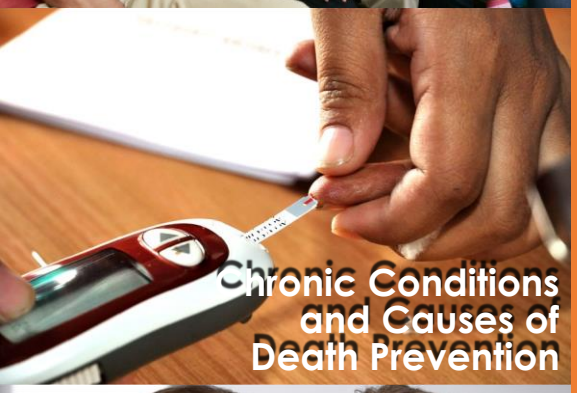

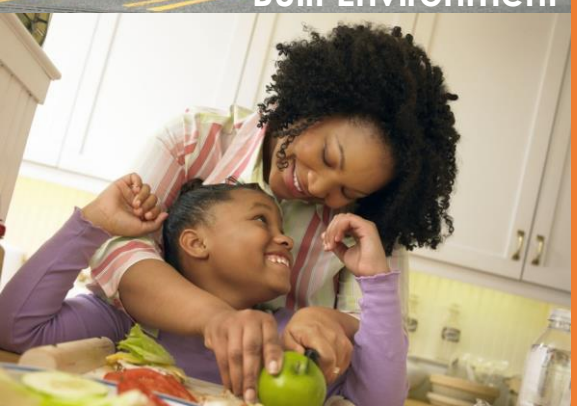

Community Health Improvement Plan (CHIP)

2016-2020

Created: March 2017

Revised: March 2019

Florida HEALTH Orange County

Produced by
Florida Department of Health in Orange County
&
CHIP Collaborative

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ACKNOWLEDGEMENTS

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Visionary Vanguard Group
Lauren Josephs, PhD

Winter Park Health Foundation
Lisa Portelli

HEALTH FOR ALL ORANGE

In an effort to capture a closing remark (from those who participated in the development of the CHIP), we asked them:

How do you see the implementation of the CHIP benefiting the community?

"The development process for Orange County's CHIP enhanced cross-sector collaboration. Implementation strengthens the collaborations and supports increased intergovernmental coordination as we strive to improve health for every resident."

Elizabeth Whitton, AICP
Metro Plan Orlando

"Access to healthy food is foundational to the health of the community. As the single largest provider of emergency and supplemental food to low-income people in the community, Second Harvest is keenly aware of the multiple negative effects of food insecurity. We believe that public recognition of food insecurity in the CHIP is a major step in improving access to healthy foods and nutrition education for people who are disproportionately affected by chronic diet-related disease."

Karen Broussard, MSW, LCSW
Second Harvest Food Bank

"The implementation of the Community Health Improvement Plan (CHIP) sets the bar for Orange County to achieve its goals for a healthy, sustainable, and equitable future. By aligning our public health, transportation, housing, and healthy food assets together, we create a cohesive strategy that will address the health needs of our citizens. From our diverse backgrounds and expertise, the crafting of the CHIP will ensure that various aspects of the built environment are improved and that we are able to reduce barriers that prevent our brothers and sisters from obtaining access to healthy foods and safer modes of travel."

Elwy Gonzalez, AICP
Orange County Transportation Planning

"It will provide healthy alternatives in multiple areas of importance to all people."

Judy Pizzo, MSURP
Florida Department of Transportation

HEALTH FOR ALL ORANGE

"For any community health improvement plan to 'move the needle' by actually favorably impacting reported health indicators, an 'all hands on deck' approach is required. With the exception of indicators completely within the control of the health department (i.e. number of environmental monitoring points), improved community health requires the work of public health 'partners' who contribute to the results. Every organization that can impact one or more of the CHIP indicators must now let the health department know how it will undertake its portion of community health improvement."

Ken Peach, MBA, FACH
Health Council of East Central Florida

"We hope that the CHP will provide valuable county level direction on regional community health priorities that benefit low income, minority, and vulnerable populations."

Anwar Georges-Abeyie
Florida Hospital

"I see the benefits in that we will be able, as a group, provide much more comprehensive and inclusive services. "

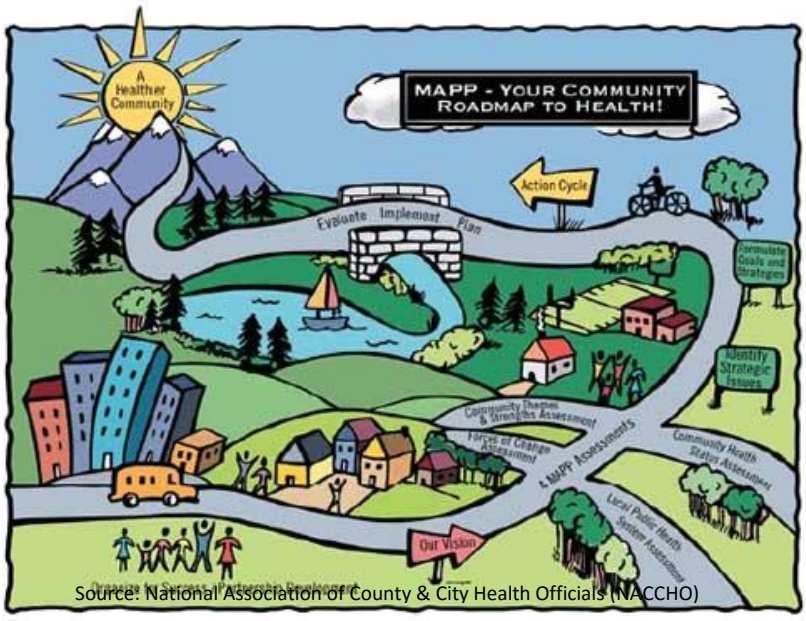
Gricelle Negron, MA, MPH
University of Florida Institute of Food and Agricultural Sciences (UF/IFAS) Extension

"One thing I definitely see the CHIP doing is facilitating comprehensive health care that affirms the whole person rather than just specific issues they are experiencing. A lot of the discussions that fed into the development of the CHIP addressed intersecting health experiences shaped by a vast web of contextual factors across multiple domains. This is the perspective we need to embrace as we plan out our approach to community health and wellness in the 21st Century.

Alexandra Nowakowski, PhD, MPH
Florida State University
College of Medicine

INTRODUCTION

The *Community Health Improvement Plan (CHIP)* is a comprehensive approach to assessing community health, developing and implementing action plans to improve community health through local public health system partner engagement[5]. The community health improvement process addresses the social and environmental determinants of health by focusing on the knowledge, assets, and resources available in the community.



