2017-2019 Community Health Plan

(Implementation Strategies)

May 15, 2017

Community Health Needs Assessment Process

Florida Hospital Wesley Chapel conducted a Community Health Needs Assessment (CHNA) in 2016. The Assessment identified the health-related needs of community including low-income, minority, and medically underserved populations.

In order to assure broad community input, Florida Hospital Wesley Chapel created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the Assessment and Community Health Plan process. The Committee included representation not only from the Hospital, public health and the broad community, but from low-income, minority and other underserved populations.

The Committee met throughout 2016 and early 2017. The members reviewed the primary and secondary data, reviewed the initial priorities identified in the Assessment, considered the priority-related Assets already in place in the community, used specific criteria to select the specific Priority Issues to be addressed by the Hospital, and helped develop this Community Health Plan (implementation strategy) to address the Priority Issues.

This Community Health Plan lists targeted interventions and measurable outcome statements for each Priority Issue noted below. It includes the resources the Hospital will commit to the Plan, and notes any planned collaborations between the Hospital and other community organizations and hospitals.

Priority Issues that will be addressed by Florida Hospital Wesley Chapel

Florida Hospital Wesley Chapel will address the following Priority Issues in 2017-2019:

1. **Heart Disease –** Within the Hospital's service area, the rate of death due to coronary heart disease per 100,000 population is 166.13 compared to the state rate of 156.1. In addition, 7.5% of adults aged 18 and older have been diagnosed with heart disease as compared to the state rate of 5.6%. Heart disease is the leading cause of death in the United states and related to high blood pressure, heart attacks, and high cholesterol. There is opportunity to extend the current Hospital programs/offerings to impact Acute Myocardial Infarction (AMI) (heart attacks), Congestive Heart Failure (CHF), High Blood Pressure, and High Cholesterol.
2. **Diabetes** – In Pasco County, 9.6% of the adults aged 20 or older have been diagnosed with diabetes. The state average is 8.89%. The Hospital has services to address diabetes.

Issues that will not be addressed by Florida Hospital Wesley Chapel

The 2016 Community Health Needs Assessment also identified the follow community health issues that Florida Hospital Wesley Chapel will not address. The list below includes these issues and an explanation of why the Hospital is not addressing them.

A. **Pneumonia** - While pneumonia is a considerable community health issue, this was not chosen as a top priority because Hospital and community programs (including the Departmental Health pneumonia immunization efforts) already exist.
B. **Smoking (Adult)** - There are current community resources and Hospital programs in place, including smoking cessation programs led by the Area Health Education Council.
C. **Access to Dental Care** – The Hospital does not provide dental services nor employ dentists. There are community resources in place.
D. **Physical Inactivity** - There are current Hospital and community resources in place.
E. **Unintentional Injuries** – The Hospital does not have the capacity to impact prevention of unintentional injuries.
F. **Cancer Screenings** - There are current Hospital programs and community resources in place.

Board Approval

The Florida Hospital Wesley Chapel Board formally approved the specific Priority Issues and the full Community Health Needs Assessment in 2016. The Board also approved this Community Health Plan.

Public Availability

The Florida Hospital Wesley Chapel Community Health Plan was posted on its web site prior to May 15, 2017. Please see www.floridaHospital.com/wesley-chapel. Paper copies of the Needs Assessment and Plan are available at the Hospital, or you may request a copy from FHWC.Marketing@ahss.org .

Ongoing Evaluation

Florida Hospital Wesley Chapel's fiscal year is January-December. For 2017, the Community Health Plan will be deployed beginning May 15 and evaluated at the end of the calendar year. In 2018 and beyond, the Plan will be implemented and evaluated annually for the 12-month period beginning January 1 and ending December 31. Evaluation results will be attached to our IRS Form 990, Schedule H.

For More Information

If you have questions regarding Florida Hospital Wesley Chapel's Community Health Needs Assessment or Community Health Plan, please contact FHWC.Marketing@ahss.org .

