9.1.2024–8.31.2027

IMPLEMENTATION STRATEGY

BAPTIST HEALTH®
RICHMOND

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 Richmond 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 Richmond 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:
    - Substance Use (drug/alcohol/tobacco use)
    - Mental Health
- 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 Richmond 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:

- Substance Use (drug/alcohol/tobacco use)
- Mental Health

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 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

Substance Use

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

1.1: Medication-Assisted Treatment

- Plan: Offer treatment for addiction using medications.
- Process Metrics: Track use of MAT and patient outcomes.
- Outcomes Metrics: Reduce the number of opioid-involved non-fatal overdoses. The 2022 county rates of opioid-involved nonfatal overdoses per 100,000 population are: 123.8 (Madison County) and 320.9 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): The hospital will employ providers able to prescribe MAT.
- 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.

1.2: Adult Chemical Dependency Intensive Outpatient Program (IOP)

- Plan: Operate an Adult Chemical Dependency Intensive Outpatient Program (IOP) that provides stabilization and assessment services, treatment options, and IOP group therapy.
- Process Metrics: Track use of IOP service.
- Outcomes Metrics: Reduce community health behaviors that indicate drug use, which may include hospital encounters for substance use. The 2022 rates per 100,000 population are: 665.5 (Madison County) and 1156.7 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, psychiatric nurse practitioners, and registered nurses.
- 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.

1.3: Patient Transportation

- Plan: Baptist Health Richmond uses hospital Foundation dollars to provide transportation for patients who are identified as needing support. By extending the hours offered by this service, the hospital can provide transportation for patients in IOP and eliminate that barrier to care.
- Process Metrics: Monitor patient needs and align transportation schedule when possible.
- Outcomes Metrics: Reduce community health behaviors that indicate drug use, which may include hospital encounters for substance use. The 2022 community rates per 100,000 population are: 665.5 (Madison County) and 1156.7 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): Baptist Health Richmond Manager, Marketing & PR will track utilization of patient transportation services.
- External Partner(s): Kentucky River Foothills Development Council
- 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.

1.4: Behavioral Health Community Outreach Navigator

- Plan: This position develops relationships and builds trust between community and the hospital, including educating the community on services offered and prevention.
- Process Metrics: Provide behavioral health support inside and outside hospital. Track applicable efforts as community benefit.
- Outcomes Metrics: Reduce community health behaviors that indicate drug use, which may include hospital encounters for substance use. The 2022 community rates per 100,000 population are 665.5 (Madison County) and 1156.7 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): Baptist Health Richmond will employ the Community Outreach Navigator.
- External Partner(s): Madison County Schools, SPARK Ministries and Enrich
- 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.

1.5: Tobacco Cessation Clinic

- Plan: Tobacco cessations efforts are led by Ambulatory Care Clinic pharmacists, who have one-on-one patient consultations to review history, previous quit attempts, triggers, etc. to provide a comprehensive treatment plan. This includes both behavioral health changes and medications to help

patients stop smoking. Pharmacists may initiate tobacco cessation therapies, including all forms of nicotine replacement therapy and/or any other FDA-approved medication for treating tobacco use.

- Process Metrics: Annually, track number of patients provided with tobacco cessation therapies.
- Outcomes Metrics: Reduce the community's smoking rate from 20% (Madison County) and 29% (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Richmond will house the Ambulatory Care Clinic. Hospital pharmacists will initiate tobacco cessation efforts.
- External Partner(s): none
- 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.

1.6: Mobile Unit for Community Partners

- Plan: In partnership with other community agencies, provide primary care services to the community through OnRequest mobile unit. This includes partnering with agencies who support community members working through substance use. Clinical services are provided by the Baptist Health Medical Group, but Baptist Health Richmond coordinates appropriate community organizations with whom to partner.
- Process Metrics: Track the number of patients served on the mobile unit.
- Outcomes Metrics: Reduce community health behaviors that indicate drug use, which may include hospital encounters for substance use. The 2022 community rates per 100,000 population are 665.5 (Madison County) and 1156.7 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): Baptist Health Richmond Manager, Marketing & PR and Community Liaison will identify partner agencies for mobile clinic.
- External Partner(s): God's Outreach Madison County Food Bank, Enrich, SPARK Ministries, Whitehouse Clinic, Madison Home, OnRequest
- 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.

