St. Joseph's Hospital

Implementation Plan –Report

September, 2013

TrippUmbach
Research • Strategy • Impact

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Introduction

St. Joseph's Hospitals are comprised of five facilities located in Tampa, FL. The five St. Joseph's Hospitals (St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, St. Joseph's Children's Hospital and St. Joseph's Hospital – Behavioral Health Center) are part of the network of 10 not-for-profit hospitals throughout the Tampa Bay area. In response to their community commitment, the five St. Joseph's Hospitals contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2012 and June 2013 (See the St. Joseph's Hospital Community Health Needs Assessment for the full report).

This report is the follow-up implementation plan that fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA), requiring that non-profit hospitals develop implementation strategies to address the needs identified in the community health needs assessment completed in three-year intervals. The community health needs assessment and implementation planning process undertaken by the five St. Joseph's Hospitals, 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 the five St. Joseph's Hospitals and a project oversight committee, which included representatives from each of the 10 not-for-profit hospitals that comprise BayCare Health System to accomplish the assessment and implementation plan.

This implementation plan includes plans to address access to affordable healthcare, the prevalence of clinical health issues, healthy behaviors and environments for residents in the five St. Joseph's Hospitals communities. As non-profit facilities, the five St. Joseph's Hospitals all intend to provide care to residents regardless of their insurance status as required by the state of Florida.

Community Definition

While community can be defined in many ways, for the purposes of this report, the St. Joseph's Hospitals community is defined first as a 55 zip code area in Hillsborough and Pasco Counties in Florida related to one or more of the following facilities (See Figure 1 & Table 1):

St. Joseph's Hospital – Main: is a 527-bed acute care hospital founded as a mission of the Franciscan Sisters of Allegany, which has served the healthcare needs of the Tampa Bay area since 1934. The geographical community definition includes 25 populated zip code areas in Hillsborough County.

St. Joseph's Hospital – North: is an acute care hospital that features 76 licensed beds and 32 observation beds and a full-service Emergency Room. The geographical community definition includes 14 populated zip code areas in Hillsborough and Pasco counties.

St. Joseph's Hospital – Behavioral Health Center: is the only freestanding inpatient Baker Act – receiving private psychiatric hospital in Hillsborough County with 50 adult beds and 10 child/adolescent beds (pediatrics four years old and up). The geographical community definition includes 38 populated zip code areas in Hillsborough and Pasco counties.

St. Joseph's Women's Hospital – is a 157-bed women's hospital that has offered personalized and specialized women's services for more than three decades. The geographical community definition includes 29 populated zip code areas in Hillsborough and Pasco counties.

St. Joseph's Children's Hospital – is a 186-bed children's hospital that is recognized throughout the southeast United States as a leader in pediatric heart services, cancer care, and emergency/trauma care. The geographical community definition includes 55 populated zip code areas in Hillsborough and Pasco counties.

While the needs identified in this report pertain to the 55 zip code areas in Hillsborough and Pasco Counties related to one or more of the St. Joseph's facilities in Florida, they may also be related to one or more of the following special populations:

- ✓ Residents with Behavioral Health Needs
- ✓ Women
- ✓ Children

St. Joseph's Hospitals Community Zip Codes and the Facilities They Are Associated With
Table 1

X = Zip code area is represented in the geographic community definition

Zip Code	Town	County	CHILDREN'S	MAIN	WOMEN'S	NORTH	BEHAVIORAL HEALTH CENTER
33510	Brandon	Hillsborough	X				X
33511	Brandon	Hillsborough	X		X		X
33523	Dade City	Pasco	X				
33525	Dade City	Pasco	X				
33527	Dover	Hillsborough	X				
33534	Gibsonton	Hillsborough	X				
33543	Wesley Chapel	Pasco	X				X
33544	Wesley Chapel	Pasco	X			X	
33545	Wesley Chapel	Pasco	X				
33547	Lithia	Hillsborough	X				
33548	Lutz	Hillsborough	X			X	X
33549	Lutz	Hillsborough	X			X	X
33556	Odessa	Hillsborough	X	X		X	X
33558	Lutz	Hillsborough	X		X	X	X
33559	Lutz	Pasco	X			X	X
33563	Plant City	Hillsborough	X				
33566	Plant City	Hillsborough	X				
33569	Riverview	Hillsborough	X				X
33570	Ruskin	Hillsborough	X				
33572	Apollo Beach	Hillsborough	X				
33576	San Antonio	Pasco	X				
33578	Riverview	Hillsborough	X		X		
33579	Riverview	Hillsborough	X				X
33584	Seffner	Hillsborough	X				X
33594	Valrico	Hillsborough	X				
33596	Valrico	Hillsborough	X				
33602	Tampa	Hillsborough	X	X	X		X
33603	Tampa	Hillsborough	X	X	X		X
33604	Tampa	Hillsborough	X	X	X		X
33605	Ybor City	Hillsborough	X	X	X		X
33606	Davis Island	Hillsborough	X	X	X		X
33607	West Tampa	Hillsborough	X	X	X		X
33609	South Tampa	Hillsborough	X	X	X		X
33610	East Lake/Orient Park	Hillsborough	X	X	X		X

Zip Code	Town	County	CHILDREN'S	MAIN	WOMEN'S	NORTH	BEHAVIORAL HEALTH CENTER
33611	South Tampa	Hillsborough	X	X	X		X
33612	Forest Hills	Hillsborough	X	X	X		X
33613	Forest Hills/ University area	Hillsborough	X	X	X	X	X
33614	Egypt Lake/Leto	Hillsborough	X	X	X		X
33615	West Tampa	Hillsborough	X	X	X		X
33616	South Tampa	Hillsborough	X	X	X		X
33617	Tampa	Hillsborough	X	X	X		X
33618	Carrollwood	Hillsborough	X	X	X	X	X
33619	East Tampa	Hillsborough	X	X	X		X
33620	U.S.F.	Hillsborough	X	X	X		X
33621	MacDill A.F.B.	Hillsborough	X				X
33624	Carrollwood	Hillsborough	X	X	X	X	X
33625	West Tampa	Hillsborough	X	X	X	X	X
33626	West Tampa	Hillsborough	X	X	X	X	X
33629	South Tampa	Hillsborough	X	X	X		X
33634	Tampa	Hillsborough	X	X	X		X
33635	West Tampa	Hillsborough	X	X	X		X
33647	New Tampa	Hillsborough	X		X	X	X
34638	Land O'Lakes	Pasco	X		X	X	X
34639	Land O'Lakes	Pasco	X			X	
34655	New Port Richey	Pasco	X				

X = Zip code area is represented in the geographic community definition

Methodology

Tripp Umbach facilitated and managed an implementation planning process on behalf of the five St. Joseph's Hospitals 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 the five St. Joseph's Hospitals and collaborating areas of BayCare Health System.

- **Community Health Needs Assessment Review:** Tripp Umbach worked with the five St. Joseph's Hospitals 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 27th, 2013 with hospital leadership from the five St. Joseph's Hospitals. 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 one of the five St. Joseph's Hospitals. 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 five St. Joseph's Hospitals 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 one or more of the five St. Joseph's Hospitals that meet significant community health needs.

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

- **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 27th, 2013. Based on the evidence-based practices previously provided, hospital leadership reviewed and discussed the strategy and subsequent action steps needed to implement best practices to begin to address the health needs identified in their respective communities. Hospital leaders aligned needs with best practice models and available resources, defined action steps, timelines, and potential partners for each need to develop the accompanying implementation plan.

