

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low - to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls; work to enroll qualifying patients within Medicaid through vendor partner</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p> <hr/> <p>Same as above</p>
	<p><b>Provide laboratory services, space and utility coverage to partner clinics serving low- and no-income populations</b></p>	<p>Maintain current partnerships for the provision of certain free laboratory services with community-based charitable clinics including Grant Park Clinic, the Center for Black Women’s Wellness, and the Good Samaritan Health Center</p>	<p>Clinic to provide a quarterly report on how many patients received labs, how many labs were processed and the top twenty labs utilized</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Maintain and grow Piedmont efforts around readmissions, care transitions and re-encounters</b></p>	<p>Maintain and grow efforts of Sixty Plus to reduce preventable readmissions and emergency department re-encounters, and to support strong care transitions</p> <hr/> <p>Maintain and grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care to manage specific diseases through readmission-specific task force initiatives</p>	<p>Internal practices and policies are regularly reviewed to align with performance measures aimed at reaching eligible seniors</p> <hr/> <p>Goal is to keep CMS readmissions ratio under 1.0000</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution points by 10 percent annually</p>	<p>Update the guide annually; engage community groups and stakeholders to ensure best information</p> <hr/> <p>Baseline: 5,000 copies with an increase to 5,500 in FY17</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Increase access to and awareness of breast and lung cancer-related programming</b></p>	<p><b>Promote access to affordable mammograms with appropriate follow-up care</b></p>	<p>Solicit and execute funding to provide no-cost mammograms to qualifying women</p> <ul style="list-style-type: none"> <li>• Komen Foundation for screening mammograms</li> <li>• It's the Journey: Genetics grant</li> </ul>	<p>Goals are specific to each grant with the purpose of fighting breast cancer through prevention</p>
	<p><b>Support Cancer Wellness programming</b></p>	<p>Offer free community education programs and support groups on various topics including nutrition, exercise, stress, caregiver information, etc.</p> <ul style="list-style-type: none"> <li>• It's the Journey: Pink grant</li> </ul>	<p>Goal to reach 8,000 encounters with CW programming in FY17</p>
	<p><b>Other cancer programming</b></p>	<p>Continue to provide information and referrals to all community services for individuals through the Cancer Center social worker</p>	<p>Opportunities to engage and work with patients are regularly evaluated and implemented</p>
	<p><b>Support community-based non-profits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to and awareness of breast and lung cancer programming, including: educational programs, breast and lung cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Reduce preventable instances of heart disease, hypertension, and stroke</b></p>	<p><b>Support community-based nonprofits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce instances of heart disease, hypertension and stroke, with priority given to educational programs, including: health coach services, community health education, patient care self-management programs and smoking cessation programs</p> <hr/> <p>Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAH every six months</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p>
	<p><b>Maintain designation as a Primary Stroke Center</b></p>	<p>Maintain DNV designation as a Primary Stroke Center</p> <hr/> <p>Implement FAST stroke education classes in the community</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Maintain designation as a Chest Pain Center</b></p>	<p>Maintain designation from Society of Cardiovascular Patient Care</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition</p> <hr/> <p>Early Heart Attack Care (EHAC)/Hands-only CPR annual course offering to the community at large</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>Same as above</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, hypertension, stroke via Public Service Announcements</b></p>	<p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>Two community-focused PSA campaigns annually</p>

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

**Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:**

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Atlanta does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Violent crime:** As a health care provider, our ability to significantly impact this issue is limited as Piedmont Atlanta does not provide services related to violent crime in-house, other than treatment and appropriate care referrals. We will continue to support awareness and explore community-based partnerships around the issue.
- **HIV/AIDS/STDs:** While will not focus on this priority over the next three years, we will continue to provide care and support to those with these health conditions, and will explore additional opportunities for community-based partnerships around prevention.

### **How the implementation strategy was developed**

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Atlanta. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Atlanta Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Atlanta leadership and the Piedmont Atlanta Hospital Board of Directors.

The Piedmont Atlanta Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on September 20, 2016.

