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

On October 19, 2022, Piedmont Walton Hospital's board of directors approved the hospital's community health needs assessment 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: Ensure affordable access to health, mental and dental care			
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% 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
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 • 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 PWH

		mental health appointments and the provision of mental health care"	• Progress evaluated by PHC and PWH every six months
Low-income patients have access to community-based care	Provide funding support for a full-time nurse practitioner to treat low-income, uninsured patients	Continue to provide funding for a full-time nurse practitioner working at local charitable clinic F.I.S.H. Medical and Dental Clinic	Regularly monitor program and patient data to evaluate program for effectiveness and opportunities for growth
• Future health workers are trained • Students in the community are aware of the different careers available in healthcare and decide to pursue a healthcare career	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 • Allow college students to volunteer in our College Volunteer program each semester • Host behind-the-scenes tours with high school students • Provide speakers at school career days with various healthcare professions to expose students to the many careers in healthcare	• Regularly monitor the program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth. • Track the opportunities provided along with the number of attendees at each • Track the number of volunteers and hours served every semester. Monitor to see if there is opportunity for growth in the program • Track the tours and number of attendees • Track these events and number of students involved
Patients and their families have meaningful input in their care	Create a mechanism for patient and family members to provide meaningful input on key areas of care	• Regularly solicit feedback of patients and their families, and especially those who have filed a grievance or complaint through Patient Experience • • Begin bedside rounding with leadership and care team	• Yes/No on if the hospital is regularly soliciting this feedback and utilizing opportunities to connect patients and families to internal leadership groups

			• Monitor and record any shifts, changes, or actions because of patient and family involvement.
Pathways to Excellence designation is maintained	Maintain Pathways to Excellence Designation		Track community events
Local community members have access to trauma services	Maintain Level III Trauma Center designation	• Participate in regional disaster management plans and exercises • Provide continuous general surgical coverage	Regularly monitor program and evaluate opportunities for improvement

Priority: Promote healthy behaviors to reduce preventable conditions, diseases, and addiction			
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 • Use Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients ways to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program and activities to compare 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	• Actively refer patients presenting at the hospital with opioid disorders to appropriate community-based care • Develop relationships with community resources to which patients can be transitioned	Regularly monitor referral program through staff feedback, continually looking for opportunities to increase referral partners and improve internal processes

		• Make these community resources known and available to our caregivers	
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 • 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 • 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 protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PWH 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 • Support community-based strategies to combat opioid abuse through partnerships and task forces • Promote local prescription take-back day activities, in partnership with local law enforcement and public health • Publicize locations to dispose of opioid medications in the community	• 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 • Track prescription take-backs and aim for an outreach increase of 7% to 10% year-over-year
More community members stop smoking	Provide the community the necessary education and tools to permanently quit smoking	• Identify team members who can assist with facilitating ongoing smoking cessation classes to help community members permanently quit • Promote free, virtual smoking cessation	• Regularly monitor attendance and participant self-reported quitting data • Regularly monitor attendance and participant self-reported quitting data

		classes (provided by Piedmont Athens) that are open to patients system-wide • Promote Lung Cancer Awareness Month in November • Provide general community awareness on tobacco's role in lung cancer and continually seek out opportunities to engage those populations at highest risk for smoking due to socioeconomic issues such as income and education level	• Regularly monitor opportunities
Reduce tobacco use and its deadly consequences in local youth population	Offer educational outreach opportunities in the schools on the dangers of smoking and vaping	• Utilizing evidence-based messaging, create an age-appropriate anti-smoking and vaping presentation • Partner with local principals to identify interest in elementary, middle, and high schools • Stroke, respiratory, and ICU leaders become certified smoking cessation educators	Regularly evaluate program to determine interest, participation, and opportunities for improvement across grade levels

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
High-risk community members receive lung cancer screening referrals	Increase local awareness of and local opportunities for lung cancer screenings	• Increase local awareness on risks, warning signs and early detection for lung cancer, particularly among high-risk groups • Increase referral CT scans for CMS-defined heavy smokers • Increase early identification of suspicious nodules and thereby increase early cancer detection • Provide lung cancer screenings for minorities in the community • Understanding low-income populations are more likely to smoke, continue mechanism for referrals for CMS-defined CT scans heavy smokers from partner clinic	• Measure awareness by availability of local resources and survey of local messaging • Track referral data, aiming to increase CT scan referrals for heavy smokers, general community • Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face significant problems accessing the health system • Track number of screenings provided to minorities year-over-year • F.I.S.H. MD to provide quarterly referral figures to hospital
More community members stop smoking	Provide the community the necessary education and tools to permanently quit smoking	• Identify team members who can assist with facilitating ongoing smoking cessation classes to help community members permanently quit • Promote free, virtual smoking cessation classes (provided by Piedmont Athens) that are open to patients system-wide	• Regularly monitor attendance and participant self-reported quitting data • Regularly monitor attendance and participant self-reported quitting data • Regularly monitor opportunities

