Morton Plant Hospital

Implementation Plan – Report

September, 2013

TrippUmbach
Research • Strategy • Impact

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Introduction

Morton Plant Hospital is a 687-bed facility, located in Clearwater, FL, and is also one of a network of 10 not-for-profit hospitals throughout the Tampa Bay area. In response to its community commitment, Morton Plant Hospital contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2012 and June 2013 (See the Morton Plant Hospital Community Health Needs Assessment for the full report).

This report is the follow-up implementation plan that fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA), requiring that non-profit hospitals develop implementation strategies to address the needs identified in the community health needs assessment completed in three-year intervals. The community health needs assessment and implementation planning process undertaken by Morton Plant Hospital, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues. Tripp Umbach worked closely with leadership from Morton Plant Hospital and a project oversight committee, which included representatives from each of the 10 not-for-profit hospitals that comprise BayCare Health System to accomplish the assessment and implementation plan.

This implementation plan includes plans to address access to affordable healthcare, the prevalence of clinical health issues, healthy behaviors and environments for residents in the Morton Plant Hospital community. As a non-profit hospital, Morton Plant Hospital intends to provide care to residents regardless of their insurance status as required by the state of Florida.

Community Definition

While community can be defined in many ways, for the purposes of this report, the Morton Plant Hospital community is defined as 20 zip code areas in Pinellas County, Florida. (See Table 1 & Figure 1) The needs identified in the CHNA report pertain to the same 20 zip code areas in Pinellas County, Florida.

Morton Plant Hospital Community

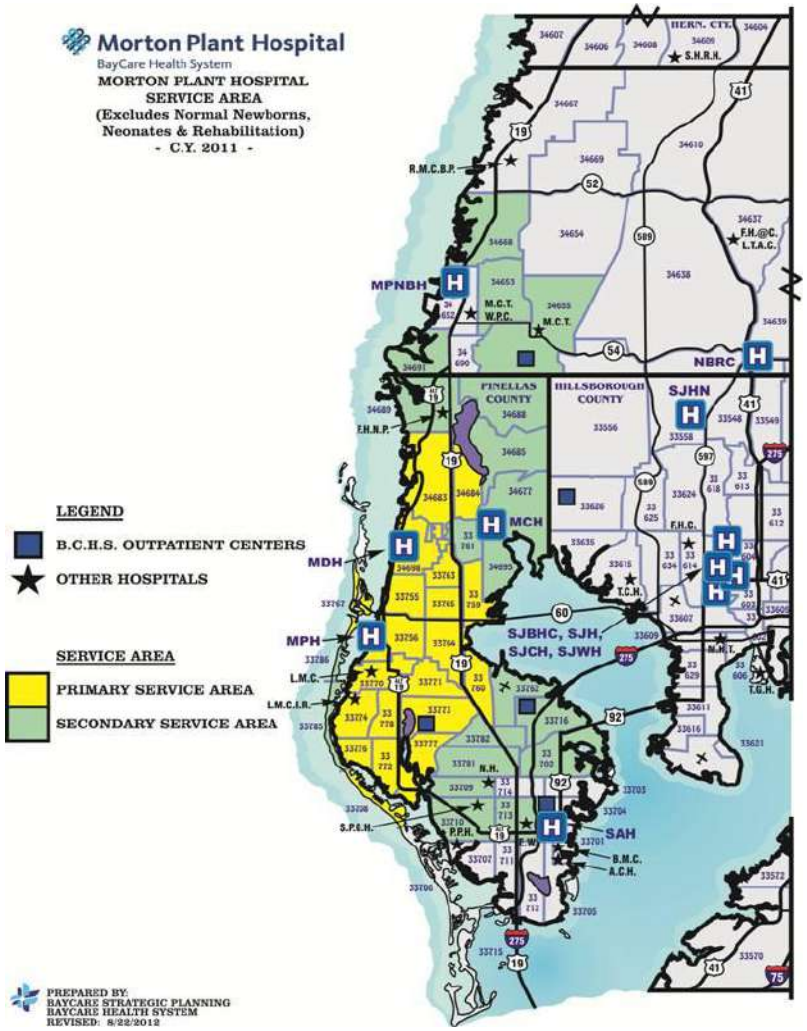
Table 1

Zip	Town	County
33708	Madeira Beach	Pinellas
33755	Clearwater	Pinellas
33756	Clearwater	Pinellas
33759	Clearwater	Pinellas
33760	Clearwater	Pinellas
33763	Clearwater	Pinellas
33764	Clearwater	Pinellas
33765	Clearwater	Pinellas
33767	Clearwater Beach	Pinellas
33770	Largo	Pinellas

Zip	Town	County
33771	Largo	Pinellas
33772	Seminole	Pinellas
33773	Largo	Pinellas
33774	Largo	Pinellas
33776	Seminole	Pinellas
33777	Seminole	Pinellas
33778	Largo	Pinellas
34683	Palm Harbor	Pinellas
34684	Palm Harbor	Pinellas
34698	Dunedin	Pinellas

Morton Plant Hospital Community Map

Figure 1



Methodology

Tripp Umbach facilitated and managed an implementation planning process on behalf of Morton Plant Hospital, resulting in the development of an implementation strategy and plan to address the needs identified in their community health needs assessment (i.e., Improving access to affordable healthcare; Decreasing the prevalence of clinical health issues; Improving healthy behaviors and environments) completed in 2013.

Key elements of the implementation planning process included:

- **Implementation Strategy Process Planning:** A series of meetings were facilitated by the consultants and the CHNA oversight committee consisting of leadership from Morton Plant Hospital and collaborating areas of BayCare Health System.

- **Community Health Needs Assessment Review:** Tripp Umbach worked with the Morton Plant Hospital to present a review of the Community Health Needs Assessment findings to hospital leaders in a meeting held on May 15th, 2013.

- **Review of CHNA, Needs Identification, and Selection:** Tripp Umbach facilitated a brief overview of the CHNA findings and facilitated a discussion process during a Webinar held on July 7th, 2013 with hospital leadership from Morton Plant Hospital. Attendees were asked to review the community health needs assessment, community resource inventory, and identify the significant health needs found in the CHNA results. Attendees then participated in a discussion to determine which of the previously identified significant needs could be and which could not be addressed by Morton Plant Hospital. Once needs were selected, hospital leadership were asked to provide rationale for the needs that the hospital could not meet.

- **Inventory of Internal Hospital Resources:** An online survey was developed based on the underlying factors identified as driving the significant health needs in the Morton Plant Hospital Community Health Needs Assessment. The survey was reviewed and administered by BayCare Health System leadership to key staff of the hospital which completed the survey. The internal survey identified what programs and services are offered at Morton Plant Hospital that meet significant community health needs.

- **Review of Best Practice Examples:** Tripp Umbach provided an inventory of national best practice resources which included resources from County Health Rankings (Population Health Institute of Wisconsin & Robert Wood Johnson Foundation), the CDC's Guide to Community Preventive Services Task Force, Healthy People 2020, and other valid national resources. Hospital leadership reviewed the best practice inventory and selected practices that best fit with the expertise, resources, mission, and vision of Morton Plant Hospital.

- **Committee Review of Evidence-Based Practices and Plan Development:** Tripp Umbach facilitated a review of strategy and evidence-based practices among hospital leaders during a Webinar held on August 23rd, 2013. Based on the evidence-based practices previously provided, hospital leadership reviewed and discussed the strategy and subsequent action steps needed to implement best practices to begin to address the health needs identified in the service area. Hospital leaders aligned needs with best practice models and available resources, defined action steps, timelines, and potential partners for each need to develop the accompanying implementation plan.

- **Final Implementation Planning Report:** A final report was developed that details the implementation plan the hospital will use to address the needs identified by the Morton Plant Hospital Community Health Needs Assessment.

Community Health Needs and Implementation Plan

Community Health Needs Identification, Prioritization, and Implementation Planning Meeting

Qualitative and informational data were presented during a meeting held on July 3rd, 2013 with Morton Plant Hospital leadership; with the purpose of identifying and prioritizing significant community health needs for hospital implementation planning.

Tripp Umbach presented the results of the CHNA and used these findings to engage the hospital leaders in a group discussion related to the needs that Morton Plant Hospital would address in implementation planning. The hospital leaders were asked to share their vision for the community, discuss a plan for health improvement in their community, and select the needs that they felt the hospital could address and assist the community in resolving, and those that they felt the hospital would not be well positioned to resolve.

Hospital leaders believe the following health needs are those to which Morton Plant Hospital is best positioned to dedicate resources to address within their community.

Improving access to affordable healthcare
Decreasing the prevalence of clinical health issues
Improving healthy behaviors and environments

Tripp Umbach completed an independent review of existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and detailed input provided by the focus groups, which resulted in the prioritization of key community health needs that hospital leaders felt related to the Morton Plant Hospital population. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) Improving access to affordable healthcare; 2) Decreasing the Prevalence of clinical health issues and 3) Improving healthy behaviors. A summary of these top needs in the Morton Plant Hospital community and the implementation strategy developed to address those needs follows:

KEY COMMUNITY HEALTH NEED #1:
IMPROVING ACCESS TO AFFORDABLE HEALTHCARE

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **Need for increased access to affordable healthcare through insurance**
- **Availability of affordable care for the under/uninsured**
- **Availability of healthcare providers and services**
- **Communication among healthcare providers and consumers**
- **Socio-economic barriers to accessing healthcare.**

According to key stakeholders, there is a need for increased coordination of care for residents, particularly those without health insurance because they do not have access to a reliable system of care, including specialty care. Key stakeholders and focus group participants agree that while there are medical resources and healthcare facilities in the community, access to healthcare resources can be limited by health insurance issues and the cost of healthcare for under/uninsured, the availability of providers, communication among providers and consumers, the level of integration of mental health services in medical health settings and the prevalence of socio-economic barriers (i.e., lack of support from employers, limited transportation, etc.)

