Phase 3- Implementation Plan

- Three Year Implementation Plan -January 1, 2024- December 31, 2026
- Annual Year Work Plan 2024/2025/2026

Phase Three – Implementation Plan Narrative

Writing/ finalizing the Houston Healthcare Community Benefit 3 Year Plan

Houston Healthcare includes Houston Healthcare- Warner Robins and Houston Healthcare- Perry. Both facilities are in Houston County and serve the same populations. Residents can and often do utilize both facilities along with the other resources provided through Houston Healthcare. Because the service area is the same population, the needs and the plan to address them are the same.

Houston Healthcare will utilize various methods to reach the goals set in the implementation plan. Healthy People 2030 information states "Educational and community-based programs and strategies will play a key role in improving the health of the community."

Community settings such as churches, lower income housing projects, and worksites increase the access to populations with health disparities. Barriers such as low literacy rates, non-traditional work hours, and limited education contribute to a decreased understanding of addressing health challenges early and setting healthy lifestyles as a priority to prevent illness.

Houston Healthcare has explored and is continuing to seek methods to reach all populations within the service area but especially those with the greatest need. This is accomplished by taking needed health information out into the communities we serve.

Community partnerships provide a vehicle to broaden the outreach as well as to provide feedback on methods to reach vulnerable populations. This includes providing screening and education through avenues such as churches, soup kitchens/food pantries, workplace/industry sites, public libraries and the Houston County Board of Education. Houston Healthcare also partners with the Houston County Health Department, local housing authority, free or lower cost medical clinics, senior centers and others to impact the health of our community.

Description of Plan

Every three years a Community Health Needs Assessment is completed and a three-year implementation plan is created. The three-year plan addresses the needs identified in the Community Health Needs Assessment. The implementation plan includes the four priority areas of

(1) Improve Modifiable Risk Factors
(2) Improve Ease of Access to Appropriate Health Care,
(3) Improve individual's Management of Chronic Disease, and
(4) Additional Assistance for Vulnerable Populations.

Each year a detailed annual work plan is developed to measure the progress of reaching the goals and address the priorities described in the three -year plan. Anticipated impact or outcomes are reviewed each year. The three-year plan will be evaluated by utilizing a score card.

This narrative will address each of the four priority areas and will include:

Priority Area

A- An overview of the health priority

B- The Goal and Strategies

C- The Score Card- objective, baseline, and strategies (Complete Score Card is in appendix 3)

Priority Area 1 – Improve Modifiable Risk Factors

Overview: Major Risk Factor- Overweight or obesity

The Nutrition and weight status information included in Healthy People 2030 reflect strong science supporting the health benefits of maintaining a healthy body weight through a balanced diet and exercise. The information also emphasizes that efforts to change diet and weight should address individual behaviors, as well as policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities. Our community adults as well as children will face chronic obesity-related health problems like heart disease, high blood pressure, diabetes, cancer, and asthma if the present trends continue.

The Community Health Needs Assessment defined overweight as BMI of 25.0 to 29.0 and obesity as BMI over 30.

Baseline

- 78.5% are overweight, 45.8% of these adults are obese.
- **21.5% of Houston County adults are at a healthy weight.**

Goal: Increase the number of adults at a healthy weight to at least 23.5% by December 2026

Strategy: The strategy will include promotion of the Healthy People 2030 recommendations to "Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, lean meats and other protein sources and water as a beverage of choice. Limit the intake of saturated and *Trans* fats, added sugars, sodium, and alcohol." The strategy also includes programs specifically designed to promote healthy weights such as the Healthy Living for Life Class, Nutrition Education/Cooking Classes along with exercise classes.

Health screenings will be provided at worksites, churches and other community sites will include BMI measurements. The local school system is targeting youth promotion of healthy weight and Houston Healthcare is providing cooking schools and education at Lindsay Transitional Center. Cooking demos are also being offered at indigent care health facilities and senior programs.

