South Florida Baptist Hospital

Implementation Plan – Final Report

September, 2013

TrippUmbach
Research • Strategy • Impact

Table of Contents

- ❑ Introduction… Page: 2
- ❑ Community Definition… Page: 3
- ❑ Methodology… Page: 5
- ❑ Community Health Needs and Implementation Plan… Page: 7
- ❑ Appendix A: Implementation Plan Document … Page: 36
- ❑ Appendix B: Needs not Addressed by the 2013 Plan … Page: 57

Introduction

South Florida Baptist Hospital is a 147-bed facility, located in Plant City, 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, South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist Hospital community. As a non-profit hospital, South Florida Baptist 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 South Florida Baptist Hospital community is defined as five zip code areas in Hillsborough County, Florida. (See Table 1 & Figure 1). The needs identified in the CHNA report pertain to the same five zip code areas in Hillsborough County, Florida.

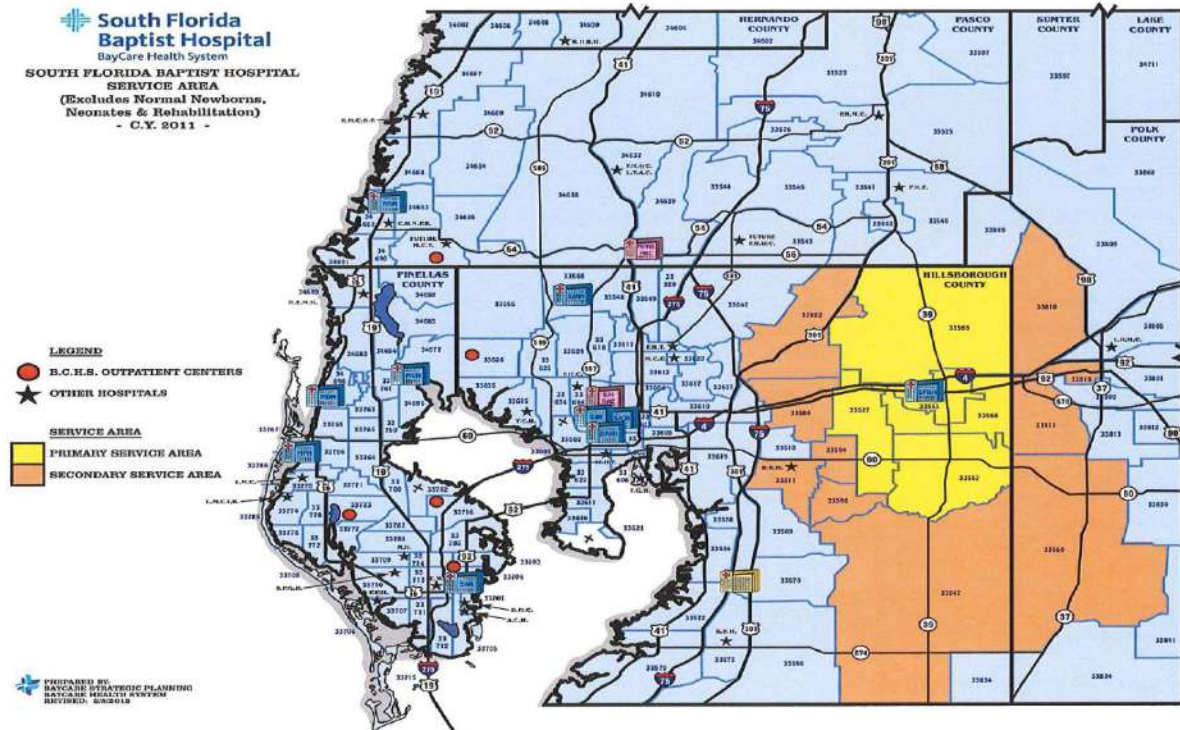
South Florida Baptist Hospital Community

Table 1

Zip	Town	County
33527	Dover	Hillsborough
33563	Plant City	Hillsborough
33565	Plant City	Hillsborough
33566	Plant City	Hillsborough
33567	Plant City	Hillsborough

South Florida Baptist Hospital Community Map

Figure 1



Methodology

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

Key elements of the implementation planning process included:

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

- **Community Health Needs Assessment Review:** Tripp Umbach worked with the South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist Hospital that meets significant community health needs.

- **Review of Best Practice Examples:** Tripp Umbach provided an inventory of national best practice resources which included resources from County Health Rankings (Population Health Institute of Wisconsin & Robert Wood Johnson Foundation), CDC the CDC's Guide to Community Preventive Services Task Force, Healthy People 2020, and other valid national resources. Hospital leadership reviewed the best practice inventory and selected practices that best fit with the expertise, resources, mission, and vision of South Florida Baptist 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 22nd, 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist Hospital is best positioned to dedicate resources to address within their community.

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

Tripp Umbach completed an independent review of existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and detailed input provided by the focus group, which resulted in the prioritization of key community health needs that hospital leaders felt related to the South Florida Baptist 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 South Florida Baptist 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**

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 employment benefits, limited transportation, etc.).

