Implementation Strategy

2023

A Joint Implementation Strategy for Vanderbilt University Hospitals, Vanderbilt Bedford County Hospital, Vanderbilt Tullahoma-Harton Hospital and Vanderbilt Stallworth Rehabilitation Hospital

Table of Contents

Introduction 3

Overview of Implementation Strategy 3

Purpose and Compliance
Process to Prioritize Needs
Addressing Needs

Implementation Strategy Action Plans 5

Goal 1: Reduce Inequities Caused by Social, Economic and Structural Drivers of Health 5

Goal 2: Cultivate and Maintain Community Partnerships that Advance Community Health Equity 10

Goal 3: Prevent Chronic Conditions and Address Preventative Care 12

Goal 4: Increase Access to Quality Healthcare 14

Goal 5: Increase Access to Mental and Behavioral Health Services 17

Anticipated Impact and Evaluation 21

Index of Acronyms 22

Introduction

Vanderbilt University Medical Center (VUMC) is located in Nashville, Tennessee, and primarily serves Tennessee, northern Alabama, and southern Kentucky. VUMC owns and operates six hospitals. Of the six hospitals VUMC owns and operates, the Vanderbilt University Adult Hospital (VUAH), Monroe Carell Jr. Children's Hospital at Vanderbilt (Children's Hospital), the Vanderbilt Psychiatric Hospital (VPH) operate under a single hospital facility license and are collectively referred to as "Vanderbilt University Hospitals." VUMC also owns and operates Vanderbilt Tullahoma-Harton Hospital (VTHH), Vanderbilt Wilson County Hospital (VWCH), and Vanderbilt Bedford County Hospital (VBCH). A CHNA and IS for VWCH were completed in FY22 and are posted on the VUMC website.

VUMC acquired Tennova Healthcare, Bedford County, and Tennova Healthcare, Coffee County, in January 2021, changing the hospital's names to Vanderbilt Bedford County Hospital (VBCH) and Vanderbilt Tullahoma-Harton Hospital (VTHH).

As part of a joint venture with Encompass Health Corporation, VUMC owns 50% of Vanderbilt Stallworth Rehabilitation Hospital ("Stallworth").

The 2023[1] VUMC Community Health Needs Assessments (CHNA) and Implementation Strategy (IS) is a joint CHNA that covers the licensed hospital facilities of Vanderbilt University Hospitals (Children's Hospital, VPH, and VUAH), Stallworth, VBCH, and VTHH. Throughout this Implementation Strategy, these entities are collectively referred to as "VUMC."

Purpose

The CHNA process is designed to identify key health needs and assets through systematic, comprehensive data collection in prioritized communities. The CHNA serves as a health profile for the community and describes significant health needs identified collaboratively within the community and gaps between current and desired health status. This Implementation Strategy (IS) is VUMC's response to the health needs identified through the CHNA process. It describes actions VUMC will take to address prioritized needs, with special attention to populations who are historically marginalized and minoritized, including groups that have been economically and socially marginalized and those with limited access to healthcare and health insurance.

Compliance and Written Comments

As part of the 2010 Patient Protection and Affordable Care Act, non-profit hospital organizations such as VUMC are required to complete a Community Health Needs Assessment (CHNA) and an accompanying Implementation Strategy (IS) every three years. As with prior CHNAs, VUMC conducted a process incorporating the collection and analysis of a broad range of primary and secondary data.

VUMC also solicits ongoing feedback from the public on our CHNA/IS. No written feedback had been submitted at the time of writing this report. VUMC's 2023 CHNA and IS are

[1] In February 2023, VUMC's CHNA and accompanying IS were adopted. The adoption was during VUMC's 2023 fiscal year, which is also the tax year 2022 per the Return of Organization Exempt from Income Tax, Schedule H, 990 Form. To be consistent with CHNA/IS reporting on Form 990, Schedule H, these documents are referred to hereinafter as the "2023 CHNA" and "2023 IS."

available on the Vanderbilt Community Health Improvement Website, where public comment on the CHNA/IS can be provided. Copies of each previous CHNA/IS report are available at VUMC facilities. The portal for comments is regularly monitored so comments can be addressed.

Identifying and Prioritizing the Needs

The extensive community process VUMC used to prioritize the most significant health needs is described in the CHNA. This phased approach involved identifying a set of county specific needs each community will address. For VUMC's purposes, each county's needs were then grouped into four overarching needs for VUMC to address. VUMC consulted the Community Health and Health Equity Advisory Committee (CHHEAC), a group of VUMC senior leaders, for guidance on the prioritized needs, given the breadth of needs identified across five counties. The Advisory Committee considered the scope, severity, ability, and capacity of VUMC to impact an issue and recommended that VUMC adopt the four high-level needs listed below.

VUMC considers the prioritized needs of equal importance and has not listed them in any order. These four identified needs guided the development of VUMC's Implementation Strategy. The VUMC Board of Directors adopted the CHNA/IS and the four needs outlined below in February 2023.