The City of Perry provides free indoor space for exercise which is staffed and promoted by Houston Healthcare. The EduCare department has an on-site exercise area for classes at the Houston Health Pavilion that target seniors, working population and families. Several classes are offered to meet participants at their movement level including chair yoga, balance class, tai chi, strength, aerobic and resistance classes.

The #HoustonHealthy initiative was started at the end of 2020 to encourage healthy habits and promote wellness with hospital employees and in the community. This initiative will continue to partner with individuals, groups, leaders, schools, businesses and organizations to support encouraging healthy options available to the people in Houston County.

Overview: Major Risk Factor Tobacco

A major goal of Healthy People 2030 is prevention and cessation of tobacco usage. The report shares "Tobacco use remains the leading cause of premature and preventable death in our nation, responsible for 443,000 deaths each year. Tobacco use causes cancer, heart disease, lung disease as well as premature birth and low birth

weight infants." In Houston County, the leading causes of death include cardiovascular disease and cancer, with tobacco as a major contributor to these diseases.

Baseline

- The rate of tobacco usage is highest among residents age 40 to 64 (14.7%)
- Lower income residents had higher rates of tobacco usage at 19.4%.
- **12.3% of persons living in Houston County smoke tobacco and 7% of residents use vaping products with most use reported among younger adults age 18-39 (under 18 was not assessed).**

Goal: Decrease the usage of tobacco use to 10% and vaping to 5% by Dec. 2026

Strategy: Addressing this health issue requires multiple methods and partnerships. While it is recognized tobacco cessation is difficult, it is possible. Houston Healthcare refers to the Georgia Quit Line which offers individual assistance through a phone line. The Quit Line utilizes trained counselors, is free, anonymous, and is easily assessable. This resource will be shared at community outreach events.

In addition, each hospitalized patient and/or class/health fair participant who states they are a tobacco user will receive tobacco cessation information along with information on the Georgia Quit Line. Additional education will also be provided regarding the harms of vaping to both young and old. Community Partners include Houston County Public Health assisting with tobacco cessation education, providing resources for the Houston County Public School system to include dangers of vaping resources to adolescents, and The American Cancer Society assisting with the annual Great American Smoke Out.

Score Card Priority Area 1- Improve Modifiable Risk Factors

Community Need Identified/Baseline	Overall Goal/ Measurable Scorecard 3-year goal-CHNA-2026	Objectives/ Anticipated Impact
Leading causes of death is cancer and cardiovascular disease both are impacted by modifiable risk factors of nutrition, exercise and tobacco use. **A-Healthy Weight**- 21.5% of community are at a healthy weight (BMI- 18.5 to 24.9)	Improve risk factors associated with the development of cancer and chronic disease **A-2- increase the number of adults at a healthy weight (BMI 18.5-24.9) to at least 23.5%**	Provide weekly educational programs to increase knowledge and skills to improve modifiable risk factors and over- all health. **A-1**-At least 50% of the participants in the Healthy Living Class will demonstrate a weight loss and report one positive healthy lifestyle change. **A-2**- Provide at least four Worksite Wellness screenings, to include BMI consultation. **A-3-** Participate in community events that promote healthy weight, healthy eating and physical activity **A-4**- Provide cooking classes and demonstrations that promote cost effective healthy food choices to prepare at home
B-Tobacco 2011 CHNA- Tobacco Use- 18.6% 2014 CHNA- Tobacco Use- 12.7%	**B- decrease the usage of tobacco to 10%**	**B-1**- Present tobacco/vaping educational materials and info. at both hospitals during Great American Smokeout. **B-2-**Tobacco cessation education including the "Georgia Tobacco Quit line" will be provided to at least four

