| #  | Objective                                                                 | Lead(s)                        | Action step                                                                 || Metrics / Indicators                                                                                       | Related "Top Community Health Needs" (as identified in 2015 CHNA)                                      |
|----|---------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1  | Improve access to services through a financial assistance program.        | Lou Ann Watson                 | Increase the number of community members served through a financial assistance program that supports uninsured residents in identifying and applying for medical benefits for which they may qualify. | 1) # of people assisted on the marketplace  
2) # of people reached through community activities related to financial assistance  
3) # of community outreach events related to financial assistance  
•Access to health services |                                                                                           |
| 2  | Improve access to Primary Care by providing care coordination at WHH ED for uninsured and Medicaid patients with non-emergent medical issues | Steve Nierman                  | 1) Partner with Haley Center Clinic and Central Florida Health Care (CFHC) to provide staff on-site at WHH ED part-time.  
2) Haley Center and CFHC staff to coordinate primary care services. | 1) # of referrals from WHH ED to Haley Center and CFHC (year-to-year comparison)  
2) % of patients who show up to follow-up clinic appointment to establish a medical home  
• Access to health services |                                                                                           |
## Winter Haven Hospital CHNA 3-year Implementation Plan (2016 - 2018)

Last updated: 4/25/2016

<table>
<thead>
<tr>
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| 3 | Improve access to pediatric services. | Jennifer Richards | 1) Initiate pediatric Services at WHWH  
2) Secure pediatric Hospitalist contract.  
3) Monitor and enhance service delivery | Pediatric patient volume (year-to-year comparison) | • Access to health services |
| 4 | Enhance coordination of care across the community through utilization of tele-ICU/medicine. | Director of e-ICU  
CKO / DW | Integrate skilled nursing facilities in tele-ICU/medicine to manage patients | # of SNFs utilizing tele-ICU/medicine to manage patients | • Access to health services |
| 5 | Collaborate with Polk County indigent care program, FQHC, and Polk County “Healthier Polk” initiative to enhance service availability. | Walter Lupke / Jeff Ware | 1) Offer Federally Qualified Health Clinic (FQHC) and Central Florida Health Care (CFHC) medical office space at no cost.  
2) Request for CFHC to place a part-time ARNP at the Center for Behavioral Health to offer primary medical services | FQHC ARNP patient visit volume (year-to-year comparison) | • Access to health services  
• Behavioral health & substance abuse |
### Objective

Expand access to behavioral health and substance abuse services.

### Lead(s)

Gail Ryder / Jeff Ware

### Action step

1) Enhance IP and OP mental health services
2) Improve uninsured and Medicaid population access to outpatient Behavioral Health Services: Implement contract between Polk County Indigent Care Division and Winter Haven Hospital for grant application support and to add partial psychiatrist, therapists care manager, and ARNP.
3) Improve coordination of substance abuse and mental health services for those served at CBH and discharged from CFP through Tri-County Human Services co-location at CBH.
4) Provide access to primary care at our OP center through relationship with FQHC
5) Enhance utilization of tele-psychiatry in ED to create just-in-time access to psychiatrists for evaluation
6) Recruit psychiatrists to enhance service availability

### Metrics / Indicators

1) IP & OP related patient volume
2) # of patients seen under expanded access
3) Implement agreement between Tri-County Human Services and WHH, Center for Behavioral Health:
   a) Develop lease agreement
   b) Identify office space
   c) Develop MOU
4) # of tele-psychiatry consults (year-to-year comparison)
5) Net new count of psychiatrists

### Related "Top Community Health Needs" (as identified in 2015 CHNA)

- Access to health services
- Need to decrease clinical health issues
- Behavioral health & substance abuse
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<td>7</td>
<td>Provide coordinated follow-up care for low-risk chest pain and heart failure patients discharged from the ED to reduce readmissions and preventable hospitalizations.</td>
<td>Debi Wolf</td>
<td>1) Establish a Heart Function Clinic based at WHH (accepts uninsured and Medicaid patients) to provide care coordination and oversight as a follow-up to ED patients post-discharge. 2) Enhance awareness through medical staff and care coordination efforts.</td>
<td>1) OP clinic volume 2) Readmission rates (HF &amp; chest pain) 3) ALOS (HF &amp; chest pain)</td>
<td>Need to decrease clinical health issues</td>
</tr>
<tr>
<td>8</td>
<td>Enhance services to further develop stroke clinical capabilities.</td>
<td>Steve Nierman / Walter Lupke / Jenny Blank</td>
<td>1) Pursue mechanical thrombectomy service offering. 2) Implement tele-neurology to improve compliance with thrombolytic therapy. 3) Pursue national benchmarks.</td>
<td>1) Addition of mechanical thrombectomy service offering 2) % of patients appropriately receiving thrombolytic therapy (year-to-year comparison)</td>
<td>Need to decrease clinical health issues</td>
</tr>
<tr>
<td>9</td>
<td>Decrease suicide rate.</td>
<td>Gail Ryder</td>
<td>Implement &quot;Mental Health 1st Aid&quot; offerings (for adults and youth) in Polk County.</td>
<td>1) # of Mental Health 1st Aid educational events 2) # of people participating in Mental Health 1st Aid 3) Suicide rate (year-to-year comparison)</td>
<td>Need to decrease clinical health issues Behavioral health &amp; substance abuse</td>
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<td>10</td>
<td>Reduce readmissions and preventable hospitalizations due to COPD.</td>
<td>Care Coordination Manager (TBD)</td>
<td>Leverage BayCare Extended Care COPD SNF initiative to reduce preventable hospitalizations and readmissions.</td>
<td>Readmission rate for COPD</td>
<td>• Need to decrease clinical health issues</td>
</tr>
<tr>
<td>11</td>
<td>Improve access to safe exercise options.</td>
<td>Rosemary Myers</td>
<td>Establish a team member discounted rate for fitness club membership.</td>
<td># of team members utilizing discounted membership</td>
<td>• Need to improve the use of healthy options</td>
</tr>
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