THE GREATEST WEALTH IS HEALTH

TWO RIVERS HEALTH CLINIC

STRATEGIC PLAN 2024-2026

AUTHORED BY PUBLIC GOODS GROUP

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I. INTRODUCTION

As a not-for-profit organization, the mission of the Two Rivers Health Clinic is **to enrich the lives of uninsured adults of Effingham County by promoting healthy lifestyles and providing free medical care for chronic illnesses.**

To support this mission, in Summer 2023, the Two Rivers Health Clinic initiated the process of creating a three-year strategic plan to guide the clinic's work for the years 2024, 2025, and 2026. In preparation, the consultancy organization Public Goods Group interviewed 12 community leaders, including board members, and 17 uninsured community members. The PGG team also conducted a micro-CHNA focused on key areas of interest to the clinic. Finally, PGG, clinic leadership, and the board of directors held two working sessions to finalize this plan. The strategic plan was approved in January 2024.

II. GOALS: 2024, 2025 and 2026

In 2024, 2025, and 2026, Two Rivers will work towards achieving the below goals.

Increase access to services for low-income, uninsured community members

- Expand clinic hours and days
- Expand specialty services
- Increase outreach to underserved populations
- Expand health promotion programming
- Increase staff training
- Expand dental services
- Grow volunteer base
- Support community-based transportation efforts

Further build community partnerships to address key areas of need

- Strengthen internal referral capacity
- Utilize social media, email campaigns, and the Clinic's website for engagement
- Build visibility of the Clinic

Strengthen governance to ensure long-term success

- Ensure strong and consistent Clinic leadership
- Equip board members with talking points
- Continue to build strong, engaged Board of Directors

Establish a diverse fundraising strategy

- Determine our fundraising needs & numbers
- Enroll senior leadership & board members to help identify and solicit potential donations
- Support recurring donations.
- Create a streamlined grant application process

II. GOALS: 2024, 2025 and 2026

Goal: Increase access to service for low-income, uninsured community member		
Objective	**Tactics**	**Metrics, Who & When**
1: Expand the days and/or hours the Clinic is open and serving patients, based upon patient input and demand.	• Establish what health data and service gaps to track on a continual basis, to inform ongoing planning. • Conduct an operational assessment to formally identify areas for potential growth, based on patient need. • Create plan and schedule for potential expansion of eligibility. • Days and/or hours are expanded.	Metrics: Assessment is conducted, plan created, days and/or hours expanded Responsible: Senior leadership & relevant volunteers Timeline: August 2026
2: Ensure access to needed specialty services for patients.	• Identify missing specialty care services by reviewing patient charts and incorporating patient asks into documentation. • Potential volunteer specialists will be identified by the ED, the Board and senior leadership and outreach plan will be established. • Specialists will be contacted and, ideally, enrolled as a volunteer provider.	Metrics: List of needs created, list of potential volunteer providers created, at least one specialty provider is onboarded Responsible: ED, medical director, board of directors Timeline: October 2024
3: Increase utilization of services among traditionally underserved populations.	In partnership with the Effingham NAACP and the Hispanic Heritage Society of Effingham County, conduct outreach events and promote awareness of Clinic services among minority and rural populations.	Metrics: African American and Hispanic/ Latino patient count increases at the clinic by 25 percent. Responsible: ED, medical staff, volunteers, community partners Timeline: January 2025

