Morton Plant North Bay Hospital and MPNB Recovery Center

Implementation Plan – Report

September, 2013

TrippUmbach
Research • Strategy • Impact

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Introduction

Morton Plant North Bay Hospital and Morton Plant North Bay (MPNB) Recovery Center are comprised of two facilities: Morton Plant North Bay Hospital, located in New Port Richey, FL and Morton Plant North Bay Hospital Recovery Center, located in Lutz, FL. The Morton Plant North Bay Hospital and MPNB Recovery Center are part of the network of 10 not-for-profit hospitals throughout the Tampa Bay area. In response to their community commitment, Morton Plant North Bay Hospital and MPNB Recovery Center contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2012 and June 2013 (See the Morton Plant North Bay Hospital and MPNB Recovery Center Community Health Needs Assessment for the full report).

This report is the follow-up implementation plan that fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA), requiring that non-profit hospitals develop implementation strategies to address the needs identified in the community health needs assessment completed in three-year intervals. The community health needs assessment and implementation planning process undertaken by Morton Plant North Bay Hospital and MPNB Recovery Center, 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 both Morton Plant North Bay Hospital and MPNB Recovery Center 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 both the Morton Plant North Bay Hospital and MPNB Recovery Center communities. As non-profit facilities, Morton Plant North Bay Hospital and MPNB Recovery Center intends to provide care to residents regardless of their insurance status as required by the state of Florida.

Community Definition

While community can be defined in many ways, for the purposes of this report, the Morton Plant North Bay Hospital and MPNB Recovery Center communities are defined first as a five zip code area in Pasco County in Florida (See Table 1 & Figure 1):

> **Morton Plant North Bay Hospital:** is a 154-bed acute care hospital, which serves as West Pasco County's only not-for-profit community hospital. The geographical community definition includes five populated zip code areas in Pasco County (See Table 1 & Figure 1).

The community served by the Morton Plant North Bay Recovery Center is defined as a population-specific community of residents of Hillsborough and Pasco Counties with behavioral health needs: (See Figure 2):

> **Morton Plant North Bay Recovery Center:** is a 72-bed, co-ed facility, which is the only freestanding psychiatric hospital in Pasco County and is a Baker Act-receiving facility. While the geographical community definition includes Hillsborough and Pasco Counties, this study will focus on the population-specific community definition of the Recovery Center.

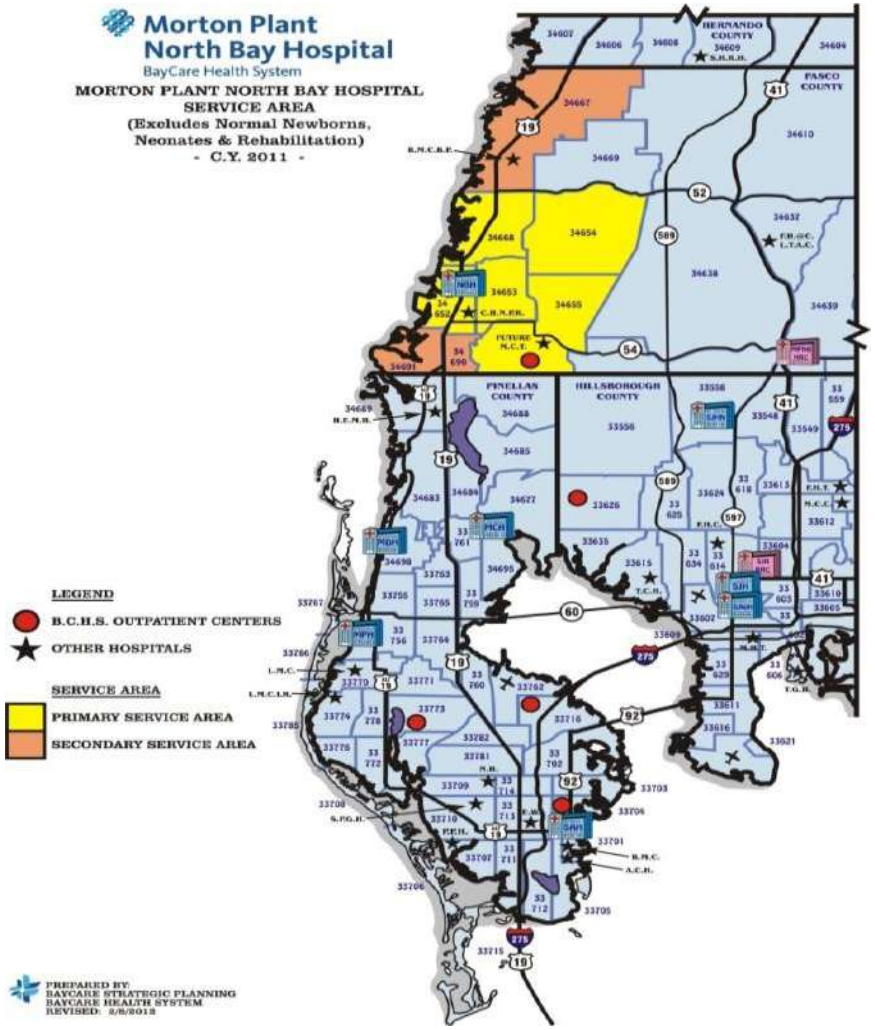
Morton Plant North Bay Hospital and MPNB Recovery Center Community

Table 1

Zip	Town	County
34652	New Port Richey	Pasco
34653	New Port Richey	Pasco
34654	New Port Richey	Pasco
34655	New Port Richey	Pasco
34668	Port Richey	Pasco

