SOUTHEAST GEORGIA HEALTH SYSTEM

Brunswick Campus
Community Health Needs Assessment
Implementation Strategy

August 2016

Approved by the SGHS, Inc. Board of Directors on August 24, 2016

Introduction

Between January and April 2016, a comprehensive Community Health Needs Assessment (CHNA) was conducted for the six-county area served by the Brunswick Campus of Southeast Georgia Health System (SGHS). Public data, data from recent health surveys, and information from interviews with medical experts including physicians and leaders of Public Health and Federally Qualified Health Centers were collected to assess the community's health status and needs. (See full CHNA at the Southeast Georgia Health System website at http://www.sghs.org/about/community-benefits.) Using information captured in that process and a defined methodology to ensure consistency across the service area, community groups in each county reviewed, discussed, and identified that individual community's priority health needs and barriers to care. A second round of review and prioritization by a service area Community Steering Committee further refined identified needs by feasibility and level of need within the service area. As might be expected, many of the same needs were identified across the service area counties. These high needs areas where positive changes can be achieved are the major focus of Southeast Georgia Health System's Implementation Strategy.

The Process of Prioritizing Needs When Needs Are Great

In order to achieve the greatest impact with its Implementation Strategy, Southeast Georgia Health System's Brunswick Campus focuses on the "high need, high feasibility" priorities that are part of the hospital's core mission and that were identified first by local community groups and confirmed by the Community Steering Committee.

SOUTHEAST GEORGIA HEALTH SYSTEM

Mission: Southeast Georgia Health System will provide safe, quality, accessible, and cost-effective care to meet the health needs of the people and communities it serves.

The selection of highest need and highest feasibility areas for focus for the Implementation Strategy does not imply the absence of other significant needs in the community. These are described in detail in the CHNA, along with specific county needs. The idea of "low feasibility" reflects not a lack of a concern about these problems but rather the intractable nature of larger, societal problems that may be "upstream" causes of poorer health outcomes. While many of these needs are not specifically addressed in the Implementation Strategy, as part of its role as a major health leader in the service area, Southeast Georgia Health System will continue to contribute staff time, resources, and expertise as it works with other community groups to address the types of community health problems that fall within a broad description as the "social determinants of health."

These "high need, low feasibility" areas identified by community groups in the Community Health Needs Assessment process include poverty, unemployment, health workforce shortages

(including specific provider shortages), low educational attainment, environmental issues, public health policy, and transportation. These broad issues reflect regional, state, and even national challenges and cannot be addressed or ameliorated by any one organization. The cooperation of multiple area organizations in different sectors is essential to create real impact for sustainable change.

Describing the social determinant and other community problems as "high need, low feasibility" points to the necessity for collaboration across the community, from the hospital to schools and health organizations to business and industry. By identifying these more global problems, the CHNA report spells out locally-identified opportunities and challenges that assist the broader community focus on the difficult factors that can, in the long term, create these "upstream" changes that can lead to a healthier community. Southeast Georgia Health System is committed to working collaboratively with others to address the social determinants of health in the service area.

For purposes of the Implementation Strategy, this report includes five primary goals identified as "high need, high feasibility" areas. Most goals will include a multi-pronged approached for change. The following sections outline prioritized needs, goals, the related objectives and activities the hospital intends to pursue to address identified health needs priorities, and a plan for evaluation of each strategy to monitor progress.

Priority Needs and Goals as Defined by the Community Steering Committee

Using information from focus groups in the Brunswick Campus' service area counties, the Community Steering Committee identified priority needs in two domains: Higher Feasibility, Higher Need and Lower Feasibility, Higher Need. (A description of the full process and reports from county focus groups and area summary reports are available in the CHNA.)

Higher Feasibility, Higher Need Findings	Lower Feasibility, Higher Need Findings
▪ Increase access to primary care for adults and children ▪ Reduce risk behaviors in order to reduce/prevent chronic disease ▪ Improve follow-up care and case management in order to: – Reduce hospital readmissions – Reduce unnecessary ER visits – Link patients to primary care – Coordinate specialty care for persons without resources ▪ Expand workplace and community health education ▪ Provide outreach and screening for preventable cancers and diabetes ▪ Expand and make available resource lists to the larger community	▪ Poverty solutions ▪ Unemployment solutions ▪ Health workforce shortages (state and national issue) ▪ After-hours non-emergency care (related to workforce) ▪ Transportation ▪ Mental health and substance abuse services ▪ Oral health services ▪ Environmental issues, including hazardous waste ▪ Low educational attainment ▪ Refocusing local government policies to include considerations for healthful living

Using the higher needs, higher feasibility findings identified by the Community Steering Committee in the chart above, final goals for the Implementation Strategy were created to establish a formal means of addressing these important regional issues.

