# BHMC-LR Implementation Plans

# Baptist Health Medical Center – Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1: Preventable Hospital Stays

### GOALS / OBJECTIVES:

Reduce the number of unnecessary hospitalizations through improved primary prevention, improved control of chronic diseases, and expanded case management for patients seen in the Emergency Department.

### STRATEGY #1:

Utilize the Baptist Health Home Health Teleheath program to monitor patients with chronic conditions at home.

### ACTION STEP #1:

Develop criteria to identify appropriate patients with chronic conditions who would benefit from a telehealth program.

### ACTION STEP #2:

Investigate grant funding opportunities to provide telehealth units to qualified patients.

### ACTION STEP #3:

Once funded, implement, monitor and provide any necessary interventions with telehealth patients.

### DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Interventions will be prompt, appropriate and cost effective to both the patient and hospital to reduce the number of patients who are admitted with chronic conditions. This process will also maintain the patient in their home environment.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- Little Rock will work with the Baptist Health Home Health network to manage these patients in the homes with the telehealth units. Home Health nurses will provide the patient monitoring and medical intervention in the homes.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Case Coordination staff, nurses and social workers, and Home Health staff will be needed to identify patients who qualify for the telehealth units. The Baptist Health Foundation will assist with finding grant money or other funds needed to purchase units to put in the homes of patients and to provide aircards for wireless internet. Interpretation services will also be used for those patients who need translation. Physicians will be used as needed to provide the referral and medical support.

**PERFORMANCE METRICS:**

Attempts to secure grant funding will begin in the first quarter of 2014. If grant funding can be obtained, readmission tracking for those patients enrolled in the program and placed on Telehealth units will be monitored and results reported annually. The goal is to reduce the readmissions of those patients placed on Telehealth units by 5% when compared to their previous 12 month history of readmissions.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be ongoing, as long as funds are available to install telehealth units in patient homes, over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Case Coordination – Sandy Guthrie

Baptist Health Home Health- Becky Pryor

Baptist Health Foundation- Missy Lewis

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Initiate proactive approaches to care for patients seen in the Emergency Department to mitigate the need for frequent emergency/acute interventions.

**ACTION STEP #1:**

Provide Case Management Services seven (7) days per week.

**ACTION STEP #2:**

Ensure as many patients as possible are connected to a Primary Care Physician with an appointment made within three days of discharge, and if needed, Home Health services.

**ACTION STEP #3:**

Arrange enrollment in free or reduced cost medication programs for all patients who qualify.

**ACTION STEP #4:**

Investigate options for diabetic patients who cannot afford measurement strips for blood sugar meters and/or insulin syringes.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Assisting patients with access to resources which facilitate compliance with recommended treatments will prevent chronic conditions from deteriorating into acute problems requiring emergency intervention. This will also link patients to the appropriate levels of care for follow up.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- Little Rock will work with physicians in the Baptist Health network and Baptist Health Home Health to manage patients with on-going health needs. Partnerships with drug companies and supply companies will also be pursued.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Case Coordination staff, nurses and social workers, will be needed to assess patient needs for discharge and coordinate services. Pharmacy staff will be needed to evaluate poly-pharmacy issues. Health Management Center staff will assist in investigating diabetes supply needs. Physicians will be used as needed to order needed services and supplies.

**PERFORMANCE METRICS:**

Case Management services will be provided in the ED seven (7) days per week in January of 2014. The number of patients enrolled in reduced cost medication programs will be tracked on a monthly basis.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be ongoing as patients will continue to be identified, over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Case Coordination - Sandy Guthrie

Baptist Health Home Health - Becky Pryor

Health Management Center - Ryan Reed

Pharmacy – David Cobb

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #3:**

Develop methods to regularly monitor Nursing Home patients who are at higher risk for readmission based on known disease progression factors and intervene early to mitigate the need for frequent emergency/acute interventions.

**ACTION STEP #1:**

Educate Nursing Homes on the need to perform daily weight and blood pressure checks on patients with chronic kidney disease who are not on dialysis or with congestive heart failure.

**ACTION STEP #2:**

Investigate use of a pilot eICU service in a Nursing Home with a high volume of readmissions.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Interventions are prompt, appropriate and cost effective to both the patient and hospital to reduce the number of patients who are admitted with chronic conditions that became acute. This will also maintain the patient in their regular environment.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- Little Rock will work with local Nursing Homes to manage patients with complex health needs, and with physicians to provide orders for interventions that support care in the patient's regular environment.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Community Outreach and Case Coordination staff will be needed to conduct regular meetings with Nursing Home representatives to provide education and come to consensus on patient management approaches. Staff from Network Development will assess capability and cost of using an eICU service in a Nursing Home environment.

**PERFORMANCE METRICS:**

Reduce the number of inpatient admissions from the Emergency Department by targeted Nursing Homes by 5% using pre- and post-initiative comparison.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be ongoing as patients will continue to be identified, over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Case Coordination - Sandy Guthrie

Community Outreach - Teresa Conner

Network Development - Leila Dockery

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetic Screening

**GOALS / OBJECTIVES:**

Promote diabetes awareness and education to increase diabetic screenings

**STRATEGY #1:**

Develop a diabetes awareness education campaign to build support and understanding among the general public regarding diabetes prevention, early detection and treatment methods.

**STRATEGY #2:**

Promote the Diabetic Risk Assessment Test to patients entering the Community Outreach Wellness Centers.

**STRATEGY #3:**

Implement community-based diabetes education classes and screenings.

**STRATEGY #4:**

Offer A1C testing to Wellness Center patients who have a previous diagnosis of diabetes. Individuals found to have elevated levels will be offered care coordination by the Community Education Nurse.

**STRATEGY #5:**

Expand screening programs and services for high-risk groups: minorities, elders, tobacco users, caregivers, underinsured, and non-insured by targeted screening events.

**STRATEGY #6:**

Enhance school-based Diabetes education and screening.

**ACTION STEP #1*:***

Work with Strategic Development to develop an educational campaign to increase the awareness of Diabetes prevention, screening and management. The campaign will include mailers, web-site, social media and television.

**ACTION STEP #2:**

Provide counseling regarding nutrition, weight control, and appropriate physical activity to patients identified as having high risk factors for diabetes. Advise identified patients to have periodic future screening for diabetes.

**ACTION STEP #3*:***

Promote diabetes screenings and education classes. Quarterly diabetes educational programs will be implemented at various Community Wellness Centers that include an educational presentation component, healthy cooking demonstrations and physical activity.

**ACTION STEP #4:**

Offer participation in the community- based diabetes management program for all individuals identified and diagnosed as diabetic by a health care provider. The program will include reminders for patients to follow-up on their eye, foot and oral exams. Patients will also receive A1C and cholesterol screenings, if needed.

**ACTION STEP #5:**

Partner with community churches, community groups and Hometown Health Coalitions in identified areas to increase the number of screenings and risk assessment tests provided for the identified population.

**ACTION STEP #6:**

Support the Arkansas Department of Health's initiative in expanding diabetes screening of targeted middle school children, along with their scoliosis screening. Assist in teaching diabetes prevention, risk factors, symptoms and the consequences of diabetes. Provide assistance in teaching students and school health providers, as needed.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The awareness of the diabetes epidemic and its severity will lead to an increased knowledge by the general public. Community members will be aware of the signs and symptoms of diabetes and the need for a risk assessment test. This will lead to an increase in the desire to be screened. Depending on the results, patients will receive the referrals needed.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health will partner with the Arkansas Department of Health's Diabetes Task Force, the American Diabetes Association of Arkansas, the Hometown Health Coalitions, the Arkansas Center for Health Improvement, and locations which support the BH community wellness centers.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development and the Print Shop. Additional resources will be needed to purchase educational and promotional materials.

**PERFORMANCE METRICS:**

The Diabetes Education Risk Assessment test will be available at all Community Wellness Centers and all screening events. 100% of patients scoring "at risk" will be offered a blood sugar screening at the Wellness Centers. Blood Sugar

screenings will be offered on a monthly basis at 10 access points. 2014 will serve as a baseline year for data collection on the number of blood sugar screenings and educational activities offered, with a goal of increasing numbers in subsequent years.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation and follow-up of this program.

**PROGRESS UPDATE:**

Metrics will be available on a monthly basis and the program will be updated on an annual basis throughout the assessment period.

# Baptist Health Medical Center – Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Smoking (Tobacco-Use Cessation)

**GOALS / OBJECTIVES:**

Promote smoking cessation within the hospital and at the community level

**STRATEGY #1:**

Implement a hospital-based tobacco education/cessation program

**ACTION STEP #1:**

Identify patients who smoke or use smokeless tobacco products from the nursing admission assessment.

**ACTION STEP #2:**

Order Tobacco Cessation Education from the Respiratory Care Department.

**ACTION STEP #3:**

Provide education on the harmful effects of using tobacco products and assess the patient's readiness to quit.

**ACTION STEP #4:**

Have identified patients sign a form to participate in the Arkansas Stamp Out Smoking initiative. Fax the form to the Arkansas Tobacco Quit Line (1-800-QUITNOW).

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Interventions are prompt, appropriate and cost effective to both the patient and the community to reduce the number of people who use tobacco products. The Stamp Out Smoking program matches assistance to patient needs, including education, support, nicotine gum and patches.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- Little Rock will work with the Arkansas Stamp Out Smoking program.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Nursing staff will be needed to identify patients who use tobacco products. The Team Leaders and Patient Care Coordinators in the Respiratory Care department will be trained to educate patients and assess their readiness to discontinue use of tobacco products. The Director of the Respiratory Care department will coordinate the service and review outcomes.

**PERFORMANCE METRICS:**

The annual goal is to educate and assess readiness of at least 70% of identified patients prior to discharge. All patients who choose to be referred will be referred. Referral outcomes will be monitored via data provided by the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This pilot will last approximately one year (2014). Evaluation will be made after the first year to determine the continuation of the program for 2015 and 2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Nursing - Jill Massiet

Respiratory Care - Shelly Brown

**PROGRESS UPDATE:**

Progress will be reviewed at the end of the year (2014).

