9.1.2024-8.31.2027

IMPLEMENTATION STRATEGY

BAPTIST HEALTH DEACONESS MADISONVILLE

Contents

Introduction

Foreword

This Implementation Strategy document, developed from June 2024–October 2024, serves as an accompaniment to the Community Health Needs Assessment (CHNA) by identifying the strategies which Baptist Health Deaconess Madisonville will employ during fiscal years 2025–2027 (September 1, 2024–August 31, 2027) to address the needs identified in the most recent CHNA. The approval and adoption of this report by the Baptist Health Deaconess Madisonville, Inc. Board of Directors complies with CHNA requirements mandated by the *Patient Protection and Affordable Care Act of 2010* and federal tax-exemption requirements.

Executive Summary

The Implementation Strategy process involved the following steps:

- From June 2024–October 2024, Baptist Health Deaconess Madisonville developed this Implementation Strategy report in response to the most recent Community Health Needs Assessment (CHNA).
- This plan identifies specific strategies to address the significant needs identified in the CHNA. The significant needs from that report include:
    - Mental Health
    - Obesity
- Details listed for each strategy include the:
    - Name of the strategy.
    - Specific goal or plan for each strategy.
    - Process metrics to identify short-term or intermediate-term goals to measure progress of the strategy.
    - Outcomes metrics to correlate long-term community health outcomes with the efficacy of the strategy.
    - Internal resources the hospital is committing to the strategy.
    - External partners associated with implementing the strategy.
    - Lens of equity to ensure equitable efforts are made across population groups to reduce health disparities.
- The hospital collaborated with the Hopkins County Health Department for this Implementation Strategy.
- This report was offered for approval to the Baptist Health Deaconess Madisonville, Inc. Board of Directors at a meeting on November 7, 2024.
- The final approved and adopted Implementation Strategy will be made public and widely-available on or before January 15, 2025 on the Baptist Health Deaconess Madisonville website: Baptist Health Deaconess - Community Health Needs Assessment.
- Next steps include documenting metrics and evaluating the strategies listed in this report. The hospital will conduct another community health needs assessment and document its implementation strategy within three years.

Background: Community Health Needs Assessment

The Baptist Health Deaconess Madisonville CHNA, approved by the Baptist Health Deaconess Madisonville, Inc. Board of Directors on August 23, 2024, outlines the significant health needs to address during the report coverage period (September 1, 2024–August 31, 2027). The needs identified include:

- Mental Health
- Obesity

The CHNA describes the process for how needs were identified, and which needs, if any, will not be addressed in the Implementation Strategy. For further background information that informs this Implementation Strategy, see the CHNA here: Baptist Health Deaconess - Community Health Needs Assessment.

Third-Party Collaboration

No third-party organizations were involved in the writing of this report. The Baptist Health System Director, Community Health and Engagement is responsible for the data gathering and writing of this report with feedback from hospital and system service line leaders. Hospital leaders reviewed and approved this plan before final authorized body approval.

Process

Development of Strategies

Each health need has an action plan that includes both existing and planned strategies. Employing existing strategies shows a continuity of efforts that underscores the hospital's ongoing commitment to addressing significant community health needs. Planned strategies may be in various stages of development and may have certain details still being formed. Evaluation of these strategies will be documented annually as required and in the "Evaluation of Efforts" section of the next CHNA.

Framework

The SMARTIE objectives framework was employed to ensure this plan listed equitable and inclusive goals that encourage a focus on health equity. The framework is used by both the Centers for Disease Control and Prevention (2021) and the Kentucky Department for Public Health (2024). SMARTIE objectives are developed by answering the following questions (Alford Group, 2024):

- **S**PECIFIC: What does your program hope to accomplish?
- **M**EASURABLE: What are your benchmarks?
- **A**CTION-ORIENTED/**A**CHIEVABLE: What are the identifiable intermediate actions or milestones?
- **R**ELEVANT/**R**EALISTIC: What results can realistically be achieved given available resources, knowledge, and time?
- **T**IMEBOUND: How will you track progress?
- **I**NCLUSIVE: How will you include representation from socially and economically marginalized individuals and groups?
- **E**QUITABLE: How do you include an element of justice or fairness that seeks to address inequity?

