Osceola County

Community Health Improvement Plan

2013-2016

Vision Statement

"Osceola County will be a community where uninsured and underinsured residents have full access to the health care services they need."

A vision was created through the work of the Osceola Health Leadership Council and the Osceola Health Summit participants. The vision was derived from the previous MAPP vision in order to maintain consistency. The revised vision created a narrower focus needed for the Community Balanced Scorecard to target specific issues.

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PUBLIC HEALTH BELONGS TO THE COMMUNITY

Public health is "what we as a society do collectively to assure the conditions in which people can be healthy."[1]

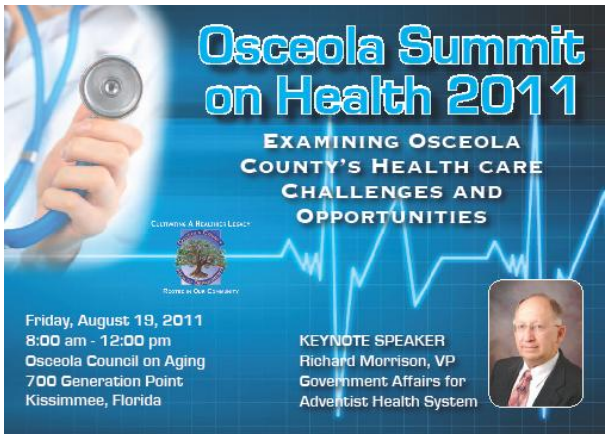
Health has been defined as being more than the absence of illness; rather, health is a "dynamic state of complete physical, mental, spiritual, and social well-being."[2]

The health of a community depends on many factors, many outside of health care. Interwoven are demographic, social, economic, and environmental factors. Also, health outcomes and how healthcare services are utilized can vary widely between different populations groups such as age, race, ethnicity, and gender, as well as education and income.

MOBILIZING THE COMMUNITY

While Public Health does belong to the community, *improving* health requires 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 (MAPP). MAPP is a nationally recognized community-wide strategic planning framework for improving public health.

Under the umbrella of the Osceola Health Leadership Council, the combined effort of stakeholders such as government, healthcare, social services, non-profits, grass-roots, faith-based, business, and an involved citizenry has enhanced our community's ability to address the public's health. As the keynote speaker at the *Osceola Summit on Health 2011*, Richard Morrison, VP Government Affairs for Adventist Health System, laid the foundation for key discussions on how we can join forces to address our community's health. Mr. Morrison stated:



"I am not pandering when I say Osceola County will be the model for addressing these very complex [health] issues. Communities that know how to collaborate will be more successful in finding solutions. And, Osceola County agencies are strides ahead of others in their ability to come together."

By utilizing our community's resources, we can make Osceola County a healthier place to **live, learn, work, and play**.

[1] Institute of Medicine: Committee for the Study of the Future of Public Health (1998)
[2] World Health Organization (1998), *Resolution EB101.R2.*, Geneva

This document, the **2013-2016 Osceola Community Health Improvement Plan**, was developed based on the collaborative efforts of many members from our community's public health system. Under the guidance of the Osceola Health Leadership Council and championed by the Osceola County Health Department, the process of assessing, prioritizing, and addressing health needs in our community resulted in this Plan and its companion document, the **2012 Community Health Assessment.** Together, these two documented processes provide clear strategic direction for achieving improvements in our community's health.

One of the major tools used in the *2012 Community Health Assessment* was the development of a **Community Balanced Scorecard**, which helped identify strategic objectives and set measureable targets to move our community forward in improving health. Both the 2012 *Community Health Assessment* and the *Community Balanced Scorecard* provide the foundation for this *Community Health Improvement Plan (CHIP)*.

The purpose of the CHIP is to describe the short- and long-term strategies and activities that will help achieve improvements in our community's health. The CHIP includes a brief description of why these strategies and activities are important. Our community health priorities are centered on the Community Balanced Scorecard's four "Perspectives," which are shown along with our strategic objectives in the table below.

Table 1: 2013-2016 Strategic Objectives

Perspective (Community Health Priority)	*Strategic Objectives*
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 diabetes health outcomes
	Improve cardiovascular health outcomes
	Improve fetal and infant mortality / morbidity rates

Osceola County's vision statement for health was created through the work of the Osceola Health Leadership Council and the Osceola Health Summit participants:

"Osceola County will be a community where uninsured and underinsured residents have full access to the health care services they need."

Targets and measures outlined in this CHIP are aligned with the national ***Healthy People 2020*** goals and objectives. This national initiative, produced by the U.S. Department of Health & Human Services, provides science-based benchmarks that our community can track and monitor. The Healthy People 2020 initiative also provides evidence-based interventions and information to guide health promotion and disease prevention efforts that can help improve the health of our community.

NEXT STEPS

During the next three years, members of the Osceola Health Leadership Council (HLC) and key stakeholders will continue to work together to find creative and effective ways to address Osceola County's community health priorities and strategic objectives. Work has already begun in addressing these strategic objectives.

Figure 1: Take Action; www.CountyHealthRankings.org

THE REVIEW PROCESS

This CHIP is an active document that will be reviewed and adjusted regularly to most effectively address our community's health improvement. The CHIP's Community Balanced Scorecard will serve as the tool for measuring progress against targets, which the HLC will review quarterly. There will be an annual review and evaluation scheduled in June of each year. This will include documentation of performance measures and description of progress. The CHIP will be revised annually as indicated based on evaluation results.

IN SUMMARY

Improving the health of our community is a shared responsibility. This effort takes not only health care providers and public health officials; it also takes a variety of others helping to contribute to the well-being of our residents and visitors.

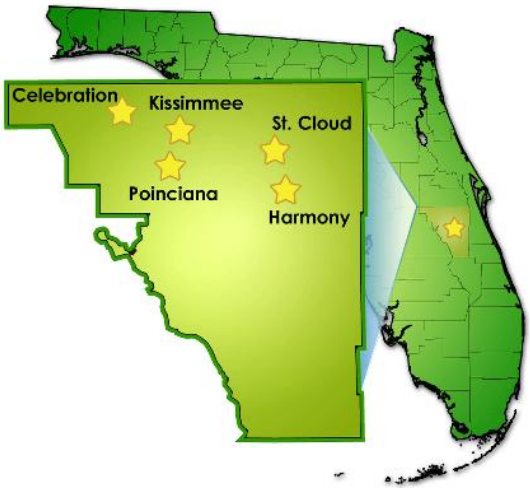
It is important to recognize that no single organization has the depth or resources needed to raise our community's health to a level of sustained excellence without the strong partnerships such as with the Osceola Health Leadership Council and key stakeholders. It is our goal to successfully leverage resources in order to address broad community health concerns, so as to have the greatest impact on improving health outcomes.

All our community partners and others who are interested in helping make Osceola County a healthier community are invited to review this CHIP, find an area or topic of interest, and ask:

"How can I help?"

Osceola County is a 1,506 square mile area that serves as the south/central boundary of the Central Florida greater metropolitan area. It is the sixth largest county in land mass in the state of Florida. While Osceola County is home to an estimated 276,163 residents, it hosts from five to six million overnight visitors each year, with approximately 100,000 visitors staying in the county on any given night. [3] This large number of international visitors has the potential to greatly impact the local public health system in times of an emergency situation.

While much of the county is a vast, sparsely populated rural expanse, the majority of the population is in the urban/suburban areas in the northwest quadrant of the county which includes Kissimmee, St. Cloud, Poinciana, and Celebration.



Osceola County experienced a 61% growth in population from 2000 to 2011. The three largest municipalities had tremendous population growth; Kissimmee 25%; St. Cloud 75%; and Poinciana 290%.[4]

The following section provides a brief, **"At-a-Glance"** overview of Osceola County facts. More detailed information is provided in the CHIP's companion document, the *2012 Community Health Assessment.*

Table 2: Race & Ethnicity Characteristics – 2010

				Within Osceola County		
	US	Florida	Osceola	Kissimmee	Poinciana	St. Cloud
White (non-Hispanic)	63.4%	57.5%	39.6%	26.2%	22.6%	62.1%
Black / African American	13.1%	16.5%	12.8%	12.4%	24.5%	5.8%
Asian	5.0%	2.6%	3.0%	3.4%	0.4%	1.7%
Hispanic Ethnicity	16.7%	22.9%	46.3%	58.9%	51.2%	29.2%

Data Source: US Census Bureau, 2010

Osceola County has a greater Hispanic population subset as compared to the state and nation. Within Osceola County, both Kissimmee and Poinciana's majority population is of Hispanic ethnicity. Osceola County's Black/African American population is lower than both the state and nation. However, when combined, the Hispanic and Black/African American population represents the majority population for both Kissimmee and Poinciana (71% and 76% respectively). This is of importance in this *Community Health Improvement Plan* in that these are population subsets considered to be at risk for suffering greater health disparities.

[3] Destination Osceola 2022 – Strategic Plan, February 2012
[4] US Census Bureau, 2010

Primary socio-economic factors that have the potential to affect health are presented in the three tables below.

Table 3: Socio-Economic Snapshot – 2010			
	Osceola	Florida	US
Per capita income	$17,600	$24,272	$26,409
Mean (average) household income	$51,487	$61,877	$68,259
Median household income	$42,413	$44,409	$50,046
Persons living below poverty	15.9%	16.5%	15.3%
Persons > 25 yrs. with high school diploma	84.4%	85.3%	85%
College graduates (Bachelor's or higher)	18.3%	25.9%	27.9%
Mean (average) travel time to work in minutes	30.2	25.7	25.2
Data Source: US Census Bureau, 2010 American Community Survey (ACS)			

Individuals in poverty are at greater risk of not having health insurance, not being able to pay for medical care, and not being able to afford healthy food, safe housing, or access to other basic goods.

Table 4: Percentage of Families & People Whose Income in Past 12 Months is Below Poverty Level					
	All families	All families w/ children ≤ 5 yrs of age	Families w/ female head of household (no husband present)	All people	All people ≥ 65 yrs of age
Osceola County	10.7%	13.6%	23.7%	13.3%	9.9%
Florida	9.9%	16.8%	25.9%	13.8%	9.9%
United States	10.1%	17.1%	28.9%	13.8%	9.5%
Data Source: US Census Bureau, American Community Survey 5-year Estimated, 2006-2010					

As documented in the national *2013 County Health Rankings* report, the magnitude of education's effect on health outcomes is substantive and statistically significant. An individual's educational attainment has a strong correlation with their future health status.

