



IMPLEMENTATION STRATEGY

2016

Community Health Needs Assessment

This report guides the development and strategy of WellStar Health System and its five legacy hospitals to address the priority health needs of the CHNA.

WellStar Cobb Hospital
Austell, GA

Cobb Hospital, Inc.
EIN#: 58-0968382
3950 Austell Road SW
Austell, GA 30106

WellStar Douglas Hospital
Douglasville, GA

Douglas Hospital, Inc.
EIN#: 58-2026750
8954 Hospital Drive
Douglasville, GA 30134

WellStar Kennestone Hospital
Marietta, GA

Kennestone Hospital, Inc.
EIN#: 58-2032904
677 Church Street
Marietta, GA 30060

WellStar Paulding Hospital
Hiram, GA

Paulding Medical Center, Inc.
EIN#: 58-2095884
2518 Jimmy Lee Smith Pkwy.
Hiram, GA 30141

WellStar Windy Hill Hospital
Marietta, GA

Kennestone Hospital, Inc.
EIN#: 58-2032904
677 Church Street
Marietta, GA 30060

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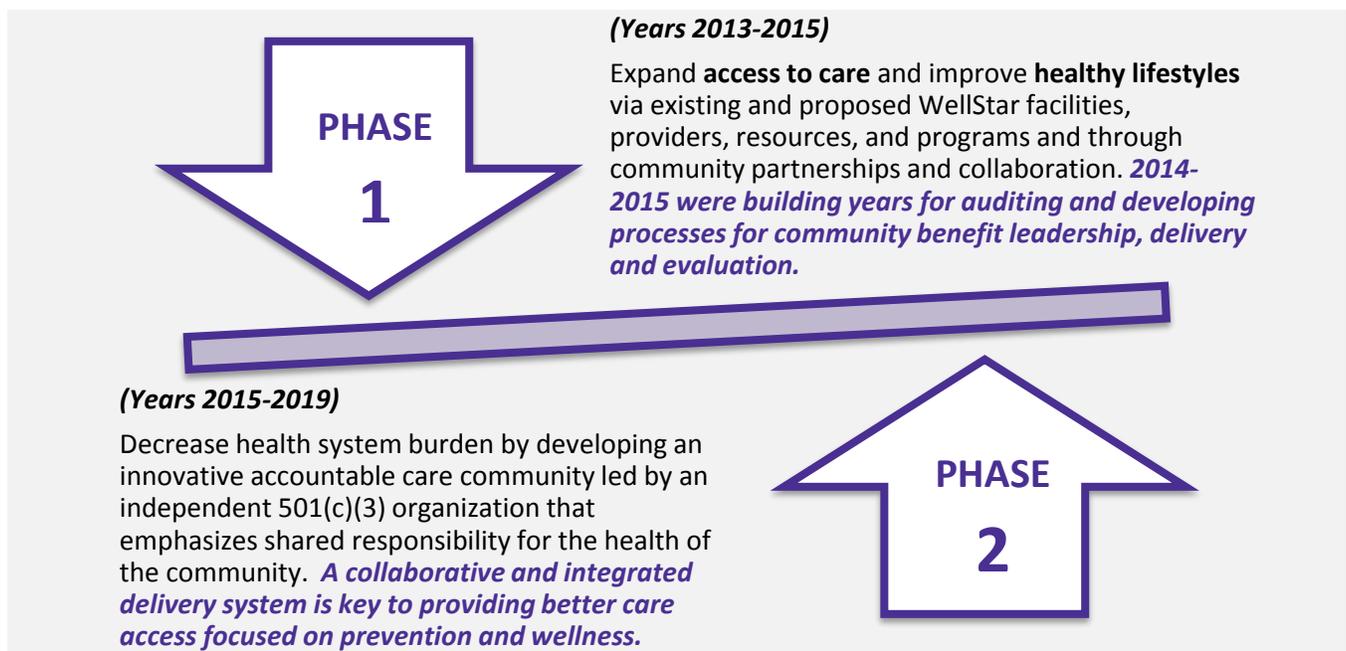
This joint Implementation Strategy for WellStar Health System's ("WellStar") five legacy hospitals has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 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. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations.

I. Background

After an analysis of community primary and secondary data gathered for the 2016 CHNA, priority health needs were identified at a February 2016 Health Needs Summit using the Triple Aim framework¹ and current assets / capacity measures² as the key indicators to improve community health. The overriding question: *Which health needs, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the most vulnerable?*

Driving the CHNA Implementation Strategy for the five WellStar legacy hospitals (WellStar Cobb, Douglas, Kennestone, Paulding, and Windy Hill hospitals) are leaders from WellStar Strategic Community Development and Population Health Management and a task force comprised of a broad spectrum of WellStar leaders and community stakeholders representing vulnerable populations participating in the Health Needs Summit.

