Community Health Needs Assessment
Fiscal Year 2019

Piedmont COLUMBUS REGIONAL

As designated 501(c)(3) nonprofit hospitals, the two campuses of Piedmont Columbus Regional Hospital are required by the Internal Revenue System to conduct a triennial community health needs assessment (CHNA), in accordance with regulations put forth by the IRS through the 2010 Patient Protection and Affordable Care Act (ACA). In its simplest definition, a CHNA is a measurement of the relative health or well-being of a given community. It's both the activity and the end-product of identifying and prioritizing unmet community health needs, which is accomplished by gathering and analyzing data, soliciting the feedback of the community and key stakeholders and evaluating our previous work and future opportunities. Through this assessment, we hope to better understand local health challenges, identify health trends in our community, determine gaps in the current health delivery system and craft a plan to address those gaps and the identified health needs.

## Key findings

- Muscogee County ranks high in measures related to clinical care, especially when it comes to physician to patient ratios.
- Rates of premature death have declined overall during the last 15 years, though they still remain higher than the state average.
- Though still not close to its peak in 2010, rates of physical activity are climbing back up after a steep decline in 2013.
- Sexually transmitted infections are also falling after a steep jump in 2014, when rates were about 50% more than they were in 2017.
- The uninsured rate in Muscogee County is high at 14%, and severely disproportionately impacts minorities.
- Heart disease still remains the community's biggest threat.
- County residents have rates higher than state and national averages for new cancer diagnoses and overall incidences.
- Rates of diabetes incidences have continued to rise over the last ten years.
- Self-reported poor mental and physical health days have continued to rise over the last five years, particularly among minorities.

## 2020 to 2022 health priorities

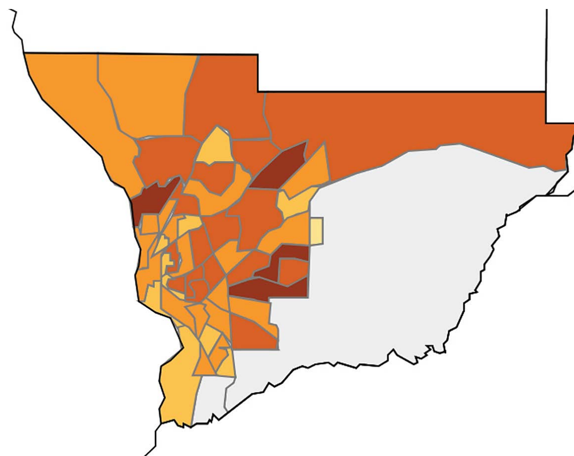
A key component of the CHNA is to identify the top health priorities we'll address over fiscal years 2020, 2021 and 2022. These priorities will guide our community benefit work. They are, in no order:

- Increase access points for appropriate and affordable health care for all community members, and especially those who are uninsured and those with low incomes
- Decrease deaths from cancer and increase access to cancer programming for those with living the disease
- Decrease preventable instances of diabetes and decrease the number of patients with uncontrolled diabetes
- Reduce rates of obesity and increase access to healthy foods and recreational activities
- Decrease the impact of and deaths from stroke
- Reduce opioid and related substance abuse and overdose deaths

With each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators. You can find more detail on how priorities were chosen, our overall process and our data sources beginning on page 14. You can find our implementation strategy beginning on page 16.

Cancer continues to have a devastating impact in Muscogee County. Among all cancers, lung cancer is the most devastating in Muscogee County, having claimed approximately 450 lives between 2013 and 2017. Lung cancer was the 4th cause of death in Muscogee County between 2013 and 2017 for all residents, and the age-adjusted death rate remains high above state and national averages.

To the left is a breakdown of premature deaths related to cancer by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue. This allows us to see exactly where we have the most instances so we can more directly target interventions to this community in the future.



The overall cancer incidence rate was 134.9 per 100,000 people, which is higher than both state and national averages between 2011 and 2015. Lung cancer rates were particularly high, with an average 133 new cases annually between 2011 and 2015.

There are increasing incidences of colon, rectum and anal cancers, which ranked 11th in age-adjusted deaths between 2013 and 2017.

Breast cancer death rates have declined over the last several years, but so has prevention. In 2015, only 56% of Medicare enrollees said they had a mammogram sometime within the previous two years, a figure significantly down from 68% in 2009.

**Cancer and health equity**

Both in Georgia and in the nation, the gap in the cancer rates widens between racial and socioeconomic groups, particularly in preventable cancers, according to the American Cancer Society.

