SOUTHEAST GEORGIA HEALTH SYSTEM

Camden Campus
Community Health Needs Assessment
Implementation Strategy

August 2016

Approved by the SGHS, Inc. Board of Directors on August 26, 2016

Introduction

Between January and April 2016, a comprehensive Community Health Needs Assessment (CHNA) was conducted for the three-county area served by the Camden 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 in the three service area counties. These high needs areas where positive changes can be achieved are the major focus of the Southeast Georgia Health System Camden Campus 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 Camden 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, which exacerbate concerns about access to care and access to 24-hour sexual assault coverage), and transportation. These 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 help 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 three 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 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

- Increase access to primary care for adults and children, including expansion of after-hours options, in order to achieve the following:
  - Prevent/reduce chronic disease
  - Reduce avoidable hospital readmissions
  - Increase number of patients with a regular provider
  - Reduce inappropriate emergency room care
- Improve communication and coordination of care between hospital, private providers, FQHCs, veteran services, mental health, public health, community and church groups, and patients to achieve the following:
  - Improve access to follow-up care, including specialty care, and case management
  - Enhance public awareness of available resources by publishing lists of service area resources, including palliative care
- Improve community health status through:
  - Wellness and chronic disease education in industry and community, including outreach for screenings to include cancer, hypertension, and diabetes
  - Assistance with insurance enrollment

Lower Feasibility, Higher Need Findings

- Reducing poverty
- Reducing unemployment
- Reducing workforce shortages to include shortages in primary care, dental care, and mental health and others who specialize in around-the-clock sexual assault coverage
- Improving transportation

Using the higher needs, higher feasibility findings identified by the Community Steering Committee, 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** Take action to improve community health status. **Goal 3** Improve opportunities for better outcomes by enhancing communication and coordination of care between hospital, other providers, and community organizations.

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: All three of the service area county focus groups recognized physician shortages as a major health need in their communities. Physician/population ratios in Camden, Charlton, and Brantley counties are well below averages for Georgia. Focus groups in all three counties recognized access to care problems, pointing to lack of physicians, cost of care, or lack of insurance as barriers to 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 will collaborate with McKinney Health Center, a Federally Qualified Health Center (FQHC), to provide a greater opportunity to expand services to more people, make available services to the uninsured and underinsured, offer low-cost medications, and to ensure greater access to dental services. The FQHC is willing and able to serve as a medical home for both the insured and the uninsured. Access to primary care will also be enhanced through a formal process of referrals of patients without a regular provider to community-based physicians and continuation of providing space for navigators assisting with Affordable Care Act enrollment. 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	▪ Hospital recruiters ▪ Physician support	▪ FQHCs ▪ Chamber of Commerce ▪ Relationships with state's medical schools	▪ Track and trend number of 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 in the area when compared to the State of Georgia

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Potential Partners	Method of Evaluation, 2019
		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.			(County Health Rankings, 2015 – 2018)
Strengthen collaboration with McKinney Medical Center (FQHC) to increase access for uninsured, underinsured, and Medicaid patients.	As a means of improving access to primary care, work with McKinney Medical Center (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) ▪ 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 identified lack of access to primary care and primary care workforce shortages	▪ Support with linkages for specialty care ▪ Coordination of transition between providers, including the ER and FQHC and hospital and FQHC ▪ Communication between hospital and FQHC ▪ Public Health referrals	▪ McKinney Medical Center (FQHC) ▪ Public Health ▪ SGHS physician offices	▪ FQHC 2019 data indicates increased number of patients accessing services at FQHC

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Potential Partners	Method of Evaluation, 2019
		as problems in the service area.			
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	▪ 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
Encourage future workforce development locally by offering Health Careers Explorer posts 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 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. Take steps to help improve community health status.

Community Input: All three area county focus groups expressed concerns about high rates of chronic disease in the service area, including heart disease, diabetes, hypertension, and obesity. Mental health and substance abuse issues were also primary concerns in all area counties. Community members also described lack of knowledge about available resources, including nonprofit programs and palliative care.

