Phoebe Putney Memorial Hospital
Community Health Implementation Plan

2020-2022

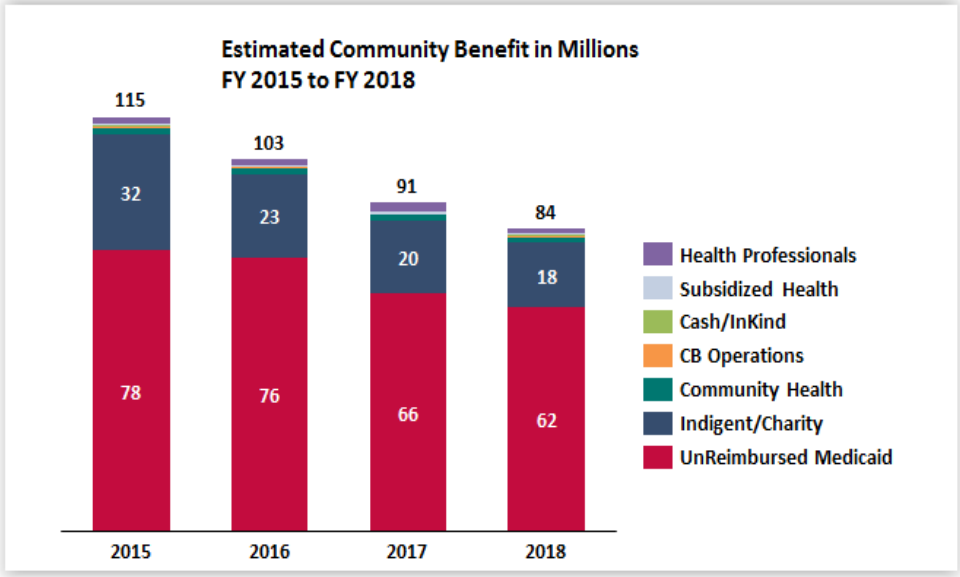
Introduction

Greater access to effective, efficient medical care is important for our nation's wellbeing, but medical care cannot deliver wellness, nor can health care system reforms alone bring costs under control. Instead, we need a new vision of health that rests on changing the lives of Americans in ways that lead to healthier, longer lives.

Robert Wood Johnson Foundation

In 1911, Phoebe Putney Memorial Hospital (PPMH) was established in answer to a community need to have a hospital in the remote southwestern corner of Georgia. The hospital was realized through the founding $25,000 donation of Judge Francis Flagg Putney. Judge Putney had three requirements aligned to his philanthropy: that the hospital serves all regardless of race or ability to pay; that it be built of brick to withstand fire; and that it be named for his mother, Phoebe Putney. Phoebe Putney Memorial Hospital garnered the immediate support of the community, whose members brought linens and supplies to stock their new hospital. In return, Phoebe Putney Memorial Hospital became the safety net for care, ministering to the most vulnerable in the community, devoting itself to improving health in a region lacking in hospitals and healthcare providers. Phoebe has stayed true to its founding mission ever since, making sure people throughout Southwest Georgia have access to the medical care they need regardless of ability to pay. In 2019, PPMH is the dominant healthcare provider and the region's second largest employer. For the fiscal year ended July 31, 2018, PPMH provided $84 *[see chart 1]* million in community benefit and reinvestment in those categories identified by the Internal Revenue Service. PPMH is the flagship of a four-hospital system (either owned/leased or managed), with two campus locations in Albany, Ga., one of which was acquired in December 2011 and converted a previously for-profit organization to tax-exempt status.

Chart 1: Community Benefit in Millions



.The ability of the hospital to provide community benefit has grown as the scale of the organization has grown, providing benefit more broadly in the Southwest Georgia region to meet mission. Facilitating access to primary care is in the best interest of the hospital and community, and therefore, in addition to its own family practices and rural clinics, PPMH has also had a long-term and beneficial relationship with Albany Area Primary Health Care, a federally qualified clinic with regional facilities and Horizon's

