VANDERBILT HEALTH

2025 IMPLEMENTATION STRATEGY

A Joint Community Health Needs Assessment for Vanderbilt University Hospitals, Vanderbilt Bedford County Hospital, Vanderbilt Tullahoma-Harton Hospital, Vanderbilt Wilson County Hospital, and Vanderbilt Stallworth Rehabilitation Hospital

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Introduction

Vanderbilt University Medical Center (VUMC) is located in Nashville, Tennessee, primarily serving Tennessee, northern Alabama, and southern Kentucky. VUMC owns and operates seven hospitals. Of the seven hospitals VUMC owns and operates, the Vanderbilt University Hospital (VUH), Monroe Carell Jr. Children's Hospital at Vanderbilt (Monroe Carell), and Vanderbilt Psychiatric Hospital (VPH) operate under a single hospital facility license and are collectively referred to as "Vanderbilt University Hospitals." VUMC also owns and operates Vanderbilt Tullahoma-Harton Hospital (VTHH), Vanderbilt Wilson County Hospital (VWCH), and Vanderbilt Bedford County Hospital (VBCH). As part of a joint venture with Encompass Health Corporation, VUMC owns 50% of Vanderbilt Stallworth Rehabilitation Hospital (Stallworth).

The 2025[1] VUMC Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) is a joint CHNA that covers the licensed hospital facilities of Vanderbilt University Hospitals (Monroe Carell, VPH, and VUH), VTHH, VWCH, VBCH and Stallworth. Throughout this report, these entities are collectively referred to as "VUMC."

Purpose

The CHNA process is designed to identify key health needs and assets through systematic, comprehensive data collection in the community served. The CHNA serves as a health profile for the community and describes significant health needs identified collaboratively with the community and gaps between current and desired health status. This Implementation Strategy (IS) is VUMC's response to the health needs identified through the CHNA process. ***The Implementation Strategy describes actions VUMC will take to address prioritized community health needs and improve community health outcomes***, with special attention to populations who experience barriers to accessing healthcare and social care resources.

Compliance and Written Comments

As part of the 2010 Patient Protection and Affordable Care Act, non-profit hospital organizations such as VUMC are required to complete a Community Health Needs Assessment (CHNA) and an accompanying Implementation Strategy (IS) every three years. As with prior CHNAs, VUMC conducted a process incorporating the collection and analysis of a broad range of primary and secondary data.

VUMC has previously published CHNA/IS reports in 2013, 2016, 2019, 2022, and 2023 and ensured they are accessible to the public via VUMC's **Community Health** and **Stallworth**

[1] In June 2025, this CHNA and accompanying IS were adopted. The adoption was during VUMC's 2025 fiscal year, which is also the tax year 2024 per the Return of Organization Exempt from Income Tax, Schedule H, 990 Form. To be consistent with CHNA/IS reporting on Form 990, Schedule H, these documents are referred to hereinafter as the "2025 CHNA" and "2025 IS."

websites. The 2025 VUMC CHNA and IS are also available on these websites. Paper copies of the reports are available at no cost at VUMC, VBCH, VTHH, VWCH, and Stallworth facilities.

VUMC also solicits ongoing feedback from the public on our CHNA/IS through a public comment portal on the Community Health website homepage. The portal for comments is regularly monitored so comments can be addressed.

Identifying and Prioritizing the Needs

The extensive community process VUMC used to prioritize health needs is described below and in more detail on page 18 of the CHNA. While overlapping themes were highlighted across counties, each county named their prioritized needs as outlined in the figure below. These county-specific needs were consolidated into broader categories—representative of each of the county specific needs that VUMC adopted.

County	Bedford	Coffee	Davidson	Rutherford	Williamson	Wilson	Consolidated Needs*
PRIORITIZED NEEDS	Mental Health	Behavioral Health	Economic Opportunity & Job Skill Development	Mental Health	Mental Health	Mental Health	**Health-Related Social Needs**
	Substance Use		Awareness/ Navigation of Community Resources	Substance Use (opioids)	Substance Use (Opioids, tobacco, and prescription medication)	Access to Healthcare	**Chronic Conditions and Preventative Care**
			Food Access	Healthcare Access	Health Promotion (Chronic Disease Prevention) Through Built Environment	Health Literacy	**Access to Healthcare**
			Housing	Attainable Housing	Affordable Housing	Housing & Transportation	**Behavioral Health**
				Infant Mortality			

*Each county-specific prioritized need was reviewed and grouped thematically into four broader categories of needs. The consolidated needs were approved as VUMC's prioritized needs.

