


## UF Health Shands

# COMMUNITY HEALTH IMPROVEMENT PLAN

**Revised January 2024**


UFHealth
UNIVERSITY OF FLORIDA HEALTH

# Table of Contents

# Introduction & Purpose

UF Health Shands is proud to unveil its 2023-2025 Implementation Strategy (IS) Plan. The primary aim of this plan is to address the significant health needs identified within the Community Health Needs Assessment (CHNA). It is imperative for non-profit hospital systems to undertake the CHNA and IS process every three years to maintain their Internal Revenue Service 501(c)(3) status.

This Implementation Strategy outlines specific goals, objectives, and strategies designed to tackle the prioritized health needs identified within the 2022 Community Health Needs Assessment. The CHNA report, adopted in July 2022, is readily accessible on the hospital's website under the Community Health section Community Health | UF Health, University of Florida Health.

This report is specific to UF Health Shands encompassing those within the seven-county service region, namely Alachua, Bradford, Columbia, Levy, Marion, Putnam, and Suwannee counties. Additionally, it includes Shands Teaching Hospital and Clinics, Inc (STHC) encompassing Select Specialty Hospital-Gainesville, LLC (SSH) and Archer Rehabilitation, LLC d/b/a UF Health Rehab Hospital (Archer Rehab).

This report includes an overview of the three health needs identified and prioritized in the most recent CHNA, a description of the process and methods used to design the implementation plan, and hospital strategies that address each health need. The prioritized health needs from the 2022 CHNA include:

**2022 Prioritized Health Needs**


# Our Hospital and the Community Served

## UF Health Shands

UF Health Shands is a private, not-for-profit hospital system affiliated with the University of Florida. It is part of UF Health, a world-class academic health center and part of one of the nation's top 5 public research universities, with main campuses in Gainesville and Jacksonville as well as community hospitals in Leesburg and The Villages®. UF Health Shands is based in Gainesville, Florida.

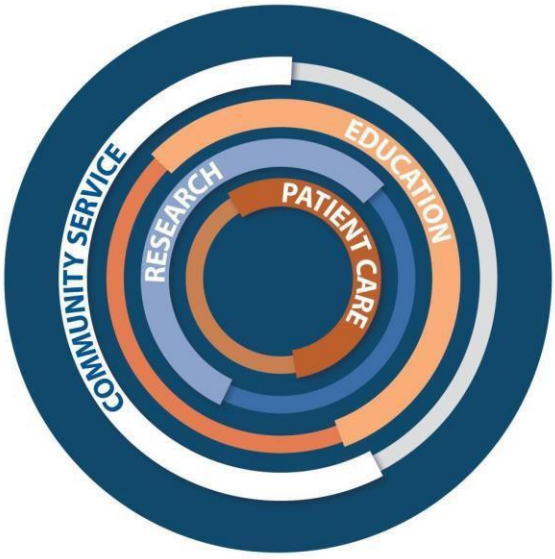
UF Health Shands has more than 1,200 expert UF College of Medicine and many community

physicians along with almost 11,000 nursing and support staff that provide comprehensive high-quality patient care, from primary care and family medicine to subspecialty tertiary and quaternary services for patients with highly complex medical conditions. It features a teaching hospital, UF Health Shands Hospital, five specialty hospitals — UF Health Shands Cancer Hospital, UF Health Shands Children's Hospital, UF Health Psychiatric Hospital, UF Health Heart & Vascular Hospital and UF Health Neuromedicine Hospital; a network of outpatient rehabilitation centers; and a home health agency. UF Health Shands is affiliated with more than 60 UF Health Physicians primary care and specialty medical practices located throughout North Central Florida. UF Health Shands Hospital is also home to a state-designated Level I trauma center, a Level IV neonatal intensive care unit, a regional burn center and an emergency air and ground transport program.

In addition, STHC partners with Select Medical Corporation to operate SSH, a 48-bed long-term acute care hospital located within STHC's primary hospital facility and Archer Rehab, which operates a 60-bed rehabilitation facility located approximately one mile from STHC's main hospital campus.