While Morton Plant Hospital, a hospital in the BayCare Health System, provides access to affordable healthcare in numerous ways, the need to improve access was identified through the most recent community health needs assessment. Recognizing that Morton Plant Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further increase access to affordable healthcare is through a mixed-strategy of: 1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Maintain the availability of all services to under/uninsured residents by continuing to provide care to residents regardless of their insurance status as required by the state of Florida.*
- ✓ *Continue to administer a financial assistance program on-site that provides uninsured residents assistance in identifying and applying for medical benefits for which they may qualify.*

- ✓ *BayCare Health System will continue to implement the Medical Home Model through BayCare Medical Group, which includes care coordination provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue to provide patient coordination including hospice and palliative care referrals, which in effect provides ongoing education and collaboration with skilled nursing facilities in the hospital service area.*
- ✓ *Continue to offer behavioral health services through BayCare Behavioral Health Department.*
- ✓ *Continue to provide MH 101 training during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at Morton Plant Hospital.*
- ✓ *Continue to provide co-located Behavioral Health Services as an available service of primary care physician practices in many communities in Pinellas County.*
- ✓ *Continue to provide a palliative care team, in partnership with local hospices, to patients that need referrals for palliative care services.*
- ✓ *The BayCare Outpatient Pharmacy, which upon patient election to participate, offers medication delivery on-site prior to discharge and medication education in a follow-up call from the pharmacy one-day post-discharge.*
- ✓ *Indigent Prescription Assistance offered through grant funding that provides the use of BayCare outpatient pharmacy and Case management partnership with a BayCare pharmacist to evaluate equally effective/less costly antibiotic options for indigent prescriptions through partnerships with BayCare pharmacies and other local pharmacies.*
- ✓ *Continuing to follow-up with all patients that are re-admitted for diabetes and congestive heart failure by making follow-up appointments and follow-up calls to patients themselves upon discharge from the hospital.*
- ✓ *Continue to provide services through the Turley Indigent Diabetes Clinic, which provides ongoing care to patients from Morton Plant Hospital that do not have a regular source of health insurance or a PCP with a primary and secondary diabetes diagnosis. The primary goal is to ensure consistent follow-up care for indigent diabetic patients discharged through Morton Plant Hospital and the secondary goal is to reduce inpatient re-admissions of indigent patients with diabetes.*

2) Evaluating new programs and services that are based in best practices and are proven to improve access to affordable healthcare in the communities served by the hospital.

- ✓ *Increase access to affordable health insurance and healthcare services in the service area by exploring the development of a resource to provide information about types of health insurance coverage to members of the Morton Plant Hospital community that are eligible for some type of medical assistance.*
- ✓ *Increase access to affordable health insurance and healthcare services in the service area by collaborating with BayCare Health System and local governments and other in the exploration of the feasibility and sustainability of establishing clinics for uninsured (including FQHC).*
- ✓ *Increase access to affordable healthcare services in the service area by enhancing care coordination between primary care clinics for uninsured/underinsured residents, Morton Plant Hospital and Bardmoor Emergency Departments.*
- ✓ *Increase the availability of mental health services by continuing to provide mental health services and increasing the availability of mental health services in the hospital service area.*

Hospital leadership developed the following three-year strategy to further align the resources of the hospital with the health needs of the community:

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement timely and effective coordination of care between primary care and Morton Plant Hospital and Bardmoor Emergency Departments	Residents in the MPH service area	**Year 1:** 1. Develop relationship with any BCHS primary care sites not at full capacity or any primary care sites in mid-Pinellas County that are funded through BCHS in some way that guarantee a number of appointment slots per day for MPH or Bardmoor ED or inpatient referrals. a. Identify potential PCP sites. b. Clearly communicate with potential partners the parameters of relationship, common	**Year 1:** 1a-c. Document the partners providing appointment slots. 2a. Document partnering sites. 2b. Document procedures. 2c. Document the number of patients	**Year1-3:** 2. Existing Physician Advocates 3. $$ of IS Access *(fill in est. figure here)*

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		goals, process, and outcomes. c. Secure and utilize appointment slots. 2. Explore partnerships with non-BCHS primary care sites in mid-Pinellas County to facilitate referrals between these sites and the MPH or Bardmoor ED. To explore relationship building MPH may employ any of the following: a. Identify potential PCP sites and set goals for Physician Advocates to enlist a set number of PCPs and review the number of PCPs enlisted quarterly. b. Develop procedures for patient referral and follow-up. c. Develop methods to track the number of patients that are referred to a site and the number of completed visits. d. Evaluate efficacy of referral process (e.g., consumer feedback, PCP feedback, outcome measures, etc.) 3. Facilitate or coordinate access to necessary information via BayCare Information System for any new primary care partners. a. Explore partnerships with BCHS. b. Identify the necessary resources. c. Identify potential partners.	referred and completed appointments. 2d. Document any recommendations. 3b. Document resources secured. 3d. Document participating partners. 3e. Document any recommendations. 4 a-d. Document the recommendations of evaluations and funding secured. 5. Document baseline metrics to monitor coordination of care. 1-5. Report progress to the IRS.	4. Possible increase in FTE depending on demands of current Health Management Services positions in ED

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		d. Facilitate access to BayCare Information System. e. Evaluate the effectiveness for each site. 4. Explore the development of a Patient Navigator role or an adjustment to the Health Management Services role to assume more navigation duties in the ED. a. Evaluate the efficacy of the current Health Management Services role (e.g., consumer feedback surveys). b. Develop recommendations based on the evaluation and best practices. c. Identify and seek resources needed to implement recommendations. d. Based on available resources, implement recommendations related to the Health Management Services role. 5. Establish metrics to monitor coordination of care between MPH or Bardmoor ED and primary care sites in mid-Pinellas County. **Year 2:** 1. Monitor compliance of BCHS primary care sites, BCHS funded primary care sites, and primary care partners on coordinating care between MPH and	**Year 2:** 1. Document the number of patients referred and completed appointments. 2. Document participating	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Bardmoor ED's and these primary care locations. 2. Identify any new primary care sites that need to be included in the Care Coordination Model. 3. Measure effectiveness of Patient Navigator (or Health Management Services) role. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in year 1. **Year 3:** 1. Monitor compliance of BCHS primary care sites, BCHS funded primary care sites, and primary care partners on coordinating care between MPH and Bardmoor ED's and these primary care locations. 2. Identify any new primary care sites that need to be included in the Care Coordination Model. 3. Measure effectiveness of Patient Navigator (or Health Management Services) role. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in Year 1. 5. Re-assess community need for care coordination.	partners. 3. Document any recommendations. 4. Document metrics to monitor coordination of care and comparison to year 1. 1-4. Report progress to the IRS. **Year 3:** 1. Document the number of patients referred and completed appointments. 2. Document participating partners. 3. Document any recommendations. 4. Document metrics to monitor coordination of care and comparison to year 1. 1-5. Report re-assessment results and	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			progress to the IRS.	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Decrease the percentage of uninsured residents in the community	Residents in the community that are eligible for some form of health insurance	**Year 1:** 1. Explore development of resource center in mid Pinellas County in collaboration with county, state, and related insurance carriers to facilitate providing information and access to members of our community that are eligible for some type of health coverage. a. Develop necessary relationships and needed agreements between MPH and related agencies and companies providing health coverage to Pinellas County residents. b. Develop a timeline for developing a resource center for access to affordable healthcare. c. Develop a referral system through community agencies and ED and primary care sites to the resource center. Resources: MPH, BCMG, Health Management Services and CBO. d. Identify best practices for accessing affordable healthcare coverage, including evaluation and documentation. 2. Collaborate with BayCare Health System and local governments in the exploration of the feasibility and sustainability in establishing clinics for uninsured.	**Year 1:** 1 a-d. Referrals made will be documented and tracked in a HIPAA compliant way. Meeting will be held with potential partnerships and documented. 2a-d. Document the collaborating partners, timeline and the results and recommendations of evaluations. 1-2. Report progress to the IRS.	**Year1-3:** **Potential Partners:** BayCare Financial Assistance Program, county, state and related insurance carriers **Resources:** Health Management Services and CBO

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Develop necessary relationships and needed agreements between related agencies and governments participating in the effort. b. Develop a timeline. c. Identify the feasibility and sustainability along with best practices in supporting the provision of clinic services to uninsured residents, including evaluation and documentation. d. Identify and seek necessary funding in collaboration with partnering organizations. **Year 2:** 1. Implement program improvements and best practices identified in year 1 a. Identify and refer patients that are eligible for health insurance and not enrolled. b. Reduce the number of uninsured accessing MPH and Bardmoor ED's by 5%. c. Evaluate the effectiveness of the resource center for access to affordable healthcare coverage and determine necessary improvements. 2. Monitor and report performance progress by year-end.	**Year 2:** 1a. Resource Center will be operational by year-end and documenting eligibility and enrollment cases in a HIPAA-compliant way. 1b. The resource center will document a 5% enrollment increase for medical assistance among the uninsured patients who are seen in	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Based on available resources and the results of evaluations completed in year 1, further explore establishing clinics for uninsured in collaboration with partnering organizations. a. Revise implementation plan to reflect action step for years 2 and 3 that are commiserate with evaluation results, partnerships and available resources among collaborating partners. b. Implement plan. **Year 3:** 1. Implement program improvements identified in year 2. 2. Reduce the number of uninsured accessing MPH and Bardmoor ED's by 10%. 3. Evaluate the effectiveness of the Resource Center for access to affordable healthcare coverage. 4. Monitor and report performance to best practice and previous year results. 5. Based on available resources and successes in year 2, revise implementation plan in year 3 and continue efforts to establish clinics for uninsured in collaboration with partnering organizations. 6. Re-assess need in the community.	the MPH service area. 1c. Targeted improvements will be documented. 2. Document funding secured and new implementation plan for year 2-3. 1-3. Report progress to the IRS. **Year 3:** 1. The resource center will document a 10% enrollment increase for medical assistance among the uninsured patients who are seen in the MPH service area. 2. Targeted improvements will be documented 5. Document new implementation plan for year 3.	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1-6. Re-assess need and Report progress to the IRS.	