II. GOALS: 2024, 2025 and 2026

Goal: Increase access to service for low-income, uninsured community members		
Objective	**Tactics**	**Metrics, Who & When**
4: Expand health promotion programming.	Explore and expand preventative health services and health promotion activities as an integral part of Clinic offerings. This can include culturally-relevant health information, screenings, and overall health promotion.	Metrics: At least one additional preventative health service or health promotion activity is added to routine services Responsible: ED, medical director, other care providers Timeline: December 2024
5: Provide required and appropriate training to ensure paid staff and professional volunteers are equipped with the knowledge and skills needed to deliver safe, quality care and service.	Develop a list of mandatory training that needs to be completed prior to volunteering that includes mandatory HIPPA Privacy Education, OSHA Training, Bloodborne Pathogen, Information Security, and Infection Control Training. Conduct training	Metrics: Training list is compiled, resources for training gathered, and training conducted Responsible: ED and medical director Timeline: Initial list created by June 2024, then work is ongoing
6: Expand dental services to better address community dental needs.	Pursue collaboration with other health providers and community-based service agencies to develop a cohesive plan for dental services throughout the county. From this collaboration, consider and develop funding strategies to support dental health.	Metrics: At least one new partnership created, funding strategy developed Responsible: ED, board of directors (to support building partnerships) Timeline: April 2025

II. GOALS: 2024, 2025 and 2026

Goal: Increase access to service for low-income, uninsured community members		
Objective	**Tactics**	**Metrics, Who & When**
7: Support the Clinic's volunteer program through expansion of the Board's role in recruiting and stewarding volunteers.	Knowing each Board member has a strong network of friends and professional colleagues, document a volunteer recruitment and retention strategy that includes clear roles for Board members to help us meet our volunteer needs and build long-lasting relationships with volunteers. Recruitment plan to be discussed at each board meeting, with members reporting on their progress.	Metrics: Volunteer recruitment & retention strategy built. Board members identify at least one new potential volunteer + approach that potential volunteer Responsible: Board of directors, board chair to lead Timeline: Strategy created by June 2024, recruitment efforts then ongoing
8: Support community-based efforts to boost transportation options within the community.	Through collaboration and partnership with local government and other nonprofit organizations, work to strengthen the county's transportation system by meaningful support of group efforts. This will, in turn, lead to fewer patients reporting transportation challenges. TRHC will monitor that through periodic surveys and during patient intake (i.e., "Do you have a reliable source to transportation to access health services, food, and other necessities?").	Metrics: TRHC is meaningfully engaged with community efforts, 20% of patients report more reliable transportation options. Responsible: ED, medical volunteers, public health intern Timeline: Ongoing

II. GOALS: 2024, 2025 and 2026

Goal: Further build community partnerships to address key areas of need		
Objective	**Tactics**	**Metrics, Who & When**
1: Strengthen internal referral capacity.	• Evaluate patient need for lab services, mental health care, disability care, dental care, housing, food, and transportation services for patients. • Produce and implement an Outreach Plan that includes monthly presentations to local health care providers and community groups on the services offered by the Clinic, who is eligible for services, and how to access them. • Strengthen and expand current referral processes and referral tracking between the Clinic and dental care partners, eye care partners, local behavioral health providers, educational institutions, and agencies working to meet basic human needs.	Metrics: Additional demographic indicators of SDOH are gathered, internal processes for gathering additional patient data developed and in place, referral organizations identified and contacted, referrals made. Responsible: ED, medical volunteers, public health intern, board of directors, community partners Timeline: Initial work by August 2024, then ongoing
2: Utilize social media, email campaigns, and the Clinic's website for engagement.	• Regularly update to the community via social media and email Clinic offerings, needs, successes, and opportunities for engagement. • Keep the Clinic's website updated so any visitor sees the latest information at a given time; include a list of Board of Directors on the website, ideally with a short biography for each. • Identify an intern or volunteer to support social media efforts.	Metrics: Website is updated with BOD information, social media strategy developed, website is updated monthly Responsible: ED & a social media expert volunteer or intern Timeline: Website updates by March 2024, social media plan and volunteer by Sept. 2024

II. GOALS: 2024, 2025 and 2026

Goal: Further build community partnerships to address key areas of need		
Objective	**Tactics**	**Metrics, Who & When**
3: Build visibility of the Clinic at the county, state, and national levels to support fundraising and partnerships.	• Develop a written outreach strategy that addresses key areas for increasing the clinic's visibility among a multitude of sectors, including government, business communities, nonprofits, elected officials, local media, churches, and medical and mental health professionals. Outreach should include the potential steward, such as a board member, with a target date for outreach. ED, board members, key volunteers, and senior leadership meaningfully participate in local civic and collaborative meetings; participation is noted via documentation, along with any resulting opportunities.	Metrics: Outreach plan created, deployed Responsible: Board of directors with a designated board lead Timeline: December 2024

