Strategic Plan

Putnam County Care Connect (PC3)

Award No. – 1 D06RH375260100

Grant No. – D06RH37526

ST. JOHNS RIVER
RURAL HEALTH NETWORK
Support Connect Improve

SMA HEALTHCARE

HEALTH PLANNING COUNCIL
OF NORTHEAST FLORIDA

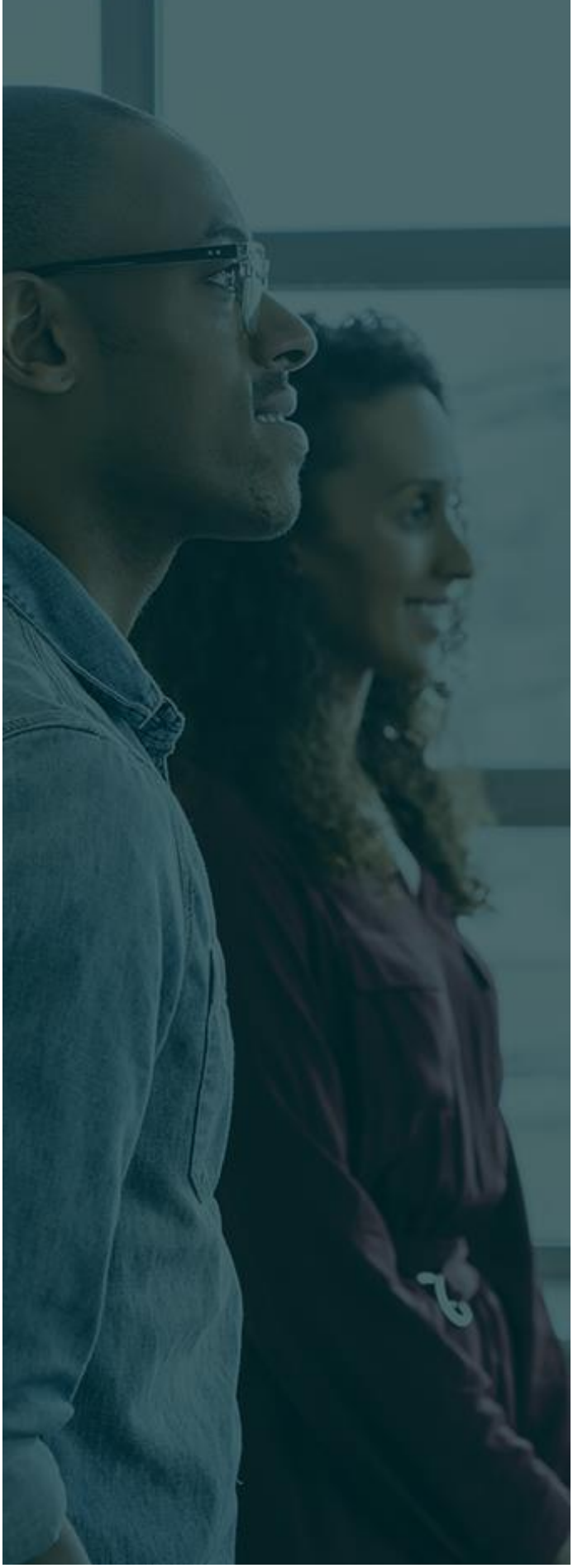
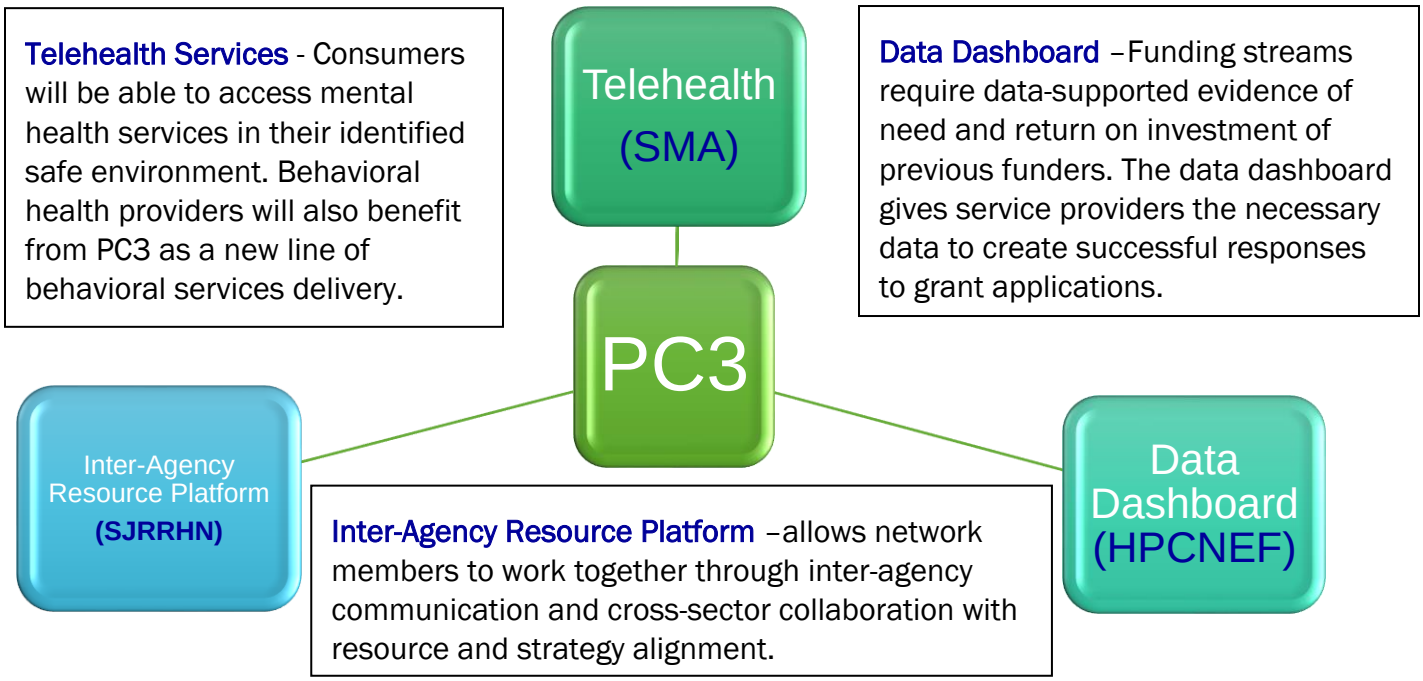


