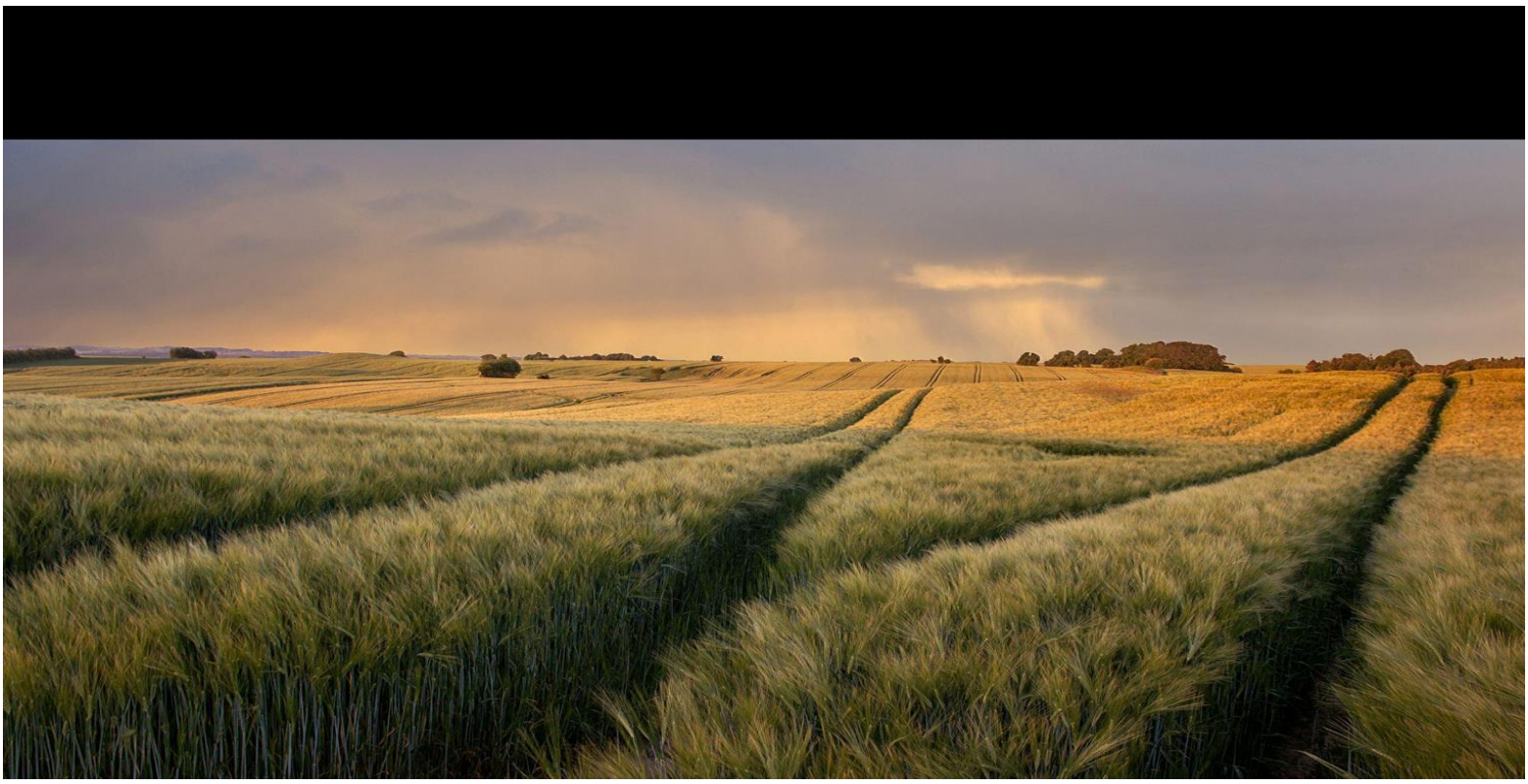
Strategic Plan

2024 - 2029

Goldenrod Outreach Initiative:

Southwest Alabama Healthcare Collaborative

West Central Alabama AHEC



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Part I. Network Narrative and Program Description