**STRATEGY #2:**

Implement a Smoking Cessation Referral Program in the Community Wellness Centers.

**ACTION STEP #1*:***

Identify individuals who utilize tobacco products during health history assessment at the Wellness Centers.

**ACTION STEP #2:**

Provide individuals with information regarding the Arkansas Tobacco Quitline Program. Upon a patient's acknowledgement of desire to discontinue tobacco utilization, the Community Education nurse will ask the patient to consent to have the Arkansas Tobacco Quitline contact them via the HIPAA Compliant Referral Form.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Patients will become aware of the risk of tobacco use and the resources available to assist them in quitting.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The Baptist Health Community Outreach Department will partner with the Arkansas Department of Health, the Coalition for Tobacco Free Arkansas, and locations which support the BH community wellness centers.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to implement this project include staff from the following departments: Community Outreach Department, Strategic Development and the Print Shop. Additional resource will be utilized to purchase items such as Carbon Monoxide monitors and educational materials.

**PERFORMANCE METRICS:**

The goal is to provide referral information for tobacco cessation intervention to 100% of all identified tobacco users, which will be recorded in the patient's Wellness Center file. Referral outcomes will be monitored via data provided by the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Baptist Health Community Outreach – Community Wellness Center Education Nurses

**PROGRESS UPDATE:**

Progress will be reviewed on a monthly basis and reported on the Community Wellness Center's Monthly Health Service Report throughout the assessment period.

# Baptist Health Medical Center – Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #4 – Obesity

### GOALS / OBJECTIVES:

Increase opportunities to participate in activities that promote good nutrition and physical activity in maintaining health and reducing obesity.

### STRATEGY #1:

Expand the Community Walking Program

### ACTION STEP #1:

Enhance Baptist Health's partnership with the City of Little Rock by offering to make the Community Walking Program available at ten (10) of its public facilities through the Parks and Recreation department.

### ACTION STEP #2:

Provide free BMI assessments at ten (10) of the Baptist Health Community Wellness Centers.

### ACTION STEP #3:

Offer one educational classes annually at four (4) Little Rock community centers, focusing on healthy eating and physical fitness.

### DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Enrollment will increase, providing increased opportunity for exposure to learning how to prepare healthy meals and the benefits of adding exercise to their daily lives.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The collaboration with the City of Little Rock will offer a wider base for promoting not only the Community Walking program but also services offered at the Community Wellness Centers, which are hosted at a number of different churches and community centers. These initiatives will aid in increasing awareness and reducing the numbers of overweight and obese adults.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources needed to implement this program include staff from the following departments: Community Outreach, Nutrition and Food Services, the Fitness Center, and Strategic Development. Educational materials will be provided and incentives will also be purchased by the hospital.

**PERFORMANCE METRICS:**

The goal is to increase the number of adults enrolled in the Community Walking Program by 25% compared to 2013.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

The program duration is one year (2014), but enrollment/re-enrollment is conducted annually (2015-2016).

**PERSON / DEPARTMENT RESPONSIBLE:**

The Community Outreach department will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Expand the We Can CATCH Kids Club Program

**ACTION STEP #1:**

Partner with the Boys and Girls Club of Central Arkansas.

**ACTION STEP #2:**

Partner with the City of Little Rock's Summer Playground Program.

**ACTION STEP #3:**

Implement the We Can Catch Kids Program in the Little Rock School District. Investigate implementation in Benton, Bryant and Sheridan.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Studies show that regular physical activity in children and adolescents promotes health and fitness. Compared to those who are inactive, physically active youth have higher levels of cardio respiratory fitness and stronger muscles. The We Can Catch kids program will address the growing concerns of childhood obesity by educating children and families on the benefit of good nutrition and exercise.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health will partner with the Little Rock School District, the Boys and Girls Clubs of Arkansas, the City of Little Rock, Arkansas Department of Health and potentially schools and community groups in Benton, Bryant and Sheridan.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development, Print Shop, Nutrition and Food Services and the Fitness Center. Additional resources will be utilized to purchase promotional and educational materials.

**PERFORMANCE METRICS:**

The goal is to provide sessions at three (3) sites in 2014. Additional goals will be determined for 2015-2016 once the baseline year (2014) is complete.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Community Outreach department will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY # 3:**

Promote Healthy Eating and Active Living to Reduce the Prevalence of Obesity.

**ACTION STEP #1:**

Provide support for the Arkansas Coalition against Obesity and the statewide goals. Baptist Health will participate in planning and implementation of initiatives, as applicable.

**ACTION STEP #2:**

Provide nutrition and physical activity education to the community through educational programs at Baptist Health wellness centers, special events and community health fairs. Social media, the Baptist Health Web-site and television interviews will also be utilized to promote Healthy Eating and Active Living.

**ACTION STEP #3:**

Pilot the Sister to Sister: Move More, Eat Better program at one new community center in 2014. The program targets African American women and promotes increased physical activity and adopting health eating habits.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

A comprehensive approach to educating the community about the hazards of obesity through participation in programs and attendance at educational classes will help them make better choices.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health will partner with the Arkansas Department of Health, Hometown Health Coalitions, and the City of Little Rock.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this project include staff from the following departments: Community Outreach, Occupational Health, Strategic Development, Nutrition and Food Services and the Fitness Center. Additional resource will be utilized to purchase promotional and educational materials.

**PERFORMANCE METRICS:**

The Sister to Sister: Move More Eat Better program will show annual improvement in participant data from pre and post-tests to demonstrate knowledge gained.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

The Community Outreach department will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #5 – Lack of a Primary Care Physician

**GOALS / OBJECTIVES:**

Increase the number of people living in the identified counties of Pulaski, Saline and Grant that have access to a Primary Care Physician.

**STRATEGY #1:**

Work with Practice Plus and Arkansas Health Group to increase the number of Primary Care physicians in Pulaski, Saline and Grant counties.

**ACTION STEP #1*:***

Support Practice Plus/AHG physician recruiting efforts for Pulaski, Saline and Grant counties with physician recruiters.

**ACTION STEP #2:**

Provide Baptist Health Healthline patient referral and scheduling for primary care practices.

**ACTION STEP #3:**

Provide specialty support via the Baptist Health network of physicians to primary care physicians.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

By providing increased physician coverage throughout the identified three-county area, primary care services will be more accessible, improving continuity of care.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- Little Rock will continue its partnership with Community Health Centers of Arkansas to provide access to Primary Care Physicians. Baptist Health Medical Center- Little Rock will also collaborate with Arkansas Health Group and Practice Plus to identify physicians who may be willing to volunteer their time and services in free clinics in the identified three-county area. Communication with the free clinics in these areas will identify the needs of each clinic and what resources Baptist Health may be able to provide.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Physician time will be needed. Additionally, grant money could be used to fund needed medications for these patients and possibly to reimburse physicians for their time.

**PERFORMANCE METRICS:**

Contacts with potential primary care physician candidates and numbers of physicians recruited will be tracked on a quarterly basis.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

The project will be ongoing.

**PERSON / DEPARTMENT RESPONSIBLE:**

Practice Plus/Arkansas Health Group – Will Rusher

Baptist Health Healthline – Mark Lowman/Cara Wade

Baptist Health Network Development – Leila Dockery

**PROGRESS UPDATE:**

Status will be updated annually.

**STRATEGY #2:**

Collaborate with Jefferson Comprehensive Care System, Inc. (JCCSI), one of the Community Health Center (CHC) networks affiliated with Baptist Health, to re-open the Little Rock Community Health Center. CHCs are 501(c)3 Healthcare Organizations which provide or make provisions for primary medical, dental, mental health, pharmacy, preventive, and support services to uninsured and underinsured individuals, as well as to those who are covered by Medicare, Medicaid, and private insurance. The service area for JCCSI includes Jefferson, Cleveland and Pulaski Counties. JCCSI operates two clinics in Pulaski County currently – one at College Station and one for the homeless on MLK Drive.

**ACTION STEP #1:**

Assist in the recruitment of provider staffing for the clinic. Provider staff could be employed directly by JCCSI or by contract through AHG/Practice Plus.

**ACTION STEP #2:**

Develop a process for referral of patients without a PCP from BH Emergency Rooms to the clinic for ongoing primary care in a more appropriate setting.

**ACTION STEP #3:**

Assist with funding of the Community Health Centers of Arkansas, which supports the Jefferson Comprehensive Care System, Inc.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

By providing a new point of access for primary care, individuals with little or no health insurance coverage will have a healthcare home and receive ongoing preventive and primary care as well as access to specialty care as needed.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center – Little Rock will collaborate with JCCSI and AHG/Practice Plus to open the clinic and to identify additional resources which

may need to be provided. Doing so will need to be in full compliance with the requirements of the Health Resources and Services Administration, an agency of the United States Department of Health and Human Services.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

BH will accept referrals for outpatient tests/procedures as well as inpatient care as needed. BH will assist JCCSI in identifying specialty physicians to take referrals as needed. BH will provide other operational expertise as needed.

**PERFORMANCE METRICS:**

Provider staffing will be solicited in the first half of 2014. If obtained, numbers of patients, encounters, medication assistance, and other statistics will be reported monthly. Monetary contributions will be reported on the BH Form 990H.

**PROJECT LENGTH:**

The clinic will be a permanent, full-time operation.

**PERSON/DEPARTMENT RESPONSIBLE:**

CHC Affiliation – Leila Dockery

AHG/Practice Plus – Will Rusher

Community Outreach – Teresa Conner

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Medical Center – Little Rock

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-LR, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-LR clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-LR Implementation Plan.

**Diabetes (Death)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

**Infant Mortality** - This need is currently being addressed by various organizations including Baptist Health Medical Center - North Little Rock, the March of Dimes of Arkansas, Arkansas Department of Health and other local healthcare providers.

**Low Birth Weight** - This need is being addressed by the March of Dimes, the Arkansas Department of Health and other local healthcare providers.

