2013

WellStar Paulding Hospital

Community Health Needs Assessment (CHNA)

Implementation Strategy

WELLSTAR

Community Health Needs Assessment
WellStar Paulding Hospital Implementation Strategy

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I. General Information

WellStar Paulding Hospital

Paulding Medical Center, Inc./ EIN#: 58-2095884

600 West Memorial Drive, Dallas, GA 30132

Submitted for Tax Year 2012 (Fiscal Year Ended June 30, 2013)

WellStar Health System's CHNA Principal Assessor and Vice Chair of WellStar's Community Benefit Steering Committee:

Allen M. Hoffman, MD, Executive Director, WellStar Community HealthCare

52 Tower Road, Marietta, GA 30060

Senior Leadership Oversight and Chair of WellStar's Community Benefit Steering Committee:

Kim Menefee, Senior Vice President, Public and Government Affairs, WellStar Health System

Date of revised Implementation Strategy written plan: Oct. 30, 2013

Date written plan was adopted by WellStar Health System's Board of Trustees: Nov. 7, 2013

II. Purpose of Implementation Strategy

This Implementation Strategy for WellStar Paulding Hospital has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment (CHNA) at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA written reports per hospital facility (made widely available through WellStar's website at http://www.wellstar.org/about-us/pages/default.aspx#chna. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations released April 2013.

III. Community Benefit Implementation Overview

Recognized as the fifth most integrated healthcare delivery system in the country, WellStar Health System ("WellStar") is one of the largest not-for-profit health systems in Georgia and serves a population of nearly 1.3 million residents in five counties. WellStar includes WellStar Kennestone Regional Medical Center (anchored by WellStar Kennestone Hospital) and **WellStar Cobb**, Douglas, Paulding and Windy Hill hospitals; the WellStar Medical Group; Urgent Care Centers; Acworth Health Park; Health Place; Homecare; Hospice; Atherton Place; Paulding Nursing Center; and the WellStar Foundation.

WellStar Health System implements and creates innovative and transformational ways to deliver world-class healthcare, not independently, but interdependently.

As an integrated healthcare system, delivery of WellStar Paulding Hospital's community benefit programs and activities is handled in a collaborative, System-wide manner utilizing leadership from various medical service lines and community outreach areas. With President and Chief Executive Officer Reynold J. Jennings and Board of Trustees oversight, the WellStar Community Benefit Steering Committee leadership is responsible for implementing community benefit strategy to meet the needs of vulnerable populations crossing service areas boundaries of WellStar's five hospitals (outlined in the CHNA). In this way, WellStar can more effectively improve the health and well-being of the individuals and communities it serves System-wide through high-quality hospital, physician and other community-related healthcare services.

WellStar Paulding Hospital's Implementation Strategy[1] includes a hospital-specific listing of community benefit initiatives and a chart outlining the System-wide community benefit initiatives to address health needs of the communities WellStar serves including goals, strategies and outcome measures (see page 12).

The prioritized needs outlined in the CHNA - providing better access to care and evidence-based primary preventions for healthy lifestyles - informed this Implementation Strategy[2]

[1]The Public Health Institute's *Advancing the State of the Art in Community Benefit (ASACB):* A User's Guide to Excellence and Accountability, Nov. 2004 provided insight and guidelines throughout the Implementation Strategy.

[2]Needs identified by the Mobilizing for Action Through Planning and Partnership (MAPP) strategic planning process for Cobb and Douglas counties and Key Informant interviews in Bartow, Cherokee and Paulding counties. This process informed the prioritized health needs outlined in the WellStar hospitals' CHNA written reports. This Implementation Strategy fulfills the 501(r) requirements, Form 990, Schedule H for tax-exempt hospital reporting and compliance.

(required by the IRS Form 990, Schedule H[3]) designed to improve the health of WellStar Paulding Hospital communities with disproportionate unmet health-related needs.[4] The Implementation Strategy initiatives were developed by the WellStar Community Benefit Steering Committee members and formally adopted by the WellStar Board of Trustees on Nov. 7, 2013.

As community benefit is implemented properly and collaboratively, a significant portion of the health system's charitable dollars will shift from high-cost medical procedures to treat preventable illnesses in the emergency room to proactive and preventive community-based care. It will have a measureable effect on the health of the vulnerable communities WellStar Paulding Hospital serves as well as the health outcomes of the community as a whole.

Implementation Strategy Mission:

*To implement a five-year, two-phased Community Benefit program that is sustainable and strategically aligned with the WellStar Health System mission and vision to address the prioritized health needs of the uninsured and low-income populations. This is accomplished through expanding provider participation, education, outreach and prevention activities/programs to promote healthy lifestyles and access to care (**Phase 1**) and creating a collaborative safety net organization for shared accountability to leverage and maximize complementary skills and capacity building (**Phase 2**).*

Initiated in August 2013, an internal WellStar Community Benefit Steering Committee representing key community benefit areas of the healthcare system regularly meets for oversight, leadership and implementation of the community benefit strategy. The proactive approach to community benefit helps increase the capacity of WellStar and its community collaborators to serve disproportionate unmet health needs.

[3]Schedule H (http://www.irs.gov/pub/irs-pdf/f990sh.pdf) dramatically increases the transparency of nonprofit hospital charitable activities and processes. By providing a framework for detailed documentation of community health needs assessments and implementation strategies, it also lays the groundwork for nonprofit hospitals' engagement of diverse stakeholders, as well as for the advancement of community health improvement practices. *Source:* The Hilltop Institute: *Hospital Community Benefits After the ACA: Schedule H and Hospital Community Benefit – Opportunities and Challenges for the States*, Kevin Barnett and Martha H. Somerville, Issue Brief, October 2012.

[4]According to the Public Health Institute, "communities with disproportionate unmet health needs meet one of two criteria: either there is a high prevalence or severity for a particular health concern to be addressed by a community benefit program or there is evidence that community residents are faced with multiple health problems and have limited access to timely, high quality healthcare."

The WellStar Community Benefit Steering Committee, along with the WellStar President and Chief Executive Officer and Board of Trustees, provides governance of community benefit care delivery and cost accountability to ensure optimal stewardship of charitable dollars and investments of services and resources by community partners.