- **Final Implementation Planning Report:** A final report was developed that details the implementation plan the hospital and the recovery center will use to address the needs identified by the five St. Joseph's Hospitals 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 27th, 2013 with the five St. Joseph's Hospitals 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 the five St. Joseph's Hospitals would address in implementation planning. The hospital leaders were asked to share their vision for their community, discuss a plan for health improvement in their community, and select the needs that they felt their hospital could address and assist the community in resolving, and those that they felt the hospital and/or recovery center would not be well positioned to resolve collectively.

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

Improving access to affordable healthcare
Decreasing the prevalence of clinical health issues
Improving healthy 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 all of the five St. Joseph's Hospitals population. Hospital leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) Improving access to affordable healthcare; 2) Decreasing the Prevalence of clinical health issues; and 3) Improving healthy behaviors. A summary of these top needs in the five St. Joseph's Hospitals communities and the implementation strategy developed to address those needs follows:

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

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

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

According to key stakeholders, there is a need for increased coordination of care for residents due to a fragmented system. Key stakeholders and focus group participants agree that while there are medical resources and healthcare facilities in the community, access to healthcare resources can be limited by health insurance issues and the cost of healthcare for under/uninsured, the availability of providers, communication among providers and consumers, the level of integration of mental health services in medical health settings, and the prevalence of socio-economic barriers (i.e., lack of support from employers and social networks, limited transportation, etc.). According to key stakeholders and focus group participants, residents do not always have access to the health services they need (i.e., primary, preventive, specialty, long-term care, and dental health care, etc.) due to transportation, the number and location of providers, lack of documentation, and provider willingness to accept Medicaid insurance.

According to focus group participants, residents do not always have access to the health services they need (i.e., birthing services, and dental health care.) due to the number and location of providers, and transportation options. Focus groups felt that a low number of high-risk birthing services are sparsely located in the region, with Hillsborough County providing the only high-risk birthing services and NICU. Key stakeholders and focus group participants indicated that the reason for fewer providers in the area relates to funding/payer source and demand for services as they relate to the sustainability of services in multiple venues. High-risk pregnancies can require a significant amount of healthcare resources and are often paid for through Medicaid due to a low-income population being disproportionately represented among the total number of high-risk pregnancies. Additionally, the birth rate in the region is projected to continue a declining trend leading to the need to consolidate birthing services. This is particularly an issue in Pasco County where there

are substantial barriers for expecting mothers to access prenatal care and birthing services. Hillsborough County often offers birthing services where the capacity is overwhelmed by the volume of need, which results from a denser population and a lack of services in surrounding counties.

According to key stakeholders and focus group participants, residents do not always have access to the behavioral health services they need (i.e., substance abuse, psychiatry, partial hospitalizations programs, intensive outpatient services, support groups for adolescents, and discrete detoxification programs) due to the number and location of providers and lack of sustainable funding for behavioral health programs. Key stakeholders gave the impression that depression can be an issue in the area. Additionally, key stakeholders felt that the mental health needs of children, seniors, and armed services veterans are not always being managed in the medical setting effectively.

Key stakeholders and focus group participants believed that children and their parents may not always have access to the healthcare services they need (i.e., service coordination early intervention services, primary medical, preventive medical, dental, well child visits, specialty care, and mental health services) due to a limited supply of providers, lack of insurance, local providers not accepting Medicaid, and/or lack of transportation. Immunizations are only offered in one location in Pasco County free of charge. This is often the case in areas where poverty is heavily concentrated. Dental health needs of children are not always being met by parents due to the perception of necessity, lack of access to affordable care, limited dental insurance coverage, and an inability to afford services and/or co-pays.
Key stakeholders and focus group participants indicated that residents with mental illness may not always be getting their needs met due to the mental health resources that are available being overwhelmed by the demand. Key stakeholders and focus groups felt that a low number of mental health and substance abuse providers are sparsely located in the region. Funding for mental health services is consistently low, which often restricts the number of providers entering an industry, decreases program stability, leads to an ever-changing provider landscape, and maintains higher provider-to-population ratios. Stakeholders indicated that there is a lack of services for indigent populations; as a result, residents are not always able to secure substance abuse services due to homelessness and/or the inability to pay. Key stakeholders also felt that after a child turns 18, they become ineligible for many mental health services and do not become eligible again for services until they are in a crisis. Finally, there is a need for more effective integration between medical and behavioral health settings. Residents are becoming addicted to pain medications when they have chronic pain, and are not being monitored and/or weaned properly. These residents may not receive treatment for their addiction until they come to the attention of the mental health and substance abuse providers in the community.

While the five St. Joseph's Hospitals, facilities in the BayCare Health System, all provide access to affordable healthcare in numerous ways: the need to improve access was identified through the most recent community health needs assessment. Recognizing that the five St. Joseph's Hospitals are not the only medical resources in their communities, hospital leadership felt that the most effective strategy to further increase access to affordable healthcare is through a mixed-strategy of: 1) Maintaining current programs and services while evaluating their effectiveness:

- ✓ *Maintain the availability of all services to under/uninsured residents by continuing to provide care to residents regardless of their insurance status as required by the state of Florida.*
- ✓ *Continue to administer a financial assistance program on-site that provides uninsured residents assistance in identifying and applying for medical benefits for which they may qualify.*
- ✓ *BayCare Health System will continue to implement the Medical Home Model through BayCare Medical Group, which includes care coordination provided by primary care physicians that are employed by BayCare Health System in the hospital service area.*
- ✓ *Continue to offer behavioral health services through BayCare Behavioral Health Department and St. Joseph's Hospital-Behavioral Health Center.*
- ✓ *Continue to provide an introduction to mental health training during New Hire Orientation for all staff employed by BayCare Health System, including staff employed at the five St. Joseph's Hospitals.*
- ✓ *Continue to provide co-located Behavioral Health Services as an available service of primary care physician practices in many communities.*
- ✓ *Continue to offer medication assistance.*
- ✓ *Continue to work closely with Skilled Nursing Facilities in the area to decrease the likelihood of preventable returns to acute care for patients discharged from St. Joseph's Hospitals through partnerships, mutual quality standards and formal agreements.*
- ✓ *Continue to provide translation services on-site.*
- ✓ *Continue to provide case management through the emergency department and social workers which assist with community process in partnership with local agency.*
- ✓ *Continue to provide follow-up coordination in the community through Faith Community Nurses.*
- ✓ *Continue to provide discharge planning & linkages to community support through chaplains.*
- ✓ *Continue to offer Nurse navigation related to the breast center, discharge planning, and heart failure.*

- ✓ *Continue the coordination with other care facilities in the community.*
- ✓ *Continue to increase referrals to local clinics through collaboration related to Cancer, Asthma, etc.*
- ✓ *Hillsborough County Health Plan uses a clinic for the recipients of the Hillsborough County Community Health Care Plan which is the county government's half-cent, sales tax-based county insurance plan, which includes behavioral health services.*
- ✓ *Continue to provide the St. Joseph's Children's Hospital Mobile Medical Bus improves access to pediatric healthcare and provides well child physicals, immunizations, hearing, vision and oral health screenings, community referrals and assistance with applying for Medicaid and Florida Kidcare in Hillsborough County.*
- ✓ *Continue to provide ambulance transportation between facilities, security transportation of patients between St. Joseph's Women's and Main/Children's.*
- ✓ *Continue, to the extent it is possible the volunteer golf cart shuttle service on Main/Children's campus.*
- ✓ *Continue, to the extent it is possible, providing bus/cab vouchers for patients unable to afford public transportation.*

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 St. Joseph's Hospital(s) identified as responsible (See tables below):

- ✓ *Decrease readmission rates and mortality rates while increasing referrals to Palliative care/hospice for CHF patients by offering comprehensive care coordination for CHF patients.*
- ✓ *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 and the recovery center with the health needs of the community:

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North

Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc). 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients. 4. Determine the level of resources required to implement a comprehensive care coordination procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other community based organizations. 6. Review options for collaboration at BayCare Health System Level (i.e., Coordination through BC Home Health, Primary Care Physicians, Parish Nursing, etc). 7. Identify and secure grants opportunities for medication assistance.	**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 1-8. Report progress to the IRS.	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health, Primary Care Physicians, Parish Nursing, etc.