**Diabetes (Chronic Conditions)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

**Hypertension** - This need is currently being addressed by the Arkansas Department of Health.

**Coronary Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

**PAP Test** - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program and other local healthcare providers.

**Stroke** - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

**Access to Healthy Food** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, the University of Arkansas Division of Agriculture and the Arkansas Department of Health.

**Cancer** - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition, the Prostate Cancer Foundation and other local healthcare providers.

**Arthritis** - This need is currently being addressed by the Arthritis Foundation of Arkansas.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care.

**Chronic Lower Respiratory** - Due to limited resources, this need will not be addressed at this time.

**Sexually Transmitted Infections** - This need is currently being addressed by the Arkansas Department of Health.

**Access to Recreational Facilities** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

**Excessive Drinking** - This need is currently being addressed by the Arkansas Department of Health and Human Services.

**Children with Single Parent Households** - This need are currently being addressed by the Arkansas Department of Health and Human Services.

**Poor or Fair Health Status** - Due to limited resources, this need will not be addressed at this time.

**Poor Physical/Mental Days** - This need is currently being addressed by the Arkansas Community Mental Health Centers.

**Percentage of Fast Food Restaurants** – This need is not an area of expertise for Baptist Health. Due to limited resources, this need will not be addressed at this time.

**Premature Death** - This need is currently being addressed by the Arkansas Department of Health.

**Violent Crime** - This need is currently being addressed by the City of Little Rock.

# BHMC-NLR
# Implementation Plans

# Baptist Health Medical Center – North Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Preventable Hospital Stays

### GOALS / OBJECTIVES:

Reduce excess readmission ratio to ≤ CMS goal. Readmission reductions focus will be on patients who have the highest risk for readmission. Due to limited resources and the current focus on these two conditions by CMS for purposes of reimbursement, BHMC-NLR plans to monitor the impact of these techniques and employ successful strategies into the future to include post-acute case management.

### STRATEGY #1:

Develop tools and support mechanisms, both inpatient and post hospital, to reduce inappropriate readmissions.

### ACTION STEP #1*:*

Adopt a Transition Model: After research of literature and networking with colleagues across the country, BHMC-NLR will adopt the Sutter Care Home Model, which includes Medication Management, Early Follow-up and Symptom Management.

### ACTION STEP #2:

Implement a Patient Assessment Tool/Questionnaire to determine reasons for readmission. Case Management Will Meet with Each Readmission

1. Did you understand your discharge instructions?
2. When was your follow up appointment?
3. Were you able to go to your appointment?
    a. If not, determine reasons, e.g., transportation, financial, scheduling, etc.

4. Determine knowledge of medications, e.g., use, taking as prescribed, new meds, getting them filled
5. Understanding signs and symptoms of their disease process and what to do when they occur.
6. Community services received and help at home.

**ACTION STEP #3:**

Establish a Care Partner: Nursing and Case Management will work with the patient and family to determine who will be a responsible partner in caring for the patient. The care partner role has been added to the communication board in each patient's room.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Through collaborative efforts, the following is expected:

1. Identify the patients who are the highest risk for readmission.
2. Patients and family will be educated with the appropriate follow up care instructions to prevent inappropriate readmission.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center- NLR is collaborating with area Home Health agencies to begin early patient education (within three days of discharge, when possible), and establish processes to seek medical attention without readmitting to an acute care setting.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Baptist Health Medical Center – NLR will provide staff from Nursing and Case Coordination as well as facility/equipment.

**PERFORMANCE METRICS:**

Reduce readmission ratio for identified groups to an index of less than 1.00, using CMS data and recommendations.

Reduce in-hospital readmission rate, rolling year, index and rate with national comparator (Data Source: American Data Network).

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

Baptist Health Community Outreach

Baptist Health Medical Center – NLR Nursing and Case Coordination.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Expand the Nursing Home/Hospital Liaison Committee to include other post-hospital providers.

**ACTION STEP #1*:***

Host meetings on a quarterly basis

**ACTION STEP #2:**

Identify problematic areas and practices and set in place effective and efficient standards to address these issues.

**ACTION STEP #3:**

Identify barriers to care which will prevent inappropriate readmissions from the nursing home to the hospital.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Post-acute care facilities will have improved processes to deal with potential patient health issues.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center North Little Rock will collaborate with nursing homes, LTACHs, acute rehabilitation centers, ambulance providers, and home health agencies to improve outcomes and reduce readmissions for identified patients.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Nurses, Case Coordination, Emergency Department personnel, pharmacists and hospitalists will be needed to participate in the quarterly meetings as well as identify areas for improvement.

**PERFORMANCE METRICS:**

A minimum of four meetings annually to discuss opportunities to improve patient outcomes and provider processes. Readmissions will be measured using CMS data.
Processes for tracking post-acute setting readmissions is currently being developed to identify which post-acute settings are readmitting more frequently and why. This will enable BHMC-NLR to work with these providers to reduce readmissions and improve patient outcomes.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Nursing Staff

Case Coordination

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #3:**

Community Based Flu Vaccination Program

**ACTION STEP #1*:***

Provide flu shots at Community Wellness Centers and targeted communities.

**ACTION STEP #2:**

Collaborate with the Arkansas Department of Health in their mass flu shot campaign.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Fewer people will contract the flu or will have milder symptoms.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center North Little Rock will collaborate with the Arkansas Department of Health.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to achieve this strategy include Baptist Health staff from Community Outreach and the Pharmacy.

**PERFORMANCE METRICS:**

Baptist Health will offer Flu shots at 10 Community Wellness Centers/Screening sites annually beginning in October 2014.

Baptist Health will participate in two Arkansas Department of Health Mass Flu Clinics beginning October 2014.

Baptist Health will track and record the number of vaccinations given at all events.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Community Outreach department will be responsible for the implementation, evaluation and follow up of the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – North Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetic Screening

**GOALS / OBJECTIVES:**

Promote diabetes awareness and education to increase diabetic screenings

**STRATEGY #1:**

Develop a diabetes awareness education campaign to build support and understanding among the general public regarding diabetes prevention, early detection and treatment methods.

**STRATEGY #2:**

Promote the Diabetic Risk Assessment Test to all patients entering the Community Outreach Wellness Centers.

**STRATEGY #3:**

Implement community-based diabetes education classes and screenings.

**STRATEGY #4:**

Offer A1C testing to Wellness Center patients who have a previous diagnosis of diabetes. Individuals found to have elevated levels will be offered care coordination by the Community Education Nurse.

**STRATEGY #5:**

Expand screening programs and services for high-risk groups: minorities, elders, tobacco users, caregivers, underinsured, and non-insured by targeted screening events.

**STRATEGY #6:**

Enhance school-based Diabetes education and screening.

**ACTION STEP #1*:***

Work with Strategic Development to develop an educational campaign to increase the awareness of Diabetes prevention, screening and management. The campaign will include mailers, web-site, social media and television.

**ACTION STEP #2:**

Provide counseling regarding nutrition, weight control, and appropriate physical activity to patients identified as having high risk factors for diabetes. Advise identified patients to have periodic future screening for diabetes.

**ACTION STEP #3*:***

Promote diabetes screenings and education classes. Quarterly diabetes educational programs will be implemented at various Community Wellness Centers that include an educational presentation component, healthy cooking demonstrations and physical activity.

**ACTION STEP #4:**

Offer participation in the community- based diabetes management program for all individuals identified and diagnosed as diabetic by a health care provider. The program will include reminders for patients to follow-up on their eye, foot and oral exams. Patients will also receive A1C and cholesterol screenings, if needed.

**ACTION STEP #5:**

Continue to partner with community churches, community groups and Hometown Health Coalitions in identified areas to increase the number of screenings and risk assessment tests provided for the identified population.

**ACTION STEP #6:**

Support the Arkansas Department of Health's initiative in expanding diabetes screening of targeted middle school children, along with their scoliosis screening. Assist in teaching diabetes prevention, risk factors, symptoms and the consequences of diabetes. Provide assistance in teaching students and school health providers, as needed.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The awareness of the diabetes epidemic and its severity will lead to an increased knowledge by the general public. Community members will be aware of the signs and symptoms of diabetes and the need for a risk assessment test. This will lead to an increase in the desire to be screened. Depending on the results, patients will receive the referrals needed.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health will partner with the Arkansas Department of Health's Diabetes Task Force, the American Diabetes Association of Arkansas, the Hometown Health Coalitions, the Arkansas Center for Health Improvement, and locations which support BH community wellness centers.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development and the Print Shop. Additional resources will be needed to purchase educational and promotional materials.

**PERFORMANCE METRICS:**

The Diabetes Education Risk Assessment test will be available at all Community Wellness Centers and all screening events. 100% of patients scoring "at risk" will be offered a blood sugar screening at the Wellness Centers. Blood Sugar

screenings will be offered on a monthly basis at 10 access points. 2014 will serve as a baseline year for data collection on the number of blood sugar screenings and educational activities offered, with a goal of increasing numbers in subsequent years.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation and follow-up of this program.

**PROGRESS UPDATE:**

Metrics will be available on a monthly basis and the program will be updated on an annual basis throughout the assessment period.

# Baptist Health Medical Center-North Little Rock

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Reduction of Infant Mortality

### GOALS / OBJECTIVES:

A decrease in the infant mortality rate by .5%

### STRATEGY #1:

Improve the overall health of newborns

### ACTION STEP #1:

Decrease non-medically indicated Early Elective Delivery (EED) deliveries before 39 weeks gestation to 7.5 %. Participate and follow the guidelines developed by the Arkansas Foundation for Medical Care.

### ACTION STEP #2:

Provide Critical Congenital Heart Disease (CCHD) screening for 100% of non-transferred newborns. Pulse oximetry readings of the right hand and foot will be done between 24-48 hours of birth. Screening criteria will follow guidelines developed in collaboration with Arkansas Children's Hospital and the University of Arkansas for Medical Science.

### ACTION STEP #3:

Give Tetanus, Diphtheria and Pertussis (Tdap) and Measles, Mumps and Rubella (MMR) immunizations to postpartum patients. Following the recommendation of the CDC, all postpartum mothers who did not receive a Tdap during pregnancy will be offered and encouraged to receive the vaccination immediately after delivery. All rubella non-immune patients will be offered and encouraged to receive an MMR. Goal is to offer immunization for Tdap and MMR to 100% of non-immunized post-partum patients.