This implementation strategy, informed and guided by the task force and the WellStar Community Education & Outreach team, features a two intervention program approach to address priority health needs. It builds upon the progress of the initial 2013 two-phased CHNA implementation strategy for the five WellStar legacy hospitals. Note: *Phase 2 is now extended from 2018 to 2019 to align with the next required triennial CHNA.*



¹ The Institute of Healthcare Improvement’s (IHI) “Triple Aim” framework: (1) Improve the patient care experience (2) Improve the health of a population (3) Reduce healthcare costs

² Other considerations: (1) The burden, scope, severity, and urgency of the need. (2) The estimated feasibility and effectiveness of possible interventions. (3) Health disparities associated with the need or the importance the community places on addressing the need.

Phase 1 work encompassed:

- Auditing and assessing what WellStar currently reports as community benefit
- Instituting processes for expanding / realigning current programs and activities
- Prioritizing and initiating the proposed community benefit initiatives both internally and with community partnerships
- Creating a hospital community benefit handbook for hospital president appointed liaisons who will report hospital-specific community benefit activities on CBISA (software platform)
- Building the framework for some of the proposed initiatives in the 2013 strategy – e.g. smoking cessation
- Developing a community benefit task force team to enact and be accountable for meeting the objectives of the 2016 priority health needs

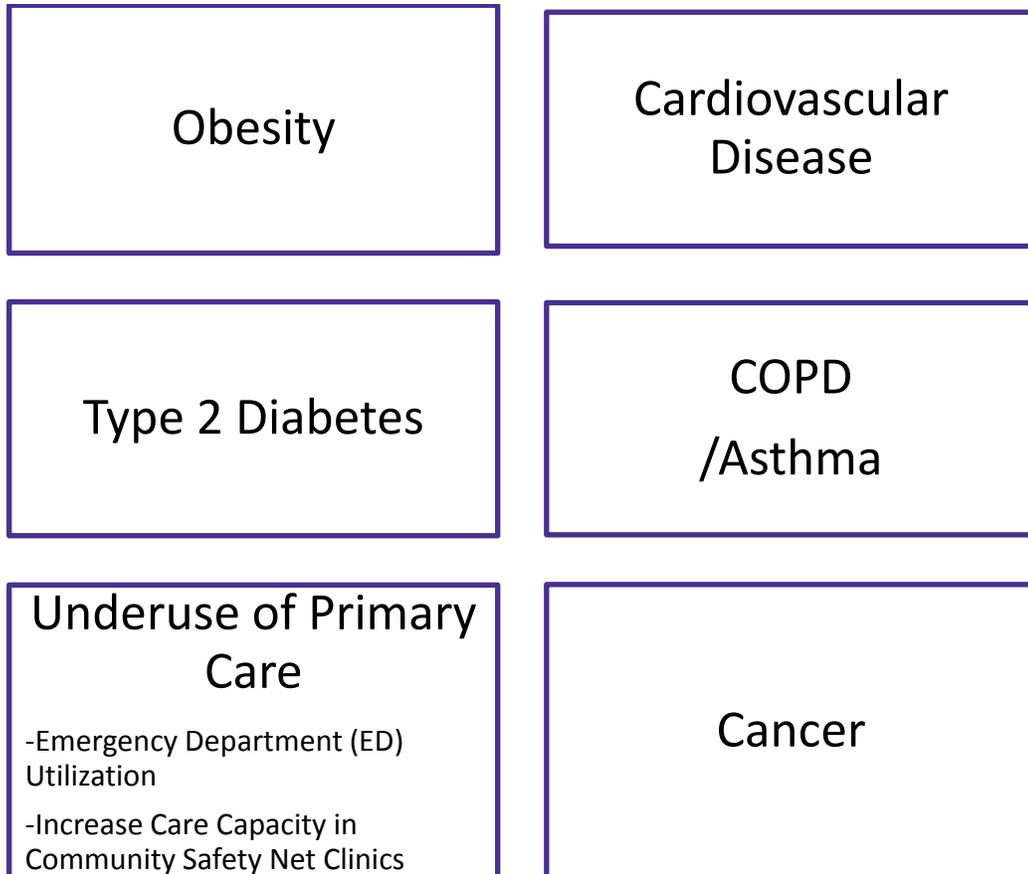
As a result, Phase 2's noted "independent 501(c)(3) organization" is being reworked as the **WellStar Community Health Collaborative (WCHC)** in order to deliver more cohesive, sustainable and value-based community benefit services with external collaborative partnerships to address priority health needs. Philosophically similar to the original Phase 2 strategy, this shift allows WellStar and its legacy hospitals to better implement initiatives and measure outcomes of collaborative efforts to improve community health, especially among the most vulnerable.

WellStar will accomplish this by implementing two new System-wide WCHC programs, WellStar 4-1 Care Network and Live Well, to address the priority health needs of the CHNA. Pairing clinical team leaders who are experts in the specific health need arena with Community Education & Outreach team members and community partners for implementation and accountability, the programs are designed to:

- ***Provide organization, framework and leadership*** to the delivery of community benefit services and enables us 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 as "Partners in Health" leveraging expertise, resources and services to complement and/or 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/non-profit partners*** by better aligning our services and resources to address priority health needs
- ***Improve overall community health, especially among the vulnerable***

II. Review of Priority Health Needs

Leaders of Kennesaw State University's A.L. Burruss Institute of Public Service & Research helped guide the WCHC task force through the prioritization process. Health needs data summaries were advanced ahead of the Health Needs Summit on Feb. 25, 2016 for review. From the significant health needs identified by CHNA research conducted in the fall/winter of 2015, the following six health needs were valuated via an online survey tool as priority for the community WellStar legacy hospitals serve:



Implementation objectives and strategies for each need were developed during two group exercises. These implementation grids were vetted on April 21, 2016 by the WellStar Community Education & Outreach team, the conduit for System-wide delivery of community health improvement services and education.

Action areas for implementation³ to improve community health are influenced by the full spectrum of the Public Health System, in which WellStar plays a vital role:

³ Centers for Disease Control and Prevention. <http://www.cdc.gov/chidatabase>

Socioeconomic Factors: Interventions that address social determinants of health, such as income, education, occupation, class, or social support. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age. These determinants contribute to a wide range of health, functioning, and quality-of-life outcomes.

Physical Environment: Interventions addressing structural and environmental conditions that have an impact on health, including the built environment, as well as the community environment. This category includes policy changes that support individuals in making healthy choices.

****Health Behaviors:*** Interventions that promote and reinforce positive individual health behaviors, and seek to enable people to increase control over their health and its determinants. They include actions that address the knowledge, barriers, and facilitators that can affect behavior.

****Clinical Care:*** Innovative interventions focused on clinical approaches to health improvement that go beyond traditional one-on-one patient care. These activities are upstream or systems-based, and include examples of clinical providers working in teams or providing direct care in a non-traditional setting.

*WellStar's greatest influence is achieved in the intervention areas of health behaviors and clinical care to address priority health needs identified in the CHNA.

The scope of WellStar's healthcare system and its commitment to the mission make us the linchpin and integrator in the community for improving overall population health by serving the underserved and uninsured. This involves providing community benefit programming internally via its System-wide and hospital-specific efforts and via the enhancement of its collaborative partnerships with stakeholders who provide care access and services to these vulnerable populations. WellStar holds itself accountable for the stewardship of resources, the enhancement of its existing community partnerships and for justifying its hospitals' not-for-profit, tax-exempt status.

III. Implementation Strategy Framework

To address the priority health needs of the 2016 CHNA, WellStar introduces two new programs to deliver community benefit services to the vulnerable populations in the community it serves. The focus is on prevention, quality/safety and care coordination to improve care access and healthy

lifestyles with the aim of proactively transforming data-driven CHNA results into an actionable and measurable community benefit program.

The WellStar 4-1 Care Network and Live Well programs provide organizational structure and accountability to WellStar and its legacy hospitals’ efforts to reach out to those in need, to improve the health of the communities we serve and to enhance access to care. These efforts flow from the WellStar mission and vision and to meet the requirements of federal government (Affordable Care Act Section 9007) of system-wide oversight and guidance regarding tracking community benefit activities, assessing community health needs and developing strategic plans that prioritize community benefit programming.

<p>ACCESS TO CARE: WellStar 4-1 Care Network <i>A Clinical Care Intervention Program</i></p> <p><i>Priority Health Need:</i> UNDERUSE OF PRIMARY CARE (ED utilization and increased care capacity in community safety net clinics)</p>	<p>HEALTHY LIFESTYLES: Live Well <i>A Health Behaviors Intervention Program</i></p> <p><i>Priority Health Needs:</i> CANCER/CARDIOVASCULAR DISEASE/COPD & ASTHMA/OBESITY/TYPE 2 DIABETES</p>
IDENTIFY	
<p>ED non-emergent (Service Level 0-2) multi-visitors to reduce utilization and readmissions and community safety net clinics in need of providers to increase patient capacity</p>	<p>“Hotspots” - areas of high need - for targeted outreach, education & screenings utilizing partnering safety net clinics and other community assets</p>
COLLABORATE	
<p>Achieve maximum outcomes to address priority health needs with a cross-functional team internally and externally. Develop and strengthen formalized external partnerships to expand outreach to vulnerable populations and internal partnerships to leverage the expertise and assets of the WellStar clinical and community outreach teams.</p>	
NAVIGATE	
<p>Prescribe resources and connect community members to assets/interventions to help eliminate socioeconomic barriers to accessing healthcare, especially preventive care</p>	
TREAT	
<p>Increase care capacity at WellStar and community safety net clinics via WMG volunteerism</p>	<p>Increase access to preventive screenings to vulnerable populations</p>
EDUCATE	
<p>Integrate Live Well education and outreach opportunities in the WellStar and community safety net clinics and prescribe appropriate resources to frequent ED visitors</p>	<p>Deliver health need-specific education to 4-1 Care Network partners and in other high need areas and trigger WellStar Connect alerts for disease-specific education in MyChart patient portal</p>

1 - WellStar 4-1 Care Network *(Access to Care – Clinical engagement)*

A Clinical Care Intervention Program

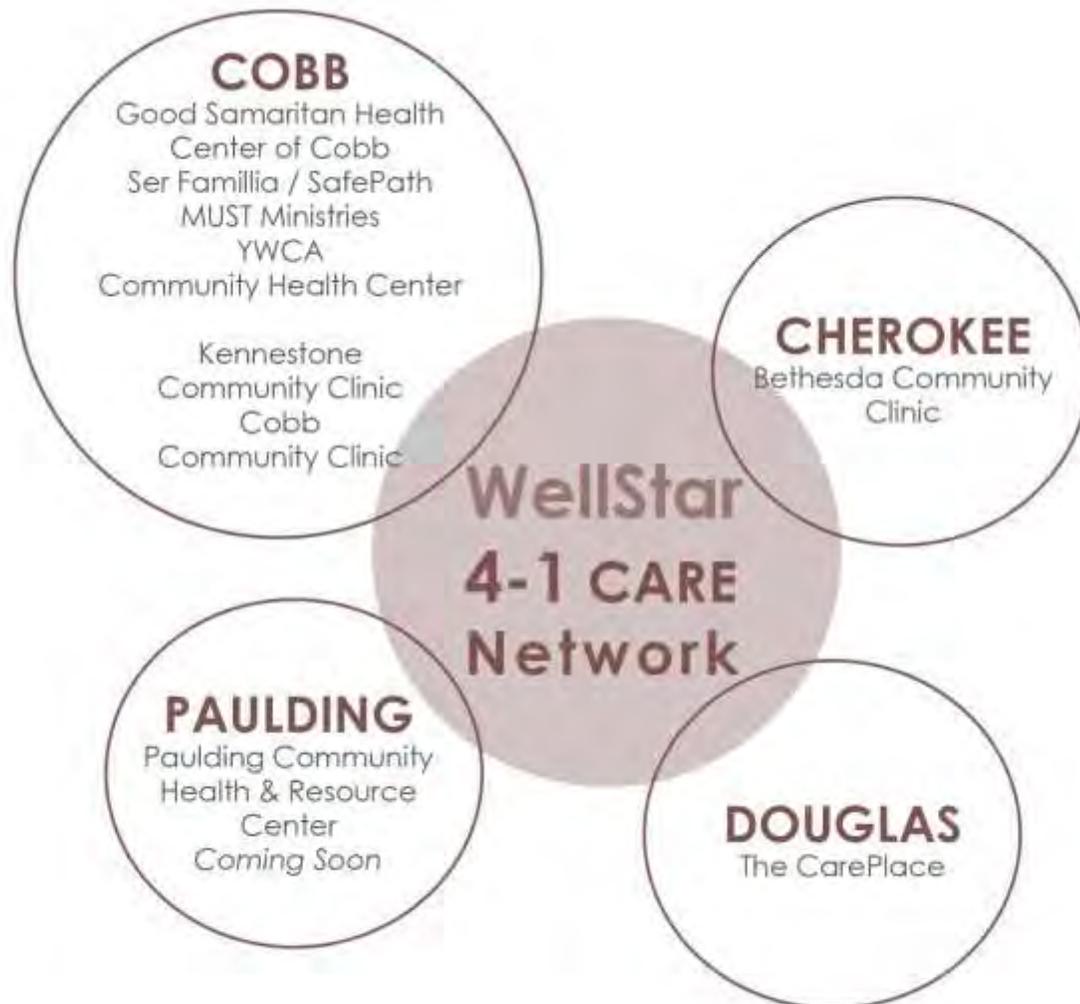
Priority Need Addressed: Underuse of Primary Care: includes ED utilization and increased care capacity at community safety net clinics

Goals:

- Expand the WellStar patient experience to partnering community safety net clinics to reduce health disparities through improved access to volunteer primary care physicians and other specialty medical services to vulnerable populations
- Build a cost-efficient model of care
- Develop and educate about available health resources and facilities to “prescribe” to the medically underserved and uninsured
- Decrease ED utilization and readmissions for non-emergent needs to deliver the right care at the right place to the medically underserved and uninsured

The name refers to the aim of the low-cost healthcare delivery system in the community to care “for one” another by addressing the underuse of primary care and reducing ED utilization and readmissions for non-emergent issues that potentially could be treated in an outpatient setting. It also reflects increasing safety net clinic capacity, education and resources via WellStar Medical Group (WVG) citizenship, with MDs and NPs volunteering four hours one time per month.

Powering this wheel is the WVG for care capacity, the ED care coordinators for referrals of frequent ED visitors for non-emergent needs, the Community Education & Outreach team, and WCHC task force leaders representing the healthy lifestyle-related priority needs for preventive outreach and education. Some of the 4-1 Network’s care channels already formally exist to address access to care barriers.



In addition to providing free and reduced cost labs and radiology to partnering community safety net clinics, WMG providers will become vital care collaborators to help diminish care access barriers and increase clinic capacity through volunteerism. Expanding partnerships with community safety net clinics and other health-related organizations will enable WellStar to achieve optimal outcomes for more medically underserved and uninsured residents and also conduct a more thorough evaluation of the impact of delivered community benefit services.

WellStar’s other community benefit program, Live Well, supports and reinforces the outreach of the WellStar 4-1 Care Network by hosting preventive health and wellness programs at the partnering care sites serving the community’s most vulnerable residents.

2 – Live Well (Healthy Lifestyles – *Community engagement*)

A Health Behavior Intervention Program

Priority Needs Addressed: Cancer, Cardiovascular Disease, COPD/Asthma, Obesity, Type 2 Diabetes

Goal:

- Improve the health of medically underserved and uninsured residents through targeted preventive services, education and outreach

Live Well’s targeted outreach to vulnerable populations to address healthy lifestyle-related priority health needs leverages the WellStar 4-1 Care Network partners by delivering health need-specific education, events and preventive screenings on-site and in other high-need site locations. Live Well works in tandem with 4-1 Care and other collaborative partnerships to help reduce the prevalence of chronic disease and its complications through prevention and wellness activities and the promotion of healthy lifestyles.

Aligning the resources of the WellStar Community Education & Outreach team, Live Well also will partner with other community groups and organizations proximate to community safety net clinics for volunteerism, health navigation, transportation, and other supportive services.

IV. Implementation Strategy to Address Priority Health Needs

WellStar 4-1 Care Network

Underuse of Primary Care

Task Force Medical Advisor:

Jeffrey Tharp, M.D. *with assistance from*
WellStar Medical Group
Hospital Care Coordination
WellStar Community Clinics
WellStar Graduate Medical Education

Objectives:

- Reduce WellStar Cobb, Douglas, Kennestone, and Paulding hospitals' ED utilization for non-emergent, ambulatory care sensitive conditions by five percent.
- Increase the care capacity of safety nets by 10 percent through WellStar Medical Group provider volunteerism.

Strategy:

- Launch the WellStar 4-1 Care Network (Fall/Winter 2016) and measure the program's impact on patient census, education and outcomes.
- Identify patients with three or more ED visits (Service Level 0-2) and those with preventable readmissions to refer to community clinics/services and prescribe resources.
- Provide health insurance enrollment and/or Community Financial Assistance outreach and support to assist eligible community members.
- Improve and expedite care delivery between hospital EDs and WellStar community clinics for the "right care at the right place" (utilize WellStar Graduate Medical Education (GME) program residents).

WCHC Partners in Health in the 4-1 Care Network include *(not an all-inclusive list as more formalized partnerships will be forged):*

- Bethesda Community Clinic (Cherokee County)
- The CarePlace (Douglas County)
- Public Health Departments
- Good Samaritan Health Center of Cobb (Cobb County)
- MUST Ministries (Cobb and surrounding counties)

- Paulding Community Health & Resource Center (Paulding County)
- SafePath Children’s Advocacy Center
- Ser Familia
- WellStar Community Clinics (Cobb & Kennestone and GME clinics)
- WellStar Congregational Health Network
- WellStar Medical Group and Clinical Partner

Live Well

Cancer

Task Force Leaders:

Vickie Beckler BSN, RN, Program Coordinator, Cancer Screening Community Education & Outreach representative

Objective:

- Increase cancer screenings by 10 percent to targeted at-risk and vulnerable populations in the WellStar legacy hospitals’ community.

Strategy:

- Reduce access barriers for preventive screenings and resources
 - *Financial:* Facilitate state Medicaid and WellStar Community Financial Assistance applications/enrollment.
 - *Transportation:* Explore partnerships with public transit, private companies and community organizations to provide transport.
 - *Mental health:* Provide mental health resources for cancer patients through the WellStar Cancer Network’s Oncology Integrated Behavioral Health Services.
- Develop a comprehensive cancer screening and early detection program to expand outreach to community, including the most vulnerable.
 - Establish a Screening & Early Detection Subcommittee to implement and monitor efforts led by WellStar Cancer Network. This includes increasing a clinical presence at community events in areas of high need and developing

community education and resources regarding screenings (guidelines and eligibility). Community Education & Outreach to support screening awareness.

