Mease Dunedin Hospital

Implementation Plan – Report

September, 2013

TrippUmbach
Research • Strategy • Impact

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Introduction

Mease Dunedin Hospital is a 143-bed facility, located in Dunedin, 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, Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin Hospital community. As a non-profit hospital, Mease Dunedin 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 Mease Dunedin Hospital community is defined as six zip code areas in Pinellas County, Florida. (See Figure 1 & Table 1). However, the needs identified in the CHNA report pertain to eight zip code areas in Pinellas County, Florida that were considered the primary service area for Mease Dunedin Hospital in 2012 when the initial CHNA was conducted. The primary service area for Mease Dunedin Hospital changed at the conclusion of FY12 as a result of a BayCare Health System decision to move an active neurosurgery program from Mease Dunedin Hospital to a nearby BayCare Health System Hospital. As a result, 75% of inpatient discharges in 2012 originated from the following six zip codes.

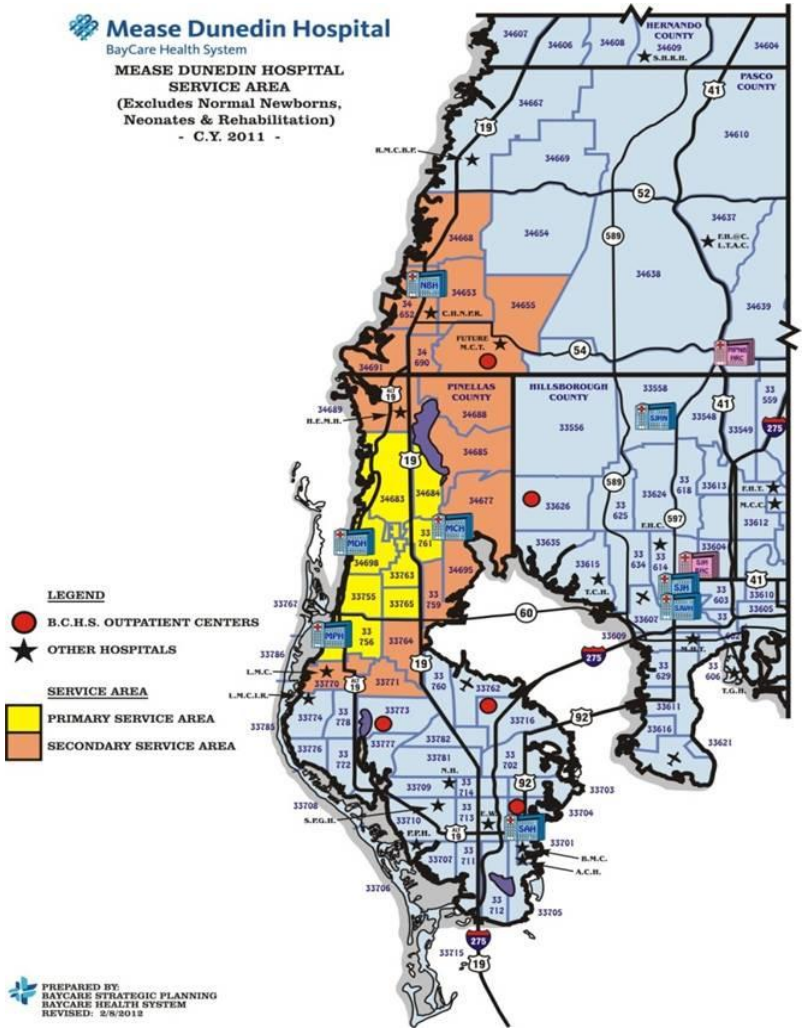
Mease Dunedin Hospital Community

Table 1

Zip	Town	County
33755	Clearwater	Pinellas
33756	Clearwater	Pinellas
33763	Clearwater	Pinellas
33765	Clearwater	Pinellas
34683	Palm Harbor	Pinellas
34698	Dunedin	Pinellas

Mease Dunedin Hospital Community Map

Figure 1



Methodology

Tripp Umbach facilitated and managed an implementation planning process on behalf of Mease Dunedin 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 behavior 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 Mease Dunedin Hospital and collaborating areas of BayCare Health System.

