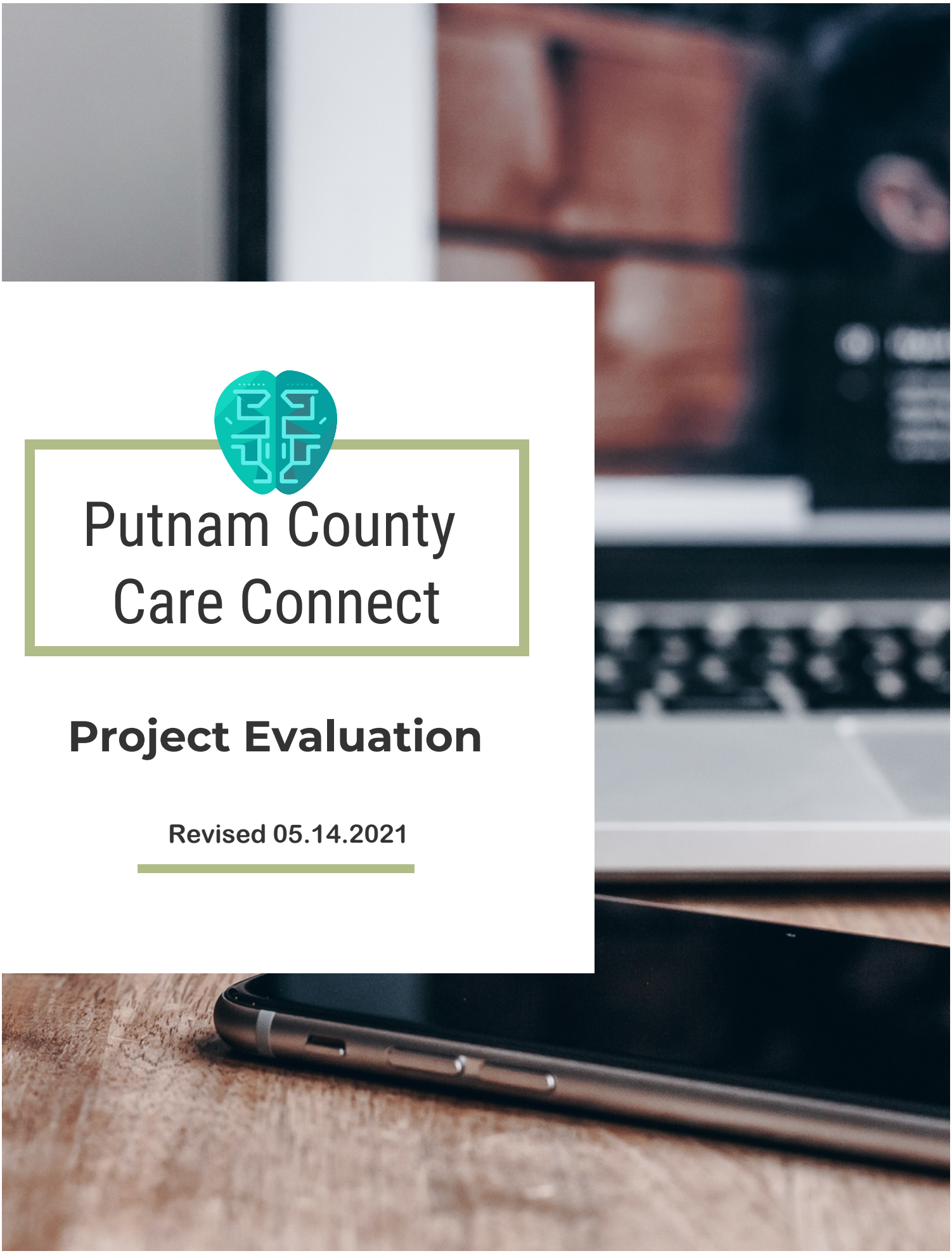


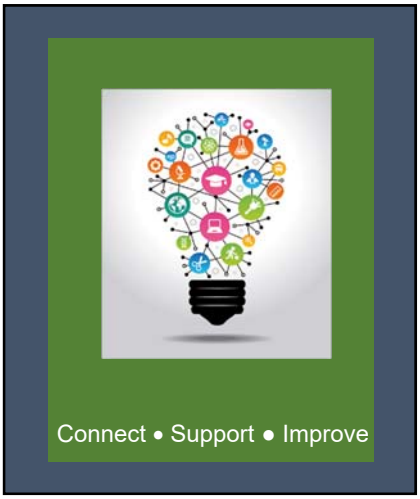
Putnam County Care Connect

Project Evaluation

Revised 05.14.2021

Putnam County Care Connect

Project Evaluation



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01. Introduction/Evaluation Purpose

The Putnam County Care Connect (PC3) network formed to implement behavioral health services through telehealth during the 2019 Health Resources Services Administration Rural Health Network Development Planning Program. The planning process connected St. Johns River Rural Health Network (SJRRHN), Health Planning Council of Northeast Florida (HPCNEF), and SMA Behavioral Healthcare (SMA).