- Identify at risk population segments in Epic eligible for screenings and at community mobile screening events and dedicate resources to connect and navigate utilizing STAT clinics and/or clinical-based referral processes as appropriate.
- Safety net clinic collaboration: Develop master order sheet and cancer screening risk assessment/questionnaire for partner safety net clinics for mammography vouchers, lung cancer screenings (WellStar Foundation funded)
- Support ACS and State of Georgia's colorectal screening goal of 80 percent by 2018 using the lung cancer screening program as guide
- Develop cancer screening education program to be presented at throughout the community and worksite locations.
- Develop a comprehensive strategy to deliver mammography vouchers throughout community targeting underserved and uninsured , including the WellStar Cancer Network, Community Education & Outreach and the WellStar Foundation.

WCHC Partners in Health include:

- American Cancer Society
- Georgia Department of Public Health
- Safety net clinic partners
- WellStar Foundation
- WellStar Community Education & Outreach

Cardiovascular Disease

Task Force Leaders:

Julie Stebbins, M.S., Director, WellStar
Cardiac Wellness and Rehabilitation
Community Education & Outreach
representative

Objective:

- Increase heart disease outreach, screenings and education, including smoking cessation and prevention, in the current underserved / uninsured WellStar community.

Strategy:

- Expand Population Health's evidence-based tobacco cessation program to WellStar Community Health Collaborative partners.
- Identify "hotspots" in community to develop and expand offering mobile cardiac screenings to high-risk populations delivered by WellStar Cardiac Network and Community Education & Outreach.
- Create disease management program - group education at 4-1 Care sites.
- Continue to focus on heart healthy school-based education for students and parents.
- Design a System-wide approach to reducing ED re-encounters and readmissions of high risk heart patients (WellStar Cardiac Network).
- Increase the outreach efforts through the Community Education & Outreach program and partners focusing on education and promotion of heart healthy behaviors.

WCHC Partners in Health include:

- Safety net clinic and other 4-1 Care Network partners
- American Heart Association
- WellStar Cardiovascular Medicine
- WellStar Community Education & Outreach
- PTAs

COPD / Asthma

Task Force Leaders:

Chirag Patel, M.D., Medical Director,
Population Health
Community Education & Outreach
representative

Objective:

- Maximize community and hospital resources for patient and community education, detection and treatment of COPD and asthma.

Strategy:

- Increase low-cost medication access beyond WellStar retail pharmacy vouchers on certain brand medications/inhalers.
- Institute centralized reduce cost Pharmaceutical Patient Access Program (PAP) and Federal 340B Drug Discount Program at the legacy hospitals.
- Introduce a discount card program in the ED to reduce costs to the patients and health system (pilot at Paulding).
- Expand tobacco cessation clinical engagement and community-based education (work with Cardiovascular Disease task force leaders)
- Utilize WellStar Congregational Health Network to support post-discharge care (Memphis Model) to lower readmission rates – *future pilot program*.
- Support early detection and education
 - Provide spirometry at WMG offices and partnering safety net clinics
 - Coordinate hospital inpatient education and prescription of resources to prevent readmissions and improve quality of life
 - Partner with Cobb & Douglas Public Health (offers asthma certifications in childcare facilities and schools)
 - Explore possibility of offering asthma education as a new topic for school health programs offered by Community Education & Outreach
 - Host a summit for school health nurses in each county to educate on asthma
 - Develop resource list of low-cost medications for community events
 - Schedule future *Speaking About Wellness* presentations focused on detection and treatment of asthma and COPD

WCHC Partners in Health include:

- Safety net clinics and other 4-1 Care Network partners
- Public Health
- Atlanta Asthma & Allergy
- Children’s Healthcare of Atlanta pediatric pulmonary
- Schools
- Clean Air Campaign
- Nobody Quits Like Georgia campaign
- WellStar Community Education & Outreach

Live Well



Obesity

Task Force Leaders:

Cecelia Patellis, Assistant Vice President,
Community Education & Outreach
Community Education & Outreach
representative

Objective:

- Increase access to obesity-specific education, screenings and health interventions to at-risk community members.

Strategy:

- Deliver obesity-related education in non-health settings in geographical areas with concentrated obesity rates exceeding state prevalence rates.
 - Increase free screenings for chronic disease in "hotspots" and education to prescribe resources for no or low-cost care and medication
 - Promote integrated mental health care models and resources, including mobile deployment (mental health screenings) to support behavior modification
 - Increase access to healthy and affordable food and education via the WellStar Nutrition Network and community partners

- Mobilize WellStar Community Health Collaborative Partners in Health to promote education and incentivize healthy lifestyle choices
 - Develop a comprehensive list of resources available to the community
 - Explore partnerships to expand offering free or reduced cost exercise classes
 - Dedicate a portion of sponsorship dollars to support activities that promote community engagement with physical activity and good nutrition

WCHC Partners in Health include:

- Safety net clinic and other 4-1 Care Network partners
- WellStar Behavioral Health Network
- Schools
- Farmer’s markets
- Fitness facilities
- Public Health partnership to enhance nutrition education
- Atlanta Community Food Bank
- Family Resource Center
- Wal-Marts
- WellStar Community Education & Outreach

Live Well

Type 2 Diabetes

Task Force Leaders:
 Brenda Brown, BSN, RN, Director, WellStar
 Diabetes Services
 Community Education & Outreach
 representative

Objective:

- Increase the number of people receiving diabetes self-management education (DSME) by ten percent.