While South Florida Baptist 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 South Florida Baptist Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further increase access to affordable healthcare is through a mixed-strategy of: 1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Maintain the availability of all services to under/uninsured residents by continuing to provide care to residents regardless of their insurance status as required by the state of Florida.*
- ✓ *Continue to administer a financial assistance program on-site that provides uninsured residents assistance in identifying and applying for medical benefits for which they may qualify.*
- ✓ *BayCare Health System will continue to implement the Medical Home Model through BayCare Medical Group, which includes care coordination provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue to offer behavioral health services through BayCare Behavioral Health Department.*

- ✓ *Continue to provide MH 101 training during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at South Florida Baptist Hospital.*
- ✓ *Continue to provide co-located Behavioral Health Services as an available service of primary care physician practices in many communities.*
- ✓ *Continue to provide translation services on-site.*
- ✓ *Continue to provide follow-up coordination in the community through Faith Community Nurses.*
- ✓ *Continue, to the extent it is possible, providing bus/cab vouchers for patients unable to afford public transportation.*
- ✓ *Continue to support a pediatric prescription fund that receives financial donations from South Florida Baptist Hospital team members: through which, patients (age 18 and under) are referred to the program by the Patient Care Coordination Team at SFBH.*
- ✓ *Continue to provide medication assistance; to the extent it is possible, to patients over 18 through arrangement with a local pharmacy.*
- ✓ *Continue, to the extent it is possible, to support to the local mission which provides housing and health services to migrant working residents.*
- ✓ *Continue to provide bilingual staff at a minimum rate of one bilingual staff person per shift.*

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 South Florida Baptist Hospital community that are eligible for some type of medical assistance.*
- ✓ *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 and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Decrease the percentage of uninsured residents in the community	Residents in the community that are eligible for some form of health insurance	**Year 1:** 1. Explore the development of a resource (e.g., PTE, expanded parameters for medical qualifiers) to facilitate providing information and access to members of the SFBH community that are eligible for some type of health coverage. a. Advocate for a federal grant-funded PTE to the SFB service area tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange effective Jan 1st, 2014 and/or Identify and refer patients that are eligible for health insurance and not enrolled. b. Identify best practices for accessing affordable healthcare coverage, including evaluation and documentation related to ACA implementation. c. Develop an outreach plan by identifying locations and venues for outreach and promotion in the community. d. Based on available resources begin enrolling residents for open enrollment	**Year 1:** 1a-b. Document if a patient navigator is assigned to SFBH and the start date. 1c-d. Document the number of patients assisted. 2a. Document the funding sought 2b-c. Document the number of patients assisted. 1-2. Report progress to the IRS.	**Year1-3:** **Potential Partners:** BCHS **Resources:** Staff time and if needed, +1 PTE

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		2013. e. Track the number of residents reached during outreach efforts and the number of residents enrolled in some type of insurance. f. Evaluate effectiveness 2. SFB President and leadership will address funding issue with the existing hospital supported Pediatric Discharge Medication Program for unfunded/underfunded hospital patients. a. Work to identify a funding source to expand funding for the SFB Pediatric Discharge Medication Program to include adults. b. Create hospital-administered Adult & Pediatric Medication Program. c. Track the number of patients assisted with current funding in Year 1 to develop a baseline. **Year 2:** 1. Review evaluations of efficacy from year 1 and develop goals and recommendations for increased enrollment in year 2. 2. Implement program improvements and best	**Year 2:** 1. Document goals for year 2. 2a-b. Document the number of patients assisted. 1-4. Report progress to	

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		practices identified in Year 1 a. Identify and refer patients that are eligible for health insurance and not enrolled. b. Evaluate the effectiveness of the resource implemented for increasing access to affordable health care coverage (i.e., PTE) and determine necessary improvements. 3. Monitor and report performance progress by year end 4. Based on available resources, expand the number of patients and/or medications offered by the SFBH Discharge Medication Program. a. Continue to seek to expand funding for the SFB Discharge Medication Program through community relationships, hospital foundation and other resources. b. Track the number of patients assisted and compare to year 1 baseline. **Year 3:** 1. Review evaluations of efficacy from year 2 and develop goals and recommendations for increased enrollment in year 3. 2. Implement program improvements and best practices identified in Year 2	the IRS. **Year 3:** 1. Document goals for year 2a-b. Document the number of patients assisted. 1-4. Reassess need and Report progress to the IRS.	

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Identify and refer patients that are eligible for health insurance and not enrolled. b. Evaluate the effectiveness of the resource implemented for increasing access to affordable health care coverage (i.e., PTE) and determine necessary improvements. 3. Monitor and report performance progress by year end 4. Based on available resources, expand the number of patients and/or medications offered by the SFB Discharge Medication Program. a. Continue to seek to expand funding for the SFB Discharge Medication Program through community relationships, hospital foundation and other resources. b. Track the number of patients assisted and compare to year 1 baseline. 5. Reassess need in the community.		