2017- CHNA- Tobacco Use- 13.9% 2017- CHNA-Tobacco Use- lower income residents- 22.7% 2020- CHNA- 11.1% tobacco use residents (17.8% low-income) 17.9% use vaping products 2023-CHNA 12.3% tobacco use (19.4% low- income) 7% use vaping products	**Decrease number of residents who vape to 5%**	worksites or community organizations serving lower income population. **B-3** Provide/participate in community outreach activities that teach dangers of vaping especially to school age children **B-4** All EduCare programs to include smoking cessation education and referrals documented in monthly report

Priority Area 2- Improve Ease of Access to Healthcare

Overview: The ease of access to healthcare services is important in the achievement of a healthy life. The Healthy People 2030 review includes "Access to health care means the timely use of personal health services to achieve the best health outcomes".
Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life. Barriers to services include:

- Lack of availability which is impacted by the number of health workers
- Limited financial ability to pay for services
- Lack of insurance coverage
- Lack of knowledge of resources for health services

These barriers to accessing health services lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Hospitalizations that could have been prevented

Baseline
The Community Health Needs Assessment information included:

- 14.6 % lack healthcare insurance coverage with 32.7% of lower income persons have no insurance coverage.
- 14.9% skipped prescription doses to save cost on medications
- 16.5% of Houston County adults have gone to a hospital emergency room more than once in the past year.
- The number of primary care physicians is 72.7 per 100,000 population which is less than the state (87.6) and national (107.3) average.
- 26.9% have completed an advance directive document
- 72% of residents have a specific source of ongoing medical care (which means 28% do not have a PCP)

Goal: Improve the ease of access to appropriate health care services.

Increase the number of Houston County residents who have a medical home or ongoing source of healthcare to at least 80%.

Strategy: Houston Healthcare is addressing this critical issue in multiple ways including: (1) Providing support for local technical schools, and colleges for training additional health care workers. (2) Providing a physician's residency program, as well as serving as a clinical site for students going into a health care profession (3) Assisting and supporting the free Volunteer Medical Clinic and operating Pavilion Family Medicine which serves uninsured, lower income residents (4) Providing a phone referral service to link community persons to needed services or medication assistance and encourage establishing a medical home. (5) Health fairs and community screenings include information on qualifying for financial assistance and obtaining a medical home (6) Partnerships with groups such as United Way and others to provide assistance in obtaining specific health services. (7) Houston Healthcare has added Care Managers to assist in-patients and ED patients to better navigate the health care system. (8) Houston Healthcare is also providing Med Stops for urgent care in three locations for easier access. (9) Policies and processes are in place to provide financial assistance.

Goal: Decrease the number of persons who frequently utilize the ED for health care to 12%

Assist members of the community to find a medical home for non-emergent health needs

Strategy: Referral Services offer information for any person needing information for a medical home based on insurance type, no insurance or low or no income. All health screenings, health fairs, community events and classes will provide information and need for a medical home. Partnership with agencies providing funding to assist with services related to health services, mammograms, prenatal care and other screenings provided as needed and made available.

Goal: Decrease the number of persons who do not take medications as prescribed to < 10%

Provide information to members of the community on sources for lower cost prescriptions or prescription assistance

Strategy: Many resources are available to the community to assist in medication cost. Organizations that offer services include- Middle Georgia Community Action Agency, Good Rx and many discount medications offered at local pharmacies. All information will be made available at all health screenings, health fairs, classes and are available through Referral Services, Care Management and in-patient services.

