

Implementation Plan (2013-2015)
Selected Priorities from 2012 Community Health Needs Assessment

Implementation Plan
2013 - 2015



Selected Priorities
From 2012

Community
Health Needs
Assessment

The Medical Center
of Central Georgia
mccg.org

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The Medical Center of Central Georgia (MCCG) located in Macon, Georgia is a not-for-profit, 637 bed, acute care, tertiary, regional and academic medical center serving Central Georgia (Macon/Bibb County and 28 surrounding counties). MCCG, a part of Central Georgia Health System, is the second largest hospital in Georgia, the only designated Level I Trauma Center in the region and is one of 42 twice designated Magnet® hospitals for nursing excellence nationwide. MCCG is accredited by the Joint Commission and was selected as one of the best regional hospitals in the Coastal Plains region for 2013-2014 by U.S. News and World Report—one of only two hospitals selected in Georgia.

The mission of MCCG is to enhance the health status of our community in partnership with our medical staff, our employees and community organizations. As such, our mission extends beyond our facilities and direct services to encompass the well-being of the communities we serve. The evolving and changing face of healthcare and meeting the healthcare needs of the people we serve require partners with joint destinies. MCCG is an organization dedicated to understanding the needs of our community and working cooperatively with others to meet these needs.

In order to know and understand how our community can become a better place for all residents to live, work and play, the health needs of our communities must be assessed. There is no better way to do that than to ask our residents. MCCG conducted its community health needs assessment in 2012 to determine the health status, behaviors and needs of residents in Bibb, Houston, Peach, Jones, Twiggs, Crawford and Monroe Counties—the primary service area for MCCG with more than 70% of admissions to MCCG originating from this seven-county area. The Community Health Needs Assessment (CHNA) was completed through a random health survey of residents in these counties, by convening key community leaders and consulting existing data sources.

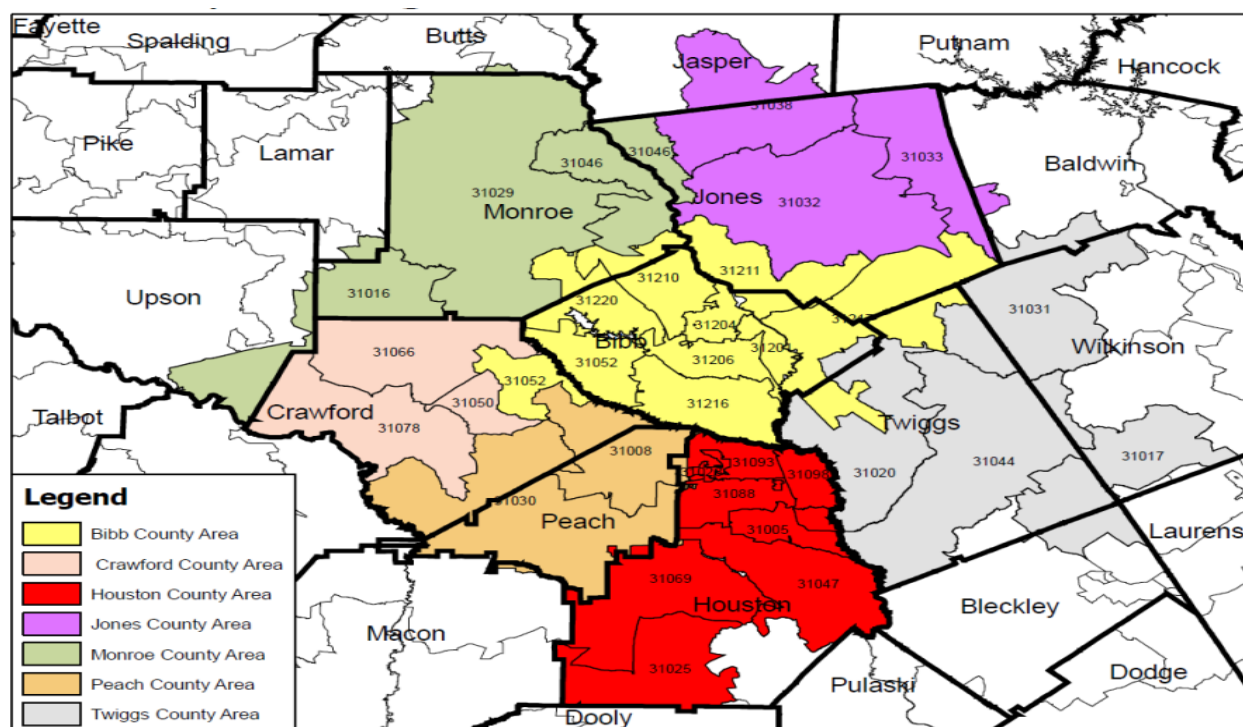
Definition of the Community Served

The Medical Center of Central Georgia's community, as defined for the purposes of the Community Health Needs Assessment, included each of the residential ZIP codes associated with Bibb, Houston, Peach, Jones, Twiggs, Monroe and Crawford Counties in Georgia which comprise the hospital's primary service area (PSA). These zip codes are:

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Counties	Zip Codes
Bibb	31201 31202 31203 31204 31205 31210 31211 31212 31213 31294 31295 31206 31207 31208 31209 31216 31217 31220 31221 31296 31297
Crawford	31050 31066 31078
Houston	31005 31028 31013 31025 31047 31069 31088 31093 31095 31099 31098
Jones	31032 31033
Monroe	31004 31029 31086 31016 31046
Peach	31008 31033
Twiggs	31017 31020 31044



In reporting summary results of the community health needs assessment, Jones, Twiggs, Monroe and Crawford county findings were grouped into a single combined area.

The population of this seven-county primary service area in 2012 is estimated to be 406,461 persons. The percentage of the total population in this seven-county area 65 years of age and older is growing, as is the trend nationwide, averaging 12% in the two most populous counties in our primary service area (Bibb and Houston) and 16% in the least populous counties (Twiggs and Crawford). The average median household income for this seven-county area is \$42,915.00 with two counties having an average median household income greater than the State, \$55,738.00 in Houston County and \$51,265.00 in Jones County. From 2010 census data, the area is 52% female and 48% male and the population by race in the two most populous counties range from 28% Black, 62%

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White in Houston County to 52% Black and 42% White in Bibb County. Approximately 19% of the residents in this seven-county primary service area have no healthcare insurance.