NEED: Improving access to affordable healthcare- Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services

Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of mental health services	Adults and pediatric residents who may require mental health services	**Year 1:** 1. Family and Patient Preservation Program- working at home with families at risk a. Convert pediatric acute care funding to outpatient preservation program b. Implement program and track measure outcomes. **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:** 1) Conversion of pediatric acute services grant to preservation program $400,000

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

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

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

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

The analysis of data collected for the CHNA process present substantial clinical health issues in the majority of the South Florida Baptist Hospital service area. Additionally, African American and Hispanic residents in Hillsborough County tend to show worse outcomes for health with increased prevalence across several indicators (i.e., cancer, asthma, diabetes, stroke, congestive heart failure, bacterial pneumonia, urinary tract infections, low birth weight, teen births, and pre-term births, etc.). However, the areas with the greatest clinical health issues show the worst socio-economic ratings. As a result, there are zip codes areas with higher clinical health issues and greater barriers to accessing health care, which appear to consume a great deal of health care resources.

There are several indicators in Hillsborough County and the service area for South Florida Baptist Hospital that are presented in county-level and zip code-level data gathered from Healthy Tampa Bay that have not yet or have only slightly surpassed the national benchmarks. However, there has been substantial increase in these indicators that, if left unchecked, could become community health needs (i.e., death rate due to strokes, non-medical use of prescription pain relievers, tobacco use, prostate cancer, infant mortality among white infants, pre-term births, tuberculosis, etc.).

While South Florida Baptist 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 South Florida Baptist 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 South Florida Baptist 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.*
- ✓ *BayCare Medical Group, through the medical home model, provides disease management and services for diabetes, pulmonary disease, etc.*
- ✓ *Encourage Faith Community Nurses to continue to provide community education, follow-up, screenings, etc.*
- ✓ *Continue to support (e.g., referrals and partnership) a Community- Based Care Transitions Program (CCTP) to reduce re-hospitalizations, including CHF, in the Medicare population in Hillsborough County through a referral coach.*
- ✓ *Continue to screen and identify patients that are considered high risk for re-hospitalization.*
- ✓ *Continue to partner with community based organizations that serve expecting mothers to implement best practice and prevention of pre-term births, low birth weight, and infant mortality while focusing on prenatal screening and early identification of risk issues. Continue, to the extent it is possible, to maintain the existing contracts with local clinics to increase access to certified nurse-midwives, which provide pre-natal care with bilingual capacity.*
- ✓ *Continue to provide physician lectures related to asthma management, etc.*
- ✓ *Continue to provide, to the extent it is possible, treatment options through medical oncologists.*
- ✓ *Continue, to the extent it is possible, the Cancer Resource Center, which donate space for groups, volunteers, and other resources for cancer patients.*

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

- ✓ *Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice for CHF patients by:*
    1. *Offering comprehensive care coordination for CHF patients.*
- ✓ *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.*

- ✓ *Reduce the rate of suicide-related deaths among residents served by BayCare Health System by increasing the awareness of and prevalence of suicide prevention.*
- ✓ *Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System by enhancing available partnership and services provided and targeting populations in the hospital services are that show health disparities related to birth outcomes.*

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

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease readmission rates and mortality rates while increasing referrals to hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc). 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice	**Year 1:** 1. Document evaluation findings 2. Document recommendations 3. Document plan 4. Document resources needed	**Year1-3:** **Resources:** Staff time **Partners:** Local agencies

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease readmission rates and mortality rates while increasing referrals to hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients. 4. Determine the level of resources required to implement a comprehensive care coordination procedure for CHF patients. 5. Explore options for maximizing current partnerships with a variety of CBOs. 6. Review options for collaboration at BayCare Health System Level (i.e., Coordination through BC Home Health, Primary Care Physicians, Faith Community Nursing, etc). 7. Identify potential funding sources and seek funding. **Year 2:** 1. Based on available resources, communicate new care coordination program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External communications and internally to patients treated	5-6. Document partnership and collaborative opportunities 7. Document funding secured 1-7. Report progress to the IRS. **Year 2:** 1. Document the communication plan (internal and external) 2. Document stages of role out. 4. Document outcomes and efficacy. 1-4. Report progress to the IRS.	and hospices

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease readmission rates and mortality rates while increasing referrals to hospice

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		and referred i.e.: WEB 4. Document outcomes and evaluate efficacy (i.e., number of readmission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six month intervals. **Year 3:** 1. Continue to offer the comprehensive care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program evaluation 4. Reassess the preventable hospitalizations for CHF in the service area.	**Year 3:** 1. Document number of participants 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report reassessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues - 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 community agencies and providers to identify community resources and assess current screening and vaccination compliance in high risk groups through Faith Community Nursing. a. Determine current screening and vaccination compliance rates in congregations. b. Determine if barriers (i.e., financial, transportation, etc.) exist for cervical cancer screening and prevention. c. Educate congregation members of cervical cancer screening and prevention guidelines. d. Identify resources needed to increase compliance rates. e. Identify possible funding sources. f. Make available advanced directive documents during any screening or education program **Year 2:** 1. Based on available resources and collected data develop programs to target low compliance populations. Partner with community based organizations to provide increased screening and	**Year 1:** 1a-b. Document baseline screening and vaccination rates and the barriers identified by FCN. 1c. Document the number of residents that are provided education. 1d. Document funding secured. 1a-d. Report progress to the IRS **Year 2:** 1a. Document number of patients provided cancer screening and vaccinations and report	**Year 1-3:** **Resources:** Staff time and any additional funding dollars **Partners:** Faith Community Nursing