Table 5: Educational Attainment Percent of Population 25 Years & Older					
	High School	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
Osceola County	35.2%	21.1%	9.8%	13%	5.3%
Metro Statistical Area*	28.9%	20.9%	9.6%	19%	8.9%
Florida	30.3%	20.6%	8.5%	16.8%	9.1%
United States	29%	20.6%	7.5%	17.6%	10.3%
Data Source: US Census Bureau, American Community Survey 5-year Estimated, 2006-2010					

Building Community Capacity through Collaboration

Community capacity building improves the ability of individuals, organizations, businesses, and government to come together; learn; make well-reasoned decisions about the community's present and future, and work together to carry out those decisions.[5] In essence, communities that have the ways and means to undertake challenges...have "capacity."

Osceola County is a community that has capacity and has had a successful track record of turning plans into results, as evidenced by the outcomes of past MAPP processes. Tangible results achieved included:

- A voluntary specialty care network, through the Council on Aging, was developed with 52 medical practitioners enrolled.
- Started a compassionate pharmacy co-op program
- Increased access to primary care with a mobile medical van
- Expanded the safety net for uninsured residents with the awarding in 2005 of a federally qualified health center (FQHC) located in Poinciana and operated by the Osceola County Health Department. This was a major accomplishment for Osceola County.
- Established a case management forum that included participants from the various health and social services agencies.

Regardless of past successes, it is important to continue to assess and build upon community capacity. Osceola County's capacity was re-assessed in the *2012 Community Health Assessment's* MAPP Phase Three process that included the **Four MAPP Assessments**. These assessments yielded important information for improving the local public health system and community health. As a review, the Four MAPP Assessments are described below:

1. The ***Community Themes and Strengths Assessment*** provides an understanding of the issues residents feel are important, how the quality of life is perceived, and what assets do we have that can be used to improve community health.
2. The ***Local Public Health System Assessment*** focuses on all of the organizations and entities that contribute to the public health system to assess the community's capacity and how the *Ten Essential Services of Public Health* is being provided in our community.
3. The ***Forces of Change Assessment*** looks at what is occurring or might occur that affects the health of our community or the local public health system and what specific threats or opportunities are generated by these occurrences.
4. The ***Community Health Status Assessment*** identifies priority community health and quality of life issues such as how healthy our residents are and what the health status of our community looks like.

Results from these four MAPP assessments enabled Osceola's collaborative partnership to identify strategic issues during MAPP Phase 4. From that the Community Balanced Scorecard (CBSC) was developed. The CBSC, which becomes the backbone of this CHIP, was used to align the identified strategic issues during MAPP Phase 5 (Formulate Goals and Strategies).

[5] Aspen Institute, Measuring Community Capacity Building

(**Note**: The following sections on pages 9-23 outline a brief, **"At-a-Glance"** overview of the results from the four MAPP Assessments. More detailed information is presented in the CHIP's companion document, the *2012 Community Health Assessment* report).

SUMMARY OF RESPONSES TO THE COMMUNITY SURVEYS – *IN THE COMMUNITY AT LARGE*

As discussed previously, a component of the MAPP Assessment--Community Themes and Strengths--included perceptions gathered directly from the community's residents as to what they thought about their health, healthcare services, and their quality of life. It was important to get this information from a variety of residents, including those living in health disparate communities and those not likely to attend focus groups or other organized interview sessions. The survey process was accomplished over a period of several months during 2010-2011 through door-to-door surveys in various neighborhood, surveys at health fairs, and an Osceola County Visioning Survey at the 192 Operation Outreach – Family Services Fair.

Environmental / Social Determinants of Health Perspective

- **27%** felt there were conditions in their neighborhood that might be causing family illness
- **91%** have access to clean water for drinking and cooking
- **41%** said there were abandoned buildings in their community that needed to be demolished or cars that needed to be removed
- **16%** said their community has adequate access to public bus transportation
- **95 %** would use the services of a mobile healthcare facility or clinic if it was available in their neighborhood
- **61%** rated police service in their community as good
- **64%** feel their community is safe from crime
- **77%** said the quality of air they breathe when outside in their neighborhood is good
- **43%** said government officials are able to respond to their community's needs

Health & Safety Issues Perspective

- **74%** have health insurance (Medicaid-31%; Medicare-27%; and Commercial-42%)
- **63%** see a health care provider regularly
- **85%** are able to get to a health care provided when necessary

In addition to the survey questions, respondents were asked to indicate their top five concerns from a list of issues. The **top five common themes** identified from this list were:

1. Transportation (sidewalks, bus stops)
2. Safety (drug dealing, violence) and neighborhood lighting (tied for #2)
3. Lack of employment
4. Access to healthcare and lack of convenient shopping (including grocery) (tied for #4)
5. Having health care available in my community

Osceola County Visioning – The Results

Of the 84 respondents: 42% had lived in Osceola County 1-5 years; 67% expect to live in here for the next 10 years; 58% expected to retire in the county; 43% were unemployed; 33% worked in retail/hospitality; and 61% were unable to save any of their monthly income.

When asked what they thought Osceola County's strengths are:

- **32%** - community's diversity, character, feel
- **30%** - health and social services
- **27%** - education
- **25%** - public safety

When asked how much impact they thought they can have making their community a better place to live:

- **36%** - a big impact
- **31%** - a moderate impact
- **26%** - a little impact

When asked what areas they think are most in need of improvement in the community:

- **56%** - employment and economic development
- **45%** - housing availability / affordability
- **38%** - education
- **35%** - health and social services
- **33%** - traffic / transportation

When asked to rate the health care system in Osceola County:

- **5%** - excellent
- **32%** - good
- **32%** - fair
- **31%** - poor

When asked what they thought would improve the health care system in Osceola County:

- **32%** - wellness programs
- **19%** - shared cost health insurance
- **11%** - prescription assistance
- **8%** - more primary care physicians
- **8%** - more specialty health care services

When asked how satisfied they are with the job local officials are doing to provide services and improve the community:

- **4%** - very satisfied
- **52%** - satisfied
- **32%** - dissatisfied
- **12%** - very dissatisfied

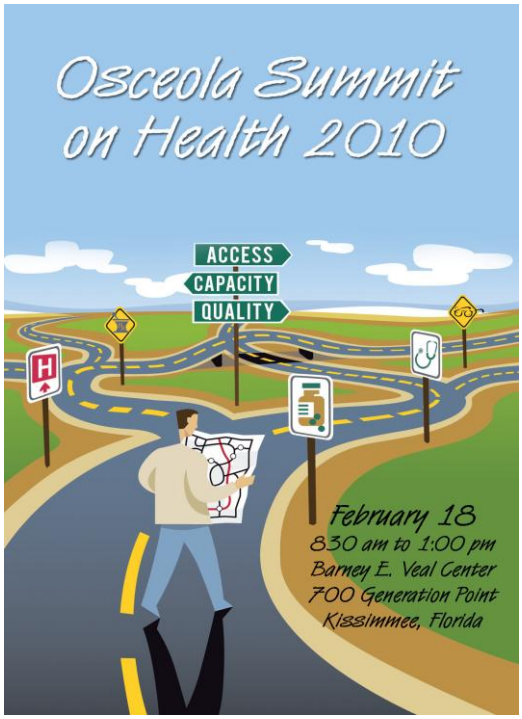
When asked what they feel are the most important issues for community leaders need to address immediately:

- **63%** - employment / economic development
- **42%** - education
- **31%** - housing availability / affordability
- **25%** - health and social services

ISSUES, PERCEPTIONS, AND ASSETS - *FROM THE OSCEOLA COUNTY PUBLIC HEALTH SYSTEM*

In addition to surveying the community at large, the next approach to the ***Community Themes and Strengths Assessment*** was to gather input from a wide sector of the local public health system. Over 75 participants from a wide variety of healthcare, government, community agencies, faith-based, grass-roots, business, citizens, and other partners came together at the *Osceola Summit on Health – 2010*.

Facilitated by the *Results That Matter Team*, of Epstein & Fass Associates, attendees at the Summit participated in a Strengths-Weaknesses-Opportunities-Threat brainstorming session that followed the SOAR (Strengths-Opportunities-Aspirations-Results) methodology.



From the work at the Summit, the following three "themes" emerged as the best candidates to focus our efforts toward improving:

1. Access to Specialty and Comprehensive Care
2. Enrollment in a Primary Care Medical Home
3. Adopt Evidenced-based Care and Sustain Best Practices

Highlights of the MAPP Assessment 2: *Local Public Health System*

Issues, Perceptions, and Assets – Themes That Emerged

The National Public Health Performance Standards Program (NPHPSP) is used to help identify strengths and opportunities for improvement within the local public health system. NPHPSP's Local Public Health System Assessment (LPHSA) tool answers the following questions:

1. What are the components, activities, competencies, and capacities of our local public health system?
2. How are the "10 Essential Public Health Services" being provided to our community? (The *"10 Essential Public Health Services"* are the core public health functions that provide the framework for the Local Public Health System Assessment).

The Osceola County Health Department took the lead in facilitating the completion of the LPHSA instrument. Two methods were utilized:

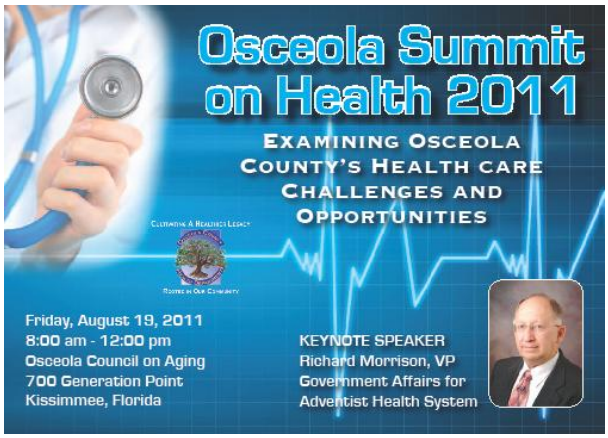
1. LPHSA instrument was sent to various key stakeholders in the Osceola County Public Health System during May-July, 2011.
2. Attendees at the *Osceola Summit on Health 2011 – The Sequel* used the responses from the key stakeholders survey to provide final consensus scores.

Osceola County's local public health system scored highest in its ability to *Educate/Empower* (75%), followed closely by *Monitor Health Status* (69%) and *Mobilize Partnerships* (68%). The lowest score was in *Research/Innovations* (28%).

Highlights of the MAPP Assessment 3: *Forces of Change*

Issues, Perceptions, and Assets – Themes That Emerged

Building upon the work from the *Osceola Summit on Health 2010,* a Forces of Change Assessment was conducted during July and August, 2011. A SWOT survey was sent to invited attendees prior to the ***Osceola Summit on Health 2011 - The Sequel***. The intent was to identify forces such as legislation, technology, and other impending changes that affect the context in which Osceola County's public health system operates. SWOT survey results were compiled by Community Vision in preparation for a presentation to Summit attendees.