Score Card- Priority Area 2- Improve Ease of Access To Health Care

Community need identified/Baseline	Overall Goal Measurable Scorecard 3- year goal- CHNA- 2026	Objectives/ Anticipated Impact
The ease of access to healthcare services impact personal health, delays appropriate care, leads to increased health care cost, hospitalizations and ED visits. **A-Medical Homes** 2014- CHNA- 73.9% report ongoing source of health care 2017 CHNA- 71.8% report ongoing source of health care 2020 CHNA- 83.2% report ongoing source of health care 2023 CHNA- 72% report ongoing source of health care **B-Appropriate Usage of Health Services** CHNA-2023 16.5% of residents have utilized the ED more than once in a year(31.8% low income)	Improve the health of individuals by improving the ease of access to care. **A-Increase the number of Houston County residents who have a medical home or ongoing source of healthcare to at least 80%.** B-**Decrease the number of persons who frequently utilized the ED for health care to 12%**	**A-1** increase in the number of persons who call Referral Services to obtain information on establishing a Medical Home by 3% compared to request in 2023. **A-2** Community screenings will include documentation on participants screening form of their medical home. If no medical home participant will be linked to Referral Services. **A-3** At least 4 health fairs with screenings will be provided in low income areas. Each event will promote medical homes, resources for persons who are uninsured, and financial assistance available. **B-**Patient Care Services, EduCare, Marketing, 1 West, Population Health and EMS will explore efforts to increase appropriate usage of the ED
C- Medications 2014 CHNA- 15.1% of residents skipped Rx doses to save cost. 2017 CHNA-11.9% of residents skipped Rx doses to save cost. 2020 CHNA- 9.5% of residents skipped Rx doses to save cost 2023 CHNA-14.9% skip RX to save cost	**C- Decrease the number of persons who do not take their medications appropriately to less than 10%**	**C-1** Referral services will refer community persons to resources for lower cost prescriptions **C-2** Information on prescription assistance will be provided at all health fairs/screenings **C-3** Patients attending Chronic Disease Education will receive information on lower cost medications and be provided medication organizers. **C-4** Medication Management will be provided to senior groups, classes, and community events stressing the importance of medication compliance and maintaining a current medication list (Know Your Meds cards)

Priority Area 3- Improve Individual's Management of Chronic Diseases

Overview: Chronic diseases are the leading cause of death and disability in the United States. Heart disease, cancer, and stroke alone cause more than 50 percent of all deaths each year. Chronic diseases include (but are not limited to): arthritis, diabetes, kidney disease, asthma, cancer, congestive heart failure/heart disease/stroke and chronic obstructive pulmonary disease (COPD)

Baseline

- Almost half of all deaths in Houston County are from cancer or cardiovascular disease (heart disease and stroke)
- 20% of the population has diabetes/ 7.2% pre-diabetes
- 17.8% of the adult population has COPD/asthma
- Stroke rate is 38.2 deaths per 100,000

Goal: **Decrease the number of residents who have diabetes to 15%**
Decrease the number of residents who have pre-diabetes to 6%
Decrease rate of deaths from strokes to 35 per 100,000
Reduce the death rate from heart disease to 175 per 100,000
Decrease hypertension rate to 40%

Provide Chronic Disease Management to equip persons with skills needed to control their condition in such a way that decreases complications, and improves their quality of life.

Strategy: The first strategy is to prevent chronic disease. These efforts are listed in our first and second priority areas which include addressing risk factors, early identification through screenings and improving the access to appropriate health services. These play a key role in addressing chronic illness.

Once a person has a chronic illness our strategy becomes; (1) to provide chronic disease management programs that empower and encourage the patient to be an active participant in their care. Provide evidenced based chronic disease management programs which include: Diabetes Management- nationally recognized program from American Diabetes Association, Arthritis Management- Walk with Ease from Arthritis Association, as well as Heart Failure, Cholesterol and Hypertension Management both based on chronic disease management models. (2) Provide a smooth transitional care process to provide hospitalized patients with education and skills to manage their illness. Transitional Care is a priority for Houston Healthcare and includes appropriate discharge planning and referrals. This is accomplished and tracked though in-patient education services and Care Management. (3) Provide education to prevent complications that can arise with the progression of an uncontrolled chronic disease.