TABLE OF CONTENTS

NETWORK NARRATIVE AND PROGRAM DESCRIPTION

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). These partners joined forces to address the behavioral health needs of Putnam County. According to the Robert Wood Johnson Foundation County Health Profiles, Putnam County ranks 66th out of 67 Florida Counties for overall healthcare. Putnam County families journey more than the proverbial "12 steps" for behavioral health services themselves or their loved ones. SJRRHN, HPCNEF, and SMA recognize that behavioral health care networks effectively address challenges as a group by aligning goals and sharing resources to improve population health and health equity.

PC3 partners developed a three-part strategy to connect the systems of care addressing Putnam County's behavioral health represented by the following graphic.



***SMA Healthcare**, founded in 1960, provides a full continuum of exceptional and comprehensive services for individuals who suffer from mental illness and addiction. It is the largest and most comprehensive behavioral health services provider in its four-county service area (Flagler, Putnam, St. Johns, and Volusia County).

***Health Planning Council of Northeast Florida, Inc. (HPCNEF)** became one of 11 Local Health Councils mandated in 1982 Florida State Statute 408.033. The purpose of the statute is to dedicate resources and expertise to regional health system utilization data management, health planning, research, community organizing, health education, promotion, and awareness programs. HPCNEF has been addressing the healthcare needs of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties (Florida Agency for Health Administration District 4) for 35 years under a variety of federal, state, and local health planning initiatives. Health education, promotion, and awareness programs are HPCNEF's critical tenets in community collaboration and strategic planning to improve health outcomes.

***St. Johns River Rural Health Network (SJRRHN)** is one of nine Florida Rural Health Networks under Statute 381.0406 in 1993 to address three fundamental problems that continue to be critical challenges today. As an active community-based, non-profit organization established in 1993 serving northeast Florida in the seven-county region of Baker, Clay, Flagler, Nassau, Putnam, St. Johns, and Volusia. The organization's mission is to ensure that quality health care is available and efficiently delivered to all persons in rural areas by:

- Providing forums for technical assistance to organizations to remove health care barriers and organize outreach and education to inform the public about rural health issues.
- Conduct studies, surveys, training, planning, and development activities to analyze regional health care issues and the deployment of related programs and initiatives.
- Serving as a critical information resource for rural health care providers, community partners, and organizations, and emphasizing collaborative partnerships as the best way to make accessible, quality health care in rural communities.