## Our Mission

UF Health Shands Hospital's guiding principles are the framework for the mission-based goals in The Power of Together strategic plan. It supports the aim to advance science, train the next generation of health care professionals and improve patient care and quality of life for Florida residents. [1] Our mission of patient care, research, education, and community service support each other and create a virtuous expanding circle.



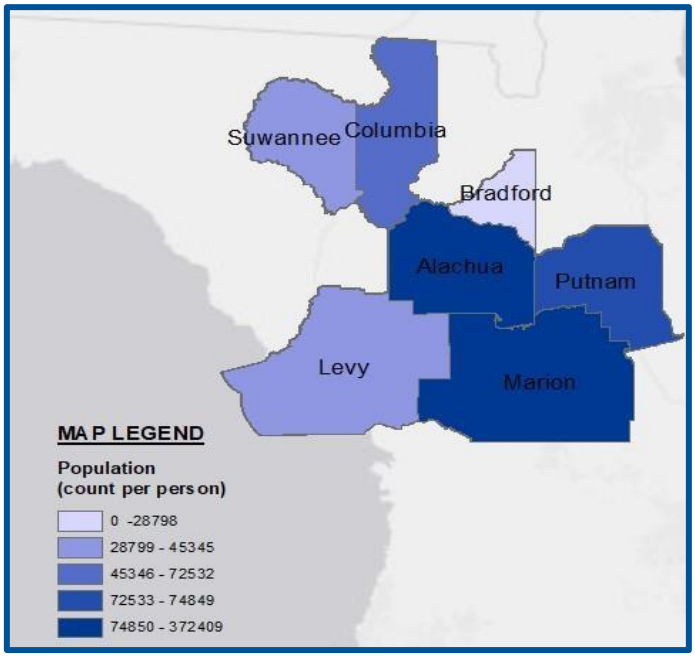

## Description of Community Served

According to the 2021 Claritas Pop-Facts population estimates, the UF Health Shands Primary Service Area has an estimated population of 908,877 in 2021, which represents 4% of Florida's total population. Figure 1 shows population size by county within the UF Health Shands service area. The darkest blues represent ZIP codes with the largest population. Geographically, there are 6,089 total square miles in the service area, or 11% of the total landmass of Florida, according to the U.S. Census Bureau American Community Survey 2015-2019 five-year estimates. The geography encompasses a mix of urban and rural areas. Population density for this entire area,

estimated at 139.21 persons per square mile, is greater than the national average population density of 90.19 persons per square mile, but less than the Florida average density of 371.64 persons per square mile.

[1] UF Health. UF Health Strategic Plan 2015-2020. Retrieved from PT_Handout_051915_FINAL.pdf (ufhealth.org)

**Figure 1: Population Size by Zip Code**




***Data Source:*** *2021 Claritas Pop-Facts®, U.S. Census Bureau 2019*

**Table 1. Population Size by County**

| Total Population | |
|---|---|
| **CHNA Region** | **908,877** |
| **Alachua** | 272,851 |
| **Bradford** | 28,798 |
| **Columbia** | 72,532 |
| **Levy** | 42,093 |
| **Marion** | 372,409 |
| **Putnam** | 74,849 |
| **Suwannee** | 45,345 |
| **Florida** | **21,908,282** |
| **United States** | **328,239,523** |

## Acknowledgments

The development of the 2022 Implementation Plan was a collective effort that included key members from UF Health Shands and input gathered from community residents and organizations in UF Health Shands seven county service region. UF Health Shands Implementation Plan project members included Lakesha Butler, PharmD, Associate Vice President, Organizational Culture and Strategic Engagement, Robert Thornton, Vice President of Finance and Paul Lipori, Director of Financial Planning and Analysis. Additional supporting members included David R. Nelson; Senior Vice President for Health Affairs at the University of Florida and President of UF Health, Colleen Koch, M.D., Dean of the UF College of Medicine; Marvin A. Dewar, M.D., J.D., Senior Associate Dean of the UF College of Medicine and Chief Executive Officer of UF Health Physicians; and the UF Health Shands Executive Team.