In 2015, the then-Athens Regional Health System administration and board approved the hospital's Community Health Needs Assessment (CHNA), which was developed using primary and secondary data, internal hospital data, findings from key stakeholder interviews and other relevant community-based information. The CHNA identified several key health priorities, which were developed using four key criteria: 1) the number of people affected, 2) the severity of the problem, 3) the health system's ability to impact, and 4) the extent to which other organizations are already meeting the need.

From the CHNA findings, and in partnership with hospital leadership and community stakeholders, Athens Regional Health System developed its implementation strategy to address the identified priorities listed in the 2015 CHNA. The initial implementation strategy was approved by the Athens Regional Health System Board of Directors on November 24, 2015.

Athens Regional joined the Piedmont Healthcare system as Piedmont Athens Regional Medical Center in October 2016. In March 2017, the Piedmont Health System community benefit team, in partnership with PAR leadership, redrafted the implementation strategy to align it with system priorities and to reflect the shift in ownership. Core strategies from the original were maintained, and several priorities were combined as they share strategies.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to care and health services</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Continue to provide free and reduced-cost care to qualifying patients through PAR's financial assistance policy; ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls; work to enroll qualifying patients within Medicaid through vendor partners</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that income thresholds and the application process are appropriate and fair for patients</p> <hr/> <p>Same as above</p>
	<p><b>Provide pharmaceuticals to partner clinics serving low- and no-income populations</b></p>	<p>Maintain current partnership for the provision of certain free pharmaceuticals with Mercy Clinic, a community-based charitable clinic</p>	<p>Provide approximately \$36,000 annually in free pharmaceuticals for low-income patients</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to care and health services</b> (cont.)</p>	<p><b>Support local efforts to increase community-based access to care</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p> <hr/> <p>Promote care for low-income populations through support of strengthened partnerships with Athens Neighborhood Health Center, a Federally Qualified Health Center, and Athens Nursing Clinic, a charitable clinic</p> <hr/> <p>Provide support to the on-campus Community Care Clinic to support care for low-income populations while providing education for internal medicine resident students</p> <hr/> <p>Maintain and regularly update the community resource guide in both online and printed format in Spanish and English</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAR every six months</p> <hr/> <p>Provide a one-time \$50,0000 allocation to sustain operations and provide operational guidance to the clinic from hospital leadership for Athens Neighborhood Health Center; provide an annual allocation to the Athens Nurses Clinic to support clinic operations</p> <hr/> <p>Measure and track patient referrals from the hospital’s case management team to the clinic; improve primary care physician identification; increase and continually measure use of Scripts to Go program, which encourages use of PAR’s retail pharmacy at discharge as to provide low-income patients with necessary medication</p> <hr/> <p>Distribute approximately 5,000 copies of the guide to low-income and high-need patients within the community; annually update the guide to ensure accuracy; and, engage