2013

Colquitt Regional Medical Center
Implementation Strategy

3131 South Main Street
Moultrie, GA 31768

Colquitt Regional Medical Center

Implementation Strategy

For FY2013-2015 Summary

Colquitt Regional Medical Center is a 99 bed not-for-profit, community hospital located in Moultrie, Georgia. In early 2013, the hospital conducted a Community Health Needs Assessment (CHNA) to identify the health needs of Colquitt County. The Implementation Strategy for Colquitt Regional Medical Center was developed based on findings and priorities established in the CHNA and a review of the hospital's existing community benefit activities.

This report summarizes the plans for Colquitt Regional Medical Center to sustain and develop community benefit programs that 1) address prioritized needs from the 2013 Colquitt Regional Medical Center CHNA and 2) respond to other identified community health needs.

The following prioritized needs were identified by the community and the CHNA steering committee. Particular focus was placed upon these needs in developing the implementation strategy.

1. Obesity and Diabetes
2. Heart Disease and Stroke
3. Access to Care-Providers and Prevention
4. Cancer
5. Respiratory
6. Senior Health
7. Mental Health
8. Access to Care –Transportation
9. Adolescent Lifestyle including Alcohol, Tobacco and Drugs
10. Teen Birth Rate

Colquitt Regional Medical Center has addressed each of the health needs identified in the CHNA. Colquitt Regional Medical Center developed implementation strategies to address each of the health issues identified over the next three years.

Specific implementation strategies for each of the CHNA identified health needs are addressed in the following appendices to this report.

1. Obesity and Diabetes (Appendix 1)
    a. There is a need for education awareness on the causes, prevention, and intervention for obesity and diabetes.
        i. There is a need for specific education on how to purchase and make healthy foods on a budget.
        ii. There is a need for lifestyle intervention education on exercise habits.
    b. There are limited places for physical activity that are safe and cost-effective.
        i. There is a need for low cost recreational facilities or education on how to stay active with limited resources.

2. Heart Disease and Stroke (Appendix 2)
    a. There is a need for education and awareness on prevention, signs and symptoms of cardiovascular risk, and intervention tactics.

3. Access to Care—Providers and Prevention (Appendix 3)
    a. There is a need for free or low cost care options for the working poor, uninsured, or underinsured.
    b. There is a shortage of providers, specialists, or services in the community.
        i. There is a lack of dermatologists.
        ii. There is a lack of gastroenterologists.
        iii. There is a lack of mental health services and/or providers.
        iv. There is a lack of pediatric dentists.
    c. There is a need for a centralized resource directory to assist community residents in identifying the appropriate resources to meet their healthcare needs.
    d. There is a need for education and awareness concerning prevention of chronic illnesses, health behaviors, and habits that promote the use of primary care and preventive medicine.
    e. There is a need for more health promotion education and outreach to the Hispanic population due to language and cultural barriers.

4. Cancer (Appendix 4)
    a. There is a need for more cancer treatment services and providers.
    b. There is a need for education and awareness regarding cancer screenings, prevention, and treatment methods.
        i. There is a need for specific education on workplace protection from environmental and occupational hazards associated with agriculture industry.

5. Respiratory (Appendix 5)
    a. There is a need for outreach education and awareness regarding respiratory disease.
    b. There is a need for more respiratory providers.
    c. There are environmental issues specific to Colquitt County due to agriculture that may influence respiratory conditions.

6. Senior Health (Appendix 6)
    a. There is a need for education and awareness in relation to Senior health issues across the healthcare continuum.
    b. There is a need for gerontologists.
    c. There is a need for family support services such as respite care.

7. Mental Health (Appendix 7)
    a. There is a need for education and awareness on mental illness.
    b. There is a need for more services, providers, and specialists relating to mental healthcare.

8. Access to Care—Transportation (Appendix 8)
    a. Transportation to healthcare providers is an issue for all population groups, especially the young, the poor and the Senior residents.

9. Adolescent Lifestyle Including Alcohol, Tobacco, and Drugs (Appendix 9)
    a. There is a need for education and awareness surrounding healthy lifestyle choices.
    b. There is a need for education to increase self-esteem.

