2019

Navicent Health

Medical Center, Navicent Health
Medical Center of Peach County, Navicent Health
Rehabilitation Hospital, Navicent Health
Navicent Health Baldwin

Implementation Strategy

FY 2018-2020

Navcient Health

Implementation Strategy

For FY2018-2020 Summary

Navicent Health (NH), the leading provider of healthcare in central and south Georgia, is committed to its mission of elevating health and wellbeing through compassionate care. Providing more than 1,000 beds and offering care in 53 specialties at more than 50 facilities throughout the region, Navicent Health provides care for healthcare consumers through an academic medical center; community, pediatric and rehabilitation hospitals; urgent care centers; physician practices; diagnostic centers; home health; hospice and palliative care; and a life plan community. Navicent Health is dedicated to enhancing health and wellness for individuals throughout the region through nationally-recognized quality care, community health initiatives and collaborative partnerships.

In 2018, the hospitals conducted Community Health Needs Assessments (CHNA) to identify the health needs of eight counties (Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach and Twiggs Counties).

This report summarizes the plans for NH to sustain and develop community benefit programs that 1) address prioritized needs from 2018 CHNAs of each hospital and 2) respond to other identified community health needs.

The following Community Health (CH) prioritized needs were identified by the Integration teams of Atrium Health and Navicent Health. Atrium Health and Navicent Health entered into a strategic combination in January 2019. Particular focus was placed upon these needs in developing the Implementation Strategy.

- CH Priorities (Structural)
  - Access
  - Behavioral Health
  - Nutrition/Physical Activity
- CH Priorities (Clinical)
  - Diabetes
  - Cardiovascular Disease
  - Obesity
- Social Determinants of Health is foundational to all of these priorities

NH has addressed each of the health needs identified in the CHNA. NH developed implementation strategies to address each of the health issues identified over the next three years.

Specific implementation strategies for each of the CHNA identified health needs are addressed in the following appendices to this report.

Approval:

The NH Board of Directors approved this Implementation Strategy through a board vote on August 16, 2019.

The following issues were identified as "priority: needs by the community participants. The findings are listed in the order of priority determined by the CHNA Steering Committee (CHSC).

1. **Behavioral Health**
    a. There is a need to improve access to mental health services.
    b. There is a need to implement strategies for awareness of mental health issues and the need for earlier treatment.

2. **Diabetes**
    a. There is a need for more awareness and education on diabetes and prevention.
        i. There is a need to increase prevention behaviors in persons a risk for diabetes with prediabetes.
        ii. There is a need to improve diabetes control among people with diabetes.
    b. There is a need for diabetes screening, testing, and diagnosis.

3. **Access**
    a. There is a need for increased physical activity in the communities we serve.
        i. There is a need to expand the availability of health care access points.
        ii. There is a need to expand access to health care services in underserved and rural areas.
        iii. There is a needed to expand healthcare services to address chronic disease burdens.
        iv. There is a need to connect patient populations to primary care and preventive services.
    b. There is a need to improve health literacy and patient education.

4. **Nutrition /Physical Activity**
    a. There is a need to increase community efforts to increase physical activity.
        i. There is a need to create healthy environments for physical activity.
        ii. There is a need to educate regarding the benefits of physical activity.
    b. There is a need to improve nutrition and health efforts.
        i. There is a need to provide knowledge and skills to make healthier choices.
        ii. There is a need to increase access to healthy food.

5. **Cardiovascular Disease**
    a. There is a need to reduce cardiovascular disease mortality.
    b. There is a need to improve cardiovascular health and quality of life.
    c. There is a need for education regarding cardiovascular risk factors.

6. **Obesity**
    a. There is a need to educate and create awareness around obesity and health status.
    b. There is a need to communicate best practices for obesity prevention.

7. **Other Strategies**
    a. There is a need to educate and create awareness around childhood asthma.
    b. There is a need to educate and create awareness around injury and fall prevention in senior citizens.

Appendix 1

Community Work Plan for Behavorial Health

CHNA Page Reference-pages 72-85

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to improve access to mental health services. b. There is a need to implement strategies for promotion and prevention in mental health.	a. Improve access to mental health services. b. Develop and implement strategies for awareness of mental health and the need for early treatment. c. Increase knowledge and awareness of depression and suicide risks.

Background and contributing factors:

The CHNA process identified that the prevalence of mental illness is high in the region as well as many in this population have co-occurring substance abuse issues. This population self-medicate with alcohol and/or drugs. The community reported that the region has an inadequate number of psychiatrists and inpatient/outpatient programs available to adults and adolescent residents, including providers to oversee medication management and provide counseling resources. Additionally, the community input identified depression and suicide as a major concern.

