9.1.2024–8.31.2027

IMPLEMENTATION STRATEGY

BAPTIST HEALTH®

CORBIN

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Introduction

Foreword

This Implementation Strategy document, developed from June 2024–November 2024, serves as an accompaniment to the Community Health Needs Assessment (CHNA) by identifying the strategies which Baptist Health Corbin will employ during fiscal years 2025–2027 (September 1, 2024–August 31, 2027) to address the needs identified in the most recent CHNA. The approval and adoption of this report by the Baptist Health System, Inc. Board of Directors complies with CHNA requirements mandated by the *Patient Protection and Affordable Care Act of 2010* and federal tax-exemption requirements.

Executive Summary

The Implementation Strategy process involved the following steps:

- From June 2024–November 2024, Baptist Health Corbin developed this Implementation Strategy report in response to the most recent Community Health Needs Assessment (CHNA).
- This plan identifies specific strategies to address the significant needs identified in the CHNA. The significant needs from that report include:
    - Substance Use (drug/alcohol/tobacco use)
    - Mental Health
    - Obesity
- Details listed for each strategy include the:
    - Name of the strategy.
    - Specific goal or plan for each strategy.
    - Process metrics to identify short-term or intermediate-term goals to measure progress of the strategy.
    - Outcomes metrics to correlate long-term community health outcomes with the efficacy of the strategy.
    - Internal resources the hospital is committing to the strategy.
    - External partners associated with implementing the strategy.
    - Lens of equity to ensure equitable efforts are made across population groups to reduce health disparities.
- This report was offered for approval to the Baptist Health System, Inc. Board of Directors at a meeting on December 10, 2024.
- The final approved and adopted Implementation Strategy will be made public and widely-available on or before January 15, 2025 on the Baptist Health website: Community Health Needs Assessments - Baptist Health.
- Next steps include documenting metrics and evaluating the strategies listed in this report. The hospital will conduct another Community Health Needs Assessment and document its Implementation Strategy within three years.

Background: Community Health Needs Assessment

The Baptist Health Corbin CHNA, approved by the Baptist Health System, Inc. Board of Directors on June 25, 2024, outlines the significant health needs to address during the report coverage period (September 1, 2024–August 31, 2027). The needs identified include:

- Substance Use (drug/alcohol/tobacco use)
- Mental Health
- Obesity

The CHNA describes the process for how needs were identified, and which needs, if any, will not be addressed in the Implementation Strategy. For further background information that informs this Implementation Strategy, see the CHNA here: Community Health Needs Assessments - Baptist Health.

Third-Party Collaboration

No third-party organizations were involved in the writing of this report. The Baptist Health System Director, Community Health and Engagement is responsible for the data gathering and writing of this report with feedback from hospital and system service line leaders. Hospital leaders reviewed and approved this plan before final authorized body approval.

Process

Development of Strategies

Each health need has an action plan that includes both existing and planned strategies. Employing existing strategies shows a continuity of efforts that underscores the hospital's ongoing commitment to addressing significant community health needs. Planned strategies may be in various stages of development and may have certain details still being formed. Evaluation of these strategies will be documented annually as required and in the "Evaluation of Efforts" section of the next CHNA.

Framework

The SMARTIE objectives framework was employed to ensure this plan listed equitable and inclusive goals that encourage a focus on health equity. The framework is used by both the Centers for Disease Control and Prevention (2021) and the Kentucky Department for Public Health (2024). SMARTIE objectives are developed by answering the following questions (Alford Group, 2024):

- **S**PECIFIC: What does your program hope to accomplish?
- **M**EASURABLE: What are your benchmarks?
- **A**CTION-ORIENTED/**A**CHIEVABLE: What are the identifiable intermediate actions or milestones?
- **R**ELEVANT/**R**EALISTIC: What results can realistically be achieved given available resources, knowledge, and time?
- **T**IMEBOUND: How will you track progress?
- **I**NCLUSIVE: How will you include representation from socially and economically marginalized individuals and groups?
- **E**QUITABLE: How do you include an element of justice or fairness that seeks to address inequity?