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		8. Document outcomes and evaluate efficacy (i.e., number of re-admission among patients whose care is coordinated, satisfaction and consumer feedback measures) in six-month intervals. **Year 2:** 1. Communicate new care coordination program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External communications and internally to patients treated and referred i.e.: WEB **Year 3:** 1. Continue to offer the care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program	**Year 2:** 1. Document the communication plan (internal and external). 2. Document stages of rollout. 4. Document outcomes and efficacy. 1-3. Report progress to the IRS. **Year 3:** 1. Document number of participants 2. Document any changes in outcome measures and trending. 3. Document program	

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		evaluation. 4. Re-assess the preventable hospitalizations for CHF in the service area.	recommendations 1-4. Report re-assessment results and progress to the IRS.	

NEED: Improving access to affordable healthcare – Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of mental health services	Adults and pediatric residents who may require mental health services	**Year 1:** 1. 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:** Conversion of pediatric acute services grant to preservation program $400,000

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

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

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

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

At first glance, the collective service areas for the St. Joseph's Hospitals appear to have a high prevalence of clinical health issues. However, this assessment shows a stratification of the zip code areas into high, moderate, or low levels of clinical health issues and areas with no notable clinical health issues. There are 12 zip codes with the highest levels of clinical health issues are represented in the secondary data as having substantially higher than average rates across the majority of the clinical health indicators this study examined at the zip code level. These zip code areas also have greater than average barriers to accessing healthcare. These zip code areas appear to consume a large percentage of healthcare resources based on the volume of clinical issues and level of severity.

There are several indicators in Hillsborough County and Pasco County and the communities served by the St. Joseph's Hospitals 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, suicide, non-medical use of prescription pain relievers, tobacco use, prostate cancer, infant mortality among white infants, pre-term births, tuberculosis, Chlamydia, syphilis, etc.).

Health disparities in health outcomes are present in all of the St. Joseph's Hospitals service areas among gender, race, and age. Secondary data representing the communities served by the St. Joseph's Hospitals depicts evidence of several health issues that women

seem to be at greater risk for in the St. Joseph's Women's Hospital service area (i.e., Asthma, COPD, Urinary tract infections, Stroke-related death, Breast cancer, Infant mortality, Low birth weight, Pre-term live births, Births to teenage mothers). Secondary data representing the communities served by the St. Joseph's Hospitals depicts evidence of several health issues that children seem to be at greater risk for in the St. Joseph's Children's Hospital service area (i.e., Asthma and immunization rates). While racial disparities appear to be positively correlated with socio-economic status there are disparities among African American and Hispanic residents (i.e., heart disease, obesity, congestive heart failure, bacterial pneumonia, diabetes, urinary tract infections, cancer, asthma, low birth weight, teen births, infant mortality, and pre-term births, stroke/motor vehicle accident/influenza and pneumonia-related deaths, dental health care).

While the five St. Joseph's Hospitals, facilities in the BayCare Health System, all provide programs and services which target clinical health issues: the need to decrease the prevalence of clinical health issues was identified through the most recent community health needs assessment. Recognizing that the five St. Joseph's Hospitals are not the only medical resources in their communities, 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 five St. Joseph's Hospital Campus remains "tobacco free".*
- ✓ *BayCare Health System will continue to disseminate health-related information throughout the service area.*
- ✓ *BayCare Health Systems will continue to promote fit-friendly organizations through partnership with national associations, educational programming, screenings and Health Risk Assessment offerings to employers to assist in helping them become a Fit-Friendly worksite and create a culture of wellness.*
- ✓ *BayCare Medical Group, through the medical home model, provides disease management and services for Pulmonary disease.*
- ✓ *Continue to contract with American Healthways for inpatient and outpatient diabetes management and patient education.*
- ✓ *Encourage Faith Community Nurses to continue to provide community education, follow-up, screenings, etc.*
- ✓ *Continue cancer screenings and education through health fairs and community outreach events.*
- ✓ *Continue to support the efforts of the local missions clinics, which target and treat underserved diabetic patients in Eastern Hillsborough County, especially farm workers. (With inpatient services offered regardless of the ability to pay).*
- ✓ *BayCare Medical Physicians Group will continue to address disease management and services to treat Diabetes, through the medical home model.*
- ✓ *Continue to provide the freedom from Smoking class*
- ✓ *Continue to provide treatment and pulmonary rehabilitation to patients that require such treatments for COPD, Asthma, etc.*

- ✓ *Continue to provide all routine inpatient and outpatient pulmonary care in hospitals, pulmonary function tests, etc.*
- ✓ *Continue to provide at St. Joseph's Children's Hospital pulmonary clinic and asthma treatment protocols with family education through community-based physicians, patient education, and educational material disbursed in the community.*
- ✓ *All hospitals will continue to strive to reduce readmissions from COPD and other pulmonary diseases (Regardless of ability to pay).*
- ✓ *Continue to provide Lipid screenings on a fee for service basis.*
- ✓ *Continue the Heart Program, which helps patient manage chronic health issues related to admissions and includes Emergency Department diversion and education components.*
- ✓ *Continue stroke screening and education as required for Joint Commission certification.*
- ✓ *Continue working with the American Heart Association to better promote stroke awareness, as well as marketing through direct mail pieces for education of stroke symptoms.*
- ✓ *Continue to partner with local clinics to offer breast health risk assessments and high-risk screening for breast cancer.*
- ✓ *Continue the diagnosis, treatment, and disease management related to cancer.*
- ✓ *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 the partnership with the governmental entities and statewide agencies to address the needs of infants born with neonatal abstinence syndrome by improving education and outreach.*

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 St. Joseph's Hospital(s) as identified below (See tables below):

- ✓ *Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc. by aligning the services offered to patients with diabetes with best practices to improve health outcomes for diabetic patients that are diagnosed and/or treated for some type of diabetes at any St. Joseph's Hospital.*

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

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

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Align the services offered to patients with diabetes with best practices to improve health outcomes for diabetic patients that are diagnosed and/or treated for some type of diabetes at any St. Joseph's Hospital.	Adult/pediatric patients that are diagnosed and/or treated for some type of diabetes at any St. Joseph's Hospital.	**Year 1:** 1. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each continue to provide current diabetes management initiatives and education for inpatients and outpatients, while evaluating the effectiveness, evidence basis, outcome measures, population served, accessibility, etc. of current models. 2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each evaluate the populations served by the facilities' diabetes management initiatives and education for inpatients and outpatients.	**Year 1:** 1-2. Document the findings of the evaluation for each St. Joseph's Hospital. 1-2. Report progress to the IRS.	**Year1-3:** **Resources:** **St. Joseph's Hospital – Main:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to diabetes, etc. **St. Joseph's Hospital – North:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to diabetes, etc. **St. Joseph's Women's Hospital:** Staff Time,

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		Year 2: 1. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each develop recommendations based in best practices for the diabetes management initiatives and education for inpatients and outpatients provided at each Hospital (including all services related to gestational diabetes provided at St. Joseph's Women's Hospital, all services related pediatric onset of diabetes provided at St. Joseph's Children's Hospital and services related to diabetes for adults at St. Joseph's Hospital – main and St. Joseph's Hospital – North). 2. Based on the findings related to the populations served by the diabetes management initiatives and education for inpatients and outpatients at St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and	**Year 2:** 1-2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will document the recommendations for each diabetes management initiative and education diabetes management initiatives and education service offered to inpatients and outpatients at each hospital location. 3. St. Joseph's	Office/medical Supplies, Curricula/Teaching tools related to gestational diabetes, etc. **St. Joseph's Children's Hospital:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to pediatric onset diabetes, etc.