| UF Health Shands Executive Team |
|---|
| **James J. Kelly Jr.**, *Interim Chief Executive Officer* |
| **Irene Alexaitis,** D.N.P., R.N., NEA-BC, *Vice President, Nursing and Patient Services* |
| **Traci Spray d'Auguste**, M.B.A., MSHA, *Chief Operating Officer* |
| **C. Parker Gibbs**, M.D., *Chief Medical Officer* |
| **Michele Lossius**, M.D., *Chief Quality Officer* |

## Consultants

UF Health Shands commissioned Conduent Healthy Communities Institute, or HCI to support report preparation for its 2023 Implementation Plan. Conduent HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. The following HCI team members were involved in the development of this report: Corinna Kelley, MPH Public Health Consultant; Elizabeth Bobo, MPH, MA, CHES Account Manager; Dari Goldman Senior Project Specialist. To learn more about Conduent HCI, please visit www.conduent.com/community-population-health.

# Findings from the 2022 CHNA

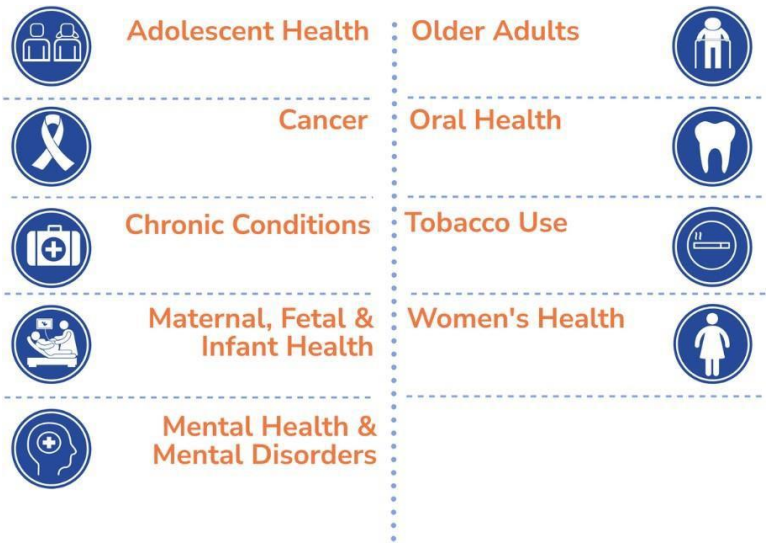
The CHNA is a systematic, data-driven approach used to determine the health status, behaviors and needs of residents in the CHNA service areas. This information is used to inform decisions and guide efforts to improve community health and wellness. A CHNA provides information from quantitative and qualitative sources so that communities may identify issues of greatest concern; explore opportunities to collaborate with community partners and commit resources to those priority areas of focus, thereby making the greatest possible impact on community health status.

The following three-year Implementation Strategy reflects a significant part of our commitment to make meaningful progress in addressing issues prioritized as part of the 2022 Community Health Needs Assessment.

## Methods for Identifying Community Needs

Multiple types of data were collected and analyzed to create the 2022 Community Health Needs Assessment. Primary data consisted of key informant interviews while secondary data included indicators spanning health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of the health needs in UF Health Shands' seven-county CHNA region.