Need

Putnam County, established in 1849, consists of 827 square miles in the central northeast region of Florida approximately 30 miles inland from the Atlantic Ocean. The Federal Office of Rural Health Policy designates all of Putman County as rural. Putnam County receives a rural area designation from the Health Resources and Services Administration (HRSA) and by the Center for Disease Control (CDC).

In 2020, Putnam County ranked 66th out of the 67 Florida counties in health outcomes, which look at the length of life and quality of life, and 67th of 67 counties in health factors.

The 2016 county-level BRFSS is the most recent county-level effort, with over 37,000 interviews completed. BRFSS's target sample size is 500 completed surveys in each county. In 2016, 477 adults in Putnam County responded to the county-level BRFSS survey.[1]

Behavioral & Mental Health Indicators from the Behavioral Risk Factor Surveillance System Survey, 2016

Indicator	Putnam	Florida
Adults who always or usually receive the social and emotional support they need (2010) *	69.5%	79.5%
Adults who are "very satisfied" or "satisfied" with their lives (2010)	88.2%	93.1%
Adults who are limited in any way in any activities because of physical, mental, or emotional problems	33.8%	21.2%
Adults who had poor mental health on 14 or more of the past 30 days	12.8%	11.4%
Adults who have ever been told they had a depressive disorder	19.9%	14.2%
Adults who think they would get better medical care if they belonged to a different race/ ethnic group (2010) *	16.3%	10.8%
Adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days (Among adults who have had one day of poor mental or physical health)	19.1%	18.6%
Adults with good mental health	87.2%	88.6%
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days (Among adults who have had at least one day of poor mental or physical health)	6.2 days	5.7days

[1] Florida Department of Health. "Florida Behavioral Risk Factor Surveillance System (BRFSS) 2016 Data: Putnam." 2016.

Average number of unhealthy mental days in the past 30 days	3.9 days	3.6 days

Data Source: FL Health Charts, www.flhealthcharts.com

Membership

Organization	Key Person	Contact Information	Project Responsibility	Health System Role
SMA Healthcare	Dr. Nancy Russo	330 Kay Larkin Drive Palatka, FL 32177 386-329-3780 NRusso@smahealthcare.org	PC3 Project Lead - has the responsibility to advise the Project stakeholders by providing direction and guidance with how the project relates to the organizational strategy.	Behavioral health service provider in Putnam County
Health Planning Council of Northeast Florida	Susan Grich	4201 Baymeadows Rd., Suite 2 Jacksonville, FL 32217 904-448-4300 Susan_Grich@hpcnef.org	Network Director – has the responsibility for overseeing the network's administrative, fiscal, and business operations at the time of the application.	Regional Local Health Council
St. Johns River Rural Health Network	Flora Davis	110 N. 11th Street, Palatka, FL 32177 386-804-7969 Flora_Davis@hpcnef.org	Project Director - has the overall responsibility for the execution of the project. The PM supports writing project plan content and is responsible for planning, executing and closing of respective milestones on time, on budget and in scope.	Regional Rural Health Network Project Lead

Purpose of Evaluation

Evaluation of the proposed work plan activities is a necessary component to determine project success. SJRRHN will conduct continuous internal assessments for process improvement. These assessments will determine if Putnam County Care Connect (PC3) meets strategic plan goals and provides accountability to its current and future funders.

The evaluation encompasses process and outcome questions examining the project by:

- Hypothesis Assessment - determines if centralized telehealth, resource management, and data dashboard hub provided a platform to improve behavioral health service delivery in Putnam County.
- Methodology Assessment – determines if the methodology specified in the work plan meets project objectives.
- Community Support – Obtains feedback from the consumers of services, residents of Putnam County, and the key stakeholders to assess if the network created buy-in and value within Putnam County.
- Quality Control – Assesses if PC3 service delivery maintained goal-focused direction and allowed for service delivery corrections.
- Impact – Assesses if PC3 improved population health, created efficiencies, returned on investment, and calculated net benefits.

Approach

PC3 network members met virtually through brainstorming sessions to assess their needs from the project. Network members reviewed the HRSA project evaluation criteria. It was then determined how to evaluate selected strategies to gauge project success. Emailed briefing documents provided small chunked assignments for network members to provide input.

