INTRODUCTION

Between January and June 2016, St. Joseph's Hospital, Inc. and Candler Hospital, Inc. jointly worked together as St. Joseph's/Candler (SJ/C) to identify the health and social determinants of health needs in Chatham County. The hospitals once again partnered with Memorial Health during the process. The three hospitals worked with the Coastal Georgia Indicators Coalition, Chatham County Safety Net Planning Council, J.C. Lewis Primary Health Centers and SJ/C's Good Samaritan Clinic to collect primary and second data on health and social needs in at risk populations and throughout the broader community. The findings were published in the joint report filed in June 2016. The entire report can be found on the St. Joseph's/Candler website under the section, "In the Community."

METHODS OF DETERMINING NEEDS

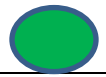
Using the findings of health and social needs identified through the Healthy Communities Institute data base and the Community Health Needs Assessment Survey, SJ/C and collaborating partner, Memorial Health, met with key collaborators to evaluate findings and prioritize the needs that were identified. 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.

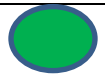
The same process of determining significant community needs in 2013 was used again in 2016. A decision tree was used to determine if an indicator was or was not a community need. There were four determination types:

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 SJ/C has the ability to either individually or collaboratively address. The needs not addressed by SJ/C, which include explanation why they are not being addressed can be found at the end of this document. In addition to the needs identified in the CHNA, SJ/C may choose to address additional needs brought to the hospital's attention by community organizations, agencies, religious bodies and others serving the health and social needs of the community.

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 June 2019**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 1: Enroll eligible patients in GA Medicaid Program Population Target: Uninsured patients living at 200% of the Federal Poverty Level or less	July 2016 – June 2019	1.) Provide Medicaid application assistance to eligible clients through St. Mary's Center's Public Benefit Enrollment Services. 2.) Assist SJ/C indigent patients with Medicaid enrollment Responsible Parties: Directors and/or Managers of SJ/C's St. Mary's Community Center and Patient Accounts	Assist 200 patients with Medicaid applications through St. Mary's **FY17 Outcomes** **New Applications Adult: 357** **Renewed Applications Adult: 136** **Enrolled Children: 484** Enroll all eligible uninsured patients in MCaid programs who qualify **FY17 Outcomes** **2,261 patient accounts processed and approved for Medicaid. Accounts included adults and children who received inpatient, outpatient and/or ED services.**
Status Report		**St. Joseph's Hospital, Candler Hospital and St. Mary's Community Center enroll patients, clients and families in applicable Medicaid programs through the State of GA**	
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	Ongoing July 2016 – June 2019	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 or who cannot afford health insurance. Responsible Parties: Director and/or Manager of SJ/C's Good Samaritan Clinic and St. Mary's Health Center	Increase access to primary care services at both sites by at least 500 new patients each year. **FY17 Outcomes** **SMHC New Patients: 715** **GSC New Patients: 515**

patients living at 200% of the Federal Poverty Level or less			
Status Report		**St. Mary's Health Center and Good Samaritan Clinic both exceeded the goal to enroll new patients in primary care health services at both sites.**	
Goal 3: Provide a program to assist self-pay and Medicaid patients locate a primary medical home accepting new patients for care.		1) Use the Emergency Department Medical Home program to connect uninsured/under insured patients with a primary medical home. Patients will be followed for up to 6 months after their initial health coach contact to assist in connecting to a medical home when needed.	Connect at least 25% of the un/under insured patients referred to a medical home with their first medical home appointment. **FY17 Outcomes** **Patients Referred: 1,424** **1st Appt Kept: 663** **% of Appts. Kept: 47%**
Status Report		Indicator includes those patients referred to primary medical homes in the area where they live including Chatham or surrounding counties.	