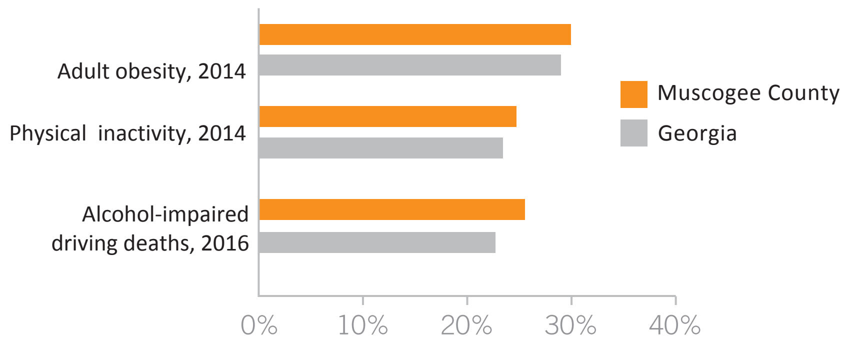
For example:

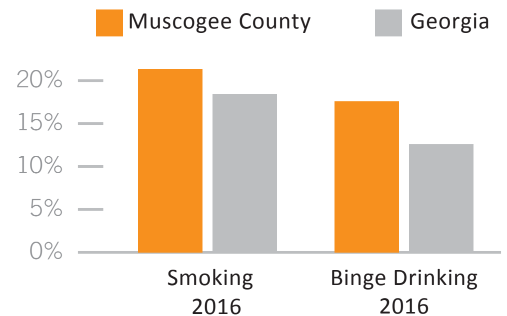
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 higher in poor men compared to affluent men.
- White females in Georgia are more likely than black females to be diagnosed with cancer.
- Black males in Georgia are more likely than white males to be diagnosed with cancer, and black males are 25 times more likely than white males to die from cancer.
- Cancer survivors carry greater financial burdens related to medical debt payments and bills versus patients without a cancer history, and younger survivors face the greatest hardships.

Unhealthy behaviors, such as tobacco use, poor diet, physical inactivity and obesity, continue to heavily contribute to cancer rates and tend to disproportionately impact low-income populations. For example, although overall smoking rates have declined statewide, high rates still persist among lower educated, lower income populations. Also, low income populations tend to have less access to healthy foods.

# Healthy behaviors

While poor health and chronic conditions are caused by a number of factors, a key contributor is healthy behaviors. All years below are for the latest time frame for which data was available.




- **Chronic obstructive pulmonary disease is the second leading cause of age-adjusted death**, and is caused almost exclusively from smoking.
- Violence is an issue in Muscogee County. **Homicide was the 9th leading cause of all deaths for African Americans within the county between 2013 and 2017, and the 3rd leading cause of premature deaths**. The violent crime rate is far above both state and national averages, with 517 violent crimes per every 100,000 residents.
- Georgia still remains one of the worst states for drug overdose deaths in the country, and this has only gotten worse. For example, **there was a 10.5% increase in overdose deaths in the state between 2016 and 2017.**
- **Chlamydia and gonorrhea rates were far above state averages and nearly double national averages in 2016,** with both being most prevalent in African American populations.
- Approximately 913 people lived with HIV in 2015. HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices. The Muscogee rate is lower than the state average but about 40% higher than the national average.

# Mental health

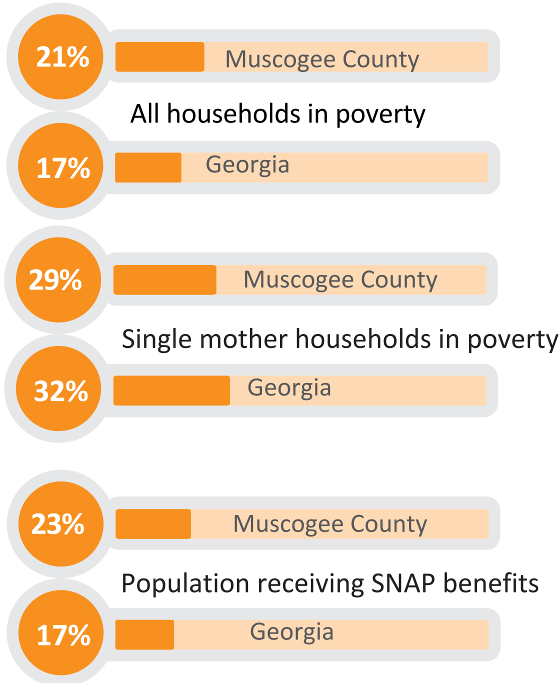
- **Mental health and behavioral disorders was the 7th leading cause of death for all county residents between 2013 and 2017.**
- We see this particularly in premature death. **Suicide was the 2nd leading cause of premature deaths for whites between 2013 and 2017.** It is most common among males aged 25 to 34 years of age.
- There was one mental health providers for every 370 residents in the county in 2017, a rate better than the state average of just one provider for every 870 residents.

# Opioid Use

- Opioid prescriptions are down. In 2007, there were approximately 108.2 retail opioid prescriptions dispensed per 100 persons, according to the CDC. That number has dropped to 86.5 in 2017. **Even so, Muscogee County remains much higher than the national average of 58.7 per 100 people and state average of 70.9.** We aren't able to tell how many prescriptions are going to a single person, just the overall figure.
- In 2016, there were 918 opioid-related overdose deaths in Georgia, a rate of 8.8 deaths per 100,000 persons.
- That said, drug overdoes in Muscogee County are lower than state averages, with only 10 overdoses per 100,000 people in 2016, versus the state average of 12.
- Opioid use is directly correlated with increased rates of Hepatitis C, according to numerous studies.

