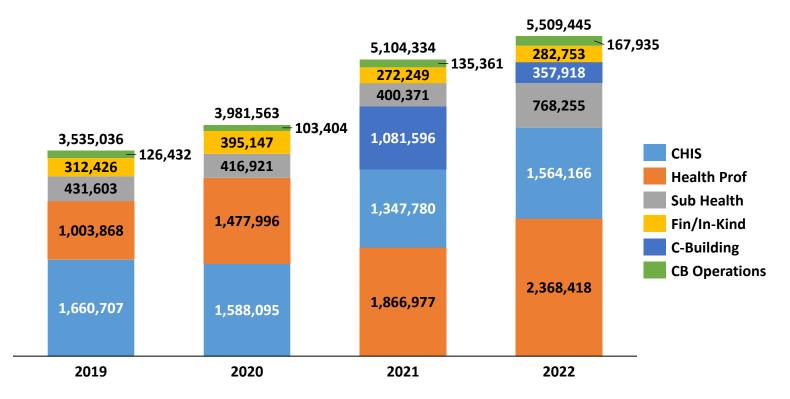


PPMH Community Health Implementation Plan FY 2023 thru FY 2025 **Community Benefits** are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes and are guided by these four principles:

- 1. Improves access to health care services
- 2. Enhances health of the community
- 3. Advances medical or health knowledge
- 4. Relieves or reduces the burden of government or other community efforts.





- I. Improving birth outcomes and reproductive responsibility
- **II.** Preventing and managing diabetes
- **III.** Cancer prevention and treatment
- IV. Mental health, alcohol & drug use & violence prevention

# A description of how the implementation strategy was developed and adopted

Upon the completion of the Community Health Needs assessment, the Strategy and Planning Team met with appropriate service line administrators and personnel to review the current plan for each of the four priority areas (Birth Outcomes, Diabetes, Cancer and Behavioral Health). The plans were updated and approved by the service line directors or designee with a final review by the Health System Chief Medical Officer, Dr. Dianna Grant. The final draft of the implementation plan was reviewed and approved by Phoebe Putney Memorial Hospital's Community Benefit Committee and approval by the full board December 7, 2022.

Please note the CHNA/Implementation plan is a <u>living document</u> adapted in response to everchanging citizens, community, and stakeholder needs. Any list(s) of partners included is not exhaustive. Phoebe Health System welcomes any organizations and stakeholders involved in priority-centered work to join our efforts.

#### **Implementation Strategy**

#### **Priority I: Birth Outcomes and Reproductive Responsibility**

| What   | Who  | Where                                   | Metric/Intended Outcomes   |
|--|--|---|--|
| Provide Pre-Natal Education and<br>Parenting to School Age Teens   | Phoebe Network of<br>Trust/School Nurse<br>program/School<br>System  | Dougherty<br>County<br>School<br>System | <ul> <li>1,000 Teens complete the Taking<br/>Time of Teens curricula and 500<br/>completing Love Notes each year</li> </ul>  |
| HIV/AIDS, STD & Reproductive<br>Responsibility Education through<br>"Taking time for Teens 3 Initiative."              | Phoebe School<br>Nurse Program /<br>School System/<br>Taking Time for<br>Teens Coalition   | Dougherty<br>County<br>School<br>System | <ul> <li>Reduce Teen Pregnancy to the GA<br/>Value of 10.0 per 1,000 teens.</li> <li>To have zero students with a repeat<br/>pregnancy age 18-19 who graduated<br/>from the NOT teen pregnancy program.</li> </ul>                           |
| Teen Early Adult MAZE  | Phoebe School Nurse<br>Program and Taking<br>Time of Teens<br>Coalition  | Dougherty<br>County                     | <ul> <li>Compared to those not in the NFP<br/>who are eligible, the NFP cohort<br/>will have:         <ul> <li>Fewer low and very low</li> </ul> </li> </ul>   |
| Targeted Public Awareness Campaign   | Taking Time for Teens  | Primary<br>Service Area                 | birthweight infants (by<br>percentage)   |
| Fully Implement & Expand Nurse<br>Family Partnership Program (NFP) to<br>Worth and Sumter County to capacity<br>(N=75) | Network of Trust/<br>Doula's /<br>Health Department<br>(WIC)/<br>Marian Worthy /<br>other OB_GYN<br>groups/<br>CareChoice<br>Foundation/<br>NFPNSO | Primary<br>Service Area                 | <ul> <li>Lower C-Section Rates</li> <li>Lower NICU admit Rates</li> <li>Lower Pre-term Birth Rates &amp;</li> <li>There will be no difference between race or ethnicity (equity metric).</li> <li>Expand NFP to 75 active Clients</li> </ul> |

