INTRODUCTION

During April and May 2013, St. Joseph's Hospital, Inc. and Candler Hospital, Inc. jointly worked together as St. Joseph's/Candler to identify the health and social determinants of health needs in Chatham County. The findings were published in the joint report filed in June 2013. The entire report can be found on the St. Joseph's/Candler website under the section, "In the Community" or by going to: http://www.sjchs.org/documents/public/sjc_needs_assessment.pdf

METHODS OF DETERMINING NEEDS

Using the findings of health and social needs identified through the Healthy Communities Institute data base and the Community Health Needs Assessment Survey, St. Joseph's/Candler and collaborating partner, Memorial Health, met with key collaborators to evaluate findings and prioritize the needs that were identified. These key collaborators have members who represent the underserved and vulnerable populations of Chatham County. Their input was invaluable in finalizing the findings of the Community Health Needs Assessment.

A decision tree was used to determine if an indicator was or was not a community need. There were four determination types:

1. Secondary Data – Is the Chatham County indicator red or yellow? If yes, the indicator is a community need
2. Secondary Data – Is the Chatham County value meeting the Healthy People 2020 target? If not, the indicator is a community need.
3. Primary Data – Did survey respondents identify additional needs? If so, they are a community need.
4. Primary Data – Did the Community input process identify addition needs? If so, they are a community need.

They were color coded green, yellow and red to match the corresponding quartile of each indicator. The final list of needs was then evaluated to see which needs St. Joseph's/Candler has the ability to either individually or collaboratively address.

FISCAL YEAR 2016 PROGRESS REPORT

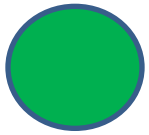
St. Joseph's Hospital, Inc. and Candler Hospital, Inc. complete an annual report together each year which high-lights the work the hospitals have done separately and together to meet identified community needs which the two hospitals have pledged to address. This report, "The 2016 Joint Implementation Plan Progress Report" includes the needs identified, objective, initiative/program/service, population target, timeline, action steps/responsible party and target date and metrics from the original plan, as well as, the current status of each of those initiatives/programs/services. A stoplight legend is used to convey to the reader the status of each objective's status. **Red** indicates the initiative/program/service has not the stated goals. **Yellow** indicates the initiative/program/service is moving in a positive direction, but has not met the original target and requires continual monitoring. **Green** indicates initiative/program/service is at target and meeting the stated

objectives. Narratives and statistics in blue font explain what has been done during the hospital's fiscal year 2014 and the measure(s) of progress for each identified need.

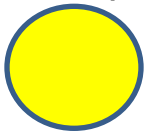
NEEDS IDENTIFIED WHICH ST. JOSEPH'S/CANDLER WILL ADDRESS

NEED IDENTIFIED:	**Increase Access to Health Insurance for Adults and Children**		
Objective:	**Contribute to the decrease in the percent of uninsured in Chatham County by December 2014**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Facilitate enrollment in Health Exchange through counseling services and on-line assistance at four SJ/C outreach sites. 1.) African American Health Information and Resource Center 2.) Good Samaritan Clinic 3.) St. Mary's Community Center 4.) St. Mary's Health Center Population Target: Uninsured Adults and Children; concentrate on residents in zip codes 31401, 31404 and 31415	Initial Oct. 2013 – Feb. 2014 Ongoing enrollment support Oct. 2013 – Feb. 2014; Oct. 2014 – Dec. 2014 and Oct. 2015 – Dec. 2015	1.) Commit staff time and resources of at least one co-worker at each of the four sites to be a credentialed counselor on the Health Exchange. **Each site has at least one co-worker who was trained to refer patients/clients to other community resources providing enrolment assistance and/or contracted insurance agent assisting with ACA enrollment and plan education.** 2.) Offer counseling and web tutorials to community members to enroll in Health Exchanges at each of the four outreach sites. **House bill 707 restricted some non-for-profit hospital's ability to provide direct one-on-one counseling to assist community members with enrollment. SJ/C opted to bring in outside presenters to educate the community on the Affordable Care Act (ACA) and the plans which are offered in the Chatham County and surrounding areas.**	1.) September 2013: 4 Co-workers trained **4 co-workers were trained on ACA education and enrollment sites in the Chatham County Area.** **In FY 15 – 4 co-workers remain committed to the referral process.** **In FY 16 – 2 co-workers remain committed to the referral process** 2.) October 2013 – February 2014: 1 counseling/web tutorial at each site. **Do to constraints created by HB 707, information sessions were only offered at the SJ/C AAHIRC.** **In FY 14: 24 information sessions provided - 138**

			people attended. **In FY 15: 13 information sessions provided. 57 people attended. 25 enrolled in health insurance for 2016 plan year** **In FY 16: 2 Information sessions provided. 22 people attended. 3 were enroll**
		3.) Provide Medicaid application assistance to eligible clients through St. Mary's Center's Public Benefit Enrollment Services. **Public Benefit Coordinator available on site to assist patients with Medicaid enrollment and renewals. Available M-F, 9a-5p.** **In FY 15, St. Mary's Community Center assisted with Medicaid/Peachcare enrollment for children through the Mayor's Initiative on Children with Health Insurance; a program grant funded through the League of Cities with more than ten (10) local partners. St. Mary's Community Center was Savannah's most successful enrollment site. Statistics are reported separately.** **In FY 16, St. Mary's Community Center was asked again to assist with the Mayor's Initiative on Children with Health Insurance. The initiative was so successful it was extended into FY 16**	3.) Ongoing Increase at least 50 Medicaid applications submitted over the previous fiscal year. **Baseline FY 13:** **New Applications: 0** **Renewal Applications: 12** **FY 14:** **New Applications: 241** **Renewal Applications: 217** **FY 15:** **New Applications: 198; 135 approved** **Renewal Applications: 210; 190 approved** **FY 15 Children's Enrollment: 229**

