St. Anthony's Hospital

Implementation Plan – Report

September, 2013

TrippUmbach
Research · Strategy · Impact

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Introduction

St. Anthony's Hospital is a 395-bed facility, located in St. Petersburg, FL and is also one of a network of 10 not-for-profit hospitals throughout the Tampa Bay area. In response to its community commitment, St. Anthony's Hospital contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2012 and June 2013 (See the St. Anthony's Hospital Community Health Needs Assessment for the full report).

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

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

Community Definition

While community can be defined in many ways, for the purposes of this report, the St. Anthony's Hospital community is defined as 11 zip code areas in Pinellas County, Florida. (See Table 1 & Figure 1). The needs identified in the community health needs assessment report pertain to the same 11 zip code areas in Pinellas County, Florida.

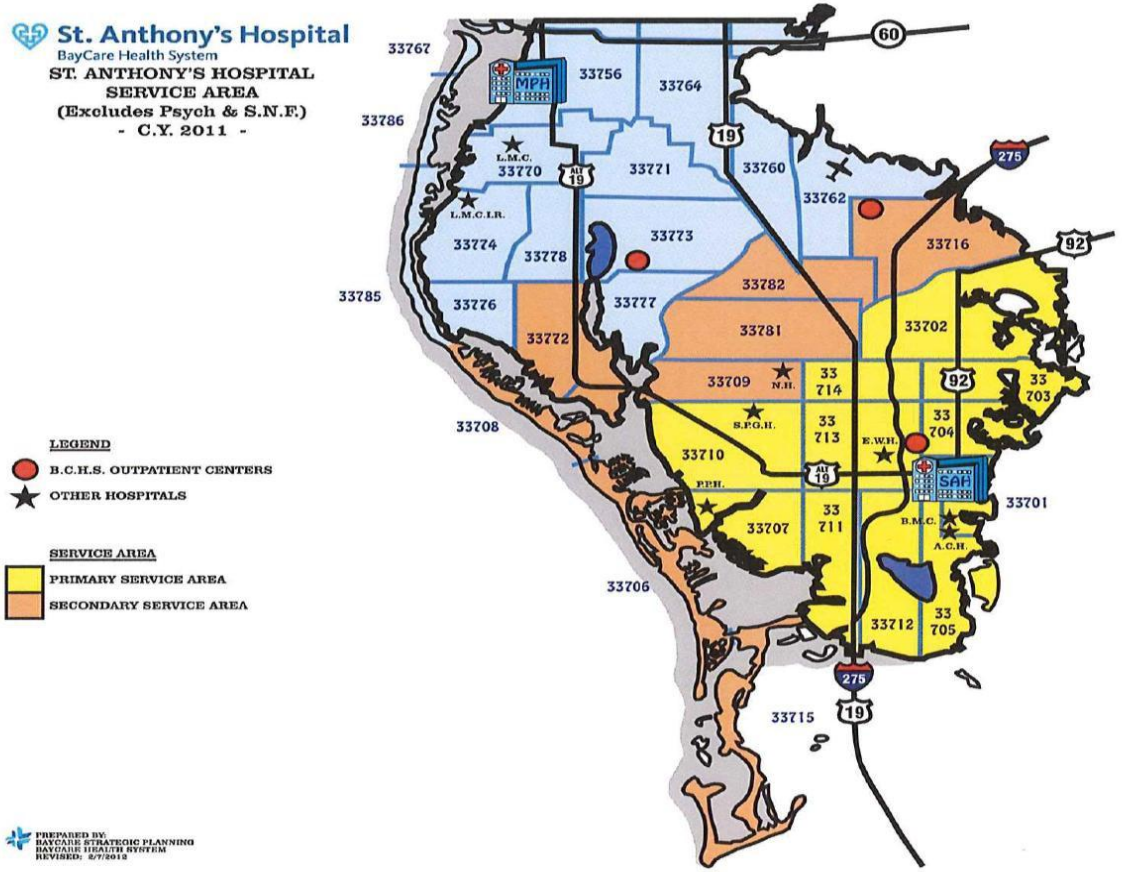
St. Anthony's Hospital Community

Table 1

Zip	Town	County
33701	St. Petersburg	Pinellas
33702	St. Petersburg	Pinellas
33703	St. Petersburg	Pinellas
33704	St. Petersburg	Pinellas
33705	St. Petersburg	Pinellas
33707	South Pasadena	Pinellas
33710	St. Petersburg	Pinellas
33711	St. Pete/Gulfport	Pinellas
33712	St. Petersburg	Pinellas
33713	St. Petersburg	Pinellas
33714	St. Petersburg	Pinellas

St. Anthony's Hospital Community Map

Figure 1



Methodology

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

Key elements of the implementation planning process included:

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

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

- **Review of CHNA, Needs Identification, and Selection:** Tripp Umbach facilitated a brief overview of the CHNA findings and facilitated a discussion process during a Webinar held on June 26th, 2013 with hospital leadership from St. Anthony's Hospital. Attendees were asked to review the community health needs assessment, community resource inventory, and identify the significant health needs found in the CHNA results. Attendees then participated in a discussion to determine which of the previously identified significant needs could be and which could not be addressed by St. Anthony's Hospital. Once needs were selected, hospital leadership were asked to provide rationale for the needs that the hospital could not meet.

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

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

- **Committee Review of Evidence-Based Practices and Plan Development:** Tripp Umbach facilitated a review of strategy and evidence-based practices among hospital leaders during a Webinar held on August 21st, 2013. Based on the evidence-based practices previously provided, hospital leadership reviewed and discussed the strategy and subsequent action steps needed to implement best practices to begin to address the health needs identified in the service area. Hospital leaders aligned needs with best practice models and available resources, defined action steps, timelines, and potential partners for each need to develop the accompanying implementation plan.

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

Community Health Needs and Implementation Plan

Community Health Needs Identification, Prioritization, and Implementation Planning Meeting

Qualitative and informational data were presented during a meeting held on June 26th, 2013 with St. Anthony's Hospital leadership; with the purpose of identifying and prioritizing significant community health needs for hospital implementation planning.

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

Hospital leaders believe the following health needs are those to which St. Anthony's Hospital is best positioned to dedicate resources to address within their community.

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

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

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

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

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

According to key stakeholders, there is a need for increased coordination of care for residents. Key stakeholders and focus group participants agree that while there are medical resources and healthcare facilities in the community, access to healthcare resources can be limited by health insurance issues and the cost of healthcare for under/uninsured, the availability of providers, communication among providers and consumers, the level of integration of mental health services in medical health settings and the prevalence of socio-economic barriers (i.e., lack of support from employers, limited transportation, etc.)