- **Access to Care**
- **Equity**
- **Social Drivers of Health**
- **Chronic Disease/Preventative Care**

Addressing Prioritized Needs

VUMC will address the prioritized needs identified by the community with institutional and other resources. These include staff time and financial support for the programs, initiatives, and activities described on the following pages. VUMC's Implementation Strategy also engages health systems leaders, faculty, staff, trainees, learners, and community partners.

Below are action plans to address the prioritized needs and a description of the anticipated impact. The action plans are organized into five broad goal areas that address each need and/or needs:

- **Reduce Inequities Caused by the Social, Economic, and Structural Drivers of Health**
- **Cultivate and maintain partnerships that advance community health equity**
- **Prevent Chronic Conditions and Address Preventative Care**
- **Increase Access to Quality Healthcare**
- **Increase Access to Mental and Behavioral Health Services**

These actions highlight a selection of the extensive work VUMC undertakes to address needs identified by the community. Because of the overlapping and cross-cutting nature of the prioritized needs, the need(s) being addressed are noted under "prioritized need." VUMC's plan to evaluate impact is embedded within each plan and described further in the narrative at the end of this document. A key for acronyms is included on Page 22.

Implementation Strategy Action Plans

Goal 1: Reduce inequities caused by the social, economic, and structural drivers of health

Prioritized Needs: Equity and Social Drivers of Health	
Strategy: Partner with UpRise to provide educational and financial support to participate in VUMC's Medical Assistant training program and focus hiring efforts through a partnership with UpRise and other community partners to increase the diversity of VUMC's workforce; support internal and external candidates to support allied health workforce development	
Anticipated Impact: Promote health, economic empowerment, and career advancement for VUMC's workforce and the community; expand opportunities for access to VUMC's wellness and health insurance offerings	
Action Steps	**Internal Leads**
Continue providing financial support for external candidates from organizations serving historically marginalized and minoritized groups to participate in the VUMC medical assistant training program; also provide access to health benefits and VUMC wellness programs	Ambulatory Nursing Leadership and Nursing Fellow; Allied Health; Human Resources; Employee Health
Develop additional programs to support internal and external candidate career mobilization in areas including Central Sterile Processing, Surgical Technicians, and other areas to expand the allied health workforce	Allied Health
Provide professional development opportunities for community partner participants focused on interviewing, general employment tips, and communication strategies.	Ambulatory Nursing Leadership and Nursing Fellow; Allied Health
Provide employment opportunities and opportunities for advancement for graduates from UpRise and other partners; address retention issues for candidates from UpRise and other community partners	Ambulatory Nursing Leadership and Nursing Fellow; Allied Health; Human Resources
Metrics & Milestones: On-going financial support provided; professional development opportunities identified; retention concerns for the employee population identified and addressed	

<table>
<tr><th colspan="2">Prioritized Needs: Equity and Social Drivers of Health</th></tr>
<tr><td colspan="2">Strategy: Support Health Equity Impact Plans (HEIPs) focused on: 1) food insecurity and 2) immigrant/refugee health that aligns with CHNA priorities and engages community partners in planning and implementation</td></tr>
<tr><td colspan="2">Anticipated Impact: Provide tangible food resources to patients and families at Children's Hospital; connect patients and families to ongoing food resources in the outpatient setting; improve health outcomes; strengthen infrastructure to improve health for immigrant and refugee patients at VUMC</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Convene the Food Insecurity Planning Committee with internal and external partners to determine the strategy for HEIP</td><td>OHE, MCJCH</td></tr>
<tr><td>Identify community organization(s) to partner with for the HEIP process and provide funding for community partners to participate in the food insecurity pilot.</td><td>OHE, MCJCH</td></tr>
<tr><td>Continue to screen and offer food resources among pediatric primary care patients and expand current screening and referral efforts to the pediatric inpatient setting</td><td>MCJCH</td></tr>
<tr><td>Create a cultural humility training that is informed by community partners and focused on refugee and immigrant patients</td><td>MCJCH, Center for Child Health Policy, OHE</td></tr>
<tr><td>Partner with immigrant and refugee serving community organizations to implement a Health Equity Impact Plan planning process to address immigrant and refugee children's health and expand to the adult enterprise</td><td>MCJCH, Center for Child Health Policy, OHE</td></tr>
<tr><td colspan="2">Metrics & Milestones: Increase food insecure patients receiving food assistance; increase enrollment in SNAP or WIC programs; engage community partners in the HEIP process; increase the availability of cultural humility training</td></tr>
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<table>
<tr><th colspan="2">Prioritized Needs: Equity and Social Drivers of Health</th></tr>
<tr><td colspan="2">Strategy: Continue to partner with Women's Health to support their Health Equity Impact Plan focused on birth equity for Black birthing people</td></tr>
<tr><td colspan="2">Anticipated Impact: Promote health equity and improve the delivery of care during and after childbirth at VUMC; improved maternal and infant health outcomes</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Build capacity to better support Black birthing patients who desire racial and culturally concordant doula services for labor support</td><td>Women's Health clinical leadership, Women's Health Vice Chair DEI, DEI Nursing, Nursing leadership</td></tr>
<tr><td>Improve existing outpatient childbirth patient education documents. Better utilize existing technology to provide patients with information regarding labor and delivery staffing, best practices, and postpartum transitions of care</td><td>Inpatient and outpatient Women's Health nursing services, Patient and Family Engagement and Patient Education</td></tr>
</table>

