

Crisp Regional Hospital

Implementation Strategy

2019

Crisp Regional Hospital

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For FY 2020-2022 Summary

Crisp Regional Hospital is a 73-bed not-for-profit community hospital located in Cordele, Georgia. In 2019, 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 2019 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.

* Social Determinants of Health
* Mental Health
* Lifestyle and Obesity
* Access to Care
* Adolescent Behavior

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 identified health issues 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 \_\_October 30, 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 Community Health Steering Committee.

1. Social Determinants of Health
   1. Poverty is the root cause of many of the access to care issues. There are a lot of residents who struggle with lack of financial means to take care of themselves and their family. More health outreach is needed for individuals who are in poverty.
   2. There is a lack of family support network which is a barrier to an individual’s access to healthcare.
2. Mental Health
   1. There is a lack of mental health facilities such as counseling and treatment facilities.
   2. There is a need for education and awareness on the signs of and symptoms of mental illness.
   3. There is a need for more outreach mental health awareness education for the Senior population.
3. Lifestyle and Obesity
   1. There is a need for education and awareness on the understanding of the risk factors associated with obesity and unhealthy lifestyles.
      1. Education related to lack of physical activity (i.e.: too much screen time).
      2. Education related to nutrition and how to cook healthy.
   2. There is a need for education on personal accountability and taking charge of one’s health.
   3. There is a need for more awareness and education on smoking and alcohol use prevention and cessation.
4. Access to Care
   1. There is a lack of transportation in the community. Residents reported a need for more convenient transportation services during extended service hours.
   2. There is lack of communication and collaboration of available community resources.
   3. There is a need for better continuity care and care coordination for all patients.
   4. There is need for more nursing homes for the growing Senior population.
5. Adolescent Behavior
   1. There is a need for education and awareness of the impact of adverse childhood experiences on community health.
      1. There is a need for parenting outreach on methods for raising a healthy child.
   2. There is a need for more outreach programming to impact the youth such as:
      1. Male role model programs
      2. Vision for future employment programs

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| Community Work Plan for Social Determinants of Health  CHNA Page Reference 89-104 | |
| Health Problem | Outcome Objective (Anticipated Impact) |
| 1. Poverty is the root cause of many of the access to care issues. There are a lot of residents who struggle with lack of financial means to take care of themselves and their family. More health outreach is needed for individuals who are in poverty. 2. There is a lack of family support which is a barrier to an individual’s access to healthcare. | 1. Increase education and awareness of primary care resources and screenings that are free or offered at a reduced cost. 2. Increase access to programs that enhance the family support of an individual. Increase patient family centered care. |
| Background:  The CHNA process identified a need for better access to care for individuals struggling with poverty. There is a need for more health outreach for individuals in poverty that lack transportation and family support. | |
| Implementation Strategy:  a. CRH formed a clinically integrated network and joined the Accountable Care Organization, TC2, to better manage our community’s health and rising healthcare costs. Working with TC2 CRH will be able to reduce hospital admissions by maintaining open slots on the daily office schedules for recently discharged patients, reviewing all ED visits, admissions, and discharges daily, and utilizing the mobile integrated health program for remote consults if needed. Through TC2 local physicians are tracking several quality measures to improve the quality of care given in the local practices. Current quality measures focus on tobacco screenings and cessation intervention, controlling A1c, and controlling high blood pressure in our patients. By focusing on these quality measures CRH will be able to reduce the social determinants of health for our community.  b. Implementing a “**Meds to beds**” **program to** prevent rehospitalization. Pharmacists and pharmacy technicians will hand-deliver prescriptions and education to hospital patients' bedsides before they are discharged, ensuring they leave with medication in hand This program also utilizes the 340B medication program to supply medication for underserved community. | |
| Possible Collaborations:   * TC2 * CIN-Clinically Integrated Network * Crisp Regional Pharmacy * Federal Drug Pricing Program | |

## **Appendix 1**

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| Community Work Plan for Mental Health  CHNA Page Reference 98, 107-108 | |
| Health Problem | Outcome Objective (Anticipated Impact) |
| 1. There is a lack of mental health facilities such as counseling and treatment facilities. 2. There is a need for education and awareness on the signs of and symptoms of mental illness. 3. There is a need for more outreach mental health awareness education for the Senior population. | 1. Increase access to local mental health and counseling and treatment facilities. 2. Increase knowledge and awareness of the warning signs and symptoms of mental and behavioral illness. 3. Increase Seniors’ education and awareness of mental health warning signs and symptoms. |
| Background:  The CHNA process identified lack of general awareness and knowledge of mental and behavioral health signs and symptoms. There is also a lack of local resources for mental and behavioral health. The Senior population was identified as underserved population that needed more outreach education on mental and behavioral health warning signs and symptoms. | |
| Implementation Strategy:  a.Crisp Regional will convene a community collaborative of stakeholders and professionals in mental and behavioral health to examine resources, define gaps and craft solutions for improved stabilization of patients.  b.Crisp Regional will continue to provide various behavioral health support groups and camps such as Camp Sunshine.  c. Expand telemedicine in our Emergency Department with hospital based TelePsych Program. This program aims at finding the most appropriate and least restrictive level of care for every consumer presenting in crisis. The goals of this hospital services include: Lower inappropriate admissions and reduce length of stays.  d. Crisp Regional will collaborate with New Hope Behavioral Clinic of Cordele for continuum of care for patients. Services include: behavioral health assessments and treatments, individual group and family counseling, psychological testing, substance abuse counseling, crisis intervention, and community support services. | |
| Possible Collaborations:   * Crisp County High school * Crisp County Community Council * Reflections Hospice * New Hope Behavioral Clinic of Cordele | |