Residents of this primary care service area are served by several healthcare facilities in this region including the Medical Center of Central Georgia. There are also other resources available within the community to respond to the health needs of the residents. These resources and facilities include:

Acute-Care Hospitals/Emergency Rooms

- Medical Center of Central Georgia
- Medical Center of Peach County (Critical Access Hospital)
- Central Georgia Rehabilitation Hospital
- HCA Coliseum Medical Centers
- Houston Medical Centers
- Monroe County Hospital (Critical Access Hospital)

Federally Qualified Health Centers and Other Safety Net Providers

- First Choice Primary Care (FQHC)
- Macon Volunteer Clinic (services for the employed, uninsured and underinsured residents of Bibb County)
- Daybreak Onsite Primary Care Clinic (clinic for persons who are homeless)

Home Health Care

Hospice Care

Skilled Nursing Facilities (Nursing Homes)

Rehab Services

Emergency Medical Services

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Mental Health Services/Facilities

Public Health Services

Other Community Based Resources

Community Health Needs Assessment

A Community Health Needs Assessment provides the information needed for communities to identify issues of greatest concern to its residents and to assist in informing decisions about resource allocation and commitment in those areas of need that would have the greatest possible impact on community health status. This information also helps to guide the collaborative efforts of community partners dedicated to improving community health and wellness.

The 2012 Community Health Needs Assessment serves as a tool toward achievement of three basic goals for the health of residents in the defined community:

To improve residents' health status, increase their life spans and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

To reduce health disparities among residents. Demographic information along with health status and behavior data makes possible the identification of population segments who are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals are developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from lack of preventive care.

The Community Health Needs Assessment was conducted on behalf of the Medical Center of Central Georgia by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United

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States since 1994. Content in this document describing methodology used to conduct the Community Health Needs Assessment (CHNA), goals of the CHNA, sample approach and design and stakeholder input through focus groups is taken directly from information provided by Professional Research Consultants (PRC), Inc.

Community Health Needs Assessment – Methodology

The assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey and research gathered through a series of Key Informant Focus Groups) and secondary research (vital statistics and other existing health-related data). Quantitative components allow for comparison to benchmark data at the state and national levels, where available.

Five Key Informant Focus Groups comprised of 34 community stakeholders:
• <i>Physicians & other health providers</i>
• <i>Social services & other community leaders</i>
• <i>Geographically focused — Bibb County vs. regional needs</i>

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control (CDC) Prevention and Behavioral Risk Factor Surveillance System (BRFSS) as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by PRC, with input from The Medical Center of Central Georgia.

Sample Approach and Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology—one that incorporates both landline and cell phone interviews—was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

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The sample design used for this effort consisted of a stratified random sample of 1,000 individuals age 18 and older in the total Primary Service Area, 300 in Bibb County, 300 in Houston County, 200 in Peach County and 200 in the combined area of Jones, Twiggs, Monroe and Crawford Counties. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Area as a whole. All administration of the surveys data collection and data analysis was conducted by Professional Research Consultants, Inc.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Community Stakeholder Input

As part of the community health assessment, there were five focus groups conducted in the region. Participants included 34 key informants in the region, including physicians, other health professionals, social service providers, business leaders and other community leaders.

Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions. Specific names/titles of those participating are available upon request.

Information Gaps

While this Community Health Needs Assessment was quite comprehensive, MCCG and PRC recognized that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community health's needs.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are medical conditions that are not specifically addressed.

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Vulnerable Populations

The Community Health Needs Assessment analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative research (survey) is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

Public Dissemination

This Community Health Needs Assessment is available to the public using the following URL- <http://maconregion.healthforecast.net/>. MCCG will also maintain at its facilities a hardcopy of the CHNA that may be viewed by any who request it.

Areas of Opportunity for Community Health Improvement

The following “health priorities” represent recommended areas of intervention, based on the information gathered through the Community Health Needs Assessment and guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see Table on following page).

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Central Georgia Region: Areas of Opportunity Identified Through This Assessment	
Access to Health Services	<ul style="list-style-type: none"> • Insurance Instability • Supplemental Coverage (65+) • Cost as a Barrier to Prescriptions/Doctor Visits • Prescription Misuse • Difficulty Obtaining Child's Healthcare • Having a Medical Home (Source of Care) • Use of the Emergency Room
Arthritis, Osteoporosis & Chronic Back Problems	<ul style="list-style-type: none"> • Prevention of Arthritis (50+) • Prevalence of Chronic Neck Pain • Activity Limitations
Cancer	<ul style="list-style-type: none"> • Lung Cancer Deaths • Prostate Cancer Deaths • Colorectal Cancer Deaths
Chronic Kidney Disease	<ul style="list-style-type: none"> • Kidney Disease Deaths
Diabetes	<ul style="list-style-type: none"> • Prevalence of Diabetes
Heart Disease & Stroke	<ul style="list-style-type: none"> • Heart Disease & Stroke Deaths • Prevalence of Stroke • Hypertension & High Cholesterol • Cardiovascular Risk Factors
Injury & Violence Prevention	<ul style="list-style-type: none"> • Accidental Deaths (Including Motor Vehicle Crashes) • Firearm-Related Deaths • Homicide Rate • Firearms in the Home (Including Homes w/children) • Unlocked & Loaded Firearms
Maternal, Infant & Child Health	<ul style="list-style-type: none"> • Low Birthweight • Infant Mortality
Mental Health & Mental Disorders	<ul style="list-style-type: none"> • Suicide Rate • Persons w/Depression Seeking Help
Nutrition, Physical Activity & Weight Status	<ul style="list-style-type: none"> • Prevalence of Obesity • Fruit & Vegetable Consumption • Lack of Leisure-Time Activity • Meeting Physical Activity Guidelines • Vigorous Physical Activity • Screen Time (Children 5 – 17)
Oral Health	<ul style="list-style-type: none"> • Dental Visits
Sexually Transmitted Diseases	<ul style="list-style-type: none"> • Gonorrhea & Chlamydia Incidence • Hepatitis B Incidence • Multiple Sexual Partners
Tobacco Use	<ul style="list-style-type: none"> • Current Smokers • Secondhand Smoke in the Home (Including Homes w/Children) • Use of Smokeless Tobacco • Prevalence of Chronic Lung Disease

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After reviewing the Community Health Needs Assessment findings, the MCCG Community Health Needs Assessment Team with input from United Way of Central Georgia-Community Services Division, Crisis Line, Trauma Services Network and the governing members of MCCG and The Medical Center of Peach County Boards determined the needs to be prioritized for implementation FY 2012-FY2014. The following criteria were established and used in the prioritization process:

Impact/Seriousness: The degree to which the issue affects or exacerbates other quality of life and health related issues and the opportunities to improve risk factors affecting quality of life.

Collaboration: The opportunities to work and partner with other community resources addressing like or similar issues to leverage resource utilization and enhance the number of persons served.

Feasibility: The ability to reasonably impact the issue, given available resources.

Outcomes: The ability to measure impact and determine results of interventional measures.

