2021

Navicent Health System

Medical Center Navicent Health
Medical Center Peach County
Navicent Health
Navicent Health Baldwin

Implementation Strategy

FY 2021-2023

Navicent Health System

Implementation Strategy

For FY 2021-2023 Summary

Navicent Health System (NH) is a comprehensive healthcare system serving Central and South Georgia and includes three acute care hospitals with a total of 802 beds located in Baldwin, Bibb, and Peach Counties. In 2020, the three hospitals conducted individual Community Health Needs Assessments (CHNA) to identify the health needs of Central Georgia. The Implementation Strategy for NH System was developed based on findings and priorities established in the CHNA and a review of each hospital's existing community benefit activities.

This report summarizes the plans for NH System to sustain and develop community benefit programs that 1) address prioritized needs from the 2020 CHNAs 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. 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 System has addressed each of the health needs identified in the CHNA. NH System 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. Over the next 3 years additional strategies might be added to this plan as opportunities arise from the integration with Atrium Health.

Approval:

The NH System Board of Directors approved this Implementation Strategy through a board vote on 04/12/2021.

The following issues were identified as “priority” needs by the community participants.

1. **Behavioral Health**
    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.

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 at 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 to improve access to quality health care and services.
        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 need 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 efforts to improve overall health.
        i. There is a need to provide knowledge and skills to make healthier choices.
        ii. There is a need to address food insecurity by increasing 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.
    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.
    c. There is a need to provide free Community COVID Screenings and Vaccinations.
    d. There is a need to focus on engaging the community to collaborate solutions for the opioid crisis and pain management in central Georgia.

Appendix 1

Community Work Plan for Behavioral Health

CHNA Page Reference-pages 60-69.

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 promotionand prevention in mental health. c. Increase knowledge and awareness of depressionand 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-medicates with alcoholand/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. Offer a myriad of Support Groups and Self-Help Groups to help the citizens of Central Georgia cope with various health issues (cancer, cardiovascular disease, etc.)
b. Offer a Smoking Cessation program including the addition of a Smoking Cessation Support Group.
c. Sponsor an intensive weekend retreat, Bo's Camp, for Central Georgia families to deal with grief and bereavement for children under the age of 18 years experiencing a loss.
d. Provide free therapy services at Children Health Center in partnership with Mercer University Marriage and Family Therapist (MFT) Program.
e. Provide free therapy services at the Anderson Health Clinic in partnership with Mercer University Marriage and Family Therapy (MFT) Program.
f. Partner with Georgia College & State University to provide Behavioral Health Education to students in Baldwin County.
g. Provide an evidence based training on mental health to the community.

OUTCOMES: Statistics will be recorded for the number of program participants and/or numberof 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 - 108-112.

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. d. Implement a patient engagement technology tool to allow for self-management of pre-diabetes.

Background and contributing factors:

The CHNA focus groups process characterized Diabetes as a major problem in the community. The CHNA reported that 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 42.0 in comparison to Baldwin County 31.9, Bibb County 11.7 and Houston County 22.1.

Implementation Strategy:

a) Partner with faith community existing programs to provide blood glucose screening tools in Baldwin County.
b) Partner with Clinical Ladder Nurses, and School House Health Nurses to increase community awareness of pediatric diabetes via the SCENT Diabetes Education program.
c) Implement Care Companion Pre-Diabetes self-management tool through Epic

- 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)

Appendix 3

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

CHNA Page Reference-pages 170-187.

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) to provide transitional care to identified patients.
b) Continue partnership with Macon Volunteer Clinic via assistance with Patient Education including specifically Diabetes Education. Supplies are also given to MVC.
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 exploring ways to increase access to healthcare via telemedicine.
h) Financially support the building of a Medical Respite Facility for homeless individuals at Daybreak.
i) Financially support the addition of two new physicians at First Choice Primary Care.
j) Institute a virtual consultation network with Phoebe Putney Hospital in Albany GA to provide pediatric consultations with residents of Southwest Georgia.
k) Continue partnership with the Smart Neighborhood MBC Project to provide access to health information in underserved and at-risk neighborhoods with the implementation of a smart kiosk system.