Final Implementation Strategy Goals Derived from High Need, High Feasibility Issues Identified Through the Community Input and Prioritization Process
Goal 1 Increase access to primary care for adults and children. **Goal 2** Use community and workplace education to help inform and ultimately reduce risk behaviors in order to reduce/prevent morbidity and mortality from chronic disease. **Goal 3** Provide outreach and screening for preventable cancers and diabetes. **Goal 4** Improve follow-up care and case management in order to: reduce hospital readmissions, reduce unnecessary emergency room visits, link patients to primary care, and coordinate specialty care for persons without resources. **Goal 5.** Expand and make available health resource lists to the larger community.

Evaluation of the Implementation Strategy

The Implementation Strategy is a plan of action to address high needs areas where SGHS and its partner organizations can make a difference in the community. As in any strategic planning process, measurement of performance is essential. The 2016 Community Health Needs Assessment describes outcomes for the 2013 Implementation Strategy. Between 2016 and 2019, SGHS will continually review, collect data, and evaluate this plan of action - the Implementation Strategy - to assess the progress made by the Health System to achieve its goals.

The following tables describe the Implementation Strategy and include planned actions, the rationale for those actions, resources required, potential partners, and how progress will be measured.

Goal 1. Increase access to primary care for adults and children.

Community Input: Five of six service area county focus groups recognized physician shortages as a major health need in their communities. All county focus groups identified either "cost of care" of "lack of insurance" as barriers to accessing primary care. Access to primary care involves both access to physicians and the ability to locate affordable care.

Background: In recognition of the vital role of primary care in identifying, treating, and preventing illness and chronic disease, SGHS continues its effort to expand its primary care workforce and to work to assist Medicaid, uninsured, and underinsured patients in finding access to primary care. As part of this effort, SGHS currently operates the Coastal Medical Access Project (CMAP), a free clinic available to patients unable to afford care and that are not eligible for Medicare, Medicaid, or any other insurance program. The Health Systems staffs CMAP with a full-time Physician Assistant, as well as volunteer physicians. CMAP also operates a MedBank, which assists qualified residents in 13 Georgia counties in accessing free prescription medications. SGHS is committed to collaborating with Coastal Community Health Services, a local Federally Qualified Health Center (FQHC), to explore a partnership that combines the dental, vision, and prescription medication resources available at CMAP with those critical primary care services available through the FQHC. Access to primary care will also be enhanced through a formal process of referrals of patients without a regular provider to community-based physicians. We believe that, over time, the impact of increasing access to primary care will demonstrate improved outcomes for patients who previously did not have a primary care physician and for those who could not afford care due to cost or lack of insurance.

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Potential Partners	Method of Evaluation, 2019
Increase total number of primary care physicians as compared to the number of primary care physicians available in 2016.	Continue aggressive physician recruitment, focusing on primary care, internal medicine, and family medicine.	▪ All service area counties have population/ physician ratios well below the Georgia average (County Health Rankings, 2015) ▪ Overuse of hospital emergency room for primary care ▪ Need for additional primary care was a finding in Public Health CHNA published January 2014 ▪ 2016 Physician Survey	▪ Hospital recruiters ▪ Physician support	▪ Federally Qualified Health Centers ▪ Chamber of Commerce ▪ Relationships with state's medical schools	▪ Track and trend primary care physicians in service area (to include internal medicine, primary care, family medicine) ▪ Number of primary care physicians recruited, 2016 – 2019 ▪ Comparison of the relative shortage of primary care physicians when compared to the State of Georgia (County Health Rankings, 2015 – 2019)