community groups and stakeholders to ensure best presentation, information, and distribution as to reach our target audience</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Support cardiovascular, cerebrovascular and respiratory health and combat obesity and diabetes</b></p>	<p><b>Support community-based nonprofits that target at-risk populations through community benefit grants</b></p>	<p>Provide grant funding to community-based non-profit organizations that work to reduce instances of heart disease, hypertension, obesity and diabetes, with priority given to educational programs not done by the community education team, including: school garden programs, cooking and shopping education programs, partnerships with farmers markets, etc.</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PAR every six months</p>
	<p><b>Continue to offer healthy lifestyle community education programming</b></p>	<p>Continue to offer “Courage to Quit” tobacco cessation classes to the community, including the venues at the Mercy Clinic, at no charge to the patients</p> <hr/> <p>Offer a program in collaboration with an PAR Pediatrician, Health Matters for Families that provides a family-centered, behavior change approach and nutrition counseling</p> <hr/> <p>Continue to provide on-going classes on healthy eating and making positive lifestyle changes through the Athens YMCA</p>	<p>Conduct approximately 25 program series, with a target goal of 115 participants in 2016, 130 participants in 2017 and 145 participants in 2018</p> <hr/> <p>Conduct approximately 200 events, with a target goal of 1,250 participants in 2016, 1,400 participants in 2017 and 1,500 participants in 2018</p> <hr/> <p>Provide 15 nutrition consultations reaching 60 participants in 2016, 18 nutrition consultations reaching 72 participants in 2017 and 20 nutrition consultations reaching 80 participants in 2018</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Support cardiovascular, cerebrovascular and respiratory health and combat obesity and diabetes</b> (cont.)</p>	<p><b>Maintain designation as a Chest Pain Center with Primary PCI and Resuscitation</b></p>	<p>Maintain designation from ACC Accreditation Services</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition education as well as blood pressure screenings</p> <hr/> <p>Early Heart Attack Care (EHAC)/ Hands-only CPR annual course offering to the community at large</p>	<p>Renewed every three years and due for renewal by 9/10/2018; Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Maintain designation as a Primary Certified Stroke Care Center</b></p>	<p>Maintain The Joint Commission designation as a Primary Stroke Center</p> <hr/> <p>Implement FAST stroke education classes in the community</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, hypertension, obesity and diabetes via Public Service Announcements</b></p>	<p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>Execute two community-focused PSA campaigns annually conducted via social media, the piedmont.org website and through community partners, with a goal to reach approximately 5,000 community members</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<b>Cancer</b>	<b>Promote access to affordable mammograms with appropriate follow-up care</b>	Increase access to screening mammograms using PAR's mobile mammography unit	Unit serves 17 counties in the PAR region, with a goal to provide up to 4,500 screening mammograms, including 3D mammograms, in a year
	<b>Provide support services to cancer patients and their families</b>	Provide support services free of charge for patients and families affected by cancer through focus group and individual counseling, education about trusted resources and treatment options, prosthetics, wigs, transportation, grief and depression counseling	Reach 2,000 encounters through cancer programming annually