Each strategy is listed in its labeled section with the following details:

- Name of the strategy.
- Specific plan for each strategy. Strategies are evidenced-based or at least promising practices in that area.
- Process metrics to identify short-term or intermediate-term goals to measure progress of the strategy. This is part of the evaluation of each strategy.
- Outcomes metrics to correlate long-term community health outcomes with the efficacy of the strategy. The outcome metrics tie back to data included in the CHNA from the County Health Rankings and the Kentucky Injury Prevention Research Center. While hospital strategies are not wholly responsible for changes in these broad metrics, we will measure efficacy of our interventions through correlation with improved health outcomes. This is also part of the evaluation plan for each strategy.
- Internal resources the hospital is committing to the strategy. Activities with costs reportable as community benefit will be reported and documented as such.
- External partners associated with implementing the strategy. These may include local partners, funders or grantors, public health agencies, or organizations that own the evidence-based programs listed in the Implementation Strategy.
- Lens of equity to ensure equitable efforts across population groups and reduce disparities. The equity examination comes from an analysis of disparities experienced by certain groups after the evaluation

of the Center for Disease Control and Prevention's (CDC) *Healthy People 2020*. An interactive dataset allowed for choosing a health area (mental health, substance use, nutrition and weight status, etc.). Each area indicates which, if any, populations experienced an increase in disparities during the *Healthy People 2020* coverage period. Groups that may experience disparities include: people of color; people with disabilities; people living in rural communities; older adults; people with mental health or substance use disorders; people with less than high school education; people with low incomes or those experiencing poverty; and people who identify as lesbian, gay, bisexual, or transgender (CDC, 2021). Populations with health disparities in the hospital's significant health needs are noted in the "Equity" section of each strategy.

Strategies to Address Significant Health Needs

Substance Use

The strategies below are the hospital's plan to address substance use.

1.1: Adult Detox Recovery Unit

- Plan: Operate a detox recovery unit that provides medically managed and monitored detoxification services for adults. The program includes diagnosis, managed withdrawal, and aftercare components.
- Process Metrics: Track the number of admissions.
- Outcomes Metrics: Reduce community health behaviors that indicate substance use, which may include nonfatal hospital encounters for substance use. The 2022 community rates per 100,000 residents are 3427 (Whitley County), 2673 (Knox County), and 1801 (Laurel County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

1.2: Adult Chemical Dependency Intensive Outpatient Program (IOP)

- Plan: Operate an Adult Chemical Dependency Intensive Outpatient Program (IOP) that provides stabilization and assessment services, treatment options, and IOP group therapy.
- Process Metrics: Track use of IOP service.
- Outcomes Metrics: Reduce community health behaviors that indicate substance use, which may include nonfatal hospital encounters for substance use. The 2022 community rates per 100,000 residents are 3427 (Whitley County), 2673 (Knox County), and 1801 (Laurel County) (Kentucky Injury Prevention and Research Center, 2024).

- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, psychiatric nurse practitioners, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

1.3: Inpatient Adolescent Unit

- Plan: Operate an adolescent psychiatric program that provides intensive hospitalization for adolescents 12-17 years of age. The unit operates 11 beds and offers psychiatric medical services and brief intensive therapy for adolescents and families. This unit cares for adolescents with substance use needs and mental health needs.
- Process Metrics: The goals for the unit are to provide family-centered care and crisis stabilization, as well as appropriate linkage to ongoing services that meet the needs of the adolescents and the family.
- Outcomes Metrics: Reduce community health behaviors that indicate substance use, which may include nonfatal hospital encounters for substance use. The 2022 community rates per 100,000 residents are 3427 (Whitley County), 2673 (Knox County), and 1801 (Laurel County) (Kentucky Injury Prevention and Research Center, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male, and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

1.4: Medication-Assisted Treatment (MAT)

- Plan: Offer treatment for addiction using medications.
- Process Metrics: Monthly, track the number of new patients for the MAT provider.
- Outcomes Metrics: Reduce the number of opioid-involved non-fatal overdoses. The 2022 county rates of opioid-involved nonfatal overdoses per 100,000 residents are 121.9 (Whitley County), 60.5 (Knox County), and 54.1 (Laurel County) (Kentucky Injury Prevention Research Center, 2024).
- Internal Resource(s): Baptist Health Corbin will employ providers able to prescribe MAT.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in substance abuse disparities based on geographic area, gender, and race/ethnicity. Populations that had the greatest increase in disparities included those living in urban areas, those who identify as male,

and those who are Black. Considerations will be made to ensure equitable efforts across population groups.