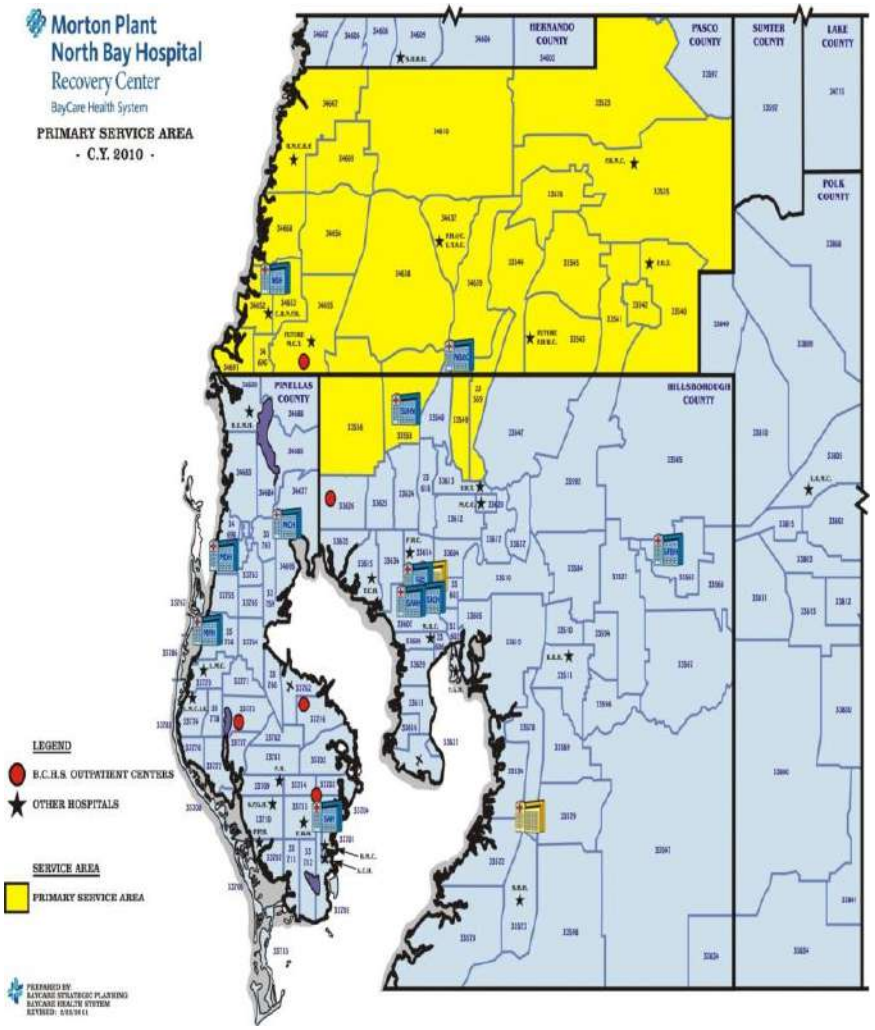
Community Map for the Morton Plant North Bay Hospital

Figure 1



Community Map for the Morton Plant North Bay Recovery Center

Figure 2



Methodology

Tripp Umbach facilitated and managed an implementation planning process on behalf of Morton Plant North Bay Hospital and MPNB Recovery Center 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, and 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 Morton Plant North Bay Hospital and MPNB Recovery Center and collaborating areas of BayCare Health System.

- **Community Health Needs Assessment Review:** Tripp Umbach worked with the Morton Plant North Bay Hospital and MPNB Recovery Center to present a review of the Community Health Needs Assessment findings to hospital leaders in a meeting held on May 15, 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 June 27, 2013 with hospital leadership from Morton Plant North Bay Hospital and MPNB Recovery Center. Attendees were asked to review the community health needs assessment, community resource inventory, and identify the significant health needs found in the CHNA results. Attendees then participated in a discussion to determine which of the previously identified significant needs could be and which could not be addressed by Morton Plant North Bay Hospital and MPNB Recovery Center. Once needs were selected, hospital leadership were asked to provide rationale for the needs that the hospital could not meet.

- **Inventory of Internal Hospital Resources:** An online survey was developed based on the underlying factors identified as driving the significant health needs in the Morton Plant North Bay Hospital and MPNB Recovery Center Community Health Needs Assessment.

The survey was reviewed and administered by BayCare Health System leadership to key staff of the hospital which completed the survey. The internal survey identified what programs and services are offered at Morton Plant North Bay Hospital and MPNB Recovery Center that meet significant community health needs.

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

- **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 27, 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 their respective communities. 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 and the recovery center will use to address the needs identified by the Morton Plant North Bay Hospital and MPNB Recovery Center 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 June 27, 2013 with Morton Plant North Bay Hospital and MPNB Recovery Center leadership with the purpose of identifying and prioritizing significant community health needs for hospital implementation planning.

Tripp Umbach presented the results of the CHNA and used these findings to engage the hospital leaders in a group discussion related to the needs that Morton Plant North Bay Hospital and MPNB Recovery Center would address in implementation planning. The hospital leaders were asked to share their vision for their community, discuss a plan for health improvement in their community, and select the needs that they felt their hospital could address and assist the community in resolving, and those that they felt the hospital and/or recovery center would not be well positioned to resolve collectively (See appendix B).

Hospital leaders believe the following health needs are those to which Morton Plant North Bay Hospital and MPNB Recovery Center are best positioned to dedicate resources to address within their community.

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

Tripp Umbach completed an independent review of existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and detailed input provided by the focus groups, which resulted in the prioritization of key community health needs that hospital leaders felt related to both the Morton Plant North Bay Hospital and MPNB Recovery Center population. Hospital 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 and environments. A summary of these top needs in the Morton Plant North Bay Hospital and MPNB Recovery Center communities and the implementation strategy developed to address those needs follows.

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

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

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

According to key stakeholders, there is a need for increased coordination of care for residents due to a fragmented system in which under/uninsured residents do not have access to a consistent provider for medical, specialty care, dental, and mental health care. Key stakeholders and focus group participants agree that while there are medical resources and healthcare facilities in the community, access to healthcare resources can be limited by health insurance issues and the cost of healthcare for under/uninsured, the availability of providers, communication among providers and consumers, the level of integration of mental health services in medical health settings, and the prevalence of socio-economic barriers (i.e., limited transportation, etc.)

Key stakeholders and focus group participants indicated that residents with mental illness may not always be getting their needs met due to the mental health resources that are available being overwhelmed by the demand. Key stakeholders and focus groups felt that a low number of mental health and substance abuse providers are sparsely located in the region. Funding for mental health services is consistently low, which often restricts the number of providers entering an industry, decreases program stability, leads to an ever-changing provider landscape, and maintains higher provider-to-population ratios. Stakeholders indicated that there is a lack of services for indigent populations. As a result, residents are not always able to secure substance abuse services due to homelessness and/or the inability to pay. Key stakeholders also felt that after a child turns 18, they become ineligible for many mental health services and do not become eligible again for services until they are in a crisis. Finally, there is a need for more effective integration between medical and behavioral health settings. Residents are becoming addicted to pain medications when they have chronic pain, and are not being

monitored and/or weaned properly. These residents may not receive treatment for their addiction until they come to the attention of the mental health and substance abuse providers in the community.

While Morton Plant North Bay Hospital and MPNB Recovery Center, two facilities in the BayCare Health System, both provide access to affordable healthcare in numerous ways, the need to improve access was identified through the most recent community health needs assessment. Recognizing that Morton Plant North Bay Hospital and MPNB Recovery Center are not the only medical resources in their communities, hospital leadership felt that the most effective strategy to further increase access to affordable healthcare is through a mixed strategy of:

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

- ✓ *Maintain the availability of all services to under/uninsured residents by continuing to provide care to residents regardless of their insurance status as required by the state of Florida.*
- ✓ *Continue to administer a financial assistance program on-site that provides uninsured residents assistance in identifying and applying for medical benefits for which they may qualify.*
- ✓ *BayCare Health System will continue to implement the Medical Home Model through BayCare Medical Group, which includes care coordination provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue to offer behavioral health services through BayCare Behavioral Health Department and MPNB Recovery Center.*
- ✓ *Continue to provide MH 101 training during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at Morton Plant North Bay Hospital and MPNB Recovery Center.*
- ✓ *Continue to provide co-located Behavioral Health Services as an available service of primary care physician practices in many communities.*
- ✓ *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.*

- ✓ *Continue targeting patient-coordinated care to address Medicaid eligibility, follow-up care, and primary care connections for residents with primary care providers in the community.*
- ✓ *Continue to provide a palliative care team, in partnership with local hospices, to patients that need referrals for palliative care services.*
- ✓ *Continue, to the extent that it is possible, the agreements with urology and orthopedic doctors to provide care to uninsured patients at the Medicare rate.*

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.

