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

On August 26, 2022, the Piedmont Mountainside board of directors approved the hospital's community health needs assessment (CHNA) implementation strategy, which laid out the tactics and strategies the hospital will undertake over the next three fiscal years to address the health priorities established in the hospital's CHNA.

| **Priority: Increase access points for appropriate and affordable health and dental care** | | | |
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| **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% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals<br>• Actively screen all potentially patients for Medicaid coverage | • Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes<br>• Consistent policy administered throughout PHC |
| Future health professions education to students as to further build the health workforce | Provide health professions education to students to further 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 |

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| Patients and their families have meaningful input in their care | Create a patient and family advisory council to provide meaningful input on key areas of care | • Create a council of approximately 10-15 advisors including patients, family members and caregivers, and staff to apply firsthand knowledge to improve the experience of future patients and caregivers.<br>• Convene first meeting to set the scope and goals of the council, to include internal initiatives to improve patient care and quality | • Yes/no on creation of the council<br>• Additional evaluation tactics to be determined based on the scope and goals set by the council |
| Older adults have increased access to care and community-based resources | Collaborate with community partners to provide improved access to, and better coordination among, existing community resources for the aging population. | • Develop and explore the concept of a principal case worker to coordinate services for the elderly population.<br>• Lead or collaborate in the creation of a business plan as agreed by the collaborators<br>• Explore the capacity if existing programs to meet the needs of vulnerable older adults | • Metrics to be developed with partners and collaborators<br>• Regularly monitor the program for efficacy and opportunities to improve |

| **Priority: Promote mental wellbeing** | | | |
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| **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 | • Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach |

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| | | • Provide ongoing education on opioid prescribing | |
| 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<br>• Make these community resources known and available to our caregivers | • Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are increased, measured by program participation and qualitative measures |
| Community-based efforts to curb opioid addiction and overdose deaths are increased | PMH provides meaningful leadership in its community by partnering with others in combatting opioid abuse | • Promote local prescription take back day activities in partnership with local law enforcement<br>• 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 taskforces | • Monitor attendance for take back day with an aim to increase participation year over year<br>• Measure general community awareness of opioid use by charting what resources and partnerships are active now, with the goal to increase those year over year |
| Mental health services for high risk individuals is strengthened | Support Pickens County Accountability court by ensuring participants within the court have access to care | • Participate in accountability court events<br>• Provide health screenings and education, including appropriate referrals to community-based providers<br>• Provide household and hygiene items to program participants | • Regularly monitor our participation within the court and evaluate opportunities to continually strengthen the partnership |

| Priority: Promote healthy behaviors to reduce preventable instances of chronic conditions | | | |
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| **Vision** | **Goal** | **Tactics** | **How to measure** |
| Women are better able to recover from breast cancer | Support the Thrive Breast Cancer Initiative to provide health needs for uninsured and underinsured breast cancer patients | • Provide information and referrals to all community services for individuals through a hospital-based case management social worker<br>• Regularly explore and implement opportunities to engage community and patients | Monitor referrals and see patient input on services received |
| More community members are screened for cancer | Overcome challenges of barriers to screenings and increase cancer screening awareness through community-based partnerships | • Identify community partners who can help provide necessary outreach and messaging<br>• Establish a mechanism for screening referrals<br>• Establish a mechanism for appropriate follow-up care that takes insurance status, income, and other barriers, such as transportation into consideration.<br>• Explore ways to create free and low-cost mammogram screening programs for uninsured and underinsured women | • Establish a baseline of current activities and partnerships<br>• Measure participation, outreach, and engagement for current new work, aiming for a significant increase year over year<br>• Monitor partnership and outreach effectiveness through qualitative methods |
| Hospital maintains stroke certification through community outreach | Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain ASR DNV certification | • Utilize community events to provide basic health screenings and education on risk factors for stroke and heart disease, BP, and the importance of yearly checkups, including labs.<br>• Provide information in appropriate languages and ensure all messaging is appropriate for lower levels of health literacy | Establish a baseline of current outreach, aiming for an increase year over year |

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| Community members know how to look for heart problems | Increase community outreach to engage local residents in education and screening for cardiovascular problems | • Continue to look for opportunities for community outreach<br>• Ensure all programs and materials are bilingual and are accessible to populations with limited health literacy | Monitor and track education screening results |
| Community members stop smoking | Provide the community with the necessary education and tools to permanently quit smoking | Partner with PAR to provide access to virtual smoking cessation programs | Regularly monitor attendance and participate in self-reported quitting data |
| Support health behaviors through community-based programs | Offer Walk with a Doc programming to community members | At least bi-monthly a Piedmont physician will lead a community-based walking program in which the participating physician will answer general health questions and promote overall wellness | Monitor participation with aim to increase year over year |
| Community-based heart attack survival rates are increased | Provide early Heart Attack Care (EHAC/Hands-only CPR) to community | • Maintain Chest Pain Accreditation<br>• Deploy programming, in partnership with community-based groups and emergency medical services<br>• Provide hands-only CPR to high school students twice a year | Monitor participation, with aim to increase year over year |
| Public is alerted to risks and ways to maintain healthy personal habits | Create CEO delivered public service announcements aimed at reaching at-risk and general populations on various health topics | Continue Denise Ray's "From My Desk to Your Home" letters/postcards for public service announcements. Distribute via direct mail, social media, community partners, community events, and media placements | Establish a baseline of current messaging and measure participation outreach, and engagement for current and new work, aiming for a significant increase year over year |