1.5: Tobacco Cessation Clinics

- Plan: Offer two pharmacist-led tobacco cessation clinics, allowable through board-authorized protocol, where pharmacists can order medications for tobacco cessation. One clinic generally sees oncology patients, which includes monthly follow-up directly from the pharmacist until the patient successfully quits smoking or opts-out. The other clinic is accessible to anyone and focuses on medication therapy management (MTM) interventions.
- Process Metrics: The oncology clinic tracks a quit success rate, which was 17.5% from February 2023-February 2024. This is 10% higher than the CDC's national average.
- Outcomes Metrics: Reduce the community's smoking rate from 26% (Whitley County), 30% (Knox County), and 25% (Laurel County) (County Health Rankings, 2024).
- Internal Resource(s): Referrals to the oncology clinic comes from general surgery and oncology. The MTM clinic is open to anyone and includes family members and caregivers of oncology patients. A pulmonologist provides the physician consent that allows the pharmacy team to operate the clinics through board-authorized protocol.
- External Partner(s): CDC 1-800-QUITNOW helpline for patients who need assistance with medication costs
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in tobacco use disparities based on geographic area, race/ethnicity, and income. Populations that had the greatest increase in disparities included those living in rural areas, those who are Hispanic of Latino ethnicity, and those with family income below middle income. Considerations will be made to ensure equitable efforts across population groups.

Mental Health

The strategies below are the hospital's plan to address mental health.

2.1: Inpatient Adolescent Unit

- Plan: Operate an adolescent psychiatric program that provides intensive hospitalization for adolescents 12-17 years of age. The unit has eleven beds and offers psychiatric medical services and brief intensive therapy for adolescents and families. This unit cares for adolescents with substance use needs and mental health needs.
- Process Metrics: The goals for the unit are to provide family-centered care and crisis stabilization, as well as appropriate linkage to ongoing services that meet the needs of the adolescents and the family.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.

- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.2: Inpatient Adult Unit

- Plan: Operate an inpatient adult behavioral health unit to treat adults ages 18-64 who require 24-hour nursing care. The inpatient unit treats individuals with complex mental illness including depression, bipolar disorder, generalized anxiety disorder, schizophrenia, schizoaffective disorder, obsessive-compulsive disorder and dual-diagnosis addictive disorders.
- Process Metrics: Track the number of admissions.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.3: Inpatient Senior Unit

- Plan: Operate an inpatient senior behavioral health unit for seniors ages 65 and above. Services offered include psychiatric evaluation and daily management; 24-hour nursing care; individual, group, and family therapy; individualized treatments and aftercare planning; medical services and consults; individualized education; and therapeutic recreational groups and activities.
- Process Metrics: Track the number of admissions.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, registered nurses, licensed clinical social workers, recreation socialists, and mental health technicians.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.4: Behavioral Health Intensive Outpatient Program

- Plan: Operate a Behavioral Health Intensive Outpatient Program (BH IOP) group therapy treatment to bridge the gap between acute inpatient and outpatient services, serving as both an alternative to hospitalization and as a transition from inpatient care.
- Process Metrics: Track use of IOP service.

- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): The treatment team includes psychiatrists, clinical social workers, psychiatric nurse practitioners, and registered nurses.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.5: Adolescent Intensive Outpatient Program (IOP)

- Plan: Operate an Intensive Outpatient Program for adolescents ages 12-17 to provide therapy, medical evaluation and follow-up. The program uses both individual and group therapy sessions.
- Process Metrics: Track use of IOP service.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): These programs are led by a master's prepared therapist and a registered nurse.
- External Partner(s): Referrals are accepted from hospitals, behavioral health agencies, court systems, private clinicians, residential treatment services, primary care physicians, and community agencies.
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.6: Motherhood Connection Program

- Plan: Complete the Edinburgh Postnatal Depression Scale before delivery with pregnant persons enrolled in program. EPDS completed before delivery to establish baseline.
- Process Metrics: Track the number of questionnaires completed and the number of referrals made for behavioral health support.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): MCP Nurse Navigators will ask questions and provide referrals, if needed. MCP Program Coordinator will provide data.
- External Partner(s): Various community partners supporting parenting people
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups. The U.S. Commission on Civil Rights noted racial disparities in maternal health outcomes, so efforts will be made to ensure equitable outcomes across race/ethnicity.