Source: National Association of County & City Health Officials (NACCHO)

The Florida Department of Health in Orange County (DOH-Orange) joined efforts with hospitals and surrounding county health departments to collaboratively compose a comprehensive Community Health Needs Assessment (CHNA), in which all the gathered data helped guide the community health improvement plan process. The collaboration engaged the consulting services of Impact Partners, LLC to lead them through the expanded process. Impact Partners, LLC worked to evaluate the progress of previous priorities by comparing historical benchmark data and measure long term progress[3].

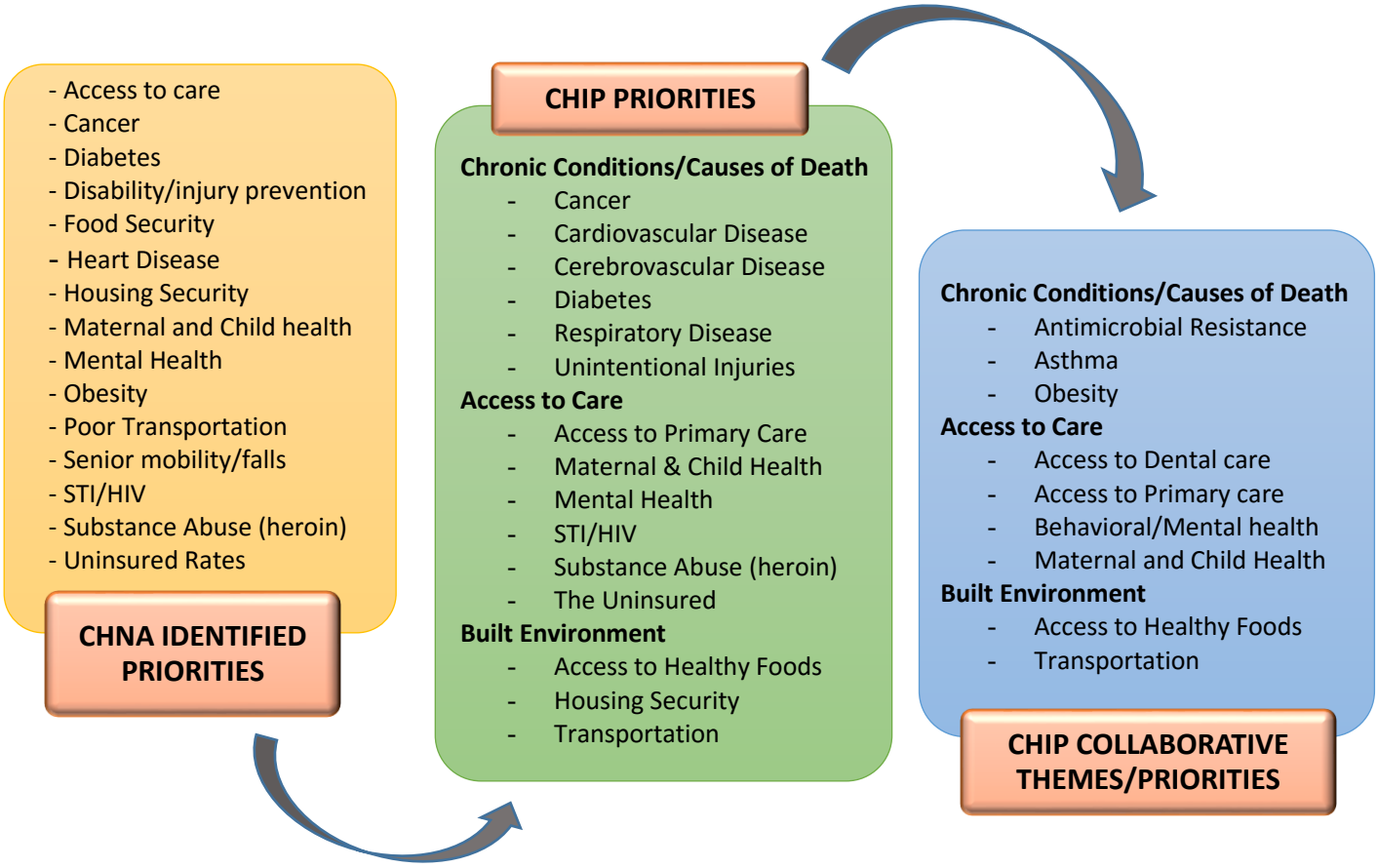
The CHIP & CHNA are required by all 67 county health departments in Florida. As a best practice for health assessments and planning, most health departments use Mobilizing for Action through Planning and Partnership (MAAP), which was developed by the National Association for City and County Health Officials (NACCHO) *(See Appendix A & Appendix B).* Based on the assessment results, the identification of strategies and goals are supported by the development of SMART (specific, Measurable, Achievable, Relevant, and Timed) objectives used to measure progress and success. The SMART objectives are aligned with the current Florida Department of Health State Strategic Plan, Orange's Strategic Plan, State Health Improvement Plan (SHIP), Healthy People 2020 targets. The objectives will be implemented based on evidence based steps and programs. The Action Cycle is a continuous process of planning, implementing, and evaluating that provides a sustainable method for the community to build upon accomplishments and attain even greater achievements.

Chronic Diseases & Causes of Death
Antimicrobial Resistance
Obesity
Asthma
Access to Care
Access to Primary Care
Behavioral /Mental Health
Maternal Health
Built Environment
Transportation
Access to Healthy Foods

The CHIP process, which followed the Community Health Assessment (CHA) and the Local Public Health System Assessment (LPHSA) identified three priority areas, and within each priority the collaborative identified specific needs as listed in the chart.

CHIP PROCESS

Based on the data gathered in the Community Health Needs Assessment (CHNA) *(See Appendix C)*, the County level collaborative identified 15 focus areas. When the first Community Health Improvement Plan face to face meeting was held, on **November 2nd 2016** at the Florida Department of Health in Orange County, the 15 focus areas were organized by three themes. Data from each Community Health Needs Assessment *(See Appendix C)* focus area, along with the information gathered from the Local Public Health System Assessment *(See Appendix D)* was presented to all participants for baseline knowledge. Following the data presentation, community participants were asked to self-select themselves into one of the themed groups according to their work/organization's priority area of focus. While in their workgroup, participants worked together to develop a goals and objectives based on their organizations area of focus. The group then utilized a multi-voting/consensus building method to prioritize the work they will be contributing to for the next three years. In the second meeting, on **January 10th 2017**, participants were invited for another face to face meeting. The objective of this meeting was to add specific activities from each participating organization. The following diagram shows the synthesized focus areas:



It takes a coordinated community effort across all sectors to improve the health of Orange County. Implementation of the action plans will ultimately strengthen the public health infrastructure; enhance the planning, research and development of community health partnerships, and promote and support the health, well-being and quality of life of residents; for a brief description of the current state of Orange County, FL please see Appendix E.

Evaluation: To ensure effectiveness, the Health for All Orange Collaborative will work together to implement and evaluate each action plan activity for success and impact on a periodic basis. CHIP participants will update their progress, on an evaluation template (See Appendix F), to continually and collaboratively improve the health of the county.