As noted above, for VUMC's CHNA and IS each county-specific need was grouped thematically into four overarching categories of needs for VUMC to address. Given the breadth of needs prioritized across six counties, VUMC consulted members of the Community Health Workgroup, a group of VUMC faculty and staff, for guidance and to confirm alignment with all county-specific needs and capacity to address them. Additionally, VUMC presented the prioritized needs to advisory groups of VBCH, VTHH, VWCH, and Stallworth.

VUMC considers the prioritized needs of equal importance and has not listed them in any order. These four broad need areas guided the development of VUMC's Implementation Strategy. The VUMC Board of Directors adopted the CHNA/IS and the four needs outlined below in June 2025.

- *Reduce Differences in Health Outcomes by Addressing Health-Related Social Needs,*
- *Prevent Chronic Conditions and Enhance Preventative Care,*
- *Increase Access to Quality Healthcare, and*
- *Enhance Delivery of and Access to Behavioral Health Services*

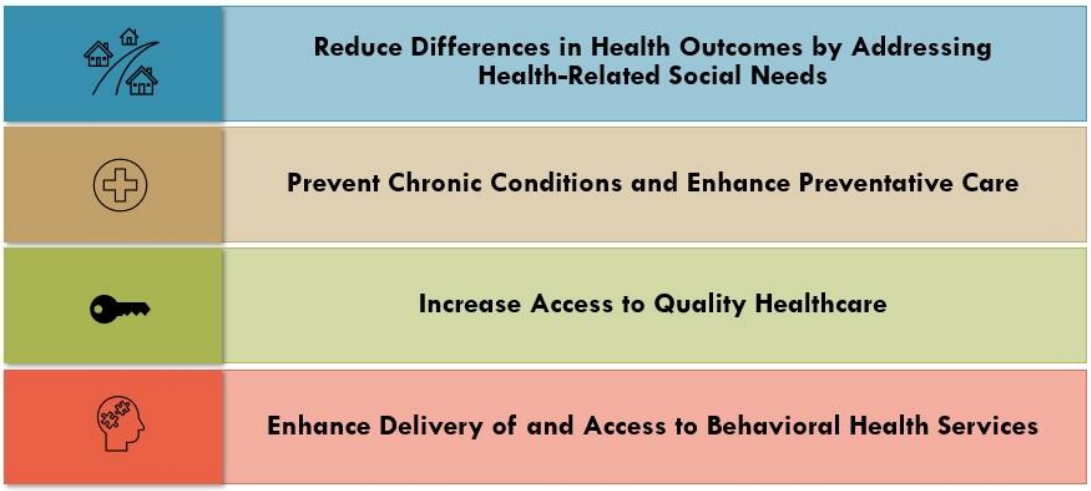
Addressing Prioritized Needs

VUMC will address the prioritized needs identified by the community with institutional and other resources. These include staff time and financial support for the programs, initiatives, and activities described on the following pages. VUMC's Implementation Strategy also engages health systems leaders, faculty, staff, trainees and learners, while also cultivating many community collaborations that reduce variability in health outcomes and promote optimal health for all.

Below are action plans to address the prioritized need or needs and a description of the anticipated impact. These action plans highlight a selection of the extensive work VUMC undertakes to address needs identified by the community. A key for acronyms is included on Page 24.

Implementation Strategy Action Plans

Each action plan addresses one or more of the prioritized health needs. The color and icon shading at the top of each table indicates which prioritized need is being addressed. Use the key below to see which needs are being addressed through each action plan.



Strategy: Provide educational and financial support for participation in VUMC's Medical Assistant training program and work with community partners to hire local residents to expand VUMC's workforce			
Anticipated Impact: Promote health, economic empowerment, and career advancement for VUMC's workforce and the community			
Action Steps:			
Continue providing financial support for external candidates to participate in the VUMC medical assistant training program; also provide access to health benefits and VUMC wellness programs			
Develop additional programs to support internal and external candidate career mobilization in areas including Central Sterile Processing, Surgical Technicians, and other areas to expand the Allied Health workforce			
Provide professional development opportunities for community partner participants focused on interviewing, general employment tips, and communication strategies			
Provide employment opportunities and opportunities for advancement; address retention issues for candidates			
Metrics & Milestones:			
On-going financial support provided; Professional development opportunities identified; Retention concerns for the employee population identified and addressed			