II. GOALS: 2024, 2025 and 2026

Goal: Strengthen governance to ensure long-term success		
Objective	**Tactics**	**Metrics, Who & When**
1: Ensure strong and consistent leadership for the clinic.	Create a Leadership Continuity Plan that addresses key areas of leadership, including succession planning for the Executive Director, Board Chair, and Medical Director.	Metrics: Leadership Continuity Plan created Responsible: Board chair with board input (or an executive committee of the board) Timeline: October 2024 (for board approval)
2: Equip board members with regularly-updated talking points.	Create a one-page talking points sheet that's updated every other month and includes the Clinic's history, key numbers, key needs, and patient stories to support board members' ability to talk about the Clinic in different settings.	Metrics: One-page sheet is created Responsible: ED, medical director Timeline: Talking points template created by February 2024, updated monthly
3: Continue to build a strong, engaged Board of Directors.	Governance: • Revisit meeting cadence, dates, and attendance expectations. • Require a recommitment statement from board members that reinforces their membership. • Build a password-protected board portal on the website where all board materials are kept and accessible at any time. • Require annual giving for all board members (financial or in-kind).	Metrics: All points above checked Responsible: Board of directors Timeline: June 2024

II. GOALS: 2024, 2025 and 2026

Goal: Strengthen governance to ensure long-term success		
Objective	**Tactics**	**Metrics, Who & When**
3: Continue to build a strong, engaged Board of Directors.	Governance cont'd: • Conduct annual board training to reinforce best practices, including those related to financial oversight, inclusive practices, facilitated goal-setting, organizational responsibility, board self-evaluation, effective communication, and engaged decision-making. Growth: • Identify any areas of knowledge that may be missing from the current Board now and brainstorm on potential members. • Ensure the full community is adequately represented on the board.	Metrics: All points above checked Responsible: Board of directors Timeline: June 2024

II. GOALS: 2024, 2025 and 2026

Goal: Establish a diverse fundraising strategy		
Objective	**Tactics**	**Metrics, Who & When**
1: Determine our fundraising needs and numbers.	• Annually establish the numerical fundraising goal. • Establish the return on investment by dollar. • Create a donor-development initiative that recognizes donors that have contributed more than a determined threshold amount since the Clinic's inception, including tiers of funding (i.e., Gold, Silver, or Steward, Supporter, etc.) that prompt donations at a certain level. Stratify this by individual and corporate donors.	Metrics: Fundraising goal established, ROI determined, tier levels decided Responsible: ED and designated board of directors member(s), the latter of which would lead the work Timeline: June 2024
2: Enroll senior leadership and board members to help identify and solicit potential donations.	Knowing that different people may resonate differently, senior leadership and board members are regularly tapped to support local donations via church, networks, and business connections (as appropriate).	Metrics: Every board member has solicited at least one donation Responsible: Board of directors Timeline: Ongoing
3: Support reoccurring donations.	Enable a recurring donation mechanism on the website.	Metrics: Reoccurring donation mechanism identified, link placed on website Responsible: ED and/or volunteer Timeline: March 2024

II. GOALS: 2024, 2025 and 2026

Goal: Establish a diverse fundraising strategy		
Objective	**Tactics**	**Metrics, Who & When**
4: Create a streamlined process for grant and funding applications.	• Patient data and stories are collected and banked regularly and public health data is annually pulled. • Evergreen content is maintained and updated as changes with the Clinic and its patients occur. • Skilled volunteers are recruited to support grant writing, editing, and review. • Maintain a database that includes grants applied for (decision, feedback, contact, date of application) and potential opportunities.	Metrics: Patient data and stories collected, evergreen content pulled from existing grant applications, database created Responsible: ED, public health intern, grant writing volunteer Timeline: Initial efforts in place by August 2024, then updated monthly

III. PROGRESS: 2021-2023

This is the clinic's second strategic plan, with the first having taken place in 2020, when the board of directors convened and crafted a plan with several key goals.