NEED: Access to affordable healthcare – Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of mental health services	Adults and pediatric residents who may require mental health services	**Year 1:** 1. Family and Patient Preservation Program- working at home with families at risk a. Convert pediatric acute care funding to outpatient preservation program. b. Implement program and track measure outcomes. **Year 2:** 1. Family and Patient Preservation Program- working at home with families at risk a. Implement program and track measure outcomes. **Year 3:** 1. Family and Patient Preservation Program- working at home with families at risk a. Implement program and track measure outcomes.	**Year 1:** 1a. Document the conversion process and dates. 1b. Document number of program participants and outcomes. 1. Report progress to the IRS. **Year 2:** 1a. Document number of program participants and outcomes. 1. Report progress to the IRS. **Year 3:** 1a. Document number of program participants and outcomes. 1. Report progress to the IRS.	**Year 1-3:** 2. Conversion of pediatric acute services grant to preservation program $400,000

KEY COMMUNITY HEALTH NEED #2:
DECREASING THE PREVALENCE OF CLINICAL HEALTH ISSUES

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **The prevalence of clinical indicators and areas of poorer health outcomes across clinical indicators that are correlated with race, geographical location and socio-economic status.**

The prevalence of clinical health issues is related to the access that residents have to health services, the environmental and behavioral factors that impact health as well as the awareness and personal choices of consumers. The health of a community is largely related to the prevalence and severity of clinical health indicators among residents.

At first glance, the 20 zip code service area appears to have a high prevalence of clinical health issues; however, this assessment shows a stratification of the zip code areas into high, moderate, and low levels of clinical health issues. The zip codes with the highest levels of clinical health issues are: 33755, 33756, 33760, 33770, 33771, and 33759. Theses six zip code areas are represented in the secondary data as having substantially higher than average rates across multiple clinical health indicators. These zip code areas also have the highest CNS scores (from 3.7 to 4.4) in the Morton Plant Hospital service area, indicating a greater than average level of barriers to accessing healthcare. These zip code areas appear to consume a large percentage of healthcare resources based on the volume of clinical issues and level of severity.

There are several indicators in which Pinellas County and the Morton Plant Hospital service area that are presented in county-level and zip code-level data gathered from Healthy Tampa Bay that have not yet or have only slightly surpassed the national benchmarks. However, there has been a substantial increase in these indicators that, if left unchecked, could become community health needs (i.e., death rate due to strokes, coronary heart disease, diabetes, infant mortality, cancer incidence/death rates, suicide rates, tuberculosis, etc.)

While Morton Plant Hospital, a hospital in the BayCare Health System, provides programs and services which target clinical health issues, the need to decrease the prevalence of clinical health issues was identified through the most recent community health needs

assessment. Recognizing that Morton Plant Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further decrease the prevalence of clinical health issues is through a mixed-strategy of:

1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Continue to ensure the Morton Plant Hospital campus remains "tobacco free".*
- ✓ *BayCare Health System will continue to disseminate health-related information throughout the service area.*
- ✓ *BayCare Health Systems will continue to promote fit-friendly organizations through partnership with national associations , educational programming, screenings and Health Risk Assessment offerings to employers to assist in helping them become a Fit-Friendly worksite and create a culture of wellness.*
- ✓ *Continue to provide indigent patients with diabetic kits that include testing meter, supplies, medications, etc. and patient education.*
- ✓ *Continue to ensure nurses are certified to provide diabetes education to inpatients at the hospital.*
- ✓ *Continue to provide scholarships for indigent patients to attend workshops and intensive outpatient programming (i.e., a full-day education session on disease management, etc.)*
- ✓ *Continue to partner with local clubs in addressing pre-diabetic and diabetic residents.*
- ✓ *Continue to partner with community-based organizations to implement best practice and prevention of pre-term births, low birth weight and infant mortality. Focus is on prenatal screening and early identification of risk issues. Partner with governmental entities and statewide agencies to address the needs of infants born with neonatal abstinence syndrome by improving education and outreach.*
- ✓ *Continue to offer services addressing pulmonary health issues (i.e., lung cancer, COPD, Asthma, etc.) through the on-site lung clinic.*

2) Evaluating new programs and services that are based in best practices and are proven effective at treating clinical health issues experienced by residents in the communities served by the hospital.

- ✓ *Decrease re-admission rates and mortality rates while increasing referrals to palliative care/hospice for CHF patients by:*
    1. *Maintaining current CHF outpatient clinic services and evaluate expansion of the model to decrease hospital re-admissions in the service area.*

2. *Offering comprehensive care coordination for CHF patients.*

- ✓ *Increase stroke education and screening by increasing resident awareness of risk reduction and stroke response strategies.*
- ✓ *Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis by increasing the risk reduction and cancer prevention strategies offered by Primary Care Physicians.*
- ✓ *Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women by implementing cervical cancer education focusing on Pap smear compliance and following HPV vaccine schedules.*
- ✓ *Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis by implementing a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.*
- ✓ *Reduce the rate of suicide-related deaths among residents served by BayCare Health System by increasing the awareness of and prevalence of suicide prevention.*
- ✓ *Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System by enhancing available partnership and services provided and targeting populations in the hospital services are that show health disparities related to birth outcomes.*

Hospital leadership developed the following three-year strategy to further align the resources of the hospital with the health needs of the community:

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Maintain current CHF outpatient clinic services at MPH and evaluate expansion of the model to decrease hospital	CHF Patients	**Year 1:** 1. Continue to provide CHF clinic services and document outcomes. 2. Evaluate need, feasibility, and sustainability of CHF clinic expansion. 3. Based on evaluations, develop a plan to expand clinic services in the most effective way.	**Year 1:** 2. Document recommendations 3. Document plan 4. Document resources needed 5-6. Document	**Year1-3:** **Resources:** Staff time **Potential**

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
re-admissions.		4. Determine the level of resources required to expand clinic services. 5. Explore options for partnering with Palliative Care. 6. Review options for collaboration at BayCare Health System level. 7. Identify potential funding sources and seek funding. **Year 2:** 1. Continue to provide CHF clinic services and document outcomes. 2. Communicate new program and relevant Action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 3. Explore other associated co-morbidities, i.e., diabetes, AMI, Hypertension, etc. 4. Communicate new program: External communication i.e., Web redesign 5. Continue to document outcomes. **Year 3:** 1. Evaluate the efficacy of the program by comparing outcome measure from one year to the next. 2. Develop recommendations based on program	partnership and collaborative opportunities 7. Document funding secured 1-7. Report progress to the IRS **Year 2:** 1. Document outcomes and compare to year 1. 2. Document the stages of implementation. 3. Document findings related to co-morbidity. 4. Document the communication plan. 5. Document outcomes and compare from clinic to clinic. 1-5. Report progress to the IRS. **Year 3:** 1. Document outcomes. 2. Document any changes	**Partners:** BayCare Health System, BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		evaluation. 3. Re-assess the prevalence of CHF in the service area.	in outcome measures. 3. Document program recommendations. 1-3. Report re-assessment results and progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc.) 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients.	**Year 1:** 1. Document evaluation findings. 2. Document recommendations. 3. Document plan. 4. Document resources needed. 5-6. Document partnership and collaborative	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health,

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		4. Determine the level of resources required to implement a comprehensive care coordination procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other CBOs. 6. Review options for collaboration at BayCare Health System level (i.e., Coordination through BC Home Health, Primary Care Physicians, Parish Nursing, etc). 7. Identify and secure grants opportunities for medication assistance. 8. Document outcomes and evaluate efficacy (i.e., number of re-admission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six month intervals **Year 2:** 1. Communicate new care coordination program and relevant Action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External	opportunities. 7. Document funding secured. 1-8. Report progress to the IRS. **Year 2:** 1. Document the communication plan (internal and external). 2. Document stages of implementation. 4. Document outcomes and efficacy. 1-4. Report progress to	Primary Care Physicians, Parish Nursing, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		communications and internally to patients treated and referred i.e., Web 4. Evaluate the efficacy of the program by comparing outcome measures, satisfaction, and consumer feedback measures from one year to the next. **Year 3:** 1. Continue to offer the care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program evaluation. 4. Re-assess the preventable hospitalizations for CHF in the service area.	the IRS. **Year 3:** 1. Document number of participants. 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report re-assessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk reduction and stroke response strategies	Residents in hospital service area	**Year 1:** 1. Evaluate existing programs and services (e.g., stroke screenings, education, etc.) provided in the community that relate to awareness and prevention of stroke and stroke response. Determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to stroke prevention and education. b. There are additional partnership opportunities to meet the needs of the community relative to stroke prevention, screening and education (e.g., integration of stroke screening in health risk assessment for high-risk patient populations). c. It is possible to develop ongoing collaborative relationships related to stroke prevention and education in the hospital service area and the county (i.e., partnership with municipality health plans). 2. Design stroke awareness community message: a. Define the problem: Evaluate clinical health issues related to stroke in the service area and the populations that are at greatest risk of stroke and where these populations seek information (e.g., television, newspaper,	**Year 1:** 1 a-c. Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 2a-e. Document the communications strategy (i.e., target populations, communication outlets and locations) and resources needed to implement strategy. 1-2. Report progress to the IRS.	**Year1-3:** **Resources:** Staff time, $30K **Partners:** Municipal health plans, community-based organizations, BayCare Health System