Florida Hospital Wesley Chapel 2017-2019 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-AMI	Reduce preventable AMI 30-day readmissions	AMI uninsured /Medicaid patients at FHWC	Enroll in Transition Care clinic upon discharge, follow up calls by RN to connect with care	Number of targeted AMI patients readmitted in 30 days	12%	11%		10%		9%		$125,000		
	Connect AMI patients with a medical home	AMI patients at FHWC who do not have a PCP	Enroll in Transition Care clinic upon discharge, follow up calls by RN to connect with a PCP	Number of all TCC patients connected to a primary care physician for follow up	12%	11%		10%		9%		see above		
Heart Disease - CHF	Reduce preventable CHF 30-day readmissions	CHF uninsured/Medicaid patients at FHWC	Enroll in Transition Care clinic upon discharge, follow up calls by RN to connect with care	% of uninsured CHF patients readmitted in 30 days	20%	19%		18%		17%		see above		
	Connect CHF patients to transition care resources to prevent Hospital readmissions	CHF uninsured/Medicaid patients at FHWC	Connect to Transition Care clinic to determine appropriate care and arrange follow up	Number of targeted patients in transition care program	10	15		15		15		see above		Hospital inpatient beds have increased, expect increase in volume of patients
Diabetes	Educate people with diabetes about reducing A1C	People with diabetes in primary service area	DSME	Diabetes classes in community settings	118	120		125		130		$		foundation funds if insurance won't cover or can't afford
	Reduce A1c levels people with diabetes	People with diabetes in primary service area	Well On Your Way Diabetes 12-week program	A1c levels to be reduced in 85% of patients as measured by beginning of class & 90 days post	44	50		55		60		$415.35 per person x 165 participants= $68, 533		foundation funds entire program, no cost to participants

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	Reduce A1c levels people with diabetes	Low income/Low Access population PSA (Need Zip Codes)	Stanford Chronic Disease Management program	Reduce blood sugar levels in those participants with diabetes by 6% as measured by blood draws before and near the end of class.	0	20		30		50		$7500		partner with CARES, Health Dept. and Premier (FQHC)
	Reduce A1c levels people with diabetes	Low income/Low Access in PSA	Food is Medicine program providing vouchers for fresh produce for people in the Stanford Chronic Disease Management	# of fresh produce vouchers issued to low income families	0	15		25		40		$4800		
	Reduce A1c levels people with diabetes	Low income/Low Access in PSA	Stanford Chronic Disease Management program biometric screenings	85% of participants with diabetes who complete the program reduce their A1c levels	0	17		25		34		see above		
High Blood Pressure	Reduce blood pressure for participants above normal range	Low income/Low Access in PSA	Stanford Chronic Disease Management program	Increase health education level regarding the causes, prevention, and treatment of High blood pressure.	0	20		30		50		see above		
	Reduce blood pressure for participants above normal range	Low income/Low Access in PSA	Food is Medicine program providing vouchers for fresh produce for people in the Stanford Chronic Disease Management	# of fresh produce vouchers issued	0	15		25		40		see above		

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	Reduce blood pressure for participants above normal range	Low income/Low Access in PSA	Biometric screenings Stanford Chronic Disease Management program	85% of participants with blood pressure levels higher than average who complete the program reduce their blood pressure	0	45		60		75		$1188		$100 for Nursing Time @ $25 per hour, $150 for Biometric Supplies @ $5 per participant=$594 per church
	Reduce blood pressure for participants above normal range	Adults in PSA	Train congregational representatives to host CREATION Health, an eight-week, faith-based wellness plan with lifestyle seminars and training. Based on 8 principles: choice, rest, environment, activity, trust, interpersonal relations, outlook and nutrition.	Increase health education regarding heart health and high blood pressure measured by self-assessment pre-and post seminar.	0	2 Faith Communities (estimate 15 participants each)		4 Faith Communities		6 Faith Communities		$4500		$350 per kit/trainer + $50 per 30 self-assessments
	Reduce blood pressure for participants above normal range	Adults in PSA	CREATION Health - program (8-week class) train congregation representatives to host community health sessions	85% of participants with blood pressure levels higher than average who complete the program reduce their blood pressure	0	12		35		50		$1188		$100 for Nursing Time @ $25 per hour, $150 for Biometric Supplies @ $5 per participant=$594 per church