Implementation Strategy:

a) Financially and otherwise support the building and expansion of River Edge Behavioral Health Services' Crisis Stabilization Unit and Crisis Service Center.
b) Offer a myriad of Support Groups and Self-Heal Groups to help the citizens of Central Georgia cope with various health issues (grief, bereavement cancer, cardiovascular disease, etc.)
c) Offer a Smoking Cessation program including the addition of a Smoking Cessation Support Group within the next year.
d) Sponsors an intensive weekend retreat, Bo's Camp, for Central Georgia families to deal with grief and bereavement of the loss of children under the age of 18 years.
e) Provide free therapy services at Children Health Center in partnership with Mercer University Marriage and Family Therapist (MFT) Program.

f) Partner with Georgia College & State University to provide Behavioral Health Education to students in Baldwin County.

g) Behavioral Health virtual care with Atrium Health Telehealth program to be available in select Primary Care Practices and The Beverly Knight Olson Children's Hospital, Navicent Health.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- River Edge Behavioral Health
- Local public-school districts
- Georgia College & State University
- Mercer University

Appendix 2

Community Work Plan for Diabetes

CHNA Page Reference-pages 137-141

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more awareness and education on diabetes prevention. ▪ There is a need to increase prevention behaviors in persons at risk for diabetes with prediabetes. ▪ There is a need to improve diabetes control among people with diabetes. b. There is a need for diabetes screening, testing, and diagnosis.	a. Increase knowledge and awareness of diabetes prevention education. b. Increase knowledge and awareness of warning signs of hyperglycemia and the available resources and support groups for this disease. c. Continue to provide diabetes screening through community and corporate health fairs; follow-up with participants with abnormal screening results.

Background and contributing factors:

The CHNA focus groups process characterized Diabetes as a major problem in the community. The CHNA reported that the number of adults in the Central Georgia region was higher than the statewide and national proportions with highest population diagnosed in Peach County. The highest age-adjusted death rate for diabetes in Peach County is 47.3 in comparison to Baldwin County 23.1, Bibb County 13.8 and Houston County 24.5.

Implementation Strategy:

a) Partnering with the Center for Disruption and Innovation and the Medical Center of Peach County, NH are examining ways to efficiently monitor patients with Diabetes in their homes via technology.
b) Assessing technology solutions through the Center for Disruption and Innovation to utilize in Peach County at a rural health clinic (RHC) and local Navicent Health Physician Group (NHPG) practice to manage patient with an A1C greater than 9 through interactive communication with their provider via an app on a smart phone.
c) Declare a clinical community health priority in Peach County.
d) Partner with faith community existing programs to provide blood glucose screening tools in Baldwin County.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Faith community organizations in local service area
- Diabetes Healthways

Appendix 3

Access to Care (includes education on prevention and communication of available resources)

CHNA Page Reference-pages 215-260

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to improve access to quality health care and services. ▪ There is a need to expand the availability of health care access points. ▪ There is a need to expand access to health care services in underserved and rural area. ▪ There is a need to expand healthcare services to address chronic diseases. ▪ There is a need to connect underserved and/or uninsured patient populations to primary care and preventative services. b. There is a need to improve health literacy and patient education.	a. Improve access to quality health care and services through expansion of available health care access points. ▪ Expand access to health care services in underserved and rural areas. ▪ Expand access to health care services for the population with chronic diseases. ▪ Increase connection for underserved and/or uninsured populations to primary care and preventative services. b. Increase opportunities to provide health literacy and patient education.

Background and contributing factors:

The CHNA process identified access to care as a major barrier to healthcare. Access to care involves everything from lack of transportation to lack of educational classes on prevention. A high number of adults in Central Georgia reported having no insurance coverage for healthcare expenses. The focus groups identified several barriers in accessing health which included difficulties or delays and the cost of prescriptions.

Implementation Strategy:

a) Continue partnership with First Choice Primary Care (FQHC).
b) Continue partnership with Macon Volunteer Clinic.
c) Continue support of the transformational community at Tindall Fields with the placement of a care coordinator (Bibb County).
d) Pledged to support another transformational community called Northside Senior Living with a placement of a care coordinator (Bibb County).

e) Develop a partnership with a local Federally Qualified Health Center (FHQC) (Baldwin County).
f) Recruit primary care physicians as well as midlevel providers to existing practices (Baldwin County).
g) Navicent Health Baldwin, The Medical Center of Peach County Navicent Health, and The Medical Center, Navicent Health are examining ways to increase access to healthcare via telemedicine.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- First Choice Primary Health Care
- Macon Volunteer Clinic
- FQHC in Baldwin County (Tinder Care or Community Health Center Services)

Appendix 4

Nutrition/Physical Activity

CHNA Page Reference-pages 174-195

Health Problem	Outcome Objective (Anticipated Impact)
a. There is need to improve community awareness to increase physical activity. ▪ There is a need to create health environments for physical activity. ▪ There is a need to educate regarding the benefits of physical activity. b. There is a need to improve nutrition and health efforts. ▪ There is a need to provide knowledge and skills to make healthier choices. ▪ There is a need to increase access to healthy food.	a. Improve community awareness and education to increase exercise/physical activity per CDC's guidelines. b. Improve nutrition and health efforts. ▪ Increase opportunities to provide knowledge and skills to make healthier choices. ▪ Increase access to healthy foods.

Background and contributing factors:

Food deserts exist in all three counties with highest in Bibb County. The U.S. Department of Agriculture data shows that 30.4% of the total Area population (representing over 135,000 residents) have low food access or live in a food desert. A total of 58.2% of Total Area adults do not participate in any types of physical activities or exercises to strengthen their muscles.

