



# Community Health Improvement Plan Annual Report, 2014

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*Florida Department of Health in  
Osceola County*

*September 2014*

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## Introduction

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This is the annual review report for the 2013-2016 Osceola County Community Health Improvement Plan (CHIP). The activities and collaborative efforts of the Florida Department of Health in Osceola County and community partners will be reflected within the report. This document will serve as a progress review of the strategies that were developed and the activities that have been implemented. While the CHIP is a community driven and collectively owned health improvement plan, the Florida Department of Health in Osceola County (DOH-Osceola) is charged with providing administrative support; tracking and collecting data; and preparing the annual review report.

The Osceola Health Leadership Council (HLC), comprised of Osceola County's key public health system partners and stakeholders, monitors the CHIP on an ongoing basis during monthly meetings. The CHIP's priority areas and strategic objectives are delineated in the *Osceola Community Balanced Scorecard* which contains the goals and assigned owners. The *Community Balanced Scorecard* ensures that the CHIP goals are both meaningful and measurable. Cascading down from the *Community Balanced Scorecard* are the individual CHIP Action Plans that the HLC developed for each goal. These CHIP Action Plans are the working documents that each goal owner, which is an HLC member, prepares as a monthly progress report and presents for discussion at HLC meetings.

The HLC held the 2014 CHIP annual review during meetings in July and August 2014. The process included discussion of key information from the monthly CHIP action plan reports. The HLC used this information to determine how successful the progress has been over the past year for each strategic objective, to decide whether the right strategies had been implemented, and to determine whether the desired outcomes had been achieved.

During this annual review, the HLC discussed the availability of community resources, what the partners thought reasonably could be achieved, and other determinants for action. The group then deliberated, ranked, and rated each of the CHIP strategic objectives. Discussion took place and all members had an opportunity to present their view of the health themes that emerged. This led to a prioritization of the actions plans and consensus on the top five critical areas to be focused on during 2015. These areas included:

1. Improve utilization of available resources
2. Increase referrals to connect residents to a Primary Care Medical Home
3. Expand primary care capacity
4. Improve population-based cardiovascular disease health outcomes
5. Improve population-based diabetes health outcomes

The HLC determined that while these top five areas will be the primary focus during 2015, work will continue on the remaining CHIP strategic objectives. Additionally, the HLC will continue to meet monthly to review progress on all action plans and offer course correction when necessary.

HLC partners that participated in the July and August 2014 annual review meetings include the following:

<b>Member</b>	<b>Agency</b>
Belinda Johnson-Cornett	Florida Department of Health in Osceola County
Donna Sines	Community Vision
Sue Ring	Community Vision
Karen Beary-Croson	Catholic Charities of Central Florida
Joanna Conley	Poinciana Medical Center Hospital
Dorrie Croissant	Florida Hospital
Chris Falkowski	The Transition House
Beverly Hougland	Osceola Council on Aging
Warren Hougland	Osceola Council on Aging
Amanda Kraft	Osceola County District Schools
JoEllen Ravell-Mallone	Victim Services Center
Bakari Burns	Orange Blossom Family Health Center
Ken Peach	Health Council of East Central Florida
Brent Burish	St. Cloud Regional Medical Center
Michael Capranica	Osceola County Fire and Rescue
Debra Perleberg	Health Insurance Store
Linda Clarke	Florida Department of Health in Osceola County staff facilitator
Melissa Lugo	Florida Department of Health in Osceola County staff facilitator

## **Overview of the Community Health Improvement Plan (CHIP)**

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In early 2013, the Department of Health in Osceola County convened the Osceola Health Leadership Council (HLC) CHIP planning team. (The HLC is comprised of a diverse leadership group of key public health system partners and stakeholders including Board of County Commissioners, government services, school system, local university, healthcare, social services, non-profits, and businesses). The HLC's planning team facilitated the CHIP process through using the National Association of City and County Health Official's Mobilizing for Action through Planning and Partnership (MAPP) strategic planning model. The CHIP planning team held a gathering of a multitude of community stakeholders and key partners on May 2, 2013 for the **2013 Osceola Business of Health Summit**. This collaborative effort included subject matter experts from across a diverse group of partners that conducted the four assessments suggested by the MAPP process. Individually, the assessment yielded in-depth analyses of factors and forces that impact population health. Taken together, the assessment findings contribute to a comprehensive view of health and quality of life in Osceola County.

During *MAPP Phase 4: Identification of Strategic Issues* that was begun during the development of the 2012 Community Health Assessment, one of the major tools used was the Community Balanced Scorecard, which helped identify strategic objectives and set measureable targets to move our community forward in improving health. The 2012 Community Health Assessment that includes the high level Community Balanced Scorecard provides the foundation for this Community Health Improvement Plan (CHIP).

Based on the results of the two Osceola Summits on Health in 2010 and 2011 and the four MAPP assessments, including an analysis of health statistical data and community feedback, the HLC CHIP planning team drafted a list of strategic priorities. The selection process was based on:

- Whether the health status statistical data were trending up or down and comparison with State, Regional, and Peer County averages, and the National average. The Healthy People 2020 goals also were considered.
- Consideration was given to the fact that Osceola's population segments considered at greater risk for health disparities, Black / African American and Hispanic, represent the majority population. When combined, these population groups represent the following majority: Osceola County, 59%; Kissimmee, 71%; and Poinciana, 76%.
- Community perception of health and related socio-economic issues in Osceola County.
- Given our available resources and capacity within Osceola's public health system, what improvement opportunities have the potential to have the greatest impact during the next three years (of the MAPP action cycle).

The following criteria also were used to assist in the determination of the most important strategic objectives:

1. Must move toward addressing a strategic issue

2. Must be realistic
3. Should be attainable in 1-3 years during the MAPP action cycle period
4. Must be measurable.

The HLC's CHIP planning team's drafted strategic priorities were presented for review and vetting during the **2013 Osceola Business of Health Summit**. The Summit was held May 2, 2013 at the Florida Hospital Celebration Nicholson Center. There were approximately 130 representatives from health care (local public health, hospitals, and health providers); public health officers from neighboring Orange and Seminole Counties; businesses; service organizations; Osceola County government and elected officials; faith-based; university system; Osceola County School District; Kissimmee and St. Cloud Chambers of Commerce; and citizens of Osceola County.



Strategies that emerged from the Summit breakout sessions served to affirm and further support the work done in the prior Summits, the four MAPP assessments, the 2012 Community Health Assessment, and the Community Balanced Scorecard. These strategies also served to support the development process for *MAPP Phase 5: Formulating Goals & Strategies*. Strategy suggestions included:

1. Expanding the scope and type of health care practice approaches.
2. Identifying solutions so that the uninsured / underinsured residents can get reduced cost laboratory and diagnostic testing for diabetes and cardiovascular illnesses.
3. Community Care Model – Evidence-based practice models to reduce hospital readmissions, manage patients with multiple chronic diseases, and reduce emergency department visits.
4. Developing a “Community Resource Toolkit” to identify existing resources and market this in a community awareness campaign.
5. Reaching women of childbearing age with health education and preconception peer support to improve health before pregnancy.

The HLC planning team further developed the findings and presented these to the entire HLC committee. The HLC set priorities through a facilitated consensus process by looking for cross-cutting strategic issues that had emerged. The HLC reached consensus on four strategic issue areas for the CHIP's Community Balanced Scorecard: 1.0 Community Assets; 2.0 Community Process and Learning; 3.0 Community Implementation; and 4.0 Community Health Status.

