

State of the Health of Georgia



Cardiovascular Conditions

Diabetes

Respiratory Conditions

Dehydration

Urinary/Kidney Conditions

Low Birthweight

Teen Pregnancy

Let us tell you what is working in Georgia!

Community Programs are being offered through the collaborative efforts of hospitals and their communities. Now more than ever, these health care services are needed. With Georgia's unemployment rate at 8.1%, and individuals facing hard economic times, increases in the uninsured and underinsured as well as chronic conditions are reality. Often, at times like these, care of one's health is forgotten until it is too late.

The following are examples of work being accomplished in Georgia. It is important that these programs are acknowledged for the proactive nature as well as sustained and supported in order to meet the needs of the community. They are offered to expand the individuals' knowledge on health and healthcare, engage them in their well-being improving their health and quality of life.

Healthy Savannah

Savannah is a community committed to supporting healthy lifestyles 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. During the summer of 2007, Savannah Mayor Otis Johnson launched the Healthy Savannah 2012 Initiative, with the aim of making Savannah a healthier place to live by the year 2012. www.healthysavanna.org/about

Lowndes County Partnership for Health

The Lowndes County Partnership for Health, Inc. is a non-profit organization whose mission is to improve the health of the community through an inclusive and unified partnership. Health care providers, educators, public health, the business community, and the faith community are brought together for the purpose of evaluating the health needs of the community and creating cost efficient solutions. <http://www.lcpfh.org/>

Tobacco-Free Schools Project

All school districts are eligible to receive signage, training in Alternative To Suspension, Not On Tobacco school-based youth prevention and cessation interventions, and Asthma Case Management planning for schools conducted by the American Lung Association. In addition, earned media campaigns are to be developed to educate the public about the new policy in preparation for the current and upcoming school year. We are dedicated to continuing to promote and disseminate QuitLine and Georgia Smokefree Air materials throughout these school districts. Our new baseline is 35 out of 181 and counting! Approximately 700,000 youth are protected by a policy that eliminates exposure to the dangers of secondhand smoke.

Georgia's Go Local

National Library of Medicine that will link consumers to local health information from the Medlineplus.gov national consumer health web site. <http://apps.nlm.nih.gov/medlineplus/local/georgia/homepage.cfm?areaid=29>

Health Promotion Volunteers, Inc

Organized by District Four Health Services in LaGrange, this group is comprised of volunteers from the faith base community that have Health Ministries and are located in various counties in District Four's service area (12 counties). http://www.district4health.org/health_promotion.htm

Georgia Hospital Association Tobacco-Free Hospital Initiative

In 2007, the Georgia Hospital Association, with a grant from the Georgia Department of Human Resources, began an initiative to encourage every hospital in Georgia to become tobacco-free campuses. We have provided an online toolkit with a full set of tools and graphics for implementation. To date, 45 hospitals in Georgia have committed to the Tobacco-Free Hospital Campus initiative. www.gha.org/pha/Community/TobaccoFree/Toolkit/index.asp

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Youth Becoming Healthy Project, Inc.

Youth Becoming Healthy is a middle school initiative in Dougherty County designed to address obesity in children. It is an after school fitness and nutrition program that has been established in local schools. www.ybhproject.org

Georgia Campaign for Adolescent Pregnancy Prevention (GCAPP)

GCAPP works to prevent adolescent pregnancy in Georgia. <http://www.gcapp.org/>

Georgia Coalition for Physical Activity and Nutrition (G-PAN)

G-PAN is a collaboration of public, private, non-profit organizations, and businesses whose mission is to improve the health of all Georgians by promoting healthy eating and physical activity. <http://www.g-pan.org/>

Piedmont Hospital's Transitions in Care

Despite the overwhelming need for clear communication flow between care settings, patients often move from the hospital to the community without safe transitions in place. In partnership with Visiting Nurse Health System, Sixty Plus Older Adult Services and the Piedmont Hospital Internal Medicine Service are addressing process change and methods to improve communication and coordination of care along the continuum. Through a federally funded demonstration project, the focus has been on four primary interventions to help the patient: Medication management, understanding one's chronic disease and having a plan to seek care if certain symptoms appear, obtaining timely postdischarge follow-up care, and maintaining a personal health record. The Transition Work Team is working to improve internal communication processes between staff, physicians, patients/families and community agencies with a primary focus on home health. For more information contact: Nancy Morrison - 404-605-1951 or nancy.morrison@piedmont.org