10. Teen Birth Rate (Appendix 10)
    a. There is a need for early education and awareness for adolescents concerning sex education and contraceptive use.
    b. There is a need for more after school activities.
    c. There is a need for education to increase self-esteem and self-worth.

Community Work Plan for Obesity and Diabetes
CHNA Page Reference – pages 51-59

Health Problem	Outcome Objective
A. Lack of prevention education and awareness B. Limited places and resources for physical activity and healthy living	A. Reduction of the number of adults and children in Colquitt County that are overweight, obese, or diabetic B. Increased access to places or resources for physical activity and healthy living

Description of the health problem, risk factors and contributing factors:

A. The prevalence of adult obesity in Health District 8-2 (33.9 percent) was higher than the State (27.6 percent) and the U.S. (33.8 percent). The Healthy People 2020 goal is set at 30.6 percent. Colquitt County had a higher prevalence of obesity (31 percent) compared to the Health District and State, but was lower than the U.S. The prevalence of diabetes in Health District 8-2 (12.4 percent) was higher than the State (9.5 percent) and the U.S. (8.1 percent). Colquitt County was higher (12 percent) than the State and U.S. According to community focus groups and key stakeholder interviews conducted in 2013, the community reported a lack of education and awareness about obesity and diabetes prevention.

B. The prevalence of physical inactivity among adults in Colquitt County (29 percent) was lower than the Health District (30.3 percent), but higher than the State (23.9 percent). According to community focus groups and key stakeholder interviews conducted in 2013, the community reported a lack of affordable and safe places for exercise. In addition, the community reported a need for more after school activities for children to keep them active throughout the day.

Related Healthy People 2020 objectives:

NWS-9 Reduce the proportion of adults who are obese
NWS-10 Reduce the proportion of children and adolescents who are considered obese.
D-1 Reduce the annual number of new cases of diagnosed diabetes in the population
D-3 Reduce the diabetes death rate

Implementation Strategy:

A. The hospital will work toward reducing the number of adults and children in Colquitt County that are obese, overweight, or diabetic by implementing health promotion programs that increase self-awareness of body mass index (weight status) and increase nutrition education. Increasing self-awareness of weight status will be achieved by offering screening of BMI, providing nutritional education, and having a nutritionist onsite at health fairs for adults and children.

B. The hospital will increase access to affordable places and resources for exercise by collaborating with the Boys and Girls Club, the YMCA, and Colquitt County Parks and Recreation

Department to support healthy behavior change through building, strengthening and maintaining social networks.
Possible Collaborations: • Local Churches • Senior Center • Boys and Girls Club • Healthcare providers • Colquitt County Parks and Recreation Department • YMCA • Colquitt County High School • Diabetes Support Group Meetings • Community Health Fairs

Community Work Plan for Heart Disease and Stroke
CHNA Page Reference – pages 36-39

Health Problem	Outcome Objective
Lack of education and awareness on prevention	Increased access to education and awareness for early prevention of heart disease and stroke

Description of the health problem, risk factors and contributing factors:

Heart disease and stroke are preventable diseases. Colquitt County had a higher death rate due to heart disease (135.8 per 100,000 population) compared to Georgia (109.7 per 100,000 population). The stroke death rate in Colquitt County (45.3 per 100,000 population) was lower than Georgia (47.4 per 100,000 population). Heart disease and stroke have similar modifiable risk factors such as: tobacco smoke, poor nutrition, overweight and obesity, stress, and high cholesterol.

Related Healthy People 2020 objectives:

HDS-2 Reduce coronary heart disease deaths
HDS-3 Reduce stroke deaths
TU-1.1 Reduce cigarette smoking by adults
TU-2.2 Reduce cigarette use by adolescents within last 30 days
TU-4 Increase smoking cessation attempts by adult smokers
TU-7 Increase smoking cessation attempts by adolescent smokers
D-13 Increase the proportion of adults with diabetes who perform self-blood glucose monitoring
D-14 Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
D-15 Increase the proportion of persons with diabetes whose condition has been diagnosed

Implementation Strategy:

The hospital will provide blood pressure monitoring devices to area churches. Hospital staff will train designated members of the church on proper methods to monitor blood pressure for church members. The hospital will provide education materials to at-risk patients through health fairs, health screenings, and physician visits.