# Social determinants of health

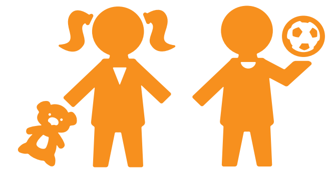
As defined by the World Health Organization, social determinants of health (SDHs) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Included among these is economic stability, housing stability, food security, adequate income to pay for core services such as utilities, literacy, access to healthy food, access to safe recreational spaces, access to health care and access to services in languages the person understands. SDHs often carry negative health impacts, including increased risk of mortality, poor health, and increased cardiovascular disease risks.




- 6% of adults were unemployed in 2017, a figure just above the national average of 5%.
- 36% of those living in poverty in the county did not graduate high school in the 2015-2016 school year.
- In 2015, 36% of the population had limited access to healthy foods and 21% reported having extended periods when they aren't sure how they or their families will eat.
- There were 109 fast food restaurants per 100,000 residents in Muscogee County in 2016, much higher than state and national averages, and 111,790 people live in a food desert, meaning it is difficult to buy affordable or good-quality fresh food in those particular communities.
- 38% of households had housing costs that exceeded more than 30% of total household income in 2017, indicating a cost burdened household more likely to face overall financial difficulty.

## Families and children

- **49% of children lived in single-parent homes in 2017**, a statistic often linked to lower graduation rates. This number has remained steady since our last CHNA, and is high above the state average of 38%.
- **73% of children qualified for free or reduced cost lunch in the 2015-2016 school year,** a statistic that represents poverty and food instability. This is a sharp increase from our FY15 CHNA, when about 37% of children qualified for free or reduced cost lunch. Muscogee County is also high above the 2017 state average of 62%.
- **For every 1,000 teen girls aged 15 to 18 in Muscogee County, 49 birth gave birth to a child** on average each year between 2010 and 2016. African American teens were twice as likely to have a baby than their white counterparts. Children born to teen are statistically much more likely to experience adverse health and socioeconomic issues as they grow older.

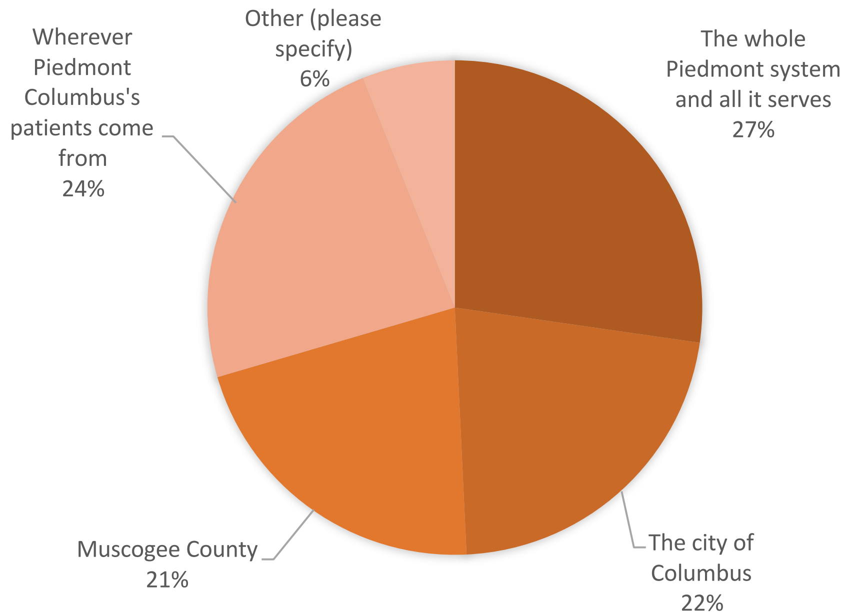


**31% of children in Muscogee County lived in poverty in 2017,** a figure that has steadily increased over the last ten years. It is significantly higher than the state average of 24%. When broken down by race, 44% of African American children and 13% of white children lived in poverty. Poor children are statistically less likely to graduate high school or attend college, and are nearly twice as likely to become poor adults than their non-poor counterparts.

# PCR stakeholder survey

In December 2018 and December 2019, 133 key stakeholders within the Piedmont Columbus community provided their thoughts on community health, community assets and the role of the hospital in addressing unmet community health needs via a web survey. Below are the results of that survey.

## How would you best define Piedmont Columbus Regional's community?




## What do you think are the most pressing health problems in Piedmont's community?

Top ten answers:

1. Ability to pay for care
2. Lack of health insurance
3. Cost of health care
4. Mental health
5. Lack of transportation to health care services
6. Cancer
7. Obesity in adults
8. Diabetes
9. Drug abuse prescription medication
10. Prescription medication too expensive

## What issues do you think may prevent community members from accessing care?

Top ten answers:

1. No insurance and unable to pay for the care
2. Unable to pay co-pays/deductibles
3. Transportation
4. Fear (e.g., not ready to face/discuss health problem)
5. Don't know how to find doctors
6. Don't understand the need to see a doctor
7. Cultural/religious beliefs
8. Language barriers
9. Unable to use technology to help schedule an appt., find a doctor, etc.
10. Lack of availability of doctors

## How important are the following actions in improving the health of Piedmont's communities?

Top 10 answers ranked "most important":

1. Access to health care services
2. Access to low-cost mental health services
3. Financial assistance for those who qualify
4. Free or affordable health screenings
5. Additional access points to affordable care within the community
6. Access to local inpatient behavioral health facilities
7. Local outpatient mental health services
8. Community-based programs
9. Services to help physically or developmentally disabled children and adults
10. Expanded access to specialty physicians

## What do you think is the main reason children do not receive medical care in our community?

Answers ranked in order of importance given by respondents:

1. Cost
2. Lack of insurance
3. No transportation
4. Does not accept my insurance
5. Distance
6. Provider doesn't speak our language
7. Wasn't open when I could get there
8. Too long a wait for an appointment
9. Too long a wait in the waiting room
10. No access for those with disabilities

### What is your vision for a healthy community?

Some answers:

"People to be educated, live healthy, and be proactive in their medical care."