Community Partnerships - Working Together for Community Benefit

The Medical Center of Central Georgia (MCCG) has been a committed and involved community partner in Community Health Action Councils and Coalitions, Community Health Summits and Health Task Forces focused on planning for and improving the health of the residents in this community.

Collaborating and partnering with churches, retirement centers, colleges and universities, health care facilities, primary and secondary schools, businesses, voluntary health agencies, city and county governmental entities and public health organizations continues to be central and critical to achieving the mission of MCCG which is "to enhance the health status of our community in partnership with our medical staff, our employees and *community organizations*".

The areas of opportunity identified through the Community Health Needs Assessment (CHNA) and prioritized for implementation used as one of its key criteria, collaboration-- opportunities to partner with other community resources addressing same or similar issues. Leveraging the collective resources in a community and aligning like or complimentary goals for improving the health of the community extend the breadth and depth of the services that can be delivered, the number of persons reached and outcomes realized. There are several key partnerships actively addressing other areas of

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opportunity identified through the CHNA. It is important to note that prioritization considered the extensive work already being done in these areas by MCCG and others in the community.

MCCG and The Medical Center of Peach County are active participants and regional partners with Health Care Central Georgia dba Community Health Works (CHW). CHW is a multi-sector, non-profit organization in Central Georgia committed to improving the health of residents and bolstering the capacity of the local health care community to serve the needs of central Georgia's uninsured and medically underserved residents. CHW includes many regional partners dedicated to educating communities in this region about prevention of chronic disease and healthy lifestyle behaviors.

The Cancer Life Center works very closely with CHW, the local partner for the Georgia Cancer Coalition. In addition, CHW organized the Central Georgia Stroke Coalition in 2010 in which MCCG is integrally involved. The Central Georgia Stroke Coalition has representatives from thirteen counties working together to coordinate health resources and services across the stroke care continuum—from prevention to acute to rehabilitation to sub-acute care.

The Cancer Life Center partners extensively with the Bibb County American Cancer Society (ACS) for community education, patient navigation, prevention and screening activities. In 2012, the Cancer Life Center was the recipient of a Health Equities Grant from the ACS for colorectal cancer education and screening in the Bibb County African American Community. Quarterly events were scheduled in four large African American churches with the assistance of a local legislator interested in public health and educating this targeted demographic about colorectal cancer, nutrition, genetics and financial resources available. ACS has funded a cancer resource navigator based on demographics of the underserved population of this region.

The Cancer WellFit project has numerous community partners including ACS, Susan G. Komen Breast Cancer Foundation, Medcen Community Health Foundation, H.E.A.T. (Hospital Employees Achieving Tomorrow), Elkin Foundation, MCCG Retirees and Auxiliary and Tobacco Use and Prevention Program making it possible to provide this exercise, education and support program to oncology patients at no cost to any Central Georgia citizen diagnosed with cancer.

Community Health Works funds a van to provide transportation for chemotherapy patients who do not have their own transportation resources. The Burke Foundation, a private foundation, has provided grant monies for the third year to improve lung cancer care at MCCG; has funded a dedicated lung nurse navigator and is expanding support

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this year to include lung cancer screening CT scans to qualified patients for the purpose of identifying lung cancer when it is hopefully treatable.

MCCG is actively participating in a community collaborative focused on improving primary care services to the homeless at an onsite clinic based in a day shelter for the homeless, Daybreak. This collaborative is also working to establish a community based clinic for persons with Hepatitis C.

MCCG supports the services being provided at the Macon Volunteer Clinic which serves the working uninsured who are residents of Bibb County and also partners with the only Federally Qualified Health Center in Bibb County, First Choice Primary Care.

MCCG has partnered with Macon/Bibb County Parks and Recreation on an exercise and fitness initiative to make a local park more "exercise friendly." The goal was to increase access to benches and to provide a water fountain for community residents who want to increase their exercise in Tattnall Park and need opportunities to rest and hydrate in intervals.

CHW is one of many community partners addressing the prevention of childhood obesity. Childhood obesity increases the incidence and prevalence of chronic diseases and overall decreases quality of life and enjoyment of those activities that enhance wellness and well-being.

The American Heart Association and MCCG are key partners in educating the community about risk factors for heart disease, conducting risk assessments, high blood pressure screenings, cholesterol and glucose testing.

Educating the community on car seat safety and performing car seat safety is an activity in which MCCG (through The Children's Hospital and The Wellness Center) is involved every year in collaboration with the Kohl's Kid Safety Zone, Middle Georgia Traffic Enforcement Network, the Governor's Office of Highway Safety and the Georgia Traffic Injury Prevention Institute. Car seats are given to families who qualify.

These are a few examples of the MCCG collaborative partnerships and relationships in the Central Georgia region dedicated to improving the health of the community.

Priority Health Issues Selected from 2012 Community Health Needs Assessment

There was a wide range of priority health issues identified from the Community Health Needs Assessment and the challenge remains in resourcing all of them. The priorities

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selected involve longer term interventions and support to improve the quality of life and health outcomes of persons with these needs and to address changing lifestyle behaviors for those at risk that will prevent these health problems and issues from occurring. The capability to measure the outcomes of these interventions was also a determining factor in prioritization as was the opportunity to work with other community partners also addressing these health care issues.

Diabetes /Nutrition/Physical Fitness/Access to Health Care Services– Adults - The prevalence of diabetes in our primary service area is 15.6% as compared to the prevalence in Georgia of 9.7% and in the United States of 10.1%. Bibb and Peach Counties have the highest prevalence, 17.0 and 17.3% respectively. Adults with diabetes have strokes and fatal heart attacks two to four times as often as people who do not have diabetes and diabetes is a leading cause of kidney failure and blindness. The age-adjusted death rate in this seven-county area for stroke is 53.6 per 100,000 population compared to 49.4 for Georgia and 42.2 for the US. The age adjusted death rate for kidney disease in the total primary care service area is 28.6 per 100,000 population as compared to 21.2 for Georgia and 14.6 for the US. Obesity is a significant risk factor for type 2 diabetes. Our focus will be to increase awareness in the general community about diabetes and how healthy lifestyle behaviors such as eating for good health and exercising will reduce risk. Collaborating with other health care providers serving persons with diabetes and those at risk for diabetes by offering nutrition classes, exercise programs and diabetes education will also be a focus. The year-long Diabetes Prevention programs will be held in Bibb and Peach Counties to improve access and to reduce or eliminate transportation to this service/program as a barrier. Patients with diabetes will be referred to Central Georgia Home Health for continued follow-up and support for disease management. Home health will also participate in the community education and outreach programs on diabetes.

