2024-2026

Community Health Improvement Plan

Atrium Health Navicent The Medical Center

Atrium Health Navicent Peach

Atrium Health Navicent Baldwin

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IDENTIFYING SIGNIFICANT HEALTH NEEDS

ABOUT ADVOCATE HEALTH

As part of Advocate Health (AH), Atrium Health Navicent (AHN) values its collaborations with the third-largest nonprofit integrated health system in the United States – created from the combination of Advocate Aurora Health and Atrium Health. Providing care under the names Advocate Health Care in Illinois, Atrium Health in the Carolinas, Georgia and Alabama, and Aurora Health Care in Wisconsin, Advocate Health is a national leader in clinical innovation, health outcomes, consumer experience and value-based care, with Wake Forest University School of Medicine serving as the academic core of the enterprise. Headquartered in Charlotte, North Carolina, AH serves a population of nearly 6 million patients and is engaged in hundreds of clinical trials and research studies. It is nationally recognized for its expertise in cardiology, oncology, pediatrics and rehabilitation, as well as organ transplants, burn treatments and specialized musculoskeletal programs. AH employs nearly 155,000 team members across 68 hospitals and over 1,000 care locations and offers one of the nation's largest graduate medical education programs with over 2,000 residents and fellows across more than 200 programs.

Committed to equitable care for all, Advocate Health provides nearly $6 billion in annual community benefits with regional and community partners and continues to lead the nation in health equity and community benefit strategies through the development of local services and care delivery. Nationally recognized as #1 in community benefit investments, AH is the architect in the nation's leading health equity models and is committed to finding solutions for the greatest disparities affecting care gaps in rural and urban communities. Focused on affordability, learning and discovery, creating the next generation workforce, health equity, safety and health outcomes and environmental sustainability, AH continues its national impact built through its network of high-quality healthcare services.

National Relevance | Regional Density | Local Presence

ABOUT ATRIUM HEALTH NAVICENT THE MEDICAL CENTER A PART OF ADVOCATE HEALTH

Atrium Health Navicent The Medical Center (AHNTMC), based in Macon, Georgia, is a nationally recognized academic medical center and adult Level 1 Trauma Center. Part of Advocate Health, AHNTMC is licensed for 637 beds and serves 30 central and south Georgia counties. AHNTMC has over 4,500 employees and a medical staff of approximately 700 physicians. AHNTMC is accredited by DNV-GL.

Hospital facts and details:

- Magnet designated hospital for nursing excellence
- Certified Primary Stroke Center (DNV)
- Primary academic hospital for Mercer University School of Medicine
- Chest Pain Center with Primary PCI Accreditation (American College of Cardiology)
- Heart Failure Accreditation (American College of Cardiology)
- Atrial Fibrillation with EPS Accreditation (American College of Cardiology)
- Level 1 Trauma Center (American College of Surgery)

It is our mission to provide quality healthcare services with efficiency. AHNTMC provides the following services:

- Inpatient
- Outpatient
- Urgent and Emergency Care
- Surgical Services
- Women's Services
- Children's Services
- Primary Care
- Rehabilitation
- Cancer
- Adult Specialty Care
- Heart Center
- Hospice and Palliative Care
- Healthy Communities Programming

AHNTMC maintains a Healthy Communities Department dedicated to addressing outreach objectives to serve the entire community, not only those who come through the hospital's doors. Building on a long tradition of service, the Healthy Communities Department utilizes hospital strengths while also connecting with well-established community partners.

This strategy allows AHNTMC to better understand and reach the most vulnerable sectors of the community, while meeting pressing healthcare needs. Our goal is to improve the community's overall health status by empowering residents to make healthy life choices through education, programming and partnerships.

AHNTMC completed its most recent Community Health Needs Assessment in 2023.

OUR COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

AHNTMC recently embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues impacting our community.

Definition of the Community Served

The AHNTMC community, as defined for the purposes of the Community Health Needs Assessment and Implementation Strategy, includes each of the residential ZIP codes that comprise the hospital's Primary Service Area (PSA) as outlined in the following table.