The Diabetes Self-Management program at Henry Medical Center

Two day class taught by Certified Diabetes Educators and targets newly diagnosed and uncontrolled patients. The goal of the program is to decrease acute and chronic complications related to diabetes mellitus. This program has shown, in previous outcome studies, to increase the number of diabetes patients performing blood glucose monitoring and self foot exams. In addition, there has been a decrease shown in the average weight of 76% of patients and a decrease in the hemoglobin A1C in 70% of program participants.

Henry Medical Center Tobacco Prevention and Cessation Program

This program has reached well over 4,000 people in our community in 2008. The tobacco and alcohol prevention program for youth targets children ages 4-18 in the Henry County school system, as well as private schools and day care centers. The adult smoking cessation program (Fresh Start) is offered quarterly by the hospital. A 2007 outcome study on our Fresh Start program revealed that 69% of patients who attended this program were still not smoking 6 months after quitting. The hospital has also demonstrated recently, through core measure studies on inpatients with Congestive Heart Failure, Pneumonia, and Heart Attack, that 98% of those patients received adult smoking cessation advice or counseling before discharge.

Eat Right Get Fit

The Henry Medical Center Community Education program has provided nutrition and exercise education to youth in the community since 1995. Recognizing the rise in childhood obesity as a problem, the hospital has begun placing more emphasis on healthy food choices and appropriate activity levels for our youth. In 2008, the Eat Right Get Fit program reached 2,290 children in Henry County. An outcome study performed in 2007 revealed a 90% retention rate of information taught to fifth graders.

SOURCE (Service Options Using Resources in Community Environments)

This program was established to improve the health outcomes of persons with chronic conditions, through the development of a cost-effective, comprehensive managed care model. SOURCE is distinguished from other waiver programs in Georgia by the linkage of primary medical care to community services, through a Primary Care Physician/Case Manager team. In order to qualify for SOURCE one must have SSI Medicaid. Goals identified for SOURCE include: reducing the need for long-term institutional placement and increase options for alternative community placement, preventing the level of disability and disease from increasing in chronically

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ill adults, eliminating fragmented service delivery, and increasing the cost-efficiency and value of Medicaid LTC funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible. The SOURCE program is sponsored by the Georgia Department of Community Health and administered by the Wesley Woods Center in Dekalb and Fulton County. For more information call 404-728-6555 or you can access the information at www.ghp.georgia.gov

Team Lean

At a time when most hospitals are actively involved in treating these obesity-related diseases, Memorial Hospital and Manor is taking a proactive role in preventing this epidemic by creating "Team Lean," an innovative community-wide weight loss program. The overall goal of the Team Lean weight loss competition is to reduce obesity and improve health outcomes by motivating individuals to take charge of their own health and wellness by (1) increasing physical activity, and (2) practicing healthier eating habits to prevent and control obesity and other chronic diseases. Memorial Hospital and Manor sponsored two Team Lean competitions for its employees in 2005 and 2006, which resulted in a total weight loss of over 3200 lbs. This hospital took a creative position in promoting this effort when it approached the Bainbridge/Decatur County YMCA about joining them in bringing Team Lean to the community in 2007, and again in 2008. This altruistic approach to addressing a real community health problem brought people together from all walks of life. The end results are enough to prove the success of this initiative, with over 16,000 pounds lost by over 900 people in 2007, and over 13,000 pounds lost by over 700 people in 2008. The third Team Lean competition has just begun with almost 800 registered participants. Lives have been changed and the community has become more health conscious because Memorial Hospital and Manor and the YMCA cared enough to motivate people to lose weight. As a result, overall community health is improved.