WellFlorida provided valuable guidance on the Putnam County Health Department's comprehensive health needs assessment and community health improvement plan. During those processes, WellFlorida reviewed the behavioral health secondary analysis provided to the network from the St. Johns River Rural Health Network. WellFlorida's technical assistance identified gaps in the data and discussed Putnam County resident engagement opportunities through focus groups and interviews.

Network members attempted a narrative completion of the assigned deliverable. However, when network members completed the table and compared it to the narrative sections above in the document, there was an apparent disconnect. Network members decided to keep the evaluation work plan table, utilize the table to guide the narrative, salvage applicable previous attempts, and fill remaining narrative gaps.

Evaluation Plan Development

Putnam County Care Connect (PC3) values working together toward a healthier Putnam County. Successful strategy implementation is difficult without inter-agency communication and cross-sector collaboration. Consistent with membership categories, implementation strategies are: Connect, Support, and Improve.

Connect – Network Development – Early Implementation Stage

Need: Putnam County has limited resources and funding availability requiring providers to align efforts and strategies to address behavioral health disparities.

Goal 1: Putnam County Care Connect will create a diverse and inclusive network fostering an environment valuing community input, data integration, information sharing, and analysis necessary to support better population health outcomes.

Objective 1: By October 31, 2022 create Putnam County Care Connect network of providers.

- Activity 1: Identify five new organizations to become PC3 members
- Activity 2: Contact Putnam County service providers monthly to understand their needs, objectives, and desires to enhance network development.
- Activity 3: Engage two new organizations to become linked PC3 members.
- Activity 4: Report the networks activities to community stakeholders to increase Putnam County’s awareness of network efforts toward health improvements.

Objective 2: By June 30, 2021, obtain a Putnam County resident community perspective on behavioral health and wellness.

- Activity 1: Provide an annual behavioral health data report for Putnam County by the end of each project year.
- Activity 2: Conduct a resident community perspective telehealth needs assessment.

Support – Provider Support – Early Implementation Stage

Need: Putnam County has limited resources to reduce rural health disparities.

Goal 2: Putnam County Care Connect will ensure equitable access to service opportunities and community resources.

Objective 1: By May 31, 2021, improve Putnam County Care Connect network member's cultural competency.

- Activity 1: Design CLAS standards educational activity.
- Activity 2: Implement CLAS educational activity.

Objective 2: By February 28, 2022, increase access to resource availability for Putnam County residents.

- Activity 1: Design St. Johns River Rural Health Network project website.
- Activity 2: Promote SJRRHN and Putnam County website.
- Activity 3: Design referral system through website.
- Activity 4: Promote SJRRHN and Putnam County website.

Objective 3: By September 30, 2021, implement behavioral telehealth services.

- Activity 1: Design telehealth service delivery.
- Activity 2: Train SMA providers on telehealth system.
- Activity 3: Implement telehealth service delivery to consumers.

Improve – Network Sustainability – Planning Stage

Need: Putnam County needs a long-term provider network working to address population health needs.

Goal 3: St. Johns River Rural Health Network will create Putnam County Care Connect as a sustainable provider network to address population health needs.

Objective 1: February 28, 2021, create Putnam County Care Connect project

- Activity 1 – Determine baseline environment for Putnam County Care Connect project.
- Activity 2 – Develop strategic plan

Objective 2: Develop sustainability plan for Putnam County Care Connect project

- Activity 1 – Develop marketing plan
- Activity 2 – Develop business model
- Activity 3 – Develop final sustainability plan

Findings Utilization

Network members will review summaries of findings discovered during the Putnam County Care Connect evaluation process to gleam lessons learned. The project director will develop HRSA reporting deliverables and provide copies to the network members made available through social media, newsletters, and info graphics.

Lessons learned from the overall project, and its findings will drive future project development and help maintain the network's sustainability.

02. Logic Model

SITUATION

Need: To improve behavioral health of Putnam County on limited resources

Desired Result: Shared resources create efficiencies, collaborations, and improve population health.

Enabling "protective" Factors: Network willingness to streamline services under the restraint of limited resources.

Limiting "risk" factors: Sustainable resources for network support

Strategies and best practices: Principles of Community Engagement network development
Use of telehealth services
CLAS Standards focused professional development for workforce

INPUTS

What we invest (resources)

- Human capital
- Technical expertise
- Economic resources
- Shared costs
- Lessons learned
- Community Needs Assessments

OUTPUTS

Activities

What we do

Create a network of direct service providers and regionally focused coordinators to address the behavioral population health of Putnam County.

Obtain community resident perspective on telehealth service needs.

Improve provider network cultural competency knowledge skills

Create website for referrals and resources to inform Putnam County on project activities.

Implement behavioral telehealth services.

Create a sustainable network through strategic, marketing, and sustainability plans.