- ✓ *Reduce the use of Emergency Departments for non-emergent and/or primary care purposes by increasing the appropriate use of available healthcare resources, use of affordable primary care clinics and FQHC.*
- ✓ *Continuing to provide mental health services while 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 and the recovery center with the health needs of the community:

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Increase the appropriate use of available healthcare resources by increasing the use of affordable primary care clinics and FQHC (i.e. Premier, Good Samaritan and Health Department)	Residents in the Morton Plant North Bay Hospital service area	**Year 1:** 1. Explore partnerships with non-BCHS primary care sites in Pasco County to facilitate referrals between these sites and MPNBH. To explore relationship building MPNBH may employ any of the following: a. Identify potential sites and set goals for enlisting a set number of PCPs and review the number of PCPs enlisted quarterly. b. Develop procedures for patient referral and follow-up. c. Develop methods to track the number of patients that are referred to a site and the number of completed visits. d. Evaluate efficacy of referral process (e.g., consumer feedback, PCP feedback, outcome measures, etc.)	**Year 1:** 1a. Document the list of site selected. 1b-c. Document procedures and tracking methods. 1d. Document results of evaluation. 2. Document metrics being used. 1-2. Report progress to the IRS.	**Year1:** Existing staff (Administration, ED and Case Management) to allot time to develop plan/partnership. **Year 2-3:** TBD **Potential Partners:** Government entities, local clinics, etc.

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		2. Establish metrics to monitor coordination of care between MPNBH and primary care sites in Pasco County. **Year 2:** 1. Monitor the coordination of patient care between MPNBH and the partnering primary care locations. 2. Identify any new primary care sites that could be included in the Care Coordination Model and solicit their participation. 3. Evaluate the effectiveness of the Care Coordination Model implemented in year 1 and develop recommendations for improvement. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in year 1. **Year 3:**	**Year 2:** 1. Document annually the outcome of ongoing monitoring. 2. Document any new partnering sites. 3. Document the results of an evaluation and recommendations. 4. Document goals set. 1-4. Report progress to the IRS. **Year 3:** 2. Document annually the outcome of ongoing	

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		1. Implement improvements to care coordination program that were identified in year 2. 2. Monitor the coordination of patient care between MPNBH and the partnering primary care locations. 3. Identify any new primary care sites that could be included in the Care Coordination Model and solicit their participation. 4. Evaluate the effectiveness of the Care Coordination Model implemented in year 2 and develop recommendations for improvement. 5. Establish quantitative goals for improvement from Care Coordination metrics developed in Year 2. 6. Reassess community need for care coordination.	monitoring. 3. Document any new partnering sites. 4. Document the results of an evaluation and recommendations. 5. Document goals set. 1-6. Report reassessment and 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 **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
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. Increase service capacity for children with mental health needs through expansion of SIPP beds by 4 to give access to Intermediate Care Programming in Pasco County. a. Identify resources needed (funding, staff, materials, etc.) b. Apply for state funding c. Establish the program d. Launch operation e. Track number of children served 2. Family and Patient Preservation Program- working at home with families at risk. a. Convert pediatric acute care funding to outpatient preservation program. b. Implement program and track measure outcomes. **Year 2:** 1. Continue to offer services for children with mental health needs through expanding SIPP beds by 4 to give access to Intermediate Care Programming in	**Year 1:** 1 a&b. Document the resources needed and secured funding. 1c-d. Document locations, hire dates of staff, and launch date. 1e. Document the increase in capacity and number of children served. 2a. Document the conversion process and dates. 2b. Document number of program participants and outcomes. 1-2. Report progress to the IRS. **Year 2:** 1a. Document the number of children served.	**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 **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Pasco County. a. Continue to track number of children served 2. Family and Patient Preservation Program- working at home with families at risk a. Implement program and track measure outcomes. **Year 3:** 1. Continue to offer services for children with mental health needs through expanding SIPP beds by 4 to give access to Intermediate Care Programming in Pasco County. a. Continue to track number of children served 2. Family and Patient Preservation Program- working at home with families at risk. a. Implement program and track measure outcomes.	2a. Document number of program participants and outcomes. 1-2. Report progress to the IRS. **Year 3:** 1a. Document the number of children served. 2a. Document number of program participants and outcomes. 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.

There are several clinical indicators (i.e., COPD, asthma, diabetes, low birth weight, and urinary tract infection) that show higher than average rates in four or more of the five zip code areas. While there are clinical health issues throughout the service area that are above average for the Tampa Bay region, the rates are not often higher than the national benchmarks (with the exception of low birth weight births). This assessment shows a stratification of the frequency and severity of clinical health indicators across zip code areas that appear to be reflective of the socio-economic indicators of the area. The zip codes with the highest levels of clinical health issues are: 34653, 34652, and 34668. The three zip code areas are represented in the secondary data as having substantially higher than average rates across the majority of clinical health indicators. They display the most severe clinical health rates that are often substantially higher than the Tampa Bay region. However, often the rates of clinical health issues in these zip code areas are not greater than the most recently reported national rates (where comparable). These zip code areas appear to consume a large percentage of healthcare resources based on the volume of clinical issues and level of severity.

There are several indicators in Pasco County and the communities served by the Morton Plant North Bay Hospital and MPNB Recovery Center that are presented in county-level and zip code-level data gathered from Healthy Tampa Bay that have not yet or have only slightly surpassed the national benchmarks. However, there has been a substantial increase in these indicators that, if left unchecked, could become community health needs (i.e., death rate due to strokes, suicide, substance abuse including alcohol consumption and non-medical use of prescription pain relievers, tobacco use, prostate cancer, infant mortality among white infants, etc.)