1.7: Madison County Opioid Task Force Advisory Council

- Plan: Baptist Health Richmond will have a seat on this council. This group seeks to understand need, identify gaps, and make recommendations for addressing mental health in the community.
- Process Metrics: Since the advisory council has just started meeting, action items have yet to be determined. The hospital will participate in recommendations made by the board.
- Outcomes Metrics: Reduce the number of opioid-involved non-fatal overdoses. The 2022 county rates of opioid-involved nonfatal overdoses per 100,000 population are: 123.8 (Madison County) and 320.9 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).

- Internal Resource(s): The Baptist Health Richmond Executive Director, Specialty Services will serve on this Board.
- External Partner(s): Madison County Health Department, Kentucky River Foothills, Whitehouse Clinic, Madison County Attorney's Office
- 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.

Mental Health

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

2.1: Inpatient Adult Unit

- Plan: Operate an inpatient adult behavioral health unit to treat adults 18-64 who require 24-hours nursing care. The inpatient unit treats individuals with complex mental illness including depression, bipolar disorder, generalized anxiety disorder, schizophrenia, schizoaffective disorder, obsessive-compulsive disorder and dual-diagnosis addictive disorders.
- Process Metrics: Track unit data, including the number of admissions.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, psychiatric nurse practitioners, and registered nurses.
- External Partner(s): none
- Equity: According to the CDC's Healthy People 2020 final data review, there was in 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.

2.2: Patient Food Pantry

- Plan: In recognizing the connection between meeting basic needs and mental health, Baptist Health Richmond operates a food pantry for patients who are food insecure. Patient need is determined by hospital Case Managers utilizing the SDOH (Social Drivers of Health) tool in Epic (the electronic health record).
- Process Metrics: Track utilization of food bank.
- Outcomes Metrics: Reduce the percentage of the community impacted from food insecurity from 12% (Madison County) and 19% days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Richmond Manager, Marketing & PR will track utilization.
- External Partner(s): God's Outreach Madison County Food Bank
- Equity: According to the CDC's Healthy People 2020 final data review, there was in 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.

2.3: Community Liaison

- Plan: This position provides resources to community members, including resources that address social drivers of health. This position also identifies partners for the hospital and the mobile unit.
- Process Metrics: Liaise with community partners who will benefit the community and the hospital's patients. Track applicable efforts as community benefit.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Richmond will employ the Community Outreach Navigator.
- External Partner(s): God's Outreach Madison County Food Bank, SPARK Ministries, Whitehouse Clinic, Madison Home
- Equity: According to the CDC's Healthy People 2020 final data review, there was in 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.

2.4: Therapist on Mobile Unit

- Plan: Use external funding to add a therapist to the mobile unit who can provide individual counseling. Frequency is to be determined. Continue to seek funding for additional opportunities for mobile therapy services.
- Process Metrics: Track the number of patients provided with therapy services on mobile unit.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): The Baptist Health Richmond Executive Director, Specialty Services and Marketing & PR Manager will seek funders for this effort.
- External Partner(s): PACA (Pattie A. Clay Auxiliary), as well as future funders to be determined
- Equity: According to the CDC's Healthy People 2020 final data review, there was in 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.

2.5: Mental Health First Aid

- 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 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health System Behavioral Health team will lead/support hospital staff in providing classes.
- External Partner(s): National Council for Mental Wellbeing and various community non-profits and schools
- Equity: According to the CDC's Healthy People 2020 final data review, there was in 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.

2.6: Chalk the Walk

- Plan: Host community Chalk the Walk event annually to reduce the stigma around mental health and spread positive messages.
- Process Metrics: Track the staff time spent participating in Chalk the Walk activities.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Richmond Behavioral Health will organize events.
- 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.

2.7: Motherhood Connection Program

- Plan: Complete the Edinburgh Postnatal Depression Scale 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 5.9 days (Madison County) and 6.3 days (Estill County) (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 in 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.