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**
		vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screening and vaccinations at FCN network partners. Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Continue to partner with community based	rate increases. 1b.Document the number of patients that are provided education. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-e. Report progress to the IRS **Year 3:** 1a. Document number of patients provided cancer screening and	

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
		organizations to provide increased screening and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screening and vaccinations at FCN network partners. Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.).	vaccinations and report rate increases. 1b.Document the number of patients that are provided education. 1g. Document the number of advanced directive materials provided. 1h. Document metrics related to program effectiveness. 1a-g. Reassess community health need and report progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues - Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **ANTICIPATED IMPACT:** Reduce the rate of suicide related death among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths (i.e., communications plan, analytics necessary to profile high risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding **Year 2:** 1. Maximize relationships and collaborative opportunities with community based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc.	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured 1-6. Report progress to the IRS **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 3. Document the metrics	**Year1-3:** $30,000 BCBH

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

<table>
<tr><td colspan="5">NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes
UNDERLYING FACTORS: Pre-term births, low-birth weight births, infant mortality
ANTICIPATED IMPACT: Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System</td></tr>
<tr><th>Objective</th><th>Target Population</th><th>Strategies and Action Description</th><th>Timeframe/ Measures</th><th>Potential Resources/ Partners</th></tr>
<tr><td>Improve birth outcomes for patients served by facilities and organizations associated with BayCare Health System</td><td>Expecting mothers at risk of poor birth outcomes</td><td>Year 1:
1. South Florida Baptist Hospital will continue to provide current initiatives for inpatients and outpatients while evaluating the effectiveness, evidence basis, outcomes measures, population served, accessibility, etc. of current models. These models include relationships with community based organizations that serve expecting mothers at risk of poor birth outcomes to determine if:
a. The hospital has maximized opportunities to meet the needs of the community relative to improving birth outcomes:
b. If there are additional partnership opportunities to meet the needs of the community relative to improving birth outcomes
c. It is possible to develop ongoing collaborative relationships related to expecting mothers in the hospital service areas.
2. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.)
3. Develop baseline metrics by collecting outcome</td><td>Year 1:
1 & 2.Document the results of an evaluation of hospital collaboration with community based organizations and recommendations made for changes to existing partnerships, programs/services, etc.
3. Document outcome measures for each collaborating CBO.
1-3. Report progress to the IRS</td><td>Year 1:
Grants, substance abuse and treatment grant for NICU navigators, Staff, office supplies, educational material</td></tr>
</table>

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

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

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

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

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

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

The health of a community largely depends on the health status of its residents. Key stakeholders and focus group participants believed that the lifestyles of some residents may have an impact on their individual health status and consequently, cause an increase in the consumption of healthcare resources. Specifically, key stakeholders and focus group participants discussed lifestyle choices (i.e., poor

nutrition, inactivity, smoking, etc.) that can lead to chronic illnesses (i.e., cancer, obesity, diabetes, hypertension, strokes, 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 South Florida Baptist 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 South Florida Baptist Hospital is not the only medical resource in the hospital's service area, hospital leadership felt that the most effective strategy to further improve healthy behaviors and environments is through a mixed-strategy of:
1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Faith Community Nurses will continue to addresses the healthcare needs of the vulnerable and underserved populations in the hospital service area.*
- ✓ *Continue to identify and establish healthy alternatives for staff (i.e., reduction of Trans fats in meals, encouragement of physical activities, offering nutritionist services, etc.)*
- ✓ *BayCare Health System will continue to provide preventive care and weight management through the BayCare Medical Group as a component of the Medical Home Model provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue community partnerships related to the reduction of substance abuse in the communities served by the hospital.*
- ✓ *Continue to offer bariatric surgery and nutritionist services on-site.*
- ✓ *Continue, to the extent possible, to offer financial assistance for program fees to attend SJH smoking cessation programs.*

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 migrant workers have to health services related to nutrition by collaborating with local clinics in the service area.*
- ✓ *Increase the availability of substance abuse services by increasing the early identification and substance abuse services available to families with substance abuse issues.*

- ✓ *Increase the use of risk reduction and cancer prevention strategies by increasing resident awareness of and access to risk-reduction and cancer-prevention strategies*

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

NEED: Improve healthy behaviors and environments - Disease management: general population including uninsured and migrant working residents **UNDERLYING FACTORS:** Obesity education and community outreach & Health Services for Migrant Workers **ANTICIPATED IMPACT:** Increase the access that migrant workers have to health services related to nutrition				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Collaborate with local clinics in the service area to increase services available to migrant workers and uninsured residents	Uninsured residents and migrant workers	**Year 1:** 1. Explore the opportunity to lease certified nutritionists to local clinics in Plant City and Dover on a part-time basis to provide diet and obesity education to clinic patients including migrant workers. 2. Evaluate existing programs and relationships with local clinics in Plant City and Dover to determine if: a. The hospital has maximized opportunities to meet the needs of the community relative to diet and obesity education. b. If there are additional partnership opportunities to meet the needs of the community relative to diet and obesity education. c. It is possible to enhance ongoing collaborative relationships related to diet and obesity education.	**Year 1:** 1-4. Report progress to the IRS.	**Year1-3:** **Potential Partners:** Local clinics **Resources:** Staff time