Each strategy is listed in its labeled section with the following details:

- Name of the strategy.
- Specific plan for each strategy. Strategies are evidenced-based or at least promising practices in that area.
- Process metrics to identify short-term or intermediate-term goals to measure progress of the strategy. This is part of the evaluation of each strategy.
- Outcomes metrics to correlate long-term community health outcomes with the efficacy of the strategy. The outcome metrics tie back to data included in the CHNA from the County Health Rankings and the Kentucky Injury Prevention Research Center. While hospital strategies are not wholly responsible for changes in these broad metrics, we will measure efficacy of our interventions through correlation with improved health outcomes. This is also part of the evaluation plan for each strategy.
- Internal resources the hospital is committing to the strategy. Activities with costs reportable as community benefit will be reported and documented as such.
- External partners associated with implementing the strategy. These may include local partners, funders or grantors, public health agencies, or organizations that own the evidence-based programs listed in the Implementation Strategy.

- Lens of equity to ensure equitable efforts across population groups and reduce disparities. The equity examination comes from an analysis of disparities experienced by certain groups after the evaluation of the Center for Disease Control and Prevention's (CDC) *Healthy People 2020*. An interactive dataset allowed for choosing a health area (mental health, substance use, nutrition and weight status, etc.). Each area indicates which, if any, populations experienced an increase in disparities during the *Healthy People 2020* coverage period. Groups that may experience disparities include: people of color; people with disabilities; people living in rural communities; older adults; people with mental health or substance use disorders; people with less than high school education; people with low incomes or those experiencing poverty; and people who identify as lesbian, gay, bisexual, or transgender (CDC, 2021). Populations with health disparities in the hospital's significant health needs are noted in the "Equity" section of each strategy.

Strategies to Address Significant Health Needs

Mental Health

The strategies below are the hospital's plan to address mental health.

1.1: Inpatient Care

- Plan: Continue operating a 22-bed acute psychiatric unit to care for patients with a variety of mental health needs, including psychosis, dementia, suicidal thoughts and depression.
- Process Metrics: Monitor occupancy of beds and scale depending on use. Hospital-employed Community Liaison will work with referring agencies to improve utilization.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): The inpatient Behavioral Health team includes physicians, nurses, and other clinical and nonclinical staff.
- External Partner(s): Referring agencies
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.2: Outpatient Care

- Plan: Based on community feedback on the need for such a service, explore adding outpatient behavioral health services. Recruit psychiatrist for outpatient services.
- Process Metrics: Track use of outpatient services and offer program based on need.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): The inpatient Behavioral Health team includes physicians, nurses, and other clinical and nonclinical staff.
- External Partner(s): The outpatient behavioral health team will include physicians and other clinical and nonclinical staff.

- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.3: Pennyroyal Center

- Plan: Continue renting space on hospital campus to the Pennyroyal Center, which offers outpatient therapy and substance abuse counseling.
- Process Metrics: Track any community benefit impact associated with rental agreement.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): The finance team oversees the lease agreement and services provided as part of space rental.
- External Partner(s): Pennyroyal Center
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.4: Community Mental Health Efforts

- Plan: Explore opportunities to engage with the Hopkins County Health Department in support of their Kentucky Emergency Management grant. This grant is focused on the ten counties affected by the 2020 tornado and will cover mental health efforts. This may include the hospital engaging in Mental Health First Aid classes provided to the community.
- Process Metrics: Track any community benefit impact associated with staff time or resources provided to support these efforts.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): To be determined but may include Baptist Health System team members providing Mental Health First Aid classes.
- External Partner(s): Hopkins County Health Department, Hopkins County School System
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.5: Motherhood Connection Program (MCP)

- Plan: Complete the Edinburgh Postnatal Depression Scale (EPDS) before delivery with pregnant persons enrolled in program. EPDS completed before delivery to establish baseline.
- Process Metrics: Track the number of questionnaires completed and the number of referrals made for behavioral health support.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): MCP Nurse Navigator(s) will ask questions and provide referrals, if needed. System MCP Program Coordinator will provide data.

- External Partner(s): Various community partners supporting parenting people
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.6: Rural Communities Opioid Response Program-Neonatal Abstinence Syndrome (RCORP NAS)

- Plan: This grant focuses on reducing structural and system-level barriers to increase access to behavioral health care, especially substance use disorders, including opioid use disorder, services for rural pregnant and postpartum persons and their families, and address community risk factors and social determinants of health. It will strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum persons and their families by implementing coordinated, evidence-based, trauma-informed, family-centered SUD/OUD and other services.
- Process Metrics: Track the number of participants in the Harm Reduction Program; the number of patients receiving treatment; the number of healthcare professionals that attend training as it relates to screening, diagnosing, and treating patients with SUD/OUD; the number of providers who have obtained the training to provide medication-assisted treatment; and referrals to other services.
- Outcomes Metrics:
    - Improve the number of screenings, referrals and participants receiving treatment.
    - Reduce the incidence and impact of neonatal abstinence syndrome in the community.
    - Reduce the physical and social barriers for patients.
- Internal Resource(s): Outpatient behavioral health provider, maternity nurse navigator, social worker, lactation consultant, pharmacy navigator, and other clinical and non-clinical staff
- External Partner(s): Health Resources and Services Administration (HRSA), Baptist Health Deaconess Medical Group, Hopkins County Health Department, and BrightView
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