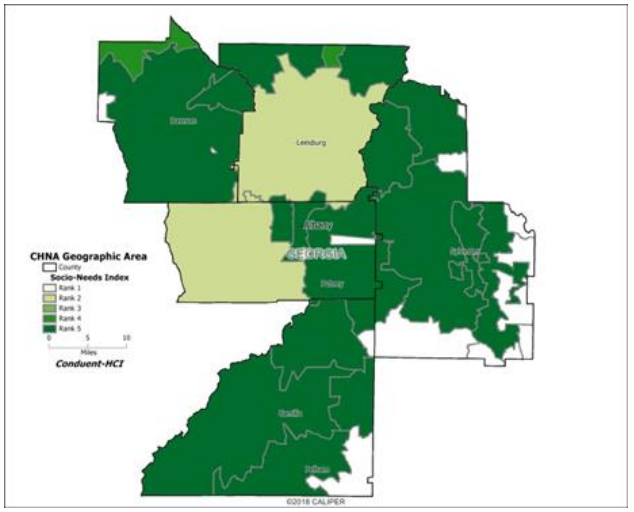
Community Solutions in diabetes management and cancer screenings for the uninsured. PPMH delivers high quality, safe healthcare to its patients and families, and extends its commitment further by reinvesting in the greater community. The organization believes in creating capacity in the community and is an active partner with patients, families, neighborhoods, government and civic organizations to provide access to care, innovation in treatments and research, and advocacy for change. The area served is a high-need community, and the hospital leadership recognizes the priorities identified in the needs assessment, but also the broader responsibility to provide services and service lines that might not otherwise be available to the citizens of the region. As PPMH considers its implementation strategies, it is informed by its specialty areas and populations, especially all women and children's services, inpatient rehabilitation, trauma, emergency and urgent care, neuroscience, cardiovascular and hospice and palliative care. These carefully planned services provide the infrastructure for delivering total community benefit and meeting the mission. PPMH funds and supports medical education and graduate medical education, and through its family medicine residency program has greatly alleviated the shortage of physicians in rural areas and will continue to evaluate the recruitment of physicians in specialties impacted by shortage. PPMH's leadership is committed to growing programs and services, both in and outside the hospital, that place care in the most effective and appropriate settings.

Community Served –While the Community Health Needs Assessment reviewed data for its five county Primary Service Area, the implementation plan focused on those areas with the greatest population density and the greatest socio-economic need that correlates with preventable hospitalizations and poor health outcomes ***[see map 1***]. The geographic target population will emphasize Dougherty County and designated hotspots with some implementation including other counties within its Primary Service Area (Lee, Mitchell, Terrell & Worth).

How It Works

- **All Communities can be described by various social and economic factors that are well known to be strong determinants of health outcomes.**
- **The SocioNeeds Index takes these factors (which range from poverty to education), and**
- **Generates and Index Value (from 1-100) for each zip code in the nation. Those with the highest values have the highest socioeconomic need which is correlated with preventable hospitalizations and premature death.**
- **Index values are assigned a rank of 1 to 5.**
- **Of the 21 zip codes, only 2 have a rank of 3 or better(31721,31763).**

Map 1: *Socio Needs Index Created by Community Health Solutions shows high socio economic need correlated with poor health outcomes in zip codes in darker green(**Primary Service Area).***



A description of how the implementation strategy was developed and adopted

Upon the completion of the Community Health Needs assessment, a series of pre-selection meetings attended by Dr. Jim Hotz, M.D., Albany Area Primary Health Care Clinical Services Director, Lori Jenkins—Director of PPMH Strategy and Development, and Mark Miller, PPMH Data Strategy Analyst—Project Lead. The pre-selection team reviewed the assessment findings and used Conduent-HCI Scoring Priority Tool ***(see next page for details)*** to make recommendations to the PPMH community benefit subcommittee for approval to the full board.

On 05/15/209 the pre-select committee met with PPMH board subcommittee members and senior executives ***(see page 6 for participant list)*** to review findings, present the priority scoring tool and receive feedback from the subcommittee . The subcommittee review the recommendations and renewed the previous priorities (Improving Birth Outcomes, Diabetes , Behavioral Health Advocacy) and added a fourth-- Cancer Screening and Early Detection. It was a unanimous decision . The full board approved the Community Health Needs Assessment and 4 Priority areas on July 10, 2019.

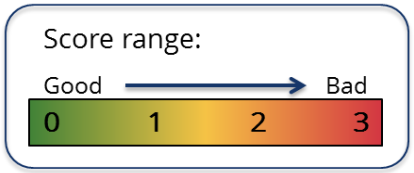
Dr. Jim Hotz, M.D, Albany Area Primary Health Care, Clinical Services Director met with key leaders once the board approved the Community Health Needs Assessment and adopted the four priority areas. Dr. Hotz previewed the priority areas with Scott Steiner, CEO, Phoebe Health System and Dr. Suresh Lakhanphal, President of Phoebe Physician Group, to set the context and framework for the implementation plan. Dr. Hotz and Mark Miller, M.S., Project Lead, met with strategic internal and external partners individually and in groups.