Score Card Priority Area 3- Chronic Disease Management

Community need identified/Baseline	Overall Goal Measurable Scorecard 3-year goal- CHNA- 2026	Objectives/ Anticipated Impact
A- Diabetes 2011- CHNA- 14% Houston County Residents are diagnosed with diabetes 2014- CHNA- 11.7% Houston County Residents diagnosed with diabetes (6.7% with pre-diabetes) 2017- CHNA- 18.3% of Houston County residents diagnosed with diabetes. (4.2% with pre-diabetes) 2020-CHNA- 17.3% of Houston County residents diagnosed with diabetes (10.3% with pre-diabetes) 2023 CHNA- 20% with diabetes (7.2%with pre-diabetes)	-Decrease diabetes related complications and improve quality of life of patients living with diabetes **-Decrease the number of residents who have diabetes to 15%** **Decrease the number of residents who have pre-diabetes to 6%**	**A-1**-Maintain National Recognition for Diabetes Management Program through annual audit (due Sept 2025) **A-2**-Decrease ED visits and hospitalizations to <20% for participants in Diabetes Management program (3 month tracking) **A-3**- Decrease the 30- day readmission rate for patients receiving in-patient diabetes education to less than 20%. **A-4-** The Diabetes Advisory Board will include at least one patient with diabetes who has experienced a hospitalization **A-5**- At least 50% of pts. Referred will be scheduled. **A-6** Start at least 2 National Diabetes Prevention Program Cohorts with 50% of participants completing full year program **A-7** NDDP to maintain CDC full recognition status (due Nov 2026)

B- Hypertension/Cholesterol Management – 2014- CHNA- 38.3%- residents have high blood pressure 2017- CHNA- 43.5%- residents have high blood pressure 2020 CHNA-51.3% residents have high blood pressure, 40.8% have high cholesterol 2023 CHNA- 43.3% residents have high blood pressure, 45.6% residents have high cholesterol **Stroke rate is 38.2 deaths per 100,000** **Rate heart disease deaths per 100,00** 2011- CHNA- 182.7 2014 CHNA--179.6 2017- CHNA- 181.3 2020-CHNA- 203.2 2023 CHNA- 214.0	**B-**Decrease complications of hypertension **Decrease rate of deaths from strokes to 35 per 100,000** **Reduce the death rate from heart disease to 175 per 100,000**	**B-1-**Decrease ED visits & hospitalizations by at least 50% for participants in Hypertension Management program (3 month F/U tracking) **B-2-** At least 75% of hypertension/cholesterol management class will list at least one lifestyle change **B-3**- 100% of persons with abnormal BP/cholesterol screening will receive education and referral as needed to additional follow up health care.
C-Heart Failure Diseases of the heart account for the number one cause of death in Houston County	**C**-Improve the ability of persons with heart failure to manage this condition, and improve their quality of life	**C-1-**80% of class participants will report increase in knowledge and skills to management heart failure **C-2-**Readmissions from Heart Failure will decrease to <15% (in-patient 1 month tracking, class 3 month tracking) **C-3-** Meet as a work group to improve the care of persons with heart failure.
D-CPR 14.9% report receiving CPR training in last year	D-Improve outcomes for those with an out-of-hospital cardiac event **Increase number trained in CPR to 60% (3-year scorecard)**	**D-** Multi-department effort to provide hands-only CPR training at 10 or more community events

Priority Area 4- Assist Vulnerable Populations-

Improve the health of populations at higher risk for poor health specifically targeting women with higher risk pregnancies as well as older adults, persons with behavioral health challenges, and hospital/ED frequent users

Overview: Low Birth Weight Infants

Preterm/ low birth weight is the leading cause of newborn death in the United States. Low birth weight babies, (newborns weighing less than 5 pounds 8 ounces) at birth are much more prone to illness and neonatal death than are babies of normal weight. Risk factors for low birth weight are continuing to be studied, however, known risk factors include women who are uninsured and lower income, tobacco usage and lack of prenatal care as well as pre-existing medical conditions.

Baseline:

- 9% low birth weight
- 19.1% no prenatal care in the first trimester
- 10 infant death rate per 1,000 births (infant defined as birth to 1 yr. old)

Goal: Increase the number of women having a healthy newborn by addressing the risk factors for newborn low birth weights and preterm births.

