The Miriam Hospital

Community Health Needs Assessment Implementation Strategy

October 1, 2022 - September 30, 2025

As a result of the Community Health Needs Assessment (CHNA) prepared for The Miriam Hospital (TMH) as of September 30, 2022, TMH's leadership team, executive management, and other individuals critical to the organizational planning process have created an implementation strategy detailing action item plans covering the period from October 1, 2022 through September 30, 2025 to address the significant needs identified in TMH's CHNA report. Based on the complex health issues in the community, TMH has strategically planned ways to address these significant needs in order to maximize the improvement of the overall health and wellness of residents within its community. As discussed in the September 30, 2022 CHNA, available online at https://www.lifespan.org/sites/default/files/2022-09/TMHCommunityHealthNeedsAssessment2022.pdf, TMH identified the following issues as significant health needs currently facing its community:

1. Access to Healthcare Services
2. Chronic Disease Management
3. Mental and Behavioral Health Services for Patients and Caregivers
4. Grow and Diversify the Workforce
5. Community-based Access to Health Information
6. Navigation Supports in Hospital and Community Settings

Significant Health Need #1: Access to Healthcare Services			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
1.1 Provide transportation assistance to medical appointments.	• Utilize the Round Trip rideshare app in the electronic health record • Build funding for subsidized transportation in annual department budgets	• Increased access to reliable, free or discounted transportation • Reduction in cancelled, no-show and missed appointments • Improved access to care for patients with limited mobility or challenges with transportation	• Ride share companies contracted through Round Trip application

1.2 Add Navigators/Community Health Workers in key service lines to improve continuity of care and availability.	• Financial support for Navigators/Community Health Workers • Participation in state planning efforts to grow and strategically deploy the Community Health Worker workforce	• Increase colorectal, breast and cervical cancer screening rates • Advance health equity when implemented among populations who often have lower screening rates and/or experience greater health disparities, including people from historically disadvantaged racial and ethnic populations and people with lower incomes • Help patients overcome barriers to accessing screening services. • Client reminders, reduced structural barriers or improved assistance getting around them, reduced out-of-pocket costs, or a combination of these services • Access to one-on-one or group education. • Culturally and linguistically appropriate care • Improved quality of care • Improved patient outcomes	• Community Health Worker Association of Rhode Island • Community Health Worker training programs • Rhode Island Certification Board • Rhode Island Department of Health • Rhode Island Executive Office of Health and Human Services
1.3 Continue offering free skin cancer screenings and add locations to diversify the audience.	• Lifespan Community Health Institute • Educational materials about skin cancer, translated into multiple languages	• Free skin cancer prevention and screening service in accessible, community locations • Close disparities in skin cancer screening rates by race & ethnicity • Increase early diagnosis and treatment of melanomas	• Partnership to Reduce Cancer in Rhode Island • Rhode Island Department of Health • Brown Dermatology • NBC 10
1.4 Continue offering blood pressure and glucose screenings in community settings.	• Lifespan Community Health Institute • TMH staff support • Educational materials about heart disease and diabetes, translated into multiple languages	• Raise awareness of biometrics to enable patients to self-manage • Education to help patients understand the resources and services available, as well as the benefits of risk factor management • Assistance with referrals to	• Community organizations that host screening events

		primary care	
1.5 Continue offering influenza vaccination clinics in community settings.	• Lifespan Community Health Institute • TMH staff support • Educational materials about influenza, translated into multiple languages	• Reduce disparities in influenza vaccination rates by population • Education to help patients understand the resources and services available, as well as the benefits of risk factor management • Assistance with referrals to primary care	• Rhode Island Department of Health • Community organizations that host screening events
1.6 Improve collection of race, ethnicity and language data in LifeChart.	• Lifespan Health Equity Committee • TMH staff support	• Patient demographic data in health records match the patients' self-described demographics • Improved data collection for analysis and planning purposes • Ability to accurately measure and target racial and ethnic health disparities	• N/A
1.7 Increase flow and reduce wait times in emergency department.	• TMH staff support • Quality and Safety • Financial resources	• Improved patient experience through provision of timely care • Reduction in number of patients who leave without being seen • Increase referrals to appropriate follow-up care • Optimization of emergency department staffing mix	• N/A
1.8 Improve patient experience by improving communication between providers, patients and caregivers.	• Lifespan Patient Experience Committee	• Help patients overcome barriers to accessing screening services. • Improved access to care by reducing barriers, improving coordination, and reducing cancellations	• N/A
Significant Health Need #2: Chronic Disease Management			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
2.1 Offer annual breast, cervical, lung, and prostate cancer screening for uninsured and low-income residents.	• Lifespan Cancer Institute • Lifespan Community	• Cancer prevention education, screening, and linkage to	• Community organizations that help

