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

On September 29, 2022, the Piedmont Newnan Hospital 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 potentially 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 have access to community-based care	Process labs on behalf of the clinic, providing results to the clinic in a timely manner	Continue to provide lab services free of charge to Coweta Samaritan charitable clinic	Review the relationship each quarter to identify and eliminate any issues

Future health 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 and evaluate the local school program and how many healthcare workers graduate in their field
Patients and their families have meaningful input in their care; preventable readmissions and re-encounters are reduced	Create a patient and family advisory council to provide meaningful input on key areas of care	Create a council of approximately 10 to 20 advisors composed of patients, their families, and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers	Meeting minutes will be captured and any concerns will be addressed by hospital leadership or through the grievance process. Evaluation tactics to be determined by specific goals of the council
Older adults have increased access to care and community-based resources	Provide classes and resources free of charge to all community members	Through our Sixty Plus program, provide services that support healthy aging and resources for family caregivers, regardless of if they are a Piedmont patient	Regularly monitor program and patient self-reported information to evaluate programs and classes for effectiveness, opportunities for growth
Low-income patients have access to behavioral health in the community	Low-income patients are connected to community mental health resources	• Referrals are sent to Pathways from Coweta Samaritan's Clinic when a patient has a mental health need • Monthly meetings between Pathways and CSC to discuss patient care • CSC has all new patients sign a medical release so that meds can be monitored between both facilities	Regularly monitor program and patient self-reported information to evaluate programs and classes for effectiveness, opportunities for growth
Low- and no-income patients have access to community-based care	Through a hospital/clinic shared licensed medical social worker, connect recently discharged hospital patients to the Coweta Samaritan clinic, which will provide ongoing support to these patients to address issues related to socioeconomic factors	Utilize a shared hospital/clinic skilled staff member to work with low-income, uninsured patients with ongoing needs and appropriate follow-up care; fund Epic EMR licensure	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities, and growth. Utilize staff member feedback to create stronger mechanisms for support for these vulnerable patients

Priority: Promote healthy behaviors to reduce preventable conditions, obesity, diseases, and addiction.			
Vision	**Goal**	**Tactics**	**How to measure**
Older adults can safely exercise	Older adults maintain healthy weights, better control of chronic conditions	Through the evidence-based Exercise is Medicine program, provide older adults with chronic conditions the opportunity to regularly exercise in safe ways that promote healing and healthy weights	Monitor participation through attendance logs and qualitative surveys and interviews to continually seek out ways to improve programming
Physicians have the tools they need to reduce opioid prescriptions	Hospital-based prescriptions for opioids and related drugs are reduced	Through the multi-specialty Clinical Governance Council, develop a program to educate physicians in opioid prescribing utilizing specialty/procedure-specific guidelines	Track reduction in inappropriate opioid prescriptions
Local stakeholders are actively engaged in addressing the opioid epidemic	Community members have the tools they need to proactively address the opioid epidemic	Meaningfully engage in the Drug Free Coweta Program by: • Coordinating with Coweta FORCE to implement a program that, through a grant, will provide Peer Support post discharge for Piedmont patients struggling with addition. • Distributing Educational materials to physician offices to help patients understand the risks of addiction and how to prevent it • Sponsoring and promoting drug take-back days • Implementing school curriculum educating children and youth of the dangers of opiate addiction/substance abuse	Measuring number of children educated through the Coweta County School System and the number of prescriptions turned in during drug take-back days.

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
Cancer patients have the support they need to recover	Provide support services free of charge to cancer patients through Cancer Wellness	Provide supportive services to any cancer patient, regardless of where they receive care; services include cancer education, nutrition workshops and cooking demonstrations, support groups, psychological counseling, and exercise classes, among other programs. We will continually explore new opportunities to better serve cancer patients	Measure current participation in programs and aim for annual increase in program participation. Utilize client feedback and other qualitative measures to evaluate programming and effectiveness.
Low-income women are screened for cancer	All women can be screened for breast cancer	Provide a free and/or low-cost mammogram screening program for underserved and/or uninsured women	Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary screening and diagnostic mammograms. Solicit foundation and grant support to increase funding.
EMR capacities are enhanced to support healthy behaviors	More community members are screened for cancer and referred to smoking cessation programs	Through the Piedmont Integrated Network Cancer Committee, implement "Just ASK," an elective quality improvement project focused on leveraging existing resources to address smoking by asking all newly diagnosed cancer patients about their smoking status	Target goal is to increase asking baseline questions by 20% or achieve >90% overall asking rate among new cancer patients.
Cancer screenings are available to all members of the community	Overcome challenges of barriers to screenings and increase cancer screenings awareness through community-based	Identify community partners who can help provide necessary outreach and messaging; provide cancer education programs, information booth, and screening kits at events with	Establish a baseline of current activities and partnerships. Measure participation, outreach, and engagement for current and new work,

	partnerships	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	aiming for a significant increase year over year. Monitor partnerships and outreach effectiveness through qualitative methods, including interviews and surveys.

Priority: Reduce preventable instances of death from heart disease.			
Vision	**Goal**	**Tactics**	**How to measure**
Local EMS, paramedics, and other health professionals have the tools they need to decrease stroke deaths	• Primary Stroke Center designation is maintained; local community members are aware of heart risks and are appropriately screened; stroke • Stroke education is provided to local EMS and paramedics • Two stroke educational classes are taught monthly and slots are open to outside medical facilities as well as to West Georgia Technical College nursing students	Offered stroke awareness educational materials and blood pressure screenings at health fairs and community events to maintain Primary Stroke Center DNV designation	Measure increases in recognition of stroke symptoms evidenced by the increase in Stroke Alerts.
The community is educated on the risks of heart and	Educate the community at large to reduce preventable instances	Alert public to risks and ways to reduce harm from heart disease, hypertension, and stroke via	Two community-focused PSA campaigns annually Create and

vascular disease	of heart disease	Public Service Announcements	maintain a link to and instructional Hands Only CPR video on the public hospital website
Low-income community members will have access to cardiac specialist clinic.	Low-income community members have access to cardiovascular care	Continue to provide employed cardiologist volunteers at Samaritan Clinic monthly	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities, and growth; utilize staff member feedback to create stronger mechanisms for support for these vulnerable patients.
More underserved women are educated on preventing and managing heart disease.	Educate women, with a particular focus on African American women and uninsured women, on preventing and managing heart disease	Explore 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	Monitor and track education results through readiness to change surveys, screening results, and coaching results through SF-36 survey