See Table below for Strategic Issue Areas/Community Health Priorities with their goals, developed by a workgroup of subject matter experts and vetted by the Osceola HLC.

<b>Table 1: 2013-2016 Osceola County Strategic Objectives</b>	
<b>Strategic Issue / Community Health Priority</b>	<b>Strategic Objectives</b>
1.0 Community Assets	Improve utilization of available resources
2.0 Community Process & Learning	Improve delivery & quality of health care using evidence-based best practices
3.0 Community Implementation	Expand primary care capacity for uninsured / underinsured residents
	Increase referrals to connect residents to Primary Care Medical Home
	Increase capacity of specialty care network
4.0 Community Health Status	Improve population-based diabetes health outcomes
	Improve population-based cardiovascular health outcomes
	Improve population-based fetal and infant mortality / morbidity rates

The HLC developed Osceola’s priorities, goals, targets, and measures and ensured alignment with the Florida Department of Health’s state priorities and the national Healthy People 2020 goals and objectives.

The CHIP’s priority areas and strategic objectives are delineated in the *Osceola Community Balanced Scorecard* which contains the goals and assigned owners. The *Community Balanced Scorecard* ensures that the CHIP goals are both meaningful and measurable. Cascading down from the *Community Balanced Scorecard* are the individual CHIP Action Plans that the HLC developed for each goal. These CHIP Action Plans are the working documents that each goal owner, which is an HLC member, prepares as a monthly progress report and presents for discussion at HLC meetings.

The annual review and evaluation, scheduled for August of each year, helps to inform key decision makers to decide whether the right strategies were implemented, as well as whether the desired outcomes are being achieved.

## **Summary of CHIP Annual Review Meeting**

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The HLC held the CHIP annual review during two consecutive monthly meetings, July 3 and August 7, 2014. The process included discussion of key information from the monthly CHIP action plan reports. The HLC used this information to determine how successful the progress has been over the past year for each strategic objective, to decide whether the right strategies had been implemented, and to determine whether the desired outcomes had been achieved.

During this annual review, the HLC discussed the availability of community resources and other determinants for action. The group then deliberated, ranked, and rated each of the original CHIP strategic objectives. Discussion took place and all members had an opportunity to present their view of the health themes that emerged. This led to a prioritization of the actions plans and consensus on the top five critical areas to be focused on during 2015. These areas included:

1. Improve utilization of available resources
2. Increase referrals to connect residents to a Primary Care Medical Home
3. Expand primary care capacity
4. Improve population-based cardiovascular disease health outcomes
5. Improve population-based diabetes health outcomes

Note: While the HLC determined that these top five areas will be the primary focus during 2015, work will continue on the remaining CHIP strategic objectives.

### **Strategic Issue Area #1: Community Assets**

It is critical that the public health system utilize as many of the community assets as are available. The public health system needs to look at how we can leverage more community resources to work to address our priority health issues; how to best reach out to attract residents, partners, and other resources; and how to develop these assets to improve the public's health.

#### **Goal: Improve utilization of available resources**

*Strategy 1: To expand the Community Vision Resource Tool to contain health care and related resources to inform residents. Key Partners: Community Vision*

*Strategy 2: To increase the distribution of the Community Vision Resource Tool so that more residents have access to this tool. Key Partners: Community Vision*

*Strategy 3: To develop the Community Vision Resource Tool in software application format for use in electronic media. Key Partners: Community Vision and City of Kissimmee*

**Why this is important to our community:**

Improving the public's health requires an extensive array of community partners. Osceola County is a community with an impressive history of coming together to address the public's health. The community has greatly benefited from the tangible results that have occurred over the past decade based on the needs identified through three iterations of Mobilizing for Action through Planning and Partnerships.

Objective	Indicator	Current Level	Target	Status	Explanation of Status*
1.1 Improve utilization of available resources	<b>1.1.1</b> <ul style="list-style-type: none"> <li>Expand Community Vision Community Resource Tool to include health by September 2013.</li> </ul>	<b>1.1.1</b>	<b>1.1.1</b>	<b>1.1.1</b> 	<ul style="list-style-type: none"> <li>Printed 1,000 copies August 2013</li> <li>Uploaded PDF on CV website July 2013</li> <li>Uploaded by Ken Peach on Healthy Measures website July 2013</li> </ul>
	<b>1.1.2</b> <ul style="list-style-type: none"> <li>Increase distribution of Community Vision Resource Tool from 2,000 to 2,500 by September 2013.</li> </ul>	<b>1.1.2</b> 2,000	<b>1.1.2</b>	<b>1.1.2</b> 	<b>1.1.2</b> <ul style="list-style-type: none"> <li>Distributed 40 copies at Non-Profit Roundtable meeting August 7, 2013</li> <li>Distributed 100 copies at School District Back to School Fair August 28, 2013</li> <li>Emailed to Osceola agencies August 30, 2013</li> <li>6/30/14: Identify new funders to offset costs of research, redesign and increased content.</li> </ul>
	<b>1.1.3</b> <ul style="list-style-type: none"> <li>Develop Community Resource Tool in software application format by June 2014.</li> </ul>	<b>1.1.3</b>	<b>1.1.3</b>	<b>1.1.3</b> 	<b>1.1.3</b> <ul style="list-style-type: none"> <li>July 2014: Secured grant funding from City of Kissimmee to develop online format</li> <li>July 2014: Plan to secure Valencia Community College intern to host focus groups to improve usability of guide.</li> <li>Information to be updated for inclusion in web-based guide</li> </ul>

## **Strategic Issue Area 2.0: Community Process & Learning**

### **2.1 Improve delivery & quality of health care using evidence-based best practices**

The community process and learning perspective includes ensuring the community achieves improvements in policies and plans; evaluation; health status monitoring; evidence-based research; and the MAPP process. The public health system looks at:

- How can we ensure public health goals influence planning and policy decisions?
- How can we get organizations to work more as a team to benefit the community?
- How best can we learn from monitoring, evaluation, and research to guide policies/plans?

#### **Goal: Improve delivery & quality of health care using evidence-based best practices**

*Strategy 1: Ensure an increased understanding of asthma and treatment compliance in children 5-12 years old. Key Partners: Nemours Children's Hospital, University of Central Florida (UCF), and Osceola County Schools.*

*Strategy 2: Improve senior citizen's perception of their physical / psychological well-being after attending a 12-week Tai Chi course. Key Partners: Council on Aging and Osceola Regional Hospital.*

*Strategy 3: Explore the potential for setting up pilot programs to manage patients with multiple chronic diseases. Key Partners: Health Council of East Central Florida*

<b>Why this is important to our community:</b>					
The public health system need to ensure that public health goals influence planning and policy decisions; that organizations work more as a team to benefit the community; and that we use learning from monitoring, evaluation, and research to guide policies and plans.					
<b>Objective</b>	<b>Indicator</b>	<b>Current Level</b>	<b>Target</b>	<b>Status</b>	<b>Explanation of Status*</b>
2.1 Improve delivery & quality of health care using evidence-based best practices	2.1.1 Increased understanding of asthma and treatment compliance in children 5-12 years old	2.1.1	2.1.1 Offer summer camp for children 5-12 years old by June 2014	2.1.1 	2.1.1 <ul style="list-style-type: none"> <li>• Summer Camp was held at Kissimmee Middle School in June 2014. 30 children participated.</li> <li>• American Lung Association sponsored the camp utilizing Open Airways curriculum and facilitated by the UCF College of Nursing faculty and students.</li> <li>• Parent training component incorporated each day of camp</li> <li>• Research component: Daily Peak flow meter</li> </ul>