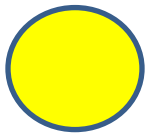
		Responsible Parties: Director and/or Manager of SJ/C's African American Health Information and Resource Center, the Good Samaritan Clinic, St. Mary's Community Center and St. Mary's Health Center	**FY 16** **New Applications: 345, 280 approved** **Renewal Applications: 62; 58 approved** **FY 16 Children's Enrollment: 281**
Goal 2: Provide a primary medical home for ineligible patients or for those who miss the enrollment periods, provide a primary medical home Population Target: Uninsured patients living at 200% of the Federal Poverty Level or less **Status Report** 	Ongoing FY 14, 15 & 16 Jul. 2013 – Jun. 2016	1.) Increase access to health care services at St. Mary's Health Center and the Good Samaritan Clinic for those who do not qualify for care under the Affordable Care Act, for example those people who are undocumented or those who miss the enrollment period Responsible Parties: Director and/or Manager of SJ/C's Good Samaritan Clinic and St. Mary's Health Center	All - Ongoing • *Operate 2 free health centers* for the uninsured **SJ/C operates two free health centers as part of the System's extensive outreach programs. Both health centers were approved for continued operation in FY 14. An additional provider was hired for SMHC to see additional patients.** **In FY 15, both free clinics were fully staffed – 3 NPs at SMHC and 2.5NPs at GSC. This increase in practitioners is responsible for the explosive growth in unduplicated patients.** • Increase new unduplicated patients by 1% over prior year. **FY 14:** **GSC: 316** **SMHC: 522**

			FY 15: **GSC: 1,095** **SMHC: 1,123** **FY 16:** **GSC: 2,655** **SMHC: 3,835**

NEED IDENTIFIED:	**Adults with Diabetes**		
Objective:	**Contribute to improved chronic disease management for vulnerable populations through clinical diabetes management programs at SJ/C's St. Mary's Health Center and the Good Samaritan Clinic by 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Goal: Operate comprehensive culturally and linguistically appropriate diabetic management programs Program(s): St. Mary's Health Center and Good Samaritan Diabetes Programs Population Target: Uninsured patients who have diabetes living at 200% of the Federal Poverty Level or less **Status Report** 	July 2013 – June 2016	1.) Provide free diabetes testing supplies for those patients enrolled in the diabetes management programs 2.) Provide A1C testing for those patients enrolled in the diabetes management program at least annually 3.) Enroll diabetic patients in diabetes group or one-on-one education at least annually a. Provide at least one culturally and linguistically appropriate group education annually Responsible: Director and/or Manager of SJ/C's Good Samaritan Clinic and St. Mary's Health Center	All – Implemented by June 2014 - 100% of program participants • Number of program participants **SMHC: 12** **GSC: N/A** • Pre/post program A1C levels • Number of education classes provided **During FY 14, SMHC began managing diabetic patients utilizing SMHC for their medical home. GSC has decided not to implement a formal program due to the low number of diabetic patients they serve. GSC will have ability to refer their patients to SMHC for the diabetes program.**

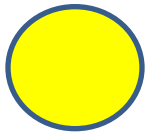
			In FY15, a comprehensive wellness program was introduced at SMHC for chronic disease patients. The diabetes program was rolled into this program. Statistics specific to diabetes were not kept separately. In FY 15, the program had 61 patient visits. Patients at the GSC continue to be referred to SMHC as necessary. **In FY16 – 59 patient visits**

NEED IDENTIFIED:	**Age Adjusted Death Rate Due to Prostate Cancer**		
Objective:	**Contribute to interventions that supporting a decrease in age adjusted death rate due to prostate cancer at the Good Samaritan Clinic, St. Mary's Health Center, Service Options Using Resources in Community Environments (SOURCE) clinic, and one Medical Group Management (MGM) clinic by December 31, 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Support evidence-based prostate cancer screening and early detection at the Good Samaritan Clinic, St. Mary's Health Center, the one SOURCE clinic, and one MGM clinic. Goal 2: Continue to provide prostate cancer care including navigation services, social services support, palliative care, and survivorship support at SJ/C	2013 - 2016	1.) Implement evidence-based prostate cancer screenings and follow-up guidelines at clinics. **In March 2014 the Lewis Cancer & Research Pavilion, part of SJ/C, provided evidence-based cancer screening guidelines, including recommended prostate cancer screening guidelines, to the Good Samaritan Clinic, St. Mary's Health Center, and the Georgia Infirmary/ SOURCE clinic.** 2.) Provide PSA screening to qualified Good Samaritan Clinic and St. Mary's Health Center	All - Interventions by December 31, 2016 1.) PSA implemented and follow up guidelines in at least 4 clinics **As of June 2014 prostate cancer screening guidelines and follow-up procedures were implemented at three clinics. Other MGM**