PRIORITY 1: CHRONIC DISEASES & CAUSES OF DEATH

Antibiotics and similar drugs, together called antimicrobial agents, have been used for the last 70 years to treat patients who have infectious diseases. Since the 1940s, these drugs have greatly reduced illness and death from infectious diseases. However, these drugs have been used so widely and for so long that the infectious organisms the antibiotics are designed to kill have adapted to them, making the drugs less effective[1].

The Department of Health in Orange County (DOH-Orange) has participated in a Healthcare Associated Infections and Antibiotic Stewardship Demonstration project with the National Association of County and City Health Officials (NACCHO) and the Center for Disease Control and Prevention (CDC).

GOAL 1: Reduce chronic conditions through education/prevention, and decrease the causes of death in our focus areas through health prevention activities.
Antimicrobial Resistance
Objective 1.1: Increase the number of Hospital-Acquired Infection (HAI) collaboration projects to at least 5 by December 2019
Performance indicator: # of Hospital-Acquired Infection (HAI) collaboration projects
Baseline: Baseline data is currently not available. The scheduled activities will provide the baseline information **Target Date:** December 2019 **Lead Organizations:** DOH- Orange Epidemiology & FSU College of Medicine

Alignment: No alignment to Healthy People 2020, State or Local strategic plan; however, identified as key issues by county-wide Collaborative working on HAI.
Policy Changes: No policy changes at this moment
Assets & Resources: See Appendix G

PRIORITY 1: CHRONIC DISEASES & CAUSES OF DEATH

Excess pounds increase an individual's risk of major health problems; people who are obese are at higher risk of developing a chronic disease. Efforts to reduce Orange County resident weight will help decrease incidence and prevalence of chronic diseases.

GOAL 1: Reduce chronic conditions through education/prevention, and decrease the cause of death in our focus areas through health prevention activities.
Obesity
Objective 1.2. Decrease by 3% the prevalence of obesity among Orange County residents by December 2019 through culturally and linguistically appropriate nutrition education, physical activity and food access efforts (measured by reductions in Hb A1c and BMI).
Performance Indicator(s): % of OC residents with Hb A1c levels in "normal range" % of OC residents with BMI levels in "normal range"
Baseline: Adults who meet moderate physical activity recommendations = *20.2% (2013)* Adults Diagnosed with Diabetes = *10.3% (2013)* Adults who are Obese = *25% (2013)* Middle School Students Reporting BMI at or above 95th Percentile *9% (2012)* High School Students Reporting BMI at or above 95th Percentile *14% (2012)* **Target Date:** December 2019 **Lead Organizations:** DOH- Orange, Florida Hospital, Orlando Health, UF/IFAS Extension

Alignment: Healthy People 2020 (0-5.1), Florida State Health Improvement Plan 2016-2019 (2.1.1); DOH-Orange Strategic Plan (C3.4.5); State Health Improvement Plan (TBD)
Policies Changes: Supporting community organizations to disseminate health education to adults and children
Assets & Resources: See Appendix G

PRIORITY 1: CHRONIC DISEASES & CAUSES OF DEATH

According to the American Lung Association, asthma is a major health problem in our society. Asthma affects both adults and children; it is the leading cause of limitations in daily activity[2]. Reducing the public burden of asthma through community interventions may help close disparities and improve outcome to all Orange County residents.

GOAL 1: Reduce chronic conditions through education/prevention, and decrease the causes of death in our focus areas through health prevention activities.
Asthma
Objective 1.3: Decrease by 3% emergency department use for asthma by in Orange County by December 2019.
Performance Indicator: # of Emergency Department visits due to asthma-related events
Baseline: Adult Emergency Department Visits due to Asthma: *3,335 (2015)* Children Emergency Department Visits due to Asthma: *3,672 (2015)* **Target Date:** December 2019 **Lead Organizations:** DOH- Orange, FSU College of Medicine, Florida Hospital

Alignment: No alignment to State and Local strategies; however, it was identified as a key issue in Community Health Needs Assessment; Healthy People 2020 (NW2)
Policy Changes: Adopt smoke free and indoor air quality policies in public schools; Policies for medical insurance reimbursements for asthma self-managing and home visits.
Assets & Resources: See Appendix G

PRIORITY 2: ACCESS TO CARE

Community Asset mapping is a positive approach to building a stronger community. It raises community awareness on strengths and resources available for a more effective linkage system to client /patients needed services.

GOAL 2: Increase Access to Primary Care (including behavioral, dental & maternal health) through asset mapping, linkage, partnerships, health information exchange, and community engagement.
Asset Mapping
Objective 2.1: Create an asset map to include behavioral, dental, maternal health, providers, and services in Orange County by September 30, 2017.
Performance Indicator: Create one map to be distributed to the community
Baseline: Baseline data currently not available. The scheduled activities will provide the baseline information **Target Date:** August 2018 **Lead Organizations:** DOH- Orange

Alignment: DOH-Orange Strategic Plan (CE.2.1, CE 4.2, CE 4.3); State Health Improvement Plan (TBD); Healthy People 2020 (AHS-5.1, 6.1, 6.2, 6.3)
Policy Changes: No Policy Changes
Assets & Resources: See Appendix G

PRIORITY 2: ACCESS TO CARE

GOAL 2: Increase access to primary care (including behavioral, dental & maternal health) through asset mapping, linkage, partnerships, health information exchange, and community engagement.
Education & Awareness
Objective 2.2: Increase education/awareness to health services by April 15, 2018.
Performance Indicator: Increase the # of efforts to educate about services per month.
Baseline: Baseline data currently not available. The scheduled activities will provide the baseline information **Target Date:** December 2018 **Lead Organizations:** DOH- Orange, Access to Care- CHIP Collaborative

Alignment: DOH-Orange Strategic Plan (CE 2.1, CE 4.2, CE 4.3); State Health Improvement Plan (TBD); Healthy People 2020 (AHS- 5.1, 6.1, 6.2, 6.3)
Policy Changes: No Policy Changes
Assets & Resources: See Appendix G

PRIORITY 2: ACCESS TO CARE

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured or underinsured, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access[9]. Collaborative community efforts in increasing access to care will aid in reducing overall health outcomes in a community.

