

COMMUNITY HEALTH IMPLEMENTATION PLAN



2026



ST. Joseph's | Candler
Live smart.



Introduction

St. Joseph's/Candler Health System (SJ/C) is the only faith-based, locally operated, not-for-profit system in historic Savannah, GA. Formed on April 1, 1997, SJ/C has a presence and reputation in the Chatham County Community. SJ/C offers healthcare services across the entire continuum of care, including a wide variety of community outreach and education efforts.

St. Joseph's/Candler conducted the Community Health Needs Assessment (CHNA) during the Fall and Winter of 2024. Many community organizations worked collaboratively with SJ/C to provide better coordination with existing resources and data. In May of 2025, the Board of Trustee reviewed and adopted the 2025 Community Health Needs Assessment.

Identified Needs

Below, are five priorities St. Joseph's/Candler (SJ/C) identified through the Community Health Needs Assessment (CHNA) and will address in the next three years:

1. Improve chronic disease management for diabetes, hypertension, and high cholesterol among the un/underinsured patients receiving care through SJ/C.
2. Decrease the number of un/underinsured SJ/C patients without primary care.
3. Provide prenatal education and wrap around services to un/underinsured expectant mothers in Chatham County.
4. Facilitate nutrition education programs and nutrition services within Chatham County for vulnerable populations.
5. Promote physical activity and a healthy lifestyle for Chatham County residents.

YEAR 1:

OBJECTIVES AND GOALS FOR FY 26

Objective 1: Improve chronic disease management for diabetes, hypertension, and high cholesterol among the un/underinsured patients receiving care through SJ/C.

GOAL 1A: COMMUNITY CLINICS	YEAR 1: STATUS REPORT
1. Determine the number of referrals in a 12 month period for those with an A1C of 9 or greater (or sudden jumps in A1C). Prediabetes determined as 5.8–6.4.	• 62 referrals for diabetes
2. Track the number of referrals to Community Nurse Educator and Pharm D for diabetes education.	• 77 referrals to Pharm D • 62 referrals to Nurse Educator
3. Determine the number of patients referred to Pharm D or Community Nurse Educator for medication management and education related to hypertension.	• 10 referrals for hypertension
4. Determine the number of patients with high cholesterol referred to Community Nurse Educator for cholesterol education.	• 21 referrals for high cholesterol
GOAL 1B: COMMUNITY CENTERS	YEAR 1: STATUS REPORT
1. Determine the baseline of completed referrals from SJ/C clinics to Community Nurse Educator. Referrals will be for managing diabetes, hypertension, or cholesterol.	• 93 referrals from SJ/C clinics to Nurse Educator
2. Establish a baseline of participants who had a decrease in their A1C.	• 27 participants lowered their A1C (most weren't in recheck window)

Objective 2: Decrease the number of un/underinsured SJ/C patients without primary care.

GOAL 2A: ED TO MEDICAL HOME PROGRAM	YEAR 1: STATUS REPORT
1. Obtain and utilize 52 appointment slots across St. Mary's and Good Samaritan (community clinics) for FY 26.	• 631 total (405 new/236 renewal)
2. Determine the percentage of patients that kept their appointments with community clinics in FY 26.	• Unable to determine because of limited information from DFCS
GOAL 2B: COMMUNITY CENTERS	YEAR 1: STATUS REPORT
1. Determine the number of clients that apply for Medicaid (exclude Pregnancy Medicaid) in FY 26.	• 82 appointments utilized **(Exceeded goal by 58%)**
2. Determine the percentage of clients that were approved for Medicaid in FY 26.	• 46% kept their appointment
GOAL 2C: RCA	YEAR 1: STATUS REPORT
1. Determine the number of patients that applied for Medicaid while inpatient at the hospital.	• 1,465 total applications
2. Determine the percentage of patients that were approved for Medicaid while in patient at the hospital.	• 53% were approved for Medicaid after applying through RCA.

Objective 3: Provide prenatal education and wrap around services to un/underinsured expectant mothers in Chatham County.

GOALS 3A: COMMUNITY CENTERS	YEAR 1: STATUS REPORT
1. Provide six (6) prenatal education programs throughout the year.	• Met
2. Determine the number of patients that applied for Pregnancy Medicaid.	• 142 applicants
GOAL 3B: MOTHER BABY UNIT	YEAR 1: STATUS REPORT
1. Develop a relationship with the Department of Public Health to assist with WIC applications before leaving the hospital.	• DPH representative is on campus 3x a week for WIC applications
2. Determine the encounters with lactation specialists.	• Unable to obtain data

Objective 4: Facilitate nutrition education programs and nutrition services within Chatham County for vulnerable populations.