Roles of the WellStar Community Benefit Steering Committee:

- Evaluate current community benefit activities and whether they help meet the prioritized health needs of the community - viewed through the strategic lens of **Access to Care** and **Prevention-Healthy Lifestyles**
- Review Healthy People 2020 national prevention strategies[5] to supplement, expand or address community benefit activities on an ongoing basis
- Integrate community benefit activities into WellStar's overall strategic planning process
- Evaluate where current community benefit activities are provided and make appropriate shifts in location and volume to improve reach to underserved populations
- Evaluate quality of current community benefit activities consistent with the Affordable Care Act's National Quality Strategy[6]
- Assess current community benefit activities and the involvement of other community collaborators to help maximize resources and impact (shift from a proprietary / competitive approach to a strategic approach)
- Manage delivery of annual community benefit assessment, response / reporting functions, and monitor / measure health improvement efforts using outcomes-based benchmarks (i.e. rate of preventable hospital utilization and incidence of chronic disease)
- Conduit for processing and addressing feedback from the community and WellStar executive and hospital leadership for ongoing community benefit review and refinement

[5]See www.healthypeople.gov. Healthy People serves as the foundation for prevention efforts across the U.S. Department of Health and Human Services and The **ACA National Prevention Strategy** – seven priorities are: Tobacco Free Living Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive and Sexual Health, and Mental and Emotional Well-Being. http://www.surgeongeneral.gov/initiatives/prevention/strategy/index.html

[6]Created under the Affordable Care Act, this strategy will guide local, state and national efforts to improve quality of care to tie into national strategies

The Community Benefit Steering Committee uses the Public Health Institute's *Advancing the State of the Art in Community Benefit* (ASACB) Performance Measures as guideline standards to return optimal benefit to the communities WellStar Paulding Hospital serves:[7]

Standard #1: Show evidence of formal commitment to a Community Benefit program for a designated community. ***Met through the formalized WellStar Community Benefit Steering Committee and Board of Trustees adoption of Community Benefit Implementation Strategy per federal requirements of WellStar hospitals' 501(c)(3) status.***

Standard #2: The scope of the Community Benefit program includes hospital-sponsored projects to improve health status, address the health problems of the medically underserved and contain healthcare costs. ***Met through expanding current Community Benefit activities to address the access to care and healthy lifestyles health needs identified by the CHNA.***

Standard #3: *The hospitals should foster an internal environment that encourages institution-wide involvement.* ***Met by facilitating vulnerable populations with access to free, low-cost or sliding scale community-based healthcare clinics, primary care-based Patient Centered Medical Homes (PCMH), transportation and other subsidized health services, community health education (including health fairs, school-based programming, screenings), and Health Parks for education, primary and specialty care and outpatient surgical services.***

Standard #4: The program should include activities designated to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community. ***Met through ongoing involvement in collaborative organizations including Cobb 2020, alignment with WellStar county Public Health Departments and the newly formed non-profit, Cobb Access Health.***

[7] ASACB Performance Measures build on the work of the Hospital Community Benefit Standards Program funded by the W.K. Kellogg Foundation and coordinated through the Robert F. Wagner Graduate School of Public Service at New York University.

IV. List of Community Health Needs Identified in CHNA Written Report:

CHNA Prioritized Health Needs

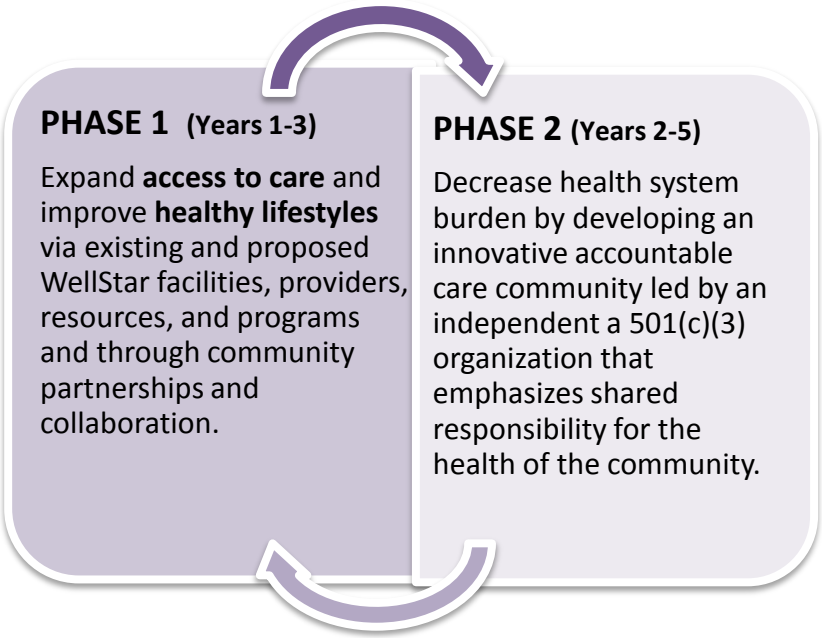
HIGH		MEDIUM	LOW
Access to Care		Breast Cancer (Screening)	Transportation
Chronic Diseases	Cardiovascular Disease	Prostate Cancer (Screening)	Air Quality
	Cancer ▪ Lung ▪ Colon ▪ Breast ▪ Prostate	Colon Cancer (Screening)	Dental Care
	Stroke	Alcohol	Sexually Transmitted Infections
	Chronic Obstructive *Pulmonary Disease*	Prenatal Care	Teen Pregnancy
	Diabetes		
Healthy Lifestyles	Physical Activity		
	Healthy Eating		
	Obesity		
	Smoking		
	Education		
Mental / Behavioral Health			

V. Health Needs Planned to be Addressed

WellStar Paulding Hospital's Community Benefit Implementation Strategy strengthens an integrated and innovative health delivery system internally and externally through community-based collaborative partnerships. Delivering community benefit for the medically underserved and uninsured will span the continuum of care (**access to care**) and promote prevention (**healthy lifestyles**) to decrease hospital utilization and costs related to low-income care.

Phase 1 *(Years 1-3)* **STRATEGIC GOAL: Expand the delivery of current WellStar community benefit activities focused on enhancing access to care and providing evidence-based primary prevention programming for healthy lifestyles** to improve the health of communities served with disproportionate unmet health needs (DUHN). This includes WellStar's community health improvement and education services, community-based clinical services, research activities to help improve overall community health, community capacity-building activities to respond to vulnerable populations, and healthcare support and subsidized services.

Phase 2 *(Years 2-5)* **STRATEGIC GOAL: Provide leadership and support as an integrator with the community to develop a collaborative care organization.** The mission of this 501(c)(3) organization is to create an accountable care community that increases the access to and volume of preventive care provided to vulnerable populations with the ultimate goal of reducing the prevalence of chronic disease and lowering healthcare costs.