NEED: Improve healthy behaviors and environments - Disease management: general population including uninsured and migrant working residents
UNDERLYING FACTORS: Obesity education and community outreach & Health Services for Migrant Workers
ANTICIPATED IMPACT: Increase the access that migrant workers have to health services related to nutrition

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		3. Identify and seek funding opportunities if necessary to expand services related to diet and obesity education. 4. Develop baseline metrics by collecting outcome measures for each local clinic. **Year 2:** 1. Based on resources available and results from efforts in year one; begin leasing certified nutritionists to local clinics in Plant City and Dover. a. Track outcomes of new services in Plant City and Dover locations (i.e., the number of patients seen, outcome measures, etc.). **Year 3:** 1. Based on resources available and results from efforts in year one; continue leasing certified nutritionists to local clinics in Plant City and Dover. a. Track outcomes of new services in Plant City and Dover locations (i.e., the number of patients seen, outcome measures, etc.). 2. Reassess community need related to obesity and health services for migrant workers.	**Year 2:** 1. Report progress to the IRS. **Year 3:** 1-2. Report reassessment results and progress to the IRS	

NEED: Improve 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. 2. Substance Abuse Case Management for Mom's and babies-addicted to prescription drugs a. Identify necessary resources (e.g., funding, staff, space, materials, etc.) b. Identify and acquire funding required for Case Management team. c. Develop case management program d. Hire staff	**Year 1:** 1a&b. Document secured funding 1c. Document the Start dates for program staff. 1d&e. Document the number of patients referred to the program and the number of patients participating in the program. 2a-b. Document resources required and resources secured. 2d. Document start dates of staff hired. 2e. Document the number of families served. 1-2. Report progress to the IRS	**Year 1-3:** BCHS 1) 3 mill - Pathways BCHS 2) $130,000 – Mom's and babies

NEED: Improve healthy behaviors and environments - 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**
		e. Implement case management by connecting mothers and babies to community services and partners. **Year 2:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Mom's and babies-addicted to prescription drugs. **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Mom's and babies-addicted to prescription drugs.	**Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served. 1-2. Report progress to the IRS **Year 3:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program	

NEED: Improve 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**
			outcomes. 2. Document the number of families served. 1-2. Report progress to the IRS	

NEED: Improve healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk reduction and cancer prevention strategies	Residents in hospital service area and congregations served by Faith	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.)	**Year 1:** 1. Document the forms of cancer that have higher than average rates and the populations most at risk. 2. Document the gaps in	**Year1-3: Resources:** Staff time and additional funding dollars

NEED: Improve healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
	Community Nurses	provided in the community and at churches that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung) with the assistance of Community Health and Faith Community Nursing. a. Identify high-risk groups that are not accessing cancer screening through Faith Community Nursing and provide education to congregations about the importance of such screenings. b. Prioritize cancer screening opportunities in high risk populations for breast, prostate and lung cancers. c. Provide advanced directive documentation. 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency and reach. 4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources or partnership	risk reduction and cancer prevention activities. 3. Document the evidence basis, demographics of populations reached, location, frequency and number of attendees for hospital risk reduction and cancer prevention efforts. 4. Document recommendations to increase resident awareness of risk reduction and cancer prevention strategies and resources needed. **Year 2:**	**Partners:** FCN

NEED: Improve healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		opportunities to implement recommendations and secure funding. 2. Implement changes for which partnerships and/or funding is available on site and in the community, including churches. 3. Partner with community based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Work with Faith Community Nursing to provide information about screenings taking place and assistance with scheduling screenings. b. Continue to provide advanced directive documentation. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year two and revise strategy for year three as needed, including	1. Document programs for which funding and/or partnerships are sought. 2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report progress to the IRS **Year 3:** 1. Document any revisions	

NEED: Improve healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Develop a baseline measure of patients diagnosed with late stage cancer and compare to cancer registry. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 4. Reassess the prevalence of cancer in the service area at the end of year 3.	2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached, location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report reassessment results and progress to the IRS	

APPENDIX A

Implementation Strategy

SOUTH FLORIDA BAPTIST HOSPITAL
August, 2013

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance
UNDERLYING FACTORS: Access related to insurance coverage
ANTICIPATED IMPACT: To increase patient population that has some form of health insurance

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Decrease the percentage of uninsured residents in the community	Residents in the community that are eligible for some form of health insurance	**Year 1:** 1. Explore the development of a resource (e.g., PTE, expanded parameters for medical qualifiers) to facilitate providing information and access to members of the SFBH community that are eligible for some type of health coverage. a. Advocate for a federal grant-funded PTE to the SFB service area tasked with educating and enrolling eligible, uninsured citizens into the new federally-run Florida insurance exchange effective Jan 1st, 2014 and/or Identify and refer patients that are eligible for health insurance and not enrolled. b. Identify best practices for accessing affordable healthcare coverage, including evaluation and documentation related to ACA implementation. c. Develop an outreach plan by identifying locations and venues for outreach and promotion in the community. d. Based on available resources begin enrolling residents for open enrollment 2013. e. Track the number of residents reached	**Year 1:** 1a-b. Document if a patient navigator is assigned to SFBH and the start date. 1c-d. Document the number of patients assisted. 2a. Document the funding sought 2b-c. Document the number of patients assisted. 1-2. Report progress to the IRS.	**Year1-3:** **Potential Partners:** BCHS **Resources:** Staff time and if needed, +1 PTE