					<p>(PFM) and Fraction of exhaled nitric oxide (FeNO) collected on a daily basis. Aims to examine quantitative measures with asthma control and child health care utilization.</p> <ul style="list-style-type: none"> <li>• Utilization of Asthma Care Plan.</li> <li>• Examined child plan with actual home management.</li> <li>• Research will also examine pre- and post-test of knowledge of management of asthma;collecting clinical data (PFM, FeNO) and asthma care plan assessment.</li> <li>• Results are being reviewed for measured success.</li> <li>• Results and action plans will be implemented into community based on evidenced success .</li> </ul>
	<p><b>2.1.2</b> Improved senior citizens' perception of their physical / psychological well-being after attending 12 weeks of Tai Chi classes</p>	<p><b>2.1.2</b></p>	<p><b>2.1.2</b> Offer Tai Chi classes at Osceola Council on Aging by June 2014</p>	<p><b>2.1.2</b></p> <p></p>	<p><b>2.1.2</b></p> <ul style="list-style-type: none"> <li>• Established Tai Chi classes for seniors.</li> <li>• Measuring attendees' perception of their physical/psychological well-being after attending 12 weeks of Tai Chi classes.</li> <li>• Classes will be offered on a weekly basis.</li> <li>• Surveys and feedback will measure self-reported improvements in physical/ psychological well-being post 12-weeks.</li> </ul>
	<p><b>2.1.3</b> Explore potential for setting up pilot programs to manage patients with multiple</p>	<p><b>2.1.3</b></p>	<p><b>2.1.3</b> Evaluate pilot practices by June 2014</p>	<p><b>2.1.3</b></p> <p></p>	<p><b>2.1.3</b></p> <ul style="list-style-type: none"> <li>• Evaluate pilot practices that have proven ability to reduce hospital readmissions, management patients with multiple chronic diseases,</li> </ul>

	chronic diseases by June 2014.				<p>and reduce ED visits for potential replication in Osceola County Including: 1) Poly-Chronic Care Network (PCCN) in Brevard County and 2) Special Care Unit (SCU) model in West Orange County.</p> <ul style="list-style-type: none"> <li>• No funding, people or materials required as these programs funded by organizations in Brevard and West Orange counties.</li> <li>• Re-evaluation is needed to determine funding opportunities for program development and implementation.</li> </ul>
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**Strategic Issue Area 3.0: Community Implementation**

**3.1 Expand primary care capacity for uninsured / underinsured residents**

The priority areas identified in Osceola County’s three iterations of MAPP over the past 10 years included growing numbers of uninsured, lack of primary care services, lack of chronic care services, and inappropriate emergency room (ER) utilization. MAPP’s findings are clearly validated by the data on primary care provider shortages and preventable hospital stays (as shown by data listed in the CHIP). *County Health Rankings* show Health Factors, including clinical access, are in a slightly upward (negative) trend where Osceola ranked 41<sup>st</sup> out of Florida’s 67 counties in 2012; 40<sup>th</sup> in 2013; and 42<sup>nd</sup> in 2014. Osceola is federally designated as a Health Professional Shortage Area (HPSA) for primary medical, dental, and mental health. Access to healthcare was identified in community surveys as one of the top five concerns for residents.

**Goal: Expand primary care capacity for uninsured / underinsured residents**

*Strategy 1: Ensuring clinical care access for Osceola’s low income, health disparate, disadvantaged population will have a positive effect on population-based health status indicators.*

*Key Partners: Florida Department of Health in Osceola County’s federally qualified health centers and Catholic Charities of Central Florida*



disadvantaged, low income, and uninsured, inappropriately utilize Emergency Medical Services (EMS) 911 calls for non-emergency, chronic illness care. Many of these residents do not have a medical home where they can receive primary health care services for ambulatory care sensitive conditions. Inappropriate EMS utilization will be reduced by referring frequent users to a primary care medical home.

**Goal: Implement Phone-to-Home Patient Navigator Referral System**

*Strategy 1: To increase the number of residents connected to needed health / social services by implementing a Phone-to-Home patient navigator referral system to connect residents who are frequent non-emergency users of emergency medical services (EMS) to a Primary Care Medical Home.*

*Key Partners: Florida Department of Health in Osceola County’s federally qualified health centers, Osceola County Fire-Rescue, and Osceola County.*

Why this is important to our community:					
One of the main barriers to improving community-wide health outcomes is in ensuring clinical access for the disadvantaged, health disparate populations that tend to have higher rates of chronic diseases and related poor health outcomes. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups. Having a Primary Care Medical Home will help ensure these residents have access to healthcare appropriate for their needs.					
Objective	Indicator	Current Level	Target	Status	Explanation of Status*
<b>Objectives listed in the CHIP</b>	**this is the space for the indicator used to measure performance/success**	**current value of the indicator as of last reporting**	**Target value set within the CHIP**	**See box below for explanation**	**An explanation of the status given
<b>3.2.1</b> Increase number of residents connected to needed health / social services.	<ul style="list-style-type: none"> <li>Decrease number of frequent users of EMS 911 calls for ambulatory care sensitive conditions.</li> </ul>	TBD Need to establish 2014 baseline number of residents connected to needed services.	TBD Develop 2015 target percentage increase in number of residents connected to needed services.		<ul style="list-style-type: none"> <li>Research conducted to develop model program.</li> <li>Hired Patient Navigator position to work in Osceola County 911 Call Center to connect residents with needed health/social services.</li> <li>Need to establish 2014 baseline for number of residents connected to needed health/social services.</li> <li>Develop target for percentage of increase in number of residents connected to needed health/social services during following year</li> </ul>

					(2015). <ul style="list-style-type: none"> <li>• Consult with Osceola County and Florida Department of Health legal to ensure health privacy compliance.</li> </ul>
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### 3.2.2 Increase referrals to connect residents to Primary Care Medical Home

#### Goal: 3.2.2 Increase referrals to connect residents to Primary Care Medical Home

*Strategy a: To increase community awareness of importance of preventive health care.*

*Strategy b: To develop a Health Literacy Campaign.*

*Key Partners: Community Vision and Osceola Health Leadership Council*

Why this is important to our community:					
One of the main barriers to improving community-wide health outcomes is in ensuring clinical access for the disadvantaged, health disparate populations that tend to have higher rates of chronic diseases and related poor health outcomes. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups.					
Objective	Indicator	Current Level	Target	Status	Explanation of Status*
<b>3.2.2</b>	<b>3.2.2</b>		<b>3.2.2</b>		
<b>3.2.2a</b> Community awareness campaign to educate residents on importance of preventive health care	<b>3.2.2a</b> To develop a community awareness campaign to educate residents on importance of preventive health care by March 2014.		<b>3.2.2a</b> An ongoing community awareness campaign developed by 2014.		<ul style="list-style-type: none"> <li>• Developed a community health education campaign re: importance of primary care vs. emergency room for ambulatory care sensitive conditions.</li> <li>• Developed Public Service Announcements and other media avenues to target health disparate areas.</li> <li>• Determined health disparate areas in order to target with awareness campaign blitz.</li> </ul>
<b>3.2.2b</b> Health Literacy Campaign	<b>3.2.2b</b> To develop a Health Literacy Campaign		<b>3.2.2b</b> An ongoing health literacy campaign developed by 2014.		<ul style="list-style-type: none"> <li>• Regularly participate in and host community events, health fairs, networking events and area festivals to promote access to primary care services and healthy</li> </ul>

					living practices <ul style="list-style-type: none"> <li>• Implemented Healthy 100 campaign promoting healthy living to individual and business consumers</li> <li>• Developed patient messages in culturally appropriate materials and settings</li> </ul>
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**(Strategic Issue Area 3.0: Community Implementation – con’t.)**

**3.3 Increase capacity of specialty care network**

Osceola County has a critical shortage of referral sources for specialty providers, particularly for children who are disadvantaged, low income, and uninsured.

