Bellin Health

Community Health Implementation Plan

2018-2020

BELLIN HEALTHCOMMUNITY HEALTH IMPLEMENTATION PLAN 2018-2020

INTRODUCTION

For more than a century, Bellin Health has served the people of Northeast Wisconsin and Michigan's Upper Peninsula with caring, expertise and a second-to-none focus on quality that make it the region's premier health system. Known for its emphasis on preventive healthcare, Bellin is the area's leader in cardiac, orthopedics, sports medicine, digestive health, mental health and primary care medicine.

Bellin's flagship campus in Green Bay, Wis. is home to Bellin Hospital, a 244-bed general medical and surgical hospital that *Consumer Reports* rated as the safest in the nation in 2013. Just down the road, the 80-bed Bellin Psychiatric Center provides top-quality inpatient, outpatient and addiction treatment services for individuals from across the region. And 30 minutes to the north, Bellin Health Oconto Hospital, a 10-bed critical care access facility, offers care close to home for patients outside the Green Bay metro area.

Bellin Health's vision is that the people in its region will be the healthiest in the nation, and the health system's 32 primary care physician clinics are at the heart of that effort. That aim is further bolstered by an ambulatory surgery center, urgent care services, 83 employer clinics, five Bellin Health FastCare retail health clinics, three Bellin Fitness Centers, and Bellin College, an accredited nursing and medical imaging institution. The Cancer TEAM at Bellin Health serves patients and families with a multidisciplinary approach to quality patient care, and Bellin is a founding partner of Unity Hospice, a nonprofit community provider of hospice care, palliative care and grief support serving Northeast Wisconsin.

In addition to serving its patients with award-winning care, Bellin Health is renowned for its community outreach efforts. Bellin is the official healthcare partner of the Green Bay Packers, a relationship that will be further strengthened by a new 52,000-square-foot sports medicine and orthopedics clinic that is scheduled to open in 2017 in the Titletown District just west of Lambeau Field. Bellin annually hosts one of the nation's largest 10K events, the Bellin Run, which brings walkers and runners of all ages and fitness levels to the streets of Green Bay in the spirit of health, wellness and community fun. The health system's 3,900 employees make it the second-largest employer in the Green Bay area, making Bellin Health a major contributor to the economic vitality of the region.

Even beyond its service area, Bellin is a powerful player in creating positive large-scale change around healthcare. The health system is a founding member of the Institute for Healthcare Improvement (IHI), an international organization dedicated to improving health and healthcare worldwide, as well as the Wisconsin Collaborative for Healthcare Quality. Through its Bellin-

ThedaCare Healthcare Partners collaboration, Bellin was a participant in the Centers for Medicare & Medicaid Services' (CMS) Pioneer Accountable Care program, generating $14 million in savings while producing the highest quality and lowest cost in the country among Medicare ACOs. Bellin is now independently participating in the Next Generation ACO model, CMS' newest Accountable Care Organization program.

Bellin Health is the only health care system in our market with a locally governed Board of Directors, whom are community focused. In addition to community health improvement services guided by our triennial CHNA process, the hospital contributes to other needs through our broader community benefit program including community health services, health professional education, subsidized health services, financial and in-kind contributions and community building activities. In FY2017, the community benefit contributions totaled more than $46 million.

Bellin Health conducted a Community Health Needs Assessment in collaboration with Brown County Health and Human Services Division of Public Health, HSHS, United Way of Brown County, and Aurora Bay Care in 2017. Primary and secondary data was gathered from multiple sources to assess the needs of Brown County. This data was presented to a broad cross-section of community stakeholders who together recommended the health priorities to be addressed in the FY2018 through FY2020 Implementation Plan.

PRIORITIZED SIGNIFICANT HEALTH NEEDS

Based on the data presented and the prioritization process, the following priorities were selected:

- Alcohol, and Other Drug Abuse (AODA)
- Mental Health
- Physical Activity, Obesity and Nutrition
- Oral Health (sustained)

HEALTH NEEDS THAT WILL NOT BE ADDRESSED

Following feedback from community leaders, it was agreed that ongoing efforts with Oral health should be sustained.
In addition to the health needs selected as top priorities, community members identified other significant health needs in Brown County. While these issues will not be addressed by the hospital as priority health needs, we will provide support to those community efforts whenever possible.

