2017-2019 Community Health Plan
(Implementation Strategies)
May 15, 2017

Community Health Needs Assessment Process

Florida Hospital Waterman conducted a Community Health Needs Assessment (CHNA) in 2016. The Assessment identified the health-related needs of the Lake County community including low-income, minority, and medically underserved populations.

To assure broad community input, Florida Hospital Waterman created a Community Health Needs Assessment Committee (CHNAC) to help guide the hospital through the Assessment and Community Health Plan process. The Committee included representation not only from the hospital, public health and the broad community, but also from low-income, minority and other underserved populations.

The Committee met throughout 2016 and early 2017. The members reviewed primary and secondary data, initial priorities identified in the Assessment, considered the priority-related Assets already in place in the community, used specific criteria to select the specific Priority Issues to be addressed by the hospital, and helped develop this Community Health Plan (implementation strategy) to address the Priority Issues.

This Community Health Plan lists targeted interventions and measurable outcome statements for each Priority Issue noted below. It includes the resources the hospital will commit to the Plan, and notes any planned collaborations between the hospital and other community organizations.

Priority Issues that will be addressed by Florida Hospital Waterman

Florida Hospital Waterman will address the following Priority Issues in 2017-2019.

1. Access to Care: Focusing on social determinants of health, including poverty, the uninsured and transportation; Access to care was selected due to the concerns regarding the rising cost of healthcare services and the ease of access to available resources.
2. Colon and Cervical Cancer: Focusing on all ethnicities ages 40 and older, these conditions were selected because data show cancer is in the top 5 causes of death in Lake County and colon and cervical screenings in Lake County are lower than the Healthy People 2020 goal and certain minority had higher non-compliance rates.
3. Obesity: Focusing on all ethnicities and all age groups, this condition was selected because data show the proportion of obese adults in Lake County is higher than the Healthy People 2020 goal, and there is a strong community concern about the impact of obesity on both children and adults.
4. Heart disease: Focusing on all ethnicities ages 40+ and older, this condition was selected because data show that heart disease is one of the top five causes of death in Lake County and is higher than the Healthy People 2020 goal.
5. Diabetes: Focusing on all ethnicities ages 18+, this condition was selected because data show that diabetes is one of the leading causes of death in Lake County, and the percentage of adults with diagnosed diabetes in Lake County is higher than the Healthy People 2020 goal.

Issues that will not be addressed by Florida Hospital Waterman

The 2016 Community Health Needs Assessment also identified the following community health issues that Florida Hospital Waterman will not address. The list below includes these issues and an explanation of why the hospital is not addressing them.

6. Mental Illness/Depression: This is a component of poor mental health. Other local organizations such as Lifestream Behavioral Health is working to and is in a better position to address substance abuse. We are committed to working to improving the health and wellness of our communities, and fully support local government and wellness coalitions in their efforts to positively impact these issues.

7. Poor Access to Food/Nutrition: A large portion of the county has a modified retail food environmental index score below 15 (low access, poor access, or no access to healthy retail food outlets). Additionally, the entire county is without a census tract with a score over 30, indicating high access.

8. Substance Abuse: Addiction is understood to be a component of poor mental health. Local behavioral health partners such as Lifestream Behavioral Health is in a better position to address substance abuse. We are committed to working to improving the health and wellness of our communities, and fully support local government and wellness coalitions in their efforts to positively impact these issues.

9. Poor Birth Outcomes: While this issue appears to be an issue for Lake County, especially among black residents. Other local organizations such as the Lake County Department of health are already working to address poor birth outcomes. Additionally, when compared to other nearby communities, the Florida Hospital Waterman community has overall lower birth rates.

10. Poverty: Florida Hospital Waterman is already working with community partners such as local food banks and in many community outreach projects to help support and care for the underserved in our community.

11. Asthma: While we have the means to treat the symptoms of asthma, the exact cause of asthma in unknown. The triggers for signs and symptoms are different from person to person and are generally based on environmental settings including pollen, mold, etc. If the community has access to preventative and primary care, this may improve symptom rates in Lake County.

12. Falls: While the hospital has means to treat falls, it does not have the resources to effectively prevent them outside the hospital facility. Additionally, there are programs such as the Florida Department of Health's Injury Prevention Program would be more suited to address this issue.

13. HIV/AIDS: The HIV rate has increased in Lake county, and it has consistently remained lower than the state level. Additionally, while the hospital has the means to treat STIs, it does not have the resources to effectively prevent them. If the community has access to preventative and primary care, this may help STI rates of STIs.

14. Drowning: The hospital does not have the resources to effectively prevent drownings. Additionally, there are existing programs such as the Florida Department of Health's Injury Prevention Program would be more suited to address this issue. We are committed to working to improving the health and wellness of our communities, and fully support local government and wellness coalitions in their efforts to positively impact these issues.

15. Dental Care: While the hospital has means to treat specific dental problems, it does not have the resources to effectively address dental hygiene. Additionally, there are additional programs more available in the county available to address this issue. We are committed to working to improving the health and wellness of our communities, and fully support local government and wellness coalitions in their efforts to positively impact these issues.