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 2016 – 2019.**		
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 patients living at 200% of the Federal Poverty Level or less	Ongoing July 2016 – June 2019	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 • Provide at least two days of MedBank Service Provider coverage at SMHC and GSC each week. **FY17 Outcomes** **SMHC – 3 days each week** **GSC – 2 days each week** • Provide medications for at least 50 patients each fiscal year. This includes medication assistance for affiliated and non-affiliated provider patients **FY17 Outcomes** **Number of patients who receive their 1st prescription through SJ/C and their cost: 247 patients, $41,489**
Status Report			

NEED IDENTIFIED:	**Affordable Medications**		
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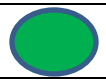
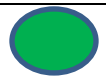
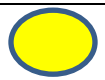
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Goal 2: Continue support for MedBank, Inc. Support will include in-kind donations to support operations and reduce operating cost. Population Target: Uninsured patients outside who meet MedBank eligibility requirements including, but not limited to use of the Federal Poverty Guidelines.	Ongoing July 2016 – June 2019	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: Director of Operations, Mission Services	All – June 2019 • Annual cost of in-kind operations contributions • Dedicate at least one co-worker to serve on MedBank's BOD: **FY17 Outcomes** **In-kind office space, including utilities and offices supplies were provided to MedBank, Inc. in FY 17. Total value: $51k** **Three SJ/C co-workers served on the BOD in FY 17**
Status Report			

NEED IDENTIFIED:	**Access to Exercise Opportunities**		
Objective:	Provide adult exercise classes targeting populations and people with high incidences of hypertension, diabetes and/or obesity.		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
Population Target: Program(s) will be open to the broader community with special attention on enrolling clients who have history of hypertension, diabetes, or obesity.	July 2016 – June 2019	1.) Enroll clients in exercise fitness classes at the AAHIRC Responsible Party: Director of AAHIRC	Ongoing • Enroll an average of 25 new members each quarter • Increase class participation contacts by at least 15% each year **FY17 Outcomes** **New Members: 262** **Total participation: 2,245 encounters**
Status Report		**Total encounters include two sites, AAHIRC and Delaware Center (satellite classes). Classes provided included Tai Chi, aerobics, Zumba and Line Dancing.**	

NEED IDENTIFIED:	**Access to Chronic Disease/Specialty Care**		
Objective:	**Continue to contribute to Cancer Care interventions implemented in 2013. Evaluate other care services which may be implemented during the 2016 – 2019 reporting period including where there is an identified need.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Goal 1: Continue Cancer Care interventions established in 2013 (see Cancer specific sections immediately following this indicator section.) Goal: 2 Evaluate top three specialty needs for at risk populations. Population Target: Program(s) will be open to the broader community with special attention given to the un/under insured and patients living in poverty.	2016 - 2019	1.) Continue Cancer Care Interventions and increase access to those services – see the following sections on cancer. 2.) Evaluate the top three greatest specialty needs in at risk populations to determine if services, including physician service agreements, can be obtained to address the specialty care needs of those populations. ***NOTE: This is a long term strategy intended to create access and services beyond 2019 as access to specialty care continues to be a significant need in Chatham and surrounding counties***. Responsible: Directors of Mission Service Operations, and SJ/C Outreach Centers/Programs	June 2019 1) Establish top three specialty care needs in the Chatham and surrounding community populations 2) Convene evaluation committee to design systems to provide the most needed services to the un/under insured populations a. Establish relationships with providers to open additional access points throughout the community for those services. b. Create baseline and measurement data for program(s) implementation
Status Report		**In FY 17, SJ/C opted to fully launch Hepatitis C cure program in addition to working on the identified targets/metrics in this section. Hepatitis C program's goal will be to cure another 18 people in FY 18.** **Indicator is colored yellow to notate no progress has been made on original goals, but**	**FY17 Outcomes** **Hepititis C Cure Program: 34 patients, 18 "cured", 4 in progress, 12 in beginning stages of starting program (quitting drinking, smoking, abstaining from unprotected sex and eating**

		Hepatitis C program has priority as SJ/C had opportunity to work on this important health issue within the vulnerable population in collaboration with MedBank, Inc. who may not be able to provide drugs beyond FY 18. Each patient's medication cost is $300,000 for a three month treatment and is being provided at no cost to the patient. The significant advantages of using MedBank program while available outweighed the original goals in this section.	**healthy.)**

CANCER SPECIFIC CARE INDICATORS

NEED IDENTIFIED:	**Age Adjusted Death Rate Due to Colorectal Cancer**		
Objective:	**Continue to contribute to interventions that support a decrease in age adjusted death rate due to colon and rectal cancer at the Good Samaritan Clinic and St. Mary's Health Center.**		
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 and St. Mary's Health Center. 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.	2016 - 2019	1.) Continue evidence-based screenings for colorectal cancer and follow-up guidelines at clinics. 2.) Provide Fecal Immunochemical Test (FIT) screening to qualified Good Samaritan Clinic and St. Mary's Health Center patients. 3.) Provide cancer treatment support services to individuals with colorectal cancer at SJ/C Lewis Cancer & Research Pavilion. Responsible: Disparities Program Manager, Nurse Navigator, Social Workers and Clinical Special Services Manager	July 2016 • Number of qualified patients at St. Mary's and the Good Samaritan screened. • Number of follow up care provided at SJ/C LCRP **FY17 Outcomes** **Screenings: 362** **Follow up care at LCRP: 2**
Status Report		Decreased death rate is **a long-term outcome**; this change will be seen past the reporting period for this implementation plan.	

