



# BEEBE HEALTHCARE COMMUNITY HEALTH IMPLEMENTATION PLAN

*Sussex County is Our Specialty*



**NOVEMBER 2022**



**Beebe**  
Healthcare



# COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY PLAN

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# LETTER FROM THE CEO

## Our Commitment to Your Good Health

With over a century of commitment to Sussex County, Beebe Healthcare is the healthcare provider of choice to the people and families of our community. Over the past 100 years, we have grown from a small community hospital to a progressive integrated healthcare system focused on bringing clinically sophisticated and innovative programs to our area to help people in our community lead and maintain healthy lifestyles.

We are pleased to present our Community Health Implementation Plan. Beebe Healthcare conducts a community health needs assessment every three years as a nonprofit health system to identify our county's evolving health priorities. This is accomplished by engaging our community members, leaders, and partners through surveys, interviews, and focus groups. These findings help Beebe Healthcare target solutions and specialize in what our communities need - by listening to those we serve and developing focused plans. We deeply believe in the importance of this work.

I would like to offer my gratitude to the residents, stakeholders, partners, and focus group participants throughout Sussex County for their valuable contributions and the time they offered to our CHNA process. We thank all our community partners for their dedicated collaboration to date and look forward to our next phase of implementation planning that will continue to include collective strategies for the greatest impact.

We are committed to serving the needs of our growing community. We are proud that our Medical Staff continues to grow because of the excellent clinical programs and opportunities. A robust medical staff helps address a lack of access to care. Since our previous CHNA, Beebe has added well over 100 clinicians, and this new assessment will facilitate adding more.

In June of 2022, Beebe announced its new 5-year strategic plan: One Beebe. This plan renews our commitment to providing the best care for our patients and our community. To ensure that we remain the best choice for area residents and visitors alike, we must strategically reaffirm our mission and vision, build on our momentum through focused action in pursuit of distinctive and essential goals, and strengthen our culture of empathy and excellence for all.



Beebe Healthcare is solely focused on the healthcare needs of the people who live, work, visit, and seek care in Sussex County. As the only health system headquartered in and focused solely on Sussex County, it is our unique position to truly understand the programs, technologies, and barrier breakers needed to provide excellent healthcare services to those we serve because Sussex County is Our Specialty.

Sincerely,

A handwritten signature in black ink, appearing to read "David A. Tam".

**David A. Tam** MD, MBA, CPHE, FACHE  
**President & CEO**

## MISSION

Beebe Healthcare's charitable mission is to encourage healthy living, prevent illness, and restore optimal health with the people residing, working, or visiting the communities we serve.

## VISION

Our vision is that Beebe Healthcare will be the health system of choice for all people in Sussex County.





## INTRODUCTION

### Who Are We?

Beebe Healthcare, founded in 1916, is a not-for-profit community health system with services offered throughout Sussex County, Delaware. Beebe has become the premier healthcare facility in the county, serving thriving coastal towns, vacation resort areas, the desired retirement destination, and farming and rural communities. Beebe provides comprehensive inpatient, outpatient, and emergency services. Current structure includes the Margaret H. Rollins Lewes Campus and its 210-bed medical center, the Rehoboth Health Campus, South Coastal Health Campus, and primary and specialty care practices throughout southern Delaware.

Outpatient services include Home Care, an Outpatient Surgical Center, Diagnostic Imaging, Physical Rehabilitation, four Walk-In Care Centers and three High School Based – Wellness Centers. In addition, the Margaret H. Rollins School of Nursing at Beebe Healthcare is the only hospital-based nursing school in Delaware.

Over the last five years, Beebe Healthcare has expanded and improved access to health care in Sussex County with its South Coastal Health Campus near Millville that includes a free-standing Emergency Department and Cancer Center. In addition, the expansion includes a brand-new Specialty Surgical Hospital on the Rehoboth Campus and an extension of its Center for Heart and Vascular Services at the Lewes Campus. Beebe was also the first hospital in the state to launch a Hospital at Home Program which allows qualifying patients to be treated for their medical condition in the comfort of their own home as a substitute for traditional inpatient, in-the-hospital care.