Total Area				
	Bibb County			
	31052	31206	31212	31294
	31201	31207	31213	31295
	31202	31208	31216	31296
	31203	31209	31217	31297
	31204	31210	31220	
	31205	31211	31221	
	Houston County			
	31005	31028	31088	31098
	31013	31047	31093	31099
	31025	31069	31095	
	Peach County			
	31008	31030		
	Baldwin County			
	31034	31059	31061	31062
	Other Counties (Crawford, Jones, Monroe, and Twiggs Counties)			
	31050	31033	31031	31029
	31066	31038	31044	31046
	31078	31017	31004	31086
	31032	31020	31016	

How CHNA Data Was Obtained

The CHNA incorporated data about the community from multiple sources, including primary and secondary data:

- A population-based survey among a representative sample of community residents
  (the Professional Research Consultants (PRC) Community Health Survey)
- An online survey of public health representatives, health providers, and a variety of other community service providers and stakeholders (the PRC Online Key Informant Survey)

- A review of existing vital statistics, public health documents, census documents, and other data

The CHNA allowed for extensive comparison to benchmark data at the state and national levels. The assessment was conducted on behalf of AHNTMC by PRC, a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Identifying & Prioritizing Health Needs

Areas of Opportunity

Significant health needs (or "Areas of Opportunity") were determined in our CHNA after consideration of various criteria, including:

- Standing in comparison with benchmark data
- Identified trends
- The preponderance of significant findings within topic areas
- The magnitude of the health concerns in terms of the number of persons affected and the potential health impact of a given health concern

Prioritized List of Health Needs

After reviewing the Community Health Needs Assessment findings, AHN teammates and community stakeholders met to evaluate and prioritize the top health needs for our community. The participants were asked to evaluate each health concern considering two criteria: 1) scope and severity of the health issue; and 2) the hospital's/community's ability to impact that issue. Individual ratings for each criterion were averaged for each tested health issue, and then these composite scores were averaged to produce an overall score. This process yielded the following prioritized list of health needs for our community:

1. Mental Health
2. Diabetes
3. Nutrition, Physical Activity & Weight
4. Substance Use
5. Heart Disease & Stroke
6. Injury and Violence
7. Tobacco Use
8. Disabling Conditions

9. Sexual Health
10. Access to Healthcare Services

ADDRESSING SIGNIFICANT HEALTH NEEDS

HOSPITAL-LEVEL COMMUNITY BENEFIT PLANNING

This summary outlines AHNTMC's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and/or 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Priority Health Concerns to Be Addressed

In consideration of the top health priorities identified through the CHNA process — and considering hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that AHNTMC would focus on developing and/or supporting strategies and initiatives to improve:

- Heart Disease & Stroke
- Diabetes
- Nutrition, Physical Activity & Weight
- Injury and Violence
- Maternal & Child Health
- Access to Healthcare Services

AHNTMC has been on a journey to transform healthcare delivery through a long-term strategic plan shown above. In this Community Health Implementation Plan, the next three years will be defined, but it is imperative that the entire strategy be revealed. The first phase of transformation began with the most advanced illnesses prevalent in the community.

Congestive Heart Failure and advanced Diabetes Care Management programs were developed to address the most at risk and top 5% of the population. Through these programs connecting with the community members most affected, the root cause of unmanaged illness was uncovered. This led to the development of services and community partnerships to begin addressing the gaps in care.

In the 2024-2026 plan, AHNTMC will build off the foundational services that have been successful to date. There will also be expansion of these services moving forward, but new innovative and advanced strategies will be necessary to reach individuals suffering from chronic diseases. As the strategy unfolds there will be a larger volume of people to

serve and will call for the use of technology, increased partnerships, and innovative ways to reach this population.

Health Concerns That Will Not Be Addressed during this CHIP plan and Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, AHNTMC determined that it could effectively focus on those which it deemed most pressing, most under-addressed, and/or most within its ability to influence.

Health Priorities Not Chosen for Action	***Reason***
Mental Health	*AHNTMC recognizes mental health as one of the regional issues identified by CHNA responses and is in the planning phase of creating a pathway to provide clinical and community support. We are currently working with several community organizations, many of which already have infrastructure and programs in place to better meet this need, and we will continue to explore opportunities for collaboration.*

Action Plans

The following tables outline AHNTMC's plans to address priority health issues chosen for action in FY2024-FY2026.