Board Approval

The Florida Hospital Waterman Board formally approved the specific Priority Issues and the full Community Health Needs Assessment in 2016. The Board also approved this Community Health Plan.

Public Availability

The Florida Hospital Waterman Community Health Plan was posted on its web site prior to May 15, 2017. Please see https://www.floridahospital.com/community-health-needs-assessments Paper copies of the Needs Assessment and Plan are available at the hospital, or you may request a copy from renee.furnas@ahss.org

Ongoing Evaluation

Florida Hospital Waterman's fiscal year is January-December. For 2017, the Community Health Plan will be deployed beginning May 15 and evaluated at the end of the calendar year. In 2018 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 attached to our IRS Form 990, Schedule H.

For More Information

If you have questions regarding Florida Hospital Waterman's Community Health Needs Assessment or Community Health Plan, please contact renee.furnas@ahss.org .

Florida Hospital Waterman

2017-2019 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**
Access to Care	Increase awareness of community health resources available	Uninsured or resident's w/o Medicaid	Identify and/or compile free or reduced cost of community resources available, distribute 150 to targeted population	Number of resource guides distributed	0	50 Guides		100 Guides		150 Guides		Program costs	TBD	
	Maintain number of patient's visits provided through the Family Health Clinic around 2,500 per year	Residents living below 150% of the poverty level	Provide free health services to 2500 of the identified target population in Lake County	Total number of clinic visits	2,118	Retain total number of patient visits > 2,500		Retain total number of patient visits > 2,500		Retain total number of patient visits > 2,500		$112 per visit		

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
Access to Care	Eligible uninsured low-income patients without a primary care provider referred to Community Primary Health Clinic from Care Management	Inpatients discharged 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 inpatients w/o a primary care provider applying to Primary Health Clinic for services	11%	Maintain at least 11% conversion rate		Maintain at least 11% conversion rate		Maintain at least 11% conversion rate		$112 per visit; program and tracking costs		
	Transition at least 11% of patients identified as low-income without a primary care provider to the Primary Health Clinic	ER patient's w/o 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 ER patient's w/o a primary care provider applying to Primary Health Clinic for services	11%	Maintain at least 11% conversion rate		Maintain at least 11% conversion rate		Maintain at least 11% conversion rate		$112 per visit; program and tracking costs		
	Reduce avoidable readmissions among identified patient populations through transitional care program	Identified patients at risk for readmission with AMI, CHF, pneumonia	Clinical outreach, lifestyle education and follow up with patients before discharge/transition to home	Percentage of readmissions among identified patients	30%	< 20%		< 18%		< 16%		Program costs		
Obesity	Increase awareness and education of obesity and its impact on overall health	Adults, 18+, community and employees	Provide 1,500 BMI screenings total and lifestyle education for obesity	Total number of people screened	1,500 annually	500 BMI screenings		500 BMI screenings (1,000 total)		500 BMI screenings (1,500 total)		Staff costs – approx. < $5 per screening		
				Percentage of people with BMIs > 40% who are referred to a physician or healthy eating programs and percent of people with completed follow up.		100; 50		100; 50		100; 50				

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	Encourage healthy eating and weight loss through employee and family programs	Adults, Employees	Increase participation and completion rate in employee/family weight loss programs by 5% each year	Total number of participants enrolled: % of people who complete the program	435; TBD	Increase completion rate by 5%		Increase completion rate by 5%		Increase completion rate by 5%		Program costs		
				Percentage of "graduates" who report greater knowledge of healthy eating skills		85%		88%		90%				
	Increase awareness and provide health education to children and families on programs geared towards combating obesity maintaining a healthy weight/	Children, Obese	Develop a program to engage local Pediatricians (2) to refer obese children's and their families to CREATION Health programs	Number of physicians engaged; children participating in program	0	Create program, and engage 2 local physicians		2;10		2;20				
Heart Disease	Increase awareness, educate and screen community through 300 heart disease risk screenings and assessments to improve heart health	Adults, 40+	Provide community heart disease screenings and health assessment including glucose and lipid panel	Total number of screenings	Continue 2013 CHP initiative	100 screenings		200 screenings		300 screenings		Approximate $15.50 per screening		
				Percentage of people found to be at high risk who are referred to a physician/treatment center and percent of people with completed follow up.		100;50		100;50		100;50				
	Increase awareness and educate on Early Heart Attack Care (EHAC) and the signs and symptoms of acute coronary syndromes (ACS).	Adults; Employees, community and providers	Provide EHAC handouts/pledge to target population and partner with local employers to educate internally	Percent of targeted audience who take the EHAC pledge; number of employers engaged	0	Communication reaching > 50% of PSA; 5		Communication reaching > 50% of PSA; 5		Communication reaching > 50% of PSA 5		Printing cost, ad cost.		