01 | MORE PATIENTS

Accomplished! Clinic patient load has increased over last three years.

02 | FREE STANDING CLINIC

Accomplished! Clinic is now permanently located at 711 Zitterour Drive in Rincon.

03 | MEDICAL EQUIPMENT

Partially accomplished. Some outstanding needs but have made strong gains.

04 | TRANSPORTATION

Partially accomplished, with a recent grant to address transportation issues

05 | FULL-TIME MEDICAL DIRECTOR

Not yet accomplished

06 | DENTAL, VISION, AND HEARING

Mostly accomplished! Established partnerships for vision and hearing.

07 | DIAGNOSTIC PARTNERSHIPS

Accomplished! Have since established partnerships.

08 | STEM STUDENTS

Not yet accomplished.

09 | PUBLIC RELATIONS

Mostly accomplished! Created program advocates but not Ambassadors.

10 | HEALTH EDUCATION

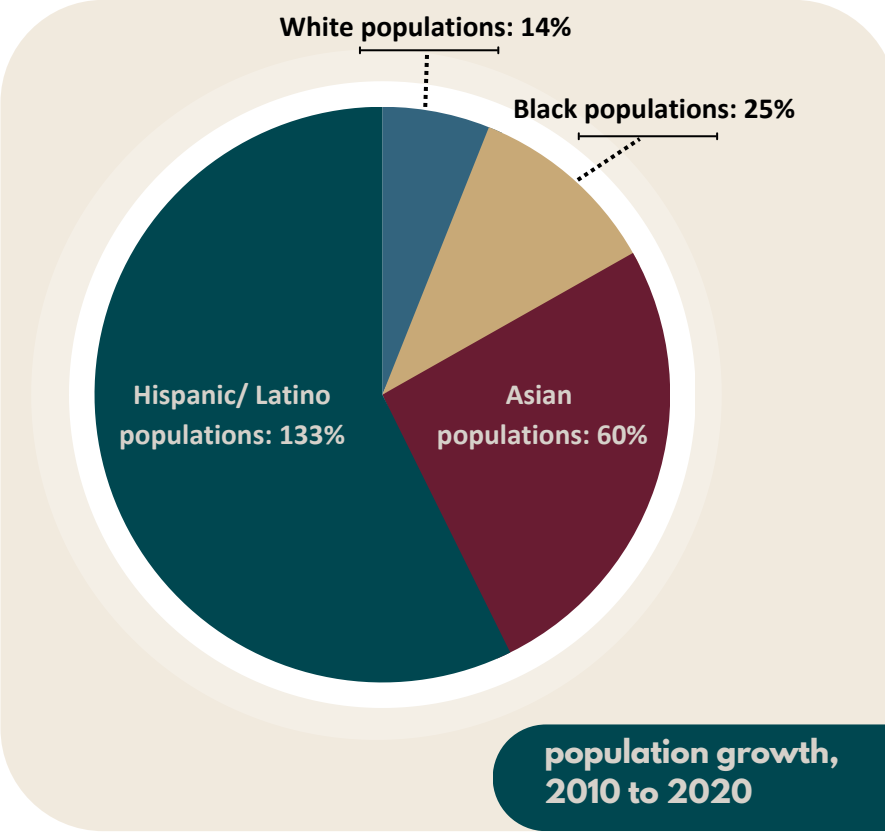
Accomplished and growing!

IV. ABOUT THE COMMUNITY

Demographics

About 63,500 people lived in Effingham County in 2021 and 62 percent of those were adults between the ages of 18 and 65, according to the US Census. The county is growing, with an increase of nearly 25 percent in the county's population between 2010 and 2020. As continued housing and industrial development indicate, that surge will only continue.