	Health Institute • Financial support • Facility space • Physician, nursing and professional staff support	appropriate follow-up care • Increase in early detection and entry into treatment • Reduced racial and ethnic disparities in cancer staging at initiation of treatment	promote the events • Rhode Island Department of Health
2.2 Facilitate referrals from primary care practices within Lifespan to the Lifespan Cancer Institute.	• Lifespan Cancer Institute • Physician, nursing and professional staff support	• Cancer prevention education, screening, and linkage to treatment • Increase in early detection and entry into treatment • Reduced racial and ethnic disparities in cancer staging at initiation of treatment	• Coastal Medical
2.3 Open a cardiac care center and cardiac lab at RIH in order to serve more patients.	• Financial support • Facility space • Physician, nursing and professional staff	• Heart disease prevention education, screening, and linkage to treatment • Increased access to comprehensive cardiac care in the service area	• N/A
2.4 In partnership with HopeHealth, integrate palliative care early in the care of cardiac patients.	• Financial support • Facility space • Physician, nursing and professional staff	• Improved pain and disease management among patients • Improved patient experience	• HopeHealth
2.5 Incorporate telehealth and telemonitoring in cardiac rehabilitation to drive patient & family self-efficacy.	• Financial support • Lifespan Information Services	• Improved patient disease self-management • Improved patients' access to care and provider feedback • Improved patient experience	• N/A
2.6 Provide multidisciplinary supports and increase utilization of the palliative care nurse, psychologist, and social worker in the advanced heart failure clinic.	• Financial support • Facility space • Physician, nursing and professional staff	• Improved coordination of care • Improved patient experience • Improved cardiac health outcomes	• HopeHealth
2.7 Assess social determinants of health among patients in the Heart Failure Clinic and consider the provision of medically tailored meals to food insecure patients.	• Financial support • Lifespan Community Health Institute staff support • Lifespan Information Services	• Increased access to community-based services to manage health-related social needs • Improved food and nutrition security among patients	• Community organizations that provide services to address social determinants of health

2.8 Launch smoking cessation and weight loss programs at cardiac rehabilitation.	• Financial support • Facility space • Physician, nursing and professional staff support	• Skill-building for long-lasting behavior change • Improved health outcomes from adoption of health-promoting behaviors • Decreased incidence of cardiac disease, overweight & obesity, and related chronic diseases	• Smoking cessation and weight loss programs vendors
2.9 Partner with Coastal Medical to facilitate referrals between primary care and cardiology.	• Physician, nursing and professional staff support • Lifespan Information Services	• Improve patient access to cardiology services, patient experience and health outcomes • Reach a wider population of eligible candidates with cardiac disease, resulting in improved clinical and psychosocial outcomes and positive impact on morbidity and mortality	• Coastal Medical
Significant Health Need #3: Mental and Behavioral Health Services for Patients and Caregivers			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
3.1 Offer Mental Health First Aid in English and Spanish.	• Financial support • Facility space • Human Resources support to recruit diverse professionals • Professional staff support to deliver training • Marketing & Communications staff support	• Reduced stigma associated with mental and behavioral health • Increased community support for navigation to mental and behavioral health services • Increase in the number of individuals and school staff who can identify, understand and respond to signs of mental illnesses and substance use disorders • Increase in the number of individuals and school staff who will reach out and provide initial help and	• Johns Hopkins University • Rhode Island Department of Education • Municipal school districts