OUTCOMES-IMPACT

Short term results (1-4 years)

- Telehealth as a virtual health and wellness option
- Shared resource management platform
- Shared data dashboard providing sustainability project data

Longterm results (5-7 years)

- Network sustainability through human and financial capital.
- Putnam County community buy in on the value of project

Ultimate impact (8+ years)

- Improved population health evidenced by secondary data analysis
- Robust network of providers providing social support services through resources
- Efficiencies created through shared resources.

ASSUMPTIONS

Behavioral telehealth services are an acceptable option of care within Putnam County

Providers will be willing to connect into all sections of PC3: telehealth, resource management, and data dashboard.

Regional care organization will value improve clinical outcomes

EXTERNAL FACTORS

Payment for telehealth services will become an activity for reimbursement

Resources to sustain PC3 project will continue to be identified and secured.

EVALUATION

1. Patient satisfaction with the telehealth offerings.
2. Provider satisfaction of telehealth services.
3. Network member satisfaction of strategic plan implementation.
4. Provider satisfaction with resource management services.
5. Provider participation and satisfaction in CLAS Standards focused professional development opportunities.
6. Improved population health data on Putnam County.

03. Evaluation Questions

Project evaluation utilizes both process and outcome questions to assess the success of the implementation. The PC3 project will seek to answer both process and outcome questions for Connect – Network Development, Support – Collaborative Sharing, and Improve – CLAS-Focused Professional Development. Process questions concentrate on understanding how implementation occurred. On the other hand, outcome questions determine whether or not the strategies achieved the desired changes for the target service population.

Connect – PC3 Network Development

Process:

- Who participated in the meetings?
- How many meetings were conducted?
- Did the network gain the support of new organizations members?
- Did the network outline new partnership criteria?
- Were communications distributed?
- Were contact lists updated?
- Were behavioral health assessments distributed?
- Were report findings communicated to the network?

Outcomes:

- What five new organizations were identified?
- What were their needs from the network?
- Did the network obtain new Memorandums of Agreement?
- What new memberships were created?
- Were quarterly communications created?
- Was a distribution list created?
- Was an annual behavioral health profile created and updated?
- Was a resident community perspective assessment on telehealth conducted?

Support – Collaborative Sharing

Process:

- Was a cultural competency knowledge assessment found for modeling?
- What questions were selected for the knowledge assessment?
- What CLAS activities were posted and when?
- What website developers were research and which one was selected?
- Was the website launched?
- What referral system providers were researched and what one was selected?
- What telehealth system providers were researched and what one was selected?
- What consumers were selected for the telehealth program?
- What did the consumers need to enroll into the telehealth program?
- Did the consumers receive the supplies?
- Were telehealth appointments conducted with the consumer?

Outcome:

- Was the cultural competency knowledge assessment posted for network use?
- Did cultural competency knowledge assessment scores improve?
- Were contracts obtained for the website developer, referral system, and telehealth provider?
- Are network members utilizing the website, referral and telehealth systems?
- Are consumers satisfied with telehealth services?

Improve – CLAS-Focused Professional Development

Process:

- Was the baseline behavioral health assessment provided to the network?
- Were meetings scheduled and conducted for the SWOT anaylsis, strategic plan, marketing plan, business model and the final sustainability plan?
- Who participated in the meetings?
- How many meetings were conducted?
- Were the strategic, marketing and sustainability plans provided to the network?
- Was the business model provided to the network?
- Were updates made?
- Were funding streams to the network diversified?

Outcome:

- Was a baseline behavioral assessment provided to the network?
- Was a SWOT analysis conducted?
- Was a strategic plan, marketing plan, business model, and sustainability plan created?

04. Data Collection Plan

The Improve phase of the PC3 project is still in a planning phase. The following Data Collection Plan is proposed and by no means limits or restrains the number of performance measures. The plan is also fluid. Some collection methods may need adjustment to the actual test run for any information gathering.

Intervention/Strategy: Create Putnam County Care Connect network to address and improve the behavioral health status of Putnam County.

Connect – PC3 Network Development

Data sources include both primary and secondary data sources. Summaries compile both types of data to provide readable format to network.

Measurements:

- Partners attending meetings
- # of meetings between partners
- Lists of organizations
- Research briefings
- Terms of agreements
- Info summaries
- Behavioral health profiles
- Contractual services obtained
- # of ditributions and updates

Data Sources/Methods:

Data sources will be primary and secondary sourced data

- Meeting agendas, sign-in, and minutes
- Memorandums of Agreement
- Quarterly infographic summaries
- Distribution lists
- Behavioral health profile
- Communite telehealth assessment

Collection Leads and Responsibilities:

- WellFlorida – assess Putnam County residents and social support provider's perceived value of telehealth assessment.
- Research Data Analyst – assess strategic and work plan completion and determine economic impact.
- Project Director – obtains documents for research bring, behavioral health profiles, meetings between partners.
- Network Director - responsible for Memorandums of Agreements and contractual service agreements.