Healthy Eating and Physical Fitness Camp and Weight Loss/Maintenance Program for Children – In partnership with The Wellness Center, and Dr. Farah Khatoon and Dr. Tarek Bisat, pediatric endocrinologists, a 12 month program which includes an intensive nutrition and fitness camp will be held for 20-30 children who fall in the category of 91st-95th percentile in weight for their age group. The program will target children 8-11 years of age. The percentage of children ages 5-17 who spent more than 3 hours per day watching television and using computers (screen time) was 61.4% as compared to 43.4% for the US. Also, more than 25% of children in this age group are overweight.

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Tobacco Use/ Chronic Obstructive Pulmonary Disease/Access to Health Care Services

The prevalence of tobacco use (% of current smokers) is 23.2 % in our PSA compared to 17.6% for Georgia and 16.6% for the US. Cigarette smoking is the most common cause of COPD and quitting smoking is the best way to avoid developing COPD. Community education programs about COPD and risk factors such as tobacco use will be offered in counties throughout the primary service area. A COPD Disease Management Program will also be offered for patients diagnosed with COPD who are smokers and have chosen to quit to improve their health and well-being. Participants will be chosen from patients readmitted with COPD exacerbations identified through MCCG Pulmonary Rehab and Respiratory Service Staff and must be MD referred. The program will be facilitated by Heartworks staff. COPD patients will be referred to Central Georgia Home Health for home monitoring and continued follow-up and management. Central Georgia Home Health will be involved in the community education programs on Chronic Obstructive Pulmonary disease and risk factors for COPD.

Injury and Violence Prevention—The percent of homes with firearms/weapons that are unlocked and loaded in this seven-county primary service area is 31.1% compared to 16.9% in the US. The age-adjusted death rate from firearms is 15.8 compared to 12.6 in Georgia and 10.2 in the US. Nearly 50% (49.1%) of homes with children have a firearm in the home. The focus will be to increase awareness of injuries and deaths associated with firearms, firearm safety and violence prevention. Participants knowledge of information shared will be assessed.

Physical Activity and Weight Status – In support of the community's rebuilding of Tatnall Square Park which includes adding bicycle and walking/running trails, MCCG will install a water fountain (drinking fountain) for people exercising.

Priority Health Issues to be Addressed

In consideration of the top health priorities identified through the Community Health Needs Assessment process and in overall alignment with the hospitals' mission, goals and strategic priorities, it was determined that the Medical Center of Central Georgia would focus on developing, supporting and collaborating on strategies and initiatives to improve:

- Access to Health Care Services
- Adult Diabetes

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- Physical Activity, Nutrition and Weight Loss in Children
- Tobacco Cessation in Persons with Chronic Obstructive Pulmonary Disease
- Injury and Violence Prevention

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DIABETES EDUCATION/ACCESS TO HEALTH CARE SERVICES/NUTRITION, PHYSICAL ACTIVITY and WEIGHT STATUS	
Community Partners/Planned Collaboration	<ul style="list-style-type: none"> • Macon Volunteer Clinic (free clinic for uninsured and underinsured employed residents of Bibb County) • First Choice Primary Care (a federal qualified health care center) • Medical Center of Peach County- Dr. Guruwaj Nayak, Dr. Michael Early, Dr. Crystal Brown and Dr. Cynthia Giles- Primary Care Physician Practices • Diabetes Healthways • The Wellness Center • Central Georgia Home Health
Goal	<p>Improve the health status of 1) selected adult patients (18 years of age and older) who are diabetic and have a Hgb (hemoglobin) A1C above 9.0 and BMI scores ≥ 24 kg/m² (≥ 22 kg/m² if Asian) and 2) selected adult patients (18 years of age and older) with a HgBA1c of 5.7 to 6.4 and BMI scores ≥ 24 kg/m² (≥ 22 kg/m² if Asian) who are pre-diabetic. Fifty percent (50%) of each core class will be patients who are pre-diabetic. The focus of the program to improve the A1c of patients who are prediabetic and to reduce the hemoglobin A1c of patients with an A1c >than 9.0.</p> <p>Increase awareness of diabetes and diabetes risk factors to the general community in each of the seven counties of the primary care service area (Bibb, Houston, Jones, Twiggs, Peach, Monroe and Crawford Counties).</p>
FY2013-FY2015	
Scope	<p>This strategy will focus on selected patients from Macon Volunteer Clinic, First Choice Primary Care and primary care practices in Peach County with HgbA1C levels above 9.0 and 5.7-6.4(prediabetic) who have BMI scores ≥ 24 kg/m² (≥ 22 kg/m² if Asian). Due to the significantly higher prevalence of diabetes in the Black population, 20.4% compared to 13.4% for White, and 7.6% other and a rate twice that of the US (10.1%), a minimum of 50% of the patients selected will be from this demographic. In addition, the rate of diabetes precipitously increases with age, 2.5% ages, 18-39, 21.8% ages 40-64 and 31% in persons greater than 65 years of age. Persons who are low income are also represented at a greater percentage than mid/high income individuals.</p> <p>The Diabetes Prevention Program, research study through Emory University and supported by the National Institutes of Health will be provided and administered through a lifestyle coach. Certified Diabetes Educators through Diabetes Healthways will participate in the instruction. Annually, 16 patients will be selected from MVC, 16 from First Choice and 16 from Peach County. Over 3 years, 144 patients will participate in this program.</p> <p>Diabetic patients will be referred to Central Georgia Home Health for continued monitoring and disease management support.</p>
Strategies & Objectives	<p>Strategy #1: Provide Diabetes Education, Weight Status, Nutrition Education and Physical Activity.</p> <ul style="list-style-type: none"> • Identify participating patients using established criteria • Patients will be referred by Medical Directors at both MVC, First Choice and by Dr. Nayak, Dr. Giles, Dr. Early and Dr. Brown in Peach County • Offer Emory University Lifestyle Diabetes Coaching Program <p>Strategy #2:</p> <ul style="list-style-type: none"> • Fitness Instructors will offer exercise instruction and guided walking sessions • Incentives will be offered to those who wish to join the Wellness Center <p>Strategy #3:</p> <ul style="list-style-type: none"> • Provide education on diabetes and risk factors for diabetes to community –at-large throughout primary care service area • Central Georgia Home Health and Diabetes Healthways will be involved in community education about diabetes and diabetes risk factors <p>Strategy #4:</p> <ul style="list-style-type: none"> • Refer all patients with diabetes to Central Georgia Home Health for continued monitoring and disease management support