**Goal: Develop pediatric specialty referral system**

*Strategy 1: Establish a pediatric specialty referral system so that disadvantaged, low income, uninsured children can be seen by specialty providers when referred by their primary care pediatrician.*

*Key Partners: Florida Hospital*

Why this is important to our community:					
One of the main barriers to improving community-wide health outcomes is in ensuring clinical access for the disadvantaged, health disparate populations that tend to have higher rates of chronic diseases and related poor health outcomes. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups. Having a Primary Care Medical Home will help ensure these residents have access to healthcare appropriate for their needs.					
Objective	Indicator	Current Level	Target	Status	Explanation of Status*
3.3 Increase capacity of specialty care network.	3.3 Develop a pediatric specialty referral system.		By June 2016		<ul style="list-style-type: none"> <li>• Resource inventory research continues to determine specialty capacity.</li> <li>• Specialist recruitment efforts continue through outreach by current volunteer physicians.</li> <li>• Discussions by providers to design and implement referral system.</li> </ul>

## **Strategic Issue Area 4.0: Community Health Status**

### **4.1 Improve Population-based Diabetes Health Outcomes**

Diabetes is the second leading cause of death from chronic diseases in Osceola County. This accounts for 3.4% of all deaths. In terms of the potential for health disparity, the diabetes death rate was higher in the Hispanic and Black populations. Both populations worsened in the rate of diabetes from 2007-09 to 2009-11 (Blacks from 26.5 per 100,000 population to 38.2; Hispanics from 24.9 to 25.3).

#### **Goal: Improve Population-based Diabetes Health Outcomes**

*Strategy 1: By improving diabetes health outcomes of the low income, health disparate, disadvantaged population served in Osceola's federally qualified health centers, we will have a positive effect on population-based health status indicators. We will track quarterly measurement through medical record reviews of patients attending the federally qualified health centers; annual reporting for the Unified Data System (UDS) report; and adherence to prescribed treatment regime*

*Key Partners: Florida Department of Health in Osceola County's federally qualified health centers.*

<b>Why this is important to our community:</b>					
One of the main barriers to improving community-wide diabetes health outcomes is in reaching the disadvantaged, health disparate populations that tend to have higher rates of diabetes and related poor health outcomes. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups.					
<b>Objective</b>	<b>Indicator</b>	<b>Current Level</b>	<b>Target</b>	<b>Status</b>	<b>Explanation of Status*</b>
<b>4.1</b> Improve diabetes health outcomes by improving HbA1c levels that are less than/equal to 9 from 2012 baseline of 81.3% to 85.4% by September 2016. (Healthy People	Percentage of DOH-Osceola/FQHC diabetic patients whose HbA1c levels are $\leq$ 9.  Data Source: DOH-Osceola Quarterly / annual chart audits	80%  Data Source: DOH-Osceola 3 <sup>rd</sup> quarter 2015 chart audits	85.4%  (Healthy People 2020 target)		<ul style="list-style-type: none"> <li>• Chart audit reports are shared with the clinical providers so they are cognizant of the issues that need addressing.</li> <li>• Providers and clinical support staff continue to educate our patients on the HbA1c levels and encourage them to adhere to the treatment plan to improve their levels.</li> <li>• Patients with HbA1c levels higher than 8.5 are referred to Lifestyle Intervention Family Education Diabetes Management program at Council on Aging</li> </ul>

2020 target)					admission. They receive classes on nutrition, exercise, medication monitoring, complications, depression, and stress.
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## 4.2 Improve Population-based Cardiovascular Health Outcomes

Heart Disease is the leading cause of death (26.4% of all deaths) in Osceola County. When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths. In terms of the potential for health disparity, the hypertension death rate trend for the Black population has increased from 2.9 per 100,000 population in 2008-10 to 8.5 in 2009-2011. Reducing hypertension is a controllable risk factor that can have a positive impact on overall cardiovascular health.

### Goal: 4.2.1 Improve Population-based Cardiovascular Health Outcomes

*Strategy 1: By improving cardiovascular health outcomes of the low income, health disparate, disadvantaged population served in Osceola's federally qualified health centers, we will have a positive effect on population-based health status indicators. We will track quarterly measurement through medical record reviews of patients attending the federally qualified health centers; annual reporting for the Unified Data System (UDS) report; and adherence to prescribed treatment regime.*

*Key Partners: Florida Department of Health in Osceola County's federally qualified health centers*

**Why this is important to our community:**

One of the main barriers to improving community-wide cardiovascular health outcomes is in reaching the disadvantaged, health disparate populations that tend to have higher rates of hypertension and other cardiovascular illnesses. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups.

Objective	Indicator	Current Level	Target	Status	Explanation of Status*
<p><b>4.2.1</b> Improve cardiovascular health outcomes by improving the percentage of adult patient diagnosed with hypertension whose most recent blood pressure was less than 140/90 from 2012 baseline of 56%% to 61.2% by September 2016. (Healthy People 2020 target)</p>	<p>Percentage of DOH-Osceola/FQHC adult patients diagnosed with hypertension whose most recent blood pressure was &lt; 140/90.</p> <p>Data Source: DOH-Osceola Quarterly / annual chart audits</p>	<p>54%</p> <p>Data Source: DOH-Osceola 3<sup>rd</sup> quarter 2015 chart audits</p>	<p>61.2%</p> <p>(Healthy People 2020 target)</p>		<ul style="list-style-type: none"> <li>• Chart audit reports are shared with the clinical providers so they are cognizant of the issues that need addressing.</li> <li>• Providers and clinical support staff continue to educate our adult hypertensive patients on blood pressure control and encourage them to adhere to the treatment plan to improve levels.</li> <li>• In process of hiring chronic disease nurse case manager to work with patients whose blood pressure is uncontrolled and provide education and monitoring for better outcomes.</li> </ul>

**4.2 Improve Population-based Cardiovascular Health Outcomes**

Heart Disease is the leading cause of death (26.4% of all deaths) in Osceola County. When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths. In terms of the potential for health disparity, the hypertension death rate trend for the Black population has increased from 2.9 per 100,000 population in 2008-10 to 8.5 in 2009-2011. Reducing tobacco usage is a controllable risk factor that can have a positive impact on overall cardiovascular health.

**Goal: 4.2.2 Improve Population-based Cardiovascular Health Outcomes**

*Strategy 1: Establish policy change that restricts tobacco usage to create smoke-free environments in public places such as health facilities, schools, businesses, and multi-unit dwelling places.*

*Key Partners: Osceola Tobacco Free Partnership*

**Why this is important to our community:**

Heart disease and cancer are the two leading causes of death in Osceola County. Tobacco usage is a controllable risk factor that can have a positive effect on both these health outcomes. *County Health Rankings 2012* show 22% of Osceola adults smoke tobacco compared to 19% Florida average and 14% for the national benchmark.