1.7: Chalk the Walk

- Plan: Sponsor community Chalk the Walk event annually to reduce the stigma around mental health and spread positive messages. Encourage community organizations to participate every September in honor of Suicide Prevention Awareness month.
- Process Metrics: Track the number of community partners who have Chalk the Walk activities at their location.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.8 days (County Health Rankings, 2024).
- Internal Resource(s): The hospital marketing and behavioral health teams will lead this initiative.
- External Partner(s): In 2024, activities had 39 community partners, including local schools, businesses and nonprofits.
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

Obesity

The strategies below are the hospital's plan to address obesity.

2.1: Farmers Market

- Plan: Host Farmers Market on hospital campus every Thursday during the summer months to provide access to fresh produce.
- Process Metrics: Monitor use of Farmers Markets.
- Outcomes Metrics: Reduce the community's rate of population who have limited access to healthy foods from 7% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Hospital Food & Nutrition
- External Partner(s): Local farmers
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in nutrition and weight disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.2: Food As Medicine

- Plan: Partner to host a Food As Medicine program. The Food As Medicine campaign focuses on creating partnerships between hospitals and local farmers and connecting patients to a consistent healthy food resource.
- Process Metrics: Track efforts that connect local food the community. Increase the hospital's use of locally grown food.
- Outcomes Metrics: Reduce the community's rate of population who have limited access to healthy foods from 7% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Food & Nutrition and hospital leadership
- External Partner(s): Kentucky Hospital Association, Kentucky Department of Agriculture, and local farmers
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in nutrition and weight disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.3: Wellness Park

- Plan: Provide Wellness Park on hospital campus for use by staff and community members. Pediatric program also uses the park for therapy. A combination of hospital dollars and BHDM Foundation funds will support maintenance and park improvement.
- Process Metrics: Track the maintenance costs associated with park upkeep and report as community benefit. When needed, the Foundation will fund improvement efforts, but this will not be reportable as community benefit.
- Outcomes Metrics: Reduce the community's physical inactivity rate from 31% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Facilities and BHDM Foundation
- External Partner(s): community members

- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in physical activity disparities according to income level. Considerations will be made to ensure equitable efforts across income levels.

2.4: Diabetes and Endocrinology

- Plan: Recognizing the connection between diabetes and obesity, offer a comprehensive program of preventative and maintenance services. Offer endocrinological services to care for patients affected by hormone-related diseases and disorders, many of which can impact body weight.
- Process Metrics:
    - Explore technology options, like telehealth, to support a greater reach and provide services to patients who may not be able to be in-person.
    - Maintain staff with Certified Diabetes Educator certification.
    - Growth plan includes building a certified diabetes education program.
    - Increase the number of endocrinology providers.
- Outcomes Metrics: Reduce the community's prevalence of diabetes from 11% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Diabetes Program and Baptist Health Deaconess Medical Group - Endocrinology
- External Partner(s): (none)
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in diabetes disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.5: Sports Medicine Program

- Plan: Provide sports medicine care dedicated to the treatment and prevention of sports-related injuries.
- Process Metrics: Continue to monitor needs of patients and community for additional or complementary services.
- Outcomes Metrics: Reduce the community's physical inactivity rate from 31% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Sports Medicine program team
- External Partner(s): (none)
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in physical activity disparities according to income level. Considerations will be made to ensure equitable efforts across income levels.

2.6: Sports Physicals

- Plan: Offer free sports physicals for public school students in Hopkins, Christian, and Muhlenberg County schools to encourage physical activity.
- Process Metrics: Track the number of students who are provided free physicals. In 2024, this number exceeded 800 students.
- Outcomes Metrics: Reduce the community's physical inactivity rate from 31% during next CHNA cycle (County Health Rankings, 2024).

- Internal Resource(s): Hospital physicians and residents and other clinical and nonclinical staff
- External Partner(s): Local schools
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in physical activity disparities according to income level. Considerations will be made to ensure equitable efforts across income levels.