- **Community Health Needs Assessment Review:** Tripp Umbach worked with the Mease Dunedin 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 1st, 2013 with hospital leadership from Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin 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), CDC 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 Mease Dunedin 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 21st, 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 Mease Dunedin 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 1st, 2013 with Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin 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 behavior 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 group, which resulted in the prioritization of key community health needs that hospital leaders felt related to the Mease Dunedin 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 Mease Dunedin 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 and a less fragmented health system, particularly for the more at-risk and underserved populations that often do not get their medical needs met (i.e., specialty care, dental, medical, and mental health care) due to issues with affordability, access, and time. 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, and the prevalence of socio-economic barriers (i.e., lack of support from employers, limited transportation, etc.)

While Mease Dunedin 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 Mease Dunedin 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 its Medical Home Model, which includes care coordination.*
- ✓ *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 mental health 101 training, provides training related to sensitivity and awareness of patients with mental illness during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at Mease Countryside 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 area 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.*

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 Mease Dunedin 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 local governments and other organizations in the exploration of the feasibility and sustainability of establishing clinics for uninsured (including FQHC).*

- ✓ *Increase access to affordable health insurance and healthcare services in the service area by enhancing care coordination with clinics for uninsured/under insured residents.*
- ✓ *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: Improving access to affordable healthcare
UNDERLYING FACTORS: Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination.
Anticipated Impact: To increase access to affordable health insurance and healthcare services

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Enhance care coordination for uninsured/under insured residents	Under/uninsured patients served by the hospital	**Year 1:** 1. Explore the development of a resource to assist members of the Mease Countryside Hospital community with information about health insurance coverage. a. Explore options to secure a federal grant-funded patient navigator position tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange. b. Develop procedure for navigator referrals from existing Financial Assistance team members. c. Conduct internal and community education and outreach activities to raise awareness about affordable health	**Year 1:** 1a. Document if a patient navigator is assigned to MDH and the start date 1b -h. Document the number of residents assisted with enrollment, provided information about insurance, etc. 2a-d. Document the collaborating partners, timeline and the results and recommendations of	**Year1-3:** **Potential Partners:** Government entities, local clinics, etc. **Resources:** Staff time

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		insurance options. d. Based on available resources, begin enrolling residents for open enrollment in 2013. e. Enroll eligible uninsured patients in presumptive Medicaid. f. Analyze ER hours currently uncovered by the Financial Assistance team for ROI from presumptive Medicaid. g. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. h. Evaluate effectiveness. 2. Collaborate with local governments and other organizations in the exploration of the feasibility and sustainability in establishing clinics for uninsured (including FQHC). 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	evaluations. 3-4. Document partnering clinics and base line data collected. 1-4. Report progress to the IRS.	

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 3. Enhance the relationship with local clinics a. Develop and finalize referral form and process with clinic and case management department. b. Mease Countryside Hospital will provide a dedicated cell phone for patient referrals. c. Mease Countryside Hospital will ensure transportation to local clinics. d. Determine the availability and cost of transportation. e. Create algorithm for patients with high volume of ED visits to establish with local clinics. f. Develop tracking tool. g. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic).		

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		4. Enhance the relationship with clinics in Pasco County that provide health services to under/uninsured residents. a. Hold meetings with relevant parties and define parameters of the partnership. b. Clarify the scope of services provided. c. Develop and finalize referral process with clinic and case management department. d. Develop tracking tool for referrals & patient follow-up. a. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic). **Year 2:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. Based on available resources and the results of evaluations completed in year 1, further explore	**Year 2:** 1a-b. Document the number of patients assisted. 2a-b. Document the timeline and plan for implementation in year 2-3	

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 3. Continue to enhance patient coordination with local clinics and explore enhancing the relationship with other local free clinics . a. Hold meeting with relevant parties and define parameters of the partnership. b. Clarify the scope of services provided. c. Develop and finalize referral process with clinic and case management department. d. Develop tracking tool for referrals & patient follow-up. e. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic). 4. Continue to enhance the relationship with clinics in Pasco County that provide health services to under/uninsured residents.	3 a-d. Document partnering clinics. 3e-4. Document base line data. 1-3.Report progress to the IRS.	

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Track and compare to baseline data (# of patients referred compared to # of patients who establish services with the clinic). **Year 3:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. 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. 3. Continue to enhance patient coordination with local free clinics in Pinellas and Pasco Counties. a. Track and compare to baseline data (# of patients referred compared to # of patients who establish services with the clinic).	**Year 3:** 1a-b. Document the number of patents assisted. 2. Document the number of residents that receive community resource information. 3. Document base line data. 1-4. Reassess need and Report progress to the IRS.	

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		4. Reassess need in the community.		

NEED: Improving 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. 2. Expand services to the northern part of Pinellas County by moving inpatient beds to Mease Dunedin Hospital – expanding services: a. Identify resources needed (funding, space, staff, materials, etc.) b. Identify and build out space for program.	**Year 1:** 1a. Document the conversion process and dates. 1b. Document number of program participants and outcomes. 2a. Document the resources needed. 2b-e. Document location, hire dates of staff, and launch date. 1-2. Report progress to	**Year 1-3:** 2. Conversion of pediatric acute services grant to preservation program $400,000

		c. Establish the program on location. d. Hire staff. e. Launch operation. **Year 2:** 1. Family and Patient Preservation Program- working at home with families at-risk a. Implement program and track measure outcomes. 2. Continue to offer services in the northern part of Pinellas County a. Track the utilization of Mease Dunedin Hospital services: **Year 3:** 1. Family and Patient Preservation Program- working at home with families at-risk a. Implement program and track measure outcomes. 2. Continue to offer services in the northern part of Pinellas County b. Track the utilization of Mease Dunedin Hospital services:	the IRS **Year 2:** 1a. Document number of program participants and outcomes. 2a. Document utilization statistics 1-2. Report progress to the IRS **Year 3:** 1a. Document number of program participants and outcomes. 2a. Document utilization statistics. 1-2. Report progress to the IRS	

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.

The zip codes with the highest levels of clinical health issues 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 (both 4.4) in the Mease Dunedin 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. Both zip codes show above average rates for urinary tract infection, COPD, congestive heart failure, adult asthma, diabetes long-term complications, ER visits due to diabetes, ER visits due to pediatric asthma, and alcohol consumption.

There are several indicators in which Pinellas County and the Mease Dunedin 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 set by Healthy People 2020. 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 Mease Dunedin 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 Mease Dunedin 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 Mease Dunedin Hospital campus remains "tobacco free" and maintain the incentives offered employees for not smoking.*
- ✓ *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 a patient educator that provides bedside patient education.*
- ✓ *Continue to ensure nurses are certified to provide diabetes education to inpatients at the hospital.*
- ✓ *Continue to partner with local clubs in addressing pre-diabetic and diabetic residents.*
- ✓ *Continue to collaborate with EMS and provide outreach and education related to a variety of topics (e.g., Pediatrics, stroke, etc.)*

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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice for CHF patients by:*
    1. *Maintaining current CHF outpatient clinic services at MPH and evaluate expansion of the model to decrease hospital readmissions in the MDH 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.*
- ✓ *Reduce the rate of suicide-related death among residents served by BayCare Health System by increasing the awareness of and prevalence of suicide prevention.*

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 readmission 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 readmissions in the MDH service area.	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 with other departments in the BayCare Health System. 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.,	**Year 1:** 2. Document recommendations 3. Document plan 4. Document resources needed 5-6. Document partnership and collaborative opportunities 7. Document funding secured 1-8. Report progress to the IRS **Year 2:** 1. Document outcomes and compare to year 1 2. Document the stages of implementation 3. Document findings	**Year1-3:** **Resources:** Staff time **Potential 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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. Reassess the prevalence of CHF in the service area.	related to co-morbidity 4. Document the communication plan 5. Document outcomes and compare from clinic to clinic. 1-6. Report progress to the IRS. **Year 3:** 1. Document outcomes 2. Document any changes in outcome measures. 3. Document program recommendations 1-3. Report reassessment 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 readmission 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 procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other community based organizations. 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 readmission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six month intervals	**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 secured 1-7. Report progress to the IRS. **Year 2:**	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health, 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 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. Reassess the preventable hospitalizations for CHF in the service area.	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. **Year 3:** 1. Document number of participants 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report reassessment 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).	**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	**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**
		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 education and community message: a. 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, word-of-mouth). b. Define what information to communicate and the goals for each topic (i.e., signs and symptoms of stroke). c. 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.	populations, communication outlets and locations) and resources needed to implement strategy. 1-2. Report 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**
		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. 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. Reassess the health outcomes related to stroke in	**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 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 reassessment results	

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**
		the service area.	and 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	**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	**Year1-3:** $30,000 BCBH

		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. 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	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 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	

		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 one to those gathered in year two.	of participants) 3. Compare prevention metrics from year two to the baseline developed in year one.	

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**

Key stakeholders and focus group participants believed that the outcomes of behaviors that negatively impact health include a lack of awareness, limited understanding and utilization of services, poorer outcomes for residents, including those requiring behavioral health services, undetected/untreated illnesses, children that develop poor nutritional habits, concentration of chronic conditions in lower-income communities, perpetuated substance abuse, and higher preventable mortality rates.

While Mease Dunedin 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 Mease Dunedin 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, local clubs, 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*

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

NEED: Improving 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,	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	**Year 1:** 1. Document the number of education sessions provided, the number of attendees and locations. 2. Document the number of nurses	**Year1-3:** **Potential Partners:** Churches, Communities, etc. **Resources:** Staff – 2 FTE's

NEED: Improving 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**
education and health literacy services to a greater number of residents.		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. 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	added to MDH. 3. Document the number of communities added to MDH. 1-3. Report progress to the IRS.	(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 automatic BP machines (used for community events). One retractable banner, two

NEED: Improving 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**
		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 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 2:** 1. Document the number of education sessions provided, the number of attendees and location annually. 1-5. Report progress to the IRS.	exhibit tablecloths, one tri-fold table sign. **Additional resources needed:** FTE for Transition Care Coordinator Explore partnering with Case Management discharge phone call team for referral

NEED: Improving 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. 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 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	**Year 3:**	

NEED: Improving 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**
		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 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. Based on progress in year 2, continue to explore	1. Document the number of education sessions provided, the number of attendees and location annually. 1-5. Reassess and report progress to the IRS.	

NEED: Improving 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**
		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: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **GOAL:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing 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. **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 **Year 3:** 1. Complete the full implementation of the Coaching	**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 1. Report progress to the IRS **Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes 1. Report progress to the	**Year 1-3:** BCHS 1) $3 mill – Pathways BCHS

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **GOAL:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways 2. Reassess the community health needs in the service area.	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 1-2. Report reassessment results and progress to the IRS	

APPENDIX A

Implementation Strategy

MEASE DUNEDIN HOSPITAL
August, 2013

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Enhance care coordination for uninsured/under insured residents	Under/uninsured patients served by the hospital	**Year 1:** 1. Explore the development of a resource to assist members of the Mease Countryside Hospital community with information about health insurance coverage. a. Explore options to secure a federal grant-funded patient navigator position tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange. b. Develop procedure for navigator referrals from existing Financial Assistance team members. c. Conduct internal and community education and outreach activities to raise awareness about affordable health insurance options. d. Based on available resources, begin enrolling residents for open enrollment in 2013. e. Enroll eligible uninsured patients in presumptive Medicaid. f. Analyze ER hours currently uncovered by the Financial Assistance team for ROI	**Year 1:** 1a. Document if a patient navigator is assigned to MDH and the start date 1b -h. Document the number of residents assisted with enrollment, provided information about insurance, etc. 2a-d. Document the collaborating partners, timeline and the results and recommendations of evaluations. 3-4. Document partnering clinics and base line data collected. 1-4. Report progress to the IRS.	**Year1-3:** **Potential Partners:** Government entities, local clinics, etc. **Resources:** Staff time

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		from presumptive Medicaid. g. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. h. Evaluate effectiveness. 2. Collaborate with local governments and other organizations in the exploration of the feasibility and sustainability in establishing clinics for uninsured (including FQHC). 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 (e.g., Pinellas County Government HHS.)		