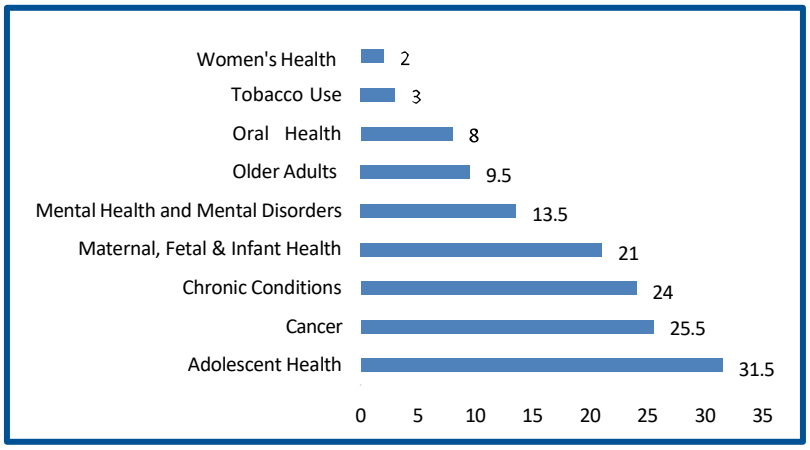
The following significant health needs were identified through the UF Health Shands 2022 CHNA and represented potential areas to consider for prioritization and action.



## Prioritized Health Needs

In March 2022, UF Health Shands convened a group of hospital leaders to participate in a virtual presentation of data on health needs facilitated by HCI. Following the presentation, question and discussion session, participants were invited to complete a prioritization activity which allowed participants to assign a score to each health need based on magnitude of the health issue and ability to impact. A total of seven individuals representing UF Health Shands leadership participated in the activity. Completion of the online exercise resulted in a numerical score for each health topic and criterion. Numerical scores for the two criteria were equally weighted and averaged to produce an aggregate score and overall ranking for each health topic. The aggregate ranking can be seen in Figure 2.

**FIGURE 2. AGGREGATE RESULTS OF ONLINE PRIORITIZATION ACTIVITY (N=7)**




Leadership at UF Health Shands Hospital reviewed the scoring results of the community needs alongside additional supporting evidence and agreed to proceed with implementation planning for the top three priority areas: adolescent health, cancer, and chronic conditions.

## Needs that will not be Addressed

Beyond the three prioritized health needs identified in figure 2, the following additional significant health needs emerged from review of the primary and secondary data including maternal, fetal & infant health, mental health and mental disorders, older adults, oral health, tobacco use, and women's health. At this time UF Health Shands acknowledges these issues, but will focus their efforts on the three prioritized health needs over the next three years. While not directly targeted in this plan, many of these topics overlap with the prioritized health needs and will be positively impacted through existing collaborative strategies and activities.

# 2023-2025 Implementation Plan

This Implementation Strategy (IS), or Implementation Plan was completed through a series of virtual meetings incorporating key UF Health Shands hospital leadership and program managers. UF Health Shands completed a comprehensive analysis of the data collected as part of the 2022 CHNA process, including input solicited from the community representing diverse populations such as medically underserved, low-income communities, and minority populations.

On December 20, 2023, UF Health Shands convened key stakeholders to reassess the previous implementation plan, aiming to craft a pragmatic and measurable strategy to tackle the top three community health needs identified in the 2022 Community Health Needs Assessment (CHNA): Adolescent Health, Cancer, and Chronic Conditions. The workshop's objective was to gather essential insights into existing programs and initiatives addressing these prioritized health topics, devise methods for monitoring and evaluating progress, and propose goals and objectives for review and implementation. The agenda encompassed a thorough examination of CHNA data findings, a review of objectives outlined in the 2023 Implementation Strategy (IS) plan, exploration of best practices and case studies from other UF Health hospitals in Florida, and discussions on goal-setting, visioning, and monitoring and evaluation strategies tailored to each health topic.

The revised implementation plan is designed to adhere to the Internal Revenue Service 501(c)(3) status, mandating non-profit hospital systems to conduct a comprehensive community health needs assessment and develop an implementation strategy every three years. The written plan outlined below delineates the actions the hospital intends to undertake to address the three significant health needs identified in the CHNA (Adolescent Health, Cancer, Chronic Conditions), the allocation of resources to each health need, planned collaborations between hospital facilities or organizations, and the anticipated impact of these actions.

## Community Benefit Operations

UF Health Shands is committed to engaging in community benefit operations and have invested in conducting community health needs assessments and implementation strategy development every three years. They perform ongoing community activities and community benefit data collection and hired Conduent Health Communities to collect and analyze data and incorporate community voices in the prioritization of health needs for the 2022 CHNA report and 2023 IS report.

