

**Piedmont Macon Medical Center and Piedmont Macon North Hospital
CHNA Implementation Strategy – Fiscal Years 2023, 2024, and 2025**

On September 26, 2022, the board of directors for Piedmont Macon Medical Center and Piedmont Macon North Hospital 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-income, uninsured working community members have access to necessary lab and radiology	Increase lab and radiology services to working uninsured patients	Continue to provide increased access for lab and radiology services for working uninsured patients through partnership with Macon Volunteer Clinic	Clinic to provide a quarterly report on how many patients received lab and radiology services

services			
Patients have access to community-based care, including specialty services through the Community Health Care Systems (FQHC)	Increase access for patients - especially low-income patients - to community-based care, including specialty services through the FQHC, Community Health Care Systems	<ul style="list-style-type: none"> • Support the FQHC clinic with the Piedmont Macon Internal Medicine Residency Program, equipment, equipment maintenance, and resident fees • Appropriate Emergency Room and Hospital patients without PCP are offered FQHC options at discharge • Evaluate expansion of subspecialty services at CHCS and design system to better connect patients to current resources • Evaluate imaging need for uninsured patients and consider adding a similar contract to MVC 	<ul style="list-style-type: none"> • Regularly monitor program, readmission rates and patient data to evaluate program for effectiveness, opportunities for growth • Utilize staff member feedback to create stronger mechanisms for support • Next available appointment for establishing care and hospital follow up • Next available appt for mental health with therapist
Utilization of local resources is increased	Increase awareness of local health resources	<ul style="list-style-type: none"> • Provide resource guide of state and local health-related services and other relevant information to vulnerable community members • Publish online, digital (QR code) and in print • Distribute widely throughout hospital and community 	Annual distribution number of guides to equal 1.5K distributed throughout the Macon community each year
At-risk patients have access to care close to home	Provide at-risk patients access to community-based care, possibly through a community partnership	<ul style="list-style-type: none"> • Explore opportunities to provide place-based care, such as a mobile unit targeting high risk patients • Evaluate and create project plan to provide place based, which could include utilizing the CHNA to determine locations to focus efforts, such as public housing; consider best way to provide care; create appropriate referral and 	Metrics and evaluation would be dependent on programming

		follow-up information mechanisms; consider utilizing GME residents/teleconsults as well	
Extend access to care and treat mental health problems in the homeless population	Increase access to mental health care for the homeless population	Psychiatry residents provide free psychiatric care once per week at the Daybreak homeless shelter	Total number of patients served and visits at clinic
Vulnerable patients will have greater access to dental services	Support the local public health department with their efforts to provide dental care to vulnerable/low -income community members	<ul style="list-style-type: none"> • Explore funding for dental providers; consider loan forgiveness programs, build relationships with dental schools • Explore state dental care • Consider grants • Continue and expand relationship with Macon Volunteer Clinic which does provide some dental care 	<ul style="list-style-type: none"> • Number of providers available at dental clinic • Number of patients seen in one year at dental clinic
More community members are supported through common groups	<ul style="list-style-type: none"> • Provide support through facility led support groups for mental health and stroke • Evaluate the need for infant mortality group 	<ul style="list-style-type: none"> • Provide/facilitate professional led support groups for mental health, addiction, and grief • Begin stroke support group for patients and caregivers who have had stroke and those currently in rehabilitation recovering from a stroke • Evaluate the need for infant mortality group; find a leader for this group 	<ul style="list-style-type: none"> • Track number of offered support opportunities • Track attendance at stroke meetings including current patients and if they return post discharge

Priority: Promote healthy behaviors to reduce preventable conditions, diseases, and addiction

Vision	Goal	Tactics	How to measure
Public is alerted to risks and ways to reduce harm from heart disease, hypertension, and stroke	Reach and educate at-risk populations on various health topics	<ul style="list-style-type: none"> Utilizing evidence-based messaging, create and deploy local public service announcements aimed at high-risk populations and the public Distribute via social media, community partners, Piedmont.org website, community events Ensure all programming and relevant materials are accessible to populations with limited health literacy 	<ul style="list-style-type: none"> Establish baseline of current messaging Measure participation, outreach, and engagement for current and new work, aiming for a significant increase year over year
Community members have the tools to get - and stay - healthy; families have the tools to make behavior changes that lead to healthier weights	Provide ongoing education, training, and support to community members to help them manage their weight and weight-related conditions	<ul style="list-style-type: none"> Provide on-going classes on healthy eating and making positive lifestyle changes Provide cooking classes through the health educator Consider building/supporting a community garden partner with local schools to provide education 	Will monitor and track education results
Low-income community members have access to healthy foods	Connect eligible families to Supplemental Nutrition Assistance Program (SNAP) benefits	<ul style="list-style-type: none"> Connect eligible families to Supplemental Nutrition Assistance Program (SNAP) benefits Consider providing funding support for a SNAP navigator at FQHC to assist patients through application process Support Meals on Wheels program aimed at 	<ul style="list-style-type: none"> Aim for a decrease in SNAP-eligible participants that don't receive that support year over year for three years Will track through clinic referral and

		those with no transportation	approval records
Community-based efforts to curb opioid addiction and overdose deaths are increased	Provide meaningful leadership in our community by partnering with others in combating opioid abuse	<ul style="list-style-type: none"> • 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 • 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 • Support local DEA-approved prescription drug take-back days through partnership and patient awareness • Provide/facilitate access to life saving reversal agents 	Measure take-back day participation, creating a baseline from FY23 activities, and aim to increase local awareness and involvement year over year
Community has access to support needed to combat chronic diseases	Provide a Center for Chronic Disease Education and Management with a dedicated space and health educators to provide education on chronic diseases prevalent in middle Georgia including diabetes, elevated cholesterol, heart disease, cancer, and obesity	<ul style="list-style-type: none"> • Develop plan for space and staff • Begin with one health educator to lead the efforts • Create a space for educational materials and classes including group and one-on-one classes for education on diseases/disorders 	Monitor and track classes, groups, services provided
Low-income and/or high-risk community members have relevant information on chronic diseases	Identify and support low-income and/or high-risk community members at risk for chronic disease through	<ul style="list-style-type: none"> • Provide place-based prevention education, chronic disease management education, screenings, and referrals to health and social services 	Set target number of people reached, using current baseline metrics, and aim for an increase in both number of people reach (10% to 15%) and

	increased screening, education, and referrals for relevant programming	<ul style="list-style-type: none"> • Provide education and referrals for patients/clients of strategic community partners • Education and referral provided to local night shift workers, in partnership with employers 	strategic locations targeted (one to two) year over year
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Priority: Prevention and treatment of heart disease

Vision	Goal	Tactics	How to measure
Community members with high risk will engage in healthier behaviors to reduce risk	Identify patients, specifically women, with high-risk profiles through chest pain education clinics and help reduce risk through education and tools	<ul style="list-style-type: none"> • Identify patients with a high-risk profile through clinics partnerships • Provide education in follow up from clinics • Initiate heart walk with education • Identify and use risk stratification tools for follow ups 	<ul style="list-style-type: none"> • Risk assessment score monitoring • Utilize PHC systems for tracking purposes
More community members are aware of stroke signs and risks	<ul style="list-style-type: none"> • Educate at risk populations on the risk of stroke through educational materials and blood pressure screenings at health fairs and community events • Ensure local EMS providers are educated to recognize signs of a stroke 	<ul style="list-style-type: none"> • Provide stroke education to local EMS and paramedics • Offer two stroke educational classes monthly with slots open to outside medical facilities • Provide materials and screenings at local health fairs 	<ul style="list-style-type: none"> • Establish baseline of current outreach, aim for an increase year over year • Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)

	<ul style="list-style-type: none"> Annual Stroke Designation is maintained 		
More community members survive a heart attack	Increase heart attack recognition and prevention	<ul style="list-style-type: none"> Provide community education through physician forums Partner with the AHA to increase community awareness and educate on heart disease Participate in AHA Heart Walk each year to support their local efforts towards education and prevention 	Track number of educational opportunities offered and participation
Low-income populations are more likely to survive a heart attack	Identify and support high risk and low-income patients for prevention of sudden cardiac arrest due to arrhythmias	<ul style="list-style-type: none"> HPA Agreement Identify population selection Provide training and education along with physician practices 	Track patients that were eligible for HPA
More community members survive a heart attack	<ul style="list-style-type: none"> Increase public awareness of and capability of AEDS by educating and servicing existing AEDs in our community Assess the need for additional equipment and seek funding 	<ul style="list-style-type: none"> Identify business, institutional needs Initiate funding Deploy and educate Work with SCARE partners 	<ul style="list-style-type: none"> Number of locations and personnel trained on existing equipment Number of new locations identified and equipment provided
Improve physician access in the field to ensure more appropriate treatment in the moment for rural communities	Extend EMS access to physicians for urgent interpretation and support of patients with cardiac events by increasing access to Lifenet service	<ul style="list-style-type: none"> Identify need for rural areas and volunteer EMS services (Heartland) Determine funding to assist in license or extending from PMM Physician support Deploy and educate 	Track STEMI door to balloon time for improvement in process
Improve early warning for CHF changes and decrease	Improve awareness and reduce need for hospitalization due to	<ul style="list-style-type: none"> Identify population Identify funding/partners 	Monitor readmissions for CHF

hospitalization by visiting the office	heart failure management challenges	<ul style="list-style-type: none"> • Provide CHF kit: scale, tape measure, blood pressure monitor, education pamphlet, symptoms, and weight log 	
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Priority: Reduce preventable instances of and death from cancer			
Vision	Goal	Tactics	How to measure
Patients are aware of hospital-based services that can support their recovery	Increase awareness of nurse navigator services throughout the community, including physicians, nurses, residents, nursing students, hospital staff and patients	<ul style="list-style-type: none"> • Oncology NN; work and participate in local or regional coalitions (RCCG) • Engage/ provide education to residents, physicians and PMM/PMM staff on NN role to ensure patients are made aware of services • Do this by attending quarterly GME meetings, nursing student post-clinical debrief sessions, and monthly staff orientation • Adding to computer monitor screen savers and placing NN brochures in patient traffic areas • Offer education to the community regarding NN role in care, specifically to underserved communities by going to programs such as Daybreak, Salvation Army, Macon Volunteer Program, and local churches 	<ul style="list-style-type: none"> • Track number of patients seen year over year • Track number of NN brochures utilized within the hospital • Track number of participants attending information sessions held within the hospital for residents, nursing students, and hospital staff • Track number of NN information events held in the community as well as number of participants