While St. Anthony's Hospital, a hospital in the BayCare Health System, provides access to affordable healthcare in numerous ways, the need to improve access was identified through the most recent community health needs assessment. Recognizing that St. Anthony's Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further increase access to necessary medical care 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.*
- ✓ *Continue to provide Mental Health 101 training during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at St. Anthony's Hospital.*
- ✓ *Continue to provide co-located Behavioral Health Services as an available service of primary care physician practices in many communities in Pinellas County.*
- ✓ *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.*
- ✓ *Continue to provide case management, education, referrals, and assistance in scheduling follow-up appointments: to prevent readmissions, provide appropriate follow-up care and decrease recidivism for patients who are unfunded or underfunded.*
- ✓ *Continue to provide, to the extent it is possible, some coverage for medications and transportation needs for unfunded/underfunded residents.*
- ✓ *Continue to provide follow-up calls to patients discharged from the hospital in an effort to provide education, referral and coordination of care with local health departments and primary care services.*
- ✓ *Continue to provide education and assistance with referrals and community resources through follow-up phone calls made to all patients discharged from St. Anthony's Hospital within three days to review medications and discharge instructions.*
- ✓ *Continue to the extent it is possible, to provide a full-time RN to serve as the Nurse Navigator for the patients served by the St. Anthony's Breast Center. The Nurse Navigator works in collaboration with the existing Breast Center office staff, radiologists, referring physicians, Cancer Center team, and external resources and programs in the community.*
- ✓ *Continue following up with parishioners that have been hospitalized through Faith Community Nurses.*
- ✓ *Continue to coordinate and provide medical respite and social services to homeless patients requiring ongoing care that are discharged to community shelters.*

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

- ✓ *Increase access to affordable health insurance and healthcare services in the service area by exploring the development of a resource to provide information about types of health insurance coverage to members of the St. Anthony's Hospital community that are eligible for some type of medical assistance.*
- ✓ *Increase access to affordable health insurance and healthcare services in the service area by collaborating with BayCare Health System, county health departments and other community providers in the exploration of the feasibility and sustainability of establishing clinics for uninsured (including FQHC).*
- ✓ *Increase access to affordable healthcare services in the service area by enhancing the awareness among residents of clinics for uninsured/under insured residents including homeless residents.*
- ✓ *Increase the availability of mental health services by continuing to provide mental health services and increasing the availability of mental health services in the hospital service area.*

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

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Care coordination for uninsured/under insured and homeless residents; including access and awareness	Residents in the community that are under/ uninsured	**Year 1:** 1. Explore the development of a resource to facilitate providing information and access to members of the St. Anthony's Hospital community that are eligible for some type of health coverage. a. Explore options to secure a federal grant-funded patient navigator position tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange. b. Based on available resources, begin enrolling	**Year 1:** 1a-b. Document if a patient navigator is assigned to SAH and the start date. 1c-d. Document the number of patients assisted. 2a-c. Document the best practice methods chosen and funding secured.	**Year1-3:** **Potential Partners:** **Resources:** 1. 1 FTE (grant funded) 3. Admin time allocation to develop

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		residents for open enrollment in 2013. c. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. d. Evaluate effectiveness. 2. Increase the awareness that residents have about available healthcare resources. a. Evaluate best practice methods to disseminate information and health messaging. b. Determine the level of resources required to implement best practices. c. Identify funding sources and seek funding. 3. Collaborate with BayCare Health system and county health departments and other in the exploration of the feasibility and sustainability establishing a clinic for uninsured (including FQHC). a. Develop necessary relationships and needed Agreements between related agencies and governments participating in the effort. b. Develop a timeline. c. Identify the feasibility and sustainability along with best practices in supporting the provision of clinic services to uninsured residents, including evaluation and documentation. d. Identify and seek necessary funding in collaboration with partnering organizations	3a-d. Document the collaborating partners, timeline, and the results and recommendations of evaluations. 1-3. Report progress to the IRS.	partnership, rent-free space for community clinic.

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. Based on available resources, develop education program and materials on accessing the community resources that are available in the service area. a. Train Faith Community Nurses on the community resource outreach education programming developed. b. Develop a plan to incorporate the community resource outreach education into the activities conducted by Faith Community Nurses in the community (i.e., screenings, events, etc.). c. Track the number of residents reached by the outreach efforts. 3. Based on available resources and the results of evaluations completed in year 1, further explore establishing clinics for the uninsured in collaboration with partnering organizations. a. Revise implementation plan to reflect action step for years 2 and 3 that are commiserate with evaluation results, partnerships, and available resources among collaborating	**Year 2:** 1a-b. Document the number of patients assisted. 2a-b. Document the timeline for training and implementation of outreach education. 2c. Document the number of residents that receive community resource information. 3. Document funding secured and new implementation plan for years 2-3. 1-3.Report progress to the IRS.	

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		organizations. b. Implement plan. **Year 3:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. Based on available resources, continue to incorporate the community resource outreach education into the activities conducted by Faith Community Nurses in the community (i.e., screenings, events, etc.). a. Track the number of residents reached by the outreach efforts. 3. Based on available resources and successes in year 2, revise implementation plan in year 3 and continue efforts to establish clinics for uninsured in	**Year 3:** 1a-b. Document the number of patients assisted. 2. Document the number of residents that receive community resource information. 3. Document new implementation plan for year 3. 1-3. Re-assess need and Report progress to the IRS.	

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		collaboration with partnering organizations. 4. Re-assess need in the community.		

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

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

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

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

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

The analysis of data collected for the CHNA process present substantial clinical health issues in the majority of the St. Anthony's Hospital service area. The volume and severity of need is greater in the hospital service area than the rest of the county. There are several clinical indicators (i.e., bacterial pneumonia, urinary tract infection, dehydration, alcohol consumption, and asthma) that show higher than average rates in seven or more of the 11 zip code areas. While there are severe clinical health issues throughout the service area, 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: 33705, 33712, 33711, 33714, and 33701. These five zip code areas are represented in the secondary data as having substantially higher than average rates across the majority of clinical health indicators.

