Brookwood Baptist Health

Princeton Baptist Medical Center Community Health Needs Assessment Implementation Strategy

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Introduction

Implementation Strategy Process for Princeton Baptist Medical Center

The most recent Community Health Needs Assessment (CHNA) for Princeton Baptist Medical Center (PBMC) was adopted on December 11, 2019. The Implementation Strategy was developed by hospital leadership to describe how PBMC will address the significant needs identified during the CHNA.

Current Health Priorities for Princeton Baptist Medical Center

1. Access to Care
2. Social Determinants of Health
3. Diabetes
4. Heart Disease
5. Weight Status
6. Mental Health

Implementation Strategy

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Community Health Need	Target Population		Strategy	Goals	Existing Partners	Potential Partners	Rationale
Access to care	Whole community	1	**Improve access to the right level of care via walk-in and urgent care facilities**	A) Through the BBH Managed Care Network, provide patients with various levels of care B) Continue to partner with FQHCs and local free/low-cost clinics to expand access for low-income and uninsured populations C) Utilize a care continuity tool integrated within the EHR to ensure proper follow-up care is obtained	Cahaba Medical, Christ Health, MPower Health		"Efforts to make more efficient use of existing resources by smoothing patient census and improving admission, handoffs, and discharge processes can have significant benefits not only in terms of improved safety and more continuous care, but also in terms of increased efficiency and revenue." - The Commonwealth Fund
Access to care	Whole community	2	**Increase early detection of chronic disease**	A) Conduct health screenings at community events		Capstone Clinic, ARMS Clinic, Jefferson County Health Department, local Community Action Funds	"Six in ten Americans live with at least one chronic disease, like heart disease and stroke, cancer, or diabetes. These and other chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of health care costs. Most chronic diseases can be prevented by eating well, being physically active, avoiding tobacco and excessive drinking, and getting regular health screenings. " - Centers for Disease Control and Prevention
Access to care	Low-income individuals	3	**Improve awareness of free or low-cost healthcare providers in the community**	A) Streamline internal processes for referrals to partner organizations B) Engage faith-based organizations to provide marketing materials about clinics and providers offering free or low-cost services	FQHCs, Cahaba Medical, Christ Health, MPower Health	Samford's Congregational Health Programs, Aunt Bertha, La Casita	"Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2018, 45% of uninsured adults said that they remained uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, while others have income above the cutoff for financial assistance. Additionally, undocumented immigrants are ineligible for Medicaid or Marketplace coverage. People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2018 went without needed medical care due to cost. Studies repeatedly demonstrate that uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases." - Kaiser Family Foundation
Access to care	Individuals eligible for Medicaid benefits	4	**Increase the number of eligible individuals who are enrolled in the Medicaid program**	A) Provide enrollment assistance within inpatient and outpatient settings via case management B) Educate providers and employees on criteria and how to engage patients in enrollment and re-enrollment		Jefferson County Health Department, 211, local FQHCs	"Navigators play a vital role in helping consumers prepare applications to establish eligibility and enroll in coverage through the Marketplaces and potentially qualify for an insurance affordability programs. They also provide outreach and education to raise awareness about the Marketplace, and refer consumers to health insurance ombudsman and consumer assistance programs when necessary." - Centers for Medicare & Medicaid Services
Access to care	PBMC patients	5	**Increase the number of individuals with a regular source of care**	Utilize a care continuity tool with the electronic health record to improve attendance at follow-up appointments			"Continuity of care is the process by which the patient and his or her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective medical care. Continuity can be measured at both the patient and clinician level: A) Patient-centered continuity is the percent of patients that have visits with his or her empaneled physician. B) Clinician-centered continuity is the percent of visits a clinician has with his or her empaneled patients. " - American Academy of Family Physicians
Access to care	PBMC patients	6	**Improve medication adherence**	A) Offer prescription assistance through the hospital's pharmacy B) Refer patients to FQHCs and other clinics with medication assistance programs	Dispensary of Hope Programs (accessed via FQHCs and free clinics)		"Average total drug spending per hospital admission increased by 18.5% between FY2015 and FY2017" - Association of Health-System Pharmacists