Support – Collaborative Sharing

Data sources include both primary and secondary data sources. Summaries compile both types of data to provide readable format to network.

Measurement:

- Research briefings
- Knowledge assessment
- Communication types and number
- CLAS participation scores and progress made
- Contractual services
- Platforms developed and usage monitoring
- Program consumer enrollments
- Service satisfaction levels

Data Sources/Methods:

- Consumer satisfaction surveys
- Provider satisfaction surveys
- Progress reports
- Cultural competency knowledge scores

Collection Leads and Responsibilities:

- SMA Healthcare – provides progress reports, consumer satisfaction surveys, and provider satisfaction surveys.
- Research Data Analyst – monitors system usage, provides research briefing, compiles report matierials.
- Project Director – summarizes data and communicates to network.
- Network Director – signs and implements contractual agreements, monitors project progress.

Improve – CLAS-Focused Professional Development

Data sources include both primary and secondary data sources. Summaries compile both types of data to provide readable format to network.

Measurement:

- SWOT analysis
- Strategic plan
- Behavioral health assessment
- Distribution lists and numbers
- Marketing plan and business model

Data Sources/Methods:

- Communication types and distributions
- Meeting agendas, sign-ins, and minutes
- Document and deliverable submissions

Collection Leads and Responsibilities:

- Network Members – provides the input necessary for the project to Research Data Analyst and Project Director

- Research Data Analyst – monitors work plan activities, provides research briefing, compiles report matierials.
- Project Director – summarizes data and communicates to network.
- Network Director – monitors project progress.

05. Analysis Plan

Connect – PC3 Network Development

Approach:

- Review strategic and work plans.
- Summarize implementation in project progress reports and briefings.
- Provide final evaluation in a summary report.
- Document each shared resource among network and leveraged costs.
- Obtain final costs of the project from final budget spending.
- The project's document cost, assess available human and financial capital, determines project sustainability in the final report.

Data Analysis

The Putnam County Care Connect project utilizes SureImpact for its project evaluation analysis. SureImpact provides a cloud-based data collection and reporting solution that empowers mission-driven organizations to more easily track, manage, and communicate their unique social impact. SureImpact provides enterprise-level security at a price you can afford. SureImpact is hosted in the Microsoft Azure cloud, a secure SaaS platform that meets multiple U.S. and international standards for data storage, access, and transmission, including HIPAA, ISO27001, 42-CFR Part 2, and GDPR.

Roles and Responsibilities:

- Consumers of Services – provides primary data on satisfaction level on services obtained through telehealth section of project.
- Network Members – provides the necessary input on the direction and progress of network activities.
- Research Data Analyst – compiles the raw data obtained from network members and service platforms.
- Project Director – analyzes raw data, summarizes into readable format for project communications.
- Network director – assesses project costs, economic impact assessment and determines project sustainability beyond HRSA project period.

Analytic Tools:

- Work plan
- Strategic plan
- Social determinants of health-focused project evaluation software.
- Rural Health Information Hub – Economic Impact Assessment tool

Limitations to Data:

- Self-reporting bias

Stakeholder Engagement:

- Network members review project briefings and progress reports.
- Report to Putnam County community members on project status.
- Obtain feedback for review and troubleshooting.

06. Communications/Dissemination Plan

Working together toward a healthier Putnam County cannot be successful without inter-agency communication and cross-sector collaboration. SJRRHN recognizes the need to develop communication and messaging platform that reflects rural culture and norms. Open communication provides a forum for creative and innovative project development. However, traveling great distances from rural areas to meetings, spending valuable time and resources to explain needs, and leaving with continued unmet needs frustrates and induces burnout.

Internal Communications

SJRRHN will utilize Cureo as the primary source of inter-agency communication. This platform will serve as a forum for providers to collaborate on projects, coordinate patient care, share resources, and review strategic planning efforts.

Monthly meeting with the PC3 technical assistance advisor and HRSA contract manager guides the PC3 in network development.

As needed, communication occurs between the project director, data coordinator, network director, and direct to assess project status and troubleshoot difficulties.

External Communications

The PC3 project director attends the Putnam County Behavioral Health Consortium meetings. These monthly meetings utilizing Ring Central provide a face-to-face forum to provide behavioral health organizations with PC3's project progress.

Quarterly newsletters, distributed through email lists, acts as a forum to report project progress regionally. Members receive articles of interest promoting professional development opportunities and promising technology practices as reported from reputable sources.