			
Strategy: Support nutrition security efforts that align with CHNA priorities and engages community partners in planning and implementation, led by an interdisciplinary team at Monroe Carell			
Anticipated Impact: Provide tangible food resources to patients and families at Monroe Carell identified as food insecure; connect patients and families to ongoing food resources in the outpatient setting; improve health outcomes			
Action Steps:			
With leadership support and funding, continue to pilot a nutrition security program called Champ's Cupboard in Monroe Carell to provide meals and ongoing food resources to patients and families			
Collect and evaluate 6-month pilot data to determine model and funding needed to scale the program out to additional hospital units			
Develop and implement a training curriculum for students, interns, and other learners to serve as volunteer food resource navigators			
Continue to partner with community organizations that received funding for engagement and involvement in food resource navigation program			
Metrics & Milestones:			
Number of food insecure patients receiving meals/food assistance through program; Increase enrollment in SNAP or WIC programs; Increase student involvement in program			

			
Strategy: Support existing efforts focused on patients with language and other barriers to accessing and navigating care that aligns with CHNA priorities and engages community partners in planning and implementation			
Anticipated Impact: Strengthen infrastructure to improve community health			
Action Steps:			
Foster mutually beneficial relationships with community partners to better serve the needs of pediatric populations in Middle Tennessee			
Bolster language services provided to VUMC pediatric patients and families			
Metrics & Milestones:			
Improve patient experience reported by demographic variables such as preferred language, zip code and other sociodemographics			

			
Strategy: Continue to partner with Women's Health to support improving birthing experiences and maternal and infant health outcomes for all expectant mothers			
Anticipated Impact: Improve the delivery of care during and after childbirth at VUMC; improved maternal and infant health outcomes			
Action Steps			
Build capacity to better support patients who desire doula services for labor support			
Improve the birth experience and maternal and infant health outcomes by providing personalized care that values each patient's autonomy and decision-making			
Explore strategies to improve inpatient HCAHPS survey feedback from obstetric patients			
Identify and address differences in birth outcomes by monitoring key obstetric quality indicators			
Improve inpatient and outpatient childbirth education			
Provide a platform for women to share their positive birth experiences and community organizations to share resources for a positive birth experience			
Metrics & Milestones:			
Improved Telehealth utilization for patient care and patient education; Expanded options for group prenatal education; Internal "Doula Best Practice document" developed; Joint Commission obstetric outcome dashboard			

			
Strategy: Through Rooted Community Health, expose all VUMC employees to the ways in which we grow, source, prepare, and distribute our food has impacts on health and well-being			
Anticipated Impact: A workforce and student body that has exposure to the roles our food system plays in the health outcomes of patients			
Action Steps:			
Partner with three local regenerative farms' CSA programs to connect any employees who may be interested to subsidized fresh produce and prioritize financial support for employees who earn less than $45,000 annually			
Partner with volunteer VU medical students to transport leftover Growing Good Health CSA shares to the Shade Tree Clinic to divert food waste and connect fresh produce with people experiencing food insecurity			
Facilitate workshops in the Garden of Hope to educate employees on how to grow food, "food is medicine" workshops, and how the food system impacts health and well-being			
Assist facilitating course offered to VU medical students titled "Ecology & Health Care"			

Present to departments within VUMC to discuss the impacts of the environment and food insecurity on human health and wellbeing
Assist in the creation of the Food Navigation Resource Center (FNRC) to address food insecurity. Supervise dietetic interns, and strategize ways to incorporate fresh produce to patients experiencing food insecurity
Metrics & Milestones:
Increase number of Garden of Hope participants; Increase number of Growing Good Health CSA participants (and corresponding numbers of those who receive the 100% and 20% subsidies); Increase number of dietetic interns taken on in an academic year; Increase number of Rooted Community Health presentations shared with non-CBES departments; Increase number of food resources distributed in the FNRC

Strategy: Improve organizational alignment and health access and outcomes across the region through Meharry Vanderbilt Alliance's community engagement efforts
Anticipated Impact: Improved alignment and mobilization of institutional resources to support community needs
Action Steps
Support inter-institutional partnerships through facilitation processes and the mobilization of resources
Expand outreach and engagement activities to support greater development of institutional and community partnerships
Develop bi-directional community relationships through collaborative partnership processes and shared resources
Metrics & Milestones:
Provide facilitation processes and mobilize resources to support requested inter-institutional partnerships; Expanded community of partners to support the origination of impactful institution and community partnerships; Utilization of collaborations and shared resources for the development of initiatives and programs