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<b>Maternal and infant health</b>	<b>Continue to offer community education programming</b>	Continue to offer classes and programs to the underserved	Reach 250 individually through programming annually

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

In the 2015 CHNA, three priorities emerged that we will not focus on during the FY16 to FY18 implementation strategy:

- **Mental health and substance abuse:** PAR does not provide mental health services, and therefore will not focus on this priority during this implementation strategy cycle. This is a change from the original 2015 Implementation Strategy, which stated the hospital would address mental health. However, the hospital will continue to support awareness and explore community-based partnerships around the issue.
- **Injury prevention and safety:** PAR will support and encourage injury prevention and safety, however we are unable to maintain this as a core priority, as identified in 2015, due to a limitation in hospital resources to adequately address it. However, the hospital will continue to look for opportunities to be supportive of community-based and government entities in their efforts.
- **HIV/AIDS and STDs:** While will not focus on this priority over the next three years, we will continue to provide care and support to those with these health conditions, and will explore additional opportunities for community-based partnerships around prevention.

The Piedmont Athens Regional Board of Directors approved this revised implementation strategy to address identified health issues on March 23, 2017.



## Community Health Needs Assessment Implementation Strategy FY17 to FY19

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low - to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls; enroll qualifying patients in Medicaid</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p>
	<p><b>Provide laboratory services to partner clinic serving low- and no-income populations</b></p>	<p>Maintain current partnership for the provision of certain free laboratory services with Fayette C.A.R.E. Clinic and the Healing Bridge Clinic</p>	<p>Clinics will provide a quarterly report on how many patients received labs, how many labs were processed and the top twenty labs utilized</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; programs are evaluated by PHC/PFH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Maintain and grow Piedmont efforts around readmissions, care transitions and re-encounters</b></p>	<p>Maintain and grow efforts of Sixty Plus to reduce preventable readmissions and emergency department re-encounters, and to support strong care transitions</p> <hr/> <p>Maintain and grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care to manage specific diseases through readmission-specific task force initiatives</p> <hr/> <p>Paramedicine pilot program</p>	<p>Internal practices and policies are regularly reviewed to align with performance measures aimed at reaching eligible seniors</p> <hr/> <p>Goal is to keep CMS readmissions ratio under 1.0000</p> <hr/> <p>Application for grant to be submitted in fall 2016</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution points by 10 percent annually</p>	<p>Update annually the guide; engage community groups and stakeholders to ensure best information</p> <hr/> <p>Increase distribution from 2,500 copies to 2,750 in FY17</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; programs are evaluated by PHC/PFH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Increase access to and awareness of breast cancer-related programming</b></p>	<p><b>Promote access to affordable screenings with appropriate follow-up care</b></p>	<p>Solicit and execute funding to provide no-cost mammograms to qualifying women</p>	<p>Provide up to 325 free breast cancer screenings and up to 45 biopsies; refer patients with positive diagnosis to navigator</p>
	<p><b>Provide educational programs through Cancer Wellness</b></p>	<p>Offer free community education programs and support groups on various topics including nutrition, exercise, stress, caregiver information, etc.</p>	<p>Goal to reach 6,000 encounters through Cancer Wellness programming annually</p>
	<p><b>Support linkage to community programs</b></p>	<p>Continue to provide information and referrals to all community services for individuals through the Cancer Center social worker</p> <hr/> <p>Offer outreach efforts to the community including the Hispanic Health Fair and distributing cancer screening resource info at community events</p>	<p>Opportunities to engage and work with patients are regularly evaluated and implemented</p> <hr/> <p>(shared with the above)</p>
	<p><b>Support community-based nonprofits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to and awareness of breast cancer programming including: educational programs, breast cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; programs are evaluated by PHC/PFH every six months</p>

**Reduce preventable instances of heart disease, stroke, and obesity and obesity-related diseases**

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
	<p><b>Support community-based nonprofits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce instances of heart disease, stroke and obesity, with priority given to educational programs, including: health coach services, community health education, patient care self-management programs, smoking cessation programs, Cooking Matters curriculum, nutrition education or farmers market programming, community and school gardening education programs, physical activity programs</p> <hr/> <p>Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues</p> <hr/> <p>Conduct outreach efforts and events around heart, stroke and obesity</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; programs are evaluated by PHC/PFH every six months</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p> <hr/> <p>(shared with the above)</p>
	<p><b>Maintain designation as a Primary Stroke Center</b></p>	<p>Maintain DNV designation as a Primary Stroke Center</p> <hr/> <p>Implement FAST stroke education classes in the community</p>	<p>Conduct a yearly review with a 3-year recertification process occurring in June 2017</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Maintain designation as a Chest Pain Center</b></p>	<p>Maintain designation from Society of Cardiovascular Patient Care</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition</p> <hr/> <p>Offer Early Heart Attack Care (EHAC)/ Hands-only CPR annual course to the Fayette community and groups</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>(shared with the above)</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, stroke, obesity and obesity-related diseases via public service announcements</b></p>	<p>Create public service announcements aimed at reaching at-risk populations with high instances of heart disease, stroke and obesity-related diseases</p>	<p>Two community-focused PSA campaigns annually</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<b>Maintain and, when possible, grow efforts around senior health.</b>	<b>Support community-based nonprofits that target at-risk populations through community benefit grants</b>	Provide funding to community-based non-profit organizations that work to address senior health issues	Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PFH every six months

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Fayette does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts

### How the implementation strategy was developed

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Fayette. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Fayette Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Fayette leadership and the Piedmont Fayette Hospital Board of Directors.

The Piedmont Fayette Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on August 10, 2016.