Dorminy Medical Center

In September, Dorminy Medical Center hosts the FREE PSA blood testing day where men in our community can come in and receive a FREE PSA blood test to check for prostate cancer. The results are run on this day and sent to the patient and their physician. In October, Dorminy Medical Center hosts a FREE Breast Cancer Screening Day where we partner with our general surgeon Dr. Tony Sison and Dr. William Parham, one of our local OB GYNs, to check ladies in our community for breast cancer. If a patient needs a mammogram or ultrasound per the physician BSE, we have staff on sight to schedule those appointments at our local hospital.

Candler County Hospital - Diabetes Mellitus

The Candler County Hospital offers a monthly support group for community members diagnosed with Diabetes Mellitus. Diabetic participants enrolled in our program attend monthly support group meetings. These meetings provide a variety of resources that can be used to improve control and live actively with their disease. In addition to a wide variety of speakers providing monthly educational sessions, participants receive free bi-annual lab work, and vital signs and weight measurements. Interested participants may contact Teal Jeffers, RN at 912(685-1712) for more information. In reviewing lab results, approximately 80% of our participants have a current HgbA1C at or below the recommended limit. Our supposition is that longitudinal education delivered through the forum of a disease management program/support group does help participants to better control and live with this chronic disease.

The 1-West Joint In Motion Program For Total Hip and Knee Patients

Our Joints In Motion Program at Northeast Georgia Medical Center was designed to improve patient experiences and outcomes when joint replacement surgery is necessary. Following surgery, our goal is to have the patients up moving and exercising as soon as possible so they can return to their normal lifestyle. The program involves our medical team of doctors, nurses, physical therapist, and occupational therapist. An education class is provided to the patient and their family prior to surgery emphasizing pre-op & post-op care. A "support" person is chosen by the patient to assist them during and after their post-op recovery period. The average hospital length of stay is usually 3 to 4 days. During that time the patient receives a physical therapy visit twice a day and a daily newsletter highlighting the daily events and tips for their recovery. To ensure a safe discharge, the case manager works with the patient, physical therapist and their insurance company to receive the necessary home therapy and equipment.

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Northeast Georgia Medical Center developed a comprehensive Inpatient Heart Failure Disease Management Program

Heart failure is the fastest growing disease diagnosis in the country. It is a chronic illness with no cure. The patient is plagued by exacerbations of shortness of breath, swelling of the feet, legs, abdomen and overall poor quality of life. Research has shown that with each hospitalization, the heart failure patient's life expectancy is shortened. With this in mind, Northeast Georgia Medical Center developed a comprehensive Inpatient Heart Failure Disease Management Program that has grown to include an Outpatient Diuresis Clinic. The goal of this unit is to avert an emergency department visit or hospital admission for intravenous diuretic administration. Stable heart failure patients who are volume overloaded are brought in, assessed by the Heart Failure Disease Manager, who is a nurse practitioner, tested through lab work and given a dose of IV diuretic. After appropriate diuresis response to the medication, and education on heart failure dietary restrictions, by the heart failure education nurse, the patient is sent home to follow up the next day with their primary care provider. The patient also receives follow-up phone monitoring by the Heart Failure Support Services nurses who monitor: daily weight, blood pressure and medication compliance. If any issues are identified, the Heart Failure Support Services nurse calls the physician for instructions. The Heart Failure Disease Manager also conducts a heart failure clinic, twice monthly for indigent patients at the Good News Clinic. Patients receive medical management, dietary education, education on their medication, and education on symptom management. The readmission rate of heart failure patients to Northeast Georgia Medical Center has decreased by 50%, since the implementation of the Heart Failure Disease Management Program.

Dare to C.A.R.E. at Hamilton Medical Center in Dalton, GA

Dare to C.A.R.E. is a comprehensive cardiovascular disease program focusing on early detection and education. It is offered quarterly and is free to men and women over the age of 60 and for those over 50 with vascular risk factors such as high blood pressure, high cholesterol, diabetes, obesity, smoking or family history of vascular disease. The free screening consists of a blood pressure check and non-invasive ultrasound examination of the carotid arteries, abdominal aorta and the circulation of the legs. Recommendations for follow-up are based on the outcome of assessment.

The C.A.R.E. acronym stands for:

C – Carotid artery disease, the primary source of preventable deaths

A – Abdominal aortic aneurysms, the 10th leading cause of death in men

R – Renal artery stenosis, responsible for at least 20% of patients of dialysis

E – Extremity artery disease, which affects 12 million Americans and has a mortality rate significantly higher than breast cancer.