Of all populations, Hispanic and Latino populations far outpaced other races and ethnicities in terms of numbers. The chart to the right shows both the percentages of a given's group migration into the county, as well as their share of total county growth. There's no indication these trends will reverse in coming years. This is important as services inclusive of the Hispanic and Latino community will see increased demand.



population growth, 2010 to 2020

Effingham is still considered to be mostly rural, with nearly three-fourths of its population living within a designated rural census tract. Accordingly, this can cause transportation issues for many of the county members, should they not have reliable access to a vehicle.

Income

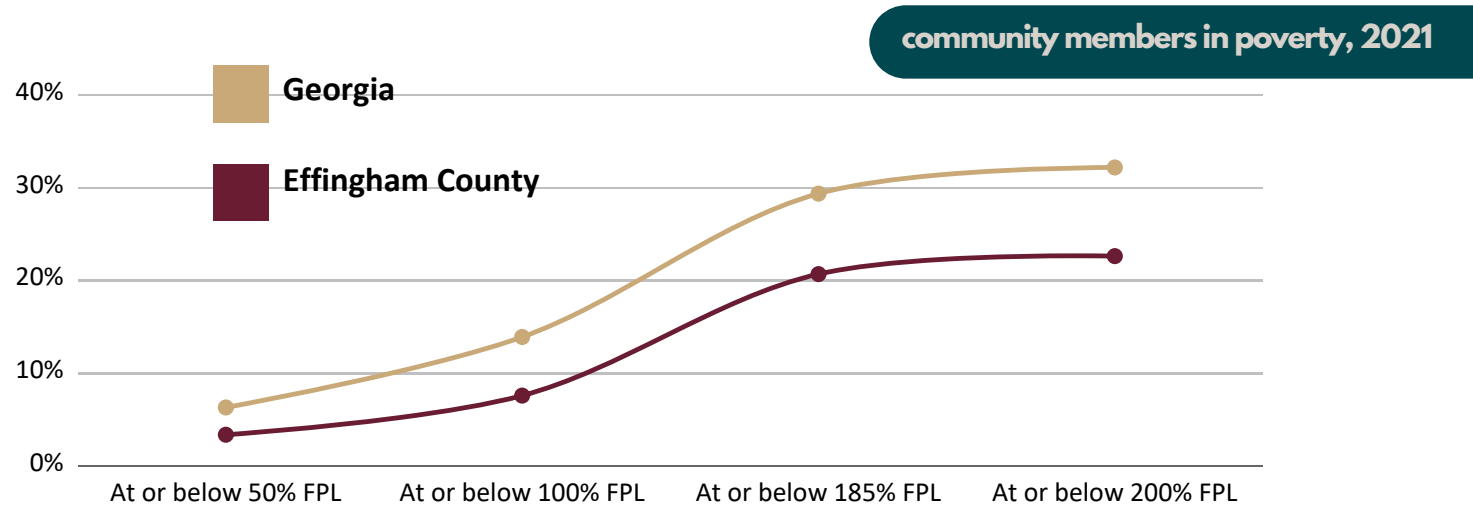
In 2021, the average person in the county made $34,544 a year. People living in Rincon tended to make more, at an average $45,075 annual income that year. People living in Clyo did a bit worse at an average $30,027 annual salary, according to the US Census.

Only about three percent of the county's residents were considered unemployed in May 2023, a rate better than the state average. About all communities within the county had similar rates, with Meldrim's slightly higher. The rate has generally stayed between 2.4 percent and 2.9 percent over the last year, according to the US Department of Labor's Bureau of Labor Statistics. Jobless is usually directly related to insurance status.

IV. ABOUT THE COMMUNITY

Poverty and affording life

A person's income status is directly related to their health status, and predictably the more money you have, the healthier you tend to be. The chart to the right demonstrates how many community members live in poverty or near-poverty. In 2021, the Federal Poverty Level (FPL) placed a family of four as having a total household income of $26,500. Even when living at twice the FPL, families are likely unable to afford many of life's basics. The poorest zip code within Effingham County was Clyo, where nearly a third of the population lived at or below twice the FPL in 2021.