- **Environmental Health**: Bellin Health has made conscious efforts to improve the environmental health of our community. Areas of focus include conversion to LED lighting, exploring solar energy opportunities and aggressive medical and medication waste programs. Examples of the waste management programs include use of the Neptune System in the ORs and conversion of our disinfectant products to a more environmentally friendly product called Oxycide. Due to resource limitations, our efforts have been internally focused.

- **Creating a Culture of Safety**: Bellin Health has a system-wide focus on safety for patients and employees. We periodically assess our culture of safety through a survey of the staff. We also encourage reporting of all safety issues, followed by timely identification of the root causes, improvement plans, follow up monitoring, spread to other areas and ongoing monitoring. Due to resource limitations, our efforts have been internally focused, however we do participate in community emergency preparedness.

IMPLEMENTATION PLAN

Bellin Health's Implementation Plan is part of a broad community effort to address the priority health needs in the community. The health system works collaboratively with a broad range of direct service organizations, coalitions and government agencies to address these needs.

The Implementation Plan 2018 below outlines the actions that the health system will take to address Brown County's health needs. However, as noted below, many implementation strategies will be implemented collaboratively. Recognizing that no one organization effects substantial community change alone, the long-term outcomes identified in this Implementation Plan will be achieved as many community organizations work together for collective impact.

Alcohol and other drug abuse (AODA):
Bellin Health's Chief Nursing Officer has provided leadership to this team since 2012.

Goal: By 2020, Bellin Health, in partnership with the Brown County Health Department and other organizations and the Alcohol and Drug Task Force will create community-wide partnerships with individuals, families and organizations creating cultural change that leads to a measured decrease in binge drinking behavior, drug use and fatalities.

Long-term performance indicators:

- Reduce binge drinking rate from 24 percent to 22 percent by June 30, 2020.
- Percent of driving deaths with alcohol involvement will decrease to 50 percent by June 30, 2020. Current rate is 67 percent in the 2017 county health rankings.
- Deaths related to drug misuse will decrease to at least eight by June 30, 2020 as indicated in the county health rankings. 2017 county health rankings is 13 deaths.
- By June 30, 2020 community members seeking support and/or needing to gain access will receive services same day they are sought.

Strategy One: Access
Bellin Health will collaborate with the Mental Health Task Force and other community stakeholders on the following tactics. Each tactic will take 120 days.

- Create a community-wide portal for patients and providers to access where AODA services are available.
- Participate in the asset-mapping process to identify where gaps exist in accessing AODA services.
- Support the expansion of recovery coaching as a way to offer support to those awaiting services.

- Collaborate on community stakeholder initiatives that are focused on opioids and identify any crossover to the AODA task force surrounding access to treatment/support.

Mid-term performance indicators:
Effective advocacy and support of a minimum of one evidenced-based policy change that leads to fewer fatalities associated with alcohol and drug addiction and misuse within Brown County by June30, 2020. (Measure: Percent of driving deaths with alcohol involvement and deaths related to drug misuse)

Hospital resources:
- Colleague time
- Travel

Supporting information:
- Target population: Residents of Brown County
- Evidence base: SAMSHA's Strategic Prevention Framework (SPF) guides you in selecting, implementing, and evaluating effective, culturally appropriate, and sustainable prevention activities. The effectiveness of the SPF begins with a clear understanding of community needs and involves community members in all stages of the planning process.

Strategy Two: Policy
Bellin Health will collaborate with the Mental Health Task Force and other community stakeholders on the following tactics. Each tactic will take 120 days.
- Partner with law enforcement and the tavern league to assist in supporting policies that lower the risk of deaths associated with driving while under the influence.
- Advocate for the uniform and effective request of the "Place of last drink" report from tavern owners.
- Advocate for and support legislation that creates increased access to care for those suffering with substance abuse/misuse.
- Identify and communicate a minimum of two best practice approaches that decrease exposure of drugs and alcohol to youth, and support needed policy or practice changes in the community.
- Annually educate legislators and community stakeholders, at a community event, on needed policy change that impacts alcohol and drug misuse
- Collaborate with the Wisconsin Hospital Association (WHA) to advocate for new and innovative policy and/or legislative changes that support a healthy substance use culture in Brown, Oconto and Sheboygan Counties.