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance
UNDERLYING FACTORS: Access related to insurance coverage
ANTICIPATED IMPACT: To increase patient population that has some form of health insurance

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		during outreach efforts and the number of residents enrolled in some type of insurance. f. Evaluate effectiveness 2. SFB President and leadership will address funding issue with the existing hospital supported Pediatric Discharge Medication Program for unfunded/underfunded hospital patients. a. Work to identify a funding source to expand funding for the SFB Pediatric Discharge Medication Program to include adults. b. Create hospital-administered Adult & Pediatric Medication Program. c. Track the number of patients assisted with current funding in Year 1 to develop a baseline. **Year 2:** 1. Review evaluations of efficacy from year 1 and develop goals and recommendations for increased enrollment in year 2. 2. Implement program improvements and best practices identified in Year 1 a. Identify and refer patients that are eligible	**Year 2:** 1. Document goals for year 2. 2a-b. Document the number of patients assisted. 1-4. Report progress to the IRS.	

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		for health insurance and not enrolled. b. Evaluate the effectiveness of the resource implemented for increasing access to affordable health care coverage (i.e., PTE) and determine necessary improvements. 3. Monitor and report performance progress by year end 4. Based on available resources, expand the number of patients and/or medications offered by the SFBH Discharge Medication Program. a. Continue to seek to expand funding for the SFB Discharge Medication Program through community relationships, hospital foundation and other resources. b. Track the number of patients assisted and compare to year 1 baseline. **Year 3:** 1. Review evaluations of efficacy from year 2 and develop goals and recommendations for increased enrollment in year 3. 2. Implement program improvements and best practices identified in Year 2 a. Identify and refer patients that are eligible for health insurance and not enrolled.	**Year 3:** 1. Document goals for year 2a-b. Document the number of patients assisted. 1-4. Reassess need and Report progress to the IRS.	

NEED: Improving access to affordable healthcare - Care coordination, insurance and financial assistance **UNDERLYING FACTORS:** Access related to insurance coverage **ANTICIPATED IMPACT:** To increase patient population that has some form of health insurance				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		b. Evaluate the effectiveness of the resource implemented for increasing access to affordable health care coverage (i.e., PTE) and determine necessary improvements. 3. Monitor and report performance progress by year end 4. Based on available resources, expand the number of patients and/or medications offered by the SFB Discharge Medication Program. a. Continue to seek to expand funding for the SFB Discharge Medication Program through community relationships, hospital foundation and other resources. b. Track the number of patients assisted and compare to year 1 baseline. 5. Reassess need in the community.		

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

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

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease readmission rates and mortality rates while increasing referrals to hospice

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc). 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients. 4. Determine the level of resources required to implement a comprehensive care coordination procedure for CHF patients. 5. Explore options for maximizing current partnerships with a variety of CBOs. 6. Review options for collaboration at BayCare Health System Level (i.e., Coordination through BC Home Health, Primary Care Physicians, Faith Community Nursing, etc). 7. Identify potential funding sources and seek funding. **Year 2:**	**Year 1:** 1. Document evaluation findings 2. Document recommendations 3. Document plan 4. Document resources needed 5-6. Document partnership and collaborative opportunities 7. Document funding secured 1-7. Report progress to the IRS. **Year 2:**	**Year1-3:** **Resources:** Staff time **Partners:** Local agencies and Hospices

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease readmission rates and mortality rates while increasing referrals to hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		1. Based on available resources, communicate new care coordination program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External communications and internally to patients treated and referred i.e.: WEB 4. Document outcomes and evaluate efficacy (i.e., number of readmission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six month intervals. **Year 3:** 1. Continue to offer the comprehensive care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program evaluation 4. Reassess the preventable hospitalizations for CHF in	1. Document the communication plan (internal and external) 2. Document stages of role out. 4. Document outcomes and efficacy. 1-4. Report progress to the IRS. **Year 3:** 1. Document number of participants 2. Document any changes in outcome measures and trending. 3. Document program recommendations 1-4. Report reassessment results and progress to the IRS	

NEED: Decreasing the prevalence of clinical health issues - Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease readmission rates and mortality rates while increasing referrals to hospice

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		the service area.		

