Florida Hospital Heartland Medical Center – Sebring and Lake Placid

2017-2019 Community Health Plan

(Implementation Strategies)

May 15, 2017

Community Health Needs Assessment Process

Florida Hospital Medical Center Sebring and Lake Placid Hospital (the Hospitals) share a Hospital license and service area. They conducted a joint Community Health Needs Assessment (CHNA) in 2016. The Assessment identified the health-related needs of community including low-income, minority, and medically underserved populations.

In order to assure broad community input, Florida Hospital Medical Center Sebring and Lake Placid Hospital 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 Hospitals, public health and the broad community, but from low-income, minority and other underserved populations.

The Committee met throughout 2016 and early 2017. The members reviewed the primary and secondary data, reviewed the 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 Hospitals will commit to the Plan, and notes any planned collaborations between the Hospitals and other community organizations and hospitals.

Priority Issues that will be addressed by Florida Hospital Medical Center Sebring and Lake Placid Hospital

Florida Hospital Medical Center Sebring and Lake Placid Hospital will address the following Priority Issues in 2017-2019.

1. **Heart Disease** – Number two cause of death in the Primary Service Area (PSA). The service area also presents a higher than state average rate of high blood pressure and cholesterol.

2. **Diabetes** – Higher than state average of diabetes rates, and lower than average access to diabetes self-management and Pre-diabetes education programs.
3. **Obesity/Nutrition** – 41% of residents in the PSA have low food access (food desert). 31.9% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) in the "overweight" category. 34.7% of adults aged 20 and older self-report that they have a BMI in the "obese" category.
4. **Access to Care (Mental Health Services)** – PSA is a designated Health Professional Shortage Area (HPSA)
5. **Access to Care (Primary Care)** – PSA is a designated HPSA

Issues that will not be addressed by Florida Hospital Medical Center Sebring and Lake Placid Hospital

The 2016 Community Health Needs Assessment also identified the follow community health issues that Florida Hospital Medical Center Sebring and Lake Placid will not address. The list below includes these issues and an explanation of why the Hospital is not addressing them.

A. Cancer Incidence/Screening/ Tobacco Cessation – the Hospital already participates with Area Health Education Center (AHEC) to offer community tobacco cessation classes.
B. Poverty/Unemployment/Literacy Rates – The Hospital does not have the capacity to address social determinants.
C. Chronic Obstructive Pulmonary Disease/Upper Respiratory Infection/Asthma – The Hospital employs several pulmonologists and sponsors tobacco cessation classes.
D. Lack of Transportation – The community lacks public transportation services, and the Hospital does not have public transportation capacity.

Board Approval

The Florida Hospital Medical Center Sebring and Lake Placid Hospital 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 Medical Center Sebring and Lake Placid Hospital Community Health Plan was posted on its web site prior to May 15, 2017. Please see www.floirdahospital.com/heartland/PopularLInks/CommunityBenefit. Paper copies of the Needs Assessment and Plan are available at the Hospital, or you may request a copy from Cathy.Albritton@ahss.org

Ongoing Evaluation

Florida Hospital Medical Center Sebring and Lake Placid'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 Medical Center Sebring and Lake Placid Hospital's Community Health Needs Assessment or Community Health Plan, please contact Cathy.Albritton@ahss.org .

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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 $ - 3-year estimate**	**Matching $**	**Comment**
1. Heart Disease/Stroke/High Blood Pressure/ Cholesterol	Educate participants regarding chronic disease self-management	All adults with chronic disease in zip codes 33825, 33843, 33870,33872, 33875,33873, 33852,33960, 33876,33857	Offer free, evidence-based Stanford Chronic Disease Self-Management Program (CDSMP) 6-week class series	% of participants who stated in post-class surveys that they increased self-care knowledge to manage chronic illness	90%	80%		85%		90%		$18,750 for instructor time and location	All materials donated by Senior Connection Center, Inc. (local Area Agency on Aging), $25/participant (book, CD/supplies)	
				# of CDMSP participants	30	30		40		40		See above		
				# of graduates	25	25		33		33		See above		

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	Educate population regarding nutrition, healthy lifestyle choices	Adults in zip codes 33825,33843, 33870,3872, 33875,33873, 33852,33960, 33876,33857	Hold Complete Health Improvement Program, a lifestyle enrichment program designed to reduce disease risk through better health habits and appropriate lifestyle modifications. Goals: lower cholesterol, hypertension and blood sugar levels; reduce excess weight through improved dietary choices; enhance daily exercise; increased support systems and decreased stress. Proven scientific results.	% of participants who experience improved biometric indices (program measures blood sugar levels, cholesterol, blood pressure, BMI and weight)	50%	50% of partici-pants		50% of partici-pants		50% of partici-pants				