		support to someone who may be developing a mental health or substance use problem or experiencing a crisis	
3.2 Work with the addiction medicine team at RIH on prevention and outreach to reduce racial & ethnic disparities in overdose rates and fatalities.	• Addiction Medicine Division • Financial support • Facility space • Professional staff support	• Reduced racial and ethnic disparities in overdose rates and fatalities • Reduced racial and ethnic disparities in access to and initiation of evidence-based treatments • Reduction in overdoses and overdose fatalities	• RIH Opioid COBRE Center
3.3 Offer services to manage addiction disorders among the adult population transitioning out of incarceration.	• Lifespan Transitions Clinic • Financial support • Facility space • Professional staff support	• High risk population will have greater access to continuous treatment for substance use disorders, resulting in fewer overdoses • Appropriate referrals for incarcerated persons who are preparing for community reentry	• Rhode Island Department of Corrections • Center for Health and Justice Transformation
3.4 Facilitate rapid access to treatment for substance misuse through the development of a "bridge" clinic, a low-threshold transitional clinic for the treatment of substance use for patients who are not yet established in outpatient addiction care.	• Financial support • Facility space • Professional staff support	• Patients will have prompt access to evidence-based treatment for substance use disorders, resulting in increased treatment initiation	• Governor's Overdose Task Force • Opioid Settlement Advisory Committee
3.5 Contribute research and policy leadership to statewide initiatives to reduce opioid overdose and fatality rates.	• Professional staff support • Addiction Medicine Division	• Help create conditions that facilitate prevention, screening, harm reduction, and treatment for all through equitable strategies • Research to understand the mechanisms underlying opioid use disorder and develop innovative solutions	• RIH Opioid COBRE Center • Governor's Overdose Task Force • Opioid Settlement Advisory Committee
3.6 Develop family and community-based strategies for supporting individuals with substance use disorder through harm reduction and removing barriers to care.	• Financial support • Facility space • Professional staff support	• Increase initiation of and retention in substance misuse treatment programs	• Governor's Overdose Task Force • Opioid Settlement

		• Reduce overdose and death rates	Advisory Committee
Significant Health Need #4: Grow and Diversify the Workforce			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
4.1 Hire Community Health Workers in key service lines, e.g., Lifespan Cancer Institute (LCI), Lifespan Cardiovascular Institute (CVI).	• Financial support for Navigators/Community Health Workers • Human Resources staff support	• Increase cancer and cardiovascular disease screening rates • Advance health equity when implemented among populations who often have lower screening rates and/or experience greater health disparities, including people from historically disadvantaged racial and ethnic populations and people with lower incomes • Help patients overcome barriers to accessing screening services • Client reminders, reduced structural barriers or improved assistance getting around them, reduced out-of-pocket costs, or a combination of these services • Access to one-on-one or group education • Culturally and linguistically appropriate care • Improved quality of care • Improved patient health outcomes	• Community Health Worker Association of Rhode Island
4.2 Diversify the clinical workforce to better reflect the diversity of patients served.	• Human Resources staff • Job fairs • Workforce Development Program	• Increasingly diverse clinical workforce • Culturally and linguistically appropriate care • Improved quality of care • Improved patient health	• Contracted recruitment and sourcing firms • Rhode Island Department of Labor and Training

		outcomes	• Rhode Island Executive Office of Health and Human Services • Local colleges and universities
4.3 Employ diversity, equity and inclusion strategies to improve the recruitment, retention and promotion of a diverse workforce.	• Diversity, Equity and Inclusion Office • Human Resources staff • Workforce Development Program	• Increasingly diverse workforce across professional bands • Culturally and linguistically appropriate care • Improved quality of care • Improved patient health outcomes	• Contracted recruitment and sourcing firms • Local colleges and universities
4.4 Create opportunities for employees to participate in community health improvement activities as a demonstration of TMH's commitment to the community it serves.	• Employee Wellbeing Office • Lifespan Community Health Institute	• Improved employee engagement and retention	• Nonprofit partners
4.5 Provide job shadow and mentoring opportunities to primary and secondary school youth in the service area.	• Human Resources staff • Lifespan Community Health Institute • Lifespan Cancer Institute staff • Workforce Development Program	• Improved workforce pipelines • Increasingly diverse workforce	• Local primary and secondary schools
4.6 Offer internships for college and graduate school students.	• Human Resources staff • Lifespan Community Health Institute	• Improved workforce pipelines • Increasingly diverse workforce	• Local colleges and universities

Significant Health Need #5: Community-based Access to Health Information			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
5.1 Deliver healthy living and healthy eating programs in community settings.	• Financial support • Facility space • Professional staff support • Lifespan Community Health Institute	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting behavior change • Improved health outcomes from adoption of health-promoting behaviors	• Community organizations that host and help promote the events