Possible Collaborations:

- Community Health Fairs
- Senior Center
- SOWEGA Council on Aging
- Civic Organizations
- Health Department
- Local providers
- Local Churches

Community Work Plan for Access to Care-Providers and Prevention
CHNA Page Reference – pages 80-93

Health Problem	Outcome Objective
A. Access to affordable healthcare B. Provider shortages C. Education regarding available services D. Education on prevention E. Health promotion outreach to the Hispanic population	A. Increased access to healthcare for the underinsured and uninsured residents B. Recruit health care providers to the community C. Increased community awareness of healthcare resources and financial assistance available in community D. Increased awareness and access to prevention education E. Increased awareness and access to prevention education (health promotion activities) for the Hispanic population

Description of the health problem, risk factors and contributing factors:

A. According to 2010 U.S. Census data, Colquitt County had a higher proportion of uninsured (25.5 percent) than the U.S. (15.2 percent).

B. According to the 2008 Physician Workforce Report, Colquitt County had an inadequate supply of physicians in the following specialties: emergency medicine, radiology, internal medicine, OB/GYN, and pediatrics. According to focus group meetings conducted in 2013, community members perceived a need for the following specialties or services: dermatologists, gastroenterologists, mental health services and providers, and pediatric dentists.

C. According to focus groups and key stakeholder interviews conducted in 2013, community members were not aware of available health care resources, particularly for the uninsured, low income, chronic disease and minority populations.

D. According to 2013 focus group meetings, community members reported a need for education and awareness concerning prevention of chronic illnesses, health behaviors, and habits that promote the use of primary care and preventive medicine.

E. According to the 2010 U.S. Census report, the Hispanic population represents 17.1 percent of Colquitt's population. The Hispanic population has increased significantly since the 2000 census (10.8 percent). The Hispanic population is predicted to be even higher due to under-reporting of census data. According to key stakeholder interviews and focus group meetings, the community reported that there is a need for more translators due to the growing Hispanic population. The community also reported concerns for education on self-awareness of health conditions due to language barriers.

Related Healthy People 2020 objectives:

AHS-1 Increase the proportion of persons with health insurance
AHS-3 Increase the proportion of persons with a usual primary care provider
AHS-4 Increase number of practicing primary care medical providers – Developmental

Implementation Strategy:

A. The hospital will improve access to the uninsured and underinsured by helping to minimize the cost of healthcare to the individual. The hospital will do this by increasing healthcare access through the hospital's financial charity and indigent care program.

B. The hospital will continue its recruitment efforts for physicians and mid-level practitioners who will serve the uninsured and underinsured population of the community. The hospital will perform a Physician Needs Assessment to identify the physician needs in the community.

C. During the community focus group meetings and key stakeholder interviews, it became apparent that there is a need for a centralized community resources directory. The directory will be distributed to physician offices, hospital registration areas, rural health clinics, local papers, and other venues with special emphasis on reaching the low-income, uninsured, minority and chronic disease populations.

D. The hospital will provide community outreach programs to educate individuals on the prevention of diseases and conditions, and education on the importance of having a primary care provider.

E. The hospital will provide community outreach programs to educate the Hispanic population on the prevention of diseases, and education on the importance of having a primary care provider. The hospital will collaborate with area Hispanic Churches or Hispanic community leaders to encourage active participation in these programs.

Possible Collaborations:

- Health Department
- Local Churches
- Healthcare providers
- Senior Center
- Ellenton Clinic (Migrant Workers)
- Doerun Clinic
- Norman Park Clinic
- NAACP, Friendship Baptist Church

Community Work Plan for Cancer
CHNA Page Reference – pages 26-35

Health Problem	Outcome Objective
A. Lack of affordable options for screenings and treatment B. Lack of community awareness for cancer prevention and treatment methods	A. Increased access to cancer screenings and treatment for the uninsured and underinsured B. Increased number of individuals receiving cancer screenings; also, increased number of individuals receiving treatment

Description of the health problem, risk factors and contributing factors:

A. According to U.S. Census data, Colquitt County had a higher proportion of uninsured (25.5 percent) than Georgia (19.4 percent) and the U.S. (15.2 percent). The community also reported there was a lack of affordable screenings and treatment for the uninsured and underinsured. According to U.S. Census data, Colquitt County had a higher percentage of individuals whose income was below poverty (25 percent) compared to Georgia (16 percent) and the U.S. (14 percent).