## Community Health Improvement Services

Dedicated to reducing disparities in healthcare and bolstering community trust and engagement the UF HealthStreet program bridges the gap between community members and resources available to them. The HealthStreet model of community engagement focuses on four pillars, including assessing community members' medical problems and concerns, linking people to medical and social opportunities to participate in research, engaging with the community, and being a trustworthy partner to the community. [2]

[2] UF Health. Clinical and Translation Science Institute. Retrieved from UF HealthStreet and Cooperative Extension collaboration wins first place Innovations award from AAMC » Clinical and Translational Science Institute » University of Florida (ufl.edu)

UF Healthstreet was recently awarded first place in the 2022 Association of American Medical Colleges, or AAMC for their collaborative innovations with UF/IFAS Extension who both deploy community health workers and extension agents in the communities. The program tracks and monitors collective impact and focuses its work on minority populations, areas of high vaccine hesitancy, rural communities and communities with high opioid overdose rates.

## Expanding Services to Underserved Populations

As part of a broad initiative and unified effort to improve the health and well-being of underserved populations, UF Health will be adding an urgent care center in East Gainesville, Alachua County. Offering access to convenient walk-in/immediate care and a patient-friendly alternative to the emergency room is an important part of the medical continuum. In 2020 the Alachua County Health Assessment showed ZIP codes 32609 and 32641 (two of the most populated East Gainesville ZIP codes) to have the highest rates of ER visits for "avoidable hospital admissions," dental care and mental health compared to other county ZIP codes.

The purpose of this project is to address the disproportionate availability of healthcare resources to underserved communities on the eastside of Gainesville. This endeavor is in collaboration with key local government officials and a multidisciplinary group of individuals including providers, medical practice planners, dental and mental health representatives, faculty experts, and non-medical community representatives. The initiative will connect, coordinate and leverage a number of existing standalone activities aimed at improving the health of the Eastside community.

The facility will provide services to individuals of all ages, treating various medical problems and will see patients irrespective of insurance coverage. The urgent care center is planned to operate seven days a week and include extended evening hours. Anticipated outcomes include improving access for acute medical needs during the initial phase of the project.

The ultimate objective is to improve community health. Measurement and evaluations will be conducted by obtaining community assessments of satisfaction with acute healthcare service availability once the facility is open. Other outcome measures include number and scope of new community engagement activities, number of residents provided community health education, and number of different community groups connected through the center. A few initial key performance indicators include the center being open and operational no more than 18 months after zoning approval is completed, seeing patients seven days a week with extended hours, year two patient care volumes between 12,000 to 15,000 visits, at least 13 jobs created for center staffing.

## Adolescent Health

Addressing the mental health needs of adolescents is paramount in ensuring their overall well-being and resilience. With this in mind, our goal is to improve the mental health outcomes of adolescents through a comprehensive and integrated approach that focuses on enhancing the identification and intervention of mental health conditions. Central to this objective is the improvement of the screening process for mental health conditions during routine well visits. Our strategy involves the proactive implementation of ACEs, PHQ-9, and anxiety assessment tools during non-mental health visits to effectively screen and assess adolescents for mental health concerns. To support this initiative, we have outlined various programs and activities, including the development of training programs for healthcare providers, integration of mental health screening into routine well visits, and the establishment of a robust system for timely follow-up and intervention for identified mental health issues.

Collaboration with local healthcare providers, social workers, schools, community organizations, and telemedicine partners is crucial to ensuring the success of our efforts. With the allocation of resources such as training materials, funding for screening tools, and technology infrastructure, we aim to achieve our anticipated outcomes of increased identification of mental health conditions, timely intervention and support for adolescents in need, improved collaboration among stakeholders, and ultimately, enhanced mental health and well-being for the adolescent population we serve.

**Goal:**

Improve the mental health outcomes of adolescents by enhancing the identification and intervention of mental health conditions through a comprehensive and integrated approach. Ensure appropriate resources are available for interventions.