			
Strategy: Provide education and resource support for children and families during their hospital stay to ensure caregivers are able to provide safe transportation to their children upon discharge through the Pediatric Trauma Injury Prevention Program and Family Resource Center at Monroe Carell			
Anticipated Impact: Promote best practices and car/booster seat usage for safe child passenger transportation; Reduced MVC rates in Middle Tennessee			
Action Steps			
Implement office hours, on-site, and virtual classes for caregivers to practice car seat installation and to learn basic principles and state laws of child passenger safety Trauma Injury Prevention Program and Family Resource Center at Monroe Carell			
Update Child Passenger Safety standard operating procedure and ensure staff and families have access to important information such as how to obtain a car seat despite inability to pay, how to find classes, where to practice installing a seat, what the TN state laws are, and where to find fitting stations to ensure the seat is installed properly Trauma Injury Prevention Program and Family Resource Center at Monroe Carell			
Metrics & Milestones:			
Number of patients served; Review number of car seats distributed; MVC trends on the trauma service indicating number of children properly restrained			

			
Strategy: Increase partnerships with community-based programs to support VUMC's patients who screen positive for health-related social needs (food insecurity, transportation, housing, utilities, financial needs, and interpersonal safety)			
Anticipated Impact: Deliver comprehensive care for patients at a high risk for readmission, address preventable ED utilization, and/or poor health outcomes due to unmet social needs; enhance ability to identify health differences and needs			
Action Steps:			
Create and implement a robust community-based resource directory used across the enterprise to enhance productivity and improve patient outcomes			
Leverage TMO, nursing and other case management expertise to continue to assess social needs, psychosocial challenges, and financial barriers for patients			
Explore feasibility of working with community partners on a closed loop referral process and explore the ROI of an enhanced community referral resource			
Establish a multi-level initiative to incorporate social needs screening into adult primary care to improve outcomes for patients with diabetes in Davidson County			

Develop recommendations for scaling of community health worker roles at VUMC to facilitate navigation to resources in areas where there is a high rate of positive screens
Metrics & Milestones:
Percentage of positive HRSN screened patients referred to a community-based program; Improve ratios of case managers/community health workers to patients; Percentage of high-risk patients screened with complex medical and social needs in settings to be identified; Implement an integrated community resource directory into the electronic medical record.

			
Strategy: Improve the accuracy of race, ethnicity and language data (REaL) and other sociodemographic data collected from all patients			
Anticipated Impact: Deliver quality care to all patients			
Action Steps:			
Engage and learn from front end staff on the barriers to documenting REaL and other sociodemographic data			
Gather perspectives from Annual Advise Vanderbilt Pulse Survey			
Scale QI efforts across the enterprise to improve the quality of REaL and other sociodemographic data at VUMC			
Expand the We Ask Because We Care campaign to educate patient and staff on the importance of REaL and sociodemographic data			
Explore strategies for improving capture of disability data			
Metrics & Milestones:			
Improve capture of quality REaL and sociodemographic data			

			
Strategy: Increase availability of resources, education, and training for career advancement for VUMC employees			
Anticipated Impact: Positively impact the number of nursing candidates and improve the retention rates for nurses; Expand economic opportunity for employees			
Action Steps:			
Establish partnerships with Schools of Nursing within the southeast region to provide mentorship, encourage an inclusive workforce environment, and foster nursing student professional education			

Through a community outreach subcommittee, partner with community organizations to provide nurse-led health education sessions to older adults on recommended health screenings and available health resources in the community
Provide community mentorship and healthcare career fairs to an identified community high school
Establish and support partnerships, discussions, and relationship building sessions focused on student's needs
Provide one-day intensive immersion session at VUMC for senior nursing students to develop career planning, develop mentor relationships with nurse staff and expose students to nursing culture
Develop and maintain partnerships with community schools and other organizations to expand recruitment efforts
Develop and implement a career ladder for non-exempt positions
Metrics & Milestones:
Students reached through community outreach; Improvements in nursing recruitment and retention; Career paths developed

			
Strategy: Partner with VUSM learners and community-based organizations focused on policy to address upstream factors that impact health outcomes
Anticipated Impact: Create opportunities for all populations to achieve optimal health through advocacy; Expand medical and public health student knowledge through immersive experiences; Increase access to healthcare
Action Steps:
Provide funds to community organizations to offer a community health immersive experience to VUSM MD & MPH students through the Lefkowitz Fund that exposes students to advocacy and policy
Partner with VUSM student-run group Social Mission Committee to connect students to additional community experiences and opportunities
Provide meaningful community health applied learning experiences for graduate level MPH students through a graduate assistantship program
Metrics & Milestones:
Number of grants awarded; Grantee progress towards improving health access and opportunity discussed in 6-month and 12-month reports