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low- to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p> <hr/> <p>Same as above</p>
	<p><b>Provide laboratory services, diagnostic and other medical services, space and utility coverage to partner clinics serving low- and no-income populations</b></p>	<p>Maintain current partnerships for the provision of certain free laboratory services, diagnostic and other medical services, physical space and utility coverage with community-based charitable clinic Hands of Hope</p> <hr/> <p>Provide funding for additional staffing as part of the Sams Care program in partnership with the Hands of Hope Clinic</p>	<p>Clinic to provide semi-annual report on how many patients received labs, how many labs were processed and the top twenty labs utilized</p> <hr/> <p>Ability for clinic to stay open longer and see more patients, as well as hospital cost avoidance figures and hospital ED utilization rates</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PHH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Maintain and grow Piedmont efforts around readmissions</b></p>	<p>Maintain and grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care</p>	<p>Goal is to keep CMS readmissions ratio under 1.00</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution copies by 10 percent annually</p>	<p>Update the guide annually; engage community groups and stakeholders to ensure best information</p> <hr/> <p>Baseline: 3,000 copies with an increase to 3,300 in FY17</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PHH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Increase access to and awareness of breast cancer-related programming</b></p>	<p><b>Promote access to affordable mammograms with appropriate follow-up care</b></p>	<p>Solicit and execute Komen Foundation funding to provide no-cost mammo-grams to qualifying women</p> <ul style="list-style-type: none"> <li>• GA Core Grant</li> <li>• Komen Grant</li> </ul>	<p>Goals are specific to each grant with the purpose of fighting breast cancer through prevention</p>
	<p><b>Cancer Wellness educational programs</b></p>	<p>Offer free community education programs and support groups on various topics including nutrition, exercise, stress, caregiver information, etc.</p>	<p>Goal to reach 1,000 encounters with CW programming in FY17</p>
	<p><b>Other Piedmont cancer offerings</b></p>	<p>Continue to provide information and referrals to all community services for individuals through the Cancer Center social worker</p> <hr/> <p>Provide breast center advocate services to assist breast cancer patients</p>	<p>Opportunities to engage and work with patients are regularly evaluated and implemented</p> <hr/> <p>Opportunities to engage and work with patients are regularly evaluated and implemented</p>
	<p><b>Support community-based non-profits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to increase access to and awareness of breast cancer programming, including: educational programs, breast cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PHH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable instances of heart disease, hypertension, and stroke</b></p>	<p><b>Support community-based nonprofits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to reduce instances of heart disease, hypertension and stroke, with priority given to educational programs, including: health coach services, community health education, patient care self-management programs and smoking cessation programs</p> <hr/> <p>Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PHH every six months</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p>
	<p><b>Maintain designation as a Primary Stroke Center</b></p>	<p>Maintain DNV designation as a Primary Stroke Center</p> <hr/> <p>Implement FAST stroke education classes in the community</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Maintain designation as a Chest Pain Center</b></p>	<p>Maintain designation from Society of Cardiovascular Patient Care</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition</p> <hr/> <p>Early Heart Attack Care (EHAC)/Hands-only CPR annual course offering to the community at large</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>Same as above</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, hypertension and stroke via Public Service Announcements</b></p>	<p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>Two community-focused PSA campaigns annually</p>

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

**Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:**

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Henry does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts

### **How the implementation strategy was developed**

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Henry. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Henry Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Henry leadership and the Piedmont Henry Hospital Board of Directors.

The Piedmont Henry Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on September 12, 2016.



## Community Health Needs Assessment Implementation Strategy FY17 to FY19

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low-to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls; work to enroll qualifying patients within Medicaid through vendor partner</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p> <hr/> <p>Same as above</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PMH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Maintain the Sixty Plus program, aligning it with system readmission goals</b></p>	<p>Maintain and grow efforts of Sixty Plus to reduce preventable readmissions and emergency department re-encounters, and to support strong care transitions</p>	<p>Internal practices and policies are regularly reviewed to align with performance measures aimed at reaching eligible seniors</p>
	<p><b>Maintain and grow Piedmont efforts around readmissions</b></p>	<p>Maintain and grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care to manage specific diseases through readmission-specific task force initiatives</p>	<p>Goal is to keep CMS readmissions ratio under 1.0000</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution copies by 10 percent annually</p>	<p>Update the guide annually; engage community groups and stakeholders to ensure best information</p> <hr/> <p>Baseline: 1,000 copies with an increase to 1,100 in FY17</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PMH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Increase access to and awareness of breast cancer-related programming</b></p>	<p><b>Promote access to affordable mammograms with appropriate follow-up care</b></p>	<p>Continue to offer free mammograms to uninsured women in October</p>	<p>Goal to reach 20 individuals through program</p>
	<p><b>Support community-based non-profits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to and awareness of breast cancer programming, including: educational programs, breast cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PMH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable instances of heart disease, hypertension and stroke</b></p>	<p><b>Support community-based non-profits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce instances of heart disease, hypertension and stroke, with priority given to educational programs including: health coach services, community health education, patient care self-management programs and smoking cessation programs</p> <hr/> <p>Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PMH every six months</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, hypertension and stroke via Public Service Announcements</b></p>	<p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>Two community-focused PSA campaigns annually</p>
	<p><b>Maintain designation as a Chest Pain Center</b></p>	<p>Maintain designation from Society of Cardiovascular Patient Care</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition</p> <hr/> <p>Early Heart Attack Care (EHAC)/Hands-only CPR annual course offering to the community at large</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>Same as above</p>