Mid-term performance indicators:
Effective advocacy and support of a minimum of one evidenced-based policy change that leads to fewer fatalities associated with alcohol and drug addiction and misuse within Brown County by June 30, 2020. (Measure: Percent of driving deaths with alcohol involvement and deaths related to drug misuse)

Hospital resources:

- Colleague time
- Travel

Supporting information:

- **Target population**: Residents of Brown County
- **Evidence base**: *A Community Anti-Drug Coalitions of America* (CADCA) offers strategies to address drug issues in a community, one of which is policy change. This strategy supports formal changes in written policies, laws and procedures aimed at preventing current and future prescription drug abuse. Examples include workplace initiatives, law enforcement procedures and practices, public policy actions and systems change within government, communities and organizations.

Strategy Three: Public Awareness

Bellin Health will collaborate with the Mental Health Task Force and other community stakeholders on the following tactics. Each tactic will take 120 days.

- Support a minimum of two community conversations and public awareness events around alcohol and drug misuse annually.
- Create a video in partnership with HWLI (Healthy Wisconsin Learning Initiative) that creates awareness around "access to care" for those struggling with substance misuse.
- Partner with statewide coalitions to raise awareness and identify key practices that influence culture. Evaluate these practices and implement these in Brown County as appropriate.
- Partner with key stakeholders around their work surrounding opioid abuse and utilize existing educational materials to create awareness in the community.
- Support the drug take-back events, either through volunteering at event or educating the community.
- Participate in a minimum of two field trips each year that bring task force members out into the community to engage with key stakeholders that are impacted by drug and alcohol addiction and misuse.
- Create a process for sustaining the notification letter that goes out to local establishments and organizations that are hosting events. This letter will outline best practices for safe serving. Also establish the process to send a "thank you" to those organizations that follow the best practice standards.

Mid-term performance indicators:

By June 30, 2020, increase public awareness around the impact of alcohol and drug addiction and misuse within our community. This will be evidenced by behavior change and a decrease in the binge drinking rate from 27 percent to 22 percent and fewer than eight drug-related deaths in Brown County. (Measure: binge drinking rate)

Hospital resources:

- Colleague time

- Travel
- Volunteer time

Supporting information:

- **Target population**: Residents of Brown County
- **Evidence base**: *A Community Anti-Drug Coalitions of America* (CADCA) includes seven strategies, one of which is policy change. This strategy supports formal changes in written policies, laws and procedures aimed at preventing current and future prescription drug abuse. Examples include workplace initiatives, law enforcement procedures and practices, public policy actions and systems change within government, communities and organizations.

Community resources and partners for alcohol and other drug abuse (AODA)

Trevor Allcock, UWGB

Rebecca Arrowood, Family Services
Sharla Baenen, Bellin Psychiatric Center
Shawn Blakley, American Foundations Counseling
Dave Bertrand, Willow Creek Behavioral Health
Erin Bongers, De Pere Health Department
Dan Braaten, Prevea Behavioral Health

Danielle Brockman, Bellin Health
Larry Connors, Jackie Nitschke Center
Monica Davis, Willow Creek Behavioral Health
Father Paul Demuth, Bay Area Community Council
Cathy DeValk-Holl, Aurora Health Center
Tom Doughman, St. Norbert College
Elaine Doxtator, Hospital Sisters Health System
Phil Duket, NE AWY Prevention Center Coordinator

Kris Kovacic, BC Health & Human Services
Bonnie Kuhr, N.E.W. Community Clinic
Tyler Luedke, Brown County Treatment
Paula Manley, Prevea & Eastern WI Div of HSHS
Antonia Nelson, DarJune

Mike Panosh, Wisconsin State Patrol
John Plageman, Aging & Disability Resource Center
Kelly Rowe, Green Bay School District
Pat Ryan, Brown County Drug Alliance
Dan Sandberg, Brown County Sheriff's Department
Heidi Selberg: Community member

Scott Stokes, ARCW
Mandy Suthers, DarJune
Erin Tisch, BC Health & Human Services

Theresa Weise, UW-Green Bay

In addition to the above, Bellin Health is focused on increasing our medical and community awareness to the opioid crisis. We will continue our outreach into the Northern Wisconsin and Upper Michigan counties, where overdose rates far exceed national averages. Secondly, we will work in tandem with our medical providers and patients to develop new strategies to address chronic pain and further reduce the quantity of prescription opioids in circulation.

We are also working on a pilot project in our ED to assign overdose patients with a volunteer coach that is a recovered addict. The goal is to provide support after discharge.

MENTAL HEALTH

Bellin Health's Psychiatric Center President has provided leadership to this team since 2015.

Goal: Brown County will improve access to mental health services, information, and education for all populations in the county by creating a common platform that consumers, mental health providers, partner agencies, and stakeholders can access.