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		word-of-mouth). b. Based on the results of the evaluation, define what information to communicate and the goals for each topic (i.e., signs and symptoms of stroke). c. Based on the results of the evaluation, identify the most appropriate outlet to provide information to the populations that are at greatest risk of stroke. d. Develop communications strategy; identify the methods for communicating with the target audiences. e. Identify resources needed to implement communication strategy. **Year 2:** 1. Identify where collaboration is possible (i.e., collaborative partnership building, service/program development, etc.) 2. Identify potential funding sources to implement communication strategies and seek funding. a. Based on available resources, develop communications and test communication strategies (e.g., focus group, survey, test market, etc.)	**Year 2:** 1. Document organizations and collaborations formed. 2. Document funding secured and new awareness and prevention strategies to be implemented. 2d. Document the	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		b. Produce materials for dissemination. c. Launch communication plan. d. Measure and track reach and frequency of communications. **Year 3:** 1. Continue to evaluate opportunities to collaborate with community based organizations (i.e., collaborative partnership building, service/program development, etc.) 2. Evaluate the effectiveness of communication strategies implemented in year 2 and revise strategy for year 3 as needed. 3. Re-assess the health outcomes related to stroke in the service area.	number of residents reached with messaging. 1-2. Report progress to the IRS **Year 3:** 1. Document organizations and collaborations formed. 2. Document the results and recommendations of evaluation. 1-3. Report re-assessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the risk reduction and cancer prevention strategies offered by Primary Care Physicians	Adult residents	**Year 1:** 1. Increase prevention education about risk reduction and cancer prevention strategies being provided by PCPs a. Develop partnerships with PCPs in the community. b. Increase education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs c. Track the number and types of cancer screenings taking place in BayCare Medical Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 2:** 1. Increase cancer prevention screening being provided by PCPs a. Evaluate what resources are available/needed for BayCare Medical Group PCPs to increase cancer screening. b. Seek funding for increased cancer screening opportunities. c. Increase cancer prevention screenings used	**Year 1:** 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group. 1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-d. Report progress to the IRS. **Year 2:** 1b. Document funding secured. 1c. Document number of patients provided cancer screening and compare to previous year. 1d.Document the number	**Year 1-3:** **Resources:** TBD **Potential Partners:** BayCare Health System, BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		among BayCare Medical Group and community partner PCPs. d. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. e. Track the number and types of cancer screening taking place in BayCare Medical Group. f. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Continue cancer prevention screening used among BayCare Medical Group and community partner PCPs. b. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. c. Track the number and types of cancer screenings taking place in BayCare Medical	of patients that are provided education. 1e. Document cancer screenings taking place at BayCare Medical Group. 1f. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-f. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screening and compare to previous year. 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group. 1d. Document the	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. e. Evaluate program and re-assess the prevalence of late-stage diagnosis.	number of patients adopting risk reduction and cancer prevention strategies. 1a-e. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement cervical cancer education focusing on PAP smear compliance and	Women	**Year 1:** 1. Partner with local health departments and other providers to identify community resources and assess current screening and vaccination compliance in high-risk groups through Faith Community Nursing.	**Year 1:** 1a-b. Document baseline screening and vaccination rates and the barriers identified by FCN.	**Year 1-3:** Estimated $25K - $50K increased annual expense to

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
following HPV vaccine schedules.		a. Determine current screening and vaccination compliance rates in congregations. b. Determine if barriers (i.e., financial, transportation, etc.) exist for cervical cancer screening and prevention. c. Educate congregation members of cervical cancer screening and prevention guidelines. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial barrier for high risk groups to access cervical cancer screenings and HPV vaccinations. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Based on collected data develop programs to target low compliance populations. Partner with community-based organizations to provide increased screening and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screenings	1c. Document the number of residents that are provided education. 1d. Document funding secured. 1a-d. Report progress to the IRS. **Year 2:** 1a. Document number of patients provided cancer screenings and vaccinations and report rate increases. 1b.Document the number of patients that are provided education.	provide education through FCN. Drug cost: HPV 100 Vaccines @ $360/course = $36K

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		and vaccinations at FCN network partners. Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Continue to partner with community-based organizations to provide increased screenings and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis.	1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screenings and vaccinations and report rate increases. 1b.Document the number of patients that	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Provide mobile cervical cancer screenings and vaccinations at FCN network partners. Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be screened and/or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.)	are provided education. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.

Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high risk populations.	Residents at risk of lung cancer	**Year 1:** 1. Partner with local health departments and other providers to identify community resources and assess current screening compliance in high risk groups through Faith Community Nursing and partner PCPs. a. Partner PCPs and FCN network can identify high risk groups. Use cancer registry data to determine stage distribution. b. Determine if barriers (i.e., financial, transportation, etc.) exist for lung cancer screening. c. Educate and promote smoking cessation and lung cancer screening guidelines to congregation members. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial barrier for high-risk groups to access cancer screenings. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Educate PCPs and other physicians to lung cancer screening guidelines. a. Ensure all CIN and BMG physicians are	**Year 1:** 1a-b. Document baseline screening and the barriers identified by FCN. 1c. Document the number of residents that are provided education. 1e. Document funding secured. 1a-e. Report progress to the IRS. **Year 2:** 1b. Document number of patients provided cancer screening and	**Year 1-3:** Estimated $25K - $50K increased annual expense to provide education through FCN. 150 low dose CT lung cancer screening = $22.5K.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		aware of current lung cancer screening guidelines. b. Use CIN and BMG physicians to identify high-risk individuals and refer to lung cancer screening. c. Use CIN and BMG physicians as well as FCN network to promote smoking cessation and lung cancer screening guidelines. d. Pursue grant funding to provide low-income, high-risk individuals low-dose CT scans for lung cancer screening at no cost. e. Continue to provide advanced directive documentation. f. Track the number of residents that adopt risk reduction and cancer prevention strategies. g. Measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Based on collected data develop programs to	report rate increases. 1c.Document the number of patients that are provided education. 1e. Document the number of advanced directive materials provided. 1g. Document metrics related to program effectiveness. 1a-g. Report progress to the IRS **Year 3:** 1a. Document number of patients provided cancer screening.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		target low-compliance populations. Partner with community-based organizations to provide increased screening and cessation opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide 150 no-cost low-dose CT lung cancer screenings for high-risk population b. Work with Faith Community Nursing to encourage congregation members to be screened and adopt risk reduction and cancer prevention strategies (i.e., smoking cessation), provide information about screenings taking place and available resources for cessation, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.)	1b.Document the number of patients that are provided education, screening and cessation resources. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **Anticipated Impact:** Reduce the rate of suicide-related death among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide-related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide-related deaths (i.e., communications plan, analytics necessary to profile high-risk suicide, $30,000 for developing and marketing, etc.) 4. Secure funding **Year 2:** 1. Maximize relationships and collaborative opportunities with community-based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc.	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-4. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 3. Document the	**Year1-3:** $30,000 BCBH

		3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1, implement comprehensive wellness initiative that will focus on preventing suicide-related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community-based organizations and evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide-related deaths, etc.) by comparing the baseline measures gathered in year 1 to those gathered in year 2.	metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS. **Year 3:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. Document the reach of the program (number of participants). 3. Compare prevention metrics from year 2 to the baseline developed in year 1.	

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low birth weight births, infant mortality **Anticipated Impact:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

Improve birth outcomes for patients served by facilities and organizations associated with BayCare Health System	Expecting mothers at risk of poor birth outcomes	**Year 1:** 1. Morton Plant Hospital will continue to provide current initiatives for inpatients and outpatients while evaluating the effectiveness, evidence basis, outcomes measures, population served, accessibility, etc. of current models. These models include relationships with community-based organizations that serve expecting mothers at risk of poor birth outcomes to determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to improving birth outcomes. b. There are additional partnership opportunities to meet the needs of the community relative to improving birth outcomes. c. It is possible to develop ongoing collaborative relationships related to expecting mothers in the hospital service areas. 2. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.) 3. Identify funding opportunities to expand services to expecting mothers at risk of poor birth outcomes. 4. Develop baseline metrics by collecting outcome measures for each collaborating CBO. **Year 2:** 1. Implement recommendations for existing	**Year 1:** 1 & 2.Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 3. Document identified funding opportunities. 4. Document outcome measures for each collaborating CBO. 1-4. Report progress to the IRS. **Year 2:**	**Year 1:** Grants, substance abuse and treatment grant for NICU navigators, staff, office supplies, educational material **Year 2:** Funds, grants or other allocation, staff, office supplies.

		programs: a. Seek identified funding. b. Begin implementation of the programs/services for which funding is secured. c. Track outcomes of new programs and services. 2. Continue to evaluate opportunities for expansion and funding for these opportunities. 3. Continue to collect outcome measures for each collaborating CBO, including expanded programs and services. **Year 3:** 1. Complete implementation and begin to evaluate the effectiveness of the newly implemented programs/services. a. Make recommendations based on evaluation.	1a. Document programs for which funding is sought and the outcomes of each effort. 1b. Document the phases of implementation for each program/service for which funding is secured. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating CBO and compare to baseline metrics from year 1. 1 -3. Report Progress to the IRS. **Year 3:** 1a. Document the	Educational material/collateral **Year 3:** Funds, grants or other allocation, staff, office supplies. Educational material/collateral

		b. Identify resources needed to implement recommendations of evaluation. c. Seek funding to implement recommendations. 2. Continue to evaluate opportunities for expansion and funding for these opportunities. 3. Continue to collect outcome measures for each collaborating CBO, including expanded programs and services. 4. Re-assess community need related to birth outcomes in the service area.	results of program evaluation. 1b. Document the resources needed to implement recommendations. 1c. Document efforts to gather resources (e.g., fundraising, grant writing, etc.) 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating CBO and compare to baseline metrics from year 2. 1-4. Report progress to the IRS in re-assessment.	

KEY COMMUNITY HEALTH NEED #3:
IMPROVING HEALTHY BEHAVIOR AND ENVIRONMENTS

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **Awareness and education about healthy behaviors**
- **Presence of unhealthy behaviors**
- **Residents resisting seeking health services**

The health of a community largely depends on the health status of its residents. Key stakeholders and focus group participants believed that the lifestyles of some residents may have an impact on their individual health status and consequently, cause an increase in the consumption of healthcare resources. Specifically, key stakeholders and focus group participants discussed lifestyle choices (i.e., poor nutrition, inactivity, smoking, substance abuse – including alcohol and prescription drugs, etc.) that can lead to chronic illnesses (i.e., obesity, diabetes, cancer, pulmonary diseases, poor birth outcomes, including low birth weight, pre-term births, physical/mental limitations of infants, etc.). Key stakeholders discussed the need for chronic disease management due to the increasing rates of obesity, substance abuse, etc. An increase in the number of chronic conditions diagnosed in a community can lead to a greater consumption of healthcare resources due to the need to monitor and manage such diagnoses.