A. **Network Narrative**

The Southwest Alabama Healthcare Collaborative, otherwise known as SAHC, is a multi-member network of healthcare providers, community leaders and civic organizations, was founded in 2020 through a HRSA grant to execute a multisectoral approach aimed at increasing community capacity for prevention, treatment, and recovery support for those at-risk and diagnosed with substance use disorder (SUD). The SAHC will initially cover six counties where strong partnerships have been established and will utilize similar programming developed during the substance use/opioid use program to target two comorbidities–diabetes and heart disease–among rural, underserved and tribal populations in the following counties: Choctaw, Clarke, Escambia, Marengo, Monroe and Sumter. The West Central Alabama AHEC, in collaboration with members of the Southwest Alabama Healthcare Collaborative (SAHC) including *Southern Alabama AHEC, *Health and Wellness Education Center, and *Whitfield Regional Hospital. After the project was awarded, three additional members joined the Collaborative, including *Oak Grove Assembly of God, *V&C Outreach Resource Center Resource Center, and the *Chu Clinic. All Collaborative members will implement the Goldenrod Outreach (GO) Initiative, a coordinated community-based approach involving multi sectoral interventions to increase services for prevention, treatment and long-term management among those at risk for diabetes and heart disease in rural Alabama. *These network members will receive funding from the RHND grant for the provision of services, expertise, etc. This project will allow the SAHC to build necessary infrastructure to become a recognized entity, create committees to address chronic disease in the region, and create support programs for both individuals and healthcare providers to prevent, treat and support recovery for those at-risk of diabetes and/or heart disease in rural Southwest Alabama across the above listed counties. Through continued development and infrastructure building of the SAHC–an integrated healthcare network–members will be able to help create healthier, more resilient communities across rural Alabama with reproducible programming in similar communities across the country. The GO Initiative, administered by the SAHC, will be a formal continuation of strong community and healthcare partnerships made official through a HRSA Rural Communities Opioid Response Program (RCORP) in 2020. Although the partners on the Collaborative have been working together for decades, the RCORP program began the formal relationship between the entities to address substance use and opioid use disorder in rural Alabama, and the Collaborative is excited about the opportunity to further expand its capacity and reach across rural Southwest Alabama.

Collaborative members will work to address governance, leadership and workforce standards by recruiting individuals and organizations on a continuous basis to serve as representatives of their respective communities on the Collaborative. Collaborative members will also work to educate and train governance, leadership, and workforce in culturally and linguistically appropriate practices by adapting workforce and community training to address specific social determinants of health that prevent or hinder members in the community from participating in prevention activities and treatment of existing chronic illnesses. Examples include, but are not limited to, providing appropriate patient and community outreach materials based on an overall literacy level as defined through the needs assessment process, reinforcing provider teach back methods for patients, and providing community health workers to assist patients through the Care Coordination process. Collaborative members will also work to provide overall guidance on Engagement, Continuous Improvement and Accountability Standards by

assisting facilities to collect required PIMS data for evaluation, which will include reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. Additional social determinants of health that impact patient outcomes in the service area include access to care, lack of transportation and lack of health insurance.

B. Vision, Mission and Strategic Purpose

Vision:

Our Vision is to enhance the patient-provider relationship, connect rural communities to new and existing resources, and enhance community education, outreach, and engagement in diabetes and heart disease resources.

Mission:

Our mission is to connect communities to education, outreach and resources regarding diabetes and heart disease, resulting in strengthened working partnerships and an increased utilization of resources, in order to address social determinants of health.

Strategic Purpose:

The Goldenrod Outreach Initiative's aim is to help address health equity for individuals at risk and/or diagnosed with diabetes and/or heart disease by creating greater connection and utilization of resources between clinical and nonclinical realms.

C. Management Communications

The SAHC will be initially led by the Network Director, because the current Collaborative structure does not have separate governance or committee structures. During Year 1, the Collaborative will work under the coordination of the Network Director, Annie Jones, to build a Governance Committee, which will oversee all programmatic and operational activities on behalf of the Collaborative. The Governance Committee will convene as directed in the Bylaws and will be responsible for providing performance feedback to the Network Director, all of which will be communicated back to the overall Collaborative members at monthly meetings. Because the proposed service area is vast and rural, Collaborative members will be given the option to attend meetings virtually if they are not solely convened virtually. This will ensure that members can attend and be given communication regarding network operations and outcomes, along with gaining their approval for voting-related matters. Between meetings, the method of communication is virtual communication. During monthly meetings, Collaborative members will utilize the Work Plan and Strategic Plan to gauge the network's movement towards long-term system changes, value-based care, population health management and program sustainability. The Collaborative will work closely with the External Evaluator, Dr. Lisle Hites, to develop methods to measure outputs and outcomes related to success metrics. Leadership from the Project Director, Network Director and Governance Committee will encourage collective decision making across network member organizations by requiring a majority of the quorum to vote on essential Collaborative matters, such as financial reports and new member recommendations. The Network Director meets quarterly with the Board Members, to report on success and progress of the program.