**ACTION STEP #4:**

Provide the Neonatal Car Seat Screening/and Angel Tolerance Test for 100% newborns that meet the following criteria: less than 37 weeks gestation, less than 5 pounds or discharging on oxygen or an apnea monitor.

**ACTION STEP #5:**

Provide breastfeeding support services to include: prenatal education on breastfeeding; access to a Lactation Consultant; outpatient consultations; and onsite breast pump rentals. Improve percentage of newborns exclusively fed breast milk during hospitalization by 5%.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Newborn health will be improved by decreasing risk of premature birth with the EED Program. Screening for CCHD and positional hypoxia will lead to the provision of early treatment. Immunizations of the mother will lower the risk of communicable diseases to the newborn. Breast fed newborns will have greater immunity through their mother's immunoglobulins.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center-North Little Rock will collaborate with the Arkansas State Health Department and OB/GYNs in the communities served.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Baptist Health Medical Center- North Little Rock will provide nursing staff and Lactation Consultants.

**PERFORMANCE METRICS:**

Early Elective Delivery percentage is monitored quarterly through the BHMC-NLR internal Quality Department as well as the VHA and March of Dimes. The goal is to decrease to 7.5 % by December 2014.

Non- transferred newborns receive CCHD screenings. Data will be measured through the BHMC-NLR electronic medical record (EMR). The goal is to achieve 100% by December 2014.

The Angle Tolerance Test is given to select newborns. Data will be measured through the BHMC-NLR electronic medical record (EMR). The goal is to test 100% of newborns meeting criteria by December 2014.

The Arkansas Medicaid program measures the 100% Exclusive Breastfeeding and provides reports. The goal is to improve by 5% by the final quarter of 2014.

Postpartum immunizations will be monitored internally by data collected in the EMR. The goal will be to offer Tdap and MMR immunization to 100% of non-immunized mothers by December 2014.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Medical Center North Little Rock Women's Center Staff.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Promote Perinatal and Well Baby Care Education in the Community

**ACTION STEP #1:**

Utilize the Heaven's Loft Wellness Center Program to provide perinatal and infant care education and resources to clients, utilizing a voucher incentive component to reward expectant and new mothers for attendance and participation.

**ACTION STEP #2:**

Screen expectant mothers for potential issues in relation to hypertension and gestational diabetes on a weekly basis.

**ACTION STEP #3:**

Provide two school-based perinatal and well-baby care educational classes in the North Little Rock School District.

**ACTION STEP #4:**

Conduct outpatient prenatal classes

**ACTION STEP #6:**

Identify new and expectant mothers who smoke. Provide individuals with information regarding the Arkansas Tobacco Quitline Program. Upon the patient's acknowledgement of desire to discontinue tobacco utilization, the Community Education nurse will make the appropriate referral to the Arkansas Tobacco Quitline and/or others resources. The process will be implemented weekly on an annual basis.

**ACTION STEP #7:**

Provide one immunization clinic annually for children during National Immunization Month

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Women of childbearing age and expectant mothers participating in the programs will be educated on healthy preconception behaviors and the importance of medical care for a healthy pregnancy. Mothers will be educated on the impact of smoking, drugs, appropriate weight gain, folic acid, preterm labor, and other factors that affect infant mortality. Mothers will be educated on the importance of breast feeding, well baby care and routine immunizations for the lifelong health of their infant.

**DESCRIBE COLLABORATIONS WITH OTHER HOSPITALS AND COMMUNITY ORGANIZATIONS:**

Baptist Health will collaborate with the Arkansas Department of Health, Obstetricians, Pediatricians, Family Practice Physicians, the Crisis Pregnancy Center Program, the Cooperative Extension Program of the University of Arkansas, the United Way of Arkansas, Community Churches, Rhea Lana Events, as well as surrounding school districts.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEED:**

The resources needed to implement this project include staff from the following Baptist Health departments: Community Outreach and Baptist Health Medical Center North Little Rock Women's Center, Strategic Development, and the Print Shop. Additional resources will be used to purchase educational and promotional materials, as well as newborn care items.

**PERFORMANCE METRICS:**

Two school based prenatal educational classes will be held at Jacksonville High School.

One Immunization clinic will be held at the Heaven's Loft Wellness Center. The number of immunizations and participants will be tracked and reported.

The number of expectant mothers referred to the Tobacco Quit Line on a weekly basis will be tracked and reported on a monthly basis.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

The projects will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation, and follow-up of the programs.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #3:**

Promotion of Infant Safety

**ACTION STEP #1:**

Provide infant CPR, Newborn Care, Childbirth Classes, and Safe Sitter Classes.

**ACTION STEP #2:**

Implement a Child Passenger Safety Program serving all mothers participating in the Heaven's Loft and the School-Based Prenatal Programs on an annual basis.

**ACTION STEP #3:**

Implement two Baby Safety Showers in English and Spanish for expectant and delivered mothers with babies less than 6 months of age. Provide safety items such as smoke alarms, cabinet latches, door handle safety knobs, bath thermometers and car seats. Promote safe infant sleep practices and prevention of shaken baby syndrome.

**ACTION STEP #4:**

Provide annual childhood immunizations for children during National Immunization Month

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Mothers will be educated on safe infant care and infant injury prevention, as well as learn how to properly install and use safety items provided.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center North Little Rock will collaborate with the Arkansas Department of Health Injury Prevention and Immunization Programs, Arkansas Children's Hospital, the Safe Kids Coalition, Bank of America (Grant), local Police

and Fire Departments, University of Arkansas for Medical Sciences Child Passenger Safety Program, the North Little Rock Health Department and North Little Rock Physicians.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALH NEED:**

The resources needed to implement this project include staff from the following Baptist Health department: Community Outreach, Baptist Health Medical Center North Little Rock, Strategic Development, and the Print Shop. Additional resources will be utilized to purchase baby safety items and car seats.

**PERFORMANCE METRICS:**

Two Safety Baby Shower classes will be held at Heaven's Loft. One will be in English and one in Spanish.

One Immunization clinic will be held at the Heaven's Loft Wellness Center. The number of immunizations and participants will be tracked and reported.

Fifty car seats will be provided annually as a part of the Child Passenger Safety program.

The number of car seats distributed.

The number of immunizations administered.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation, and follow-up of the programs.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Medical Center – North Little Rock

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-NLR, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-NLR clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-NLR Implementation Plan.

**Diabetes (Death)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

**Low Birth Weight** - This need is being addressed by the March of Dimes, the Arkansas Department of Health and other local healthcare providers.

**Diabetes (Chronic Conditions)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

**Hypertension** - This need is currently being addressed by the Arkansas Department of Health.

**Coronary Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

**PAP Test** - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program and other local healthcare providers.

**Stroke** - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

**Access to Healthy Food** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, the University of Arkansas Division of Agriculture and the Arkansas Department of Health.

**Cancer** - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition, the Prostate Cancer Foundation and other local healthcare providers.

**Arthritis** - This need is currently being addressed by the Arthritis Foundation of Arkansas.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care.

**Chronic Lower Respiratory** – This need was rated lower in the prioritization process, and due to limited resources will not be addressed at this time.

**Sexually Transmitted Infections** - This need is currently being addressed by the Arkansas Department of Health.

**Access to Recreational Facilities** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

**Lack of PCP** – The lack of PCP issue is currently being met by several free community clinics with the primary care issues addressing this concern in our market area. Limited resources also impact any initiative we may attempt.

**Obesity** - Currently the Arkansas Department of Health has a statewide Obesity Initiative

**Smoking** – The Arkansas Department of Health and the Stamp Out Smoking Initiative covers this area of concern.

**Premature Death** - This need is currently being addressed by the Arkansas Department of Health.

**Poor or Fair Health Status** - This need was rated lower in the prioritization process, and due to limited resources will not be addressed at this time.

**Poor Physical/Mental Days** - This need is currently being addressed by the Arkansas Community Mental Health Centers.

**Excessive Drinking** - This need is currently being addressed by the Arkansas Department of Health and Human Services.

**Violent Crime** - This need is currently being addressed by the City of North Little Rock.

**Children with Single Parent Households** - This need is currently being addressed by the Arkansas Department of Health and Human Services.

**Percentage of Fast Food Restaurants** - Due to limited resources and this need not being an area of expertise for BHMC-NLR, it will not be addressed at this time.

# BHMC-A Implementation Plans

# Baptist Health Medical Center – Arkadelphia

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Colorectal Screening

### GOALS / OBJECTIVES:

Increase the number of people who are educated about the importance of getting colorectal screenings.

Increase the number of screenings provided locally to identify health issues earlier.

### STRATEGY #1:

Promote colorectal screenings with local county health department and area physicians on getting their patients screenings performed locally.

### ACTION STEP #1:

Provide brochures to physician practices and the local health department with information about colorectal screenings available locally.

### ACTION STEP #2:

Provide information to the public at community events, health fairs, and civic group meetings throughout the county.

Community Events

- Arkadelphia Community Health Fair
- Cruising in the Park
- Ladies Night Out

Civic Groups

- Red River Baptist Association
- Alpha Kappa Alpha Sorority, Inc. - Chi Nu Omega Chapter

- Arkadelphia Lions Club
- Arkadelphia Rotary Club
- Arkadelphia Rotary Sunrise Club
- Gurdon Rotary Club
- La Primera Inglesia Bautista
- National Association for the Advancement of Colored People
- The Sunshine Service Club

**ACTION STEP #3:**

Advertise in local and service area newspapers on a quarterly basis.

**STRATEGY #2:**

Increase the number of days the hospital offers screenings from one to two per week.

**ACTION STEP #1:**

Recruit one more local physician to perform additional screenings within the next two years.

**ACTION STEP #2:**

Identify time slots with schedulers within the next year.