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

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

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

- ✓ *Continue to ensure the St. Anthony's Hospital campus remains "tobacco free".*
- ✓ *BayCare Health System will continue to disseminate health-related information throughout the service area.*
- ✓ *BayCare Health Systems will continue to promote fit-friendly organizations through partnership with national associations, educational programming, screenings and Health Risk Assessment offerings to employers to assist in helping them become a Fit-Friendly worksite and create a culture of wellness.*
- ✓ *Faith Community Nursing community outreach provides preventive screenings, health fairs, and education through collaborative partnerships with 110 volunteer nurses in 47 churches.*

- ✓ *Continue services at the LifeHelp Diabetes and Nutrition Center which provides education and nutritional counseling services for diabetic and obese individuals. The LifeHelp program is American Diabetes Association recognized and offers diabetes and weight loss support groups, food shopping tours, cooking classes, and community lectures/screenings. The mission of the LifeHelp Nutrition and Diabetes Center is to provide quality, comprehensive diabetes self-management and nutrition education that supports informed decision-making, self-care behaviors, problem solving, and active collaboration with the healthcare team and to improve clinical outcomes, health status, and quality of life. Services are planned based on cultural relevance, consumer- and community-centered needs consistent with current national standards for residents that are adults (18 years and over) in the community with type 1 and 2 diabetes, women with gestational diabetes, adults with glucose intolerance and other digestive disorders, and adults with weight management or cardiovascular disorders in Pinellas County. Additionally, St. Anthony's Hospital is pursuing Joint Commission Accreditation in Diabetes Care, which includes more focused inpatient care and better coordination when transitioning into the home environment.*
- ✓ *Continue the nursing program being launched in the fall to reduce readmissions for COPD patients through which the hospital will be providing education to enhance the nursing staff's knowledge of COPD, the treatments and risk for readmission and will be required education through our online learning system for nursing staff in all appropriate departments.*
- ✓ *The BayCare Education Council will develop and standardize patient education across the BayCare continuum of care to include Home Health and Primary Care physician offices.*
- ✓ *Continue to provide inpatient treatment and pulmonary rehab for lung cancer, COPD, and Asthma.*
- ✓ *Continue to offer services through the COC Accredited Oncology Center, NAPBC Accredited Breast Center which is designated as a ACR Breast Imaging Center of Excellence.*
- ✓ *Continue the current collaboration with the Mammography Voucher Program to provide mammograms for uninsured (125 Mammogram vouchers) and the commitment to provide follow-up treatment to residents that are diagnosed.*
- ✓ *Continue to provide the Lymphedema program for patients diagnosed with breast cancer.*

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

- ✓ *Improve the resources for residents related to diabetes diagnosis and treatment by increasing the access uninsured residents have to screening, diagnostic, and treatment services for diabetes in the community.*
- ✓ *Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis by increasing the risk reduction and cancer prevention strategies offered by primary care physicians.*
- ✓ *Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women by implementing cervical cancer education focusing on PAP smear compliance and following HPV vaccine schedules.*
- ✓ *Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis by implementing a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.*
- ✓ *Reduce the rate of suicide-related deaths among residents served by BayCare Health System by increasing the awareness of and prevalence of suicide prevention.*

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

NEED: Decreasing the prevalence of clinical health issues - Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the access residents have to screening, diagnostic, and treatment services for diabetes	Uninsured residents in the St. Anthony's service area	**Year 1:** 1. LifeHelp Diabetes and Nutrition Center provides education and nutritional counseling services for diabetic and obese individuals. The program is American Diabetes Association Recognized and offers diabetes and weight loss support groups, food shopping tours, cooking classes, and community lectures/screenings. a. Evaluate the populations most in need of supplemental funding (i.e., patients that often do	**Year 1:** 1a-c. Document the results of evaluation and recommendations, resources secured and limitations of funding. 2a. Document the number of nurses trained, dates, and locations.	**Year1-3:** **Potential Partners:** LifeHelp Diabetes and Nutrition Center, FCN **Resources:** Allocation of existing Staff

NEED: Decreasing the prevalence of clinical health issues - Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		not have adequate coverage for services through insurances or other venues) through case reviews. b. Identify and secure resources needed to provide/supplement services to individuals without insurance coverage (e.g., grant funding, scholarships, insurance dollars, etc.). c. Clearly define the qualification parameters for funding secured and services that can be covered by grant funding. 2. Increase community outreach related to disease management for diabetic residents: a. Develop a cross-training program through which, LifeHelp will collaborate with Faith Community Nursing to train select nurses on effective education programs, tools and techniques related to self-management of diabetes. b. Volunteer nurses will implement training by meeting patients in the hospital and then follow-up post-discharge via phone call or home visit to reinforce training. 3. Faith Community Nursing collaborative effort with local diabetes prevention programs to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and screening programs at local churches and in underserved	2b. Document the number of residents volunteer nurses assist. 3. Document the number of screenings, locations, and number of residents served annually. 1-3. Report progress to the IRS.	time to coordinate activities and tracking, volunteer nurses to participate in events, additional medical supplies for screenings

NEED: Decreasing the prevalence of clinical health issues - Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		areas. **Year 2:** 1. Based on resources available, provide LifeHelp Diabetes and Nutrition Center services to diabetic individuals without insurance coverage a. Expand services to the number of under/uninsured residents, for which funding was secured. b. Track the number of participants, insurance status, demographics and outcome of program participation. c. Continue to identify and secure additional funding opportunities. 2. Volunteer nurses will continue to meet patients in the hospital and then follow-up post-discharge via phone call or home visit to reinforce training. a. Track the number of patients served and outcome. 3. Faith Community Nursing collaborative effort with local diabetes prevention programs to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and	**Year 2:** 1a-c. Document the number of residents served, insurance status and program outcome. 2. Document the number of residents volunteer nurses assist. 3. Document the number of screenings, locations, and number of residents served annually.	Seek funding to cover $10K-$20K in annual expense for diabetic counseling to those without insurance coverage

NEED: Decreasing the prevalence of clinical health issues - Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		screening programs at local churches and in underserved areas. **Year 3:** 1. Based on resources available, continue to provide LifeHelp Diabetes and Nutrition Center services to diabetic individuals without insurance coverage a. Expand services to the number of under/uninsured residents, for which funding is secured. b. Track the number of participants, insurance status, demographics and outcome of program participation. c. Continue to identify and secure additional funding opportunities. 2. Volunteer nurses will continue to meet patients in the hospital and then follow-up post-discharge via phone call or home visit to reinforce training. a. Track the number of patients served and outcome. 3. Faith Community Nursing collaborative effort with local diabetes prevention program to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and	1-3. Report progress to the IRS. **Year 3:** 1a-c. Document the number of residents served, insurance status and program outcome. 2. Document the number of residents volunteer nurses assist. 3. Document the	

NEED: Decreasing the prevalence of clinical health issues - Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		screening programs at local churches and in underserved areas.	number of screenings, locations and number of residents served annually. 1-3. Report re-assessment and progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the risk reduction and cancer prevention strategies offered by Primary Care Physicians	Adult residents	**Year 1:** 1. Increase prevention education about risk reduction and cancer prevention strategies being provided by PCPs a. Develop partnerships with PCPs in the community. b. Increase education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs.	**Year 1:** 1ab. Document the number of PCPs contacted and resources distributed into offices. 1a-b. Report progress to the IRS.	**Year 1-3:** Patient education materials and staff time to implement/monitor.