2.7: Mental Health First Aid

- Plan: Offer at least two Mental Health First Aid classes to community members as an evidence-based, early intervention course to teach people about mental health and substance use challenges.
- Process Metrics: Track the number of community members educated in MHFA classes.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health System Behavioral Health team will lead/support hospital staff in providing classes.
- External Partner(s): National Council for Mental Wellbeing and various community non-profits and schools
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.8: Chalk the Walk

- Plan: Host community Chalk the Walk event annually to reduce the stigma around mental health and spread positive messages.
- Process Metrics: Track the staff time spent participating in Chalk the Walk activities.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health System Behavioral Health will lead these efforts.
- External Partner(s): none
- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

2.9: Community Behavioral Health Liaison

- Plan: Liaison bridges community and behavioral health services, including connecting people with needed treatment. This position develops relationships and builds trust between community and the hospital.
- Process Metrics: Provide behavioral health support inside and outside hospital. This includes attending community outreach events to educate on services and prevention, as well as liaising with other hospitals, treatment facilities, and local businesses to share information about services and assist with linking to those services.
- Outcomes Metrics: Reduce the community's number of poor mental health days in the past 30 days from 6.3 days in Whitley County, 6.8 days in Knox County, and 6.0 days in Laurel County (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Corbin will employ the Community Behavioral Health Liaison.
- External Partner(s): Tri-County Domestic Violence Board; VOA; Goodwill; District Courts in Whitley, Knox and Laurel Counties; Whitley County Schools and other local schools and colleges; UNITE for Whitley, Knox and Laurel Counties; QRT Team; Fair Team for Whitley, Knox and Laurel Counties

- Equity: According to the CDC's Healthy People 2020 final data review, there was in an increase in mental health disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

Obesity

The strategies below are the hospital's plan to address obesity.

3.1: Diabetes Management

- Plan: Provide one-on-one diabetes management education for patients in the inpatient and outpatient settings.
- Process Metrics: Track the number of patients seen in each setting.
- Outcomes Metrics: Reduce the diabetes prevalence in the community from 12% (Whitley County), 14% (Knox County), and 12% (Laurel County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Corbin employs the Diabetes Nurse Educator.
- External Partner(s): none
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in diabetes disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

3.2: Diabetes Community Education

- Plan: Acknowledging the connection between diabetes and obesity, provide free community education related to healthy eating and managing blood sugar. This hands-on education includes teaching about hidden fats and sugars in foods, as well as appropriate food portions, will be held at a variety of community events.
- Process Metrics: Track the number of people educated, the type of education provided, and the time spent at community events.
- Outcomes Metrics: Reduce the diabetes prevalence in the community from 12% (Whitley County), 14% (Knox County), and 12% (Laurel County) (County Health Rankings, 2024).
- Internal Resource(s): Baptist Health Corbin employs the Diabetes Nurse Coordinator.
- External Partner(s): AHEC, SOAR, local churches, local schools, and others to be determined
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in diabetes disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

3.3: Stroke Community Education

- Plan: Acknowledging the connection between stroke and obesity, provide free education and/or screenings related to stroke risk factors. This may include blood pressure assessment and blood glucose and lipid testing. After the assessments, clinical staff will provide one-on-one education with community members discussing their personal risk factors and options for lifestyle modifications.
- Process Metrics: Provide at least one community education event per year.
- Outcomes Metrics: Reduce the obesity rate in the community from 42% (Whitley County), 42% (Knox County), and 47% (Laurel County) (County Health Rankings, 2024).

- Internal Resource(s): Baptist Health Corbin employs the Stroke Coordinator.
- External Partner(s): Future partners to be determined, but may include local churches Parkway Ministries, St. Paul's, and St. John's
- Equity: According to the CDC's Healthy People 2020 final data review, there was an increase in nutrition and weight disparities according to geographic area. Considerations will be made to ensure equitable efforts across both urban/metropolitan and rural/nonmetropolitan population groups.

Community Health Improvement Matrix (CHIM)

To illustrate the depth and breadth of the strategies in place to address our community health needs, we borrowed a tool from the National Association of County & City Health Officials (NACCHO, 2017). The Community Health Improvement Matrix (CHIM) allows us to see where our strategies fall in terms of the prevention and intervention levels. We have developed a matrix for each health need as a graphic representation of our work.

