescues, SPCA 5k	Participation in 5k	0	300		350		400		In-kind support		Staffing and promotion

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	Offer education program aimed at increasing energy via nutrition, stress management, and exercise	Spouses of Florida Hospital employees (who are not also employed by the system)	Energy for Performance 4-hour workshop	Number of non-employees who attend class	173	180		200		220		In-kind staff support and materials		
	** Provide education to increase knowledge of and positive behaviors toward healthy eating and exercise	Children in the primary service area (PSA)	Mission FIT Possible Program for children	Number of children who have completed program	3,461	3,600		3,650		3,700		$130,000	$170,00	Staffing and operational support
	Reduce household food insecurity by introducing low cost, SNAP eligible, fresh fruit and vegetable options to the community	Residents of Eatonville	Deploy Hebni Nutrition Consultants' Mobile Farmer's Market to stop in Eatonville once per week	# of individuals who purchase produce from Mobile Farmer's Market	0	2,000		4,000		6,000		$329,050 over 2 years	$550,000 over 3 years	Hebni Nutrition Consultants
				Value of support donated to operate the Mobile Farmer's Market	0	$218,850		$110,200		TBD				Hebni Nutrition Consultants
	Increase the availability of fruits to the diets of the population aged 2 and older	Residents of Eatonville	Deploy Mobile Farmer's Market to provide fresh fruits and vegetables alongside education opportunities	Report of increased consumption by persons aged 2 and older	0-0.5 cup equivalent per 1,000 calories	0.5 cup equivalent per 1,000 calories		0.7 cup equivalent per 1,000 calories		0.9 cup equivalent per 1,000 calories		$329,050 over 2 years	$550,000 over 3 years	Hebni Nutrition Consultants
	Increase the availability of total vegetables to the diets of the population aged 2 and older	Residents of Eatonville	Mobile Farmer's Market offering food and education to stop in Eatonville once per week	Report of cup equivalent total vegetables consumed by persons aged 2 and older	0-0.8 cup equivalent per 1,000 calories	0.8 cup equivalent per 1,000 calories		1.0 cup equivalent per 1,000 calories		1.1 cup equivalent per 1,000 calories				Hebni Nutrition Consultants
	**Offer educate program aimed at increasing energy via nutrition, stress management, and exercise	Spouses of Florida Hospital Employees (who are not also employed by the system)	Energy for Performance 4-hour workshop	Number of non-employees who attend class	173	180		200		220				

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Access to Care	**Increase the availability of free or low-cost mammograms	Uninsured and underinsured women in PSA	Women's mobile coach sites and diagnostic centers	Number of women who are screened	3,906	3,980		4,056		4,133		TBD		Staffing and operations
	**Continue to support access to primary care for uninsured and underinsured residents of Orange County	Uninsured and underinsured patients	Provide financial support for operations and case management to Grace Medical Home	Financial Support	$100,000	$100,000		$100,000		$100,000			Orlando Health	
	Continue to support maternal and child health initiatives in Orange County	Pregnant women in Orange County	Provide financial support to the Healthy Start Coalition of Orange County	Value of donation	$15,000	$15,000		$15,000		$15,000				
			Provide office space to the Healthy Start Coalition	Value of office space subsidized	$3,620	$3,620		$3,620		$3,620				
	Support the education and training of medical practitioners in the tri-county region	Nursing and medical students of Valencia College, Seminole State College, University of Central Florida, Florida State University, and Adventist University of Health Sciences	Financially support the professional development and education of medical and nursing students	Value of support	$28 million	TBD		TBD		TBD		TBD		
		UCF, VC, SSC, Vo-Tech, Technical Education Center of Osceola County (TECO) and additional schools	Provide sites for clinical rotations and residency sites for graduates of medical education programs	Number of sites	100 academic contracts	100 academic contracts		TBD		TBD		TBD		
	Support efforts to provide IDs for individuals who do not have identification	Homeless and precariously housed residents of Central Florida	iDignity	Financial support	$25,000	$25,000		TBD		TBD		$25,000		