2.8: Mentoring Program

- Plan: Build resiliency in middle school students identified as needing support. Hospital employees will build mentoring relationship with students through job shadow opportunities and monthly lunches.
- Process Metrics: Track the number of students connected with a mentor.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 5.9 days (Madison County) and 6.3 days (Estill County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Richmond Manager, Marketing & PR will track data on this project.
- External Partner(s): B. Michael Caudill Middle School
- 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.

2.9: Patient Transportation

- Plan: Baptist Health Richmond uses hospital Foundation dollars to provide transportation for patients who are identified as needing support. This includes providing transportation to patients who are accessing behavioral health appointments.
- Process Metrics: Track use of transportation.
- Outcomes Metrics: Reduce community health behaviors that indicate drug use, which may include hospital encounters for substance use. The 2022 community rates per 100,000 are 665.5 (Madison County) and 1156.7 (Estill County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): Baptist Health Richmond Manager, Marketing & PR will track utilization of patient transportation services.
- External Partner(s): Kentucky River Foothills Development Council
- 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.

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:

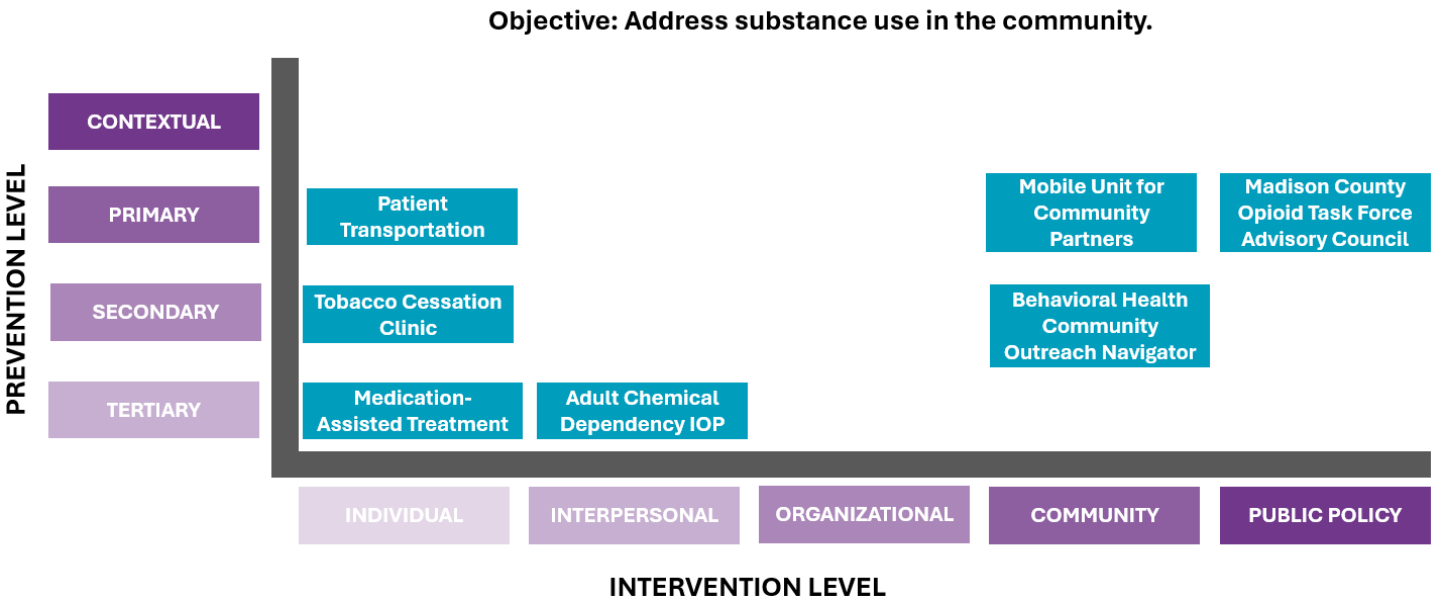
- Contextual: prevent the emergence of predisposing social and environmental conditions that can cause disease
- Primary: reduce susceptibility of exposure to health threats
- Secondary: detect and treat disease in early stages
- Tertiary: alleviate the effects of disease and injury