Improving Birth Outcomes	**Diabetes Management**	**Cancer**	**Behavioral Health**
Jim Hotz, AAPHC Lois Edge, AAPHC Kayla Roach, PPMH Jennifer Lawson, PPMH Deborah Block, PPMH Brittany Berry, PPMH Dr. Francis Kwarteng, AAPHC Dr. William Sewell, PPMH Dr. Michael Edwards, PPMH	Dr. Jim Hotz, AAPHC Dr. Derek Heard, PPG Tina Halverson, PPG Jackie Jenkins, Public Health Ebonee Kirkwood, Public Health Denise Ballard, Com Health Sol Kimberly Scott, Comm Health Sol Betsey Powell, AAPHC Rashundra Trice, PPG	Dr. Jim Hotz, AAPHC Dr. Adam Jones, Phoebe-Oncology Colleen Vann, PPMH * Made Priority Presentation to the full Cancer Committee	Dr. Jim Hotz, AAPHC Mark Miller, PPMH Darrell Sabbs, PPMH

PRIORITY SETTING

Hospital staff pre-met with Dr. Jim Hotz, a nationally recognized expert in Population Health, to review and recommend to the ***Selection Team*** *identified community need using Healthy Communities Institute Priority Setting Tool and Catholic Health Association Selection Filter. The pre-selection team recommended Birth Outcomes and Reproductive Responsibility, Cervical Cancer, Behavioral Health, and Diabetes for consideration.*

For each indicator, each county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.



Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and target values. Targets values include the nation-wide Healthy People 2020 (HP2020) goals as well as locally set goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Compared to State or National Value

Compared to Health People 2020 Target

Priority Selection

CATHOLIC HEALTH ASSOCIATION RECOMMENDATION SELECTION FILTERS

Magnitude. The magnitude of the problem include the number of people impacted by the problem.

Severity. The severity of the problem includes the risk of morbidity and mortality associated with the problem.

Historical Trends.

Alignment of the problem with the organizations strengths and priorities.

Impact of the Problem on Vulnerable Populations.

Importance of the problem to the community.

Existing Resources Addressing the Problem.

Relationship of the Problem to other Community Issues.

Feasibility of change, availability of tested approaches.

Value of Immediate Intervention vs. any delay, especially for long-term or complex threats.

Recommendation

1. ***Birth Outcomes and Reproductive Responsibility***
2. ***Diabetes Management and Prevention***
3. ***Behavioral Health and Addictive Disease Advocacy***
4. ***Cancer Prevention and Treatment***

Selection Committee

John Culbreath- Ph.d., PPMH Board Chair, Tary Brown- Retired CEO AAPHC, Joe Austin-COO, Phoebe Putney Health System, Dr. Jim Hotz M.D.- AAPHC*, Brian Church-CFO, Phoebe Putney Health System, Evelyn Olenick- SVP and CNO, PPMH, Dr. Derek Heard, M.D.-Medical Director for Primary Care

*** Represents Low Income, Medically Underserved, and Minority Populations**

FY 2020-2022 Implementation Strategy

What	Who	Where	Metric/Intended Outcomes
PRIORITY I: Birth Outcomes and Reproductive Responsibility			
To Provide Pre-Natal Education and Parenting to School Age Teens	Phoebe's Network of Trust/School Nurse	Dougherty County School System	• Improve 1st Trimester Prenatal enrollment to 80% • Decrease Teen Pregnancy to the GA value • Reduce Repeat Pregnancy toward the GA Value • Improve Infant Mortality Rates toward the GA Value • Improve low Birthweight Outcomes toward the GA Value
HIV/AIDS and STD Education & Reproductive Responsibility	Phoebe School Nurse Program	Dougherty County	
Teen Early Adult MAZE	Phoebe School Nurse Program and Taking Time of Teens Coalition	Dougherty County	
Conduct a 2nd Trimester Research Study of Women Entering the Prenatal Care	PPMH/AAPHC	PSA	
Targeted Public Awareness Campaign	PPMH/AAPHC	PSA	
Find Funding Streams to Address Socio-determinants that health that hinder healthy mother/health baby	PPMH/AAPHC	Dougherty County and PSA	
PRIORITY II: Diabetes Prevention and Management			
Continued Support of Community Gardens in the School System and Other Locations in our community	Network of Trust, PPMH	Dougherty County	• Promote the Eating of Fresh Fruits and Vegetables • A Decline of Age Adjusted Death Rate toward the GA value • Decrease in IP Discharges Due to Diabetes • Reduction of IP Self-Pay Cost • PPG and AAPHC work toward no more than 20% of its diabetic patients with a HC1 of 9 or higher • Diabetes PQI Indices (mortality, readmit rates) will trend toward 1.0.
Develop a Primary Care High-Risk Protocol	PPHM & AAPHC	PSA	
Pre-Diabetic Management and Referral System	PPMH	Dougherty County	
Professional and Public Education Campaign	PPMH	Dougherty County/PSA	
Develop a Dedicated Diabetes Specific Care Management Program in the ER to connect patients to Primary care Provider	PPMH	Dougherty County	