Priority Area #1: Heart Disease & Stroke	
Community Health Need	Heart disease and stroke are illnesses that contribute to poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors such as high blood pressure and high cholesterol. These illnesses have the following local community benchmark numbers (deaths per 100,000). **Heart Disease Mortality**: Total Population Area-235.8 Georgia- 178.3 United States- 164.4 **Stroke Mortality**: Total Population Area- 41.4 Georgia- 42.8 United States- 37.6 These high mortality rates indicate a need for more education to make the community aware of risks and ways to mitigate and manage these conditions.
Goal(s)	• Decrease prevalence of heart disease and stroke • Decrease community diagnosis of "uncontrolled" hypertension which is a blood pressure reading equal to or greater than 140/90 • Increase community awareness for hypertension and encourage individuals to 'know their numbers' so they can seek medical intervention, if needed • Demonstrate ability to identify stroke symptoms for the purpose of getting earlier intervention if needed
Target Population(s)	All adults served by AHN
Partnering Organization(s)	• Paul Coverdale National Acute Stroke Program • American Heart Association • American Stroke Association • College of Health Sciences, Georgia College and State University

Action Plan	**<u>Continuing Foundational Strategies 2024-2025:</u>** **Strategy 1: Healthy Communities** In response to the evolving needs of the community and the realization that a novel approach was necessary to address the true needs of patients, AHNMC set out on a bold plan to elevate community-based care by forming an interdisciplinary department called “Healthy Communities.” The Healthy Communities department strives to increase access to medical care and reduce disparities, resulting in increased health care equity. It has deployed social intervention methods such as population health care management, community health interventions, and most recently, virtual health initiatives. Healthy Communities serves central Georgia residents through targeted one-on-one interventions and in collaboration with community partnerships. Programs were developed to fill the service gaps and improve the community's overall health. Healthy Communities employs registered nurses, care coordinators, health educators, community health workers, and certified medical assistants, who provide care for high-risk patients aimed at improving their health and well-being. By harnessing the expertise of a diverse team, Healthy Communities aims to go beyond traditional clinical care by tackling the non-medical factors that influence health outcomes, or social determinants of health (SDoH). For example, AHNTMC identified through hearing directly from current patients, that food insecurity was one of the major SDoH for Middle Georgia residents. (see Priority Area #3) Patients enrolled in AHN Healthy Communities care management programs for congestive heart failure and diabetes can also receive food and education that support disease-specific needs. As of April 2023, this program had served 3,195 individuals, received 165 Food as Medicine Market referrals and given 48,990.85 pounds of food to middle Georgia community members. AHNTMC will build upon this foundation of services and expand to meet larger volumes of individuals. As seen in the strategy, the services will begin to move further back in the disease progression to make an impact on the overall wellbeing of the community. The plan will include the use of virtual care at home to reach those who have difficulty accessing care in the traditional facilities.

Strategy 2: Medical Toolkit
Healthy Communities and the AHNTMC Stroke prevention services department will provide education about hypertension through distribution of a Community Medical Education Tool Kit which also provides printed materials and instructions for how to visit a website for updated educational materials about congestive heart failure, hypertension, and stroke. Individuals learn in diverse ways and seek information through their church or community gatherings. The Medical Toolkit brings information to these areas where people go for help.

<u>Transforming Foundational Strategies 2024-2025:</u>
NEW Strategy 3: Regional Hypertension Clinic
The Heart and Vascular Center, part of the Atrium Health Navicent Medical Group, in collaboration with Healthy Communities will offer a new Hypertension Clinic for patients who do not have a primary care provider or who need additional support to manage their hypertension. Patients are identified from a report generated through the electronic medical record system and are contacted by a nurse. Once patients have agreed to services, the nurse and a social worker will continue to follow up with patients based on their needs. This program will focus on equity of care by providing services not accessible in the past.

NEW Strategy 4: Creations of Faith Outreach
AHNTMC will partner with faith-based and community-based organizations to provide hypertension checks, health screenings and education. The hospital will also partner with Georgia College and State University's College of Health Sciences to increase the impact of HTN education and treatment in Baldwin and surrounding counties.