VI. WellStar Paulding Hospital-Specific Initiatives to Address Health Needs

All proposed WellStar Paulding Hospital initiatives meet one or more the following qualifiers for new Patient Protection and Affordable Care Act (ACA) "community benefit" law:

- *Identifying community health needs*
- *Improving access to healthcare services*
- *Enhancing health of the community*
- *Advancing medical or health knowledge*
- *Reducing the burden of government or other community efforts*

1. **Improve access to care to vulnerable populations**
   - Strengthen collaborative partnerships with the following community stakeholders to increase access to preventative and primary care, improve quality and reduce costs:
     - Local and State Public Health (Northwest Georgia Public Health)
     - Cobb2020
     - Hospitals

- Community mental health
- Existing healthcare alliances and groups
- Federally Qualified Health Clinics (FQHCs), free and community-based clinics
- Community and business leaders
- State and national organizations- Georgia Department of Public Health and the Centers for Disease Control and Prevention (CDC)
- Other organizations and individuals serving vulnerable populations: faith-based, medically underserved, low-income, minority, seniors, and chronic diseases

- Increase the number of hospital-affiliated/WellStar Physicians Group primary care providers and specialists providing free or low-cost healthcare programs/clinics via a Graduate Medical Education program

- Reduce preventable hospital admissions, readmissions and Emergency Department visits by redirecting care to community clinics and primary care (Patient Centered Medical Home model) via the hospital-based care management program

- Improve medication access through centralized reduced cost Pharmaceutical Patient Access Programs and the Federal 340B Drug Pricing Program for the management of chronic disease and to reduce complications

- Evaluate hospital-based subsidized health services to more effectively and efficiently allocate assets addressing prioritized needs of the medically underserved and uninsured

- Expand the accessibility to hospital inpatient and outpatient Diabetes Self-Management Education (DSME) and services to the medically underserved and uninsured

2. Promote healthy lifestyles via preventative care, programs and activities

- Engage faith-based organizations in coordination and provision of care (MEMPHIS Model)

- Provide assistance with the School-Based Health Center pilot in Acworth School District

- Expand free, hospital-based health screenings to the underinsured and uninsured through WellStar Corporate & Community Health

- Improve prevention-based educational resources and the referral process to free or low-cost healthcare clinics for continuity of care within the Emergency Department (including nurse navigator training and bi-lingual materials)

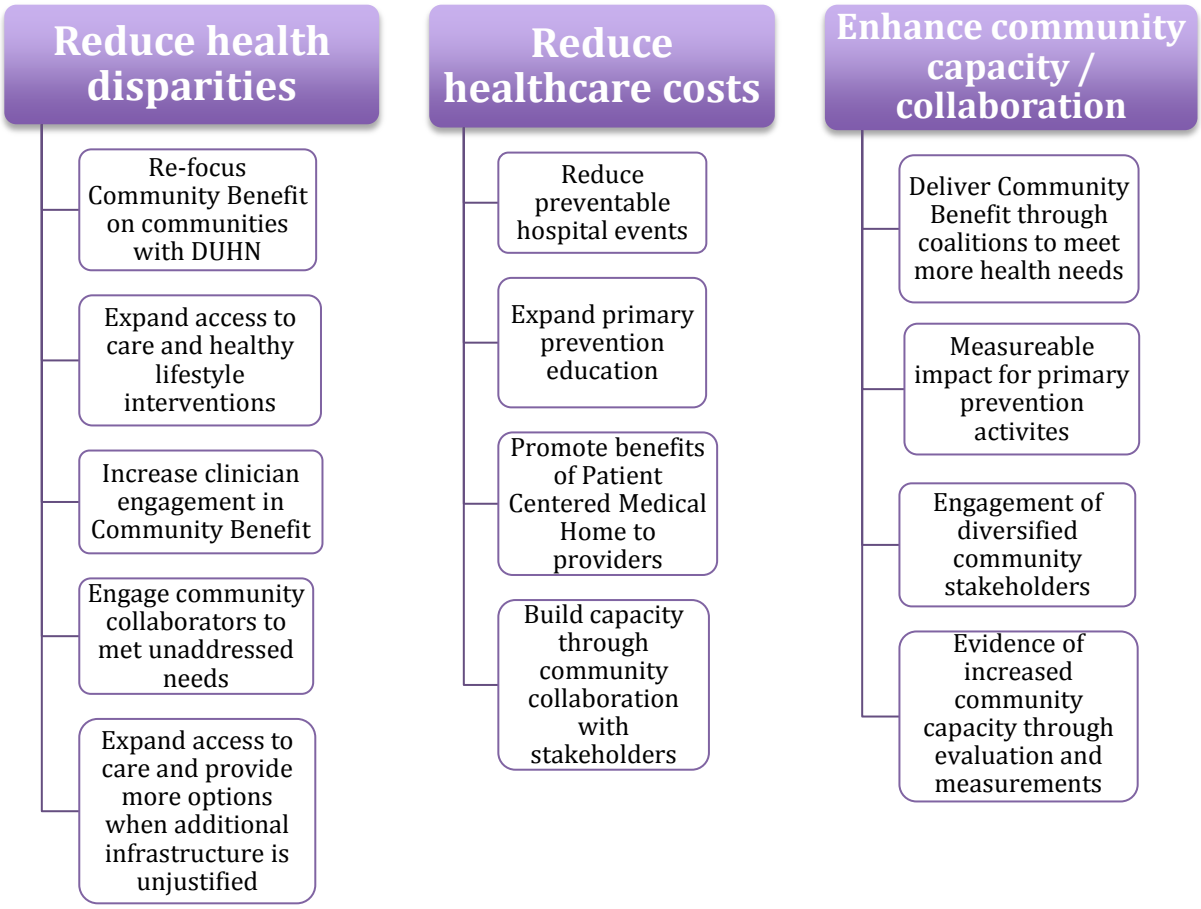
- Improve education and referral system within the Emergency Department for chronic disease management and preventative care

Anticipated Impact of the Implementation Strategy:

With WellStar Paulding Hospital's focus on prevention, quality/safety and care coordination to improve care access and healthy lifestyles, its aim is to proactively transform data-driven CHNA results into an actionable and measureable community benefit program to:[8]

- Reduce health disparities
- Reduce healthcare costs
- Strengthen community capacity and collaboration for shared responsibility to address the health needs of a greater number of people in the communities WellStar Paulding Hospital serves

[8]Public Health Institute, Kevin Barnett. *Quality and Stewardship in Community Benefit*, March 11, 2010.



WellStar Paulding Hospital's Implementation Strategy focuses on the desired end result – to provide medically underserved and uninsured people better access to primary care for improved health and early intervention which will impact the health of the community as a whole.

Planned Collaboration with Other Facilities and Organizations:

WellStar Paulding Hospital's integrated approach to community benefit involves all of WellStar's five hospital facilities, Health Parks, community clinics and other community organizations and stakeholders vital to delivering healthcare, programs and services to vulnerable populations. Working in coordination with community partners is vital to improving access to care and healthy lifestyle interventions through public health policies, referral processes, community-based care and services, health education programs, and other community benefit initiatives.

Shifting the healthcare community's culture of working independently (mutual awareness) toward collaborative interdependence (partnership) helps WellStar Paulding Hospital, public health and the community share the responsibility of care and costs while offering access to a full healthcare continuum.