## **Appendix 2**

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| Community Work Plan for Lifestyle and Obesity  CHNA Page Reference 54-59 | |
| Health Problem | Outcome Objective (Anticipated Impact) |
| 1. There is a need for education and awareness on the understanding of the risk factors associated with obesity and unhealthy lifestyles.    1. Education related to lack of physical activity (i.e.: too much screen time).    2. Education related to nutrition and how to cook healthy. 2. There is a need for education on personal accountability and taking charge of one’s health. 3. There is a need for more awareness and education on smoking and alcohol use prevention and cessation. | 1. Increase knowledge and awareness on the risk factors associated with obesity like lack of physical activity and education on how to cook healthy. 2. In Increase awareness on the need for personal accountability and taking charge of one’s health. 3. Increase knowledge and awareness of smoking and alcohol use prevention. |
| Background:  The CHNA process identified lifestyle and obesity as a health issue that needs to be addressed. Thirty-three percent of Crisp County residents were reported to be obese. Lifestyle and obesity issues were reported in all population groups. Other lifestyle issues like smoking and alcohol use were reported as an issue. | |
| Implementation Strategy:  a. Crisp Regional will produce a monthly email newsletter which features articles on healthy living as well as healthy recipes in each newsletter. We also offer gym memberships at a discounted rate and nutritional counseling to employees. 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.  f. Crisp Regional will provide nutritional health fairs for teachers and students at the local school. Also | |
| Possible Collaborations:   * Crisp County High School * Run for Your Lungs * Cancer Coalition * Camp Sunshine * Crisp Regional Dietician | |

## **Appendix 3**

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| **Community Work Plan for Access to Care**  **CHNA Page Reference 89-104** | |
| **Health Problem** | **Outcome Objective (Anticipated Impact)** |
| 1. **There is a lack of transportation in the community. Residents reported a need for more convenient transportation services during extended service hours.** 2. **There is lack of communication and collaboration of available community resources.** 3. **There is a need for better continuity care and care coordination for all patients.** 4. **There is need for more nursing homes for the growing Senior population.** | 1. **Increase knowledge and awareness of available transportation services and hours of availability.** 2. **Increase knowledge and awareness of available community resources.** 3. **Increase the continuity of care for patients in-between different clinics, hospitals, and home care.** 4. **Increase awareness of the nursing home bed shortage and identify any plans available to increase number of beds in the area. Increase the awareness of available nursing home care in the local area.** |
| **Background:**  **The CHNA process identified a need for various physical resources such as transportation and nursing homes. Continuity of care was reported as a concern among patients receiving care in multiple settings. Overall, a lack of communication and collaboration of available resources could help solve a lot of access to care issues.** | |
| **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.  d. 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.  e. 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.  f. The eICU will allow Crisp Regional Hospital to increase access to care for critically ill patients while allowing them to receive the care they need in their community, and reduce costs for patient families that are required to travel when their loved ones are transferred for care. A shortage of intensivist physicians in rural areas can negatively impact patient outcomes, putting critically ill patients at increased risk for death and complications. These complications result in longer hospital stays, higher mortality rates, higher costs of care, and more frequent transfers to tertiary hospitals for specialized care. The implementation of eICU has proven to positively impact each of the mentioned complications. | |
| **Possible Collaborations:**   * Phoebe Putney * CRH Auxiliary * Crisp County EMS * Albany Primary Healthcare * Emory Healthcare | |

## **Appendix 4**

## **Appendix 5**

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| Community Work Plan for Adolescent Behavior  CHNA Page Reference – 64 and 72-81 | |
| Health Problem | Outcome Objective (Anticipated Impact) |
| 1. There is a need for education and awareness of the impact of adverse childhood experiences on community health.    1. There is a need for parenting outreach on methods for raising a healthy child. 2. There is a need for more outreach programming to impact the youth such as: 3. Male role model programs 4. Vision for future employment programs | 1. Increase awareness of adverse childhood experiences overall impact. Increase parenting outreach and education on methods for raising a healthy child. 2. Increase outreach programming for youth that focuses on male role model programs and future employment opportunities. |
| Background:  The community identified a lack of parenting skills and the need for education on raising children and providing parental oversight. The need for role models was emphasized. | |
| Implementation Strategy:  a. Crisp Regional will collaborate with Crisp County high school to participate in Teen Maze. Teen maze is an experiential learning event that delivers powerful information to middle and high school students, which helps teens understand life choices, consequences of those choices, and how to become better decision makers.  Teen Maze is a fun, creative, and interactive event which effectively demonstrates the various possible consequences of teen choices.  b. Crisp Regional will continue to partner with Crisp County High School to offer a Work Based Learning Program (WBL) for those students interested in the profession of Sports Medicine -Athletic Training and healthcare careers. Students are able to gain hands-on experience while gaining work experience with Crisp Regional Health Services and Certified Athletic Trainer (ATC).  From learning prevention of injuries, first aid, skill and leadership development, therapeutic modality treatments, and rehabilitation, students gain hand-on experience while being educated and mentored by CRH employees.For students interested in the health sector, work based learning plays a critical role in exposing students to the wide variety of jobs available in the healthcare sector. **The mission of the Work-Based Learning Program is to assist in providing a highly trained, technologically sophisticated and career oriented young work force.  This program is**  uniquely positioned to expand the “pipeline” to recruit, attract, engage and retain qualified young people (of all ages) to help resolve the critical health care shortage facing this nation | |
| Possible Collaborations:   * Crisp County High school (WBL Program) * Crisp County Community Council | |