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

On October 20, 2022, Piedmont Rockdale 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**
Eligible patients will receive financial assistance	Ensure eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program for access to care	• 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 is available for eligible low- and no-income populations	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Eligible patients will receive care (medical & dental) at no	Ensure that patients at not-for-profit local charitable clinic,	• Provide certain lab services free of charge to Mercy Heart	• Clinic will provide quarterly reports on how many patients received labs,

cost through Mercy Heart services through continued coordination between the hospital and Mercy Heart	Mercy Heart, have access to the care needed and available through this resource	• Provide Mercy Heart with specialty care physicians regularly at no charge to the clinic or its patients • Continually explore areas for collaboration and support including strengthening referral systems between hospital-based care management and the clinic and the provision of read-only right to EPIC electronic medical records for shared patients	how many labs were processed, the top twenty labs utilized, trends in patient care, and the number of specialty care appointments during that period • Additional data and information will be shared for measurement purposes as needed
Support provided will help other community-based organizations provide needed services to the population in need	Support local efforts to increase access to care by providing funding support for specific programs or not-for-profit organizations who provide direct physical and/or mental health services to low-income patients	• Provide funding or any other type of support to community-based non-profit organizations that work to increase access to care for vulnerable populations through direct service • Support can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of medical, dental, or mental services	• Goals to measure of funded programs are to be determined by the individual organization and approved by PHC and PRH • Progress to be evaluated by PHC and PRH every six months
Create more access to care through the support and development of programs to grow the healthcare workforce in the community	Strengthen access to care through the support of education to health profession students to further build the healthcare workforce	• Continue to provide health education opportunities within the hospital through affiliations with various training/school programs in the area, and grow services when possible and appropriate • Support partnership with Athens Tech and Piedmont Walton/Newton to start a nursing program focused on attracting students in the local area, and further partnership with Georgia Piedmont Technical College all aimed at increasing students entering healthcare professions and providing workforce	• Regularly monitor programs through touch point meetings and evaluating available data on students to assess effectiveness of programs and any opportunities for growth or expansion

		placement after graduation • Grow opportunities for students to volunteer and gain first-hand knowledge in the healthcare field	
Input to help guide services and decisions	Develop a patient and family advisory council to provide meaningful input on key areas of care and need	• Develop council of approximately 10 to 15 advisors comprised of patients, their families, and other caregivers, as well as staff, who apply firsthand knowledge to improve the experience for other patients and caregivers • Convene first meeting in-person or virtually to set specific scope and goal of council, which could include internal initiatives to improve patient care and quality	Evaluation will be based on goals created through the council
Vulnerable community members will be provided information on services close to their home as needed	Provide resource information including state and local health-related services, and other relevant information to vulnerable community members	• Update information annually • Provide detailed and printed information to patients in need upon discharge for needed services • Information to be accessed and provided at any time including those that may call the hospital for information	Evaluate process to ensure information is distributed regularly

	Priority: Promote healthy behaviors to reduce preventable conditions, diseases, and addictions		
Vision	**Goal**	**Tactics**	**How to measure**
The community comes together to reduce preventable conditions and promote healthy behaviors	Build and engage community-based partnerships to identify and eliminate potential barriers around health, disease, and addictions	• Identify key health and community stakeholders who can represent the local community, including local governmental agencies, the Rockdale Health Department, the Rockdale Coalition for Children and Families and the Conyers Housing Authority • Convene stakeholders to identify overlapping and/or related tactics to address issues related to preventable conditions • Create shared goals, develop strategies to achieve goals	• Through designated hospital leader, ensure partnerships are being actively built and cultivated • Specific measurement to be determined based on shared goals
Direct support and/or participation is provided to community level events	Provide direct support and promotion of healthy behaviors at community level events through hospital and physician partners	• Between hospital and physician partners, work to ensure participation and support occurs for any community level events where there is an opportunity to promote healthy behaviors or provide resources • Ensure appropriate staff is involved in planning or implementing community events to further enhance the ability to participate • Develop goals and strategies for each potential event to ensure objectives are clear and are met	• Monitor participation in identified community level events and review for effectiveness • Continually look for ways to enhance or improve outreach through a variety of internal resources
Public is alerted to risks and ways to reduce preventable conditions	Create public service announcements with community partners aimed to promote	• Utilizing community partners and knowledge, create and deploy local public service announcements aimed at high-risk	• Establish baseline of current messaging • Measure participation, outreach,

