2016

Crisp Regional Hospital

Implementation Strategy

Crisp Regional Hospital

Implementation Strategy

For FY2017-2019 Summary

Crisp Regional Hospital is a 73 bed not-for-profit community hospital located in Cordele, Georgia. In 2016, the hospital conducted a Community Health Needs Assessment (CHNA) to identify the health needs of Crisp County. The Implementation Strategy for Crisp Regional Hospital was developed based on findings and priorities established in the CHNA and a review of the hospital's existing community benefit activities.

This report summarizes the plans for Crisp Regional Hospital to sustain and develop community benefit programs that 1) address prioritized needs from the 2016 Crisp Regional Hospital CHNA and 2) respond to other identified community health needs.

The following prioritized needs were identified by the community and the CHNA steering committee. Particular focus was placed upon these needs in developing the implementation strategy.

- Access to Care – Prevention
- Access to Care – Education
- Lifestyle and Obesity
- Hypertension
- Diabetes
- Access to Care - Transportation

Crisp Regional Hospital has addressed each of the health needs identified in the CHNA. Crisp Regional Hospital 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.

The Crisp Regional Hospital Board approved this Implementation Strategy through a board vote on November 30, 2016.

Please reference additional appendices to this report for the implementation strategy for each of the health priorities.

The following issues were identified as "priority" needs by the community participants. The findings are listed in the order of priority as determined by the focus groups.

1. Access to Care - Prevention
    a. There is a need for education, and awareness (culture change) concerning prevention of chronic illnesses, health behaviors, and creating habits that promote the use of primary care and preventive medicine.
    b. There is a need for free or low cost care options for the working poor, uninsured, or underinsured.
    c. There is a need for better continuity of care and care coordination for all patients.

2. Access to Care – Education
    a. There is a need for more education to occur in a family's household, so that when children learn in school, it is also reinforced at home.
    b. There is a need for healthier lifestyle education to reduce chronic illnesses.

3. Lifestyle and Obesity
    a. There is a need for specific education on how to purchase and make healthy foods on a budget.
    b. There is a need for education on ways to incorporate physical activity into daily living.

4. Hypertension
    a. There is a need for more awareness and education concerning prevention and treatment of hypertension.

5. Diabetes
    a. There is a need for more awareness and education concerning prevention and treatment of diabetes.

6. Access to Care – Transportation
    a. Transportation to healthcare providers is an issue for all population groups, especially the young, the poor, and the Senior residents.

Community Work Plan for Access to Care - Prevention

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for education, and awareness (culture change) concerning prevention of chronic illnesses, health behaviors, and creating habits that promote the use of primary care and preventive medicine. b. There is a need for free or low cost care options for the working poor, uninsured, or underinsured. c. There is a need for better continuity of care and care coordination for all patients.	a. Increase education and awareness of primary care utilization and the benefits of enhancing health behaviors and wellness in order to prevent chronic disease. b. Increase access to free or low cost care through awareness and outreach. c. Increase continuity of care compliance through resource networking and patient education.

Background:

The CHNA process identified a need for better access to care through focusing on prevention. The community reported that a lot of patients wait until a health issue is an emergency before they seek care. They also reported that a lot of patients do not understand the importance of having a primary care physician.

Implementation Strategy:

a. We will implement a doctor's table with a minimum of one doctor or advanced practice nurse at two of our largest community health fairs. This will provide an opportunity for people to ask questions to medical professionals without having to make an appointment. Crisp Regional will continue to staff a social worker who will consult with patients daily regarding home care services available in the community. We will continue to make the physician directory available through the hospital or on our website. We will continue to offer a Joint Camp for patients who are having joint replacement surgery. The Camp educates patient on what the surgery entails, anesthesia, pain control, and rehabilitation post-op. We highly encourage all patients having a joint replacement to attend. This Camp is provided free of charge. We will implement a monthly Community Health Education seminar educating the community on various chronic illnesses, stroke, and childhood obesity to name a few. In addition, we will offer SOLAS for our seniors on a monthly basis educating them on topics such as chronic illnesses, services offered at Crisp Regional, new physicians available to them and proper nutrition.