About 24 percent of Effingham's county members have housing costs that go above 30 percent of their income, a trend particularly prevalent within Springfield, where about 2,500 households are cost burdened. Of those households, **a third have housing costs that are more than half their household income,** leaving about 900 Springfield families in a financially precarious spot. It's important to note that Springfield housing also comes with the most issues. For example, according to the Census, in 2021, nearly 40 housing units had no working indoor plumbing.

About 6,800 people received benefits through the Supplemental Nutrition Assistance Program in 2021, equaling a rate of about 10.5 percent. This was below the state and national averages of 16 percent and 12.6 percent, respectively. People living in Guyton or Springfield comprise most of recipients. Unsurprisingly, though, even with this support, **about eight percent of the community remains food insecure, a figure that jumps to 29 percent when looking only at low-income populations.**

IV. ABOUT THE COMMUNITY

Effingham's uninsured

in 2020, about 5,600 adults between the ages of 18 and 65 likely faced some sort of barrier to care, whether it was forgoing preventative services or delaying necessary treatment outside of emergency care

As in many communities throughout Georgia, Effingham County has a relatively high rate of uninsured populations, with about 18 percent of adults aged 18 to 64 having no health insurance in 2021. This was far above the national average of 12 percent but relatively on par with the state average.

According to the US Census, in Meldrim, approximately 44 percent of all adult men were uninsured in 2021, which is one of the highest rates in the state. Not surprisingly, 36 percent of all adults, both women and men, were uninsured that year, once again placing it among the top rates in the state. In comparison, the next highest rate was found in Springfield, where 10.6 percent of its adult population was uninsured.

When looking at race, Hispanic/Latino populations far outpace their other racial and ethnic counterparts in terms of being uninsured. According to the US Census Bureau, about 27 percent of all adult Hispanic and Latino populations had no insurance, compared to approximately 9 percent for all other race and ethnic groups in 2021.

Factors that lead to being uninsured

There are several socioeconomic factors that contribute to being uninsured:

- Living in a state without Medicaid expansion, such as Georgia
- High school graduation rates, as those without a high school graduation are statistically more likely to work in jobs that do not offer health insurance
    - In Effingham, about ten percent of county adults aged 25 and older lacked a high school diploma in 2021, according to the US Census
- Having a child while still a teen, as education and job opportunities are inevitably impacted due to the demands of parenting, should they keep the child post-birth
    - In Effingham, for every 1,000 females aged 15 to 19, 20 had a child in 2021
- Joblessness, though Effingham's rates are fairly steady and low
- Not speaking English, as people considered to have Limited English Proficiency are three times as likely to be uninsured as compared to those who are English proficient
    - In Effingham in 2021, only about 1 percent of the population were LEP

V. STAKEHOLDER INPUT

A critical and ongoing aspect of the strategic plan is capturing stakeholder input. This helps us better understand how others view the clinic, the community and the opportunities before us. For this process, we separated stakeholders into two main groups: community leaders (board members, civic leaders, and nonprofit leaders) and uninsured community members.

Twelve community leaders and 17 uninsured persons were interviewed for this interim report. Interviews were conducted via phone or in-person in June and July 2023. Uninsured community members were identified through a convenience sample, as they self-selected themselves for inclusion based on word-of-mouth referrals to Public Goods Group.

Uninsured community members

- Only three interviewees reported having been to the clinic at some point
- Nearly half had unreliable access to a vehicle, including at least three who lived in households where multiple people shared access to the same vehicle or the interviewee no longer drove
- Only one person had a doctor visit within the last year that was prompted by a health concern addressed only at their spouse's insistence, highlighting the significant role families can play in healthcare
- Four individuals have received a diagnosis of diabetes, three have been diagnosed with hypertension and seven have not undergone testing for either condition in recent years
  - One with hypertension splits medicine with his aunt, who has a doctor and a prescription to Atacand; neither take the recommended amount
- Among those who have not been tested, the most common response to the question "Why not?" was a variation of either "I don't want to know" or "I can't afford it" (and frequently both)
- Most delayed any care until they needed to go to the emergency room, with two specific recent examples related to diabetes management; neither received follow-up care
- The vast majority are parents or grandparents to minor children, and nearly half of those are single caregivers solely responsible for their child or children's care
- More than half were employed, with most working shift jobs; three worked the graveyard shift (noting that overnight workers generally experience worse health outcomes)
- Two are veterans and one served in combat
- All were interested in the clinic, though a few felt going would mean people would know they were poor

> **“What's the point of knowing if I do have hypertension? There's nothing I could do about it. Then I just know but nothing changes.”**

V. STAKEHOLDER INPUT

Board members and community leaders

Providers are top of mind

- Growing into a fuller practice schedule means increased demand for providers
- Potential resources include nursing schools, medical schools, physicians who are about to retire or have recently retired, and residents needing training opportunities
- Potential volunteer providers might not know the opportunity exists

County growth can present opportunities

- Further build the board with those new to the area and with relevant leadership experience
- Potential business supporters to help strengthen relationships with the commerce community
- More patients needing services

Funding remains a challenge but the clinic's progress provides a strong case for support

- Can make a business case on the clinic's current and future impact on the community and other community-based health providers, esp. if orgs could share data
- A permanent location = more opportunity to treat new patients and add new services

Community partnerships have strengthened among orgs, including the clinic, but there is need for more collaboration

- Especially among other health organizations, specialty care providers, mental health providers, and dentists
- Safety net resources exist but aren't always connected or utilized

The organization is well-led with opportunities to become stronger

- Most interviewees stressed the need for continued board development, including recruitment and board tools, presents further inroads into the community
- Succession planning for all key roles is vital to ensure the clinic's future

Dental and mental health need our attention

- There is a critical need for dental health and mental health services though there are significant limitations to finding providers for either critical service

> **"How can someone get a job - and maybe health insurance - with missing teeth? What company around here would hire them for anything that pays a living wage?"**

- Most noted the connection between dental health and socioeconomic status, especially considering the affordability of extractions versus fillings or implants
- The nickname "Methingham" still feels relevant for some stakeholders, and the persistent prevalence of opioid use within the county was also noted as a challenge in helping those needing mental health services

VI. SWOT ANALYSIS

An analysis of Strengths, Weaknesses, Opportunities, and Threats can help guide an organization as they plan future growth. Below is a definition for each and, on the following page, there is a starting point of a SWOT analysis to help clinic, the board and community leadership assess the current environment and plan for the next three years.

STRENGTHS

These are the internal factors that give an organization an advantage as they fulfill their mission. Strengths could be unique skills or expertise, a strong reputation, or access to resources that are difficult to imitate.

WEAKNESSES

These are the internal factors that put an organization at a disadvantage when trying to fulfill its mission. Weaknesses could be a lack of resources, inadequate skills or expertise, or limited grant availability.

OPPORTUNITIES

These are external factors that could benefit the organization. Opportunities could be emerging partnerships, new technologies, or changes within the community.

THREATS

These are external factors that could harm the organization. Threats could be significant shifts in the community, changes in regulations or laws, or economic downturns.

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VI. SWOT ANALYSIS

STRENGTHS

- Clinic leadership
- Permanent location
- Continued patient growth
- Connection to vision and hearing services
- Increasing community awareness of clinic
- Integration of telehealth

WEAKNESSES

- Providers
- Reliable transportation options
- Timely, affordable access to medications
- Dental services, mental health services
- Partnerships with other health orgs within the community

OPPORTUNITIES

- Community is growing with potential new clients and supporters
- Outreach to growing Hispanic and Latino populations
- Further board development
- New location may mean additional funding opportunities + new services
- Can further explore opportunities to strengthen work around social determinants of health, mental health, dental health

THREATS

- A growing community could mean fragmentation of social services
- Transportation issues are expected to worsen
- Uninsurance rates likely to grow with industrial growth throughout the community
- Loss of sense of community as new people move in