**ACTION STEP #3:**

Train additional staff to accommodate the increase in screenings.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Increase the number of colorectal screening performed at BHMC-Arkadelphia annually.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANZIATIONS:**

Partner with each of the medical practices in the service area.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources needed to implement these goals include educational materials for the community and hospital staff, facility and equipment.

**PERFORMANCE METRICS:**

The number of people educated at community events and the number of colorectal screenings performed at BHMC-A. With a goal of 5% more educated and 2% more colorectal screenings within 3 years.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Sheree Hendrix, Director of Nursing

Diane Duren, OR/OPS/GI Unit Manager

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Arkadelphia

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Mammography Screening

**GOALS / OBJECTIVES:**

Increase the number of women who undergo mammography screenings locally.

Increase the number of women who are educated about importance of getting mammography screenings performed as recommended by the American Cancer Society.

**STRATEGY #1:**

Promote mammography screenings with local county health department and area physicians on getting their patients screenings performed locally.

**ACTION STEP #1:**

Provide brochures to physician practices and the local health department with information about mammography resources available locally.

**ACTION STEP #2:**

Provide information to the public at community events, health fairs, and civic group meetings throughout the county.

Community Events

- Arkadelphia Community Health Fair
- Cruising in the Park
- Ladies Night Out

Civic Groups

- Red River Baptist Association
- Alpha Kappa Alpha Sorority, Inc. - Chi Nu Omega Chapter
- Arkadelphia Lions Club
- Arkadelphia Rotary Club
- Arkadelphia Rotary Sunrise Club
- Gurdon Rotary Club
- La Primera Inglesia Bautista
- National Association for the Advancement of Colored People
- The Sunshine Service Club

**ACTION STEP #3:**

Advertise in local and service area newspapers on a quarterly basis.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

An increase in the number of mammography screenings performed locally that will increase/improve breast cancer survival rates in the service area.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Partnerships with the Arkadelphia Medical Clinic, Baptist Health Family Clinic Gurdon, Compassions Women Clinic, Arkadelphia's Women Clinic, Clark County Health Department, and other local physicians in the service area.

**DESCRIBE RESOURCES HOSPITALS PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources needed to address this health need include brochures, scripts for various types of outreach, employee staff time, and display on mammography screening.

**PERFORMANCE METRICS:**

The number of mammograms performed at BHMC-Arkadelphia. 2014 will be the baseline with a goal of 5% increase per year in 2015 and 2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

David Hennessee – Radiology

Sheree Hendrix – Director of Nursing

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Arkadelphia

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Stroke

**GOALS / OBJECTIVES:**

Improve the community's awareness on stroke prevention and the warning signs/symptoms.

**STRATEGY #1:**

Promote stroke awareness in the service area.

**ACTION STEP #1:**

Post signage throughout the community and county.

- Exxon, 3036 Pine St, Arkadelphia, AR
- Citgo – Smithpeters Station, 410 South Front Street, Gurdon, AR
- Baptist Health Medical Center – Arkadelphia, Emergency Department
- Local physician offices

**ACTION STEP #2:**

Promote stroke awareness by participating in various community events such as Relay for Life and providing monthly presentations to local civic groups, churches and organizations.

**ACTION STEP #3:**

Provide hospital staff education about stroke through in-service and "ACT FAST" reminder cards attached to their badges.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Early recognition and intervention of stroke signs and symptoms resulting in better health outcomes for people affected within the service area.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

UAMS Outreach Telehealth

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Educational materials and equipment used for presentations. Staff time for training in Nursing Administration, Routine Nursing, and Emergency Department.

**PERFORMANCE METRICS:**

The number of presentations made at community events.

The number of people who received stroke awareness through community presentations.

2014 will be the baseline year with goals sets in 2015 and 2016 based on initial year data.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will have an initial timeframe for community event and education preparation of six months. This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Stephen Sanford, Emergency Room Manager

Sheree Hendrix, Director of Nursing

Steve Maxwell, ER/Ambulance Director

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Medical Center – Arkadelphia

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-A, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-A clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-A Implementation Plan.

**Lack of PCP's** - This is currently being addressed by other means within the community through recruiting efforts by AHG/Practice Plus.

**Hypertension** - This need is included within our Stroke plan.

**Diabetes** - This need is addressed by other facilities and/or organization in the community by AllCare Pharmacy.

**Sexual Transmitted Infections** - This need is being addressed through our local health unit, and college on-campus health units.

**Obesity** - This need is being address through the community "Healthier Clark County" campaign. A brochure is distributed through our local health department and schools within the county covering various activities promoting physical exercise.

**Asthma** - Low priority assigned to the need based on the criteria used by BHMC-A.

**Arthritis** - Low priority assigned to the need based on the criteria used by BHMC-A.

**Poor Physical Health** - This need is being addressed through the community "Healthier Clark County" campaign. A brochure is distributed through our local health department and schools covering various activities promoting physical exercise.

**Fast Food Restaurants** - Lack of expertise or competency to effectively address the need.

**Single Parent Households** - Due to lack of expertise or competency to effectively address the need, this need will not be addressed by BHMC-A at this time.

**Uninsured** - Due to limited resources this need will not be addressed by BHMC-A at this time. Also, this need is addressed by the community "Free Health Clinic".

# BHMC-HS
# Implementation Plans

# Baptist Health Medical Center – Heber Springs

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Prostate Screening

**GOALS / OBJECTIVES:**

Raise awareness in the community about prostate cancer and the importance of screening.

**STRATEGY #1:**

Develop a prostate cancer awareness campaign utilizing Arkansas Prostate Cancer Foundation.

**ACTION STEP #1*:*** Include information about the importance of prostate screenings in various primary healthcare provider promotions and at community wellness centers.

**ACTION STEP #2** Host educational sessions about prostate health for the community.

**ACTION STEP #3:** Participate in Prostate Awareness Month (September) annually by offering discounted prostate screening and providing information through social and local media, Baptist Health websites, and in local primary care offices throughout the next three years.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The community will take advantage of educational opportunities provided and participate in prostate screenings. The number of prostate screenings will increase by 5% each year after the established baseline year of 2014.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHMC-HS will collaborate with the following:
Heber Springs Community Center
Baptist Health Strategic Development
Arkansas Urology
Local Primary Care Providers

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to implement this strategy will include staff from the following Baptist Health departments: Baptist Health Medical Center Heber Springs, Strategic Development, the BHMC-HS Auxiliary, and the Print Shop.

**PERFORMANCE METRICS:**

An internal database/data file will be built to document and track the number of prostate cancer screenings performed at BHMC-HS and the number of attendees at the educational sessions. 2014 will be the baseline year with a goal set of +5% for prostate screenings and session attendees in subsequent years of 2015 and 2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

Community Outreach Nurse.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Establish an on-going community prostate screening program.

**ACTION STEP #1**:

Collect information about each person screened as a result of the outreach and education in strategy #1.

**ACTION STEP #2:**

Create a log or report of all prostate screenings and organize a process to notify the recipients of their recommended follow-up dates.

**ACTION STEP #3:**

Send reminders to each person screened in the Community Outreach Program as described in Strategy #1 when it is time to have their next screening.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The community will take advantage of educational opportunities and have regular prostate screenings during this assessment period. The number of prostate screenings will increase by 5% each year after the established baseline year of 2014.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHMC-HS will collaborate with the following: Heber Springs Community Center; Baptist Health Strategic Development; Arkansas Urology and local primary care providers.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

The resources needed to implement this strategy will include staff from the following Baptist Health departments: Baptist Health Medical Center Heber Springs, Strategic Development, the BHMC-HS Auxiliary, and the Print Shop.

**PERFORMANCE METRICS:**

- The number of prostate cancer screenings performed during this assessment period.
- The number of reminder cards sent during this assessment period.

An internal database/data file will be built to document and track the number of prostate cancer screenings performed during the annual assessment periods (2014, 2015 and 2016) and the number of reminder cards sent. 2014 will be the baseline year with a goal set of +5% for prostate screenings and session attendees in subsequent years of 2015 and 2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Community Outreach Nurse

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Heber Springs

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Lack of PCP/No Personal Doctor

**GOALS / OBJECTIVES:**

Increase accessibility for those living in the Cleburne County area to Primary Care Physicians.

**STRATEGY #1:**

Investigate the feasibility of recruiting additional PCP's for the Cleburne County area, including OB/Gyns.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Increase availability of primary care resources in the Cleburne County area.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHMC-HS will collaborate with the following:
Baptist Health Strategic Development – utilizing results of PCP Outmigration Study which was conducted in 2012, promotion of primary care physician resources.
AHG/PP, BH Network Development – Potential physician recruitment
Chamber of Commerce – promote local clinics

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Recruit additional primary care resources.

Speakers

**PERFORMANCE METRICS:**

Number of physicians added during 2014-2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

BHMC-HS VP & Administrator

BH Practice Plus

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Investigate the possibility of increasing access to current primary care physicians in the Cleburne County area.

**ACTION STEP #1**:

Work with local PCPs to assess desire to utilize physician extenders (Nurse Practitioners, Physician Assistants, etc.) in current practices.

**ACTION STEP #2:**

Explore the need and options for extended clinic hours (nights, weekends)

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Increased availability of primary care resources in the Cleburne County area.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS**:

BHMC-HS will collaborate with the following: ARCare

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Staff to coordinate services, as needed.

**PERFORMANCE METRICS:**

Number of physician extenders added to local area practices during 2014-2016.
Number of physician offices to begin offering non-traditional office hours (evening clinics, Saturdays, etc.) during 2014-2016.

**PROJECT LENGTH/ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON/DEPARTMENT RESPONSIBLE**:

BHMC-HS VP & Administrator; AHG/PP

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY # 3:**

Provide additional points of access for underserved.

**ACTION STEP #1**

Free service through Christian Health Center.

**ACTION STEP #2**

Free transportation for tests, treatments.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The underserved of Cleburne County will have increased availability of primary care resources.

**PERFORMANCE METRICS:**

2014 will be the baseline year in which data will be collected in a database/data spreadsheet.

Each year (2014-2016) the dollar amounts of services provided at the Christian Health Center will be calculated and tracked.

Each year (2014-2016) the number of van transports to the Christian Health Center will be documented and tracked.