Lewis Cancer & Research Pavilion to underserved populations. Population Target: Disparate populations including geography, race/ethnicity, socio-economic status, insurance status (un/under insured, age and gender.		patients. **Both clinics routinely offer prostate cancer screening using PSA to age-eligible men seen at the clinics.** 3.) Provide cancer support services to individuals with prostate cancer at SJ/C Lewis Cancer & Research Pavilion (LCRP.) **An active referral system exists between the clinics and the LCRP to ensure that patients from St. Mary's Health Center and the Good Samaritan Clinic diagnosed with prostate cancer receive navigation services to facilitate access to their cancer treatment.** Responsible: Disparities Program Manager, Nurse Navigator, Social Workers and Clinical Special Services Manager	**clinics are also aware of screening guidelines.** 2.) Number of qualified patients at St. Mary's and the Good screened **FY 2014, Good Samaritan Clinic: 89** **FY 2014, St. Mary's: 84** **FY 2015, Good Samaritan Clinic: 74** **FY 2015, St. Mary's: 63** **FY 2016: Good Samaritan Clinic: 66** **FY 2016, St. Mary's: 75** 3.) Number of follow up care provided at SJ/C LCRP **5 underserved prostate cancer patients from St. Mary's Health Center accessed cancer care at the LCRP with nurse navigation.** Decreased death rate is a long-term outcome; this change will be seen past the reporting period for this implementation plan.
Status Report: 	**Evidence-based cancer screenings, including for prostate cancer, are actively promoted through both provider and patient based interventions at St. Joseph's/ Candler's two free clinics for uninsured, predominately minority patients. In January 2014, the Georgia Infirmary/ SOURCE clinic also began to systematically implement, with LCRP programmatic support, evidence-based cancer screenings for their patients. LCRP nurse navigators work to facilitate access to cancer care for any underserved patients diagnosed with prostate cancer.**		

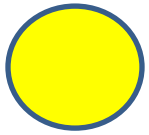
NEED IDENTIFIED:	**Age Adjusted Death Rate Due to Colorectal Cancer**		
Objective:	**Contribute to interventions that support a decrease in age adjusted death rate due to colon and rectal cancer at the Good Samaritan Clinic, St. Mary's Health Center, SOURCE clinic, and MGM clinic by December 31, 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Support evidence-based colon & rectal cancer screening and early detection at the Good Samaritan Clinic, St. Mary's Health Center, the one SOURCE clinic, and one MGM clinic. Goal 2: Continue to provide colon & rectal cancer care including navigation services, social services support, palliative care, and survivorship support at SJ/C Lewis Cancer & Research Pavilion to underserved populations. Population Target: Disparate populations including geography, race/ethnicity, socio-economic status, insurance status (un/under insured, age and gender.	2013 - 2016	1.) Implement evidence-based screenings for colorectal cancer and follow-up guidelines at clinics. **In March 2014 the Lewis Cancer & Research Pavilion, part of SJ/C, provided evidence-based cancer screening guidelines, including recommended colorectal cancer screening guidelines, to the Good Samaritan Clinic, St. Mary's Health Center, and the Georgia Infirmary/ SOURCE clinic.** 2.) Provide Fecal Immunochemical Test (FIT) screening to qualified Good Samaritan Clinic and St. Mary's Health Center patients. **Both clinics routinely refer age-eligible patients seen at the clinics for colorectal screening using FIT.** 3.) Provide cancer treatment support services to individuals with colorectal cancer at SJ/C Lewis Cancer & Research Pavilion. **An active referral system exists between the clinics and the LCRP to ensure that patients from St. Mary's Health Center and the Good Samaritan Clinic diagnosed with colorectal cancer receive navigation services to facilitate access to their cancer treatment.**	All - Interventions by December 31, 2016 1.) Colorectal screenings and follow up guidelines in at least 4 clinics. **As of June 2014 colorectal cancer screening guidelines and follow-up procedures were implemented at three clinics. Other MGM clinics are also aware of screening guidelines.** 2.) Number of qualified patients at St. Mary's and the Good Samaritan screened. **FY 2014** **GSC: 117** **SMHC: 93** **FY 2015** **GSC: 65** **SMHC: 78**

		Responsible: Disparities Program Manager, Nurse Navigator, Social Workers and Clinical Special Services Manager	**FY 2016** **GSC: 67** **SMHC:87** 3.) Number of follow up care provided at SJ/C LCRP **FY 2014** **0 underserved patients from the medical homes were treated for colorectal cancer at the LCRP.** **FY 2015** **0 underserved patients from the medical homes were treated for colorectal cancer at the LCRP.** **30 Diagnostic colonoscopies were provided** **FY 2015** **2 underserved patients from the medical homes were treated for colorectal cancer at the LCRP.** **18 Diagnostic colonoscopies were provided** Decreased death rate is a long-term outcome; this change will be seen past the reporting period for this implementation plan.

