Pinellas County CHIP: 2016-17
Access to Care

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)	July - September 2016	October - December 2016
AC 1: Provide equal access to appropriate health care services and providers	1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	1. Promote Direct Connect Partnership between PSTA and Uber to community partners (including TD late shift). 2. Implement St. Petersburg Police Dept. Mobile Resource Bus Connection.	1. Promote program and PSTA events to a minimum of one community group per quarter. 2. Publicize mobile resource bus to community partners each month. Track and increase number of residents connected to resources during the August 2016-July 2017 CHIP period.	1. PSTA 2. Healthy St. Pete	1. Uber, DOH-Pinellas 2. Foundation for a Healthy St. Pete, DOH-Pinellas, SPPD	Adults who had a medical checkup in the past year	1. Information shared with CHAT in September 2016 about Transportation Disadvantaged (TD) late shift PSTA rides. 2. Bus location publicized to partners by Healthy St. Pete during July, August, and September. 46 total walk-ups for this quarter.	1. No updates this quarter. 2. The bus was active in October and November. 22 total walkups.
	1.2: Develop and implement a standardized training program for Community Health Workers.	1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	**Strategy met: http://flcertificationboard.org/certifications/certified-community-health-worker-cchw/**				15% of identified CHWs have enrolled in or completed a standardized training	1. Updated workgroup at the annual CHIP update in August that this measure has been completed. Representatives from the CHW Coalition and SPC will continue to attend CHAT meetings and keep community partners updated about CHW progress in Pinellas County.	1. No update.
	1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.	1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	1. Implement Cultural & Linguistic Competency Initiative	1. 4 organizations complete CLC program led by TBHC.	Tampa Bay Healthcare Collaborative	Collaborative Labs USF Public Health	CLC cohort completed	1. DOH-Pinellas joined the CLC cohort program. Meetings began in September 2016.	1. DOH-Pinellas continues to assess its cultural competency via surveys of clients and staff. Results available and reported in early 2017.
AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	2.1: Improve communication among providers and care coordinators through data integration.	2.1.1: -By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	1. Identify providers enrolled in Direct Trust and encourage its use as an HIE. 2. Implement electronic Pinellas County Health Program application and make available at community partner organizations.	1. Increase # of providers identified 2. Increase # organizations making electronic application available	1. DOH-Pinellas 2. Pinellas County Human Services	1. USF Health 2. DOH Pinellas, hospitals, community organizations	At least four new partnerships developed between social service and medical agencies in Pinellas County.	1. No change this quarter. 2. The PCHP e-app will be available online and at DOH locations on the lobby computers. Human Services will also have computers available in their offices for clients to apply. Clients can complete the application from any device connected to the internet, anywhere. The 'go-live' date is Feb. 1, 2017. Clients will be able to apply for PCHP, MMU, and get contact information for other services in the community.	1. DOH-Pinellas is now enrolled in Direct Trust for Health Information Exchanges. Work is continuing to identify community partners in the Direct Trust network willing to accept transmittals. DOH-Pinellas has received a directory of all current Florida providers in the Direct Trust and partners are being contacted in regards to their use of HIE. 2. Go-live date still scheduled for early 2017.

AC 3: Reduce infant mortality and morbidity	3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.	3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	1. Implement Figuring it Out for the Child. 2. Use Fetal Infant Mortality Review data to identify trends and educate women of childbearing age in Pinellas.	1. Increase the number of pregnant couples seen each year to 100. 2. Identify trends in losses and offer interventions in the form of educational materials to all 32 Pinellas OB offices and Healthy Start Care Coordinators	1. USFSP - Lisa Negrini 2. Healthy Start Coalition - Michele Schaefer	1. CHCP, DOH-Pinellas, Healthy Start, Mt. Zion 2. FIMR Partners	• Reduce teen pregnancy rates in Pinellas • Reduce teen STD rates in Pinellas • Reduced rate of low birth rate babies in sample group of FOFC • Decrease in child deaths	1. Transitional quarter; revising activity. 2. Delivery of educational materials to all OB providers, distribution of HALO sacks to all our care coordinators to use as a teaching tool when teaching safe sleep guidelines and to encourage parents to not use blankets, distribution of Prevent Needless Death Campaign materilas to interested parties that included 11 OB offices, 7 Pediatric providers and all Pinellas Pregnancy Centers, Official letter sent to all Pediatric providers informing them how many babies had died in the last three years due to unsafe sleep environments and encourage them to use consistent messaging by AAP, distribution of toothbrushes for mom and baby for all care coordinators to use as a teaching tool when encouraging dental health.	1. 50 couples have been seen in the FIOC intervention. 2. Delivery of educational materials to all OB providers, special distribution and special addition to our materials request form about pre-ecalmpsia, update or our Resource Guide, planning and finalizing a new Beds 4 Babies program to be officially launched 1/17, safe sleep survey that was started the second quarter of 2015-16 year has been completed and currently being analyzed.
	3.3: Address disparities in Black and Hispanic infant mortality.	3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births. 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	1. Build Florida Healthy Babies Task Force.	Convene group minimum of quarterly and create action plan.	DOH-Pinellas	IFMHC, JWB, JCACH, Healthy Start	Increase membership of the CAN and Hispanic Outreach Center. Reduce the number of infant deaths due to unsafe sleeping practices. Increase percentage of Pinellas mothers receiving prenatal care.	1. Healthy Babies task force met on 8/9/2016 and 9/13/2016.	1. Notified that funding will be available from DOH for Healthy Babies in 2017. No activity this quarter.