For more information call 706.272.6114.

Take it to Heart at Hamilton Medical Center in Dalton, GA

Cardiovascular disease is the number one killer among Americans today. More than 32 percent of these deaths were premature, meaning they were before the age of 75 which is well below the expected life-expectancy of 77.9 years. **Take it to Heart** is a program focusing on early detection and education about heart disease. It is offered quarterly and is free to men and women of any age who have a family history of heart disease, are smokers, morbidly obese and are currently not being treated by a cardiologist. Combined with a night of education provided by the Chief of Cardiology, participants benefit from a free cardiac risk assessment. The assessment includes blood pressure measurement, lab work (total cholesterol and HDL), height, weight and a series of questions. The information collected during the assessment is calculated by the Framingham Risk Assessment. This will provide the participants risk percentage of developing heart disease in the next ten years. Recommendations for follow up are based on the outcome of the assessment. For more information call 706.272.6114.

Screven County Hospital Outreach Program

This program has been serving Screven County residents since 1999. The focus of the program is to provide free community health screenings and patient prescription assistance. Over 650 free events, which included both health screenings and educational programs, have been held on such health issues as diabetes, hypertension, heart disease and cancer. Over 3400 individuals have registered with the program, with an attendance at all events of over 24,000. One of the highlights of the program is the weekly hypertension screening. In addition, over one million dollars of free prescription medicine has been made available through the program to county residents for emergency and chronic conditions. Contact information: outreachsch@windstream.net or 912-564-5238.

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Tanner Home Health Services

Tanner Home Health Services is owned by Tanner Medical Center and provides services to the residents of Carroll, Coweta, Douglas, Haralson, Heard, and Paulding Counties. The agency performed over 35,000 visits during FY 2008 and provided service to 1,823 patients through-out the six-county region. Tanner Home Health recognized the need to decrease the agency's hospitalization rate and took a proactive approach to implementing guidelines to decrease this rate. The agency put together a team to audit and study the causes of patient re-hospitalizations. The team discovered that the majority of patients being re-hospitalized had diagnoses of COPD and CHF. The team also realized this patient population was re-hospitalized within the first week of service. As a result of this finding, guidelines were established in order to identify potential at risk patients significantly improving patient care and decreasing the re-hospitalization rate.

Listed below are the team's guidelines for all patients with COPD and CHF. These guidelines include:

- Complete physical assessment
- Assessment for in-home tele-monitoring unit
- High frequency (3-5) nurse visits during the first week of service
- Therapy if indicated for strengthening and endurance
- Medication management training
- Standardized education packet with specific instructions for when to call 911 and when to call a Home Health nurse
- Caregiver education

Also, the skilled nurses work closely with the patient's physician as the initial signs of CHF, such as edema, are presented in order that the nurse may request orders to increase the dosage of the patient's diuretic or administer the diuretic intravenously. This proactive approach has proven to be successful alleviating patient emergency room visits and / or re-hospitalizations.

When Tanner Home Health began its initiative in 2005 the agency's hospitalization rate was 35%. Tanner now has one of the region's lowest hospitalization rates with only 24% of the patients admitted requiring re-hospitalization. This rate is much lower than the national target of 29% and is largely due to the implementation of established guidelines and the innovative use of remote tele-monitoring devices.

Houston Healthcare- Parish/ Church Outreach

The Parish Health Outreach Program provides for the health related needs of church families, and the community the church serves, through a nurse led committee providing education, support & nurturing, health screening, referrals and counseling. In 2008, 1207 blood pressures were screened, 345 church members were contacted at church or by phone concerning health issues, and a total of 194 referrals were made to physicians, EDs, Med Stops, community services, and support groups. Health Education Programs related to prevention of illness as well as controlling chronic disease was presented to approximately 1555 participants. The program continues to expand and grow under the support of Houston Healthcare.

Houston Healthcare's Walk for Wellness 2008

Houston Healthcare's Walk for Wellness promotes increased physical activity. This walking program for adults allows participants to set their own time and pace. Participants receive a walking logbook and pedometer. Incentive awards are given at 100/500 mile increments. Monthly evaluations performed by a registered nurse include weight, blood pressure and blood sugar (if diabetic).