Prevention levels describe where in time we can intervene to address a health need. These levels are described as follows:

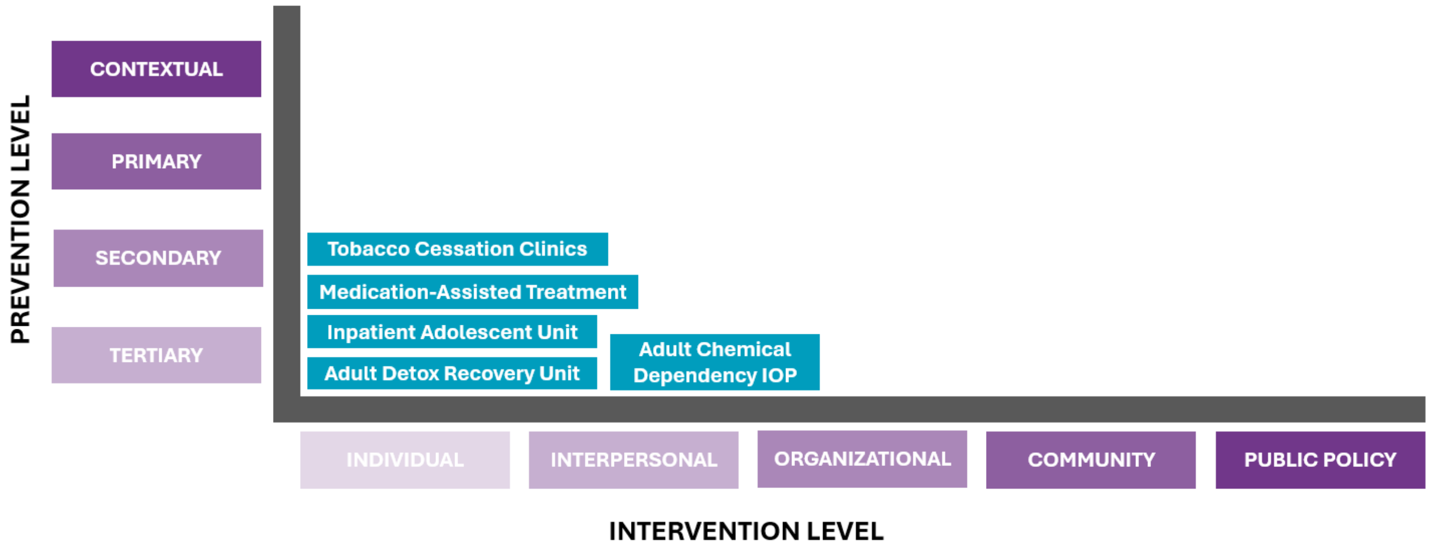
- Contextual: prevent the emergence of predisposing social and environmental conditions that can cause disease
- Primary: reduce susceptibility of exposure to health threats
- Secondary: detect and treat disease in early stages
- Tertiary: alleviate the effects of disease and injury

Intervention levels describe the context in which these interventions occur. These levels are described as follows:

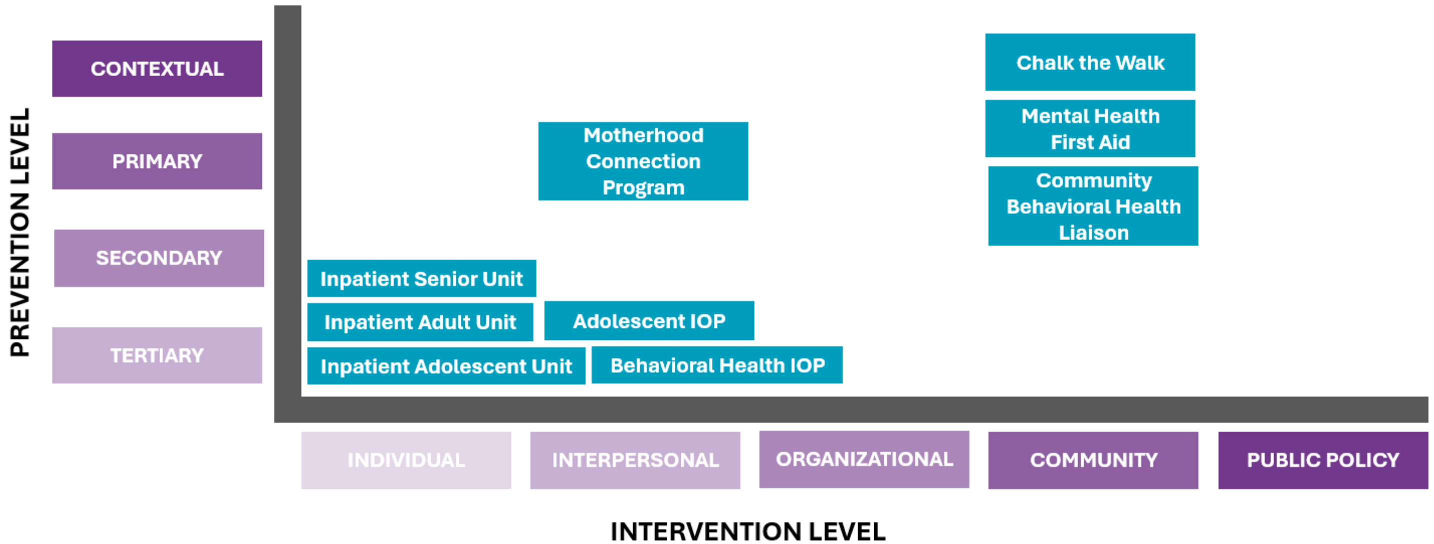
- Individual: characteristics of the individual, such as knowledge, attitudes, behaviors, self-concept, skills, etc.
- Interpersonal: formal and informal social network and social support systems, including family, work group, and friendship networks
- Organizational: social institutions with organizational characteristics and rules/regulations for operation
- Community: relationships among organizations, institutions, and informal networks within defined boundaries
- Public Policy: local, state, and national laws and policies