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		St. Joseph's Children's Hospital, each St. Joseph's Hospital will develop recommendations to further offer services to populations that show health disparities related to diabetes. 3. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each evaluate resources needed to implement recommendations. **Year 3:** 1. Based on the funding secured, St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each revise the diabetes implementation plan for year three to reflect the recommendations for each diabetes management and education initiative for which funding was secured.	Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each Document secured resources. 1-3. Report progress to the IRS. **Year 3:** 1. Document the revised implementation plan. 2. Document action step completion dates and outcomes. 3. Document the metrics identified. 1-4. Re-assess need	

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each implement the action steps from the revised plan. 3. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each develop measures of efficacy and outcomes (i.e., outcome measures, demographics of patients, etc.) and develop a baseline. 4. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each re-assess community need.	and Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **GOAL:** Decrease readmission rates and mortality rates while increasing referrals to Palliative care/hospice **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Maintain current CHF outpatient clinic services and expand model to decrease hospital readmissions	CHF Patients	**Year 1:** 1. Continue to provide CHF Clinic services and document outcomes. 2. Evaluate need, feasibility and sustainability of CHF clinic expansion. 3. Based on evaluations, develop a plan to expand clinic services in the most effective way. 4. Determine the level of resources required to expand Clinic services. 5. Explore options for partnering with Palliative Care 6. Review options for collaboration at BayCare Health System Level. 7. Identify potential funding sources and secure funding. **Year 2:** 1. Continue to provide CHF Clinic services and document outcomes. 2. Communicate new program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 3. Explore other associated co-morbidities, i.e., diabetes, AMI, Hypertension, etc. 4. Communicate new program: External	**Year 1:** 2. Document recommendations. 3. Document plan. 4. Document resources needed. 5-6. Document partnership and collaborative opportunities. 7. Document funding secured. 1-7. Report progress to the IRS. **Year 2:** 1. Document outcomes and compare to year 1 2. Document the stages of implementation 3. Document findings related to co morbidity 4. Document the communication plan	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **GOAL:** Decrease readmission rates and mortality rates while increasing referrals to Palliative care/hospice **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		communication i.e.: Web redesign. 5. Continue to document outcomes. **Year 3:** 1. Evaluate the efficacy of the program by comparing outcome measure from one year to the next. 2. Develop recommendations based on program evaluation. 3. Re-assess the prevalence of CHF in the service area.	5. Document outcomes and compare from clinic to clinic. 1-5. Report progress to the IRS. **Year 3:** 1. Document outcomes and any changes in outcome measures. 3. Document program recommendations 1-3. Report re-assessment results and progress to the IRS.	

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

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		and the populations that are at greatest risk of stroke and where these populations seek information (e.g., television, newspaper, word-of-mouth). b. Based on the results of the evaluation, define what information to communicate and the goals for each topic (i.e., Signs and symptoms of stroke). c. Based on the results of the evaluation, identify the most appropriate outlet to provide information to the populations that are at greatest risk of stroke. d. Develop communications strategy: identify the methods for communicating with the target audiences. e. Identify resources needed to implement communication strategy. **Year 2:** 1. Identify where collaboration is possible (i.e., collaborative partnership building, service/program development, etc.). 2. Identify potential funding sources to implement Communication strategies and seek funding.	**Year 2:** 1. Document organizations and collaborations formed. 2. Document funding secured.	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Based on available resources, develop communications and test communication strategies (e.g., focus group, survey, test market, etc.). b. Produce materials for dissemination. c. Launch communication plan. d. Measure and track reach and frequency of communications. **Year 3:** 1. Continue to evaluate opportunities to collaborate	2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the death due to stroke by demographics annually. 2 a-c. Document the evidence basis and dates of communication launch. 2d. Document the number of residents reached with messaging. 1-2. Report progress to the IRS. **Year 3:** 1. Document	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		with community-based organizations (i.e., collaborative partnership building, service/program development, etc.). 2. Evaluate the effectiveness of communication strategies implemented in year two and revise strategy for year three as needed. 3. Re-assess the health outcomes related to stroke in the service area.	organizations and collaborations formed. 2. Document the results and recommendations of evaluation. 1-3. Report re-assessment results and progress to the IRS.	

NEED: Improve the prevalence of clinical health indicators – Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital

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

NEED: Improve the prevalence of clinical health indicators – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. e. Identify methods to track the number and types of cancer screening taking place in BayCare Medical Group. **Year 3:** 1. Continue cancer prevention screening and education being provided by PCPs and evaluate effectiveness. a. Continue cancer prevention screening used among BayCare Medical Group and community partner PCPs. b. Maintain education about risk reduction (i.e., smoking cessation, use of sunscreen, etc.) being provided by BayCare Medical Group PCPs and community partner PCPs. c. Track the number and types of cancer screening taking place in BayCare Medical Group. d. Evaluate program and re-assess the prevalence of late-stage diagnosis.	BayCare Medical Group 1a-e. Report progress to the IRS. **Year 3:** 1a. Document number of patients provided cancer screening and compare to previous year. 1b. Document the number of patients that are provided education. 1c. Document cancer screenings taking place at BayCare Medical Group. 1d. Document the number of patients adopting risk reduction and cancer prevention strategies. 1a-d. Re-assess	

NEED: Improve the prevalence of clinical health indicators – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.	Residents at risk of lung cancer	**Year 1:** 1. Develop algorithm for lung cancer screening for high risk residents consistent with American Cancer Society protocols. This will include care coordination for those testing positive for screening so that appropriate treatment is provided. 2. Partner with governments entities and other providers to identify community resources and assess current screening compliance in high risk groups through Faith Community Nursing and partner PCPs. a. Partner PCPs and FCN network can identify high risk groups. Use cancer registry data to determine stage distribution. b. Determine if barriers (i.e., financial, transportation, etc.) exist for lung cancer screening. c. Educate and promote smoking cessation and lung cancer screening guidelines to congregation members. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial	**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 1-3:** Estimated $25K - $50K increased annual expense to provide education through FCN. 150 low dose CT lung cancer screening = $22.5K.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		barrier for high-risk groups. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Educate PCPs and other physicians to lung cancer screening guidelines. a. Promote awareness of current lung cancer screening guidelines to all CIN and BMG physicians. b. Use CIN and BMG physicians to identify high risk individuals and refer to lung cancer screening. c. Use CIN and BMG physicians as well as FCN network to promote smoking cessation and lung cancer screening guidelines. d. Pursue grant funding to provide low-income, high-risk individual's low-dose CT scans for lung cancer screening. e. Continue to provide advanced directive documentation. f. Measure program effectiveness by tracking developed metrics (i.e., demographics of	**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 effectiveness. 1a-e. Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Based on collected data develop programs to target low-compliance populations. Partner with community-based organizations to provide increased screening and cessation opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Work with Faith Community Nursing to encourage congregation members to be screened and adopt risk reduction and cancer prevention strategies (i.e., smoking cessation), provide information about screenings taking place and available resources for cessation, assistance with scheduling screenings and assessing transportation options. b. Continue to provide advanced directive documentation. c. Continue to measure program effectiveness by tracking developed metrics	**Year 3:** 1a. Document number of patients provided cancer screening. 1b.Document the number of patients that are provided education, screening and cessation resources. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-c. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		(i.e., demographics of population reached, insurance status of program participants, screening results, etc.).		