**PROJECT LENGTH/ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON/DEPARTMENT RESPONSIBLE**:

BHMC-HS VP & Administrator

Director of Nursing

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Heber Springs

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Diabetes

**GOALS / OBJECTIVES:**

Raise awareness in the Cleburne County area about the risk factors and effects of Diabetes.

**STRATEGY #1:**

Provide educational opportunities to the public in various settings.

**ACTION STEP #1*:***

Schedule annual community educational sessions at local wellness centers.

**ACTION STEP # 2:**

Provide diabetes education materials for programs and events.

**ACTION STEP #3**:

Explore opportunities to provide diabetes education to local civic groups and other non-profit organizations.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The community will have additional opportunities to be exposed to information regarding the risk factors for diabetes and prevention of diabetes.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHMC-HS will collaborate with the following:
Heber Springs Hospital Auxiliary
Heber Springs Community Center

Area Chambers of Commerce
Practice Plus / AHG Physician Groups
Christian Health Center
ARCare

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Hospital staff will organize and host educational events throughout the year, focusing on the areas of need identified via the community health needs assessment.

**PERFORMANCE METRICS:**

The number of people attending the educational sessions offered for 2014, 2015, 2016. An internal database/data file will be built to document and track the number of attendees at the educational sessions. 2014 will be the baseline year with a goal set of +5% for session attendees in subsequent years of 2015 and 2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Community Outreach Nurse

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Provide education to community members in need of diabetes management education

**ACTION STEP #1*:***

Provide diabetes education materials and screenings in the Community Wellness Centers, as well as referrals to PCPs when needed.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Members of the community in need of diabetes education and support will have the opportunity to receive materials, screenings and referrals to PCPs will have an on-going resource available to them through the Community Wellness Centers.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Locations for the Cleburne County Wellness Centers are provided by Waychoff Senior Center, Heber Springs and Renegar Apartments Community Room, Quitman.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Educator and teaching supplies.

**PERFORMANCE METRICS:**

- The number of people attending sessions at the Community Wellness Clinics in 2014, 2015, 2016.
- The number of people who received the risk assessment.
- The number of people who received a diabetes screening.
- The number of people referred to a PCP.
  An internal database/data file will be built to document and track 1-4 above. 2014 will be the baseline year with a goal set of +5% for all measures 1-4 above in subsequent years of 2015 and 2016.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

Community Outreach Nurse, Dietitian

**PROGRESS UPDATE:**

Progress to be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Medical Center – Heber Springs

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-HS, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-HS clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-HS Implementation Plan.

**Flu Shots** - This need is currently being addressed by the Cleburne County Health Department.

**Mammograms** - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, and the Arkansas Cancer Coalition.

**Colorectal** - Focusing limited resources on other needs due to low priority need assessment of this issue.

**High Cholesterol** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

**Smoking** - This need is currently being addressed through the Arkansas Department of Health "Stamp Out Smoking" program.

**Physical Activity** - Heber Springs/Cleburne County offers a wealth of opportunities for physical activities through its various community organizations, private businesses, area parks and recreation. Additionally, the Heber Springs Community Center is addressing these issues with various exercise equipment and classes, including an aquatics center with classes for the elderly and arthritic.

**Excessive Drinking** - This need is addressed by the Arkansas / Cleburne County Health Department, as well as the Cleburne County Chapter of Mothers Against Drunk Driving (MADD).

**Coronary Artery Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

**Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

**Arthritis** - This need is currently being addressed by the Arthritis Foundation of Arkansas.

**Poor or Fair Health Status** - Hometown health improvement is currently addressed by the Arkansas/Cleburne County Health Department.

**Low Birth Weight** - This need is being addressed by the March of Dimes, and the Arkansas/ Cleburne County Department of Health.

**Poor Physical /Mental Health Days** - This need is currently being addressed by the Arkansas/Cleburne County Health Department.

**Chronic Lower Respiratory** - Focusing limited resources on other needs due to low priority need assessment of this issue.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care.

**Access to Recreational Facilities** - Heber Springs/Cleburne County offers a wealth of opportunities for recreation through its various community organizations, private businesses, and area parks. Additionally, the Heber Springs Community Center is addressing these issues with various exercise equipment and classes, including an aquatics center with classes for the elderly and arthritic.

**No Personal Doctor** - This need is currently being met by several free community clinics with the primary care issues addressing this concern in our market area.

# BHMC-S Implementation Plans

# Baptist Health Medical Center – Stuttgart

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Smoking

**GOALS / OBJECTIVES:**

Promote the reduction/cessation of tobacco use within the hospital and in the community

**STRATEGY #1:**

Implement and promote a hospital-based tobacco education /cessation program

**ACTION STEP #1**

Identify patients who use tobacco products

Identification of patients who use tobacco products will be made utilizing the nursing admission process and assessment.

**ACTION STEP #2:**

Order tobacco cessation education

Tobacco cessation education will be ordered from the Respiratory Care department by the nurse for relevant patients

**ACTION STEP #3:**

Assess patient's readiness for cessation of tobacco products use by asking the patient if he or she has an interest in tobacco cessation or desire to stop using tobacco.

Provide education on the harmful effects that result from the use of tobacco products to those who express affirmatively that they have a desire to stop smoking or an interest in receiving the information.

**ACTION STEP #4:**

Identified patients will be provided a form to sign to participate in the Arkansas Stamp Out Smoking initiative. This form will be faxed to the Arkansas Tobacco Quit Line (1-800-QUITNOW)

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

To increase the number each year of patients who participate in education or sign up with the Stamp Out Smoking program. This approach is prompt, appropriate and cost effective for the patient, the community and the facility. The Stamp Out Smoking program will match assistance to quit to the individual patient's needs. The program includes education, support, nicotine gum and nicotine patches.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center-Stuttgart will work in collaboration with the Arkansas Stamp Out Smoking program and with Baptist Health Medical Center-Little Rock Respiratory Care Department.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Nursing staff will be utilized for the identification of patients for this initiative. The Respiratory staff will receive any needed training and the educational resources needed to provide as assessment on readiness to quit the use of tobacco products and to implement education on tobaccos harmful effects on the general health and well-being of patients. The Director or Team Leader will coordinate all services and monitor outcomes.

**PERFORMANCE METRICS:**

The goal for this initiative will be to identify, educate and assess the readiness to quit for a minimum of 70% of all patients admitted at Baptist Health Medical Center-Stuttgart prior to discharge. This data will be abstracted by our Quality department, reported through American Data Network and monitored by the

Respiratory Care department. The referral outcomes will be monitored thru the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Nursing - Susan Williams, CNO

Respiratory Care - Clay Brazeal and Shelly Brown, Director

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY #2:**

Implement Smoking Cessation education in the Fitness Center and market area

**ACTION STEP #1:**

Provide information and education through the Fitness Center and the Rural Health Clinic network for health benefits in Tobacco-Use Cessation

Educational information in the form of brochures and posters will be available in the fitness center and all Baptist Health- rural health clinics in Arkansas, Prairie and Monroe counties to promote Smoking/Tobacco-Use Cessation.

**ACTION STEP #2:**

Individuals who request information on tobacco cessation will be provided information

Individuals can request information on tobacco cessation at rural health clinic facilities and the Fitness Center.

**ACTION STEP #3:**

Refer individuals for needed assistance

Identified individuals will be provided a form to sign to participate in the Arkansas Stamp Out Smoking initiative. This form will be faxed to the Arkansas Tobacco Quit Line (1-800-QUITNOW)

**ACTION STEP #4:**

Complete two direct mailings annually in the market area, regarding tobacco cessation information.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Employees and other members of the community who utilize the Fitness Center and the Rural Health Clinic network will gain knowledge on the benefits of health in tobacco-use cessation and be aware of the resources available to assist them in quitting. The market area population will receive information on resources available for tobacco cessation.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR ANY COMMUNITY ORGANIZATION:**

Baptist Health Medical Center-Stuttgart Fitness Center will partner with the Arkansas Department of Health and the Coalition for Tobacco Free Arkansas.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEEDS:**

Resources that will be available include the Fitness Center and the rural health clinic staff, brochures and educational resource information from the Arkansas Department of Health and the Coalition for Tobacco Free Arkansas, Baptist Health Strategic Development, Baptist Health Community Outreach and Print Shop.

**PERFORMANCE METRICS:**

The goal is to provide referral information to all Fitness Center members for tobacco cessation at 70% of all identified tobacco users annually. The referral outcomes will be monitored through the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

Provide Tobacco Cessation information to 200 households in the defined market area annually. Data to support goal will be address roster for household mailed to be maintained annually.

**PROJECT LENGTH/ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON/DEPARTMENT RESPONSIBLE:**

Nursing - Susan Williams, CNO

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center – Stuttgart

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetes

**GOALS / OBJECTIVES:**

To promote the control of diabetes through raising awareness and knowledge of the benefits of regular exercise, good nutrition and healthy life styles.

**STRATEGY #1:**

Diabetes education will be provided for individuals with diabetes and those who are at risk for the development of diabetes.

**ACTION STEP #1*:***

Identify individuals at risk

Identification of individuals will be achieved through the nursing admission assessment, the Fitness Center application, physician clinic referral and Health Expo screenings.

**ACTION STEP #2:**

Provide comprehensive instruction for successful self-management

Educational/instructional sessions will include information on understanding diabetes, self-monitoring, and medications used to treat, avoiding complications, coping, proper med administration, safe exercise, and nutrition therapy.

**ACTION STEP #3:**

Assess knowledge level

The individual's knowledge will be assessed at the beginning and the completion of the program utilizing a standardized clinical form.

**ACTION STEP #4:**

Community events will be held during National Diabetes Awareness month.

**ACTION STEP #5:**

Complete two (2) direct mailings annually, in the market area regarding resources available for screening for diabetes and self-management of known diabetes.

**STRATEGY #2:**

Financial assistance will be provided to individuals identified with a qualifying need for medication, equipment and supplies.

**ACTION STEP #1:**

Individuals will be referred to on-site Medication Assistance Liaison to initiate application process.