GOAL 2: Increase Access to Primary Care (including behavioral, dental & maternal health) through asset mapping, linkage, partnerships, health information exchange, and community engagement.
Access to Care
Objective 2.3: Reduction in preventable conditions (mental health & Chronic disease) due to their inability to access care services by December 2019.
Performance Indicator: % or # decrease in Mental Health & Chronic Disease rates
Baseline: Adults who could not see a doctor at least once in the past year due to cost = *23.6% (2013)* Percent uninsured population = *19.9% (2015)* Adults who have ever been told they have diabetes = *10.3% (2013)* Deaths from diabetes = *242 counts (2015)* Preventable hospitalizations under 65 from congestive heart failure = *1,224 Count (2014)* Preventable hospitalization under 65 from Asthma = *1,955 count (2014)* Heroin Deaths = *69 (2014)* Cancer Deaths (All)= *1,755 count (2015)* Asthma Deaths = *14 counts (2015)* Suicide Deaths = *136 count (2015)* **Target Date:** August 2018 **Lead Organizations:** DOH- Orange, PCAN Network

Alignment: DOH-Orange Strategic Plan (CE 2.1, CE 4.2, CE 4.3); State Health Improvement Plan (TBD); Healthy People 2020 (AHS-3, AHS-5, AHS-6)
Policy Changes: No Policy Changes
Assets & Resources: See Appendix G

PRIORITY 3: BUILT ENVIRONMENT

Transportation is a commonly identified barrier in public health. Several studies have found transportation to be a barrier to prenatal care, preventative medical visits, cancer care, and chronic disease management, and access to healthy food establishments[9]. Working together as a community to improve transportation options will provide a positive outcome to the health community residents especially those in a more rural, low income community.

GOAL 3: Identify and leverage existing community resources that can equitably improve, access to healthy foods, transportation and connectivity.
Transportation
Objective 3.1: Ensure access to multi-modal options by providing equitable transportation alternatives to and within rural and urban areas across diverse income communities by December 2019.
Performance Indicator: Increase multi-modal options by 25%
Baseline: Baseline data not currently available. The scheduled activities will provide the baseline information. **Target Date:** December 2018 **Lead Organizations:** DOH-Orange, Metro Plan, East Central Florida Regional Planning Council, LYNX, Built Environment Collaborative

Alignment: DOH-Orange Strategic Plan (CE 2.1, CE 4.2, CE 4.3); State Health Improvement Plan (TBD); Healthy People 2020 (EH-2)

Policy Changes: Working with transportation sectors to create equitable and healthy transportation polices.

Assets & Resources: See Appendix G

PRIORITY 3: BUILT ENVIRONMENT

People who live in food deserts are less likely to have access to supermarkets or grocery stores that provide healthy choices for food[10]. With limited or no access to food retailers, these communities may be more likely to suffer from certain chronic disease. Adequate access to healthy foods is a key driver to maintain a healthy lifestyle. Collaborative efforts to ensure accessibility to healthy foods will help improve the health outcomes.

GOAL 3: Identify and leverage existing community resources that can equitably improve access to healthy foods, transportation and connectivity.
Access to Healthy Foods
Objective 3.2: Champion policies and partnerships that will increase availability to low cost healthy foods across communities by December 2019.
Performance Indicator: Increase low cost healthy foods availability to 25% across communities
Baseline: Baseline data not currently available. The scheduled activities will provide the baseline information. **Target Date:** December 2019 **Lead Organization:** DOH-Orange, Metro Plan Orlando, East Central Florida Regional Planning Council, Second Harvest, LYNX, Built Environment – CHIP Collaborative

Alignment: DOH-Orange Strategic Plan (CE 2.1, CE 4.2, CE 4.3); State Health Improvement Plan (TBD)

Policy Changes: Possible change in polices to increase access to healthy foods in food desert communities.

Assets & Resources: See Appendix G

Revisions (2017)

The following modifications was made to the CHIP as a collaborative decision with community partners with approval from the DOH-Orange Performance Management Council. These changes were based off the original

First set of changes: December 2017

***System Change Description**:*

- Goal 1, Objective 1.1, activity 1.1.3 will be revised by changing the name of the lead organizations to DOH; however, Orlando Health will still be reporting to this activity. No process will be affected
- Goal 1, Objective 1.1 activity 1.1.4 will be omitted. The process will not be completed
- Goal 1, Objective 1.2 activity 1.2.4 will be omitted. The process will not be completed
- Goal 1, Objective 1.2 activity 1.2.2a add Apopka
- Goal 1, objective 1.3 activity 1.3.2, 1.3.2.a, 1.3.2.b, and 1.3.2.c, one of the lead organizations will be omitted (UF/IFAS). No processes will be reported in this activity.
- Goal 1, Objective 1.3, activity 1.3.2 – 1.3.3 will be omitted. The processes will not be completed
- Goal 2, Objective 2.1 activity 2.1.2 will be revised to change the target date and lead organization. The process will take longer to complete.
- Goal 2, objective 2.1 activity 2.1.2 will be revised by changing the target date. The process will take longer to complete
- Goal 2, objective 2.1 activity 2.1.4 will be revised by changing the verbiage from the activity and the lead organization. No process will be affected
- Goal 2, objective 2.1 activity 2.1.5 will be revised by changing the target date. The process will take longer to complete.
- Goal 2, objective 2.1 activity 2.1.6 will be revised by changing the target date and lead organization. The process will take longer.
- Goal 2. Objective 2.2 activity 2.2.1 will be revised by changing the target date and lead organization. A difference organization will be responsible for reporting the process.
- Goal 2, objectives 2.2 activity 2.2.2 will be revised by changing the target date and lead organization. The process will take longer to complete.
- Goal 2, objectives 2.2 activity 2.2.3 will be revised by changing the target date and lead organization. The process will take longer to complete
- Goal 2, objectives 2.2 activity 2.2.4 will be omitted. The process will no longer to complete
- Goal 2, objectives 2.3 will be omitted. The process will no longer to complete
- Goal 3, all activities under object 3.1 and 3.2 will be revised by changing the target date. The processes will take longer to complete.
- Goal 3, objective 3.1., activity 3.1.2 will be rephrased to say Establish baseline data for communities by multiple methods. No process will be affected.

The request was requested by community partners working on the activities. Changes were suggested during CHIP meetings and changes occurred immediately after approval.

Community partners felt they needed more time in some activities. Target dates were realized to allow ample time for activities to be accomplished. Led individuals and organization took ownership on some activities, therefore, the change needs to be state on the document. There was an error when assigning an organization to an activity. Also, some changes needed to be made due to unresponsiveness and lack of commitment of some partners.

Second Set of Changes: March 2018

System Change Description *(state exactly what is being changed and what processes are affected)***:**
Some activities under Goal 1, 2 and 3 of the action plans will be revised or omitted. No processes will be affected.

The list of activities from Goals 1, 2, and 3 will be omitted from the CHIP document; however, the activities will not be omitted from the VMSG Dashboard, where activities will be tracked and any changes in the activities will be documented. No processes will be affected.

CHIP Administrator suggested the change to decrease the number of future change request procedures. Community partners agreed on the change.

Community partners working on the activity requested the change. Activities and activity target dates are subject to multiple changes throughout the CHIP process, therefore it was preferred to omit the activities from the CHIP document to decrease the number of multiple change request procedures. Changes will occur immediately after approval.