Objective	Indicator	Current Level	Target	Status	Explanation of Status*
4.2.2 Policy change to restrict tobacco usage in certain areas to create smoke-free environments.	By June 2014: Establish policy change to restrict tobacco usage in certain areas to create smoke-free environments.		At least one policy change by June 2014		<ul style="list-style-type: none"> <li>• January 6, 2014 – County resolution #14-005R passed urging tobacco retailers to stop the sale and marketing of flavored tobacco products in Osceola County.</li> <li>• January 2014 – local employer (Park Place Behavioral Health) passed tobacco-free policy on its campuses and encourages tobacco cessation to both staff and patients. They were able to accomplish this through education and resources provided by the DOH-Osceola Tobacco Prevention Program staff and Osceola Tobacco Free Partnership.</li> <li>• DOH-Osceola Tobacco Prevention Program staff continues to educate multi-unit dwelling property managers and to provide assistance with cessation classes; 3-Ways to Quit; resident education opportunities, and technical assistance as requested.</li> </ul>

**4.3 Improve Fetal / Infant Mortality / Morbidity**

Osceola County’s rates for the following are all worse than Healthy People (HP) 2020 targets:

1. Fetal deaths (6.5 per 1,000 live births; HP 2020=5.6)
2. Neonatal deaths (4.5 per 1,000 live births; HP 2020=4.1)
3. Infant deaths (6.3 per 1,000 live births; HP 2020=6.0)
4. Premature births (13.6%; HP 2020=11.4%)
5. Low birth weight (8.3%; HP 2020=7.8%)

In terms of the potential for health disparity, fetal, neonatal, and infant death rates are worse for Osceola’s Black and Hispanic populations as shown in the *2012 Osceola Community Health Assessment*. Improving the well-being of mothers, infants, and children is an important public health goal that can have a tremendous impact on our community’s current and future health.

**Goal: 4.3.1 Improve Fetal / Infant Mortality / Morbidity**

*Strategy 1: Develop a health education campaign on importance of healthy weight pre-pregnancy; provide health education blitzes in targeted zip codes and census tracts with highest rates of fetal / infant mortality / morbidity; and provide health education for the community at large.*

*Key Partners: Fetal & Infant Mortality Review (FIMR) Community Action Team*

Why this is important to our community:					
Improving the well-being of mothers, infants, and children is an important public health goal that has a tremendous impact on the current and future health of Osceola County. Our community can help reduce the risk of maternal and infant mortality and pregnancy-related complications by increasing access to quality health care before and between pregnancies and providing education on the importance of a healthy weight for mothers at the time of conception and throughout pregnancy. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.					
Objective	Indicator	Current Level	Target	Status	Explanation of Status*
4.3.1 Improve percent of births to mothers that were obese at time pregnancy occurred.	<p>Improve the percentage of births to mothers that were obese at time pregnancy occurred from 2012 baseline of 22.5% to 20.3% by September 2016.</p> <p>Data Source: Florida CHARTS</p>	<p>22.5%</p> <p>Data Source: Florida CHARTS 3-year rolling rates 2009-12 (Next 3-year rolling rate will be 2012-15; published in 2015)</p>	<p>20.3%</p> <p>By 2016 (Healthy People 2020 target)</p>		<ul style="list-style-type: none"> <li>• January 2014- Osceola Gazette newspaper article regarding Birth Defects Preention Month and promoting pre-conception health and healthy pre-pregnancy weight.</li> <li>• February 2014 – Benefits of and materials on healthy weight distributed in Census Tracts 423 Zip 34744 and Census Tract 435 Aip 34769.</li> <li>• June 2014 – presented/distributed information on healthy eating and Healthiest Weight Florida initiative as related to pre-pregnancy health at FIMR Community Action and Case Review team meetings. Partners asked to distribute to</li> </ul>

					<p>their contacts.</p> <ul style="list-style-type: none"> <li>• July 2014 - (1) Update on FIMR activities and its connection with “Healthiest Weight Initiative” presented at Healthy Start Coalition board meeting and at Health Leadership Council meeting. (2) Healthy Start Coalition signed contract with Lynx Bus System for placards in English / Spanish in 20 buses serving Osceola and South Orange Counties and reaching approximately 24,000 riders per day.</li> </ul>
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**Goal: 4.3.2 Improve Fetal / Infant Mortality / Morbidity**

*Strategy 1: Policy change to ensure health providers use unified messages about pre-pregnancy and inter-conception health.*

*Key Partners: Fetal & Infant Mortality Review (FIMR) Community Action Team*

Why this is important to our community:					
<p>Improving the well-being of mothers, infants, and children is an important public health goal that has a tremendous impact on the current and future health of Osceola County. Our community can help reduce the risk of maternal and infant mortality and pregnancy-related complications by increasing access to quality health care before and between pregnancies and providing education on the importance of a healthy weight for mothers at the time of conception and throughout pregnancy. Healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.</p>					
Objective	Indicator	Current Level	Target	Status	Explanation of Status*
4.3.2 Policy change to ensure health providers use unified messages about pre-pregnancy and inter-conception health.	Policy change to ensure health providers use unified messages about pre-pregnancy and inter-conception health.		-By Jun 2014:  One or more policy changes		<ul style="list-style-type: none"> <li>• February 2014 – FIMR Community Action Team in process of developing action plan to address nutrition/healthy weight</li> <li>• July 2014 – Developed comprehensive email list of OB, Pediatric and family practice health care providers in process.</li> </ul>

\* Status indicators are as follows:



= Little to no movement towards objective target



= some progress towards meeting the objective target



= reached or surpassed objective target

## Revisions

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The HLC held the CHIP annual review during two consecutive monthly meetings, July 3 and August 7, 2014. The process included discussion of key information from the monthly CHIP action plan reports. The HLC used this information to determine how successful the progress has been over the past year for each strategic objective, to decide whether the right strategies had been implemented, and to determine whether the desired outcomes had been achieved.

During this annual review, the HLC discussed the availability of community resources and other determinants for action. The group then deliberated, ranked, and rated each of the original CHIP strategic objectives. Discussion took place and all members had an opportunity to present their view of the health themes that emerged. This led to a prioritization of the actions plans and consensus on the top five critical areas to be focused on during 2015. These areas included:

1. Improve utilization of available resources
2. Increase referrals to connect residents to a Primary Care Medical Home
3. Expand primary care capacity
4. Improve population-based cardiovascular disease health outcomes
5. Improve population-based diabetes health outcomes

Note: While the HLC determined that these top five areas will be the primary focus during 2015, work will continue on the remaining CHIP strategic objectives.

### **Strategic Issue Area #1: Community Assets**

It is critical that the public health system utilize as many of the community assets as are available. The public health system needs to look at how we can leverage more community resources to work to address our priority health issues; how to best reach out to attract residents, partners, and other resources; and how to develop these assets to improve the public's health.