			
Strategy: Develop and enhance infrastructure to support the engagement of VUMC's workforce in community-academic partnerships that improve health outcomes			
Anticipated Impact: Increase community partnerships that support initiatives at VUMC and in the community to reduce variability in health outcomes and promote optimal health for all.			
Action Steps:			
Serve as a resource hub for community-engaged research to help facilitate community health efforts			
Offer education, training, and consultations to support faculty conducting community-engaged research projects			
Enhance and implement a Community Impact Tracker to create a multi-user platform that both community partners and VUMC employees can access to align, leverage, and better collaborate on community health efforts			
Metrics & Milestones:			
Number of initiatives captured in the Community Impact Tracker (CIT); Community collaborations facilitated through CIT; Number of trainings or educational offerings			

			
Strategy: Provide funding to community partners through the Community Health Mini-Grants to address CHNA prioritized needs and identify and support opportunities for building community partner capacity			
Anticipated Impact: Build capacity of community partners to address community health; Improved health outcomes			
Action Steps:			
Solicit proposals from community and faith-based organizations, neighborhood associations, community health centers, and service providers, who address CHNA priorities and work to advance community health			
Provide funding support for organizations that supplement specific programmatic or capacity needs that align with CHNA priorities			
Host training and networking opportunities for all grantees (e.g. community health data platform training through Healthy Communities Institute)			
Metrics & Milestones:			
Number of grants awarded; Number of training and networking opportunities hosted; Grantee progress towards improving health access and opportunity discussed in 6-month and 12-month reports			

			
Strategy: Maintain an accessible computer lab and increase digital access for all employees in service roles; through accessible placement of devices and educational support, facilitate access to VUMC email, Workday, the Learning Management System, financial literacy and other training and resources			
Anticipated Impact: Increase access to computers, increase digital and financial literacy among employees; improve health outcomes			
Action Steps:			
Purchase computers for the lab and devices such as kiosks for other areas; create accessible educational materials to support computer use			
Pilot financial literacy workshop to gather input from employees; finalize and scale workshop to other areas of VUMC			
Collaborate with HR, IT, service role and operational departments to finalize computer lab, device locations and trainings			
Develop outreach strategies to attract employees to utilize computer lab and devices in accessible areas			
Metrics & Milestones:			
Number of employees using the computer lab; Number of employees completing computer training; Number of employees completing financial literacy classes; Increase awareness of VUMC resources; reduce manager time spent providing computer/digital instruction			

			
Strategy: Address prioritized health needs and support community health improvement plans (CHIPs) in Bedford, Coffee, Davidson, Rutherford, Williamson, and Wilson Counties through partnerships with local county health councils, health departments, community organizations and others			
Anticipated Impact: Improved health outcomes; Stronger community partnerships and collaborations; Enhanced multi-sector community engagement in address community health			
Action Steps:			
Provide strategic support to county health councils in counties listed above through workgroup and other targeted participation			
Partner with community organizations and coalitions that address health priorities of VUMC and health councils including the Safety Net Consortium of Middle Tennessee, the Tennessee Community Health Worker Association, ACE Nashville and others			
Metrics & Milestones:			
Number of partnerships developed; Number of meetings attended; Number of collaborations and connections made between VUMC and the community to advance health needs			

			
Strategy: Develop CHNA and CHIPs collaboratively with health departments, health systems and community partners; implement a dissemination strategy for the CHNA and raise awareness about the Healthy Communities Institute (HCI) data platform			
Anticipated Impact: Enhanced use of data by community partners to improve health outcomes; stronger community partnerships and collaborations; enhanced multi-sector engagement to address community health			
Action Steps:			
Design a collaborative CHNA process and develop county specific reports that can be used by health departments, health councils and other community partners to improve community health			
Use a multipronged dissemination strategy to share CHNA county specific reports and the HCI data platform across counties			
Provide tailored support to community partners to use data and evidence-based strategies to advance community health needs			
Metrics & Milestones:			
Streamlined CHNA process and enhanced coordination; CHNA and data dissemination strategy development; partner utilization of HCI; increase use of promising/evidence-based strategies			

			
Strategy: Work with community partners to improve institutional community engagement practices and support projects that improve community health outcomes			
Anticipated Impact: Stronger partnerships with community organizations; Improved health outcomes			
Action Steps:			
Support Community Advisory Group of community leaders that will inform community engagement practices, policies, and procedures for community health improvement			
Continue to explore partnerships with organizations and community leaders in rural counties			
Draft a process for connecting community partners to VUMC resources for community events such as health fairs, education, and screening opportunities			
Metrics & Milestones:			
Stronger connections with partners; Number of advisory group meetings; Improved understanding of community-based organizations serving all populations in rural and other counties			