<p>More patients are diagnosed with cancer earlier, leading to better outcomes</p>	<p>Increase availability of screening for four primary cancers: breast, lung, prostate, and colon Increase knowledge through education for patients and providers via various media about national guidelines for screening and ways to diminish cancer risk</p>	<ul style="list-style-type: none"> • Provide an annual day of free/reduced cost screening for each of the four primary cancers at both campuses, along with identified partners in the community, such as Radiology Associates of Macon for reduced cost of reading fee • Explore/partner with area nursing or respiratory therapy students to help at screenings • Remind/educate providers and patients about screenings covered under Affordable Care Act • Provide screening guidelines/awareness info flyers to PCP's and their patients • Participate in community health fairs (businesses, colleges, churches) to provide ed about screening guidelines/availability and cancer risk factors/risk-mitigating strategies (tobacco cessation, HPV vaccination, weight management, dietary changes) w/ referral to community resources for care • Develop relationship w/community resources for underserved pts listed above to publicize screening events/provide info • Explore development of Parish Nurse program alongside local pastor group • Explore access to mobile mammography 	<ul style="list-style-type: none"> • Track number of referrals and mammograms provided, creating a baseline from FY21 figures • Aim for increase year over year • Monitor referrals/participation for lung, prostate, and colon, creating increase in numbers seen for screening year over year
<p>Genetic counseling and testing help patients understand their risk for</p>	<p>Increase awareness and offer high-risk screenings and genetic counseling and testing to the</p>	<ul style="list-style-type: none"> • Identify and offer high-risk screenings and genetic counseling and testing to patients at higher risk for developing cancer based on 	<p>Track # of referrals for genetic counseling/testing, with increase year over year</p>

<p>cancer, take appropriate steps</p>	<p>community, resulting in an increase of clients who are counseled and tested</p>	<p>personal or family history to diminish risk through earlier screening and prophylactic measures for patients identified through genetic counseling and testing</p> <ul style="list-style-type: none"> • Educate PCP offices on the referral process and distribute contact information for genetic counseling services 	
<p>Cancer patients and their families have necessary support for recovery and well-being</p>	<ul style="list-style-type: none"> • Provide comprehensive, evidence-based psychosocial support for cancer patients and their families • Increase timely referrals to PC to support patients and their families • Integrate Palliative Care in the continuum of cancer care 	<ul style="list-style-type: none"> • Educate patient/families/medical providers to palliative care • hard-wire PC consults and care plan as ordered by physician into inpatient EMR as identified by working sub-committee • Identify criteria to be used to trigger referrals to PC services • Work with local Pastoral Care Group to educate on PC and local community resources • Refer to community therapists that are no cost/low cost • Give attention to spiritual needs as identified by the customer • Develop/expand bereavement support group • Partner with Caregiver Support Group • Explore the need for full-time FT FTE SW/therapist 	<ul style="list-style-type: none"> • Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness
<p>Fewer community members smoke or vape</p>	<p>Provide to the community the necessary education and tools to permanently quit smoking and vaping</p>	<ul style="list-style-type: none"> • Market and offer "Courage to Quit" tobacco cessation classes via WebEx via PAR's program • Offer information and access to the Georgia 	<ul style="list-style-type: none"> • Gather and provide needed data per Just Ask study guidelines throughout the year • Track number of participants who

		<p>Tobacco Quit hotline</p> <ul style="list-style-type: none"> • Offer school and community-based education for teens, parents, and other members of the community about the risk of using tobacco products as well as providing information/access to smoking cessation • Participate in Just Ask initiative to reduce tobacco/smoking • Reminders to PCPs to capture smoking/vaping data in EMR at time of clinic visit • Partner with area college/ university to support the cause • Attend local sporting events to increase awareness of risks of using tobacco / vaping products 	<p>attend school and community-based events as well as tracking number of brochures given out</p>
<p>More people can physically access care</p>	<p>Support transportation services to necessary oncology care</p>	<ul style="list-style-type: none"> • Look for aid in transportation to cancer care appointments for low-income patients, in partnership with community-based transportation providers • Work with area businesses to donate MTA low-cost transportation vouchers and LYFT services • Partner with community churches to utilize their parish buses/vans 1-2 days every few months to bring parish members to doctor appointments 	<p>Track transportation services and regularly evaluate mechanisms to improve services</p>