		• Decreased incidence of overweight & obesity and related chronic diseases • Increased nutrition security	
5.2 Offer community-based Hands-only CPR classes for underserved, elderly, and secondary students who may be in a life-saving situation.	• Financial support • Facility space • Professional staff support • AHA certified CPR instructors • Lifespan Community Health Institute – AHA Community Training Center	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting intervention • Increase in application of life-saving cardiopulmonary resuscitation	• Community organizations that host and help promote the programming
5.3 Offer Stop the Bleed first aid education that could be partnered with CPR classes.	• Financial support • Facility space • Professional staff support	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting intervention	• Community organizations that host and help promote the classes
5.4 Continue to offer the Diabetes Prevention Program and become a Medicare DPP supplier.	• Financial support • Facility space • Professional staff support • DPP certified coaches	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting behavior change • Improved health outcomes from adoption of health-promoting behaviors • Prevention of Type II Diabetes	• Community organizations that host and help promote the classes
5.5 Offer conferences, workshops and presentations on topics requested by community partners.	• Financial support • Facility space • Professional staff support • TMH subject matter experts • Lifespan Community Health Institute	• Access to group education and peer support in familiar and accessible settings • Increased health literacy among participants	• Community organizations that host and help promote the events
5.6 Provide Tar Wars programming for youth across service area	• Financial support • Facility space • Professional staff support	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting behavior change	• Community organizations that host and help promote the programming • American Academy of

		• Reduced initiation of tobacco products among youth	Family Physicians
5.7 Provide Safe Sitter programming for youth across service area.	• Financial support • Facility space • Safe Sitter certified instructors • Professional staff support	• Access to group education and peer support in familiar and accessible settings • Skill-building for long-lasting behavior change • Prevention of unintentional injuries among children	• Community organizations that host and help promote the classes
5.8 Continue to offer a monthly health ambassador lecture series for the general public.	• Financial support • Professional staff support • TMH subject matter experts	• Access to group education and peer support in virtual format • Increased referrals to and utilization of health maintenance programs • Increased health literacy among lecture attendees	• Community organizations that help promote the lecture series • Non-TMH subject matter experts
Significant Health Need #6: Navigation Supports in Hospital and Community Settings			
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on TMH Community	Outside groups collaboration
6.1 Hire Community Health Workers in key service lines, e.g., LCI, CVI.	• Financial support for Navigators/Community Health Workers • Human Resources staff support	• Increase cancer and cardiovascular disease screening rates • Advance health equity when implemented among populations who often have lower screening rates and/or experience greater health disparities, including people from historically disadvantaged racial and ethnic populations and people with lower incomes • Help patients overcome barriers to accessing screening services. • Client reminders, reduced structural barriers or improved assistance getting around them, reduced out-	• Community Health Worker Association of Rhode Island

		of-pocket costs, or a combination of these services • Access to one-on-one or group education. • Culturally and linguistically appropriate care • Improved quality of care • Improved patient outcomes	
6.2 Build LifeChart functionality to create an alert when qualifying criteria are met for a Community Health referral.	• Information Services staff support • Lifespan Community Health Institute	• Increased access to community-based education, screening and lifestyle change programs	• N/A
6.3 Improve patient experience by creating and posting FAQs and resources on the lifespan.org site for patients and caregivers to prepare for hospital care and discharge.	• Professional staff support • Marketing & Communications staff support	• Improved adherence with follow-up care • Increased patient satisfaction • Reduction in no-shows and cancellations	• N/A
6.4 Make Connect for Health Express Sheets available on Patient & Guest Services intranet and through the external lifespan.org site.	• Lifespan Community Health Institute • Marketing & Communications staff support	• Increased patient access to community-based services to manage health-related social needs • Increased provider satisfaction with being able to respond to patients' health-related social needs	• N/A
6.5 Consider expansion of Connect for Heath to the adult primary care clinic.	• Lifespan Community Health Institute • Financial resources • Facility Space	• Increased access to community-based services to manage health-related social needs • Increased provider satisfaction with being able to respond to patients' health-related social needs	• Unite Us, Inc.
6.6 Leverage the UniteUs platform to offer patients referrals to community-based services and supports.	• Financial support • Information Services staff support • Lifespan Community Health Institute	• Increased access to community-based services to manage health-related social needs • Training and tools for TMH staff to help patients and families address health-related social needs	• Unite Us, Inc.

		• Aggregate data to improve understanding of health-related social needs among patient population, which can inform program planning and policy development	

Conclusion

The Miriam Hospital Implementation Strategy report was authorized and approved by The Miriam Hospital Board of Trustees on March 14, 2023.

TMH will document progress on the implementation strategies presented as part of its commitment to the community it serves each year in its Form 990 tax return filings as required by the IRS. TMH appreciates the continued support of its partners, recognized below, which help it meet the health care needs of Rhode Islanders. Questions or comments on the TMH CHNA or Implementation Plan may be submitted to:

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