			
Strategy: Increase involvement of VUMC's workforce, including learners and trainees, in community health improvement			
Anticipated Impact: Enhanced community support; Stronger partnerships with community organizations; Improved workflow for workforce involvement in community events			
Action Steps:			
Engage workforce leaders and community partners in cataloging engagement capacity and opportunities for collaboration			
Continue to support workforce engagement groups and connect them to community opportunities, including groups from Vanderbilt Eye Institute and Orthopedic and Dental Surgery Residents			
Pilot a platform for connecting workforce groups to community engagement activities			
Metrics & Milestones:			
Piloted procedure and/or platform to connect VUMC teams to community partners; Increased engagement of smaller community organizations			

			
Strategy: Facilitate health fairs and health education events in regional counties to improve access to healthcare and to resources			
Anticipated Impact: Enhance public and community education on prevention; Increase access to care and improved health outcomes; Foster stronger community partnerships			
Action Steps:			
Utilize existing community relationships with organizations such as WEMA, Wilson County Health Department, City of Lebanon, and others to provide variety of health events like Stop the Bleed program, Wilson County Heart Walk, Hands Only CPR Training, and other health fairs			
Partner with additional community organizations to offer health education events and resources in the community regarding early heart attack signs and effective prevention strategies			
Metrics & Milestones:			
Number of health events attended; Number of community members that have received care; Number of community partnerships			

			
Strategy: Collaborate with Wilson Rides to support older adults in Wilson County who do not have access to transportation through efforts of the VUMC Office of Community & Government Affairs			
Anticipated Impact: Improve transportation access for older adults; Foster community relationships to support the Wilson Rides program			
Action Steps:			
Continue to collaborate with the local mayors and elected officials to support Wilson Rides			
Collaborate with VWCH case managers to support patient needs when transportation is a need for older patients			
Grow awareness of key community councils to influence additional support for Wilson Rides			
Identify opportunities from a state and federal level			
Metrics & Milestones:			
Number of participants receiving rides; Strengthened community partnerships			

			
Strategy: Improve preventative care and access for VUMC employees and explore opportunities for partnerships in the Nashville region			
Anticipated Impact: Increase wellness visits for VUMC employees in service roles; Improve health outcomes			
Action Steps:			
Analyze employee completion of annual care visit data			
Interview and engage managers of employees with lower completion rates of annual primary care visits			
Pilot an initiative to schedule annual care visits for employees at orientation and test other strategies to increase access to preventative care for all employees			
Metrics & Milestones:			
Process to increase access developed and pilot implemented			

			
Strategy: Develop an intervention to increase breast cancer screening			
Anticipated Impact: Improve Breast Cancer screening rates for women ages 45-75; Improve health outcomes			
Action Steps:			
Explore stratification of Breast Cancer screening rates			
Based on data, pilot process and strategies to address differences			
Determine the most significant focus area based on data that promotes increased screening and access to care			
Identity community-based organizations to partner with to reduce or subsidize patient costs for preventative screening including mobile mammography			
Metrics & Milestones:			
Data is stratified; Project team develops plans, and the demonstration project is outlined			

			
Strategy: Work with community partners to support people experiencing homelessness			
Anticipated Impact: Decrease preventable emergency department utilization; address housing and insurance needs of people who are unstably housed or experiencing homelessness and health needs			
Action Steps:			
Develop and expand capability of the Homeless Health Service (HHS) care center			
Develop a consult process for the HHS team for patients who are experiencing homelessness (PEH)			
Support process to screen for and address housing needs in VUMC patients and use data collected to improve future programming			
Expand immersion and service-learning opportunities for UME, GME, and Addiction Medicine Fellows to support people who are unstably housed or experiencing homelessness in Nashville and surrounding counties			
Explore opportunities to partner with the Community Health Worker training program to offer students field placement within VUMC			
Conduct a needs assessment for respite in Nashville to help guide collaborations and solutions			
Metrics & Milestones:			
Pilot execution, and data collected from ED screen; Multidisciplinary team collaborating; Learners and trainees engaged and impacted; SOAR referrals and HRSN addressed; Data gathered to articulate the respite need in Nashville			

Strategy: Address health care access for all individuals with barriers to navigating the health system
Anticipated Impact: Increase rate of patients connected to primary care; Improve clinical outcomes through better medication adherence and enhanced quality of life
Action Steps:
Provide accessible, high quality primary care, health education, case management and social services to uninsured patients through the Shade Tree Clinic, Vanderbilt University School of Medicine's student-run free clinic
Support patients with limited healthcare and insurance access through Vanderbilt Primary Care West End Clinic and North Nashville Clinic, which are Vanderbilt nurse faculty practice clinics. Implement a Post ED Discharge Clinic at West End to connect patients with community resources and establish a VUMC or other primary care provider
Provide medication assistance to patients through the Medication Assistance Program and increase the accessibility of pharmacy services to patients with limited resources
Revise procedures to facilitate access to care for all
Metrics & Milestones:
Decreased preventable emergency department utilization and readmissions; Increase rate of medication access and adherence; Procedures revised