Explore strategies to improve inpatient HCAHPS survey feedback from Black birthing people.	Women's Health, Patient and Family Engagement
Identify and address inequities in birth outcomes by monitoring key obstetric quality indicators according to race, ethnicity, language, and available social determinants of health data	Women's Health/Vice Chair of DEI for Dept of ObGyn, and Director Quality and Safety for Obstetrics, Vice Chair Quality Dept of ObGyn
Expand specialty specific education focused on health disparities, maternal mortality, and racial equity for faculty. Utilize faculty and nursing resources to expand diversity, bias, antiracism and health equity educational opportunities for nursing staff	Women's Health/Vice Chair of DEI for Dept of ObGyn; Women's Health Nursing Leadership, DEI Nursing; ANO, OHE
Metrics & Milestones: Track improvements in patient education, develop nursing-doula scope of practice document, identify and implement outpatient and inpatient strategy to encourage completion of the HCAHPS survey, strategy developed to track global utilization of doula services, strategy developed to capture just in time doula satisfaction with patient care/labor support	

Prioritized Needs: Access to Care, Equity, Preventative Care, Social Drivers of Health	
Strategy: Promote racial equity and address institutional and structural racism through implementation of actions in VUMC's Racial Equity Plan (REP)[2]	
Anticipated Impact: Improved health outcomes for VUMC's patients, workforce, and communities; recognition of racism as a public health and healthcare crisis	
Action Steps	**Internal Leads**
Recruit, retain, and promote a racially and ethnically diverse workforce	Per REP
Equitably promote economic and career advancement	Per REP
Equitably deliver healthcare; eliminate racialized medicine	Per REP
Increase VUMC investments in community organizations and community vendors and suppliers who will help advance racial equity	Per REP
Metrics & Milestones: Achievement of metrics and milestones as outlined in the REP	

[2] Additional actions from the Racial Equity Plan related to the CHNA prioritized needs are embedded in other plans included in this Implementation Strategy.

Prioritized Need: Social Drivers of Health	
Strategy: Increase collection of social determinants of health (SDOH) data in the electronic medical record and partner with resources in the community to effectively address patient social needs; improve the accuracy of race, ethnicity and language data (REaL)	
Anticipated Impact: Deliver comprehensive care for patients at a high risk for readmission, address preventable ED utilization, and/or poor health outcomes due to unmet social needs; enhance ability to identify health inequities	
Action Steps	**Internal Leads**
Establish a committee to implement collection of SDOH data	CHSO, QSRP
Leverage TMO expertise to continue to assess social needs, psychosocial challenges, and financial barriers for patients; explore expansion/scaling of Emergency Department housing insecurity screen	TMO, ED
Update race and ethnicity fields in eStar; provide training to staff; roll out a patient-facing campaign about the importance of REaL data	OHE, HealthIT
Metrics & Milestones: Percentage of high-risk patients screened with complex medical and social needs in settings to be identified; increase capture of quality REaL data	

Prioritized Needs: Access to Care, Equity and Social Drivers of Health	
Strategy: Increase the number of racial and ethnic minorities in the candidate pool and hired into positions at VUMC; increase availability of resources, education, and training for career advancement for VUMC employees who are racial and ethnic minorities	
Anticipated Impact: Positively impact the number of diverse nursing candidates and improve the retention rates for nurses; expand economic opportunity for minoritized employees	
Action Steps	**Internal Leads**
Establish partnerships with HBCU Schools of Nursing within the southeast region to provide mentorship, encourage an inclusive workforce environment, and foster nursing student professional education	Sr. Director Nurse DEI, Nurse Leadership
Provide community outreach sessions focused on VUMC's nurse clinical practice, professionalism, and workforce	Sr. Director Nurse DEI, Nurse Leadership
Establish and support partnerships, discussions, and relationship building sessions focused on HBCU student's needs	Sr. Director Nurse DEI, Nurse Leadership
Provide one-day intensive immersion session at VUMC for HBCU senior nursing students to enhance inclusion and belonging, develop career planning, develop mentor relationships with nurse staff and expose students to nursing culture	Sr. Director Nurse DEI, Nurse Leadership, Human Resources, Nurse Education and Professional Development Team