While Morton Plant North Bay Hospital and MPNB Recovery Center, two facilities in the BayCare Health System, both provide programs and services which target clinical health issues, the need to decrease the prevalence of clinical health issues was identified through the most recent community health needs assessment. Recognizing that Morton Plant North Bay Hospital and MPNB Recovery Center are not the only medical resources in the hospitals' service areas, hospital leadership felt that the most effective strategy to further decrease the prevalence of clinical health issues is through a mixed strategy of:

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

- ✓ *Continue to ensure the Morton Plant North Bay Hospital and MPNB Recovery Center campuses remain "tobacco free".*
- ✓ *BayCare Health System will continue to disseminate health-related information throughout the service area.*
- ✓ *BayCare Health Systems will continue to promote fit-friendly organizations through partnership with national associations, educational programming, and 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 offer outreach and education to seniors through the Share Program, which focuses on topics like pulmonary health.*
- ✓ *Continue to provide respiratory therapists or nurse navigators to follow up with patients post discharge with COPD in order to ensure they are compliant and reduce the number of patients returning to the hospital.*

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 hospitals.

- ✓ *Increase the resources available to residents with pulmonary health issues by evaluating the feasibility of creating a "Lung Center" in Pasco County.*
- ✓ *Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis by increasing the risk reduction and cancer prevention strategies offered by Primary Care Physicians.*
- ✓ *Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women by implementing cervical cancer education focusing on Pap smear compliance and following HPV vaccine schedules.*
- ✓ *Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis by implementing a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.*
- ✓ *Reduce the rate of suicide-related 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 and the recovery center with the health needs of the community:

NEED: Decreasing the prevalence of clinical health issues - Pulmonary Health (i.e., Asthma, COPD and Smoking)
UNDERLYING FACTORS: Higher rates of Asthma, COPD and Smoking among residents in the services area
ANTICIPATED IMPACT: Increase the resources available to residents with Pulmonary health issues
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Evaluate feasibility of creating a "Lung Center" in Pasco County	Residents in the community that have pulmonary issues	**Year 1:** 1. Evaluate the need for pulmonary services and rehabilitation (i.e., what drives the issues and best practices to address those issues) in Pasco County, the feasibility and sustainability of implementing a pulmonary rehabilitation program. 2. Develop recommendations based on evaluation related to planning implementation. a. Define the scope of work and time required to implement recommendations b. Identify the resources required to implement recommendations c. Identify the funding available to implement recommendations 3. Seek funding required to implement recommended programs and services **Year 2:** 1. Based on available resources, implement the pulmonary services recommended from the	**Year 1:** 1-2. Document the result of the evaluation and revise the implementation plan as needed. 3. Document funding secured. 1-3. Report progress to the IRS. **Year 2:** 1a. Document any additional resources needed. 1b-e. Document phases of implementation.	**Year1-3:** **Year 1:** Existing staff (admin, respiratory therapy, etc.) to dedicate time for program development. **Years 2-3** TBD; estimated 2 RRTs and $25K for marketing expense; dedicated space needed for rehab, equipment expenses, etc. **Potential Partners:** National associations

NEED: Decreasing the prevalence of clinical health issues - Pulmonary Health (i.e., Asthma, COPD and Smoking) **UNDERLYING FACTORS:** Higher rates of Asthma, COPD and Smoking among residents in the services area **ANTICIPATED IMPACT:** Increase the resources available to residents with Pulmonary health issues **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		evaluation in year 1. To the extent that it is necessary MPNBH may need to: a. Identify additional resources needed (funding, space, staff, materials, etc.) b. Identify and build out space for program c. Establish the program d. Develop metrics to measure success e. Hire/train staff f. Launch operation **Year 3:** 1. Track the number of patients referred to the program and the number of patients participating in the program. 2. Evaluate the treatment effectiveness using metrics identified in year 2. 3. Based on evaluation; develop program recommendations. 4. Reassess community need.	**Year 3:** 1. Document the number of patients served and outcome measures. 2-3. Document results of evaluations and subsequent recommendations. 1-4. Reassess need and Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate and lung cancer patients who present with late stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the risk reduction and cancer prevention strategies offered by Primary Care Physicians	Adult residents	**Year 1:** 1. Increase prevention education about risk reduction and cancer prevention strategies being provided by PCPs. a. Develop partnerships with PCPs in the community. b. Increase education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. c. Track the number and types of cancer screenings taking place in BayCare Medical Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 2:** 1. Increase cancer prevention screening being provided by PCPs. a. Evaluate what resources are available/needed for BayCare Medical Group PCPs to increase cancer screening. b. Seek funding for increased cancer screening opportunities.	**Year 1:** 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group 1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-d. Report progress to the IRS. **Year 2:** 1b. Document funding secured. 1c. Document number of patients provided cancer screening and compare to previous year. 1d.Document the number	**Year 1-3:** BayCare Health System and BayCare Medical Group

NEED: Decreasing the prevalence of clinical health issues - Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate and lung cancer patients who present with late stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		c. Increase cancer prevention screenings used among BayCare Medical Group and community partner PCPs. d. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. e. Track the number and types of cancer screenings taking place in BayCare Medical Group. f. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Continue cancer prevention screening used among BayCare Medical Group and community partner PCPs. b. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs.	of patients that are provided education. 1e. Document cancer screenings taking place at BayCare Medical Group. 1f. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-f. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screening and compare to previous year. 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group.	

NEED: Decreasing the prevalence of clinical health issues - Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate and lung cancer patients who present with late stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		c. Track the number and types of cancer screenings taking place in BayCare Medical Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. e. Evaluate program and reassess the prevalence of late stage diagnosis.	1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-e. Reassess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Suicide Prevention
UNDERLYING FACTORS: Higher than average suicide rates
ANTICIPATED IMPACT: Reduce the rate of suicide related death among residents served by BayCare Health System
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners

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
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths (i.e., communications plan, analytics necessary to profile high risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding. **Year 2:** 1. Maximize relationships and collaborative opportunities with community based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-4. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities.	**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 **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1. Implement comprehensive wellness initiative that will focus on preventing suicide related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community based organizations and evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide related deaths, etc.) by comparing the baseline measures gathered in year one to those gathered in year two.	3. Document the metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS. **Year 3:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. Document the reach of the program (number of participants). 3. Compare prevention metrics from year two to the baseline developed in year one.	

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

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

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

The health of a community largely depends on the health status of its residents. Key stakeholders and focus group participants believed that the lifestyles of some residents may have an impact on their individual health status and consequently cause an increase in the consumption of healthcare resources. 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 health outcomes for residents including those requiring behavioral health services, undetected/untreated illnesses, concentration of chronic conditions in lower-income communities, perpetuated substance abuse, and higher preventable mortality rates.