b. We identified a need for pediatric care through a data analysis this past year. Utilizing funding through the Rural Hospital Stabilization Grant, Crisp Regional has recently partnered with Albany Area Primary Health Care to place a school based clinic in the Primary School which houses over 1400 students. This school clinic brings healthcare to those children who lack access to a physician. It is staffed with Mid-Level Providers and is available to both the students and faculty. In addition, we identified a need for behavioral health consults for the students in the Primary School. AAPHC will provide a Licensed Clinical Social Worker

in the school clinic once a week for group and individual therapy. We used some of the grant funding to purchase telemedicine equipment and will utilize it for mental health consults with the students such as behavioral health. We will continue to provide these services to our community.

c. Also through the grant, Crisp Regional has implemented a Mobile Integrated Healthcare Program where Paramedics visit frequent fliers and potential 30-day readmit patients. Often times these patients suffer from chronic illnesses. This program is designed to help them gain compliance with their illness and route them to the most appropriate setting for their healthcare needs. We continue to add patients and will continue providing this service.

Possible Collaborations:

- Albany Area Primary Health Care (FQHC)
- Crisp County EMS
- Crisp County Board of Education

Community Work Plan for Access to Care - Education

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more education to occur in a family's household, so that when children learn in school, it is also reinforced at home. b. There is a need for healthier lifestyle education to reduce chronic illnesses.	a. Increase education and knowledge of both parents and children regarding the risk factors and intervention tactics associated with chronic illnesses. b. Increase knowledge and awareness of healthy lifestyles.

Background:

The CHNA process identified lack of education and outreach as an issue that needs to be addressed. In particular, educational outreach was reported as a need for the entire family unit to attend educational classes at the same time so the same information is reinforced.

Implementation Strategy:

a. The school based-clinic in our primary school provides education to the students with regards to healthy eating and healthy lifestyles. They do this through one on one patient visits as well as activities and contests to educate the students on the importance of being healthy. We will implement a monthly Community Health Education seminar educating the community on various chronic illnesses, stroke, and childhood obesity to name a few. In addition, we will offer SOLAS for our seniors on a monthly basis educating them on topics such as chronic illnesses, services offered at Crisp Regional, new physicians available to them and proper nutrition.

b. Through our Mobile Integrated Healthcare Program we will make home visits weekly on chronic illness patients educating them on becoming compliant with their chronic illness. For CHF patients that means educating the patients on weighing themselves daily. For our diabetic patients we will encourage checking their blood sugar appropriately and taking their insulin, or being compliant with O2 for our COPD patients. We will encourage lifestyle changes that promote good health.

Possible Collaborations:

- Albany Area Primary Health Care
- Crisp County Board of Education
- Crisp County EMS

Community Work Plan for Lifestyle and Obesity

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for specific education on how to purchase and make healthy foods on a budget. b. There is a need for education on ways to incorporate physical activity into daily living.	a. Increase knowledge and awareness on how to cook and purchase healthy foods on a budget. b. Increase knowledge and awareness of available resources to help incorporate physical activity into one's daily life.

Background:

The CHNA process identified lifestyle and obesity as a health issue that needs to be addressed. Thirty-four percent of Crisp County residents were reported to be obese. Lifestyle and obesity issues were reported in all population groups. Overall, the community reported a need for a consistent message to be communicated to the entire family unit so children are reinforced with the health education they receive both at home and school.

Implementation Strategy:

a. Crisp Regional will produce a quarterly publication, Crisp Living, which features articles on healthy living as well as healthy recipes in each edition. We will offer Weight Watchers to employees at a reduced cost to encourage people to maintain their ideal weight. It is open to the public as well.

b. CRH will continue to place an Athletic Trainer at Crisp County High School to help in guiding the students and athletes in a healthier way of life, mentoring the students on eating habits and maintaining an ideal weight as well as protecting them from injury due to sports.

c. We will offer several organize community walks at the Perry Busbee Walking track located on the hospital campus. These walks will be free of charge and encourage weight loss at a slower pace.

d. CRH will also sponsors several 5K runs throughout the year to encourage people to stay active. A few of those runs are Run for your Lungs, Cancer Coalition Walk/Run, Watermelon Run and Camp Sunshine Run.

e. Crisp Regional will offer monthly health education classes to the public with topics such as childhood obesity, the importance of a healthy diet and exercise.