Develop and maintain partnerships with HBCUs, Minority Serving Institutions, and community colleges to expand recruitment efforts	Human Resources
Develop and implement a career ladder for non-exempt positions, starting with roles where racial and ethnic minorities are disproportionately represented	Human Resources
Metrics & Milestones: Students reached through community outreach; diversity in nursing recruitment and retention; increase in HBCU & VUMC partnerships; career paths developed	

Prioritized Need: Equity, Social Drivers of Health, Access to Care	
Strategy: Partner with VUSM learners, community-based organizations focused on advocacy and policy, and community health centers to address upstream factors that impact health	
Anticipated Impact: Create equitable opportunities for all populations to achieve optimal health through advocacy and expand medical and public health student knowledge through immersive health equity experiences; increase access to healthcare	
Action Steps	**Internal Leads**
Provide funds to community organizations to offer a community health and health equity immersive experience to Vanderbilt Medical and Public Health students through OHE's Lefkowitz Fund that exposes students to advocacy and policy	OHE, VUSM
Explore processes and procedures to further support learner and trainee engagement in delivering community-based clinical services in rural and community health center settings	OHE, VUSM, GME
Metrics & Milestones: Number of students and organizations participating in OHE's Lefkowitz Fund; number of collaborations with advocacy organizations; increase exposure of learners/trainees to rural medicine	

Prioritized Need: Equity, Social Drivers of Health, Access to Care, Preventative Care	
Strategy: Provide Health Equity Innovation Awards that foster innovative ideas to advance health equity and improve health outcomes for marginalized and minoritized groups	
Anticipated Impact: VUMC's workforce and VUSM learners are engaged in developing solutions that advance health equity	
Action Steps	**Internal Leads**
Through a competitive award process, provide funds to faculty, staff, trainees, fellows and learners	OHE
Create a learning community with awardees funded since 2020	OHE
Metrics & Milestones: Number of students and organizations participating in OHE's Lefkowitz Fund; number of collaborations with advocacy organizations; increase exposure of learners/trainees to rural medicine	

Goal 2: Cultivate and maintain partnerships that advance community health equity

Prioritized Needs: Equity and Social Drivers of Health	
Strategy: Develop and enhance infrastructure to support the engagement of VUMC's workforce in community partnerships that advance health equity	
Anticipated Impact: Increase equitable and sustainable community partnerships that support health equity initiatives internally and in the community.	
Action Steps	**Internal Leads**
Convene internal collaborators to discuss and coordinate community engagement projects and resources	OHE, in collaboration with UME, GME, VICTR, Ambulatory Nursing, and others
Develop standard procedures and guidelines for VUMC faculty and staff on equitable community engagement and partnership development using internal and external community expertise	OHE, in collaboration with UME, GME, VICTR, Ambulatory Nursing, and others
Share standard procedures and guidelines for engagement enterprise-wide	OHE, in collaboration with UME, GME, VICTR, Ambulatory Nursing, and others
Enhance Health Equity Inventory to create a multi-user platform that community partners and VUMC employees can access to align and leverage community health equity efforts	OHE, VICTR
Metrics & Milestones: Internal and external partners engaged in standard procedure development; completed standard procedures and guidelines; areas reached through campaign to share standard procedures and guidelines for engagement	

Prioritized Needs: Equity, Social Drivers of Health, Preventative Care, Access to Care	
Strategy: Provide funding to community partners through the Community Health Improvement Mini-Grants to address CHNA prioritized needs with a focus on efforts that address policy and systems change	
Anticipated Impact: Improved health outcomes	
Action Steps	**Internal Leads**
Solicit proposals from community and faith-based organizations, including advocacy groups, coalitions, neighborhood associations, community health centers, and service providers, who address CHNA priorities and work to advance community health and health equity	OHE
Engage community partners in the mini-grant process by convening a review committee that makes recommendations for funding and through collaborations with local funders	OHE
Build capacity among grantees for centering equity and using a health equity lens in their work by hosting a Seeds of Equity Training for all grantees	OHE
Metrics & Milestones: Number of grants awarded; grantee progress towards advancing health equity discussed in 6-month and 12-month reports	

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<tr><th colspan="2">Prioritized Needs: Access to Care, Equity, Preventative Care, Social Drivers of Health</th></tr>
<tr><td colspan="2">Strategy: Support local county health council structure and community health improvement plans (CHIPs) for addressing prioritized health needs in Bedford, Coffee, Davidson, Rutherford, Williamson, and Wilson Counties</td></tr>
<tr><td colspan="2">Anticipated Impact: Improved health outcomes, stronger community partnerships and collaboration, and enhanced community support</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Provide administrative and strategic support to county health councils in counties listed above</td><td>OHE</td></tr>
<tr><td>Support and partner with community organizations that address identified health priorities of health councils</td><td>OHE</td></tr>
<tr><td>Share community health data, including raising awareness about the OHE data platform, at council meetings and via email newsletters to support community health equity efforts</td><td>OHE</td></tr>
<tr><td colspan="2">Metrics & Milestones: Number of meetings attended; number of collaborations; number of newsletters sent</td></tr>
</table>