According to NACCHO, “Activities that fit under organizational, community or public policy targets at a primary prevention level are more likely to address social determinants than others on the matrix. All the activities may be important for the community’s work in addressing a problem; the advantage of the CHIM framework is that it can give a sense of the balance of the community’s endeavors.”

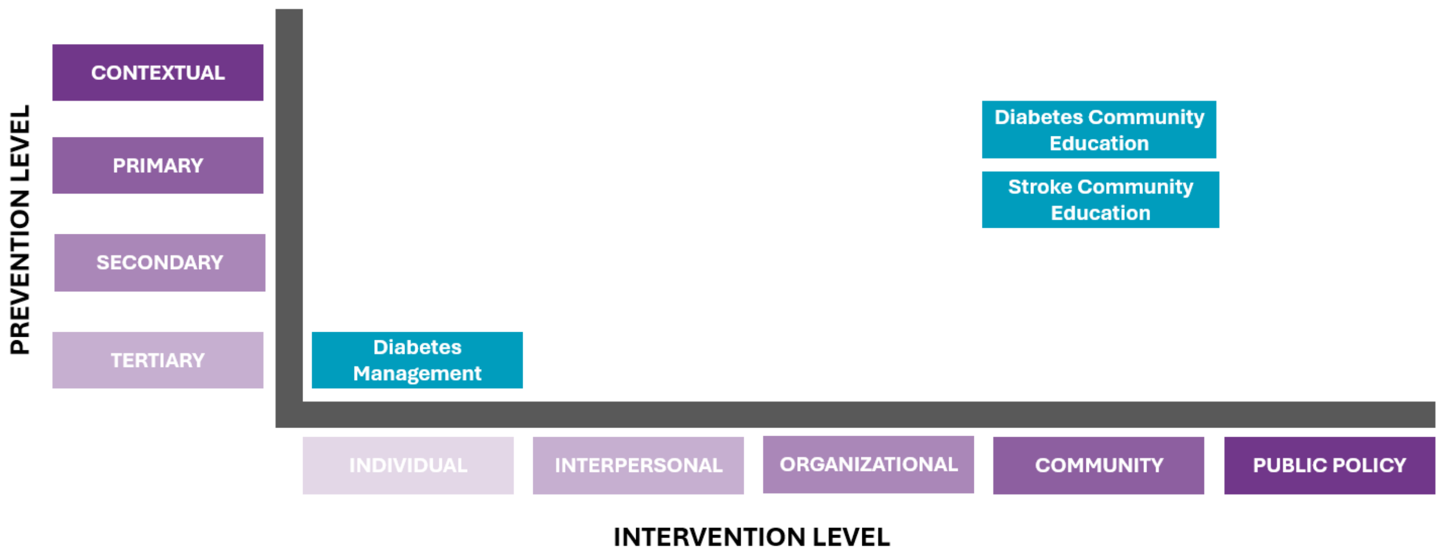
CHIM: Substance Use



CHIM: Mental Health



CHIM: Obesity



Next Steps

Once approved by the Baptist Health System, Inc. Board of Directors, this CHNA will be made public and widely available no later than January 15, 2025.

Baptist Health Corbin is committed to documenting metrics and evaluating the strategies listed in this report. The hospital will conduct another community health needs assessment and document its implementation strategy within three years.

Approval and Adoption

As an authorized body of Baptist Health Corbin, Baptist Health System, Inc. Board of Directors approves and adopts this Implementation Strategy on the date listed below.

Chair, Baptist Health System, Inc. Board of Directors
Dec. 10, 2024
Date

References

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