Piedmont Hospital
CHNA Implementation Strategy – Fiscal Years 2023, 2024, and 2025

On September 20, 2022, Piedmont Hospital's board of directors approved the hospital's community health needs assessment (CHNA) implementation strategy, which laid out the tactics and strategies the hospital will undertake over the next three fiscal years to address the health priorities established in the hospital's CHNA.

Priority: Ensure affordable access to health, mental and dental care			
Vision	**Goal**	**Tactics**	**How to measure**
Low- and no-income patients receive assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	• Financial assistance is available for eligible low- and no-income populations • Patients are adequately alerted that financial assistance is available • Patients are given tools, resources, and ample opportunity to apply for assistance • Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals • Actively screen all potential patients for Medicaid coverage	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income patients receive necessary laboratory tests	Ensure that patients at partner not-for-profit charitable clinics have access to the care needed to get – and stay – healthy	• Provide lab services at no charge to charitable clinic partners or their patients (partners are Center for Black Women's Wellness, Good Samaritan Health Center, Grant Park Clinic and Urban Health and Wellness)	• Clinics to provide a quarterly report on how many patients received labs, how many labs were processed, the top twenty labs utilized, and relevant trends in patient care

Local efforts to increase access to care are strengthened and grown	When appropriate, provide funding to support specific programs of not-for-profit organizations who provide direct physical and/or mental health services to low-income patients	• Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service • Areas can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of mental health care	• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PAH • Progress evaluated by PHC and PAH every six months
Future health workers are trained	Provide health professions education to students as to further build the health workforce	Continue to provide health education opportunities within the hospital for nurses, doctors, and other relevant health services fields, growing the program when possible and appropriate	Regularly monitor program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth
Future health workers are trained	Provide high school students with leadership training and skills	In partnership with nonprofit organization 21st Century Leaders, continue to provide focused leadership development training on-site at the hospital to area high school students; program participants are generally 80 percent minority students, 60 percent female, and about 33 percent low-income	Regularly evaluate program to determine efficacy and opportunities to further partner with 21st Century Leaders
Community members are better able to self-manage care	Explore programming to streamline referrals between the hospital and community-based charitable clinics and FQHCs to better address low acuity health needs in community setting	With clinical community partner(s), evaluate potential referral process to refer to the clinics low-income patients with certain chronic conditions	Regularly evaluate program to determine efficacy and opportunities for improvement
Community members are screened for common health conditions in a community-based setting	Provide community-based care to community members	In partnership with the nonprofit and faith-based community, continue to provide on-site health services to congregants and members of churches such as Ebenezer Baptist Church	Continually evaluate partnerships and explore opportunities for community-based care

Priority: Promote healthy behaviors to reduce preventable chronic conditions and diseases			
Vision	**Goal**	**Tactics**	**How to measure**
Hospital-based prescriptions for opioids and related drugs are reduced	Patients are at low risk of misusing opioids	• Track opioid prescribing by physician • Use Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients ways to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach
Hospital-based prescriptions for opioids and related drugs are reduced	PHC adopts and uses appropriate non-opioid pain management strategies	• Continue to use Enhanced Recovery After Surgery (ERAS) throughout Piedmont • Offer multi-modal pain module to caregivers to provide options for opioid in treating pain • Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy)	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PAH provides meaningful leadership in its community by partnering with others in combating opioid abuse	• Promote local prescription take-back day activities, in partnership with local law enforcement and public health • Serve as leaders in community-based programs to address opioid abuse and addiction	• Monitor attendance for take-back day with an aim to increase participation year over year • Measure general community awareness of opioid use by charting what resources and partnerships are active now, with a

		• Support community-based strategies to combat opioid abuse through partnerships and task forces	goal to increase those year over year
Community members have necessary health education to stay well	Using social media and the system's website, continue to provide health education to patients on topics ranging from heart health to obesity	Regularly publish tips and tools to help community members get – and stay – healthy	Monitor engagement, continually look for ways to increase engagement among target audiences

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
Cancer patients receive needed comprehensive services for their recovery	Provide support services free of charge to cancer patients through Cancer Wellness	• Provide services to any cancer patient, regardless of where they receive care; services include cancer education, nutrition workshops and demos, support group, psychological counseling, and exercise classes, among other programs • Continue to explore opportunities to expand offerings and services	• Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness
High-risk community members receive lung cancer screenings	Increase local awareness of and local opportunities for lung cancer screening	• Increase CT scans for CMS-defined heavy smokers • Increase early identification of suspicious nodules and thereby increase early cancer detection utilizing new technology that identifies nodules often missed	• Measure current awareness by availability of local resources and a survey of local messaging • Utilizing FY22 figures, aim to increase CT scans for heavy smokers, general community

		• Understanding low-income populations are more likely to smoke, explore potential mechanisms for referrals for CT scans heavy smokers from partner clinics	• Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system
More community members are screened for cancer	Overcome challenges of barriers to screenings and Increase cancer screening awareness through community-based partnerships	• Identify community partners who can help provide necessary outreach and messaging • follow-up care that takes insurance status, income, and other barriers, such as transportation, into consideration	• Establish baseline of current activities and partnerships • Measure participation, outreach, and engagement for current and new work, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

Priority: Reduce preventable instances of and deaths from heart disease			
Vision	**Goal**	**Tactics**	**How to measure**
Public is alerted to risks and ways to reduce harm from heart disease, hypertension and stroke	Create public service announcements aimed at reaching at-risk populations on various health topics	• Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the public, in appropriate languages • Distribute via social media, community partners, Piedmont.org website, community events • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	• Establish baseline of current messaging • Measure participation, outreach, and engagement for current and new work, aiming for a significant increase year over year
Hospital maintains stroke certification through community outreach	Offered stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain stroke certification	• Utilize community events to provide basic health screenings and education on risk factors for stroke and heart disease, BP; recommend income and insurance-appropriate local primary care physician, if the patient does not have one; will utilize community-based partnerships, including those with charitable clinics, to target high-risk populations • Provide information in appropriate languages and ensure all messaging is appropriate for lower levels of health literacy	• Establish baseline of current outreach, aim for an increase year over year • Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)

Heart disease education and outreach to the Hispanic/Latino community is increased	Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Work with utilize best practices for engaging the Hispanic/Latino community • Identify community agencies/organizations that work with the Latino communities • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, early detection, and education • Utilize website, social media, community partners to distribute information	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach, and engagement, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys
Low-income patients receive necessary cardiology care	Continue to provide cardiology services to the Good Samaritan Health Center of Atlanta	Continue to provide at least two cardiologists and four medical assistants each month to serve the low-income patient population that is largely Hispanic or Latino	Continually evaluate partnership and services and explore additional opportunities to support heart health among this population
Women receive necessary healthy heart and lifestyle coaching	Continue to provide healthy heart support and education to women	Provide six free sessions of wellness coaching to individuals and groups through the Women's Heart Program to any patient, goals are tailored to each individual patient	Continually monitor program, participation, and opportunities for improvement and/or growth