Implementation Strategy:

a) Continue to send volunteers to work at the Middle Georgia Food Bank and staff mobile food clinics.
b) Sponsor community road races (Bibb and Peach Counties).
c) Sponsor Heart Healthy luncheons and cooking classes (Bibb and Peach Counties).
d) Sponsor school system's community garden (Baldwin County).
e) Sponsor existing Weekend Backpack programs for feeding students in need during times school is not in session (Baldwin County).
f) Continue to promote the use of Exercise Tracks at all facilities and conduct a "Take it Off Macon-Bibb" competition as well as in Baldwin and Peach Counties for Navicent Health Employees and the general public.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Middle Georgia Food Bank
- Baldwin County Public Schools
- One South
- Loaves & Fishes
- Meals on Wheels

Appendix 5

Cardiovascular Disease

CHNA Page Reference-pages 89-102

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to reduce cardiovascular disease mortality. b. There is a need to improve cardiovascular health and quality of life. c. There is a need to for education regarding cardiovascular risk factors.	a. Reduce the number of mortalities related to cardiovascular diseases. b. Improve the cardiovascular health and quality of life. c. Increase awareness and knowledge of risk factors for cardiovascular disease.

Background and contributing factors:

Key informants in the CHNA process characterized Heart Disease & Stroke as a major problem. Between 2014 and 2016, there was an annual average age-adjusted heart disease mortality rate of 229.5 deaths per 100,000 population in the Total Area which is much higher than Georgia and national rates. This rate is far from satisfying the Healthy People 2020 target of 156.9 or lower. Overall, the heart disease mortality rate in the Total Area has remained relatively constant, while trends across Georgia and the U. S. have decreased. In the same time frame, there was an annual average age-adjusted stroke mortality rate of 47.4 deaths per 100,000 population in the Total Area which is similar to Georgia's rate and slightly higher than the national rate. This rate fails to satisfy the target of 34.8 or lower with the highest rate in Peach County.

Implementation Strategy:

a) Provide Cardiac screening for neonates in Baldwin County.
b) Continue to assign care coordinators to work patients with congestive heart failure (Bibb).
c) Continue hypertension screenings at community and corporate health fairs; provide follow-up referrals to participants with abnormal results.

d) Continue to provide the Toolkit with congestive heart failure and hypertension information to faith community organizations (Bibb County).
e) Sponsor Hands Only CPR training at community heart fairs.
f) Provide thousands of free blood pressure, cholesterol, and glucose screenings throughout Central Georgia (Navicent Health) in partnership with various civic and community groups.
g) Provide free Angioscreens to U. S. Military veterans.
h) Partner with local school system to offer Early Heart Attack Care and Hands Only CPR to staff and students.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Faith Community Organizations
- American Heart Association
- Local School system
- Local businesses

Appendix 6

Obesity

CHNA Page Reference-pages 187-195.

Health Problem	Outcome Objective (Anticipated Impact)
c. There is a need to educate and create awareness around obesity and weight status. d. There is a need to communicate best practices for obesity prevention.	a. Increase awareness and education of obesity and reduce obesity related health issues. b. Increase communication for best practices for obesity prevention.

Background and contributing factors:

The CHNA participant process identified weight status as a major problem as there is a high prevalence of overweight and obesity in the community. Busy work-driven lifestyles lend themselves to fast, convenient meals and many people lack the knowledge on how to make healthy choices. Compounding the issue, the rural communities (Baldwin and Peach) do not have easy access to a grocery store, nor are they within proximity. However, the participants voiced that the level of physical activity has room for improvement.

Implementation Strategy:

a) Support and maintain walking trails on the hospitals' grounds (Bibb, Baldwin and Peach Counties).
b) Continue to offer healthy living and wellness seminars to the community.
c) Continue to offer the "Walk with a Doc" program for the community.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Macon-Bibb County Recreation Department
- Walk with a Doc
- Local school districts
- Bike Walk Macon
- Middle Georgia Wellness and Fitness Festival

Appendix 7

Other Strategies

CHNA Page Reference-pages 116-123, 124-136

Health Problem	Outcome Objective (Anticipated Impact)
a) There is a need for education and awareness for other health concerns such as asthma and trauma. b) There is a need to provide access for sport physicals for special needs students participating in Special Olympics. c) There is a need to provide other health screenings for elementary school-aged children.	a) Increase education and awareness for other health concerns including asthma and trauma injuries. b) Continue to provide sport physicals for special needs students participating in the Special Olympics. c) Continue to provide other health screenings for elementary school-aged children.

Background and contributing factors:

The CHNA identified other areas of need for children as it relates to asthma and access for those with special services.

Implementation Strategy:

- Continue to sponsor Camp Open Airways for children with asthma.
- Continue to sponsor Stop the Bleed classes throughout Central Georgia.
- Continue to sponsor a Matter of Balance programs throughout Central Georgia.
- Continue to provide sports physicals for special needs students participating the Special Olympics.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference “Outcome Objective” box on previous page)

Possible Collaborations:

- Local school systems
- Community agencies
- Senior Centers
- Local fire departments