NEED: Decreasing the prevalence of clinical health issues – Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **ANTICIPATED IMPACT:** Reduce the rate of suicide-related deaths among residents served by BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide-related deaths (e.g., educational programs, website resources, etc.). 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths (i.e., communications plan, analytics necessary to profile high-risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding. **Year 2:** 1. Maximize relationships and collaborative opportunities with community-based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-6. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. 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 deaths among residents served by BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1; implement comprehensive wellness initiative that will focus on preventing suicide-related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community-based organizations and evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide-related deaths, etc.) by comparing the baseline measures gathered in year one to those gathered in year two.	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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
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. The BayCare hospital that provide obstetric services (SJWH, SJHN, SFB, MCH and MPH) will each 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: Consider local medical school for medical education related to NAS, access to care barriers, preventive measures for SIDs, and awareness of post-delivery adverse newborn outcomes once discharged into the community. c. It is possible to develop ongoing	**Year 1:** 1 & 2.Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 3. Document identified funding opportunities. 4. Document outcome measures for each collaborating community based organization. 1-4. Report progress to the IRS.	**Year 1:** Grants, substance abuse and treatment grant for NICU navigators, Staff, office supplies, educational material

NEED: Decreasing the prevalence of clinical health issues – Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low-birth weight births, infant mortality **ANTICIPATED IMPACT:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		collaborative relationships related to expecting mothers in the hospital service areas. 2. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.). 3. Identify funding opportunities to expand services to expecting mothers at risk of poor birth outcomes. 4. Develop baseline metrics by collecting outcome measures for each collaborating community based organization. **Year 2:** 1. Implement recommendations for existing programs: A. Seek identified funding. B. Begin implementation of the programs/services for which funding is secured. C. Track outcomes of new programs and services. Use partnership with community based agencies that serve expecting mothers to share information related to improved outcomes. 2. Continue to evaluate opportunities for expansion and funding for these opportunities.	**Year 2:** 1A. Document programs for which funding is sought and the outcomes of each effort. 1B. Document the phases of implementation for each program/service for which funding is	**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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Continue to collect outcome measures for each collaborating community based organization, including expanded programs and services. **Year 3:** 1. Complete implementation and begin to evaluate the effectiveness of the newly implemented programs/services.	secured. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating community based organization and compare to baseline metrics from year 1. 1 -3. Report Progress to the IRS **Year 3:** 1A. Document the results of program evaluation.	**Year 3:** Funds, – grants or other allocation, staff, office

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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 community based organization, including expanded programs and services.	1B. Document the resources needed to implement recommendations. 1C. Document efforts to gather resources (e.g., fundraising, grant writing, etc.). 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating community based organization and compare to baseline metrics from year 2.	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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1-3. report progress to the IRS in re-assessment.	

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

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

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

The health of a community largely depends on the health status of its residents. Key stakeholders and focus group participants believed that the lifestyles of some residents may have an impact on their individual health status and consequently, cause an increase in the consumption of healthcare resources. Key stakeholders and focus group participants believed that the outcomes of behaviors that negatively impact health include a lack of awareness, limited understanding and utilization of services, an increased risk of poor birth outcomes (i.e., low birth weight, pre-term births, physical/mental limitations of infants), poorer health outcomes for children, mothers

and residents requiring behavioral health services, undetected/untreated illnesses, children that develop poor nutritional habits, concentration of chronic conditions in lower-income communities, perpetuated substance abuse, and higher preventable mortality rates.

Key stakeholders and focus group participants discussed lifestyle choices (i.e., poor nutrition, inactivity, smoking, substance abuse - including alcohol and prescription drugs, etc.) that can lead to chronic illnesses (i.e., COPD, heart disease, adult and childhood diabetes, obesity, cancer, etc.). Key stakeholders discussed the need for chronic disease management due to the increasing rates of obesity, substance abuse, etc. An increase in the number of chronic conditions diagnosed in a community can lead to a greater consumption of healthcare resources due to the need to monitor and manage such diagnoses.

Additionally, focus group participants believed that expecting mothers are not always practicing healthy behaviors (i.e., smoking, substance abuse, and avoiding prenatal care) causing poorer birth outcomes (i.e., low birth weight, pre-term births, rates as high as one baby a day being born addicted to a substance in some birthing facilities, etc.). Focus group participants believed that expecting mothers are not always practicing healthy behaviors (i.e., smoking, substance abuse, and avoiding prenatal care) causing poorer birth outcomes (i.e., low birth weight, pre-term births, rates as high as one baby per day being born addicted to a substance in some birthing facilities, etc.).

Key stakeholders and focus group participants discussed substance abuse, and specifically, prescription drug abuse and the related increased chronic illness costs. Addiction to prescription medication is on the rise due to what stakeholders referred to as "pill mills" or physician's offices that write prescriptions for narcotic pain medications without weaning patients properly. Stakeholders also felt that the lack of integration between behavioral health and medical health settings is a detriment to patients becoming addicted to narcotic prescription medications.

Key stakeholders and focus group participants believed that the health and health practices of parents has an impact on the health and health practices of children particularly as it relates to drug abuse, nutrition, accessing preventive health services, and managing chronic illnesses. Chronic illnesses are becoming more prevalent among children (i.e., obesity, Type II diabetes, asthma, allergies, seizures, etc.), which may be the result of parents' poor lifestyle choices and limited parenting skills. (i.e., prescription drug abuse, limited physical activity, mismanagement of illness, and poor eating habits).

While the five St. Joseph's Hospitals, facilities in the BayCare Health System, all provide programs and services which target healthy behaviors: the need to improve healthy behaviors and environments was identified through the most recent community health needs assessment. Recognizing that the five St. Joseph's Hospitals are not the only medical resources in the hospitals' communities, hospital leadership felt that the most effective strategy to further improve healthy behaviors and environments is through a mixed-strategy of:

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

- ✓ *Faith Community Nurses will continue to 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 to provide, both on and off-site, incentives and giveaways related to health, wellness screenings an education related to cardiac, cancer, diabetes, obesity, (adult and children's Why Weight Classes) etc.*
- ✓ *Continue, to the extent it is possible, providing the Mobile Medical Clinic (MMC), which provides well child care and immunizations to children in need and to facilitate timely entrance to school and daycare facilities. The MMC employs bi-lingual staff and provides well child exams, all required and recommended vaccinations, vaccine registry, Medical Home status, Florida KidCare and Medicaid assistance, unintentional Injury, assessment, developmental screenings, fluoride varnish, hearing screenings, lead and hemoglobin screenings, community referrals, helmets, booster seats, and home safety products.*
- ✓ *Continue to offer bariatric surgery.*
- ✓ *Continue to offer education and assistance with end of life directives through chaplains, mission team, Faith Community Nurses, Palliative care and hospice.*

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 St. Joseph's Hospital(s) as identified below (See tables below):

- ✓ *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 and recovery center with the health needs of the community:

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase resident awareness of risk-reduction and cancer-prevention strategies	Residents in hospital service area and congregations served by Faith Community Nurses	**Year 1:** 1. Identify the types of cancer with prevalence rates higher than average in the hospital service area and the populations that are at greatest risk of diagnosis and death. 2. Evaluate existing programs and services (e.g., cancer screenings, behavior cessations, etc.) provided in the community and at churches that relate to awareness and prevention of cancer (i.e., breast, cervical, prostate, and lung). 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	**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	**Year1-3:** Resources: $50,000 to $100,000 for FCN expansion Mammograms: $11.5K PSA + DRE:~ $12.5K Low dose CT: $15K Additional $50K - $75K in statistical analysis cost as well as FCN annual

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		documentation. 3. Evaluate programs currently offered by the hospital (including Faith Community Nursing) to determine: effectiveness, evidence basis, penetration of population most at risk, accessibility of location, frequency and reach. 4. Based on results of evaluation, develop program recommendations including resources required. **Year 2:** 1. Identify potential funding sources to implement recommendations and secure funding. 2. Implement changes for which funding is available on-site and in the community, including churches. 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, assistance with scheduling screenings and assessing transportation options. b. Continue to provide advanced directive	prevention efforts. 4. Document recommendations to increase resident awareness of risk-reduction and cancer-prevention strategies and resources needed. **Year 2:** 1. Document funding secured. 2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by	expense associated with education and tracking. Partners: FCN

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		documentation. c. Develop a baseline measure of patients diagnosed with late-stage cancer and compare to cancer registry. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed, including Faith Community Nursing. d. Continue to provide advanced directive documentation. a. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants.	demographics annually. 4. Document the evidence basis, population reached, location, and number of participants for each effort. 1-4. Report progress to the IRS. **Year 3:** 1. Document any revisions. 2. Document the awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached, location, and number of participants for each effort. 4. Document the cancer	

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 4. Re-assess the prevalence of cancer in the service area.	rates (incidence and prevalence) by demographics annually. 1-4. Report re-assessment results and progress to the IRS	

APPENDIX A

Implementation Strategy

ST. JOSEPH'S HOSPITALS
August, 2013

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Offer comprehensive care coordination for CHF patients	CHF Patients	**Year 1:** 1. Evaluate current internal and external care coordination of CHF patients (i.e., patient education, prescription assistance, referral, related department processes, ED, inpatient departments, discharge processes, PCP processes, SNF processes, etc). 2. Develop recommendations based on evaluation. 3. Based on evaluations and best practice considerations, develop a plan to implement a comprehensive care coordination procedure for CHF patients. 4. Determine the level of resources required to implement a comprehensive care coordination procedure for CHF patients. 5. Explore options for partnering with Palliative Care and other community based organizations. 6. Review options for collaboration at BayCare Health System Level (i.e., Coordination through BC Home Health, Primary Care Physicians, Parish Nursing, etc). 7. Identify and secure grants opportunities for medication assistance. 8. Document outcomes and evaluate efficacy (i.e., number of re-admission among patients whose care	**Year 1:** 1. Document evaluation findings. 2. Document recommendations. 3. Document plan. 4. Document resources needed. 5-6. Document partnership and collaborative opportunities 7. Document funding secured 1-8. Report progress to the IRS.	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BC Home Health, Primary Care Physicians, Parish Nursing, etc.

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF)
UNDERLYING FACTORS: Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance
ANTICIPATED IMPACT: Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		is coordinated, satisfaction and consumer feedback measures) in six-month intervals. **Year 2:** 1. Communicate new care coordination program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 2. Based on the funding secured, implement a comprehensive care coordination procedure for CHF patients including medication assistance. 3. Communicate new program: External communications and internally to patients treated and referred i.e.: WEB **Year 3:** 1. Continue to offer the care coordination procedure to CHF patients. 2. Evaluate the efficacy of the program by comparing outcome, satisfaction and consumer feedback measures from one year to the next. 3. Develop recommendations based on program evaluation. 4. Re-assess the preventable hospitalizations for CHF in	**Year 2:** 1. Document the communication plan (internal and external). 2. Document stages of rollout. 4. Document outcomes and efficacy. 1-3. 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 re-assessment	

NEED: Improving access to affordable healthcare – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination, medication compliance **ANTICIPATED IMPACT:** Decrease re-admission rates and mortality rates while increasing referrals to Palliative care/hospice **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		the service area.	results and progress to the IRS.	

NEED: Improving access to affordable healthcare – Mental health treatment **UNDERLYING FACTORS:** Access to mental health treatment **ANTICIPATED IMPACT:** Increase the availability of mental health services **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Continue to provide while increasing the availability of mental health services	Adults and pediatric residents who may require mental health services	**Year 1:** 1. 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:** Conversion of pediatric acute services grant to preservation program $400,000

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
Align the services offered to patients with diabetes with best practices to improve health outcomes for diabetic patients that are diagnosed and/or treated for some type of diabetes at any St. Joseph's Hospital.	Adult/pediatric patients that are diagnosed and/or treated for some type of diabetes at any St. Joseph's Hospital.	**Year 1:** 1. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each continue to provide current diabetes management initiatives and education for inpatients and outpatients, while evaluating the effectiveness, evidence basis, outcome measures, population served, accessibility, etc. of current models. 2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each evaluate the populations served by the facilities' diabetes management initiatives and education for inpatients and outpatients.	**Year 1:** 1-2. Document the findings of the evaluation for each St. Joseph's Hospital. 1-2. Report progress to the IRS.	**Year1-3:** **Resources:** **St. Joseph's Hospital – Main:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to diabetes, etc. **St. Joseph's Hospital – North:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to diabetes, etc. **St. Joseph's Women's Hospital:** Staff Time,

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		Year 2: 1. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each develop recommendations based in best practices for the diabetes management initiatives and education for inpatients and outpatients provided at each Hospital (including all services related to gestational diabetes provided at St. Joseph's Women's Hospital, all services related pediatric onset of diabetes provided at St. Joseph's Children's Hospital and services related to diabetes for adults at St. Joseph's Hospital – main and St. Joseph's Hospital – North). 2. Based on the findings related to the populations served by the diabetes management initiatives and education for inpatients and outpatients at St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and	**Year 2:** 1-2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will document the recommendations for each diabetes management initiative and education diabetes management initiatives and education service offered to inpatients and outpatients at each hospital location. 3. St. Joseph's	Office/medical Supplies, Curricula/Teaching tools related to gestational diabetes, etc. **St. Joseph's Children's Hospital:** Staff Time, Office/medical Supplies, Curricula/Teaching tools related to pediatric onset diabetes, etc.