Goal 3: Prevent chronic conditions and address preventative care

Prioritized Needs: Preventative Care and Equity	
Strategy: Partner with relevant PCCs, and QSRP to explore inequities and develop a pilot intervention that incorporates a community partnership to support patients with chronic disease management/preventative care	
Anticipated Impact: 1) Improve screening rates for diabetes, cancer, and mental health 2) Increase wellness visits 3) Improve health outcomes	
Action Steps	**Internal Leads**
Explore stratification of adult mental health/diabetes/cancer screening rates and wellness visits data by REaL data variables and zip code	Executive Medical Directors, ANO, and AOO of relevant PCCs, QSRP
Based on data, pilot process with PCCs to address inequities and incorporate into PCC goal setting	Executive Medical Directors, ANO, and AOO of relevant PCCs, QSRP
Determine the most significant focus area based on data that creates linkages to primary care	Executive Medical Directors, ANO, and AOO of relevant PCCs, QSRP
Identify funding opportunities, such as Health Equity Innovation Awards, and key collaborators to support a community health improvement demonstration project and monitor improvements in health outcomes	OHE, Faculty/Clinical Leaders based on project focus, QSRP to continue to provide analytics
Metrics & Milestones: Data are stratified, PCCs develop plans, and a demonstration project is outlined	

Prioritized Need: Preventative Care and Equity	
Strategy: Leverage VUMC resources to create "Health Equity Toolkits" for community health centers and other community partners on topics driven by community needs	
Anticipated Impact: Increase knowledge of chronic conditions and overall health literacy for mental health, diabetes, and substance use disorders	
Actions Steps	**Internal Leads**
Establish a committee with interdisciplinary frontline staff (e.g., nursing, dental assistants, athletic trainers); collect formative data from internal and external partners to shape intervention design	Ambulatory Nursing Leadership and Nursing Fellow
Create toolkit(s) in English, Arabic, and Spanish and provide training and training on toolkit use with at least two community health center partners	Ambulatory Nursing Leadership and Nursing Fellow; Community Partner(s); Ambulatory Magnet Program Coordinator
Distribute toolkit(s), implement a pre-post evaluation, and gather volunteer input	Ambulatory Nursing Leadership and Nursing Fellow; Community Partner(s); Ambulatory Magnet Program Coordinator

Metrics & Milestones: Pre/post literacy levels of patients established; committee meets regularly; toolkits developed and distributed

Prioritized Need: Access to Care, Preventative Care, and Equity	
Strategy: Improve preventative care and access for VUMC employees who are economically marginalized and explore opportunities for health equity-focused partnerships with employers and others in the Nashville region	
Anticipated Impact: 1) Improve screening rates for diabetes, cancer, and mental health in VUMC's employee population 2) Increase wellness visits 3) Improve health outcomes 4) Address social factors that prevent employees from achieving optimal health	
Action Steps	**Internal Leads**
Develop a process for VHAN care management outreach to historically marginalized and minoritized VUMC employees with limited financial resources	Office of Population Health
Apply learnings to inform design of VHAN clinical programs and VUMC health plans that incorporate social drivers and health equity for VUMC employees	Office of Population Health, Office of Health Equity
Explore opportunities to partner with employers in the Nashville region to address health equity and improve community health	VHAN, Office of Population Health, Office of Health Equity
Increase VUMC employees' access to health by providing health care in socially vulnerable communities where employees reside	CHSO
Offer a fully subsidized Community Supported Agriculture (CSA) share at a discounted rate for VUMC employees earning less than $40,000 per year	Center for Biomedical Ethics and Society/Rooted Community Health, Human Resources
Metrics & Milestones: Process developed, and pilot implemented; opportunities identified for working with employers; clinic established; GGH program supporting employees	

Prioritized Need: Social Drivers of Health, Preventative Care, Equity, Access to Care	
Strategy: Increase access to educational initiatives and opportunities, including community lunch and learns, and monthly diabetes and educational workshops within historically marginalized groups and those without access to healthcare and/or health insurance	
Anticipated Impact: Increase knowledge of chronic conditions and overall health literacy	
Action Steps	**Internal Leads**
Use internal and community-based partners to increase awareness of upcoming VTHH education opportunities	VTHH Market Development; Strategic Market Engagement
Continue engagement and collaboration with local organizations that focus on equitable care	VTHH Market Development; Strategic Market Engagement
Use prioritized needs to drive education topics	VTHH Market Development
Metrics & Milestones: Number of participants; number of partnerships with community organizations	