NEW Strategy 5: Community Health Worker Programming
AHNTMC is actively advocating for the use of Community Health Workers in the State of Georgia to address the disparity issues within health care.

The first goal of advocacy will be to support a **certification for CHWs (Community Health Worker) in Georgia**. A robust Community Health Worker Program will be developed to effectively serve the community, especially in the rural service areas. Community Health Worker positions serve as an entry level job in the healthcare profession. The

	individuals recruited have true life experiences in the issues of the specific community. Research has shown this strategy to be highly effective in fostering positive changes toward healthier living. Further advocacy will support recognizing the CHW profession as a billable service under Georgia Medicaid.
Measuring Our Impact	• Number of people enrolled in AHN's congestive heart failure and hypertension disease management programs • Number of new patients seen at the Hypertension Clinic and the number of visits • Percentage of Atrium Health Primary Care Practice patients receiving re-checks for hypertension • Number of community members who have received health screenings, hypertension checks, and education\ • Number of people reached through digital platform

Priority Area #2: Diabetes	
Community Health Need	Diabetes is the 7th leading cause of death in the United States. Unfortunately, racial/ethnic minorities are more likely to have diabetes and many individuals with diabetes are unaware that they have it. Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. In our community, 16.8 percent of individuals have been diagnosed with diabetes, while another 13.2 percent have been diagnosed with "pre-diabetes" making our benchmark higher than state and national averages. These high incidences of diagnoses indicate a need for more education and community awareness surrounding diabetes risk and the importance of managing diabetes if a person is diagnosed.
Goal(s)	With proper interventions in place to help those diagnosed with diabetes to reduce the risk of complications and strategies —such as a healthier diet, physical activity, and managing weight — the following goals have been developed: • Decrease the number of diabetic patients with uncontrolled A1C levels • Reduce the incidence of diabetes in our community
Target Population(s)	Women, men, children, and pregnant women served by AHN.
Partnering Organization(s)	• American Diabetes Association • College of Health Sciences, Georgia College and State University

Action Plan	**<u>Continuing Foundational Strategies 2024-2025:</u>** **Strategy 1: Healthy Communities (**see Priority #1, Strategy 1) AHNTMC will build upon this foundation of services and expand to meet larger volumes of individuals. As seen in the strategy, the services will begin to move further back in the disease progression to make an impact on the overall wellbeing of the community. The plan will include the use of virtual care at home to reach those who have difficulty accessing care in the traditional facilities. **Strategy 2: Expanding the Speakers Bureau** Work with the AHN Speakers Bureau, to participate in health fairs, and lunch-n-learns to educate the community on diabetes. **<u>Transforming Foundational Strategies 2024-2025:</u>** **NEW Strategy 3: High Risk Obstetrics Care Management** A care manager will work with AHNTMC's high-risk obstetrics clinic to provide ongoing education and monitoring to pregnant mothers identified as having gestational diabetes and pre-eclampsia. A care manager will also seek to identify Social Drivers of Health and provide patients with assistance in mitigating barriers which may be preventing them from managing their health. This program will be expanded to reach patients earlier in their pregnancy through the above-mentioned CHW program. This will lead to improved outcomes for mothers at risk of mortality and morbidity. **NEW Strategy 4: Creation of Faith Outreach** AHNTMC will partner with faith-based and community-based organizations to provide glucose checks, health screenings and education. Partner with Georgia College and State University's College of Health Sciences to increase impact in Baldwin and surrounding counties. **NEW Strategy 6: CDC Diabetes Prevention Program (DPP)** AHNTMC will implement the Diabetes Prevention Program that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. This training consists of 16 core sessions and is approved through the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program, or National DPP.