The top three Forces of Change key areas identified that would determine success on long-range goals to support the Osceola County's vision were:

1. Availability of health care resources
2. Prevention and wellness / health equity
3. Insufficient coordination among agencies

These issues are factored into the development of the Community Balanced Scorecard.

SUMMARY OF COMMUNITY HEALTH STATUS - *AT-A-GLANCE*

(**NOTE**: The Community Health Status data presented in this section provide a brief overview for the CHIP. More detailed Community Health Status information is presented in CHIP's companion document, the *2012 Community Health Assessment* report).

Data collected through the *MAPP Assessment 4: Community Health Status* provided vital information in the development of the CHIP and its Community Balanced Scorecard strategic objectives. The results from the other three MAPP Assessments are the drivers for success in improvement in this assessment—**the health of the community.**

Mortality rates are key indicators of a community's **"State of Health."** Some deaths are considered premature and preventable through behavior modification and risk reduction. This concept particularly applies to those deaths attributable to heart disease, stroke, diabetes, some cancers, and motor vehicle accidents. Individuals may reduce their risk and improve the length and quality of their lives by leading healthier lifestyles and receiving preventive health care services.

The figure below summarizes age-adjusted rates for the leading causes of death in Osceola County in 2011. Heart disease, 26.4%, was the leading cause of all deaths, with cancer, 23.7%, as the second leading cause. When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths in Osceola County. Chronic Lower Respiratory Disease (including emphysema, chronic bronchitis, and asthma), 5.6%, and diabetes, 3.4%, are the other chronic diseases responsible for leading causes of death.

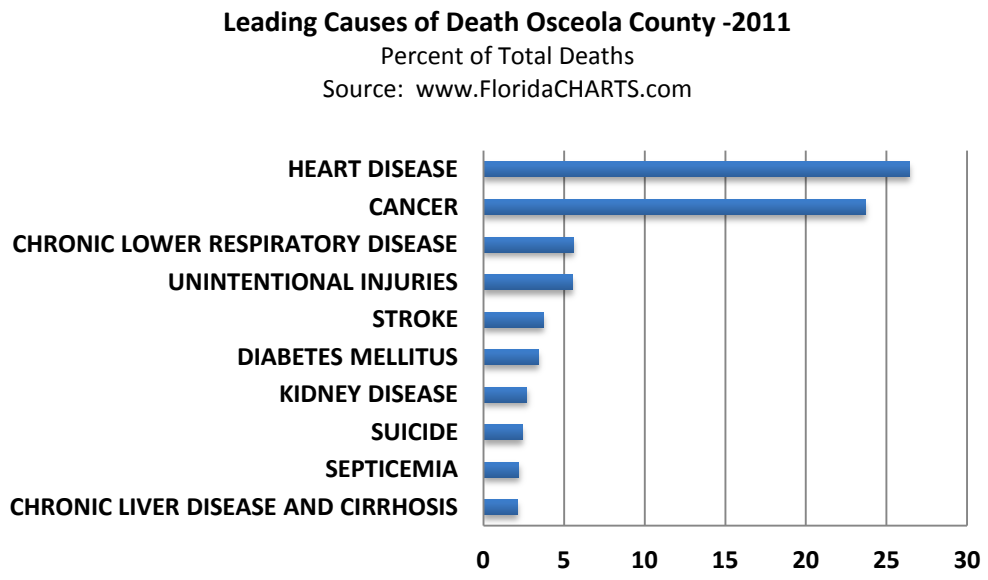


Figure 2: Leading Causes of Death

THE NATIONAL COUNTY HEALTH RANKINGS REPORT

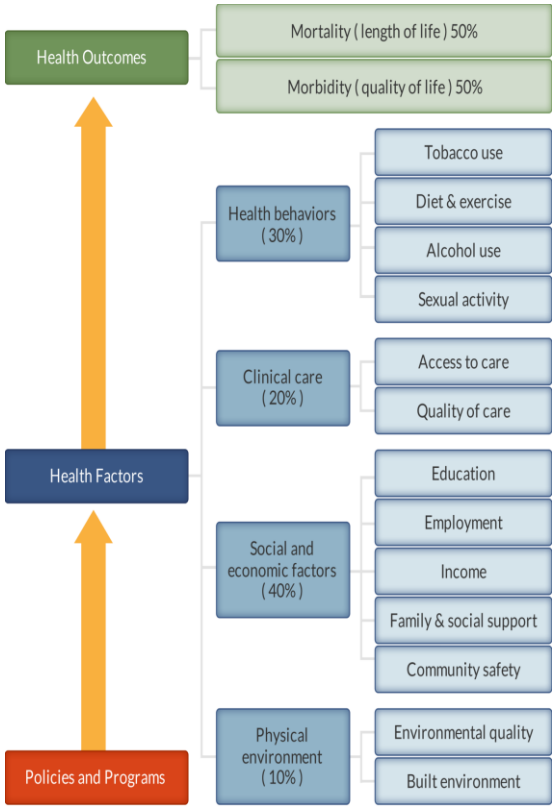
The national *County Health Rankings* report is produced by the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Population Health Institute. The *County Health Rankings* shows that **where we live, learn, work, and play...matters to our health** and that much of what influences our health happens outside the doctor's office – from access to healthy food or opportunities for physical activity to education and jobs.

The *County Health Rankings* allow counties to compare themselves with others within their state and also compare to national benchmarks. Counties can see where they are doing well and where they are not, so they can make changes to improve health. The report was one of the tools used to help Osceola Health Leadership Council and the health collaborative partnership focus on areas where public health needs were identified.

The County Health Rankings provide two overall measurement categories to help determine how healthy a community is:

1. **Health Outcomes:** *"Today's health"* (green boxes) represents how healthy a county is--how long people live (mortality) and how healthy people feel (morbidity). In 2012, Osceola County ranked in the top quarter, or 23rd out of Florida's 67 counties. This represented an improvement in the three-year trend from 26th in 2010 and 25th in 2011.

2. **Health Factors:** *"Tomorrow's health"* (blue boxes) are the factors that shape a community's health outcomes, including health behaviors; clinical care; social and economic factors; and the physical environment. These factors are based on several measures, some of which the Osceola Health Leadership Council has addressed (those in the following bold font) in this CHIP—**tobacco use; diet and exercise**; alcohol use; **access to care**; **quality of care**; family and social support; and the built environment.



County Health Rankings model ©2012 UWPHI

(Note: At the time this CHIP was published, June 2013, the County Health Rankings report recently had been updated for 2013. However, since the previous CHIP work from the Summits and HLC were based on the 2012 Rankings, those are the data sets used in this CHIP).

OSCEOLA'S COUNTY HEALTH RANKINGS REPORT

Osceola County's three-year overall rankings, out of Florida's 67 counties, are presented below:

Table 6: Osceola County Health Rankings by Category

Category	2010 Ranking out of 67 Counties	2011 Ranking out of 67 Counties	2012 Ranking out of 67 Counties	3-Year Trend*
Health Outcomes *(Mortality and morbidity)*	26th	25th	23rd	↑
Health Factors *(Health behavior; clinical access; socio-economic; environment)*	28th	33rd	41st	↓
Data Source: 2012 County Health Rankings				

***About 3-Year Trend:**

- **Green** upward arrow indicates positive (improving) 3-year trend.
- **Red** downward arrow indicates negative (worsening) 3-year trend.

Table 7 shows Osceola County results segmented for the ***Health Outcomes*** category:

Table 7 : Osceola County Health Rankings – Snapshot of Health Outcomes

Health Outcome Category *Osceola County Rank = 23rd of 67 counties*	Osceola 2012*	Osceola Trend (2010-2012)	Florida 2012	National Benchmark 2012**	
Mortality Indicator					
Premature Death *"Years of potential life lost before age 75 per 100,000 population"*	**7,313**		7,781	5,466	↓
Morbidity Indicators					
Poor or fair health *"percent of adults reporting fair or poor health (age-adjusted)"*	**18%**		15%	10%	↓
Poor physical health days *"Average number of physically unhealthy days reported in past 30 days (age-adjusted)"*	**4.4**		3.5	2.6	↓
Poor mental health days *"Average number of mentally unhealthy days reported in past 30 days (age-adjusted)"*	**3.7**		3.6	2.3	↓
Low birth weight *"Percent live births with low birth weight (<2500 grams)"*	**8.3%**		6.0%	8.6%	--
Data Source: 2012 County Health Rankings					

***About Osceola 2012 rate:**

- **Green** highlight indicates Osceola compares favorably (or better) than the Florida rate.
- **Red** highlight indicates Osceola compares unfavorably (or worse) than the Florida rate.

****About the National Benchmark:**

- Set at the 90th percentile. Only 10% of counties nationwide are better than the measure.
- The arrows indicate the direction Osceola County needs to go to achieve improvement in the health outcome indicator in comparison with National Benchmark.

OSCEOLA'S COUNTY HEALTH RANKINGS REPORT - CONTINUED

Table 8 shows Osceola County results segmented for the ***Health Factors*** category:

Table 8 –Osceola County Health Rankings – Snapshot of Selected Health Factors					
Health Factors Category ***Osceola County Rank = 41st of 67 counties***	**Osceola 2012***	**Osceola Trend (2010-2012)**	**Florida 2012**	**National Benchmark 2012***	
Health Behaviors Indicator					
Adult smoking *"Percent of adults currently smoke cigarettes"*	**22%**		19%	14%	↓
Adult obesity *"Percent of adults who report a BMI>=30"*	**29%**		26%	25%	↓
Sexually transmitted diseases *"Chlamydia rate per 100,000 population"*	**382**		398	84	↓
Teen birthrate – ages 15-19 *"Teen birth rate per 1,000 female population"*	**54**		44	22	↓
Clinical Access Indicators					
Primary care physicians *"Ratio of population to primary care physician"*	**1559:1**		983.1	631:1	↑
Dentists *"Ratio of population to dentist"*	**4879:1**	---	2525:1	---	---
Mental health providers *"Ratio of population to mental health provider"*	**22,217:1**	---	3441:1	---	---
Preventable hospital stays *"Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees"*	**91**		64	49	↓
Social & Economic Indicators					
Violent crime rate *"Violent crime rate per 100,000 population"*	**612**		674	73	↓
Data Source: 2012 County Health Rankings					

***About Osceola 2012 rate:**

- **Green** highlight indicates Osceola compares favorably (or better) than the Florida rate.
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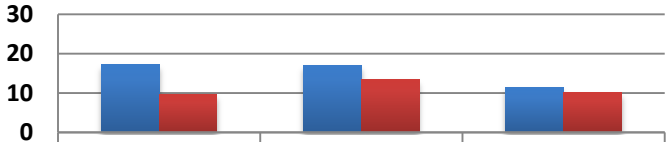
****About the National Benchmark:**

- Set at the 90th percentile. Only 10% of counties nationwide are better than the measure.
- The arrows indicate the direction Osceola County needs to go to achieve improvement in the health outcome indicator in comparison with National Benchmark.