	healthy behaviors and reduce preventable conditions	populations and the public, in appropriate languages • Identify opportunities to use the Rockdale County TV channel to deliver messaging • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	and engagement for current and new work
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 of Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients methods to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program activities around 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	• Develop relationships with community resources to which patients can be transitioned • Make these community resources known and available to caregivers	• Monitor patients with an opioid use disorder and are referred to treatment or support • Evaluate effectiveness of programs through qualitative measures
Hospital-based prescriptions for opioids and related drugs are reduced	Use of appropriate non-opioid pain management strategies	• Implement Enhanced Recovery After Surgery (ERAS) • Offer multimodal pain module to caregivers to provide options for opioid in treating pain • Create support for exploring other non-opioid pain management therapies	Regularly monitor non-opioid pain management strategies throughout the hospital, increasing non-opioid pain protocols and therapies
Community-based efforts to reduce opioid addiction and	PRH provides meaningful leadership in the community by	• Promote local prescription take-back day activities, in partnership with local law	Regularly monitor non-opioid pain management strategies throughout the

| overdose deaths are increased | partnering with others in combating opioid abuse | enforcement
• Support community-based programs to address opioid abuse and addiction through partnerships and task forces
• Explore partnership with Rockdale County and the Stepping Up Initiative as it is developed to determine its ability to serve as a transitional resource for those with addiction disorders | hospital, increasing non-opioid pain protocols and therapies |

Priority: Reduce preventable instances of and death from cancer			
Vision	**Goal**	**Tactics**	**How to measure**
Free or reduced-cost mammograms are provided to women that do not have insurance to receive diagnostic care and prevention of breast cancer and certain lab services are provided at aligned events	Provide options for low-income community members receive appropriate to receive appropriate cancer screenings	• Provide a free Mammogram Voucher Program (MVP) to underserved and/or underinsured women • Provide certain lab screenings for community members are health fairs • Support Kim's Closet, which provides free wigs to underserved/uninsured patients and provides prosthetics, gift bags with port pillows, blankets, and other items for cancer patients	• Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary mammograms • Solicit foundation and grant support to increase funding, community support
Awareness and access is improved specifically around lung cancer for those in high-risk and vulnerable groups	Increase awareness and access to lung cancer screening for high-risk community members	• Continue to partner with Piedmont Pulmonology group and their outpatient practice in the community • Develop local awareness of risks, warning signs, and early detection for lung cancer, particularly among high-risk groups • Ensure access for CT scans for high-risk groups • Increase early identification of suspicious nodules and thereby early cancer detection • Coordinate with Mercy Heart to ensure patients seen there have access to appropriate care for lung cancer • Provide free smoking cessation classes for community members	• Participate in community opportunities to spread education and awareness • Track lung cancer CT screening volume • Continually improve methods of access and referrals for low-income or high-risk groups

Access to Oncology services and therapies are available in the community, and specifically to low-income and high-risk populations	Continue to grow access through Oncology practice and supportive chemotherapy and infusion services	• Recruit additional Oncologist for practice • Ensure all navigator and other supportive staff services are provided to coordinate access and care • Ensure hospital provides the necessary chemotherapy and infusion services to cancer patients and access is available • Coordinate with Mercy Heart to ensure patients seen there have access through Piedmont Oncology services	• Track volumes and growth of Oncology practice and infusion services • Continually to evaluate to ensure local services are meeting the needs of the community
Cancer prevention education to the Hispanic/Latino community is increased	Reduce cultural barriers to cancer prevention and education for the Hispanic/Latino community	• Identify opportunities to improve/enhance delivery methods to the Hispanic/Latino community • Identify community agencies/organizations that work with the Hispanic/Latino community • Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on education • Engage with Spanish-speaking providers and staff that see a larger number of Hispanic/Latino community members to discover opportunities and other best practices	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach and engagement, and work to increase this year over year • Monitor partnership and outreach effectiveness