Background: Although SGHS has always offered comprehensive educational opportunities for the community, SGHS responds to the CHNA identification of high rates of chronic disease 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 the region 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 education activity in all service area counties and working with school children on improving nutrition. This Implementation Strategy takes advantage of a successful program already in place at SGHS, the mobile health 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. The intended impact is to increase healthy behaviors as a means of preventing or ameliorating the effects of chronic disease. In addition, the hospital will continue efforts to ensure that patients without insurance are assisted in enrollment in appropriate plans.

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.	Host at least four health education events focused on chronic disease annually in primary service area counties to promote healthy behaviors that can reduce the effects of chronic disease. Topics should relate to high needs areas and may include, among others, the following:	▪ 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 area counties when compared to U.S.	▪ Health educators ▪ Partner agencies	▪ Public Health ▪ McKinney Medical Center ▪ Schools ▪ Nonprofit organization ▪ Worksite wellness programs ▪ Other health care	▪ Number of sessions held ▪ Number of people participating in sessions ▪ Post-education survey to determine effectiveness, when appropriate

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	▪ Smoking cessation ▪ Exercise promotion ▪ Stress management ▪ Diabetes education ▪ Good nutrition, including school-based education			providers	
	Annually support at least one health education event in cooperation with a local organization or organizations in secondary service 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 ▪ McKinney Medical Center ▪ Schools ▪ Nonprofit organization ▪ Worksite wellness programs ▪ Businesses and industries ▪ Other health care providers	▪ Number of attendees ▪ Number of health education events held in cooperation with community partners
	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	▪ Community providers who contribute	• Hospital staff • Other providers	▪ Number of subscribers

Objective	Tactics/Actions Planned to Address Health Need	CHNA Community Health Need/ Rationale for Strategy	Resources Required	Partners	Method of Evaluation, 2019
		compared to U.S			
Provide space and leadership for support groups to foster improved outcomes for persons with chronic diseases.	Provide 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
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
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	▪ Public health survey support for more community education on chronic diseases ▪ Physician acknowledgement of need for additional community education	▪ Health educators ▪ Partner agencies	▪ Public Health ▪ McKinney Medical Center ▪ Schools	▪ Number of sessions held ▪ Number of people participating in 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
	(colorectal, skin, prostate, and breast) in hospital's primary service area.	▪ High rates of preventable cancer deaths ▪ Rates of diabetes higher than national averages			
Expand use of mobile unit to include mammography and other types of screenings in primary service area and to support community-based health fairs in secondary service areas without hospitals.	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 ▪ Promotion of special services and schedules ▪ Participation in health fairs ▪ Appropriate equipment as required for non-invasive screenings	▪ 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 attended by mobile health unit ▪ 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-	▪ Health educators ▪ Public health ▪ FQHC ▪ Other nonprofit organizations	▪ Public Health ▪ McKinney Medical Center ▪ Schools ▪ Nonprofit	▪ Track number of health fairs conducted by hospital ▪ Track number of screenings provided at health fairs

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		reported poor or fair health ▪ High rates of preventable mortality in all counties when compared to U.S.		organization ▪ Businesses and industries through worksite wellness program	▪ 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 navigators to assist in identifying and referring persons when the navigator has detected hypertension, or elevated blood sugar levels.	▪ High rates of heart disease, stroke, lung disease, smoking, physical inactivity in region	▪ Medical equipment for measuring blood pressure and doing finger stick glucose checks	▪ Faith community, churches	▪ Number of navigators trained ▪ Number of churches participating ▪ Number of screenings held in churches ▪ Number of people referred to a physician

Goal 3. Improve communication and coordination of care between hospital, other providers, and community organizations.

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. 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: 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 McKinney Medical Center (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. Community members believe that part of the problem in improving health and accessing care is lack of awareness of available and appropriate services, including the work of nonprofits and palliative care organizations. As part of the CHNA, SGHS has created a newly expanded Resource List that includes both health and social service support that is available in the communities served. The list is ever-changing and incomplete, but as part of its Implementation Strategy, SGHS will continue to 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.

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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	▪ 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

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		they do not have a "regular physician" (Public Health Survey, 2014)			with 2018) ▪ 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	▪ Number of FQHC referrals to specialty physicians ▪ Track and trend cost of uncompensated care
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 website hits ▪ Track and trend number of organizations on resource list