"Access to health care, jobs, good education, public safety, well-lighted bicycle and walkable streets and trails, access to fresh and healthy foods and well maintained parks, recreation centers and water activities during summer."

"A hospital working outside its walls."

"One that is improving, not worsening overall health."

"Access to affordable care particularly specialty care."

### What is the single most pressing issue you feel our patients face?

The majority answers centered on the topics:

Substance abuse when it comes to pain medication

Access to all services and more importantly follow up care and prevention

Cost of care

Services that support the overall person, not just the immediate health concern

Lack of information about their own health

Little referral to services outside of Piedmont, and especially for housing and food

Affordable urgent care, financial assistance for urgent care

# PCR community meeting

On Wednesday, 06 March 2019, Piedmont Columbus Regional community benefit team convened a meeting of key stakeholders to discuss health challenges and needs in the local community. Among the 47 stakeholders present were representatives from MercyMed of Columbus charitable clinic, Valley Healthcare System, the Muscogee County School District, the Muscogee County Health Department and Columbus Consolidated Government.

Community stakeholders were presented with the preliminary findings from our FY19 community health needs assessment, and were asked to rank health issues and potential solutions. Among the questions and top responses were:

What do you think are the most pressing health problems in Piedmont's community?

- Heart disease
- Cancer

What issues do you think may prevent community members from accessing care?

- Lack of health insurance
- Transportation

How important are the following actions in improving the health of Piedmont's communities?

- Free or affordable health screenings
- Access to health care services

What do you think is the main reason children do not receive medical care in our community?

- Cost
- No Transportation

What do you think is the main reason children visit our Pediatric Emergency Room rather than their pediatrician?

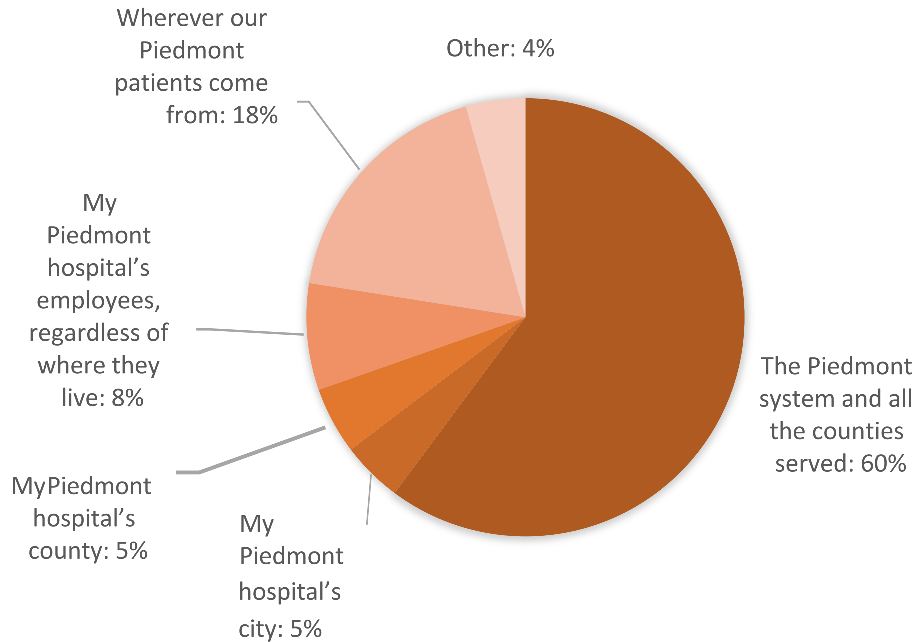
- No primary care physician
- No insurance

Responses from the meeting were used inform the CHNA process including the recommended priorities that both Piedmont Columbus Regional will undertake over the next three years.

# PHC employee survey

Approximately 298 Piedmont Columbus Regional employees completed an internal CHNA assessment. Questions focused on issues facing community members, as well as how Piedmont staff feels the hospital should address those issues. Below are the results from all who answered the surveyed throughout the system, which had a total 897 responses.