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	Item	Cost	Year 1	Year 2	Year 3	Total
Financial Commitment	Diabetes Disease Management Program (48 patients per year)	\$245 per patient	\$11,760.00	\$11,760.00	\$11,760.00	\$35, 280.00
	Travel to Peach County (16 cores sessions and 8 monthly sessions)	\$30 per session	\$720.00	\$720.00	\$720.00	\$2160.00
	Education/Awareness program for primary service area (7 sessions per year)	\$100 per session	\$700.00	\$700.00	\$700.00	\$2100.00
	Total		\$13, 180.00	\$13, 180.00	\$13, 180.00	\$39, 540.00
Anticipated Impact	<ul style="list-style-type: none"> • Improve HgbA1C scores of > than 50 % of selected patients • Improve BMI scores of selected patients to less than 22 • Reduce Emergency Room/Urgent Care Center visits of selected patients • Improve quality of life as reported by participants • Increase community knowledge about Diabetes and Diabetes Prevention • Increase referrals to Central Georgia Home Health. 					
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Evaluate HgbA1C of selected participating patients at 3 month intervals. • Evaluate BMI of selected patients at 3 months intervals. • Evaluate appropriate ED utilization of patients enrolled in the Diabetes Prevention Program at all sites. • Evaluate conversion referrals to admissions for home health. 					
Results	<p>This program was suspended by the Assistant Vice President. There was great difficulty in engaging patients to meet the criteria to participate. Community seminars were also suspended by Assistant Vice Presidents due to lack of and/or extremely low attendance.</p>					

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TOBACCO USE/ACCESS TO HEALTH CARE SERVICES/NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT STATUS	
Community Partners/ Planned Collaboration	<ul style="list-style-type: none"> • COPD Disease Management Program • Wellness Center • Respiratory Services –MCCG • Central Georgia Home Health
Goal	<p>Improve healthcare outcomes for patients who are diagnosed with COPD and are smokers. The focus of this program is to provide access to a smoking cessation program by providing 12 week exercise/education program services to patients diagnosed with COPD, who smoke, and do not meet the traditional criteria Pulmonary Rehabilitation within 1 year.</p> <p>Increase awareness of COPD and risk factors to the general community in each of the seven counties of the primary care service area (Bibb, Houston, Jones, Twiggs, Peach, Monroe and Crawford Counties).</p>
Timeframe	FY2013 - FY2015
Scope	<p>This strategy will focus on selected Medical Center of Central Georgia patients with COPD who are smokers, newly diagnosed with COPD, and patients who have been readmitted for COPD exacerbations. These patients will be identified through our Pulmonary Rehab and Respiratory Therapy staff. A 12 week exercise/education program designed for the COPD with no insurance or insurance that does not cover patient's participation in a COPD management program. The COPD Disease Management Program includes a smoking cessation program. Two boxes of nicotine patches will also be provided to assist the patient in this behavior change. The 12 week program would be followed by a maintenance program which would include but is not limited to case management phone calls, follow-up visits and support group programming for an additional nine (9) months. The total program consists of a year and is MD referred and facilitated at Heartworks. COPD patients will be referred to Central Georgia Home Health.</p>
Strategies & Objectives	<p>Strategy #1: Provide a 12-week Exercise/Education Program designed for the COPD patient who smokes</p> <ul style="list-style-type: none"> • Identify 50 patients diagnosed with COPD that have been in Emergency Department (ED) the last 12 months or are newly diagnosed (for preventable avoidable future admissions) • Identify the patients that are currently inpatients diagnosed with COPD and are smokers through physician referral and/or consultations by respiratory services prior to discharge • Ascertain patient's commitment to program participation prior to initial schedule appointment <p>Strategy #2: Provide a smoking cessation program</p> <ul style="list-style-type: none"> • Provide two boxes of 28 nicotine patches- one will be provided the first night of class and the other, the final night of class <p>Strategy #3: Provide a maintenance program after Smoking Cessation/Exercise/Education program</p> <ul style="list-style-type: none"> • Provide case management follow-up phone calls, follow-up visits and support group for one year to determine compliance with smoking cessation/exercise • Provide home health monitoring and disease management support to COPD patients <p>Strategy #4: Provide Education on COPD, tobacco use and risk factors to the community at large throughout the primary care service</p> <ul style="list-style-type: none"> • Provide one annual education session in each of the seven counties of the primary service area (Central Georgia Home Health will be involved in community education about COPD)

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

	Item	Cost	Year 1	Year 2	Year 3	Total
Financial Commitment	COPD Disease Management Program (50 patients per year)	\$200 per patient	\$10,000.00	\$10,000.00	\$10,000.00	\$30, 000.00
	Nicotine Patches (2 boxes per patient)	\$46 per patient	\$2300.00	\$2300.00	\$2300.00	\$6900.00
	Transportation (25 patients per year)	\$30 per patient	\$750.00	\$750.00	\$750.00	\$2250.00
	Education/Awareness program for primary service area	\$100 per session	\$700.00	\$700.00	\$700.00	\$2100.00
	Total		\$13, 750.00	\$13, 750.00	\$13, 750.00	\$41, 250.00
Anticipated Impact	<ul style="list-style-type: none"> • Patients will not smoke after the completion of the program. • Patients participating in the COPD Disease Management Program will have a readmission rate less than state average for COPD Readmission. Reduce readmission for at risk patients to the hospital unscheduled physician visits including emergency room and/or urgent care related to non-compliance. 					
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Track the number of patients that stopped smoking and remained smokeless at the end of the year. <ul style="list-style-type: none"> ○ Fifty percent (50%) of patients at the end of the first year. ○ Forty percent (40%) of the patients at the end of the second year. • Track if the patient report that their quality of life improved. • Track trends of the identified patients for ED utilization and hospital re-admission. <ul style="list-style-type: none"> ○ Hospital readmission for patients in this program less than 16%. • Track use of post-acute services to assist patients with disease management. 					
Results	<p>Ongoing. Continuous programs, each one 12 weeks in length.</p> <ul style="list-style-type: none"> • Partially Accomplished: FY 2014 -2015: <p>10 participants:</p> <ul style="list-style-type: none"> • 54% showed improvement in functional lung capacity. • 17% showed improvement in blood pressure results. • 13% showed improvement in quality of life scores. • 33.33% quit smoking. 					

