2016

Morgan Memorial Hospital

Implementation Strategy

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For FY2017-2019 Summary

Morgan Memorial Hospital is a 25 bed non-profit, critical access hospital located in Madison, Georgia. In 2016, the hospital conducted a Community Health Needs Assessment (CHNA) to identify the health needs of Morgan County. The Implementation Strategy for Morgan Memorial Hospital was developed based on findings and priorities established in the CHNA and a review of the hospital's existing community benefit activities.

This report summarizes the plans for Morgan Memorial Hospital to sustain and develop community benefit programs that 1) address prioritized needs from the 2016 Morgan Memorial Hospital CHNA and 2) respond to other identified community health needs.

The following prioritized needs were identified by the community and the CHNA steering committee. Particular focus was placed upon these needs in developing the implementation strategy.

- Access to Care
- Lifestyle - Obesity and Diabetes
- Mental Health
- Senior Health
- Substance Abuse

Morgan Memorial Hospital has addressed each of the health needs identified in the CHNA. Morgan Memorial Hospital developed implementation strategies to address each of the health issues identified over the next three years.

Specific implementation strategies for each of the CHNA identified health needs are addressed in the following appendices to this report.

The Morgan Memorial Hospital Board approved this Implementation Strategy through a board vote on October 27, 2016.

Please reference additional appendices to this report for the implementation strategy for each of the health priorities.

The following issues were identified as "priority" needs by the community participants. The findings are listed in the order of priority as determined by the focus groups.

1. Access to Care
    a. There is a need for education and awareness concerning prevention of chronic illnesses, health behaviors, and habits that promote the use of primary care and preventive medicine.
    b. There is a need for a centralized resource directory to assist community residents in identifying the appropriate resources to meet their healthcare needs.
    c. There is a shortage of providers, specialists, or services in the community.
    d. There is a need for free or low cost care options for the working poor, uninsured, or underinsured.
    e. Transportation to healthcare providers is an issue for all population groups, especially the young, the poor, and the Senior residents.

2. Lifestyle - Obesity and Diabetes
    a. There is a need for education and awareness on the causes, prevention, and intervention for obesity and diabetes.
        i. There is a need for specific education on how to purchase and make healthy foods on a budget.
        ii. There is a need for lifestyle intervention education on exercise habits.
    b. There are limited places for physical activity that are cost-effective.
        i. There is a need for low cost recreational facilities or education on how to stay active with limited resources.
    c. There is a need for specific education to individuals with Type 2 diabetes on how to manage the disease through self-management strategies.

3. Mental Health
    a. There is a need for more services, providers, and specialists relating to mental health care.
    b. There is a need for education and awareness on mental illness.
    c. There is a need for education about resources for free or low cost care options.

4. Senior Health
    a. There is a need for education and awareness in relation to Senior health issues across the healthcare continuum.
        i. Medication education
        ii. Prevention/wellness education
        iii. Caregiving for the elderly
5. Substance Abuse
    a. There is a need for education and awareness surrounding healthy lifestyle choices related to alcohol, tobacco and drug use (especially prescription drugs).
    b. There is a need for education and awareness about child neglect due to parents abusing drugs and alcohol.

Community Work Plan for Access to Care

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for education and awareness concerning prevention of chronic illnesses, health behaviors, and habits that promote the use of primary care and preventive medicine. b. There is a need for a centralized resource directory to assist community residents in identifying the appropriate resources to meet their healthcare needs. c. There is a shortage of providers, specialists, or services in the community. d. There is a need for free or low cost care options for the working poor, uninsured, or underinsured. e. Transportation to healthcare providers is an issue for all population groups, especially the young, the poor, and the Senior residents.	a. Increase education and awareness of the risk factors associated with chronic illnesses and health behaviors. Increase community behavior to access primary care and preventive medicine. b. Increase awareness of community resources by centralizing and publicizing a community resource directory. c. Increase access to specialists by increasing awareness of when specialists are available for appointments locally. d. Increase awareness of free or low cost care options in the community. e. Increase awareness of available transportation services for certain population groups. Increase health promotion and screening outreach clinics to underserved population groups.

Background:

The CHNA process identified a need for more transportation to access healthcare. It also identified an overall need for better resource communication regarding available transportation services, reduced cost care options, and other community resources to increase access to prevention services.

Implementation Strategy:

a. Offer bi-monthly free, community education classes on a variety of health related topics. Calendar will be developed in partnership with clinical educator, department managers, and other community partners. Classes can be publicized via the MMH web calendar and through partner organizations.

b. Build upon directories that already exist, such as the one produced by Morgan County Family Connection, and link to the MMH website, www.mmh.org.

c. Continue to build upon specialists available locally through Piedmont Athens Regional collaboration agreement and enhance marketing efforts. This should expand significantly when the new hospital is constructed.

d. Increase awareness of indigent care policy developed in keeping with 501r regulations. Coordinate with community partners, such as Morgan County Health Department, to determine what other services are available and share this information through community education classes, Meals on Main, Caring Place, and other locations where the underserved can best be reached.

e. Evaluate possibility of providing a quarterly free/reduced cost clinic at Morgan Physician Services. Coordinate with community partners to offer basic screenings and education opportunities at Meals on Main, Caring Place, and other locations as appropriate. Coordinate with Morgan Co. Transit and evaluate possibility of offering transportation vouchers as an incentive for making and keeping medical appointments.