In 2008, 40 persons participated in the walking program. A total of 128 lbs. was lost.

- 5 people reached 100miles
- 4 people reached 500 miles
- 3 people reached 1000 miles
- 3 people reached 1500 miles
- 5 people reached 2000 miles
- 8 people reached 2500 + miles.

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Houston Healthcare Diabetes Management

Houston Healthcare's Diabetes Management Program is nationally recognized through the American Diabetes Association and received The Georgia Diabetes and Prevention Program Award in 2007 and 2008. With six certified diabetes educators on staff, participants receive one on one education, nutrition instruction, comprehensive education and screenings. At the completion of the program, participants are followed up at three, six and twelve month intervals as well as referred into a monthly support group. The program has demonstrated successful outcomes with decreased hospitalizations, ED visits and A1C results. Participants (N = 249) entering the program in 2008 had an average A1C of 8.2 compared to 6.5 (N = 56) at 12month follow up. Participants (N = 141) reported 17 hospitalizations and 30 ED visits and at 12 month follow up no hospitalizations and only 1 ED visit. 95% of participants performed daily self-exam of feet compared to 68 percent nationally. 86% performed daily self-monitoring of blood glucose compared to 63 percent nationally and 100% of diabetic patients (N = 46) that are tobacco users were counseled about tobacco use and advised to quit. For more information call (478)923 -9771 or visit www.hhc.org.

Healthy Pregnancy Outreach Project

Houston Healthcare serves as the lead organization for Central Georgia Perinatal Coalition. This coalition includes several organizations with the goal of ensuring all pregnant women have access to all services to support a healthy pregnancy outcome. The coalition targeted women with higher risk of poor pregnancy outcomes including preexisting medical conditions as well as women at higher risk due to socio-economic factors (low literacy, uninsured, low income, non-English speaking). Each identified at-risk woman received a Nurse Care Manager who provided linking to resources, education, and support. Funding was received from the Catholic Church, March of Dimes and Babies Born Healthy. We attribute the success to Nurse Care Management and the coalition efforts to provide access to care and services required by women with higher risk pregnancies. The summary of outcomes for the past six months includes:

- 204 Received Nurse Care Management (121 with socio-economic risk and 83 with medical risk)
- 110 have delivered (51 socio-economic risk and 59 with medical risk)
- Delivered at less than 37 weeks gestation or premature rate- 6 premature infants (includes two sets of twins for socio-economic risk group) and 8 premature infants one set of twins from medical risk
- Hospitalizations not resulting in delivery- 3 from Socio-economic risk group, 2 from medical risk group

Houston Healthcare SeniorCare

SeniorCare has the goal of promotion of wellness and assistance in controlling chronic illness among older adults as well as ensuring each older adult has a personal physician. There are numerous activities and outreach efforts including Senior Camp, Senior exercise classes, health related classes and screenings. One activity of SeniorCare is to provide Blood Pressure screenings which allow time for one to one question and answer concerning participants health. Blood pressure screening along with health related information is provided monthly at Senior Centers in Houston County. In 2008:

- 1,156 older adults received blood pressure screening and health information including medication management, good nutrition, weight loss and encouragement to exercise
- 233 had blood pressure that were over 140/90 and received counseling and referrals with the goal of preventing strokes, heart attacks
- 55 had blood pressure that warranted direct referral to their physician

Southwest Georgia Health Network

Southwest Georgia – Chronic diseases such as diabetes, heart disease and cancer are among the most prevalent, costly and preventable of health problems in Quitman and Stewart counties. The Southwest Georgia Health Network was created to transform the approach to these chronic diseases and to manage them in a comprehensive manner at the community, organizational, practice and patient levels.

The Chronic Disease Management Project was developed to provide care management for the underserved and rural populations of these counties. Contact Ajay Gehlot, CEO. 229-887-3324, email is ceo@swrhi.com.

