



2014-16 Community Health Plan

May 15, 2014

Florida Hospital Kissimmee 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 Florida Department of Health at Orange County, 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 populationsⁱ. 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 Kissimmee. The hospital Board approved the priorities and the full Assessment.

1. Obesity
2. Diabetes
3. Heart Disease

With a particular focus on these priorities, the Council helped Florida Hospital Kissimmee develop this Community Health Plan (CHP) or "implementation strategyⁱⁱ." 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 Kissimmee'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.

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.

Outcome statements marked with a "***" are system initiatives. Funds are distributed to one central program rather than to each campus

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															
	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	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					
	Increase and track the proportion of physician office visits (made by adult patients who are obese) that include counseling or education related to weight reduction, nutrition, or physical activity	Florida Hospital Medical Group Primary Care Physicians serving residents of Kissimmee	Peer physician education	% of primary care encounters with obese adult patients that include charting on counseling or education	Baseline pending	5% increase		5% increase		5% increase					
	**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
	**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 and materials		
Heart Disease															
	Evaluate establishing health education and strategies in the area of chronic disease management to Kissimmee residents	Residents of Kissimmee	Expand Stanford Chronic Disease Self-Management program to Kissimmee	# of Kissimmee residents who complete chronic disease self-management classes	0	40		60		80		\$5,000			
	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			

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	**Support efforts to reduce heart related conditions through the funding of research and programs	Residents of the primary service area (PSA)	Provide support and board membership to the American Heart Association	Value of support	\$100,000	\$100,000		\$100,000		\$100,000		\$300,000		
			Encourage employee participation in the annual Heart Walk	Number of FH walkers	500	600		650		675				
Access to Care														
	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	\$9,415	\$10,000		TBD		TBD				
	**Continue to increase access to primary and secondary care	Uninsured and underinsured residents of Osceola County	Provide financial support for operations and case management at the Hope Clinic	Financial Support	\$65,000	\$50,000		\$50,000		\$50,000		\$150,000 over 3 years		
				Number of unique patients seen per year at Hope Clinic	1,475	1,500		TBD		TBD				
	Continue to increase access to primary and secondary care	Uninsured and underinsured residents of Osceola County	Provide financial support for operations and case management to the Council on Aging Clinic	Financial support	\$47,000	\$47,000		\$47,000		\$47,000				
				Number of patients seen per year at Council on Aging Clinic	1475	1500		1500		TBD				
	**Continue to increase access to primary care for uninsured and underinsured residents of Osceola County	Uninsured and underinsured patients	Provide financial support for operations and case management to the Hope Clinic operated by Health Care Center for the Homeless	Financial Support	\$50,000	\$50,000		\$50,000		\$50,000		\$150,000		
	Actively participate in health planning efforts in Osceola County	Uninsured and underinsured residents of Osceola County	Continue leadership role with the Osceola Health Leadership Council	Meeting attendance	8 meetings	8 meetings		8 meetings		8 meetings				Dorie Croissant
		Uninsured and underinsured residents of Osceola County	Health Summit	Attendance and support	1	0		1		0		Provide meeting space and refreshments		Health Summit every other year
		Uninsured and underinsured residents of Osceola County	Other activities/events developed by the Health Leadership Council	Number of activities/events	0	1		1		1				

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	Strengthen partnership for establishing a secondary care clinic with the Council on Aging Clinic and volunteer providers	Uninsured and underinsured residents of Osceola County	Promote volunteer opportunities to physicians and other clinical staff to explore the possibility of staffing secondary care clinic	Number of volunteer providers	0	600		800		1,100				
	**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
	Encourage medical home enrollment	Uninsured and underinsured residents of Osceola County	Continue to refer uninsured and underinsured emergency department (ED) and inpatients to Federally Qualified Health Centers (FQHCs) medical homes in St. Cloud, Kissimmee, Poinciana, and Intercession City	Total number of uninsured and underinsured patients enrolled in the FQHCs	28,000	30,000		32,000		34,000			\$325,000 HRSA Grant	
	Support broad community health planning through Community Vision	Florida Hospital Kissimmee and Celebration Health primary service areas	Interest from Community Vision endowment (from original CHIC) supports health-related efforts by Community Vision. Endowment resides in the Community Foundation	Annual interest payment to Community Vision from the Community Foundation	\$40,000	\$40,000		\$40,000		\$40,000				David Banks, Maureen Kersmarki
	**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	\$28 million		TBD		TBD		TBD		
	**Support the education and training of medical practitioners in the tri-county region	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 the education and training of CNAs in Osceola County	CNA students at the Technical Education Center of Osceola County	Provide financial support to aid in program operations and materials	Number of students in class and number of classes	0; 0	14; 2		TBD		TBD		\$26,000		

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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		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		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		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		TBD		
		Patients identified by CCN Team	Implement Health Coaches program	Number of patients seen, evaluated and followed by Health Coaches	0	TBD		TBD		TBD		TBD		
Violent Crime	Support efforts of law enforcement to provide necessary screenings and counseling to survivors of sexual abuse	Survivors of sexual abuse in Kissimmee	Provide space for the Sexual Assault Treatment Center for Osceola County	Value of donated space	\$39,892	\$39,892		\$39,892		\$39,892		TBDS		
Diabetes														
	Offer opportunities for increased nutritional competency	Diabetic patients and their families in Kissimmee	Cooking classes offered once a quarter at Florida Hospital Kissimmee by Chef Edwin	Number of attendees	0	20		40		60		\$1,000		
				Percentage of attendees who report improved understanding of nutritional principles	0	20%		30%		40%				

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	Enhance diabetes services in Osceola County	Uninsured and underinsured Osceola residents with diabetes	Increase patients who enroll in and complete the Life DM program offered at the Osceola Council on Aging in cooperation with the Florida Hospital Diabetes Institute (FHD)	Number of patients who complete the Life DM program	121	200		TBD		TBD		\$394,652 over 2 years		Additional support donated in-kind by the hospital
	Evaluate establishing health education and strategies in the area of diabetes management to Kissimmee residents	Residents of Kissimmee	Establish diabetes management program to Kissimmee	# of Kissimmee residents who enroll in diabetes management class	0	40		60		80		\$5,000		

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