Possible Collaborations:

- Morgan County Family Connection
- Morgan County Health Department
- Morgan County Ministerial Association
- Piedmont Athens Regional Health Educators

Community Work Plan for Lifestyle – Obesity and Diabetes

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for education and awareness on the causes, prevention, and intervention for obesity and diabetes. There is a need for specific education on how to purchase and make healthy foods on a budget. b. There is a need for lifestyle intervention education on exercise habits. There are limited places for physical activity that are cost-effective. There is a need for low cost recreational facilities or education on how to stay active with limited resources. c. There is a need for specific education to individuals with Type 2 diabetes on how to manage the disease through self-management strategies.	a. Increase knowledge of the risk factors and intervention tactics associated with obesity and diabetes. Increase access to educational workshops on how to make healthy foods on a budget. b. Increase community knowledge of exercise habits and resources for an active lifestyle. Increase knowledge of available resources for physical activity that are free or low cost. c. Increase knowledge and education of individuals with type 2 diabetes on how to manage the disease through self-management strategies.

Background:

The CHNA process identified obesity and lifestyle as an issue that needs to be addressed. There are many modifiable risk factors associated with obesity and lifestyle such as poor nutrition, lack of physical activity, and stress. These risk factors also contribute to other diseases such as heart disease, stroke, diabetes, and cancer.

Implementation Strategy:

a. Include diabetes and obesity as topics for the bimonthly community education classes.

b. Include partner organizations currently offering free or reduced cost opportunities for physical activities in the community directory and invite them to participate when hosting outreach screenings at locations such as Meals on Main and the Caring Place.

c. Partner with local physician offices to identify individuals with Type 2 diabetes. In keeping with all HIPAA protocols, provide educational opportunities geared towards needs of this target group.

Possible Collaborations:

- Local Primary Care Providers
- Piedmont Athens Regional Health Educators
- Morgan County Recreation Department

Community Work Plan for Mental Health

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more services, providers, and specialists relating to mental health care. b. There is a need for education and awareness on mental illness. c. There is a need for education about resources for free or low cost care options.	a. Increase knowledge and awareness of available mental health resources that are local. Increase networking with local and regional mental health facilities to increase knowledge of available resources for Morgan County patients. b. Increase community knowledge of the risk factors and causes of mental illness. c. Increase knowledge of available mental health resources that are free or low cost.

Background:

The CHNA process identified mental health as a health issue that need to be addressed. The community reported a lack of local mental health providers and services. Additionally, the community reported a need for general education on the risk factors of mental illness to reduce the stigma associated with the disease.

Implementation Strategy:

a. Network with mental health facilities and providers to compile a list of available resources and services both locally and regionally. Information can be shared with local care providers, and patients as needed.

b. Include mental health as a topic for bimonthly community education program.

c. Have resource list available to distribute when doing screenings and free/reduced clinics.

Possible Collaborations:

- Advantage Behavioral Health
- Madison FUMC/Samaritan Counseling Center
- Morgan County Charter School System/Counselors
- Morgan County Ministerial Association

Community Work Plan for Senior Health

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for education and awareness in relation to Senior health issues across the healthcare continuum. a. Medication education b. Prevention/wellness education c. Caregiving for the elderly	a. Increase knowledge and awareness of Senior lifestyle issue to both the caregiver and Senior populations. a. Increase knowledge of medication compliance. b. Increase knowledge of prevention and wellness tactics. c. Increase knowledge of caregiving.

Background:

The CHNA process identified a need for more education and awareness for the Senior population and their caregivers. Morgan County is considered a retirement county. Approximately 16 percent of the population is 65 and older.

Implementation Strategy:

a. Offer educational programs at the Morgan County Senior Center, Primetimers, Assisted Living facilities and other locations where Seniors are likely to gather.

Possible Collaborations:

- Morgan County Senior Center
- Madison FUMC - Primetimers
- Local Assisted Living facilities

Community Work Plan for Substance Abuse

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for education and awareness surrounding healthy lifestyle choices related to alcohol, tobacco and drug use (especially prescription drugs). b. There is a need for education and awareness about child neglect due to parents abusing drugs and alcohol.	a. Increase knowledge and awareness of risk factors and prevention of alcohol, tobacco, and drug use (prescription drug use). b. Increase awareness and knowledge of child neglect issues associated with parental drug abuse.

Background:

The CHNA process identified substance abuse as an issue in the community. The majority of the issue surrounded lack of awareness of substance abuse problems in the population and lack of awareness of child neglect cases that originate from parental drug abuse.

Implementation Strategy:

a. Continue participation in the Teen Maze at Morgan County High School. Identify other community partners currently offering drug and alcohol programming and support them in their efforts.

b. Participate in child abuse prevention month activities hosted by Morgan County Family Connection and other local groups. Increase awareness amongst community members and law enforcement of our car seat safety program.

Possible Collaborations:

- Morgan County Sherriff's Office
- Morgan County Family Connection
- Morgan County Health Department
- Morgan County DFACS