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Increase cancer prevention screening being provided by PCPs a. Seek funding for increased cancer screening opportunities. b. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. b. Based upon availability of funding, implement programs for increased cancer screening and follow-up in at-risk populations. c. Evaluate program and re-assess the prevalence of late-stage diagnosis.	**Year 2:** 1a. Document funding secured. 1b.Document the number of resources provided to offices. 1a-b. Report progress to the IRS. **Year 3:** 1a. Document number of resources provided to offices. 1b. Document new screening efforts and the number of patients screened. 1a-c. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **ANTICIPATED IMPACT:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement cervical cancer education focusing on PAP smear compliance and following HPV vaccine schedules.	Women	**Year 1:** 1. Partner with organizations to identify barriers, community resources available and assess current screening and vaccination compliance in high-risk groups a. Educate community on cervical cancer screening, prevention guidelines and options for vaccination in community. b. Pursue grant funding in partnership with other agencies to remove financial barrier for high-risk groups to access cervical cancer screenings and HPV vaccinations. **Year 2:** 1. Continue to educate community on cervical cancer screening , prevention guidelines and options for vaccination in community. 2. If grant funding secured then work with partner agencies to increase vaccinations provided in accordance with grant requirements. **Year 3:** 1. Continue to educate community on cervical cancer screening , prevention guidelines and options for vaccination in community. 2. If grant funding available then work with partner agencies to increase vaccinations provided in accordance with grant requirements.	**Year 1:** 1a. Document the number of residents that are provided education. 1b. Document if funding secured. 1a-b. Report progress to the IRS. **Year 2:** 1. Document number of patients educated. 2. Document the number of additional vaccinations provided through funding source. 1-2. Report progress to the IRS. **Year 3:** 1-2. Document education, vaccinations and re-assess community health need and report progress to the IRS.	**Year 1-3:** Staff resource time to coordinate partnerships and identify grant funding. Potential partners include local health departments and primary care or community clinics.

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.	Residents at risk of lung cancer	**Year 1:** 1. Conduct program review of low-dose CT lung cancer screening program and make improvements if necessary. 2. Promote screening guidelines and availability of services to local agencies, physicians, community groups and corporations. 3. Provide community lecture(s) to educate and promote smoking cessation and lung cancer screening guidelines. **Year 2:** 1. Continue to provide community lectures to educate and promote smoking cessation and lung cancer screening guidelines. 2. Pursue funding to implement low-income, high-risk individuals low-dose CT scans for lung cancer screening at no cost. **Year 3:** 1. Continue to provide community lectures to educate and promote smoking cessation and lung cancer screening guidelines. 2. Implement program to provide high-risk individuals low-dose CT scans for lung cancer screening at no cost based upon funding availability.	**Year 1:** 1a. Document program improvements, if any. 1b. Document efforts to promote screening guidelines throughout the community. 1c. Document the number of residents attending lectures. 1a-c. Report progress to the IRS. **Year 2:** 1a.Document the number of residents attending lectures. 1b. Document success of funding search 1a-e. Report progress to the IRS. **Year 3:** 1a. Document the number of residents attending lectures 1.b. Document number of patients provided lung cancer screening.	**Year 1-3:** Availability of low-dose CT lung cancer screening program, staff time to coordinate and promote screening guidelines and lectures. Staff time to search and apply for funding source for screenings and treatment.

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1a-g. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **ANTICIPATED IMPACT:** Reduce the rate of suicide-related deaths among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide-related death (i.e., communications plan, analytics necessary to profile high-risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding	**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.	**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 deaths among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Maximize relationships and collaborative opportunities with community-based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1, implement comprehensive wellness initiative that will focus on preventing suicide-related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community-based organizations and evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide-related deaths, etc.) by comparing the baseline measures gathered in year 1 to those gathered in year 2.	**Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 3. Document the metrics identified to measure effectiveness of program implementation and Document the baseline. 1-4. Report progress to the IRS **Year 3:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. Document the reach of the program (number of participants). 3. Compare prevention metrics from year 2 to the baseline developed in year 1.	

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**
- **Chronic environmental stressors**
- **Residents resisting seeking health services**

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

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

1) Maintaining current programs and services while evaluating their effectiveness:
   - ✓ *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 to provide transportation to patients that are not able to afford transportation.*
- ✓ *Continue community partnerships related to the reduction of substance abuse in the communities served by the hospital.*
- ✓ *Faith Community Nurses will continue to address the healthcare needs of the vulnerable and underserved populations in the hospital service area such as services for the homeless and the African American community who are at greatest risk of being diagnosed with hypertension, diabetes, obesity, CVD; the working poor with inadequate or no insurance.)*
- ✓ *Continue to provide medical respite services to homeless patients discharged from the hospital requiring ongoing treatment.*
- ✓ *Continue to provide both on-site and in the community preventive screenings, consultations, education sessions, weight management programs, inpatient vaccines, cholesterol screenings, referrals and coordination of education for diabetes management (e.g., to the diabetes health educator), coordination of primary care appointments, women's health in the community, LifeHelp Program, lectures, health fairs, flu shots, and Faith Community Nursing through collaborative partnerships with 110 volunteer nurses in 47 churches. Some of the topics covered by these activities include obesity, diabetes, hypertension, stroke, heart, vascular and other health issues including specific events for homeless individuals.*
- ✓ *Continue to provide classes at not-for-profit agencies and in faith communities on topics such as 8 Weeks to Wellness (diabetes and heart health), Conversation Mapping (diabetes), Stress Management and Respecting Choices Classes (advance directives).*
- ✓ *Continue the annual wellness conference addressing health issues in the community.*
- ✓ *Continue to offer incentives to patients (gift cards) for keeping their first primary care appointment at local health centers.*
- ✓ *Continue the LifeHelp program, which offers a 12-week weight loss program that incorporates a variety of service lines: referral to the gym at Carillon and use of an exercise physiologist to develop an exercise program; Psychologist to address emotional factors; Nutritionist services and weight checks; meal supplements for calorie reduction; shopping tours and cooking classes.*
- ✓ *Continue the surgical weight-loss program, which offers an information session either online or in person to begin the surgical process which includes: pre-surgical consult with the bariatric surgeon, diet, psychological evaluation, exercise program, and*

emotional support. Post-surgery, the patient is supported with similar services and support groups through the first year and beyond. The bariatric program manager will track their progress and stay in touch with the patient to provide support, and to make sure that they are following up on their post-operative regiment to ensure success.