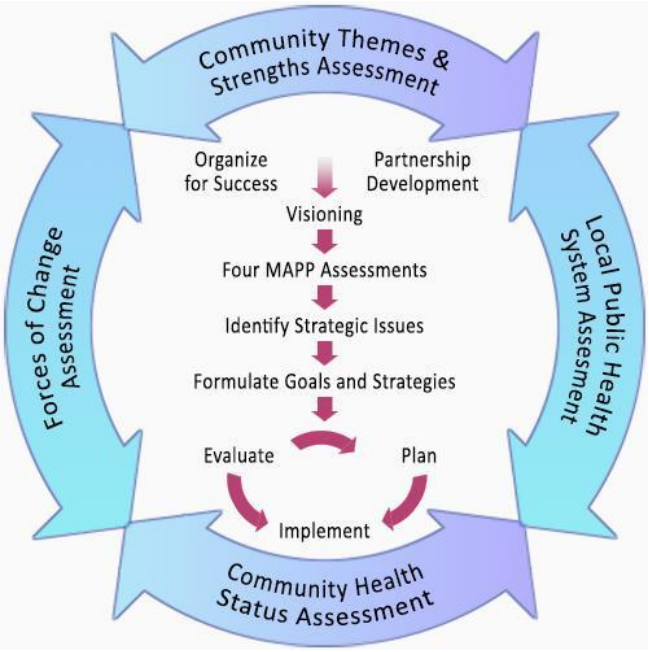
Revisions (2018)

No revisions were made on the CHIP objective; however, the only revision made was on extending the CHIP time period from 2016-2019 to 2016-2020. This revision was approved by the DOH-Orange Performance Management Council. Documentation of the revision can be found in the Change request form.

APPENDIX A: THE MAPP PROCESS

Framework: Mobilizing Action through Planning & Partnerships (MAPP)

The Mobilizing for Action through Planning & Partnership (MAPP) process is a community-driven strategic planning process for improving community health. The process helps communities apply strategic thinking to identify and prioritize health issues and identify resources to address them. There are four individual assessments.



Source: National Association of County & City Health Officials (NACCHO)

Community Themes & Strength Assessment (CTSA)

The CTSA provides a deep understanding of the issues and concerns residents feel are important. It answers questions such as: "What's important to our community?" and: How is quality of life perceived in our community?"

Local Public Health System Assessment (LPHSA)

The LPHSA is a comprehensive assessment of all the organizations/entities that contribute to the public's health. It answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

Community Health Assessment (CHA)

The CHA assesses the current health status of a community through the selection and collection of relevant data indicators. It identifies priority issues related to community health and quality of life.

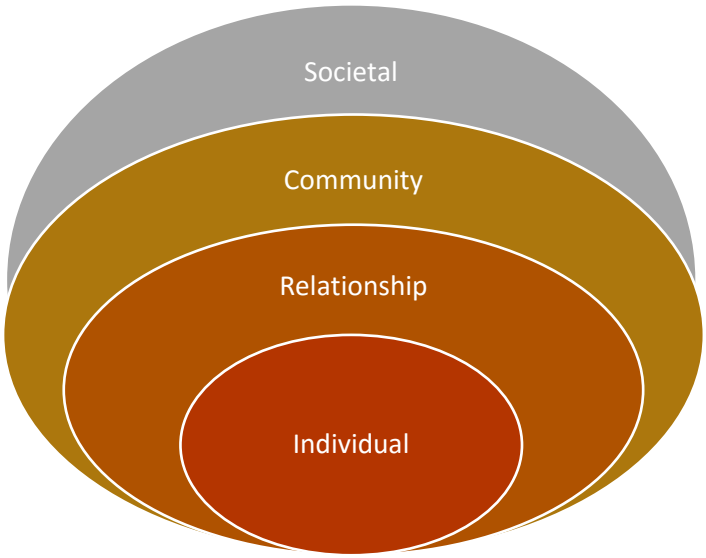
Forces of Change Assessments (FOCA)

The FOCA identifies forces, such as trends or events, and other issues that affect the context in which the community and its public health system operates.

APPENDIX B: KEY MAPP FINDINGS

APPENDIX C: COMMUNITY HEALTH ASSESSMENT (CHA)

Public health Framework



The *Social-Ecological Model of Health (SEM*) is used to holistically describe four social levels of influence that explain the complex interaction between individuals and the social context in which they live, work and play.

Health and well-being is shaped not only by behavior choices of individuals but also by complex factors that influence those choices. The SEM provides a framework to help understand the various factors and behaviors that affect health and wellness. This model can closely examine a specific health problem in a particular setting or context.

Data Source

Primary Data (Community Themes and Strengths Assessment)

- Consumer Surveys
- Provider Surveys
- Stakeholder In-depth Interviews
- Collaboration County-level Themes
- Community Conversations

Secondary Data (Community Health Assessment)

- U.S Census Bureau
- American Community Suevey
- Florida CHARTS
- Centers for Disease Control and Prevention's BRFSS
- U.S Department of Health and Human Services
- County Health Rankings
- Hospital Utilization data
- Hospital Claims Data
- Healthy People 2020

Benchmarking

For comparison, each indicator was measured against the performance of the state of Florida as a whole, as well as Healthy People 2020 (HP2020) objectives. Healthy People is an initiative of the U.S Department of Health and Human Services that provides empirically-based national objectives for improving the health of Americans.

In order to prioritize and address specific areas of focus, the Health for All Orange collaborative were presented with the most recent data available on the first meeting. The following information was presented:

County Health Rankings Source: County Health Rankings - 2016	Rank Orange County
Health Outcomes	21
Length of Life (Mortality)	7
Quality of Life (Morbidity)	43
Health Factors	21
Health Behaviors	18
Clinical Care	31
Socioeconomic	18
Physical Environment	53

County Health Rankings produce a report by ranking the counties in each state. Out of 67 counties, Orange County ranked better than 46 other counties in Health outcomes and Health Factors. However, the concern lies in that ranking for Health factors has dropped from 13 (2015), to now 21; as well as the health factors from 19 (2015) to now 21.

Mortality from certain chronic diseases and unintentional injuries is top concerns in the county. If morbidity and preventable unintentional injuries are reduced, it can greatly impact the life expectancy of Orange County residents. As the chart shows, all top causes of death have steadily been decreasing throughout the years, in exception of cerebrovascular disease and unintentional injuries. In addition, heroin related deaths and cases of infant deaths are also of great concern to the community.