GOAL 4A: COMMUNITY CENTERS	YEAR 1: STATUS REPORT
1. Offer a nutrition program once a quarter.	• Met. Classes offered monthly.
2. Determine the number of clients that applied for SNAP benefits in FY 26.	• 1,681 applicants

Objective 5: Promote physical activity and a healthy lifestyle.

GOAL 5A: COMMUNITY CENTERS	YEAR 1: STATUS REPORT
1. Establish a chair yoga program.	• Met
2. Report on the improvement of participants after the program.	• Increased strength observed through participants using stronger resistance bands.

YEAR 2:

OBJECTIVES AND GOALS FOR FY 27

Objective 1: Improve chronic disease management for diabetes, hypertension, and high cholesterol among the un/underinsured patients receiving care through SJ/C.

GOAL 1A: COMMUNITY CLINICS & CENTERS

1. For patients referred to Health Educator and Pharm D for diabetes management education, what percentage completed the referral process? (GS/SMHC)
2. Of those that received diabetes education, how many reported it was beneficial? Results obtained by post appointment survey with health educator. (AAHIRC)
3. Of patients greater than 40 years old and diabetic, what percentage are on a statin? (Goal is as close to 100% as possible) (GS/SMHC)
4. Of all the patients with a diagnosis of hypertension, what percentage are we seeing at least two times a year? (GS/SMHC)
5. Report number of patients coming in for blood pressure checks and hypertension education. (AAHIRC)

Objective 2: Decrease the number of un/underinsured SJ/C patients without primary care.

GOAL 2A: ED TO MEDICAL HOME PROGRAM

1. Track the overall number of clients that apply for Medicaid (*excludes* Pregnancy Medicaid). (SMCC/AAHIRC)
2. Increase and utilize the number of appointment slots across Good Samaritan Clinic and St. Mary's Health Center by 20% (62 appointments) in FY 27. (EDMH)

Objective 2: Decrease the number of un/underinsured SJ/C patients without primary care.

GOAL 2B: COMMUNITY CENTERS

1. Increase the percentage of patients that kept their appointments with SJ/C health centers to 50% in FY 27 (was 46% in FY 26). (EDMH)
2. Identify the patients referred to SJ/C Community Centers by ED to Med. Home in FY 26, who are continuing as active patients in FY 27? (EDMH)
3. Explore relationship potential with one community health clinic in the area. (EDMH)

GOAL 2C: RCA

1. Track the number of patients that applied for Medicaid while inpatient at SJ/C. (RCA/Mission)
2. Track the percentage of patients that were approved for Medicaid while inpatient at the hospital. (RCA/Mission)

Objective 3: Provide prenatal education and wrap around services to un/underinsured expectant mothers in Chatham County.

GOALS 3A: COMMUNITY CENTERS

1. Establish a baseline of referrals between Mommy and Me and MGM. (AAHIRC)
2. Of patients identified in goal 1, how many attended a prenatal education program sponsored by SJ/C? (AAHIRC)
3. Continue to provide six (6) prenatal education programs throughout the year. (AAHIRC)
4. Have a representative from the Department of Public Health on Candler Campus four times a week to assist with WIC applications. (Telfair)

Objective 4: Facilitate nutrition education programs and nutrition services within Chatham County for vulnerable populations.

GOAL 4A: COMMUNITY CENTERS

1. Monitor the number of encounters for the food pantry at St. Mary's Community Center. (SMCC)
2. Identify the number of people assisted with a Kroger food card at St. Mary's Community Center. (SMCC)
3. Increase nutrition program class to once a month at the African American Health Information Resource Center. (AAHIRC)
4. Offer a nutrition program quarterly in Spanish at the African American Health Information Resource Center. (AAHIRC)
5. Record the number of participants for nutrition programs at the African American Health Information Resource Center. (AAHIRC)
6. Monitor the number of people that apply for SNAP at both community centers. (SMCC/AAHIRC)

Objective 5: Promote physical activity and a healthy lifestyle.

GOAL 5A: COMMUNITY CENTERS

1. Provide an exercise program weekly. (Programs include but aren't limited to chair exercise, tai chi, chair yoga, and move and groove). (AAHIRC)
2. Identify number of participants that attend each exercise program. (AAHIRC)