Goal 4: Increase access to quality healthcare

Prioritized Need: Access to Care and Social Drivers of Health	
Strategy: Work with community partners (Open Table Nashville, People Loving Nashville, Park Center) to address access to care and SDOH for people experiencing homelessness	
Anticipated Impact: Decrease preventable emergency department utilization; address housing and insurance needs of people who are unstably housed or experiencing homelessness and upstream health needs.	
Action Steps	**Internal Leads**
Create a team and pilot the Street Medicine program	Emergency Department, Med/Peds, Global Health
Support process to screen for and address housing needs in VUMC patients and use data collected to improve future programming	Emergency Department, TMO, Health IT, SDOH Committee
Expand immersion and service-learning opportunities for UME, GME, and Addiction Medicine Fellows to support people who are unstably housed or experiencing homelessness in Nashville and surrounding counties	GME, UME/VUSM, Shade Tree Clinic
Explore opportunities to partner with the Community Health Worker training program to offer students field placement within VUMC	Emergency Department, TMO, OHE
Metrics & Milestones: Pilot execution, and data collected; multidisciplinary team collaborating; learners and trainees engaged	

Prioritized Need: Access to Care, Equity	
Strategy: Engage community partners in developing solutions to increase access to care and decrease inequities among marginalized and minoritized patients and communities	
Anticipated Impact: Improved health outcomes	
Action Steps	**Internal Leads**
Develop an engagement plan that brings together community partners and VUMC leadership to develop strategies that address access to care in marginalized and minoritized groups	OHE, OORA, Office of Population Health,
Launch a pilot project in collaboration with Project Access Nashville to expand access to care in needed specialty areas	Office of Population Health, VUAH
Conduct a needs assessment to understand why racial and ethnic minority patients choose non-VUMC providers	OHE, CHSO
Metrics & Milestones: Engagement plan created; pilot project with Project Access Nashville launched; needs assessment completed	

Prioritized Need: Access to Care, Social Drivers of Health, Equity	
Strategy: Increase access to care by advancing and strengthening VUMC's initiatives to improve health and well-being for individuals who have limited access to healthcare and health insurance	
Anticipated Impact: Increase rate of patients connected to primary care; improve clinical outcomes through better medication adherence and enhanced quality of life	
Action Steps	**Internal Leads**
Provide accessible, high quality primary care, health education, case management and social services to uninsured patients through the Shade Tree Clinic, Vanderbilt University School of Medicine's student-run free clinic	Executive Medical Directors
Through Nurse Faculty Practice clinics, support patients with limited healthcare and insurance access at Vanderbilt Primary Care West End and North Nashville Clinics	VUSN/Clinical and Community Partnerships
Provide medication assistance to patients with financial hardship through the Medication Assistance Program and increase the accessibility of pharmacy services to patients with limited resources	Medication Assistance Program
Metrics & Milestones: Unique patient encounters and a reduction in hospital readmissions and preventable emergency department utilization; increase rate of medication access and adherence	

Prioritized Need: Social Drivers of Health, Access to Care	
Strategy: Address inequities and increase access to care for LGBTQ patients by providing comprehensive services supported by trained providers	
Anticipated Impact: Improved health outcomes	
Action Steps	**Internal Leads**
Support education and advocacy around LGBTQ health	Program for LGBTQ Health
Foster research on optimal care for LGBTQ patients and families	Program for LGBTQ Health
Continue to offer mental health services, HIV care, PrEP, and more through the LGBTQ health program	Program for LGBTQ Health
Metrics & Milestones: Number of patients served; providers trained; research support provided	

Prioritized Need: Access to Care, Preventative Care, and Equity	
Strategy: Increase access to care for Spanish-speaking patients through pilot efforts at Vanderbilt Children's Primary Care and Women's Health that will be scaled throughout VUMC	
Anticipated Impact: Improved health outcomes for Spanish-speaking patients	
Action Steps	**Internal Leads**
Use internal and community-based awareness building strategies to increase enrollment of Spanish-speaking patients in MHAV	Marketing, Human Resources, Patient and Family Engagement, HealthIT
Meaningfully engage Spanish-speaking patients about the availability of MHAV in Spanish and promote utilization	Marketing, Patient and Family Engagement, HealthIT
Address access through both the Spanish speaking Advise Vanderbilt platform and Patient and Family Advisory Group to add the voice of the patient to work focused on access	Patient and Family Engagement
Enhance availability and increase the accessibility of patient education materials in Spanish using Krames on FIHR and make VUMC's patient facing workforce aware of resources (videos, print, etc.) available through Krames	Patient and Family Engagement, Patient Education
Metrics & Milestones: Increase patients who join MHAV in Spanish; increase in percentage of patients who access educational materials	

Prioritized Need: Access to Care, Social Drivers of Health	
Strategy: Provide community resource support to VSRH patients to ensure patients have multiple resources to provide them with needed care	
Anticipated Impact: Reduced ED utilization and reduced stroke readmissions	
Action Steps	**Internal Leads**
Provide ongoing stroke support group meetings to allow patients to discuss their journeys post discharge	VSRH Stroke Team Leaders
Provide survivors and caregivers with resource packets with detailed information and steps on how to access community resources	VSRH Stroke Team Leaders
Case managers provide guidance and support post-discharge to survivors	VSRH Director of Care Management
Continue to partner with community-based organizations that provide resources to VSRH economically marginalized TBI and spinal cord injury patients.	VSRH Brain Injury and Spinal Cord Team Leaders
Metrics & Milestones: Number of support groups and resource packets distributed; number of partnerships with local, state, and national organizations	

