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

Top 10 answers ranked most important:

1. Access to health care services
2. Access to low-cost mental health service
3. Additional access points to affordable care within the community
4. Access to affordable inpatient behavioral care
5. Affordable healthy food
6. Expanded access to specialty physicians
7. Financial assistance for those who qualify
8. Local outpatient mental health services
9. Safe places to walk/play
10. Transportation for care



What is your vision for a healthy community?

Some answers:

"My vision for a healthy community would be all members having access to equitable healthcare services and transportation to get there."

"Access to affordable health care, healthy eating outlets and safe places for physical activity."

"Access to care and wrap around services."

"Healthcare that people can actually afford."

"Assistance with long term care for people with chronic conditions. They may receive help when in a crisis, but once the crisis is over, they have no follow-up and continued care due to lack of income."

"Access (transportation) to healthcare."



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

Some answers:

"Lack of housing, which creates many health issues."

Health care costs."

"Obesity."

"Not aware of assistance or services that may be available."

"Lack of intensive mental health services."

"Low incomes."

"Transportation is one of the largest barriers for community members."

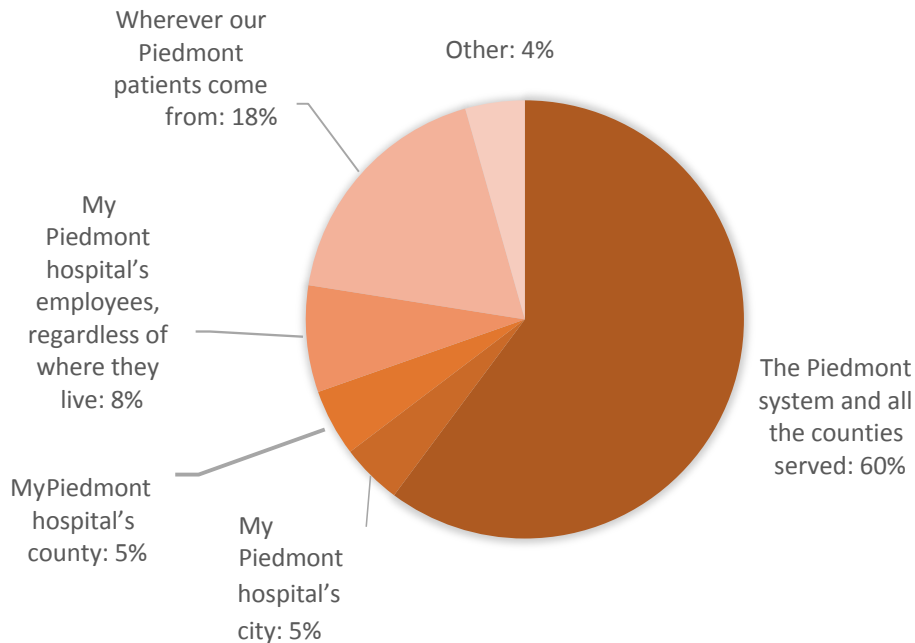
"Affordability of health care."

"Mental health services that are affordable and available to everyone in the community, with ongoing support."

# PHC EMPLOYEE SURVEY

Seventy-four Piedmont Rockdale Hospital 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

# PHC EMPLOYEE SURVEY (continued)

## 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

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# PHC stakeholder interviews

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As a part of our process, we interviewed 31 state and regional stakeholders and policy makers that represent public health, low-income populations, uninsured and uninsured persons, minorities, chronic conditions and older adults, as well elected officials and lawmakers. These interviews were conducted for people representing the entire region, including Rockdale 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 Piedmont Rockdale, 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.

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## PHC stakeholder interviews (continued)

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### 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 interviews 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.

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## CHNA approval

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This community health needs assessment was unanimously approved by the Piedmont Rockdale Hospital Board of Directors on April 18, 2019. The CHNA implementation strategy was unanimously approved October 17, 2019.

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## Methodology

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The Piedmont Rockdale Hospital CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Rockdale Hospital leadership and direct input from board members both at a March 2018 board meeting and through individual meetings with hospital leadership, including the hospital's chief executive officer and chief operating officer.

### 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 equal 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.

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## Methodology (continued)

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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.

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 chosen priorities were recommended by the community benefit department with sign-off from hospital and board leadership. The following criteria were used to establish the priorities:

- The number of persons affected;
- The seriousness of the issue;
- 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. By federal mandate, community benefit programs must:

- Generate a low or negative margin;
- Respond to the needs of vulnerable populations;
- Supply services or programs that would likely be discontinued if the decision to offer this program was made on a purely financial basis;
- Respond to an identified public health need; and/or,
- Involve education or research that improves overall community health.

The CHNA guides Piedmont's community benefit work.

**Piedmont Rockdale Hospital  
CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022**

On October 17, 2019, Piedmont Rockdale's 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.

<b>Priority: Increase access points for appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes</b>			
<b>Vision</b>	<b>Goal</b>	<b>Tactics</b>	<b>How to measure</b>
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	<ul style="list-style-type: none"> <li>• Financial assistance is available for eligible low- and no-income populations</li> <li>• Patients are adequately alerted that financial assistance is available</li> <li>• Patients are given tools, resources and ample opportunity to apply for assistance</li> <li>• Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals</li> <li>• Actively screen all potential patients for Medicaid coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes</li> <li>• Consistent policy administered throughout PHC</li> </ul>
Low- and no-income patients have access to community-based care	Ensure that patients at not-for-profit charitable clinic Mercy Heart have access to the care	<ul style="list-style-type: none"> <li>• Provide certain lab services free of charge to Mercy Heart</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic to provide a quarterly report on how many patients received labs, how many labs were processed, the top twenty labs utilized, trends in patient care, and the number of</li> </ul>



	needed to get – and stay – healthy	<ul style="list-style-type: none"> <li>• Provide Mercy Heart with specialty care physicians regularly at no charge to the clinic or its patients</li> <li>• Continually explore areas for collaboration, including strengthened referral systems between hospital-based case management and the clinic and the provision of read-only rights to Epic electronic medical records for shared patients</li> </ul>	specialty care appointments during that time
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	<ul style="list-style-type: none"> <li>• Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service</li> <li>• Areas can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of mental health care</li> </ul>	<ul style="list-style-type: none"> <li>• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PRH</li> <li>• Progress evaluated by PHC and PRH every six months</li> </ul>
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	Create a patient and family advisory council to provide meaningful input on key areas of care	<ul style="list-style-type: none"> <li>• Create a council of approximately 10 to 15 advisors comprised of patients, their families and other caregivers, as well as staff, who</li> </ul>	<ul style="list-style-type: none"> <li>• Yes/no on creation</li> </ul>

		<p>apply firsthand knowledge to improving the experiences of other patients and caregivers</p> <ul style="list-style-type: none"> <li>• Convene first meeting setting specific scope and goal of council, which could include internal initiatives to improve patient care and quality</li> </ul>	<ul style="list-style-type: none"> <li>• Other evaluation tactics to be determined by specific goals of council</li> </ul>
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	<ul style="list-style-type: none"> <li>• Update guide annually</li> <li>• Publish online and in print</li> <li>• Distribute widely throughout hospital and community</li> </ul>	Annual distribution number of guides 10% year over year increase for FY20 to FY22 (approximately 3.5K distributed throughout Rockdale community in FY19)

**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	<ul style="list-style-type: none"> <li>• Track opioid prescribing by hospital and physician</li> <li>• Use Epic EMR to provide caregivers with tools to monitor opioid use</li> <li>• Offer patients ways to safely dispose of unused medication</li> </ul>	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach

		<ul style="list-style-type: none"> <li>• Provide ongoing education on opioid prescribing</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Develop relationships with community resources to which patients can be transitioned</li> <li>• Make these community resources known and available to our caregivers</li> </ul>	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
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	<ul style="list-style-type: none"> <li>• Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction</li> <li>• Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities</li> </ul>	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	<ul style="list-style-type: none"> <li>• Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont</li> <li>• Offer multi-modal pain module to caregivers to provide options for opioid in treating pain</li> <li>• Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy)</li> </ul>	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies

<p>Community-based efforts to curb opioid addiction and overdose deaths are increased</p>	<p>PRH provides meaningful leadership in its community by partnering with others in combating opioid abuse</p>	<ul style="list-style-type: none"> <li>• Promote local prescription take-back day activities, in partnership with local law enforcement</li> <li>• Serve as leaders in community-based programs to address opioid abuse and addiction</li> <li>• Support community-based strategies to combat opioid abuse through partnerships and task forces</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor attendance for take-back day with an aim to increase participation year over year</li> <li>• 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</li> </ul>
<p>Local efforts to decrease opioid abuse and overdose deaths are increased</p>	<p>Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients</p>	<ul style="list-style-type: none"> <li>• Issue of a notice of available funding to all communities soliciting grant applications to curb opioid addiction and overdose deaths</li> <li>• Award annual funding based on merit of application and group's ability to positively impact issue</li> <li>• Monitor grant progress</li> </ul>	<ul style="list-style-type: none"> <li>• Goals of funded programs are to be determined by the individual organizations and approved by PHC</li> <li>• Progress evaluated by PHC and PRH every six months</li> </ul>
<p>Community members are more familiar with identifying addiction and local resources to help support recovery</p>	<p>Create and widely distribute an opioid-centric Georgia-based resource guide</p>	<ul style="list-style-type: none"> <li>• Develop an eight- to ten-page guide to address issues of opioid use and prevention</li> <li>• Print and distribute guide throughout Piedmont communities and to patients</li> </ul>	<p>Aim for initial community-wide distribution of 1,000 copies, to be increased 15% year over year</p>

