Piedmont Columbus Regional

CHNA Implementation Strategy – Fiscal Years 2023, 2024 and 2025

On October 05, 2022, the board of directors for Piedmont Columbus Regional Midtown Campus and Northside Campus 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: Decrease preventable instances of diabetes and decrease the number of patients with uncontrolled diabetes			
Vision	**Goal**	**Tactic**	**How to measure**
Community members can safely and more effectively manage their diabetes	Increased awareness and community participation in Diabetes Prevention and Outpatient Diabetes Self-Management Education initiatives	Increase marketing and outreach, through traditional communication modes and social media outlets, to include local and regional medical practices, community health departments, faith-based organizations, and others	Regularly monitor program and outreach effectiveness through qualitative surveys, participant interviews, and pre- and post-program assessments
Community members can safely and more effectively manage their diabetes	Increased focus with continuation of Diabetes Prevention Program accreditation and services, with a focus on at-risk populations	Provide prediabetes, diabetes, and cardiovascular disease risk reduction education with an emphasis on lifestyle modification through improved nutrition practices, physical activity, appropriate medication usage, stress management, and coping with chronic disease	Regularly monitor program and outreach effectiveness through qualitative surveys, participant interviews, pre and post program assessments, and review of laboratory trending (when applicable)

Community members are able to safely and more effectively manage their diabetes	Incorporation of a glycemic/ diabetes management clinical rotation with medical, nursing, dietetics, and pharmacy residents and students	Through our health professions education program, provide precepting opportunities and clinical rotations with glycemic management services to expose preceptees to key concepts related to treatment, management strategies, care transition practices, and risk reduction for both acute and chronic complications associated with prediabetes, diabetes, obesity, and dyslipidemia	Regularly monitor program and outreach effectiveness through program participation/growth, qualitative surveys, participant interviews, pre- and post-program assessments

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
High-risk community members receive prostate cancer screenings.	Increase local awareness of and local opportunities for prostate cancer screening services.	Partner with local community, civic and faith-based organizations to educate on early detection for those that are considered high risk.	• Measure current awareness by availability of local resources and a survey of local messaging. • Create a database spreadsheet to track education, screenings, and community partners • Monitor positive results and continually improve referral process for follow-up care, particularly for men that are high

High-risk community members receive colorectal cancer screenings	Increase local awareness of and local opportunities for colorectal cancer screening	• Continue to partner with local community healthcare facilities, senior centers, and civic organizations • Continue to educate on the importance of getting screened at the appropriate screening age • Engage previous participants to continue to get screening and encourage other to be screened	• Measure current awareness by availability of local resources and a survey of local messaging • Utilizing data from FY22 to increase our goal by 10% • Monitor and follow-up on positive results, particularly for those that are high risk
Cancer prevention and screenings to the Hispanic/Latino and African American community is increased	Increase local awareness of and local opportunities for cancer screenings within those targeted communities	• Continue to partner with local community healthcare facilities, senior centers, faith-based and civic organizations, and Hispanic Outreach Committee • Continue to educate on the importance of prevention and screening at the appropriate age • Engage previous participants to continue to get screening and encourage other to be screened	• Establish baseline of current activities • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year • Monitor outreach effectiveness through qualitative methods, including interviews and surveys
Promote the breast cancer support group to those that are newly diagnosed and survivors	Increase the number of newly diagnosed breast cancer patients and survivors	• Create a new patient orientation class to include those new diagnosed • Continue to reach out to current breast cancer patients to participate in the support group • Promote fun engaging activities and include speakers • Allow survivors to facilitate sessions	• Create participant sign-in sheet and ask if newly diagnosed or survivor • Create a survey to solicit input on activities, speakers, and discussions for future sessions

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 • Provide guidance to educators on the dangers of vaping and how to identify and eradicate vaping among students • 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			
Vision	**Goal**	**Tactics**	**How to measure**
Community-bases stroke survival rates are increased	Increase the percentage of patients arriving within the treatment window for acute stroke therapy.	Increase community knowledge and awareness of the B.E. F.A.S.T. acronym, which is meant to remind us to act quickly when a stroke is suspected	Monitor participation, with aim to increase year over year
Public is alerted to risks and ways to reduce disability from stroke	Local community members are aware of stroke risks and are appropriately screened	Provide stroke educational materials and screenings to community members at health fairs and community events, with focus on the most at-risk, as identified in our CHNA	• Establish baseline of current activities and outreach, with aim to increase year over year. • Measure participation and efficacy of outreach through qualitative mechanisms (surveys and other participant feedback)

Primary Plus Stroke Center (PSC+) designation is achieved and maintained	Increase the referral rate for hospitals requiring advanced stroke care for their patients	Increase community awareness of the PSC+ capabilities by providing hospitals and EMS outreach to the extended service area to include 17 surrounding counties	Establish a baseline of current referral network, with aim to increase year over year.

Priority: Ensure affordable access to health, mental and dental care for all community members, and especially those that are low income and/or uninsured			
Vision	**Goal**	**Tactics**	**How to measure**
Low- and no-income patients receive assistance for necessary care.	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program.	• Financial assistance is available for eligible low- and no-income populations. • Patients are adequately alerted that financial assistance is available. • Patients are given tools, resources and ample opportunity to apply for assistance. • Eligibility threshold of 300 percent Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals. • Actively screen all potential patients for Medicaid coverage.	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes. • Consistent policy administered throughout PHC.
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 vape education to schools, faith-based organizations, housing areas and other community organizations.	Track current outreach, aim to increase by 5 to 10 percent annually.
Low- and no-income patients have access to	Utilize mobile unit clinic team which includes a family practice resident,	• Conduct weekly clinics at Safe House and Valley (alternating locations) to provide medical care to homeless population.	• Increase number of patients seen by 10% (current patient load is 25-30 patients monthly)

community-based healthcare.	pharmacy resident, and registered nurse to conduct weekly clinics instead of monthly clinics to reduce emergency admissions.	• Partner with key staff members at each location (i.e., case workers) to help establish and continuum of care plan for individuals • LCSW will assist with recruitment and navigation of patients at new clinical site (Safe House Victory)	• Work to increase patients at new location by 5% to 10% • Schedule quarterly mobile unit steering committee meetings to review best practices for patient population
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 and opportunities for growth.

Priority: Reduce rates of obesity and increase access to healthy foods and recreational activities			
Vision	**Goal**	**Tactics**	**How to measure**
Support food access to low-income children and families.	Support healthy food access for low-income children and families	• 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. • Continue to serve on Muscogee County Wellness Committee focusing on providing health, nutrition, and physical activity opportunities for families.	Develop ongoing, specific measurement tactics to ensure program effectiveness and evaluate opportunities for growth and improvement.
Support healthy eating for high-risk community members.	Convene local task force to evaluate tactics to support local fresh eating, including fresh prescription vouchers and increased partnerships with local food banks for low-income patients.	• Establish partnership with the Mobile Food Van to join PCR Mobile Unit during weekly clinics to provide fresh fruits and vegetables to targeted populations identified in the CHNA offering discounts for using their SNAP benefits while providing health education and conducting blood pressure screenings. • Establish an onsite PCR Mobile Pantry for patients to receive fresh prescription vouchers.	Develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement.