



2022

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

IMPLEMENTATION PLAN



Wellstar

More than healthcare.

PEOPLECARE



Health equity is when everyone has the opportunity to be as healthy as possible. To achieve health equity, multi-sectoral efforts are needed to address the severe and far-reaching health disparities that plague our state by expanding access and removing the social and economic obstacles that lead to poor health outcomes. These barriers include but are not limited to poverty, poor housing and unsafe or unhealthy environments, as well as lack of access to good jobs, quality education and comprehensive, high quality health care.

Driven by structural racism, discrimination, stigma and longstanding disenfranchisement, these obstacles overwhelmingly impact communities that are underserved, including communities of color, people with disabilities, members of the LGBTQ+ community, women, people who are incarcerated or without homes and those who live in rural or frontier settings.

These inequities do not just affect those groups that are hardest hit. They affect us all. The COVID-19 pandemic is the most recent and glaring example. By diminishing the economic, health, educational and overall human potential of millions of people in Georgia, health inequities and disparities weaken our entire society and leave us unprepared for public health threats.

Background

After an analysis of primary and secondary data gathered for the 2022 Wellstar Health System Community Health Needs Assessment (CHNA), priority health needs were identified at a Community Health Summit.

To deliver more comprehensive, collaborative and value-based community benefit initiatives, services, education and events, a task force, the Wellstar Community Health Collaborative (WCHC), was created in the fall of 2016 at the system level to address Legacy Wellstar's priority health needs.¹

The WCHC is now expanded to encompass all Wellstar hospital communities after the April 2016 acquisition of six hospitals in Georgia, five of which were converted to not-for-profit in 2017, including Wellstar Health System. This cross-functional task force enables Wellstar to better implement community benefit initiatives and measure outcomes of collaborative efforts to improve community health.

WCHC ensures that Wellstar's community benefit initiatives are designed to:

- Provide organization, framework and leadership to the delivery of community benefit services, which enables Wellstar to more effectively evaluate and measure the impact on community health,
- Strengthen Wellstar's strategic community partnerships in public and private sectors through formalized engagement that leverages shared expertise, resources and services to help build capacity, bridge intervention gaps and address health disparities,
- Boost Wellstar's ability to replicate and deliver community benefit services across an expanding health system footprint,
- Maximize the investment in Wellstar's safety-net clinic/nonprofit partners by better aligning our services and resources to address priority health needs and
- Improve overall community health, especially among the under-resourced community members.

¹ Legacy Wellstar is defined as the community where Wellstar Cobb Hospital, Wellstar Douglas Hospital, Wellstar Kennestone Hospital, Wellstar Paulding Hospital and Wellstar Windy Hill Hospital are located. Legacy Wellstar is the entity prior to the acquisition of Wellstar West Georgia Medical Center and former Tenet hospitals — Wellstar Atlanta Medical Center and Atlanta Medical Center South, Wellstar North Fulton Hospital, Wellstar Spalding Regional Hospital and Wellstar Sylvan Grove Hospital.

Review of Priority Health Needs

Wellstar Health System remains dedicated to improving the health of the community. The Implementation Plan focuses on transforming the data-driven CHNA results into actionable and measurable programs and services to optimize patient outcomes and improve overall community health.