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Mountainside does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts
- **Motor vehicle accidents:** While we not actively work on this issue in-house, we will continue to support programs and policies that aim to reduce motor vehicle accidents in and around Pickens County.

### How the implementation strategy was developed

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Mountainside. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Mountainside Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Mountainside leadership and the Piedmont Mountainside Hospital Board of Directors.

The Piedmont Mountainside Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on September 23, 2016.

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low- to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls; work to enroll qualifying patients within Medicaid through vendor partner</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p> <hr/> <p>Same as above</p>
	<p><b>Provide laboratory services, space and utility coverage to partner clinic serving low- and no-income populations</b></p>	<p>Maintain current partnerships for the provision of certain free laboratory services, physical space and utility coverage with community-based charitable clinic Coweta Samaritan Clinic</p>	<p>Clinic to provide a quarterly report on how many patients received labs, how many labs were processed and the top twenty labs utilized</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Maintain the Sixty Plus program, aligning it with system readmission goals</b></p>	<p>Maintain and grow efforts of Sixty Plus to reduce preventable readmissions and emergency department re-encounters, and to support strong care transitions</p>	<p>Internal practices and policies are regularly reviewed to align with performance measures aimed at reaching eligible seniors</p>
	<p><b>Maintain and grow Piedmont efforts around readmissions</b></p>	<p>Maintain and grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care to manage specific diseases through readmission-specific task force initiatives</p>	<p>Goal is to keep CMS readmissions ratio under 1.0000</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution copies by 10 percent annually</p>	<p>Update the guide annually; engage community groups and stakeholders to ensure best information</p> <hr/> <p>Baseline: 1,750 copies with an increase to 1,925 in FY17</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Increase access to and awareness of breast cancer-related programming</b></p>	<p><b>Promote access to affordable mammograms with appropriate follow-up care</b></p>	<p>Solicit and execute Foundation funding to provide no-cost mammograms to qualifying women</p> <ul style="list-style-type: none"> <li>• It's the Journey: screening grant</li> </ul>	<p>Goals are specific to each grant with the purpose of fighting breast cancer through prevention</p>
	<p><b>Cancer Wellness</b></p>	<p>Offer free community education programs and support groups on various topics including nutrition, exercise, stress, caregiver information, etc.</p>	<p>Goal to reach 2,000 encounters with CW programming in FY17</p>
	<p><b>Other cancer programming</b></p>	<p>Continue to provide information and referrals to all community services for individuals through the Cancer Center social worker</p>	<p>Social Worker will contact 100% of new locally-diagnosed cancer patients scoring 4 and above on Psychosocial Distress Screenings</p>
	<p><b>Support community-based non-profits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to increase access to and awareness of breast cancer programming, including: educational programs, breast cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Reduce preventable instances of heart disease, stroke, obesity and obesity-related diseases</b></p>	<p><b>Support community-based non-profits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding to community-based non-profit organizations that work to reduce instances of heart disease, stroke and obesity, with priority given to educational programs, including: health coach services, community health education, patient care self-management programs, smoking cessation programs, Cooking Matters curriculum, nutrition education or farmers market programming, community and school gardening education programs and physical activity programs</p> <hr/> <p>Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNH every six months</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p>
	<p><b>Maintain designation as a Primary Stroke Center</b></p>	<p>Maintain DNV designation as a Primary Stroke Center</p> <hr/> <p>Implement FAST stroke education classes in the community</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p>
	<p><b>Maintain designation as a Chest Pain Center</b></p>	<p>Maintain designation from Society of Cardiovascular Patient Care</p> <hr/> <p>Provide annual educational offerings that address the identified needs of the community based on the CHNA findings, including content on tobacco cessation and heart healthy nutrition</p> <hr/> <p>Early Heart Attack Care (EHAC)/Hands-only CPR annual course offering to the community at large</p>	<p>Conduct yearly review to ensure we are maintaining designation</p> <hr/> <p>Opportunities to engage and work with the community are regularly evaluated and implemented</p> <hr/> <p>Same as above</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, hypertension and stroke via Public Service Announcements</b></p>	<p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>Two community-focused PSA campaigns annually</p>