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Potential Partners	Method of Evaluation, 2019
		identified lack of access to primary care and primary care workforce shortages as problems in the service area			
	As a means of improving access to primary care, work with Coastal Community Health Services (FQHC) to increase access to uninsured, underinsured, and Medicaid patients and to others who do not have a usual source of care.	▪ All service area counties have population/ physician ratios well below the Georgia average (County Health Rankings, 2015) ▪ Promise Zone Survey (2015-2016) data indicated lack of primary care and convenient access as issues for City of Brunswick, a low-income area within the SGHS service area ▪ Overuse of hospital emergency room for primary care ▪ Need for additional primary care finding in Public Health CHNA published January 2014 ▪ 2016 Physician Survey identified lack of access to primary care and primary care workforce shortages as problems in the service area	▪ Support FQHC with linkages for specialty care in high needs areas ▪ Coordination of transition between providers, including the ER and FQHC and hospital and FQHC ▪ Communication between hospital and FQHC ▪ Public Health referrals	▪ Coastal Community Health Services (FQHC) ▪ Public Health ▪ SGHS physician offices	▪ Develop strategic partnership or transition of management of CMAP to FQHC ▪ FQHC 2019 data indicates increased number of patients accessing services at Brunswick location
Support efforts to assist uninsured with enrollment in insurance programs.	Provide linkages and space for insurance enrollment to patients without insurance.	▪ Relatively high number of uninsured in area counties	▪ Staff support ▪ Office space	▪ Staff ▪ DFCS ▪ Navigators	▪ Relative increase in the number of ACA enrollees, 2016 – 2019 in region ▪ Number of referrals for Medicaid enrollment

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Potential Partners	Method of Evaluation, 2019
Encourage future workforce development locally by offering Health Careers Explorer Post program for local high school students.	Introduce local students to career opportunities in health through an Explorer Post program and opportunities for volunteer service.	▪ Provider shortages	▪ Hospital staff	▪ Work with schools to publicize opportunity	▪ Number of participants
Provide training opportunities for physicians, nurses, and other professions at SGHS to support recruitment efforts.	Host service-learning, internships, preceptorships, and other clinical experiences to encourage recruitment to the Community.	▪ Provider shortages	▪ Hospital staff	▪ Colleges ▪ Medical schools ▪ Vocational schools	▪ Total number of students trained at Health System ▪ Number of medical students trained at Health System ▪ Number of nursing students trained at Health System

Goal 2. Use community, school, and workplace education to help inform and ultimately reduce risk behaviors in order to reduce/prevent morbidity and mortality from chronic disease.

Community Input: Half of the county focus groups identified lack of education or awareness about chronic disease as a factor in poorer health outcomes.

Background: Although SGHS has always offered comprehensive educational opportunities for the community, SGHS responds to the CHNA identification of education as a high needs area by focusing this Implementation Strategy on community and workplace education to teach the community about the role that healthy behaviors can play in reducing morbidity and mortality from chronic disease. The educational effort will include the following: community and worksite education; health promotion to include community events that promote healthy behaviors; education directed to area residents through media and social media; and health information shared at other public venues. SGHS also commits to serving as a partner for local organizations in conducting at least one annual education activity in all service area counties that do not have hospitals. The intended impact is to increase healthy behaviors as a means of preventing or ameliorating the effects of chronic disease.

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
Mitigate the effects of chronic disease by reducing unhealthy behaviors through community, school, and worksite education.	Annually, host at least six health education events focused on chronic disease in primary service area counties to promote healthy behaviors that can reduce the effects of chronic disease. Topics should include: ▪ Smoking cessation ▪ Exercise promotion ▪ Stress management ▪ Diabetes education ▪ Good nutrition, including nutrition training for children in schools	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S.	▪ Health educators ▪ Partner agencies	▪ Public Health ▪ Coastal Health Care Services (FQHC) ▪ Schools ▪ Nonprofit organization ▪ Worksite wellness programs ▪ Other health care providers	▪ Number of education sessions held ▪ Number of people participating in education sessions ▪ Post-education survey to determine effectiveness, when appropriate

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
	Annually support at least one health education event in cooperation with a local organization or organizations in secondary service area counties without a hospital.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S.	▪ Health educators ▪ Partner agencies to support	▪ Public Health ▪ Coastal Health Care Services (FQHC) ▪ Schools ▪ Nonprofit organization ▪ Worksite wellness programs ▪ Other health care providers	▪ Number of attendees ▪ Partners participating in education activities
	Provide on-line, anytime education opportunities through emailed newsletter that contains valuable tips on staying healthy.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S	▪ Community providers who contribute	▪ Hospital staff ▪ Other providers	▪ Number of subscribers
Promote and support activities that advocate for healthy lifestyles, including exercise.	Continue support, maintenance, and promotion of indoor walking trail at the Glynn Place Mall and of walking trail on St. Simons Island.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all service area counties when compared to U.S.	▪ Resources for maintenance, promotion	▪ Glynn Place Mall	▪ Track and trend estimates of the number of people who use the walking track at the Glynn Place Mall ▪ Track and trend estimates of the number of people who use the walking track at St. Simons Island
	Continue support of Bridge Run to engage community and encourage exercise.	▪ Low rates of exercise when compared to U.S. and Georgia	▪ Resources for planning, promotion, and prizes for Bridge Run	▪ Health providers ▪ EMS ▪ Physicians ▪ Media	▪ Track and trend number of participants ▪ Track and trend number of community organizations participating

