



2019

Community Health Needs
Assessment



ST. MARY'S
Good Samaritan HospitalSM

A Member of Trinity Health



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GOOD SAMARITAN HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT 2019

Executive Summary

Community Health Needs Assessments (CHNA) are produced to identify and prioritize health needs, and to present relevant resources to address those needs within our community. This CHNA used a comprehensive mixed-methods approach with the latest available data on health outcomes and behaviors, demographics of the community, healthcare supply, and healthcare utilization.

Under the Affordable Care Act (ACA), nonprofit hospitals are required to conduct these assessments every three years to submit to the Internal Revenue Service (IRS). In addition to the assessment, an Implementation Strategy is required, detailing the hospital's plan to address the identified health needs.

The 2019 St. Mary's Health Care System's Community Health Needs Assessment (CHNA) was produced to satisfy the requirements of Section 501(r) of the IRS code for three St. Mary's Health Care System hospitals: St. Mary's, Good Samaritan, and Sacred Heart.



This report presents data on the five county region served by Good Samaritan Hospital and accomplishes three CHNA goals: 1) Identifying Health Needs; 2) Prioritization of Needs; 3) Presentation of Community Health Resources. Data collection and analysis resulted in identification of the top ten health needs presented below, with their respective prioritization scores.

2019 CHNA Scores for the Top Ten Health Needs

- | | | | |
|---|-------------------------------------|----|------------------------------|
| 1 | Cardiovascular Health (216) | 6 | Reproductive Health (193) |
| 2 | Nutrition & Physical Activity (209) | 7 | Cerebrovascular Health (177) |
| 3 | Behavioral Health (208) | 8 | Cancer (172) |
| 4 | Maternal & Child Health (204) | 9 | Respiratory Health (159) |
| 5 | Healthcare Access (194) | 10 | Injuries & Accidents (133) |

MOVING FORWARD

In January 2019, a research team from the College of Public Health at the University of Georgia partnered with St. Mary's Health Care System and the J.W. Fanning Institute for Leadership to produce the 2019 CHNA for the 17 county region served by the system's three hospitals. This study defines health broadly, and applies the social determinants of health model to assess regional health from a population perspective, looking also at the impact of where people live, work, and play on their health outcomes.

The result is a robust understanding of health and its determinants for the population as a whole, but also for vulnerable sub-populations. Special attention was given to analyzing and presenting health disparities where observable for low income families, racial and ethnic minorities, and rural residents, among others. The result is a deeper understanding of the challenges and strengths in our community, which will be used to design the implementation strategy for Good Samaritan Hospital and St. Mary's Healthcare System and their approach to community benefits for the next three years.

INTRODUCTION



INTRODUCTION

ABOUT

St. Mary's Health Care System is a not-for-profit Catholic health care ministry whose mission is to be a compassionate healing presence in the communities we serve. Founded in 1906 and now a member of Trinity Health, St. Mary's focuses on neurosciences, cardiac care, orthopedics, general medicine/general surgery, women's health, and gastroenterology. Services include emergency care, intensive care, stroke care, cardiac catheterization, home health care/hospice services, inpatient and outpatient rehabilitation, assisted living, Alzheimer's/dementia care, preventive care, state-of-the-art diagnostic and therapeutic services and a growing network of physician practices.

Georgia's Large Hospital of the Year in 2006, 2010, 2015 and 2018, St. Mary's is an accredited Chest Pain Center with Primary PCI, a gold-plus hospital for stroke care, and has received the Joint Commission Gold Seal of Approval™ for advanced primary stroke care, advanced inpatient diabetes, heart failure care, knee and hip replacement, spine surgery, and COPD.

MISSION

We, St. Mary's Health Care System and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

VISION

As a mission-driven, innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most trusted health partner for life.

VALUES

Reverence - We honor the sacredness and dignity of every person.

Justice - We foster right relationships to promote the common good, including sustainability of the Earth.

Commitment to Those Who Are Poor - We stand with and serve those who are poor, especially those most vulnerable.

Stewardship - We honor our heritage and hold ourselves accountable for the human, financial, and natural resources entrusted to our care.

Integrity - We are faithful to who we say we are.

Health Facilities Owned & Operated by Trinity Health

Trinity Health owns and operates three separate hospitals in the St. Mary's Healthcare System, the largest being St. Mary's Hospital in Athens-Clarke County. Good Samaritan Hospital is the smallest campus in the system serving the five county service area detailed in this report. Below is a list of each hospital campus, its location, and the number of beds at each facility.

Facility	Location	Number of Beds
St. Mary's Hospital	Athens, GA (Clarke County)	196
Good Samaritan Hospital	Greensboro, GA (Greene County)	25
Sacred Heart Hospital	Lavonia, GA (Franklin County)	56

Services Provided by St. Mary's Good Samaritan Hospital

Emergency Department

St. Mary's Good Samaritan Hospital offers 24/7 Emergency Department with rapid, on-site diagnostic, laboratory and treatment capabilities for medical emergencies, including stroke and heart attack. Partnering with the Georgia Regents University REACH telestroke program, we provide leading-edge emergency stroke treatment right here.

Inpatient and Swing Bed Program

As a state-of-the-art critical access hospital with 25 private patient rooms, staff cares for acute care as well as swing bed patients. Highly skilled healthcare professionals take care of acute care as well as the swing bed patients. The Swing Bed Program is developed to provide patients with a short-term rehabilitative therapy which will help the patient ease from acute care to home or other residential living arrangements.

Surgery

St. Mary's Good Samaritan Hospital is dedicated to providing high quality health care and continues to embrace leading-edge technologies to fulfill its mission. Good Samaritan offers a wide range of general surgeries with some procedures utilizing minimally invasive-laparoscopic equipment. Procedures in urology, gynecology, orthopedics, podiatry, and gastroenterology are offered as well.

Imaging & Laboratory

From fast 64-slice CT scanning and laboratory testing for stroke patients to routine annual mammograms and blood testing. Imaging capabilities include CT, MRI, echocardiography, stress testing, nuclear medicine, 3D mammography, ultrasound and bone density testing. Laboratory services offers a full range of laboratory testing services, from routine blood-work to the diagnosis of pathogens and cancers, and is accredited by the College of American Pathologists (CAP) and State of Georgia.

Hospitalists

The hospitalist group provides the oversight of inpatient care and utilizes consults specialized hospitalist services in neurosciences and cardiology.

Rehabilitation Services

St. Mary's Good Samaritan Hospital provides a comprehensive rehabilitative care to help our patients maximize their recovery. One-on-one services are available to transition a patient on an inpatient, Swing Bed or outpatient basis for a variety of surgical and nonsurgical orthopedic and neurological conditions. Good Samaritan offers physical therapy, occupational therapy, and speech therapy.

Medical Group

St. Mary's Medical Group provides a growing continuum of medical practitioners to enhance access to care across the entire region. In addition to primary care (internal medicine and family medicine) and pediatrics, SMMG provides specialized care in cardiology, endocrinology, general surgery, industrial medicine, infectious disease, neurology, OB/GYN and rheumatology.

Graduate Medical Education

Partnering with the Augusta University/University of Georgia Medical Partnership, St. Mary's is the participating site for the Internal Medicine Residency Program, Northeast Georgia's first graduate medical education program. Up to 33 physician residents provide supervised care with increasing levels of independence as the final stage of their medical education. The program is designed to address Georgia's physician shortage and attract new doctors to our region.

Spiritual Care

As part of the St. Mary's Health Care System, St. Mary's Good Samaritan Hospital's mission is to be a compassionate healing presence in our community. Volunteer Chaplains are available as well as the Hospital's Chapel is available for private prayer and meditation.

Respiratory Care

St. Mary's Respiratory Care Department is available for any breathing-related need, from ventilator management in the critical care setting to outpatient breathing tests, smoking cessation, and a support group. St. Mary's is certified by The Joint Commission for COPD care.

Continuum of care

St. Mary's Outpatient Diagnostic, Rehab and Wellness Center on Daniells Bridge Road provides imaging, laboratory and rehabilitation services, a sleep disorders center and a wellness center in a freestanding location convenient to Loop 10, Ga. 316 and the Oconee Connector. Preventive care services at the hospital and/or the outpatient center include diabetes education, support groups, cardiac rehabilitation and nutritional counseling.

St. Mary's Home Health Care/Hospice Services.

Homebound patients can receive nursing and rehabilitative care, aides, social work services and more in their home in a multi-county area of Northeast Georgia. Also, people diagnosed with a life-limiting illness and their family can receive care to maximize quality of life through St. Mary's home hospice services and inpatient hospice house.

Highland Hills Village

St. Mary's retirement community provides independent living, assisted living and memory care in a beautiful facility on wooded grounds convenient to Athens, Bogart and Watkinsville.

SUMMARY OF PREVIOUS CHNA: *St. Mary's Health Care System, 2016*

St. Mary's Health Care System completed a Community Health Needs Assessment (CHNA) in order to meet the requirements of the Internal Revenue Service (IRS), Notice 2011-52. The document assessed population factors, health conditions, community priorities, and health behaviors in Athens-Clarke County and the surrounding counties in Northeast Georgia. Additionally, and as the IRS-requirement suggests, the assessment was used for the development of the hospitals community benefits program, including outreach services and resource development, for the following three years (2016-2019).

The St. Mary's Health Care System hospital service area was defined at the patient visit level. For the purposes of the CHNA, existing secondary and primary data were gathered from local, state, and federal data sources. Primary data were gathered through administration of a household survey in Athens-Clarke County and focus groups in surrounding counties to gain insight into the most pressing community health needs. Special focus was given to populations where health disparities were present, including those without health insurance and low-income families.

The Community Advisory Committee assessed this data in order to accomplish a prioritization of health conditions and risk factors for which the hospital could concentrate their efforts and improve community health. Following the identification and prioritization of health needs, St. Mary's staff worked with faculty from the J.W. Fanning Institute for Leadership to construct an implementation plan to systematically address the health needs in the service area. This implementation plan provided specific areas of focus with objectives and strategies to accomplish stated objectives for the three years following the 2016 CHNA. Through this process, the following needs were recognized as the most important issues to be addressed to improve the health and quality of life in our community: access to health services; nutrition, physical activity, obesity; and cardiovascular disease.

One of the health needs addressed from the 2016 CHNA for Good Samaritan Hospital was chronic disease including: cerebrovascular health, cardiovascular health, diabetes and obesity. Good Samaritan successfully re-established a monthly diabetes support group, hosted Diabetes Empowerment Education Program (DEEP) sessions annually. Walk to Wellness is also a six-week program that is offered twice a year. This program was created to be able to impact the overall health of the participant just by walking daily. The participants are able to commit to walking for at least two out of five days a week. Participants are given a pre and post-test to be able to compare results. These tests include glucose testing, blood pressure checks, cholesterol, and body mass index. The focus is to increase their walking distance over time while tracking progress.

To address access to care, Good Samaritan Hospital continued to support Tendercare and St. Mary's Medical Group in the recruitment efforts for Primary Care Physicians. St. Mary's Good Samaritan Hospital partnered with Augusta University/University of Georgia Medical to provide a rural rotation which includes hospital as well as physician practices. After the residents complete their rotation; it is hopeful they will have a desire to want to come back and practice in Greene County.

Good Samaritan Hospital offered 40 no-cost mammograms in the month of October. Out of 32 patients that received 3D mammograms, two were called back for further diagnostic testing. Of these three women, there was one found to have breast cancer. Recommendations and follow-ups were made with a physician for the other women. The Power of One community event was also held in October to spread awareness to the community about the importance of annual mammograms and early detection. Good Samaritan Hospital has continued a strong standing relationship with the following partners: TenderCare Clinic, Greene County Health Department, and Greene County Family Connection.

RESPONSES TO 2016 CHNA

From United Way of Northeast Georgia:

Solicited: January 2019

Received: February 2019

"United Way of Northeast Georgia motivates and mobilizes resources to meet the highest priority needs of those living in Northeast Georgia. We understand that the health of our community and access to healthcare for all, especially the most vulnerable populations, is of great priority for our region. The St. Mary's Community Health Needs Assessment very thoroughly assesses the health needs of their 17 county service area through both quantitative and qualitative data analysis, both current and longitudinal, that engaged community members and leaders from throughout the Northeast Georgia region.

St. Mary's went above and beyond in the scope of their assessment, leading to a clear prioritization of needs to guide the hospital's work moving forward. What is helpful not only in the hospital's work, but for our community, is the data provided on the unique needs of vulnerable populations in our region. This information, and the included resource information, help to guide our work and the work of other organizations in Northeast Georgia."