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Newnan does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts

### How the implementation strategy was developed

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Newnan. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Newnan Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Newnan leadership and the Piedmont Newnan Hospital Board of Directors.

The Piedmont Newnan Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on September 15, 2016.

This strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities listed in the 2016 community health needs assessment.

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>To maintain and, when possible, increase access to necessary and affordable care for low - to no-income patients</b></p>	<p><b>Provide financial assistance and cover shortfalls incurred for necessary care for low- and no-income populations</b></p>	<p>Ensure PHC financial assistance policy and practice remains aligned with federal standards</p> <hr/> <p>Continue to support care for Medicaid populations through coverage of cost shortfalls</p>	<p>Policies impacting low-income patients are to be reviewed annually to ensure compliance with federal guidelines, and to ensure that qualifying patients are well-served by the policies</p> <hr/> <p>Same as above</p>
	<p><b>Provide laboratory services, space and utility coverage to partner clinic serving low- and no-income populations</b></p>	<p>Maintain current partnerships for the provision of certain free laboratory services, physical space and utility coverage with community-based charitable clinic Willing Helpers Medical Clinic</p>	<p>Clinic to provide a quarterly report on how many patients received labs, how many labs were processed and the top twenty labs utilized</p>
	<p><b>Support local efforts to increase community-based access to care through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to increase access to care for vulnerable patients, including: mobile health units, expanded primary care services for low-income patients, increased access to specialty services and expansion of safety net services within communities designated as medically underserved</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNTH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Reduce preventable readmissions and emergency department re-encounters</b></p>	<p><b>Grow Piedmont efforts around preventable readmissions</b></p>	<p>Grow the Hospital Readmissions Reduction Program (HRRP) by continuing to improve active coordination of care for recently discharged patients through the care transitions program, and continuing to improve care standardization efforts to ensure appropriate delivery of care to manage specific diseases through readmission-specific task force initiatives</p>	<p>Goal is to keep CMS readmissions ratio under 1.0000</p>
	<p><b>Increase awareness of community-based resources for vulnerable patients</b></p>	<p>Maintain and regularly update the community resource guide in both online and printed format</p> <hr/> <p>Increase community distribution points by 10 percent annually starting in FY18</p>	<p>New to Newton: will distribute 3,000 copies in FY17 in English and Spanish</p> <hr/> <p>Update the guide annually; engage community groups and stakeholders to ensure best information</p>
	<p><b>Support efforts of community-based clinics aimed at reducing preventable emergency department encounters through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to reduce preventable ED encounters, including: recuperative care programs for homeless individuals, patient navigator services, cultural competency programs and community health worker programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNTH every six months</p>
	<p><b>Sixty Plus</b></p>	<p>Grow efforts of Sixty Plus to reduce preventable readmissions and emergency department re-encounters, and to support strong care transitions</p>	<p>To be determined in Newton community</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p style="text-align: center;"><b>Increase access to and awareness of breast cancer-related programming</b></p>	<p><b>Promote access to affordable mammograms with appropriate follow-up care</b></p>	<p>Solicit and execute funding to provide no-cost mammograms to qualifying women</p>	<p>To be determined</p>
	<p><b>Women's Diagnostic Center and Hope Boutique</b></p>	<p>Continue to provide information and referrals to all community services for individuals through the Cancer Center social worker</p> <hr/> <p>Hope Boutique: Create a policy to use donated funds to pay for taxi and gas vouchers to that patients can get to/from screenings and appointments</p>	<p>Opportunities to engage and work with patients are regularly evaluated and implemented</p> <hr/> <p>Increase compliance of follow up appointments in vulnerable patients</p>
	<p><b>Support community-based nonprofits aligned with our cancer goals through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to increase access to and awareness of breast cancer programming, including: educational programs, breast cancer screening programs and patient navigation services for those needing follow-up care</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNTH every six months</p>