Diabetes and Childhood Obesity Management/Prevention - Meadows Regional Medical Center

Our purpose is to provide quality, comprehensive, culturally appropriate education in Diabetes and Childhood Obesity Management/

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Prevention and to remove major barriers to access to care. Program goals include: Increasing awareness of the seriousness of diabetes among high risk groups, improve understanding about diabetes and its control and to promote better self-management behaviors among people with diabetes, improve health care providers' understanding of diabetes and its control and promote an integrated approach to care, promote health care policies that improve the quality of and access to diabetes care, and reduce disparities in health in racial and ethnic populations disproportionately affected by diabetes. Please contact Nancy Stanley – Director of Community Wellness – 912-277-2141, email – nstanley@meadowsregional.org.

The Southeast Georgia Health System Bariatric Care Center is an American Society for Bariatric Surgery Bariatric Surgery Center of Excellence and a Blue Shield Association Blue Distinction Center for Bariatric Surgery. This program services candidates from all over Georgia. Candidates must be motivated to make a lifelong behavioral commitment that includes well-balanced eating and physical activities necessary to achieve the best results. The Center's team of professionals offers structured education, empowerment, and emotional support to ensure patients' well-being and excellent results. For more information, please call 912-466-7420.

The **Bariatric Center at North Fulton Regional Hospital** provides a comprehensive approach to weight loss that consists of two programs: Weight loss (Bariatric) Surgery for patients who meet the NIH criteria for obesity (a body mass index (BMI) of 40 or more, or have a BMI of 35 or more with life-threatening illness that may be improved with weight loss such as sleep apnea, type 2 diabetes or heart disease) and who have tried other weight loss methods but have not been able to achieve desired results and Medically Supervised Weight Loss – Lifestyles. A comprehensive weight management program that stresses the importance of diet, physical activity and behavior modification techniques for weight loss and maintenance. For more information please visit our website: www.northfultonregional.com/bariatrics or call Virginia "Ginger" Rock, Bariatric Program Assistant, 770-751-2924.

Piedmont Hospital's Heart Failure Resource Center

The Fuqua Heart Failure Resource Center at Piedmont Hospital in Atlanta combines guideline-driven care and a unique care delivery model for patients with chronic heart failure. The strategy behind the center has been to improve care through a continuum based approach, by employing treatment strategies and advanced patient and family education in the outpatient setting, thus reducing hospital admissions and more importantly, readmissions. Since the inception of the center, the clinic population has consistently demonstrated statistically significant lower readmission rates than heart failure patients in the general hospital population. Hospital readmission 30 days after discharge for heart failure diagnosis groups treated by the center was two percent for fiscal year 2008, significantly lower than for heart failure patients not in the program. The national average for readmission 30 days after discharge for heart failure diagnosis groups is 20 percent. This has been accomplished along with high patient and staff satisfaction scores and positive support from the medical staff. The Heart Failure Resource Center uses a cost avoidance model, identifying reduction in heart failure admissions and re-admissions as a way to help cover the cost of the program.

Piedmont Hospital's Diabetes Resource Center

The Piedmont Hospital Diabetes Resource Center has been recognized by the American Diabetes Association in accordance with the National Standards for Diabetes Patient Education Programs. The center's mission is to provide diabetes self-management and prevention services that empower the individual. The Diabetes Resource Center's most recent clinical data, for the period July 01, 2007 – June 30, 2008, demonstrates an average decrease of 1.55 percent in participants' HbA1C level. Clinical studies report that for every percentage point reduction in the HbA1C there is a reduction of long term complications by 35 percent. In an effort to slow the ever increasing prevalence of diabetes, the center also provides diabetes prevention classes and programs. Piedmont's diabetes prevention programs replicate the results of the large, multicenter clinical research study called the Diabetes Prevention Program (DPP). DPP found that study participants who lost a modest amount of weight through dietary changes and increased physical activity sharply reduced their chances of developing diabetes.

Northside Hospital New Start, Weight Smart

12-week program includes weekly classes about diet modification and exercise in addition to, weekly weight checks, a grocery store tour, a heart monitor and pedometer, a session manual and two free personal training sessions. In Atlanta: 404-851-6023 Individual 1:1 weight loss consults with a Registered Dietitian for those who do not wish to participate in group classes.

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Northside Hospital's Diabetes Education and Nutrition

Classes offered in Atlanta, Alpharetta and Cherokee. Patients learn about diabetes and how to adapt a diabetes self-care plan to fit their individual lifestyles. Programs are available to patients with Type 1, Type 2 and pre-diabetes, and patients with PCOS and metabolic syndrome. Diabetes prevention classes and support groups also are available. Gestational Diabetes Education Classes are offered 3 times a week. Atlanta & Alpharetta: 404-851-6023, Cherokee: 678-493-1503.

Electronic Personal Health Record (ePHR) Medical College of Georgia

This three-year AHRQ clinical trial examines the impact of a PFCC (Patient- and Family-Centered Care) oriented ePHR on the management of chronic disease. Researchers will study the feasibility, acceptability and impact of a PFCC modified ePHR. The intervention group, patients using the PFCC ePHR, will be compared to patients receiving standard care. Hundreds of MCG patients with hypertension participating in the study will be able to post their blood pressure, weight and dietary information into their medical record. They will be able to e-mail their physicians when needed. Unique to the study design is the incorporation of PFCC principles such as extensive patient participation in technology design, development of study methods and qualitative discussions.

Specific Aims: To improve the application of patient- and family-centered care elements in an existing ePHR, based on feedback from a pilot study of patients and their families. Hypertension patients and their families will pilot test the modified ePHR. A team of physicians, mid-level practitioners, nurse clinicians and support staff in two ambulatory settings will implement and test the effectiveness of the PFCC modified ePHR with patients undergoing treatment for hypertension. Monitor changes in provider and support staff awareness and incorporation of patient- and family-centered care resulting from use of the ePHR.

Tift Regional Medical Center Community Health Initiatives

Tift Regional Medical Center (TRMC), based in Tifton, serves 12 counties in South Central Georgia and is committed to enhancing community health and reducing hospitalizations. Programs include Tift Community Health Center, which offers treatment of chronic, non-acute health problems for patients who are economically-disadvantaged. Specialists from the TRMC medical staff rotate to the hospital's HealthPlus outreach clinics to provide easier access to evaluations and follow-up exams for patients living in surrounding rural counties. Two of the four HealthPlus locations also offer full-time primary care services. WorkSmart is a special occupational health center that helps local business and industry effectively manage employee health issues. The TRMC "Community Spirit" program offers free lectures, medical screenings, support groups, prepared childbirth classes and special senior services. The "Better Health at TRMC" initiative is designed to improve the health and fitness of the hospital's 1,500 employees by providing ongoing health risk assessments, wellness coaching, group exercise programs and special incentives.

Northside Hospital's Check It Out

This is a collaborative effort with the Greater Atlanta Hadassah, which provides breast health education to high school juniors and seniors. The main objective is to teach young women how to do proper breast self-examinations to promote early detection and the education of risk factors. Cobb, Fulton, Gwinnett and DeKalb counties have accepted the program as part of their health curriculum. In 2008, the program was presented to 16 groups, reaching more than 1,800 young women.

Northside Hospital's Community Cancer Screenings

Northside hosts annual free screenings to detect skin cancer and prostate cancer in the community. In 2008, three free Prostate Cancer Screenings took place in September as part of Prostate Cancer Awareness Month. Screenings were held at Northside Hospital-Atlanta, Northside Hospital-Forsyth and Northside Hospital-Cherokee. Participation included 172 men with 6 men recommended for medical follow up as a result of suspicious findings. Two confirmed cases of prostate cancer were made and 3 potential cases are pending. Free Skin Cancer Screenings were held in May – one at each hospital campus. With 244 participants, the screenings were extremely successful. Seventy-one people were recommended to seek follow-up treatment because of abnormal findings.

Community Health Works

Since 2000, Community Health Works has sought innovative solutions and provided compassionate advocacy for central Georgians financially compromised by their medical needs. Community Health Works operates a variety of direct service programs providing access to health screenings and health improvement through our vast network of physician, hospital and community partners. Through

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the Central Georgia Cancer Coalition, a focused initiative, CHW provides cancer awareness education and access to cancer screenings for residents of a twenty-five county central Georgia region. The Central Georgia Cancer Coalition is also working to build a rural cancer care network through regional coalition building and targeted training for health professionals that will ensure that residents of rural Georgia have equal access to an array of cancer care and support services. CHW serves the central state as a Regional Center for Health Innovation, a laboratory for the incubation and development of cutting-edge programs that redefine the parameters of service delivery, health care organization and health care financing.

