FLORIDA HOSPITAL
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2014-16 Community Health Plan

Florida Hospital Wesley Chapel conducted a Community Health Needs Assessment (CHNA) in 2013.

The Assessment looked at the health-related needs of the primary community served by Florida Hospital Wesley Chapel including those of low-income, minority and underserved populations. The Assessment included both primary and secondary data, and identified the following priorities:

- Reduce ER visits and hospitalizations due to uncontrolled diabetes
- Promote Healthy Weight and Healthy Living
- Improve Heart Health of Community
- Reduce ER visits and hospitalizations due to uncontrolled COPD
- Reduce ER visits and hospitalizations due to uncontrolled pneumonia
- Reduce ER visits and hospitalizations due to uncontrolled asthma

After conducting the Community Health Needs Assessment, Florida Hospital Wesley Chapel developed a Health Improvement Plan[i], or "implementation strategy. The hospital's Community Health Needs Assessment Committee participants, hospital leadership and the hospital board reviewed the needs identified in the Assessment. The hospital Board approved the priorities and the full Assessment.

Next, with a particular focus on these priorities, the community partnership helped developed a Community Health Improvement Plan (CHIP) or "implementation strategy[ii]." The CHIP has been approved by the Florida Hospital Wesley Chapel Board and posted by May 31, 2014 at the web location noted below. The Plan lists targeted interventions and measurable outcome statements for each effort. Many interventions engage multiple community partners. This supplemental document describes the activities and outcomes measures for the Plan.

Florida Hospital Wesley Chapel's fiscal year is January-December. For 2014, the Community Health Improvement Plan will be deployed beginning May 31 and evaluated at the end of the calendar year. In 2015 and beyond, the CHIP will be evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be posted annually and attached to our IRS Form 990.

If you have questions regarding this Community Health Improvement Plan or Community Health Needs Assessment, please contact Tracy Clouser, community benefits manager, at tracy.clouser@ahss.org.

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[i] Also posted on this web site.

[ii] This Community Health Plan does not include all Community Benefit activities. Those activities are included on Schedule H of our Form 990.

Florida Hospital Wesley Chapel

2014-2016 Community Health Plan

OUTCOME GOALS						OUTCOME MEASUREMENTS								
CHNA Priority	**Outcome Statement**	**Target Population**	**Strategies/Outputs**	**Outcome Metric**	**Current Year Baseline**	**Year 1 Outcome Goal - #**	**Year 1 Actual**	**Year 2 Outcome Goal - #**	**Year 2 Actual**	**Year 3 Outcome Goal - #**	**Year 3 Actual**	**Hospital $**	**Matching $**	**Comments**
Heart Disease	Reduce preventable CHF 30-day readmissions by 20% over three years	Hospital inpatients over 65 on Medicare with CHF who reside in zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639	Case Management Transitional Care Program	# of Medicare patients over 65 with CHF who participate	190	190		190		1190				
	Reduce preventable CHF 30-day readmissions by 20% over three years	Hospital inpatients over 65 on Medicare with CHF who reside in zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34640	Case Management Transitional Care Program	% of targeted CHF patients readmitted in 30 days	8%	7%		6%		5%				
Diabetes	Educate uninsured FHWC patients show are diabetic to manage their diabetes	Uninsured FHWC patients with diabetes in zip codes 33541, 33541, 33543, 33544, 33545, 33559, 33576 and 34639	ADA approved Diabetes-Self Management 10 hour classes, exercise min of 3x/week, & additional nutrition and wellness coaching.	# of FHWC patients with diabetes who are uninsured who participate in the diabetes management program		90		150		150		Program Scholarships		

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
	Lower A1c levels in 75% of diabetic patients who participate in program	Uninsured FHWC patients with diabetes in zip codes 33541, 33541, 33543, 33544, 33545, 33559, 33576 and 34639 who participate in the program	Special Diabetes Program through FHWC includes 10 hour classes, exercise min of 3x/week, & additional nutrition and wellness coaching.	A1c levels to be reduced in 75% of patients as measured from beginning of class and 6 months after completion	0 patients	90		150		150		Scholarships, in kind time		
Obesity	Educate adults about healthy eating and exercise	Adults in zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639	CREATION Health, Wellness Classes, Nutrition Counseling	Curriculum and pre/post test development	0 students	90		120		150		Staff time, Educational Materials	N/A	
	Educate adults about healthy eating and exercise	Adults in zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34640	CREATION Health, Wellness Classes, Nutrition Counseling	# of students	0 students									
	Educate adults about healthy eating and exercise	Adults in zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34641	CREATION Health, Wellness Classes, Nutrition Counseling	90% of students "pass" the post-test	0 students	120		150		180				

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
	Educate children and adults on Behavioral Change for kids to lose Weight Management	Overweight children from area who participate in KidShape 2.0 program (area is zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639)	KidShape 2.0 Family Based Weight Loss/Management program	# of students	0 students	30		50		50				
	Behavioral Change Weight Management program for kids	Overweight children from area who participate in KidShape 2.0 program (area is zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639)	Family Based Weight Loss/Management program	90% of students "pass" the post-test	0	27		45		45				
	Behavioral Change Weight Management program for kids	Overweight adults in area who participate in balanced 360 weight Loss program (area is zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639)	Weight loss/management program including nutritional counseling and exercise with a personal training, group classes and follow up	# of students	0 students	50		75		90				

CHNA Priority	Outcome Statement	Target Population	Strategies/Outputs	Outcome Metric	Current Year Baseline	Year 1 Outcome Goal - #	Year 1 Actual	Year 2 Outcome Goal - #	Year 2 Actual	Year 3 Outcome Goal - #	Year 3 Actual	Hospital $	Matching $	Comments
	Give adults who are overweight/obese tools to lose weight	Overweight adults in area who participate in balanced 360 weight Loss program (area is zip codes 33541, 33543, 33544, 33545, 33559, 33576 and 34639)	Weight loss/management program including nutritional counseling and exercise with a personal training, group classes and follow up	90% of students "pass" the post-test		45		68		81				