***Evaluation Methods*:**

Community benefit success will be measured by expanding access to care and delivering evidence-based primary prevention (healthy lifestyles) outreach, education and activities for chronic diseases and behavioral health to improve and sustain overall population health. Integrated with WellStar's System-wide Implementation Strategy, WellStar Paulding Hospital's community benefit can be measured by an initiative's strategic outcome measures and the quantitative data gathered including:

- Volume of people served via community benefit activities compared to previous years
- Internal data tracking preventable emergency department visits, hospital stays, length of stays, readmits, and costs as an effective community benefit program redirects resources outside of the hospital and into the community
- Increased utilization of primary care
- Community health education and screening participation

VII. WellStar Health System Community Benefit Initiatives[9] [10] Chart

COMMUNITY HEALTH IMPROVEMENT SERVICES

Community Health Education

1. Access to Care via Faith-Based Communities
2. Healthy Lifestyle/Prevention Education

Community Based Clinical Services

1. School-Based Health Services
2. Access to Free Health Screenings
3. Nurse-Family Partnership®
4. Diabetes Education

Healthcare Support Services

1. Cobb Access Health – Community Collaboration to Improve Access to Care
2. Hospital-Based Care Management Program

Self Help Programs

1. Smoking Cessation
2. 24-Hour Suicide Hotline
3. Pharmaceutical Access Programs/Federal 340B Drug Pricing Program

HEALTH PROFESSIONS EDUCATION

1. Graduate Medical Education

SUBSIDIZED HEALTH SERVICES

1. Audit of Currently Subsidized Health Services

RESEARCH (Community Health and Clinical)

1. Community Health and Healthcare Delivery Studies
2. Research Papers for Professional Journals and Presentations

CASH AND IN-KIND DONATIONS

1. Grants
2. Cash/Sponsorships
3. In-Kind

COMMUNITY BUILDING ACTIVITIES

1. Integrator Role in Collaborative Low-Income Healthcare Delivery System
2. *Live Well, Marietta*
3. Advocacy

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[9] *All programs and activities respond to the prioritized health needs of the community and meet at least one of these objectives:* (1) Improve access to healthcare services (2) Enhance population health (3) Advance increased general knowledge (4) Relieve or reduce the burden of government to improve health.

[10] Through a nominal group process and a preparatory overview of the prioritized health needs, the WellStar Community Benefit Steering Committee collectively outlined these implementation initiatives at its inaugural meeting on Sept. 16, 2013 and finalized them on Oct. 8, 2013.

Community Benefit Category: **COMMUNITY HEALTH IMPROVEMENT SERVICES**

Community Health Education

Initiative Name:	**Access to Care via Faith-Based Communities**	**Healthy Lifestyle/Prevention Education**
Goal	Expand assistance and support of the WellStar Congregational Health Network to improve access to healthcare services for vulnerable populations.	Increase the number of community members participating in free health education to advance health knowledge and improve population health in community settings, schools and worksites.
Hospital / Community Partners	WellStar Congregational Health Network Promotores de Salud MUST Ministries Kennesaw State University Community Health Workers Program Hispanic Healthcare Coalition Centering Pregnancy Program	WellStar Corporate & Community Health WellStar Community Clinics / Senior Centers/Health Parks Local safety net organizations Cobb 2020
Outcome Measure	Increase the number of health education, home visits, screenings, and referrals for community clinic primary care offered to targeted vulnerable populations by the WellStar Congregational Nurse Network.	Increase the number of health education programs and activities conducted at the various community-based settings and referrals for primary care.
Scope	Low-income populations without coverage for prevention and treatment services.	Populations utilizing community clinics and senior centers and without a patient-centered medical home.
Strategy	1. Audit existing partnerships 2. Create new ones based upon demographics and need 3. Recruit and train nurses 4. Assign partner congregations to specific service area hospitals' social workers 5. Using the MEMPHIS Model[11] as a reference model and the *WellStar Congregational Nurses Network* (representing **all hospitals**) for care provision, access to healthcare is increased to low-income community-based congregation members through capacity-building partnerships	1. Conduct *Healthy Lifestyle*-specific lectures at senior centers and in other community settings 2. "Train the Trainer" workshops for school healthcare workers 3. "Speaking of Wellness" at senior centers
Strategy Measure(s)	1. # of congregational partnerships 2. # of people receiving education,	1. # of people receiving education at the various sites

[11] The MEMPHIS Model leverages existing resources by integrating congregational and community caregiving with traditional healthcare to create a system of health built on webs of trust and integrated into hospital initiatives including re-admission prevention in CHF/AMI/PNI, charity care management, HCAHPS, ambulatory care ACO, and care transitions.

	screenings, primary care referrals, and pastoral care 3. % growth of Latino community health outreach	2. # of people referred to treatment

Community-Based Clinical Services

Initiative to Implement	**School-Based Health Services**	**Access to Free Health Screenings**	**Nurse-Family Partnership®**	**Diabetes Education**
Goal	Use the Acworth School District School-Based Health Center pilot program as a model for future expansion.	Expand free health screenings to the underinsured and uninsured to help prevent the incidence and prevalence of high and medium prioritized CHNA health needs.	Support the development and implementation of Metro Atlanta's first Nurse-Family Partnership®, an early intervention community health program that helps transform the lives of vulnerable, first-time mothers.	Expand the accessibility to hospital inpatient and outpatient Diabetes Self-Management Education (DSME) and services to the medically underserved and uninsured.
Hospital / Community Partners	WellStar Corporate and Community Health Acworth School District WellStar Medical Group clinical staff Cobb County School District Northside Psychological Services United Way Acworth Mayor's Office Cobb & Douglas Public Health Steering Committee funded by Urban Healthcare Planning	All WellStar hospitals, *WellStar Corporate & Community Health* and Health Park facilities Atlanta Community Food Bank Local community safety net clinics Senior Centers Title 1 schools Cobb and Douglas Community Services Board (for behavioral health screenings) Cobb Community Collaborative YMCA and YWCA The Center for	WellStar Hospital representatives of Women's and Children's Health WellStar Congregational Health Network Nurse-Family Partnership® WellStar Home Health Cobb & Douglas Public Health WellStar Medical Group United Way of Metro Atlanta Isis Parenting	WellStar Diabetes Services – American Diabetes Association recognized DSME program WellStar Cobb Hospital – inpatient education WellStar Kennestone Hospital – inpatient education WellStar Paulding, Douglas and Windy Hill hospitals – *referrals to outpatient education via provider, care coordinator and/or discharge call center* WellStar Community Clinics – referring provider for prediabetes/diabetes