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				▪ Vendors ▪ Community organizations	▪ Track and trend number of vendors participating ▪ Track and trend money raised for cancer care programs ▪ Monitor informal feedback
Use media and engage experts to advocate for healthy lifestyles.	Raise awareness of the relationship between health behaviors and health outcomes through the use of media to include social media and blogging on health topics by health professionals.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S.	▪ Physician and health educator time to write blogs	▪ Physician bloggers ▪ Technical support from hospital	▪ Number of articles published in area media ▪ Hits on wellness pages on website ▪ Track and trend number of hits on blogs
	Promote speakers bureau with hospital-based experts to discuss health issues.	▪ High rates of preventable mortality	▪ Volunteer speakers	▪ Civic organizations	▪ Number of speakers bureau volunteers ▪ Number of speeches given
Provide space and leadership for support groups to foster improved outcomes.	Provider space and leadership for support groups.	▪ High rates of mental illness, arthritis ▪ High rates of death from diabetes ▪ High rates of cancer	▪ Meeting resources ▪ Communication ▪ Leadership	▪ Support groups in community	▪ Number of support groups meeting at hospital ▪ Participation in support groups

Goal 3. Provide outreach and screening for preventable cancers and diabetes.

Community Input: Five of six county focus groups in the service area see transportation as a primary barrier to improved health. Half of the county focus groups identified lack of information or knowledge about health as barriers to improved health outcomes. All six county focus groups recognized cancer and/or chronic disease that includes diabetes and precursors to diabetes including obesity as high needs problems in their communities.

Background: The goal that derives from these needs is to expand efforts to take screening and outreach opportunities to the communities served by SGHS, in part to reach area residents who may have barriers to access because of lack of a physician, lack of education, or lack of transportation. This Implementation Strategy takes advantage of a successful program already in place at SGHS, the mobile unit program, and builds on a long track record of participation in health fairs and community health events. The intended impact of this Implementation Strategy is to reach even more people with information and facts about their health status and to encourage and support those who are identified as at risk to not seek primary care.

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
Increase awareness and intervention for preventable cancers and diabetes through screenings.	Host at least two health fairs annually and at least four others in partnership with workplaces and other community partners for early identification of diabetes and preventable cancers (colorectal, skin, prostate, and breast) in hospital's primary service area.	▪ Public health survey support for more community education on chronic diseases ▪ Physician acknowledgement of need for additional community education ▪ High rates of preventable cancer deaths ▪ Rates of diabetes higher than national averages	▪ Health educators ▪ Partner agencies	▪ Public Health ▪ Coastal Health Care Services (FQHC) ▪ Schools ▪ Area businesses and industries ▪ Health care community	▪ Number of sessions held ▪ Number of people participating in sessions ▪ Post-education survey to determine effectiveness, if appropriate
Continue expanding use of mobile health unit to include other types of screenings in primary service area and to support community-based health fairs in	Make use of mobile health unit to conduct mammography and other types of screening (to include diabetes screenings) in primary service area.	• High rates of preventable cancers in service area • High death rates from diabetes	▪ Mobile health unit ▪ Additional training for staff to expand services, if	▪ Hospital Nursing Staff ▪ Community Organizations	▪ Number of mammograms completed ▪ Number of diabetes screenings completed ▪ Number of other types of screenings completed ▪ Number of community events

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
secondary areas without hospitals.			needed ▪ Promotion of special services and schedules ▪ Participation in health fairs ▪ Appropriate equipment as required for screening		attended by mobile mammography ▪ Number of referrals made by mobile unit
Promote cancer and diabetes awareness in the service area.	Support Relay for Life as a tool for raising cancer awareness	▪ High rates of preventable cancers	▪ Hospital staff ▪ Hospital volunteers ▪ Other financial resources ▪ Educational materials	▪ Hospital staff and volunteers	▪ Money raised by hospital staff and volunteers for cancer programs ▪ Number of people who visit the hospital tent at Relay for Life
	Provide education and health screenings at health fairs conducted by hospital and in partnership with other host organizations.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region ▪ High rates of self-reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S.	▪ Health educators ▪ Public health ▪ FQHC ▪ Other nonprofit organizations	▪ Public Health ▪ Coastal Health Care Services (FQHC) ▪ Schools ▪ Nonprofit organization ▪ Businesses and industries through worksite wellness program	▪ Track number of health fairs conducted by hospital ▪ Track number of screenings provided at health fairs ▪ Track number of partners involved in health fairs
	In Year 2, launch prevention initiative with faith-based organizations in the service area to provide screenings at the church facility OR train	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region	▪ Medical equipment for measuring blood pressure and doing finger	▪ Faith community, churches	▪ Number of navigators trained ▪ Number of churches participating ▪ Number of screenings held in churches ▪ Number of people referred to a physician