While Morton Plant Hospital, a hospital in the BayCare Health System, provides programs and services which target healthy behaviors: the need to improve healthy behaviors and environments was identified through the most recent community health needs assessment. Recognizing that Morton Plant Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further improve healthy behaviors and environments is through a mixed-strategy of:

1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Faith Community Nurses will continue to addresses the healthcare needs of the vulnerable and underserved populations in the hospital service area.*
- ✓ *Continue to identify and establish healthy alternatives for staff (i.e., reduction of trans fats in meals, encouragement of physical activities, offering nutritionist services, etc.)*

- ✓ *BayCare Health System will continue to provide preventive care and weight management through the BayCare Medical Group as a component of the Medical Home Model provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue developing health education programming with outreach, screenings, education, etc. through partnerships with community-based organizations like employers, municipalities, libraries, etc.*
- ✓ *Continue to provide transportation to patients that are not able to afford transportation to preventive care appointment.*
- ✓ *Continue the Parent Power pilot program in an attempt to connect parents of children 18 year old or younger residing in diverse communities to education about the importance of nutrition and movement for better health and wellness.*
- ✓ *Continue community partnerships related to the reduction of substance abuse in the communities served by the hospital.*

2) Evaluating new programs and services that are based in best practices and are proven effective at improving healthy behaviors and environments in the communities served by the hospital.

- ✓ *Increase the access that residents have to preventive care, health education, and outreach in the community by increasing the availability of Faith Community Nurses to provide preventive screenings, education, and health literacy services to a greater number of residents.*
- ✓ *Increase the availability of substance abuse services by increasing the early identification and substance abuse services available to families with substance abuse issues.*
- ✓ *Increase the use of risk reduction and cancer prevention strategies by increasing resident awareness of and access to risk-reduction and cancer-prevention strategies*

Hospital leadership developed the following three-year strategy to further align the resources of the hospital with the health needs of the community:

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the availability of Faith Community Nurses to provide preventive screenings, education and health literacy services to a greater number of residents.	Residents in the hospital service area	**Year 1:** 1. Maintain the number of Faith Community Nurses operating in the area (88 Registered Nurses in 48 communities) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational sessions; CPR/AED training for staff and the congregation; Diabetes education; BP and Stroke screenings; Facilitate flu, pneumonia, and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter. 3. Increase community partnerships: a. Develop or obtain distribution list of area clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care.	**Year 1:** 1. Document the number of education sessions provided, the number of attendees and locations. 2. Document the number of nurses added to MPH. 3. Document the number of communities added to MPH. 1-3. Report progress to the IRS.	**Year1-3:** **Potential Partners:** Churches, Communities, etc. **Resources:** Staff – 2 FTE's (currently one FT Manager and two PT coordinators) FCN budget, Office space – Two offices and one storage room Equipment Three PC's, two laptops and one smart phone. Four

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		c. Encourage nurse referrals to be outside of communities already served. d. Track the number of referrals obtained. 4. Explore opportunities for the FCN program to be involved in reducing preventable re-admissions. a. Continue to raise awareness within MPM Healthcare as to the vital role that FCN could play in helping to reduce preventable re-admissions. b. Survey MPM FCN's to find out their willingness to participate in a follow-up of a discharged patient who is at high risk for re-admission. c. Continue to become more knowledgeable regarding the Affordable Care Act and the components that deal with the re-admission challenge. **Year 2:** 1. Based on available resources, maintain the number of Faith Community Nurses operating in the area (including those added in year 1) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational	**Year 2:** 1. Document the number of education sessions provided, the number of attendees	commercial-grade automatic BP machines (used for community events). One retractable banner, two exhibit tablecloths, one tri-fold table sign. **Additional resources needed:** FTE for Transition Care Coordinator Explore partnering

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		sessions; CPR/ AED training for staff and the congregation; Diabetes education; BP and Stroke screenings; Facilitate flu, pneumonia and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Continue to increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter. 3. Continue to increase community partnerships: a. Develop or obtain distribution list of area clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care. c. Encourage nurse referrals to be outside of communities already served. d. Track the number of referrals obtained. 4. Explore opportunities for the FCN program to be involved in reducing preventable re-admissions. a. Develop strategies to connect discharged patients with their faith community or a local member congregation. b. Pilot partnering with Case Management	and location annually. 1-5. Report progress to the IRS.	with Case Management discharge phone call team for referral

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		discharge phone call team for referrals. c. Utilize new BayCare database (replacing current) to facilitate gathering of patient faith community. 5. Focus on ways to further combine MPM community health outreach events and the FCN partnership program. **Year 3:** 1. Based on available resources, maintain the number of Faith Community Nurses operating in the area (including those added in year 2) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational sessions; CPR/AED training for staff and the congregation; Diabetes education; BP and Stroke screenings; Facilitate flu, pneumonia and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Continue to increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter.	**Year 3:** 1. Document the number of education sessions provided, the number of attendees and location annually. 1-5. Re-assess and report progress to the IRS.	

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Continue to increase community partnerships: a. Develop or obtain distribution list of area clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care. c. Encourage nurse referrals to be outside of communities already served. d. Track the number of referrals obtained. 4. Based on progress in year 2, continue to explore opportunities for the FCN program to be involved in reducing preventable re-admissions. 5. Continue to focus on ways to further combine MPM community health outreach events and the FCN partnership program.		

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the availability of substance abuse services	Adults and pediatric residents who are abusing addictive substances and/or addicted to a substance	**Year 1:** 1. Fully develop and implement the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways a. Identify funding sources and seek funding for program. b. Secure funding. c. Hire staff (e.g., manager and coaching staff). d. Implement program. e. Track the number of patients referred to the program and the number of patients participating in the program. 2. Substance Abuse Case Management for Moms and babies addicted to prescription drugs a. Identify necessary resources (e.g., funding, staff, space, materials, etc.). b. Identify and acquire funding required for Case Management team. c. Develop case management program. d. Hire staff. e. Implement case management by connecting mothers and babies to community services and partners.	**Year 1:** 1a&b. Document secured funding 1c. Document the start dates for program staff. 1d&e. Document the number of patients referred to the program and the number of patients participating in the program. 2a-b. Document resources required and resources secured. 2d. Document start dates of staff hired. 2e. Document the number of families served. 1-2. Report progress to the IRS.	**Year 1-3:** BCHS 1) $3 mill – Pathways BCHS 2) $130,000 – Mom's and babies

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Moms and babies addicted to prescription drugs. **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways. 2. Continue Substance Abuse Case Management for Moms and babies-addicted to prescription drugs.	**Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served. 1-2. Report progress to the IRS. **Year 3:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served.	

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1-2. Report progress to the IRS.	

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk-reduction and cancer-prevention strategies	Residents in hospital service area and congregations served by Faith Community	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that	**Year 1:** 1. Document the forms of cancer that have higher than average rates and the populations most at risk. 2. Document the gaps in	**Year1-3:** Resources: $ $50,000 to $100,000 for FCN expansion Mammograms: $11.5K

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
	Nurses	relate to awareness and prevention of cancer (i.e., breast, cervical, prostate, and lung). a. Identify high-risk groups that are not accessing cancer screening through Faith Community Nursing and provide education to congregations about the importance of such screenings. b. Prioritize cancer screening opportunities in high risk populations for breast, prostate, and lung cancers. c. Provide advanced directive documentation. 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach. 4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources to implement recommendations and secure funding. 2. Implement changes for which funding is available	risk-reduction and cancer-prevention activities. 3. Document the evidence basis, demographics of populations reached, location, frequency and number of attendees for hospital risk-reduction and cancer-prevention efforts. 4. Document recommendations to increase resident awareness of risk-reduction and cancer-prevention strategies and resources needed.	PSA + DRE:~ $12.5K Low dose CT: $15K Additional $50K - $75K in statistical analysis cost as well as FCN annual expense associated with education and tracking. Partners: FCN

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		on-site and in the community, including churches. 3. Partner with community-based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide high-risk populations: 150 mammograms; 250 PSA + DRE; 100 Low-dose CT. b. Work with Faith Community Nursing to provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Develop a baseline measure of patients diagnosed with late-stage cancer and compare to cancer registry. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants.	**Year 2:** 1. Document funding secured. 2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by demographics annually. 4. Document the evidence basis, population reached, location, and number of participants for each effort. 1-4. Report progress to the IRS.	