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

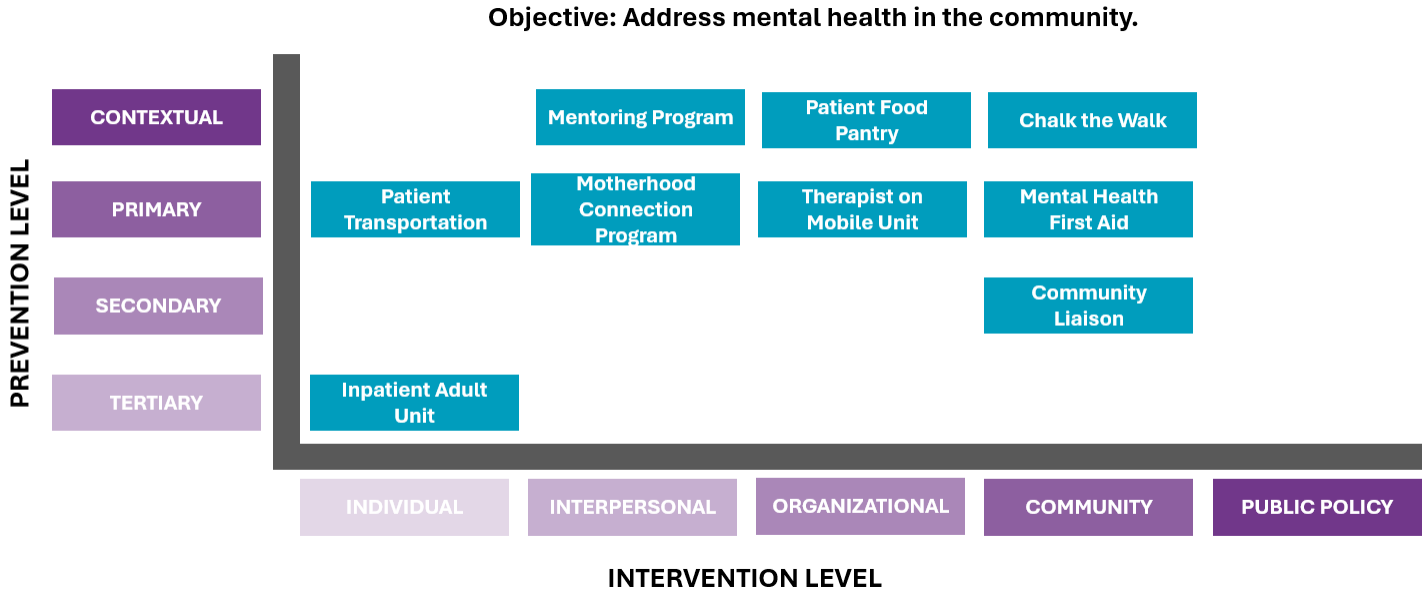
- Individual: characteristics of the individual, such as knowledge, attitudes, behaviors, self-concept, skills, etc.
- Interpersonal: formal and informal social network and social support systems, including family, work group, and friendship networks
- Organizational: social institutions with organizational 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: Substance Use



CHIM: Mental Health



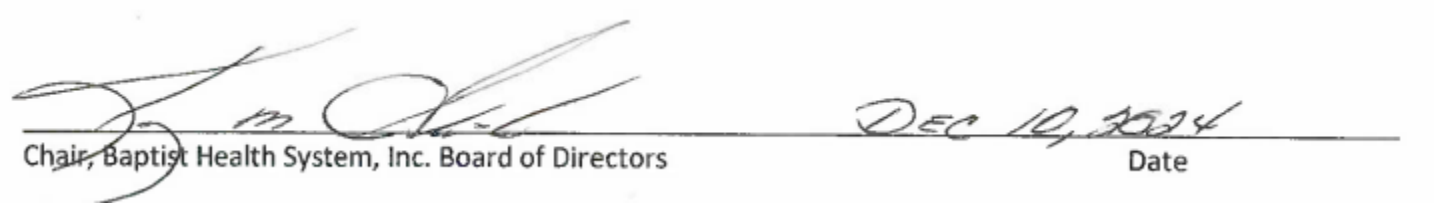
Next Steps

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



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