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 community agencies and providers to identify community resources and assess current screening and vaccination compliance in high risk groups through Faith Community Nursing. a. Determine current screening and vaccination compliance rates in congregations. b. Determine if barriers (i.e., financial, transportation, etc.) exist for cervical cancer	**Year 1:** 1a-b. Document baseline screening and vaccination rates and the barriers identified by FCN. 1c. Document the number of residents that are provided education. 1d. Document funding	**Year 1-3:** **Resources:** Staff time and any additional funding dollars **Partners:**

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
		screening and prevention. c. Educate congregation members of cervical cancer screening and prevention guidelines. d. Identify resources needed to increase compliance rates. e. Identify possible funding sources. f. Make available advanced directive documents during any screening or education program **Year 2:** 1. Based on available resources and collected data develop programs to target low compliance populations. Partner with community based organizations to provide increased screening and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screening and vaccinations at FCN network partners. Vaccinate 100 uninsured community members. b. Work with Faith Community Nursing to encourage congregation members to be	secured. 1a-d. Report progress to the IRS **Year 2:** 1a. Document number of patients provided cancer screening and vaccinations and report rate increases. 1b.Document the number of patients that are provided education. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program	Faith Community Nursing

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
		screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Continue to partner with community based organizations to provide increased screening and vaccination opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Provide mobile cervical cancer screening and vaccinations at FCN network partners. Vaccinate 100 uninsured community members.	effectiveness. 1a-e. Report progress to the IRS **Year 3:** 1a. Document number of patients provided cancer screening and vaccinations and report rate increases. 1b.Document the number of patients that are provided education. 1g. Document the number of advanced directive materials provided.	

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
		b. Work with Faith Community Nursing to encourage congregation members to be screened and or vaccinated for cervical cancer, provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. c. Continue to provide advanced directive documentation. d. Continue to measure program effectiveness by tracking developed metrics (i.e., demographics of population reached, insurance status of program participants, screening results, etc.).	1h. Document metrics related to program effectiveness. 1a-g. Reassess community health need and report progress to the IRS	

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

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

NEED: Decreasing the prevalence of clinical health issues - Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **ANTICIPATED IMPACT:** Reduce the rate of suicide related death among residents served by BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide related deaths (e.g., educational programs, website resources, etc.) 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths (i.e., communications plan, analytics necessary to profile high risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding **Year 2:** 1. Maximize relationships and collaborative opportunities with community based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community based organizations that provide services related to suicide, risk of suicide, etc.	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured 1-6. Report progress to the IRS **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 3. Document the metrics	**Year1-3:** $30,000 BCBH

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

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low-birth weight births, infant mortality **ANTICIPATED IMPACT:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System

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

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

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes
UNDERLYING FACTORS: Pre-term births, low-birth weight births, infant mortality
ANTICIPATED IMPACT: Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		Year 3: 1. Complete implementation and begin to evaluate the effectiveness of the newly implemented programs/services. A. Make recommendations based on evaluation. B. Identify resources needed to implement recommendations of evaluation. C. Seek funding to implement recommendations. 2. Continue to evaluate opportunities for expansion and funding for these opportunities. 3. Continue to collect outcome measures for each collaborating CBO, including expanded programs and services. 4. Reassess community need related to birth outcomes in the service area	metrics from year 1. 1 -4. Report Progress to the IRS. **Year 3:** 1A. Document the results of program evaluation 1B. Document the resources needed to implement recommendations 1C. Document efforts to gather resources (e.g., fundraising, grant writing, etc.). 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities.	**Year 3:** Funds, - grants or other allocation, staff, office supplies. Educational material/collateral

NEED: Decreasing the prevalence of clinical health issues - Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low-birth weight births, infant mortality **ANTICIPATED IMPACT:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			3. Document outcome measures for each collaborating CBO and compare to baseline metrics from year 2. 1-4. Report progress to the IRS in reassessment.	

<table>
<tr><td colspan="5">NEED: Improve healthy behaviors and environments - Disease management: general population including uninsured and migrant working residents
UNDERLYING FACTORS: Obesity education and community outreach & Health Services for Migrant Workers
ANTICIPATED IMPACT: Increase the access that migrant workers have to health services related to nutrition</td></tr>
<tr><td>Objective</td><td>Target Population</td><td>Strategies and Action Description</td><td>Timeframe/ Measures</td><td>Potential Resources/ Partners</td></tr>
<tr><td>Collaborate with FQHC in the service area to increase services available to migrant workers and uninsured residents</td><td>Uninsured residents and migrant workers</td><td>Year 1:
1. Explore the opportunity to lease certified nutritionists to local clinics in Plant City and Dover on a part-time basis to provide diet and obesity education to clinic patients including migrant workers.
2. Evaluate existing programs and relationships with local clinics in Plant City and Dover to determine if:
a. The hospital has maximized opportunities to meet the needs of the community relative to diet and obesity education.
b. If there are additional partnership opportunities to meet the needs of the community relative to diet and obesity education.
c. It is possible to enhance ongoing collaborative relationships related to diet and obesity education.
3. Identify and seek funding opportunities if necessary to expand services related to diet and obesity education.
4. Develop baseline metrics by collecting outcome measures for each local clinic.</td><td>Year 1:
1-4. Report progress to the IRS.</td><td>Year1-3:
Potential Partners: Local clinics