OSCEOLA COUNTY CHRONIC DISEASES – *AT-A-GLANCE*

DIABETES PREVALENCE

Diabetes Prevalence by Race & Ethnicity
Percent Adults Diagnosed with Diabetes, Year 2010
Source: Minority Health Profile, www.FloridaCHARTS.com



	Hispanic	Black	White
Osceola	17.1	17	11.3
Florida	9.6	13.4	10.1

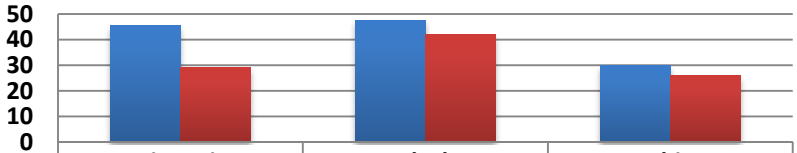
- In terms of potential health disparity, the prevalence of diabetes is higher in the Hispanic and Black populations than the White.
- Osceola's diabetes rate is worse than the state for all population subsets.

Figure 3: Diabetes Prevalence by Race & Ethnicity

Osceola County's measure, i.e., rate of diabetes prevalence, is not the same as the HP 2020 national health target measure, which is the annual number of *new cases* of diagnosed diabetes. It is interesting to note that the HP 2020 target is to reduce the annual number of *new cases of diagnosed diabetes* from 8.0 to 7.2 per 1,000 population.

OBESITY

Obesity Prevalence by Race & Ethnicity
Percent Adults with BMI >=30, Year 2010
Source: Minority Health Profile, www.FloridaCHARTS.com



	Hispanic	Black	White
Osceola	45.5	47.6	29.9
Florida	29.2	42	25.9

- Osceola's obesity prevalence is significantly worse for the Hispanic and Black populations than the White.
- Osceola's rate for each population subset is worse than the state averages.

Figure 4: Obesity Prevalence by Race & Ethnicity

The HP 2020 national health target is to reduce the proportion of adults who are obese to 30.6%. While Osceola County's Hispanic and Black populations are worse than the HP 2020 target, the White population of 29.9% is slightly better.

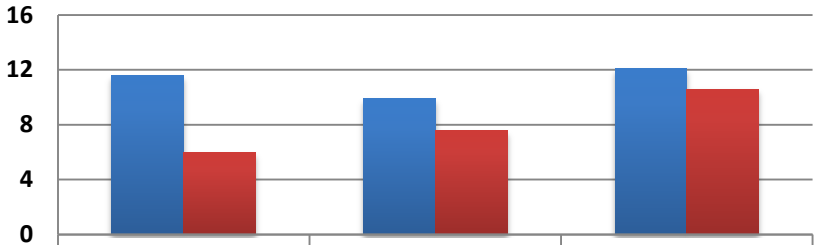
OSCEOLA COUNTY CHRONIC DISEASES – *AT-A-GLANCE*

CARDIOVASCULAR

Cardiovascular Disease Prevalence by Race & Ethnicity

Percent Adults - Heart Attack, Angina, or Coronary Heart Disease, Year 2010

Source: Minority Health Profile, www.FloridaCHARTS.com



	Hispanic	Black	White
Osceola	11.6	9.9	12.1
Florida	6	7.6	10.6

- Osceola's cardiovascular disease prevalence rate is worse in the Hispanic and White populations than the Black.
- Osceola's rate for each population subset is worse than the state averages.

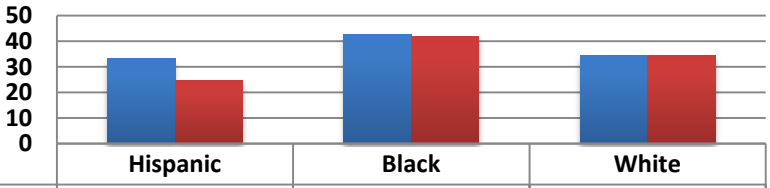
Figure 5: Cardiovascular Prevalence by Race & Ethnicity

One of the HP 2010 national health targets that is still in the developmental stage is to increase overall cardiovascular health in the U.S. population. This target has not yet been published.

Hypertension by Race & Ethnicity

Percent Adults Diagnosed with Hypertension - Year 2010

Source: Florida Behavioral Risk Factor Surveillance Survey



	Hispanic	Black	White
Osceola	33.1	42.8	34.5
Florida	24.8	41.7	34.4

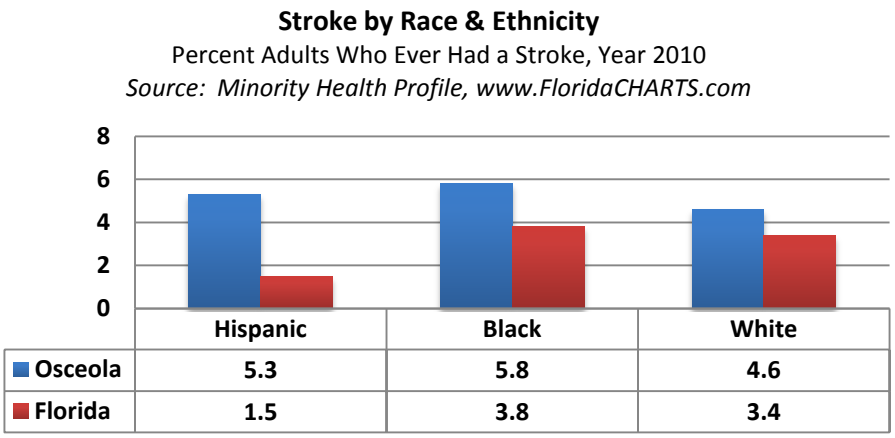
- Osceola's rate of hypertension is worse in the Black and White populations than the Hispanic.
- Although Osceola's rate is similar to the state average for the Black and White populations, the Hispanic rate is significantly worse that the state Hispanic average.

Figure 6: Hypertension by Race & Ethnicity

The HP 2020 national health target is to reduce the proportion of adults 18 years and older with hypertension to 26.9%. Osceola County's rate for all population subsets is worse than the HP 2020 target.

OSCEOLA COUNTY CHRONIC DISEASES – *AT-A-GLANCE*

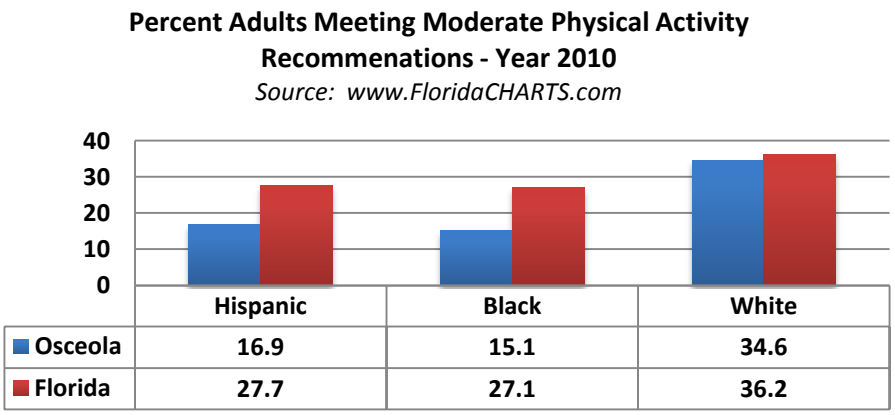
CARDIOVASCULAR - CONTINUED



- Osceola's incidence of stroke is worse in the Hispanic and Black populations when compared to the White.
- Osceola's rate for each population subset is worse than the state averages.
- Of note, Osceola's Hispanic rate is significantly worse than the state Hispanic average.

Figure 7: Stroke by Race & Ethnicity

PHYSICAL ACTIVITY



- Osceola's rate of adults getting enough physical activity is worse in all population subsets when compared to the state averages.
- The Hispanic and Black populations show a significantly lower percentage of physical activity compared to the White population.

Figure 8: Moderate Physical Activity Recommendations

The HP 2020 national health target is to increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity to 47.9%. Moderate intensity is defined as at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination. Osceola County's rate for all population subsets is worse than the HP 2020 goal, particularly in the Hispanic and Black populations.

Note: About the data presented in the following sections for Preventable Hospital Stays and Fetal/Infant Mortality:

*Regional Peer Average is a rate of comparison that includes counties in the metropolitan statistical area -- Orange, Brevard, and Seminole counties.

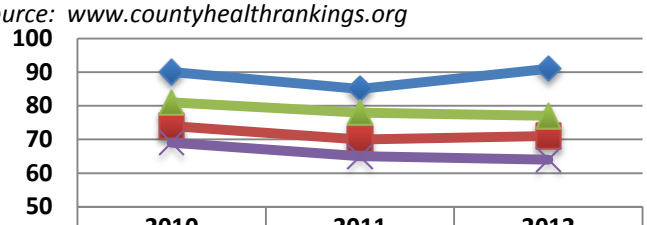
* *Peer Average, as determined by the U.S. Department of Health & Human Services Community Health Status indicators, includes Okaloosa and Santa Rosa counties. *www.communityhealth.hhs.gov/homepage.aspx*

PREVENTABLE HOSPITAL STAYS & INAPPROPRIATE ER UTILIZATION – *AT-A-GLANCE*

Preventable Hospital Stays

Hospitalization Rate - Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees

Source: www.countyhealthrankings.org



	2010	2011	2012
Osceola County	90	85	91
Regional Peer Average	74	70	71
Peer County Average	81	78	77
State Total Average	69	65	64

Figure 9: Preventable Hospital Stays

The priority areas identified in Osceola County's latest iteration of MAPP in 2009 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. In 2009, 82% of Osceola County's ER visits were considered avoidable; i.e. visits for those ambulatory-care sensitive conditions that could have been treated more effectively in a primary care medical home setting. The ER avoidable rate rose in 2011 to 83.3%.[6]

The cost of providing primary care services in a medical home setting is a fraction of the cost of providing similar services in the ER. The average ER charge in Florida for an ambulatory-care sensitive condition is approximately $1,253 for pediatrics and $2,936 for adults. This compares to the average cost of $151.62 in a primary medical home setting.[7]

At Osceola County Health Department's FQHC health centers network, the cost for a primary care medical visit is $116.92.[8]

[6] Health Council of East Central Florida, Osceola County Health Profile 2009 & 2011
[7] AHCA Primary Care Access Networks, Annual Report February 2009
[8] Uniform Data System (UDS), 2011

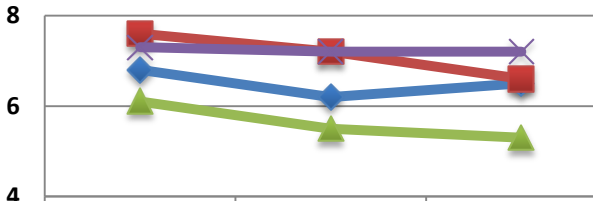
FETAL AND INFANT MORTALITY – *AT-A-GLANCE*

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 a community. A 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. 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.