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 3: 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed, including Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. 4. Re-assess the prevalence of cancer in the service area.	**Year 3:** 1. Document any revisions. 2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached, location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report re-assessment results and	

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			progress to the IRS	

APPENDIX A

Implementation Strategy

MORTON PLANT HOSPITAL
August, 2013

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement timely and effective coordination of care between primary care and Morton Plant Hospital and Bardmoor Emergency Departments	Residents in the MPH service area	**Year 1:** 1. Develop relationship with any BCHS primary care sites not at full capacity or any primary care sites in mid-Pinellas County that are funded through BCHS in some way that guarantee a number of appointment slots per day for MPH or Bardmoor ED or inpatient referrals. a. Identify potential PCP sites. b. Clearly communicate with potential partners the parameters of relationship, common goals, process, and outcomes. c. Secure and utilize appointment slots. 2. Explore partnerships with non-BCHS primary care sites in mid-Pinellas County to facilitate referrals between these sites and the MPH or Bardmoor ED. To explore relationship building MPH may employ any of the following: a. Identify potential PCP sites and set goals for Physician Advocates to enlist a set number of PCPs and review the number of PCPs enlisted quarterly. b. Develop procedures for patient referral and follow-up. c. Develop methods to track the number of patients that are referred to a site and the	**Year 1:** 1a-c. Document the partners providing appointment slots. 2a. Document partnering sites. 2b. Document procedures. 2c. Document the number of patients referred and completed appointments. 2d. Document any recommendations. 3b. Document resources secured. 3d. Document participating partners. 3e. Document any recommendations. 4 a-d. Document the recommendations of evaluations and funding secured. 5. Document baseline	**Year1-3:** 2. Existing Physician Advocates 3. $$ of IS Access *(fill in est. figure here)* 4. Possible increase in FTE depending on demands of current Health Management Services positions in ED

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		number of completed visits. d. Evaluate efficacy of referral process (e.g., consumer feedback, PCP feedback, outcome measures, etc.) 3. Facilitate or coordinate access to necessary information via BayCare Information System for any new primary care partners. a. Explore partnerships with BCHS. b. Identify the necessary resources. c. Identify potential partners. d. Facilitate access to BayCare Information System. e. Evaluate the effectiveness for each site. 4. Explore the development of a Patient Navigator role or an adjustment to the Health Management Services role to assume more navigation duties in the ED. a. Evaluate the efficacy of the current Health Management Services role (e.g., consumer feedback surveys). b. Develop recommendations based on the evaluation and best practices. c. Identify and seek resources needed to implement recommendations. d. Based on available resources, implement	metrics to monitor coordination of care. 1-5. Report progress to the IRS.	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		recommendations related to the Health Management Services role. 5. Establish metrics to monitor coordination of care between MPH or Bardmoor ED and primary care sites in mid-Pinellas County. **Year 2:** 1. Monitor compliance of BCHS primary care sites, BCHS funded primary care sites, and primary care partners on coordinating care between MPH and Bardmoor ED's and these primary care locations. 2. Identify any new primary care sites that need to be included in the Care Coordination Model. 3. Measure effectiveness of Patient Navigator (or Health Management Services) role. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in year 1. **Year 3:** 1. Monitor compliance of BCHS primary care sites, BCHS funded primary care sites, and primary care partners on coordinating care between MPH and	**Year 2:** 1. Document the number of patients referred and completed appointments. 2. Document participating partners. 3. Document any recommendations. 4. Document metrics to monitor coordination of care and comparison to year 1. 1-4. Report progress to the IRS. **Year 3:** 1. Document the number of patients referred and completed appointments. 2. Document participating	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Patient navigation, financial assistance, access to care for the un/underinsured and/or underserved **ANTICIPATED IMPACT:** Enhance access to affordable healthcare services in the service area				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Bardmoor ED's and these primary care locations. 2. Identify any new primary care sites that need to be included in the Care Coordination Model. 3. Measure effectiveness of Patient Navigator (or Health Management Services) role. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in Year 1. 5. Re-assess community need for care coordination.	partners. 3. Document any recommendations. 4. Document metrics to monitor coordination of care and comparison to year 1. 1-5. Report re-assessment results and progress to the IRS.	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Decrease the percentage of uninsured residents in the community	Residents in the community that are eligible for some form of health	**Year 1:** 1. Explore development of resource center in mid Pinellas County in collaboration with county, state, and related insurance carriers to facilitate providing information and access to members of our community that are eligible for some type of health coverage.	**Year 1:** 1 a-d. Referrals made will be documented and tracked in a HIPAA compliant way. Meeting will be held with potential partnerships	**Year1-3:** **Potential Partners:** BayCare Financial Assistance

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
	insurance	a. Develop necessary relationships and needed agreements between MPH and related agencies and companies providing health coverage to Pinellas County residents. b. Develop a timeline for developing a resource center for access to affordable healthcare. c. Develop a referral system through community agencies and ED and primary care sites to the resource center. Resources: MPH, BCMG, Health Management Services and CBO. d. Identify best practices for accessing affordable healthcare coverage, including evaluation and documentation. 2. Collaborate with BayCare Health System and local governments in the exploration of the feasibility and sustainability in establishing clinics for uninsured. a. Develop necessary relationships and needed agreements between related agencies and governments participating in the effort. b. Develop a timeline. c. Identify the feasibility and sustainability along with best practices in supporting the provision of clinic services to uninsured	and documented. 2a-d. Document the collaborating partners, timeline and the results and recommendations of evaluations. 1-2. Report progress to the IRS.	Program, county, state and related insurance carriers **Resources:** Health Management Services and CBO

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		residents, including evaluation and documentation. d. Identify and seek necessary funding in collaboration with partnering organizations. **Year 2:** 1. Implement program improvements and best practices identified in year 1 a. Identify and refer patients that are eligible for health insurance and not enrolled. b. Reduce the number of uninsured accessing MPH and Bardmoor ED's by 5%. c. Evaluate the effectiveness of the resource center for access to affordable healthcare coverage and determine necessary improvements. 2. Monitor and report performance progress by year-end. 3. Based on available resources and the results of evaluations completed in year 1, further explore establishing clinics for uninsured in collaboration with partnering organizations. a. Revise implementation plan to reflect action step for years 2 and 3 that are commiserate with evaluation results, partnerships and	**Year 2:** 1a. Resource Center will be operational by year-end and documenting eligibility and enrollment cases in a HIPAA-compliant way. 1b. The resource center will document a 5% enrollment increase for medical assistance among the uninsured patients who are seen in the MPH service area. 1c. Targeted improvements will be documented. 2. Document funding secured and new implementation plan for	

NEED: Access to affordable healthcare **UNDERLYING FACTORS:** Access Related to Insurance Coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		available resources among collaborating partners. b. Implement plan. **Year 3:** 1. Implement program improvements identified in year 2. 2. Reduce the number of uninsured accessing MPH and Bardmoor ED's by 10%. 3. Evaluate the effectiveness of the Resource Center for access to affordable healthcare coverage. 4. Monitor and report performance to best practice and previous year results. 5. Based on available resources and successes in year 2, revise implementation plan in year 3 and continue efforts to establish clinics for uninsured in collaboration with partnering organizations. 6. Re-assess need in the community.	year 2-3. 1-3. Report progress to the IRS. **Year 3:** 1. The resource center will document a 10% enrollment increase for medical assistance among the uninsured patients who are seen in the MPH service area. 2. Targeted improvements will be documented 5. Document new implementation plan for year 3. 1-6. Re-assess need and Report progress to the IRS.	

NEED: Access to affordable healthcare – Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of mental health services	Adults and pediatric residents who may require mental health services	**Year 1:** 1. Family and Patient Preservation Program- working at home with families at risk a. Convert pediatric acute care funding to outpatient preservation program. b. Implement program and track measure outcomes. **Year 2:** 1. Family and Patient Preservation Program- working at home with families at risk a. Implement program and track measure outcomes. **Year 3:** 1. Family and Patient Preservation Program- working at home with families at risk a. Implement program and track measure outcomes.	**Year 1:** 1a. Document the conversion process and dates. 1b. Document number of program participants and outcomes. 1. Report progress to the IRS. **Year 2:** 1a. Document number of program participants and outcomes. 1. Report progress to the IRS. **Year 3:** 1a. Document number of program participants and outcomes. 1. Report progress to	**Year 1-3:** 2. Conversion of pediatric acute services grant to preservation program $400,000

NEED: Access to affordable healthcare – Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Maintain current CHF outpatient clinic services at MPH and evaluate expansion of the model to decrease hospital re-admissions.	CHF Patients	**Year 1:** 1. Continue to provide CHF clinic services and document outcomes. 2. Evaluate need, feasibility, and sustainability of CHF clinic expansion. 3. Based on evaluations, develop a plan to expand clinic services in the most effective way. 4. Determine the level of resources required to expand clinic services. 5. Explore options for partnering with Palliative Care. 6. Review options for collaboration at BayCare Health	**Year 1:** 2. Document recommendations 3. Document plan 4. Document resources needed 5-6. Document partnership and collaborative opportunities 7. Document funding	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System,

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		System level. 7. Identify potential funding sources and seek funding. **Year 2:** 1. Continue to provide CHF clinic services and document outcomes. 2. Communicate new program and relevant Action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 3. Explore other associated co-morbidities, i.e., diabetes, AMI, Hypertension, etc. 4. Communicate new program: External communication i.e., Web redesign 5. Continue to document outcomes. **Year 3:** 1. Evaluate the efficacy of the program by comparing outcome measure from one year to the next. 2. Develop recommendations based on program evaluation. 3. Re-assess the prevalence of CHF in the service area.	secured 1-7. Report progress to the IRS **Year 2:** 1. Document outcomes and compare to year 1. 2. Document the stages of implementation. 3. Document findings related to co-morbidity. 4. Document the communication plan. 5. Document outcomes and compare from clinic to clinic. 1-5. Report progress to the IRS. **Year 3:** 1. Document outcomes. 2. Document any changes in outcome measures. 3. Document program recommendations.	BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1-3. Report re-assessment results and progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc.) 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients. 4. Determine the level of resources required to implement a comprehensive care coordination	**Year 1:** 1. Document evaluation findings. 2. Document recommendations. 3. Document plan. 4. Document resources needed. 5-6. Document partnership and collaborative opportunities. 7. Document funding	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health, Primary Care