#### **Goal: Improve utilization of available resources**

*Strategy 1: To expand the Community Vision Resource Tool to contain health care and related resources to inform residents. Key Partners: Community Vision **Completed***

*Strategy 2: To increase the distribution of the Community Vision Resource Tool so that more residents have access to this tool. Key Partners: Community Vision*

*Strategy 3: To develop the Community Vision Resource Tool in software application format for use in electronic media. Key Partners: Community Vision and City of Kissimmee*

Revised Strategic Objective	Current Strategic Objective	Indicator (Data Source)	Current Level	Target	Explanation for Revision
<b>1.1</b>  Improve utilization of available resources  <u><b>Note: 9/20/14</b></u> Remains the same as 2014-2015 Strategic Priority.	<b>1.1.1</b> <b>Completed</b>	<b>1.1.1</b>	<b>1.1.1</b>	<b>1.1.1</b>	<b>Completed</b>
	<b>1.1.2</b> <u><b>Note: 9/20/14</b></u> Remains the same as 2014-2015 Strategic Priority.	<b>1.1.2</b> 6/30/14: Identify new funders to offset costs of research, redesign and increased content.	<b>1.1.2</b>	<b>1.1.2</b>	<b>1.1.2</b> Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.
	<b>1.1.3</b> <u><b>Note: 9/20/14</b></u> Remains the same as 2014-2015 Strategic Priority.	<b>1.1.3</b> Develop Community Resource Tool in software application format by June 2016.	<b>1.1.3</b>	<b>1.1.3</b>	<b>1.1.3</b> Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.

### **Strategic Issue Area 3.0: Community Implementation**

#### **3.1 Expand primary care capacity for uninsured / underinsured residents**

The priority areas identified in Osceola County's three iterations of MAPP over the past 10 years included growing numbers of uninsured, lack of primary care services, lack of chronic care services, and inappropriate emergency room (ER) utilization. MAPP's findings are clearly validated by the data on primary care provider shortages and preventable hospital stays (as shown by data listed in the CHIP). *County Health Rankings* show Health Factors, including clinical access, are in a slightly upward (negative) trend where Osceola ranked 41<sup>st</sup> out of Florida's 67 counties in 2012; 40<sup>th</sup> in 2013; and 42<sup>nd</sup> in 2014. Osceola is federally designated as a Health Professional Shortage Area (HPSA) for primary medical, dental, and mental health. Access to healthcare was identified in community surveys as one of the top five concerns for residents.

**Goal: Expand primary care capacity for uninsured / underinsured residents**

*Strategy 1: Ensuring clinical care access for Osceola’s low income, health disparate, disadvantaged population will have a positive effect on population-based health status indicators.*

*Key Partners: Florida Department of Health in Osceola County’s federally qualified health centers and Catholic Charities of Central Florida*

Revised Strategic Objective	Current Strategic Objective	Indicator (Data Source)	Current Level	Target	Explanation for Revision
<p><b>3.1</b> Increase number of patients accessing primary care services.</p> <p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p><b>3.1.1</b></p> <ul style="list-style-type: none"> <li>Number of patients accessing primary care services at DOH-Osceola/FQHC health centers from 2012 baseline of 23,221 by 15% in 2016.</li> </ul>	<p><b>3.1.1</b></p> <p><b>2013:</b> 23,030</p> <p>Data Source: 2013 Unified Data System (UDS) report is current</p>	<p><b>3.1.1</b></p> <hr/> <p><b>2016:</b> 26,704</p> <p>*This will be 15% increase over 2012 baseline</p>	<p><b>3.1.1</b></p> <p>Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.</p>

**3.2.1 Increase referrals to connect residents to Primary Care Medical Home**

The priority areas identified in Osceola County’s three iterations of MAPP over the past 10 years included growing numbers of uninsured, lack of primary care services, lack of chronic care services, and inappropriate emergency room (ER) utilization. Residents, particularly those disadvantaged, low income, and uninsured, inappropriately utilize Emergency Medical Services (EMS) 911 calls for non-emergency, chronic illness care. Many of these residents do not have a medical home where they can receive primary health care services for ambulatory care sensitive conditions. Inappropriate EMS utilization will be reduced by referring frequent users to a primary care medical home.

**Goal: Implement Phone-to-Home Patient Navigator Referral System**

*Strategy 1: To increase the number of residents connected to needed health / social services by implementing a Phone-to-Home patient navigator referral system to connect residents who are frequent non-emergency users of emergency medical services (EMS) to a Primary Care Medical Home.*

*Key Partners: Florida Department of Health in Osceola County's federally qualified health centers, Osceola County Fire-Rescue, and Osceola County.*

Revised Strategic Objective	Current Strategic Objective	Indicator (Data Source)	Current Level	Target	Explanation for Revision
<p><b>3.2.1</b> Increase number of residents connected to needed health / social services.</p> <p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<ul style="list-style-type: none"> <li>Decrease number of frequent users of EMS 911 calls for ambulatory care sensitive conditions.</li> </ul>	<p>TBD</p> <p>Need to establish 2014 baseline number of residents connected to needed services.</p>	<p>TBD</p> <p>Develop 2015 target percentage increase in number of residents connected to needed services.</p>	<p>Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.</p>

### **Strategic Issue Area 4.0: Community Health Status**

#### **4.1 Improve Population-based Diabetes Health Outcomes**

Diabetes is the second leading cause of death from chronic diseases in Osceola County. This accounts for 3.4% of all deaths. In terms of the potential for health disparity, the diabetes death rate was higher in the Hispanic and Black populations. Both populations worsened in the rate of diabetes from 2007-09 to 2009-11 (Blacks from 26.5 per 100,000 population to 38.2; Hispanics from 24.9 to 25.3).

#### **Goal: Improve Population-based Diabetes Health Outcomes**

*Strategy 1: By improving diabetes health outcomes of the low income, health disparate, disadvantaged population served in Osceola's federally qualified health centers, we will have a positive effect on population-based health status indicators. We will track quarterly measurement through medical record reviews of patients attending the federally qualified health centers; annual reporting for the Unified Data System (UDS) report; and adherence to prescribed treatment regime*

*Key Partners: Florida Department of Health in Osceola County's federally qualified health centers*

Revised Strategic Objective	Current Strategic Objective	Indicator (Data Source)	Current Level	Target	Explanation for Revision
<p>4.1 Improve diabetes health outcomes by improving HbA1c levels that are less than/equal to 9 from 2012 baseline of 81.3% to 85.4% by September 2016. (Healthy People 2020 target)</p> <p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p>Percentage of DOH-Osceola/FQHC diabetic patients whose HbA1c levels are <math>\leq</math> 9.</p> <p>Data Source: DOH-Osceola Quarterly / annual chart audits</p>	<p>80%</p> <p>Data Source: DOH-Osceola 3<sup>rd</sup> quarter 2015 chart audits</p>	<p>85.4%</p> <p>(Healthy People 2020 target)</p>	<ul style="list-style-type: none"> <li>Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.</li> </ul>

## 4.2 Improve Population-based Cardiovascular Health Outcomes

Heart Disease is the leading cause of death (26.4% of all deaths) in Osceola County. When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths. In terms of the potential for health disparity, the hypertension death rate trend for the Black population has increased from 2.9 per 100,000 population in 2008-10 to 8.5 in 2009-2011. Reducing hypertension is a controllable risk factor that can have a positive impact on overall cardiovascular health.