From Envision Athens:

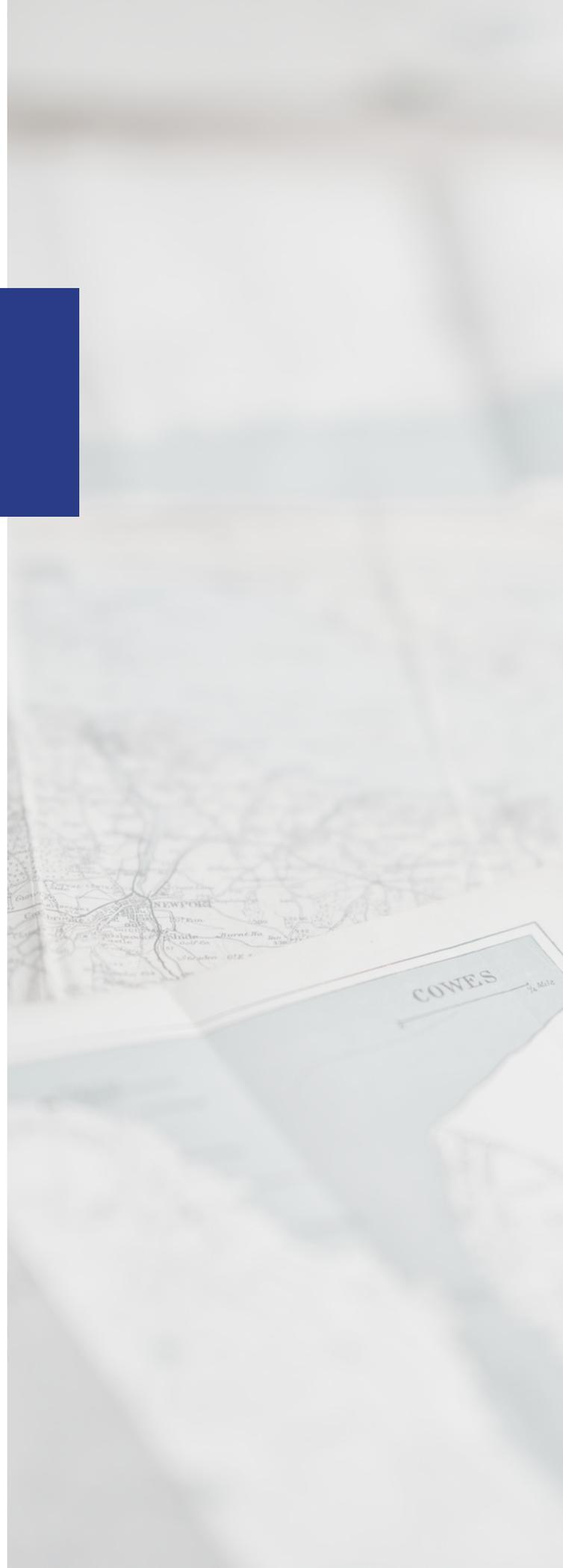
Solicited: January 2019

Received: February 2019

"Envision Athens is the 20 year strategy for community and economic development in Athens-Clarke County. As this strategy moved into implementation phase in mid-2017, it was imperative that we had real-time community based data to help inform our decision making which directly impacts the programs, policies, and procedures which affect our stakeholders and residents.

This data and approach also further connects this hospital system in relationship with other care providers and stakeholders in a way that moves the local hospital from facility to community partner and decision-maker. This report helps position the healthcare system as the informed leader that it is and that we need."

COMMUNITY SERVED



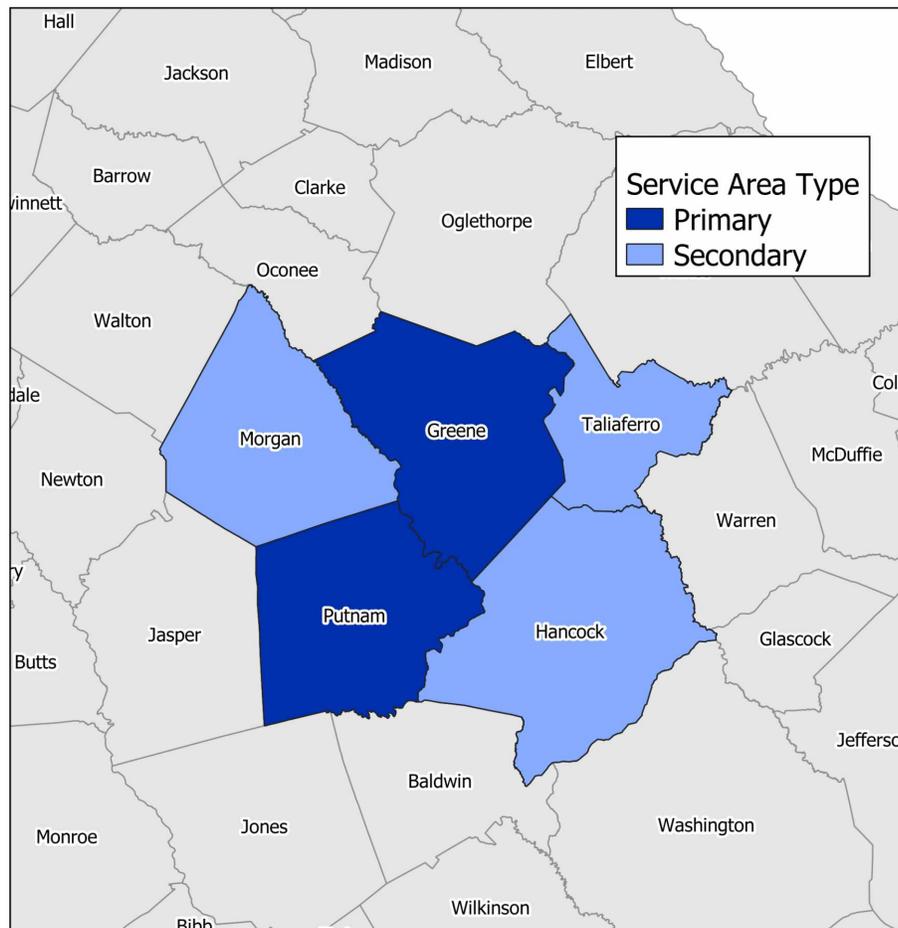
COMMUNITY SERVED

Good Samaritan Hospital Service Area

The geographic service area was defined at the county-level for the purposes of the 2019 Community Health Needs Assessment (CHNA). The service area was determined by counting the number of patient visits by county of residence. Five counties are defined as the service region for Good Samaritan Hospital: Greene, Hancock, Morgan, Putnam and Taliaferro. The counties with the most patient visits are the "primary service region." The counties with the next highest patient visits are the "secondary service region." See Figure 1 for a map of the service area.

Figure 1. Service Area Map.

Good Samaritan Service Area



Service Area: Demographic Overview

The numbers presented below are a snapshot of the five county service area for Good Samaritan Hospital, including the total population of the counties served, the total square mileage covered, and the median household income. The following pages contain community profiles for each county served, presenting a demographic overview, strengths and challenges, and healthcare supply information.

67,612 Service Area Population
Across All 5 Counties

Population estimate as of July 1, 2017 according to the U.S. Census Bureau's Quick Fact Profiles.

1,745.9 Service Area Land Mass, in
Square Miles

Estimate as of July 1, 2017 according to the U.S. Census Bureau's Quick Fact Profiles.

\$42,549 Median Household Income,
2013-2017 Average

Adjusted to 2017 dollars. Median household income data from U.S. Census Bureau's American Community Survey. Median income across all five counties in service area.

Greene County: Community Profile

Population: 17,281
Miles from Hospital: 0

Strengths

Access to PCPs and Dentists

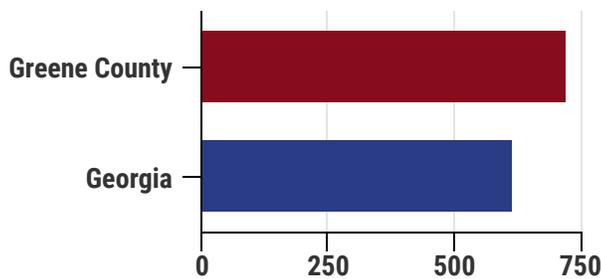
	Greene Co	Georgia
Ratio of residents to PCPs	1,890:1	1,520:1
Ratio of residents to dentists	1,020:1	1,960:1

(County Health Rankings, 2019)

Challenges

Sexually Transmitted Infections

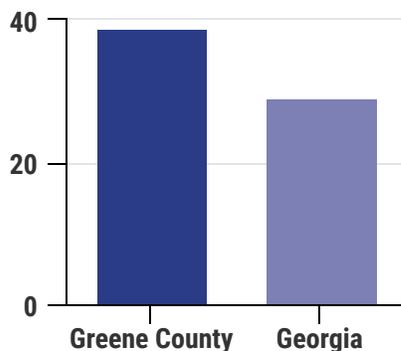
724.1 newly diagnosed chlamydia cases (per 100,000 people), compared to the state rate of 614.6



(County Health Rankings, 2019)

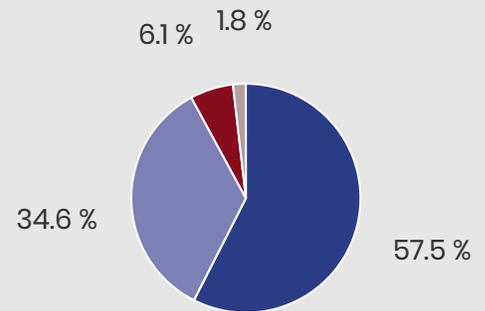
Teen Birth Rate

39 (per 1,000 births), compared to the state rate of 29



(County Health Rankings, 2019)

Race & Ethnicity



● White, not Latinx ● African-American
● Latinx ● Other

(Census, 2010)

Education

Less Than High School

17.6%

High School diploma

82.4%

Bachelor's Degree

25.6%

(Census, 2010)

Economy

% Living in Poverty

17.0%

Median income

\$45,069

Unemployment Rate

4.5%

(Census, 2010)

(Dept. of Labor, 2019)

Other Demographics

% with broadband internet

64.9%

% without health insurance

18.7%

County Health Ranking

82/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,890



Mental
1 : 5,760



Dental
1 : 1,020

(County Health Rankings, 2019)

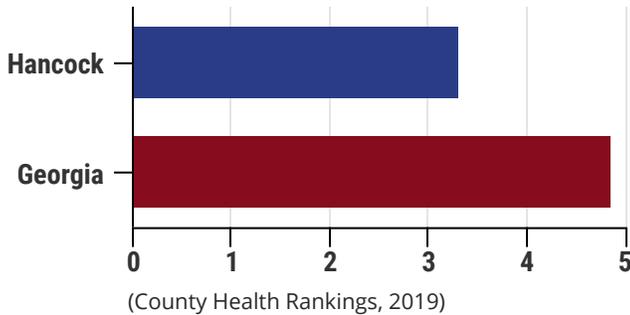
Hancock County: Community Profile

Population: 8,561
Miles from Hospital: 27

Strengths

Preventable Hospital Stays

Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees



Challenges

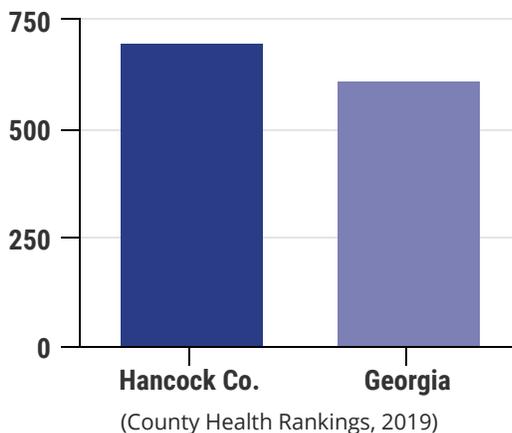
Income Disparity

45% of Hancock Co. children live in poverty, compared to 22% across the state

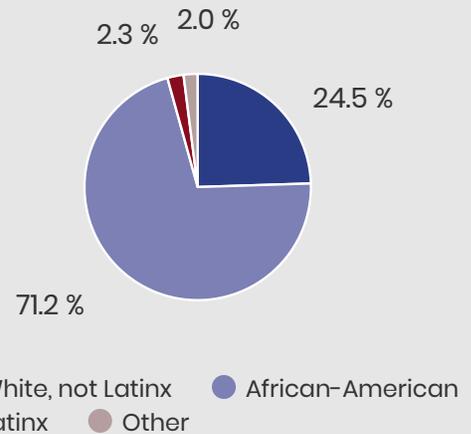
(County Health Rankings, 2019)

Sexually Transmitted Infections

701.7 newly diagnosed chlamydia cases (per 100,000 people), compared to the state rate of 614.6



Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
30.2%	69.8%	8.7%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
30.3%	\$29,268	6.3%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
43.6%	13.7%	153/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 4320



Mental
1 : 4280



Dental
1 : 8560

(County Health Rankings, 2019)

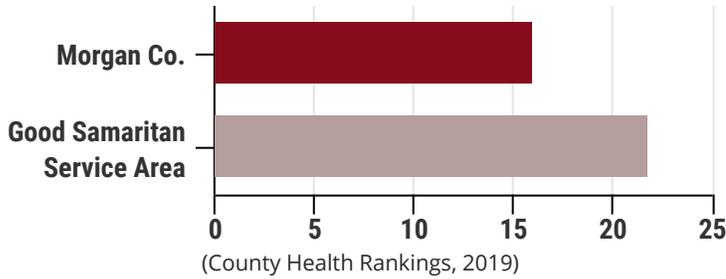
Morgan County: Community Profile

Population: 18,412
Miles from Hospital: 22.1

Strengths

Good Health Status

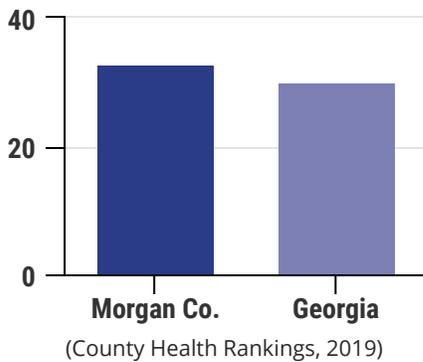
Percentage of adults reporting fair or poor health (age-adjusted)