**Objective**:

Improve the screening process of mental health conditions among adolescents during routine well visits.

**Strategy: Screening and Assessment**

Implement ACEs, PHQ-9 and anxiety assessment tools during non-mental health visits to proactively screen and assess adolescents for mental health conditions.

**Programs/Activities:**

1. Develop training programs for healthcare providers on the effective use of ACEs and PHQ-9 tools.
2. Integrate mental health screening into routine well visits for adolescents.
3. Establish a system for timely follow-up and intervention for identified mental health issues.

**Collaboration Partners:**

1. Local healthcare providers, including pediatricians and mental health specialists.
2. Social workers
3. Schools and educational institutions
4. Community organizations focused on adolescent health and well-being
5. Telemedicine partners

**Resources:**

1. Training materials for healthcare providers.
2. Funding for the implementation of mental health screening tools.
3. Technology infrastructure for efficient data management and follow-up.

**Target Population:**

Adolescents aged 12-18 years attending routine well visits at local healthcare facilities.

**Anticipated Outcomes:**

1. Increased identification of mental health conditions in adolescents.
2. Timely intervention and support for adolescents with identified mental health concerns.
3. Improved collaboration and information-sharing among healthcare providers, schools, and community partners.
4. Enhanced overall mental health and well-being of the adolescent population served.

# Cancer

Cancer remains a formidable challenge in healthcare, particularly for underserved and at-risk populations facing barriers to accessing timely screenings and care. Our goal is clear: to reduce cancer-related disparities and enhance access to quality care within the next several months. To achieve this, our objective is to significantly increase cancer screenings among underserved and uninsured patients, along with ensuring a higher rate of receiving recommended workup for positive cancer screens within these populations. Our strategy involves the development and implementation of culturally sensitive outreach programs and educational materials tailored specifically for underserved communities. Through targeted community outreach activities, educational initiatives via Wellness University, and collaborations with churches and rural women's health projects, we aim to engage communities in cancer education, HPV vaccination, and screenings.

Strengthening partnerships with organizations like the Cancer Disparities Research Collaborative and Children Beyond our Borders underscores our commitment to comprehensive cancer care. With the support of diverse collaboration partners and allocated resources, including funding for outreach programs and human resources for community engagement, we strive to achieve our anticipated outcomes of increased screenings, improved engagement with at-risk communities, and sustainable impact through continuous evaluation and adaptation of our strategies.

**Goal:**

Reduce cancer-related disparities and enhance cancer care access for at-risk populations.

**Objective:**

Achieve an increase in cancer screenings among underserved and uninsured patients and an increase in receiving recommended workup for positive cancer screens within the specified populations.

**Strategy**:

Develop and implement culturally sensitive outreach programs and educational materials for underserved and uninsured populations.

**Programs/Activities:**

1. Conduct targeted community outreach activities and forums.
2. Develop educational content through Wellness University tailored to at-risk populations.
3. Collaborate with churches to engage communities in cancer education, HPV vaccination and screenings.
4. Explore partnerships with rural women's health projects to create safe spaces for healthcare services.
5. Strengthen collaborations with CDRC, Care 2 initiative, and existing networks for comprehensive cancer care.
6. Partner with middle and high schools to offer HPV vaccination

**Collaboration Partners:**

1. Wellness University for educational content development.
2. CDRC (Cancer Disparities Research Collaborative), Care 2 initiative and Children Beyond our Borders for collaborative efforts.
3. Churches for community engagement and outreach.
4. Rural women's health projects for safe spaces and support.

5. Community organizations and networks to build trust and enhance access.
6. Vaccine manufacturing company to supply HPV vaccine at lower/no cost for underserved population

**Resources:**

1. Funding for targeted outreach programs and educational materials.
2. Support from existing collaborations and partnerships such as the MOC OBGYN colposcopy clinic.
3. Human resources for community engagement and outreach activities.
4. Wellness University for content development.
5. Mobile clinic outreach for on-the-ground support.

**Target Population:**

At-risk and underserved patients facing challenges in accessing cancer care.