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

CHILD HEALTH/ACCESS TO HEALTH SERVICES/NUTRITION, PHYSICAL ACTIVITY and WEIGHT STATUS																																																
Community Partners/ Planned Collaboration		<ul style="list-style-type: none">• Children’s Hospital• Wellness Center• Health Services of Central Georgia (Dr. Farah Khatoon and Dr. Tarek Bisat)																																														
Goal		<p>Improve healthcare outcomes for patients 8-11 years of age who fall in the category of 91st to 95th percentile in weight for their age group. The program will target the age group of 8 to 11 years of age because this age group is more malleable in terms of future change actions and reasoning.</p> <p>Increase awareness of childhood obesity and risk factors associated with being overweight/obese.</p>																																														
Timeframe		FY2013 - FY2015																																														
Scope		<p>This strategy will focus on selected at-risk Health Services of Central Georgia patients who are ages 8-11 years old and fall in the category of 91st to 95th percentile in weight for their age group in the primary care service area (Bibb, Houston, Jones, Twiggs, Peach, Monroe and Crawford Counties). These at-risk patients will be identified through physician referrals. The five (5) day medically-supervised program will be held at the Wellness Center and the maintenance support program will be provided bi-monthly by these physicians.</p>																																														
Strategies & Objectives		<p>Strategy #1: Provide a five (5) day short-term medically supervised camp</p> <ul style="list-style-type: none">• Identify 30 patients between the ages of 8-11 who fall in the category of 91st to 95th percentile in weight for their age group• Ascertain patients’ and parents’ commitment to program participation <p>Strategy #2: Provide maintenance program</p> <ul style="list-style-type: none">• Provide follow- up on bi-monthly basis with selected physicians• Provide a quarterly participant-family meeting for BMI check-in, dinner, and healthy nutrition education• Provide discount on a family package for membership at the Wellness Center																																														
Financial Commitment		<table><tr><th>Item</th><th>Cost</th><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Total</th></tr><tr><td>Five day camp</td><td>\$ 150 per patient</td><td>\$4500.00</td><td>\$4500.00</td><td>\$4500.00</td><td>\$13,500.00</td></tr><tr><td>Transportation (field trips during camp: one long trip and two short trips)</td><td>\$2000 per year</td><td>\$2000.00</td><td>\$2000.00</td><td>\$2000.00</td><td>\$6000.00</td></tr><tr><td>Healthy Eating meals to include lunch and dinner for family up to 4 maximum</td><td>\$8 per person</td><td>\$2500.00</td><td>\$2500.00</td><td>\$2500.00</td><td>\$7500.00</td></tr><tr><td>Give a-ways and awards</td><td>\$500 per year</td><td>\$500.00</td><td>\$500.00</td><td>\$500.00</td><td>\$1500.00</td></tr><tr><td>Quarterly meetings/health meals</td><td>\$8 per person)</td><td>\$960.00</td><td>\$960.00</td><td>\$960.00</td><td>\$2880.00</td></tr><tr><td>Total</td><td></td><td>\$10, 460.00</td><td>\$10, 460.00</td><td>\$10, 460.00</td><td>\$31, 380.00</td></tr></table>	Item	Cost	Year 1	Year 2	Year 3	Total	Five day camp	\$ 150 per patient	\$4500.00	\$4500.00	\$4500.00	\$13,500.00	Transportation (field trips during camp: one long trip and two short trips)	\$2000 per year	\$2000.00	\$2000.00	\$2000.00	\$6000.00	Healthy Eating meals to include lunch and dinner for family up to 4 maximum	\$8 per person	\$2500.00	\$2500.00	\$2500.00	\$7500.00	Give a-ways and awards	\$500 per year	\$500.00	\$500.00	\$500.00	\$1500.00	Quarterly meetings/health meals	\$8 per person)	\$960.00	\$960.00	\$960.00	\$2880.00	Total		\$10, 460.00	\$10, 460.00	\$10, 460.00	\$31, 380.00				
Item	Cost	Year 1	Year 2	Year 3	Total																																											
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Total		\$10, 460.00	\$10, 460.00	\$10, 460.00	\$31, 380.00																																											
Anticipated Impact		<ul style="list-style-type: none">• Patients will lose weight and/or reduce BMI by completion of the program• Patients participating in the program will understand the importance of nutrition and exercise																																														

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

	<ul style="list-style-type: none"> • Patients participating in the program will follow-up on a quarterly basis with selected physicians • Patients participating in the program and family will be able to discuss challenges and celebrate success.
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Track the pre-weight, pre-BMI, post-weight and post- BMI. • Track if the patient report that the quality of life improved.
Results	<p>Ongoing, continuous July 7-11, 2014 (Summer 2014)</p> <ul style="list-style-type: none"> • 33 children participated <ul style="list-style-type: none"> • 36% showed a reduction in weight. • 15% showed improvement in the Pacer test. • 33% showed improvement in the sit-up test. • 27% showed improvement in the push-up test.

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

INJURY & VIOLENCE PREVENTION: COMMUNITY EDUCATION PROGRAM						
Community Partners/ Planned Collaboration	<ul style="list-style-type: none"> • Macon-Bibb County Fire Department • Kohl's Kids Safety Zone 					
Goal	<i>Provide at least 21 free community speakers bureau presentations in the safety fields of Violence and Injury Prevention.</i>					
Timeframe	FY2013-FY2015					
Scope	<i>This strategy will focus on delivering free Violence and Injury prevention speaker's bureau presentations to community members in their churches, businesses, senior centers, schools and other such venues.</i>					
Strategies & Objectives	Strategy #1: <ul style="list-style-type: none"> • Identify speakers • Identify audiences Strategy #2: <ul style="list-style-type: none"> • Market Violence and Injury prevention speakers bureau presentations to community members 					
Financial Commitment	<i>Item</i>	<i>Cost</i>	<i>Year 1</i>	<i>Year 2</i>	<i>Year 3</i>	<i>Total</i>
	<i>Injury and Violence Prevention Community Education</i>	<i>\$100 per session</i>	<i>\$700.00</i>	<i>\$700.00</i>	<i>\$700.00</i>	<i>\$2100.00</i>
	Total		\$700.00	\$700.00	\$700.00	\$2100.00
Anticipated Impact	<ul style="list-style-type: none"> • Increase community awareness in the primary care service area (Bibb, Houston, Jones, Twiggs, Peach, Monroe and Crawford Counties) about Violence and Injury Prevention 					
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Count number of presentations • Pre and Post Cognitive Assessments 					
Results	<p>Throughout the year; accomplished FY 2013- 2015.</p> <p style="text-align: center;">Violence Prevention</p> <p>FY2013: 3 presentations; FY2014 – FY2015: 5 presentations</p> <p style="text-align: center;">Injury Prevention</p> <p>FY2013: 25 presentations; FY2014- 23 presentations; FY2015: 20 presentations</p>					