Strategy: Provide community resource support to Vanderbilt Stallworth Rehabilitation Hospital (VSRH) patients to ensure patients have multiple resources to provide them with needed care
Anticipated Impact: Reduced ED utilization and reduced stroke readmissions
Action Steps:
Provide ongoing stroke support groups meetings to allow patients to discuss their journeys post discharge
Provide survivors and caregivers with resource packets with detailed information and steps on how to access community resources
Case managers provide guidance and support post-discharge to survivors
Continue to partner with community-based organizations that provide resources to VSRH economically marginalized brain injury and spinal cord injury patients
Metrics & Milestones:
Number of support groups and resource packets distributed; Number of partnerships with local, state, and national organizations

			
Strategy: Promote the implementation and dissemination of evidence-based cancer prevention, control, and care in the community through Vanderbilt Ingram Cancer Center (VICC)'s Office of Community Outreach & Engagement			
Anticipated Impact: Enhance public and community education on cancer prevention, risk reduction, and early detection, while working to reduce the cancer burden and address differences in health outcomes; Foster stronger relationships with patients and community stakeholders; Community-informed research priorities, cancer control strategies, and care initiatives			
Action Steps:			
Deliver comprehensive educational services, including events, materials, newsletters, and more, to ensure our communities have access to essential cancer information and resources			
Support community partners in their efforts to promote cancer awareness, support advocacy efforts, and advance research initiatives			
Broaden access to quality cancer screening and diagnostic care to patients in rural and underserved communities to help improve cancer outcomes			
Leverage VICC's advisory councils in bidirectional communication to ensure the community's input into efforts to effectively address the unique needs of the VICC catchment area			
Metrics & Milestones:			
Number of individuals reached; Number of individuals navigated into screening, reaching varied geographic and populations in activities; Number of community partners; Dollars contributed; Increased engagement with advisory councils			

			
Strategy: Utilize Vanderbilt Behavioral Health (VBH)'s Pediatric and Adult Behavioral Health Consult Programs in conjunction with Vanderbilt Health Affiliated Network (VHAN) to continue to provide real-time expert consultation to assist providers regarding mental health diagnosis, interventions, and recommendations as needed for their patients			
Anticipated Impact: Improved patient access and outcomes allowing for more integrated care with community partners while also assisting in addressing the shortage of behavioral healthcare providers and reducing ED utilization			
Action Steps:			
Continue to provide consultation and support specific to behavioral health services and assist in the determination of appropriate LOC			

Continue to refine consult process and provide information on various evidence-based treatment strategies
Continue to provide timely referral information
Metrics & Milestones:
Number of consults completed; VHAN provider satisfaction survey

			
Strategy: Continue to offer treatment for addiction and co-occurring disorders through the Vanderbilt Integrated Services for the Treatment of Addiction (VISTA) in conjunction with the VBH Adult IOP co-occurring disorder track, whose services integrate comprehensive assessment and treatment modalities, including pharmacotherapy and psychosocial treatment			
Anticipated Impact: Facilitation of successful hospital transitions into long-term wellness in recovery and engagement with a personalized care plan, prevention of future hospitalizations, and ultimately mortality. Decrease in patient length of stay and rate of readmission			
Action Steps:			
Continue strengthening our services as a hub provider through contracts with the state (TDMHSAS) for OUD treatment			
Offer post-acute care for patients seen in the ED for up to 3 months			
Through VUMC's Bridge Clinic, provide comprehensive SUD services to patients following hospital/ED discharges and brings together a multidisciplinary team of specialists to achieve better patient outcomes			
Continue strengthening our services as a hub provider through contracts with the state (TDMHSAS) for OUD treatment			
Metrics & Milestones:			
Volume metrics			

