FLORIDA HOSPITAL
HEARTLAND MEDICAL CENTER

2014-16 Community Health Plan

Florida Hospital Lake Placid and Florida Hospital Heartland conducted a joint 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. Cancer
2. Heart Disease / Stroke
3. Diabetes
4. Access to Health Care
5. Chronic Disease Management

With a particular focus on these priorities, the Committee helped the hospitals 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 Lake Placid'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 Jamie Bateman, Community Benefit Manager, at jamie.bateman@ahss.org.

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[i] The full Community Health Needs Assessment can be found at www.floridahospital.com/lakeplacid 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 Lake Placid

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**
Cancer	Increase early detection efforts	Uninsured adults in zip codes 33872, 33852, 33825, 33873, 33890, 33865, 33834	Hold Smoking Cessation Classes.	Number of additional participants	230	230		230		230				
				Number of classes	23	23		23		23				
	Educate broad and underserved populations	All adults in zip codes 33872, 33852, 33825, 33873, 33890, 33865, 33834	Hold Smoking Cessation Classes.	Number of graduates who stop for at least six months										
	Educate through Pink Army efforts	All adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834 & 33960	Community education for early detection of Breast Cancer	Number of attendees	670	670		700		750				
				Number of Online Mammos	112	112		120		130				
				Number of Events	44	44		50		55				
				Number of Survivors	62	62		70		75				
				Number of volunteers	187	187		190		195				
	Educate on eating habits and managing stress	Insured and uninsured adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834 & 33960	Hold Healthy Heart education classes	Number of attendees	0	30		30		30				

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
			Improved Biometric Indexes	Percentage of attendees who report	99%	99%		99%		99%				
				Percentage of attendees who report increased knowledge of nutrition principles	100%	100%		100%		100%				
	Promote routine checkups with primary physician education	Insured and uninsured adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834 & 33960	Hold Education Classes	Percentage of attendees	100%	100%		100%		100%				
Heart Disease - Stroke	Cardiac Screenings	All Adults people with Chronic Heart Disease	Hold Chronic disease self manage programs	Number of attendees who report better understanding of chronic disease	0	10		10		10				
	Health Fairs		Nutrition Information given	Number of attendees	800	800		816		832				
	Reduce preventable CHF 30-day readmissions by 5% over three years	All Medicare CHF Admissions with diabetes in zip codes 33872, 33825, 33852, 33875, 33873, 33890, 33865, 33834	Reduce Admissions	Number of targeted CHF patients readmitted in 30 days	1%	1%		3%		5%				
	Lectures on Stroke	Uninsured people in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834 & 33960	Lectures provided by Dr. Ramkissoon on Stroke Education programs	Number of attendees	80	80		80		80				

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	Diabetes Support Group	Uninsured people with diabetes in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834	Community Diabetes education program	Minimum 90-150 minutes/week of physical activity in 50% of patients	52%	52%		60%		60%				
				Achieve 5% Weightl loss in 50% of overweight or obese patients over six months	30%	30%		30%		40%				
			Personal Foot exams	Percentage of patients that do this 3 times/week	90%	90%		90%		90%				
			Quality of life improvement	Participants rate themselves on their quality of life	0%	0%		90%		90%				This was not measured in past but will be implemented in coming year 2 and 3.
			Participants set two goals at end of courses	Percentage of attendees who report a nutritional goal was met	60%	60%		60%		60%				
				Percentage of attendees who report taking medications/day as ordered by Physicians	95%	95%		95%		95%				
	Reduce A1c levels in uninsured people	All people with diabetes in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834		Percentage of attendees who report lowered A1c levels over six month, More than 7.5% attendees reduce by 1%	88%	88%		88%		88%				

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
	Educate on Cardiac Rehab	All people with diabetes in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834	Community Cardiac Rehab classes	Attendees who participate in Diet & Nutrition Classes 1/month related to Cardiac	69	69		70		75				
	Gestational Diabetes Management	All people with diabetes in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834	Community Diabetes education program	Number of participants	24	24		34		44				
	Diabetes Self-Management training	All people with diabetes in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834	Community Diabetes education 10 hour courses	Number of 10-Hour courses provided	100	100		110		120				
	Medical Nutrition Therapy	All people with Nutritional problems in zip codes 33872, 33825, 33852, 33875, 33870, 33873, 33890, 33865, 33834	Community Diabetes education program; 1-on-1 course	Number of participants	42	42		62		84				
Access to Health Care	Build community knowledge of available services	Adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834, & 33960	Increase community awareness of available Health care services	Number of volunteers	35	35		45		55				
	Increase availability of affordable labs	Uninsured adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, & 33960	$2.5M in donated services by using a voucher system for Lab and Imaging Services	Number of labs/month	20	20		30		40				

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 availability of affordable Imaging at free clinic	Uninsured adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834 & 33960	$2.5M in donated services by using a voucher system for Lab and Imaging Services	Number of Images/month	35	35		40		45				
	Health Fairs	All adults in zip codes 33825, 33872, 33870, 33875, 33876, 33857, 33852, 33873, 33890, 33865, 33834, & 33960		Number of Health Fairs	8 Health Fairs	8		8		8				
				Number of attendees	75	75		75		75				
Chronic Disease Management Project	Decrease **30-day** preventable readmission rates for CHF patients participants	CHF patient participants	Implement Stanford Chronic Disease Self-Management/CREATION Health Program (CDSM/CHP)	Number of targeted CHF patients who are readmitted in 30 days				15		15				
	Participants will perceive their health as having "increased" after completing program	CHF patient participants	survey participants pre- and post-program	Completers who state their health has "increased" since participating in program				70		70				
	Participants that complete the program will be satisfied with the program	CHF patient participants	Implement pre- and post-program evaluations	Completers who state they are satisfied with the program				85		85				