Long-term performance indicators
By July 2020, the average number of poor mental health days per 30 days, as reported by county residents, will decrease from 3.4 to 3.2.

Strategy One: Screening Tool Assessment and Best Practice Identification
Bellin Health will work collaboratively with the Brown County Health Department and Mental Health task force to:

- Assist in completing an inventory of current behavioral health screening tools used across settings.
- Assist in completing an inventory of current suicide risk screening tools used across settings (consider collaboration with the Brown County Coalition for Suicide Prevention on this activity).
- Identify best practice behavioral health screening tools and develop recommendations for tools used in various community settings.
- Identify best practice suicide risk screening tools and develop recommendations for tools used in various community settings.

Mid-term performance indicators:
By Dec. 31, 2019, the Mental Health Task Force will complete an inventory of mental health screening tools currently utilized across community settings and develop best practice, evidence-based screening processes, that are appropriate for each community setting (schools, crisis 9 center, psychiatric hospitals, emergency departments, primary care, mental health clinics, and other healthcare settings).

Hospital resources:

- Colleague time
- Travel

Supporting information:

- **Target population**: Residents of Brown County
- **Evidence base**: Although suicide is a statistically very rare event, even within psychiatric populations, improvement efforts *focused on the processes of care* in which patients and clinicians live and work can drive successful clinical quality improvement work. Source: *Behavioral Health Treatment Needs Assessment Toolkit for States (SAMHSA), Zero*

Suicide in Health and Behavioral Health Care (SAMSHA, SPRC, National Action Alliance for Suicide Prevention) Perfect Depression Care (Henry Ford Health System)

Strategy Two: "No Wrong Door" Access Platform for Mental Health Treatment and Providers

Bellin Health will work collaboratively with the Brown County Health Department and Mental Health Task Force to:

- Implement Trilogy – network of care in collaboration with NEW Connections
- Work with primary care providers to identify education needs and strengthen primary care as the entry point to "Right Care, Right Person, Right Time" mental health treatment.
- Investigate and implement a "no wrong door" referral process between community agencies to guarantee the right access at the right time.

Mid-term performance indicators:

By Dec. 31, 2019, the Mental Health Task Force will create a community-wide "no wrong door" access platform for mental health treatment and connection between mental health providers. The goal is to create the right access, at the right time by having a comprehensive view and collaborative connections between all Brown County mental health service providers.

Hospital resources:

- Colleague time
- Travel
- Training time

Supporting information:

- **Target population**: Residents of Brown County
- **Evidence base**: *NACCHO/ASTHO, "No Wrong Door: Assuring Services and Seamless Care" Program.* Source: *N.E.W. Mental Health Connection, "No Wrong Door"*

Strategy Three: Develop a Network of Peer Support, Increasing Availability of Immediate Resources to Community

Bellin Health will work collaboratively with the Brown County Health Department and Mental Health task force to:

- Complete an inventory of current mental health peer support resources available in the community.
- Identify educational/training programs available to those interested in providing peer support in the community (e.g. QPR, Mental Health First Aid, etc.).
- Develop a peer support network, implement services and provide resource contacts to community organizations and agencies.

Mid-term performance indicators:
By Dec. 31, 2019, the Bellin Health will collaborate with the Brown County Mental Health Task Force to develop a network of peer support that increases the availability of immediate resources to consumers. This will expand the continuum of mental health resources available in Brown County.

Hospital resources:
- Colleague time
- Travel

Supporting information:
- **Target population**: Residents of Brown County
- **Evidence base**: Healthiest Wisconsin 2020: Develop comprehensive data to track disparities. Assure access to high-quality health services for all. Increase the proportion of persons who have a specific source of ongoing care (AHS-5). Increase the proportion of adults with mental health disorders who receive treatment (MHMD-9). National Prevention Strategy: Standardize and collect data to better identify and address disparities. Reduce barriers to accessing clinical and community preventive service, especially among populations at greatest risk.