Decrease low birth rate to 8% in Houston County
Decrease infant death rate to 6 per 1000 births (infant defined as birth to 1 year old)

Strategy: The strategy is to target women with a higher risk pregnancy due to socio-economic risk or a medical risk. Activities will include (1) Partnering with other organizations providing pregnancy related services through the Perinatal Coalition. (2) Providing a Hispanic interpreter/care manager for uninsured and non-English speaking pregnant women (3) work with the local health department as well as local physicians to ensure all women have access to prenatal care (4) Providing a Nurse Care Manager for pregnant women with a medical condition (5) Providing a Nurse Educator to meet with pregnant teens in schools as requested. (6) Partner with agencies providing safety interventions for infants (DPH, Safe Kids, Family Connections, etc).

Overview: Senior Adults 65+

Older adults are among the fastest growing age group accounting for 12.5% of residents in Houston County. 65.4% of older adults will manage more than one chronic condition. Managing one chronic condition is challenging, however, with each additional disease, control becomes more difficult often involving more medications, and the need for increased monitoring, additional health services and education.

Another risk among older adults is accidental falls. Falls are the second leading cause of death due to unintentional injury among older adults. According to the Healthy People 2030 Report, "Behaviors such as participation in physical activity, self-management of chronic diseases, or use of preventive health services can improve health outcomes." In our work with older adults the desire to maintain independence was identified as a major goal among this population. To support the older population to maintain their independence requires additional assistance in health education, monitoring, chronic disease management and opportunities to improve physical strength, balance and fitness.

Baseline:

- 65.4% of adults over age 65 are managing three or more chronic conditions
- 97.7% of adults over age 65 exhibit one or more cardiovascular risk behaviors including smoking, no physical activity, hypertension, high cholesterol and/or are overweight

- 27% of 65+ year old's report "fair" or "poor" overall health
- 12% of adults over age 65 meet physical activity recommendations each week
- 53.1 per 100,000 of unintentional injury deaths among 65+ is related to falls

Goal: Improve the health, function, and quality of life of older adults.

Reduce senior "3 or more" chronic conditions to 90%
Decrease rate of unintentional injury deaths related to falls to 15%
Increase seniors meeting physical activity recommendations to 20%.

Strategy: (1) Provide free exercise program for older adults in collaboration with other community organization's such as the Warner Robins Recreation Department, local care homes, senior centers and the Perry Recreation Department. (2) Provide health education programs which include health screenings, education at convenient locations, and referrals as needed to physician's care and other resources. (3) Partner with other local organizations that are providing services for older adults by providing health related information as well as information on resources. Priorities for these health information programs includes: tools for medication management and the importance of being engaged and taking responsibility for personal health, prevention of falls, and chronic illness related information. (5) Ensure opportunities for caregiver training are available in order to establish support for older adults.

Overview: Mental Health

For the first time on the Houston County Community Needs Health Assessment, mental health was at the top of problem health topics from key informants with 50% listing as a major problem and 42.3% as a moderate problem. Following the Covid-19 epidemic, mental health has gained public attention in relation to prevalence and determining options for addressing increasing concerns. Estimates suggest that only half of all people with mental health disorders receive the treatment they need. With mental health and physical health being so closely related, it is imperative that this concern be addressed in order to attain all other health concern goals discussed in this workplan.

Baseline:

- 30% diagnosed with depression, 43.2% experience symptoms of chronic depression
- 17.9 per 100,000 suicide deaths
- 21.2 receiving mental health treatment
- 71.5 mental health providers per 100,000 of population (117 including psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health)

Goal: Improve the mental health/well-being of the community.