Secondary data representing the communities served by the Morton Plant North Bay Hospital and MPNB Recovery Center depicts evidence of higher provider ratios for mental health providers in Pasco County, and a need for mental health and substance abuse services. Key stakeholders and focus group participants discussed substance abuse and specifically prescription drug abuse and the related increased chronic illness costs. Addiction to prescription medication is on the rise due to what stakeholders referred to as “pill mills” or physician’s offices that write prescriptions for narcotic pain medications without weaning patients properly. Key stakeholders felt that untreated addiction can disrupt the stability of home life, cause newborns to be born addicted to substances due to the pregnant mother abusing addictive substances, and cause poor health outcomes due to lifestyle choices. Additionally, key stakeholders felt that an addiction to prescription medication can lead to other illegal drug use. Often residents are getting addicted to prescription drugs due to attending a pain clinic in the area and not being weaned off of prescription pain medications properly. Stakeholders also felt that the lack of integration between behavioral health and medical health settings is a detriment to patients becoming addicted to narcotic prescription medications. Focus group participants felt that residents requiring behavioral health services may not always have access to a detoxification facility that is as discrete as they would like and/or close enough to be convenient.

While Morton Plant North Bay Hospital and MPNB Recovery Center, two facilities in the BayCare Health System, both provide programs and services which target healthy behaviors, the need to improve healthy behaviors and environments was identified through the most recent community health needs assessment. Recognizing that Morton Plant North Bay Hospital and MPNB Recovery Center are not the only medical resources in the hospitals' communities, 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 address the healthcare needs of the vulnerable and underserved populations in the hospital service area.*
- ✓ *Continue to identify and establish healthy alternatives for staff (i.e., reduction of trans fats in meals, encouragement of physical activities, offering nutritionist services, etc.)*
- ✓ *BayCare Health System will continue to provide preventive care and weight management through the BayCare Medical Group as a component of the Medical Home Model provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue developing health education programming with outreach, screenings, education, etc. through partnerships with community-based organizations like employers, municipalities, libraries, etc.*
- ✓ *Continue to provide transportation to patients that are not able to afford transportation to preventive care appointments.*
- ✓ *Continue community partnerships related to the reduction of substance abuse in the communities served by the hospital.*
- ✓ *Continue to address COPD and adult asthma through the Respiratory Care Department which includes group support and education (i.e., Better Breathers group for COPD patients, smoking cessation classes and mini clinics – nonsmoking materials and education, Great American teach in brochures and information provided to middle and/or high school students), disease management education in one-on-one or group settings (i.e., disease process, instruction on use of inhalers, environmental triggers, etc.), screening and education at health fairs, grocery stores, or other locations (i.e., World Asthma Day, Great American Smoke out Day, COPD Day), and lectures by physicians and environmentalist.*
- ✓ *Continue to provide scholarships for indigent patients to attend workshops and intensive outpatient programming (i.e., a full day education session on disease management, etc.)*

- ✓ *Continue to offer preventive screenings (i.e., Blood pressure, Cholesterol, Sleep apnea, Glucose and BMI, etc.) both on-site and off-site.*
- ✓ *Continue to provide dietary consults through hospital dieticians which is provided to both inpatients and outpatients.*

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 evaluating the feasibility of implementing an educational program.*
- ✓ *Increase the use of risk-reduction and cancer-prevention strategies by increasing resident awareness of and access to risk-reduction and cancer-prevention strategies.*
- ✓ *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 and recovery center with the health needs of the community:

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
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: Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives
ANTICIPATED IMPACT: Evaluate feasibility of implementing an educational program
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Evaluate feasibility of implementing an educational program	Residents in the community that are under/ uninsured	**Year 1:** 1. Evaluate the feasibility and sustainability of implementing an educational program together with community partners focused on nutrition, obesity, wellness and preventative care. 2. Evaluate existing programs and relationships with community-based organizations (e.g., MPM diabetes outreach) to determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. b. There are additional partnership opportunities to meet the needs of the community relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. c. It is possible to develop ongoing	**Year 1:** 1. Document the result of the evaluation and revise the implementation plan as needed. 2-3. Document the results of an evaluation of hospital collaboration with community based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 4. Document identified funding opportunities and any secured funding. 1-4. Report progress to the IRS.	**Year1-3:** **Year 1:** Existing staff (admin, MPM Education, Wellness Centers) to develop plan. **Years 2-3**: 1 FTE dedicated to coordinate activities and program, office supplies, promotional materials. **Potential Partners:** Turley Diabetic Indigent Clinic

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach
UNDERLYING FACTORS: Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives
ANTICIPATED IMPACT: Evaluate feasibility of implementing an educational program
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		collaborative relationships related to education and outreach focused on nutrition, obesity, wellness, and preventative care in the hospital service area and the county. 3. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.) 4. Identify and seek funding opportunities to expand education and outreach services to under/uninsured residents relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. **Year 2:** 1. Based on available resources, implement an educational program together with community partners focused on nutrition, obesity, wellness, and preventative care and based on work from year 1:	 **Year 2:** 1a-b. Document planned outreach efforts (e.g., topics, dates, locations, target audience and community partners, etc.) 1c. Document results of	**Resources:** FCN

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Maximize partnerships with community based organizations to provide education and outreach focused on nutrition, obesity, wellness, and preventative care. b. Work with community partners to implement the programs/services for which funding is available. c. Develop measures of success (i.e., number of participants, consumer feedback/satisfaction surveys, etc.) 2. Continue to evaluate opportunities for expansion of education and outreach and funding for these opportunities. 3. Evaluate the effectiveness of the education and outreach efforts and develop recommendations. **Year 3:** 1. Based on available resources implement	measures administered. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document results of evaluations and subsequent recommendations. 1-3. Report progress to the IRS. **Year 3:** 1. Document	

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		recommendations from Year 2. 2. Based on available resources, continue to provide educational programs together with community partners focused on nutrition, obesity, wellness, and preventative care. 3. Continue to measure success of individual outreach efforts and compare to previous year measures. 4. Evaluate the effectiveness of the education and outreach efforts and develop recommendations. 5. Reassess community need for preventive education and outreach focused on nutrition, obesity, wellness, and preventative care.	recommendations implemented. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc., and any identified funding opportunities. 3-4. Document results of evaluations and subsequent recommendations. 1-5. Reassess need and report progress to the IRS.	

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk reduction and cancer prevention strategies	Residents in hospital service area and congregations served by Faith Community Nurses	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung). 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach. 4. Based on results of evaluation, develop program recommendations including resources required. 5. Identify potential funding sources to implement recommendations and secure funding. **Year 2:**	**Year 1:** 1. Document the forms of cancer that have higher than average rates and the populations most at risk. 2. Document the gaps in risk reduction and cancer prevention activities. 3. Document the evidence basis, demographics of populations reached, location, frequency, and number of attendees for hospital risk reduction and cancer prevention efforts. 4. Document recommendations to increase resident awareness of risk	**Year1-3:** Resources: Additional funding for FCN expansion. Funding available for mammograms, PSA + DRE, and low dose CT. Additional in statistical analysis cost as well as FCN annual expense associated with education and tracking.