Measuring Our Impact	• Number of people reached through community outreach efforts • Number of children served at the Camp Kudzu • Number of people served through the High-Risk OB Care Management Program • Number of people served through the Adult Diabetes Care Management Program • Number of community members who have received health screenings, glucose checks, and education • Number of individuals reached through digital platform

Priority Area #3: Nutrition, Physical Activity and Weight	
Community Health Need:	In the Macon and the surrounding central Georgia community, 28.7 percent of adults experience low food access, and difficulty accessing affordable fresh fruit and vegetables. This represents a significant increase from previous findings of 16.9 percent. This disparity is highest in Baldwin County, (38.3 percent). The prevalence decreases with age and income level and is reported more often among women, Hispanic respondents, people of diverse races, and LGBTQ+ adults (https://health.gov/healthypeople2030). Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans (https://health.gov/paguidelines/second-edition/pdf/Physical_Activity_Guidelines_2nd_edition.pdf) lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people do not get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities. 31.2 percent of adults report no leisure-time physical activity in the past month. Obesity is linked to many serious health problems, including Type 2 diabetes, heart disease, stroke, and some types of cancer. While some racial /ethnic groups are more likely to have obesity, this results in an increased risk of chronic diseases. Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce the risk of becoming overweight and obese. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight. Most total area adults (72.5 percent) are overweight. This includes 42.5 percent of area adults who are obese.
Goal(s)	• Demonstrate improved access to healthy foods, including easy access of fresh produce • An increased number of patients will receive nutritional education • An increased number of people in the community will report healthier lifestyles

Target Population(s)	Children and adults
Partnering Organization(s)	• Society of St Andrew • Middle Georgia Community Food Bank • UGA Cooperative Extension • Walk with A Doc • Macon-Bibb Parks and Recreation • Southeast Produce Council • College of Agriculture, Family Sciences and Technology, Fort Valley State University • Meals on Wheels • TGW Agriculture and Education • College of Health Sciences, Georgia College and State University

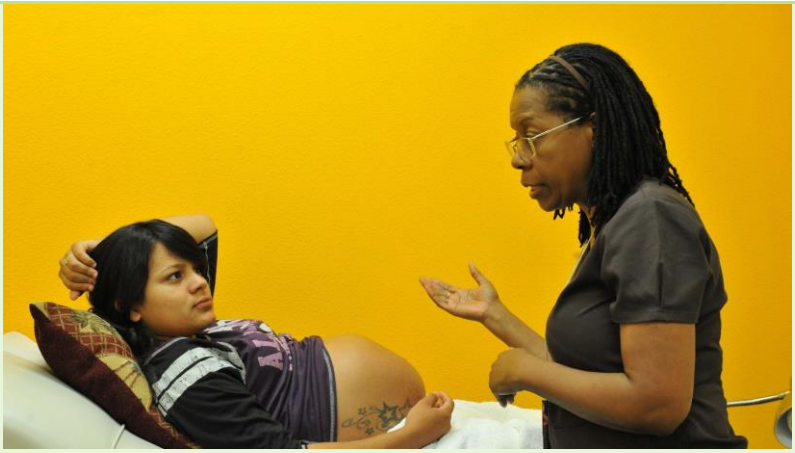
Action Plan	**<u>Updating Foundational Strategies 2024-2025:</u>** **Strategy 1: Expanding Food As Medicine Concept** • AHNTMC will continue to provide access to healthy foods through the Food as Medicine Market, a community grant funded program, to community members with food security needs. This will include produce provided by the Society of St Andrew, the Southeast Produce Council and produce grown by use of hydroponic gardens. • Both inpatient and community patients will be referred by clinicians to our Food Farmacy, our medical/food security partnership. • Any community member facing food insecurity is welcome. • A partnership with Meals on Wheels allows bedbound patients to receive services at home. • An expansion to open a Food as Medicine Market in Baldwin and Peach counties is planned for 2025. • AHNTMC will partner with the Middle Georgia Community Food Bank to provide mobile food distribution services to vulnerable counties in the AHN footprint. • AHNTMC will expand the partnership with Meals on Wheels to prepare meals to serve community members with low food access in seven Middle Georgia Counties (Bibb, Jones, Monroe, Crawford, Twiggs, Houston, Baldwin and Peach) **Strategy 2: Expanding Walk with a Doc** About Walk with a Doc: As an international non-profit organization, Walk with a Doc is committed to inspiring communities through movement and conversation with physician-led walking groups. Started in 2005 by Dr. David Sabgir, a cardiologist in Columbus, Ohio, the program now extends to over 500 communities throughout the world. The walks are a fun, free, and safe place to get some steps, learn about health, and meet new friends. Learn more at www.walkwithadoc.org AHNTMC will continue the Walk with A Doc program to encourage physical activity and provide disease-specific education in both Bibb and Baldwin Counties. To enhance this, we will increase participation in the monthly walks by advertising within local schools and universities and we will start another Walk with a Doc