Reduce those who experience chronic depression symptoms to 38%
Reduce suicide deaths to 12 per 100,000
To increase metal health organizations and mental health providers/partners to 81 per 100,000

Strategy: (1)Ensure a mental health educational component be included in all chronic disease education and classes (2) Provide a mental health self-assessment guide with community resources available at all health fairs/screenings (3) Offer mental health talks to senior groups, churches, businesses, organizations through speakers bureau (4)Make referrals to Department of Public Health Mental Health Clinic, Emergency Room

Services, 1 West, and Middle Flint Behavioral Health as needed (5) Promote the Suicide Prevention and Crisis Line

Score Card- Priority Area 4-Additional Assistance for Vulnerable Populations

Community need identified/Baseline	Overall Goal Measurable Scorecard 3-year goal- CHNA- 2025	Objectives/Anticipated Impact
A-Pregnant Women and Newborns 2014- CHNA- 8.9% Low birth weight 2017-CHNA- 8.5%- Low birth weight 2020 CHNA-8.8% low birth weight 2014- CHNA-8.9 infant death rate per 1,000 births 2017-CHNA- 7 infant deaths per 1,000 births 2020 CHNA- 7.8 infant deaths per 1,000 births 2023 CHNA- 10 infant deaths/1,000 9% low birth weight	**A-1 Decrease the low birth weight to 8% (<2500g or 5lbs 8oz)** **A-2- Decrease infant death rate to 6 per 1,000 births**	Provide education and services for assistance to vulnerable populations to decrease the deliveries with low birth weight among women identified with a **higher risk pregnancy.** **A-1-** Class Survey will show 90% can list: -Risk factors for pre-term birth -Symptoms of pre-term labor -Importance of 39 weeks gestational -Benefits of breastfeeding **A-1** L+D records to show decreased low birth weight/pre-term delivery rates **A-2** Class survey will show 90% can list: -car seat safety starting at discharge from the hospital -back to sleep to prevent SIDS -co-sleeping risks -not to shake the baby/ways to comfort -aware of community resources available for infant safety

B- Older Adults 97.7% of adults over age 65 have one or more cardiovascular risk behaviors 65.4% of senior adults are managing 3 or more chronic conditions 53.1/100,000 of senior unintentional injury deaths is related to falls 12% of 65+residents meet physical activity recommendations (light-mod activity 150 min/week or 75 min vigorous activity/week)	**B- 1 Reduce Seniors "1 or more" risk to 90%** **B2- Reduce Seniors "3 or more" chronic conditions to 60%** **B-2 Decrease rate of unintentional injury deaths related to falls to 45/ 100,000** **B-3 25% of seniors will meet activity recommendations**	**B-1-** Health and safety educational programs will be provided each month at facilities serving older adults. **B-1-**Provide Stroke Prevention/Heart Protection Program -Monthly screenings will be provided each month at facilities serving older adults. -RN providing the BP screening will also provide education on controlling BP and signs and symptoms of stroke, heart disease and medication management -RN will make referrals to physicians as needed **B2& 3-**Participants in the Senior Adult exercise programs: -80% surveyed will continue or increase their exercise plan as a result of programs offered -80% surveyed will report making safety changes -80% surveyed will report improved balance
C- Mental Health 30% diagnosed with depression, 43.2% experience symptoms of chronic depression 17.9 per 100,000 suicide deaths 21.2% receiving mental health treatment 71.5% mental health providers per 100,000 (117 actual)	**C-1 Reduce those who experience chronic depression symptoms to 38%** **C-2 Reduce suicide deaths to 12 per 100,000** **C-3 Increase mental health organizations and mental health providers/partners to 81 per 100,000**	**C-1** Ensure a mental health educational component be included in all chronic disease education and classes **C-1&2** Provide a mental health self-assessment guide with community resources available at all health fairs/screenings **C-1&**2Offer mental health talks to senior groups, churches, businesses, organizations through speakers bureau **C-2** Promote the Suicide Prevention and Crisis Line at classes, screenings and community speaking events **C-3** Make referrals to Department of Public Health Mental Health Clinic, Emergency Room Services, 1 West, Population Health and Middle Flint Behavioral Health as needed. Participant in Coalition groups with same goals**.**