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Based on resources available, partner with community based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Identify high-risk groups that are not accessing cancer screenings through Faith Community Nursing and provide education to congregations about the importance of such screenings. b. Prioritize cancer screening opportunities in high risk populations for breast, prostate and lung cancers. c. Provide advanced directive documentation. d. Evaluate the opportunity to provide high risk populations additional screening opportunities: mammograms, PSA + DRE, and low dose CT. e. Work with Faith Community Nursing to provide information about screenings taking place, assistance with scheduling screenings, and assessing transportation options.	reduction and cancer prevention strategies and resources needed. **Year 2:** 1. Document funding secured. 1b. Document new awareness and prevention strategies to be implemented. 1e. Document the screenings provided, number and demographics of participants. 1f. Document the cancer rates (incidence and prevalence) by demographics annually. 2. Document the evidence basis, population reached, location, and number of	Partners: FCN

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		f. Develop a baseline measure of patients diagnosed with late stage cancer and compare to cancer registry. 2. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year two and revise strategy for year three as needed, including Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Measure the percentage of high risk patients diagnosed with late stage cancer compared to baseline and cancer registry. 2. Based on available resources, continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of	participants for each effort. 1-2. Report progress to the IRS. **Year 3:** 1. Document any revisions 2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached,	

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. 4. Reassess the prevalence of cancer in the service area.	location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report reassessment results and progress to the IRS.	

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
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. Increase service capacity for co-occurrence - CSU Beds move back to New Port Richey to co-locate with detox program giving access to acute services in the highly populated towns in Pasco County 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 2. Expand detoxification services in Pasco County. a. Acquire new finance subsidy to open new beds (i.e. State allocation of $300,000). 3. 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	**Year 1:** 1a. Document the resources needed. 1b-e. Document location, hire dates of staff, and launch date. 2. Document the number of census increase. 3a&b. Document secured funding. 3c. Document the Start dates for program staff. 3d&e. Document the number of patients referred to the program and the number of patients participating in the program. 1-3. Report progress to the IRS.	**Year 1-3:** 1&2. $300,000-Detox BCHS 3. 3 mill - Pathways BCHS 4. $130,000 –Mom's and babies

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		participating in the program **Year 2:** 1. Continue to maintain effective treatment for patients with co-occurrence. a. Evaluate the treatment effectiveness and capacity for patients with co-occurrence. b. Based on evaluation, develop and implement program recommendations 2. Continue to evaluate the need for and opportunities to provide sustainable detoxification services, beds, etc. 3. 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. Continue to maintain effective treatment for patients with co-occurrence. a. Evaluate the treatment effectiveness and	**Year 2:** 1a-b.Document treatment outcomes, utilization statistics, etc. 2. Document utilization statistics for detox beds. 3. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 1-3. Report progress to the IRS. **Year 3:** 1a-b.Document treatment outcomes, utilization statistics, etc. 2. Document utilization	

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		capacity for patients with co-occurrence. b. Based on evaluation, develop and implement program recommendations. 2. Continue to evaluate the need for and opportunities to provide sustainable detoxification services, beds, etc. 3. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways	statistics for Detox beds 3. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 1-3. Report progress to the IRS.	

APPENDIX A

Implementation Strategy

MORTON PLANT NORTH BAY HOSPITAL AND MPNB RECOVERY CENTER
August, 2013

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Increase the appropriate use of available healthcare resources by increasing the use of affordable primary care clinics and FQHC (i.e. Premier, Good Samaritan and Health Department)	Residents in the Morton Plant North Bay Hospital service area	**Year 1:** 1. Explore partnerships with non-BCHS primary care sites in Pasco County to facilitate referrals between these sites and MPNBH. To explore relationship building MPNBH may employ any of the following: a. Identify potential sites and set goals for enlisting a set number of PCPs and review the number of PCPs enlisted quarterly. b. Develop procedures for patient referral and follow-up. c. Develop methods to track the number of patients that are referred to a site and the number of completed visits. d. Evaluate efficacy of referral process (e.g., consumer feedback, PCP feedback, outcome measures, etc.) 2. Establish metrics to monitor	**Year 1:** 1a. Document the list of site selected. 1b-c. Document procedures and tracking methods. 1d. Document results of evaluation. 2. Document metrics being used. 1-2. Report progress to the IRS.	**Year1:** Existing staff (Administration, ED and Case Management) to allot time to develop plan/partnership. **Year 2-3:** TBD **Potential Partners:** Government entities, local clinics, etc.

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		coordination of care between MPNBH and primary care sites in Pasco County. **Year 2:** 1. Monitor the coordination of patient care between MPNBH and the partnering primary care locations. 2. Identify any new primary care sites that could be included in the Care Coordination Model and solicit their participation. 3. Evaluate the effectiveness of the Care Coordination Model implemented in year 1 and develop recommendations for improvement. 4. Establish quantitative goals for improvement from Care Coordination metrics developed in year 1. **Year 3:** 1. Implement improvements to care coordination program that were	**Year 2:** 1. Document annually the outcome of ongoing monitoring. 2. Document any new partnering sites. 3. Document the results of an evaluation and recommendations. 4. Document goals set. 1-4. Report progress to the IRS. **Year 3:** 2. Document annually the outcome of ongoing monitoring. 3. Document any	

NEED: Improving access to affordable healthcare
UNDERLYING FACTORS: Patient referral and navigation to better coordinate care. Including racial and socio-economic groups that show disparities in the service area.
ANTICIPATED IMPACT: Increase the use of affordable primary care clinics and FQHC, whereby reducing the use of Emergency Departments for non-emergent and/or primary care purposes.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		identified in year 2. 2. Monitor the coordination of patient care between MPNBH and the partnering primary care locations. 3. Identify any new primary care sites that could be included in the Care Coordination Model and solicit their participation. 4. Evaluate the effectiveness of the Care Coordination Model implemented in year 2 and develop recommendations for improvement. 5. Establish quantitative goals for improvement from Care Coordination metrics developed in Year 2. 6. Reassess community need for care coordination.	new partnering sites. 4. Document the results of an evaluation and recommendations. 5. Document goals set. 1-6. Report reassessment and 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
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

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. Increase service capacity for children with mental health needs through expansion of SIPP beds by 4 to give access to Intermediate Care Programming in Pasco County. a. Identify resources needed (funding, staff, materials, etc.) b. Apply for state funding c. Establish the program d. Launch operation e. Track number of children served 2. Family and Patient Preservation Program- working at home with families at risk. a. Convert pediatric acute care funding to outpatient preservation program. b. Implement program and track measure outcomes. **Year 2:** 1. Continue to offer services for children with mental health needs through expanding SIPP beds by 4 to give access to Intermediate Care Programming in Pasco County. a. Continue to track number of children served 2. Family and Patient Preservation Program- working at home with families at risk	**Year 1:** 1 a&b. Document the resources needed and secured funding. 1c-d. Document locations, hire dates of staff, and launch date. 1e. Document the increase in capacity and number of children served. 2a. Document the conversion process and dates. 2b. Document number of program participants and outcomes. 1-2. Report progress to the IRS. **Year 2:** 1a. Document the number of children served. 2a. Document number of program participants and outcomes. 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
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		a. Implement program and track measure outcomes. **Year 3:** 1. Continue to offer services for children with mental health needs through expanding SIPP beds by 4 to give access to Intermediate Care Programming in Pasco County. a. Continue to track number of children served 2. Family and Patient Preservation Program- working at home with families at risk. a. Implement program and track measure outcomes.	the IRS. **Year 3:** 1a. Document the number of children served. 2a. Document number of program participants and outcomes. 1-2. Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Pulmonary Health (i.e., Asthma, COPD and Smoking)
UNDERLYING FACTORS: Higher rates of Asthma, COPD and Smoking among residents in the services area
ANTICIPATED IMPACT: Increase the resources available to residents with Pulmonary health issues
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners

NEED: Decreasing the prevalence of clinical health issues - Pulmonary Health (i.e., Asthma, COPD and Smoking)
UNDERLYING FACTORS: Higher rates of Asthma, COPD and Smoking among residents in the services area
ANTICIPATED IMPACT: Increase the resources available to residents with Pulmonary health issues
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Evaluate feasibility of creating a "Lung Center" in Pasco County	Residents in the community that have pulmonary issues	**Year 1:** 1. Evaluate the need for pulmonary services and rehabilitation (i.e., what drives the issues and best practices to address those issues) in Pasco County, the feasibility and sustainability of implementing a pulmonary rehabilitation program. 2. Develop recommendations based on evaluation related to planning implementation. a. Define the scope of work and time required to implement recommendations b. Identify the resources required to implement recommendations c. Identify the funding available to implement recommendations 3. Seek funding required to implement recommended programs and services **Year 2:** 1. Based on available resources, implement the pulmonary services recommended from the evaluation in year 1. To the extent that it is necessary MPNBH may need to:	**Year 1:** 1-2. Document the result of the evaluation and revise the implementation plan as needed. 3. Document funding secured. 1-3. Report progress to the IRS. **Year 2:** 1a. Document any additional resources needed. 1b-e. Document phases of implementation.	**Year1-3:** **Year 1:** Existing staff (admin, respiratory therapy, etc.) to dedicate time for program development. **Years 2-3** TBD; estimated 2 RRTs and $25K for marketing expense; dedicated space needed for rehab, equipment expenses, etc. **Potential Partners:** National associations

NEED: Decreasing the prevalence of clinical health issues - Pulmonary Health (i.e., Asthma, COPD and Smoking) **UNDERLYING FACTORS:** Higher rates of Asthma, COPD and Smoking among residents in the services area **ANTICIPATED IMPACT:** Increase the resources available to residents with Pulmonary health issues **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Identify additional resources needed (funding, space, staff, materials, etc.) b. Identify and build out space for program c. Establish the program d. Develop metrics to measure success e. Hire/train staff f. Launch operation **Year 3:** 1. Track the number of patients referred to the program and the number of patients participating in the program. 2. Evaluate the treatment effectiveness using metrics identified in year 2. 3. Based on evaluation; develop program recommendations. 4. Reassess community need.	**Year 3:** 1. Document the number of patients served and outcome measures. 2-3. Document results of evaluations and subsequent recommendations. 1-4. Reassess need and Report progress to the IRS.	

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

NEED: Decreasing the prevalence of clinical health issues - Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate and lung cancer patients who present with late stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		b. Seek funding for increased cancer screening opportunities. c. Increase cancer prevention screenings used among BayCare Medical Group and community partner PCPs. d. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. e. Track the number and types of cancer screenings taking place in BayCare Medical Group. f. Track the number of patients adopting risk reduction and cancer prevention strategies. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Continue cancer prevention screening used among BayCare Medical Group and community partner PCPs. b. Maintain education about risk reduction (i.e., smoking cessation, use of sun screen,	previous year. 1d.Document the number of patients that are provided education. 1e. Document cancer screenings taking place at BayCare Medical Group. 1f. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-f. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screening and compare to previous year. 1b. Document the number of patients that are provided education. 1c. Document cancer	

NEED: Decreasing the prevalence of clinical health issues - Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate and lung cancer patients who present with late stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. c. Track the number and types of cancer screenings taking place in BayCare Medical Group. d. Track the number of patients adopting risk reduction and cancer prevention strategies. e. Evaluate program and reassess the prevalence of late stage diagnosis.	screenings taking place at BayCare Medical Group. 1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-e. Reassess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Suicide Prevention
UNDERLYING FACTORS: Higher than average suicide rates
ANTICIPATED IMPACT: Reduce the rate of suicide related death among residents served by BayCare Health System
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners

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
RESPONSIBLE HOSPITAL: Morton Plant North Bay Recovery Center

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths (i.e., communications plan, analytics necessary to profile high risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding. **Year 2:** 1. Maximize relationships and collaborative opportunities with community based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-4. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities.	**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 **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1. Implement comprehensive wellness initiative that will focus on preventing suicide related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community based organizations and evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide related deaths, etc.) by comparing the baseline measures gathered in year one to those gathered in year two.	3. Document the metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS. **Year 3:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. Document the reach of the program (number of participants). 3. Compare prevention metrics from year two to the baseline developed in year one.	

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Evaluate feasibility of implementing an educational program	Residents in the community that are under/ uninsured	**Year 1:** 1. Evaluate the feasibility and sustainability of implementing an educational program together with community partners focused on nutrition, obesity, wellness and preventative care. 2. Evaluate existing programs and relationships with community-based organizations (e.g., MPM diabetes outreach) to determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. b. There are additional partnership opportunities to meet the needs	**Year 1:** 1. Document the result of the evaluation and revise the implementation plan as needed. 2-3. Document the results of an evaluation of hospital collaboration with community based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 4. Document identified funding opportunities and any secured funding. 1-4. Report progress to the IRS.	**Year1-3:** **Year 1:** Existing staff (admin, MPM Education, Wellness Centers) to develop plan. **Years 2-3**: 1 FTE dedicated to coordinate activities and program, office supplies, promotional materials.

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach
UNDERLYING FACTORS: Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives
ANTICIPATED IMPACT: Evaluate feasibility of implementing an educational program
RESPONSIBLE HOSPITAL: Morton Plant North Bay Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		of the community relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. c. It is possible to develop ongoing collaborative relationships related to education and outreach focused on nutrition, obesity, wellness, and preventative care in the hospital service area and the county. 3. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.) 4. Identify and seek funding opportunities to expand education and outreach services to under/uninsured residents relative to education and outreach focused on nutrition, obesity, wellness, and preventative care. **Year 2:** 1. Based on available resources, implement	**Year 2:** 1a-b. Document planned	**Potential Partners:** Turley Diabetic Indigent Clinic **Resources:** FCN

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		an educational program together with community partners focused on nutrition, obesity, wellness, and preventative care and based on work from year 1: a. Maximize partnerships with community based organizations to provide education and outreach focused on nutrition, obesity, wellness, and preventative care. b. Work with community partners to implement the programs/services for which funding is available. c. Develop measures of success (i.e., number of participants, consumer feedback/satisfaction surveys, etc.) 2. Continue to evaluate opportunities for expansion of education and outreach and funding for these opportunities. 3. Evaluate the effectiveness of the	outreach efforts (e.g., topics, dates, locations, target audience and community partners, etc.) 1c. Document results of measures administered. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document results of evaluations and subsequent recommendations. 1-3. Report progress to the IRS.	