#### **Priority II: Diabetes Prevention and Management**

| What   | Who  | Where               | Metric/Intended Outcomes   |
|--|--|---------------------|--|
| Continued Support of Community<br>Gardens in the School System and<br>other locations in our community.                        | Phoebe Network of<br>Trust, PPMH & Farmer<br>Fredo | Do Co               | <ul> <li>Promote the Eating of Fresh<br/>Fruits and Vegetables</li> <li>PPG and AAPHC work toward</li> </ul>   |
| Promote Healthy Lifestyle through demonstrations and Presentations   | Network of Trust/PPG                               | Do Co<br>Schools    | <ul> <li>no more than 20% of its diabetic patients with a HC1 of 9 or higher</li> <li>Diabetes PQI Indices (mortality, readmit rates) will trand toward 1.0</li> </ul>   |
| Develop a Dedicated Diabetes Specific<br>Care Management Program in the ER<br>to connect patients to Primary care<br>Provider. | PPMH/ER/AAPHC                                      | Dougherty<br>County | <ul> <li>trend toward 1.0.</li> <li>Reduce % of patients with diabetes related conditions without a Primary Care Physician seen in the Emergency Room.</li> <li>Develop a Dedicated Diabetes Specific Care Management Program in the ER to connect patients to Primary care</li> </ul> |
| Prescriptions for Produce Initiative   | PPG/Farmer Fredo                                   | Do Co               | patients to Primary care<br>Provider<br>6  |

### **Priority III: Cancer Prevention & Treatment** (Cervical, Lung, Colorectal, Breast, and Prostate)

| What  | Who  | Where                   | Metric/Intended Outcomes  |
|---|--|-------------------------|---|
| <u>Cervical</u><br>Increase the number of females and<br>males who complete Human<br>Papilloma Virus (HPV) vaccine series<br>in accordance with the National<br>Advisory Committee of Immunization<br>Practices (ACIP) and<br>recommendations | Pediatric Clinics/<br>Public Health/<br>Network of Trust<br>within School System/<br>Phoebe Mobile Units/<br>PPG Primary Care<br>Offices/<br>Peachstate Medicaid/<br>American Cancer<br>Society/ | Primary<br>Service Area | <ul> <li>Meet the 80% HPV target<br/>recommended by the<br/>National Advisory Committee<br/>on Immunization Practices<br/>(ACIP)</li> </ul> |
| Use a Health systems & Policy<br>Approach to target health systems to<br>prioritize HPV vaccinations.   |  | Primary<br>Service Area |   |
| Expand Public awareness campaigns<br>and stakeholder engagement aimed<br>at increasing knowledge and<br>changing perceptions to inform<br>decision making related to HPV  |  | Primary<br>Service Area |   |

### **Priority III: Cancer Prevention & Treatment** (Cervical, Lung, Colorectal, Breast, and Prostate)

| What  | Who  | Where                   | Metric/Intended Outcomes   |
|---|--|-------------------------|--|
| Lung<br>Reduce disparities in screening rates<br>among people, groups & population  |  |                         | <ul> <li>Reduce screening rate<br/>disparities</li> <li>10% gap reduction in lung<br/>screening rates</li> </ul>         |
| Facilitate Initiatives to address low<br>screening rate with a focus of<br>disparate populations  |  |                         | <ul> <li>screening rates</li> <li>2.5% per annum increase in residents appropriately screened for lung cancer</li> </ul> |
| Promote and support direct and in-<br>kind funding for lung cancer<br>screening in low income and<br>uninsured individuals  | Phoebe Cancer<br>Center/<br>American Cancer<br>Society | Primary<br>Service Area |  |
| Increase the number of eligible<br>Georgia residents who are<br>appropriately screened for lung<br>cancer regardless of income, race,<br>insurance, or employment |  |                         |  |
| Create a Lung Cancer and Awareness<br>Campaign  |  |                         | 8  |