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				# of participants sponsored	0	20 scholar-ship students per year		20 scholar-ship students per year		20 scholar-ship students per year		$18,000 for class + $750 for nursing and lab draws		
				% of participants who self-report improved knowledge of nutrition principles	75%	75%		80%		85%				
2. Diabetes	Increase activity level and nutrition education among students at Title I schools	Elementary or Middle school students in select Title 1 schools in zip codes 33825,33843, 33870,33872, 33875,33873, 33852,33960, 33876,33857	PILOT PROGRAM - 4 Title I schools participate in Morning Mile (walking) Program in collaboration with American Diabetes Association (ADA)	65% of students at each school	0	65% of total student body (4 schools)		65% of total student body (4 schools		65% of total student body (4 schools		$8,000 estimated for the 2017-2018 school year; $24,000 over three years		ADA metric
				# miles/ student	0	50 miles average		50 miles average		50 miles average				ADA metric

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3. Obesity/ Nutrition	Increase nutrition and healthy lifestyle knowledge	Faith Communities from zip codes 33825,33843, 33870,33872, 33875,33873, 33852,33960, 33876,33857	Offer CREATION Health, an eight-week, faith-based wellness plan with lifestyle seminars and training for those who want to live healthier lives. Based on eight principles: choice, rest, environment, activity, trust, interpersonal relations, outlook and nutrition.	# of program graduates (graduate = attended at least 6 of 8 sessions	0	20		30		50		$240 for assess-ments, $750 for nursing and biometric screening		
				% of participants self-reporting improved lifestyle choices as measured by CREATION Health self-assessment form	0	75%		80%		85%				

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	Build Trainer capacity for CREATION Health Program	Hospital staff, clergy, or lay members, community health care workers in Primary Service Area	Implement "Train the Trainer" sessions	# number of Hospital staff members or others who become trainers (100% is 2 trainers per Hospital campus)	0	100% of 4 trainees		100% of 2 trainers		100% of 2 trainees				
				# of CREATION Health kits sponsored	0	100% of 4 kits		100% 0f 2 kits		100% of 2 kits		$2400 for leadership kits		
	Reduce blood sugar levels	Low income/Low Access or Food Desert population in Primary service area (PSA)	Build framework for Food is Medicine Program Pilot, a nutrition/food access program that provides nutrition education and free vouchers for fresh produce.	Hire Divisional Food Is Medicine Program Coordinator	0	1 shared employee		N/A		N/A		$7,500 share of 1 year pilot cost		Pilot will be expanded after year 1.

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			Implement Food is Medicine Program in underserved area and province access to nutritious produce	Reduce blood sugar for 10% of participants as measured by finger sticks the first and last day of class	0	10% of Partici-pants		10% of partici-pants		10% of partici-pants		$1050		
			Offer fresh produce vouchers to class participants	# of fresh produce vouchers (vouchers are $10.00 per person per class)	0	$2,000		$3000		$4000		$9000		
4. Access to Primary Care	Increase community awareness and availability of local health care services for un/unde-rinsured individuals	Un/under-insured individuals in 33825,33843, 33870,33872, 33875,33873, 33852,33960, 33876,33857	CREATION Health ministry outreach	# volunteers	40	45		50		55		$5,400		

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			Discounted home-supply prescriptions for low-income patients discharged from Hospital care	Dollar amount – value	$1500	$1250		$1250		$1250		$3,750		
			Monetary support of Samaritan's Touch free clinic	Monetary donation	$62,500	$43,750		$43,750		$43,750		$131,250		For clinic operations
			In-kind lab and imaging services for Samaritan's Touch patients	Monetary amount	$500,000	$375,000		$250,000		$250,000		$875,000		
5. Access to Mental Health Services	Increase access to mental health services for un/underinsured adults	Underserved population in zip codes 33825,33843, 33870,33872, 33875,33873, 33852,33960, 33876,33857	Research community partners and host free Mental Health First Aid classes in the community to increase capacity	One new class series held on-site	0	1		1		1		40 2-hr meetings X $50 = $4000 in-kind		

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			Host free Mental Health First Aid classes in the community to increase capacity	# of attendees	0	10		10		10		See above		