Goal 5: Increase access to mental and behavioral healthcare services

Prioritized Need: Access to Care	
Strategy: Utilize the Pediatric Behavioral Health Consult Program in conjunction with Vanderbilt Health Affiliated Network (VHAN) to continue to provide real-time expert consultation to assist pediatric providers regarding mental health diagnosis, interventions, and recommendations as needed for their patients	
Anticipated Impact: Improved patient access and outcomes allowing for more integrated care with community partners while also assisting in addressing the shortage of pediatric behavioral healthcare providers and reducing ED utilization	
Action Steps	**Internal Leads**
Continue to provide consultation and support specific to behavioral health services and assist in the determination of appropriate level of care	VBH/VHAN
Continue to refine the consultation process and provide information on various evidence-based treatment strategies	VBH/VHAN
Continue to provide timely referral information	VBH/VHAN
Expand service model to include adult network providers and their patients.	VBH/VHAN
Metrics & Milestones: Number of consults completed; VHAN provider satisfaction survey	

Prioritized Need: Access to Care, Preventative Care	
Strategy: Continue to offer treatment for addiction and co-occurring disorders through the Vanderbilt Integrated Services for the Treatment of Addiction (VISTA), whose service lines integrate comprehensive assessment and treatment modalities, including pharmacotherapy and psychosocial treatment. Additionally, VUMC's Bridge Clinic aims to provide comprehensive SUD services to patients following hospital/ED discharges	
Anticipated Impact: Facilitation of successful hospital transitions into long-term wellness in recovery and engagement with a personalized care plan, prevention of future hospitalizations, and ultimately mortality. Decrease inpatient length of stay and rate of readmission.	
Action Steps	**Internal Leads**
Continue strengthening our services as a hub provider through contracts with the state (TDMHSAS) for OUD treatment.	VBH/VISTA
Offer PAC for patients seen in the ED for up to 3 months.	VBH/VISTA
Expand treatment services to include IOP.	VBH/VISTA
Metrics & Milestones: Volume Metrics	

<table>
<tr><th colspan="2">Prioritized Need: Preventative Care, Access to Care, Social Drivers of Health</th></tr>
<tr><td colspan="2">Strategy: Utilize existing collaborative relationships with health and mental health organizations across Tennessee and the region to best serve VUMC’s patients and communities with mental health needs. VBH leadership will continue to serve on various boards for organizations, including but not limited to: Mental Health America of the Mid-South, Tennessee Voices, NAMI Davidson County, and Park Center, as well as serving on other community task forces and coalitions.</td></tr>
<tr><td colspan="2">Anticipated Impact: Foster collaboration with key mental health organizations; provide patient, family, provider, and general community education; enhance access and outreach for individuals and stakeholders throughout the community.</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Continue to collaborate with organizations such as the National Alliance on Mental Illness (NAMI) through event sponsorships and support of the annual NAMI Walk, as well as providing monthly support groups and an education series for the public.</td><td>VBH</td></tr>
<tr><td>Offer PAC for patients seen in the ED for up to 3 months.</td><td>VBH/VISTA</td></tr>
<tr><td>Grow presence on key community boards/advisory councils to influence further policy and potentially the development of additional community-based services.</td><td>VBH</td></tr>
<tr><td>Explore new relationships as deemed appropriate based on patient and organizational needs.</td><td>VBH</td></tr>
<tr><td colspan="2">Metrics & Milestones: Number of boards, task forces, advisory councils, etc., on which VBH has a strategic presence</td></tr>
</table>

<table>
<tr><th colspan="2">Prioritized Need: Social Drivers of Health</th></tr>
<tr><td colspan="2">Strategy: Work with Vanderbilt Behavioral Health to provide advanced clinical programs and training and exposure to multiple points of entry into the healthcare system</td></tr>
<tr><td colspan="2">Anticipated Impact: Workforce development to increase integrated behavioral healthcare services, thus allowing additional patients to receive care.</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Implement a multifaceted clinical rotation plan to serve a wide array of patients and their co-morbid diagnoses.</td><td>VBH</td></tr>
<tr><td>Develop focus groups to gather information on mental health and substance use programming needs in conjunction with NAMI Davidson County.</td><td>VBH</td></tr>
<tr><td colspan="2">Metrics & Milestones: Number of clinicians trained; Number of focus group participants</td></tr>
</table>