## How would you best define Piedmont's community?




## What do you think are the most pressing health problems in Piedmont's community?

Top ten answers:

1. Ability to pay for care
2. Lack of health insurance
3. Cost of health care
4. Mental health
5. Prescription medicine too expensive
6. Lack of transportation to health care services
7. Drug abuse - prescription medications
8. Cancer
9. Obesity in adults
10. Lack of supportive services for patients

## What issues do you think may prevent community members from accessing care?

Top ten answers:

1. No insurance and unable to pay for the care
2. Unable to pay co-pays/deductibles
3. Transportation
4. Fear (e.g., not ready to face/discuss health problem)
5. Don't understand the need to see a doctor
6. Unable to use technology to help schedule appointments, find the doctor, etc.
7. Don't know how to find doctors
8. Language barriers
9. Lack of availability of doctors
10. Cultural/religious beliefs

## How important are the following actions in improving the health of Piedmont's communities?

Top 20 answers ranked "most important":

1. Access to low-cost mental health services
2. Access to local inpatient behavioral health
3. Free or affordable health screenings
4. Local outpatient mental health services
5. Additional access points to affordable care within the community
6. Financial assistance for those who qualify
7. Expanded access to specialty physicians
8. Affordable healthy food
9. Services to help physically or developmentally disabled children and adults
10. Safe places to walk/play
11. Community-based health education
12. Community-based programs for health
13. Cancer awareness and prevention
14. Increased social services
15. Opioid awareness and prevention campaigns
16. Transportation for care
17. Substance abuse rehabilitation services
18. Programs to address SDHs
19. Access to dental care services
20. Partnerships with local charitable clinics

### Q What do you think is most helpful well in how Piedmont works with the community?

Answers centered on the following themes:

Health education

Financial assistance program

Support for local charitable services and community partnerships

The Cancer Wellness Program

Continued growth with beds and services

The Walk with a Doc program

Sixty Plus Program

Giving Epic to local clinics

Care coordination services

Breast feeding training for new moms

The community benefit grants program

### Q What do you think is missing in how Piedmont works with the community?

Answers centered on the following themes:

More Piedmont-sponsored low-cost clinics

More visible community involvement, especially with minorities

More outreach and free services for preventative care

Increased access to specialty physicians

More attention to mental health

More attention to opioid and substance abuse

Screenings that are free for community members, especially for cancers

A better system for referring patients to the services they need that are outside the hospital

# PHC stakeholder interviews

As a part of our process, we interviewed 31 statewide key stakeholders and policy makers that represent public health, low-income populations, minorities, chronic conditions, older adults and lawmakers. These interviews were conducted for people representing the entire region, including Muscogee County. Answers carried certain themes. Below is a summary of comments.

## Affordability and access

- Health insurance coverage was identified among almost every interviewee as a key pressing health need, and 84 percent of interviewees felt the hospitals could play a larger role in promoting public policies that could expand coverage (such as Medicaid eligibility expansion) or in promoting local activities to encourage enrollment in existing programs. As one interviewee stated: **"Hospitals tend to wait until the patient shows up sick to consider how that patient can afford their care or if he or she can get coverage. If they supported more outreach for getting coverage, the patient would probably have been able to get care before they were so sick they needed hospital care."**
- Some interviewees suggested programs such as expanded scope of service for nurse practitioners and physician assistants could broaden access to affordable care, as well as the expanded use of telehealth. Each interviewee cited the role that Federally Qualified Health Centers (FQHCs) and low-cost clinics currently play in addressing the needs of uninsured patients, and all encouraged further investment in these organizations through the provision of free labs and imagery and shared EMRs.
- Several interviewees noted the need for increased access to follow up and specialty care for all patients. One patient advocate interviewee stated she fielded questions daily from publicly insured patients who didn't understand how their network worked and uninsured patients who were directed to follow up with a specialist but didn't know who would take them.
- Affordability is a barrier, as many private physicians do not provide financial assistance. As one interviewee stated: **"The patient then just decides they can't get to that specialist and, most likely, their condition gets worse and they are back in the emergency department, sicker and needing even more care now."**
- Almost every interviewee noted transportation issues as a key barrier to access, particularly for older adults and those who are disabled.

## Local investment and care coordination

- Most interviewees stated a need for stronger hospital intervention and investment in local communities. While most acknowledged the positive role Piedmont hospitals currently play in the community, some were critical of how Piedmont handles patients and programs that don't pay well.
- Several interviewees noted the need for Piedmont hospitals, including Columbus Regional, to better coordinate with surrounding rural communities, including the expansion of primary and specialty care physicians into underserved areas, perhaps through the use of telehealth.

## Mental and behavioral health

- Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize the role of behavioral health in diagnoses and make appropriate referrals.
- Interviewees also stated a need for hospital investment in substance abuse, addiction and prevention services, including its own approach to issues like opioid prescriptions, due to the health impacts addiction have on patients.

# PHC stakeholder interviews (continued)

**Social determinants and root causes of poor health**

- All interviewees discussed the role of social determinants of health (SDHs) as a critical issue Piedmont is well-positioned to address. As one interviewee stated: **"Piedmont is... in a great position to create programs and referral systems to help address the underlying issues that many patients face. Piedmont could lead all hospitals in this space."**
- Some interviewees noted that SDHs are issues that impact everyone, and are a key cost driver due to the role SDHs play in preventing people from staying well.
- Most interviewees felt that the issues facing our community members were not just solely the responsibility of the hospital, but all acknowledged the outsized role hospitals can play in triggering and sustaining long-term positive change, particularly when working in partnerships with others in the community.

# CHNA approval

This community health needs assessment was unanimously approved by the Piedmont Columbus Regional Board of Directors on June 06, 2019. The CHNA implementation strategy was unanimously approved October 03, 2019.

# Methodology

The Piedmont Columbus Regional CHNA was led by the Piedmont Healthcare community benefits team, with significant input and direction from Piedmont Columbus leadership, including the hospital's community outreach team.