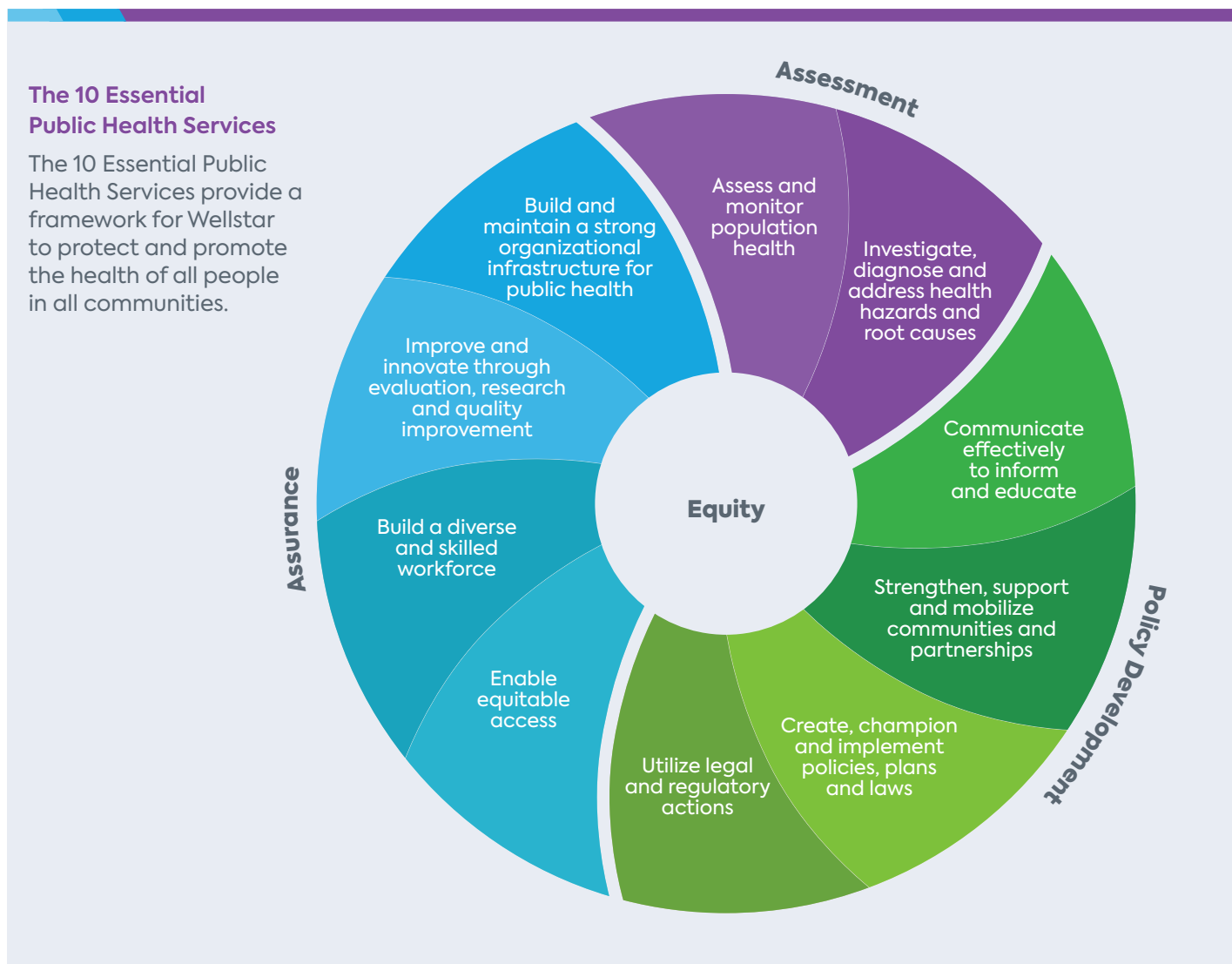
The following strategic domains were valued as priority for the community that Wellstar Health System serves. These strategic domains will inform the Wellstar Center for Health Equity programs and partnerships (internally and externally).



Implementation strategies for each need were recommended during key stakeholder interviews and focus groups with senior leadership. The strategies were later reviewed by Wellstar’s Senior leadership and vetted by the Wellstar board of trustees’ Community Advocacy and Engagement Committee, the Wellstar Board of Trustees and the Wellstar Center for Health Equity committee, the conduits for system-wide delivery of equity centric improvement services and education.

Strategy Framework and Guiding Principles

At Wellstar Health System, we strive and commit to achieving healthcare equity and eliminating healthcare disparities across the diverse communities we serve. In 2017, Wellstar Health System signed the American Hospital Association Health Equity Pledge, which aligns with the CHNA Implementation Plan. Recognizing that there are areas for improvement is a first step, but it must be followed by actionable strategies and tactics to make sustainable improvements. The 2022 CHNA demonstrated the impact and complexities of health disparities as they are affected by factors related to individuals, communities, society, culture and the environment.





Strategic Approach

In alignment with the CDC's CORE Health Equity Science and Intervention Strategy, Wellstar's CHNA Implementation Plan emphasizes internal and external collaboration to plan and carry out strategies that provide impact to local communities. These collaborations will seek to actively engage those most affected by disparities in future identification, design, implementation and evaluation of promising solutions. An equity-focused system of health offers everyone an opportunity to have a healthy life regardless of race, gender, culture or income.

C

CULTIVATE Comprehensive health equity science

Wellstar will embed health equity principles in the design, implementation and evaluation of its research, data, surveillance and intervention strategies.

O

OPTIMIZE interventions

Wellstar will use scientific, innovative and data-driven intervention strategies that address environmental, place-based, occupational, policy and systemic factors that impact health outcomes and address drivers of health disparities.

R

REINFORCE and expand robust partnerships

Wellstar will seek out and strengthen sustainable multi-level, multi-sectoral and community partnerships to advance health equity.

E

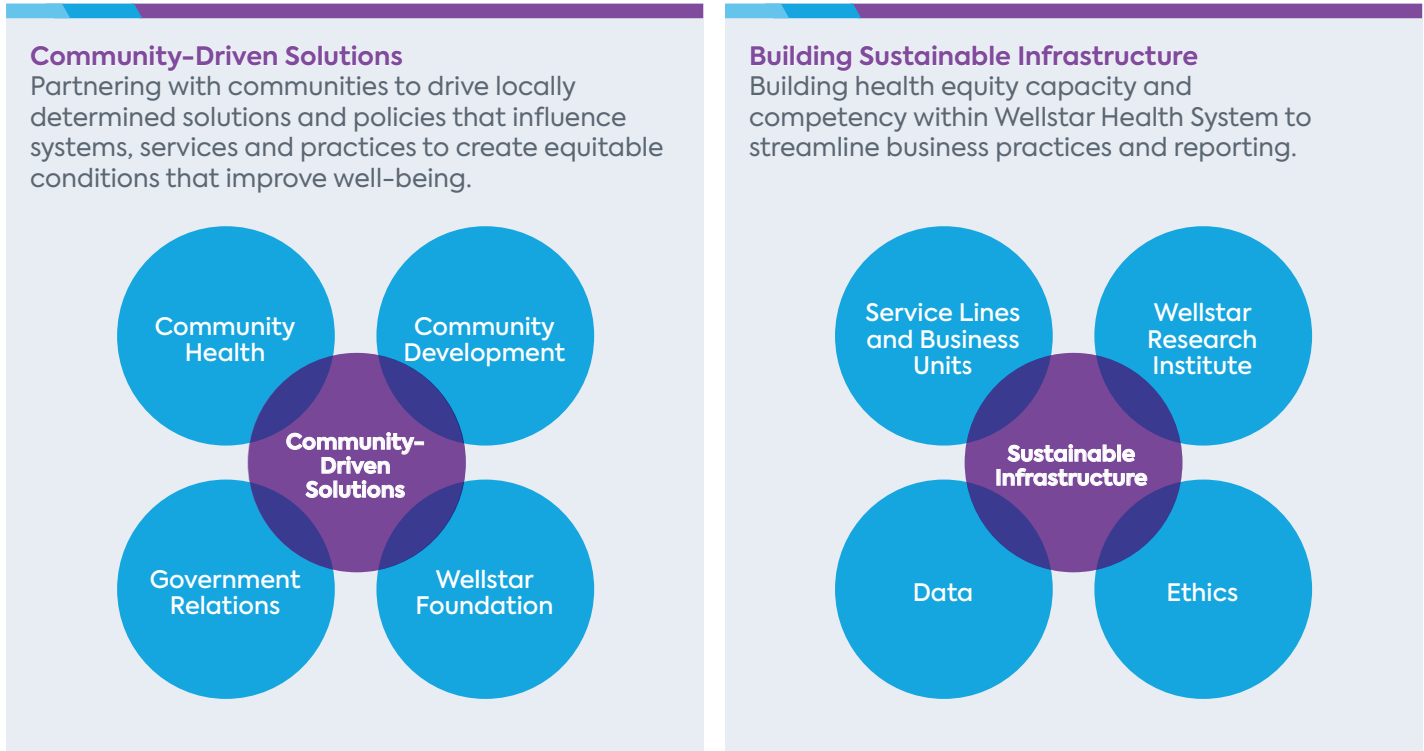
ENHANCE capacity and workforce engagement

Wellstar will build internal capacity to cultivate a multi-disciplinary workforce and more inclusive climates, policies and practices for broader public health impact.

Adapted from the CDC CORE Health Equity Science and Intervention Strategy: www.cdc.gov/healthequity/core/commitment-text/index.html

Strategic Implementation

To address the priority health needs of the 2022 CHNA, Wellstar has adopted a two-prong approach. This approach seeks to improve community conditions to support health equity and foster health for all.



Wellstar Center for Health Equity (WCHE) Dashboard and Evaluation of Action

Data, evaluation and reporting are a cornerstone for efforts to address disparities and advance health equity. Data are essential for identifying where disparities exist, directing efforts and resources to address disparities as they are identified, measuring progress toward achieving greater equity and establishing accountability for achieving progress. Without adequate data, inequities remain unseen and unaddressed.

One of the key focuses for WCHE increasing availability of high-quality, comprehensive data disaggregated by race/ethnicity is a prerequisite for efforts to advance health equity, not only related to COVID-19 but in health and health care more broadly.

At Wellstar Health System our success is measured by programmatic key performance indicators² and our ability to:

- Reduce health disparities by increasing care access and support services to under-resourced, at-risk community members
- Strengthen community capacity and collaboration for shared responsibility to address the priority health
- Improve the overall health of the community through improved access to care and a reduction of the incidence and prevalence of chronic disease?

“Without adequate data, inequities remain unseen and unaddressed.”

Kaiser Family Foundation

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

Access to Healthcare



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Community Clinic Network	Support care linkages for community residents with limited health care access by maintaining and creating formalized relationships with community safety-net clinics and graduate medical education (GME) clinics that provided subsidized care.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Value of reduced cost medical outpatient services provided to community clinic patients • Value of healthcare provided to GME clinic patients
Community Transformation Program	Increase access to healthcare and social support through the use of technology by partnering with community partners that have innovation needs.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Technology optimization and increase in reach capacity
COVID-19 Vaccinations	Increase vaccine access in underserved communities through several models including drive/walk-up, in-home and in-clinic.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Vaccines administered (1st and 2nd dose)
Colorectal Cancer Screening	Increase access to colorectal cancer screening for men who may be at high risk for colorectal cancer morbidity and mortality through a partnership with BLKHLTH (Black Health) and Cottonelle.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Clinical outcomes from screenings and connection to services by type
Mammogram Voucher Distribution	Increase access to mammogram screenings for women who may be at high risk for breast cancer morbidity and mortality through a partnership with the Wellstar Foundation and breast cancer non-profit organizations.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Clinical outcomes from screenings and connection to services by type
Social Determinants of Health Screening Program	Screen high-risk patients for core health-related social needs like housing, food, transportation, utilities and personal safety, using validated screening questions.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Clinical outcomes from screenings and connection to services by type
Primary Care Access	Increase access to healthcare through the diversification of access models.	<ul style="list-style-type: none"> • Percentage of practices that offer non-traditional office hours

Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> • Profile of partnerships that support healthcare access and social support • Social value of strategic partnerships and sponsorships • Team member volunteer hours that support access to care partner organizations
Government Relations	Lead advocacy with lawmakers, government agencies and organizations at the local, state and federal levels and shape policy to better ensure the laws and regulations implemented further advance the best interests of patients and our communities.	<ul style="list-style-type: none"> • Profile of public policy and legislation addressed that impact the lives of the people in the communities where Wellstar patients live and work.
Wellstar Foundation	Increase investments from the philanthropic community that support equitable access to healthcare and social support.	<ul style="list-style-type: none"> • Profile of partnerships that support access to healthcare and social support • Value of philanthropic partnerships and their investment in access to healthcare and social support

Behavioral Health



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Congregational Health Network “Soul Support” Program	Increase access to behavioral health education, trainings and resources at congregations across the Wellstar service area.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Connection to any services by type
Social Work Student Rotation	Increase access to social support in the community and for patients through a social work student rotation program that focuses on the influence of social determinants of health on health outcomes.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Student hours served by project type
Opioid Steering Committee	Address the opioid epidemic by leading and collaborating with Wellstar providers, patients, and the communities we serve to help reduce opioid misuse, abuse and addiction	<ul style="list-style-type: none"> • Reduction in Opioid scripts per 100 • Reduction in Co-prescribed medications (Opioids and Benzodiazepines) • Implement Fentanyl testing across the system
Zero Suicide Initiative	Lead system-wide, organizational commitment to safer suicide care to set aggressive but achievable goals to eliminate suicide attempts and deaths and organizing service delivery and support accordingly.	<ul style="list-style-type: none"> • Utilization of standardized risk screening in the Emergency Department • Safety Plan completion for all patients evaluated in the ED by a behavioral health team member who discharge to the community • Stepped-care model for high-risk patients on the Caring Outreach registry
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> • Profile of partnerships that support behavioral health • Social value of strategic partnerships and sponsorships • Team member volunteer hours that support behavioral health partner organizations
Wellstar Foundation	Increase investments from the philanthropic community that support equitable access to behavioral health.	<ul style="list-style-type: none"> • Profile of partnerships that support behavioral health • Value of philanthropic partnerships and their investment in behavioral health

Food Access and Chronic Disease Management



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Food Rescue Initiative	Reduce Wellstar’s food waste footprint, and ensure safe food redistribution to community residents in need.	<ul style="list-style-type: none"> • Meals rescued and profile of community partners supported • Pounds of waste diverted from landfills • Pounds of carbon dioxide emissions prevented
Food Resource Train the Trainer	Train team members and partners on methods for enrolling community residents in sustainable food assistance programs for complete care after an encounter with a Wellstar Mobile Market or Population Health Team.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Food insecurity score outcomes from screenings and connection to services by type
Wellstar Mobile Market	Increase access to healthy food and wellness programs through a partnership with Goodr and neighborhood-based nonprofits. Partnering with Wholesome Wave to provide bilingual support to assist the community in navigating available resources.	<ul style="list-style-type: none"> • Sociodemographic profile of participants and high-risk zip codes served • Food insecurity score outcomes from screenings and connection to services by type
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> • Profile of partnerships access to healthy food and wellness programs • Social value of strategic partnerships and sponsorships • Team member volunteer hours that support access to healthy food and wellness organizations
Wellstar Foundation	Increase investments from the philanthropic community that support equitable access to healthy food and wellness programs.	<ul style="list-style-type: none"> • Profile of partnerships that support healthy food and wellness programs • Value of philanthropic partnerships and their investment in access to healthy food and wellness programs

Housing



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Housing Learning Community	Engage in collaborative professional learning to strengthen the working knowledge of the housing crisis in Georgia.	<ul style="list-style-type: none"> • Identify team members that serve on the Housing Learning Community to identify shared health equity goals of the system
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> • Profile of partnerships that support equitable access to housing • Social value of strategic partnerships and sponsorships that support equitable access to housing • Team member volunteer hours that support equitable access to housing
Wellstar Foundation	Increase investments from the philanthropic community that support equitable access to housing.	<ul style="list-style-type: none"> • Profile of partnerships that support equitable access to housing • Value of philanthropic partnerships and their investment in equitable access to housing