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

PHYSICAL ACTIVITY: WATER FOUNTAIN FOR TATNALL SQUARE PARK	
Community Partners/ Planned Collaboration	<ul style="list-style-type: none"> • Macon/Bibb County Parks & Recreation Department • Friends of Tattnall Square Park • Mercer University
Goal	To improve the health status of community members (including elementary school children) by encouraging/enabling exercise and physical activity at Tattnall Square Park, a large community park located in zip code 31207.
Timeframe	FY2013
Scope	<p>The citizens of Macon/Bibb County recently approved a special purpose local option sales tax (SPLOST) to improve city/county recreation sites. Many community agencies are involved. Bicycle and walk/run tracks will be added to Tattnall Square Park, in addition to many other improvements. The Medical Center will install a durable drinking fountain so that people can rehydrate while exercising/playing tennis/bicycling/walking/running. Also, children from a Magnet Elementary School, immediately across the street from Tattnall Square Park, which has no playground/athletic fields, use the park for both recess and physical education classes. Students from Mercer University (immediately across another street bordering the park) use Tattnall Square Park for many functions.</p>
Strategies & Objectives	Strategy #1: Install a multi-station durable drinking fountain in Tattnall Square Park
Financial Commitment	\$4,200
Anticipated Impact	Facilitate increased and sustained physical activity in the park by providing a source of hydration
Plan to Evaluate Impact	<ul style="list-style-type: none"> • Track Tattnall Square Park utilization numbers (provided by Friends of Tattnall Square Park and the Macon/Bibb County Parks and Recreation Department).
Results	Accomplished March 2014 (FY2014). 15,000 visitors (to the park) per year. Investment \$4,200.00

Implementation Plan (2013-2015)
Selected Priorities from 2012 Community Health Needs Assessment
Implementation Plan -Projected Total Cost

Program	Year 1	Year 2	Year 3	Total
Diabetes Prevention and Education (Adults)	\$13,180.00	\$13,180.00	\$13,180.00	\$39,540.00
Tobacco Use/COPD Disease Management Program	\$13,750.00	\$13,750.00	\$13,750.00	\$41,250.00
Obesity Disease Management Program (Children)	\$10,460.00	\$10,460.00	\$10,460.00	\$31,380.00
Injury/Violence Prevention Community Education Program	\$700.00	\$700.00	\$700.00	\$2100.00
Water Fountain- Tatnall Square Park	\$4200.00			\$4200.00
Total Cost	\$42,290.00	\$38,090.00	\$38,090.00	\$118,470.00

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Health Priorities Not Chosen for Action

<i>Health Priorities Not Chosen for Action</i>	<i>Reason</i>
<i>Arthritis, Osteoporosis & Chronic Back Conditions</i>	<i>The Medical Center feels that more pressing health needs exist in the community. Limited resources and lower priority excluded this as an area chosen for action.</i>
<i>Cancer</i>	<i>The Medical Center feels efforts already exist to provide access to health services, early detection of cancer and community education about cancer prevention (via the Cancer Life Center, Central Georgia Breast Center and community health fairs). Limited resources excluded cancer-specific initiatives as an area chosen for action at this time.</i>
<i>Mental Health & Mental Disorders</i>	<i>The Medical Center believes that this priority area falls more within the purview of the county health department and other community organizations (River Edge Behavioral Health Center, HODAC and Lake Bridge Behavioral Center.) Limited resources and lower priority excluded this as an area chosen for action.</i>
<i>Chronic Kidney Disease</i>	<i>The Medical Center feels that more pressing health needs exist in the community. Limited resources and lower priority excluded this as an area chosen for action</i>
<i>Heart Disease & Stroke</i>	<i>The Medical Center feels efforts already exist to provide access to heart disease health services through The Georgia Heart Center, Heartworks, community education and support groups. Efforts for access to stroke health services also exist through the Georgia Neuro Center, a primary stroke center, stroke education website (www.strokemacon.com) as well as community member's involvement in providing education to others in the community.</i>
<i>Maternal, Infant & Child Health</i>	<i>The Medical Center feels efforts already exist to provide access to maternal health services (Women's Connection and Supplemental) through Care Partners. Other health services exist for women and children through High Risk Obstetrics Services, the Perinatal Center and the Children's Health Center.</i>
<i>Oral Health</i>	<i>The Medical Center believes this priority area falls more within the responsibility of the county health department. Limited resources and lower priority excluded this as an area chosen for action.</i>
<i>Sexually Transmitted Diseases</i>	<i>The Medical Center believes this priority area falls more within the responsibility of the county health department. Limited resources and lower priority excluded this as an area chosen for action.</i>

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Appendix A: Diabetes Prevention Model

Overview

The diabetes prevention program will be physician referred and will be administered through a Lifestyle Coach trained at the Emory University Lifestyle Diabetes Coaching Program. The curriculum from this program is based on the Diabetes Prevention Program (DPP) research study and supported by the National Institutes of Health. To meet the reporting criteria for the Centers for Disease Control for benchmarking, program participants are enrolled in the program for 12 months.

Patient Identification

The participants for this program would be identified by the following eligibility requirements through the Macon Volunteer Clinic and First Choice Primary Care in Bibb County and by specific primary care practices in Peach County:

1. All program participants must be 18 years of age or older and have a body mass index (BMI) of ≥ 24 kg/m² (≥ 22 kg/m², if Asian)
2. A minimum of 50% of program participants must have had a recent (within past year), documented, blood-based diagnostic test indicating they have pre-diabetes, or a history of gestational diabetes mellitus (GDM), according to one of the following specifications:
 - a. Fasting plasma glucose of 100 to 125 mg/dl
 - b. Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl
 - c. A1c of 5.7 to 6.4
 - d. Clinically diagnosed GDM during a previous pregnancy (may be self-reported)
3. A maximum of 50% of a program's participants may be considered eligible without a blood based test or history of GDB only if they screen positive for diabetes based on the CDC Pre-diabetes Screening Test, which is validated for pre-diabetes using 2007-2008 National Health and Nutrition Examination Survey data.

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Program Initiation

Program initiation would begin for each group at four month increments based MD referrals, eligibility requirements, and pre-program paperwork completion. These core sessions would be limited to 16 participants per core class per DPP guidelines.

Staffing

The staffing model would include a Lead Lifestyle Coach that would be responsible for outcomes reporting to the CDC, class instruction, and scheduling. Other staff could include DBE's through Diabetes Healthways, Exercise Physiologists, Health Educators, Group Fitness Instructors, and others as needed.

Exercise Model(s)

The exercise model(s) for this program is comprised of two options:

1. Onsite exercise training at Macon Volunteer Clinic, First Choice Primary Care and Medical Center of Peach County depending on space availability. This would be supplemented by home exercise instruction.
2. Onsite exercise training and instruction at the Wellness Center (for Bibb County participants) with supplemental home exercise instruction.

Patient Monitoring

Patient monitoring would include but not limited to: Weight/BMI, Blood Glucose, Hemoglobin A1C, Blood Pressure, etc.