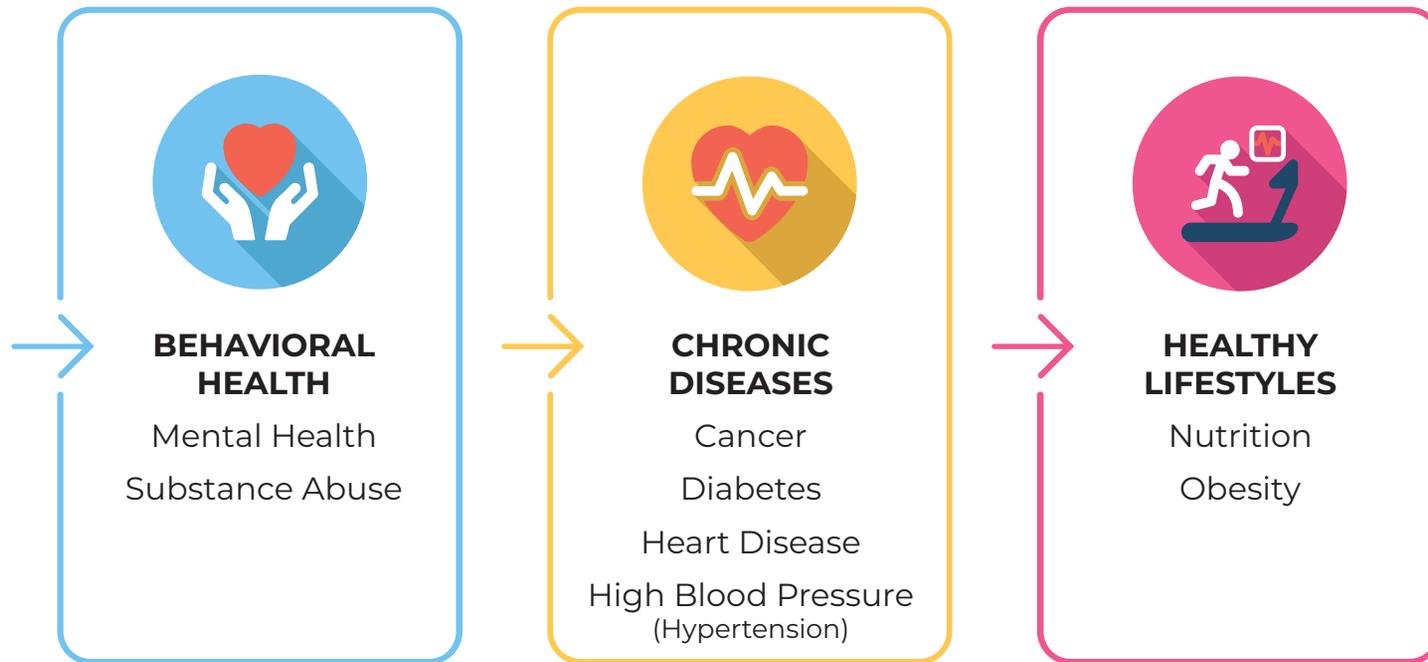
The mission of Beebe Healthcare is rooted in three actions: encouraging healthy living, preventing illness, and restoring optimal health within our community. The health care, education, and services provided today are key to healthy communities of tomorrow. To optimize the health of people in our community, Beebe supports the provision of a community health needs assessment so that Beebe may identify the community needs and adapt services to create a healthier community and bring services to where people live and work.

In 2022, Beebe Healthcare joined together with Tripp Umbach to conduct a comprehensive community health needs assessment for the service area of Sussex County. The CHNA process included input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health issues and representatives of vulnerable populations. The overall CHNA involved multiple steps depicted in the flow chart below.

**Figure 1: Process Chart of Community Health Needs Assessment 2022**



The results of the CHNA identified the following as the priorities for Beebe Healthcare's service area:



Healthcare organizations and systems strive to improve the health of the community they serve through collaboration with local, state, and national partners. The CHNA and implementation strategy plan meets the requirements of the Patient Protection and Affordable Care Act (PPACA). The act has changed how individuals obtain care and promotes reduced healthcare costs, greater care coordination, and better care and services.

The requirements imposed by the IRS for tax-exempt hospitals and health systems must include the following:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified throughout the assessment.
- Report how it addresses the needs identified in the CHNA and describe the needs that are not being addressed, with the reasons why.

Tripp Umbach worked with Beebe Healthcare's staff to complete the CHNA and the board of directors adopted it in August 2022. This implementation strategy plan outlines the needs identified in the CHNA and documents how Beebe Healthcare will be addressing the needs over the next three years. Beebe Healthcare will address all needs identified in the CHNA.

