9.1.2024–8.31.2027

IMPLEMENTATION STRATEGY

BAPTIST HEALTH®
FLOYD

Contents

Introduction

Foreword

This Implementation Strategy document, developed from June 2024–November 2024, serves as an accompaniment to the Community Health Needs Assessment (CHNA) by identifying the strategies which Baptist Health Floyd 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 System, 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–November 2024, Baptist Health Floyd 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
    - Substance Use (drug/alcohol/tobacco use)
- 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.
- This report was offered for approval to the Baptist Health System, Inc. Board of Directors at a meeting on December 10, 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 website: Community Health Needs Assessments - Baptist Health.
- 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 Floyd CHNA, approved by the Baptist Health System, Inc. Board of Directors on June 25, 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
- Substance Use (drug/alcohol/tobacco use)

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: Community Health Needs Assessments - Baptist Health.

Third-Party Collaboration

No third-party organizations were involved in the writing of this report. The Baptist Health System Director, Community Health and Engagement and Baptist Health Floyd Healthier Initiative Coordinators are 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 Indiana Department of Health. 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: Support Groups

- Plan: Offer space for external organization to host support groups in the hospital. Consider providing space for additional support groups.
- Process Metrics: Track the number of participants served by support groups.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd will provide space for groups to meet at no cost.
- External Partner(s): Parkinson's Foundation
- 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: Mental Health First Aid (MHFA)

- Plan: Offer at least two Mental Health First Aid classes to community members as an evidence-based, early intervention course to teach people about mental health and substance use challenges.
- Process Metrics: Track the number of community members educated in MHFA classes.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health System Behavioral Health team will lead/support hospital staff in providing community classes.
- External Partner(s): Various community non-profits and schools
- 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: 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 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): MCP Nurse Navigators will ask questions and provide referrals, if needed. 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. The U.S. Commission on Civil Rights noted racial disparities in maternal health outcomes, so efforts will be made to ensure equitable outcomes across race/ethnicity.

1.4: Wraparound Services—Mental Health

- Plan: Research specific geographic locations as it relates to mental health for wraparound services. This can include, but is not limited to, generational trauma, resiliency and age-related needs.
- Process Metrics: Document the specific locations (census tracts, etc.) where there are opportunities for interventions.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will work with community agencies for data review and intervention coordination.
- External Partner(s): Our Place Alcohol and Drug Education Services and LifeSpring
- 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: Medical Touchpoints

- Plan: Research system approach to mental health as it relates to acute or chronic medical diagnosis. Identify medical touchpoints that may be connected with downstream mental health needs, such as cancer diagnosis or chronic pain issues.
- Process Metrics: Document opportunities to intervene and track for improvement in mental health status or reduction in suicide rates.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will work with community agencies for data review and intervention coordination.
- External Partner(s): To be determined

- 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: Health Behaviors

- Plan: Explore opportunities for health behavior changes as it relates to mental health. This may include opportunities for education, screening, and programming.
- Process Metrics: Track the number of people impacted by activities and any behavioral changes associated with the programming.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will work with community agencies for data review and intervention coordination.
- External Partner(s): To be determined
- 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: Youth Outreach: Mental Health

- Plan: Explore opportunities with schools to work with at-risk youth on mental health prevention and resources.
- Process Metrics: Track the number of students impacted by prevention activities. Depending on specific activity, track pre and post data.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.1 days, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will work with community agencies for data review and intervention coordination.
- External Partner(s): New Albany Floyd County Schools and Let Us Learn
- 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.

Substance Use

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

2.1: Suicide Overdose Fatality Review Groups (SOFR)

- Plan: Lead the Floyd County SOFR Workgroup and Board to review suicide deaths due to substance use overdoses. Identify gaps and barriers. Set up goals related to the timeline review. Use data to inform and plan interventions.
- Process Metrics: Group goal is to reduce the number of overdose and suicide deaths in Floyd County.
- Outcomes Metrics: Reduce the number of deaths involving drug overdoses in Floyd County from 26 per year (Indiana Department of Health, 2023).

- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators chair, coordinate and attend meetings.
- External Partner(s): Southern Indiana Works (Work One), Indiana Department of Health, Floyd County Health Department, Our Place Alcohol and Drug Education Services, and various community partners
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

2.2: Floyd County Tobacco Prevention and Cessation Coalition

- Plan: Participate in coalition efforts to reduce nicotine use, including youth-focused preventative efforts.
- Process Metrics: Document interventions implemented by the coalition.
- Outcomes Metrics: Reduce the community's smoking rate from 17%, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators chair, coordinate and attend meetings.
- External Partner(s): Our Place Alcohol and Drug Education Services, Anthem, Life Spring, American Cancer Society, Community Action Southern Indiana, Family and Children's Center, and Indiana University Southeast
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

2.3: Quitline Referrals

- Plan: Through Epic (electronic medical record) integration, track referrals made from hospital units to the Indiana Tobacco Quitline.
- Process Metrics: Track the number of referrals made to the Quitline every quarter.
- Outcomes Metrics: Reduce the community's smoking rate from 17%, (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators track referrals.
- External Partner(s): Indiana Department of Health
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

2.4: Alcohol Tobacco and Other Drugs Task Force (ATOD)

- Plan: The mission of the ATOD Task Force is to provide an organization through which the community can plan and implement efforts to address the problems of substance abuse and dependency in the Floyd County community. The development of this Local Coordinating Council is state-mandated.

- Process Metrics: Document interventions implemented by the task force.
- Outcomes Metrics: Reduce the community's excessive drinking rate from 17%, (County Health Rankings, 2024). Reduce the community's number of Emergency Department visits due to drug use from 182 per year (Indiana Department of Health, 2023).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators chair, coordinate, and attend meetings.
- External Partner(s): Our Place Alcohol and Drug Education Services, Floyd County Probation, Floyd County Community Corrections, Family and Children's Center, Brandon's House, and The Breakaway
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups. According to the CDC's *Healthy People 2020* final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

2.5: Freedom from Smoking

- Plan: Host and facilitate fall, spring, and summer smoking cessation classes.
- Process Metrics: Track participant numbers and their outcomes.
- Outcomes Metrics: Reduce the community's smoking rate from 17% (County Health Rankings, 2024). Document percentage of patients who self-report abstaining from nicotine at the end of the program.
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will facilitate classes.
- External Partner(s): American Lung Association
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

2.6: School Athletic Training Program

- Plan: Collaborate with Baptist Health Athletic Trainers in the high schools to review gaps/barriers related to suicide/overdose deaths by the end of 2025.
- Process Metrics: Establish interventions by the end of 2027.
- Outcomes Metrics: Maintain low percentage of students who have used prescription painkillers not prescribed to them in the past 30 days. Only 0.61% of high school students in Region 9 (which includes Floyd County) had ever misused prescription painkillers not prescribed to them (Indiana Youth Survey, 2024).
- Internal Resource(s): Healthier Community Initiative Coordinators will work with Baptist Health Athletic trainers.

- External Partner(s): Greater Clark County Schools, Austin High School, Silver Creek School Corporation, North Harrison High School, Paoli Community School Corporation, West Washington School Corporation, Borden Henryville School Corporation, New Albany-Floyd County Schools, Crawford County Community Schools, Lanesville Community School Corporation, and South Harrison Community Schools
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in adolescent health disparities based on disability status. Populations that had the greatest increase in disparities included persons with disabilities or activity limitations. Considerations will be made to ensure equitable efforts across population groups.

2.7: Wraparound Services—Substance Use

- Plan: Research specific geographic locations as it relates to overdose deaths for wraparound services. This may include case management-type services.
- Process Metrics: Document the specific locations (census tracts, etc.) where there are opportunities for interventions.
- Outcomes Metrics: Reduce the community's number of Emergency Department visits due to drug use from 182 per year (Indiana Department of Health, 2023).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will work with community agencies for data review and intervention coordination.
- External Partner(s): To be determined
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