Community resources and partners for mental health:
Ian Agar, Brown County Becky Heldt, Rawhide
Officer Kamra Allen, GBPD Ashley Hopp, Bellin Health
Debbie Armbruster/Sara Lornson, De Pere Health Department Sarah Inman, BC United Way
Sharla Baenen, Bellin Psychiatric Center Tana Koss, Family Services
Lissa Balison, UW-Green Bay Andrea Kressin, Brown County Public Health
Kay Baranczyk, Bellin Psychiatric Center Margaret Kubek, UWGB
Dave Bertrand, Willow Creek Behavioral Health Bonnie Kuhr/Seth Moore, NEW Community Clinic
Brian Binder, ADRC of Brown County Lois Mischler, Family Services
Shromona Bose-Bigelow, BC United Way Althea Noukki, PhD, BC Human Services
Franchesca Carley-Vasquez, Family & Childcare Resources Michelle Peterson, Intern BC Human Services
Marilou Counard, Bellin Psychiatric Center Katie Rollin, PsyD, Aurora Health Care
Bree Decker, Connections for Mental Wellness Lisa Schubring, Prevea
Julie Duffy, Rawhide Eric Seubert, The Gathering Place
Rebecca Fairman, Connections for Mental Wellness Rose Smits, Community Member
Julie Feld, Foundations Cheryl Weber, JOSHUA Group
Officer Barb Gerarden, GBPD Christopher Zahn, Recovery
Christina Gingle, GBAPSD
In addition to the above, Bellin Health will work closely with the Wisconsin Hospital Association 2018 Goals and Initiatives Task Force, which is working to address issues surrounding mental health, AODA and opioids.

Supporting information:
- Target population: Residents of Brown County

- Evidence base: *NACCHO/ASTHO," No Wrong Door: Assuring Services and Seamless Care".* Source: *N.E.W. Mental Health Connection, "No Wrong Door"*

PHYSICAL ACTIVITY, OBESITY AND NUTRITION

Goal: Increase number of individuals with healthy weight

Long-term performance indicators: By 2020, increase number of individuals with a healthy weight by three percent, as evidenced by an increase in the number of community members with a BMI under 30. (Baseline measure: 72 percent at healthy weight, based on County Health Rankings 2017- 2013 data).

Strategy One: Food as Medicine

Bellin Health will work collaboratively with the Brown County Health Department to improve equitable access to healthy food, and increase the proportion of Brown County residents who consume the recommended number of servings of fruits and vegetables by at least two percent (short term) and four percent (long term) by:

- Establishing relationships with various community groups and offering assistance to facilitate change or maintenance for programs that focus on consumption of healthy foods
- Monitoring healthy food donations at Scouting for Foods drive
- Maintaining and promoting Food Drive 5 toolkit
- Monitoring and encouraging food pantry infrastructure that promotes healthy food choices
- Institute a platform of healthy snacks in the school system by eliminating candy, high fat snacks and soda from vending machines and cafeterias
- Tracking the ratio of eligibility for EBT program to those who use the Double Your Bucks program at the farmer's market
- Ben's Wish program that assists local communities in fighting food insecurity issues through food drive collection, weekend backpack program and educational activities.

Mid-term performance indicators:
By June 30, 2020, residents in Brown County will improve nutrition through increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened beverages and other less nutritious foods.

Hospital resources:

- Colleague time
- Volunteer time
- Financial support

Supporting information:

- **Target population: Residents of Brown County**
- **Evidence base:** Food security and improved access to quality food empowers all members of the community to be able to consume healthy food, which is a proven way to support healthy weight, and prevent and reverse chronic disease**.** Source: BRFSS, County Health Rankings, Community Survey, LIFE study, YBRS, Food Insecurity data, Survey

of Brown County At-Risk Households 2016, UW-Extension data. Healthiest Wisconsin 2020: Make healthy foods available for all. Increase access to healthy foods and support breastfeeding. Healthy People 2020: Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older (NWS-17). Reduce household food insecurity and, in doing so, reduce hunger (NWS-13). National Prevention Strategy: increase access to healthy and affordable foods in communities.

Strategy Two: Movement as Medicine

Bellin Health will work collaboratively with the Brown County Health Department to decrease physical inactivity (short-term by two percent, long-term by four percent) through empowering community members to use active means of transport/movement by partnering with the Greater Green Bay Active Community Alliance. Encourage Brown County residents to utilize community resources (e.g. walking/biking trails, fitness centers, etc) and facilitate campaign(s) that promote(s) healthy lifestyles through safe and affordable modes of physical activity (as measured by a decrease in physical inactivity) by structuring the work around the three Es (engineering, education, enforcement). Together, we will accomplish this by:

- Inventorying existing initiatives that are in alignment with this objective.
- Partnering with the Greater Green Bay Active Community Alliance to create a more active and connected community.
- Developing an educational strategy using the three Es in partnership with the Greater Green Bay Active Community Alliance.
- Monitoring utilization trends of active design and infrastructure to identify gaps and opportunities to improve.

