Appendix B: 2014 – 2015 Action Plan

Access to Care		
How can we ensure equal access to health care services in Pinellas County?		
Goal AC 1: Provide equal access to appropriate health care services and providers		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 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%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida Community Health Worker Coalition/SPC	As needed
Objective 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%.	BRFSS	3 years
Outcomes		
Increase in adults who had a medical checkup in the past year Increase in percentage of CHWs who have enrolled in a standardized training Implementation by at least 4 agencies of CLAS assessment and action plan At least four new partnerships developed between social service and medical agencies in Pinellas County. Establishment of a forum for dialogue about direct messaging in Pinellas County. 2 agencies have implemented CLAS assessment and action plan		

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP AC 1.1.1
Obj. 1.2.1	Florida SHIP HI3.4

Strategy 1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities

Objective 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%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Maintain document detailing existing health care provider resources for low-income patients in Pinellas County and capacity of these providers	Health & Community Services	DOH-Pinellas	July 2014-June 2015	Update resource document a minimum of twice annually.
2	Collaborate with Pinellas Suncoast Transit Authority council to identify and eliminate transportation barriers in vulnerable communities and advocate for the consideration of public health in transit decisions.	DOH-Pinellas	PSTA	July 2014-June 2015	A Community Health Action Team member will serve on the PSTA Transit Advisory Committee.
3	Provide healthcare resource information to ex-offenders enrolled at the Pinellas County Ex-Offender Reentry Coalition.	DOH-Pinellas, PERC	Pinellas County	July 2014-June 2015	Work with PERC to develop a set of healthcare provider resources and share this list with program participants.
4	Share social service and healthcare information at the Metropolitan Ministries' hot meal program.	Metropolitan Ministries	Local social service and medical providers	July 2014-June 2015	Recruit at least three social service/healthcare organizations to table at the Metropolitan Ministries' hot meal program.

Strategy 1.2: Develop and implement a standardized training program for Community Health Workers.

Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Develop a Community Health Worker registry and a standardized training/professional development toolkit.	Florida Community Health Worker Coalition (Pinellas County Chapter)	St. Petersburg College	July 2014-June 2015	Determine a baseline number of Pinellas County CHWs and identify their training needs.
2	Collaborate with other agencies in Access to Care workgroup and beyond to identify groups and job positions/titles that would be good candidates for CHW training or certification.	Florida Community Health Worker Coalition	St. Petersburg College, DOH-Pinellas	July 2014-June 2015	Identify at least three new agencies with CHW-like employees who would be good candidates for CHW training/certification.

Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.

Objective 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%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote use of the CLAS self-assessment.	Tampa Bay Healthcare Collaborative (TBHC) and DOH-Pinellas	Center for Equal Health, Moffitt Diversity, Florida Diversity Council, TBCCN	July 2014-June 2015	1. Create a concept paper 2. Support at least one organization in using the CLAS self-assessment tool (may include workshops, technical assistance, etc.)

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec. 31, 2017, increase health provider utilization of criteria for Pinellas health and social service program eligibility by 25% over baseline.	JWB	By request
Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed providers in Pinellas will be able to exchange data using direct messaging.	USF Health Regional Extension Center	By request

Outcomes

At least four new partnerships developed between social service and medical agencies in Pinellas County. Forum established for dialogue about direct messaging in Pinellas County.

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	SHIP Strategy HI1.1

Strategy 2.1: Streamline the eligibility process among community partners to increase access to services.

Objective 2.1.1: By Dec. 31, 2017, increase health provider utilization of criteria for Pinellas health and social service program eligibility by 25% over baseline.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Convene a group to explore a common eligibility tool for social services that would be used by organizations in Pinellas that serve low-income patients.	Pinellas County Health & Community Services	JWB, DOH-Pinellas, 211	July 2014 – June 2015	At least two programs will be identified to have common eligibility criteria, where eligibility for one program will by automatically qualify them for the second program.