# KEY COMMUNITY NEEDS

Throughout the community health needs assessment process, Tripp Umbach reviewed primary and secondary data from local, state, and national resources, community stakeholder interviews, community surveys, focus groups, a prioritization session, and a resource provider inventory (highlighting organizations and agencies that serve the community) to identify the regional health needs of residents in Sussex County. The data provided a cross-section of information essential to identifying Beebe Healthcare's community's key community health needs.





# HEALTH PRIORITY BEHAVIORAL HEALTH

Nationwide, behavioral health has become a prominent health issue affecting residents across all income levels, ethnic groups, and education levels. Sussex County residents are no exception to the growing health problem. Behavioral health includes the emotions and behaviors that affect one's overall well-being. Behavioral health is sometimes called mental health and often includes substance use, according to the Centers for Medicare & Medicaid Services (CMS). As a major issue and a main health concern in the study area, community stakeholder interviews, community surveys, and secondary data demonstrate the growing effects of behavioral health in the community.



It is important to note that behavioral health issues affect an individual's mental health and well-being as well as a person's spiritual, emotional, and physical health. Individuals with a mental illness can face short and long-term issues associated with the disease. Issues related to chronic diseases such as diabetes, heart disease, and cancer, in addition to an overall decrease in accessing health services, can, unfortunately, increase the likelihood of adverse health outcomes. The coexistence of a mental illness and a substance use disorder is common among people in medication-assisted treatment (MAT). People with mental illnesses are more likely to experience a substance use disorder than those not affected by a mental illness (SAMHSA).



A nationwide and regional physician shortage plays a significant role in delivering health care services to those individuals who struggle with behavioral health issues and other associated problems. As identified by community stakeholders, shortages of physicians and specialists, appropriate funding for mental and behavioral health services, access issues, and high rates of behavioral health issues create a growing concern related to the current and future state of behavioral health services in the region and the growing need for additional focus on providing adequate behavioral health services.



Obtainable behavioral health services are essential to one's physical and mental health. Effective treatment plans and prevention allow people to recover. Those suffering from behavioral health require access to providers and services to receive proper care to lead healthy and productive lives.

# GOAL

To improve behavioral and mental health by providing access to appropriate, quality behavioral, mental health, and substance use disorder services.

## Objectives and Strategies/Actions for Behavioral Health, Mental Health, and Substance Use Disorder

Target Populations	Objectives	Strategies/Actions	Metrics	Partners
Individuals with behavioral health and co-occurring conditions.	Identify patients more quickly by implementing expanded screening methods in the inpatient, outpatient, and emergency department environments.	Screen for behavioral, mental and emotional health indicators in inpatient and outpatient settings.	<ul style="list-style-type: none"> <li>Number of behavioral health patients identified</li> <li>Number of mental health patients identified</li> <li>Number of co-occurring patients identified</li> <li>Number of SUD patients identified</li> <li>Number of referrals generated by high positive Columbia Screening Tool</li> </ul>	<ul style="list-style-type: none"> <li>Sussex County BH Agency</li> <li>SUN Behavioral Health</li> <li>Focus Behavioral Health</li> <li>Lifestance Health</li> <li>Embrace Wellness</li> <li>Synergy Behavioral Health Group</li> <li>Sussex County Health Coalition</li> <li>Division of Substance Abuse and Mental Health (DSAMH)</li> </ul>
		Open BH practice in October 2022	<ul style="list-style-type: none"> <li>Number of new patients served</li> <li>Number of referrals received</li> </ul>	
		Conduct Columbia Suicide Screening Tool with every patient 12 and older.	<ul style="list-style-type: none"> <li>Number of patients screened</li> <li>Number of patients referred based on screening results</li> </ul>	
		Integrate BH provider into Primary Care Office 2-3 days a week	<ul style="list-style-type: none"> <li>Number of BH providers serving in PCP offices</li> <li>Number of patients served</li> </ul>	
	Connect clients/patients to effective community resources that provide behavioral healthcare, mental healthcare, and substance use disorder treatment programs and/or facilities.	Assess patient status and readiness and refer to appropriate services.	<ul style="list-style-type: none"> <li>Number of patients connected to quality services yearly</li> <li>Number of Peer referrals</li> <li>Date of implementation of BH RN template and Peer Recovery Specialists template</li> </ul>	
		Continue to foster relationships with Sussex County and State providers/agencies.	<ul style="list-style-type: none"> <li>Number of additional partnerships established each year</li> </ul>	
		Provide MAT induction and increase warm handoffs to MAT programs for SUD/COD patients	<ul style="list-style-type: none"> <li>Number of patients inducted</li> <li>Percent of SUD/COD patients with warm handoffs to MAT programs yearly</li> <li>Data collection reporting process established by year 1</li> </ul>	

## GOAL (CONTINUED)

To improve behavioral and mental health by providing access to appropriate, quality behavioral, mental health, and substance use disorder services.