TABLE 7.4 TOP CAUSES OF DEATH - ORANGE COUNTY (RATE PER 100,000) (2008-2014)

CAUSE OF DEATH	2008	2010	2012	2014	HEALTHY PEOPLE 2020 GOALS
CANCER	170.5	159.7	164.5	150.4	161.4
HEART DISEASE	167.2	155.7	153.9	150.6	103.4
UNINTENTIONAL INJURY	34.0	34.5	34.6	37.7	36.4
CHRONIC LOWER RESPIRATORY DISEASE	42.1	39.8	37.8	33.3	N/A
CEREBROVASCULAR DISEASE	37.1	30.7	34.8	35.7	34.8
DIABETES	26.1	23.4	24.7	23.1	65.8
ALZHEIMER'S DISEASE	22.3	20.1	20.4	20.3	N/A

ADDITIONAL CHA DATA

The Following Data was also shared with the participants:

- County Demographics
- Chronic Conditions & Causes of Death
  - Top 3 concerning cancers (Rectal, Breast, Lung)
  - GIS mapping on cancer prevalence by zip code
  - Hospitalizations rates from Cognitive Heart Failure
  - GIS mapping on Cardiovascular disease prevalence by zip code
  - Unintentional Fall rates, Unintentional Poisoning rates, and moto vehicle crash
  - Adult asthma diagnosis
  - Children's asthma hospitalization rates
  - GIS mapping of respiratory disease prevalence by zip code
  - GIS mapping of cerebrovascular disease prevalence by zip code
  - Adult diabetes diagnosis
  - Adult Obesity
  - GIS mapping of diabetes prevalence by zip code
  - Life Expectancy
- Access to care
  - GIS map of Medical Services
  - Adult Mental Health (depressive disorder)
  - Heroin Deaths
  - Uninsured adult
  - GIS map of uninsured residents by zip code
  - Infant Mortality
  - Pre-term & Low birth
  - Maternal Prenatal care
  - Births to uninsured mothers
  - HIV/AIDS cases
- Built Environment
  - Housing Security
    - Homelessness
    - Cost burden
  - Food Security
    - Food Deserts
    - SNAP Benefits
    - GIS mapping of Fast Food Locations in the County
  - Poverty
  - Transportation
- Data gathered from the Local Public Health System Assessment

APPENDIX D: LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System Assessment (LPHSA) serves as a snapshot of where the health department and public health system are relative to the National Public Health Performance Standard, and to progressively move towards refining, and improving outcomes for performance across the public health system.

Source: Centers for Disease Control, and Prevention

On March 16th 2016, 53 community partners from 37 different organization participated in an assessment. The self-assessment was structured around the Model Standards for each of the 10 Essential Public Health Services; 30 Model Standards which served as quality indicators that are organized into 10 Essential Public Health Service areas in the instrument and address the three core functions of Public Health; Priority of Model standards questionnaire, and a Local Health Department contribution, which was completed internally by Florida Department of Health in Orange County employees. After a thorough discussion of the Essential Services and its Model Standards, participants evaluated the public health system and voted on its performance *(Optimal Activity, Significant Activity, Moderate Activity, Minimal Activity, No Activity)*

Based on the responses provided by participants, an average was calculated by combining all the scores from each model standard performance measure. The average score was then inputted in the National Public Health Performance Standards database, where it then generated the average score to each Essential Service and overall. The following chart provides a composite summary of how the Model Standards performed in each of the 10 Essential Services. This gives a sense of the Local Public Health System's greatest strengths and weakness.

Optimal Activity (76-100%)	Moderate Activity (26-50%)
ES 2: Diagnose and Investigate	***ES1: Monitor Health Status***
Identification/Surveillance	Community Health Assessment
Emergency Responses	Current Technology
Laboratories	Registries
ES 5: Develop Policies and Plans	***ES 3: Inform, Educate, and empower***
Emergency Plan	Health Education and Promotion
ES 6: Enforce Laws & Regulations	Health Communication
Review Laws	***ES: 4 Mobilize Community Partnerships***
Significant Activity (51-75%)	Constituency Development
ES 3: Inform, Educate, and Empower	Community Partnerships
Risk Communication	***ES 5: Develop Polices and Plans***
ES 5: Develop Polices and Plans	CHIP/Strategic Planning
Government Presence	***ES 7: Link People to Health Services***
Policy Development	Assure Linkage
ES 6: Enforce Laws & Regulations	***ES 8: Assure Workforce***
Improve Laws	Workforce Assessment
Enforce Laws	Leadership Development
ES 7: Link People to Health Services	***ES 9: Evaluate Service***
Personal Health Service Needs	Evaluation of Population Health
ES 8: Assure Workforce	Evaluation of Personal Health
Workforce Standards	Evaluation of LPHS
Continuing Education	**Minimal Activity (1-25%)**
ES 10: Research/Innovations	None of the Essential Services scored in the Minimal/No Activity range
Foster Innovation	**No Activity (0%)**
Academic Linkages	
Research Capacity	

When participants scored the performance of each model standard they also considered the priority of each model standard to the system. This shows the performance scores in relation to how they have prioritized model standards. This information serves to strengthen the performance improvement activities resulting from the assessment process, by increasing efforts in other areas in need of attention to other areas which are currently performing well.

The final result of the prioritization, categorized the model standards in four quadrants as shown in the chart below.

Quadrant A is where the public health system needs to increase their efforts in order to strengthen and increase its overall performance.

Quadrant A *(High Priority & Low Performance)* These activities may need increased attention	**Quadrant B** *(High priority & High Performance)* These activities may need increase attention.
Quadrant C *(Low Priority & High Performance)* These activities are being done well, consideration may be given to reducing effort in these areas.	**Quadrant D** *(Low Priority & Low Performance)* These activities could be improved, but are of low priority. They may need little or no attention at this time.

The following Model standards fell into ***Quadrant A:***

ES 1.1: Community Health Assessment

ES 1.2: Current Technology

ES 3.1: Health Education/Promotion

ES 3.2: Health Communication

ES 4.1: Constituency Development

ES 4.2: Community Partnership

ES 5.3: CHIP/Strategic Planning

Recommendations for improvement

- Increase knowledge on CHIP/CHA
- Increase knowledge of other organizations work and services.
- Increase system interaction level
- Create/maintain a directory of community organizations.
- Increase health communication plans.
- Utilize more current technology to analyze and display health data

Participating Organizations: Orange County Public Schools, 4C, Head Start, Orange County Drug free office, NACDD, Department of Transportation, Orange County Medical Examiner, Healthy Start, Orlando Health Metro Plan Orlando, East Central Florida Regional Planning Council, Shepherd Hope, Mt Sinai Church, Orange County Fire Department, Interfaith Council, Healthy Start, LYNX, UF/IFAS Cooperative Extension, True Health, City of Orlando Police Department, Second Harvest, Early Learning Coalition of Orange County, Community Member, Orlando Health, UCF College of Medicine, Visionary Vanguard Group, Orange County Jail, Orange County Government, City of Orlando, Orange County office of aging, Community member, Center for Change, United way, American Lung Association, Mt Zion Missionary Baptist Church , Children's Home Society, Hunters Creek Nursing & Rehab

APPENDIX E: ORANGE COUNTY, FL: COMMUNITY DESCRIPTION

Orange County has a total of 903 square miles of land and 99 square miles of water, and it is located in Central Florida. It is bordered on the north by Seminole County, east by Brevard County, south by Osceola County, and to the west by Lake County. Orange County is home to over **1,229,039** residents. There are 13 municipalities in the county; the ***City of Orlando*** is the largest with **256,738** residents, which is **21%** of the county's population. Orlando is the largest inland city in Florida.

