BON SECOURS SOUTHAMPTON MEMORIAL HOSPITAL
BON SECOURS MERCY HEALTH, INC.
FY2021 – FY2022 IMPLEMENTATION STRATEGY

The Mission of Bon Secours Mercy Health, Inc. is to bring compassion to health care and to commit ourselves to help bring people and communities to health and wholeness as part of the healing ministry of Jesus Christ and the Catholic Church. Our mission leads us to create collaborative partnerships to address the health care needs of the underserved residents of Western Tidewater, Virginia (City of Franklin, City of Suffolk, Southampton and Isle of Wight counties). Through these partnerships, Bon Secours Southampton Memorial Hospital will positively impact the health of the community in its service area.

Using the results from the Community Health Needs Assessment (CHNA) survey, community focus groups, and analysis of secondary data, Bon Secours Southampton Memorial Hospital developed the implementation strategy while taking into account the following:

- Fit with the Bon Secours Mercy Health Mission and Strategic Quality Plan
- High morbidity/mortality/negative outcome caused by need
- Service/Support for need is available within Bon Secours Mercy Health
- Service/Support for need is already available in the region, outside of Bon Secours Mercy Health
- Strong partners are available to address this need
- Need is present in more than one region in Hampton Roads

The table below indicates the most significant health needs in our service area identified through the CHNA process.

Prioritized significant community health need	**Addressed by Southampton Memorial Hospital**
Alcohol and Substance Abuse	No
Behavioral/Mental Health	No
Chronic Disease in Aging Adults (Diabetes, Obesity/Overweight)	Yes
Heart Conditions	Yes
Smoking/Tobacco Use	No

Southampton Memorial Hospital was acquired by Bon Secours Mercy Health, Inc. on January 1, 2020. Prior to the acquisition, SMH was a for-profit hospital. As such, it was not required to complete a CHNA. In order to align all hospital year-ends and CHNA cycles, Southampton Memorial Hospital will prepare a new CHNA and Implementation Strategy for tax year ending December 31, 2022.

PRIORITY: Improve Community Health and Well-Being

GOAL: *Improve knowledge and access to healthcare opportunities to treat and manage cardiovascular disease.*

BACKGROUND ON STRATEGY

Cardiovascular diseases are a group of disorders of the heart and blood vessels which include: coronary heart disease, cerebrovascular disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, and deep vein thrombosis and pulmonary embolism. Cardiovascular diseases includes numerous problems, many of which are related to a process called atherosclerosis.

Atherosclerosis is a condition that develops when a substance called plaque builds up in the walls of the arteries. This buildup narrows the arteries, making it harder for blood to flow through. If a blood clot forms, it can block the blood flow. This can cause a heart attack or stroke.

Heart disease remains the leading cause of death in the U.S. and stroke continues to rank fifth, according to the National Center for Health Statistics Mortality Data Report for 2017. Research shows people living with diabetes are at least two times more likely to develop and die from cardiovascular disease.

The most important behavioral risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol. The effects of behavioral risk factors may show up in individuals as raised blood pressure, raised blood glucose, raised blood lipids, and overweight and obesity. These “intermediate risks factors” can be measured in primary care facilities and indicate an increased risk of developing a heart attack, stroke, heart failure and other complications.

Cessation of tobacco use, reduction of salt in the diet, consuming fruits and vegetables, regular physical activity and avoiding harmful use of alcohol have been shown to reduce the risk of cardiovascular disease. In addition, drug treatment of diabetes, hypertension and high blood lipids may be necessary to reduce cardiovascular risk and prevent heart attacks and strokes. Health policies that create conducive environments for making healthy choices affordable and available are essential for motivating people to adopt and sustain healthy behavior.

There are also a number of underlying determinants of CVDs or "the causes of the causes". These are a reflection of the major forces driving social, economic and cultural change – globalization, urbanization and population aging. Other determinants of CVDs include poverty, stress and hereditary factors.

-adapted from *https://newsroom.heart.org/news/addressing-heart-disease-brain-health-and-diabetes-is-critical-to-reducing-deaths-in-the-u-s*, *https://www.heart.org/en/health-topics/consumer-healthcare/what-is-cardiovascular-disease*, *https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)*