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other CBOs. 6. Review options for collaboration at BayCare Health System level (i.e., Coordination through BC Home Health, Primary Care Physicians, Parish Nursing, etc). 7. Identify and secure grants opportunities for medication assistance. 8. Document outcomes and evaluate efficacy (i.e., number of re-admission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six month intervals **Year 2:** 1. Communicate new care coordination program and relevant Action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External communications and internally to patients treated and referred i.e., Web	secured. 1-8. Report progress to the IRS. **Year 2:** 1. Document the communication plan (internal and external). 2. Document stages of implementation. 4. Document outcomes and efficacy. 1-4. Report progress to the IRS.	Physicians, Parish Nursing, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than average rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **Anticipated Impact:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		4. Evaluate the efficacy of the program by comparing outcome measures, satisfaction, and consumer feedback measures from one year to the next. **Year 3:** 1. Continue to offer the care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program evaluation. 4. Re-assess the preventable hospitalizations for CHF in the service area.	**Year 3:** 1. Document number of participants. 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report re-assessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk reduction and stroke response strategies	Residents in hospital service area	**Year 1:** 1. Evaluate existing programs and services (e.g., stroke screenings, education, etc.) provided in the community that relate to awareness and prevention of stroke and stroke response. Determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to stroke prevention and education. b. There are additional partnership opportunities to meet the needs of the community relative to stroke prevention, screening and education (e.g., integration of stroke screening in health risk assessment for high-risk patient populations). c. It is possible to develop ongoing collaborative relationships related to stroke prevention and education in the hospital service area and the county (i.e., partnership with municipality health plans). 2. Design stroke awareness community message: a. Define the problem: Evaluate clinical health issues related to stroke in the service area and the populations that are at greatest risk of stroke and where these populations seek information (e.g., television, newspaper,	**Year 1:** 1 a-c. Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 2a-e. Document the communications strategy (i.e., target populations, communication outlets and locations) and resources needed to implement strategy. 1-2. Report progress to the IRS.	**Year1-3:** **Resources:** Staff time, $30K **Partners:** Municipal health plans, community-based organizations, BayCare Health System

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		word-of-mouth). b. Based on the results of the evaluation, define what information to communicate and the goals for each topic (i.e., signs and symptoms of stroke). c. Based on the results of the evaluation, identify the most appropriate outlet to provide information to the populations that are at greatest risk of stroke. d. Develop communications strategy; identify the methods for communicating with the target audiences. e. Identify resources needed to implement communication strategy. **Year 2:** 1. Identify where collaboration is possible (i.e., collaborative partnership building, service/program development, etc.) 2. Identify potential funding sources to implement communication strategies and seek funding. a. Based on available resources, develop communications and test communication strategies (e.g., focus group, survey, test market, etc.) b. Produce materials for dissemination.	**Year 2:** 1. Document organizations and collaborations formed. 2. Document funding secured and new awareness and prevention strategies to be implemented. 2d. Document the number of residents	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **Anticipated Impact:** Increase stroke education and screening				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		c. Launch communication plan. d. Measure and track reach and frequency of communications. **Year 3:** 1. Continue to evaluate opportunities to collaborate with community based organizations (i.e., collaborative partnership building, service/program development, etc.) 2. Evaluate the effectiveness of communication strategies implemented in year 2 and revise strategy for year 3 as needed. 3. Re-assess the health outcomes related to stroke in the service area.	reached with messaging. 1-2. Report progress to the IRS **Year 3:** 1. Document organizations and collaborations formed. 2. Document the results and recommendations of evaluation. 1-3. Report re-assessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the risk	Adult	**Year 1:**	**Year 1:**	**Year 1-3:**

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
reduction and cancer prevention strategies offered by Primary Care Physicians	residents	1. Increase prevention education about risk reduction and cancer prevention strategies being provided by PCPs a. Develop partnerships with PCPs in the community. b. Increase education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs c. Track the number and types of cancer screenings taking place in BayCare Medical Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 2:** 1. Increase cancer prevention screening being provided by PCPs a. Evaluate what resources are available/needed for BayCare Medical Group PCPs to increase cancer screening. b. Seek funding for increased cancer screening opportunities. c. Increase cancer prevention screenings used among BayCare Medical Group and	1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group. 1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-d. Report progress to the IRS. **Year 2:** 1b. Document funding secured. 1c. Document number of patients provided cancer screening and compare to previous year. 1d.Document the number of patients that are provided education.	**Resources:** TBD **Potential Partners:** BayCare Health System, BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		community partner PCPs. d. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. e. Track the number and types of cancer screening taking place in BayCare Medical Group. f. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Continue cancer prevention screening used among BayCare Medical Group and community partner PCPs. b. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. c. Track the number and types of cancer screenings taking place in BayCare Medical Group.	1e. Document cancer screenings taking place at BayCare Medical Group. 1f. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-f. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screening and compare to previous year. 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group. 1d. Document the number of patients adopting risk reduction	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **Anticipated Impact:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		d. Track the number of patients adopting risk reduction and cancer prevention strategies. e. Evaluate program and re-assess the prevalence of late-stage diagnosis.	and cancer prevention strategies. 1a-e. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement cervical cancer education focusing on PAP smear compliance and following HPV vaccine	Women	**Year 1:** 1. Partner with Health Dept. and other providers to identify community resources and assess current screening and vaccination compliance in high-risk groups through Faith Community Nursing. a. Determine current screening and vaccination compliance rates in congregations.	**Year 1:** 1a-b. Document baseline screening and vaccination rates and the barriers identified by FCN. 1c. Document the number of residents that	**Year 1-3:** Estimated $25K - $50K increased annual expense to provide education

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
schedules.		b. Determine if barriers (i.e., financial, transportation, etc.) exist for cervical cancer screening and prevention. c. Educate congregation members of cervical cancer screening and prevention guidelines. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial barrier for high risk groups to access cervical cancer screenings and HPV vaccinations. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Based on collected data develop programs to target low compliance populations. Partner with community-based organizations to provide increased screening and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screenings and vaccinations at FCN network partners. Vaccinate 100 uninsured community	are provided education. 1d. Document funding secured. 1a-d. Report progress to the IRS. **Year 2:** 1a. Document number of patients provided cancer screenings and vaccinations and report rate increases. 1b.Document the number of patients that are provided education. 1c. Document the number of advanced	through FCN. Drug cost: HPV 100 Vaccines @ $360/course = $36K

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		members. b. Work with Faith Community Nursing to encourage congregation members to be screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Continue to partner with community-based organizations to provide increased screenings and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screenings and vaccinations at FCN network partners.	directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screenings and vaccinations and report rate increases. 1b.Document the number of patients that are provided education. 1c. Document the	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **Anticipated Impact:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be screened and/or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.)	number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high risk populations.	Residents at risk of lung cancer	**Year 1:** 1. Partner with local health departments and other providers to identify community resources and assess current screening compliance in high risk groups through Faith Community Nursing and partner PCPs. a. Partner PCPs and FCN network can identify high risk groups. Use cancer registry data to determine stage distribution. b. Determine if barriers (i.e., financial, transportation, etc.) exist for lung cancer screening. c. Educate and promote smoking cessation and lung cancer screening guidelines to congregation members. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial barrier for high-risk groups to access cancer screenings. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Educate PCPs and other physicians to lung cancer	**Year 1:** 1a-b. Document baseline screening and the barriers identified by FCN. 1c. Document the number of residents that are provided education. 1e. Document funding secured. 1a-e. Report progress to the IRS. **Year 2:**	**Year 1-3:** Estimated $25K - $50K increased annual expense to provide education through FCN. 150 low dose CT lung cancer screening = $22.5K.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		screening guidelines. a. Ensure all CIN and BMG physicians are aware of current lung cancer screening guidelines. b. Use CIN and BMG physicians to identify high-risk individuals and refer to lung cancer screening. c. Use CIN and BMG physicians as well as FCN network to promote smoking cessation and lung cancer screening guidelines. d. Pursue grant funding to provide low-income, high-risk individuals low-dose CT scans for lung cancer screening at no cost. e. Continue to provide advanced directive documentation. f. Track the number of residents that adopt risk reduction and cancer prevention strategies. g. Measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:**	1b. Document number of patients provided cancer screening and report rate increases. 1c.Document the number of patients that are provided education. 1e. Document the number of advanced directive materials provided. 1g. Document metrics related to program effectiveness. 1a-g. Report progress to the IRS **Year 3:** 1a. Document number	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **Anticipated Impact:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Based on collected data develop programs to target low-compliance populations. Partner with community-based organizations to provide increased screening and cessation opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide 150 no-cost low-dose CT lung cancer screenings for high-risk population b. Work with Faith Community Nursing to encourage congregation members to be screened and adopt risk reduction and cancer prevention strategies (i.e., smoking cessation), provide information about screenings taking place and available resources for cessation, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.)	of patients provided cancer screening. 1b.Document the number of patients that are provided education, screening and cessation resources. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-d. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **Anticipated Impact:** Reduce the rate of suicide-related death among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide-related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide-related deaths (i.e., communications plan, analytics necessary to profile high-risk suicide, $30,000 for developing and marketing, etc.) 4. Secure funding **Year 2:** 1. Maximize relationships and collaborative opportunities with community-based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community-based organizations	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-4. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative	**Year1-3:** $30,000 BCBH

NEED: Decreasing the prevalence of clinical health issues – Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **Anticipated Impact:** Reduce the rate of suicide-related death among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		that provide services related to suicide, risk of suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1, implement comprehensive wellness initiative that will focus on preventing suicide-related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community-based organizations and evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide-related deaths, etc.) by comparing the baseline measures gathered in year 1 to those gathered in year 2.	opportunities. 3. Document the metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS. **Year 3:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. Document the reach of the program (number of participants). 3. Compare prevention metrics from year 2 to the baseline developed in year 1.	