**Priority: Decrease deaths from all cancers, with a focus on lung cancer**

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	<ul style="list-style-type: none"> <li>• Create and deploy local awareness campaign on risks, warning signs and early detection for lung cancer, particularly among high-risk groups</li> <li>• Increase CT scans for CMS-defined heavy smokers</li> <li>• Increase early identification of suspicious nodules and thereby increase early cancer detection</li> <li>• Understanding low-income populations are more likely to smoke, create a mechanism for referrals for CT scans CMS-defined heavy smokers from Mercy Heart charitable clinic</li> </ul>	<ul style="list-style-type: none"> <li>• Measure current awareness by availability of local resources and a survey of local messaging</li> <li>• Utilizing FY19 figures, aim to increase CT scans for heavy smokers, general community</li> <li>• Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system</li> </ul>
Low-income community members receive appropriate cancer screenings	Create and provide a free Mammogram Voucher Program (MVP) to underserved and/or underinsured women	Free or reduced-cost mammograms are provided to women that do not have insurance to receive diagnostic care and prevention of breast cancer	<ul style="list-style-type: none"> <li>• Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary mammograms</li> <li>• Solicit foundation and grant support to increase funding, community support</li> </ul>

Cancer prevention education to the Hispanic/Latino community is increased	Reduce cultural barriers to cancer prevention and education for Hispanic/Latino community	<ul style="list-style-type: none"> <li>• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods</li> <li>• Engage staff to identify cultural barriers</li> <li>• Work with utilize best practices for engaging the Hispanic/Latino</li> <li>• Identify community agencies/organizations that work with the Latino communities</li> <li>• Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on education</li> </ul>	<ul style="list-style-type: none"> <li>• Establish baseline of current activities</li> <li>• Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year</li> <li>• Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys</li> </ul>
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**Priority: Promote healthy weights and behaviors as to decrease preventable instances of heart disease and diabetes**

Vision	Goal	Tactics	How to measure
The community comes together to eliminate obesity and support healthy behaviors	Build and engage community-based partnerships to identify and eliminate potential barriers to healthy weights and behaviors	<ul style="list-style-type: none"> <li>• Identify key health and community stakeholders who can represent the local community, including the Rockdale County Health Department, the Rockdale Coalition for Children and Families and the Conyers Housing Authority</li> <li>• Convene stakeholders to identify overlapping and/or related tactics to address issues related to obesity and unhealthy behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• Through designated hospital leader, ensure partnerships are being actively built and cultivated</li> <li>• Specific measurement to be dependent on shared goal</li> </ul>

		<ul style="list-style-type: none"> <li>• Create shared goal(s), develop strategies to achieve goal(s)</li> </ul>	
Low-income community members know how to shop for and prepare healthy foods on limited budgets	Create a Cooking Matters program in partnership with Mercy Heart and/or other community-based groups who regularly work with low-income populations, as to combat obesity and promote healthy eating	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• Potentially partner with local food banks to ensure ongoing access to healthy foods</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor participation through attendance logs</li> <li>• Monitor effectiveness through qualitative surveys and participant interviews</li> <li>• Continually seek out ways to improve programming</li> </ul>
Public is alerted to risks and ways to reduce harm from obesity-related diseases, in including heart disease and diabetes	Create public service announcements aimed at reaching at-risk populations on obesity, healthy weights, diabetes and heart disease	<ul style="list-style-type: none"> <li>• Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the general public, in appropriate languages</li> <li>• Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy</li> </ul>	<ul style="list-style-type: none"> <li>• Establish baseline of current messaging</li> <li>• Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year</li> </ul>

<p>The Hispanic/Latino community has more information on how to maintain healthy weights and behaviors education</p>	<p>Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community</p>	<ul style="list-style-type: none"> <li>• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods</li> <li>• Engage staff to identify cultural barriers</li> <li>• Work with utilize best practices for engaging the Hispanic/Latino</li> <li>• Identify community agencies/organizations that work with the Latino communities</li> <li>• Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on education</li> </ul>	<ul style="list-style-type: none"> <li>• Establish baseline of current activities</li> <li>• Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year</li> <li>• Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys</li> </ul>
<p>Low-income community members have access to healthier foods</p>	<p>Deploy a fresh prescription program for low-income patients in which we provide vouchers for healthy foods at a local Farmer's Market or food bank</p>	<ul style="list-style-type: none"> <li>• Determine relevant partners and scope of programming, eligibility requirements (potential: partnership with Mercy Heart and local food bank; will help to ensure food bank has access to healthy foods)</li> <li>• Design program</li> <li>• Deploy initial programming and monitor for issues, areas to improve</li> </ul>	<ul style="list-style-type: none"> <li>• Utilizing an initial pilot model for a fixed duration of time, we will evaluate program for efficacy, challenges, opportunities</li> <li>• With partners, determine next best steps and ways to sustainably scale program</li> </ul>



## 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 Rockdale 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, including our efforts to curb smoking within the community.
- 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.