Status Report: 	**Evidence-based cancer screenings, including for colorectal cancer, are actively promoted through both provider and patient based interventions at St. Joseph's/ Candler's two free clinics for uninsured, predominately minority patients. In January 2014, the Georgia Infirmary/ SOURCE clinic also began to systematically implement, with LCRP programmatic support, evidence-based cancer screenings for their patients. LCRP nurse navigators work to facilitate access to cancer care for any underserved patients diagnosed with prostate cancer.**

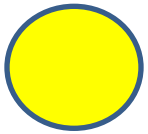
NEED IDENTIFIED:	**Breast Cancer Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in breast cancer incidence by promoting healthy lifestyles and early breast cancer detection through utilization of medical homes by December 31, 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Goal 1: Support evidence-based breast cancer screening and early detection at the Good Samaritan Clinic, St. Mary's Health Center, the one SOURCE clinic, and one MGM clinic. Goal 2: Continue to provide breast cancer treatment and care including navigation services, social services support, palliative care, and survivorship support at SJ/C Lewis Cancer & Research Pavilion to underserved populations. Population Target: Disparate populations including geography, race/ethnicity, socio-economic status, insurance status (un/under insured, age and gender.		1.) Implement evidence-based screenings for breast cancer and follow-up guidelines at clinics. **In March 2014 the Lewis Cancer & Research Pavilion, part of SJ/C, provided evidence-based cancer screening guidelines, including recommended breast cancer screening and follow-up guidelines, to the Good Samaritan Clinic, St. Mary's Health Center, and the Georgia Infirmary/ SOURCE clinic.** 2.) Provide screening mammograms to qualified Good Samaritan Clinic and St. Mary's Health Center patients. **Both clinics routinely refer age-eligible women for mammography screening and offer on-site mammography screening using the SJ/C mammography bus.** 3.) Provide cancer treatment and support	All - Interventions by December 31, 2016 1.) Breast cancer screenings and follow up guidelines in at least 2 clinics. **As of June 2014 breast cancer screening guidelines and follow-up procedures were implemented at three clinics. (The Georgia Infirmary/ SOURCE, St. Mary's, and the Good Samaritan Clinic.)** 2.) Number of qualified patients at St. Mary's and the Good Samaritan screened. **FY 2014** **GSC: 211** **SMHC: 239**

NEED IDENTIFIED:	**Breast Cancer Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in breast cancer incidence by promoting healthy lifestyles and early breast cancer detection through utilization of medical homes by December 31, 2016.**		
		services to individuals with breast cancer at SJ/C Lewis Cancer & Research Pavilion. **An active referral system exists between the clinics and the LCRP to ensure that patients from St. Mary's Health Center and the Good Samaritan Clinic diagnosed with breast cancer receive navigation services to facilitate access to their cancer treatment.** Responsible: Nurse Navigator, Social Workers and Clinical Special Services Manager	**FY 2015** **GSC: 257** **SMHC: 214** **FY 2016** **GSC: 248** **SMHC: 273** 3.) Number of follow up care provided at SJ/C LCRP **FY 2014** **11 undeserved breast cancer patients from St. Mary's Health Center and the Good Samaritan Clinic accessed cancer care at the LCRP with nurse navigation.** **FY2015** **39 underserved breast cancer patients accessed cancer care at the LCRP with nurse navigator** **FY2016** **31 underserved breast cancer patients accessed cancer care at the LCRP with nurse navigator**

NEED IDENTIFIED:	**Breast Cancer Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in breast cancer incidence by promoting healthy lifestyles and early breast cancer detection through utilization of medical homes by December 31, 2016.**		
			Decreased incidence is a long-term outcome; this change will be seen past the reporting period for this implementation plan
Status Report: 	**Evidence-based cancer screenings, including for breast cancer, are actively promoted through both provider and patient based interventions at St. Joseph's/ Candler's two free clinics for uninsured, predominately minority patients. In January 2014, the Georgia Infirmary/ SOURCE clinic also began to systematically implement, with LCRP programmatic support, evidence-based cancer screenings for their patients. LCRP nurse navigators work to facilitate access to cancer care for any underserved patients diagnosed with prostate cancer.**		

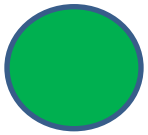
NEED IDENTIFIED:	**Lung and Bronchus Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in lung cancer incidence by supporting smoking cessation and early lung cancer detection through utilization of medical homes by December 31, 2013.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
1.) Support evidence-based lung & bronchus cancer screening, early detection, and smoking cessation at the Good Samaritan Clinic, St. Mary's Health Center, the one SOURCE clinic, and one MGM clinic. 2.) Continue to provide lung & bronchus cancer care including navigation services, social services support, palliative care, and	2013 - 2016	1.) Implement evidence-based screenings for lung cancer and follow-up guidelines at clinics. **In March 2014 the Lewis Cancer & Research Pavilion, part of SJ/C, provided evidence-based cancer screening guidelines, including recommended lung cancer screening guidelines, to the Good Samaritan Clinic, St. Mary's Health Center, and the Georgia Infirmary/ SOURCE clinic. Clinics continued to follow these guidelines in FY15.** 2.) Support healthy lifestyles and smoking	Interventions by December 31, 2016 1.) Lung cancer screenings and follow up guidelines in at least 2 clinics. **As of June 2014 lung cancer screening guidelines and follow-up procedures were implemented at two clinics.**

NEED IDENTIFIED:	**Lung and Bronchus Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in lung cancer incidence by supporting smoking cessation and early lung cancer detection through utilization of medical homes by December 31, 2013.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
survivorship support at SJ/C Lewis Cancer & Research Pavilion to underserved populations. 3.) SJ/C supports early detection of lung cancer with low contrast CT scan of the lungs to at-risk individuals for low cost. 4.) SJ/C supports smoking cessation in the community. Population Target: Disparate populations including geography, race/ethnicity, socio-economic status, insurance status (un/under insured, age and gender.		cessation through group education at the Good Samaritan Clinic and St. Mary's Health Center clinics. **St. Mary's Health Center offers smoking cessation and motivational counseling through a licensed social worker. Good Samaritan patients are referred to the State of Georgia Smoking Quit Line.** 3.) Provide cancer support services to individuals with lung cancer at SJ/C Lewis Cancer & Research Pavilion. **A lung cancer oncology nurse navigator helps to facilitate treatment for lung cancer patients at the LCRP. In addition, the LCRP offers supportive oncology services including palliative care, nutritional counseling, clinical trials, and survivorship care.** 4.) Implement a low-contrast CT scan lung screening program if feasible.	2.) Number of qualified patients at St. Mary's and the Good Samaritan screened **2014** **SMHC: 36** **GSC: 0** **2015** **SMHC: 10** **GSC: 0** **2016** **SMHC: 26** **GSC: 0** 3.) Number of follow up care provided at SJ/C LCRP **FY 2014** **0 underserved patients from the medical homes were treated for lung cancer at the LCRP.** **FY 2015** **0 underserved patients from the medical homes were**

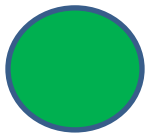
NEED IDENTIFIED:	**Lung and Bronchus Incidence Rate**		
Objective:	**Contribute to interventions that support a decrease in lung cancer incidence by supporting smoking cessation and early lung cancer detection through utilization of medical homes by December 31, 2013.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
		SJ/C offered a retail-based low-contrast CT lung screening program in FY 2014. **In FY 2015, SJ/C implemented low-dose, non-contrast CT (LDCT) screening program adhering to national evidence based guidelines and hired a diagnostic lung natigator** 5.) Offer smoking cessation program at SJ/C for the community and for hospital employees at least twice yearly. **SJ/C smoking cessation classes were available to the community and hospital employees in FY 2014. These classes continued to be provided in FY15.** Responsible: Disparities Program Manager, Nurse Navigator, Social Workers and Clinical Special Services Manager	**treated for lung cancer at the LCRP** **FY 2015** **1 underserved patient from the medical homes were treated for lung cancer at the LCRP** Decreased incidence is a long-term outcome; this change will be seen past the reporting period for this implementation plan
Status Report: 	**In December 2013 the U.S. Preventative Service Task Force recommended, with a class B rating, annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. During FY 2014, this was not a Centers for Medicare & Medicaid Services (CMS) covered service. However, in February 2015 CMS issued a national coverage determination for Medicare coverage of screening for lung cancer with LDCT if certain eligibility requirements are met. Based on these new coverage guidelines, SJ/C plans to expand availability of LDCT screening for eligible individuals in 2015-2016.**		

NEED IDENTIFIED:	**Affordable Medications**		
Objective:	**Increase access to medication assistance for low-income clients at SJ/C's St. Mary's Community Center and the Good Samaritan Clinic through in-house programs and by supporting MedBank, Inc. through continued financial, logistical and in-kind contributions 2013 – 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Increase utilization of MedBank Inc., services at St. Mary's Health Center and the Good Samaritan Clinic; provide other medication assistance when needed Population Target: Uninsured SJ/C health center patients who cannot afford medications living at 200% of the Federal Poverty Level or less	Ongoing	1.) Provide MedBank, Inc. at SJ/C's St. Mary's Health Center or the Good Samaritan Clinic 2.) Purchase medications at pharmacies for patients who do not qualify for MedBank, Inc. services or patients with other special needs Responsible: Director and/or Manager of SJ/C's Good Samaritan Clinic and St. Mary's Health Center	Ongoing • 1 MedBank Clinic each week at both sites **FY 14** **SMHC – 2 days ea. Wk.** **GSC – 1 day ea. Wk.** **FY 15** **SMHC – 4 days ea. Wk.** **GSC – 3 days ea. Week** **FY 15** **SMHC – 4 days ea. Wk.** **GSC – 3 days ea. Week** • 20 patients at each site per fiscal year **FY 14** **SMHC – 102 patients** **GSC – 51 patients** **FY 15** **SMHC – 146** **GSC – 86** **FY 16** **SMHC – 261** **GSC- 156**

NEED IDENTIFIED:	**Affordable Medications**		
Objective:	**Increase access to medication assistance for low-income clients at SJ/C's St. Mary's Community Center and the Good Samaritan Clinic through in-house programs and by supporting MedBank, Inc. through continued financial, logistical and in-kind contributions 2013 – 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
			• Number of patients who receive their 1st prescription through SJ/C **FY 14: 35 patients** **FY 15: 61 patients** **FY 16: 127 patients**
Goal 2: Support MedBank, Inc. operations through in-kind operations to reduce operating cost to ensure services are offered to the broader community outside the operations of SJ/C outreach sites Population Target: Uninsured patients outside of SJ/C operated outreach centers who cannot afford medications living at 200% of the Federal Poverty Level or	Ongoing	1.) Provide in-kind office space including utilities, maintenance and repairs 2.) Provide in-kind office supplies 3.) Support MedBank's annual fundraiser 4.) Provide support to MedBank by providing SJ/C staff on the organization's Board of Directors Responsible Party: Vice President of Mission Services and/or designee	All – June 2014 • Annual cost of in-kind operations contributions **FY 14: $65,242** **FY 15: $67,899** **FY 16: $60,443** • Dedicate at least one co-worker to serve on MedBank's BOD: **Three (3) co-workers served on the MedBank Board in FY 14. They continue to serve on the**

NEED IDENTIFIED:	Affordable Medications		
Objective:	**Increase access to medication assistance for low-income clients at SJ/C's St. Mary's Community Center and the Good Samaritan Clinic through in-house programs and by supporting MedBank, Inc. through continued financial, logistical and in-kind contributions 2013 – 2016.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
less 			**board in FY 15.** **FY 16: Two co-workers served on the MedBank Board in FY 16**

NEED IDENTIFIED:	People Living in Poverty		
Objective:	**Contribute to meeting identified socio-economic, health, workforce and education needs of individuals living in poverty through a broad spectrum of programs by providing services at SJ/C operated community outreach facilities in 2013 - 2016**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Address socio-economic needs Population Target: Un/under employed clients, especially residents in zip codes 31401,	Ongoing	1.) Provide at least one staff person to assist clients in evaluating eligibility in public benefit programs (i.e., Medicare, Medicaid, Food Stamps, etc.) 2.) Provide free income tax preparation assistance yearly 3.) Provide financial education, enrolling in bank services (checking accounts, savings accounts, etc.) and how to understand and improve credit scores	All – June 2014 • First year – document number of people served and number of encounters **Complete** • Second year – establish benchmarks for outcomes in each

NEED IDENTIFIED:	**People Living in Poverty**		
Objective:	**Contribute to meeting identified socio-economic, health, workforce and education needs of individuals living in poverty through a broad spectrum of programs by providing services at SJ/C operated community outreach facilities in 2013 - 2016**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
31404 and 31415 		Responsible: Director of SJ/C's St. Mary's Community Center	program where possible **Complete** • Third year – evaluate results and establish the next three year goals
Goal 2: Address health through services and health education 	Ongoing	1.) Provide free eye exams and assistance in purchasing eye glasses 2.) Provide health education and culturally relevant health information 3.) Provide food assistance to the broader community 4.) Provide food assistance to the senior population 5.) Provide access to SJ/C Care Call Center's Health Information Line 6.) Provide free blood pressure checks and referrals as needed 7.) Provide free blood glucose testing and referrals as needed 8.) Participate in community health fairs offering health information and health screenings 9.) Offer healthy cooking lessons for children 10.) Offer free exercise and weight loss classes at least once weekly 11.) Provide Health Literacy classes at least once yearly 12.) Provide a Certified Health Educator for patients 13.) Provide two free primary medical home clinics 14.) Provide a social worker to navigate the barriers of social determinants of health 15.) Provide mental health counseling	All – June 2014 • First year – document number of people served and number of encounters **Complete** • Second year – establish benchmarks for outcomes in each program where possible **Complete** • Third year – evaluate results and establish the next three year goals Complete

NEED IDENTIFIED:	**People Living in Poverty**		
Objective:	**Contribute to meeting identified socio-economic, health, workforce and education needs of individuals living in poverty through a broad spectrum of programs by providing services at SJ/C operated community outreach facilities in 2013 - 2016**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Population Target: Un/under insured patients living at 200% of the Federal Poverty Level or less		Responsible: Directors of SJ/C's African American Health Information and Resource Center and St. Mary's Community Center.	
Goal 3: Assists in the development of workforce skills  Population Target: Un/under insured patients living at 200% of the Federal Poverty Level or less	Ongoing	1.) Provide computer classes to learn computer basics including internet use and competency in relevant computer programs including Microsoft programs 2.) Assist clients in completing on-line and paper employment applications 3.) Provide 4-H classes weekly 4.) Provide internet surfing center 5.) Provide resume, job application and job search assistance Responsible: Directors of SJ/C's African American Health Information and Resource Center and St. Mary's Community Center	All – June 2014 • First year – document number of people served and number of encounters **Complete** • Second year – establish benchmarks for outcomes in each program where possible **Complete** • Third year – evaluate results and establish the next three year goals **Complete**
Goal 4: Assists in the educational development of children and adults		1.) Provide basic literacy education 2.) Provide General Education Diploma (GED) education, assistance and testing 3.) Provide pre-school classes for children aged 3&4 who are not accepted to the State's pre-k program 4.) Provides early literacy and culturally competent health and basic education to students aged 3&4 5.) Provide gap training for the Work Ready Certificate	All – June 2014 • First year – document number of people served and number of encounters **Complete** • Second year –

NEED IDENTIFIED:	People Living in Poverty		
Objective:	**Contribute to meeting identified socio-economic, health, workforce and education needs of individuals living in poverty through a broad spectrum of programs by providing services at SJ/C operated community outreach facilities in 2013 - 2016**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
 Population Target: Clients living at 200% of the Federal Poverty Level or less		6.) Provide tutoring assistance for the entrance exam, Compass (Savannah Technical College Responsible: Directors of SJ/C's African American Health Information and Resource Center and St. Mary's Community Center	establish benchmarks for outcomes in each program where possible **Complete** • Third year – evaluate results and establish the next three year goals **Complete**

NEEDS IDENTIFIED WHICH ST. JOSEPH'S/CANDLER WILL NOT ADDRESS DIRECTLY

St. Joseph's/Candler provides many community benefit programs that address the health and social determinants of health throughout Chatham County and the surrounding communities. Chatham County is fortunate to have a large number of health and social service agencies who work individually and collectively to provide services, programs and support for the county residents. To that end, St. Joseph's/Candler will not address some of the needs identified in the

2013 assessment because: (1) SJ/C addresses the need, but currently has no plans to expand services, (2) Other providers are already addressing the needs and (3) The need identified is beyond the scope of SJ/C.

NEED IDENTIFIED	REASON THE NEED IS NOT ADDRESSED	OTHER PROVIDER(S) ADDRESSING THE NEED
Babies with Very Low Birth Weights	Need addressed by another provider • Candler operates a skilled nursery unit for level 2 and 3 babies	• Coastal District Health Department • Memorial University
Age Adjusted Death Rate Due to Cerebrovascular Disease (stroke)	Need is addressed, but no plan for program expansion at this time. • SJ/C provides a free Stroke Tele-medicine to seven regional hospitals for stroke evaluation • SJ/C has rehabilitation facilities at both hospitals • SJ/C is one of five hospitals in the country designated as a Primary Stroke Center	• Memorial University
Affordable Dental Care	Need addressed by another provider • SJ/C provides in-kind contributions to The Children's Free Dental Clinic when requested • SJ/C refers community members to other providers through referral programs at all of SJ/C outreach centers and through SJ/C's Care Call Center	• J.C. Lewis' Peter Brassler Dental Clinic (homeless population) • Curtis V. Cooper Primary Care • The Children's Free Dental Clinic
Childhood Obesity and Health	Need addressed by another provider • SJ/C provides classes on healthy cooking for students at the African American Health Information and Resource Center	• Savannah Business Group • 100 Black Men of Savannah
Homeownership	Beyond the scope of SJ/C services and programs	• Step Up! Savannah
People Spending More than 30% of Their Income on Rent	Beyond the scope of SJ/C services and programs • SJ/C provides financial and money management occasionally at St. Mary's Community Center	• Step Up! Savannah
Access to Healthy Food	Need addressed by another provider • SJ/C provides healthy food support to the clients of St. Mary's Community Center and classes on healthy cooking for students at the African American Health and Resource Center	• Forsyth's Farmers Market • Healthy Savannah
High School Graduation	Beyond the scope of SJ/C services and programs • See "People Living in Poverty – Education Session" to	• Youth Future's Authority

NEED IDENTIFIED	REASON THE NEED IS NOT ADDRESSED	OTHER PROVIDER(S) ADDRESSING THE NEED
	review the scope of SJ/C educational activities	

KEY COLLABORATIVES IN CHATHAM COUNTY

United Way of the Coastal Empire
www.uwce.org
The mission of United Way of the Coastal Empire (UWCE) is to improve lives by mobilizing the caring power of communities. Through partnerships, long-term planning and wise investment of donor contributions, United Way supports community programs and services within four impact areas.

Four Impact Areas
- Education & Youth Development
- Economic Independence
- Health & Wellness
- Basic Human Needs

Savannah-Chatham Community Indicators Coalition
http://www.uwce.org/our-work/community-indicators/
Over the past few years there has been a growing awareness of the need to integrate community indicators and performance measurement efforts at the community level. The intention is to better assess the position and progress of communities' quality of life and to better engage the communities' citizens and stakeholders. The sponsors of the Savannah-Chatham Community Indicators Coalition have a shared responsibility for assessment, planning, evaluation, and accountability for policy change and systems change over time.

Chatham County Safety Net Planning Council (CCSNPC)
www.chathamsafetynet.org
The CCSNPC serves as a countywide planning group for healthcare. It was created in 2004 to improve the efficiency and effectiveness of the local healthcare delivery system, to advise regarding healthcare trends, and to assist the County Commissioners in better meeting the healthcare needs of uninsured and underinsured constituents. Since 2006, the Council has provided an annual evaluation to assess needs and trends and to identify key existing resources and gaps in the Community's healthcare delivery

system. This evaluation is based on voluntary submission of data from the provider partners and publicly available data on population and policies affecting healthcare.

