

Prisma Health Community Health Needs Assessment 2019–2022 Action Plan

Priority area: Drug use

Goals	Implementation strategies
<p>1 Increase provider awareness of substance use disorders through education</p>	<p>1.1 Develop provider-focused education for hospitals, practices and independent providers, including future workforce, around best practices including prescribing alternatives, using addiction treatment, identifying community resources, and reducing stigma and the impact on society and families</p> <p>1.2 Increase use of Prescription Drug Monitoring Program (PDMP)</p> <p>1.3 Develop an organization-wide strategy around integrating best practices (including PDMP, early detection, screening, etc.) in the electronic health record</p>
<p>2 Increase community awareness of substance use disorders through education</p>	<p>2.1 Develop community-focused education for the Prisma Health market around substance use, identifying community resources, using treatment options, and reducing stigma and the impact on society and families</p>
<p>3 Develop a best practice around drug-endangered children to improve patient outcomes and family resilience</p>	<p>3.1 Develop an organization-wide substance exposure program to support drug-endangered children and their families:</p> <ul style="list-style-type: none"> • Conduct an analysis of national best practices and programs • Conduct a county-wide assessment of all resources, programs and services (both internal external) • Identify gaps within each community and develop an action plan to address community needs • Develop and implement at least one pilot program
<p>4 Promote collaboration among organizations to meet the health and social needs of our community</p>	<p>4.1 Advance local and state dialogue to address substance use and addiction</p> <p>4.2 Further develop a digital referral system to better connect our patients with community-based organizations</p>

Priority area: Mental health

Goals	Implementation strategies
<p>1 Implement best practices that address community mental and behavioral health needs</p>	<p>1.1 Improve early detection of depression:</p> <ul style="list-style-type: none">• Increase depression screening rates of patients across Prisma Health primary care practices• Integrate a suicide severity screening tool organization-wide <p>1.2 Improve access to services both internally and externally:</p> <ul style="list-style-type: none">• Enhance triage and connection to treatment and community-based services and programs through use of digital solutions and referral systems
<p>2 Increase access to appropriate and affordable quality mental and behavioral health services</p>	<p>2.1 Expand access through use of digital health solutions and investment in providers</p> <p>2.2 Further integrate access to behavioral health care within primary care practices</p> <p>2.3 Enhance access through workforce development efforts via existing Prisma Health psychiatry residency programs and through development of new programs and fellowships</p>
<p>3 Promote collaboration among organizations to meet the health and social needs of our community</p>	<p>3.1 Advance local and state dialogue to address mental and behavioral health needs with state agencies, health care systems, and other community partners</p> <p>3.2 Further develop a digital referral system to better connect our patients with community-based organizations</p>

Priority area: Obesity

Goals	Implementation strategies
1 Increase awareness of healthy eating and active living programs and services	1.1 Develop provider-focused education for hospitals, practices and independent providers around healthy eating and active living programs and services 1.2 Develop community-focused education for the Prisma Health market around healthy eating and active living programs and services
2 Promote health through healthy eating and active living programs and interventions	2.1 Improve early detection of food insecurity and access to services: <ul style="list-style-type: none">• Screen patients within Prisma Health primary care practices to detect food insecurity• Develop a referral process for connection to community-based services and programs 2.2 Increase access to education and programs: <ul style="list-style-type: none">• Expand the Diabetes Prevention Program (DPP)• Expand and implement culturally-appropriate healthy eating education programming for the Latino families we serve• Increase connection to treatment and community-based services and programs through referrals to community-based organizations 2.3 Develop a best practice around children who are overweight and obese for upstream prevention: <ul style="list-style-type: none">• Expand and establish a provider-led best practice for pediatric patients with a BMI of 85% or higher including a decision support tool that includes patient and family education, best practices, evidence-based interventions, and connection and treatment to community-based services and programs• Develop an organization-wide strategy around best practices integration in the electronic health record
3 Promote collaboration among organizations to meet the health and social needs of our community	3.1 Advance local and state dialogue to address obesity, healthy eating and active living 3.2 Further develop a digital referral system to better connect our patients with community-based organizations