Possible Collaborations:

- Crisp County High School
- Run for Your Lungs

- Cancer Coalition
- Camp Sunshine

Community Work Plan for Hypertension

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more awareness and education concerning prevention and treatment of hypertension.	a. Increase knowledge and awareness of the risk factors and treatment of hypertension.

Background:

The CHNA process identified a need for more education specifically on the prevention of hypertension. Hypertension is a chronic condition associated with heart disease, stroke and other chronic diseases. The community reported that a majority of the population are unaware of their hypertension and if they are aware, do not follow medication compliance to treat their high blood pressure.

Implementation Strategy:

a.We will offer a variety of educational opportunities for our community members on heart disease and stroke. We will do this through our SOLAS program as well a speaking engagements to civic clubs.

b. We will offer a discounted screening for carotid arteries at several community health fairs each year including our Employee Health Fair.

c.Through the RHSP grant funding we will offer a Telestroke program in our Emergency Department and Intensive Care Unit. We will have 24/7 access to Neurologist for those patients presenting with stroke symptoms. Crisp Regional Hospital will work toward our goal of receiving Remote Stroke Center designation.

d. Crisp Regional will continue to work toward our goal of becoming a Chest Pain Center by monitoring our MI data and the appropriate transport of patients. By becoming a Chest Pain Center we can partner with local physicians to manage risk factors for cardiovascular disease such as hypertension, lipid management and hemoglobin A1C.

b. Crisp Regional will offer a monthly Community Health Education class such as hypertension and heart disease to name a few as a topic.

Possible Collaborations:

- Telemedicine
- Office of EMS and Trauma

- AcuteCare
- American Heart Association

Community Work Plan for Diabetes

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more awareness and education concerning prevention and treatment of diabetes.	a. Increase knowledge and awareness concerning prevention and treatment of diabetes.

Background:

The CHNA process identified diabetes as a health issue in the community. The diabetes death rate in Crisp County was higher than the Georgia rate. The community reported a need for more education on the risk factors associated with diabetes and a need for diabetes intervention though a diagnosis clinic.

Implementation Strategy:

a. The CRH diabetes test of the month will be offered several times a year encouraging people with diabetes to monitor their blood sugar levels. This test will be offered at a discounted rate to the public.

b. CRH will conduct a Diabetic Health Fair to increase awareness of the different ways to control and manage this disease.

c. The CRH Dietician will also offer one on one diabetic counseling free of charge to those who request this service.

d. In addition, the school-based clinic has the capability of recognizing diabetes in children. The clinic is staffed with an advanced practice nurse and a laboratory that can help identify illnesses such as diabetes.

e. Crisp Regional will offer a monthly Community Health Education course with diabetes management as a topic.

Possible Collaborations:

- Crisp Regional Dietician
- Albany Area Primary Health Care

Community Work Plan for Access to Care - Transportation

Health Problem	Outcome Objective (Anticipated Impact)
a. Transportation to healthcare providers is an issue for all population groups, especially the young, the poor, and the Senior residents.	b. Increase knowledge of available transportation resources in the community. Increase outreach efforts to minimize transportation needs.

Background:

The CHNA process identified a need more transportation to access healthcare. It also identified an overall need for better resource communication regarding available transportation services.

Implementation Strategy:

a.Crisp Regional Hospital will continue to partner with Phoebe Putney to help transport patients to and from Albany to receive their radiation.

b.Crisp Regional Hospital and Crisp County EMS will bring healthcare to various patients through our Mobile Integrated Healthcare program. This program will send our Paramedics to various identified patients to assist them in medication compliance, getting prescriptions refilled, durable medical equipment “teach backs”, and compliance with physician visits.

c. Crisp Regional Hospital will provide a list of transportation options to our patients that will be posted on our website.

Possible Collaborations:

- Phoebe Putney
- CRH Auxiliary
- Crisp County EMS