**Process**

The CHNA started first with a definition of our community. We looked at our entire Piedmont Healthcare service region, which spans the majority of the state. We paid particular attention to the home counties of our hospitals, which is reflected in the individual hospital CHNAs, including this one, due to the impact of our tax-exempt status. Generally, nonprofit hospitals do not pay four types of taxes: property, state and local income, sales and use, and bond financing. Of these, property taxes make up the largest segment of a hospital's tax exemption – about one-quarter. Because of this, we want to ensure that we are providing commiserate benefit to our local community. Additionally, we take into consideration patient origin, and especially that of our lower-income patients, such as those who qualify for financial assistance or receive insurance coverage through Medicaid.

Once we established our primary community, we then conducted an analysis of available public health data. This included resources from: US Census, US Health and Human Services' Community Health Status Indicators, US Department of Agriculture, Economic Research Service, National Center for Education Statistics, Kaiser Family Foundation's State Health Facts, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2017, unless otherwise noted. Health indicators are estimates provided by County Health Rankings and hospital data was provided by the hospital.

An internal survey was also conducted throughout the healthcare system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Nearly 900 employees spanning the system responded. Additionally, we conducted a community-based survey in which local stakeholders were asked their thoughts on unmet community health needs and the hospital's role in addressing those needs. These stakeholders included local leaders, nonprofit representatives, elected officials and those with a unique knowledge of the challenges vulnerable populations face.

In March 2019, the Piedmont Columbus community outreach team convened a meeting of key stakeholders to discuss health challenges and needs in the local community. Among the 47 stakeholders present were representatives from MercyMed of Columbus charitable clinic, Valley Healthcare System, the Muscogee County School District, the Muscogee County Health Department and Columbus Consolidated Government. The goal of this meeting was to establish community consensus on top unmet health needs the hospital should address.

Finally, we conducted direct interviews with 31 state and regional stakeholders and policymakers, with each representing a specific group that tends to be adversely impacted by issues of health equity. These groups included but are not limited to: Georgians for a Healthy Future, Georgia Watch, ConsiderHealth, the Community Foundation for Greater Atlanta, the Georgia Charitable Care Network, the Medical Association of Georgia and Healthy Mothers, Healthy Babies.

**How we determined our priorities**

Several key community health needs emerged during the assessment process. The priorities to be addressed were recommended by the community benefit department with significant input from hospital, board leadership and the community. The following criteria were used to establish our priorities:

- The number of persons affected;
- The seriousness of the issue;
- Community recommendations;
- Whether the health need particularly affected persons living in poverty or reflected health disparities; and,
- Availability of community and/or hospital resources to address the need.

The priorities we chose reflected a collective agreement on what hospital leadership, staff and the community felt was most important and within our ability to positively impact the issue. While the priorities reflect clinical access and certain conditions, all priorities will be viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race.

**About community benefit**

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These programs increase access to health care and improve community health, with a focus on vulnerable populations, such as those that are low-income, uninsured, underinsured, those with chronic conditions, the disabled, the elderly and any others who face additional barriers and health inequity. This CHNA will guide Piedmont's upcoming community benefit work.

**Piedmont Columbus Regional**
**CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022**

On October 03, 2019, Piedmont Columbus' board of directors approved the hospital's community health needs assessment, which measured the relative health and well-being of our community. Through this process, we identified key health priorities we'll address over the next three fiscal years. This below strategy was developed to address those identified priorities.

| **Priority: Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes** | | | |
|---|---|---|---|
| **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<br>• Patients are adequately alerted that financial assistance is available<br>• Patients are given tools, resources and ample opportunity to apply for assistance<br>• Eligibility threshold of 300 percent Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals<br>• Actively screen all potential patients for Medicaid coverage | • Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes<br>• Consistent policy administered throughout PHC |
| Local efforts to increase access to care are strengthened and grown | Provide funding to support specific programs of not-for-profit organizations who provide direct physical and/or mental health services to low-income patients | • Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service<br>• Areas can include primary and specialty care, transportation to and from physical and | • Goals of funded programs are to be determined by the individual organizations and approved by PHC and PCR<br>• Progress evaluated by PHC and PCR every six months |

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| | | mental health appointments and the provision of mental healthcare | |
| Future health workers are trained | Provide health professions education to students as to further build the health workforce | • Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate | Regularly monitor program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth |
| Patients and their families have meaningful input in their care | Utilize a patient and family advisory council to provide meaningful input on key areas of care | • Regularly convene approximately 10 to 15 advisors comprised of patients, their families and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers<br>• Set specific scope and goal of council, which could include internal initiatives to improve patient care and quality | Evaluation tactics to be determined by specific goals of council |
| Patients have an increased awareness of local resources | Provide resource guide of state and local health-related services and other relevant information to vulnerable community members | • Update guide annually<br>• Publish online and in print<br>• Distribute widely throughout hospital and community | Annual distribution number of guides 10 percent year over year increase for FY20 to FY22 (approximately 5.5K distributed throughout the Columbus County community in FY19) |
| Community has ongoing healthcare resources available where our most vulnerable patients are | Improve access to healthcare by conducting health education sessions at various high-risk identified in the CHNA | Utilizing the mobile unit, create monthly rotation schedules to include blood pressure checks, stroke, diabetes, cancer and opioid education to schools, faith-based organizations, housing areas and other community organizations | Track current outreach, aim to increase by 7 to 10 percent annually |