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Social determinants of health	Individuals experiencing social barriers	7	**Improve adherence to treatment plans and medical appointment attendance**	A) Screen for social needs or barriers using a tool such as the AHC HRSN B) Refer to partner organizations who provide case management or patient navigation services		Project ACCESS, M-POWER Ministries, Greater Birmingham Ministries	"Poverty limits access to healthy foods and safe neighborhoods, and more education is a predictor of better health. Differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying [knowledge] about SDOH, [improvements can be made to individual and population health [as well as] advancing health equity." -CDC
Social determinants of health	Whole community	8	**Improve cultural competency and trust in providers**	Establish a Patient Advisory Council to Incorporate community voices into hospital programming and strategic planning			"A patient advisory council is an established council within a health care system which meets regularly and consists of patients and family members who receive care at the facilities. Select providers, clinicians, office staff, and leadership are also integrated members of the council and work with the patient and family advisors to discuss improvements in care, processes, and experiences. Key to the council is that patients and family caregivers are viewed as respected partners and essential resources to the practice." - National Partnership for Women and Families
Social determinants of health	Low-income individuals, people with disabilities, older adults	9	**Transportation**	A) Partner with a local ride-share provider to facilitate travel to and from medical appointments B) Expand satellite locations into areas where individuals lack access to public transportation C) Through partnerships, utilize census-tract level data to examine areas with greatest need for transportation services D) Provide vouchers for transportation services to eligible patients E) Refer eligible patients to the Kid One Transport program	Birmingham on Demand Pilot Program		"There is a strong business case for hospitals and health systems to address transportation needs since individuals experiencing these issues are more likely to miss appointments or not fill prescriptions, leading to delays in care and potentially to disease progression and complications or readmissions." - American Hospital Association
Cross-Cutting: Social determinants of health and Mental Health	Neighborhoods surrounding PBMC	10	**Reduce crime, violence, and trauma**	A) Continue to partner with local law enforcement to provide a safe environment for patients and employees at Princeton B) Host regular Stop the Bleed trainings	Local law enforcement	Stop the Bleed, Shelby County Health Department	The STOP THE BLEED® campaign was initiated by a federal interagency workgroup convened by the National Security Council Staff, The White House. The purpose of the campaign is to build national resilience by better preparing the public to save lives by raising awareness of basic actions to stop life threatening bleeding following everyday emergencies and man-made and natural disasters.

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Diabetes	Individuals with prediabetes or diabetes	11	**Reduce diabetes-related complications**	A) Encourage providers to host regular diabetes education and self-management courses B) Provide diabetes education to employees of PBMC and their dependents			"Diabetes self-management education & support provides the foundation to help people with diabetes to navigate self-management decisions and activities and has been shown to improve health outcomes." -American Diabetes Association
Cross-Cutting: Diabetes, Heart Disease	Whole community	12	**Screen for chronic disease markers and risk factors including pre-diabetes and diabetes**	A) Conduct regular screening events within the community B) Utilize data to expand event offerings to target areas of highest need		Jefferson County Health Department	"Identifying patients with prediabetes has important benefits for individuals as well as healthy systems" including, better patient outcomes, cost-effectiveness, and improved population health.-National Institute of Diabetes & Digestive & Kidney Disease
Heart disease	Whole community	13	**Reduce hypertension rates**	A) Provide health education on hypertension at community events and through the employee wellness program B) Support the "Let's Get Down 35221" hypertension management program			"High blood pressure increases the risk for heart disease and stroke, two leading causes of death for Americans.1 High blood pressure is also very common. Tens of millions of adults in the United States have high blood pressure, and many do not have it under control. Uncontrolled high blood pressure is common; however, certain groups of people are more likely to have control over their high blood pressure than others. A greater percent of men (47%) have high blood pressure than women (43%). High blood pressure is more common in non-Hispanic black adults (54%) than in non-Hispanic white adults (46%), non-Hispanic Asian adults (39%), or Hispanic adults (36%). Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic white adults (32%) than in non-Hispanic black adults (25%), non-Hispanic Asian adults (19%), or Hispanic adults (25%) " - Centers for Disease Control and Prevention
Heart disease	Whole community	14	**Decrease smoking rates**	A) Provide smoking cessation classes for PBMC employees B) Partner with local schools to develop evidence-based campaigns or initiatives to reduce vaping/e-cigarette use		Jefferson County Health Department, Local schools	"Each year, smoking kills 480,000 Americans, including about 41,000 from exposure to secondhand smoke. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease which includes emphysema and chronic bronchitis. On average, smokers die 10 years earlier than nonsmokers. " - County Health Rankings
Heart disease	Whole community	15	**Improve awareness of heart disease risk factors and increase screening rates**	A) Provide regular health promotion messaging via print, web-based, and social media outlets B) Host free, community-based educational events during heart month			"Several health conditions, lifestyle, age, and family history can increase risk for heart disease. About half of all Americans (47%) have at least 1 of 3 key risk factors for heart disease: high blood pressure, high cholesterol, and smoking." - Centers for Disease Control and Prevention