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Enhance the relationship with local clinics. a. Develop and finalize referral form and process with clinic and case management department. b. Mease Countryside Hospital will provide a dedicated cell phone for patient referrals. c. Mease Countryside Hospital will ensure transportation to local clinics. d. Determine the availability and cost of transportation. e. Create algorithm for patients with high volume of ED visits to establish with local clinics. f. Develop tracking tool. g. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic). 4. Enhance the relationship with clinics in Pasco County that provide health services to under/uninsured residents. a. Hold meetings with relevant parties and define parameters of the partnership. b. Clarify the scope of services provided. c. Develop and finalize referral process with		

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination.
Anticipated Impact: To increase access to affordable health insurance and healthcare services

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		clinic and case management department. d. Develop tracking tool for referrals & patient follow-up. a. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic). **Year 2:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. 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.	**Year 2:** 1a-b. Document the number of patients assisted. 2a-b. Document the timeline and plan for implementation in year 2-3 3 a-d. Document partnering clinics. 3e-4. Document base line data. 1-3.Report progress to the IRS.	

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination.
Anticipated Impact: To increase access to affordable health insurance and healthcare services

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		b. Implement plan 3. Continue to enhance patient coordination with local clinics and explore enhancing the relationship with other local free clinics. a. Hold meeting with relevant parties and define parameters of the partnership. b. Clarify the scope of services provided. c. Develop and finalize referral process with clinic and case management department. d. Develop tracking tool for referrals & patient follow-up. e. Obtain baseline data (# of patients referred compared to # of patients who establish services with the clinic). 4. Continue to enhance the relationship with clinics in Pasco County that provide health services to under/uninsured residents. b. Track and compare to baseline data (# of patients referred compared to # of patients who establish services with the clinic). **Year 3:** 1. Based on available resources, continue enrolling residents for health exchange.		

NEED: Improving access to affordable healthcare **UNDERLYING FACTORS:** Access related to insurance coverage/financial assistance, resident awareness about what resources exist in the community, need for care coordination. **Anticipated Impact:** To increase access to affordable health insurance and healthcare services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. 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. 3. Continue to enhance patient coordination with local free clinics in Pinellas and Pasco Counties. a. Track and compare to baseline data (# of patients referred compared to # of patients who establish services with the clinic). 4. Reassess need in the community.	**Year 3:** 1a-b. Document the number of patents assisted. 2. Document the number of residents that receive community resource information. 3. Document base line data. 1-4. Reassess need and Report progress to the IRS.	

NEED: Improving 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**

NEED: Improving 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. 2. Expand services to the northern part of Pinellas County by moving inpatient beds to Mease Dunedin Hospital – expanding services: a. Identify resources needed (funding, space, staff, materials, etc.) b. Identify and build out space for program. c. Establish the program on location. d. Hire staff. e. Launch operation. **Year 2:** 1. Family and Patient Preservation Program- working at home with families at-risk a. Implement program and track measure outcomes. 2. Continue to offer services in the northern part of Pinellas County a. Track the utilization of Mease Dunedin	**Year 1:** 1a. Document the conversion process and dates. 1b. Document number of program participants and outcomes. 2a. Document the resources needed. 2b-e. Document location, hire dates of staff, and launch date. 1-2. Report progress to the IRS **Year 2:** 1a. Document number of program participants and outcomes. 2a. Document utilization statistics 1-2. Report progress to	**Year 1-3:** 2. Conversion of pediatric acute services grant to preservation program $400,000