Resources:
Staff time</td></tr>
</table>

NEED: Improve healthy behaviors and environments - Disease management: general population including uninsured and migrant working residents **UNDERLYING FACTORS:** Obesity education and community outreach & Health Services for Migrant Workers **ANTICIPATED IMPACT:** Increase the access that migrant workers have to health services related to nutrition				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Year 2: 1. Based on resources available and results from efforts in year one; begin leasing certified nutritionists to local clinics in Plant City and Dover. a. Track outcomes of new services in Plant City and Dover locations (i.e., the number of patients seen, outcome measures, etc.). **Year 3:** 1. Based on resources available and results from efforts in year one; continue leasing certified nutritionists to local clinics in Plant City and Dover. a. Track outcomes of new services in Plant City and Dover locations (i.e., the number of patients seen, outcome measures, etc.). 2. Reassess community need related to obesity and health services for migrant workers.	**Year 2:** 1. Report progress to the IRS. **Year 3:** 1-2. Report reassessment results and progress to the IRS	

<table>
<tr><td colspan="5">NEED: Improve healthy behaviors and environments - Substance Abuse
UNDERLYING FACTORS: Substance Abuse and Substance Addiction
Anticipated Impact: Increase the availability of substance abuse services</td></tr>
<tr><th>Objective</th><th>Target Population</th><th>Strategies and Action Description</th><th>Timeframe/ Measures</th><th>Potential Resources/ Partners</th></tr>
<tr><td>Continue to provide while increasing the availability of substance abuse services</td><td>Adults and pediatric residents who are abusing addictive substances and/or addicted to a substance</td><td>Year 1:
1. Fully develop and implement the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways
a. Identify funding sources and seek funding for program.
b. Secure funding
c. Hire staff (e.g., manager and coaching staff)
d. Implement program
e. Track the number of patients referred to the program and the number of patients participating in the program.
2. Substance Abuse Case Management for Mom’s and babies-addicted to prescription drugs
a. Identify necessary resources (e.g., funding, staff, space, materials, etc.)
b. Identify and acquire funding required for Case Management team.
c. Develop case management program
d. Hire staff
e. Implement case management by connecting mothers and babies to community services and partners.

Year 2:</td><td>Year 1:
1a&b. Document secured funding
1c. Document the Start dates for program staff.
1d&e. Document the number of patients referred to the program and the number of patients participating in the program.
2a-b. Document resources required and resources secured.
2d. Document start dates of staff hired.
2e. Document the number of families served.
1-2. Report progress to the IRS</td><td>Year 1-3:
BCHS
1) 3 mill - Pathways
BCHS
2) $130,000 – Mom’s and babies</td></tr>
</table>

NEED: Improve 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. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Mom's and babies-addicted to prescription drugs. **Year 3:** 1. Complete the full implementation of the Coaching and Navigation Services for Tampa Bay Families suffering with mental Health and substance abuse: Pathways 2. Continue Substance Abuse Case Management for Mom's and babies-addicted to prescription drugs.	**Year 2:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served. 1-2. Report progress to the IRS **Year 3:** 1. Continue to document the number of patients referred to the program, number of patients participating in the program and program outcomes. 2. Document the number of families served.	

NEED: Improve healthy behaviors and environments - Substance Abuse
UNDERLYING FACTORS: Substance Abuse and Substance Addiction
Anticipated Impact: Increase the availability of substance abuse services

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
			1-2. Report progress to the IRS	

<table>
<tr><th colspan="5">NEED: Improve healthy behaviors and environments - Cancer
UNDERLYING FACTORS: Higher than average cancer rates
ANTICIPATED IMPACT: Increase the use of risk reduction and cancer prevention strategies</th></tr>
<tr><th>Objective</th><th>Target Population</th><th>Strategies and Action Description</th><th>Timeframe/ Measures</th><th>Potential Resources/ Partners</th></tr>
<tr><td>Increase resident awareness of risk reduction and cancer prevention strategies</td><td>Residents in hospital service area and congregations served by Faith Community Nurses</td><td>Year 1:
1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death.
2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate and lung) with the assistance of Community Health and Faith Community Nursing.
a. Identify high-risk groups that are not accessing cancer screening through Faith Community Nursing and provide education to congregations about the importance of such screenings.
b. Prioritize cancer screening opportunities in high risk populations for breast, prostate and lung cancers.
c. Provide advanced directive documentation.
3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location,</td><td>Year 1:
1. Document the forms of cancer that have higher than average rates and the populations most at risk.
2. Document the gaps in risk reduction and cancer prevention activities.
3. Document the evidence basis, demographics of populations reached, location, frequency and number of attendees for hospital risk reduction and cancer prevention efforts.
4. Document recommendations to increase resident awareness of risk reduction and cancer prevention strategies and resources needed.</td><td>Year1-3:
Resources:
Staff time and additional funding dollars

Partners:
FCN</td></tr>
</table>

NEED: Improve healthy behaviors and environments - Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk reduction and cancer prevention strategies				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		frequency and reach. 4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources or partnership opportunities to implement recommendations and secure funding. 2. Implement changes for which partnerships and/or funding is available on site and in the community, including churches. 3. Partner with community based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Work with Faith Community Nursing to provide information about screenings taking place and assistance with scheduling screenings. b. Continue to provide advanced directive documentation. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in	**Year 2:** 1. Document programs for which funding and/or partnerships are sought. 2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report progress to the IRS	

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

APPENDIX B

Needs not Addressed by the 2013 Plan

SOUTH FLORIDA BAPTIST 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.

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 South Florida Baptist 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.

Long-term acute care:

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