### Objectives and Strategies/Actions for Behavioral Health, Mental Health, and Substance Use Disorder

Target Populations	Objectives	Strategies/Actions	Metrics	Partners
Individuals with behavioral health and co-occurring conditions.	Ensure alignment of clinical providers' prescribing behaviors and state and federal regulations surrounding pain medication management.	Support education of area providers regarding current evidence-based opioid and pain management prescribing standards.	<ul style="list-style-type: none"> <li>Number of pc offices that are involved</li> </ul>	<ul style="list-style-type: none"> <li>Sussex County BH Agency</li> <li>SUN Behavioral Health</li> <li>Focus Behavioral Health</li> <li>Lifestance Health</li> <li>Embrace Wellness</li> <li>Synergy Behavioral Health Group</li> <li>Sussex County Health Coalition</li> <li>Division of Substance Abuse and Mental Health (DSAMH)</li> </ul>
		Identify Primary Care Hubs for future expansion.	<ul style="list-style-type: none"> <li>Number of primary care hubs established</li> </ul>	
		Recruit and retain psychiatrists, advance practice providers, psychologists and therapists (LCSW, LPC, CADC).	<ul style="list-style-type: none"> <li>Number recruited each year</li> </ul>	
		By CY2023, integrate BHC Behavioral Health Team and BMG Behavioral Health into one organization team.	<ul style="list-style-type: none"> <li>Date of integration</li> </ul>	
		Develop Behavioral Health training for Family Medicine residents, psychiatric APRN students and Social Work interns by CY2025.	<ul style="list-style-type: none"> <li>Number of residents and interns trained</li> <li>Date of training initiation</li> </ul>	
	Evaluate compliance, current interventions and alignment with the Behavioral Health Consortium's three-year action plan and the Delaware State Health Improvement Plan.	Develop Behavioral Health Governing Body representing Beebe Medical Group (BMG), Beebe Medical Center (BMC) and major stakeholders	<ul style="list-style-type: none"> <li>Number of Behavioral Health Governing Body (BHGB) meetings scheduled.</li> <li>Number of Beebe representatives attending at Behavioral Health Consortium (BHC)</li> <li>Quarterly meeting with SHIP lead</li> </ul>	
	Assess and address educational deficits within the community.	Increase education and awareness about behavioral health needs, recovery, and addressing stigma.	<ul style="list-style-type: none"> <li>Number of PODs held each monthly and yearly</li> <li>Number of partnered events each year</li> </ul>	
		Engage organizing partner in annual prevention and awareness event.	<ul style="list-style-type: none"> <li>Participating as partner in annual event</li> </ul>	

Note: The 2022 ISP reflects updated objectives and strategies which intertwine the measures from the previous ISP. Beebe Health will update the ISP matrix regularly noting specific measures and accomplishments.





# HEALTH PRIORITY

## CHRONIC DISEASES

Genetics, an individual's lifestyle in addition to their environment and other factors, plays a significant role in developing a chronic disease. Chronic diseases have a big impact on community residents. The overall health care of residents with a chronic disease versus one without is staggering. Annually, direct health care costs for a patient with chronic disease average \$6,032, approximately 5 times that of a person without a chronic disease. These costs are primarily derived from more frequent hospitalizations and emergency room visits and greater prescription drug use ([American Action Forum](#)). The toll and the overall health care costs associated with chronic diseases are staggering.



Heart disease, cancer, diabetes, and stroke are leading causes of death and disability among individuals. In fact, 90% of the nation's \$4.1 trillion in annual health care expenditures are for people with chronic and mental health conditions ([CDC](#)). Chronic diseases are broadly defined as conditions that last one or more years and require ongoing medical attention and or limit activities of daily living. Six in ten adults in the U.S. have a chronic disease and four in ten adults have two or more. Chronic diseases occur when residents engage in poor lifestyle risks such as tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use.