Fetal Death Rate

Rate per 1,000 Deliveries, 3-Year Rolling Rate

Source: www.FloridaCHARTS.com



	2007-2009	2008-2010	2009-2011
Osceola County	6.8	6.2	6.5
Regional Peer Average	7.6	7.2	6.6
Peer County Average	6.1	5.5	5.3
State Total Average	7.3	7.2	7.2

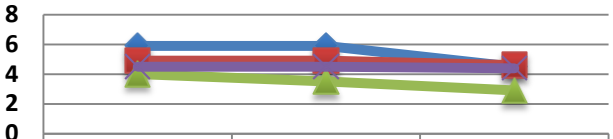
- Fetal mortality is defined as death occurring ≥ 20 weeks gestation until the absence of life at delivery.
- Osceola's trend has decreased (improved) slightly over the three measurement periods. It has remained lower (better) than the regional and state averages.

The HP 2020 target is to reduce fetal deaths to 5.6 per 1,000 live births. Osceola's rate is higher (worse) than the HP 2020 goal.

Neonatal Death Rate

Rate per 1,000 Live Births, 3-Year Rolling Rate

Source: www.FloridaCHARTS.com



	2007-2009	2008-2010	2009-2011
Osceola County	5.9	5.9	4.5
Regional Peer Average	4.9	4.9	4.6
Peer County Average	4	3.5	2.9
State Total Average	4.5	4.5	4.4

- Neonatal mortality is defined as death from the time of birth through the first 28 completed days of life.
- Although Osceola's neonatal death rate trend has improved slightly over the three measurement periods, it has remained worse than the regional and county peer averages and the state average.

The HP 2020 national health target is to reduce the neonatal death rate to 4.1 deaths per 1,000 live births. Osceola's 2009-2011 rate of 4.5 is slightly worse than the HP 2020 target.

FETAL AND INFANT MORTALITY – *AT-A-GLANCE*

Infant Death Rate

Rate per 1,000 Live Births, 3-Year Rolling Rate

Source: www.FloridaCHARTS.com

	2007-2009	2008-2010	2009-2011
Osceola County	8	7.7	6.3
Regional Peer Average	6.8	7.1	7
Peer County Average	6.9	6	5.6
State Total Average	7.1	6.9	6.6

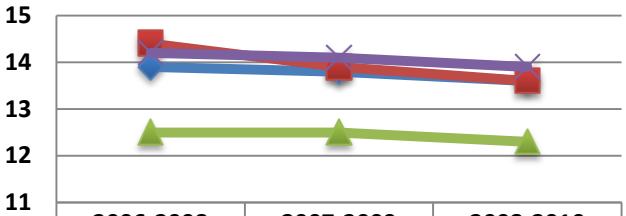
- Infant mortality is defined as death from the time of birth through the first year of life.
- Osceola's infant death rate trend has improved over the three measurement periods; it has remained lower (better) than the regional peer average and the state average.

The HP 2020 national health target is to reduce the infant death rate to 6.0 deaths per 1,000 live births. Osceola County's 2009-2011 rate of 6.3 is slightly worse than the HP 2020 target.

Premature Births

Percent of Births < 37 Weeks Gestation, 3-Year Rolling Rate

Source: www.FloridaCHARTS.com



	2006-2008	2007-2009	2008-2010
Osceola County	13.9	13.8	13.6
Regional Peer Average	14.4	13.9	13.6
Peer County Average	12.5	12.5	12.3
State Total Average	14.2	14.1	13.9

- Osceola's premature birth rate is similar to the regional and state averages and slightly worse than the peer county average.
- Osceola's rate has remained level over the three measurement periods.

The HP 2020 national health target is to reduce the preterm births to 11.4%. Osceola County's rate of 13.6% for 2008-2010 is worse than the HP 2020 target.

Osceola County's **2013-2016 Community Health Improvement Plan** (CHIP) has been developed through a collaborative effort involving a multitude of community stakeholders and key partners. Community Health Priorities, also called "Perspectives," are listed in this CHIP along with specific goals. It is important to note that this CHIP does not address every strength and weakness identified in the **2012 Community Health Assessment** (the companion document to this CHIP). It does, however, set a strategic path to follow for Osceola County's key health priorities.

MAPP Phase 4: Approach to Identifying Strategic Issues

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)*. (Note: Please see the companion document, *2012 Community Health Assessment*, for a more detailed description of the development of the Community Balanced Scorecard).

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 collaborative partnership, under the umbrella of the Osceola Health Leadership Council, 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 (the MAPP action cycle period is three years)
4. Must be measurable.

MAPP PHASE 4: APPROACH TO IDENTIFYING STRATEGIC ISSUES – CONTINUED

The drafted strategic priorities from the 2012 Community Health Assessment were presented for review and vetting during our latest *Community Gathering* at the ***2013 Osceola Business of Health Summit***. This latest in the series of three Summits (2010, 2011 and 2013) was organized and facilitated by Community Vision, Inc. under the umbrella of the Osceola Health Leadership Council.

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.

The Summit included an overview of the **State of Osceola's Economic, Physical, and Mental Health**. Attendees then participated in smaller, interactive breakout sessions that included:

1. Impact of the Affordable Care Act
2. Maximizing Existing Resources and Filling the Gaps
3. Improving Health Outcomes
4. Dollar and Sense Benefits of a Healthy Workforce / Wellness Programs

MAPP PHASE 4: APPROACH TO IDENTIFYING STRATEGIC ISSUES – CONTINUED

Strategies that emerged from the 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**.

A chef with Florida Hospital's *"Live to a Healthy 100"* campaign provided a healthy cooking demonstration for Summit attendees.

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.

These strategy suggestions have been incorporated into the CHIP's Community Balanced Scorecard.

After the"*Live to a Healthy 100"* chef's cooking demonstration, Summit participants were able to sample the healthy foods.

The Strategic Objections from the Community Health Priorities and the rational for including each are discussed in **Table 9: 2013-2016 Strategic Objectives for Osceola County** (on the following pages).

MAPP PHASE 4: APPROACH TO IDENTIFYING STRATEGIC ISSUES - CONTINUED

Table 9: 2013-2016 Strategic Objectives for Osceola County

Community Health Priorities -Strategic Objectives-	Rationale
Improve diabetes health outcomes	▶ Diabetes is the #2 cause of death from chronic diseases (3.4% of all deaths). ▶ Health disparity issue: 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). ▶ Health benefit: 1. There is a strong correlation between diabetes and cardiovascular disease. 2. 65% of those with diabetes die from some form of heart disease or stroke.[9] 3. American Heart Association considers diabetes to be 1 of the 6 controllable factors for cardiovascular disease.
Improve cardiovascular health outcomes	▶ Heart Disease is the #1 cause of death (26.4% of all deaths). ▶ When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths. ▶ Health disparity issue: death rate from hypertension is worse in the Hispanic population. ▶ Health disparity issue: 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. ▶ Health benefit: Reducing hypertension is a controllable risk factor that can have a positive impact on overall cardiovascular health.
Improve fetal / infant mortality / morbidity	▶ Osceola's rates for the following are all worse than the Healthy People 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 birthweight (8.3%; HP 2020=7.8%) ▶ Health disparity issue: fetal, neonatal, and infant death rates are worse for Osceola's Black and Hispanic populations (See *2012 Community Health Assessment* for detailed information). ▶ Health benefits: 1. Improving the well-being of mothers, infants, and children is an important public health goal that has a tremendous impact on our community's current and future health.

[9] American Heart Association

MAPP PHASE 4: APPROACH TO IDENTIFYING STRATEGIC ISSUES - CONTINUED

Table 9: 2013-2016 Strategic Objectives for Osceola County (continued)

Community Health Priorities -Strategic Objectives-	Rationale
Expand primary care capacity for uninsured / underinsured residents	▶ Identified as a strategic issue in all 3 MAPP iterations. ▶ Osceola's uninsured rate in 2011 for the non-elderly (ages 18-64) was 33%, compared to Florida at 30%. ▶ Osceola is federally designated as a Health Professional Shortage Area (HPSA) for primary medical, dental, and mental health. ▶ Osceola's ratio of 1,559 residents for every 1 primary care physician is significantly higher (worse) than regional and county peers and state average. It is more than double (worse than) the national benchmark. ▶ County Health Rankings – Osceola ranked in bottom half, or 41st out of 67 Florida counties, for health care access. ▶ Access to healthcare was identified in community survey as 1 of top 5 concerns for residents. ▶ Osceola's rate of adults who could not see a doctor in the past year due to cost increased significantly since 2007 and is worse than the state average.
Increase capacity of specialty care network	▶ Identified as a strategic issue in all 3 MAPP iterations. ▶ Identified by community residents in Osceola County Visioning Survey as a way to improve the health system.
Increase referrals to connect residents to Primary Care Medical Home	▶ Identified as a strategic issue in all 3 MAPP iterations. ▶ Osceola's rate for preventable hospital stays is significantly higher (worse) than the regional and county peers and the state average. ▶ 82% of ER visits were potentially preventable; i.e., for ambulatory-care sensitive conditions better treated in a primary care setting. ▶ Cost Benefit: Cost of providing health care in a primary care setting is a fraction of the cost of providing similar services in the ER. ▶ Health Benefit: Better chronic disease management in a primary care medical home as opposed to episodic care in the ER.
Improve delivery & quality of health care using evidence-based best practices	▶ Identified as one of the Community Balanced Scorecard drivers of improvement for health care access.
Improve utilization of available resources	▶ Identified as one of the Community Balanced Scorecard drivers of improvement for health care access.

MAPP PHASE 5: FORMULATING GOALS & STRATEGIES

Alignment with State and National Priorities and Measures:

Osceola's priorities, goals, targets, and measures outlined in this CHIP are aligned with multiple state and national sources. The national Healthy People 2020 goals and objectives were used wherever applicable. These are the best available evidence-based knowledge and are applicable at the national, state, and local levels. Healthy People has established benchmarks and monitored progress over time to empower individuals toward making informed health decisions, measure the impact of prevention activities, and identify health improvement priorities. (Alignment will be discussed in greater detail in *Appendix D*).