			
Strategy: Utilize existing collaborative relationships with health and mental health organizations across Tennessee and the region to best serve VUMC's patients and communities with mental health needs. VBH leadership will continue to serve on various boards for organizations, including but not limited to: Mental Health America of the Mid-South, Tennessee Voices, NAMI Davidson County, and Park Center, as well as serving on other community task forces and coalitions to provide education and enhanced access to care			
Anticipated Impact: Foster collaboration with key mental health organizations; Provide patient, family, provider, and general community education; Enhance access and outreach for individuals and stakeholders throughout the community			
Action Steps:			
Continue to collaborate with organizations such as the National Alliance on Mental Illness (NAMI) through event sponsorships and support of the annual NAMI Walk, as well as providing monthly support groups and education series for the public			
Grow presence on key community boards/advisory councils to influence further policy and potentially the development of additional community-based services			
Explore new relationships as deemed appropriate based on patient and organizational needs			
Educate community stakeholders regarding our new PHP for women dealing with mental health and perinatal challenges			
Educate community stakeholders regarding our expanded and enhanced older adult/geriatric inpatient services			
Increase access to Neuromodulation services for adults and youth			
Metrics & Milestones:			
Number of boards, task forces, advisory councils, etc., on which VBH has a strategic presence; Number of patients served in the various Partial Hospitalization Programs; Number of patients served in the geriatric program; Number of patients served in Neuromodulation services			

			
Strategy: Utilize Vanderbilt's Psychiatric Assessment Service (PAS) to provide specialized assessments for patients with immediate behavioral health care needs in a therapeutic and safe environment			
Anticipated Impact: Immediate assessment and stabilization of adult behavioral health patients, many of whom would otherwise have presented at the Emergency Department			
Action Steps:			
Continue to provide a full psychiatric evaluation as well as a medical screening			
Continue to offer walk-in crisis evaluations for adults			
Continue to coordinate referrals from the adult and pediatric emergency rooms as well as outside entities			

Expand telehealth services to partner with regional hospitals to assess behavioral health patients in their EDs
Metrics & Milestones:
Number of total assessments provided; Number of walk-in patients serviced

			
Strategy: Provide evidence-based mental health treatment utilizing Vanderbilt Behavioral Health school-based mental health services in schools across Davidson County for students who are enrolled in TennCare			
Anticipated Impact: Mental health care services provided for youth who would otherwise not be able to access mental health care; improved academic and behavioral functioning; reduced need for higher levels of care			
Action Steps:			
Continue to provide therapeutic services directly to students and their families, including individual, family, and group therapy and medication management services			
Provide ongoing consultation to school staff on therapeutic approaches for students' unique needs			
Assist in crisis management to promote student safety			
Continue to partner with community-based organizations to support student/family needs			
Metrics & Milestones:			
Number of students and families served; Number of schools served; Types of services provided			

Anticipated Impact and Evaluation

VUMC's Office of Community Health and Engagement will evaluate key metrics based on the anticipated impact and metrics noted in each action plan. As needed, the Community Health Workgroup will review publicly available data and other relevant data sources that provide a window into VUMC's success in addressing the prioritized needs. Publicly available data will be tracked and mapped using tools such as the HCI platform, focusing on populations most impacted by differences in health outcomes. Ongoing initiatives and programs will also be updated and tracked using the Community Impact Tracker.

Index of Acronyms

CCQIR	Center for Clinical Quality and Implementation Research
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
COO	Chief Operating Officer
CSA	Community Supported Agriculture
ED	Emergency Department
GGH	Growing Good Health
GME	Graduate Medical Education
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HRSN	Health-Related Social Needs
IOP	Intensive Outpatient Program
IS	Implementation Strategy
Monroe Carell	Monroe Carell Jr. Children's Hospital at Vanderbilt
MHAV	My Health at Vanderbilt
MPH	Master of Public Health
MVC	Motor Vehicle Collisions
NAMI	National Alliance on Mental Illness
OUD	Opiate Use Disorder
PAC	Post-Acute Care
PAS	Psychiatric Assessment Service
PCC	Patient Care Center
PFAC	Patient and Family Advisory Council
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance Use Disorder
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services Licensure

TMO	Transition Management Office
UME	Undergraduate Medical Education
VBCH	Vanderbilt Bedford County Hospital
VBH	Vanderbilt Behavioral Health
VHAN	Vanderbilt Health Affiliated Network
VICC	Vanderbilt Ingram Cancer Center
VICTR	Vanderbilt Institute for Clinical and Translational Research
VISTA	Vanderbilt Integrated Services for the Treatment of Addiction
VPH	Vanderbilt Psychiatric Hospital
VSRH	Vanderbilt Stallworth Rehabilitation Hospital
VTHH	Vanderbilt Tullahoma-Harton Hospital
VUH	Vanderbilt University Hospital
VUMC	Vanderbilt University Medical Center
VUSM	Vanderbilt University School of Medicine
VWCH	Vanderbilt Wilson County Hospital
WIC	Women, Infants, and Children