NEED IDENTIFIED:	**Breast Cancer Incidence Rate**		
Objective:	**Continue to 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.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Goal 1: Continue evidence-based breast cancer screening and early detection at the Good Samaritan Clinic and St. Mary's Health Center 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.) Continue evidence-based screenings for breast cancer and follow-up guidelines at clinics. 2.) Provide screening mammograms to qualified Good Samaritan Clinic and St. Mary's Health Center patients. 3.) Provide cancer treatment and support services to individuals with breast cancer at SJ/C Lewis Cancer & Research Pavilion. Responsible: Nurse Navigator, Social Workers and Clinical Special Services Manager	July 2016 • Breast cancer screenings and follow up guidelines in at least GSC and SMHC with intentions to expand care to other service providers. • Number of qualified patients at St. Mary's and the Good Samaritan screened. • Number of follow up care provided at SJ/C LCRP **FY17 Outcomes** **Screenings: 543** **Follow up care at LCRP: 6**
Status Report		Decreased incidence is **a long-term outcome**; this change will be seen past the reporting period for this implementation plan	

NEED IDENTIFIED:	**Lung and Bronchus Incidence Rate**		
Objective:	**Continue to 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.**		
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 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.	2016-2019	1.) Continue evidence-based screenings for lung cancer and follow-up guidelines at clinics. 2.) Support healthy lifestyles and smoking cessation through group education at the Good Samaritan Clinic and St. Mary's Health Center clinics. 3.) Provide cancer support services to individuals with lung cancer at SJ/C Lewis Cancer & Research Pavilion. 4.) Offer smoking cessation program at SJ/C for the community and for hospital employees at least twice yearly. Responsible: Disparities Program Manager, Nurse Navigator, Social Workers and Clinical Special Services Manager	July 2016 • Lung cancer screenings and follow up guidelines in at GSC and SMHC. • Number of qualified patients at St. Mary's and the Good Samaritan screened • Number of follow up care provided at SJ/C LCRP **FY17 Outcomes** **Screenings: 16** **Follow up care at LCRP: 0**
Status Report		Decreased incidence is a **long-term outcome**; this change will be seen past the reporting period for this	

NEED IDENTIFIED:	**Lung and Bronchus Incidence Rate**		
Objective:	**Continue to 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.**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date *& Metrics***
		implementation plan	

NEED IDENTIFIED:	**People Living Below Poverty**		
Objective:	**Continue to meet 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 2016-2019**		
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, 31404 and 31415	Ongoing	1.) Continue to provide at least one staff person to assist clients in evaluating eligibility in public benefit programs (i.e., Medicare, Medicaid, Food Stamps, etc.) 2.) Continue to provide free income tax preparation assistance yearly Responsible: Director of SJ/C's St. Mary's Community Center	July 2016 • Number of clients served by public benefit enrollment ○ Number of benefits qualified for **FY17 Outcomes** ❖ **659 people were enrolled in SNAP** ❖ **436 people had their SNAP application recertified** ❖ **357 people opened new Medicaid applications** ❖ **136 people renewed their Medicaid Benefit** ❖ **484 children were enrolled for the first time**

NEED IDENTIFIED:	**People Living Below Poverty**		
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Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
			or renewed for Medicaid or PeachCare
Status Report			
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 social worker to navigate the barriers of social determinants of health 13.) Provide mental health counseling	July 2016 – June 2018 • Number of patients/clients served • Design evaluation of services to include pre/post "quality of life" evaluation • Number of referrals made • Create measurements for outcomes in all services provided **FY17 Outcomes** • **Eye Glasses and eye exams: 2,570 patients** • **Referrals to eye care specialists: 37 patients** • **Food assistance: 998 clients, $19,960 in food cards; more than 10,356 food**