Heart disease and stroke cause the most deaths in Americans. More than one-third or roughly 877,500 Americans die of heart disease or stroke yearly. In addition, roughly 34.2 million Americans have diabetes and another 88 million adults in the U.S. have prediabetes. More than 1.7 million people are diagnosed with cancer, with 600,000 individuals dying from it, making it the second leading cause of death.

Although common, many chronic diseases are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy, and avoiding tobacco and alcohol can assist community residents from developing certain diseases. Health education and interventions can halt and assist with better health management of existing chronic diseases; thus, reducing direct and long-term costs and improving the health and well-being of community residents.



Preventative health measures such as obtaining vaccinations, screenings, and physicals are critical to preventing disease and disability. Disparities in preventative health care can indicate inequities in health care access, differing environmental exposures, service gaps, and other systemic factors potentially linked to race, gender, and other identities.

# GOAL

To reduce, prevent, and manage chronic diseases.

## Objectives and Strategies/Actions for Chronic Diseases such as Cancer, Diabetes, Heart Disease, and High Blood Pressure (Hypertension)

Cancer				
Target Populations	Objectives	Strategies/Actions	Metrics	Partners
Disparate, underserved, Beebe Medical Group (BMG) patients, and communities.	Improve early detection and prevention.	Provide cancer screenings, risk reduction education and follow-up care services through Care Coordination Population Health Services.	<ul style="list-style-type: none"> <li>Number of screening events held</li> <li>Number of cancer screenings</li> <li>Number of positive findings and follow-ups in FY2024 and 2025*</li> <li>Number of attendees</li> <li>Number of outreach events where materials were distributed</li> </ul>	<ul style="list-style-type: none"> <li>Quality Insights</li> <li>DPH</li> <li>American Heart Association</li> <li>Sussex County Health Coalition</li> <li>DE Breast Cancer Coalition</li> <li>Food Bank of DE</li> <li>Faith Based Organizations</li> <li>CAMP Rehoboth</li> <li>Epworth Church</li> <li>Village Volunteers</li> <li>Community Resource Center</li> <li>First State Action Agency</li> <li>Lewes Rotary</li> <li>La Esperanza</li> <li>Healthy Lifestyles</li> </ul>
Individuals with cancer diagnosis.	Expand whole person care through the cancer journey.	Assess, address needs, and barriers through Psychosocial/Navigation Staff	<ul style="list-style-type: none"> <li>Number of staff in each Psychosocial Services (PSS) area (Social Work, Navigation, Chaplain, and Nutrition)</li> <li>Number of referrals for each service area</li> <li>Number of Palliative Care referrals</li> <li>Number of providers recruited</li> </ul>	<ul style="list-style-type: none"> <li>First State Action Agency</li> <li>Lewes Rotary</li> <li>La Esperanza</li> <li>Healthy Lifestyles</li> <li>Cancer Support Community Delaware</li> <li>Delaware Breast Cancer Coalition</li> <li>Livestrong YMCA</li> <li>American Cancer Society</li> <li>Others listed above</li> </ul>
		Further integrate and expand Palliative Care services into Oncology Service Line.	<ul style="list-style-type: none"> <li>Date of integration</li> </ul>	
	Expand survivorship continuum of care programs	Offer Survivorship Programs throughout the year on various key topics.	<ul style="list-style-type: none"> <li>Number of attendees</li> </ul>	
		Increase opportunities for Survivorship programs and community engagement	<ul style="list-style-type: none"> <li>Number of programs offered yearly</li> <li>Number of attendees</li> </ul>	
		Partner with community-based organizations to expand Survivorship Programs.	<ul style="list-style-type: none"> <li>Number of community organizations participating</li> </ul>	
Increase access to cancer care throughout Sussex County	Establish and expand at South Coastal Cancer Center providing care closer to home.	<ul style="list-style-type: none"> <li>Number of existing and new patients served at South Coastal Cancer Center</li> </ul>		

## GOAL (CONTINUED)

To reduce, prevent, and manage chronic diseases.