	chapter at Atrium Health Navicent Peach to provide additional opportunities to walk, and we will continue the support of Atrium Health Navicent Baldwin's Walk with a Doc chapter with ongoing resources from the National Walk with a Doc organization. **<u>New and Innovative Strategies 2025-2026:</u>** **NEW Strategy 3: Year-round access to fresh produce** AHNTMC will partner with Fort Valley State University to grow fresh produce year-round in a large hydroponic garden. Access to fresh produce was recognized as an issue for the community making it hard to follow a healthy diet. This program will keep vegetables coming in the Food as Medicine Market for those with food insecurity. Classes will also be offered to teach individuals how to start their own hydroponic container farming at home. 
Measuring Our Impact	• Amount of food distributed measured by pounds • Number of Food Farmacy enrollees • Number of Walk with a Doc attendees • Number of families served by mobile food distribution events • Number of meals served to community members • Amount of fresh produce in pounds from hydroponic farm

Priority Area #5: Maternal and Child Health	
Community Health Need	The infant mortality rate in the United States is higher than other high-income countries, and there are major disparities by race/ethnicity. The mortality rate is 2x

	higher among births to Black mothers than to White mothers. Addressing social determinants of health is critical for reducing these disparities. In 2019, 5.3 percent of all Total area births did not receive prenatal care in the first six months of pregnancy. 11.2 percent 2014-2020 Total area births were low weight. The disparity in Bibb County is higher than the state of Georgia and U.S. rates. Babies who weigh less than 2,500 grams (about 5.51 pounds) at birth are much more prone to illness and neonatal death than normal birthweight babies. Between 2018 and 2020, there was an annual average of 8.8 infant deaths per 1,000 live births. This rate is more than twice as high among births to Black mothers than to white mothers.
Goal(s)	• Decrease infant and maternal mortality and morbidity • Raise awareness for women who are pregnant and postpartum to understand maternal warning signs • Empower women who are pregnant and post-partum to speak up and raise concerns • Encourage support systems to engage in important conversations • Convene partners with synergies to explore opportunities to promote and develop programs to promote collaborations for healthy outcomes
Target Population(s)	Women and children
Partnering Organization(s)	• North Central Health District • Healthy Mothers Healthy Babies Coalition of Georgia • Georgia Chapter of Postpartum Support International • The Federal Communications Commission (FCC) – Affordable Connectivity Program (ACP) • Georgia Perinatal Quality Collaborative • Mother's Nest • Macon AIM • Prime Baby Time

	• United Way of Central Georgia (First Step, Parents as Teachers) • Operation M.I.S.T. (Monitor, Intervene, Survive, Thrive) • Healthy Mothers Healthy Babies • HEAR HER Campaign provided by the Centers for Disease Control and Prevention (CDC) • ROBE (Reaching Our Brothers Everywhere) • ROSE (Reaching Our Sisters Everywhere)
Action Plan	**<u>Transforming Foundational Strategies 2024-2025:</u>** **NEW Strategy 1: HEAR HER Campaign** Strategically collaborate with community stakeholders to participate in the HEAR HER campaign developed by the CDC. Healthy Communities will provide materials developed by the CDC to religious, civic, and social community organizations as part of the Chronic Disease Toolkit. These organizations will then distribute the toolkit to their members to help keep them informed. AHNTMC will encourage community stakeholders to incorporate HEAR HER educational material in their organizational activities like home visits to households with pregnant women. **NEW Strategy 2: Doula Services and Advocacy** In support of the expansion of doula services, AHNTMC will continue to support the United Way of Central Georgia as it seeks funding to train new doulas. AHNTMC will continue our partnership with the Healthy Mothers Healthy Babies Coalition of Georgia's building Perinatal Support Professionals program. The program supports low-income individuals pursuing a perinatal support professional career pathway in central and South Georgia.