B. According to focus group meetings and key stakeholder interviews conducted in 2013, community members reported that the general population (especially the low-income, uninsured, and underinsured) was not aware of cancer prevention education and treatment methods.

Related Healthy People 2020 objectives:

C-1 Reduce the overall cancer death rate
C-2 Reduce the lung cancer death rate
C-3 Reduce the female breast cancer death rate
C-5 Reduce the colorectal cancer death rate
C-7 Reduce the prostate cancer death rate

Implementation Strategy:

A. The hospital will improve access to care for the underinsured and uninsured by helping to reduce out-of-pocket costs associated with cancer screenings and treatment. The hospital will do this by increasing healthcare access through the hospital's financial charity and indigent care program. Qualifying patients will be referred to Women's Health Medicaid for breast and cervical cancer treatment. The hospital will collaborate with other community services to determine specific cancer related services currently offered and to educate the community on the availability of such services.

B. The hospital will increase an individual's access to cancer screenings and treatment by first increasing self-awareness. The hospital will utilize small media methods to increase awareness. Small media methods include videos and printed materials such as letters, brochures, and newsletters. The hospital website will also be used for electronic communication of health

screening access information. These materials will be used to inform and motivate people to get screened for cancer. The hospital will tailor the information within the media and the type of media to fit specific population groups. The hospital will collaborate with churches, various community centers, and health care providers in the distribution of these materials. The hospital will implement guidance to providers on how to provide one-on-one education about cancer prevention.

Possible Collaborations:

- Local Churches
- Civic Organization
- Healthcare providers
- Health Department
- YMCA

Community Work Plan for Respiratory Disease
CHNA Page Reference – pages 40-43

Health Problem	Outcome Objective
A. Lack of outreach education and awareness on prevention B. Lack of respiratory providers C. Environmental causes of respiratory illness	A. Increased access to education and awareness for respiratory diseases B. Increased number of respiratory providers C. Increased awareness of environmental respiratory concerns

Description of the health problem, risk factors and contributing factors:

A. Chronic lower respiratory disease includes asthma, chronic bronchitis, and emphysema. Modifiable risk factors associated with respiratory diseases include tobacco smoke, unhealthy diet, physical inactivity, air pollution, allergens, and occupational agents. Colquitt County had a higher respiratory disease death rate (68.3 per 100,000 population) than Georgia (44.5 per 100,000 population) and the U.S. (42.1 per 100,000 population). Community members reported that unhealthy risk factors exist within the community.

B. According to focus group meetings conducted in 2013, the community reported a lack of respiratory providers.

C. According to focus group meetings conducted in 2013, the community reported environmental concerns such as pesticide use in agriculture, constant transition of the various crops in Colquitt County, and poor living situations may contribute to respiratory issues.

Related Healthy People 2020 Objectives:

RD-1 Reduce asthma deaths
RD-2 Reduce hospitalizations for asthma
RD-3 Reduce hospital emergency department visits for asthma
RD-4 Reduce activity limitations among persons with current asthma
RD-5 Reduce the proportion of persons with asthma who miss school or work days.
RD-6 Increase the proportion of persons with current asthma who receive formal patient education
RD-9 Reduce activity limitations among adults with chronic obstructive pulmonary disease (COPD)
RD-10 Reduce deaths from COPD
RD-11 Reduce hospitalizations for COPD
RD-12 Reduce hospital emergency department visits for COPD

Implementation Strategy:

A. The hospital will provide patient education on the risk factors associated with respiratory disease and smoking. The hospital will collaborate with other agencies in creating health programming to reach underserved areas of the community.

B. The hospital will perform a Physician Needs Assessment to identify the physician needs in the community.

C. The hospital will collaborate with an occupational nurse to establish educational material as it relates to protecting oneself against environmental hazards when working in agriculture. The hospital will increase awareness and education about potential housing environmental concerns, such as mold.