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Community Health Need	Target Population		Strategy	Goals	Existing Partners	Potential Partners	Rationale
Weight status	Whole community	16	**Increase the number of individuals who meet recommended physical activity guidelines**	A) Promote regular exercise by sponsoring walking groups B) Encourage providers to write "exercise prescriptions" and provide training for healthcare professionals on discussing behavior change with patients	YMCA		"Physical Activity is one of the best things people can do to improve their health. It is vital for healthy aging and can reduce the burden of chronic diseases and prevent early death. Active people generally live longer and are at less risk for serious health problems like heart disease, type 2 diabetes, obesity, and some cancers. For people with chronic diseases, physical activity can help manage these conditions and complications. " - Centers for Disease Control and Prevention Division of Nutrition, Physical Activity, and Obesity
Weight status	Individuals residing in food deserts and those experiencing food insecurity	17	**Improve access to healthy foods**	A) Explore opportunities to provide health education and preventative care within food pantries B) Support the "Healthy Over Hungry" initiative C) Support grocery delivery to eligible older adults D) Incorporate food insecurity screening into ED visits or as part of discharge planning E) Refer patients to community-based organizations and faith-based partners offering food assistance and assistance with basic needs	Community Food Bank of Central Alabama	Urban Ministries, local farmers markets	"The cycle of food insecurity and chronic disease begins when an individual or family cannot afford enough nutritious food. The combination of stress and poor nutrition can make disease management even more challenging. Further, the time and money needed to respond to these health conditions strains the household budget, leaving little money for essential nutrition and medical care. This causes the cycle to continue, increasing the risk of worsening existing conditions. Many families experiencing food insecurity often have several, if not all, compounding factors which makes maintaining good health extremely difficult. Food insecurity is highly stressful. When people do not know when or where they will eat their next meal, finding food may become their central focus. It can take priority over health-related behaviors, such as refilling medications and making doctor appointments." - Feeding America Hunger + Health
Weight status	Brookwood Baptist Health Employees	18	**Decrease the percentage of BBH employees who are overweight or obese**	A) Provide employee wellness incentives B) Create and promote internal health programs or initiatives (i.e. walking clubs, yoga and meditation classes, cooking classes, gym 101 education, etc.)	Health Insurance Provider		"Research in adults shows a link between physical activity and cognitive benefits like memory and focus. One study found employees who participated in a health promotion program and improved their health care or lifestyle regained an average of 10.3 hours in additional productivity annually and saved their companies an average of $353 per person per year in productivity costs compared to non-participants. According to the Centers for Disease Control and Prevention (CDC), productivity losses related to personal and family health problems cost U.S. employers $1,685 per employee per year, or $225.8 billion annually. Evidence also indicates that instituting workplace health programs can reduce the average sick leave, health plan, and workers' compensation and disability insurance costs by approximately 25 percent. " - Office of Disease Prevention and Health Promotion