OBJECTIVE #1: Establish consistent, high quality processes across the continuum of care for heart conditions (heart disease, congestive heart failure, heart attacks, hypertension, etc.).		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
• Promote consistent adherence to chronic heart failure (CHF) treatment guidelines through disease management education, readmission reduction, etc. • Provide efficient and effective care of patients with acute coronary syndrome. • Provide education to CHF patients to improve knowledge of heart disease and self-care. • Hypertension and CHF control through medical groups.	December 2021	• Improve readmission rates for Chronic Heart Failure (CHF) through participation in the *Get with The Guidelines* program. • Promote consistent adherence to CHF treatment guidelines through disease management education, readmission reduction, etc. • Maintain Chest Pain Accreditation through the American College of Cardiology. • Improve hospitalization rates among and CHF patients through disease management education, readmission reduction, etc.
• Promote consistent adherence to chronic heart failure (CHF) treatment guidelines through disease management education, readmission reduction, etc. • Provide efficient and effective care of patients with acute coronary syndrome. • Provide education to CHF patients to improve knowledge of heart disease and self-care. • Hypertension and CHF control through medical groups.	December 2022	• Reduce readmission rates by 2% for Chronic Heart Failure (CHF) through participation in the *Get with The Guidelines* program. • Promote consistent adherence to CHF treatment guidelines through disease management education, readmission reduction, etc. • Maintain Chest Pain Accreditation through the American College of Cardiology. • Reduce hospitalization rates by 2% for CHF patients through disease management education, readmission reduction, etc.
Resources Committed: • Staffing • Medical Groups		**Intended Partnerships:**

OBJECTIVE #2: Increase community health through education, screenings, and programming around heart disease and self-care.		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
• Provide educational programming and print media around heart disease and self-care in the community. Measure knowledge gained through pre- and post-tests and screenings. • Establish baseline attendance and referral mechanism for CHF education programs. • Identify and establish partner sites in community to offer programs.	December 2021	• Improve knowledge of heart disease and self-care. • Improve heart disease rates. • Reduce hospitalizations from heart disease.
• Increase attendance by 5% over 2021 baseline. Offer community class at 1 church and 1 organization	December 2022	• Improve knowledge of heart disease and self-care. • Improve heart disease rates. • Reduce hospitalizations from heart disease.
Resources Committed: • Staffing		**Intended Partnerships:** • Community Agencies • Faith-based organizations • Western Tidewater Health Department

PRIORITY: Improve Community Health and Well-Being

GOAL: *Improve access to healthcare opportunities to treat and manage chronic conditions for the aging population.*

BACKGROUND ON STRATEGY

One in four Americans has multiple chronic conditions, those that last a year or more and require ongoing medical attention or that limit activities of daily living. That number rises to three in four Americans aged 65 and older.

This high prevalence has several underlying causes: the rapidly growing population of older adults, the increasing life expectancy associated with advances in public health and clinical medicine, and the high prevalence of some risk factors, such as tobacco use and physical inactivity. In 2014, 14.5% (46.3 million) of the US population was aged 65 or older and is projected to reach 23.5% (98 million) by 2060.

As a person's number of chronic conditions increases, his or her risk for dying prematurely, being hospitalized, and even receiving conflicting advice from health care providers increases. People with multiple chronic conditions also are at greater risk of poor day-to-day functioning. Aging adults experience higher risk of chronic disease. In 2012, 60% of older adults managed 2 or more chronic conditions. Chronic conditions can lower quality of life for older adults and contribute to the leading causes of death among this population.

Having multiple chronic conditions is also associated with substantial health care costs. Approximately 71% of the total health care spending in the United States is associated with care for the Americans with more than one chronic condition.[2] Among Medicare fee-for-service beneficiaries, people with multiple chronic conditions account for 93% of total Medicare spending.[3] People with multiple chronic conditions face substantial out-of-pocket costs of their care, including higher costs for prescription drugs

-adapted from *https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults/ebrs*, *https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm*

OBJECTIVE #1: *Improve community health around chronic disease conditions, including diabetes and obesity/overweight, through clinical interventions.*		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
• Partner with medical practices to effectively monitor A1C for patients with diabetes and implement effective treatment regimens. • Establish baseline for annual Medicare wellness visits to ensure screenings are being performed to identify chronic disease. • Partner with Hayden Village Center and Senior Services of Southeastern Virginia.	December 2021	• Reduce complications related to diabetes and improve overall health of patients. • Chronic disease(s) are identified early and managed effectively. • Medical group on Hayden Village site will provide convenient access for the resident senior population and help identify and manage chronic disease(s).
• Partner with medical practices to effectively monitor A1C for patients with diabetes and implement effective treatment regimens. • Establish baseline for annual Medicare wellness visits to ensure screenings are being performed to identify chronic disease. • Partner with Hayden Village Center and Senior Services of Southeastern Virginia.	December 2022	• Rates of chronic disease(s) reduced by 2%. • Increase number of Annual Medicare wellness visits by 2%.
Resources Committed: • Staffing		**Intended Partnerships:** • Medical Groups • Hayden Village • Senior Services of Southeastern Virginia • Western Tidewater Health Department