Priority III: Cancer Screening and Early Detection (Cervical, Lung, Colorectal, Breast and Prostate)			
Promote and Support direct and in-kind for screening in low income and uninsured individuals	PPMH	PSA	• Meet the 70% HPV target recommended by the National Advisory Committee on Immunization Practices (ACIP) • !0% reduction in gap in lung screening for the uninsured and low income individuals • Increase Lung Cancer Screening Rates by 2.5% per annum • Increase Colorectal Screening Rates to 80% • 70% of Male Patients report talking to their PCP regarding Prostate Screening approaches
Expand Public Awareness Campaigns	PPMH	PSA	
Provide 200-250 Free Mammograms to the Uninsured-annually	PPMH	PSA	
Provide 500 Free Colonoscopies to the Uninsured annually	PPMH	PSA	
Facilitate access to high-quality breast cancer screening as well as genetic screening, counseling, and preventive clinical services related to Hereditary Breast and Ovarian Cancer Syndrome (HBOC) for all women, regardless of income, race, insurance, or employment status.	PPMH	PSA	
Promote the use of informed decision making for the development of appropriate prostate screen approaches.	PPMH	PSA	
Priority IV: Behavioral Health and Addiction Disease			
Manage Behavioral Health Medication for school age children	Phoebe's School Nurse Program	Dougherty County	• Appropriate and safe administration of behavioral medication • To link and refer school age children to the appropriate behavioral health service • To decrease the stigma of behavioral health diagnosis and to promote available resources
School Nurse Case Management to school age children	School Nurse Program	Dougherty County School System	
Link Partners to various Media Outlets for education, awareness and access of services	Phoebe's Community Benefit Program-	Dougherty County	
Provide issue/topic related strategy and action planning to the local BH/AD Collaborative	Phoebe Strategy and Planning	Dougherty County	
Continue Opioid Awareness and Education	Network of Trust,	Dougherty	

Community Health Needs not addressed in the implementation strategy and any reason(s) they are not being addressed

Using the Catholic Health Association's Selection filter as a means to prioritize competing significant needs, below is a list of needs that were not included as priorities but remain a concern to the community [***see below***].

PHOEBE PUTNEY MEMORIAL HOSPITAL

Reasons for Not Selecting Community Need

Priority	Filter Number	Comment
Quality, Affordable Housing	1,7	This is a significant problem and best solved by local and state governments.
Homelessness	7	This is strategically aligned with a local non-profit--Mission Change
Affordable and Quality Childcare	1,4,7	Statewide Issue and funds are provided to regions throughout the state to provide resources.
Crime and Prevention	1,4,7	Not within the scope of hospital's strategic direction.
Obesity	9	Very Complex Issue requiring a culture shift
Inpatient Adolescent Crisis Stabilization Unit	4	Not in alignment with the Hospital's current Strategic Direction

CATHOLIC HEALTH ASSOCIATION RECOMMENDATION SELECTION FILTERS

(1) Magnitude. The magnitude of the problem including the number of people impacted by the problem.

(2) Severity. The severity of the problem includes the risk of morbidity and mortality associated with the problem.

(3) Historical Trends.

(4) Alignment of the problem with the organization's strengths and priorities.

(5) Impact of the Problem on Vulnerable Populations.

(6) Importance of the problem to the community.

(7) Existing Resources Addressing the Problem.

(8) Relationship of the Problem to other Community Issues.

(9) Feasibility of change, availability of tested approaches.

(10) Value of Immediate Intervention vs. any delay, especially for long-term or complex threats.