- ✓ *Continue to address health disparities through Faith Community Nursing partnering with churches providing monthly educational materials and volunteer nurses to address health issues within the congregations while assessing the healthcare needs of the vulnerable and underserved populations in the hospital service area.*
- ✓ *Continue to provide end-of-life directives through chaplains assisting patients and families with advanced directives and consults to pastoral care, social services and/or palliative care.*

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:*
    1. *Continuing to provide the outreach services currently offered;*
    2. *Increasing the availability of Faith Community Nurses to provide preventive screenings, education, and health literacy services to a greater number of residents;*
    3. *Expanding wellness program offerings to local employers;*
    4. *Enhancing the preventive care outreach and education offered in the community to target health disparities.*
- ✓ *Increase the availability of substance abuse services by increasing the early identification and substance abuse services available to families with substance abuse issues*
- ✓ *Increase the use of risk reduction and cancer prevention strategies by increasing resident awareness of and access to risk-reduction and cancer-prevention strategies*

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

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the access that residents have to preventive care, health education, and outreach in the community by: 1. Continuing to provide the outreach services currently offered; 2. Offering monthly education sessions for volunteer nurses; 3. Expanding wellness program offerings to local employers; 4. Enhancing the preventive care outreach and	Resident in the St. Anthony's Hospital service area.	**Year 1:** 1. Offer varying education sessions for volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain and expand wellness program offerings (lectures, screenings, education. materials) for local employers. a. Determine the wellness program offerings (lectures, screenings, education, materials) local employers and employees are interested in. b. Based on evaluations and best practices, develop additional lectures, screenings, education, materials protocols for local employers. c. Offer developed protocols to local employers. 3. Determine where the health disparities are in the hospital service area (i.e., health issue by race, age, gender etc.). 4. Based on evaluation, identify potential community partners to address health disparities in the community 5. Work with community partners to evaluate existing programs and services provided in the community that relate to awareness and prevention services to	**Year 1:** 1. Document the number of education sessions provided and the number of attendees. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3. Document health disparities identified (i.e., health issue and demographic). 4. Document partners. 5. Document the finding of evaluations and any recommendations. 1-5. Report progress to the IRS.	**Year1-3:** **Potential Partners:** community-based organizations, city governments, and senior services **Resources:** Staff time – one FTE dedicated to corporate wellness (existing position). FCN Administrative time to coordinate activities and

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
education offered in the community to target health disparities.		underserved populations. Determine if: a. The hospital and partner organizations have maximized opportunities to meet the needs of the community relative to the health disparities identified (topics, populations, etc.). b. If there are additional partnership opportunities to meet the needs of the community relative to the health disparities identified (topics, populations, etc.). For example: c. It is possible to develop ongoing collaborative relationships related to the health disparities identified (topics, populations, etc.) **Year 2:** 1. Based on available resources, continue to educate volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain the new wellness program offerings (lectures, screenings, education, materials) for local employers. 3. Consider evidence-based practices related to awareness and prevention services to underserved populations addressing the specific health disparities found in St. Anthony's Hospital service area.	**Year 2:** 1. Document the number of education sessions provided, the number of attendees and location annually. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3 a-c. Document the target health disparity identified (i.e., health	track progress Staff time to educate volunteer community health nurses (~$1,000)

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		funding, to implement an evidence-based wellness initiative targeted at alleviating health disparities in the hospital service area. b. Identify one target area to focus a pilot program on. c. Work with community partners to seek funding for a pilot wellness initiative. **Year 3:** 1. Based on available resources, continue to educate volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain the new wellness program offerings (lectures, screenings, education. materials) for local employers. 3. Based on available resources, implement the pilot wellness initiative targeted at increasing awareness and prevention services to target the underserved population addressing the health disparities found in St. Anthony's Hospital service area among that population. 4. Re-assess community need related to prevention and outreach.	issue and demographic) and the funding secured. 1-3. Report progress to the IRS. **Year 3:** 1. Document the number of education sessions provided, the number of attendees and location annually. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3. Document the program developed and implementation plan for year 3 to provide the identified services.	

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of substance abuse services	Adults and pediatric residents who are abusing addictive substances and/or addicted to a substance	**Year 1:** 1. Fully develop and implement the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways a. Identify funding sources and seek funding for program. b. Secure funding. c. Hire staff (e.g., manager and coaching staff). d. Implement program . e. Track the number of patients referred to the program and the number of patients participating in the program. **Year 2:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways	**Year 1:** 1a&b. Document secured funding. 1c. Document the Start dates for program staff. 1d&e. Document the number of patients referred to the program and the number of patients participating in the program. 1. Report progress to the IRS. **Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program, and program outcomes. 1. Report progress to the IRS. **Year 3:** 1. Continue to document the number of patients referred to the program, number of	**Year 1-3:** BCHS Seek $3.3 million –Pathways

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			patients participating in the program and program outcomes. 1. 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				
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	**Year 1:** 1. Through Cancer Registry, measure the percentage of high-risk patients diagnosed with late-stage cancer to establish baseline. 2. Identify and evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung). 3. Evaluate programs and services currently offered by the hospital (including the Mammogram Voucher Program) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach.	**Year 1:** 1. Document the percentage of patients with late stage cancer. 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.	**Year1-3:** Mammogram Voucher Program screenings and follow-up care, Health Associations

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				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources to implement recommendations and secure funding with a focus on follow-up treatment opportunities in the event of diagnosis. 2. Implement changes for which funding is available on-site and in the community. 3. Partner with community-based organizations to provide increased awareness and screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. 4. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. 3. Measure the percentage of high-risk patients diagnosed	4. Document recommendations to increase resident awareness of risk reduction and cancer prevention strategies and resources needed. **Year 2:** 1. Document funding secured. 2. Document new awareness and prevention strategies to be implemented. 3. Document the screenings provided, number and demographics of participants. 4. Document the comparison of late stage cancer incidence to baseline rates. 1-4. Report progress to the IRS. **Year 3:** 1. Document any revisions. 2. Document the awareness	

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				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		with late-stage cancer compared to baseline and cancer registry. 4. Re-assess the prevalence of cancer in the service area.	and prevention strategies implemented. 3. Document the comparison of late stage cancer incidence to baseline rates. 4. Document cancer rates (incidence and prevalence). 1-4. Report re-assessment results and progress to the IRS.	