Possible Collaborations:

- Local providers
- Health Fairs
- Health Screenings
- Migrant Workers Program
- Ellenton Clinic

Community Work Plan for Senior Health
CHNA Page Reference – pages 94-95

Health Problem	Outcome Objective
A. Lack of education and awareness on health issues across the healthcare continuum B. Lack of gerontology providers C. Lack of family support services	A. Increased knowledge of senior health issues and increased access to prevention education B. Increased access to gerontology providers C. Increased access to family support services

Description of the health problem, risk factors and contributing factors:

A. According to 2010 U.S Census data, 18 percent of Colquitt County's population was 65 years or older. In Georgia, the average percentage of the population 65 years of age or older was 10.7 percent compared to 13.1 percent for the U.S. According to focus groups and key stakeholder interviews conducted in 2013, community members reported there was a lack of knowledge on how to navigate the healthcare system during various phases of care. Seniors and their caregivers have difficulty understanding when to access services. Seniors lack the comprehension of their own health which causes them to have issues that could have been prevented.

B. According to focus group meetings conducted in 2013, community members reported a lack of specialty providers for Seniors.

C. According to focus group meetings conducted in 2013, community members reported a lack of family support services for Seniors and their caregivers. There is a need for respite care and support groups for families of Seniors to understand how to navigate the complex healthcare network.

Related Healthy People 2020 objectives:

AHS-1 Increase the proportion of persons with health insurance
AHS-3 Increase the proportion of persons with a usual primary care provider
AHS-4 Increase number of practicing primary care medical providers – Developmental
OA-1 Increase the proportion of older adults who use the Welcome Medicare benefit
OA-2 Increase the proportion of older adults who are up to date on a core set of clinical preventive services

Implementation Strategy:

A. The hospital will provide community outreach education to the Senior population on basic health education to prevent unnecessary physician visits. During the community focus group meetings and key stakeholder interviews, it became apparent that Seniors and their caregivers do not know where to go for care; especially specialty care. There is a need for a centralized community resource directory. The hospital will collaborate with other community service providers to develop such a directory that can be distributed throughout the community, with special emphasis on reaching the Senior population and their caregivers (See also *Access to Care-Providers and Prevention).*

B. The hospital will perform a Physician Needs Assessment to identify the physician needs in the community.

C. The hospital will develop support groups for both Seniors in need of companionship and caregivers in need of support from other caregivers going through the same experience. The hospital will develop a strategy to host these groups in an area most convenient for the participants.

Possible Collaborations:

- Health Department
- Local Churches
- Healthcare providers
- Senior Center
- SOWEGA Council on Aging

Community Work Plan for Mental Health
CHNA Page Reference – pages 90, 95

Health Problem	Outcome Objective
A. Lack of education and awareness B. Lack of mental health services and providers	A. Increased education and awareness about mental health B. Increased access to mental health services

Description of the health problem, risk factors and contributing factors:

There is no quantitative, disease-specific data available regarding mental health in Colquitt County. The community members reported difficulty in navigating the mental healthcare system due to lack of knowledge, lack of family support services, and lack of local mental health providers.

Related Healthy People 2020 objectives:

MHMD-6 Increase the proportion of children with serious mental health problems who receive treatment
MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment

Implementation Strategy:

A. The hospital will collaborate with mental health providers to increase education and awareness surrounding mental health.

B. The hospital will collaborate with local mental health providers to develop a community resources directory to help individuals navigate and find appropriate mental healthcare services.

Possible Collaborations:

- Local NAMI (National Alliance on Mental Illness) chapter
- Health Department
- Local Churches
- Senior Center
- Mental Health Clinic
- Healthcare providers

Community Work Plan for Access to Care - Transportation
CHNA Page Reference – pages 90, 92-93

Health Problem	Outcome Objective
Transportation is an issue for all population groups, especially the young, poor, and Senior residents.	Increased access to transportation for all county residents

Description of the health problem, risk factors and contributing factors:

According to community focus groups conducted in 2013, there is no public transportation system within the community. There are other services that provide transit for specific populations. These transportation services are limited. Many people in the community cited transportation as major issue preventing access to care. Many residents depend upon family members or others in the community for their transportation needs.