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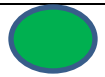
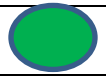
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Population Target: Un/under insured patients living at 200% of the Federal Poverty Level or less		Responsible: Directors of SJ/C's African American Health Information and Resource Center and St. Mary's Community Center.	**items (bread, fruits, vegetables) given away through Publix Grocery Store partnership** • **(Senior Food Assistance is included in the number above)** • **Care Call Center: 412,642 contacts** • **Blood Glucose testing: 630** • **Health fairs/screenings: 1,843** • **Healthy cooking classes: 63 students** • **Health Literacy Classes: 3** • **Social Worker: 1.5 FTE** • **Mental Health Counseling: 1 FTE, .25 Volunteer Psychiatrist**

NEED IDENTIFIED:	**People Living Below Poverty**		
Objective:	**Continue to meet 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 2016-2019**		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & *Metrics***
Status Report		**In FY 18, will set goal to increase total contacts in these services (FY 17: 6,144) by 5%. This will exclude Care Call Center which will be discontinued in FY 18**	
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 internet surfing center 4.) 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	July 2016 • Number of clients assisted ○ Computer classes provided ○ Job applications completed quarterly ○ Number of clients utilizing surfing centers for workforce computing **FY17 Outcomes** **Computer Classes: 872 contacts** **Internet Surfing Center: 5,369 contacts** **SMCC Workforce Assistance: 498 people assisted, 67 people gained employment**
Status Report		**In FY 18, will set goal to increase total contacts in these services (FY 17: 6,739) by 5%.**	

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

St. Joseph's/Candler provides many community benefit and community building 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 2016 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. Despite the Systems decision not to directly address the need, SJ/C will periodically re-evaluate the needs not being addressed to determine if in-kind contributions or other support can be provided to organizations addressing the need. Additionally, SJ/C will continue to participate on community organization/agency board and collaborations which are addressing the need or, if not currently participating, may seek opportunities to participate and provide general assistance as needed, such as participating in a health fair, workshop, education session or other venue sponsored by a group addressing the need.

NEED IDENTIFIED	REASON THE NEED IS NOT ADDRESSED	OTHER PROVIDER(S) ADDRESSING THE NEED
Access to Mental Health Services	Need addressed by another provider; beyond scope of SJ/C • SJ/C operates Johnny's Bridges to Hope Program to support caregivers who have family members with mental health diagnosis. This service was not identified as a significant need in the evaluation process, but SJ/C received request to help with this service in 2015. • SJ/C offers Mental Health Counseling Services as part of St. Mary's Health Clinic and those statistics are included in the "People Living Below Poverty" section of needs being addressed	• Gateway Behavioral Health • Chatham County Safety Net
Aids Prevalence Rate	Need addressed by other provider • SJ/C collaborates with other providers to offer testing a	• Chatham County Health Department
Affordable Dental Care	Need addressed by another provider • 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
Chatham County Income Per Capita	Beyond scope of SJ/C	
Education Needs Including:	Beyond scope of SJ/C	• Chatham Savannah Public School

NEED IDENTIFIED	REASON THE NEED IS NOT ADDRESSED	OTHER PROVIDER(S) ADDRESSING THE NEED
• Engaging Students, Parents and the Community in Student Education • Reading on Grade Level • Student-to-Teacher Ratio • School Displine	• SJ/C SMCC operates pre-k program, but needs identified are outside the scope of program objectives. Reading on grade level are specific indicators measured in the 4th and 8th grade	System
Directory of Health and Social Resources	Need addressed by other organization • SJ/C operates the Care Call Center, a physician referral service which also refers callers to social service agencies. This service is offered to anyone who chooses to access it. • SJ/C's SMCC and AAHIRC provide referrals services, but does not offer a directory of those services as referrals are specific to the unique need of the client/patient served.	• United Way, 211 Directory
Legal Support	Beyond scope of SJ/C	• GA Legal Aid
Opioid Abuse	Need addressed by other organization	• Gateway Behavioral Health • Recovery Place of Savannah
Quality of Life Needs Including: • Violent Crime Rate • Workers Commuting by Public Transportation • Miles of Safe, Pedestrian-Friendly Transporation • Recidivism Rate for Juvenile and Adult Offenders	Beyond scope of SJ/C	• Invest Health Savannah • Healthy Savannah • Juvenile Court System • Savannah-Chatham Metropolitan Police Department
STD Incidence Rate	Need addressed by other provider	• Chatham County Health Department

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
- 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.

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.

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/