RMC HEALTH SYSTEM

THE HEALTH CARE AUTHORITY of THE CITY of ANNISTON

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN

2021-2023

Foreword

The Health Care Authority of the City of Anniston (HCACA) utilized the 2020 Community Health Needs Assessment to confirm the top healthcare-related priorities within its service area and after soliciting input for action, HCACA has developed an Implementation Plan based on this feedback. This plan outlines the action steps that our health system will take to respond to identified community needs.

This Implementation Plan is considered to be a "working plan" that will continue to evolve and be evaluated for effectiveness in meeting the needs of the community. We cannot completely solve every problem that has been identified in our research due to resource constraints and many of the issues being beyond the mission and general capabilities of the health system. If our plan is to be successful, we must rely on collaboration with area agencies and organizations as a way to create a synergistic effect that brings out the best in all of us and allows us to work in tandem to address our communities' most pressing healthcare-related needs.

In preparing this Plan, we are identifying the ways that the health system is using and creating "community benefits" to address health and medical priorities. Those benefits are extended in the form of uncompensated care, free health screenings, health fairs, donations to community-sponsored events with health-related themes, etc.

Our communities continue to be a great place to live and work. Our hope is that together we can work to continue to bring about the type of improvements that will benefit us all.

STRATEGY

The five most significant needs, as identified by the research, are as follows:

1. Implementation of systems to reduce socioeconomic stressors
2. Improve access to primary medical care and behavioral health care
3. Increase access to healthcare education, prevention, wellness and promotion
4. More healthcare services for chronic conditions
5. Healthcare services for the elderly

HCACA's Implementation Plan will address each area of identified need in detail.

Implementation of Systems to Reduce Socioeconomic Stressors

The health of a community is largely related to the characteristics of its residents. It is well documented that an individual's age, race, ethnicity, education and income level, as well as access to nutritious food, reliable transportation and decent housing all affect health status and access to healthcare.

Priority	Improve Systems to Reduce Socioeconomic Stressors
Strategy Statement	Reduce barriers to accessing healthcare due to demographic, environmental or financial factors
Major Actions\Strategies	
• Partner with health professions advisors at high school level to emphasize high demand for healthcare workers • Continue Volunteens Program to increase exposure of high school students to the healthcare environment • Offer health-care related scholarships to high achieving low-income students as an encouragement to further education • Offer health-care related scholarships and reimbursement assistance options to our own employees and their dependents • As part of community-based health fairs, engage nutritionists and diabetic educators to participate in discussions pertaining to healthy eating • Utilize contracted resources to sign up Medicaid eligible patients to obtain insurance benefits • Expand and strengthen community outreach efforts around stroke, cardiovascular disease, diabetes and hypertension • Continue reduced payment and in-kind ancillary services for local ministries • Participate in community health fairs and provide free health screenings for common community-related diseases	

Improve Access to Primary Medical Care and Behavioral Health Care

Priority	Create a Primary Care Network that is Accessible and Affordable
Strategy Statement	Affordable primary care is essential to the establishment of a health care system that promotes well-being. More primary care in a community equates to lower mortality, better preventive care and fewer hospitalizations and emergency room visits
Major Actions\Strategies	
• Leverage technology to expand access to care through telehealth and other platforms that do not require travel/transportation • Continue to expand both the number and roles of nurse practitioners and physician assistants in our service area • Create multidisciplinary care teams (physician\nurse practitioner, nutritionist, exercise physiologist, etc.) in community health clinics in order to provide patients with a comprehensive understanding of medical conditions and the appropriate way to treat them • Incorporate and integrate electronic health records across delivery system in order to share information in real time and thus reduce duplication of services and lowers cost • Continue efforts to expand Medicaid in the State of Alabama • Establish stronger relationships with community-based clinics and federally qualified health clinics to establish referral source for low-to- moderate income patients who are unnecessarily visiting high cost emergency rooms • Partner with local municipalities and other stakeholders to establish and support for health clinics for low income and underserved populations • Offer supplements to National Health Service Corps physicians willing to relocate to rural communities within our service area • Increase social work and case management resources to ensure consistent access and availability of their services • Explore the creation of a navigator program for the uninsured and underinsured to assist in the reduction and\or prevention of non-compliant events that result in emergency room visits or hospitalizations	