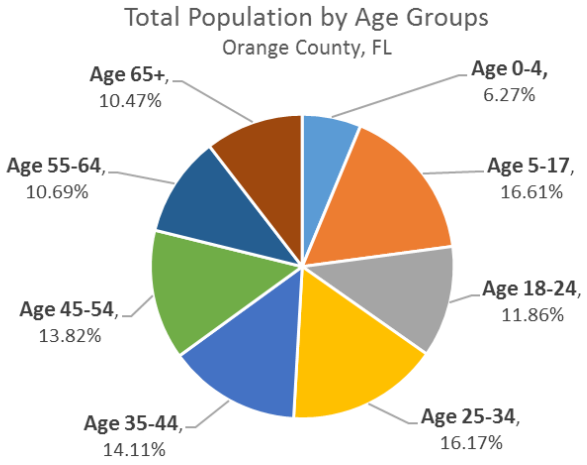
Location of Orange County, Florida

Orange County is densely populated, with an average of **1,360** people per square mile, higher than the state average, which was estimated to be 366 people per square mile in 2015. The county is located in what is known as the ***Orlando-Kissimmee-Sanford Metropolitan Statistical Area*** (MSA). The City of Orlando, known as the City Beautiful, is one of the top five travel destinations in America. It welcomes over 60 million national and international visitors every year.

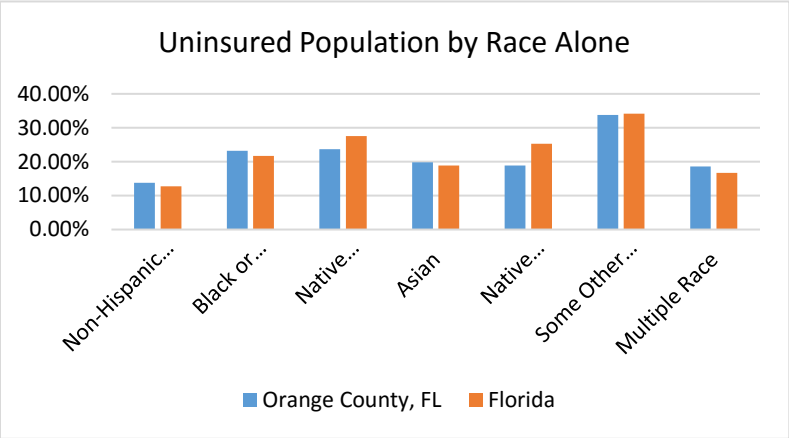
Orange County is the state's **5th** most populous county, home of **6.3%** of Florida's overall population. It is also the **16th** fastest-growing county in Florida, experiencing a population growth of **37.1%** between the 2000 and 2010 census counts, surpassing the state's growth rate of **22.9%.** If this growth rate continues, it can be predicted that by 2020 Orange county will have an estimated population of **1,387,675**.

The county is very diverse with a **64.47%** of the population identifying as White; 20.81% identifying as Black; 5.19 identifying as Asian; 28.72% identifying as Hispanic. Hispanics are the largest ethnic minority in Orange County, comprising ***29.8%*** of the total population. From 2011 to 2015, there has been a ***19.58%*** growth increase in the Hispanic community, compared to a 6.62% growth increase in the Non-Hispanic community. Over 50% of the county's population are Female and 49.14% are Male. Overall, the age distribution of Orange County is 22.9% under 18 years of age, 66.7% between 18 and 64 years, and 10.47% over 65; the county has a fairly young population.

Demographics	Orange County	Florida State
Population Overview		
Total	1,229,039	19,645,772
Female	625,093	10,045,763
Male	603,946	9,600,009
Hispanic	28.7%	23.7%
Non-Hispanic	71.3%	76.3%
Median Age	34.4	41.4
Socioeconomic Characteristics		
Poverty Rate below 100% FPL	17.8%	16.5%
% Children living below poverty level	17.8%	16.5%
Median Household Income	$56,447	$57,504
Average Family Income	$79,064	$79,510
Unemployment Rate	4.1	4.7
Source: Community Commons		

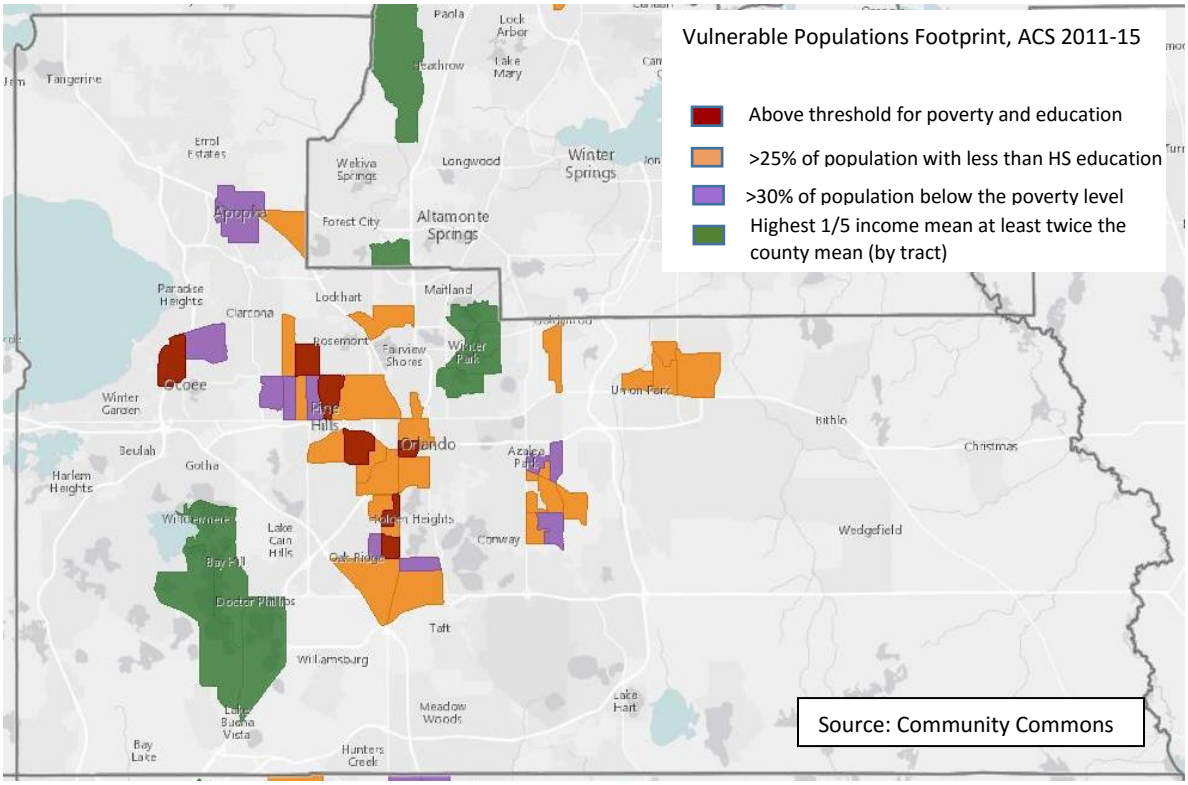


Median household income is **$56,447**, which is slightly lower than the state median household income. Median household income is the most widely used measure for income due to the fact that its less impacted by high and low incomes. A family's income has the ability to define their access to affordable housing, healthcare, higher education opportunities, and food. In 2015, **212,489** (17.7%) of the population had incomes below 100% of the Federal Poverty Level (FPL); from that population, **70,549** (25.5%) are under age 18. The lack of health insurance is considered a key driver of health. Lack of insurance is a primary barrier to health access including primary care, specialty care, and other health services that contribute to poor health status. The county **(20%)** has a slightly higher uninsured population percentage than the state (18%).