Challenges

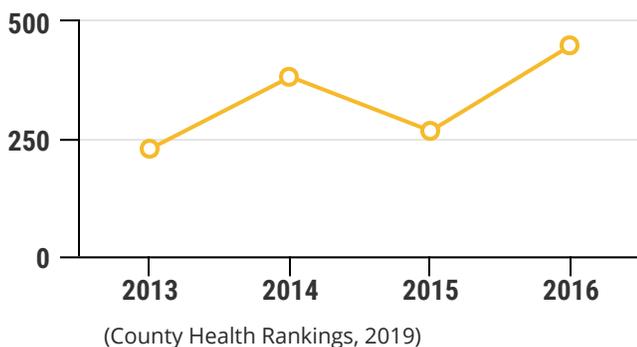
Obesity

33% of adults are obese in Morgan Co. compared to 30% in the state

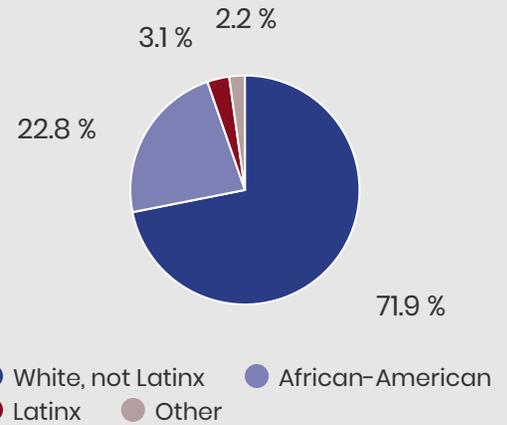


Sexually Transmitted Infections

The rate of newly diagnosed chlamydia cases in Morgan Co. per 100,000 people is trending up



Race & Ethnicity



Education

Less Than High School

13.4%

High School diploma

86.6%

Bachelor's Degree

22.1%

(Census, 2010)

Economy

% Living in Poverty

12.0%

Median income

\$59,572

Unemployment Rate

3.7%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet

71.5%

% without health insurance

14.2%

County Health Ranking

27/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,820



Mental
1 : 3,680



Dental
1 : 2,300

(County Health Rankings, 2019)

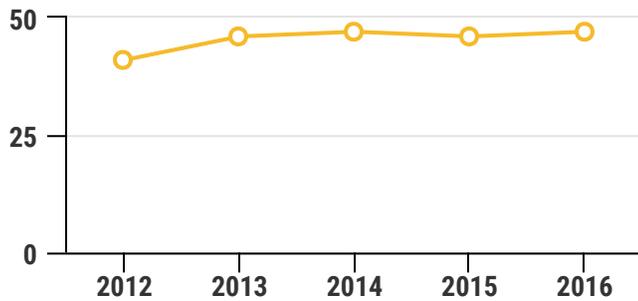
Putnam County: Community Profile

Population: 21,730
Miles from Hospital: 14.5

Strengths

Mammography Screenings

The percentage of female Medicare enrollees who received an annual mammography screening



(County Health Rankings, 2019)

Challenges

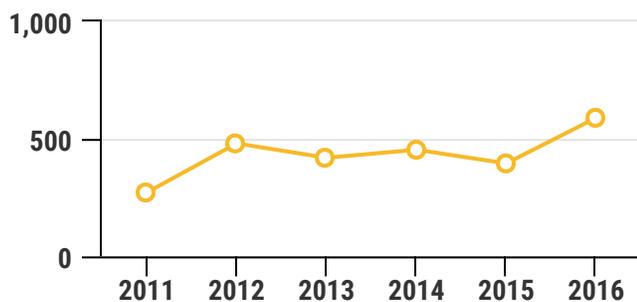
Income Disparity

31% of Putnam Co. children live in poverty, compared to 22% across the state.

(County Health Rankings, 2019)

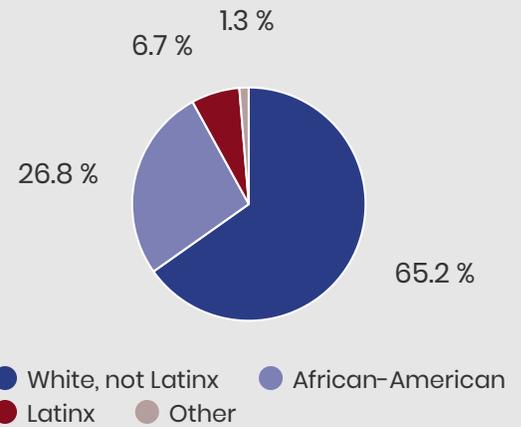
Sexually Transmitted Infections

The rate of newly diagnosed chlamydia cases in Putnam Co. per 100,000 people is trending up, at 590.1 in 2016



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School

13.2%

High School diploma

85.9%

Bachelor's Degree

21.4%

(Census, 2010)

Economy

% Living in Poverty

17.2%

Median income

\$48,340

Unemployment Rate

5.5%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet

75.9%

% without health insurance

17.7%

County Health Ranking

46/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 3,070



Mental
1 : 2,410



Dental
1 : 5,430

(County Health Rankings, 2019)

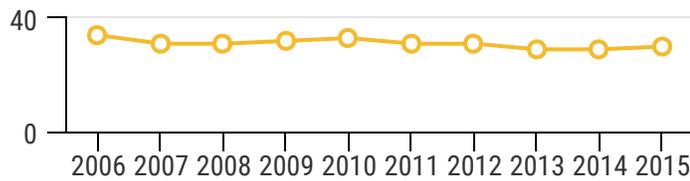
Taliaferro County: Community Profile

Population: 1,628
Miles from Hospital: 25.2

Strengths

Physical Inactivity

The percentage of adults over 20 who report no leisure-time physical activity has decreased in Taliaferro Co. since 2006, from 35% to 30%



(County Health Rankings, 2019)

Challenges

Food Environment Index

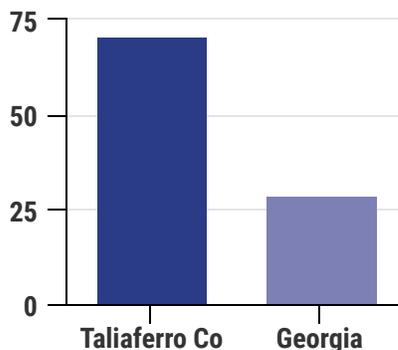


compared to 6.0 across the state

(County Health Rankings, 2019)

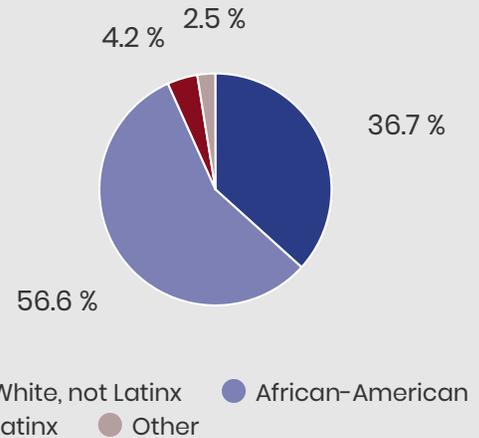
Teen Births

71 (per 1,000 births), compared to the state rate of 29.



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School

30.9%

High School diploma

69.1%

Bachelor's Degree

6.8%

(Census, 2010)

Economy

% Living in Poverty

26.5%

Median income

\$30,500

Unemployment Rate

5%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet

35.4%

% without health insurance

19.2%

County Health Ranking

129/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
0 : 1,590



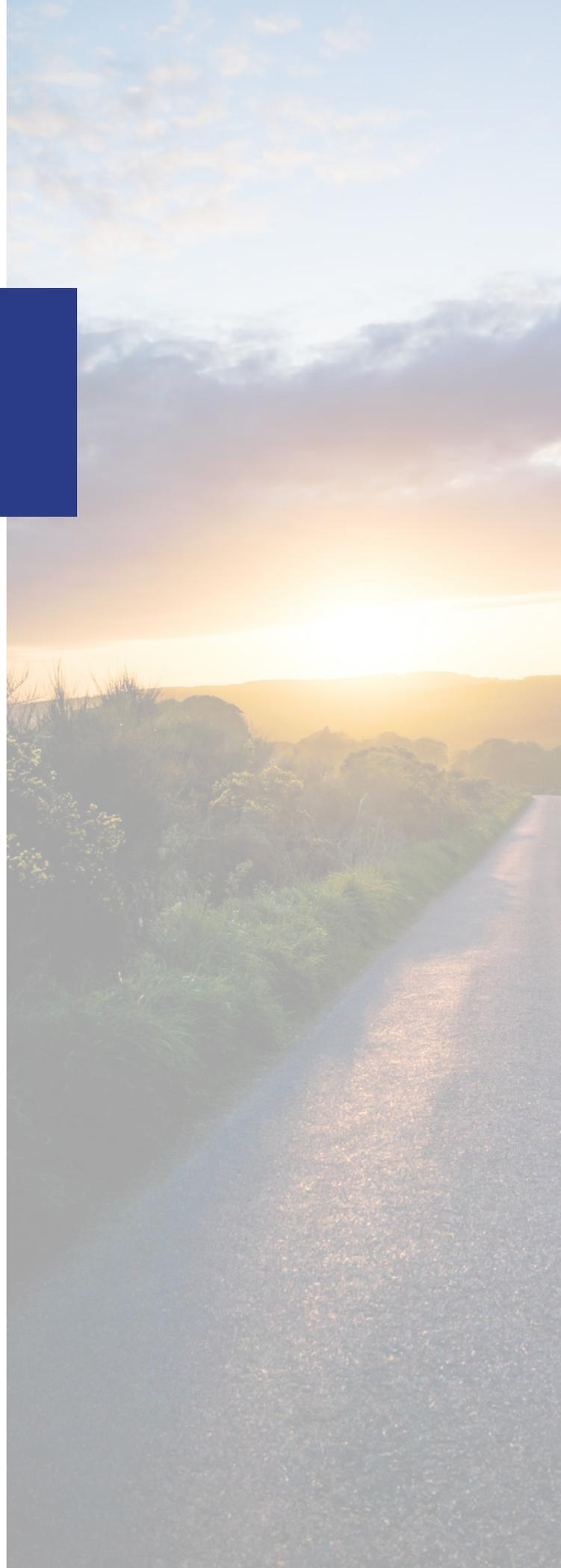
Mental
N/A



Dental
0 : 1,630

(County Health Rankings, 2019)

Top 10 Health Needs

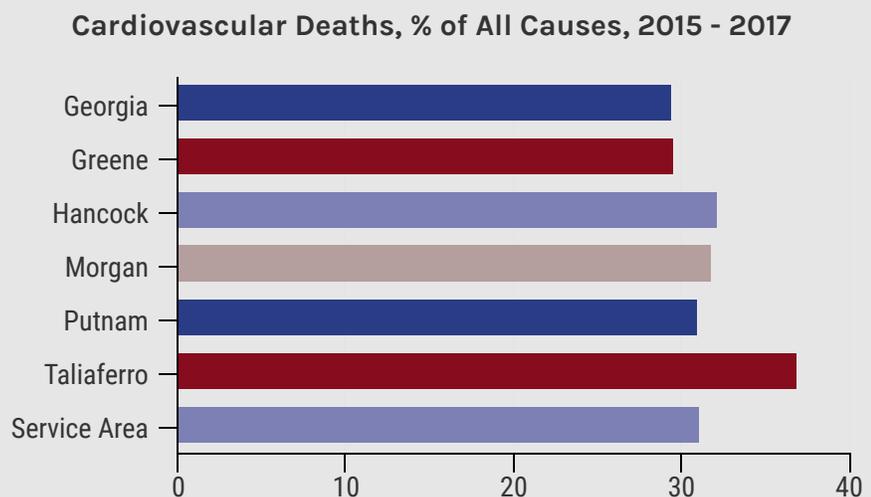


1 Cardiovascular Health

Cardiovascular health is ranked as the number one health need in our community. This includes incidence and prevalence of heart disease, which proportionally accounts for the most deaths in the service area (relative to all other causes). High blood pressure (hypertension), high cholesterol, and other cardiovascular indicators were examined across all data sources. Cardiovascular disease (CVD) and preliminary indicators of compromised cardiovascular health are also linked to many other health conditions, many of which are preventable. There was significant health disparity present in cardiovascular outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities. Cardiovascular deaths are the leading cause of preventable deaths.

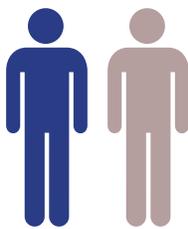
Secondary Data

Among the 5 counties in the service area, **cardiovascular diseases** accounted for 31.1% of all deaths (all ages) between 2015 and 2017. Four of the counties in the service area are slightly higher than the state average (29.4%). (Source: OASIS, 2019)

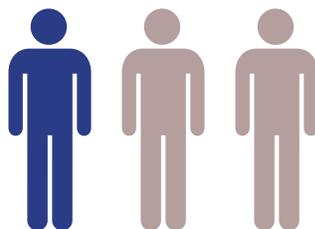


Survey Data

* **More than 1 in 2** reported hypertension in their household.



* **More than 1 in 3 (40%)** respondents reported high cholesterol in their household.



60% reported walking less than 10 minutes on at least 3 of the last 7 days.

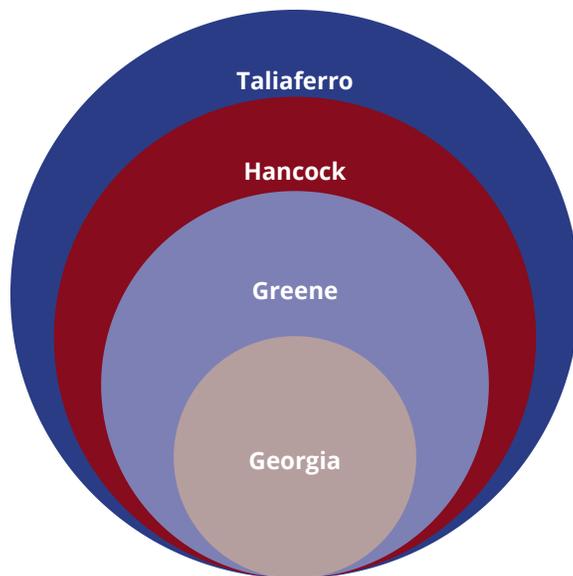
Persistent Disparities

In all counties with available data, Black residents were more likely to die from Cardiovascular Disease (CVD) than White residents. In Greene County, a Black resident was more than twice as likely to die from CVD than a White resident, and in Hancock County a Black resident was more than three times as likely to die from CVD than a White resident, adjusting for age, in 2017. (Source: OASIS).