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 ofprogram participants, participant history information, identification and tracking of keytrends, and determining which programs and efforts are the most effective at achievingdesired outcomes. (Reference “Outcome Objective” box on previous page)

Possible Collaborations:

- First Choice Primary Health Care
- Macon Volunteer Clinic
- Phoebe Putney Hospital
- Daybreak
- Community Health Care Systems, Inc. (Baldwin County)
- Macon/Bibb County Government
- Valley Medical (Peach County)

Appendix 4

Nutrition/Physical Activity

CHNA Page Reference-pages 53-55, 135-146.

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 Central Georgia with highest in Bibb County. The U.S. Department of Agriculture data shows that 30.4% of the total Area population (representing over 135,326 residents) have low food access or live in a food desert. A total of 30.9% of Total Area adults report no leisure time physical activities or exercises to strengthen their muscles with the highest in Bibb County at 33.2%.

Implementation Strategy:

a) Support 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, Baldwin 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) Explore grant funding for a Bibb County Wellness Garden to address Mental Health & Nutritional needs.

- 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
- Loaves & Fishes
- Society of Saint Andrew
- Fort Valley State University
- Health Powers

Appendix 5

Cardiovascular Disease

CHNA Page Reference-pages 73-81.

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 2016 and 2018, there was an annual average age-adjusted heart disease mortality rate of 235.9 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 2030 target of 127.4 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 44.8 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 33.4 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 provide services to 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 Chronic Disease Toolkit with congestive heart failure and hypertension informationto 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).
g) Provide free Angioscreens to U. S. Military veterans.
h) Implement HF Self-Management technology tool through Epic's Care Companion
i) Explore hiring a Health Educator for Baldwin & Peach Counties
i) 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
- Local School Districts

Appendix 6

Obesity

CHNA Page Reference-pages 142-148.

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to educate and create awareness around obesity and weight status. b. There is a need to communicate best practices for obesity prevention.	a. Increase awareness and education of obesity and weight status. 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.
d) Institute Bingocize® Exercise Program in Central Georgia

- 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
- Regional Trauma Advisory Committee (RTAC)

Appendix 7

Other Strategies

CHNA Page Reference-pages 116-136.

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 other health screenings for elementary school-aged children. c) In 2020 a worldwide pandemic was declared by the WHO. A need exists to provide free community COVID 19 screenings and free community COVID 19 vaccinations. **d)** There is a need to focus on engaging the community to collaborate on solutions for the opioid crisis and pain management in central Georgia.	a) Increase education and awareness for other health concerns including asthma and trauma injuries. b) Continue to provide other health screenings for elementary school-aged children via the School House Health program. c) Provide free community COVID 19 screenings and free community COVID 19 vaccinations. d) Develop clear and concise messaging that can be used across community settings and media avenues.

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.

The CHNA also identified opioid use disorders as an area of need. Between 2016 and 2018, there was an annual average age-adjusted unintentional drug-related mortality rate of 7.9 deaths per 100,000 population in the Central Georgia area. However, the self-reported use of prescription opioids in the Navicent Health service area in the past year was: Bibb 20.1%; Peach 28.9%; Baldwin 11.6% and Houston 20.3% with the total area at 19.7%. This rate is well above the national benchmark of 12.9%.

Implementation Strategy:

- Continue to sponsor Camp Open Airways for children with asthma.
- Examine ways to institute a phone-based educational app to distribute to families to educate patients/families about pediatric asthma.
- Continue to sponsor Stop the Bleed classes throughout Central Georgia.
- Institute the Georgia Firearms Safety Campaign in Central Georgia
- Continue to sponsor a Matter of Balance programs throughout Central Georgia.
- Sponsor free Community COVID-19 screenings and vaccinations.
- Provide free COVID-19 vaccinations to senior towers residents, Homebound patients and other selected groups.
- Establish a Community Opioid and Pain Management Collaboration Task Force to develop open communication, shared accountability to promote appropriate opioid use as well as the safe storage and disposals of opioids.

- 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
- Region 5 Regional Trauma Advisory Committee (RTAC)
- Macon Housing Authority
- Faith-Based Organizations
- Pharmacies
- Area Agency on Aging
- Department of Public Health
- Mayor’s office