PRIORITY	STRATEGY	ACTIVITY	EVALUATION/MEASURE
<p><b>Reduce preventable instances of heart disease, stroke, and obesity and obesity-related diseases</b></p>	<p><b>Support community-based nonprofits that target at-risk populations through community benefit grants</b></p>	<p>Provide funding through community benefit grants to community-based non-profit organizations that work to reduce instances of heart disease, stroke, and obesity with priority given to educational programs, including: health coach services, community health education, patient care self-management programs, smoking cessation programs, Cooking Matters curriculum, nutrition education or farmers market programming, community and school gardening education programs and physical activity programs</p>	<p>Goals of funded programs are to be determined by the individual groups and their proposals; evaluated by PHC/PNTH every six months</p>
	<p><b>Alert public to risks and ways to reduce harm from heart disease, stroke, obesity and obesity-related diseases via Public Service Announcements</b></p>	<p>Distribute heart and stroke materials to community clinic and partners</p> <hr/> <p>In partnership with internal teams, create public service announcements aimed at reaching at-risk populations on various health topics</p>	<p>A minimum of two community groups and/or clinics partnered with annually</p> <hr/> <p>A minimum of two community groups and/or clinics partnered with annually</p>
	<p><b>Other</b></p>	<p>First Steps Georgia Program: provide support services for expectant parents and children birth to five and their families</p>	<p>Provide up to 500 new moms with books, education and other materials</p>

## HEALTH ISSUES WE WILL NOT ACTIVELY ADDRESS

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle:

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Newton does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts
- **Motor vehicle accidents:** While we not actively work on this issue in-house, we will continue to support programs and policies that aim to reduce motor vehicle accidents in and around Newton County.
- **HIV/AIDS/STDs:** While will not focus on this priority over the next three years, we will continue to provide care and support to those with these health conditions, and will explore additional opportunities for community-based partnerships around prevention.

### How the implementation strategy was developed

Piedmont Healthcare's community benefit department oversaw the community health needs assessment (CHNA) and implementation strategy process for all six Piedmont hospitals, including Piedmont Newton. Core to the process was the involvement of our local communities, which included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. In total, for all six Piedmont Healthcare hospital CHNAs and implementation strategies, 917 individuals participated in Piedmont's community health needs assessment process.

- 46 key informant interviews were conducted among Piedmont's six services counties, including:
  - o 5 interviews conducted with state or organizational leaders
  - o 12 interviews conducted with public health leaders
  - o 29 interviews conducted with stakeholder partners.
- 14 Piedmont Healthcare hospital board members were interviewed.
- Two focus groups were held at community-based charitable clinics, with 18 total participants
  - o 5 patients at the Hands of Hope Clinic in Stockbridge
  - o 13 patients at the Coweta Samaritan Clinic in Newnan.
- 785 Piedmont Healthcare employees completed an online survey about their work and their community, with representation from all Piedmont communities

Piedmont Newton Hospital developed the implementation strategy for the health priorities identified by the CHNA conducted in Fiscal Year 2016. This implementation strategy will be executed over the next three fiscal years, and was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, Piedmont Newton leadership and the Piedmont Newton Hospital Board of Directors.

The Piedmont Newton Hospital Board of Directors approved this community health needs assessment and implementation strategy to address identified health issues on September 23, 2016.