Strategy:

- Increase referrals to WellStar Outpatient Diabetes Education throughout the WellStar legacy hospitals' community to improve the quality of life and prevent complications in patients with diabetes.
 - Outreach to underserved areas through partnering safety net clinic referrals, other WCHC Partners in Health and PCPs/hospitalists
 - Leverage existing PCPs and safety net clinics to conduct routine diabetes risk assessments and refer patients triggering risk factors for DSME
- Develop a comprehensive list of resources including low-cost medication access and behavioral health.
- Target underserved areas through collaborative efforts of Community Education & Outreach and Diabetes Services to increase prevention and care education.
- Activate alerts to health-need specific education and events via the WellStar Connect MyChart (electronic medical record patient portal).

WCH Partners in Health include:

- Safety net clinic and other 4-1 Care Network partners
- YMCA
- Vision clinics
- Support Groups
- Gyms
- Ser Familia
- Schools
- Pharmacies (Prescription Assistant Program)
- WellStar Community Education & Outreach

V. Health Needs Not Addressed

As outlined in the 2016 CHNA, health needs not identified as priority fall into one of three categories:

- 1) Beyond the scope of WellStar services, e.g. dental care which is addressed by safety nets clinics
- 2) Needs further intervention, but no plans for expanding current community benefit services at this time, e.g. maternal/infant health
- 3) Relying on community partners to lead efforts with expertise in these areas with WellStar in a supportive role, e.g. substance abuse, violence, suicide, STDs, transportation

VI. Evaluation of Action

Baseline data is being gathered to effectively measure the outputs and outcomes of the WellStar 4-1 Care Network and Live Well programs in order to meet objectives of priority health needs.

The programs' success can be measured by WellStar's ability to:⁴

- 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 and its hospitals serve

Did the program:

- Improve the overall health of the community⁵ through improved access to care and a reduction of the incidence and prevalence of chronic disease?
- Serve and advocate for the medically underserved populations with the goal of providing the right care at the right place?

⁴Public Health Institute, Kevin Barnett. *Quality and Stewardship in Community Benefit*, March 11, 2010.

⁵ WellStar uses a broad definition of community that allows for measurable opportunities to address population-health issues, while being focused enough to address health disparities.

- Improve the delivery and reporting of community benefit services to better demonstrate WellStar’s commitment to improve overall community health?
- Implement improved financial assistance, billing and collection policies that protect patients and reduce the number of patients relying on charity care?⁶
- Collaborate with multi-sector community partners to increase capacity for the underserved and uninsured to relieve or reduce the burden of government?

Next Steps⁷

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation question(s)
4. Evaluate partnerships and make changes
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
11. Share results

Tracking Progress

The 2013 System-level and broad-based community benefit strategies outlined in red are in progress and rollover during Phase 2 via the services of the WellStar Community Health Collaborative’s 4-1 Care Network and Live Well programs. Those outlined in gray are evaluation-focused strategies that need attention as we enact the priority health needs’ strategies, build internal frameworks for accountability and formalize, strengthen or create collaborative community partnerships.

⁶ The provision of charity care is the majority of WellStar’s community benefit investment at \$101 million for fiscal year 2015.

⁷ County Health Rankings and Roadmaps / Evaluate Actions. <http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions>

Reduce health disparities

Realign community benefit services in communities with disproportionate unmet health needs

Expand access to care and healthy lifestyle interventions

Increase clinician engagement in Community Benefit

Engage community collaborators to meet unaddressed needs

Reduce healthcare costs

Reduce preventable hospital events

Expand primary prevention education

Promote benefits of Patient Centered Medical Home to providers **This shifts to 4-1 Care onboarding*

Build capacity through community collaboration with stakeholders

Enhance community capacity / collaboration

Deliver community benefit services via coalitions to meet more health needs

Measureable impact for primary prevention activities **Live Well tracking and reporting*

Engagement of diverse community stakeholders **WCHC Partners in Health*

Evidence of increased community capacity through evaluation and measurements **4-1 Care Network tracking and reporting*

VII. Hospitals' Roles and Responsibilities

Although the majority of WellStar's community benefit services are delivered System-wide, each of WellStar's legacy hospitals (WellStar Cobb, Douglas, Kennestone, Paulding, and Windy Hill hospitals) will play a role in the implementation of the priority health needs. Hospital presidents and community benefit liaisons are vital to guiding and promoting the community benefit services programs, specifically for the clinical engagement and care coordination of the WellStar 4-1 Care Network.