NEED: Improving healthy behaviors and environments: Preventive care, health education and community outreach **UNDERLYING FACTORS:** Limited preventive care related to obesity, diabetes, disease management, poor health outcomes and disparities, and end of life advanced directives **ANTICIPATED IMPACT:** Evaluate feasibility of implementing an educational program **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		education and outreach efforts and develop recommendations. **Year 3:** 1. Based on available resources implement recommendations from Year 2. 2. Based on available resources, continue to provide educational programs together with community partners focused on nutrition, obesity, wellness, and preventative care. 3. Continue to measure success of individual outreach efforts and compare to previous year measures. 4. Evaluate the effectiveness of the education and outreach efforts and develop recommendations. 5. Reassess community need for preventive education and outreach focused on nutrition, obesity, wellness, and preventative care.	**Year 3:** 1. Document recommendations implemented. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc., and any identified funding opportunities. 3-4. Document results of evaluations and subsequent recommendations. 1-5. Reassess need and report progress to the IRS.	

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk reduction and cancer prevention strategies	Residents in hospital service area and congregations served by Faith Community Nurses	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung). 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach. 4. Based on results of evaluation, develop program recommendations including resources required. 5. Identify potential funding sources to implement recommendations and secure funding. **Year 2:**	**Year 1:** 1. Document the forms of cancer that have higher than average rates and the populations most at risk. 2. Document the gaps in risk reduction and cancer prevention activities. 3. Document the evidence basis, demographics of populations reached, location, frequency, and number of attendees for hospital risk reduction and cancer prevention efforts. 4. Document recommendations to increase resident awareness of risk	**Year1-3:** Resources: Additional funding for FCN expansion. Funding available for mammograms, PSA + DRE, and low dose CT. Additional in statistical analysis cost as well as FCN annual expense associated with education and tracking.

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Based on resources available, partner with community based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Identify high-risk groups that are not accessing cancer screenings through Faith Community Nursing and provide education to congregations about the importance of such screenings. b. Prioritize cancer screening opportunities in high risk populations for breast, prostate and lung cancers. c. Provide advanced directive documentation. d. Evaluate the opportunity to provide high risk populations additional screening opportunities: mammograms, PSA + DRE, and low dose CT. e. Work with Faith Community Nursing to provide information about screenings taking place, assistance with scheduling screenings, and assessing transportation options.	reduction and cancer prevention strategies and resources needed. **Year 2:** 1. Document funding secured. 1b. Document new awareness and prevention strategies to be implemented. 1e. Document the screenings provided, number and demographics of participants. 1f. Document the cancer rates (incidence and prevalence) by demographics annually. 2. Document the evidence basis, population reached, location, and number of	Partners: FCN

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		f. Develop a baseline measure of patients diagnosed with late stage cancer and compare to cancer registry. 2. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year two and revise strategy for year three as needed, including Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Measure the percentage of high risk patients diagnosed with late stage cancer compared to baseline and cancer registry. 2. Based on available resources, continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of	participants for each effort. 1-2. Report progress to the IRS. **Year 3:** 1. Document any revisions 2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached,	

NEED: Improving healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. 4. Reassess the prevalence of cancer in the service area.	location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report reassessment results and progress to the IRS.	

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to	Adults and	**Year 1:**	**Year 1:**	**Year 1-3:**

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
provide while increasing the availability of substance abuse services	pediatric residents who are abusing addictive substances and/or addicted to a substance	1. Increase service capacity for co-occurrence - CSU Beds move back to New Port Richey to co-locate with detox program giving access to acute services in the highly populated towns in Pasco County 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 2. Expand detoxification services in Pasco County. a. Acquire new finance subsidy to open new beds (i.e. State allocation of $300,000). 3. 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	1a. Document the resources needed. 1b-e. Document location, hire dates of staff, and launch date. 2. Document the number of census increase. 3a&b. Document secured funding. 3c. Document the Start dates for program staff. 3d&e. Document the number of patients referred to the program and the number of patients participating in the program. 1-3. Report progress to the IRS.	1&2. $300,000-Detox BCHS 3. 3 mill - Pathways BCHS 4. $130,000 –Mom's and babies

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Continue to maintain effective treatment for patients with co-occurrence. a. Evaluate the treatment effectiveness and capacity for patients with co-occurrence. b. Based on evaluation, develop and implement program recommendations 2. Continue to evaluate the need for and opportunities to provide sustainable detoxification services, beds, etc. 3. 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. Continue to maintain effective treatment for patients with co-occurrence. a. Evaluate the treatment effectiveness and capacity for patients with co-occurrence.	**Year 2:** 1a-b.Document treatment outcomes, utilization statistics, etc. 2. Document utilization statistics for detox beds. 3. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 1-3. Report progress to the IRS. **Year 3:** 1a-b.Document treatment outcomes, utilization statistics, etc. 2. Document utilization statistics for Detox beds	

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services **RESPONSIBLE HOSPITAL:** Morton Plant North Bay Recovery Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		b. Based on evaluation, develop and implement program recommendations. 2. Continue to evaluate the need for and opportunities to provide sustainable detoxification services, beds, etc. 3. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways	3. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 1-3. Report progress to the IRS.	

APPENDIX B

Needs not Addressed by the 2013 Plan

MORTON PLANT NORTH BAY HOSPITAL AND MPNB RECOVERY CENTER
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 or the recovery center during this reporting period, including a rationale for those decisions.

Obstetrics:
While hospital leaders are interested in this issue, and are interested in further evaluating the barriers that female residents experience when seeking obstetric health services, neither the Morton Plant North Bay Hospital nor the MPNB Recovery Center currently has the expertise, resources, and/or provider base to provide this service. Patients seen in the emergency room with health concerns related to obstetrics are transferred to local providers in the hospital service area. Because the primary needs within the community have dictated that financial and human resources of Morton Plant North Bay Hospital are utilized for diagnostic and therapeutic medical and surgical care and that the financial and human resources of the MPNB Recovery Center be used for behavioral health diagnostic and therapeutic care, hospital leaders have determined that obstetric health services could be better met by existing providers (i.e., Medical Center of Trinity and Mease Countryside Hospital), 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.