Across the service area, Black residents were more than twice as likely to visit an ED for CVD than White residents, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017) (Source: OASIS).

The figure below represents the orders of magnitude between the state ED visit rate disparity for the Black population in the state, and the three counties with the greatest disparity: Taliaferro, where Black residents are 4.11 times more likely than White residents to go to the ED for CVD; Hancock, where the ED rate is 3.69 greater; and Greene, where the rate was 4.11 times greater.

Emergency Department Visits for Cardiovascular Disease: Racial Disparity



Focus Group Data

What is your biggest health challenge?

“We need bike-friendly and walk-friendly communities.”

“Our community would be healthier if we had more community health fairs.”

2 Nutrition, Diabetes & Obesity

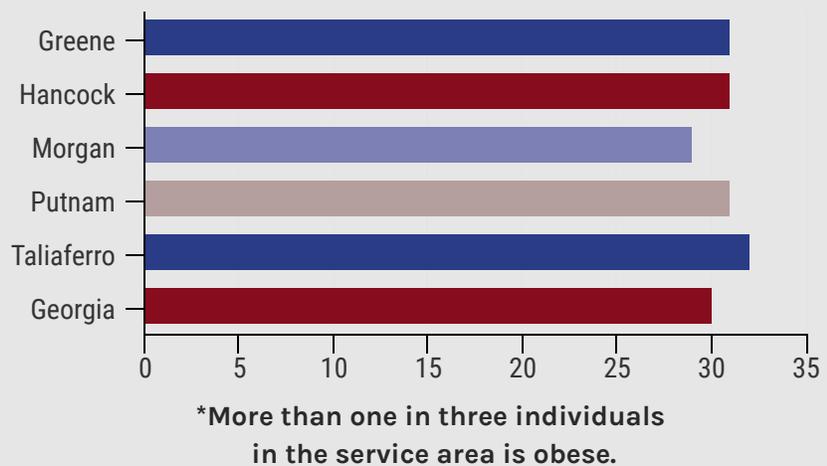
Following the *HealthyPeople 2020* categorization, the number two ranked health need includes food security (access to healthy food for all families), type II diabetes, and obesity. We examined both the demand for healthy food, health behaviors for food consumption, supply of healthy food, and incidence and prevalence of diabetes and obesity. Many of these health needs categories are inextricably linked; cardiovascular health and this category is perhaps one of the best examples of the intersectionality of health issues. We observed this need as being one of the most pressing across all data sources. Similar to cardiovascular outcomes, there was significant health disparity present in nutrition, diabetes, and obesity outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities.

Secondary Data

Obesity prevalence for the service area was comparable to the state average, but there has been a 27% increase in obesity over the last decade. (Source: OASIS, 2019)

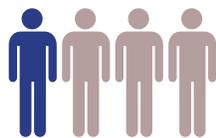
Age-adjusted ED visit rates (per 100,000) for **diabetes** exceeded the state average in all service area counties in 2017, and was more than twice the state average in Greene county. (Source: OASIS, 2019)

Obesity Prevalence (%), Service area vs. Georgia, 2018

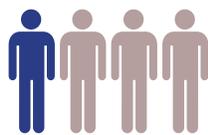


Survey Data

* **1 in 4** reported diabetes in their household.



* **1 in 4** respondents reported obesity in their household.



* **17% "never" workout** and break a sweat doing physical activity



64% report eating one or less fruits per day



65% report eating one or less veggies per day



25% report experiencing food insecurity

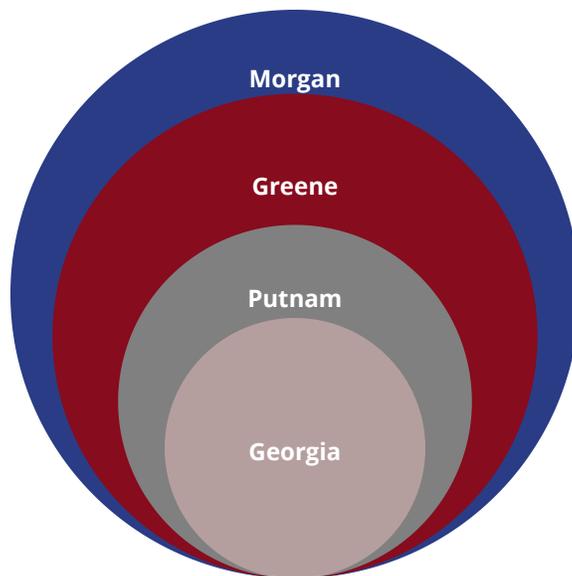
Persistent Disparities

In all service area counties (excluding Taliaferro, where the rate was not available) Black residents had a significantly higher rate of ED visits for diabetes than White residents. In addition, in all counties (excluding Taliaferro, where the rate was not available), a Black resident was more than twice as likely to visit the Emergency Department for diabetes than a White resident, adjusting for age, in 2017. According to U.S. Department of Health & Human Services data (HHS), Latinx males and females are significantly more likely to be obese or overweight than non-Latinx, White males and females.

In Greene, Morgan, and Putnam counties, a Black resident was three times as likely to visit an ED for diabetes than a White resident, and in Morgan county, a Black resident was five times more likely to visit an ED for Diabetes than a White resident, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017) (Source: OASIS).

The figure below represents the orders of magnitude between the state ED Visit rate disparity for the Black population in Georgia and the three counties with the greatest disparity.

Emergency Department Visits for Diabetes: Racial Disparity



Focus Group Data

What are your most significant health issues?

“Nutrition and knowing what to eat makes a community healthy.”

“Our biggest issue is chronic issues like diabetes, both controlled and uncontrolled.”

3 Behavioral Health

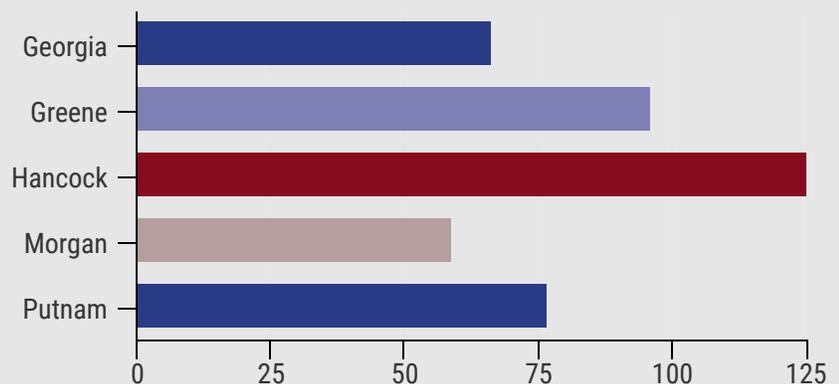
The number three ranked health need is behavioral health, which includes mental health and substance use disorder. This is the health need that has increased most drastically since the last CHNA. Due to the comorbidity of mental health and substance use disorder, the categorization of the two together is critically important and they must be addressed simultaneously. Across all data sources, this need was observed as being one of the most prevalent. Suicide and drug overdose were the leading causes of mortality within this health need. The demographic group most affected was working age white males. Within substance use disorder, licit and illicit opioid use and misuse has driven the increase in drug overdoses (many of which result in death). Health disparities for behavioral health were concentrated in low income, rural communities. Supply of behavioral health professionals and treatment for substance use disorder is a major concern in the service area.

Secondary Data

In each county besides Hancock (and Taliaferro, where rates were not available), age-adjusted mortality rates (per 100,000) for **suicide** either match or exceed the state rate in 2017. (Source: OASIS, 2019)

The age-adjusted ED visit rates (per 100,000) from 2015 - 2017 for **suicide** exceed the state rate in Greene and Putnam and is nearly double the state rate in Hancock. (Source: OASIS, 2019)

Age-Adjusted ED Visit Rates (per 100,000) for Suicide, 2015-2017



Survey Data

***1 in 4** reported depression in their household.



***1 in 3** reported anxiety in their household.



5% report another mental health disorder (e.g. bipolar disorder)



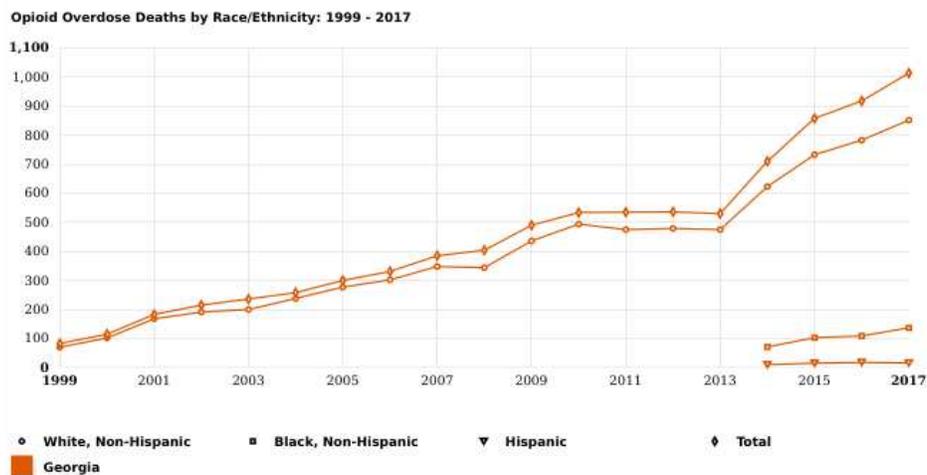
10% said they needed mental healthcare in the last 12 months but could not get it



Lack of affordability was the most common reason for not getting the mental or substance use treatment needed

Persistent Disparities

White residents in all five counties were more than twice as likely to die from issues related to opioids, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017). The time trend line below shows opioid overdose deaths over time for the state of Georgia, the service area data reflects the same trends shown below. (Source: Kaiser Family Foundation, 2019).



SOURCE: Kaiser Family Foundation's State Health Facts.

Opioid Epidemic: Cost Analysis

Using county-level data from the Georgia Department of Public Health from 2014 through 2018, we conducted a cost analysis of emergency services related to opioid overdose across the service area. We used the number of Naloxone doses administered by EMS professionals and the number of opioid overdose calls made to EMS that resulted in a visit to the scene.

\$27,580

Spent on Naloxone in the Service Area, 2014-2018



\$159,120

Spent on EMS Opioid Overdose Calls in the Service Area, 2014-2018

Focus Group Data

In the Good Samaritan service area, two issues were the third most frequently mentioned "significant health needs":

- Substance Use Disorder, specifically **opioids, heroin, and meth.**
- Mental health, and access to **behavioral health providers.**

Even in areas where such care is available, there are long waiting lists for both. Individuals requiring a police enforced psychiatric evaluation are often taken to emergency departments when mental health care providers are unavailable.

4 Maternal & Child Health

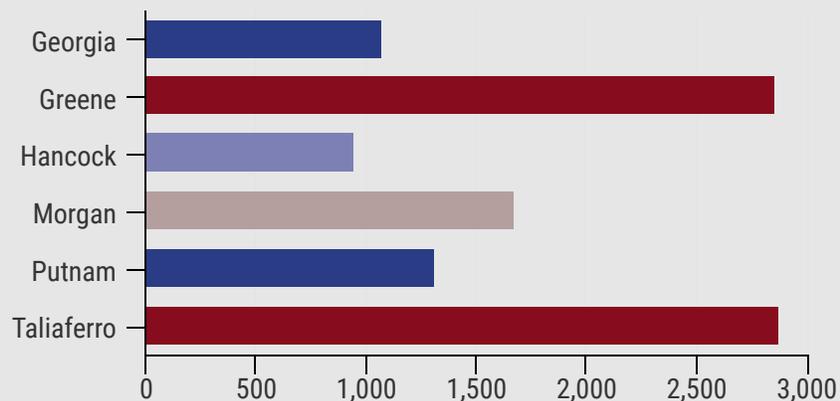
The number four ranked health need is maternal and child health. Across all data sources, this need was observed as being a concern of county residents and issues related to health care access and health outcomes. Health disparities for maternal and child health were concentrated in low income, rural communities and are especially problematic for racial and ethnic minorities. Shortage of Ob-Gyn specialists, pediatricians, and other health professionals that serve pregnant and postpartum women and their children is a major barrier to health in the service area. Many women must travel a significant distance for routine prenatal care, labor and delivery, and pediatric care for their children. Health behaviors during pregnancy are also a concern. Across the service area, the maternal smoking rate was more than twice the state's rate.

Secondary Data

In Greene and Morgan counties, the percent of **births to women who reported using tobacco** exceeded the state percentage in 2017. The percent of births to women using tobacco during pregnancy was more than double the state's value in Putnam County. (Source: OASIS, 2019)

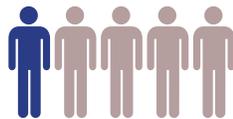
In Morgan and Putnam counties, the age-adjusted ED visit rate (per 100,000) for **pregnancy & childbirth complications** exceeded the state rate in 2017 and Greene and Taliaferro are more than double the state's rate. (Source: OASIS, 2019)

Age-Adjusted ED Visit Rates (per 100,000) for Pregnancy & Childbirth Complications, 2017



Survey Data

* **1 in 5** reported taking a child to the ED in the last 12 months.



* **42%** indicated they have family leave for caregiving as an employee benefit

Healthcare Supply

According to the Area Health Resources File (2016), four counties in the service area do not have an **obstetrician-gynecologist** in the service area: Hancock, Morgan, Putnam, and Taliaferro.

The same data show Morgan and Taliaferro do not have any **pediatricians**.