Strategy 2.2: Improve communication among health providers and coordination of care for consumers through data sharing.

Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed providers in Pinellas will be able to exchange data using direct messaging.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Determine the requirements, sources, and costs for Direct Access.	USF Health	DOH-Pinellas, JWB, Pinellas County	July 2014 – June 2015	Create report detailing requirements, sources, and costs for Direct Access.

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 3: Reduce infant mortality and morbidity

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 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%.	Florida CHARTS	Annually
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.	Florida CHARTS	Annually
Objective 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.	Florida CHARTS	Annually
Objective 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.	Florida CHARTS	Annually

Outcomes

Recruit at least three community partners to help promote health before and between pregnancies. Increase membership of the CAN and Hispanic Outreach Center. Reduce the number of infant deaths due to unsafe sleeping practices."

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Other: 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Obj. 3.3.1	Florida SHIP Objective AC5.4.4

Strategy 3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.

Objective 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%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Partner with community agencies to provide health-focused events/classes on interconceptional and pre-conception health	Sanderlin Center	Healthy Start Coalition of Pinellas, Community Health Workers Coalition, and WIC, Home Visiting Advisory Committee, Pinellas County Dental Coalition, Neighborhood Family Centers Network	July 2014 – June 2015	Sponsor at least 2 bi-annual events with community partners serving interconceptional and preconceptional women.
2	Develop a process to educate at risk youths in the community regarding the importance of their health and accessing health care services, with a focus on high schools.	Sanderlin Center	All Children's Hospital, HS Federal Project, CAN, DOH-Pinellas	July 2014 – June 2015	Conduct three focus groups with Neighborhood Family Centers to obtain input regarding engaging at risk youth in learning about their health.

2016 – 2017 Activities

- Partner with health care providers and universities to provide education and research about preconception health.
- Develop a campaign that educates women on the correlation between STDs and low-birth weight births.
- Work together with medical providers, law enforcement and health & human service agencies to address substance abuse.
- Place base initiative to identify high concentration of low birth weight infants.
- Develop policy recommendations promoting full term gestation vs. delivery prior to 39 weeks.

Strategy 3.2: Increase access to prenatal services and education.
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.
2016 – 2017 Activities
○ Educate women about healthy start screenings and Healthy Start services ○ Develop a campaign to educate women on prenatal oral health care services ○ Work with the DOH-Pinellas Centering Pregnancy program for Hispanic women to increase enrollment. ○ Develop a campaign to promote Women, Infants, and Children (WIC) services.

Strategy 3.3: Address disparities in Black and Hispanic infant mortality.

Objective 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.

Objective 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.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Partner with ACH Community Action Network (CAN) and the Hispanic Outreach Center to identify strategies to engage and provide education to African American/Black and Hispanic/Latina women about prenatal behaviors that reduce infant mortality and low-birth weight infants.	Healthy Start Federal project	DOH-Pinellas, All Children's Hospital, USF, Women of Distinction, NAACP, St. Pete College, ACNW, Sororities, Urban League, Home Visiting Advisory Council, Healthy Start Coalition, Neighborhood Family Centers, National Council of Negro Women	July 2014 – June 2015	The Healthy Start Federal Project will have conducted at least 4 presentations, roundtable discussions in collaboration with minority community based organizations about the goals of the CAN and Hispanic Outreach Center.
2	Leverage Local Planning Team partners to address gaps in training the community on safe sleeping.	Local Planning Team	Local Planning Team partners, including JWB, DCF, Medical Examiner's Office - District 6, Healthy Start Coalition, BayCare	July 2014 – June 2015	Work with the Local Planning Team to develop and implement an action plan to reduce infant deaths due to unsafe sleeping.

2015 – 2017 Activities

- Support the efforts of Addressing Racism Achieving Health Equity (ARCHE) in identifying social factors that contribute to infant mortality and premature births
- Partner with therapeutic health agencies to educate staff about the impact of racism on healthy birth outcomes within the cultural setting.