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	** Support capacity expansion for secondary care services and maintain primary urgent care at Shepherd's Hope	Uninsured and underinsured residents	Provide financial support to aid in recruitment of secondary care providers and case management at Shepherd's Hope Clinics	Financial support provided	$100,000	$100,000		$100,000		$100,000		$100,000 annually	Physician, nursing, and clerical operations are donated annually via volunteer providers	
			Provide access to services in the form of volunteer physician recruitment to Shepherd's Hope	Number of physicians recruited	18	20		30		40				
			Provide employee support in the form of volunteer recruitment to Shepherd's Hope	Number of employees who volunteer time	118	130		140		150				
			Support efforts to begin and continue electronic medical records integration and information sharing with Shepherd's Hope	Number of sites that have established an electronic medical record system	0	1		4		4				
			Continue to donate clinical services to Shepherd's Hope Patients	Amount of in-kind support donated in clinical services	$345,870	Support to continue as appropriate		Support to continue as appropriate		Support to continue as appropriate				
	Support and expand the PCAN (Primary Care Access Network) integrated system of care for the medically underserved	Uninsured and Underinsured residents of Orange County	Continue leadership of PCAN integrated leadership for uninsured and underinsured (21 partners)	Serve as board chair	$6m in IGT	$6m in IGT		$6m in IGT		$6m in IGT		Low-Income Pool/IGT funds	$12.9m from Orange County	Maureen Kersmarki, Verbelee Nielsen-Swanson, Lewis Seifert
			Support the capacity and network expansion of Federally Qualified Health Centers (3 FQHC entities)	Number of FQHC primary care medical homes	13	13		14		15		Low-Income Pool/IGT funds	FQHCs	PCAN FQHCs

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			Support the capacity and network expansion of Federally Qualified Health Centers (3 FQHC entities)	Number of FQHC primary care patients	92,000	95,000		97,000		98,000		Low-Income Pool/IGT funds	FQHCs	PCAN FQHCs
			Support the capacity and network expansion of Orange County Medical Clinic	Number of secondary care patients	10,000	10,200		10,300		10,400		Low-Income Pool/IGT funds	$30m from Orange County Health Services	
			Continue to provide donated medical services to the Orange County Medical Clinic	Value of support	TBD	TBD		TBD		TBD				
	Actively participate in health planning efforts in Orange County	Uninsured and underinsured residents of Orange County	Continue leadership role with Healthy Orange Florida	Meeting attendance	8 meetings	8 meetings		8 meetings		8 meetings				
			Health Summit	Attendance and support	0	1		TBD		TBD				Health Summit every other year
			Other activities/events developed by the Health Leadership Council	Number of activities/events	0	1		1		1				
	**Continue to support access to primary care for uninsured and underinsured residents of Orange County	Uninsured and underinsured patients	Provide financial support for operations and case management to Orange Blossom Family Health Center (Healthcare Center for the Homeless)	Financial Support	$100,000	$100,000		$100,000		$100,000		Value of charity for all homeless causes in the system: $34,492,612		
	**Offer comprehensive evaluation, treatment, and case management to improve quality of life for residents with mental health diagnoses	Uninsured residents of the tri-county region with depression, anxiety, and co-morbid medical conditions	Outlook Clinic	Number of patients seen at the Outlook Clinic	640	700		750		800		$193,340	Space donated by Orange County Governmen t Health Services	