	Grant (parents, community leaders, district representatives, and healthcare professionals) Community Services Board	Financial Resources		vulnerable populations
Initiative to Implement	**School-Based Health Services**	**Access to Free Health Screenings**	**Nurse-Family Partnership®**	**Diabetes Education**
Outcome Measure	The sustainability of School-Based Health Centers and number of interventions for early childhood/adolescent services, prevention and education to Title 1 school families.	The number of free screenings offered to low income populations in community-based and hospital-based settings.	The number of at-risk, low-income first-time mothers that have healthy pregnancies, improved child health and development and become more economically self-sufficient.	The expansion of no cost diabetes education at WellStar hospitals – Douglas, Paulding and Windy Hill. Increase referrals from community clinics and Douglas, Paulding and Bartow counties to WellStar's ADA recognized DSME program.
Scope	Children from low-income families with limited access to care to receive no or low-cost health services and healthy lifestyle education.	The underinsured and uninsured in the communities served without access to health screenings including behavioral health, colon cancer, mammography, stroke risk, blood pressure, and lipid/cholesterol at community-based events to address prioritized health needs.	At risk, first-time moms in TBD counties (pending acceptance as an implementing agency).	The approximate 30 percent of hospital patients who have hyperglycemia (some diagnosed, some not diagnosed with diabetes) and community clinic/safety net patients in need of physician-referred DSME for better disease management.
Strategy	1. Identify other potential collaborating school districts number of Title 1 schools 2. Collaboratively work with local safety net organizations in target population to boost programming and services	1. Coordination with community benefit partners to identify vulnerable populations 2. Develop plan for food bank distribution 3. Ensure community benefit criteria are met with current offerings	1. Start process to become an implementing agency 2. Determine start-up scope and lead hospital 3. Hire / train Home Visitors – registered nurses 4. Promote enrollment of low-income, first-time moms as	1. Audit EPIC physician referral process for DSME and number of community members receiving Community Financial Assistance from WellStar 2. Collaborate with the hospital's discharge call

	3. Interview Title 1 school / school district representative to identify greatest needs 4. Pilot a high-school based incentive program for obese students to lose weight in healthy ways 5. Work with community partners to provide incentive rewards	and realign and/or collaborate where necessary to outreach to the medically underserved, i.e. food pantry distribution centers and through partner agencies' events 4. Since screening referrals cannot be made only to WellStar, create a partnering evaluation form to measure outcomes and a collaborative referral process 5. For behavioral health screenings, address the Georgia Dept. of Behavioral Health and Development Disabilities in defining the approval and placement process for mentally ill patients in EDs 6. Coordinate with hospital EDs and Community Services Board's telemedicine mental health assessments, including pediatric and adolescent. 7. Assess the integration process into community-based health clinics and primary care	early as the 16th week of pregnancy and continuing through the first two years of the child's life	center and WellStar Diabetes Services to measure referrals of low-income, uninsured people 3. Reinforce education of hospitalists, physicians, mid-level providers, nurses, primary care, and community clinics regarding diabetes and education services available
Initiative to Implement	**School-Based Health Services**	**Access to Free Health Screenings**	**Nurse-Family Partnership®**	**Diabetes Education**

Initiative to Implement	**School-Based Health Services**	**Access to Free Health Screenings**	**Nurse-Family Partnership®**	**Diabetes Education**
Strategy Measure(s)	1. # of referrals to community clinics for follow-up care. 2. # of identified students with baseline BMI/weight compared to end result for reward-based programming like weight loss 3. Reduction in Medicaid expenditures related to inpatient, drug and emergency department usage 4. Increase in primary health care access by students compared to students who did not have access to a SBHC 5. Decrease in hospitalization rates of students with asthma 6. Decreased absenteeism (up to 50%) in students who have had 3 or more absences in a six-week period 7. Decrease in peer relations issues (as reported by teachers and staff) 8. Decrease in student anger (as reported by teachers and staff) 9. Decrease in	1. # of health screenings and people referred for treatment from community-based events 2. # of screenings conducted in hospitals	1. # of participating low-income first time mothers 2. Improved prenatal health via home care/education and referrals to healthcare providers 3. Fewer subsequent pregnancies and/or increased intervals between births (correlates to cost savings) 4. Improved school readiness 5. Fewer childhood injuries 6. Utilize Nurse-Family Partnership's existing data collection system to record and report family characteristics, needs, services provided, and progress toward accomplishing program goals	1. # of referrals of underserved, uninsured people for DSME (via WellStar community clinics and other community safety net providers) 2. # of inpatients from WellStar Douglas, Paulding and Windy Hill hospitals (not currently offering no cost inpatient diabetes education by Certified Diabetes Educators) to WellStar's DSME program

	student symptoms of depression (as reported by teachers and staff)			

Healthcare Support Services

Initiative to Implement	***Cobb Access Health***	**Hospital-Based Care Management Program**
Goal	Support the development and sustainability of *Cobb Access Health*, an alliance-building non-profit organization, as the point of convergence for existing community health stakeholders to form partnerships that help create a comprehensive and sustainable low-income healthcare system in Cobb County.	Grow the hospital-based, low-income care management program designed to facilitate the connection of eligible patients in the Emergency Department and hospitals to the hospital-affiliated community clinics.
Hospital / Community Partners	WellStar hospitals and other healthcare providers *Cobb Access Health* and Cobb 2020 and its partnering safety net organizations Public Health agencies Faith-based organizations Local government and businesses Educational institutions WellStar Foundation WellStar Strategic Planning Community members	WellStar Cobb Hospital (pilot program) Expand to other WellStar hospital facilities WellStar community and senior clinics
Outcome Measure	To have a measureable impact on the prioritized health needs of Cobb County at a cost reduction to the hospitals/health system and on the improvement of population health and patient outcomes/satisfaction – "Triple Aim."	Decrease in Emergency Department utilization.
Scope	The medically underserved and uninsured in Cobb County.	Low income population utilizing the WellStar hospitals' Emergency Department as primary care.

Strategy	1. Coordinate the strategic alignment of WellStar resources, services and facilities[12] to build a collaborative community-based low-income healthcare delivery system focusing on preventive and chronic care 2. Assist in identifying grants and other funding sources including in-kind contributions[13] to jumpstart organization with Executive Director hired and initial financial and facility needs met 3. Establish criteria for becoming a Cobb Access Health partner 4. Decrease burden on hospital-based care to community-based care / compare to emergency department visits 5. Establish **Patient Access Cards** to increase/expedite access to quality preventative services and care for medical interventions – chronic disease management	1. Measure effectiveness and processes of current pilot 2. Train Case Managers
Initiative to Implement	***Cobb Access Health***	**Hospital-Based Care Management Program**
Strategy Measure(s)	1. # of partnering organizations 2. Funds raised 3. Policies and governing body formed 4. # of Patient Access Cards provided 5. # of medical interventions/visits, programs and services delivered via partners	1. # of patients referred for treatment to community clinics to ensure continuum of care 2. Decrease in hospital ED utilization and costs

[12] WellStar's core mission is to provide high quality medical care and services in our own facilities. Where appropriate, we seek to provide those same services in and through the facilities of others in order to better serve communities for which the investment in infrastructure cannot be justified. In order to extend our service model into areas where WellStar cannot have a formal presence, we established a non-profit that offers mentorship and, in select cases, funds to ensure critical health needs can be met in communities.
Core business: Providing high quality medical care and services in WellStar facilities with WellStar staff.
Extended Core Business: Providing the same high quality medical care and services with WellStar staff at sites or in facilities operated by others when the circumstances allow WellStar to meet quality standards as well as established business requirements.
Mentorship business – Through a non-profit, mentor and train other organizations and providers in replicable medical and business practices that provide high quality care and services consistent with WellStar's mission and established guidelines.
Philanthropic Business – Through a non-profit, provide funding to critical providers for essential staff and or services consistent with WellStar's mission and established guidelines that cannot otherwise be provided in areas of need.
[13] A successful case study of how community collaboration impacts population health in Georgia is the Chatham County Safety Net Council (CCSNC) – www.chathamsafetynet.org. A 2011 report is available: http://www.chathamsafetynet.org/documents/2011%20CCSNPC%20Evaluation%20Report.pdf.