Priority: Reduce preventable instances and death from heart disease			
Vision	**Goal**	**Tactics**	**How to measure**
The community comes together to reduce heart disease and promote healthy behaviors	Build and engage community-based partnerships to identify and eliminate potential barriers to healthy behaviors promoting a reduction in heart disease	• Identify key health and community stakeholders who can represent the local community, including the Rockdale Health Department, the Rockdale Coalition for Children and Families and the Conyers Housing Authority • Convene stakeholders to identify overlapping and/or related tactics to address issues related to heart disease and unhealthy behaviors • Create shared goals, develop strategies to achieve goals	• Through designated hospital leader, ensure partnerships are being actively built and cultivated • Specific measurement to be determined based on shared goal
Outreach and education is provided to at-risk populations through services provided	Ensure appropriate outreach and education is provided through the various cardiology and vascular services provided	• Through services provided by Piedmont Heart & Vascular, Heart Failure Clinic, Cardiac Cath Lab & Rehab services, bring stakeholders together to plan outreach and education activities needed in the community • Utilize connections with at-risk patients to provide outreach and education on healthy behaviors • Partner across services to provide community support through health fairs or other community events that may align with objectives	• Monitor programmatic outreach activities through Piedmont cardiology and vascular services to ensure effectiveness • Measure community outcomes and identify methods to enhance or modify activities
Community education is provided to a variety of	Provide support and outreach to existing community efforts that	• Support Living Well Rockdale through the Stronger Business Stronger You virtual lunch &	• Through designated hospital leader, ensure partnerships are being

groups about healthy behaviors and methods to reduce heart disease	will help promote healthy behaviors and reduction in heart disease	learns. Monthly lunch & learns focus on many aspects of health, habits to promote health, nutrition, and overall well-being • Support the Rockdale Eats a Rainbow Program: each Wednesday, a demonstration is held at the public library on how to eat the color of the week. The community is invited to cook from home, while fact sheets, recipes, crafts, and more are held at the library • Explore Summer Canning Class where participants learn to make and preserve their own products • Support the area UGA Extension Services that may align with a goal of reducing heart disease and promoting healthy lifestyles • Potentially partner with local food banks to ensure ongoing access to healthy foods • Partner with Mercy Heart and/or other community-based groups who are regularly working with low-income populations to combat obesity and promote healthy eating (cooking classes, healthy shopping, etc.) • Provide community education on diabetes management and heart disease management • Identify other opportunities as they arise through ongoing relationships and engagement with community partners	actively built and cultivated • Track outreach through education provided by hospital dieticians, diabetes educator, and staff form dietary services • Track outreach activities through attendance logs and to identify desired outcomes and effectiveness of programs • Continually seeks ways to improve programs and tracking
Public is alerted to risks and ways to reduce harm obesity-related diseases such as heart	Create public service announcements with community partners aimed at	• Utilizing community partners and knowledge, create and deploy local public service announcements aimed at high-risk	• Establish baseline of current messaging • Measure participation, outreach,

disease	reaching at-risk populations on obesity, healthy weights, diabetes, and heart disease	populations and the public, in appropriate languages • Identify opportunities to use the Rockdale County TV channel to deliver messaging • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	and engagement for current and new work
The Hispanic/Latino community will have more information on how to maintain healthy weights and behavior education	Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community	• Assess effectiveness of current services and identify cultural barriers and opportunities to improve/enhance delivery methods • Identify community agencies/organizations that work with the Latino communities for engagement • Coordinate with community stakeholders/partners on promotional health fairs and cultural events with a focus on education	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach, and engagement • Monitor partnership and outreach effectiveness through qualitative methods
Low-income community members will have access to healthier foods	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	• Determine relevant partners and scope of programming, eligibility requirements (Potential: partnership with Mercy Heart and local food bank; will help ensure food bank has access to healthy foods) • Design program • Deploy initial programming and monitor for issues, areas to improve	• Utilizing a pilot model for a fixed duration of time, evaluate program for efficacy, challenges, opportunities • With partners, determine next best steps and ways to sustainably scale program