Spring Creek Health Cooperative

Spring Creek Health Cooperative (SCHC) is an innovative multi-county partnership that is changing the way Southwest Georgians manage their health while saving taxpayers millions of dollars in the process. SCHC goals are to eliminate health disparities, promote wellness and achieve greater health system saving by providing four necessary programs: chronic disease and behavioral case management, pharmaceutical assistance, community & school health screens, and community education and outreach. Our target population is the uninsured and underinsured population with chronic disease states such as hypertension, diabetes, obesity and asthma; in need of medication assistance; and utilized the ER for non-emergent use. A recent ROCI Analysis among four partnering hospital's ER patients receiving disease case management and pharmaceutical assistance demonstrated a decrease of inappropriate ER use by an average of 54%. This reduction created a savings of more than \$700,000 in ER cost, \$465,000 in hospital admissions and provided almost \$1.6 million in free medications. The Net Return on Community Investment among the four partner hospital was approximately \$2.4 million from June 2007 – June 2008. The Disease and Behavioral Case Management program has provided health education to more than 1300 patients since 2003. Patients receive health assessments, medical home referrals, personal care plans, nutrition assessment & education, diabetes counseling, hypertension education, medication review, medication assistance referral, specialty care referrals, emergency medications and diabetes supplies. Our Pharmaceutical Assistance Program was developed to ensure those without prescription health insurance could gain the medications needed to maintain a healthy lifestyle and reduce inappropriate ER use. SCHC has helped more than 2365 patients receive more than 80,000 prescriptions saving patients more than \$9 million since our inception.

Prevent Blindness Georgia Vision Outreach Program

Prevent Blindness Georgia, the state affiliate of Prevent Blindness America, began providing eye exam clinics and new eye glasses on site at homeless shelters in 2000. These clinics have now expanded to serve senior centers and diabetes patients at Community Health Centers around the state. In 2008, Vision Outreach provided eye exams for 2502 people. More than 1746 secured new glasses through this project and 200 were referred for treatment of eye disease. Clients come to these clinics for the eye glasses they need to drive a car, fill out a job application or be safer on the streets, but Prevent Blindness Georgia provides the eye exams to fulfill our mission of "preventing blindness and preserving sight." The eye exams diagnose vision problems that could cause permanent vision loss and then directs these patients to doctors who can provide treatment to limit vision loss. These services help patients with chronic eye disease keep their vision and live independently as long as possible. Prevent Blindness Georgia also vision screens 30,000 young children in Georgia's prekindergarten classes to insure that they will have a lifetime of good vision and trains school nurses, public health nurses and pediatric nurses to vision screen children of all ages.

Community Diabetes Support Groups

Currently, the South Central Health District coordinates two community diabetes support groups. One support group meets in Dublin at Fairview Park Hospital. The other support group meets in Eastman at Dodge County Hospital. A local Certified Diabetes Educator leads each meeting. Meetings provide diabetics and their families with an outlet for sharing and gaining information. Most importantly, it provides each participant with, much needed, support and encouragement as they manage their diabetes.

Project School Health:

In 2008, the South Central Health District launched Project School Health, a school-based program that addresses physical activity, nutrition, and tobacco use in the school setting. Schools are challenged to meet all guidelines which include offering healthy snack options in vending machines, offering 75% water options in drink machines, incorporating physical activity in the classroom setting, offering walking/running clubs for school faculty and staff, and adopting a, board-approved, 100% tobacco-free school policy- just to

State of the Health of Georgia



Cardiovascular Conditions

Diabetes

Respiratory Conditions

Dehydration

Urinary/Kidney Conditions

Low Birthweight

Teen Pregnancy

name a few! Last year, 5 schools completed the challenge, and this year, 5 additional schools are striving to meet the guidelines in an effort to create a healthier environment for their students and staff. For more information about the diabetes support groups or Project School Health, contact Melissa Brantley at 478-275-6545.