Social media and website postings on LinkedIn also keep stakeholders informed. In contrast, Facebook provides communications to residents of Putnam County and the surrounding area.

Communication Type	Objective of Communication	Medium	Frequency	Owner	Deliverable
Project Committee Meetings	Review status of the project	- Face to Face - Conference Call -Virtual Meeting Platform	Monthly during Putnam County Behavioral Health Consortium	- Project Director -Network Director	- Agenda - Project Schedule - Project Updates
Project Workgroup Meetings	Develop high level project plans and protocols.	- Face to Face - Conference Call -Virtual Meeting Platform -Email	Variable	- Project Manager - Project Leads	- Agenda - Project Schedule - Project Updates
Weekly Project Director and Network Director meetings	Project status updates and work plans	- Face to Face - Conference Call -Virtual Meeting Platform -Email	Weekly	-Network Director -Project Director	-Outcomes Report
Weekly Project Director and Data Research Analyst meetings	Project status updates and work plans	- Face to Face - Conference Call -Virtual Meeting Platform -Email	Weekly	-Network Director -Data Research Analyst	-Outcomes Report

Behavioral Health System Coordination Meetings	Overall Putnam County behavioral health status report, coordination of responsibilities and discussion	- Face to Face - Conference Call - Virtual Meeting Platform	Monthly during Putnam County Behavioral Health Consortium	-PC3 Project Lead -Administrative Assistant to PC3 Project Lead	- Agenda - Project(s) Updates for Putnam County
St. Johns River Rural Health Network Newsletter	Inform and engage partners with project news	-Cureo -Email	Quarterly	-Project Director	-Newsletter
Website	Inform and engage community and partners with project news.	-Website	Updated as needed	-Project Director -Data Research Analyst	-Webpage
Project Status Reports	Report the status of the project including activities, progress, costs, and issues	- Conference Call - Virtual Meeting Platform	Monthly	- HRSA Contract Manage - HRSA Technical Assistance - Project Director - Network Director - Data Research Analyst	-Agenda
Social Media	Engage partners and community	-Facebook	As needed	- Project Director	-Postings

07. Evaluation Work Plan

NEED: PUTNAM COUNTY HAS LIMITED RESOURCES AND FUNDING AVAILABILITY REQUIRING PROVIDERS TO ALIGN EFFORTS AND STRATEGIES TO ADDRESS BEHAVIORAL HEALTH DISPARITIES.							
GOAL 1: PUTNAM COUNTY CARE CONNECT WILL CREATE A DIVERSE AND INCLUSIVE NETWORK FOSTERING AN ENVIRONMENT VALUING COMMUNITY INPUT, DATA INTEGRATION, INFORMATION SHARING, AND ANALYSIS NECESSARY TO SUPPORT BETTER POPULATION HEALTH OUTCOMES.							
OBJECTIVE 1: CREATE PUTNAM COUNTY CARE CONNECT NETWORK OF PROVIDERS.							
P/O	**EVALUATION QUESTION**	**INDICATOR(S)**	**DATA SOURCE/ INSTRUMENT**	**METHODS**	**TARGET POPULATION**	**TIMELINE**	**INDIVIDUAL RESPONSIBLE**
P	Who participated in the meeting?	Partners attending the meeting	Meeting minutes	Sign-in sheets	Putnam County Provider Organizations	By June 30, 2022	Project Director
P	How many meetings were conducted?	# of meetings between partners	Meeting dates	Count meetings held			
O	What five organizations were identified?	List of organizations	List of organizations briefing	Action Items resulting from meetings			
P	Did the network gain Putnam County Provider support?	# of provider organizations supporting the project	Meeting minues	Action Items resulting from meetings	Selected Putnam County Organizations joining network	By October 31, 2022	Project Director Network Director
P	Did the network outline new partnership criteria?	Terms of agreement defined	Meeting minutes	Action Items resulting from meetings			
O	Did the network obtain new Memorandums of Agreement?	# of Memorandums of Agreement	Signed Memorandums of Agreement	Obtain signed Memorandums of Agreements			
O	What new memberships were created?	# of Putnam County partners joining SJRRHN					
O	Was a quarterly summary developed?	4 summaries perr year	Quarterly project summary	Venngage development	Putnam County residents and providers	By October 31, 2021	Project Director Network Members Research Data Analyst
O	Was the distribution list developed?	Distribution list created	Cureo distribution list	Cureo Email and posting			
P	Was the quarterly summary distributed?	# of summaries distributed	Quarterly project summary	Cureo Email and posting			
P	Was the distribution list updated?	# of updates to the distribution list	SureImpact	Cureo Email and posting			