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Mental health	Adults caring for seniors	19	**Provide caregiver support**	Provide education on a variety of topics specific to caring for older adults through the "Let's Talk Senior" program at BBMC and PBMC			"A variety of interventions improve caregiver outcomes, especially when provided in combination: Most effective interventions begin with an assessment of caregivers' risks, needs, and preferences. Education and skills training improve caregiver confidence and ability to manage daily care challenges. Counseling, self-care, relaxation training, and respite programs can improve both the caregiver's and care recipient's quality of life. Caregiver training strategies that involve the active participation of the caregiver are more effective than didactic approaches." - National Academies of Science, Engineering, and Medicine
Mental health	Whole community	20	**Improve access to treatment for mental health crises**	A) Refer low-income patients to an internal call center to facilitate access to treatment B) Maintain a database of local providers, community-based organizations and funding programs B) Support the development of a 24/7 psychiatric crisis center in Birmingham		NAMI, Jefferson County Health Department	"Mental health crisis response services are a vital part of any mental health service system. A well-designed crisis response system can provide backup to community providers, perform outreach by connecting first-time users to appropriate services and improve community relations by providing reassurance that the person's needs are met in a mental health crisis." - National Alliance on Mental Illness
Mental health	Whole community	21	**Increase awareness of mental health risk factors and conditions, and reduce stigma**	A) Engage faith-based organizations and leaders in mental health education B) Partner with local organizations to conduct campaigns and promote educational messaging via print, web-based, and social media outlets		NAMI, JBS Mental Health Authority, OASIS Counseling for Women & Children, The Crisis Center, Jefferson County Health Department	"For many who seek psychiatric care, religion and spirituality significantly influence their internal and external lives and are an important part of healing. Because religion and spirituality often play a vital role in healing, people experiencing mental health concerns often turn first to a faith leader. From a public-health perspective, faith community leaders are gatekeepers or "first responders" when individuals and families face mental health or substance use problems. In that role they can help dispel misunderstandings, reduce stigma associated with mental illness and treatment, and facilitate access to treatment for those in need. " - American Psychiatric Association Foundation
Mental health	Healthcare providers	22	**Improve provider self-efficacy to identify mental health concerns and refer patients to local treatment and support resources**	A) Facilitate access to mental health continuing education programs and courses for primary care and emergency medicine providers		NAMI	"While psychiatric and other mental health professionals can play an important role in the provision of high-quality mental health care services, primary care physicians are the main providers for the majority of patients. Most people with poor mental health will be diagnosed and treated in the primary care setting. Mental illness also complicates other medical conditions, making them more challenging and more expensive to manage. Together, this makes mental health an important issue for primary care physicians." - American Academy of Family Physicians

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Cross-Cutting: Mental health and Substance Abuse	Healthcare providers	23	**Improve provider understanding of trauma and its role in mental health and substance abuse disorders**	A) Trauma-informed care education for providers B) Implement trauma-informed practices at the organizational level		Trauma-Informed Care Implementation Resource Center (national), Jefferson County Collaborative for Health Equity, Children's Aid Society of Alabama	"[Trauma] results from exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors. Trauma-informed care seeks to: realize the widespread impact of trauma and understand paths for recovery; recognize the signs and symptoms of trauma in patients, families, and staff; Integrate knowledge about trauma into policies, procedures, and practices; and actively avoid re-traumatization. " - Trauma-Informed Care Implementation Resource Center
Cross-Cutting: Access to care, Mental health, and Substance Abuse	Inpatients	24	**Improve the linkages between inpatient and tertiary care settings**	A) Through an internal call center, improve the efficiency of referrals for patients requiring mental health and substance abuse treatment B) Stabilize load levels across various local treatment facilities through careful distribution of patient referrals	BBH facilities		"Effective integration of behavioral health and general health care is essential for identifying patients in need of treatment, engaging them in the appropriate level of care, and ensuring ongoing monitoring of patients with substance use disorders to reduce their risk of relapse. Implementation of systems to support this type of integration requires care and foresight and should include educating and training the relevant workforces; developing new workflows to support universal screening, appropriate follow-up, coordination of care across providers, and ongoing recovery management; and linking patients and families to available support services. Quality measurement and improvement processes should also be incorporated to ensure that the services provided are effectively addressing the needs of the patient population and improving outcomes." U.S. Dept. of Health & Human Services


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