NEED: Improving 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**
		Hospital services: **Year 3:** 1. Family and Patient Preservation Program- working at home with families at-risk a. Implement program and track measure outcomes. 2. Continue to offer services in the northern part of Pinellas County b. Track the utilization of Mease Dunedin Hospital services:	the IRS **Year 3:** 1a. Document number of program participants and outcomes. 2a. Document utilization statistics. 1-2. Report progress to 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

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 readmission 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 readmissions in the MDH service area.	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 with other departments in the BayCare Health System. 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	**Year 1:** 2. Document recommendations 3. Document plan 4. Document resources needed 5-6. Document partnership and collaborative opportunities 7. Document funding secured 1-8. 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	**Year1-3:** **Resources:** Staff time **Potential 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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. Reassess the prevalence of CHF in the service area.	communication plan 5. Document outcomes and compare from clinic to clinic. 1-6. Report progress to the IRS. **Year 3:** 1. Document outcomes 2. Document any changes in outcome measures. 3. Document program recommendations 1-3. Report reassessment 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

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 readmission 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 procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other community based organizations. 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 readmission among patients whose care	**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 secured 1-7. Report progress to the IRS.	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health, 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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 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	**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. **Year 3:** 1. Document number of participants 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report reassessment	

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 readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		evaluation. 4. Reassess the preventable hospitalizations for CHF in the service area.	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	**Year 1:** 1 a-c. Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to	**Year1-3:** **Resources:** Staff time, $30K **Partners:** Municipal health plans, community-

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**
		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 education and community message: a. 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, word-of-mouth). b. Define what information to communicate and the goals for each topic (i.e., signs and symptoms of stroke). c. Identify the most appropriate outlet to provide information to the populations that are at greatest risk of stroke. d. Develop communications strategy: identify	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.	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**
		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. 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.,	**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 reached with messaging. 1-2. Report progress to the IRS **Year 3:** 1. Document organizations and collaborations formed.	

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**
		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. Reassess the health outcomes related to stroke in the service area.	2. Document the results and recommendations of evaluation. 1-3. Report reassessment results and 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	**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	**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**
		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. 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:**	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 metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS **Year 3:**	

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**
		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 one to those gathered in year two.	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 two to the baseline developed in year one.	

NEED: Improving 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: Improving 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 MDH. 3. Document the number of communities added to MDH. 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: Improving 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: Improving 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: Improving 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 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 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. Reassess and report progress to the IRS.	

NEED: Improving 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: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **GOAL:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **GOAL:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing 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. **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 **Year 3:** 1. Complete the full implementation of the Coaching	**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 1. Report progress to the IRS **Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes 1. Report progress to the	**Year 1-3:** BCHS 1) $3 mill – Pathways BCHS

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **GOAL:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways 2. Reassess the community health needs in the service area.	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 1-2. Report reassessment results and progress to the IRS	

APPENDIX B

Needs not Addressed by the 2013 Plan

MEASE DUNEDIN 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.

Dental Care:

While hospital leaders are interested in this issue, and are interested in further evaluating the barriers that uninsured residents experience when seeking oral health services, the Mease Dunedin Hospital does not currently have the expertise, resources, and/or provider base to provide this service. Because the primary needs within the community have dictated that financial and human resources of Mease Dunedin Hospital are utilized for diagnostic and therapeutic medical and surgical care, hospital leaders have determined that oral health services could be better met by existing providers, allowing available resources to remain focused on the existing and planned health services. However, the need as identified has increased awareness and may be further evaluated as resources are made available.

Substance abuse and detoxification (alcohol, prescription medicine, and illegal drugs (i.e., heroin):

While hospital leaders are interested in this issue and intend to re-evaluate the need, there are organizations already offering substance abuse services in the community. Mease Dunedin Hospital intends to make the results of this study publicly available to providers. Other than medical stabilization of patients presenting to the emergency department with substance abuse and detoxification issues, Mease Dunedin Hospital does not currently offer substance abuse and detoxification services on-site. Mease Dunedin Hospital is interested in continuing to evaluate the need for substance abuse services in the community and will continue to consider the most sustainable methods that it may offer to address the need for substance abuse services.