Community Health Needs Assessment
Implementation Strategy
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Introduction

Executive Summary
University Hospital McDuffie’s 2019 Implementation Strategy Guide (ISG) accompanies its 2019 Community Health Needs Assessment (CHNA). The CHNA identifies McDuffie, Warren, Lincoln, and Columbia counties as the community University Hospital McDuffie serves. The CHNA lists three needs as priorities in that community: heart disease and stroke, diabetes, and women’s health. For the health needs we will address, the ISG describes the actions the hospital intends to take to address the health need and the anticipated impact of these actions. It also identifies the resources the hospital plans to commit to address the health needs and describes any planned collaboration between the hospital and other organizations in addressing those needs.

University Health Care System’s Mission, Vision, and Values

The mission of University Health Care System is to improve the health of those we serve.

The vision of University Health Care System is patients will insist on University, employees will be proud to be part of University, and physicians will prefer University because we set the standard for high-quality, safe care and exceptional service.

The values of University Health Care System are Quality, Safety, Service, People, Growth, and Affordability.
Action Steps in Response to the Adopted Health Needs
This section includes a list of action steps we are taking to address the adopted health needs.

Heart Disease and Stroke

The need we plan to address:
“Americans suffer almost 2 million heart attacks and strokes each year. Heart disease and stroke are the first and fourth leading causes of death in the United States. The major risk factors for heart disease and stroke – high blood pressure, cholesterol, smoking, and obesity – can be prevented and controlled.”
[www.cdc.gov/bloodpressure/docs/mh_commhealthworker_factsheet_english.pdf](http://www.cdc.gov/bloodpressure/docs/mh_commhealthworker_factsheet_english.pdf)

The actions the hospital plans to take to address that need:
Screen women for the major risk factors for heart disease and stroke – obesity, diabetes mellitus, atrial fibrillation, and high blood pressure on the Women’s Wellness on Wheels. Educate community members and encourage partnership with their physicians to set goals and control these risk factors to prevent heart attack and stroke. We will utilize the Women’s Wellness on Wheels to engage with community health workers to reach women where they are – at businesses and convenient locations in their communities for screening and education. The Million Hearts campaign from the AHA and the CDC Division for Heart Disease and Stroke Prevention encourage partnership with community health workers to support the people in their community in their health care needs with the goal of helping our community make better choices.

Our hospital has designed the Women’s Wellness Bus as a partnership with our oncology services to bring cancer screening and cardiovascular screening and education to the women of our community. We plan to leverage the relationships built over time with the oncology service line to encourage uptake of this new cardiovascular screening service. The hospital provides free education and educational materials at multiple locations in the community to both men and women and also provides prevention educational materials to women screened on the bus.

Anticipated impact of the actions:
Identify women at risk for cardiovascular disease and diabetes and provide education and connections to primary care services to develop a prevention plan.

Resources the hospital plans to commit to address the health need:
Resources needed include staffing for the Heart Attack & Stroke Prevention department, educational materials for community distribution at educational events and to patients on the Women’s Wellness on Wheels and maintenance expenses to run the vehicle. Vehicle expenses and printing material costs are approximately $10,000 annually for the cardiovascular screenings.

Planned collaboration with any other organizations:
University Hospital plans the screening locations for the Women’s Wellness on Wheels with business and community leaders and some rural health partners to allow for coordination of care for women. The Women’s Wellness on Wheels also receives funding for indigent patient screenings from the University Health Care Foundation. The Heart Attack & Stroke Prevention Center coordinates care with University’s primary and prompt cares as well as Christ Community Health Services for patients in need of ongoing preventative care.
Diabetes

The need we plan to address:
Diabetes and obesity are highly correlated, as the rates of obesity have climbed nationally and locally, we also see higher rates of diabetes and pre-diabetes. Our local area in GA and SC has higher than the national average rates for elevated BMI, lack of physical activity and type 2 Diabetes. People with diabetes are at an increased risk of developing serious complications such as heart disease, stroke, kidney failure, blindness, leg amputations, and premature death.

More than 84 million US adults – 1 in 3 – have pre-diabetes, and 90% of them don’t know they have it. Pre-diabetes is a risk factor for type 2 diabetes. Being overweight, being age 45 or older, and being physically active less than 3 times a week are risk factors for prediabetes and type 2 diabetes. According to the ADA (American Diabetes Association), in Georgia, 36.1% of the adult population, have prediabetes with blood glucose levels higher than normal but not yet high enough to be diagnosed as diabetes. An estimated 50,000 people in Georgia are diagnosed with diabetes every year.