Related Healthy People 2020 objectives:

AHS-3 Increase the proportion of persons with a usual primary care provider
AHS-5 Increase the proportion of persons who have a specific source of ongoing care

Implementation Strategy:

It is beyond the hospital's mission and financial resources to provide transportation. As described in the strategies related to *Access to Care - Providers and Prevention,* the hospital will increase access to health services by providing screenings and other forms of preventive care in community locations other than the hospital's main campus. The hospital will provide a community resource directory that will guide individuals to transportation services.

Possible Collaborations:

- Local Churches
- Senior Center
- Healthcare providers
- Health Department

Community Work Plan for Adolescent Lifestyle Including Alcohol, Tobacco, and Drugs
CHNA Page Reference – pages 68-74

Health Problem	Outcome Objective
Lack of education and awareness about healthy lifestyle choices	Increased education and awareness of healthy lifestyles

Description of the health problem, risk factors and contributing factors:

According to community focus group meetings conducted in 2013, the community believed that drugs and alcohol were a significant issue in the community and affected more adolescents than the report estimates. Additionally, the community reported a need for more preventive programming and resources to support healthy lifestyle decision-making.

Related Healthy People 2020 objectives:

SA-8 Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-9 Increase the proportion of person who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (developmental)

SA-2.1 Increase proportion of at risk adolescents aged 12 – 17 years who in the past year refrained from using alcohol for the first time

SA-2.2 Increase proportion of at risk adolescents aged 12 – 17 years who in the past year refrained from using marijuana for the first time

SA-13 Reduce the past-month use of illicit substances

SA-14 Reduce the proportion of person engaging in binge drinking of alcoholic beverages

ECBP-2.6 Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in alcohol or other drug use

Implementation Strategy:

Substance Abuse treatment is beyond the mission and financial resources of the hospital, so programs that address treatment will not be implemented.

The hospital will collaborate with other organizations to establish a community resource directory for individuals seeking substance abuse treatment and assistance. In addition, the hospital will collaborate with the Boys and Girls Club to develop programs that focus on the prevention of substance abuse through embracing a healthy lifestyle.

Possible Collaborations:

- Health Department
- YMCA
- Boys and Girls Club
- NAMI (National Alliance for Mental Illness)
- Mental health or substance abuse providers and therapists
- Turning Point Hospital

Community Work Plan for Teen Birth Rate
CHNA Page Reference – pages 63-65

Health Problem	Outcome Objective
A. Lack of early education and awareness regarding sex education B. Lack of afterschool activities C. Lack of self-esteem	A. Early education on sex and contraceptive use will decrease teen birth rate B. Increased access to afterschool activities for adolescents C. Improved self-esteem and self-worth among adolescents

Description of the health problem, risk factors and contributing factors:

A. The teen birth rate in Colquitt County (97 per 1,000 females) was higher than both Georgia (49.7 per 1,000 females) and the U.S. (34.3 per 1,000 females). According to focus group meetings and key stakeholder interviews conducted in 2013, community members reported that there is a lack of appropriate and comprehensive sex education.

B. According to focus group meetings conducted in 2013, the community reported there was a lack of afterschool activities available to adolescents. In addition, the community reported that there was a lack of supervision of adolescents due to working-class households.

C. In Georgia, according to self-reported reasons for not using contraception at the time of an unintended pregnancy, the top reason was that the teen did not mind if she got pregnant. The community reported that low self-esteem and low self-worth contribute to risky sexual behavior. Also, teens look forward to having a baby because they see instant gratification due to the instant love of a child.

Related Healthy People 2020 objectives:

FP-6 Increase the proportion of females or their partners at risk of unintended pregnancy who used contraception at most recent sexual intercourse

FP-8 Reduce the pregnancy rate among adolescent females

FP-9 Increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse

Implementation Strategy:

A. There is a lack of community consensus on the recommended curriculum for sex education. This lack of consensus creates a barrier to the hospital directly addressing the need. A partnership between the school system and public health would better serve this identified need. The hospital will provide a community resource directory to the community to identify health resources for pregnant teens.

B. It is beyond the scope of the hospital to provide afterschool activities for adolescents. The hospital will help community members find afterschool activities for adolescents through the community resource directory.

C. The hospital will collaborate with the YMCA, community leaders, churches, and schools to develop a program on ways to increase self-esteem among young women.

Possible Collaborations:

- Health Department
- "Girl Talk" program (self-esteem programming)
- Boys and Girls Club
- Grant program
- School System