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	**Decrease inpatient and emergency department utilization by the target population	Uninsured residents of the tri-county region with depression, anxiety, and co-morbid medical conditions	Outlook Clinic	Emergency department visits by Outlook Clinic patients	600	432		400		400			Space donated by Orange County Government Health Services	
				Inpatient admissions from the emergency department by Outlook Clinic patients	191	118		95		95				
Care Management/ Continuum of Care	Establish case management nursing and social work teams to enhance care coordination and community referrals	For identified patients	Increase RN ratios in units	Number of RNs hired to achieve 60% RN /40% SW team ratio	0	60% SW / 40% RN		TBD		TBD				
	Pilot new model of care coordination in the emergency department	Patients seen in the emergency department	Integrate case management team including social work and nursing dedicated to the ED via engaging and educating ED physicians, RNs, and social workers	Length of stay and time to see patient from ED admission	TBD	TBD		TBD		TBD				
	Establish a more succinct method for tracking and recording resources	All patients	Develop Resource Center to assist patients with discharge planning needs	Number of patients assisted	0	TBD		TBD		TBD				
	Develop CCN (Community Care Network) Team	Specific diagnosis-related groups (DRGs)/ Readmissions Conditions	Focus on specific DRGs related to CHF and pneumonia	Reduce readmissions rate	TBD	TBD		TBD		TBD				
		Patients identified by CCN Team	Implement Health Coaches program	Number of patients seen, evaluated and followed by Health Coaches	0	TBD		TBD		TBD				

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Diabetes	**Support and create opportunities for increased quality of life for diabetic and pre-diabetic patients	Residents of Eatonville	Healthy Eatonville Place	Percentage of pre-diabetic patients who do not become diabetic	New program, baseline to be established	66%		71%		76%		$177,000	$183,000	
				Percent of pre-diabetic patients who meet goal of >/= 7% weight loss	New program, baseline to be established	50%		55%		60%				
				Percent of pre-diabetic patients who make nutritional and exercise changes	New program, baseline to be established	60%		65%		70%				
				Percent of patients with poorly controlled diabetes who have a 0.7% reduction in their A1c	New program, baseline to be established	50%		55%		60%				
				Percent of patients with poorly controlled diabetes who reach their BP goal	New program, baseline to be established	80%		85%		90%				
				Percent of patients with poorly controlled diabetes who continue with program interventions and support programs	0	75%		80%		85%				
				Percent of patients with poorly controlled diabetes who attend diabetes education that know their ABC goals	0	90%		95%		95%				
				Percent of participants retained	0	65%		70%		75%				

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	Provide support and appropriate case management to geriatric emergency patients	Geriatric patients seen at Winter Park Hospital Geriatric Emergency Department (ED), on an inpatient basis, or through an outpatient residency service	Geriatric Emergency Department formation	Number of ED admissions of persons aged over 70	1,216	TBD		TBD		TBD				
	Provide support and appropriate case management to geriatric emergency patients	Geriatric patients seen at Winter Park Hospital Geriatric Emergency Department (ED), on an inpatient basis, or through an outpatient residency service	Geriatric Emergency Department formation	Length of stay for Medicare patients	4.97 days	4.88 days		4.6 days		4 days				
	Support continuum of care and coordination of services	Members of the 3 enrolled churches	Install a faith nurse in 3 churches	Number of members enrolled	0	400		520		800		$106,216	$108,887	
	Aid in improving the health and wellbeing and subjective quality of life of women who complete the program	Women in the primary service area	Life designer program for women health coaching	Number of women coached	40	200		400		600				
				Number of women referred to community resources	20	TBD		TBD		TBD		TBD		
				Number of women who reach their stress/anxiety score level	80%	TBD		TBD		TBD		TBD		
				Number of women who improve happiness score	80%	TBD		TBD		TBD		TBD		
				Number of referrals to specialists and physicians	TBD	TBD		TBD		TBD		TBD		

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				Percent of women willing to recommend the program	80%	TBD		TBD		TBD		TBD		
				Number of referrals made to the Crosby YMCA	50%	TBD		TBD		TBD		TBD		
Violent Crime	Increase access to and awareness of domestic violence resources in the county	Residents of Orange County	Screen for domestic violence and offer resources	# of employees trained to recognize signs of abuse	0	300		1,000		5,000		$50,000		Staff training
	Continue to support domestic violence initiatives in Orange County	Residents of Orange County	Support Harbor House through board membership and donations	Value of support donated to Harbor House	$5,000	$5,000		$5,000		$5,000		In-kind support		Board membership; physicians serving in advisory capacity; and donations
			Provide space for the Sexual Assault Treatment Center for Orange County	Value of donated space	$39,892	$39,892		$39,892		$39,892		In-kind support		

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