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low birth weight births, infant mortality **Anticipated Impact:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Improve birth outcomes for patients served by facilities and organizations associated with BayCare Health System	Expecting mothers at risk of poor birth outcomes	**Year 1:** 1. Morton Plant Hospital will continue to provide current initiatives for inpatients and outpatients while evaluating the effectiveness, evidence basis, outcomes measures, population served, accessibility, etc. of current models. These models include relationships with community-based organizations that serve expecting mothers at risk of poor birth outcomes to determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to improving birth outcomes. b. There are additional partnership opportunities to meet the needs of the community relative to improving birth outcomes. c. It is possible to develop ongoing collaborative relationships related to expecting mothers in the hospital service areas. 2. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.)	**Year 1:** 1 & 2.Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 3. Document identified funding opportunities. 4. Document outcome measures for each collaborating CBO. 1-4. Report progress to the IRS.	**Year 1:** Grants, substance abuse and treatment grant for NICU navigators, staff, office supplies, educational material

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low birth weight births, infant mortality **Anticipated Impact:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Identify funding opportunities to expand services to expecting mothers at risk of poor birth outcomes. 4. Develop baseline metrics by collecting outcome measures for each collaborating CBO. **Year 2:** 1. Implement recommendations for existing programs: a. Seek identified funding. b. Begin implementation of the programs/services for which funding is secured. c. Track outcomes of new programs and services. 2. Continue to evaluate opportunities for expansion and funding for these opportunities. 3. Continue to collect outcome measures for each collaborating CBO, including expanded programs and services.	**Year 2:** 1a. Document programs for which funding is sought and the outcomes of each effort. 1b. Document the phases of implementation for each program/service for which funding is secured. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc.	**Year 2:** Funds, grants or other allocation, staff, office supplies. Educational material/collateral

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low birth weight births, infant mortality **Anticipated Impact:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 3: 1. Complete implementation and begin to evaluate the effectiveness of the newly implemented programs/services. a. Make recommendations based on evaluation. b. Identify resources needed to implement recommendations of evaluation. c. Seek funding to implement recommendations. 2. Continue to evaluate opportunities for expansion and funding for these opportunities. 3. Continue to collect outcome measures for each collaborating CBO, including expanded programs and services. 4. Re-assess community need related to birth outcomes in the service area.	and any identified funding opportunities. 3. Document outcome measures for each collaborating CBO and compare to baseline metrics from year 1. 1 -3. Report Progress to the IRS. **Year 3:** 1a. Document the results of program evaluation. 1b. Document the resources needed to implement recommendations. 1c. Document efforts to gather resources (e.g., fundraising, grant writing, etc.) 2. Document any new opportunities	**Year 3:** Funds, grants or other allocation, staff, office supplies. Educational material/collateral

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low birth weight births, infant mortality **Anticipated Impact:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating CBO and compare to baseline metrics from year 2. 1-4. Report progress to the IRS in re-assessment.	

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the availability of Faith Community Nurses to provide preventive screenings, education and health literacy services to a greater number of residents.	Residents in the hospital service area	**Year 1:** 1. Maintain the number of Faith Community Nurses operating in the area (88 Registered Nurses in 48 communities) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational sessions; CPR/AED training for staff and the congregation; Diabetes education; BP and Stroke screenings; Facilitate flu, pneumonia, and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter. 3. Increase community partnerships: a. Develop or obtain distribution list of area clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care. c. Encourage nurse referrals to be outside of communities already served.	**Year 1:** 1. Document the number of education sessions provided, the number of attendees and locations. 2. Document the number of nurses added to MPH. 3. Document the number of communities added to MPH. 1-3. Report progress to the IRS.	**Year1-3:** **Potential Partners:** Churches, Communities, etc. **Resources:** Staff – 2 FTE's (currently one FT Manager and two PT coordinators) FCN budget, Office space – Two offices and one storage room Equipment Three PC's, two laptops and one smart phone. Four commercial-grade

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		d. Track the number of referrals obtained. 4. Explore opportunities for the FCN program to be involved in reducing preventable re-admissions. a. Continue to raise awareness within MPM Healthcare as to the vital role that FCN could play in helping to reduce preventable re-admissions. b. Survey MPM FCN's to find out their willingness to participate in a follow-up of a discharged patient who is at high risk for re-admission. c. Continue to become more knowledgeable regarding the Affordable Care Act and the components that deal with the re-admission challenge. **Year 2:** 1. Based on available resources, maintain the number of Faith Community Nurses operating in the area (including those added in year 1) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational sessions; CPR/ AED training for staff and the congregation; Diabetes education; BP and Stroke	**Year 2:** 1. Document the number of education sessions provided, the number of attendees and location annually. 1-5. Report progress to	automatic BP machines (used for community events). One retractable banner, two exhibit tablecloths, one tri-fold table sign. **Additional resources needed:** FTE for Transition Care Coordinator Explore partnering with Case Management

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		screenings; Facilitate flu, pneumonia and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Continue to increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter. 3. Continue to increase community partnerships: a. Develop or obtain distribution list of area clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care. c. Encourage nurse referrals to be outside of communities already served. d. Track the number of referrals obtained. 4. Explore opportunities for the FCN program to be involved in reducing preventable re-admissions. a. Develop strategies to connect discharged patients with their faith community or a local member congregation. b. Pilot partnering with Case Management discharge phone call team for referrals. c. Utilize new BayCare database (replacing	the IRS.	discharge phone call team for referral

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		current) to facilitate gathering of patient faith community. 5. Focus on ways to further combine MPM community health outreach events and the FCN partnership program. **Year 3:** 1. Based on available resources, maintain the number of Faith Community Nurses operating in the area (including those added in year 2) providing community outreach at local events in the community and at churches as well as education (i.e., Advance Directive informational sessions; CPR/AED training for staff and the congregation; Diabetes education; BP and Stroke screenings; Facilitate flu, pneumonia and shingles vaccination clinics; Facilitate Safe Sitter Courses® for the youth in the congregations). 2. Continue to increase nurse partnerships: a. Recruit nurses through nurse referrals to increase FCN outreach at MPM hospitals, participate in community events, and widen circulation of FCN newsletter. 3. Continue to increase community partnerships: a. Develop or obtain distribution list of area	**Year 3:** 1. Document the number of education sessions provided, the number of attendees and location annually. 1-5. Re-assess and report progress to the IRS.	

NEED: Improve healthy behaviors and environments – Preventive care, health education and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities and end-of-life advanced directives **Anticipated Impact:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		clergy to send electronic version of our FCN newsletter. b. Participate in clergy events offered by MPM Pastoral Care. c. Encourage nurse referrals to be outside of communities already served. d. Track the number of referrals obtained. 4. Based on progress in year 2, continue to explore opportunities for the FCN program to be involved in reducing preventable re-admissions. 5. Continue to focus on ways to further combine MPM community health outreach events and the FCN partnership program.		

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Improve healthy behaviors and environments: Behavioral Health and Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **Anticipated Impact:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the availability of substance abuse services	Adults and pediatric residents who are abusing addictive substances and/or addicted to a substance	**Year 1:** 1. Fully develop and implement the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways a. Identify funding sources and seek funding for program. b. Secure funding. c. Hire staff (e.g., manager and coaching staff). d. Implement program. e. Track the number of patients referred to the program and the number of patients participating in the program. 2. Substance Abuse Case Management for Moms and babies addicted to prescription drugs a. Identify necessary resources (e.g., funding, staff, space, materials, etc.). b. Identify and acquire funding required for Case Management team. c. Develop case management program. d. Hire staff. e. Implement case management by connecting mothers and babies to community services and partners. **Year 2:**	**Year 1:** 1a&b. Document secured funding 1c. Document the start dates for program staff. 1d&e. Document the number of patients referred to the program and the number of patients participating in the program. 2a-b. Document resources required and resources secured. 2d. Document start dates of staff hired. 2e. Document the number of families served. 1-2. Report progress to the IRS.	**Year 1-3:** BCHS 1) $3 mill – Pathways BCHS 2) $130,000 – Mom's and babies

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Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Moms and babies addicted to prescription drugs. **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways. 2. Continue Substance Abuse Case Management for Moms and babies-addicted to prescription drugs.	**Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served. 1-2. Report progress to the IRS. **Year 3:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served. 1-2. Report progress to	

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Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			the IRS.	

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk-reduction and cancer-prevention strategies	Residents in hospital service area and congregations served by Faith Community Nurses	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that relate to awareness and prevention of cancer (i.e.,	**Year 1:** 1. Document the forms of cancer that have higher than average rates and the populations most at risk. 2. Document the gaps in risk-reduction and	**Year1-3:** Resources: $ $50,000 to $100,000 for FCN expansion Mammograms: $11.5K PSA + DRE:~

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Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		breast, cervical, prostate, and lung). a. Identify high-risk groups that are not accessing cancer screening through Faith Community Nursing and provide education to congregations about the importance of such screenings. b. Prioritize cancer screening opportunities in high risk populations for breast, prostate, and lung cancers. c. Provide advanced directive documentation. 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach. 4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources to implement recommendations and secure funding. 2. Implement changes for which funding is available on-site and in the community, including churches.	cancer-prevention activities. 3. Document the evidence basis, demographics of populations reached, location, frequency and number of attendees for hospital risk-reduction and cancer-prevention efforts. 4. Document recommendations to increase resident awareness of risk-reduction and cancer-prevention strategies and resources needed. **Year 2:**	$12.5K Low dose CT: $15K Additional $50K - $75K in statistical analysis cost as well as FCN annual expense associated with education and tracking. Partners: FCN

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Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Partner with community-based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide high-risk populations: 150 mammograms; 250 PSA + DRE; 100 Low-dose CT. b. Work with Faith Community Nursing to provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Develop a baseline measure of patients diagnosed with late-stage cancer and compare to cancer registry. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. **Year 3:**	1. Document funding secured. 2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by demographics annually. 4. Document the evidence basis, population reached, location, and number of participants for each effort. 1-4. Report progress to the IRS.	

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Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed, including Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. 4. Re-assess the prevalence of cancer in the service area.	**Year 3:** 1. Document any revisions. 2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached, location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report re-assessment results and progress to the IRS	

NEED: Improve healthy behaviors and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **Anticipated Impact:** Increase the use of risk-reduction and cancer-prevention strategies				
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APPENDIX B

Needs not Addressed by the 2013 Plan

MORTON PLANT HOSPITAL
August, 2013

Based on the most recent 990 reporting requirements, hospital leaders were asked to ascertain the needs that were identified through the assessment process that they did not feel they could meet, and then, provide a rationale for the decisions. The following is a list of those needs that were identified as not being met by the hospital during this reporting period, including a rationale for those decisions.

Poverty:
While hospital leaders are interested in this issue and intend to re-evaluate the need, there are organizations offering services that address environmental stressors for residents in the service area. Improving the poverty in the service area is not directly related to the mission of Morton Plant Hospital. However, the hospital does address socio-economic issues through financial assistance and community benefits as it relates directly to healthcare and medical services of residents that are under/unfunded.