**ACTION STEP #2:**

Individuals approved for assistance will receive medications and supplies at discounted price and glucometers free of charge.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Increased awareness, early screening and access to medication, glucometers and supplies will lead to better control of diabetes.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Medical Center-Stuttgart collaborates with Arkansas County Partners in Health to provide funding for grants that are used to provide diabetic self-management educational material. Baptist Health Medical Center-Stuttgart also partners with Greater Delta Alliance for Health in the Southeast Diabetes Initiative.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources will include Nutrition and Food Services staff, Registered Dietitian, Medical Social Worker, Medication Assist Liaison, Baptist Health Strategic Development, Print Shop and Baptist Health Community Outreach.

**PERFORMANCE METRICS:**

A 100% of all individuals identified through the process to be at risk or to have diabetes will be offered screenings, nutritional counseling and educational resources annually. Our goal includes providing 15 people with glucometers and 50 diabetic screening annually.

Provide diabetes information to 200 households in the defined market area as evidenced by 200 individual household mailings annually. A roster of household addresses that information is mailed to will be maintained annually.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Nutrition & Food Services - Regina McCormick, Dietitian

Nursing - Lee Long, Social Services

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Medical Center-Stuttgart

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Obesity

**GOALS / OBJECTIVES:**

Raise awareness of the importance of good nutrition and physical activity/exercise to prevent obesity and improve the general overall health quality of each individual.

**STRATEGY #1:**

Promote physical activity to prevent or reduce obesity through indoor walking programs for employees and exercise programs for employees and individuals in the community as defined for CHNA.

**ACTION STEP #1*:***

Hospital corridors will be marked with AHA START Walking Path markers

**ACTION STEP #2:**

Promote membership to fitness center

Allow for payroll deduction payments for membership and special rates for industry memberships that cover all employees

**ACTION STEP #3:**

Promote physical activity at different levels of physical ability through Fitness Center

Low to med level activity (aerobics), medium level activity (zumba) and high level activity (boot camp) will be held at different times throughout the year.

**STRATEGY #2**:

Provide information in rural health clinic regarding the community resources available for exercise

**ACTION STEP #1:**

Provide information regarding outdoor play areas, walking tracks and community outdoor activities at each rural health clinic location.

**ACTION STEP #2:**

Provide brochures and counseling on the benefits of exercise and good nutrition in each rural health clinic.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Increased participation in the stated exercise programs and use of recreational areas available in the area.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

Baptist Health Community Outreach Program Walking Program

Arkansas County Partners in Health

Arkansas Department of Health-Health Hometown Program-Obesity Coalition

American Heart Association Learn and Live START Walking Path

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Baptist Health Medical Center-Stuttgart will provide memberships at reasonable rates for employees, the general population and group membership rates for local industry. Payroll deduction is an option for BH employees to pay for membership. Other resources include Baptist Health Strategic Development, Print Shop and Baptist Health Community Outreach.

**PERFORMANCE METRICS:**

Promote Fitness Center activities to 5 companies in 2014.

Register 50 people to participate in virtual walking programs annually, beginning in 2014. Baptist Health Community Outreach Walking Program will capture the data of BHMC-S market area participants, as defined by the CHNA for community.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

Nutrition & Food Services - Regina McCormick, Dietitian

Nursing - Susan Williams, RN CNO

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Medical Center – Stuttgart

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-S, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-S clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-S Implementation Plan.

**Heart Disease** - This need is currently being addressed through the Arkansas Department of Health and the American Heart Association

**Cancer** - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition and the Prostate Cancer Foundation.

**Stroke** - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

**Chronic Lower Respiratory** - Due to limited resources we will not address this issue at this time. Other needs were prioritized as a greater need according to the process of the CHNA.

**Injury Related Deaths** - This need is currently being addressed by the Arkansas Department of Health through the Trauma Program.

**Premature Death** - This need being is currently being addressed by the March of Dimes.

**Low Birth Weight** - This need is being addressed by the March of Dimes and the Arkansas Department of Health.

**Poor or Fair Physical Health Status** - Due to limited resources and other needs at a higher priority for this community we presently not be addressing this need.

**Poor Physical & Mental Health Days** - Due to limited resources we will not address this issue at this time.

**Hypertension** - This need is currently being addressed by the Arkansas Department of Health.

**High Cholesterol** - This need is currently being addressed by the American Heart Association, the Arkansas Heart Association, and Baptist Health Medical Center-Little Rock.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care.

**Coronary Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association

**Arthritis** - This need is currently being addressed by the Arthritis Foundation of Arkansas.

**Physical Inactivity** - This need is currently being addressed by the Baptist Health Medical Center- Stuttgart Obesity Strategy.

**Sexually Transmitted Infections** - This need is currently being addressed by the Arkansas Department of Health.

**Excessive Drinking** - This need is currently being addressed by Mothers Against Drunk Drivers and Students Against Drunk Drivers.

**Teen Birth Rate** - This need is currently being addressed by the Arkansas Department of Health through the Family Planning program.

**Lack of Healthy Eating** - This need is currently being addresses by the University Of Arkansas Division Of Agriculture and the Arkansas Department of Health.

**Colorectal Screening** - This need is currently being addressed by the American Cancer Society and the Arkansas Cancer Coalition.

**Mammography** - This need is presently being addressed by the Susan G. Komen Foundation and the Arkansas Department of Health.

**PAP Test** - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program.

**Flu Shot** - This need is currently being addressed by the Arkansas Department of Health and Baptist Health

**HIV Test** - This need is currently being addressed by the Arkansas Department of Health.

**Preventable Hospital Stays** - This need is currently being addressed by the Arkansas Foundation for Medical Care

**No Personal Doctor** - This need is currently being addressed by community based Christian organizations for free health care in Dewitt and Stuttgart.

**Lack of PCP** - This need is currently being addressed by community based Christian organizations for free health care in Dewitt and Stuttgart.

**Uninsured** - Due to limited resources we will not address this issue at this time

**Inadequate Social Support** - Due to limited resources and the need not being in our area of expertise, we will not address this issue at this time.

**Children in Single-Parent Homes** - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

**Lack of Recreational Facilities** - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

**Percentage of Fast Food Restaurants** - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

**Diabetic Screening** – This need is currently being addressed by the Arkansas Department of Health and the American Diabetes Association.

# BHRI Implementation Plans

# Baptist Health Rehabilitation Institute

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Stroke Prevention

### GOALS / OBJECTIVES:

Increase the number of people who are educated about the dietary and lifestyle patterns which increase the risk for strokes. Increase the number of people who are educated about the early warning signs of stroke and understand the appropriate action to take when these occur.

### STRATEGY #1:

Promote healthy eating and lifestyle/exercise choices aimed at reducing the risk factors for stroke as well as recognition of early signs of stroke.

### ACTION STEP #1:

Increase Baptist Health's partnership with churches and community organizations by involvement in health and wellness fairs and other educational opportunities.

### ACTION STEP #2:

Create a brochure including information on stroke prevention; early warning signs and resources such as support groups, caregiver assistance, therapy options, etc. for those who have experienced a stroke and provide those free of charge to community programs and events as well as other entities specializing in aged adult care in Baptist Health communities.

### DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Individuals attending BHRI Education events or reading the Stroke Education Brochure will be exposed to dietary and other lifestyle choices to decrease the risk for stroke as well as stroke early warning signs and the importance of urgent response to these signs.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The collaboration will be with churches, free clinics and adult day cares to increase stroke prevention and stroke treatment awareness in Baptist Health communities.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources needed to implement this program include staff from the following departments: Community Outreach, BHRI Stroke Program Team, BH Fitness Center and Strategic Development. Education materials will be provided by BHRI.

**PERFORMANCE METRICS:**

The goal is to present the "Stroke prevention" program to at least six (6) community groups or organizations in 2014 (baseline year). Goals for 2015 and 2016 will be determined from the baseline year data.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

BHRI Stroke Team will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Program progress will be reviewed annually.

# Baptist Health Rehabilitation Institute

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Injury Prevention

### GOALS / OBJECTIVES:

Increase the number of people who are educated about the lifestyle and activity choices which may lead to Brain Injury and/or Spinal Cord Injury. Increase the number of people who are educated about how to minimize fall risks in their homes.

### STRATEGY #1:

Promote lifestyle and home arrangement choices to decrease the likelihood of traumatic brain and spinal cord injuries as well as the likelihood of falls within the home.

### ACTION STEP #1:

Increase Baptist Health's partnership with Middle Schools and High Schools in Baptist Health communities presenting the "Think First" Spinal Cord and Brain Injury Prevention Program.

### ACTION STEP #2:

Provide "Fall Prevention in the Home" presentations and literature to, community programs and events as well as and other entities specializing in aged adult care in Baptist Health communities.

### DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Individuals attending the "Think First" presentations will have education on the consequences of traumatic brain and spinal cord injuries and have an understanding of ways to improve the likelihood of prevention of these through lifestyle choices. Individuals attending the "Fall Prevention" presentations or

reading the associated literature receive education regarding the actions to take to reduce the risk of falls in their homes.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The collaboration will be with community groups and entities specializing in aged adult care to provide information on injury prevention in Baptist Health.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this program include staff from the following departments: Community Outreach, The BHRI Think First and Fall Prevention Coordinator, Baptist Health Fitness Center, BHRI Physical and Occupational Departments and Strategic Development Educational Materials will be provided by BHRI.

**PERFORMANCE METRICS:**

Our first year goal is to present the "Think First" Injury Prevention Program to at least four (4) schools in 2014 (baseline year). We also want to present the "Injury Prevention in the Home" to at least four (4) community groups or organization in 2014. Goals for 2015 and 2016 will be determined from the baseline year data.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

BHRI "Think First" and "Fall Prevention" Coordinator will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

# Baptist Health Rehabilitation Institute

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #3 – Obesity

**GOALS / OBJECTIVES:**

Increase the number of children and adults that understand the importance of good nutrition and physical activity in maintaining health and reducing obesity.

**STRATEGY #1:**

Promote Healthy Eating and Active Living to Reduce the Prevalence of Obesity.