As with Healthy People 2020, the overarching goal of utilizing evidence-based goals and strategies is to ensure that Osceola County sustains its journey toward:

- Promoting quality of life, healthy development, and healthy behaviors across all life cycles.
- Achieving health equity, eliminating disparities, and improving the health of all groups.
- Creating social and physical environments that promote good health for all.
- Supporting programs or policies recommended in both the national health plans and Florida's State Health Improvement Plan.

MAPP PHASE 6: ACTION CYCLE: PLAN, IMPLEMENT, EVALUATE

This is a critical phase of MAPP in which participants plan for action, implement, and evaluate. This continuous and interactive process ensures the success of the MAPP activities. This phase is a three-year cycle that will end with the completion of the next Community Health Assessment scheduled for 2015, at which point the next three-year cycle will begin.

HOW IMPLEMENTATION PROGRESS WILL BE MONITORED

Goal Assignment:

The success of each goal is based on outcome measurements that track progress and project impact. Each goal has an assigned owner and, for some, a task force and/or additional work groups who are or will be working together to develop coordinated Action and Evaluation plans. Progress will be monitored by each owner as well as by the Health Leadership Council.

Evaluation:

Evaluation will remain important throughout the remainder of the three-year cycle so that progress toward our CHIP goals is both meaningful and measurable. Continual progress updates will regularly occur and will be based on feedback to the Health Leadership Council. Lessons learned from what actions were taken will help guide further actions. An annual evaluation scheduled for June of each year will help to inform key decision makers to decide whether the right strategies were implemented, as well as whether the desired outcomes are being achieved.

HOW IMPLEMENTATION PROGRESS WILL BE MONITORED (CONTINUED)

The Community Balanced Scorecard provided in this document (*Appendix B,* page 2 below) presents a comprehensive view of the Community Health Priorities (also known as "Perspectives"); strategic objectives; measures and targets; assigned partners; and specific actions/strategies. Use of the Community Balanced Scorecard (CBSC) will ensure the following:

- CBSC **implements** the actions and **captures performance data**, which adds rigor to the evaluation, makes partners accountable for results, and provides data for reviewing actions and improving plans as the action cycle unfolds.
- CBSC provides performance data to **evaluate progress** and determine changes needed in the MAPP action plan and the CBSC *"Strategy Map" (see Figure 10 below).*

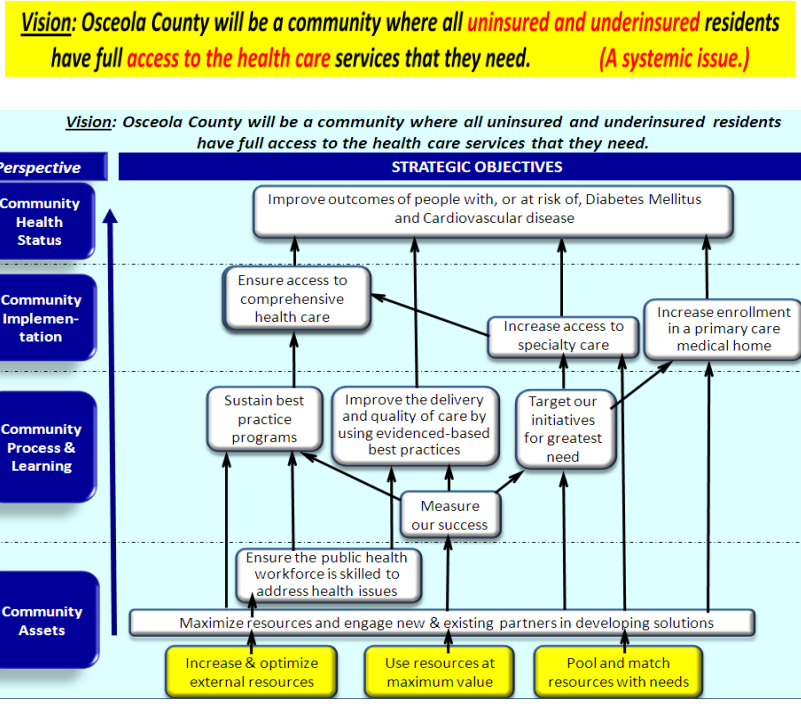


Figure 10: Community Balanced Scorecard High Level Strategy Map

As a reminder regarding the CBSC *"Strategy Maps"* that were used in developing the *2012 Osceola Community Health Assessment—this high level Strategy Map, along with the cascading detail level Strategy Maps,* served as a bridge to the CHIP. The Strategy Maps helped determine the most strategic of the actions in the MAPP action plan and were the foundation of the CBSC. (Note: For more detailed information on CBSC "Strategy Maps" used in developing this CHIP, please see the *2012 Community Health Assessment*, CHIP's companion document).

It is important to remember that while this CHIP is a three-year document, it is an **active** document that will be re-evaluated and revised on a routine basis in order to ensure Osceola County's public health system stays current with community needs and to ensure the **vision**:

"Osceola County will be a community where uninsured and underinsured residents have full access to the health care services they need."

How to Use This Community Health Improvement Plan

Each of us can play an important role in the improvement of Osceola's community health, whether in our homes, schools, workplaces, faith based, or other places. Encouraging and supporting healthy behaviors is more effective than altering unhealthy habits. Below are some simple ways to use this Community Health Improvement Plan to help improve where Osceola County citizens **live, learn, work, and play**.

Source: Take Action; www.County HealthRankings.org

Employers

- Understand priority health issues within the community and use this CHIP and recommended resources to help make your business a healthy place to work.
- Educate your staff about the link between employee health and productivity.

Community Residents

- Understand priority health issues within the community and use this CHIP to help improve the health of your community.
- Use information from this CHIP to start a conversation with community leaders about health issues important to you.
- Get involved by volunteering your time or expertise for an event or activity, or financially help support initiatives related to health topics discussed in this CHIP.

Health Care Professionals

- Understand priority health issues within the community and use this CHIP to remove barriers and create solutions for identified health priorities.
- Share information from this CHIP with your colleagues, staff, and patients.
- Offer your time and expertise to local improvement efforts.
- Offer your patients relevant counseling, education, and other preventive services in alignment with identified health needs of the Osceola community.

Educators

- Understand priority health issues within the community and use this CHIP and recommended resources to integrate topics of health and health factors into lesson plans across all subject areas such as math, science, social studies, and history.
- Create a healthier school environment by aligning this CHIP with school wellness plans/policies. Engage the support of leadership, teachers, parents, and students.

Government Officials

- Understand priority health issues within the community.
- Identify the barriers to good health in your communities and mobilize community leaders to take action by investing in programs and policy changes that help members of our community lead healthier lives.

State and Local Public Health Professionals

- Understand priority health issues within the community and use this CHIP to improve the health of this community.
- Understand how the Osceola County community compares with Peer Counties, Regional Peers, Florida, and the national population.

Faith-based Organizations

- Understand priority health issues within the community and talk with members about the importance of overall wellness (mind, body, and spirit) and local community health improvement initiatives that support wellness.
- Identify opportunities that your organization or individual members may be able to support and encourage participation.

APPENDIX A:

Osceola County Health Leadership Council
Membership Roster
2013

Catholic Charities of Central Florida
Community Vision, Inc.
Florida Blue
Florida Hospital
Health Council East Central Florida
Healthy Start of Osceola
Hispanic Health Initiatives
Nemours Children's Hospital
Osceola Council on Aging
Osceola County Board of Commissioners
Osceola County District Schools
Florida Department of Health Osceola County
Osceola County Fire Rescue & EMS
Osceola County Human Services
Osceola Regional Medical Center
Park Place Behavioral Health Care
St. Cloud Regional Medical Center
The Health Insurance Store
The Transition House
University of Central Florida, College of Medicine

Appendix B: Osceola County Community Balanced Scorecard

Osceola County Community Balanced Scorecard – 2013 - 2016						
Perspective	**Strategic Objective**	**Measure**	**Current Performance Level**	**Target**	**Critical Actions & Assigned To**	**Status R/Y/G**
4.0 Community Health Status	**4.1 Improve diabetes health outcomes**	• Percentage of OCHD/FQHC diabetic patients whose HbA1c levels are ≤ 9.	**2012:** 81.3% Data Source: Unified Data System (UDS) report	**2016:** 85.4% (Healthy People 2020 target)	**Osceola County Health Department:** • Quarterly measurement through medical record reviews. • Annual reporting for Unified Data System (UDS) report. • Clinical staff to evaluate patient at each visit to determine adherence to prescribed treatment regime.	
	4.2 Improve cardiovascular health outcomes	• Percentage of OCHD/FQHC adult patients diagnosed with hypertension whose most recent blood pressure was < 140/90.	**2012:** 56% Data Source: Unified Data System (UDS) report	**2016:** 61.2% (Healthy People 2020 target)	**Osceola County Health Department:** • Quarterly measurement through medical record reviews. • Annual reporting for Unified Data System (UDS) report. • Clinical staff to evaluate patient at each visit to determine adherence to prescribed treatment regime.	
		• Policy change to restrict tobacco usage in certain areas to create smoke-free environments.		-By Jun 2014: Establish one or more policy changes.	**Osceola Tobacco Free Partnership:** • 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.	

Status will be reviewed using a stoplight approach as follows:

RED: Not on target
YELLOW: Falling behind
GREEN: On target

APPENDIX B: Osceola County Community Balanced Scorecard – 2013 – 2016 (continued)						
Perspective	**Strategic Objective**	**Measure**	**Current Performance Level**	**Target**	**Critical Actions & Assigned To**	**Status R/Y/G**
4.0 Community Health Status (continued)	**For both 4.1 Diabetes and 4.2 Cardiovascular (above)**	• Negotiate reduced routine lab testing costs associated with diabetes and hypertension.	Not started as yet (June 2013)	-By Mar 2014	**Council on Aging & St. Thomas Aquinas:** • Ensure affordable routine lab tests for uninsured/underinsured residents with diabetes and/or hypertension. • Review CHiC program process. **Health Council of East Central Florida:** • Affordable labs model based on Parrish Medical Center DTC lab pricing. **Osceola County Health Department:** • Identify specific labs based on treatment recommendations from the American Diabetes Association, cardiology association, and current Council on Aging's CHiC program.	
	4.3 Improve fetal / infant mortality / morbidity rates	• Percent of births to mothers that were obese at time pregnancy occurred	**2012:** 22.5% Data Source: FloridaCHARTS	**2016:** 20.3%	**Fetal & Infant Mortality Review (FIMR) Community Action Team:** • Health education campaign on importance of healthy weight pre-pregnancy. Health education blitzes in targeted zip codes and census tracks with highest rates of fetal / infant mortality / morbidity. • Health education for community at large.	
		• Policy change to ensure health providers use unified messages about pre-pregnancy and interconceptional health		-By Jun 2014: Establish one or more policy changes.	**Fetal & Infant Mortality Review (FIMR) Community Action Team:** • Policy change agreements across medical care providers to better document unified health education messages for women of childbearing age regarding importance of being healthy / healthy weight before becoming pregnant, while pregnant, and between pregnancies and to track progress.	