	 **NEW Strategy 3: Breastfeeding Education and Support** AHN will partner with community organizations to provide breastfeeding education, advocacy, and support for women who are pregnant or post-partum and their families. **<u>New and Innovative Strategy 2025-2026:</u>** **NEW Strategy 4: Behavioral Health Support for Mothers** To address mental health and substance abuse support, our AHNTMC Virtual Health platforms will provide virtual and telehealth platforms for pregnant and post-partum women who do not have access to a doula. The option to participate in a virtual visit will be accompanied by information on how to get discounted internet service and/or devices. **NEW Strategy 7: Digital Platforms: High Risk OB Mgt** AHNTMC will explore and implement technological advancements to reach pregnant mothers who are considered at risk due to social, economic, or environmental factors.
Measuring Our Impact	• Number of people educated with resources provided in the Chronic Disease Toolkit • Number of pregnant women receiving telehealth visits at the High-Risk Regional OB Clinic • Number of mothers receiving breastfeeding education/support • Number of ante/post-partum women receiving doula support • Number of people reached through digital platform

Priority Area #6: Access to Healthcare Services	
Community Health Need	A total of 46.3 percent of adults report some type of difficulty or delay in obtaining healthcare services in the past year and amongst adults aged 18-64, 13 percent reported not having insurance coverage for healthcare expenses (health.gov/healthypeople). For the 46.3 percent reported in this total area, the highest area of disparity is Baldwin County (55.6 percent). People who are under or uninsured are less likely to have a primary care provider, and they may not be able to afford the healthcare services and medications they need. Under and uninsured patients in our region often miss recommended healthcare screenings because they do not have a primary care provider. Other Social Drivers of Health such as transportation, literacy and funding for office visits may prevent individuals from accessing quality preventative care. Interventions to increase access to healthcare professionals and improve communication — in person or remotely — can help more people get the care they need.
Goal(s)	• People in vulnerable communities will report greater access to care • Community members will experience greater equity of care through the screening, referral and addressing of Social Drivers of Health
Target Population(s)	All populations
Partnering Organization(s)	• St Peter AME Church (Peach) • Union Baptist Church (Bibb) • Center Hill Baptist Church (Bibb) • Bibb County Health Department • Peach County Health Department • Baldwin County Health Department • State Office of Rural Health (SORH)

Action Plan

New and Innovative Strategies 2024-2026:

NEW Strategy 1: Creation of Community Virtual Clinics

Implement rotating virtual clinics in communities with the highest disparities in Bibb, Peach and Baldwin counties utilizing churches as clinic centers. Two churches in Bibb County, and one in Peach County, have signed MOUs with a go-live date of June 3, 2024. Implementation is expected in Baldwin County post identifying a parish partner. The patients will be seen with a Certified Medical Assistant using the TytoCare Platform to connect with a virtual medical provider. This device enables the provider with a clinical-grade remote physical exam.

https://www.tytocare.com

NEW Strategy 2: Data Driven - Health Equity Improvement Plan Development

Continue work with the SORH to develop a Health Equity Improvement Plan for AHN Peach. This plan will address the use of REAL (Race, Ethnicity and Language) data and Social Drivers of Health data to inform access to resources and care. The initial SORH goals are to identify the current disparities in care for the populations served by rural Georgia hospitals, determine the best opportunities for improvement and recommended course of action, and deliver guidance and

	training to rural Georgia hospitals regarding the strategies and tools needed to drive improvement. **NEW Strategy 3: Solving Access to Care: Transportation Vouchers** AHNTMC will investigate, develop and implement a partnership with transportation companies to provide support to patients with limited transportation to access care.
Measuring Our Impact	• Number of people utilizing the rotating clinics for healthcare needs • Number of patients screened and referred to resources • Number of patients with referrals who accessed resources as demonstrated by the closed loop reporting • A completed SORH Health Equity Plan for AHN Peach • Number of transportation vouchers issued • Number of people reached through digital platform

Implementation Strategy Adoption

On May 9, 2024, the Board of Directors of AHN, approved this market-wide Community Health Implementation Plan Implementation (CHIP) Strategy to undertake the outlined measures to better address and improve the identified health needs of the community.

This CHIP is posted on the AHN website, navicenthealth.org.