Education is also a very strong predictor of health. Orange County is doing well with high school graduation and higher education rates. From the average freshmen base enrollment (14,573), **79%** students receive their high school diploma within four years. Although the rate (79%) is lower than the Healthy People 2020 Target, Orange County's rate surpasses both state and national rates of the same measure. From the total population age 25+, **41.6%** hold an associate degree or higher; **31.1%** hold a bachelor's degree or higher. These rates could possibly hold a correlation to the low unemployment rate of the county **(4.1)** compared to the state. Unemployment rates has steadily been decreasing in the county since the year 2010.

When taking a closer look at the county we can see how some areas are disproportionality affected by certain health indicators than others. The map illustrates areas of great need within Orange County. This map highlights, by census tracts, areas with a high percentage of the population living below the poverty line, and population with low education attainment.



APPENDIX F: ANNUAL EVALUATION REPORT

Florida Department of Health in Orange County Community Health Improvement Plan Progress Reporting Tool

Strategic Issue Area:												
Goal:												
Strategy:												
Objective 1.1:												
Measures	**Baseline**	**Direction of Change**	**Unit of Measurement**	**Current Measurement**				**Total**	**Year 2 Target**	**Year 5 Target**	**Data Source**	**Measure Notes**
				Q1	**Q2**	**Q3**	**Q4**					
		Increase	# of					0				
		Increase	# of					0				
		Increase	# of					0				
		Increase	# of					0				

Activity 1.1.1				
Description	**Person Responsible**	**Anticipated Completion Date**	**Status**	**Activity Progress Notes**

Actions					
Description	**Action Status**	**Deliverables/Outputs of Action**	**Key Partners/Contractors/Consultant**	**Actual Start Date**	**Finish/End Date**
1.1.1.1					
1.1.1.2					
1.1.1.3					
1.1.1.4					

Q1	**Activity Progress and Comments**
	CONTRIBUTING PARTNERS
	PARTNER CONTRIBUTIONS
	FACILITATING FACTORS OF SUCCESS
	BARRIERS/ISSUES ENCOUNTERED
	PLANS TO OVERCOME BARRIERS/ISSUES
	UNANTICIPATED OUTCOMES (optional)
	OVERALL ACTIVITY DELIVERABLES
Q2	**Activity Progress and Comments**
	CONTRIBUTING PARTNERS
	PARTNER CONTRIBUTIONS
	FACILITATING FACTORS OF SUCCESS
	BARRIERS/ISSUES ENCOUNTERED
	PLANS TO OVERCOME BARRIERS/ISSUES
	UNANTICIPATED OUTCOMES (optional)
	OVERALL ACTIVITY DELIVERABLES
Q3	**Activity Progress and Comments**
	CONTRIBUTING PARTNERS
	PARTNER CONTRIBUTIONS
	FACILITATING FACTORS OF SUCCESS
	BARRIERS/ISSUES ENCOUNTERED
	PLANS TO OVERCOME BARRIERS/ISSUES
	UNANTICIPATED OUTCOMES (optional)
	OVERALL ACTIVITY DELIVERABLES
Q4	**Activity Progress and Comments**
	CONTRIBUTING PARTNERS
	PARTNER CONTRIBUTIONS
	FACILITATING FACTORS OF SUCCESS
	BARRIERS/ISSUES ENCOUNTERED
	PLANS TO OVERCOME BARRIERS/ISSUES
	UNANTICIPATED OUTCOMES (optional)
	OVERALL ACTIVITY DELIVERABLES

APPENDIX G: ASSETS & RESOURCES

- 100 Black Men of Orlando, INC
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- Apopka Family Learning Center
- Aspire Health Partners
- Assisted Living Facilities
- Beta Center
- Boys & Girls Club of Central Florida
- Center for Change
- The Center for Disease Control and Prevention
- Center for Multicultural Wellness & Prevention
- Central Florida Commission on Homeless
- Central Florida Employment Council
- Central Florida Family Medicine
- Central Florida Partnerships on Health Disparities
- Central Florida Pharmacy Council
- Central Florida Urban League
- Central Florida YMCA
- Children's Home Society of Central Florida
- Christian Services Center of Central Florida
- City of Orlando Parks & Recreation
- Coalition for the Homeless of Central Florida
- Community Health Centers
- Community Vision
- County Chamber of Commerce
- Dental Care Assess Foundation
- Downtown Orlando Partnership
- Florida Department of Health in Orange County
- Florida Hospital
- Florida Nurses Association
- Florida State University College of Medicine
- Get Active Orlando
- Goodwill
- Grace Medical Home
- Harvest Time International, INC
- Health Central Hospital
- Healthy 100 Kids
- Healthy Central Florida
- Healthy Kids Today
- Healthy Orange Collaboration
- Hebni Nutrition Consultant
- Hispanic Health Initiatives
- Impower
- Interfaith Hospitality Network Orlando
- La Amistad Residential Treatment Center
- Leadership Orlando
- Local Physicians
- Long Term Care Facilities
- Metro Orlando Economic Development
- Mission Fit Kids
- National Alliance on Mental Health
- National Association of County and City Health Officials (NACCHO)
- Nemours
- Orange Blossom Family Health
- Orange County Parks & Recreation
- Orange County Public library
- Orange County Public School System
- Orlando Health
- Orlando Union Rescue Mission Men's Division
- Orlando VA Medical Center
- Overeater Anonymous
- Park Place Behavioral HealthCare
- Pathways Drop in Center
- Primary Care Access Network (PCAN)
- Reduce Obesity in Central Florida
- Second Harvest Food Bank
- Seniors Resource Alliance
- Shepherds Hope
- The Center Orlando
- The Chrysalis Center, Inc
- The Collaborative Obesity Prevention Program
- The grove Counseling Center
- The Mental Association of Central Florida
- The National Kidney Foundation
- The Transition house
- True Health
- United Against poverty
- United Way 2-1-1
- University Behavioral Center
- University of Central Florida
- USA Dance
- Visionary Vanguard
- Wayne Densch Center
- Winter Park Health Foundation
- Workforce Central Florida

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