APPENDIX B: Osceola County Community Balanced Scorecard – 2013 – 2016 (continued)						
Perspective	**Strategic Objective**	**Measure**	**Current Performance Level**	**Target**	**Critical Actions & Assigned To**	**Status R/Y/G**
3.0 Community Implementation	**3.1 Expand primary care capacity for uninsured / underinsured residents**	• Number of patients accessing primary care services at OCHD/FQHC health centers.	**2012:** 23,221 Data Source: Unified Data System (UDS) report	**2016:** 26,704 (15% increase)	**Osceola County Health Department:** • Open new FQHC center at Intercession City. • Expand Boggy Creek dental facility. • Open dental center at St. Cloud facility.	
		• Mobile medical van one day per week in 192 corridor.	Not started as yet (June 2013)	-By Mar 2014	**St. Thomas Aquinas:** • Secure travel expense funding to drive mobile medical van to the 192 motel corridor one-day per week to provide primary care services for homeless population.	
	3.2 Increase referrals to connect residents to Primary Care Medical Home	• Community awareness campaign to educate residents on importance of preventive health care.	Not started as yet (June 2013)	-By Mar 2014	**Health Leadership Council:** • Community health education campaign re: importance of primary care vs. emergency room for ambulatory care sensitive conditions. • Develop Public Service Announcements and other media avenues to target health disparate areas.	
		• Health Literacy Campaign	Not started as yet (June 2013)	-By Mar 2014	**Florida Hospital:** • Develop Health Literacy Campaign through case manager task force.	
	3.3 Increase capacity of specialty care network	• Develop pediatric specialty referral system	Not started as yet (June 2013)	-By Jun 2014	**Nemours Children's Hospital:** • Determine inventory of resources for medical provider pediatric specialty referral slots. • Develop best practice pediatric specialty referral model.	

APPENDIX B: Osceola County Community Balanced Scorecard – 2013 – 2016 (continued)						
Perspective	**Strategic Objective**	**Measure**	**Current Performance Level**	**Target**	**Critical Actions & Assigned To**	**Status R/Y/G**
2.0 Community Process & Learning	**2.1 Improve delivery & quality of health care using evidence-based best practices**	• Increased understanding of asthma and treatment compliance in children 5-12 years old	-Need baseline	-TBD	**Nemours Children's Hospital:** • Summer Asthma Camp for children 5-12 years old. • Measure understanding of asthma and treatment compliance pre and post camp.	
		• Improved senior citizens' perception of their physical / psychological well-being after attending 12 weeks of Tai Chi classes	-Need baseline	-TBD	**Council on Aging and Osceola Regional Hospital:** • Establish Tai Chi classes for seniors • Measure attendees' perception of their physical / psychological well-being pre and post 12 weeks of Tai Chi classes.	
		• Explore potential for setting up pilot programs to manage patients with multiple chronic diseases.	Not started as yet (June 2013)	-By 2016	**Health Council of East Central Florida:** • Evaluate pilot practices that have a proven ability to reduce hospital readmissions, manage patients with multiple chronic diseases, and reduce ED visits for potential replication in Osceola County. These include: 1) poly-chronic care network (PCCN) in Brevard County and 2) Special Care Unit (SCU) model in West Orange County.	

APPENDIX B: Osceola County Community Balanced Scorecard – 2013 – 2016 (continued)						
Perspective	**Strategic Objective**	**Measure**	**Current Performance Level**	**Target**	**Critical Actions & Assigned To**	**Status R/Y/G**
1.0 Community Assets	**1.1 Improve utilization of available resources**	• Expand Community Vision Community Resource Tool to include health • Increase distribution of Community Resource Tool	-2000 (copies distributed)	-By Dec 2013 -2500 copies annually	**Community Vision:** • Expand Community Resource Tool to include health. • Work with Tupperware to increase printing.	
		• Develop Community Resource Tool in software application format	Not started as yet (June 2013)	-By Jun 2014	**University of Central Florida:** • UCF student project to develop downloadable application for Community Resource Tool.	
		• Implement Phone-to-Home Patient Navigator referral system. • Increase number of residents connected to needed health / social services.	-Need baseline	-By Dec 2013 -TBD	**Team Osceola** (Osceola EMS, Osceola Government, Osceola Legal, FDOH Osceola, FDOH Osceola Legal, Community Vision, Florida Hospital, Health Council of East Central Florida): • Osceola County Health Department - Hire patient navigator position. • Patient navigator position to work in Osceola County 911 Call Center to connect residents with needed health / social services. • Establish baseline number of residents connected to needed health / social services and develop target for percentage of increase for following year.	

Appendix C: Rationale & Resources to Support Community Health Improvement Action Plans

Rationale & Resources to Support the Community Health Improvement Action Plans - 2013 – 2016 Action Plan Cycle			
Community Health Priorities & Alignment	**Strategic Objective**	**Why is this important to our community**	**Available Community Resources**
4.0 **Community Health Status** Alignment w/Essential Services of Public Health: **Improve** health outcomes & health factors; **Minimize** health risks.	**4.1** **Improve diabetes health outcomes**	• Diabetes is the #2 cause of death from chronic diseases (3.4% of all deaths). • Health disparity issue: 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). • Health benefit: 1. There is a strong correlation between diabetes and cardiovascular disease. 2. 65% of those with diabetes die from some form of heart disease or stroke. 3. American Heart Association considers diabetes to be 1 of the 6 controllable factors for cardiovascular disease.	**Osceola County Health Department** Federally Qualified Health Center network providing primary care clinical services for the underserved population **Health Resources & Services Administration's Bureau of Primary Health Care** Support system for federally qualified health centers **East Central Florida Healthy Communities Dashboard** **www.CFLHealthyMeasures.org** Program planning and evaluation for funders and funded programs **American Diabetes Association**
	4.2 **Improve cardiovascular health outcomes**	• Heart Disease is the #1 cause of death (26.4% of all deaths). • When heart disease is combined with stroke, these cardiovascular diseases were responsible for 30% of all deaths. • Health disparity issue: death rate from hypertension is worse in the Hispanic population. • Health disparity issue: 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. • Health benefit: Reducing hypertension is a controllable risk factor that can have a positive impact on overall cardiovascular health.	**Osceola County Health Department** Federally Qualified Health Center network providing primary care clinical services for the underserved population **Health Resources & Services Administration's Bureau of Primary Health Care** Support system for federally qualified health centers **East Central Florida Healthy Communities Dashboard** **www.CFLHealthyMeasures.org** Program planning and evaluation for funders and funded programs **Osceola County Health Department** Tobacco Prevention Program **Osceola Tobacco Free Coalition**

	4.3 **Improve fetal / infant mortality / morbidity rates**	• Osceola's rates for the following are all worse than the Healthy People 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 birthweight (8.3%; HP 2020=7.8%) • Health disparity issue: fetal, neonatal, and infant death rates are worse for Osceola's Black and Hispanic populations (See 2012 Community Health Assessment for detailed information). • Health benefit: Improving the well-being of mothers, infants, and children is an important public health goal that has a tremendous impact on our community's current and future health.	**Osceola County Health Department** Federally Qualified Health Center network providing primary care clinical services for the underserved population **Health Resources & Services Administration's Bureau of Primary Health Care** Support system for federally qualified health centers **Fetal & Infant Mortality & Morbidity (FIMR) Committee** **FIMR Community Action Coalition** **Osceola County Health Department** Healthy Start Program & WIC Program **Healthy Start Coalition of Osceola County** **Local Hospitals**
3.0 **Community Implementation** Alignment w/Essential Services of Public Health: **Diagnose & Investigate** community health problems/hazards; **Inform, Educate & Empower** people; **Link** people to needed services.	**3.1** **Expand primary care capacity for uninsured / underinsured residents**	• Identified as a strategic issue in all 3 MAPP iterations. • Osceola's uninsured rate in 2011 for the non-elderly (ages 18-64) was 33%, compared to Florida at 30%. • Osceola is federally designated as a Health Professional Shortage Area (HPSA) for primary medical, dental, and mental health. • Osceola's ratio of 1,559 residents for every 1 primary care physician is significantly higher (worse) than regional and county peers and state average. It is more than double (worse than) the national benchmark. • County Health Rankings – Osceola ranked in bottom half, or 41st out of 67 Florida counties, for health care access. • Access to healthcare was identified in community survey as 1 of top 5 concerns for residents. • Osceola's rate of adults who could not see a doctor in the past year due to cost increased significantly since 2007 and is worse than the state average.	**Osceola County Health Department** Federally Qualified Health Center network providing primary care clinical services for the underserved population **Health Resources & Services Administration's Bureau of Primary Health Care** Support system for federally qualified health centers **Council on Aging** primary care clinic **St. Thomas Aquinas** primary care clinic

	3.2 **Increase referrals to connect residents to Primary Care Medical Home**	• Identified as a strategic issue in all 3 MAPP iterations. • Osceola's rate for preventable hospital stays is significantly higher (worse) than the regional and county peers and the state average. • 82% of ER visits were potentially preventable; i.e., for ambulatory-care sensitive conditions better treated in a primary care setting. • Cost Benefit: Cost of providing health care in a primary care setting is a fraction of the cost of providing similar services in the ER. • Health Benefit: Better chronic disease management in a primary care medical home as opposed to episodic care in the ER.	**Team Osceola** Community collaborative developing the Phone-to-Home case management system to work in 911 call center to refer residents to primary care medical home. **Osceola County Health Department** Connect-to-Care ER Diversion Program **Local Hospital Emergency Department** referrals **Osceola County Health Department** Federally Qualified Health Center network providing primary care clinical services for the underserved population **Health Resources & Services Administration's Bureau of Primary Health Care** Support system for federally qualified health centers
	3.3 **Increase capacity of specialty care network**	• Identified as a strategic issue in all 3 MAPP iterations. • Identified by community residents in Osceola County Visioning Survey as a way to improve the health system.	**Nemour's Children's Hospital** Pediatric specialty physicians' referral source under development. **Council on Aging** Specialty physicians collaborative
2.0 **Community Process & Learning** Alignment w/Essential Services of Public Health: **Monitor** health status; **Develop policies**/plans; **Evaluate** effectiveness of services; **Research** & Innovation	**2.1** **Improve delivery & quality of health care using evidence-based best practices**	• Identified as one of the Community Balanced Scorecard drivers of improvement for health care access.	**Nemours Children's Hospital** Summer Asthma Camp for children 5-12 years old. **Council on Aging and Osceola Regional Hospital** Tai Chi classes for seniors **Osceola County Health Department** Primary Care Medical Home certification by The Joint Commission for Ambulatory Care Accreditation **Health Council of East Central Florida** Evaluate pilot practices that have a proven ability to reduce hospital readmissions, manage patients with multiple chronic diseases, and reduce ED visits.
1.0 **Community Assets** Alignment w/Essential Services of Public Health: **Mobilize** community partnerships; **Assure** competent workforce	**1.1** **Improve utilization of available resources**	• Identified as one of the Community Balanced Scorecard drivers of improvement for health care access.	**Community Vision, Inc.** Community Resource Toolkit development and dispersal into community. **University of Central Florida** Students to develop downloadable software application for Community Resource Toolkit