**ACTION STEP #1:**

Work with Employers through Community Outreach's Corporate Wellness program to promote physical activity among employees during the work day.

**ACTION STEP #2:**

Provide nutrition and physical activity education to the community through educational programs at Baptist Health wellness centers, special events and community health fairs, churches and private businesses. Social media, the Baptist Health Web-site and television interviews will also be utilized to promote Healthy Eating and Active Living.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

A comprehensive approach to educating the community about the hazards of obesity through participation in programs and attendance at educational classes will help them make better choices.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHRI will partner with the Arkansas Department of Health, Hometown Health Coalitions, the City of Little Rock, Strategic Development and Corporate Partners.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development, Nutrition and Food Services and the Fitness Center. Additional resource will be utilized to purchase promotional and educational materials.

**PERFORMANCE METRICS:**

The goal is present the "healthy eating and active living" program to at least six (6) groups or organization in 2014 (baseline year) to reduce the prevalence of obesity. Goals for 2015 and 2016 will be determined from the baseline year data.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The Fitness Center and Community Outreach department will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

**STRATEGY # 2:**

Promote behavioral change in obese and morbidly obese adolescents.

**ACTION STEP #1:**

Obtain funding to conduct a summer adolescent weight loss program.

**ACTION STEP #2:**

Identify adolescents who are obese or morbidly obese and enroll them in the Baptist Health Adolescent Weight Loss Program. Have parents sign participation forms which will define expectation for participants and their families.

**ACTION STEP #3:**

Implement the program, which includes a curriculum of education, physical activity, socialization and reward.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

The Adolescent Weight Loss Program will involve the family unit in understanding and addressing the health risks of the participants through education, physical activity and reward. Additional medical and mental health service referrals will be provided, as needed.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

BHRI will work with the BHMC-LR Health Management Center, the Baptist Health Weight Loss Program and Community Outreach will partner with the Little Rock School District and the North Little Rock School District to identify candidates for participation.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this project include staff from the following departments: BHRI Fitness Center, Health Management Center, BH Weight Loss Program, Community Outreach, Strategic Development, Print Shop, Nutrition and Food Services and the Fitness Center. The pool at BHRI will be used weekly to provide low impact exercise for these adolescents. Additional resources will be needed to purchase promotional and educational materials.

**PERFORMANCE METRICS:**

The goal is to sign up at least ten (10) adolescents to the weight loss program in 2014 (baseline year). The hope is they will lose weight and improve other health metrics, compared to baseline measures. Goals for 2015 and 2016 will be determined from the baseline year data.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

The project will last 10 weeks, during the summer 2014. Project will also be held in 2015 and 2016.

**PERSON / DEPARTMENT RESPONSIBLE:**

The BHRI Fitness Center in conjunction with the Health Management Center and the BH Weight Loss Program will be responsible for implementing and evaluating the program.

**PROGRESS UPDATE:**

Progress will be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Rehabilitation Institute (BHRI)

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHRI, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHRI clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHRI Implementation Plan.

**Diabetes (Death)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

**Diabetes (Chronic Conditions)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

**Hypertension** - This need is currently being addressed by the Arkansas Department of Health. We will focus our limited resources on the other needs identified.

**Coronary Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care.

**Chronic Lower Respiratory** - Due to limited resources we will not address this issue at this time and will focus on the other prioritized needs identified in our assessment.

**Access to Recreational Facilities** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

**Smoking** - The Arkansas Department of Health and the Stamp Out Smoking Initiative covers this area of concern.

**Mammography** - This need is being addressed by the Arkansas Department of Health, the University of Arkansas for Medical Sciences Cancer Control Outreach Center and the Komen Foundation of Arkansas.

**Poor or Fair Health Status** - Due to limited resources, this need will not be addressed at this time.

**Poor Physical/Mental Days** - This need is currently being addressed by the Arkansas Community Mental Health Centers.

**Colorectal Screening** - This need is being addressed by the Arkansas Cancer Coalition and the University of Arkansas for Medical Sciences Cancer Control Outreach Center.

**Percentage of Fast Food Restaurants** – This need is not an area of expertise for Baptist Health. Due to limited resources, this need will not be addressed at this time.

# BHECH Implementation Plans

# Baptist Health Extended Care Hospital

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #1 – Stroke Prevention

**GOALS / OBJECTIVES:**

Increase the number of BHECH stroke patients who receive information regarding the dietary, lifestyle and medication management patterns which increase the risk for secondary strokes. Increase the number of patients and their family members who can recognize the early warning signs of stroke and are aware of the appropriate action to take when these occur.

**STRATEGY #1:**

Promote risk reduction behaviors aimed at reducing the risk factors for secondary stroke, as well as recognition of early signs of stroke.

**ACTION STEP #1:**

Develop a secondary stroke prevention template for individualized instruction on diet, activity and medication management to mitigate risk factors for secondary stroke.

**ACTION STEP #2:**

Provide all patients/caregivers with the Community Resource Manual at the time of discharge to provide resources that will assist patients and their caregivers in reducing stroke risk.

**ACTION STEP #3**:

Participate in the Hospital/Nursing Home Liaison Committees at BHMC-Little Rock and BHMC-North Little Rock. Act as a resource related to stroke prevention and treatment. Provide copies of the Community Resource Manual to area nursing

homes to assist them in providing programs and resources for their clients and families.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Patients and families of Baptist Health Extended Care Hospital and nursing home representatives will receive information regarding dietary and other lifestyle choices to decrease the risk for stroke, stroke early warning signs and the importance of urgent response to these signs, as well as community resources available to them in the area of stroke prevention.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The collaboration will initially be with BHRI, BHMC-LR, BHMC-NLR, area community groups, and nursing homes to increase secondary stroke prevention and stroke treatment awareness in Central Arkansas.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:**

Resources needed to implement this program include staff from the following departments: Baptist Health Extended Care Hospital Case Management, Baptist Health Community Outreach, BHRI Stroke Program Team, and Strategic Development. Education materials will be provided by Baptist Health Extended Care Hospital and BHRI.

**PERFORMANCE METRICS:**

The number of individuals who receive education on secondary stroke prevention, early signs of stroke and proper response will be tracked on a monthly basis with annual reporting.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

Baptist Health Extended Care Hospital Leadership Team, with assistance from the Baptist Health Community Outreach department.

**PROGRESS UPDATE:**

Progress to be updated annually throughout the assessment period.

# Baptist Health Extended Care Hospital

# Community Health Needs Implementation Plan

## IDENTIFIED COMMUNITY HEALTH NEED #2 – Injury Prevention

**GOALS / OBJECTIVES:**

Increase the number of people who receive information regarding how to minimize injuries and fall risks.

**STRATEGY #1:**

Promote lifestyle and home arrangement choices to decrease the likelihood of injuries and falls.

**ACTION STEP #1:**

Provide all patients and families of Baptist Health Extended Care Hospital with fall prevention information upon discharge.

**ACTION STEP #2:**

Provide "Fall Prevention in the Home" presentations and literature to community groups and other entities specializing in aged adult care, in conjunction with BHRI.

**ACTION STEP #3:**

Participate actively in the Hospital /Nursing Home Liaison Committees at BHMC-Little Rock and BHMC-North Little Rock to act as a resource for injury and fall prevention to nursing homes in the Central Arkansas area.

**DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:**

Individuals attending the "Fall Prevention" presentations or reading the associated literature will have a better understanding of actions to take in order to reduce the risk of falls in their homes.

**DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:**

The collaboration will be with area community groups and entities specializing in aged adult care to provide information on injury and fall prevention.

**DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH**

The resources needed to implement this program include staff from the following departments: Baptist Health Community Outreach, Baptist Health Extended Care Hospital staff, BHRI Physical and Occupational Therapy Departments and Strategic Development. Educational Materials will be provided by Baptist Health Extended Care Hospital and BHRI.

**PERFORMANCE METRICS:**

The number of individuals who attend presentations and/or receive information on Fall Prevention will be tracked on a monthly basis, with annual reporting.

**PROJECT LENGTH / ESTIMATED COMPLETION DATE:**

This project will be on-going over the next three years 2014-2016

**PERSON / DEPARTMENT RESPONSIBLE:**

Baptist Health Extended Care Hospital Leadership Team, with assistance from the Baptist Health Community Outreach department.

**PROGRESS UPDATE:**

Progress to be updated annually throughout the assessment period.

## COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

## Baptist Health Extended Care Hospital (BHECH)

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHECH, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHECH clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHECH Implementation Plan.

**Poor or Fair Health Status** - This need is currently being addressed by the Arkansas Department of Health and numerous other healthcare organizations and entities.

**Poor Physical Health and Mental Health Days** - This need is currently being addressed by the Arkansas Department of Health, Community Mental Health Centers, and numerous healthcare and mental health organizations and providers.

**Diabetes (Chronic Conditions)** - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

**Hypertension** - This need is currently being addressed by the Arkansas Department of Health and the American Heart Association.

**Coronary Heart Disease** - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

**Asthma** - This need is currently being addressed by the Arkansas Foundation for Medical Care and the Lung Association of Arkansas.

**Chronic Lower Respiratory (Death)** - Due to limited resources, this issue will not be addressed at this time. This was rated as a lower priority compared to other issues, so resources will be focused on higher priority issues.

**Access to Recreational Facilities** - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

**Percentage of Fast Food Restaurants** - Due to limited resources and lack of expertise, this issue will not be addressed at this time.

**Smoking**- This need is currently being addressed by the Arkansas Department of Health, Lung Association of Arkansas, American Heart Association and numerous other healthcare providers and entities.

**Obesity** - This need is currently being addressed by the Arkansas Department of Health, numerous healthcare providers, and many community based programs and businesses.

**Colorectal Screening**- This need is currently being addressed by the American Cancer Society, the Arkansas Cancer Coalition, the Arkansas Department of Health, and other local healthcare providers.

**Mammography**- This need is currently being addressed by the American Cancer Society, the Arkansas Department of Health, the Susan G. Komen Foundation, and other local healthcare providers.