APPENDIX A

Implementation Strategy

ST. ANTHONY'S HOSPITAL
August, 2013

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Care coordination for uninsured/under insured and homeless residents; including access and awareness	Residents in the community that are under/uninsured	**Year 1:** 1. Explore the development of a resource to facilitate providing information and access to members of the St. Anthony's Hospital community that are eligible for some type of health coverage. a. Explore options to secure a federal grant-funded patient navigator position tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange. b. Based on available resources, begin enrolling residents for open enrollment in 2013. c. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. d. Evaluate effectiveness. 2. Increase the awareness that residents have about available healthcare resources. a. Evaluate best practice methods to disseminate information and health messaging. b. Determine the level of resources required to implement best practices. c. Identify funding sources and seek funding. 3. Collaborate with BayCare Health system and county health departments and other in the exploration of the feasibility and sustainability	**Year 1:** 1a-b. Document if a patient navigator is assigned to SAH and the start date. 1c-d. Document the number of patients assisted. 2a-c. Document the best practice methods chosen and funding secured. 3a-d. Document the collaborating partners, timeline, and the results and recommendations of evaluations. 1-3. Report progress to the IRS.	**Year1-3:** **Potential Partners:** **Resources:** 1. 1 FTE (grant funded) 3. Admin time allocation to develop partnership, rent-free space for community clinic.

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		establishing a clinic for uninsured (including FQHC). a. Develop necessary relationships and needed Agreements between related agencies and governments participating in the effort. b. Develop a timeline. c. Identify the feasibility and sustainability along with best practices in supporting the provision of clinic services to uninsured residents, including evaluation and documentation. d. Identify and seek necessary funding in collaboration with partnering organizations. **Year 2:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. b. Evaluate effectiveness. 2. Based on available resources, develop education program and materials on accessing the community resources that are available in the service area . a. Train Faith Community Nurses on the	**Year 2:** 1a-b. Document the number of patients assisted. 2a-b. Document the timeline for training and implementation of outreach education. 2c. Document the number of residents that receive community resource information. 3. Document funding secured and new	

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		community resource outreach education programming developed. b. Develop a plan to incorporate the community resource outreach education into the activities conducted by Faith Community Nurses in the community (i.e., screenings, events, etc.). c. Track the number of residents reached by the outreach efforts. 3. Based on available resources and the results of evaluations completed in year 1, further explore establishing clinics for the uninsured in collaboration with partnering organizations. a. Revise implementation plan to reflect action step for years 2 and 3 that are commiserate with evaluation results, partnerships, and available resources among collaborating partners. b. Implement plan. **Year 3:** 1. Based on available resources, continue enrolling residents for health exchange. a. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance.	implementation plan for years 2-3. 1-3.Report progress to the IRS. **Year 3:** 1a-b. Document the number of patients assisted. 2. Document the number of residents that receive community resource	

NEED: Improving access to affordable healthcare - Care coordination: Insurance/financial assistance **UNDERLYING FACTORS:** Access Related to Insurance Coverage, resident awareness about what resources exist in the community. **ANTICIPATED IMPACT:** To increase access residents have to and effective use of healthcare resources				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		b. Evaluate effectiveness. 2. Based on available resources, continue to incorporate the community resource outreach education into the activities conducted by Faith Community Nurses in the community (i.e., screenings, events, etc.). a. Track the number of residents reached by the outreach efforts. 3. Based on available resources and successes in year 2, revise implementation plan in year 3 and continue efforts to establish clinics for uninsured in collaboration with partnering organizations . 4. Re-assess need in the community.	information. 3. Document new implementation plan for year 3. 1-4. Re-assess need and Report progress to the IRS.	

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

NEED: Decreasing the prevalence of clinical health issues – Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the access residents have to screening, diagnostic, and treatment services for diabetes	Uninsured residents in the St. Anthony's Service area	**Year 1:** 1. LifeHelp Diabetes and Nutrition Center provides education and nutritional counseling services for diabetic and obese individuals. The program is American Diabetes Association Recognized and offers diabetes and weight loss support groups, food shopping tours, cooking classes, and community lectures/screenings. a. Evaluate the populations most in need of supplemental funding (i.e., patients that often do not have adequate coverage for services through insurances or other venues) through case reviews. b. Identify and secure resources needed to provide/supplement services to individuals without insurance coverage (e.g., grant funding, scholarships, insurance dollars, etc.). c. Clearly define the qualification parameters for funding secured and services that can be covered by grant funding. 2. Increase community outreach related to disease management for diabetic residents: a. Develop a cross-training program through which, LifeHelp will collaborate with Faith Community Nursing to train select nurses on effective education programs, tools and techniques related to self-management of diabetes.	**Year 1:** 1a-c. Document the results of evaluation and recommendations, resources secured and limitations of funding. 2a. Document the number of nurses trained, dates, and locations. 2b. Document the number of residents volunteer nurses assist. 3. Document the number of screenings, locations, and number of residents served annually. 1-3. Report progress to the IRS.	**Year1-3:** **Potential Partners:** LifeHelp Diabetes and Nutrition Center, FCN **Resources:** Allocation of existing Staff time to coordinate activities and tracking, volunteer nurses to participate in events, additional medical supplies for screenings

NEED: Decreasing the prevalence of clinical health issues – Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		b. Volunteer nurses will implement training by meeting patients in the hospital and then follow-up post-discharge via phone call or home visit to reinforce training. 3. Faith Community Nursing collaborative effort with local diabetes Prevention Program to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and screening programs at local churches and in underserved areas. **Year 2:** 1. Based on resources available, provide LifeHelp Diabetes and Nutrition Center services to diabetic individuals without insurance coverage a. Expand services to the number of under/uninsured residents, for which funding was secured. b. Track the number of participants, insurance status, demographics and outcome of program participation. c. Continue to identify and secure additional funding opportunities. 2. Volunteer nurses will continue to meet patients in the	**Year 2:** 1a-c. Document the number of residents served, insurance status and program outcome. 2. Document the number of residents volunteer nurses assist. 3. Document the number of screenings, locations, and number of residents served annually.	Seek funding to cover $10K-$20K in annual expense for diabetic counseling to those without insurance

