

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

On September 12, 2022, Piedmont Henry Hospital’s 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: 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	<ul style="list-style-type: none"> • 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 potentially patients for Medicaid coverage 	<ul style="list-style-type: none"> • Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income Henry County patients have access to community-based care	Support Hands of Hope charitable clinic through the provision of free services	<ul style="list-style-type: none"> • Provide diagnostics and other services currently provided for patients of Hands of Hope, including bloodwork, x-rays, CT scans, 	Review the relationship each quarter to identify any issues, opportunities for growth

		<p>echocardiograms, MRIs, stress tests, wound care, physical therapy, and diabetes education classes</p> <ul style="list-style-type: none"> • Provide clinical and office space on site for clinic at no charge 	
Appropriate patients referred to “Operation Walk”	Participate in Operation Walk in collaboration with Hands of Hope and local surgeon	Support Operation Walk USA, which provides free joint replacement surgeries	Review the relationship each quarter to identify any issues, opportunities for growth
Patients have an increased awareness of local resources	Local community members are aware of local resources through website information widely distributed throughout hospital and community	Provide resource website information to vulnerable community members	Begin distribution through Care Management personnel and admissions personnel; aim for a 10% year-over-year increase for FY23-FY25
Low-income populations have access to specialty care	Develop a program to identify high-risk, low-income patients, who present to the ED and have a health need that will require ongoing care; address issues with patient, including placement in an appropriate care setting; work with registration to complete FA forms	Create a program, for low-income patients, that utilizes Care Management staff to work with high-risk, low-income patients who have presented to the ED with a condition that will need ongoing care	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities for growth

Priority: Reduce preventable instances and death from cancer

Vision	Goal	Tactics	How to measure
More community members receive cancer screenings	Promote both the prevention and treatment of breast and lung cancers especially among those most vulnerable to the disease	Community screenings in collaboration with community partners	Number of attendees
More community members stop smoking	Support smoking cessation by providing tools and education to all community members	<ul style="list-style-type: none"> • Assess patients for tobacco abuse upon admission; when smoking is confirmed upon admission, patient receives smoking cessation information upon discharge • Provide information on online smoking cessation classes to help community members permanently quit • Engage with GA Tobacco quit line to order smoking cessation brochures to be distributed to patients 	Track how many patient materials are provided to at Piedmont Henry
More women are screened for breast cancer	Low-income community women receive appropriate cancer screenings through community-based partnerships	Collaborate with Henry County Health Department and Hands of Hope Clinic to provide free and/or low-cost mammogram screening program for underserved and/or underinsured women	<ul style="list-style-type: none"> • Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary mammograms • Solicit Foundation and grant support to increase funding and community support

High-risk community members receive lung cancer screenings	CMS-defined heavy smokers are actively referred to CT scans	<ul style="list-style-type: none"> • Increase local awareness of low-cost options available to those without insurance or ability to pay for lung cancer screening • Increase CT scans for smokers; increase early identification of suspicious nodules and thereby increase early cancer detection 	<ul style="list-style-type: none"> • Measure current awareness by availability of local resources and a survey of local messaging • Utilize previous year data with aim to increase number of CT scans for heavy smokers
Appropriate follow-up care and referrals for all with any indication of lung cancer	Patients identified with lung cancer of appropriately referred	Educate and give referral information to local primary care and pulmonology providers	Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face issue accessing the health system

Priority: Promote healthy behaviors to reduce preventable chronic conditions and diseases

Vision	Goal	Tactics	How to measure
Patient health will improve reducing readmissions	Provide health education to patients promoting healthy behaviors and encourage avoidance of risky behaviors	Nurses provide information on discharge	Through Epic, monitor number of patients who receive information on discharge
Patient medication is properly managed	Develop medication historian program	<ul style="list-style-type: none"> • Implement a new medication historian program, where specially trained staff work with patients and family to identify all the patient's home medications and dosages, working with the patient's pharmacy for 	Regularly monitor participation, with a goal of 75% of admitted patients having had the medication historian assist with medication reconciliation

		<p>clarifications when the patient/family are unsure</p> <ul style="list-style-type: none"> Uncover duplications, medication errors and misinformation or misunderstanding by the patient for how to take their medications 	
Community members are educated on the behaviors that impact their lives	Provide health education and programming promoting healthy behaviors and encourage community members to avoid risky behaviors such as smoking, exercise, and obesity	Partner with Hands of Hope to host free health fairs Educate the residents of Henry County on Trauma Prevention through health fairs and educational learnings at local businesses	Monitor attendance and aim for annual increases in participation

Priority: Reduce preventable instances and death from heart disease

Vision	Goal	Tactics	How to measure
Fewer community members die from heart disease	To promote both prevention and treatment of heart disease emphasizing early detection and healthy behaviors to reduce risk	<ul style="list-style-type: none"> Emergency department providers diuresis the patient and discharge the patient from the ED to a same day or next day appointment with the cardiologist who will see and modify the patients' medications to address fluid overload PHH emergency department providers work directly with Atlanta Heart providers to manage heart failure patients presenting to the ED, whereby the patient often can be managed as an outpatient 	Number of patients referred to Atlanta Heart

Community members have the tools to recover from a heart attack	Patients taught how to rebuild their strength and maximize their quality of life after a heart attack	Offer cardiopulmonary rehab for patients recovering from heart attacks	Number of patients referred to cardiopulmonary rehab
Better tools to support heart health are in place	Ensure availability of state-of-the-art cardiac CT equipment in the community	Invest in a \$2.2M cardiac CT scanner to ensure that patients in our community have the best access to high quality cardiac imaging	Number of patients referred for heart CT
Patients can better recover from heart attacks	Use a 24/7 STEMI program to support heart recovery	Provide a 24/7 STEMI program to all regardless of ability to pay, as to support revascularization of the heart muscle where patients can be discharged from the facility	Track attempts for revascularization in heart attack (STEMI) patients, success rate