VISION AND STRATEGIC PURPOSE STATEMENT

What Our Network Does:

Putnam County Care Connect provides holistic person-centered care by promoting health equity and virtual wellness technology, resulting in improved population health.

How We Do the Work:

Putnam County Care Connect (PC3) leveraging multidisciplinary member organizations, strengthening collaborative partnerships, and sharing innovative technology solutions to address the health disparities impacting those in the rural fabric.

For Whom:

Putnam County's rural families living in small quiet towns, disconnected from substantial city resources, challenged by limited healthcare options, healthcare workforce shortages, and transportation availability.

Vision Statement:

Connecting in technology and improving community wellness for a healthier tomorrow.

Strategic Purpose Statement:

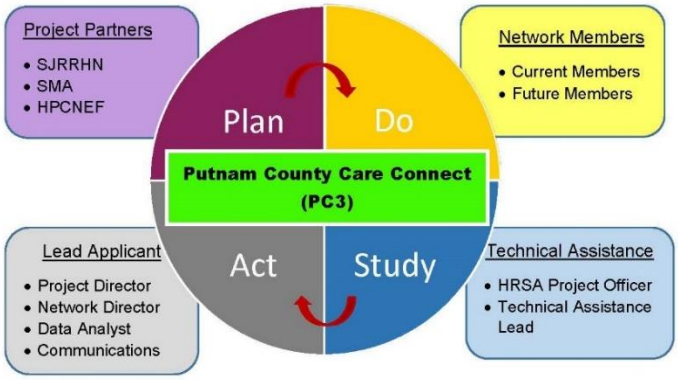
Putnam County Care Connect serves rural residents by providing person-centered behavioral health care services by leveraging multidisciplinary organizations, strengthening collaborative partnerships, and sharing innovative technology solutions to address health disparities.

MANAGEMENT AND COMMUNICATIONS

Putnam County Care Connect (PC3) values working together toward a healthier Putnam County. Holding this value cannot be successful without inter-agency communication and cross-sector collaboration. PC3 membership consists of three workgroup categories: Connect, Support, and Improve. Each represents a level of engagement for the network members as follows:

- Connect – community representatives consisting of low-level engagement; these members receive monthly communications of network activities and project progress.
- Support – workgroup members providing medium-level engagement; these members participate in meetings and give valuable input on network activities.
- Improve – leadership with a high-level of engagement participating in project implementation and sustainability planning.

These workgroups provide the primary and secondary data that funnels into evaluating work plan performance metrics and the Plan-Do-Study-Act cycle. Project partners review collected data and ***Plan*** strategies and activities to improve population health. Network members to ***Do*** activities within the community in which technical assistance ***Study*** the performance measures indicated in the work plan. The lead applicant then ***Acts*** upon the Study results from technical assistance. The cycle restarts with additional information for the project partners to plan activities after reviewing the new primary and secondary data made available by the workgroups



Leadership

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	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	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

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

IDENTIFICATION OF NEED

In 2018, Putnam County Behavioral Health Consortium (PCBHC) formed as a group of providers meeting monthly to identify gaps and assess how best to mitigate those gaps. SMA Behavioral Health Care (SMA) is the lead organization for PCBHC. Other members include LSF Health Systems, Hanley Foundation, and the Florida Department of Health in Putnam County – these are just some of the critical members of the PCBHC. During the 2019-2020 Rural Health Network Development planning grant, the Health Planning Council of Northeast Florida, Inc. (HPCNEF) provided Putnam County Care Connect (PC3) leadership and the PCBHC with a thirty-three-page comprehensive behavioral health assessment focusing on Putnam County as the target area. This document emphasized that the quality of behavioral health care delivery systems depends on personnel and infrastructure availability to provide needed services.