In regard to how the Collaborative will make decisions, the SAHC, as the oversight entity implementing the GO Initiative, will create a more robust governance structure through funding from the SAHC program and work to further its collective vision of improving health outcomes and health equity among community members in rural Southwest Alabama. The SAHC has an effective governance structure currently in place, which includes collective governance responsibilities by each signatory member, although the Collaborative hopes to utilize funding from the Rural Health Network Development Program to further strengthen relationships between members and implement activities which address the four SAHC domains. The SAHC will oversee all financial and programmatic decisions for the project utilizing financial policies and procedures of the West Central Alabama AHEC as outlined under the Applicant Organization section of the Project Narrative and will build sustainable methods for continuing project operations past SAHC funding. Current SAHC members recruited for the implementation of the GO Initiative were chosen through collaborative relationships and past implementation efforts, as well as their roles within the community. All partners recruited for participation in the GO Initiative are leaders in their communities and embody the purpose of the SAHC goals by working to increase health outcomes among rural and underserved populations.

Part II. Engagement in the Strategic Planning Process

A. Identification of Need

According to the CDC in 2018, 12.48% of the population in the service area had a diabetes diagnosis, and the average percentage of the project service area that is more vulnerable to diabetes diagnosis than other counties was listed as 74.75%. According to the US Census Bureau in 2018, diabetes was the cause of death of 48 individuals in the project service area. According to the US Census Bureau in 2021, heart disease was the cause of death for 568 individuals in the project service area. The G.O. Initiative addresses SAHC domains to address prevention, education and treatment of diabetes and heart disease in rural areas through improving access to care by creating an even stronger network between patient and provider, expanding capacity and services by implementing evidence-based protocols and peer networking opportunities, enhancing health and economic outcomes of these rural communities through community-based lifestyle programs and provider reimbursement support, and finally, ensuring sustainability of Collaborative activities through value-based care and population health management. In order to capture the needs of the counties SAHC serves, Collaborative Members created a Needs Assessment modeled after SAOR Needs Assessment and reflected it to address diabetes and heart disease needs from both providers point-of-view and community members' point-of-view. The progress of this grant is still ongoing, and there have not been any foreseeable changes that would impact the Needs Assessment considering the ongoing work. There are no changes that would impact this grant in the foreseeable future and would impact the Needs Assessment before it is published.

B. Network Engagement

Collaborative members were engaged in the development of the Strategic Plan by reading the draft, and engaging their thoughts and comments. After each member was able to review the draft, comments were taken into consideration, and each member was then able to vote upon the

final draft of the Strategic Plan. In regards to day-to-day activities, Collaborative members are engaged on a regular basis in different aspects. For example, our clinical partners are seeing diabetic patients and informing them of the resources available in our community. Our clinical partner in Marengo county, Dr. Chu, is partnering with Richard Bryant, who teaches fitness classes in the area they are in the process of developing a physical activity program in which obese and overweight individuals with heightened health markers participate learning about nutrition, and exercising several times a week, as well as measuring their health markers at specified intervals over a three month period. Our partner in Sumter County, Health and Wellness Education Center, has started several physical activity programs. One program just concluded in Sumter County called Walk with Ease Program in which participants met with the incentive of gaining prizes and walked each week in order to address their health needs. This program is currently being replicated in both Marengo and Choctaw counties and participants have already been recruited. Southern Alabama Area Health Education Center partners with Monroe Hospital and is also in the process of locating resources and starting outreach programs and/or physical activity programs in the counties they serve (Clarke, Monroe and Escambia counties). Both V& C Outreach and Oak Grove Assembly of God is responsible for passing out informational brochures to community members and collecting data, as well as opening their facilities for community educational classes. Whitfield Regional Hospital hired a diabetes educator in order to provide education and outreach to diabetic patients in Marengo County. They are also responsible for starting community-based classes in the area as well as utilizing and advertising existing resources in Marengo county. All Collaborative members are responsible for seeking out resources in their county/counties, as well as advertising existing resources and the Needs Assessment. Members communicate via email, telephone and on Zoom meetings at our monthly consortium meetings held the 4th Thursday of the month from 1:00 to 2:00 PM central Standard Time.