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		St. Joseph's Children's Hospital, each St. Joseph's Hospital will develop recommendations to further offer services to populations that show health disparities related to diabetes. 3. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each evaluate resources needed to implement recommendations. **Year 3:** 1. Based on the funding secured, St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each revise the diabetes implementation plan for year three to reflect the recommendations for each diabetes management and education initiative for which funding was secured.	Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each Document secured resources. 1-3. Report progress to the IRS. **Year 3:** 1. Document the revised implementation plan. 2. Document action step completion dates and outcomes. 3. Document the metrics identified. 1-4. Re-assess need	

NEED: Decreasing the prevalence of clinical health issues – Diabetes
UNDERLYING FACTORS: Higher rates of diabetes among residents including health disparities
ANTICIPATED IMPACT: Continue to provide high-quality diabetes management initiatives and education for inpatients and outpatients while enhancing and aligning the services provided by all St. Joseph's Hospitals to more effectively address the needs of populations that show a greater risk of diagnosis, poor health outcomes, etc.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital

Objective	Target Population	Strategies and Action Description	Timeframe/ Measures	Potential Resources/ Partners
		2. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital and St. Joseph's Children's Hospital will each implement the action steps from the revised plan. 3. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each develop measures of efficacy and outcomes (i.e., outcome measures, demographics of patients, etc.) and develop a baseline. 4. St. Joseph's Hospital – Main, St. Joseph's Hospital – North, St. Joseph's Women's Hospital, and St. Joseph's Children's Hospital will each re-assess community need.	and Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **GOAL:** Decrease readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Maintain current CHF outpatient clinic services and expand model to decrease hospital readmissions	CHF Patients	**Year 1:** 1. Continue to provide CHF Clinic services and document outcomes. 2. Evaluate need, feasibility and sustainability of CHF clinic expansion. 3. Based on evaluations, develop a plan to expand clinic services in the most effective way. 4. Determine the level of resources required to expand Clinic services. 5. Explore options for partnering with Palliative Care 6. Review options for collaboration at BayCare Health System Level. 7. Identify potential funding sources and secure funding. **Year 2:** 1. Continue to provide CHF Clinic services and document outcomes. 2. Communicate new program and relevant action Steps to: 1) Physician, 2) Staff, 3) Foundation, and 4) The community. 3. Explore other associated co-morbidities, i.e., diabetes, AMI, Hypertension, etc. 4. Communicate new program: External communication i.e.: Web redesign.	**Year 1:** 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:** 1. Document outcomes and compare to year 1 2. Document the stages of implementation 3. Document findings related to co morbidity 4. Document the communication plan 5. Document outcomes	**Year1-3:** **Resources:** Staff time **Potential Partners:** BayCare Health System, BayCare Medical Group, etc.

NEED: Decreasing the prevalence of clinical health issues – Congestive Heart Failure (CHF) **UNDERLYING FACTORS:** Higher than averages rates of CHF, preventable hospitalizations, need for care coordination **GOAL:** Decrease readmission rates and mortality rates while increasing referrals to Palliative care/hospice				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		5. Continue to document outcomes. **Year 3:** 1. Evaluate the efficacy of the program by comparing outcome measure from one year to the next. 2. Develop recommendations based on program evaluation. 3. Re-assess the prevalence of CHF in the service area.	and compare from clinic to clinic. 1-5. Report progress to the IRS. **Year 3:** 1. Document outcomes and any changes in outcome measures. 3. Document program recommendations 1-3. Report re-assessment results and progress to the IRS.	

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

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		and the populations that are at greatest risk of stroke and where these populations seek information (e.g., television, newspaper, word-of-mouth). b. Based on the results of the evaluation, define what information to communicate and the goals for each topic (i.e., Signs and symptoms of stroke). c. Based on the results of the evaluation, identify the most appropriate outlet to provide information to the populations that are at greatest risk of stroke. d. Develop communications strategy: identify the methods for communicating with the target audiences. e. Identify resources needed to implement communication strategy. **Year 2:** 1. Identify where collaboration is possible (i.e., collaborative partnership building, service/program development, etc.). 2. Identify potential funding sources to implement Communication strategies and seek funding.	**Year 2:** 1. Document organizations and collaborations formed. 2. Document funding secured.	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		a. Based on available resources, develop communications and test communication strategies (e.g., focus group, survey, test market, etc.). b. Produce materials for dissemination. c. Launch communication plan. d. Measure and track reach and frequency of communications. **Year 3:** 1. Continue to evaluate opportunities to collaborate	2. Document new awareness and prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the death due to stroke by demographics annually. 2 a-c. Document the evidence basis and dates of communication launch. 2d. Document the number of residents reached with messaging. 1-2. Report progress to the IRS. **Year 3:** 1. Document	

NEED: Decreasing the prevalence of clinical health issues – Stroke **UNDERLYING FACTORS:** Higher than average death rates and racial disparities **ANTICIPATED IMPACT:** Increase stroke education and screening **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		with community-based organizations (i.e., collaborative partnership building, service/program development, etc.). 2. Evaluate the effectiveness of communication strategies implemented in year two and revise strategy for year three as needed. 3. Re-assess the health outcomes related to stroke in the service area.	organizations and collaborations formed. 2. Document the results and recommendations of evaluation. 1-3. Report re-assessment results and progress to the IRS.	

NEED: Improve the prevalence of clinical health indicators – Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital

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

NEED: Improve the prevalence of clinical health indicators – Cancer
UNDERLYING FACTORS: Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes
ANTICIPATED IMPACT: Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis.
RESPONSIBLE HOSPITAL: St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital

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

NEED: Improve the prevalence of clinical health indicators – Cancer **UNDERLYING FACTORS:** Higher than average death rates due to cancer, late-stage diagnosis and poorer treatment outcomes **ANTICIPATED IMPACT:** Decrease the percentage of breast, prostate, and lung cancer patients who present with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Implement a lung cancer screening program to increase the percentage of lung cancers diagnosed at Stage I in high-risk populations.	Residents at risk of lung cancer	**Year 1:** 1. Develop algorithm for lung cancer screening for high risk residents consistent with American Cancer Society protocols. This will include care coordination for those testing positive for screening so that appropriate treatment is provided. 2. Partner with government entities and other providers to identify community resources and assess current screening compliance in high risk groups through Faith Community Nursing and partner PCPs. a. Partner PCPs and FCN network can identify high risk groups. Use cancer registry data to determine stage distribution. b. Determine if barriers (i.e., financial, transportation, etc.) exist for lung cancer screening. c. Educate and promote smoking cessation and lung cancer screening guidelines to congregation members. d. Identify resources needed to increase compliance rates. e. Pursue grant funding to remove financial	**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 1-3:** Estimated $25K - $50K increased annual expense to provide education through FCN. 150 low dose CT lung cancer screening = $22.5K.

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		barrier for high-risk groups. f. Make available advanced directive documents during any screening or education program. **Year 2:** 1. Educate PCPs and other physicians to lung cancer screening guidelines. a. Promote awareness of current lung cancer screening guidelines to all CIN and BMG physicians. b. Use CIN and BMG physicians to identify high risk individuals and refer to lung cancer screening. c. Use CIN and BMG physicians as well as FCN network to promote smoking cessation and lung cancer screening guidelines. d. Pursue grant funding to provide low-income, high-risk individual's low-dose CT scans for lung cancer screening. e. Continue to provide advanced directive documentation. f. Measure program effectiveness by tracking developed metrics (i.e., demographics of	**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 effectiveness. 1a-e. Report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		population reached, insurance status of program participants, screening results, etc.). **Year 3:** 1. Based on collected data develop programs to target low-compliance populations. Partner with community-based organizations to provide increased screening and cessation opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Work with Faith Community Nursing to encourage congregation members to be screened and adopt risk reduction and cancer prevention strategies (i.e., smoking cessation), provide information about screenings taking place and available resources for cessation, assistance with scheduling screenings and assessing transportation options. b. Continue to provide advanced directive documentation. c. Continue to measure program effectiveness by tracking developed metrics	**Year 3:** 1a. Document number of patients provided cancer screening. 1b.Document the number of patients that are provided education, screening and cessation resources. 1c. Document the number of advanced directive materials provided. 1d. Document metrics related to program effectiveness. 1a-c. Re-assess community health need and report progress to the IRS.	

NEED: Decreasing the prevalence of clinical health issues – Cancer **UNDERLYING FACTORS:** Higher rates of lung cancer **ANTICIPATED IMPACT:** Decrease the rate of lung cancer patients diagnosed with late-stage disease at time of diagnosis. **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		(i.e., demographics of population reached, insurance status of program participants, screening results, etc.).		