Self Help Programs

Initiative to Implement	**Smoking Cessation Program**	**24-Hour Suicide Hotline**	**Pharmaceutical Access Program**
Goal	Expand smoking cessation healthcare professional training/education to other hospitals, WellStar Medical Group practices and community clinics.	Increase utilization/referral efforts through collaboration with Community Services Board	Improve pharmaceutical access through (1) centralized reduced cost Pharmaceutical Patient Access Programs (PAP) and (2) the Federal 340B Drug Pricing Program.
Hospital Leadership / Community Partners	WellStar Cobb Hospital (pilot program)	WellStar Cobb Hospital's inpatient psychiatric unit Cobb and Douglas Community Services Board	WellStar Cobb Hospital (340B program) All WellStar hospitals (PAPs) Community safety net organizations Cobb Access Health
Outcome Measure	Increase number of participating WellStar primary care physicians and healthcare professionals to provide in-office education.	Improve access for increased mental health referrals/assessments	Improve and expand access to medications for chronic diseases and other conditions through WellStar community and senior clinics and via other safety net providers
Scope	Smokers to decrease the prevalence of multimorbidity	Mentally ill population	Underinsured or uninsured low-income population
Strategy	1. Pilot program leadership at WellStar Cobb Hospital to help expand to other hospitals and WellStar Physician Group primary care offices/clinics 2. Promote the Georgia quit line, 1-877-270-STOP	1. Audit current utilization and improve referral processes	*PAPs:* 1. Improve the facilitation and access to patients needing help acquiring low-cost/free medications 2. Expand community-based distribution channels *340B Program:* 1. Implement program to provide chronic disease medications at low-cost
Strategy Measure(s)	1. # of participating WellStar primary care physicians and healthcare professionals	1. # of phone interventions 2. # of behavioral health referrals	1. # of prescriptions filled and patients served through the PAPs 2. # of prescriptions filled through the Federal 340B program / dollars saved

Community Benefit Category: **HEALTH PROFESSIONS EDUCATION**

Initiative to Implement	**Graduate Medical Education (GME)**
Goal	Increase the number of primary care and specialty providers serving non-paying patients to improve access to care and promote healthy lifestyles to reduce chronic disease.
Hospital / Community Partners	WellStar Kennestone Regional Medical Center (granted Institutional Accreditation from the Accreditation Council for Graduate Medical Education – ACGME) All WellStar hospitals WellStar Medical Group WellStar Health Parks Community safety net and senior clinics
Outcome Measure	Increase number of volunteer WellStar physicians and healthcare professionals to provide free or low-cost healthcare programs/clinics.
Scope	Primary care and specialty care providers part of WellStar Medical Group, affiliated physicians and community-based clinic physicians
Strategy	1. Initiate the GME volunteer training program for WellStar Medical Group primary care and specialty providers 2. Curriculum and process planning 3. Develop a more robust clinic setting for training that engages the local safety net clinics 4. Develop a GME program with internships, residencies and fellowships by 2016 5. Augment nurse training program 6. Integrate Patient-Centered Medical Home model into training
Strategy Measure(s)	1. # of WellStar volunteer physicians and healthcare professionals participating in GME training 2. # of residents training in underserved clinics

Community Benefit Category: **SUBSIDIZED HEALTH SERVICES**

Initiative to Implement	**Audit of Currently Subsidized Health Services**
Goal	Poll service line leadership for a System-wide audit of current subsidized health services
Hospital / Community Partners	WellStar hospital/service line leadership (including Hospice, Home Care, Pharmacy, Paulding Skilled Nursing Facility, Medical Group, Foundation)
Outcome Measure	A more targeted allocation of subsidies to address prioritized health needs.
Scope	Involve all service lines aligning with access to care and healthy lifestyles community benefit activities/programs. Include hospital outpatient services, primary/ambulatory care centers (community clinic and low-income programs), mobile units, NICU, Cardiovascular, Cancer, Women's and Children's Services, Corporate and Community Health, etc.
Strategy	1. One-on-one meetings 2. Evaluate where subsidizes are being spent, how much and to what populations 3. Research more targeted and specific allocations of subsidies, i.e. the creation of a comprehensive follow-up clinic for NICU graduates
Strategy Measure(s)	1. Total financial investment in subsidies for health services to underinsured and uninsured populations

Community Benefit Category: **RESEARCH**

Initiative to Implement	**Community Health and Healthcare Delivery Studies**	**Research Papers for Professional Journals and Presentations**
Goal	Utilize Community Health Needs Assessment (CHNA) data to better meet disproportionate unmet health needs (i.e. incidence rates of chronic conditions among underinsured/uninsured).	Develop a reporting mechanism for research activities among staff.
Hospital / Community Partners	All WellStar hospitals *Cobb Access Health* and partnering organizations WellStar Community Benefit Steering Committee	WellStar Research Institute
Outcome Measure	Prevalence of chronic disease and primary care utilization in communities served.	Number of published papers relating to community benefit delivery and prioritized health needs of the CHNA.
Scope	Five county service area of WellStar	WellStar healthcare professionals
Strategy	1. Accountability and governance of CHNA activities by WellStar CEO, Board of Trustees and Community Benefit Steering Committee 2. Conduct patient survey / exit polls in community safety net clinics / *Cobb Access Health* partners for ongoing assessments of community health needs 3. Gather data for every three-year written CHNA report and Implementation Strategy - federal requirement 4. Develop Patient-Centered Medical Home model	1. Encourage and promote studies among participating physicians in the GME, serving in community clinics or providing indigent care
Strategy Measure(s)	1. Percentage improvements in chronic disease prevalence. 2. # of low-income patients with access to primary care	1. # of published works relating to chronic disease care and healthy lifestyles in meeting Affordable Care Act requirements