WellStar Cobb Hospital

- A hospital president-appointed community benefit liaison will track and report hospital-based community benefit (such as volunteerism and blood drives) not evaluated as part of the WCHC programs to address priority health needs (those community benefit services will be reported in the community benefit software, CBISA, by Community Education & Outreach and the WellStar 4-1 Care Network team)
- Hospital care coordination will play a vital role in the implementation of the 4-1 Care Network to address ED utilization among frequent visitors with non-emergent needs who potentially could be treated in an outpatient setting
- The human resources of WMG hospital-based and service line providers will help increase care capacity in community safety net clinics to address the underuse of primary care as volunteers in the 4-1 Care Network, specifically in clinics proximate to the hospital including Good Samaritan Health Center of Cobb. Also, the provision of clinical assistance/staffing for preventive screenings and education delivered by the Live Well community benefit services program will maximize chronic disease-focused programming and be more effective through the task force pairing of Community Education & Outreach and health need-specific clinical leadership.
- Utilize hospital-based retail pharmacies for access to low-cost medication and resources / **Features a 340B drug pricing program as a Medicare/Medicaid Disproportionate Share Hospital*
- Assist with government-sponsored health insurance enrollment and applications for WellStar's Community Financial Assistance
- Health Parks (hospital outpatient facilities of Kennestone – East Cobb & Acworth - and upcoming in Vinings for Cobb hospital) provide an outreach and education setting for Live Well community health improvement activities and education
- WellStar Community Clinics (hospital outpatient facilities of Cobb and Kennestone hospitals) help increase low-cost care capacity; working with ED care coordinators

WellStar Douglas Hospital

- A hospital president-appointed community benefit liaison will track and report hospital-based community benefit (such as volunteerism and blood drives) not evaluated as part of the WCHC programs to address priority health needs (those community benefit services will be reported in the community benefit software, CBISA, by Community Education & Outreach and the WCHC team)
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- Utilize hospital-based retail pharmacy for access to low-cost medication and resources
- Assist with government-sponsored health insurance enrollment and applications for WellStar's Community Financial Assistance

WellStar Kennestone Hospital

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Ministries clinic. Also, the provision of clinical assistance/staffing for preventive screenings and education delivered by the Live Well community benefit services program will maximize chronic disease-focused programming and be more effective through the task force pairing of Community Education & Outreach and health need-specific clinical leadership.

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WellStar Paulding Hospital

- A hospital president-appointed community benefit liaison will track and report hospital-based community benefit (such as volunteerism and blood drives) not evaluated as part of the WCHC programs to address priority health needs (those community benefit services will be reported in the community benefit software, CBISA, by Community Education & Outreach and the WCHC team)
- Hospital care coordination will play a vital role in the implementation of the 4-1 Care Network to address ED utilization among frequent visitors with non-emergent needs who potentially could be treated in an outpatient setting
- Paulding will be the pilot site to implement an adapted MEMPHIS model for post-discharge care.
- The human resources of WMG hospital-based and service line providers will help increase care capacity in community safety net clinics to address the underuse of primary care as volunteers in the 4-1 Care Network, specifically clinics proximate to the hospital including the Paulding Community Health & Resource Center scheduled to open Dec. 1, 2016.
- The provision of clinical assistance/staffing for preventive screenings and education delivered by the Live Well community benefit services program will maximize chronic disease-focused programming and be more effective through the task force pairing of Community Education & Outreach and health need-specific clinical leadership.
- Utilize hospital-based retail pharmacy for access to low-cost medication and resources
- Assist with government-sponsored health insurance enrollment and applications for WellStar's Community Financial Assistance

WellStar Windy Hill Hospital

- A hospital president-appointed community benefit liaison will track and report hospital-based community benefit (such as volunteerism and blood drives) not evaluated as part of the WCHC programs to address priority health needs (those community benefit services will be reported in the community benefit software, CBISA, by Community Education & Outreach and the WCHC team)
- Hospital care coordination will play a vital role in the implementation of the 4-1 Care Network to address ED utilization among frequent visitors with non-emergent needs who potentially could be treated in an outpatient setting
- The human resources of WMG hospital-based and service line providers will help increase care capacity in community safety net clinics to address the underuse of primary care as volunteers in the 4-1 Care Network, specifically clinics proximate to the hospital including Good Samaritan Health Center of Cobb
- The provision of clinical assistance/staffing for preventive screenings and education delivered by the Live Well community benefit services program will maximize chronic disease-focused programming and be more effective through the task force pairing of Community Education & Outreach and health need-specific clinical leadership
- Utilize hospital-based retail pharmacies for access to low-cost medication options
- Assist with government-sponsored health insurance enrollment and applications for WellStar's Community Financial Assistance
- Health Parks (hospital outpatient facilities of WellStar Kennestone – East Cobb & Acworth - and upcoming in Vinings for WellStar Cobb hospitals) provide an outreach and education setting for Live Well community health improvement activities and education

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