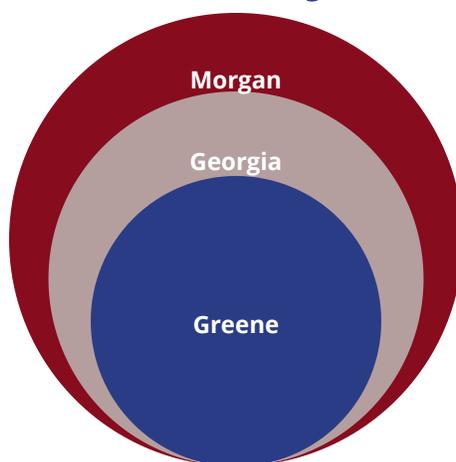
Maternal and child health outcomes are also the worst for these counties relative to the other counties, adjusting for age and population size.

Persistent Disparities

Evidence from the Pregnancy Risk and Monitoring System data (PRAMS) indicate Latinx women were significantly more likely to delay prenatal care than non Latinx (58% vs 78% accessing care in first trimester, respectively).

In Greene and Morgan counties, a Black resident was more likely to have less than five prenatal care visits than a White resident, adjusting for age and population, in 2017. In Morgan County, a Black resident was more than 2.5 times more likely to have less than five prenatal care visits than a White resident, adjusting for age, in 2017. This trend has been sustained over time; which is significant because, while infant mortality has been declining in the aggregate for the last twenty years, the decrease has not been steady for racial and ethnic minorities.

Probability of Black Women Having <5 Prenatal Care Visits



The education level of the mother correlates with prenatal visits. Where data is available, the rates for how many women receive less than five prenatal visits (per 1,000 live births) increased as education level decreased. In the service area rates (per 1,000 live births) for women receiving less than 5 prenatal care visits were: 3.2 for women with some college or more, 6.9 for women with a high school diploma or GED, and 11.5 for women with less than a high school diploma. (Source: OASIS, 2019)

Focus Group Data

- ➔ To **deliver babies**, parents tend to go to Athens, Gainesville, Macon, Augusta, and Baldwin. In some areas, routine care is not available which means people have to travel long distances and miss work.
- ➔ Residents utilize the local health department for **care of babies and preventive care**. For hospital and specialty healthcare, many residents travel outside of their county and tend to go to places such as Athens, Atlanta, Gainesville, Lake Oconee, Augusta, Macon, Washington, Thompson, Putnam, Stephens, and Covington.

5 Healthcare Access

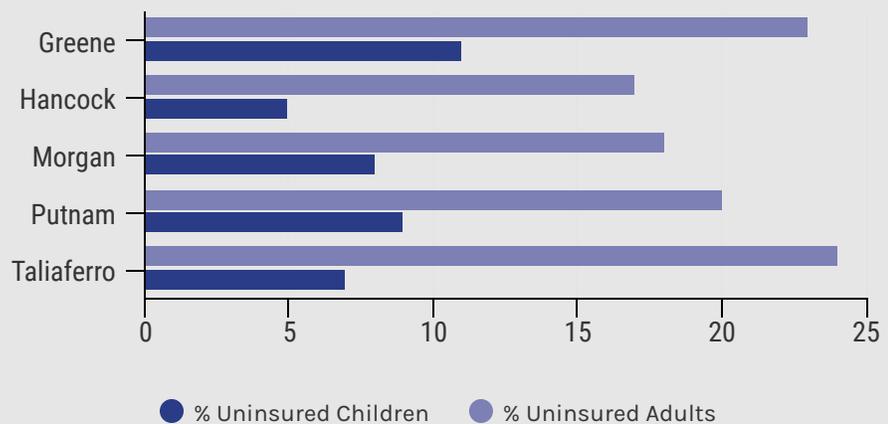
The number five ranked health need is healthcare access. In contrast with the other nine health needs, healthcare access is substantively different. It is the only need that does not cover a specific set of conditions or health outcomes. Rather, access is a complex, multidimensional area of need that is ubiquitous in all communities and is deeply connected to all the other health needs presented in this study. Similar to other needs, health disparities were concentrated in low income, rural communities and are especially problematic for racial and ethnic minorities. Shortage in health professionals of all types is a primary factor in this category. Transportation and drive time were two other predominant themes, as was being uninsured and underinsured. Addressing healthcare access presents an opportunity to simultaneously intervene on all health needs, because when access improves, so does community and public health.

Secondary Data

In Hancock and Putnam counties there were less **dental providers** per 100,000 than the state average and in Taliaferro county there were none. (Source: AHRF, 2016)

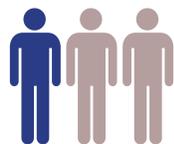
In each county in the service area there were less **physicians per 100,000 residents** than in the state overall. (Source: AHRF, 2016)

Percentage of Uninsured Children & Adults by Service Area County, 2018

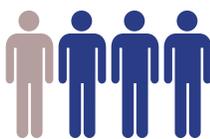


Survey Data

* **1 in 3** anticipate caregiving for a loved one in the next two years



* Almost **3 in 4** needed dental care but could not get it



* **11% of households** reported having trouble finding a doctor to accept their insurance in the last 12 months



6% of respondents traveled over an hour to get to the doctor



28% of respondents traveled 30-60 minutes to the doctor



97% rely on a personal car as their primary source of transport

Persistent Disparities

In all counties in the service area, being in a low income family significantly decreased your access to healthcare. Survey data showed that one in seven households indicated they did not take their medication as prescribed due to cost of the medication. We also found that 26% of people who had indicated that they went to the Emergency Department (ED) in the last year went to the ED because that is the place where they receive "most of their care." Being uninsured and low income was significantly ($p < .01$) associated with using the ED as their primary place for receiving care.

Across health department interviews and focus groups, the dominating narrative around barriers to health and health care was about access; with a particular focus on rural counties. Dr. Maritza Keen noted that the majority of comments during the focus group discussion pertaining to barriers to care focused on lack of transportation, including public transit, lack of a personal vehicle, or lack of access to vans or other forms of transportation such as Uber or taxis. The next major barriers were cost of healthcare services and lack of insurance. Respondents also indicated there was a lack of awareness/education concerning what health services were available in their communities, and the need for patient advocates or educators to help patients understand medical issues and treatment. The non-availability of providers rounded off the top barriers to access.

Barriers to Health	Number of Comments	% of Total
Transportation	45	52%
Cost/Lack of Insurance	36	41%
Education/Awareness	12	14%
Availability of Providers	11	13%

Focus Group Data

- ➔ Other factors mentioned concerning barriers to health: **language and culture** (Latinx community).
- ➔ When asked what is needed for a healthier community, the most common responses centered on the need for **more local health care providers**, including: urgent care, rural clinics, specialty care, dental care, and hospitals.

6 Reproductive Health

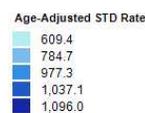
Reproductive health is ranked as the number six health need in our community. This includes sexually transmitted infections (STIs), family planning, and teen pregnancy. Prevalence of STIs was examined across all data sources. There were significant health disparities present in reproductive health outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities. Service area rates (at 518.1 per 100,000) were lower than the 2013 to 2017 five-year state rate (752 per 100,000).

Secondary Data

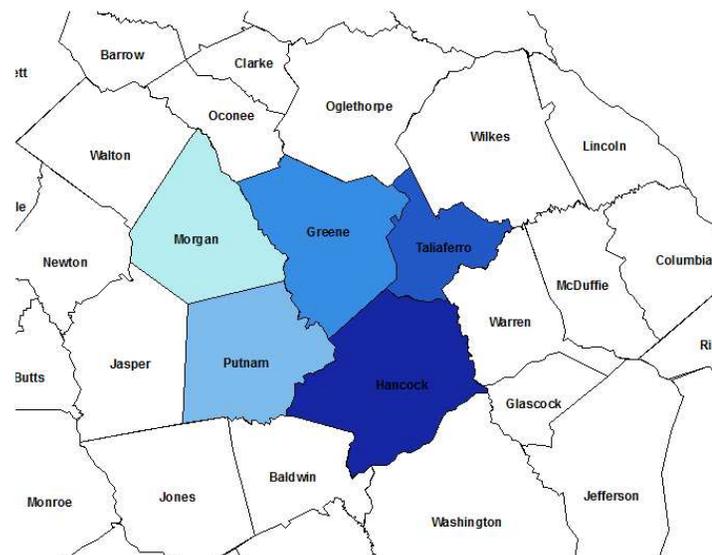
Among the 5 counties in the service area, age-adjusted STI rates (per 100,000) were highest for Hancock County, followed by Putnam, then Greene and Morgan counties, respectively (Source: OASIS, 2019).

The **teen pregnancy** rates (females under 20 years of age, per 1,000) between 2015 and 2017 were greater than the state rate in Greene, Hancock, Putnam, and Taliaferro counties.

Age-Adjusted STD Rate by County of Residence, Greene, Hancock, Morgan, Putnam and Taliaferro Counties, All STD except Congenital Syphilis, 2013-2017



Legend
County



Reproductive Health Education

According to Georgia's 2013 Youth Risk Behavior Survey of high school students, the percentage of students who report ever being taught about AIDS or HIV infection in school by race and ethnicity differed significantly.



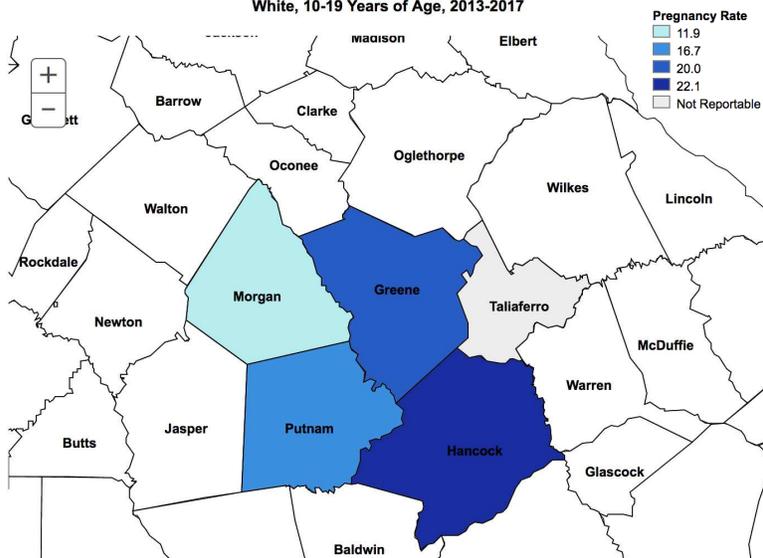
Race/Ethnicity	% Taught About HIV/AIDS
African American	85%
Latinx	81%
White	91%

Persistent Disparities

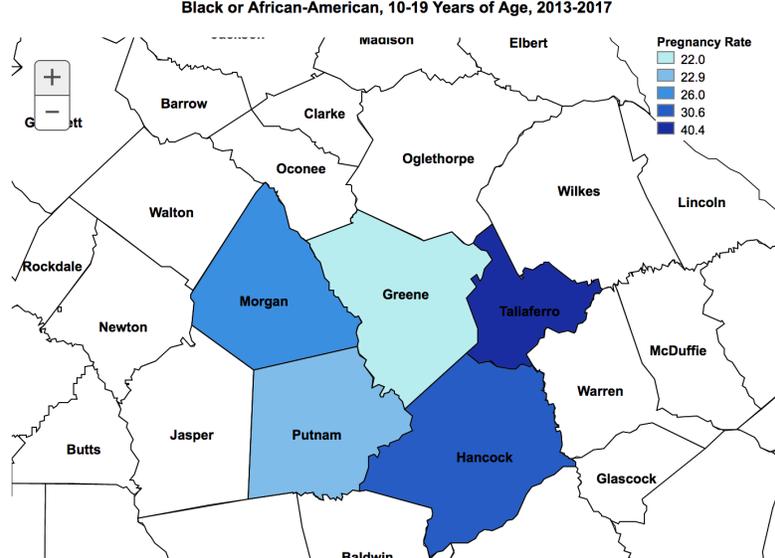
A Black resident in the five county service area was nearly six times more likely to have an STI than a White resident after adjusting for age and county population from 2015 to 2017. This disparity is particularly pronounced in Morgan, Hancock, and Putnam counties (Source: OASIS, 2019).

Racial disparity also exists in the teen pregnancy rate. Teen pregnancy (ages 10-19) was significantly higher among Black women relative to White women. Differences between teen pregnancy rates by race are especially striking. The maps below show teen pregnancy five year averages across service area counties for White and Black women (Source: OASIS, 2013-2017).

Pregnancy Rate by County of Residence, Greene, Hancock, Morgan, Putnam and Taliaferro Counties, White, 10-19 Years of Age, 2013-2017



Pregnancy Rate by County of Residence, Greene, Hancock, Morgan, Putnam and Taliaferro Counties, Black or African-American, 10-19 Years of Age, 2013-2017



Health Department Interviews

What is going well in terms of meeting county health needs?



"We offer free teen services including family planning and STD visits."
Putnam Co. Health Department.

"We have a health educator at the health department." Morgan Co. Health Department

What are the greatest health needs you see in the county?