Members of the PCBHC meetings informally identified three needs:

1.) Putnam County has limited resources and funding availability requiring providers to align efforts and strategies to address behavioral health disparities.
2.) Putnam County has limited resources to reduce rural health disparities.
3.) Putnam County needs a long-term provider network working to address population health needs.

The comprehensive behavioral health assessment served as a primary focus at the beginning of the 2020 year. Project partners recognized a need to shift priority from telehealth focused strategic plan to a data dashboard focused plan to sustain the PC3 through evidence of need and return on investment through project performance evaluation. Three months later, in March 2020, the focus re-shifted again due to COVID-19. The strategic plan changed telehealth into virtual wellness re-embracing telehealth. Data dashboard and virtual health now share an equal focus within the strategic plan. The national events of May 2020, marked with social unrest, brought an additional focus of health equity to PC3.

NETWORK ENGAGEMENT

The majority of the strategic planning process occurred during the Rural Health Network Development Planning Program months of April and May 2020. Partners met via the Life-Size meeting platform SMA Healthcare (SMA) quickly implemented in response to the COVID-19 pandemic lockdown restrictions issued in March 2020. Life-Size was also the platform utilized to host the Putnam Behavioral Health Consortium meetings. Other strategic planning discussions occurred in Zoom meetings hosted by the St. Johns River Rural Health Network. Most of the communication happened through the project director offering goals, objectives, and activities to the group through emailed worksheets. The partners then reviewed the attached documents during an available time, reported review comments, and proposed additional verbiage to fill in gaps. As a result, Putnam County Care Connected completed the strategic planning process for the planning grant.

Rural Health Network Development Program grant began in July 2020. PC3 implemented proposed work plan activities. PC3 reviewed the strategic plan through emailed worksheets and at the beginning of December 2020. A Zoom meeting hosted by the St. Johns River Rural Health Network served as a comprehensive review of the first work plan and resulted in significant additions to the work plan.

SWOT ANALYSIS

Strengths

The Putnam County Care Connect (PC3) model is fluid and allows for a change in focus. New network partners may seek to join other projects currently in implementation mode or choose to focus on another aspect of their model. Each network partner brings a specific area of expertise, collaborates on issues, and then seeks out other experts if there is a knowledge gap.

Trust is the cornerstone for the successes of the PC3 network partners. Meetings are robust, with information quickly shared regardless of the issue. Network partners complete tasks and share their expertise, creating a trusting environment for members. Network partners focus on their knowledge and organizational missions with limited straying to seek additional resources. Network partners complete tasks and share their expertise, creating a trusting environment for members.

Putnam County Behavioral Health Consortium provides a diverse group of members ranging from providers, law enforcement, and government officials. Meetings are robust, with information readily shared to ensure Putnam County consumers receive the services they need.

Research into the available technology to improve individual consumer and population health is a good strength for PC3. Network members continuously research no-cost or low-cost technology to create work efficiency. Knowledge of available technology increases weekly. Each additional knowledge point gained is an opportunity to increase access to care and improve population health.

Weaknesses

Putnam County Care Connect has a great vision that appears to work well on paper, but it is hard to communicate that vision to others. Providers are uncertain of changing to new platforms because of the time it takes and the culture of "this is how we've always done things." For example, many providers came into their field wanting to help people. Many feel that digital services do not provide as much confidence as in-person services convey. Here is where a looping spiral presents itself. Start-up projects show their value when implemented. Implementation occurs with funding; however, to qualify for funding, the project must show deal through its effectiveness. The challenge is to find an opportunity to step out of this loop.

A focus on technology also creates another possible weakness in that technology is expensive and may be difficult to sustain. The sustainability of a technology emphasis also runs the risk of platforms or devices becoming outdated quicker than the best model practices that do not involve technology. As a result, network partners will need to assess how to sustain projects and continuously implement new ones. PC3 needs experts to assist in technology selection and implementation.

Provider fatigue also presents a problem. COVID-19 allowed virtual and remote work as a viable option; however, providers are becoming fatigued over virtual meetings, reflecting a well-known phrase of "Zoomed out". Virtual meetings provide greater efficiency in scheduling meetings, yet multiple back-to-back meetings limit basic self-care routines.