**Anticipated Outcomes:**

1. Increased cancer screenings among undocumented individuals and non-citizen children.
2. Increase recommended workup for positive cancer screens within the specified populations.
3. Improved trust and engagement with at-risk communities.
4. Enhanced collaboration with community organizations for sustainable impact.
5. Continuous evaluation and adaptation of strategies to address evolving disparities and challenges.

## Chronic Conditions

Chronic conditions pose significant challenges to individuals' health and well-being, particularly within communities where resources may be limited. In response to this pressing issue, our focus is on enhancing chronic care management and reducing emergency room visits for adults in the community, with a specific emphasis on COPD, heart failure, diabetes, and hypertension. Over the next several months, our goal is to achieve a measurable reduction in readmissions related to COPD and heart failure while establishing an operational urgent care center in East Gainesville. To accomplish this objective, we have devised a multifaceted approach comprising targeted strategies and initiatives. These include improving chronic care management within primary care settings, increasing community awareness and education about chronic conditions, and collaborating with home visiting programs to prevent unnecessary readmissions.

Additionally, we will implement Transition of Care Management groups for follow-up and support and engage with Health Street for community outreach and resource alignment. Our partnership with various stakeholders, including home visiting programs, community health workers, and local healthcare providers, underscores our commitment to delivering comprehensive patient care and fostering collaboration within the community. Through these concerted efforts, we aim to achieve tangible outcomes, such as a reduction in hospital readmissions and emergency department visits, establishment of an urgent care center, and improved community awareness of chronic conditions.

**Goal**:

Enhance chronic care management and reduce emergency room visits for adults in the community, focusing on COPD, heart failure, diabetes, and hypertension, through targeted strategies and initiatives.

**Objective**:

Achieve a reduction in readmissions related to COPD and heart failure and establish an operational urgent care center in East Gainesville.

**Strategies**:

1. Improve chronic care management of COPD, heart failure and hypertension within primary care to reduce readmissions.
   Increase community awareness and education about chronic conditions.
2. Collaborate with home visiting programs to prevent unnecessary readmissions.
3. Implement Transition of Care Management groups for follow-up and support.
4. Engage with Health Street for community outreach and resource alignment.
5. Increase the completion of transitional care (hospital discharge) outreach phone calls and visits in a timely manner, within 2 business days and 14 days respectfully.

**Programs/Activities:**

1. Establish an urgent care center in East Gainesville to provide acute medical services to assist in addressing exacerbations of chronic medical conditions in a timely manner
2. Conduct community engagement activities, forums, and meetings to involve the community in the development of the urgent care center.
3. Develop community health programs addressing topics such as stress management, diabetes awareness, tobacco cessation, and nutrition.

4. Collaborate with local stakeholders, including the health department and community organizations, to build infrastructure and support for community health initiatives.

**Collaboration Partners:**

1. Home visiting programs and community health workers for coordinated care and prevention of readmissions.
2. Health Street and Mobile Outreach Clinic for community outreach and resource alignment.
3. Local stakeholders, including the health department and community organizations, for infrastructure and support.
4. Primary care physicians, hospital staff, home care providers and community health workers for collaborative patient care.
5. UF cardiology and pulmonary specialists

**Resources**:

1. Human resources for community engagement activities and Transition of Care Management groups.
2. Educational materials and programs for chronic condition awareness and management.
3. Support from local stakeholders and community organizations for infrastructure development.

**Target Population:**

Adults in the community, especially those with COPD, heart failure, diabetes, and hypertension, focusing on East Gainesville.

**Anticipated Outcomes:**

1. Reduction in hospital readmissions and ED admissions related to COPD and heart failure.
2. Reduction in hypertensive urgency and emergency diagnoses in ED
3. Reduction in hyperglycemia-related and hypo-glycemia-related ED visits
4. Establishment of an operational urgent care center in East Gainesville.
5. Improved community awareness and education on chronic conditions.
6. Enhanced collaboration and coordination among healthcare providers for comprehensive patient care.