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| Low- and no-income patients have access to community-based healthcare | Utilize mobile unit clinic team which includes a family practice resident, pharmacy resident and registered nurse to conduct weekly clinics instead of monthly clinics to reduce emergency admissions | • Conduct weekly clinics at Safe House and Valley (alternating locations) to provide medical care to homeless population<br>• Partner with key staff members at each location (i.e. case workers) to help establish a continuum of care plan for the individuals<br>• Hire a LCSW to assist with navigation of community resources | • Increase number of patients seen by 15 percent (current patient load is 27 to 33 patients monthly)<br>• Schedule quarterly mobile unit steering committee meetings to review best practices for patient population. |

| **Priority: Reduce opioid and related substance abuse and overdose deaths** | | | |
|---|---|---|---|
| **Vision** | **Goal** | **Tactics** | **How to measure** |
| Hospital-based prescriptions for opioids and related drugs are reduced | Patients are at low risk of misusing opioids | • Track opioid prescribing by hospital and physician<br>• Use Epic EMR to provide caregivers with tools to monitor opioid use<br>• Offer patients ways to safely dispose of unused medication<br>• Provide ongoing education on opioid prescribing | Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach |
| Patients are supported in recovery from their opioid addiction | All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery | • Develop relationships with community resources to which patients can be transitioned | Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are |

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| | | • Make these community resources known and available to our caregivers | increased, measured by program participation and qualitative measures |
| Opioid addiction is viewed as a disease | All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma | • Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction<br>• Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities | Regularly monitor percentage of PHC employees who report that they view opioid use disorders as a medical condition, free of stigma are increased, measured by qualitative mechanisms |
| Hospital-based prescriptions for opioids and related drugs are reduced | PHC adopts and uses appropriate non-opioid pain management strategies | • Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont<br>• Offer multi-modal pain module to caregivers to provide options for opioid in treating pain<br>• Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy) | Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies |
| Community-based efforts to curb opioid addiction and overdose deaths are increased | PCR provides meaningful leadership in its community by partnering with others in combating opioid abuse | • Serve as leaders in community-based programs to address opioid abuse and addiction<br>• Support community-based strategies to combat opioid abuse through partnerships and task forces | • Measure general community awareness of opioid use by charting what resources and partnerships are active now, with a goal to increase those year over year |

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| Local efforts to decrease opioid abuse and overdose deaths are increased | Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients | • Issue of a notice of available funding to all communities soliciting grant applications to curb opioid addiction and overdose deaths<br>• Award annual funding based on merit of application and group's ability to positively impact issue<br>• Monitor grant progress | • Goals of funded programs are to be determined by the individual organizations and approved by PHC and PCR<br>• Progress evaluated by PHC and PCR every six months |
| Community members are more familiar with identifying addiction and local resources to help support recovery | Create and widely distribute an opioid-centric Georgia-based resource guide | • Develop an eight- to ten-page guide to address issues of opioid use and prevention<br>• Print and distribute guide throughout Piedmont communities and to patients | Aim for initial communitywide distribution of 1,500 copies locally, to be increased 15 percent year over year |

| **Priority: Decrease deaths from cancer and increase access to cancer programming for those with living the disease** | | | |
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| **Vision** | **Goal** | **Tactics** | **How to measure** |
| High-risk community members receive lung cancer screenings | Increase local awareness of and 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<br>• Increase CT scans for CMS-defined heavy smokers<br>• Increase early identification of suspicious nodules and thereby increase early cancer detection | • Measure current awareness by availability of local resources and a survey of local messaging<br>• Utilizing FY19 figures, aim to increase CT scans for heavy smokers, general community<br>• Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members |

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| | | • Understanding low-income populations are more likely to smoke, continue mechanism for referrals for CT scans heavy smokers from partner clinic | and others who may face particular issue accessing the health system |
| Cancer prevention and screenings to the Hispanic/Latino community is increased | Reduce cultural barriers to cancer prevention and education for Hispanic/Latino community | • Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods<br>• Engage staff to identify cultural barriers<br>• Work with utilize best practices for engaging the Hispanic/Latino<br>• Identify community agencies/organizations that work with the Latino communities<br>• Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, early detection and education | • Establish baseline of current activities<br>• Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year<br>• Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys |
| More community members are screened for cancer | Overcome challenges of barriers to screenings and Increase cancer screenings for colorectal, prostate and skin cancer | • Identify community partners who can help provide necessary outreach and messaging<br>• Establish a mechanism for screenings<br>• Establish a mechanism for appropriate follow-up care that takes insurance status, income and other barriers, such as transportation, into consideration<br>• Utilize mobile van unit to provide cancer awareness to high-risk community members, including direct consultation by cancer nurse navigators | • Establish baseline of current activities<br>• Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year<br>• Monitor outreach effectiveness through qualitative methods, including interviews and surveys |