Increase Access to Health Care Education, Prevention, Wellness and Promotion

Priority	Provide Education that Promotes Prevention, Early Detection and Risk Reduction
Strategy Statement	The risk factors of smoking, obesity, hypertension, diabetes and limited physical activity contribute to a wide range of preventable health conditions. Wellness programs need to be designed and geared towards hard-to-reach, lower income and culturally-diverse groups in order to both educate them regarding risk and stress the importance of early detection of disease onset
Major Actions\Strategies	
• Partner with medical staff and other healthcare professionals to develop educational programs focused on health and wellness and combat stigmas that may exist in certain communities and patient populations • Take a more active role in promoting and encouraging wellness and healthy living with our own employees and their dependents • Conduct more frequent screenings in low-to-moderate income neighborhoods • Work with the local municipalities to establish and promote the use of walking tracks at area parks and recreation centers • Target outreach to underserved women through the National Breast and Cervical Cancer Early Detection Program • Work with local medical and nursing schools in an effort to expand coursework in areas such as communication, cultural competency and health disparities, and ensure that they receive “hands-on” experiences with culturally diverse patients • Assess the viability of a navigator program in underserved communities • Tout the benefits of nicotine patches at community health fairs as a possible means of smoking cessation • Work with local churches and civic organizations to advertise and promote screening exams and programs provided by the health system • Initiate incentive programs among participants\organizations regarding weight loss, smoking cessation, etc. as a means of reducing disparities • Utilize social media and other electronic marketing channels to further spread the news about events and educational and wellness programs currently offered	

Increase Healthcare Services for Patients with Chronic Conditions

Priority	Establish additional resources for individuals living with chronic disease conditions
Strategy Statement	The high prevalence of citizens living with chronic diseases such as diabetes, hypertension, obesity and heart disease makes it imperative to assist in the management of these conditions in order to avoid acute and costly hospital visits
Major Actions\Strategies	

- Utilize existing resources to establish chronic care programs for individuals with heart disease and other chronic conditions
- Continue and expand the Transition of Care program to follow more chronically ill patients in an effort to improve medication adherence and health compliance
- Ensure access to a full range of health services for the chronically ill patients
- Support legislative measures that increase the number of people with health coverage
- Work to amend licensure laws in order to make it easier for health centers to care for the chronically ill
- Offer reduced-cost programs for low-income chronically ill patients seeking health care
- Provide access to electronic health records so that conditions can be reviewed in real time and thereby speed up the care process
- Assist in the location of programs that will provide low-cost or no-cost medications to patients with chronic conditions
- Continue to provide assistance to low income, chronically ill patient in helping them register and get approved for programs that may provide healthcare coverage at little to no out of pocket expense
- Coordinate follow-up access to outpatient provider services for patients prior to being discharged from the acute care setting with chronic conditions to help ensure seamless access and coordination of care

Improve the Accessibility of Healthcare Services to the Elderly

Priority	Improve access and availability of healthcare services to older adults in the community
Strategy Statement	The population of our service area is getting older. With the closest major city being 60 miles away, it is imperative that we provide as many healthcare and social services as possible at the local level
Major Actions\Strategies	

- Work with local agencies to ensure that adequate public and\or private transportation sources are available to take patients to appointments
- Develop partnerships with local EMS services to provide basic care and wellness checks in the home for those patients that have difficulty getting to a traditional care site
- Continue to work to change scope of practice laws that enable non-physician providers to work at the top of their licenses, thereby creating more appointment slots and “capacity”
- Develop coordinated care models via the creation of patient centered medical homes (PCMHs) to improve access and efficiency while decreasing complications
- Extend or stagger clinic hours for patients who are not able to make appointments during regular business hours due to transportation or other social issues
- Utilize telehealth and virtual care platforms to provide basic primary care and chronic care access for established patients
- Continue workforce investment at high school and college level to insure that an adequate number of healthcare workers are being trained to meet the demands of an increasingly aged population
- Utilize navigators to monitor compliance with medications and physician office visits
- Develop community-based, mobile and telehealth clinics and to assist with access issues
- Partner with academic medical centers or larger tertiary referral hospitals to bring sub-specialty access to care to our communities through the use of telehealth platforms and outreach clinics.

- Advocate shared appointments among the elderly with similar health concerns\conditions
- Support the repeal of the physician payment formula that threatens steep cuts to physician pay, and any other reform that preserves the physician\patient relationship
- Conduct a comprehensive provider needs assessment and develop a recruitment plan to ensure appropriate and timely access to care