Educational Programming

Core Sessions – 4 Months (Sessions 1-16)

1. Introduction to Program
2. Be a Fat and Calorie Detective
3. Three Ways to Eat Less Fat and Fewer Calories
4. Healthy Eating
5. Move Those Muscles

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

6. Being Active: A Way of Life
7. Tip the Calorie Balance
8. Take Charge of What's Around You
9. Problem Solving
10. Four Keys to Healthy Eating Out
11. Talk Back to Negative Thoughts
12. The Slippery Slope of Lifestyle Change
13. Jump Start Your Activity Plan
14. Make Social Cues Work for You
15. You Can Manage Stress
16. Ways to Stay Motivated

Post-Core Sessions – 8 Months (6-8 delivered depending on participant goals)

- Introduction to Post-Core Program
- Fats: Saturated, Unsaturated, and Trans-Fats
- Food Preparation and Recipe Modification
- Healthy Eating: Taking It One Meal at a Time
- Healthy Eating with Variety and Balance
- More Volume, Fewer Calories
- Staying on Top of Physical Activity
- Stepping Up to Physical Activity
- Balance Your Thoughts for Long-Term Maintenance
- Handling Holidays, Vacations, and Special Events
- Preventing Relapse
- Stress and Time Management
- Heart Health
- A Closer Look at Type 2 Diabetes
- Looking Back and Looking Forward (Program Conclusion)

Outcomes

The following outcomes will be documented based for each participant.

1. Weight Loss/BMI
2. Exercise/Activity
3. Program Compliance
4. Fasting Blood Glucose Levels

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

5. Hemoglobin A1c levels
6. Hospital Admissions
7. Unscheduled MD Visits
8. Quality of Life (SF-36)

Program Model

- 12 month exercise/education program onsite at Macon Volunteer Clinic/First Choice/Medical Center of Peach County
 - 4 months of weekly training/classes + monthly maintenance programming thereafter for 8 months
 - Staffed by Wellness Center instructors

Cost - \$45 per month x 4 months = \$180

\$35 Assessment/Registration Fee \$35 (Evaluation/First Visit)

\$30 Follow-up Management (9 months Maintenance)

Total = \$245

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Appendix B: COPD Disease Management Program

Description

12 Week Exercise/Education Program designed for the COPD patient that does not meet criteria for traditional Pulmonary Rehabilitation. This model would be followed by a maintenance program that would include but is not limited to case management phone calls, follow-up visits, and support group programming for an additional 9 months. The total program consists of a year and is MD referred and facilitated at Heartworks.

Patient Identification

The patient is identified through hospital consults by the Respiratory Therapy, Pulmonary Rehabilitation, and MD referrals.

Cost

\$45 per month x 3 months = \$135 (3 months)

\$35 Assessment/Registration Fee = \$35 (1st Visit)

\$30 Follow-Up Management (9 months Maintenance)

Total = \$200

Program Initiation

A consult is completed before the patient is discharged and they are scheduled with a History and Physical appointment at Heartworks. The patient receives a program participation packet to complete before they arrive for their appointment. This includes a History Intake Form, Program Summary, and a Quality of Life Survey.

Staffing

The staffing will be facilitated by Respiratory Therapists, Exercise Physiologists, and RN's in the Heartworks/ Cardiopulmonary Rehabilitation Department. Current volume projections for program will add no new expense from a staffing prospective (Respiratory and Heartworks will absorb).

Exercise Model

The participant will be scheduled to exercise three times per week at Heartworks in a supervised setting. Additional exercise recommendations will be given by staff professionals for home and maintenance programming.

Patient Monitoring

The program participants will be monitored by staff to include but not limited to the following: Oxygen Saturations, Blood Pressure, Blood Glucose, Heart Rate, Perceived Exertion, Weight, Medication Compliance, etc.

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Educational Programming

The educational component may include but not limited to the following topics: Lung Disease Overview, Breathing Exercises, Symptom Triggers, Nutrition, Medications, Preventing Infection, O2 Therapy, Exercise, Stress, Smoking Cessation

A community support group for COPD is needed for our region. This group should be led by a COPD expert resource person. Our team of COPD educators will lead this meeting at least once a quarter in the primary service area. We would encourage smoking cessation, medication understanding and adherence, and disease management. The goal would be for a 30 minute instructor led discussion and then time for questions and support group activity / story sharing equaling approximately 1 hour.

Outcomes

Outcomes will be evaluated but not limited to the following: Functional Capacity, Exercise Duration, Quality of Life (SF-36), Blood Pressure, Weight, Hospital Re-admissions, Unscheduled MD Visits.

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Appendix C: Healthy Eating, Physical Fitness and Medical Weight Management for Children

Description – Short and Long Term Intervention

Five day program designed for 20-30 children of primary service area who fall in the category of 91st-95th percentile in weight for their age group followed by a bi-monthly support group and quarterly family meeting.

Patient Identification

This program will be target the age group of 8-11 years of age because this age group is more malleable in terms of future change actions and reasoning.

The program will use the following measurements:

Short Term – 5-day Camp:

- Pre weight & post weight
- Pretest knowledge of nutrition & exercise
- Physical Fitness Test:
 - Sit ups, push-ups, pull-ups, run/walk component
- Nutritional sessions
- Evening healthy eating cooking demonstrations
- Field trips related to healthy living
- Guideline to fitness sessions

Long Term - Post-Camp

Follow up on bi-monthly basis with Dr. Farah Khatoon & Dr. Tarek Bisat

- Quarterly family-participant meetings at The Wellness Center for BMI check-in, dinner, and healthy nutrition education. Families can also discuss challenges & celebrate successes. Will look at incentive to attend meetings (gift card drawing, etc.)
- Family package available at The Wellness Center

Implementation Plan (2013-2015)

Selected Priorities from 2012 Community Health Needs Assessment

Estimated Costs for Healthy Eating, Physical Fitness and Medical Weight Management for Children

ITEM	Cost
Staffing To include Nutritionist, lead person (administrative), & group fitness instructor	\$4500
Transportation To include 2-3 trips a week locally and one long distance trip	\$2000
Healthy Eating To include food prep & clean up by Morrison, Approximately \$8 a head(depending on food choice) & max family of 4, and nutritionist to accompany food demonstration of the importance of food choices & preparation. Price would also include lunch for campers.	\$2500
Give a ways & awards	\$500
Quarterly meetings/dinner	\$960
Total	\$10,460.00

Implementation Plan (2013-2015)
Selected Priorities from 2012 Community Health Needs Assessment

Adoption of Implementation Plan

On _____(date), the Board of the Medical Center of Central Georgia met to discuss this Plan for addressing selected community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Plan and the related budget items to undertake these measures to meet specific health needs in the community.

CGHS/MCCG, CEO/President Approval and Adoption:

Name & Title

Date

MCCG Board Approval & Adoption:

Name & Title

Date