Part III. Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

A. SWOT Analysis

Internal	**External**
Strengths: ● Community partners in all six counties we serve ● No other program like this in the community currently ● A great need for the program due to rural area and lack of existing resources and poor nutrition ● Eager community partners with consistent engagement with Collaborative ● Strong community connections in rural counties	**Opportunities:** ● Grant funding to impact the communities in service area ● Grant activities will increase awareness of existing resources ● Grant funding will help create new resources ● Job opportunities created in rural areas we serve (diabetes educator position, Community Health Workers) ● Whitfield Regional Hospital will become a DSME/DSMT certified site,

	which currently does not exist in the area
Weaknesses : ● There is a lack of resources in the communities we serve ● No certified diabetes educators currently in our Network ● Lack of resources that lends to non-certified diabetes educators in the counties that we serve ● Not enough community awareness ● Lack of incentives for community members	**Threats:** ● Low employment rate of certified educators (currently none reside in the counties we serve according to CDE website) ● Lack of doctors / specialists in the community; therefore, a lack of a connection/rapport with community as well) ● Law response rate of community ● Lack of abundant public transportation resources ● Lack of resources readily available

Strengths:

- Community partners in all six counties we serve
- No other program like this in the community currently
- A great need for the program due to rural area and lack of existing resources and poor nutrition
- Eager community partners with consistent engagement with Collaborative
- Strong community connections in rural counties

Weaknesses:

- There is a lack of resources in the communities we serve
- No certified diabetes educators currently in our Network
- Lack of resources that lends to non-certified diabetes educators in the counties that we serve
- Not enough community awareness
- Lack of incentives for community members

Opportunities:

- Grant funding to impact the communities in service area
- Grant activities will increase awareness of existing resources

- Grant funding will help create new resources
- Job opportunities created in rural areas we serve (diabetes educator position, Community Health Workers)
- Whitfield Regional Hospital will become a DSME/DSMT certified site, which currently does not exist in the area

Threats:

- Low employment rate of certified educators (currently none reside in the counties we serve according to CDE website)
- External threat of lack of doctors / specialists in the community, and a lot of the existing ones are out of Birmingham (for example, Dr. Sass, a cardiologist, who hosts virtual clinics in Clarke Co. and only comes in person once a month, therefore, a lack of a connection/rapport with community as well)
- Law response rate of community
- Lack of abundant public transportation resources
- Lack of resources readily available

B. Strategic Actions Identified from SWOT Analysis

1. We can use the above listed strengths to take advantage of above listed opportunities by utilizing all Collaborative members to not only increase awareness of existing resources, but also through coming together/partnering with each member to create new resources (i.e. Dr. Chu and Richard Bryant's "Successful Life Initiative"). This will also be marketed at his clinic, which can help other community members hear about this resource, as well as link the participants to Whitfield Regional's upcoming Community Education Classes regarding Diabetes. Collaborative members also utilize the extension centers in Alabama in order to communicate regarding the existing resources in education and outreach that the extension centers produce.
2. We can also take advantage of the strengths available to avoid both existing and potential threats by providing partners with contacts, resources, and information that will lead to their success. For example, by linking Whitfield Regional's diabetes educator with the contacts at the Alabama Extension Center as well as other located Certified Diabetes Educators (such as the CDE of Escambia County), the Network Director can ensure that the educator is provided with the tools to succeed in order to create job continuity, and continuity of care of patients. By utilizing existing resources, the SAHC can better connect with community members in order to create a rapport with members that will lead to the success of both the programs and educational classes, but also the treatment of diabetes and heart disease in the communities that the SAHC serves.
3. The SAHC can also utilize the available opportunities in order to minimize and perhaps even overcome the weaknesses that exist by utilizing members and the collective in order to increase awareness of existing resources, which can lead to creating the foundation in order to create more resources. In addition, creating more job opportunities, such as at Whitfield Regional Hospital through establishing Whitfield Regional as a DSME/DSMT site, consequently there will be not only more revenue in rural areas, but also more

community members that can not only be an asset to both the SAHC, but also to the community as a whole.

4. The SAHC can also minimize weaknesses in order to avoid threats by creating better marketing tactics, get feedback from the community through the Needs Assessment, get feedback from the providers in the community, and utilize these findings in order to not only better existing resources, but also target the gaps in care in these communities, and bridge the gaps between providers and community members.
5.