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
	navigators to assist in identifying and referring persons when the navigator has detected hypertension, or elevated blood sugar levels		stick glucose checks		

Goal 4. Improve follow-up care and case management in order to: reduce hospital readmissions, reduce unnecessary emergency room visits, link patients to primary care, and coordinate specialty care for persons without resources.

Community Input: Experts interviewed for the 2016 CHNA identified referrals and linkages to primary and specialty care as a major need in the service area. Access to primary care and barriers related to education, transportation, cost of care, and lack of insurance were identified by community groups.

Background: SGHS already has a program in place to make referrals to SGHS physicians, but the hospital will expand that effort to include emergency room patients who are unattached, to make referrals for uninsured and underinsured patients to Coastal Health Care Services (FQHC), and to continue efforts to reduce readmissions of older patients by providing case management and additional support as needed. In addition, as part of its Implementation Strategy, SGHS will provide defined services for FQHC and certain other patients for needed services that they otherwise would not be able to access.

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
Improve linkages to patients without a regular physician by arranging follow-up appointments for emergency room patients with SGHS and/or FQHC physicians.	For patients without a regular physician, link emergency room patients with SGHS staff physicians by setting up an office visit or by making referrals to the FQHC.	▪ Proportion of non-emergency cases in hospital emergency room ▪ Proportion of patients presenting at ER without a regular physician ▪ Proportion of service area residents who say they do not have a "regular physician" (Public Health Survey, 2014)	▪ ER/hospital staffing for case management ▪ FQHC support for initiative	▪ FQHC ▪ SGHS Staff Physicians	▪ Reduce proportion of non-emergent ER visits (Hospital Data) ▪ Increase proportion of service area residents who say they have a primary care physician (County Health Rankings Data, 2015 compared with 2019) ▪ Track and trend readmissions of patients who present in ER
Provide a referral mechanism for FQHC patients who require but are unable to arrange for specialty care services.	Create a cooperative arrangement with the FQHC to provide referral mechanism for patients who require specialty care services and ensure information is provided regarding SGHS' Financial Assistance Program.	▪ FQHC reports of inability for patients to access specialty care ▪ Physician survey reports indicating inability to get referrals for certain patients	▪ Physician and staff support ▪ Case management ▪ FQHC follow-up and reporting	▪ SGHS physicians and staff ▪ FQHC	▪ Track and trend number of FQHC referrals to SGHS specialty physicians ▪ Track and trend cost of uncompensated care

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
Continue support of case management program operated by Coastal Home Care or a similar organization.	Reduce hospital readmissions by providing case management support for recent discharges fitting criteria for program.	▪ High rates of readmission of Medicare patients	▪ Funding ▪ Case managers ▪ Referrals	▪ Coastal Home Care or similar organization	▪ Track and trend hospital readmissions of all patients and patients in case management program

Goal 5. Expand and make available health resource lists to the larger community.

Community Input: Lack of awareness of health services and lack of knowledge of available resources, including nonprofit resources, and lack of education about those resources were identified as areas of need by focus groups and the Community Steering Committee. In addition, the service area has multiple, overlapping, and sometimes out-of-date resource lists, which can create further confusion about available services and supports.

Background: As part of the Community Health Needs Assessment, SGHS created a newly expanded Resource List that includes both health and social service services that are available in the communities served. The list is ever-changing and incomplete, but as part of its Implementation Strategy, SGHS will solicit support from community partners and agencies to further expand and refine the list and to keep the list updated on the SGHS website as a central point of reference for other community organizations.

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
With the support of area health and nonprofit organizations, update and make available on the SGHS website a resource list of potential health and social services resources that could provide services and support to area residents.	Continue to update and make available to the public a resource list of area resources that are available to assist area residents with health, wellness, and social needs.	Focus Groups and Community Steering Committee identified lack of awareness of available services as a barrier to improved health.	▪ Time of SGHS staff ▪ Website ▪ Community support	▪ Community organizations, including social service, government, and other health organizations	▪ Number of websites hits ▪ Track and trend number of organizations on resource list