Appendix D: Alignment of Local, State, and National Goals, Objectives, and Measures

Osceola County Community Balanced Scorecard – 2013–2016 Alignment of Local, State, National					
Osceola Perspective	**Osceola Strategic Objective**	**Osceola CHIP**	**FDOH Osceola County Health Department Strategic Plan**	**Florida State Health Improvement Plan**	**National**
4.0 Community Health Status	**4.1 Improve diabetes health outcomes**	• Percentage of OCHD/FQHC diabetic patients whose HbA1c levels are ≤ 9.	• Monitor and improve health status indicators	• Goal CD1: Healthy Weight (Including strategies CD1.1; CD1.2; CD1.3; CD2.1; CD2.2) • Goal CD3: Chronic Disease (including strategies CD3.1; CD3.2; CD3.3; CD3.3)	• HRSA/BPHC federally qualified health centers Clinical Performance Standards • Healthy People 2020 NWS Objectives • CDC Winnable Battle: Nutrition, Physical Activity, and Obesity • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks.
	4.2 Improve cardiovascular health outcomes	• Percentage of OCHD/FQHC adult patients diagnosed with hypertension whose most recent blood pressure was < 140/90.	• Monitor and improve health status indicators	• Goal CD1: Healthy Weight (Including strategies CD1.1; CD1.2; CD1.3; CD2.1; CD2.2) • Goal CD3: Chronic Disease (including strategies CD3.1; CD3.2; CD3.3; CD3.3)	• HRSA/BPHC federally qualified health centers Clinical Performance Standards • Healthy People 2020 NWS Objectives • CDC Winnable Battle: Nutrition, Physical Activity, and Obesity • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks.
		• **Policy change** to restrict tobacco usage in certain areas to create smoke-free environments.	• Monitor and improve health status indicators	• Goal CD4: Tobacco use and secondhand smoke exposure (Including strategies CD4.1; CD4.2; CD4.3)	• Healthy People 2020 TU Objectives • CDC Winnable Battle: Nutrition, Physical Activity, and Obesity • CDC Community Guide recommendations • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks.
	For both 4.1 Diabetes and 4.2 Cardiovascular (above)	• Negotiate reduced routine lab testing costs associated with diabetes and hypertension.	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	• Goal AC: Access to Care (Including strategies AC1.1; AC2.2)	• Healthy People 2020 AHS Objectives • HHS Action Plan to Reduce Disparities, Goal II • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks.
	4.3 Improve fetal /	• Percent of births to mothers that were	• Monitor and improve health status	• Goal CD1: Healthy Weight (Including strategies CD1.1;	• Healthy People 2020 NWS; MICH-5 & MICH-16; FP-7 Objectives

	infant mortality / morbidity rates	obese at time pregnancy occurred	indicators	CD1.2; CD1.3; CD2.1; CD2.2) • Goal AC: Access to Care (Including strategies AC5.1 Being healthy prior to pregnancy) • DOH Long Range Program Plan Objective 4B	• National Prevention Strategy • CDC Winnable Battle: Nutrition, Physical Activity, and Obesity • HRSA/BPHC federally qualified health centers Clinical Performance Standards • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks
		• **Policy change** to ensure health providers use unified messages about pre-pregnancy and inter-conception health	• Monitor and improve health status indicators	• Goal CD1: Healthy Weight (Including strategies CD1.1; CD1.2; CD1.3; CD2.1; CD2.2) • Goal AC: Access to Care (Including strategies AC5.1 Being healthy prior to pregnancy) • Goal CR3: Culturally and linguistically competent care	• Healthy People 2020 NWS; MICH-5 & MICH-16; FP-7 Objectives; ECBP-11 Objective • National Prevention Strategy • CDC Winnable Battle: Nutrition, Physical Activity, and Obesity • HRSA/BPHC federally qualified health centers Clinical Performance Standards • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks
3.0 Community Implemen-tation	**3.1 Expand primary care capacity for uninsured / underinsured residents**	• Number of patients accessing primary care services at OCHD/FQHC health centers.	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	• Goal AC: Access to Care (Including strategies AC1.1; AC2.2; AC3.1; AC4.1; AC4.2; AC4.3; AC4.4; AC6.2; AC6.5) DOH Long Range Program Plan, Objectives 2A, 2B, 2C, 4B	• Healthy People 2020 AHS; OH, OA; HC/HIT; MHMD Objectives • HHS Action Plan to Reduce Disparities, goal I & II • CDC Community Guide recommendation • HRSA/BPHC federally qualified health centers • CDC Oral Health Strategic Plan, Goal 1 & 6 • National Prevention Strategy • Department of Elder Affairs Long Range Program Plan, Objective 1.2 & 1.3 • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services
		• Mobile medical van one day per week in 192 corridor.	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	Same as above	Same as above

	3.2 Increase referrals to connect residents to Primary Care Medical Home	• Community awareness campaign to educate residents on importance of preventive health care.	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	Same as above	Same as above
		• Health Literacy Campaign		• Goal CR3: Culturally and linguistically competent care • Goal AC: Access to Care (including strategy AC7.1)	• Healthy People 2020 ECBP-11; HC/HIT-2; Objectives • HHS Action Plan to Reduce Disparities, goal 1 • National Prevention Strategy • HRSA/BPHC federally qualified health centers • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services
	3.3 Increase capacity of specialty care network	• Develop pediatric specialty referral system	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	• Goal AC: Access to Care (including strategy AC1.1; AC2.2)	• 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services • Healthy People 2020 AHS-4 Objectives
2.0 Community Process & Learning	**2.1 Improve delivery & quality of health care using evidence-based best practices**	• Increased understanding of asthma and treatment compliance in children 5-12 years old	• Monitor and improve health status indicators	• Goal CD3: Chronic Disease (including strategy CD3.1; CD3.2; CD3.3)	• Healthy People 2020 D-14; AOCBC-8; RD 7.3; C-3; C-4; C-5; HDS-6, D15; D5; RD 7.1; NWS-6 Objectives • US Preventive Services Task Force Recommendations (USPSTF) • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services • HRSA/BPHC federally qualified health centers Clinical Performance Standards
		• Improved senior citizens' perception of their physical / psychological well-being after attending 12 weeks of Tai Chi classes	• Monitor and improve health status indicators	• Goal HP: Health Protection (including strategy HP4.1: Injury Prevention)	• Healthy People 2020 IVP-25 • National Prevention Strategy • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services • 10 Essentials of Public Health Services: Improve

					health outcomes & health factors; Minimize health risks
		• Explore potential for setting up pilot programs to manage patients with multiple chronic diseases.	• Monitor and improve health status indicators • Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	• Goal CD3: Chronic Disease (including strategies CD3.1; CD3.2; CD3.3; CD3.3)	• Healthy People 2020 D-14; APCBC-8; RD 7.3; C-3, C4, C5; HDS-6; D15. • 10 Essentials of Public Health Services: Improve health outcomes & health factors; Minimize health risks • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services
1.0 Community Assets	**1.1 Improve utilization of available resources**	• Expand Community Vision Community Resource Tool to include health • Increase distribution of Community Resource Tool	• Ensure customer access to affordable health care services		• 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services
		• Develop Community Resource Tool in software application format	• Ensure customer access to affordable health care services		• 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services
		• Implement Phone-to-Home Patient Navigator referral system. • Increase number of residents connected to needed health / social services.	• Ensure customer access to affordable health care services • Ensure continued availability of primary health care services	• Goal AC: Access to Care (Including strategies AC1.1; AC2.2; AC3.1; AC4.1; AC4.2; AC4.3; AC4.4; AC6.2; AC6.5) • DOH Long Range Program Plan, Objectives 2A, 2B, 2C, 4B	• Healthy People 2020 AHS; OH, OA; HC/HIT; MHMD Objectives • HHS Action Plan to Reduce Disparities, goal I & II • CDC Community Guide recommendation • HRSA/BPHC federally qualified health centers • CDC Oral Health Strategic Plan, Goal 1 & 6 • National Prevention Strategy • 10 Essentials of Public Health Services: Inform, Educate & Empower people; Link people to needed services

Appendix E: 2013 Osceola Business of Health Summit Participant Organizations

ADA
Associates in Dermatology
Bank of America
Barker Specialties
Brightstar Care
Celebration Foundation
Century Link
Cigna
City of Kissimmee
Comfort Keepers
Community Hope Center
Community Vision
CV Volunteer
Family Healthcare Clinical Studies
Family Healthcare of Central Florida
Farm Bureau
Florida Blue
Florida Department of Health Orange County
Florida Department of Health Osceola County
Florida Department of Health Seminole County
Florida Healthcare Coalition
Florida Hospital
Florida Hospital - Celebration
Florida Traditions Bank
Good Samaritan Village
Health Council East Central Florida
Health Insurance Exchange
Healthy Start Coalition of Osceola
HFUW
Hispanic Health Initiatives
Humana
Intervention Services, Inc.
Keystone Health
KUA
Leadership Legends
MZI Healthcare
Nemours Children's Hospital
Osceola Council on Aging
Osceola County
Osceola County Commissioner
Osceola County District Schools
Osceola County EMS & Fire Rescue
Osceola County Extension
Osceola County Human Services
Osceola County District Schools
Osceola Woman
Park Place Behavioral Health Care
Physician Dispensing Company
PNC Bank
Poinciana Medical Center
Popular Community Bank
Residents
S3 Industry Corp.
Serenity Massage
Sevilla Inn
St. Cloud Regional Med. Ctr.
St. Cloud Regional Medical Center
St. Cloud Sports Medicine
St. Cloud/UCF Incubator
Stetson University
The Health Insurance Store
The Transition House
Tupperware Brands
UBS Financial Services
University of Central Florida College of Medicine
VITAS