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

On X X, XXXX Piedmont Fayette 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**
Eligible low and no-income patients will receive financial assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	• Provide financial assistance to qualifying patients through presumptive eligibility and manual application • Alert patients that financial assistance is available • Give patients tools, resources, and ample opportunity to apply for assistance • Maintain eligibility threshold of 300% Federal Poverty Level for financial assistance 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. • Annual tracking of financial assistance spend, by ZIP code, unique numbers of patients, total number of visits by FAP-eligible patients, and spend at cost • Consistent policy administered throughout PHC

Low and uninsured patients will receive needed laboratory services and needed care	Ensure that low- and no-income patients at partner not-for-profit charitable clinics have access to the care needed to get - and stay - healthy.	Continue to partner with local charitable clinics (Healing Bridge Clinic), including the provision of certain services, including pro-bono lab services and Epic EMR licensure (Fayette C.A.R.E. Clinic)	• Review relationships with the clinic quarterly to identify and eliminate any issues. • Monitor number of patients receiving labs, how many labs were processed, the top twenty labs utilized and relative trends in patient care.
Future healthcare workers are trained	Provide health professions education to students to further build the health workforce.	Continue to provide health education opportunities within the hospital, 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
Input will drive improvements in patient care and patient communication about patient care	Regularly convene the Patient Family Advisory Council to provide meaningful input on key areas of care	• Regularly convene approximately standard group of 10 -20 advisors comprised of patients, their families, and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers • Set specific scope and goal of council, which could include internal initiatives to improve patient care and quality	• Meeting minutes will be captured. • Evaluation tactics to be determined by specific goals of council
Promote mental well-being among all community members	Reduce barriers to improve access to mental health and substance use screening and assessment	Activities could include partnering with stakeholders to support education, prevention, intervention, treatment services and recovery by partnering with local non-profit mental health providers to raise awareness for community mental health resources to those in need	Regularly monitor partnerships, evaluating effectiveness and opportunities to increase collaboration
Promote health and wellness among senior adults	Older adults have access to care and community-based resources	Sixty Plus program provides services that support healthy aging and resources for family caregivers	Regularly monitor partnerships, evaluating effectiveness, opportunities

			to increase collaboration and opportunities for growth

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
Patients receive tools necessary for healthy recovery from cancer	Increase promotion of PHC Cancer Wellness to community via non-profits, faith-based community, and others	• Provide services to patients and caregivers regardless of where they receive clinical care that include, but aren't limited to nutrition counseling, cooking demos, personal strength coaching, mindfulness, exercise, music and art therapy, financial counseling, and psychosocial support services • Educate patient and families as it relates to symptom management techniques during treatment, as well as lifestyle changes that support healthy recovery and long-term survivorship"	• Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness • Explore new opportunities to better serve cancer patients
Cancer prevention and screenings increase for the low- and no-income community members, Hispanic/Latino community members and other at-risk minority community members	Reduce cultural barriers to cancer prevention and education for low- and no-income community members and at-risk minority community members	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Engage staff to identify cultural barriers • Work with community partners to utilize best practices for engaging with specific demographics • Identify community agencies/ organizations that work with specific demographics	• 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

		• Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on screening, early detection, and education	
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 • Provide cancer education programs, information booth, and screening kits at events with community partners who are serving uninsured and high-risk individuals • Establish a mechanism for screening referrals • Establish a mechanism for appropriate 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 diabetes and increase access to care for those living with the disease			
Vision	**Goal**	**Tactics**	**How to measure**
Community members can self-manage their diabetes	Conduct group diabetic education sessions and one-on-one counseling to help patients learn about diabetes and how to manage the disease	• Provide ongoing diabetes education includes information on diabetes management, physical activity, medication usage, complication prevention and how to cope with this chronic disease • Provide nutrition education that focuses on food choices and improving blood sugar control.	• Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve programming • Survey community members to gauge familiarity with local/community resources to help

		• Provide education to reduce negative impact of diabetes reduce heart disease risk factors and improve weight management • Provide diabetes-during-pregnancy education through individualized instruction and intensive diabetes self-management instruction on insulin therapy	manage diabetes
Reduce preventable instances of diabetes and diagnosis of the disease among high-risk populations.	Provide information on diabetes prevention and set up regular screening activities for community members	In partnership with relevant community-based groups, determine education opportunities, scope of programming, eligibility requirements	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement

Priority: Reduce rates of obesity and increase access to healthy foods and recreational activities			
Vision	**Goal**	**Tactics**	**How to measure**
Promote healthy lifestyle through walking and exercise	Continue the Walk with a Doc program	• Each month, participants walk 2.5 miles with physicians and can ask health-related questions • Walk is held at local farmers market to encourage healthy eating choices	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement
More community members understand the importance of healthy lifestyles and exercise	Overcome challenges of sedentary and unhealthy lifestyles through community-based partnerships	• Identify community partners who can help provide necessary outreach and messaging • Provide nutrition, health, wellness education programs and information events with	• Establish baseline of current activities and partnerships • Measure participation, outreach, and engagement for current and

		community partners who are serving uninsured and high-risk individuals	new work, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys
Current cancer patients benefit with better outcomes before, during and after treatment	Address challenge of obesity and sedentary lifestyle for community members facing disease and treatment	Partner with Cancer Wellness and Piedmont Wellness to continue to refer to and provide MyFitRX and EVOLVE program to current cancer patients who would benefit	Monitor number of patients referred to and taking part in the program; develop ongoing, specific measurement tactics to ensure program effectiveness and evaluate opportunities for growth

Priority: Support senior health, healthy aging, and good mental health			
Vision	**Goal**	**Tactics**	**How to measure**
Promote mental health wellbeing among senior population	Address isolation and loneliness issues among senior population	• Partner with Fayette Senior Services to increase wellness checks for homebound seniors through the Meals on Wheels program and maintain support for program • Partner with Sixty Plus Services to maintain Dementia Support Group activity • Partner with Real Life Center to support their older adult congregate meal program to reduce isolation and maintain support for program services • Identify greater needs of seniors upon	• Regularly monitor effectiveness through outcomes measurement and continually seek out ways to improve programming • • Measure current participation in programs and aim for an annual increase in participation

		discharge to connect them with valued resources such as senior centers with congregate meal programs, transportation to church, food banks, and community activities	
Promote health and wellness among senior adults	Older adults have access to care and community-based resources	• Partner with Sixty Plus program to provide services that support healthy aging and resources for family caregivers • Partner with Fayette Senior Services to provide recurring health and wellness education that supports healthy lifestyle and healthy aging • Identify opportunities to provide health and wellness education to senior populations and organizations	Regularly monitor partnerships and education opportunities, evaluating effectiveness, opportunities to increase collaboration and opportunities for growth

Priority: Reduce preventable instances and death from heart disease			
Vision	**Goal**	**Tactics**	**How to measure**
More community members survive a stroke	Primary Stroke Center designation is maintained; local community members are aware of heart risks and are appropriately screened	• Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to maintain Primary Stroke Center DNV designation • Stroke education provided to local EMS, paramedics, nursing students, community members	• Measure increases in recognition of stroke symptoms evidenced by the increase in Stroke Alerts. • Measure increases of stroke arrival by EMS vs. walk-in
Public is alerted to risks and ways to reduce harm from	Create public service announcements aimed at	• Utilizing evidence-based messaging, create and deploy local public service	• Establish baseline of current messaging

heart disease, hypertension and stroke	reaching at-risk populations on various health topics	announcements aimed at high-risk populations and the public, in appropriate languages • Distribute via community partners, Piedmont.org website, community events • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	• Measure participation, outreach, and engagement for current and new work, aiming for a significant increase year over year
Community based heart survival rates are increased	Provide Early Heart Attack Care (EHAC)/Hands-only CPR to community	• Utilizing data from CHNA, determine priority areas for free CPR training to nonprofit partners and civic organizations • Deploy programming, in partnership with community-based groups and emergency medical services	Monitor participation, with aim to increase year over year
Women have necessary information to prevent or survive heart disease	Educate women on preventing and managing heart disease through multimodal traditional and complementary/alternative education; focus efforts on African American women and uninsured women	• Partner with Piedmont Women's Heart Support Network educators with opportunities for community outreach, • connect with physicians for referrals to coaching, host community education sessions (lectures, cooking classes, farmers market tours, etc.), involve a vast array of stakeholders and building on work already in place • Partner with Piedmont Fayette Women's Health Connection program to identify opportunities for education, referrals, and screening for heart disease	Will monitor and track education results through readiness to change surveys, screening results and coaching results
Heart disease education and screenings increase for the	Reduce cultural barriers to heart disease and education for low-	• Assess effectiveness of current services and identify opportunities to improve/enhance	• Establish baseline of current activities

low- and no-income community members, Hispanic/Latino community members and other at-risk minority community members	and no-income community members, Hispanic/Latino community members and other at-risk minority community members	delivery methods • Engage staff to identify cultural barriers • Work with community partners to utilize best practices for engaging with specific demographics • Identify community agencies/ organizations that work with specific demographics, connect provider volunteers at community free clinic (Fayette Care Clinic) • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, risk factors and education	• 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
Chest Pain Center Accreditation through the American College of Cardiology is maintained	Provide ongoing resources and education to community members as to maintain high level of chest pain care at hospital	Provide quarterly cardiovascular disease screenings to those community populations identified at risk for heart disease.	Conduct yearly review to ensure we are maintaining CPCA designation Opportunities to engage and work with the community are regularly evaluated and implemented