FY23

PIEDMONT MCDUFFIE

COMMUNITY HEALTH NEEDS ASSESSMENT
Implementation Strategy

Piedmont
MCDUFFIE

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Introduction

Piedmont McDuffie's 2023 Implementation Strategy Guide accompanies its 2023 Community Health Needs Assessment (CHNA). The CHNA identifies McDuffie County (GA) as the community Piedmont McDuffie serves. The CHNA lists the following needs as priorities in that community: ensure affordable access to health and mental health care, reduce preventable instances and death from heart disease, promote healthy behaviors to reduce preventable conditions and diseases, reduce preventable instances of and death from cancer. For the health needs we will address, the ISG describes the actions the hospital intends to take to address the health need and the anticipated impact of these actions. It also identifies the resources the hospital plans to commit to address the health needs and describes any planned collaboration between the hospital and other organizations in addressing those needs.

Priority: Ensure affordable access to health and mental health care		
Goal	**Strategy**	**Metrics**
Eligible low- and no-income patients are enrolled in appropriate financial assistance program	- 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	- Annual review of policy, guidelines, updated to reflect any changes - Consistent policy administered throughout Piedmont Augusta
Provide lab services free of charge to partner community clinics	Continue to provide lab services free of charge to patients of partner clinics Christ Community Health Services, Lamar Clinic, Druid Park and Harrisburg Family Health clinic	Clinic 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
Support efforts and programs within and outside of our organization that provide services for addiction and mental health	- Continue to develop behavioral health resources within our Emergency Departments - Continue to staff and provide rooms for voluntary detox - Implement a system approach to behavioral health - Continue to support local non-profits such as Peer Recovery and Respite Center of Augusta	Monitor outreach and engagement to ensure that we support local non-profits that address mental health issues. Aim to increase reach year over year.
Support efforts and programs outside of our organization that provide services for dental health	Continue to support community nonprofit organizations such as Christ Community Health Services, with building programs to serve the dental needs of our uninsured and under-insured residents.	Review reports from clinic to determine number of residents served
Provide nursing and allied health clinical instruction for students to further build the health workforce	Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate. Such programs include: Stephen Brown School of Radiography, School of Cardiovascular Technology, Residency Program, Aiken Tech program at Summerville Campus	Monitor annual enrollment, graduation rates and job placement

Priority: Reduce preventable instances and death from heart disease		
Goal	**Strategy**	**Metrics**
Create public service announcements aimed at reaching at-risk populations on various health topics including ways to reduce harm from heart disease, hypertension and stroke	- Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the general public - Distribute via social media, community partners, Piedmont.org website, community events - Ensure all programming and relevant materials 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
Maintain Stroke certification and Primary Stroke Center designation	- 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 and ensure all messaging is appropriate for lower levels of health literacy - Continue providing stroke education to EMS and paramedics - Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to maintain stroke certification	- Establish baseline of current outreach, aim for an increase year over year - Measure participation in Ambassador program - Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)
Reduce barriers to heart disease prevention and education for at-risk populations in our community	- Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods - Work with staff to utilize best practices for engaging the community - Identify community agencies/organizations that work with at-risk populations in our communities - Coordinate with community stakeholders/ partners on promotional health fairs and 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

Priority: Reduce preventable instances and death from heart disease (cont'd)		
Goal	**Strategy**	**Metrics**
Reduce barriers to heart disease prevention and education for at-risk populations in our community	- Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods - Work with staff to utilize best practices for engaging the community - Identify community agencies/organizations that work with at-risk populations in our communities - Coordinate with community stakeholders/ partners on promotional health fairs and 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
Educate women on preventing and managing heart disease through multimodal traditional and complimentary/alternative education; focus efforts on African American Women and uninsured women	Continue to look for opportunities for community outreach, connect with physicians for referrals to host community education sessions, involve stakeholders and build on work already in place	Will monitor and track education results through number of events and attendance

Priority: Promote healthy behaviors to reduce preventable conditions and diseases		
Goal	**Strategy**	**Metrics**
Provide ongoing education, training and support to community members to help them manage their diabetes	Increase marketing and outreach initiatives to local and regional medical practices, community health departments, faith-based organizations, and others to promote awareness of educational resources	Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve through best practices
Continue the accredited Diabetes Prevention Program, with a focus on at-risk populations	- Provide ongoing diabetes education including information on diabetes management, physical activity, medication usage, complication prevention and how to manage this chronic disease - Provide education that focuses on food choices and improving blood sugar control, reduce heart disease risk factors and improve weight management	Measure attendance through attendance rosters. Effectiveness measured through continued recognition through CDC.
Provide Diabetes Self-Management Education for low-income community members	Expand current Sweet Success classes within the community	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement. Expansion of attendance measured through attendance rosters.
Reduce preventable instances of diabetes and diagnosis of the disease among high-risk populations	Provide information on diabetes prevention and set up education opportunities in partnership with relevant community based groups	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement

Priority: Reduce preventable instances of and death from cancer		
Goal	**Strategy**	**Metrics**
Increase awareness of local opportunities for lung cancer screening	- Create and deploy local awareness campaign on risks, warning signs and early detection for lung cancer, particularly among high-risk groups - Increase early identification of suspicious nodules and thereby increase early cancer detection - Enhance referrals for CT scans heavy smokers from partner clinics	- Measure current awareness by availability of local resources and a survey of local messaging - Utilizing FY19 figures, aim to increase CT scans for heavy smokers and general community at risk - Monitor positive results and continually improve referral process for follow-up care for all members of the community
Provide the community the necessary education and tools to permanently quit smoking	Resume in person smoking cessation classes, utilize other Piedmont location smoking cessation online classes. Expand relationship with the American Cancer Society to utilize available resources	Regularly monitor attendance and participant self-reported quitting data
Increase access to screening to mammograms	- Utilize mobile mammography unit to provide place-based screening, including screening for low-income women - Accept referrals from charitable care clinic partners	Monitor referrals and mammograms provided, creating a baseline from FY19 figures
Overcome barriers to screenings and increase cancer screenings and awareness through community-based partnerships	- Identify community partners who can help provide necessary outreach and messaging - Provide follow-up care that takes insurance status, income and other barriers 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
Increase promotion of Piedmont Augusta Survivorship Program to local providers and to community via non-profits, faith-based community and others	Provide services that include, but aren't limited to: nutrition counseling, mindfulness, yoga, music therapy and psychosocial support services. Continue to partner with services and agencies to provide educational material and transportation needs for oncology patients.	- Measure current participation in programs; aim for an annual increase in participation - Utilize client feedback and other qualitative measures to evaluate programming and effectiveness - Establish a baseline to measure increase in physician referrals to the program