2.7: Bariatric Surgery Program

- Plan: Offer weight loss surgery options. Build program to include the total package of services needed.
- Process Metrics: Monitor patient needs for opportunities to improve and offer various resources needed for patients to have optimal outcomes.
- Outcomes Metrics: Reduce the community's obesity rate from 41% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): Bariatric Program team
- External Partner(s): (none)
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in nutrition and weight disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.8: School Nutrition

- Plan: Explore opportunities to support Hopkins County Health Department (HCHD) efforts with local schools. HCHD provides nutrition education to elementary school students.
- Process Metrics: Track any community benefit impact associated with staff time or resources provided to support these efforts.
- Outcomes Metrics: Reduce the community's rate of food insecurity from 15% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): To be determined
- External Partner(s): Hopkins County Health Department and Hopkins County School System
- Equity: The CDC's *Healthy People 2020* final data review did not have data to indicate disparities in this area.

2.9: Summer Feeds Program

- Plan: Explore opportunities to support Hopkins County Health Department (HCHD) with the Summer Feeds Program.
- Process Metrics: Track any community benefit impact associated with staff time or resources provided to support these efforts.
- Outcomes Metrics: Reduce the community's rate of food insecurity from 15% during next CHNA cycle (County Health Rankings, 2024).
- Internal Resource(s): To be determined
- External Partner(s): Hopkins County Health Department and YMCA
- Equity: The CDC's *Healthy People 2020* final data review did not have data to indicate disparities in this area.

Community Health Improvement Matrix (CHIM)

To illustrate the depth and breadth of the strategies in place to address our community health needs, we borrowed a tool from the National Association of County & City Health Officials (NACCHO, 2017). The Community Health Improvement Matrix (CHIM) allows us to see where our strategies fall in terms of the prevention and intervention levels. We have developed a matrix for each health need as a graphic representation of our work.

Prevention levels describe where in time we can intervene to address a health need. These levels are described as follows:

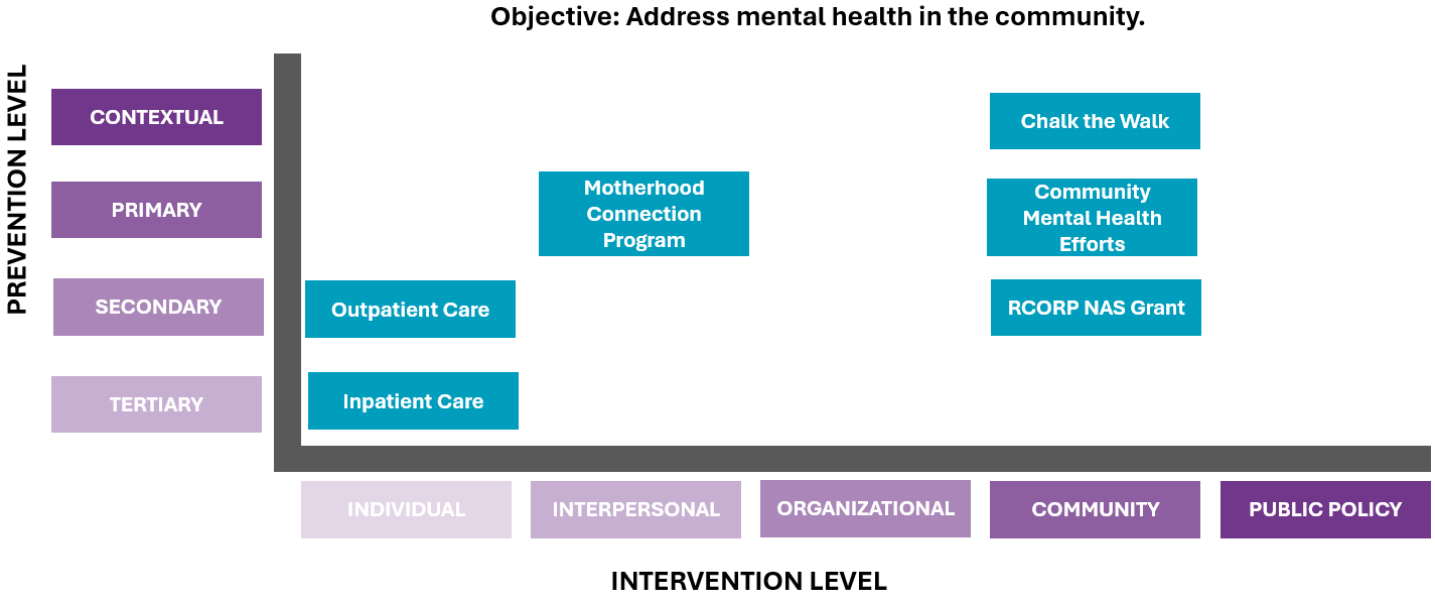
- Contextual: prevent the emergence of predisposing social and environmental conditions that can cause disease
- Primary: reduce susceptibility of exposure to health threats
- Secondary: detect and treat disease in early stages
- Tertiary: alleviate the effects of disease and injury