Community Benefit Category: **CASH AND IN-KIND DONATIONS**

Initiative to Implement	**Grants**	**Cash / Sponsorships**	**In-Kind**
Goal	Secure matching grants to address prioritized community needs.	Audit current cash contributions and sponsorships to be more intentional about direction of funds to meet community health needs.	Leverage WellStar leadership and resources to help integrate community-based health care, delivery, services and education.
Hospital Leadership / Community Partners	WellStar Foundation – grants for school-based health programs Safe Kids Cobb County SafePath Children's Advocacy Center *Cobb Access Health*	WellStar Health System	WellStar CB Steering Committee Cobb Access Health Cobb 2020 MUST Ministries *Cobb Access Health* Good Samaritan and other safety net/community social service orgs Cobb & Douglas Public Health School-Based Health Centers
Outcome Measure	Identifiable opportunities to fund organizations addressing identified health needs thereby reducing health system and government costs		
Scope	Targeted to community benefit activities, services or programs aligning with WellStar's strategic plan to address prioritized health needs.		
Strategy	1. Leverage WellStar Foundation and partnering organizations like *Cobb Access Health* to identify funding opportunities		1. Make available facility space for community non-profits at Health Parks and other WellStar facilities aligning with health needs. 2. Engage WellStar staff to assist and evaluate community collaboration outcomes.
Strategy Measure(s)	Amount of grants, cash/sponsorships and in-kind donations invested targeting prioritized health needs and meeting community benefit requirements		

Community Benefit Category: **COMMUNITY BUILDING ACTIVITIES**

Initiative to Implement	**Integrator Role in Collaborative Low-Income Healthcare Delivery System**	***Live Well, Marietta***	**Advocacy**
Goal	Collaboration leadership for a low-income healthcare delivery system to expand care access and promote healthy lifestyles to medically underserved and uninsured Cobb County residents at or below 200 percent of the Federal Poverty Level (FPL).	Strengthen the partnership between WellStar and the City of Marietta to connect citizens and local businesses through a common interest in healthy living and expand resources to make a measureable impact on community health.	Assist government agencies as an advocate for addressing physical, environment, transportation, and social issues affecting community health.
Hospital / Community Partners	WellStar Cobb Hospital WellStar Kennestone Regional Medical Center Cobb 2020 *Cobb Access Health*	City of Marietta and other partnering Municipalities WellStar Corporate & Community Health	WellStar Public & Governmental Affairs representing all WellStar hospitals County and city government Public Health Chambers of Commerce
Outcome Measure	Meet "Triple Aim" objectives	% of businesses engaged in promoting community health	Policy-changes promoting access to care and healthy lifestyles to underserved and uninsured population
Scope	Cobb County residents at or below 200 percent FPL	City of Marietta residents	Five county WellStar service area
Strategy	1. Partnership and sponsorship of Cobb 2020 and *Cobb Access Health* 2. Leverage Center for Health Transformation to help improve healthcare quality, increase access and lower costs.	1. Work with city restaurants and grocers to provide and identify healthier food choices.	1. Involvement in Chambers of Commerce and other community-based initiatives to influence health-related policies
Strategy Measure(s)	1. # of people utilizing community-based healthcare services and programs 2. Decrease in ED utilization in Cobb County	3. # of participating businesses helping to promote healthy lifestyle choices in underserved communities	1. # of policy changes creating a more healthy community

VIII. Health Needs the Hospital Does Not Intend to Address

As part of an integrated healthcare delivery system, WellStar Paulding Hospital has participatory roles and responsibilities in an overarching community benefit Implementation Strategy. How WellStar Health System's hospital-specific CHNAs and Implementation Strategies are integrated to provide community benefit is shared in Figure 1 of the Appendix (page 27). Health needs not specifically addressed by WellStar Paulding Hospital, as outlined in Section VI, are addressed by another WellStar hospital facility, service line and/or in collaboration with community partners.

Alcohol use, listed as medium ranked prioritized health needs, and the low ranked sexually transmitted infections (STI) and teen pregnancy needs are not addressed in WellStar Paulding Hospital's Implementation Strategy leaving awareness education with schools, family and churches. From a health system standpoint, these needs can be offered as part of health education, but the issue is more cultural and societal. Also, the need for dental care will be best addressed outside WellStar Paulding Hospital in community clinics providing low-income dental care services due to lack of resources, providers and lack of expertise in this area.

Improvement to prioritized low-ranking health needs stemming from socioeconomic and physical environmental issues (transportation and air quality) get traction from public policy and education. WellStar Paulding Hospital can complement efforts to impact policy, but has to rely on public health, state and local municipalities and federal governmental agencies to drive these types of health improvements.

# # #

IX. Appendix

Figure 1

How WellStar Health System's CHNAs and Implementation Strategies are Integrated to Provide Community Benefit