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| Fewer students vape | Lead a school-based education program to reduce instances of vaping among school-age children | • Visit schools to educate children on the dangers of vaping<br>• Provide guidance to educators on the dangers of vaping and how to identify and eradicate vaping among students<br>• Target all efforts to those most at-risk for vaping | Utilize school-reported data on prevalence of smoking among students, which could include student self-reported data |

| **Priority: Decrease the impact of and deaths from stroke** | | | |
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| **Vision** | **Goal** | **Tactics** | **How to measure** |
| Community-based stroke survival rates are increased | Increase EMS as the preferred mode of transportation by 10 percent over the next three years | Increase community knowledge of signs and symptoms with emphasis on "T" for time in the stroke survival campaign of F.A.S.T. (Facial drooping, Arm weakness, Speech difficulties and Time to call emergency services) | Monitor participation, with aim to increase year over year |

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| Public is alerted to risks and ways to reduce harm from stroke | Create public service announcements aimed at reaching at-risk populations on various health topics | • Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the general public, in appropriate languages<br>• Distribute via social media, community partners, Piedmont.org website, community events<br>• Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy | • Establish baseline of current messaging<br>• Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year |
| Primary Stroke Center designation is maintained; local community members are aware of stroke risks and are appropriately screened | Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain stroke certification, community awareness | Provide education and screenings to community members, with a focus on those most at-risk, as identified in our CHNA | • Establish baseline of current outreach, aim for an increase year over year<br>• Measure efficacy of program through qualitative mechanisms (surveys and other participant feedback) |
| Stroke education and outreach to the Hispanic/Latino community is increased | Reduce cultural barriers to stroke prevention and education for Hispanic/Latino community | • Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods<br>• Work with utilize best practices for engaging the Hispanic/Latino community<br>• Identify community agencies/organizations that work with the Latino communities<br>• Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, early detection and education | • Establish baseline of current activities<br>• Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year<br>• Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys |

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| | | • Utilize website, social media, community partners to distribute information | |

| Priority: Reduce rates of obesity and increase access to healthy foods and recreational activities | | | |
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| **Vision** | **Goal** | **Tactics** | **How to measure** |
| Low-income community members know how to shop for and prepare healthy foods on limited budgets | Create a Cooking Matters program in partnership with charitable clinics, FQHCs and/or other community-based groups who regularly work with low-income populations, as to combat obesity and promote healthy eating | • Using current blueprint, design and execute programming for healthy eating and shopping for families utilizing food stamps or have limited food budgets, and in consideration of conditions such as heart disease, diabetes and obesity<br>• Recruit patients for a four-week, four-session hour-long program that includes a trip to a convenient and affordable grocery store to learn how to best shop and read labels to encourage healthy eating<br>• Potentially partner with local food banks to ensure ongoing access to healthy foods | • Monitor participation through attendance logs<br>• Monitor effectiveness through qualitative surveys and participant interviews<br>• Continually seek out ways to improve programming |
| Support food access to low-income children | Support healthy food access for low-income children | In partnership with local schools, support efforts to ensure that low-income children have access to healthy foods both during the school year and in times when school is not in session | Will develop ongoing, specific measurement tactics to ensure program effectiveness and evaluate opportunities for growth and improvement |

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| Support healthy eating for high-risk community members | Convene local task force to evaluate tactics to support local fresh eating, which could include a fresh prescription vouchers for low-income patients, increased partnerships with local food banks | • In partnership with relevant community-based groups, determine scope of programming, eligibility requirements<br>• Design program<br>• Deploy initial programming<br>• Continually monitor for issues, areas to improve | Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement |

| **Priority: Decrease preventable instances of diabetes and decrease the number of patients with uncontrolled diabetes** | | | |
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| **Vision** | **Goal** | **Tactics** | **How to measure** |
| Community members are able to self-manage their diabetes | Increase the number of Outpatient Diabetes Self-Management Education attendees | Increase marketing and outreach initiatives to local and regional medical practices, community health departments, faith-based organizations, and others to promote/increase awareness of educational resources | Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve programming |

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| Community members are able to self-manage their diabetes | Continue the accredited Diabetes Prevention Program, with a focus on at-risk populations as identified in our CHNA | • Provide ongoing diabetes education includes information on diabetes management, physical activity, medication usage, complication prevention and how to cope with this chronic disease<br>• Provide nutrition education that focuses on food choices and improving blood sugar control<br>• Provide education to reduce negative impact of diabetes reduce heart disease risk factors and improve weight management | Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve programming |
| Community members with diabetes are better able to manage their condition | Incorporate and initiate a glycemic management/ diabetes management rotation with medical and pharmacy residents | Through our health professions education program, provide resident rotations with the glycemic management team as to help medical and pharmacy students gain further insight and application of management strategies and care transition practices, subsequently serving as "Glycemic Champion" for their respective teams | Regularly monitor program through participant feedback; continually seek out ways to improve rotations |

**Health issues we will not actively address as a top identified priority:**

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. These include:

- 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. We will also continue to solicit applications to our community benefit grants program from nonprofits that actively address issues of transportation within the Columbus community.
- 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.
- Alzheimer's disease:  Alzheimer's disease continues to be a leading cause of death in the community. Although this is not a stated priority of the hospital during the FY20 to FY22 community benefit cycle, the hospital will actively support services aimed at patients and families suffering from the disease, and particularly those services offered through our Sixty Plus program.