Prioritized Need: Access to Care, Equity	
Strategy: Utilize Vanderbilt's Psychiatric Assessment Service (PAS) to provide specialized assessments for patients with immediate behavioral health care needs in a therapeutic and safe environment	
Anticipated Impact: Immediate assessment and stabilization of adult behavioral health patients, impact preventable ED utilization	
Action Steps	**Internal Leads**
Continue to provide a complete psychiatric evaluation as well as a medical screening	VBH
Continue to offer walk-in crisis evaluations for adults	VBH
Continue to coordinate referrals from the adult and pediatric emergency rooms as well as outside entities	VBH
Expand telehealth services to partner with community hospitals to assess behavioral health patients in their EDs	VBH
Metrics & Milestones: Number of assessments provided; number of walk-in patients served	

Prioritized Need: Access to Care, Equity	
Strategy: Provide evidence-based mental health treatment utilizing Vanderbilt Behavioral Health school-based mental health services in school-based clinics across Davidson County for students who are enrolled in TennCare	
Anticipated Impact: Mental health care services provided for youth who would otherwise not be able to access mental health care; improved academic and behavioral functioning; reduced need for higher levels of care	
Action Steps	**Internal Leads**
Continue to provide therapeutic services directly to students and their families, including individual, family, and group therapy and medication management services.	VBH
Provide ongoing consultation to school staff on therapeutic approaches for students' unique needs.	VBH
Assist in crisis management to promote student safety.	VBH
Continue to partner with community-based organizations to support student/family needs.	VBH
Metrics & Milestones: Number of students and families served; number of schools served; types of services provided	

<table>
<tr><th colspan="2">Prioritized Need: Preventative Care, Access to Care</th></tr>
<tr><td colspan="2">Strategy: Continue to support the VBH Patient and Family Advisory Council (PFAC), individuals seeking to ensure that needs of the community are understood and that VBH is addressing pertinent issues as they arise</td></tr>
<tr><td colspan="2">Anticipated Impact: Improvement in overall services and improved access to the highest quality clinical care and community resources</td></tr>
<tr><th>Action Steps</th><th>Internal Leads</th></tr>
<tr><td>Continue to involve former patients and family members in planning programs and policies as well as in our general orientation curriculum.</td><td>VBH</td></tr>
<tr><td>Continue to recruit council members with the goal of increasing diversity</td><td>VBH</td></tr>
<tr><td>Provide enhanced information regarding viable community resources.</td><td>VBH</td></tr>
<tr><td colspan="2">Metrics & Milestones: Number of new members year-over-year; number of new staff oriented by PFAC members</td></tr>
</table>

Anticipated Impact and Evaluation

VUMC's Office of Health Equity and the Community Health and Health Equity Advisory Committee will evaluate key metrics annually based on the anticipated impact and metrics noted in each action plan. As needed, the Community Health Improvement Working Group will review publicly available data and other relevant data sources that provide a window into VUMC's success in addressing the prioritized needs. Publicly available data will be tracked and mapped using tools such as the HCI platform, focusing on populations most impacted by health inequities. Ongoing initiatives and programs will also be updated using the Health Equity Inventory.

Index of Acronyms

ANO	Associate Nursing Officer
AOO	Associate Operating Officer
CHHEAC	Community Health and Health Equity Advisory Committee
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHSO	Chief Health System Officer
CSA	Community Supported Agriculture
DEI	Diversity, Equity, and Inclusion
ED	Emergency Department
GGH	Growing Good Health
GME	Graduate Medical Education
HBCU	Historically Black Colleges and Universities
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HEIP	Health Equity Impact Plan
IOP	Intensive Outpatient Program
IS	Implementation Strategy
LGBTQ	Lesbian, gay, bisexual, transgender, and queer
MCJCH	Monroe Carell Jr. Children's Hospital at Vanderbilt
MHAV	My Health at Vanderbilt
MPH	Master of Public Health
NAMI	National Alliance on Mental Illness
OHE	Office of Health Equity
OORA	Office of Outpatient Referral Assistance
OUD	Opiate Use Disorder
PAC	Post-Acute Care
PAS	Psychiatric Assessment Service
PCC	Patient Care Center
PFAC	Patient and Family Advisory Council
PrEP	Patient and Family Advisory Committee
QSRP	Quality, Safety, and Risk Prevention
REaL	Race, Ethnicity, and Language
REP	Racial Equity Plan
SDOH	Social Drivers of Health
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance Use Disorder
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services Licensure

TMO	Transition Management Office
UME	Undergraduate Medical Education
VBCH	Vanderbilt Bedford County Hospital
VBH	Vanderbilt Behavioral Health
VHAN	Vanderbilt Health Affiliated Network
VICTR	Vanderbilt Institute for Clinical and Translational Research
VISTA	Vanderbilt Integrated Services for the Treatment of Addiction
VPH	Vanderbilt Psychiatric Hospital
VSRH	Vanderbilt Stallworth Rehabilitation Hospital
VTHH	Vanderbilt Tullahoma-Harton Hospital
VUAH	Vanderbilt University Adult Hospital
VUMC	Vanderbilt University Medical Center
VUSM	Vanderbilt University School of Medicine
VVI	Vizient Vulnerability Index
VWCH	Vanderbilt Wilson County Hospital
WIC	Women, Infants, and Children