### Goal: 4.2.1 Improve Population-based Cardiovascular Health Outcomes

*Strategy 1: By improving cardiovascular health outcomes of the low income, health disparate, disadvantaged population served in Osceola's federally qualified health centers, we will have a positive effect on population-based health status indicators. We will track quarterly measurement through medical record reviews of patients attending the federally qualified health centers; annual reporting for the Unified Data System (UDS) report; and adherence to prescribed treatment regime.*

*Key Partners: Florida Department of Health in Osceola County's federally qualified health centers*

Revised Strategic Objective	Current Strategic Objective	Indicator (Data Source)	Current Level	Target	Explanation for Revision
<p>4.2.1 Improve cardiovascular health outcomes by improving the percentage of adult patient diagnosed with hypertension whose most recent blood pressure was less than 140/90 from 2012 baseline of 56%% to 61.2% by September 2016. (Healthy People 2020 target)</p> <p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p><b>Note: 9/20/14</b> Remains the same as 2014-2015 Strategic Priority.</p>	<p>Percentage of DOH-Osceola/FQHC adult patients diagnosed with hypertension whose most recent blood pressure was less than 140/90.</p> <p>Data Source: DOH-Osceola Quarterly / annual chart audits</p>	<p>54%</p> <p>Data Source: DOH-Osceola 3<sup>rd</sup> quarter 2015 chart audits</p>	<p>61.2%</p> <p>(Healthy People 2020 target)</p>	<ul style="list-style-type: none"> <li>• Remains the same. HLC voted by consensus to keep the objective the same and voted it as one of the top five priorities for 2014-15.</li> </ul>

# Accomplishments

Goal	Objective	Accomplishment
<p>1. Policy change to restrict tobacco usage in certain areas to create smoke-free environments.</p>	<p>1.1 At least one policy change by June 2014</p>	<ul style="list-style-type: none"> <li>• January 6, 2014 – County resolution #14-005R passed urging tobacco retailers to stop the sale and marketing of flavored tobacco products in Osceola County.</li> <li>• January 2014 – local employer (Park Place Behavioral Health) passed tobacco-free policy on its campuses and encourages tobacco cessation to both staff and patients. They were able to accomplish this through education and resources provided by the DOH-Osceola Tobacco Prevention Program staff and Osceola Tobacco Free Partnership.</li> </ul>
<p><b>How it's important for our community:</b> Heart disease and cancer are the two leading causes of death in Osceola County. Tobacco usage is a controllable risk factor that can have a positive effect on both these health outcomes. <i>County Health Rankings</i> 2012 show 22% of Osceola adults smoke tobacco compared to 19% Florida average and 14% for the national benchmark.</p>		
<p>2. Increase number of residents connected to needed health / social services.</p>	<p>1.1 Decrease number of frequent users of EMS 911 calls for ambulatory care sensitive conditions.</p>	<ul style="list-style-type: none"> <li>• Patient Navigator position to work in Osceola County 911 Call Center to connect residents with needed health/social services.</li> </ul>
<p><b>How it's important for our community:</b> One of the main barriers to improving population-based health outcomes in Osceola County is in ensuring clinical access for the disadvantaged, health disparate populations that tend to have higher rates of chronic diseases and related poor health outcomes. Factors include, but are not limit to, poverty and low health literacy. These social determinants disproportionately affect low income groups. Ensuring access to a Primary Care Medical Home will help these residents obtain healthcare appropriate for their needs. This was a successful project involving our community partners and it relates to the <i>Essential Public Health Services</i> by: 1) Inform, educate, and empower people about health issues; 2) mobilize community partnerships to identify and solve health problems; and 3) link people to needed personal health services and assure the provision of health care when otherwise unavailable.</p>		

## Conclusion

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Osceola County's CHIP serves as a roadmap for a continuous health improvement process for the local public health system by providing a framework for the chosen strategic issue areas. It is not intended to be an exhaustive and static document. We will evaluate progress on an ongoing basis through quarterly CHIP implementation reports and quarterly discussion by the Osceola Health Leadership Council and other community partners. We will conduct annual reviews and revisions based on input from partners and create CHIP annual reports by September of each year. The CHIP will continue to change and evolve over time as new information and insight emerge at the local, state and national levels.

By working together, we can have a significant impact on the community's health, improving where we live, work and play and realize the vision of a healthier Osceola County.

## Appendices

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The following appendices are included in the CHIP Annual Review Report:

1. Annual CHIP Review Community Meeting Agendas
2. Annual CHIP Review Community Meeting Minutes
3. Annual CHIP Review Community Meeting Sign-in Sheet
4. Comprehensive List of Community Partners – the list of member names and organizations is included in the sign-in sheets



## Agenda Health Leadership Council July 3, 2014

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- I. Call to Order Belinda Johnson-Cornett, Chairperson
  
- II. Approval of the June 5<sup>th</sup> Meeting Minutes
  
- III. Order of Business
  - a. CHIP Action Plan Updates
    - Cardiovascular Outcomes – Belinda Johnson-Cornett, OCHD
    - Diabetes Outcomes – Belinda Johnson-Cornett, OCHD
    - Fetal Infant Mortality Review Committee – Linda Clarke, RN, OCHD
    - Tobacco Prevention – Melissa Lugo, OCHD
    - Mobile Medical Van – Karen Beary, Catholic Charities
    - Family Resource Guide – Donna Sines, Community Vision
  
  - b. CHIP/CBSC Action Plan – Priority Determination
  
- IV. What's Up/New Business
  
- V. Adjournment

Notes:



Agenda  
Health Leadership Council  
August 7, 2014

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- I. Call to Order Belinda Johnson-Cornett, Chairperson
  
- II. Approval of the July 3, 2014 Meeting Minutes
  
- III. Order of Business
  - a. CHIP Action Plans – Workgroup Planning
    - 1.1: Improve Utilization of available resources: this includes the phone to home patient navigator system and increase number of residents connected to needed health/social services. CHAMPIONS: Donna Sines, Chris Falkowski, Vilma Quintana and Dan Capranica
    - 3.2: Increase referrals to connect residents to Primary Care Medical Home: Community awareness campaign to educate residents of the importance of preventive care. CHAMPIONS: Karen Beary, Bev Hougland, Jim Shanks
    - 3.1: Expand primary care capacity: Increase number of patients accessing primary care services at OCHD/FQHC health centers CHAMPIONS: Belinda Johnson-Cornett, Wes Fischer/Debra Perleberg
    - 4.1: Improve diabetes health outcomes CHAMPIONS: Warren Hougland, Dorie Croissant
    - 4.2: improve cardiovascular disease health outcomes CHAMPIONS: Brent Burish, Chris Falkowski, Amanda Kraft
  
  - b. CHIP Action Plan Updates
    - Cardiovascular Outcomes
    - Diabetes Outcomes
    - Fetal Infant Mortality Review Committee
    - Tobacco Prevention
  
- IV. What’s Up/New Business
  
- V. Adjournment



## Minutes Health Leadership Council July 3, 2014

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### I. Call to Order

**Belinda Johnson-Cornett, Chairperson**

**Summary:** Chairperson Belinda Johnson-Cornett called the meeting to order at 8:32 a.m.

**Present:** Karen Beary-Croson, Dorie Croissant, Chris Falkowski, Beverly Hougland, Warren Hougland, Belinda Johnson-Cornett, Amanda Kraft, Ken Peach, Brent Burish, Michael Capranica, Linda Clarke, Melissa Lugo, Debra Pereleberg, Donna Sines (staff) and Sue Ring (staff).

### II. Approval of the June 5<sup>th</sup> Meeting Minutes

**Summary:** Minutes of the June 5<sup>th</sup> meeting were presented for approval. Chris Falkowski motioned for approval. Ken Peach second. Minutes approved.