Mid-term performance indicators:

By June 30, 2020, Brown County residents will have decreased their physical inactivity by two percent.

Hospital resources:

- Colleague time
- Volunteer time

Supporting information:

- **Target Population:** Residents of Brown County
- **Evidence base:** County Health Rankings. **Source:** http://www.activecommunitieswi.org/. Healthiest Wisconsin 2020 - Community designs that foster safe and convenient foot, bicycle and public transportation, and physical recreation. Healthy People 2020 - Physical Activity in Adults (PA 2.4). National Prevention Strategy - Integrate health criteria into decision making, where appropriate, across multiple sectors.

Strategy Three: Culture change:

Bellin Health will work collaboratively with the Brown County Health Department to link LIFE study data, CHIP and The GROW Project together to collaborate on community initiatives. Together we will create a community driven by multi-sectored partnerships supportive of cultural well-being that improves the health of Brown County by:

- Convening meetings with leadership from LIFE study, CHIP and the GROW Project.

- Testing a community education platform supporting the connection between nutrition, movement and health status.
- Engaging and empowering the growth and development of relationships between agencies in the food-related and well-being sectors.
- Adopting Healthful Hospital Food American Medical Association Resolution 406.

Mid-term performance indicators:
By June 30, 2020, the LIFE study, CHIP and the GROW Project data will be analyzed.

Hospital resources:
- Colleague time

Supporting information:
- **Targeted population:** Residents of Brown County
- **Evidence base:** Healthiest Wisconsin 2020, The GROW Project, LIFE Study. Healthiest Wisconsin 2020 - Identify resources to support partnerships. Build effective partnerships resulting from respect and empowerment. Healthy People 2020 -Obesity in Adult (NWS-9). Obesity in Children and Adolescents (NWS-10.4). National Prevention Strategy- Engage and empower people and communities to plan and implement prevention policies and programs.

Community resources and partners for physical activity, obesity and nutrition include: Kristin Ely-Bluemke- Boy Scouts	Karen Early – BC UW Extension	Tim Meyer - UWGB Marketing
Andrea Werner-Bellin	Laura Grovogel – Aurora BayCare	Chris O'Brien – Boy Scouts
Becky Nyberg -BCHD	Meredith Hansen – ADRC of Br County	Carey Redmann – Feeding America
Jamie Campbell – WIC	Stephanie Lazzari – HSHS	Jennifer Schnell – Aurora BayCare
Steve Reinders – Bellin	Becky Delain / Margo Marquette- Ben's Wish	Leanne Zhu – UWGB
Vicky Darragh – Feeding America	Sara Lornson – DePere Health Dept.	Shromona Bose-Bigelow- BC United Way
Joan Swigert/Chad Clements- BC Food and Hunger Network	Maggie Koch - Bellin	Paul Linzmeyer- The Farmory
Natalie Bomstad- LIVE 54218	Eric Weydt- Diocese of Green Bay	Ben Chan- UW-GB

In addition to the above, Bellin Health has been focused on providing healthy meals to our patients and staff. Over the past several years, we have eliminated many of the high fat and sugar choices from our cafeteria and patient meals. We also supported a farmer's market at one of our campuses.

HEALTH EQUITY

In addition to the three community teams, Bellin is has an internal team focused on addressing health equity. Primary drivers in this work include: Leadership and advocacy as healthcare leaders for health equity, Organization focus to address opportunities for health care equity and partnerships with the key stakeholders and communities. One of the key project that this team will focus on us the collection and use of REAL (race, ethnicity and language) data. Some additional projects that the team has prioritized fall under the secondary drivers of developing a recruitment and retention strategy to evolve the workforce to reflect the community we live in, and the qualitative and quantitative understanding of the populations we serve by addressing the social determinates of health.

NEXT STEPS

The Implementation Plan outlines a three-year community health improvement process. Annually, the hospital will:

- Review the Implementation Plan and update strategies for the following fiscal year
- Set and track annual performance indicators for each implementation strategy
- Track progress toward Mid Term Performance Indicators
- Report progress toward the performance indicators to the hospital board, community benefit advisory committee, other
- Share actions taken and outcomes achieved to address priority health needs with the community at large

APPROVAL

The Implementation Plan was adopted by the hospital's board on August 28, 2018.