NEED: Decreasing the prevalence of clinical health issues – Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		hospital and then follow-up post-discharge via phone call or home visit to reinforce training. a. Track the number of patients served and outcome. 3. Faith Community Nursing collaborative effort with local diabetes prevention program to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and screening programs at local churches and in underserved areas. **Year 3:** 1. Based on resources available, continue to provide LifeHelp Diabetes and Nutrition Center services to diabetic individuals without insurance coverage a. Expand services to the number of under/uninsured residents, for which funding is secured. b. Track the number of participants, insurance status, demographics and outcome of program participation. c. Continue to identify and secure additional funding opportunities.	1-3. Report progress to the IRS. **Year 3:** 1a-c. Document the number of residents served, insurance status and program outcome. 2. Document the number of residents volunteer nurses assist. 3. Document the number of screenings, locations and number of residents served	coverage

NEED: Decreasing the prevalence of clinical health issues – Diabetes **UNDERLYING FACTORS:** Higher rates of diabetes, need for disease management and poor health outcomes and disparities **ANTICIPATED IMPACT:** Improve the resources for residents related to diabetes diagnosis and treatment.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		2. Volunteer nurses will continue to meet patients in the hospital and then follow-up post-discharge via phone call or home visit to reinforce training. a. Track the number of patients served and outcome. 3. Faith Community Nursing collaborative effort with local diabetes prevention programs to provide cholesterol/glucose screening and education at health fairs and senior events. Community lectures and screening programs at local churches and in underserved areas.	annually. 1-3. Report re-assessment and progress to the IRS.	

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

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Increase the risk reduction and cancer prevention strategies offered by Primary Care Physicians	Adult residents	**Year 1:** 1. Increase prevention education about risk reduction and cancer prevention strategies being provided by PCPs a. Develop partnerships with PCPs in the community. b. Increase education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. **Year 2:** 1. Increase cancer prevention screening being provided by PCPs a. Seek funding for increased cancer screening opportunities. b. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group	**Year 1:** 1ab. Document the number of PCPs contacted and resources distributed into offices. 1a-b. Report progress to the IRS. **Year 2:** 1a. Document funding secured. 1b.Document the number of resources provided to offices. 1a-b. Report progress to the IRS. **Year 3:** 1a. Document number of resources provided to offices. 1b. Document new screening efforts and the	**Year 1-3:** Patient education materials and staff time to implement/monitor.

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		PCPs and community partner PCPs. b. Based upon availability of funding, implement programs for increased cancer screening and follow-up in at-risk populations. c. Evaluate program and re-assess the prevalence of late-stage diagnosis.	number of patients screened. 1a-c. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **ANTICIPATED IMPACT:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement cervical cancer education focusing on PAP smear compliance and following HPV vaccine schedules.	Women	**Year 1:** 1. Partner with organizations to identify barriers, community resources available and assess current screening and vaccination compliance in high-risk groups a. Educate community on cervical cancer screening, prevention guidelines and options for vaccination in community. b. Pursue grant funding in partnership with other agencies to remove financial barrier for high-risk groups to access cervical cancer screenings and HPV vaccinations.	**Year 1:** 1a. Document the number of residents that are provided education. 1b. Document if funding secured. 1a-b. Report progress to the IRS.	**Year 1-3:** Staff resource time to coordinate partnerships and identify grant funding. Potential partners include Florida

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of cervical cancer **ANTICIPATED IMPACT:** Decrease the rate of cervical cancer through increasing risk reduction and cancer prevention strategies among women				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Continue to educate community on cervical cancer screening , prevention guidelines and options for vaccination in community. 2. If grant funding secured then work with partner agencies to increase vaccinations provided in accordance with grant requirements. **Year 3:** 1. Continue to educate community on cervical cancer screening , prevention guidelines and options for vaccination in community. 2. If grant funding available then work with partner agencies to increase vaccinations provided in accordance with grant requirements	**Year 2:** 1. Document number of patients educated. 2. Document the number of additional vaccinations provided through funding source. 1-2. Report progress to the IRS. **Year 3:** 1-2. Document education, vaccinations and re-assess community health need and report progress to the IRS.	Health Department Pinellas County, St. Pete Free Clinic and Community Health Centers of Pinellas.

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of	Residents at risk of lung cancer	**Year 1:** 1. Conduct program review of low-dose CT lung cancer screening program and make improvements if necessary. 2. Promote screening guidelines and availability of	**Year 1:** 1a. Document program improvements, if any. 1b. Document efforts to promote screening	**Year 1-3:** Availability of low-dose CT lung cancer screening

NEED: Decreasing the prevalence of clinical health issues - Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis.				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
lung cancers diagnosed at Stage I in high-risk populations.		services to local agencies, physicians, community groups and corporations. 3. Provide community lecture(s) to educate and promote smoking cessation and lung cancer screening guidelines. **Year 2:** 1. Continue to provide community lectures to educate and promote smoking cessation and lung cancer screening guidelines. 2. Pursue funding to implement low-income, high-risk individuals low-dose CT scans for lung cancer screening at no cost. **Year 3:** 1. Continue to provide community lectures to educate and promote smoking cessation and lung cancer screening guidelines. 2. Implement program to provide high-risk individuals low-dose CT scans for lung cancer screening at no cost based upon funding availability.	guidelines throughout the community. 1c. Document the number of residents attending lectures. 1a-c. Report progress to the IRS. **Year 2:** 1a.Document the number of residents attending lectures. 1b. Document success of funding search 1a-e. Report progress to the IRS. **Year 3:** 1a. Document the number of residents attending lectures 1.b. Document number of patients provided lung cancer screening. 1a-g. Re-assess community	program, staff time to coordinate and promote screening guidelines and lectures. Staff time to search and apply for funding source for screenings and treatment.