Intervention levels describe the context in which these interventions occur. These levels are described as follows:

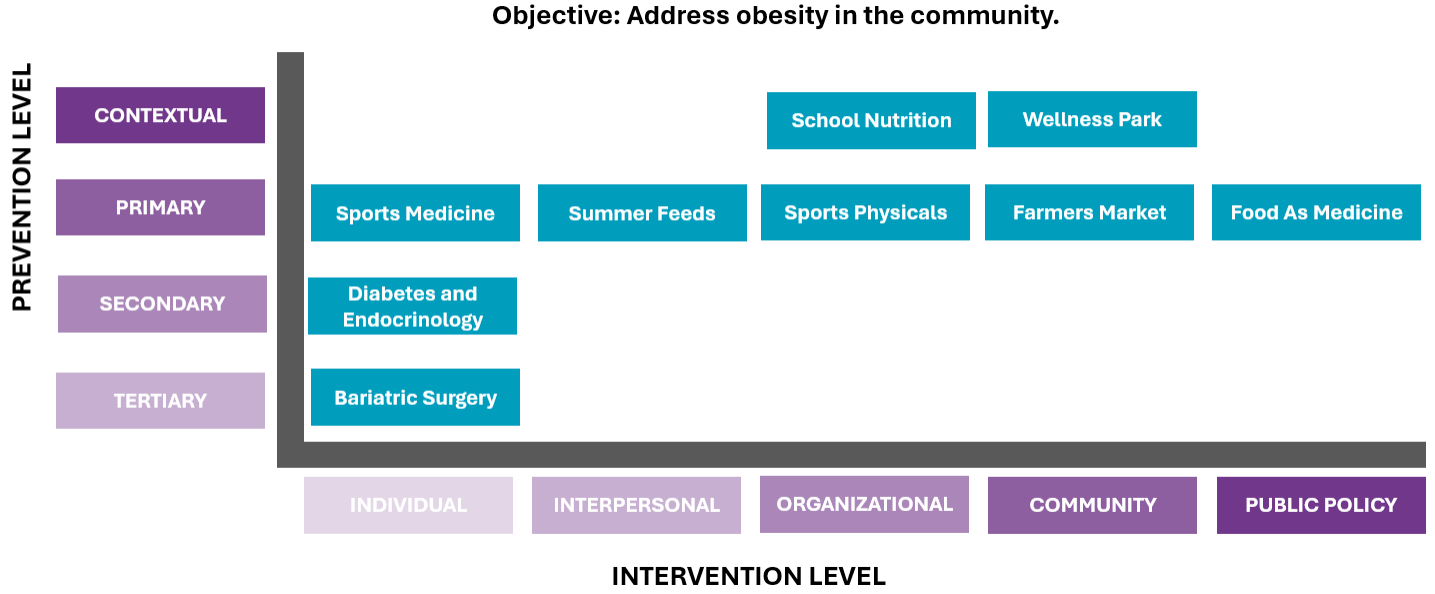
- Individual: characteristics of the individual, such as knowledge, attitudes, behaviors, self-concept, skills, etc.
- Interpersonal: formal and informal social network and social support systems, including family, work group, and friendship networks
- Organizational: social institutions with organizational characteristics and rules/regulations for operation
- Community: relationships among organizations, institutions, and informal networks within defined boundaries
- Public Policy: local, state, and national laws and policies

According to NACCHO, “Activities that fit under organizational, community or public policy targets at a primary prevention level are more likely to address social determinants than others on the matrix. All the activities may be important for the community’s work in addressing a problem; the advantage of the CHIM framework is that it can give a sense of the balance of the community’s endeavors.”

CHIM: Mental Health



CHIM: Obesity



Next Steps

Once approved by the Baptist Health Deaconess Madisonville, Inc. Board of Directors, this CHNA will be made public and widely available no later than January 15, 2025.

Baptist Health Deaconess Madisonville is committed to documenting metrics and evaluating the strategies listed in this report. The hospital will conduct another community health needs assessment and document its implementation strategy within three years.

Approval and Adoption

As an authorized body of Baptist Health Deaconess Madisonville, Baptist Health Deaconess Madisonville, Inc. Board of Directors approves and adopts this Implementation Strategy on the date listed below.

12/19/2024

Chair, Baptist Health Deaconess Madisonville, Inc. Board of Directors — Date

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