### Objectives and Strategies/Actions for Chronic Diseases such as Cancer, Diabetes, Heart Disease, and High Blood Pressure (Hypertension)

Diabetes				
Target Populations	Objectives	Strategies/Actions	Metrics	Partners
Individuals living with chronic conditions.	Reduce and prevent the occurrence of diabetes and pre-diabetes diagnosis through health screenings and health education.	Expand community-based education and awareness on the health risks and lifestyle behaviors associated with diabetes.	<ul style="list-style-type: none"> <li>Number of education programs, awareness sessions, health fairs held.</li> <li>Number of attendees</li> <li>Improved lifestyle changes and A1C levels reported</li> </ul>	<ul style="list-style-type: none"> <li>Non-BMG PCP offices</li> <li>Endocrinology Specialists</li> <li>Quality Insights</li> <li>Delaware Diabetes Coalition</li> </ul>
		Reduce A1C rates across hospital service areas.	<ul style="list-style-type: none"> <li>Number of outpatients with A1c &lt;9% in measurement period</li> <li>Number of outpatients with A1c &gt;9Percent that received referral for follow up</li> <li>Percent of reduction from initial A1c value (continue measurement)</li> <li>Percent of participants reaching personal goal by completion of group series</li> <li>Number of admission referrals (insulin pumps, Continuous glucose monitors, U 500 and insulin other than Lantus)</li> </ul>	
		Continue partnerships with organizations to support outreach.	<ul style="list-style-type: none"> <li>Number of persons reached with letter campaigns distributed through Quality Insights</li> <li>Number of collaborations with Beebe Population Health to increase referral services</li> <li>Number served in each zip code to monitor outreach success</li> </ul>	
		Expand access to Diabetic Courses offered through Beebe Diabetes Self-Management Education (DSME)	<ul style="list-style-type: none"> <li>Number of telemedicine visits</li> <li>Number of total enrollments in program</li> <li>Number of support group meetings (minimum of 6 per year)</li> <li>Number of no-shows and cancellation rates</li> <li>Complete optimization of Cerner (EMR) to streamline documentation and allow for more patient visits/access</li> </ul>	
		Continue to support early intervention for children enrolled in school-based health centers	<ul style="list-style-type: none"> <li>Number of students with calculated BMI</li> <li>Number of referrals to dietician within SBHC for dx of obesity or overweight</li> <li>Number of diabetic (Type 1 or Type 2) serviced in the School Based Health Center (SBHC).</li> </ul>	

# GOAL (CONTINUED)

To reduce, prevent, and manage chronic diseases.

## Objectives and Strategies/Actions for Chronic Diseases such as Cancer, Diabetes, Heart Disease, and High Blood Pressure (Hypertension)

Heart Disease				
Target Populations	Objectives	Strategies/Actions	Metrics	Partners
Individuals living with chronic conditions.	Reduce and prevent the occurrence of heart disease through health screenings and health education	Expand community-based awareness on heart disease prevention and the health risks associated with heart disease.	<ul style="list-style-type: none"> <li>Number of heart disease prevention education sessions conducted</li> <li>Number of attendees</li> <li>Number of health fairs, events held</li> <li>Number of heart health prevention materials distributed</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care offices not within BMG network</li> <li>Delaware Cardiovascular Associates</li> <li>Cardiovascular Consultants of Southern Delaware</li> <li>Cardiovascular Interventionalist Associates</li> <li>Clinic by the Sea</li> <li>American Heart Association</li> </ul>
		Continue to conduct health screenings for early detection of heart disease and appropriate treatment	<ul style="list-style-type: none"> <li>Number of heart screenings conducted</li> <li>Number of referrals</li> </ul>	
	Expand community outreach education on improvement and management of heart disease.	Provide heart health education to churches, civic associations, schools, community health fairs and events.	<ul style="list-style-type: none"> <li>Number of heart health education/awareness programs conducted</li> <li>Number of events and health fairs held</li> <li>Number of attendees</li> </ul>	
High Blood Pressure (Hypertension)				
	Reduce and prevent the occurrence of hypertension and stroke through health screenings and health education.	Expand education and awareness on health risks and lifestyle behaviors (diet, weight, activity) associated with hypertension and stroke.	<ul style="list-style-type: none"> <li>Number of education and awareness sessions, health fairs held.</li> <li>Number of attendees</li> <li>Increase in number of people achieving normal blood pressure range</li> </ul>	<ul style="list-style-type: none"> <li>Primary Care offices not within the BMG network</li> <li>Delaware Cardiovascular Associates</li> <li>Cardiovascular Consultants of Southern Delaware</li> <li>Cardiovascular Interventionalist Associates</li> <li>Clinic by the Sea</li> <li>American Heart Association</li> </ul>

\*Source of data is Risk Navigator

Note: The 2022 ISP reflects updated objectives and strategies which intertwine the measures from the previous ISP. Beebe Health will update the ISP matrix regularly noting specific measures and accomplishments.