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

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the access that residents have to preventive care, health education, and outreach in the community by: 1. Continuing to provide the outreach services currently offered; 2. Offering monthly education sessions for volunteer nurses; 3. Expanding wellness program offerings to local employers; 4. Enhancing the preventive care outreach and education offered in the	Resident in the St. Anthony's Hospital service area.	**Year 1:** 1. Offer varying education sessions for volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain and expand wellness program offerings (lectures, screenings, education. materials) for local employers. a. Determine the wellness program offerings (lectures, screenings, education, materials) local employers and employees are interested in. b. Based on evaluations and best practices, develop additional lectures, screenings, education, materials protocols for local employers. c. Offer developed protocols to local employers. 3. Determine where the health disparities are in the hospital service area (i.e., health issue by race, age, gender etc.). 4. Based on evaluation, identify potential community partners to address health disparities in the community. 5. Work with community partners to evaluate existing programs and services provided in the community that relate to awareness and prevention services to underserved populations. Determine if: a. The hospital and partner organizations have	**Year 1:** 1. Document the number of education sessions provided and the number of attendees. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3. Document health disparities identified (i.e., health issue and demographic). 4. Document partners. 5. Document the finding of evaluations and any recommendations. 1-5. Report progress to the IRS.	**Year1-3:** **Potential Partners:** community organizations, city governments, senior service programs **Resources:** Staff time – one FTE dedicated to corporate wellness (existing position). FCN Administrative time to coordinate activities and track progress

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
community to target health disparities.		maximized opportunities to meet the needs of the community relative to the health disparities identified (topics, populations, etc.). b. If there are additional partnership opportunities to meet the needs of the community relative to the health disparities identified (topics, populations, etc.). For example: c. It is possible to develop ongoing collaborative relationships related to the health disparities identified (topics, populations, etc.) **Year 2:** 1. Based on available resources, continue to educate volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain the new wellness program offerings (lectures, screenings, education, materials) for local employers. 3. Consider evidence-based practices related to awareness and prevention services to underserved populations addressing the specific health disparities found in St. Anthony's Hospital service area. a. Determine the resources required, including funding, to implement an evidence-based wellness initiative targeted at alleviating health disparities in the hospital service area.	**Year 2:** 1. Document the number of education sessions provided, the number of attendees and location annually. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3 a-c. Document the target health disparity identified (i.e., health	Staff time to educate volunteer community health nurses (~$1,000)

NEED: Improving healthy behaviors and environments - Preventive care, health education, and community outreach **UNDERLYING FACTORS:** Obesity, disease management, poor health outcomes and disparities, and end-of-life advanced directives **ANTICIPATED IMPACT:** Increase the access that residents have to preventive care, health education, and outreach in the community				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		program on. c. Work with community partners to seek funding for a pilot wellness initiative. **Year 3:** 1. Based on available resources, continue to educate volunteer nurses so they can educate Faith Community partners. 2. Based on available resources, maintain the new wellness program offerings (lectures, screenings, education. materials) for local employers. 3. Based on available resources, implement the pilot wellness initiative targeted at increasing awareness and prevention services to target the underserved population addressing the health disparities found in St. Anthony's Hospital service area among that population. 4. Re-assess community need related to prevention and outreach.	1-3. Report progress to the IRS. **Year 3:** 1. Document the number of education sessions provided, the number of attendees and location annually. 2. Document new services offered, the number of services provided to local employers, location and the number of employees participating in each. 3. Document the program developed and implementation plan for year 3 to provide the identified services. 1-4. Re-assess and report 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

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Continue to provide while increasing the availability of substance abuse services	Adults and pediatric residents who are abusing addictive substances and/or addicted to a substance	**Year 1:** 1. Fully develop and implement the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways a. Identify funding sources and seek funding for program. b. Secure funding. c. Hire staff (e.g., manager and coaching staff). d. Implement program. e. Track the number of patients referred to the program and the number of patients participating in the program. **Year 2:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental health and substance abuse: Pathways	**Year 1:** 1a&b. Document secured funding. 1c. Document the Start dates for program staff. 1d&e. Document the number of patients referred to the program and the number of patients participating in the program. 1. Report progress to the IRS. **Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program, and program outcomes. 1. Report progress to the IRS. **Year 3:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes.	**Year 1-3:** BCHS Seek $3.3 million –Pathways

NEED: Improving healthy behaviors and environments - Substance Abuse **UNDERLYING FACTORS:** Substance Abuse and Substance Addiction **ANTICIPATED IMPACT:** Increase the availability of substance abuse services				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1. 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				
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	**Year 1:** 1. Through Cancer Registry, measure the percentage of high-risk patients diagnosed with late-stage cancer to establish baseline. 2. Identify and evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung). 3. Evaluate programs and services currently offered by the hospital (including the Mammogram Voucher Program) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency, and reach. 4. Based on results of evaluation, develop program recommendations including resources required.	**Year 1:** 1. Document the percentage of patients with late stage cancer. 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	**Year1-3:** Mammogram Voucher Program screenings and follow-up care, Health Care Assoca-tions

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				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			of risk reduction and cancer prevention strategies and resources needed.	
		Year 2: 1. Identify potential funding sources to implement recommendations and secure funding with a focus on follow-up treatment opportunities in the event of diagnosis. 2. Implement changes for which funding is available on-site and in the community. 3. Partner with community-based organizations to provide increased awareness and screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. 4. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry.	**Year 2:** 1. Document funding secured. 2. Document new awareness and prevention strategies to be implemented. 3. Document the screenings provided, number and demographics of participants. 4. Document the comparison of late stage cancer incidence to baseline rates. 1-4. Report progress to the IRS.	
		Year 3: 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in	**Year 3:** 1. Document any revisions. 2. Document the awareness and prevention strategies implemented. 3. Document the	

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				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		attendance, location, satisfaction of attendees, and number of participants. 3. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. 4. Re-assess the prevalence of cancer in the service area.	comparison of late stage cancer incidence to baseline rates. 4. Document cancer rates (incidence and prevalence). 1-4. Report re-assessment results and progress to the IRS.	

APPENDIX B

Needs not Addressed by the 2013 Plan

ST. ANTHONY'S HOSPITAL
August, 2013

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

Low birth weight and pre-term births:

While hospital leaders are interested in this issue, and are interested in further evaluating the barriers that female residents experience when seeking health services related to birthing services, the St. Anthony's Hospital does not currently have the expertise, resources, and/or provider base to provide this service. Because the primary needs within the community have dictated that financial and human resources of St. Anthony's Hospital are utilized for diagnostic and therapeutic medical and surgical care, hospital leaders have determined that services addressing low birth weight and pre-term births could be better met by existing providers allowing available resources to remain focused on the existing and planned health services. However, the need as identified has increased awareness and may be further evaluated.

Chronic environmental stressors in the service area:

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