Opportunities

PC3 partners are committed to the success of the network. Network members maintain relationships with City, County, and State policymakers to ensure ordinances, zoning rules, and other policies to support the PC3 initiatives. PC3 champions will also be critical in developing the organizational and programmatic capacity for long-term sustainability. PC3's organization structure will provide a mechanism for ongoing leadership, formalizing the consortia, identifying a lead agency to absorb some consortia governance, and recruiting additional staff/volunteers.

Key partnerships will help maintain awareness, secure support, and attract funding resources to aid in the sustainability of PC3 operations and activities. PC3 created a plan that includes sustainable funding sources, aligned with existing programs and their objectives. Partnerships will create a communication strategy to assist with disseminating network messages to policymakers, community leaders, and target populations. Partners will also be instrumental in developing an ongoing evaluation for performance improvement. PC3 will establish a set of performance measures using available data that allows for continuous quality improvement.

The social unrest events of 2020 promoted health equity and cultural competency to address the social determinants of health. Cultural competency addresses group behaviors beyond the limitations of race. Utilizing the Cultural Linguistic Appropriate Service Standards provides an opportunity to enhance person-centered care.

Threats

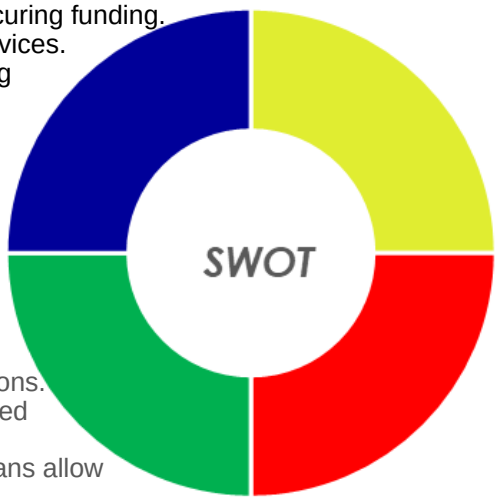
Putnam County is an impoverished county with many complex issues that can be very frustrating and time-consuming. Burn out and minimal time availability becomes the number one threat to the growth and sustainability of PC3. The ability to minimize this threat would be the ongoing commitment of the PC3 network and the ability to bring additional funding into the community to address the decades of poverty that consumes the County.

STRENGTHS

- Diverse groups in PCBHC.
- Care Connect model allows for each member to focus on their service of choice.
- Members are collaborative in securing funding.
- Members are experts at their services.
- Limited mission drifting in seeking additional funding resources.
- Robust knowledge of available data and technology resources.

WEAKNESSES

- Current workforce stretched thin.
- Limited capacity to continuously apply for additional grants.
- Northeast Florida is decreasing in rural designations.
- Expectations to do more with fewer resources.
- Virtual meeting fatigue.
- Limited in-person meetings due to pandemic restrictions.



OPPORTUNITIES

- Ages 18 to 65 have the Health Insurance Marketplace.
- County support in grant applications.
- Telehealth Medicare billing allowed in rural areas.
- More private health insurance plans allow for telehealth.
- USDA grants assist with Broadband infrastructure.
- Co-occurring diagnosis may help with grant dollars off-setting costs.

THREATS

- Recruiting workforce is difficult due to location and pay rate.
- Accreditation process is difficult.
- Medicaid expansion is not successful in Florida.
- Public transportation is limited.
- Barriers to prescribing mental health medications.

Strategic Actions Identified from SWOT

Putnam County Care Connect identified the following strategic actions from the SWOT analysis:

- Identify an evidence-based model to engage a broad sector of the community to provide a readily available primary data source.
- Develop an annual comprehensive report on the behavioral health landscape in Putnam County.
- Build a data dashboard to provide easy-to-read charts and graphs to inform government officials and policymakers on Putnam County's behavioral health trends.
- Provide data on a Federal, State, and County level comparison. Identify areas for improvement and celebrate areas of success.
- Align work plan efforts with Healthy People 2030 objectives for comparisons.
- Utilize Cultural Linguistic Appropriate Service Standards to enhance work plan efforts to address health disparities and social determinants of health.
- Develop a referral system to assess underinsured consumers for available payer sources to reduce access to care issues.