NEED: Decreasing the prevalence of clinical health issues – Suicide Prevention **UNDERLYING FACTORS:** Higher than average suicide rates **ANTICIPATED IMPACT:** Reduce the rate of suicide-related deaths among residents served by BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
Increase the awareness of and prevalence of suicide prevention	Residents most at risk of attempting suicide	**Year 1:** 1. Evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Develop a comprehensive wellness initiative that will focus on meeting the needs of residents at risk of attempting suicide and preventing suicide-related deaths (e.g., educational programs, website resources, etc.). 3. Identify the resources required and potential funding sources to implement a comprehensive wellness initiative that will focus on preventing suicide related deaths(i.e., communications plan, analytics necessary to profile high-risk suicide, $30,000 for developing and marketing, etc.). 4. Secure funding. **Year 2:** 1. Maximize relationships and collaborative opportunities with community-based organizations related to suicide. 2. Continue to evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of	**Year 1:** 1. Document the community resources related to suicide and any potential collaborative opportunities. 2. Document in a plan the facets of the comprehensive wellness initiative. 3. Document funding needed to implement and funding secured. 1-6. Report progress to the IRS. **Year 2:** 1. Document the community resources related to suicide and any additional collaborative opportunities. 2. 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 deaths among residents served by BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Behavioral Health Center				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		suicide, etc. 3. Develop metrics to measure the reach and effectiveness of the initiative. Develop a baseline. 4. Based on the level of funding secured in year 1; implement comprehensive wellness initiative that will focus on preventing suicide-related deaths. **Year 3:** 1. Continue to maximize relationships and collaborative opportunities with community-based organizations and evaluate existing programs and relationships with community-based organizations that provide services related to suicide, risk of suicide, etc. 2. Continue the suicide prevention initiative. 3. Continue to measure the reach and effectiveness of the suicide prevention initiative and evaluate effectiveness (e.g., number of participants, feedback/satisfaction surveys, suicide-related deaths, etc.) by comparing the baseline measures gathered in year one to those gathered in year two.	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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
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. The BayCare hospital that provide obstetric services (SJWH, SJHN, SFB, MCH and MPH) will each 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: Consider local medical school for medical education related to NAS, access to care barriers, preventive measures for SIDs, and awareness of post-delivery adverse newborn outcomes once discharged into the community. c. It is possible to develop ongoing	**Year 1:** 1 & 2.Document the results of an evaluation of hospital collaboration with community-based organizations and recommendations made for changes to existing partnerships, programs/services, etc. 3. Document identified funding opportunities. 4. Document outcome measures for each collaborating community based organization. 1-4. Report progress to the IRS.	**Year 1:** Grants, substance abuse and treatment grant for NICU navigators, Staff, office supplies, educational material

NEED: Decreasing the prevalence of clinical health issues – Improving birth outcomes **UNDERLYING FACTORS:** Pre-term births, low-birth weight births, infant mortality **ANTICIPATED IMPACT:** Improve birth outcomes for expecting mothers seen at facilities associated with BayCare Health System **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		collaborative relationships related to expecting mothers in the hospital service areas. 2. Identify where expansion is possible (i.e., collaborative partnership building, service/program development, etc.). 3. Identify funding opportunities to expand services to expecting mothers at risk of poor birth outcomes. 4. Develop baseline metrics by collecting outcome measures for each collaborating community based organization. **Year 2:** 1. Implement recommendations for existing programs: A. Seek identified funding. B. Begin implementation of the programs/services for which funding is secured. C. Track outcomes of new programs and services. Use partnership with community based organizations that serve expecting mothers to share information related to improved outcomes. 2. Continue to evaluate opportunities for expansion and funding for these opportunities.	**Year 2:** 1A. Document programs for which funding is sought and the outcomes of each effort. 1B. Document the phases of implementation for each program/service for which funding is	**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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Continue to collect outcome measures for each collaborating community based organization, including expanded programs and services. **Year 3:** 1. Complete implementation and begin to evaluate the effectiveness of the newly implemented programs/services.	secured. 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating community based organization and compare to baseline metrics from year 1. 1 -3. Report Progress to the IRS **Year 3:** 1A. Document the results of program evaluation.	**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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		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 community based organization, including expanded programs and services.	1B. Document the resources needed to implement recommendations. 1C. Document efforts to gather resources (e.g., fundraising, grant writing, etc.). 2. Document any new opportunities identified as they evolve and recommendations made for changes to existing partnerships, programs/services, etc. and any identified funding opportunities. 3. Document outcome measures for each collaborating community based organization and compare to baseline metrics from year 2.	

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 **RESPONSIBLE HOSPITAL:** St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
			1-3. report progress to the IRS in re-assessment.	

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

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

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		3. Partner with community-based organizations to provide increased screening opportunities to high-risk communities with a focus on follow-up treatment opportunities in the event of diagnosis. a. Work with Faith Community Nursing to provide information about screenings taking place, assistance with scheduling screenings and assessing transportation options. b. Continue to provide advanced directive documentation. c. Develop a baseline measure of patients diagnosed with late-stage cancer and compare to cancer registry. 4. Evaluate newly implemented awareness and prevention strategies including Faith Community Nursing by tracking evidence basis, population in attendance, location, satisfaction of attendees, and number of participants. **Year 3:** 1. Evaluate the effectiveness of awareness and prevention strategies implemented in year 2 and revise strategy for year 3 as needed, including	prevention strategies to be implemented. 3a-b. Document the screenings provided, number and demographics of participants. 3c. Document the cancer rates (incidence and prevalence) by demographics annually. 4. Document the evidence basis, population reached, location, and number of participants for each effort. 1-4. Report progress to the IRS. **Year 3:** 1. Document any revisions. 2. Document the	

NEED: Improving healthy behavior and environments – Cancer **UNDERLYING FACTORS:** Higher than average cancer rates **ANTICIPATED IMPACT:** Increase the use of risk-reduction and cancer-prevention strategies **RESPONSIBLE HOSPITAL:** St. Joseph's Hospital – Main, St. Joseph's Hospital – North and St. Joseph's Women's Hospital				
Objective	**Target Population**	**Strategies and Action Description**	**Timeframe/ Measures**	**Potential Resources/ Partners**
		Faith Community Nursing. a. Continue to provide advanced directive documentation. b. Measure the percentage of high-risk patients diagnosed with late-stage cancer compared to baseline and cancer registry. 2. Continue to offer effective awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 3. Evaluate the awareness and prevention strategies by tracking evidence basis, population in attendance, location, satisfaction of attendees and number of participants. 4. Re-assess the prevalence of cancer in the service area.	awareness and prevention strategies to be implemented. 3. Document the evidence basis, population reached, location, and number of participants for each effort. 4. Document the cancer rates (incidence and prevalence) by demographics annually. 1-4. Report re-assessment results and progress to the IRS	

APPENDIX B

Needs not Addressed by the 2013 Plan

ST. JOSEPH'S HOSPITALS
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 any of the five St. Joseph's Hospitals during this reporting period, including a rationale for those decisions.

Developmental disabilities:

While hospital leaders are interested in this issue, and are interested in further evaluating the barriers that residents with developmental disabilities and their families experience when seeking services, none of the five St. Joseph's Hospitals currently have the expertise, resources, and/or provider base to provide these services in a sustainable way. Because the primary needs within the community have dictated that financial and human resources of the five St. Joseph's Hospitals are utilized for diagnostic, therapeutic, medical, behavioral health and surgical care; hospital leaders have determined that developmental disabilities 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.