		• Provide general community awareness on tobacco's role in lung cancer and continually seek out opportunities to engage those populations at highest risk for smoking due to socioeconomic issues such as income and education level	
Cancer prevention and screenings to the minorities in the community is increased	Reduce cultural barriers to cancer prevention and education for minorities in the community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Engage staff to identify cultural barriers • Promote Breast Cancer Awareness Month in October • Identify and collaborate with community agencies/organizations that work with minorities in the community • Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on screening, early detection, and education, with appropriate referrals	• Establish baseline of current activities • Monitor through interviews and surveys • Monitor output of activities and measure participation, outreach, and engagement, aiming or a significant increase year-over-year
More community members are screened for cancer and it's detected earlier	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 • Establish a mechanism for screening referrals • Establish a mechanism for appropriate follow-up care that takes insurance status, income, and other barriers, such as transportation, into consideration	• Establish baseline of current activities and partnerships • Measure participation, outreach, and engagement for current and new work, aiming for a significant increase year-over-year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys"

		• Create and provide a free and/or low-cost mammogram screening program for underserved and/or underinsured women	• Solicit foundation and grant support to increase funding, community support
Community members with cancer, caregivers and survivors have necessary social support	Restart cancer support group services	• Identify team members who can assist with facilitating support group and explore opportunities to partner with independent oncologists in the community • Establish how the support group will function • Explore ways to draw awareness to support group and connect members with any needed resources in the community	• Establish a cancer support group to meet monthly • •Measure participation and effectiveness through survey

Priority: Reduce preventable instances and death from heart disease			
Vision	**Goal**	**Tactics**	**How to measure**
Support healthy behaviors through community-based programming	Provide Walk with a Doc programming to community members	Each month, a Piedmont physician will lead a community-based walking program in which the doctor will also answer general health questions and promote overall healthiness	Track attendance and regularly solicit feedback from community members on way to improve programming
Community-based heart attack survival rates are increased	Provide Early Heart Attack Care (EHAC) and Hands-only CPR free of charge as to reduce the impact and potential death from heart and stroke-related issues	• Maintain Chest Pain Accreditation • Deploy programming, in partnership with community-based groups and emergency medical services • 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 reduce harm from heart disease, hypertension, and stroke	Create public service announcements aimed at reaching at-risk populations on various health topics	• Utilizing evidence-based messaging, create and deploy local public service announcements aimed at high-risk populations and the public, in appropriate languages • Distribute via social media, community partners, piedmont.org website, community events • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	• Establish baseline of current messaging • Measure participation, outreach, and engagement for current and new work, aiming for significant increase year-over-year
Designated Remote Treatment Stroke Center designation is maintained; local community members	Offer stroke awareness educational materials, blood pressure screenings and BMI screenings at health fairs and	• Stroke education is provided to local EMS and paramedics • Two stroke educational classes are taught quarterly to staff	• Establish baseline of current outreach, aim for an increase year-over-year

are aware of heart risks and area appropriately screened	community events to maintain stroke certification	• Promote Heart Month in February • Utilize community events to provide basic health screenings and education on risk factors for stroke and heart disease, blood pressure and BMI screenings; recommend local primary care physician, if the patient does not have one; will utilize community-based partnerships, including those with charitable clinics, to target high-risk populations	• Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)
Heart disease education and outreach to the minorities in the community is increased	Reduce cultural barriers to heart disease prevention and education for minorities in the community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Work to utilize best practices for engaging the minorities in the community • Identify community agencies/organizations that work with the minorities in the community • Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on screening education, early detection, and education • Utilize website, social media, community partners to distribute information	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach, and engagement, aiming for a significant increase year-over-year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys • Establish baseline of current activities
Community members can self-manage their weight and/or weight-related issues	Conduct group education sessions and support programs to help patients learn and manage weight-related issues	Provide ongoing weight education and support opportunities, including classes and programming targeted specifically to those with weight-related conditions, such as Type II diabetes	Regularly monitor effectiveness through participant feedback and continually seek out ways to improve programming