GOALS AND OBJECTIVES

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.		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Identify five new organizations to become PC3 members.	Partners attending meeting # of meetings between partners List of organizations	Project Director	By June 30, 2022
2. Contact Putnam County service providers to monthly to understand their needs, objectives, and desires to enhance network development.	Organization representative attending meeting # of meetings for network engagement List of network needs from potential new members	Project Director Network Director	By June 30, 2022
3. Engage two new organizations to become linked PC3 members.	# of provider organizations supporting the network Terms of agreement defined # OF Memorandums of Agreement # of new Putnam County Partners joining SJRRHN	Project Director Network Director	By October 31, 2022
4. Report the network's activities to community stakeholders to increase Putnam County's awareness of network efforts toward health improvements.	Infographics per year created Distribution created # of infographics distributed # of updates to distribution list	Project Director Network Members	By October 31, 2021
Objective 2:	Obtain a Putnam County community resident perspective on behavioral health and wellness.		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Provide an annual behavioral health data report for Putnam County by the end of each project year.	Behavioral health profile created # of behavioral health profiles distributed # of updates to behavioral health profile	Project Director Data Research Analyst	By January 31, 2021
2. Conduct a community perspective telehealth needs assessment.	# of possible service providers contract for service obtained contractual services completed community telehealth assessment report 3 of distributions by person and communication mode	Project Director Network Director Contracted Service Provider Network Members	By June 30, 2021

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:	Improve the Putnam County Care Connect network member's cultural competency.		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Design CLAS Standards educational activity.	Research briefing List of questions to include in the knowledge assessment Post-survey for project use	Project Director	By May 31, 2022
2. Implement CLAS educational activity	Emails announcing available CLAS educational activity Evaluate network progress on CLAS activity	SMA Healthcare Data Research Analyst	
Objective 2:	Increase access to resource availability for Putnam County Residents		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Design St. Johns River Rural Health Network Putnam County Project website.	Service provider research briefing # of possible service providers 1 contract for service obtained 1 website developed	Project Director Network Director	By July 1, 2021
2. Promote SJRRHN and Putnam County project website.	# of notices to network announcing website launch # of website visits	Network Members Website Developer	By December 31, 2021
3. Design referral system through website.	Referral system research briefing # of possible service providers Contract for service obtained 1 referral system developed	Project Director Network Director	By October 31, 2021
4. Promote SJRRHN and Putnam County project website.	Announce referral system availability to network Evaluate referral system usage on website	Network Members SureImpact	By February 28, 2022
Objective 3:	Obtain a Putnam County community resident perspective on behavioral health and wellness.		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Provide an annual behavioral health data report for Putnam County by the end of each project year.	Behavioral health profile created # of behavioral health profiles distributed # of updates to behavioral health profile	Project Director Data Research Analyst	By January 31, 2021
2. Conduct a community perspective telehealth needs assessment.	# of possible service providers contract for service obtained contractual services completed community telehealth assessment report 3 of distributions by person and communication mode	Project Director Network Director Contracted Service Provider Network Members	By June 30, 2021
3. Implement telehealth service delivery to consumers	# of possible consumers to enroll into telehealth List of consumer needs to enroll into telehealth Invoiced consumer telehealth supplies # of telehealth appointments by type # of completed satisfaction surveys	SMA Healthcare Project Evaluator	By September 30, 2021

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:	Create Putnam County Care Connect Project		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Determine baseline environment for Putnam Care Connect Project.	Putnam County behavioral health assessment SWOT Analysis # of distributions	Project Director Network Members Project Director	By January 31, 2021 December 1, 2021 By February 28, 2021
2. Develop strategic plan for Putnam County Care Connect Project	Partners attending the meeting # of meetings between partners 5-year Strategic Plan # of distributions # of updates	Project Director Network Members	By December 14, 2020
Objective 2:	Develop Sustainability Plan for Putnam County Care Connect Project		
Activity	**Indicators**	**Responsible Party**	**Time Frame**
1. Develop Marketing Plan	Partners attending the meetings # of meetings between partners Marketing plan # of distributions # of updates	Project Director Putnam County Care Connect Members	December 31, 2021
1. Develop Business Model	Partners attending the meetings # of meetings between partners Business Model # of distributions # of updates	Project Director Putnam County Care Connect Members	December 15, 2022
1. Develop Final Sustainability Plan	Partners attending the meetings # of meetings between partners Final Sustainability Plan # of distributions # of updates	Project Director Putnam County Care Connect Members	December 15, 2022