OBJECTIVE #2: *Improve community awareness of chronic disease conditions in the aging population, including diabetes and obesity/overweight.*		
ACTION PLAN		
Activity	**Target Date**	**Anticipated Impact or Result**
• Establish baseline attendance and referral mechanisms for community education to the aging population through "In the Know" sessions and food/ nutrition classes by registered dieticians. • Partnership with Western Tidewater Health Department Certified Diabetes Educator.	December 2021	• Increase knowledge of chronic disease and treatments. • Partner with Western Tidewater Health Department Certified Diabetes Educator for referral for disease specific education. • Reduced rates of chronic disease rates in the aging population. • Reduce rates of hospitalization for chronic disease in the aging population
• Establish baseline attendance and referral mechanisms for community education to the aging population through "In the Know" sessions and food/ nutrition classes by registered dieticians. • Partnership with Western Tidewater Health Department Certified Diabetes Educator.	December 2022	• Increase knowledge of chronic disease and treatments measured through pre- and post-tests. • Partner with Western Tidewater Health Department Certified Diabetes Educator for referral for disease specific education. • Reduced rates of chronic disease rates in the aging population. Reduce rates of hospitalization for chronic disease in the aging population
Resources Committed: • Staffing		**Intended Partnerships:** • Medical Practices • Western Tidewater Health Department • Community organizations • Faith-based organizations

PRIORITY: Alcohol and Substance Abuse

GOAL: Southampton Memorial Hospital will not add any additional strategies to directly address this community need and thus not be making it one of its top priorities. Referrals to local community service boards will also continue. Active participation in coalitions addressing Alcohol and Substance Abuse will continue. There are other resources in the Southampton service area with more resources or expertise to address alcohol and substance abuse, some of which are listed below.

Community Resources Available:

- Bon Secours Maryview Medical Center Behavioral Medicine Services
- Children's Hospital of the King's Daughters
- Sentara Obici Hospital
- Veterans Administration Medical Center
- Virginia Department of Health
- Western Tidewater Free Clinic

PRIORITY: Behavioral/Mental Health

GOAL: Southampton Memorial Hospital will not add any additional strategies to directly address this community need and thus not be making it one of its top priorities. Referrals to local community service boards will also continue. Active participation in coalitions addressing behavioral/mental health, especially in the area of opioid abuse, will continue. There are other resources in the Southampton service area with more resources or expertise to address behavioral and mental health, some of which are listed below.

Community Resources Available:

- Bon Secours Maryview Medical Center Behavioral Medicine Services
- Catholic Charities of Eastern Virginia
- Children's Hospital of the King's Daughters
- Senior Services of Southeastern Virginia
- Veterans Administration Medical Center
- Virginia Department of Health
- Western Tidewater Community Services Board

PRIORITY: Smoking/Tobacco Use

GOAL: Southampton Memorial Hospital will not add any additional strategies to directly address this community need and thus not be making it one of its top priorities. Referrals to local community service boards will also continue. Active participation in coalitions addressing Smoking/Tobacco Use will continue. There are other resources in the Southampton service area with more resources or expertise to address alcohol and substance abuse, some of which are listed below.

Community Resources Available:

- Bon Secours Maryview Medical Center Behavioral Medicine Services
- Children's Hospital of the King's Daughters
- Sentara Obici Hospital
- Veterans Administration Medical Center
- Virginia Department of Health
- Western Tidewater Free Clinic

OTHER IDENTIFIED COMMUNITY HEALTH NEEDS NOT ADDRESSED IN IMPLEMENTATION PLAN

Although Bon Secours Southampton Memorial Hospital recognizes the importance of all the needs identified by the community, resources are limited within the organization to prioritize all of these needs. There are other providers and organizations addressing these needs with specialized programs and services, many of whom serve on the regional Community Health Needs Assessment Coalition. Southampton Memorial Hospital is prepared to collaborate or assist with these efforts beyond the current set of services we provide.

The list below provides names of some resources in the area that can help meet the identified needs of the community:

- American Cancer Society
- American Diabetes Association
- Bon Secours Maryview Medical Center
- Catholic Charities
- Children's Hospital of the King's Daughters
- City of Franklin Chamber of Commerce
- Franklin Ministerial Alliance
- Senior Services of Southeastern Virginia
- Veterans Administration Medical Center
- Virginia Department of Health
- Western Tidewater Chamber of Commerce
- Western Tidewater Free Clinic

For a list of additional resources available to meet identified needs of the community, please review the Virginia Department of Health's Community Services Resource Guide at https://www.vdh.virginia.gov/Resources.

The Bon Secours Southampton Memorial Hospital 2021 – 2022 Implementation Plan was approved by the Bon Secours Hampton Roads Board of Directors on September 22, 2020.