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
Heart Disease	Increase awareness and lifestyle education by providing free blood pressure screenings in the community	Adults, 18+	Sponsor free blood pressure screening kiosks at local Publix Supermarkets	Total number of screenings/video education (100,000 per year);	105,334	Provide 100,000 screenings/video education		Increase total number of participants by 5%		Increase total number of participants by 5%		$1,600 per month; $2,500 startup costs		
				Percentage of people followed up via email (10%)		10%		10%		10%				
	Provide patients at discharge information on CREATION Health lifestyle packets	Adults, current Inpatients	Included in MyCare folder at discharge	Total number of discharged patients	14,253	13,000		13,000		13,000				
	Increase awareness and educate patients about smoking cessation at discharge	Adults, current inpatients	Promotion of smoking cessation programs	Distribution of smoking cessation program education to at least 75% smokers identified at discharge		Distribute materials to 75% of identified smokers		Distribute materials to 80% of identified smokers		Distribute materials to 90% of identified smokers				
	Increase awareness and educate patients about smoking cessation identified through the Cancer Center	Adults, cancer patients	Promotion of smoking cessation programs	Distribution of smoking cessation program education to at least all smokers identified		Distribute materials to 100% of identified smokers		Distribute materials to 100% of identified smokers		Distribute materials to 100% of identified smokers				
Diabetes	Increase awareness, provide and promote diabetes education and classes	Adults diagnosed with pre diabetes, type I and type II diabetes	Introduce diabetes education course covered by insurance with scholarships available	Total number of classes held; Total number of class participants	2;46	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	

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Diabetes	Increase awareness and provide 300 free glucose screenings and diabetes education to identified audiences	Adults at risk for diabetes	Screen identified audience for elevated glucose levels	Total number of screenings	Continue 2013 CHP initiative	100 screenings		200 screenings		300 screenings		Approximate $15.50 per screening	Focus on churches and community centers	
				Percentage of people with elevated glucose levels who are referred to diabetes education classes and have to follow up.		90%		92%		95%				
				Percentage of people with elevated glucose levels who are referred to a physician or treatment facility		90%		92%		95%				
	Increase awareness and provide and promote diabetes support group	Adults, diabetic, pre-diabetic	Provide diabetes support group 2x monthly with 10 people per session including diabetes education and nutrition	Total number of sessions held; total number of participants	24; 288	24; 240		24; 240		24; 240				
	Increase education for gestational diabetes and host a gestational diabetes clinic	Pregnant women, 26 – 28 weeks	Provide gestational diabetes clinic once a week with one 6-week follow up post-partum	Total of number of clinics held; total number of participants	0	26; 50		52; 100		52;100				

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Colon Cancer	Increase education and awareness of the benefits of colon cancer prevention and access to care to more than 50% of population each year	Adults, age 50+	Promote colonoscopy 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	Continue 2013 CHP initiative	Communication reaching > 50% of adult PSA		Communication reaching > 50% of adult PSA		Communication reaching > 50% of adult PSA		Staff time, media costs, advertising ($15,000 per year)	N/A	
	Educate health care providers in regarding cancer patient navigator services for colorectal cancer	Health care providers	Introduce and operationalize cancer coordinator/patient navigator	Number of providers (physicians and extenders) educated - 150 identified providers	Continue 2013 CHP initiative	50 provider education sessions		50 providers educated (100 total)		50 providers educated (150 total)		Existing staff time - physician relations. $5,000 materials per year	N/A	
	Increase education and awareness of colon cancer prevention and screenings	Employees/Auxiliaans, 50-75	Partner with the ACS to bring education and identification of system resources to facilitate increased colorectal screening compliance	80% of targeted audience regularly tested for colon cancer	0	Increase screening rate by 5%		Increase screening rate by 5%		Increase screening rate by 5%				
				Percentage of employees/auxiliaans who is screened for colorectal cancer		85%		88%		90%				
GYN Cancer	Increase education and awareness of the benefits of cervical cancer screening/ pap smears among at least 50% of the target population	Adult women (Age 18+)	Promote education through paid and earned media, community outreach encounters and physician offices	Communication reach via earned and paid media through communication distribution and media affidavits	Continue 2013 CHP initiative	Communication reaching > 50% of PSA		Communication reaching > 50% of PSA		Communication reaching > 50% of PSA				
	Provide and promote 6 free GYN screening / assessment	Uninsured adult women (18+)	Engage women to take part in GYN Cancer prevention and screening	Total number of screening events; total number of participants	2;20	2;20		4;40		6; 60		TBD	N/A	

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GYN Cancer				Number of women found to be at high risk who are referred to a physician/treatment center and percent of women with completed follow up.		100; 50%		100; 50%		100; 50%				
	Educate health care providers in regarding cancer patient navigator services for GYN cancers	Health care providers	Introduce and operationalize cancer coordinator/patient navigator	Number of providers (physicians and extenders) educated - 150 identified providers	0	50 provider education sessions		50 providers educated (100 total)		50 providers educated (150 total)		Existing staff time - physician relations. $5,000 materials per year	N/A	