The CCSNPC Provider Network is composed of both primary care providers and other agencies which support the delivery of healthcare.
Key CCSNPC Health Care Providers

- Chatham C.A.R.E. Center – Chatham County Health Department Ryan White Clinic
- Community Health Mission (CHM) – Volunteer Medicine Clinic
- Curtis V. Cooper Primary Healthcare (CVCPHC) – Federally Qualified Health Center
- J.C. Lewis Primary Healthcare Center (JCLPHCC) – Federally Qualified Health Center
- MedBank Foundation – Prescription Assistance Program
- SJ/C Good Samaritan (GS) – Volunteer Medicine Clinic
- SJ/C St. Mary's Health Center (SM) – Volunteer Medicine Clinic
- Memorial health Emergency Department
- St. Joseph's/Candler Health System Emergency Departments

Healthy Savannah, Inc.
www.healthysavannah.org
Healthy Savannah is dedicated to making Savannah a healthier place to live. Healthy Savannah leads and supports healthy lifestyles in Savannah by:

- Creating an environment that makes a healthy choice an easy choice,
- Building a collaborative network that identifies and shares resources,
- Collecting and disseminating information,
- Promoting best practices and implementing innovative programs, and
- Advocating for effective policies.

2012-2013 Aim
To increase opportunities for citizens to engage in physical activity and consume a nutritious, balanced diet.

Step-Up Savannah, Inc.
www.stepupsavannah.org
Step Up Savannah, Inc., a collaborative of organizations, businesses, and government agencies, seeks to move families toward economic self sufficiency.

Three Focus Areas

- Workforce development and jobs
- Wealth building and financial understanding

- Work supports

Chatham-Savannah Youth Futures Authority (YFA)
www.youthfutures.com
The Chatham-Savannah Youth Futures Authority (YFA) is a state legislated authority serving as the collaborative for addressing issues relevant to children, youth and families in Chatham County. The collaborative is comprised of representatives from city, county and state government, the local board of education, more than 20 health and human service providers with a focus on children, youth and families, the United Way of the Coastal Empire, faith community, area businesses, and neighborhoods.

OTHER HEALTH PROVIDERS

Chatham County Health Department
Health care services and wellness programs for Adults, Children, and Women's Health are available through the Georgia Department of Public Health. Services include immunizations, eye, ear and dental screenings, tuberculosis skin testing, family planning, sexually transmitted disease services, HIV testing and counseling, child health check and sports physical, the Children First program, breast feeding support, lead program, WIC, Babies Born Healthy, and a breast and cervical cancer program.

Community Health Mission
The Community Health Mission is free for those who qualify and offers primary (non-emergency) health care to individuals that do not have health insurance, including Medicare or Medicaid. Services include annual medical exams and preventive health care, treatment for diabetes, hypertension, cardiovascular disease and respiratory disease, women's health services, enrollment in the GA Breast and Cervical Cancer Screening program, smoking cessation and health education.

Curtis V. Cooper Primary Health Care
Curtis V. Cooper Primary Health Care provides discounted services for qualifying patients. Services include adult medicine, pediatric health care, health education, gynecological clinic (by referral), Medicaid screening, prenatal (pregnancy) services, family planning services (birth control, etc.), pharmacy services, dental services, nutrition services, laboratory services, radiology services.

Dental Care Treatment Sites
There are several dental care treatment sites in Chatham County serving uninsured clients. To find out more information about dental sites, please visit: http://www.chathamsafetynet.org/dental-care-treatment-sites/index.html

J.C. Lewis Primary Health Care Center
The J.C. Lewis Primary Health Care Center provides primary health care, physician services, medication assistance, medical case management, health promotion and disease prevention, optometry, podiatry, shelter & housing referrals, economic education & referral, nutritional education and planning, dietary supplementation, prisoner re-entry program, 24-hour respite care, and behavioral

health counseling.

Phoenix Clinic
The Phoenix Clinic provides Comprehensive Primary Health Care to persons living with HIV/AIDS. Services include primary health care, physician services, medication assistance through the AIDS Drug Assistance Program, housing case management, health promotion and disease prevention, social service referrals, nutritional education and planning, dietary supplementation, housing programs, behavioral health counseling, and dental services.

Prescription Assistance
You can get prescription assistance from the City of Savannah, PharmaCare, Medicare Prescription Drug Plan, GeorgiaCares, NeedyMeds, MedBank, your doctor, or by purchasing generic medications. For more information on prescription assistance, please visit: http://www.chathamsafetynet.org/prescription-assistance/index.html

This information is provided with permission by the Chatham County Safety Net Planning Council.

OTHER SOCIAL SERVICES
There are many other social service agencies serving Chatham County too. The United Way 211 program assists residents in identifying available programs throughout the county. For a complete listing of the programs and services available in the 211 database, please visit: http://www.referweb.net/uwce/