To help prevent type 2 diabetes, the American Medical Association and the Centers for Disease Control and Prevention developed a toolkit to help health care teams screen, test and refer at-risk patients to in-person or online diabetes prevention programs. Our local community does not have access to a CDC recognized Diabetes Prevention Program (DPP). The closest CDC recognized DPP is in Columbia, S.C. There is solid evidence that participating in a Diabetes Prevention Program will improve health outcomes.

CDC supports this lifestyle change program because research shows it works. A randomized, controlled clinical trial showed that completing this lifestyle change program reduced program participants’ chances of developing type 2 diabetes by 58% compared to placebo (71% for individuals aged 60 and older.) A 10-year follow-up study showed that participants were still one-third less likely to develop type 2 diabetes a decade later than individuals who took a placebo. Those who did develop type 2 diabetes delayed the onset of the disease by about four years.

The actions the hospital plans to take to address that need:
UH Diabetes Services will launch a Diabetes Prevention Program. During the first year, we will offer this program to UH employees – education will focus on healthy food choices, fitness, and ways to incorporate healthy lifestyle changes into their daily routine. We are modeling the launch of a successful DPP program out of another large health system, which started their DPP program with employees the first year. They have since begun offering the DPP to the community.

Anticipated impact of the actions:
The first year, we will offer eligible UH employees the opportunity to participate in the Diabetes Prevention Program, free of charge – this is an opportunity to make a commitment to a healthier lifestyle and to reduce health risks down the road.

Employees at risk for developing type 2 diabetes will have the opportunity to enroll. DPP participants will be provided a trained lifestyle coach and a support group over the course of the year. The yearlong commitment is required to submit participant outcomes to the CDC to apply for full recognition.
Full CDC recognition of the DPP is required in order to bill for this service – in 2019, Medicare began reimbursing for this program, along with many private insurers. The program will serve our community in a variety of capacities – the trained lifestyle coach could partner with local churches, community centers, the YMCA (many YMCAs across the country offer the DPP – ours locally does not), civic groups, etc.

**Resources the hospital plans to commit to address the health need:**
Resources needed include training for 1 educator to become certified as a lifestyle coach through the CDC, AMA or AADE.

**Planned collaboration with any other organizations:**
The first year will focus on collaborating internally with University Hospital employees. In the second year and beyond, collaboration will expand to local churches, community centers, the YMCA, and civic groups.
Maternal Health

The need we plan to address: Maternal Mortality and Morbidity

Approximately 700 women die each year in the U.S. as a result of pregnancy or its complications. The CDC defines pregnancy-related deaths as “the death of a woman while pregnant or within one year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”

The actions the hospital plans to take to address that need:
Review POST-BIRTH warning signs (by AWHONN) with every Mother that gives birth. This will be incorporated with their hospital discharge information.

- Childbirth educator will incorporate POST-BIRTH warning signs as a part of class participants’ prenatal curriculum
- Social media campaign to bring awareness to Maternal Mortality in Georgia – will give information on POST-BIRTH warning signs/symptoms and when women should follow up with their healthcare provider – (Indicate at UH we want to empower the community with knowledge to be proactive in their own healthcare.)
- Internal campaign to educate and create awareness of POST-BIRTH warning signs to nursing staff in the Women’s Center and Emergency Department (as some patients will present to ED post-delivery with these symptoms)

Anticipated impact of the actions:
The anticipated impact would be an increase in awareness of complications women can experience after birth that could lead to death. Increased awareness among these women will reduce the risk that they will delay seeking emergency care when they experience POST-BIRTH warning signs. We would also bring attention to Georgia’s ranking as it concerns the phenomena of increasing maternal death rates in the United States, and how important it is for early detection of complications.

The ultimate impact, save the life of a new mother.

Resources the hospital plans to commit to address the health need:
The hospital can commit to providing color copy resources to have this handout given to every Mom that delivers, and/or provide plastic placards and place color copies in every room that could potentially house a postpartum mother (would have to pass infection prevention protocols). Salary and wage resources needed to incorporate new curricula into existing childbirth education programs.

Planned collaboration with any other organizations:
AWHONN (Association of Women’s Health, Obstetric and Neonatal Nurses) produces this handout and it is listed that unlimited print copies are allowed for patient education.