Advancing the State of the Art in Community Benefit – Five Core Principles

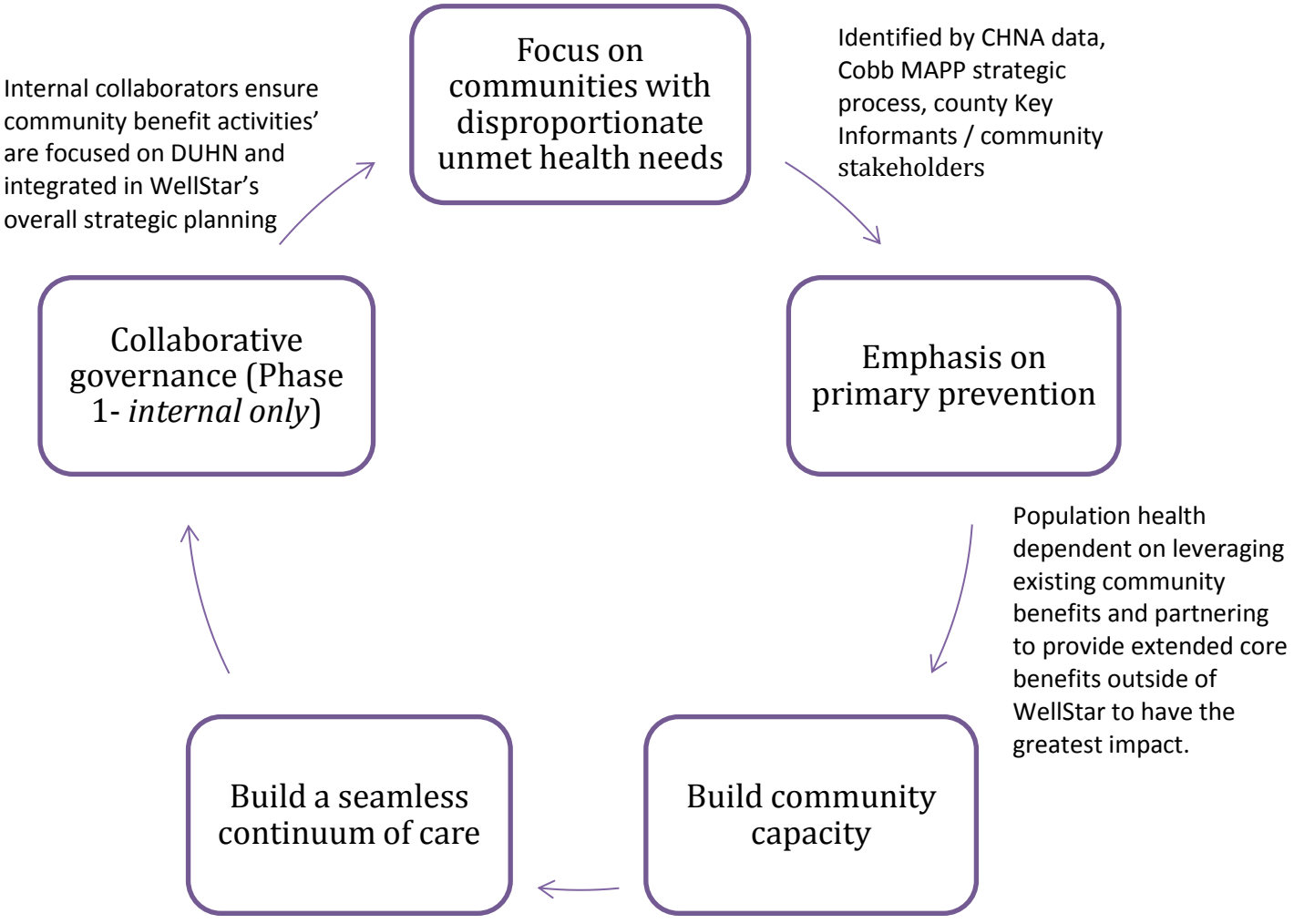

Figure 2

WellStar's Strategic Objective Scorecard[14] for Access to Health Services

Community Health Status *The desired community health outcome*	• Improve access to quality health services for the medically underserved population
Community Implementation *What must be accomplished system-wide to deliver those outcomes*	• Coordinate and facilitate care within the community with the Phase 2 goal of establishing a non-profit organization to act as community-wide "integrator" • Define ways existing facilities and channels/resources of care integrate into the community benefit model • Align with prevention-based cost-containment goals for national health reform.
Community Learning and Planning *The policies, plans, evaluation, and methodologies need to accomplish desired outcomes*	• Educate caregivers on the value of community benefit • Communicate the scope of the problem (CHNA results) • Educate the community on the available care options - how to navigate access to care
Community Assets *Community parternships and resources to enable the implementation*	• Develop partnerships to leverage resources • Prepare for safety net organziation's non-profit status by researching for grants and other funding / in-kind contributions

[14]Scorecards developed from the Cobb MAPP Community Health Improvement Plan and WellStar's CHNA process.

Figure 3

WellStar's Strategic Objective Scorecard for Healthy Lifestyles

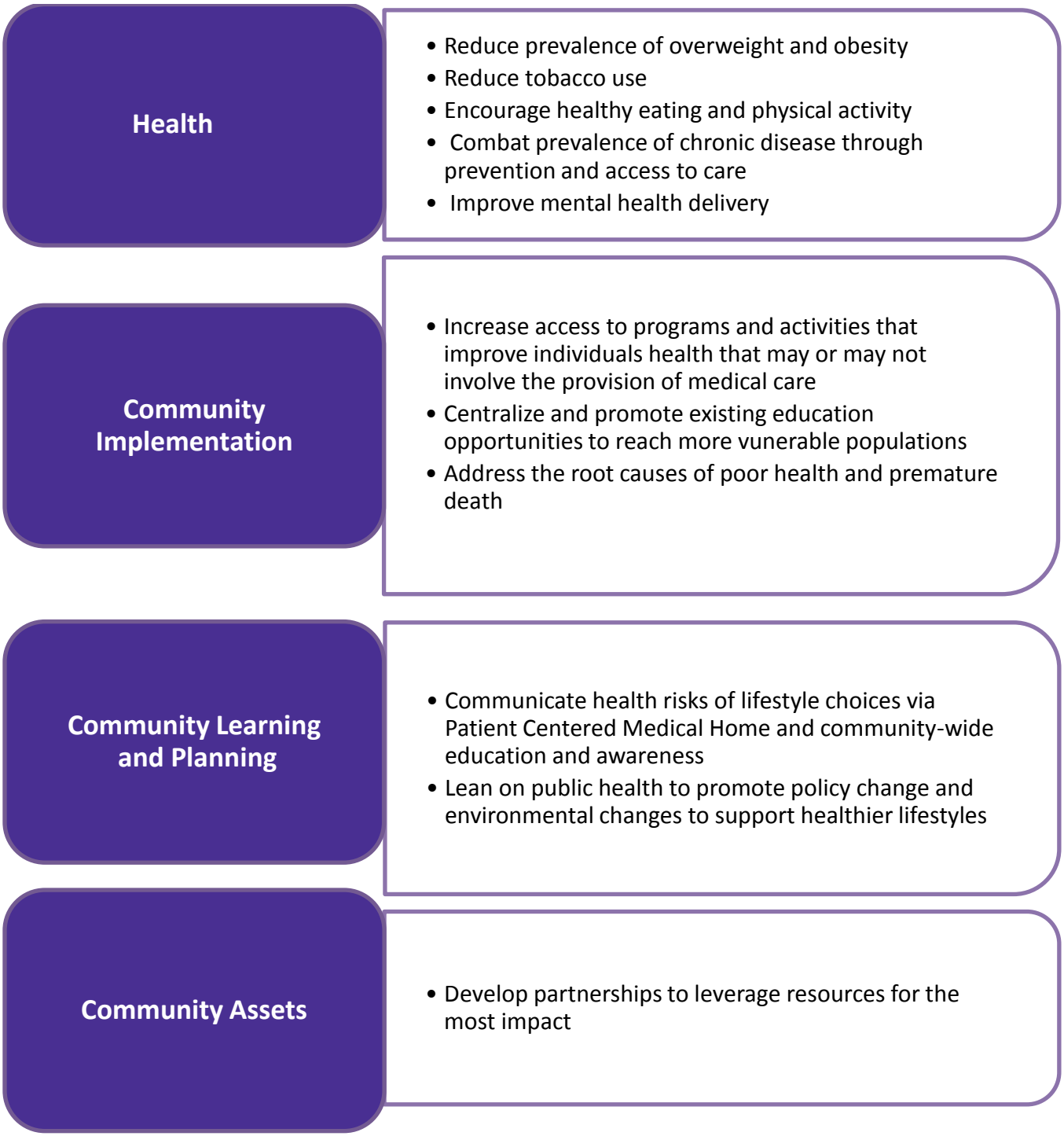

Figure 4

Transforming Healthcare for the Medically Underserved for WellStar Health System's System-Wide Implementation Strategy - Phase 2

Affordable Care Act Qualifiers:

Strengthen healthcare infrastructure

Build community capacity

Improve access to care

Improve health outcomes