# HEALTH PRIORITY

## HEALTHY LIFESTYLES

Personal lifestyle choices can affect one's health and, in many cases, people can control their lifestyles. Socioeconomic factors and conditions, and the lack of education are reasons people do not lead healthy lifestyles. Poor health behaviors, such as smoking or lack of physical activity, and an unhealthy diet are health behaviors that can lead to chronic diseases. It is essential for health providers and community organizations to continue to provide health education and information promoting the long-term benefits associated with living a healthy lifestyle.



Physical activity plays a significant role in a person's overall health. Just like other health behaviors one's level of physical activity is a determinant of health. Failing to be physically active can increase a person's chance of chronic diseases and negatively affect one's overall health. The Office of Disease Prevention and Health Promotion created the [Physical Activity Guidelines for Americans](#) to provide recommendations on how to improve health through physical activity to increase levels of physical activity in the U.S. According to the guide, regular physical activity includes participation in moderate and vigorous physical activities and muscle-strengthening activities. At least 150 minutes a week of moderate-intensity aerobic activity consistently reduces the risk of many chronic diseases and other health outcomes. Unfortunately, only 53.3% of adult Americans aged 18 and over met the Physical Activity Guidelines for aerobic physical activity. According to the CDC, a dismal 23.3% meet the aerobic and muscle-strengthening activity, according to the [CDC](#). Obesity-related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancer. These are among the leading causes of preventable, premature death.



Poor nutrition/diet is a top reason for high obesity rates. Much like physical inactivity, the lack of education, socioeconomics, and the inability to implement the long-term benefits associated with a healthy diet are top reasons why community residents do not follow or eat a healthy diet. Beebe Healthcare, community leaders, and organizations recognize the detrimental effects of this poor health behavior.



For many, a healthy diet is prohibited as healthier fresh foods are more expensive. This makes it difficult for some residents to obtain these types of foods and makes it more likely for low-income residents to purchase processed foods. Education also plays a role in the obesity problem. Obesity prevalence decreased with levels of education. Adults without a high school degree or equivalent had the highest self-reported obesity (38.8%), followed by adults with some college (34.1%) or high school graduates (34.0%), and then by college graduates (25.0%) ([CDC](#)). Arming residents on how to eat properly and healthily, especially for those on a budget can be instilled in future generations.

# GOAL

To improve health and quality of life.

## Objectives and Strategies/Actions for Healthy Lifestyles

Target Populations	Objectives	Strategies/Actions	Metrics	Partners
<p>Individuals living with chronic conditions identifying as overweight or obese with a BMI greater than 25.</p> <p>Individuals who need additional nutritional support.</p> <p>Individuals in low-socioeconomic areas, including but not limited to, Hispanic and African American ethnicities, 65 yrs.+</p>	<p>Increase the percentage of Sussex County residents reporting targeted health behaviors including healthy eating and an active lifestyle.</p>	<p>Refine, build, and expand Beebe programs that target individuals who are living with chronic health conditions or are overweight/obese.</p>	<ul style="list-style-type: none"> <li>Number of education/awareness programs conducted that promote disease management, prevention, healthy eating and active lifestyle</li> <li>Number of community outreach events including Social Vulnerability Index (SVI)</li> </ul>	<ul style="list-style-type: none"> <li>Non- BMG Primary Care offices</li> <li>School Based Wellness Centers at Cape Henlopen High School, Indian River High School, Sussex Central High School</li> <li>Endocrinology Specialists</li> <li>Outpatient Registered Dietitians</li> <li>YMCA</li> <li>Senior Centers</li> <li>Area gyms</li> <li>La Red Federally Qualified Health Center</li> <li>WIC program staff</li> <li>Veterans Administration</li> </ul>
		<p>Provide awareness and education on healthy eating and making good food choices to outpatients, schools and community.</p>	<ul style="list-style-type: none"> <li>Number of nutrition programs offered</li> <li>Number of partnerships with community-based organizations and schools</li> <li>Number of participants</li> <li>Number of outpatient nutrition referrals including school-based wellness centers</li> </ul>	
		<p>Leverage community partnerships for more efficient and effective implementation of programs, improving reach and outcomes.</p>	<ul style="list-style-type: none"> <li>Number of nutrition programs offered</li> <li>Number of partnerships with community-based organizations and schools</li> </ul>	
	<p>Increase the percentage of Sussex County residents with a healthy weight range.</p>	<p>Expand programs that promote weight management and healthy living.</p>	<ul style="list-style-type: none"> <li>Number of weight management and healthy living programs offered</li> <li>Number of attendees</li> <li>Track Percent of Sussex County residents who are overweight/obese</li> </ul>	
		<p>Connect patients to resources that implement and support patient-centered lifestyle changes.</p>	<ul style="list-style-type: none"> <li>Number of patients screened and connected to appropriate resources</li> </ul>	
		<p>Provide awareness and education on benefits and risks of bariatric surgery.</p>	<ul style="list-style-type: none"> <li>Track number of bariatric surgeries performed</li> </ul>	
		<p>Expand education and awareness regarding weight management alternatives and implications of obesity.</p>	<ul style="list-style-type: none"> <li>Document results of bariatric surgery through follow-up at 6-month, 9-month, and 1-year intervals (check on timing &amp; intervals)</li> </ul>	