Objective 2: Obtain a Putnam County community resident perspective on behavioral health.							
P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
O	Was the behavioral health profile developed?	1 behavioral health profile created	Florida Health Charts Census.gov	Obtain data and synthesize	Putnam County residents and providers	By January 31, 2021	Project Director Research Data Analyst
P	Was the behavioral health profile distributed?	# of behavioral health profiles distributed	Cureo distribution list	Cureo Email and posting			
O	Was the behavioral health profile updated?	3 updates to the behavioral health profile	Florida Health Charts Census.gov	Review and update data on profile			
P	Was the contractual service provider identified?	# of possible service providers	Research briefing	Develop research briefing			
O	Was the contractual service provider engaged?	1 contract for service obtained					
O	Was a community resident perspective on telehealth conducted?	Contractual services completed					
O	Was the community resident perspective on telehealth report obtained?	1 community resident perspective on telehealth report					
P	Were the report findings communicated to the network?	# of distributions by persons and communications mode					

NEED: PUTNAM COUNTY HAS LIMITED RESOURCES TO REDUCE RURAL HEALTH DISPARITIES.							
GOAL 2: PUTNAM COUNTY CARE CONNECT WILL CREATE A DIVERSE AND INCLUSIVE NETWORK FOSTERING AN ENVIRONMENT VALUING COMMUNITY INPUT, DATA INTEGRATION, INFORMATION SHARING, AND ANALYSIS NECESSARY TO SUPPORT BETTER POPULATION HEALTH OUTCOMES.							
OBJECTIVE 1: IMPROVE THE PUTNAM COUNTY CARE CONNECT NETWORK MEMBER'S CULTURAL COMPETENCY.							
P/O	**EVALUATION QUESTION**	**INDICATOR(S)**	**DATA SOURCE/ INSTRUMENT**	**METHODS**	**TARGET POPULATION**	**TIMELINE**	**INDIVIDUAL RESPONSIBLE**
P	What cultural competency knowledge assessment found for modeling?	1 research briefing	Research briefing	Review cultural competency knowledge assessment; draft briefing	Putnam County Network Members	By May 31, 2021	Project Director Research Data Analyst PC3 Project Lead Network Members
P	What questions were selected for the cultural competency knowledge assessment?	List of questions to include in knowledge assessment	Drafted knowledge assessment	Google Forns Adobe Forms			
O	Was the survey posted for network use?	1 knowledge assessment posted	Cureo	Email postings and Cureo			
P	What CLAS educational activiers were posted and when	Distributions by number and type	Cureo	Email postings and Cureo	Putnam County Network Members	By May 31, 2021	Project Director Research Data Analyst PC3 Project Lead Network Members
O	Did network members cultural competency knowledge scores improve	10 participant evaluation scores	Knowledge Assessment	SureImpact			
OBJECTIVE 2: INCREASE ACCESS TO RESOURCE AVAILABILTY FOR PUTNAM COUNTY RESIDENTS							
P/O	**EVALUATION QUESTION**	**INDICATOR(S)**	**DATA SOURCE/ INSTRUMENT**	**METHODS**	**TARGET POPULATION**	**TIMELINE**	**INDIVIDUAL RESPONSIBLE**
P	What website developers were researched?	1 research briefing	Research briefing	Research and draft briefing	St. Johns River Rural Health Network	By July 1, 2021	Project Director Network Director Website developer
P	What website developer was selected?	Selected website developer	Selected website developer	Contact made with developer			
O	Was a contract obtained from the website developer?	1 contracted service obtained	1 signed contract obtained	Signed contract			
O	Were the website design meetings conducted?	1 website developed	Emails and phone call summaries	Saved communications			

P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
P	What referral developers were researched?	1 research briefing	Research briefing	Research and draft briefing	St. Johns River Rural Health Network	By February 28, 2022	Project Director Network Director Referral Developer
P	What referral developer was selected?	Selected referral developer	Selected referral developer	Contact made with developer			
O	Was a contract obtained from the referral developer?	1 contracted service obtained	1 signed contract obtained	Signed contract			
O	Were the referral design meetings conducted?	1 referral developed	Emails and phone call summaries	Saved communications			

Objective 3: Develop a behavioral telehealth service system through SMA HEalthcare.							
P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
P	What telehealth developers were researched?	1 research briefing	Research briefing	Research and draft briefing	SMA Healthcare	By June 30, 2021	Project Director Network Director PC3 Project Lead Telehealth Developer
P	What telehealth developer was selected?	Selected telehealth developer	Selected telehealth developer	Contact made with developer			
O	Was a contract obtained from the telehealth developer?	1 contracted service obtained	1 signed contract obtained	Signed contract			
O	Were the telehealth design meetings conducted?	1 telehealth developed	Emails and phone call summaries	Saved communications			
P	What telehealth trainings were researched?	# of possible telehealth trainings	Research briefing	Research and draft briefing	SMA Healthcare	By August 31, 2021	Project Director PC3 Lead
O	What telehealth training was selected?	1 identified training approved for the network	Selected training	Announcement to SMA Healthcare			
P	Who participated in the telehealth trainings?	Documented network members obtaining training	Training certificates	Obtain completed training certificates			