Part IV. Goals and Objectives

Goals

The overall goal of the GO Initiative is to increase community capacity of prevention, treatment and ongoing support mechanisms for individuals at risk and diagnosed with diabetes and/or heart disease, which will aim to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs in accordance with the national CLAS Standards.

Strategic Objectives

The objectives of the SAHC/Goldenrod Outreach Initiative follow logical progression and are measurable, specific, attainable, realistic, and time bound. Through these objectives, the members of the SAHC can utilize/dedicate resources in order to bring about a positive outcome and impact in the communities that we serve.

The following are the strategic objectives for 2024-2029 to guide the Network in achieving its vision and mission.

1. Expand the capacity and sustainability of the Southwest Alabama Healthcare Collaborative to address barriers to care for individuals at risk and/or diagnosed with diabetes and/or heart disease by formalizing network structure by August 2024. Addresses SAHC Domains 1, 2, 3, 4.

   Objective 1 will be measured through analysis of the documentation that is created thought formalizing the network structure of the SAHC, including the SAHC Bylaws, meeting minutes and attendance, and assessing the progress at scheduled meetings through analysis of these documents.

2. Identify and address gaps in community-based prevention and treatments for diabetes and heart disease by increasing membership of the Southwest Alabama Healthcare Collaborative by 50% by August 2025. Addresses SAHC Domains 1, 2, 3, 4.

   Objective 2 will be measured through the number of new members brought on to the SAHC, as well as through analysis of the Needs Assessment that is currently being

distributed throughout the project service area.

3. Increase the quality and quantity of chronic disease treatments available for community members in West Alabama by identifying and implementing at least two evidence-based protocols for individual and group care for diabetes and/or heart disease in conjunction with population health management by August 2027. Addresses SAHC Domains 1, 3, 4.

   Objective 3 will be measured through the number of programs that are implemented using evidence-based protocols in the project service area.

4. Facilitate a minimum of 6 continuing education offerings for health professionals and staff aimed to increase knowledge of chronic diseases, value-based care and the impact of social determinants of health on treatments, patient outcomes and billing opportunities at least 10% by August 2027. Addresses SAHC Domains 2, 4.

   Objective 4 will be measured through the Needs Assessment analysis, including the number of individuals reached in both the Community Needs Assessment and the Providers Needs Assessment, as well as the baseline data collected from SAHC for PIMS reporting, and the number of organizations represented.

5. Improve provider and community capacity for care and reduce social, economic and environmental barriers to better health for individuals at risk and diagnosed with diabetes and/or heart disease by implementation of a Community Health Worker Program in 2 community facilities by August 2027. Addresses SAHC Domains 1, 2, 3, 4.

   Objective 5 is measured through the Needs Assessment for community members and providers; # of individuals reached; baseline data collected from SAHC for PIMS reporting; # of organizations represented# of hours completed during training; # of certified CHWs # of facilities who implement CHWs; # of PDSA cycles completed; # of workflows completed; # of standing orders issued during project period concerning diabetes # of materials given, # of contact hours spent, # of educational offerings provided, # of referrals provided for DSMES/DSMT participation # of surveys distributed; # of contact hours spent, qualitative outcomes.

6. Enhance the community's ability to prevent and support ongoing efforts to reduce the impact of comorbidities by implementing at least 4 community-based education and/or physical activity programs each year which will reach at least 500 individuals by August 2027. Addresses SAHC Domains 2, 3, 4.

   Objective 6 is measured through Surveys for community members and providers; # of individuals reached; baseline data collected from SAHC for PIMS reporting; # of responses, # of organizations represented; DSMES/DSMT classes offered; # of participants in each class; # of trainings provided; # of people trained; # of training hours provided; monetary amount of billable services increased as a result of project activities; # of protocols identified Protocol(s) identified; protocol(s) implemented;

educational materials; # of trainings provided; # of people trained; # of training hours provided; monetary amount of billable services increased as a result of project activities; # of providers who implement the protocol(s); # of staff trained on the protocol(s), # of participants served # of individuals reached; # of classes offered; # of participants at each class; knowledge gain; # of individuals reached; # of vouchers offered; # of patients who attended clinic and referral appointments

Work Plan Updates

There are no updates or revisions to the Work Plan from the original submission.

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