2.8: Patient and Employee Needs

- Plan: Collaborate internally on substance use needs for hospital patients and employees.
- Process Metrics: Based on need, develop specific programs and activities.
- Outcomes Metrics: Reduce the community's number of Emergency Department visits due to drug use from 182 per year (Indiana Department of Health, 2023).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will lead collaborative efforts with Emergency Department, Case Management and Employee Health.
- External Partner(s): To be determined
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

2.9: Narcan Distribution

- Plan: Explore process for internal Narcan distribution. Use process at other Baptist Health hospitals as a template.
- Process Metrics: Track the number of patients who are discharged with Narcan.
- Outcomes Metrics: Reduce the community's number of unintentional overdose deaths from 35 deaths per year (Indiana Department of Health, 2023).
- Internal Resource(s): Baptist Health Floyd Healthier Community Initiative Coordinators will lead efforts.
- External Partner(s): none
- Equity: According to the CDC's *Healthy People 2020* final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

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

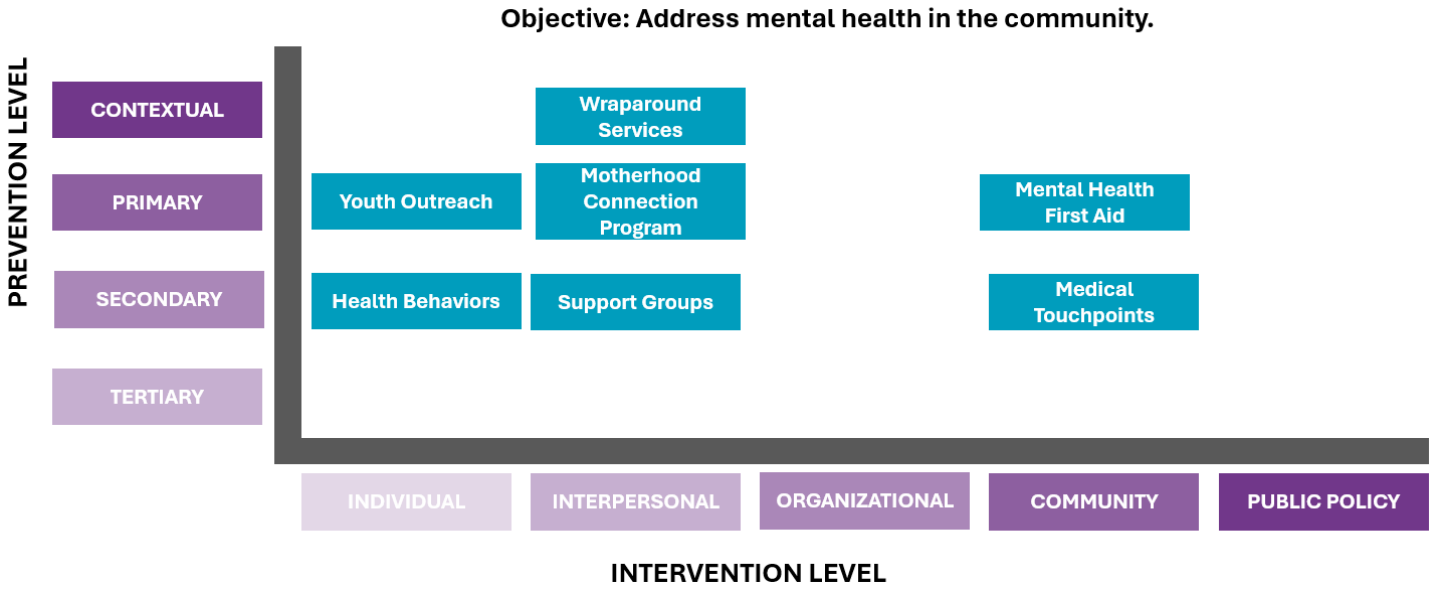
Intervention levels describe the context in which these interventions occur. These levels are described as follows:

- 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

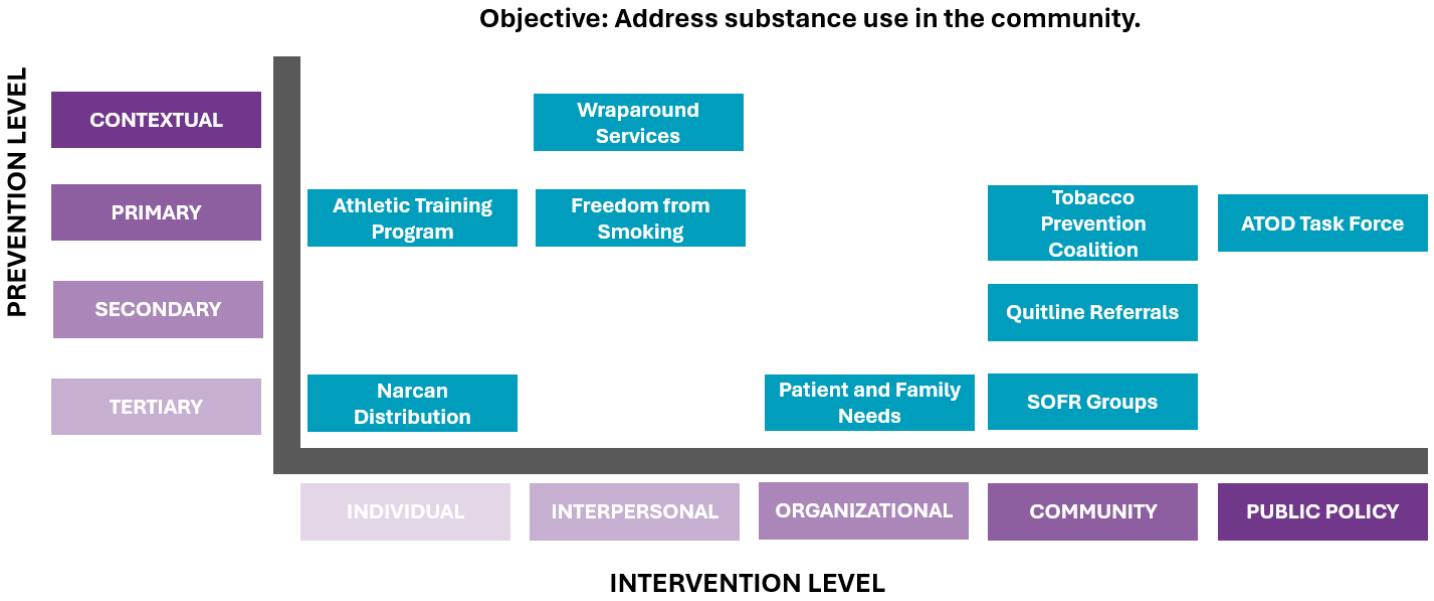
According to NACCHO, “Activities that fit under organizational, community or public policy targets at a primary prevention level are more likely to address social determinants than others on the matrix. All the activities

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: Substance Use



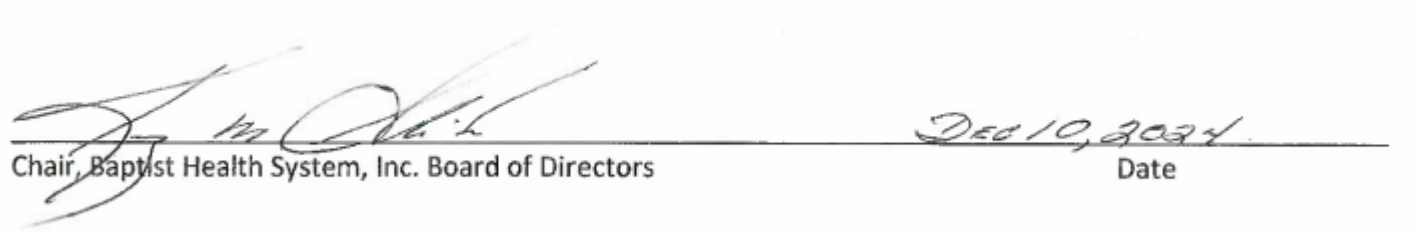
Next Steps

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

Baptist Health Floyd 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 Floyd, Baptist Health System, Inc. Board of Directors approves and adopts this Implementation Strategy on the date listed below.



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