## **Priority III: Cancer Prevention & Treatment** (Cervical, Lung, <u>Colorectal</u>, Breast, and Prostate)

| What  | Who   | Where                            | Metric/Intended Outcomes |
|---|---|----------------------------------|--------------------------|
| Colorectal<br>Increase screening and appropriate<br>genetic testing for colorectal cancer<br>in adults at high risk and/or with a<br>family history of colorectal cancer<br>regardless of insurance status.<br>Develop and test communication<br>messages aimed at groups with low<br>screening rates and other high risk<br>groups | Who<br>Phoebe Cancer<br>Center/<br>American Cancer<br>Society/Phoebe<br>Physician Group | Where<br>Primary<br>Service Area | Metric/Intended Outcomes |
| Pursue and support direct and in-kind<br>funding for cancer screening in low<br>income and uninsured individuals.   |   |                                  | 9                        |

#### Priority III: Cancer Prevention & Treatment (Cervical, Lung, Colorectal, <u>Breast</u>, and Prostate)

| What   | Who   | Where                   | Metric/Intended Outcomes  |
|--|---|-------------------------|---|
| Sustain existing community- based breast<br>cancer screening programs that screen at<br>least 60 percent of women from<br>racial/ethnic minority groupsCenter<br>Amer<br>Societ<br>PhysicProvide 200-250 free breast exams to the<br>uninsured.Public<br>PrimaPromote genetic screening to all low-Media | be Cancer<br>r/<br>ican Cancer<br>ty/Phoebe<br>cian Group/<br>c Health/<br>iry Care/<br>caid &<br>Benefit | Primary<br>Service Area | <list-item><list-item><list-item><list-item><list-item></list-item></list-item></list-item></list-item></list-item> |

#### Priority III: Cancer Prevention & Treatment (Cervical, Lung, Colorectal, Breast, and <u>Prostate</u>)

| What  | Who   | Where                   |  |
|---|---|-------------------------|--|
| <u>Prostate Cancer</u><br>Increase the use of population-specific<br>screening                            |   |                         |  |
| Promote approaches that reduce<br>morbidity and mortality from prostate<br>cancer and its treatment       | Phoebe<br>Physician Group/<br>Phoebe Cancer<br>Center/<br>Public Health/<br>Area Churches/<br>Morehouse | Primary<br>Service Area |  |
| Promote the use of informed decision<br>making for the development of<br>appropriate screening approaches | School of<br>Medicine   |                         |  |
| Complete Project Elevate Program  |   |                         |  |

#### **Metric/Intended Outcomes**

- 70% of Male patients report talking to their PCP regarding Prostate Screening approaches.
- Train 20 Community Lay Health Workers
- Facilitate 1,000 men getting a free PSA

#### **Priority IV: Mental Health, Alcohol & Drug Use & Violence Prevention**

| What   | Who   | Where                   | Metric/Intended Outcomes  |
|--|---|-------------------------|---|
| Manage Behavioral Health<br>Medication for school age children           | Phoebe's School<br>Nurse Program  | Dougherty<br>County     | <ul> <li>Safe administration of<br/>behavioral medication</li> </ul>  |
| School Nurse Case Management to school age children(referral)            | Phoebe's School<br>Nurse Program  | Dougherty<br>County     | <ul> <li># Of linked and referred<br/>school age children to the<br/>appropriate behavioral health</li> </ul> |
| Seek National Health Service<br>Corporation Certification                | Phoebe Behavioral<br>Health   | Regional                | <ul> <li># of Narcan delivered to EMT<br/>and Law Enforcement</li> </ul>                                      |
| To create an internal/and or<br>behavioral health<br>workgroup/taskforce | Phoebe Strategy &<br>Planning<br>Department/Phoebe<br>Behavioral Health | Primary<br>Service Area | <ul> <li>Reduce the # of Overdose<br/>Patients into the Emergency<br/>Center</li> </ul>                       |
| Continue Opioid Awareness and<br>Education                               | Network of Trust  | Regional                | <ul> <li>Hired additional Psychiatrists<br/>and LCSW.</li> </ul>  |