### III. Order of Business

#### a. CHIP Action Plan Updates

- **Fetal Infant Mortality Review Committee – Linda Clarke, RN, OCHD**

**Summary:** Linda Clarke provided an overview of FIMR Committee activities and strategies to improve birth outcomes, especially in black population. A pilot project in Marydia has included education campaigns, health fairs and community outreach to encourage healthy practices and activities pre-pregnancy through birth. Promoted messaging includes:

- \* Healthy babies starts w/ healthy moms and families
- \* Everyone is involved
- \* Breastfeeding is best

Free pregnancy info is available in a "Text for Baby" campaign - [text4baby.com](http://text4baby.com). They have also been emphasizing the importance of healthy weight as obesity has a negative impact on birth outcomes. This effort coincides with the state's Healthiest Weight Florida campaign.

**- Tobacco Prevention – Melissa Lugo, OCHD**

**Summary:** Melissa provided an update on Tobacco Prevention efforts. The Tobacco Free Partnership focuses on adults with SWAT (Students Working Against Tobacco) focuses on youth. Strategies include encouraging tobacco free workplaces & multi-unit housing, limiting tobacco product marketing at point of sale and harms of flavored tobacco products.

**b. CHIP/CBSC Action Plan – Priority Determination**

**Summary:** Belinda provided an overview of CHIP activities to date including the background of the process, purpose and goals of the Community Health Improvement Plan. To help move action plans forward, the Health LOC decided to prioritize the action plans and strategic objectives. Work plan champions and team members were also identified. The top 5 Strategic Objectives and CHIP were determined as:

1. 1.1: Improve Utilization of available resources: this includes the phone to home patient navigator system and increase number of residents connected to needed health/social services. CHAMPIONS: Donna Sines, Chris Falkowski, Vilma Quintana and Dan Capranica
2. 3.2: Increase referrals to connect residents to Primary Care Medical Home: Community awareness campaign to educate residents of the importance of preventive care. CHAMPIONS: Karen Beary, Bev Hougland, Jim Shanks
3. 3.1: Expand primary care capacity: Increase number of patients accessing primary care services at OCHD/FQHC health centers CHAMPIONS: Belinda Johnson-Cornett, Wes Fischer/Debra Perleberg
4. 4.1: Improve diabetes health outcomes CHAMPIONS: Warren Hougland, Dorie Croissant
5. 4.2: improve cardiovascular disease health outcomes CHAMPIONS: Brent Burish, Chris Falkowski, Amanda Kraft

**IV. What's Up/New Business**

- Catholic Charities: Karen Beary reported Seminole Co has expressed interest in Mobile Medical Van. She also reported that patient volume at St. Thomas Clinic has actually decreased. They are exploring ways to promote clinic availability.
- St. Cloud Regional Medical Center: Brent Burish reported hospital is expanding services and recently acquired some new primary care physicians increasing patient capacity.
- HCECF: Ken Peach continues to work on the REACH grant for Seminole Co.
- COA: Warren Hougland reported they received a HFUW Secondary Care Expansion Grant increasing their capacity and providing for diagnostic services in W192 area. Additionally, capacity has increased in St. Cloud through expansion of the OCHD.

The Council has partnered with Extension Services to offer a community garden at Valencia. Garden proceeds will go to area food pantries. The Meals on Wheels program was recognized by the national association and was awarded \$10K. The Success Express continues to grow providing transportation to homeless/low income to get to TECO and Valencia.

- Community Vision: Sue & Donna encouraged HLOC members to participate in the upcoming discover Osceola event Thursday, September 18<sup>th</sup> from 4-8pm @ OHP.
- Florida Blue: Vilma Quintana reminded the committee that she has an ACA Community Educator available to provide information on the business and consumer implications of the Affordable Care Act.
- Transition House: Chris Falkowski said their Victory Village complex is full. The recently added therapy services continue to grow due to demand for service.
- OCDS: The partnership Asthma Camp with Nemours was a great success. The District is analyzing results to determine camp success and possible expansions and/or program enhancements.
- The Health Insurance Store: Debra Perleberg reported that they led the state of Florida in ACA sign-ups with over 15,000. More than 80% were new insurance sign-ups.

#### **V. New Business**

- Due to a conflict with a Council on Aging special event, the August Health LOC meeting will take place immediately following the breakfast event. The meeting should start around 9-9:15 am.

#### **VI. Adjournment**

**Summary:** With no further business to discuss, the meeting was adjourned at 10:02 a.m.



## Minutes Health Leadership Council August 7, 2014

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### **I. Call to Order**

**Belinda Johnson-Cornett, Chairperson**

**Summary:** In Belinda Johnson-Cornett's absence, Donna Sines called the meeting to order at 9:30 a.m.

**Present:** Karen Beary-Croson, Joanna Conley, Dorie Croissant, Chris Falkowski, Beverly Hougland, Amanda Kraft, Bakari Burns, Donna Sines (staff) and Sue Ring (staff).

### **II. Approval of the July 3, 2014 Meeting Minutes**

**Summary:** The minutes of the July 3<sup>rd</sup> meeting were presented for approval. Chris Falkowski motioned for approval. Dorie Croissant second. Minutes approved as presented.

### **III. Order of Business**

#### **a. CHIP Action Plans – Workgroup Planning**

**Summary:** Donna provided a background of the Community Health Improvement Plan and related Action Plans. To help keep forward progress on plans, the Health Leadership Council decided to prioritize Action Plans. At the July meeting, HLOC members reviewed all action plans and strategic objectives. Champions were determined to lead specific action plan efforts with support from all Health Leadership members. The following action plans were determined to be of highest priority. The associated champion(s) are listed with each plan.

- 1.1: Improve Utilization of available resources: this includes the phone to home patient navigator system and increase number of residents connected to needed health/social services. CHAMPIONS: Donna Sines, Chris Falkowski, Vilma Quintana and Dan Capranica
- 3.2: Increase referrals to connect residents to Primary Care Medical Home: Community awareness campaign to educate residents of the importance of preventive care. CHAMPIONS: Karen Beary, Bev Hougland, Jim Shanks
- 3.1: Expand primary care capacity: Increase number of patients accessing primary care services at OCHD/FQHC health centers CHAMPIONS: Belinda Johnson-Cornett, Wes Fischer/Debra Perleberg

- 4.1: Improve diabetes health outcomes CHAMPIONS: Warren Hougland, Dorie Croissant
- 4.2: improve cardiovascular disease health outcomes CHAMPIONS: Brent Burish, Chris Falkowski, Amanda Kraft

Donna reminded the council that work will continue on additional action plans with status updated at future Health Leadership meetings.

**b. CHIP Action Plan Updates**

- Cardiovascular Outcomes
- Diabetes Outcomes
- Fetal Infant Mortality Review Committee
- Tobacco Prevention

**Summary:** Donna encouraged the council members to review the updated action plans provided in the meeting packet.

**IV. Adjournment**

**Summary:** Due to the lateness of the meeting start, the Council decided to table further action items to the September meeting. The next meeting will be Thursday, September 4<sup>th</sup> at 8:30 a.m. at the Council on Aging. With no further business to discuss, the meeting was adjourned at 10:30 a.m.

Health Leadership Council

Health Leadership Council  
July 3, 2014

Sign In	First	Last	Agency	Address 1	City	ST	Zip	Phone	Email
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Health Leadership Council

This is the HLC sign-in sheet for August 7, 2014. It also is a comprehensive list of all HLC members.

Health Leadership Council  
August 7, 2014

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	Patria	Alguila	Hispanic Health Initiatives	201 Live Oaks Blvd.	Casselberry	FL	32707	407-339-2001	patria@hhi2001.org
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	Donna	Sines	Community Vision	704 Generation Point #101	Kissimmee	FL	34744	407-933-0870	dsines@communityvision.org
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*[Handwritten signature]*

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