P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
P	What consumers were selected for the telehealth program?	# of possible consumers to enroll into telehealth	Research briefing	Research and draft briefing	SMA Healthcare Consumers of Services	By September 20, 2021	PC3 Project Lead SMA IT Specialist Project Director
P	What does the consumer need to enroll into telehealth services?	List of consumer need to enroll into telehealth services	Invoice	Draft invoice by client			
P	Did the consumer receive telehealth supplies?	Invoiced consumer telehealth supplies	Signed invoice by SMA and Client	Obtain invoice			
P	Were telehealth appointments conducted with consumer?	# of telehealth appointments by type	Progress Report	Obtain monthly progress report from SMA Healthcare			
O	Are the consumers satisfied with telehealth services?	# of completed satisfaction surveys	Satisfaction surveys	SureImpact			

Need: Putnam County needs a long-term network provider to address population health needs.

Goal 3: St. Johns River Rural Health Network will create Putnam County Care Connect as a sustainable provider network to address population health needs.

Objective 1: Create Putnam County Care Connect

P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
O	Was a baseline behavioral health assessment conducted?	1 Putnam County behavioral health assessment	FL Health Charts Census.gov	Collect and review secondary data and synthesize	Putnam County Providers and Residents	By February 28, 2021	Project Director Project Members
O	Was a SWOT analysis conducted?	1 SWOT analysis conducted	Meeting notes	Conduct SWOT analysis among partners	PC3 project members	December 1, 2020	
P	Was the baseline assessment provided to the network?	# of distributions to nework	Emails and Cureo posting	Saved communications	PC3 project members	February 28, 2021	

P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
P	Were strategic plan meetings conducted?	Partners attending meeting	Sign-in sheets	Obtain sign-in sheet	PC3 Network Members	By December 14, 2020	Project Director Network Members
P	Were the strategic plan meetings conducted?	# of meetings	Meeting minutes	Drafted meeting minutes			
O	Was the strategic plan created?	1 strategic plan	Drafted strategic plan	Strategic plan document			
P	Was the strategic plan provided to the network?	# of distributions.	Emails and Cureo posting	Saved communications			
P	Were updates made to the plan?	# of updates	Reviewed and updated drafts	Project status summaries			
Objective 2: Develop sustainable Putnam County Care Connect project							
P/O	Evaluation Question	Indicator(s)	Data Source/ Instrument	Methods	Target Population	Timeline	Individual Responsible
P	Were marketing plan meetings conducted?	Partners attending meeting	Sign-in sheets	Obtain sign-in sheet	PC3 Network Members	By December 31, 2021	Project Director Network Members
P	Were the marketing plan meetings conducted?	# of meetings	Meeting minutes	Drafted meeting minutes			
O	Was the marketing plan created?	1 marketing plan	Drafted marketing plan	Marketing plan document			
P	Was the marketing plan provided to the network?	# of distributions.	Emails and Cureo posting	Saved communications			
P	Were updates made to the plan?	# of updates	Reviewed and updated drafts	Project status summaries			
P	Were business model plan meetings conducted?	Partners attending meeting	Sign-in sheets	Obtain sign-in sheet	PC3 Network Members	By December 15, 2022	Project Director Network Members
P	Were the business model plan meetings conducted?	# of meetings	Meeting minutes	Drafted meeting minutes			
O	Was the business model plan created?	1 business model plan	Drafted business model plan	Business model plan document			
P	Was the business model plan provided to the network?	# of distributions.	Emails and Cureo posting	Saved communications			
P	Were updates made to the plan?	# of updates	Reviewed and updated drafts	Project status summaries			

P	Were final sustainability plan plan meetings conducted?	Partners attending meeting	Sign-in sheets	Obtain sign-in sheet	PC3 Network Members	By December 15, 2022	Project Director Network Members
P	Were the final sustainability plan plan meetings conducted?	# of meetings	Meeting minutes	Drafted meeting minutes			
O	Was the final sustainability plan plan created?	1 final sustainability plan plan	Drafted final sustainability plan plan	Final sustainability plan plan document			
P	Was the final sustainability plan plan provided to the network?	# of distributions.	Emails and Cureo posting	Saved communications			
P	Were updates made to the plan?	# of updates	Reviewed and updated drafts	Project status summaries			