Pediatrics



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Child Health Screening	Provide comprehensive screening of pediatric patients to gain valuable insight into the child's family life, safety, education and social capital, and opportunities for physical activity.	<ul style="list-style-type: none"> Wellstar Pediatric service line to track the programs benefiting the pediatric community
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> Profile of partnerships that support child health Social value of strategic partnerships and sponsorships that support child health Team member volunteer hours that support child health
Medical Home Access	Guarantee that every newborn born at a Wellstar facility has a Pediatric Medical Home, is seen within 24-48 hours, and receives timely completion of 0-30 months well visits.	<ul style="list-style-type: none"> Ensure and track attendance of every WellCheck and Immunization 0-30 months 100% access to newborns delivered in WHS hospitals
Childhood Lipid Screening	Increase childhood lipid screening to prevent early childhood heart disease, and enhance the education towards healthy lifestyle modifications.	<ul style="list-style-type: none"> Perform lipid screening during well visits once 9-11 years and once 17-21 and at other visits for at risk patients Appropriate referral to subspecialty follow-up care
Depression Screening in Adolescents	Increase depression screening to identify early symptoms of clinical depression and identify need for referral.	<ul style="list-style-type: none"> Complete depression screening tool 12 years and older yearly Increase access to behavioral care
Wellstar Foundation	Increase investments from the philanthropic community that support equitable child health.	<ul style="list-style-type: none"> Profile of partnerships that support child health Value of philanthropic partnerships and their investment in child health

Women's Health



Program/Tactic	Purpose	Key Performance Indicators <i>(not an exhaustive list)</i>
Wellstar's Women's Alliance for Healthier Outcomes (WAHOO)	Improve outcomes related to key focus areas each year utilizing a process improvement cycle-based framework.	<ul style="list-style-type: none"> • Clinical outcomes as it relates to each focus area
Perinatal Education	Increase skills, knowledge, and abilities through patient education.	<ul style="list-style-type: none"> • Number of patients and families served • Number of education materials distributed
Perinatal Kit Program	Distribute perinatal care packages monthly during the prenatal and postpartum period as an early intervention to maternal mortality and the effects of perinatal mood and anxiety disorders and other key drivers of maternal morbidity.	<ul style="list-style-type: none"> • Number of perinatal care packages distributed monthly • Number of families reached • Profile and number of community partners engaged • Sociodemographic profile of participants and high-risk zip codes served • Value of kit
Doula Program	To increase community doula programs and services available	<ul style="list-style-type: none"> • Number of doula training hours contributed • Number of doula referrals • Profile and number of community partners engaged • Sociodemographic profile of participants and high-risk zip codes served • Clinical outcomes of doula clients: Pre-term birth, low birth weight, NICU admission, unplanned/ planned cesarean and breastfeeding initiation at six months
Community Development	Increase corporate social responsibility investments and provide positive social value through strategic partnerships and sponsorships.	<ul style="list-style-type: none"> • Profile of partnerships that support women's health • Social value of strategic partnerships and sponsorships that support women's health • Team member volunteer hours that support women's health
Wellstar Foundation	Increase investments from the philanthropic community that support women's health.	<ul style="list-style-type: none"> • Profile of partnerships that support women's health • Value of philanthropic partnerships and their investment in women's health • Team member volunteer hours that support equitable access to housing

Health needs not addressed

Health needs not identified as priority to the hospitals fall into one of three categories. Wellstar has:

1. Determined that addressing a health need is outside the scope of Wellstar services;
2. Identified community partners to lead efforts with expertise in these areas with Wellstar in a supportive role and;
3. Created a “Learning Committee” to further research evidence-informed interventions that can be implemented over time.

Next Steps³

To inform strategic action plans and strategically align this Implementation Plan with the needs of our communities, Wellstar Health System will:

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnerships and create new health need focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs

³ *County Health Rankings and Roadmaps/Evaluate Actions.*
<http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions>



Wellstar
HEALTH SYSTEM

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