Note: The 2022 ISP reflects updated objectives and strategies which intertwine the measures from the previous ISP. Beebe Health will update the ISP matrix regularly noting specific measures and accomplishments.



## CONCLUSION

Beebe Healthcare's commitment to improving the health of Sussex County residents is unwavering. The 2022 Implementation Strategy Plan report shows the goals and plans that will aid Sussex County residents to achieve and improve health and quality of life. The prioritization of the identified needs serves to guide the community health improvement efforts for residents served by Beebe Healthcare. The ISP will strive to meet the identified community health needs and ensure that the assessment results and its impact on the community are appropriately recorded and communicated.

The Implementation Strategy Plan further provides an opportunity to ignite existing community relationships and to forge new relationships with community leaders and organizations. Working in collaboration with community partners and organizations, Beebe Healthcare will maximize health system and community assets and resources as they fully engage in the necessary implementation actions and steps to assist the community residents they serve. Tracking the progress of the goals and its achievements will be an important factor for Beebe Healthcare.

Upon adopting the CHNA Implementation Strategy Plan by the hospital board of directors, Beebe Healthcare's CHNA Implementation Strategy Plan report complies with IRS regulations as outlined by The Patient Protection and Affordable Care Act.

Beebe Healthcare will leverage its strengths, resources, and outreach to help identify ways to address their communities' health needs, thus improving overall health and addressing the critical health needs and well-being of residents in their communities. CHNA partners will be instrumental in assisting Beebe Healthcare to execute the best ways to address these priorities. Working closely with CHNA partners, Beebe Healthcare will implement strategies and actions and most importantly gather support from community residents. The developed strategies will include performance metrics through which progress can be measured. A comprehensive evaluation of impact will further encourage community engagement, strengthen community relationships, and inform the broader community of Beebe Healthcare's strategic priorities and sustainability of improvement efforts.



## OUR PLANS FOR THE FUTURE

- Execute the implementation strategy plan (ISP) phase to continue to provide high-quality health care services.
- Improve level of awareness related to available services and programs.
- Strengthen communication and community engagement. Solidify existing partnerships and collaborations.
- Continue to improve health literacy and promote prevention by addressing the community health issues related to behavioral health, chronic diseases, and healthy lifestyles.



## CONSULTANTS

Beebe Healthcare contracted with Tripp Umbach, a private healthcare consulting firm with offices throughout the United States, to complete a community health needs assessment (CHNA). Tripp Umbach has worked with more than 300 communities in all 50 states. More than one in five Americans live in a community where our firm has worked.

From community needs assessment protocols to fulfilling the new Patient Protection and Affordable Care Act (PPACA) IRS 990 requirements, Tripp Umbach has turned needs assessments into practical action plans with sound implementation strategies, evaluation processes, and funding recommendations for hundreds of communities. Tripp Umbach has conducted more than 400 community health needs assessments and has worked with more than 800 hospitals.

Changes introduced as a result of the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the overall health of communities.





[www.beebehealthcare.org](http://www.beebehealthcare.org)