"Teen Pregnancy."
Putnam Co. Health Department

"STD Prevention."
Putnam Co. Health Department

7 Cerebrovascular Health

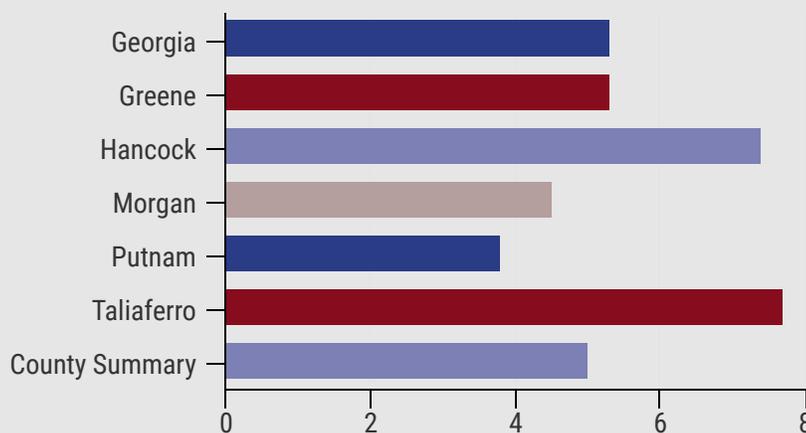
The number seven ranked category is cerebrovascular health. This covers both ischemic and hemorrhagic stroke. Due to the time sensitive nature of getting a patient experiencing a stroke to the hospital, healthcare access (i.e. distance to hospital) stood out as a concern across all data sources. According to the Georgia Department of Public Health, Georgia is part of the United States' "Stroke Belt" where stroke morbidity and mortality rates are well above those of other states. Eighty percent of strokes are preventable, which is an important reason for communities to intervene on preventive health in this area. In 2013, hospital charges related to stroke totaled over \$1 billion in Georgia (Source: Georgia Department of Public Health, 2017). Similar to other needs, health disparities were concentrated in low income, rural communities and are especially problematic for racial and ethnic minorities. Access to ambulance transportation is limited or nonexistent in some rural counties. This is a major barrier to improving stroke-related outcomes.

Secondary Data

Among the 5 counties, **strokes** accounted for 5% of all deaths (all ages) between 2015 and 2017. (OASIS, 2019)

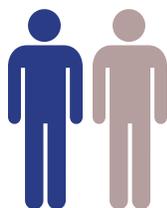
Georgia is part of the United States' "Stroke Belt" where **stroke** morbidity and mortality rates are well above those of other states. 80% of strokes are preventable. (Source: Georgia Department of Public Health, 2019)

Stroke Deaths as a % of all deaths, 2015 - 2017



Survey Data

*** >1 in 2 (57%)** households reported having high blood pressure. Evidence shows that uncontrolled high blood pressure can lead to stroke. (Source: Mayo Clinic, 2019)



38% of hemorrhagic strokes result in death in <30 days

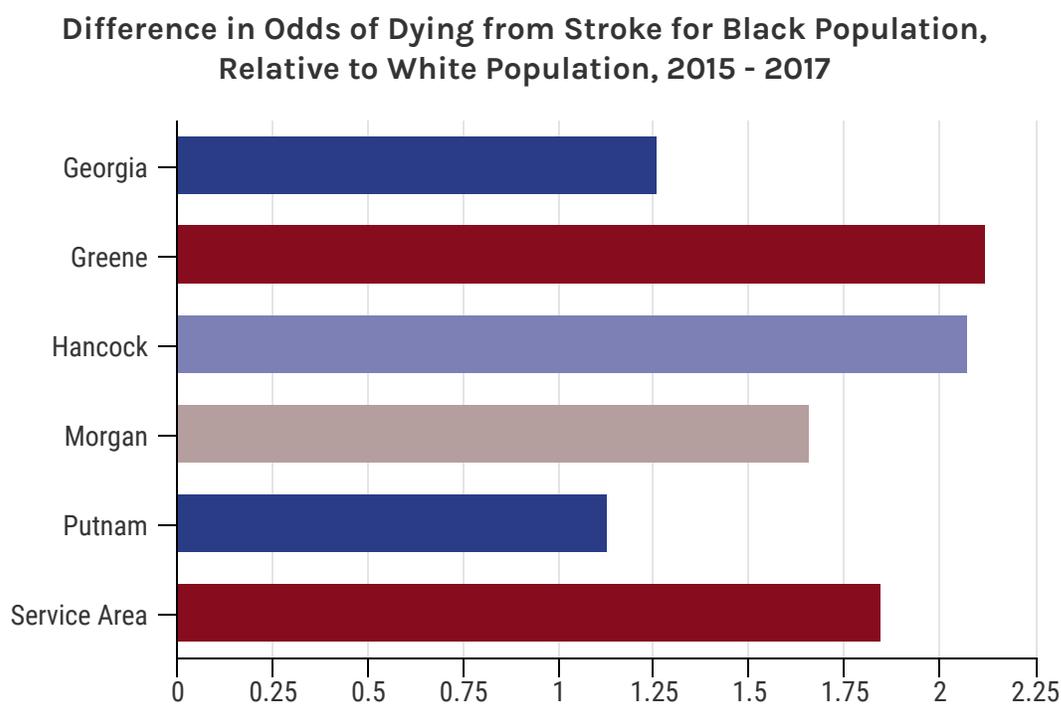


Being more than **37 miles** from a hospital increases the mortality rate for stroke by 3%

Persistent Disparities

In all five counties, Black residents had a higher rate of death from stroke than White residents. In Greene and Hancock counties, a Black resident was more than twice as likely to die from a stroke than a White resident, adjusting for age, from 2015 - 2017 (Source: OASIS, 2019).

The following graphic shows the magnitude of disparity by presenting the odds of dying from stroke for Black residents of the service area by county. The disparity was greatest in Greene and Hancock where a Black resident was more than twice as likely to die from a stroke than a White resident. Note: Rates for Taliaferro were unavailable. (Source: OASIS)



Health Department Data

- ➔ Health department interviews showed that many patients come in with **uncontrolled high blood pressure and cholesterol**, both of which put patients at significantly greater risk of experiencing stroke.
- ➔ **Transportation** needs were cited numerous times, including public transit, increased and improved local ambulance service, and hospital vans for patient appointments. This is a critical component of stroke prevention and treatment.

8 Cancer

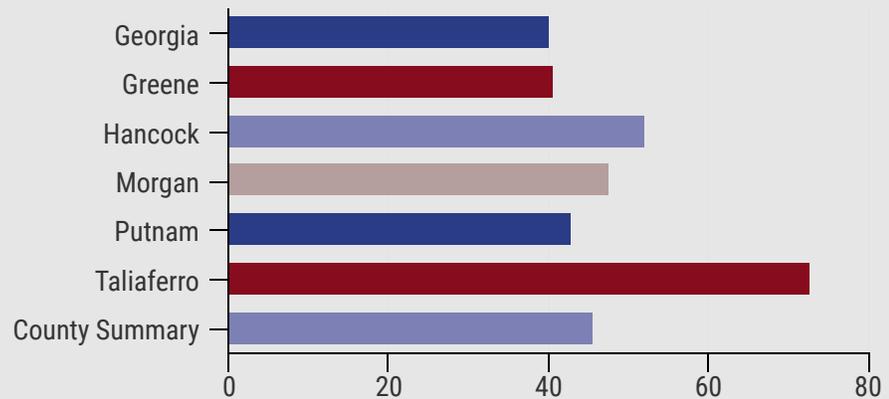
The number eight ranked health need is cancer. This category covers cancer of all types; the data in this overview is not comprehensive of cancer trends and specific diseases or stages within the category. According to the Georgia Department of Public Health, cancer is the second leading cause of death in the state. Here, secondary data are presented on lung cancer, which has some of the highest rates of prevalence and that are also largely preventable. As with the other health needs, cancer stood out as a concern across all data sources. Further, we examined and presented data on smoking, given that smoking is a major cause of cancer and prevalence of smoking is higher in the southern United States than other regions. Smoking cessation efforts, especially for pregnant women and low income families, can significantly decrease smoking and adverse outcomes related to that behavior. Similar to other health needs, health disparities were concentrated in low income, rural communities and were more pronounced for racial minorities.

Secondary Data

The service area age-adjusted death rate for **lung cancer** (at 45.5 per 100,000) was statistically significantly higher than the state rate of 40.1 from 2015 to 2017. (OASIS, 2019)

Taliaferro, Hancock, and Morgan counties had the highest age-adjusted death rates for **lung cancer** in the service area during this time period. (Source: OASIS, 2019)

Age-Adjusted Lung Cancer Death Rate (per 100,000), 2015 - 2017



Survey Data

* **18%** of households reported having a smoker



* **28%** of households in **poverty** reported having a smoker in their family



22% of respondents indicated that someone in their house had been diagnosed with cancer at some point



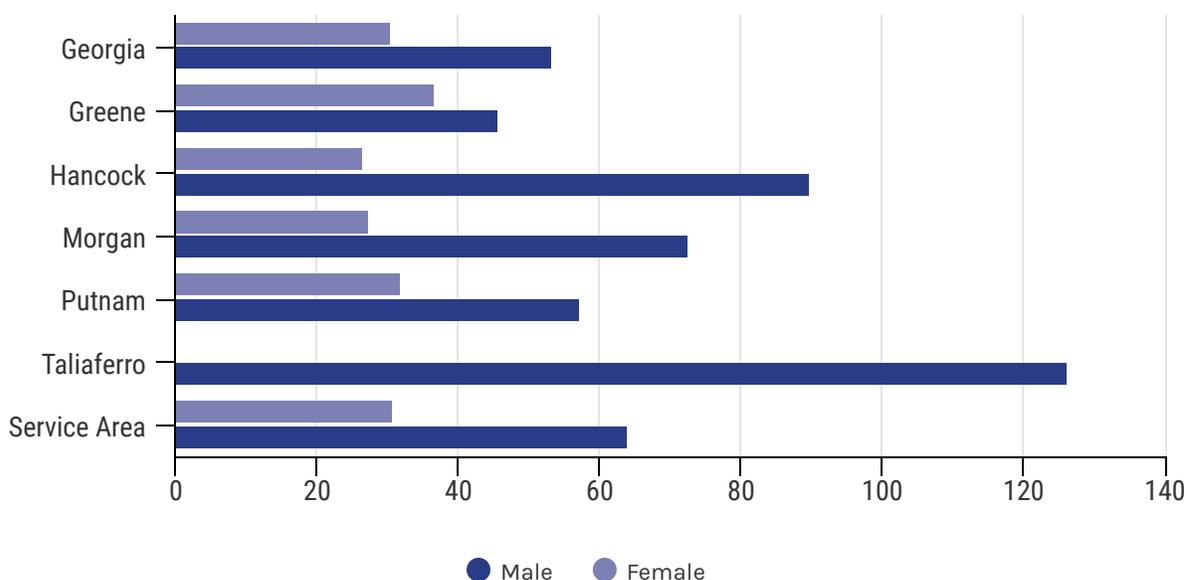
Average age of households with cancer: **59.9 years**

Persistent Disparities

In the five county service area, a Black resident was nearly twice as likely to die from colon cancer than a White resident, adjusting for both age and population, between 2015 and 2017.

In all counties, male residents were more likely to die from lung cancer than female residents between 2015 and 2017. The differences were especially pronounced in Hancock, Morgan, and Putnam. Note: rates for female lung cancer deaths were unavailable in Taliaferro County, where the rates of lung cancer for men are significantly higher than other counties. (Source: OASIS, 2019)

Gender Disparity in Lung Cancer Death Rates (per 100,000), 2015-2017



Focus Group Data

- ➔ **Access to specialty care** is a major issue in all service area counties, especially where focus groups were conducted. When a serious diagnosis such as **cancer** occurs, patients need timely access to specialty care and treatment.
- ➔ **Cancer** was commonly cited in the focus groups as one of the biggest health concerns.

9 Respiratory Health

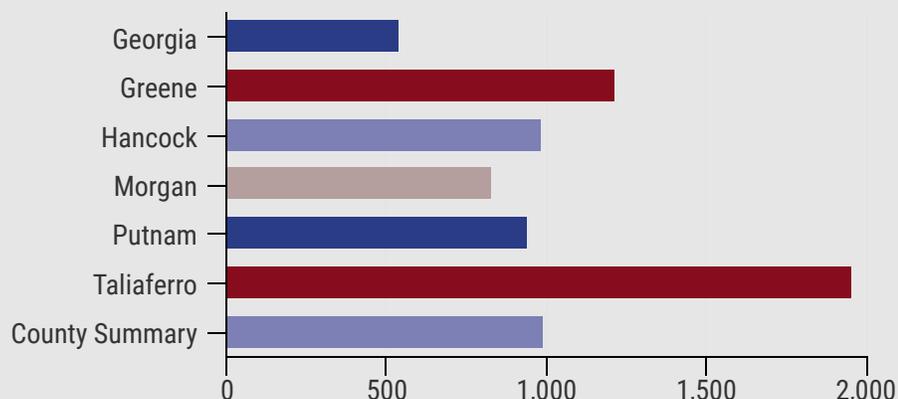
The number nine ranked health need is respiratory health. This category includes chronic conditions such as asthma and COPD, but also acute illnesses such as influenza and pneumonia. Due to the inextricable link between respiratory health and environmental factors (e.g. *air quality*), data are presented on household measures such as mold and pests in the home. We also present information on vaccination for influenza because of the link between vaccination and flu incidence and prevalence. Risky health behaviors such as smoking also compromise respiratory health, and are correlated with prevalence of emphysema. While mortality rates due to respiratory health issues in the five county service area were comparable to the state rate, there are striking and significant differences in emergency room visits. Similar to other health needs, health disparities were concentrated in low income, rural communities and were especially problematic for racial and ethnic minorities.

Secondary Data

Age-adjusted ED visit rate for **flu** was greater than the state rate in all counties between 2015 and 2017. In Greene it was more than three times the state rate. In Putnam it was more than double.

Age-adjusted ED visit rate for **pneumonia** was greater than the state rate in all counties from 2015 - 2017. In Taliaferro it was more than twice the state rate. (Source: OASIS, 2019)

Age-Adjusted Asthma ED Visit Rate (per 100,000), 2015 - 2017



Survey Data

* Did not get a **flu shot** in the last 12 months **41%**

* **28%** low income households have a smoker 



18% of respondents have asthma in their household



~8% of respondents have mold in their home



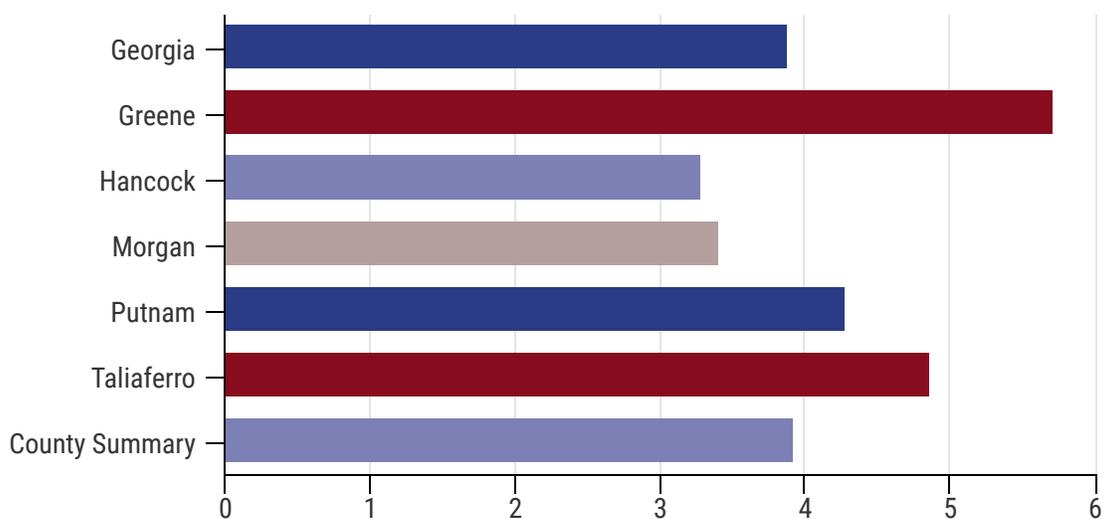
~10% of respondents have pests in their home

Persistent Disparities

In the five county service area, the age-adjusted ED visit rate for respiratory diseases for Black residents was nearly four times the age-adjusted rates for White residents in 2017 (OASIS, 2019). More specifically, all were more than three times the state rate, Putnam and Taliaferro were more than four times, and in Greene county a Black resident was over five times more likely to visit an ED for asthma between 2015 and 2017.

The graph below represents the orders of magnitude for ED visit rates for Black residents as compared to white residents in the state, the five counties, and the service area, overall.

Racial Disparity in Asthma Emergency Department Visits, 2015-2017



Focus Group Data



Asthma, especially among children was cited as one of the biggest health concerns in the community among focus group participants.

Regarding respiratory health among children, one person said: "smoking and vaping is a big problem here. The kids are all doing it."

10 Injuries & Accidents

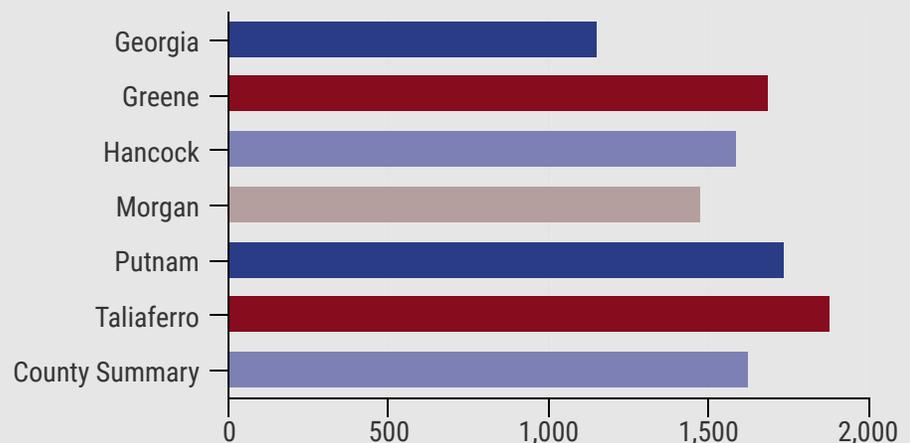
The number ten ranked health need is injuries and accidents. This category includes motor vehicle accidents and falls. Similar to other needs, health disparities were concentrated in low income, rural communities. Evidence from the International Journal of Preventive Medicine and the American Journal of Epidemiology shows that lower levels of education and socioeconomic status are associated with higher rates of mortality from motor vehicle crashes (Sehat, 2012; Harper, 2015). Age disparity is also an issue: falls are disproportionately experienced by older adults and motor vehicle crashes are disproportionately experienced by young adults.

Secondary Data

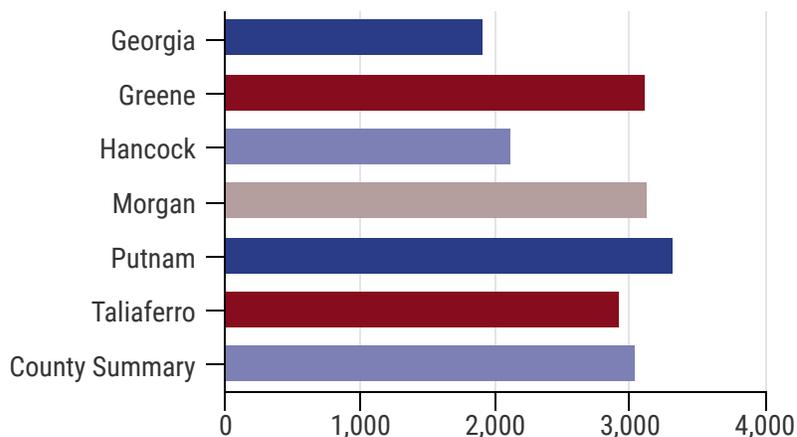
In each of the five counties, ED visit rates (per 100,000) for **motor vehicle crashes** exceeded the state rate from 2015 and 2017. (Source: OASIS, 2019)

Likewise, ED visit rates (per 100,000) due to **falls** were greater for each county in the service area than for the state between 2015 and 2017. (Source: OASIS, 2019)

Motor Vehicle Crash Rates (per 100,000), 2015 - 2017



Age-Adjusted Fall Rate (per 100,000), 2017 - 2015



Survey Data



65% of respondents traveled <30 minutes to the doctor



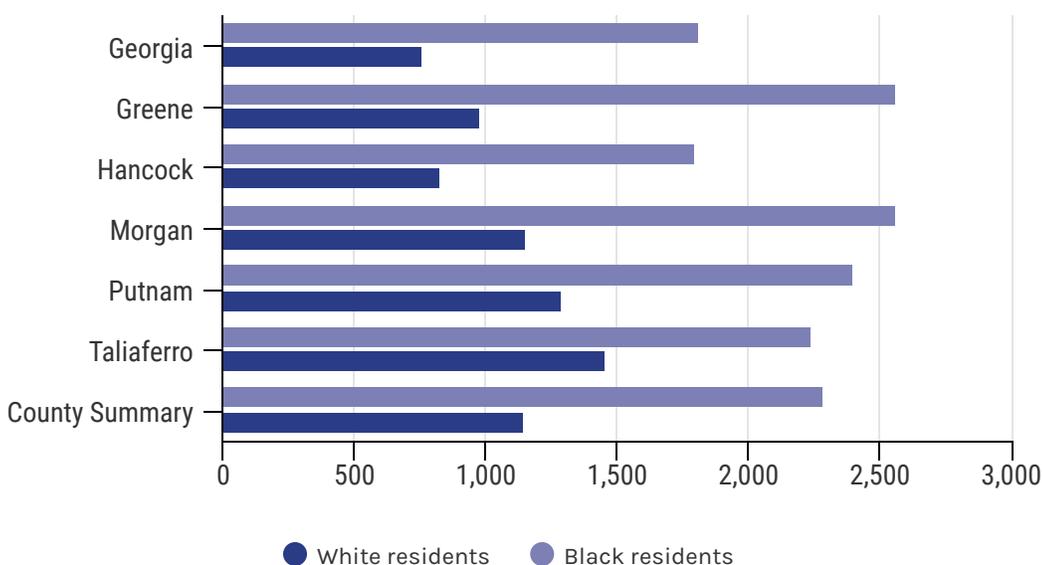
97% rely on a personal car as their primary source of transport

Persistent Disparities

In the five county service area between 2015 and 2017, men were nearly four times as likely to die from a fall than women. Conversely, women were slightly more likely to visit an emergency room than men due to a motor vehicle crash. (Source: OASIS, 2019)

In Morgan, Hancock, and Taliaferro counties, a Black resident was significantly more likely to visit the Emergency Department for a motor vehicle crash than a White resident from 2015 through 2017.

Motor Vehicle Crash ED Visit Rates (per 100,000) for Black and White Residents, 2017 - 2015



Focus Group Data

➔ **Transportation and access to ambulance services** were cited as major issues in all focus groups. When accidents or injuries occur, emergency care is needed and time is of the essence in treating serious injury.

"Car crashes are the cause of a lot of people dying under 40."

PRIORITIZATION OF NEEDS



Prioritizing Needs: *Building a Rubric*

Prioritizing Health Needs

In order to determine how to prioritize the health needs, we first conducted a Best Practices Analysis of existing resources. This included review of tools by The Centers for Disease Control and Prevention and World Health Organization; over 35 CHNAs from across the United States; publicly available city, county, and state health initiatives; and the Trinity Health System's CHNA toolkit. Finding no consistent method, our research team created a unique, customized rubric tool with which each health issue could be objectively and consistently prioritized using qualitative and quantitative measures. An example is included in this CHNA at the end of this section.

Rubric Inclusion Criteria

Face Validity: Does each element make sense on its own and with the others?

Objectivity: Can each criteria be scored using evidence and/or data as opposed to opinions?

Replicability: Can multiple people, working separately and given the same data, arrive at the same (or very nearly the same) final score?

Accessibility: Is each element of the rubric straightforward enough for an unfamiliar user to operate the tool?

Once the questions were determined, a scoring system was created. Each item had the potential to score from 0 (not applicable) through 4 (dire). A score of zero was given if the question was not applicable. Example: What is the average length of hospitalization for Healthcare Access? Though a lack of access may cause health problems that require hospitalization, lack of access itself did not. Therefore, a score of 0 was given.

Prioritizing Needs: *Building a Rubric*

Individual questions included on the rubric were placed into four distinct categories:

Micro: To what extent, if any, is this a health issue – right here, right now?

Equity: To what extent does this health issue disproportionately impact groups of people and are those groups already members of vulnerable populations?

Scope: To what extent is Good Samaritan hospital able to work on this health issue?

Macro: To what extent is this health issue impacting the whole population – right now and over time?

In order to give measures appropriate influence, each score was multiplied by a predetermined weight of 1 through 4. Weights were determined by Best Practice Analysis results, as well as consultations with each CHNA research team member. Example: A weight of 4 was applied to the measure “What is the prevalence?” whereas a weight of 2 was given for “What is the average length of hospitalization?” This was done in order to give greater impact to the pervasiveness of a health issue than to how long a health issue caused a person to be hospitalized. The image below shows how the score was calculated for each item on the rubric.



Prioritizing Needs: *Final Scores*

Once calculations for each rubric item was complete, weighted scores were totaled to give a final score to each health issue. The possible range of scores was from zero (if each measure was deemed “not applicable”) to 240 (if each measure was deemed “dire”). Final scores for the top ten health needs are presented below.

2019 CHNA Scores for the Top Ten Health Needs

1	Cardiovascular Health (216)	6	Reproductive Health (193)
2	Nutrition & Physical Activity (209)	7	Cerebrovascular Health (177)
3	Behavioral Health (208)	8	Cancer (172)
4	Maternal & Child Health (204)	9	Respiratory Health (159)
5	Healthcare Access (194)	10	Injuries & Accidents (133)

A sample rubric complete with the scores for cardiovascular health is included on the following page. Completed rubrics for each of the top ten health needs can be found in the Appendix to this report.

Prioritizing Needs: Sample Rubric

Organization: Good Samaritan

Health Issue: Cardiovascular

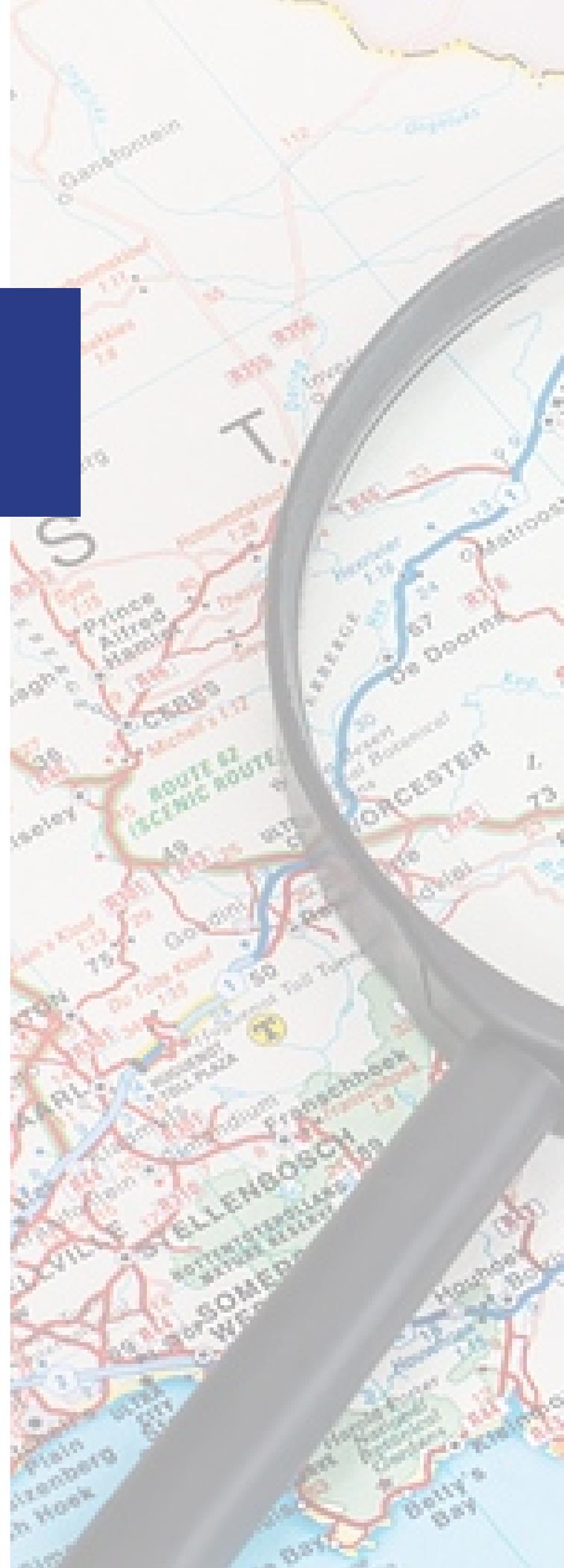
		N/A 0	Problem 1	Serious 2	Severe 3	Dire 4	Choose score:	Weight	Final score:
Micro	What is the prevalence?	-	0.1% to 9%	10% to 19%	20% - 29%	30% +	4	4	16
	What is the severity?	-	illness	severe illness	some death	premature death common	4	3	12
	What is our ability to evaluate outcomes?	-	anecdotal	anecdotal + some numbers	anecdotal + specific numbers	anecdotal + specific numbers over time	4	1	4
	What is the average required length of hospitalization?	-	none	1 to 6 days	7 days to 1 month	more than 1 month	2	2	4
	What is the average required length of treatment?	-	none	1 day to 1 month	1 month to 1 year	1 year to a lifetime	4	3	12
	Is this topic a theme in focus group or Health Department responses?	-	no	rarely	sometimes	often	3	4	12
Equity	Are specific groups more at risk?	-	no	yes one	yes some	yes several	4	2	8
	Are vulnerable populations disproportionately impacted?	-	no	yes one	yes some	yes several	4	4	16
Scope	Are there evidence-based interventions in place?	-	no	few	many	several / large scale	2	2	4
	Are there evidence-based interventions available?	-	no	few	many	several + gold standard	4	3	12
	Does this issue align with hospital mission/values?	-	no	partially	mostly	yes	4	4	16
	Is the hospital equipped to handle this issue?	-	no	partially	mostly	yes	2	3	6
	Is it appropriate for the hospital to handle this issue?	-	no	partially	mostly	yes	3	4	12
	Is there an opportunity to intervene at the prevention level?	-	no	little	some	yes	4	4	16
Macro	Has the community acknowledged this as an issue?	-	no	some acknowledgement	full acknowledgement	acknowledgement & action	4	2	8
	Is this issue trending up?	-	no	slightly	significantly	long time / large spike	4	4	16
	Is this a root cause of other health problems?	-	no	correlation	causation some	causation several	4	4	16
	Does this impact community issues?	-	no	few	some	many	3	2	6
	Are there barriers to intervention?	-	no	few	some	many	4	1	4
	What % of the population is at risk?	-	0.1% to 9%	10% to 19%	20% - 29%	30% +	4	4	16

Notes:

TOTAL

216

PROCESS & METHODS



Process & Methods: Mixed-Methods Approach

Methods Used

A mixed-methods approach was used, which is a combination of qualitative and quantitative data and analyses. Using a mixed-methods approach allows for more confidence in the findings of the CHNA and ensures robustness in identification of health needs. The methods to solicit input from primary sources (survey data, focus groups, health department interviews) are detailed in Section V. Where secondary data sources were used, a quantitative approach was applied. This means that population estimates (e.g. the percentage of people experiencing a particular condition such as heart disease) were examined for each county in the service area and aggregated across counties. Averages were calculated for the service area counties in aggregate form where appropriate.

Secondary data were downloaded from the hosting institution's website (see the previous table). Time trends were accounted for by downloading several years for each indicator--where possible we examined at least eight years of data to examine and show longitudinal measures (typically 2010-2017). When data had limited availability (e.g. one cross section, or year), the latest available year was collected and reported.

Description of Study Team

The study team was composed of faculty and graduate students from the College of Public Health and the J.W. Fanning Institute for Leadership at the University of Georgia. Dr. Grace Bagwell Adams (College of Public Health) served as the Principal Investigator for the CHNA and oversaw research design, data collection, data analysis, and composition of the final report. Graduate students (see Acknowledgments for a full list of team members) from the College of Public Health, the College of Pharmacy, and the School of Public and International Affairs contributed to all aspects of project development and data analysis. Ben Gardner served as the Project Manager for the Athens-Clarke County data collection efforts.

Dr. Maritza Soto Keen, Dr. Carolina Darbisi, Lori Tiller, and Emily Bonness of the J.W. Fanning Institute for Leadership designed and facilitated the focus groups with stakeholders in service area counties. They also conducted theme analysis of focus group data and wrote the findings for that aspect of CHNA data collection. Graduate student Rachel Colegrove assisted in focus group facilitation.

Process & Methods: Data Overview

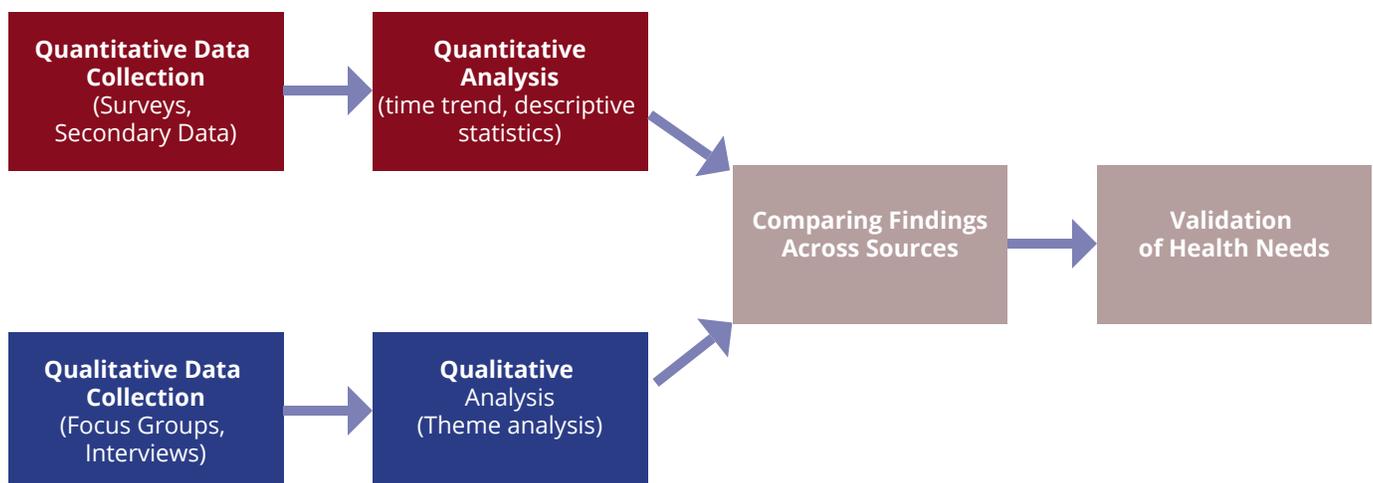
There were five main data sources used for the 2019 CHNA. These data sources used can be broken into two main types:

1. Primary Data

Primary data are data that were generated by the CHNA process. These are original data sources that were collected by the study team and include three outputs for this study, each of which are detailed in Section VI of this report: 1) surveys in primary service area counties; 2) focus groups in service area counties; 3) interviews with health department key personnel in service area counties.

2. Secondary Data

Secondary data are data that were publicly available from existing sources including local, state, and federal agencies that routinely collect and report population-level data. These sources were free and available to download for analysis and reporting purposes. In order to measure both supply and demand-side factors, secondary data were collected on the demographics, healthcare utilization, and health outcomes of service area populations in addition to supply-side measures on the number of licensed physicians, specialists and the health provider shortage areas in service-area counties. Each of these sources are detailed in table on the next page; all observation time frames were collected for the latest available date as of Spring 2019.



2019 CHNA Secondary Data Source List

Dataset	Indicator Focus	Observation Time frame	Source
Behavioral Risk Factor Surveillance System (BRFSS)	Health-related risk behaviors by county and service area	2011-2012, 2018	Centers for Disease Control and Prevention
Census QuickFacts	Demographic factors by county	2017	U.S. Census Bureau
Health Professional Shortage Areas	HPSA Scores (1-26) for Primary Care, Mental Health, and Dental by county	2017	Health Resources & Services Administration
Area Health Resource Files	Count and rate of health practitioners by county	2016	Health Resources & Services Administration
OASIS Emergency Department Utilization	Emergency Department visits by disease type, county, race, and payor	2010-2017	Georgia Department of Public Health
OASIS Mortality	Causes of Death by disease type, county, and race	2010-2017	Georgia Department of Public Health
OASIS Hospital Discharges	Hospital discharges by disease type, county, race, and payor	2010-2017	Georgia Department of Public Health
OASIS Opioid Mortality	Opioid deaths by drug category and county	2014-2017	Georgia Department of Public Health
County Health Rankings	Social determinants of health; health outcomes, county-level rankings	2018	Robert Wood Johnson Foundation

COMMUNITY PARTNERS



Community Partners

The hospital system engaged with several community partners in order to complete the Community Health Needs Assessment. These partners include health departments in each of the 17 counties in the service area, the J.W. Fanning Institute for Leadership, and the College of Public Health at the University of Georgia.

St. Mary's Community Benefit Manager, Alex Lundy, and Director of Corporate Health Services, Courtney Vickery, assembled and oversaw the community benefits team that coordinated with the College of Public Health and the J.W. Fanning Institute to design the CHNA approach. The data collected and analyzed provide unique representation of underrepresented groups and special populations that have historically been medically underserved.



**UNIVERSITY OF
GEORGIA**
College of Public Health

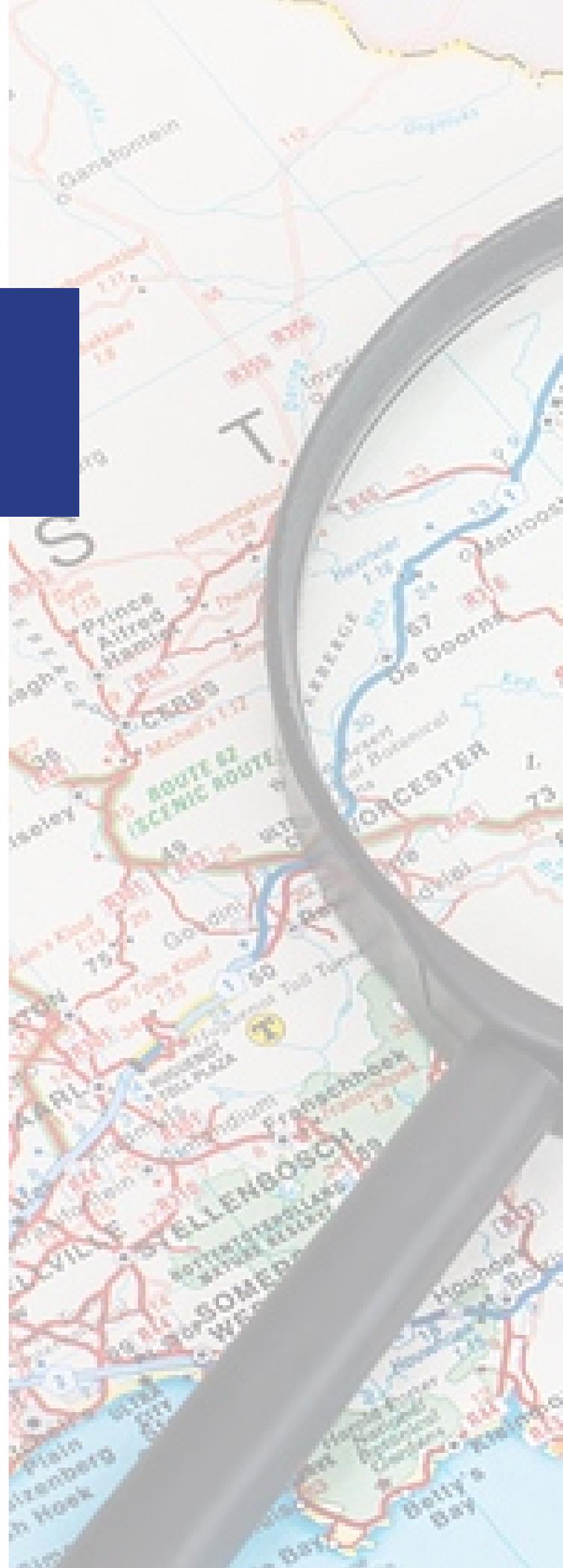


**J.W. Fanning Institute
for Leadership Development**
UNIVERSITY OF GEORGIA

 **ST. MARY'S**
Good Samaritan HospitalSM

A Member of Trinity Health

COMMUNITY INPUT



Community Input: *Health Department Interviews*

Local Organizations: County-Level Health Department Interviews

Community input was gathered from each health department in the hospital service area. This was done by emailing key health department staff members an open-ended interview questionnaire with the questions listed in the table below.

An internet search and phone calls were used to determine staff members names and email addresses. Emails were sent on 2/22/2019 and 2/25/2019. Follow up phone calls and emails were done on 2/26/2019 and 2/27/2019, respectively. Input was provided beginning on 2/22/2019 and continued through 4/8/2019.

Health Department Interview Questions	
1	What county does your health department serve?
2	What are the greatest health needs you see in the county?
3	What is going well in the county in terms of meeting those needs?
4	How can healthcare providers (hospitals, doctors, health departments) improve to better serve county residents?
5	Please share any additional thoughts or comments.

Upon completion of the health department interviews, a methodological approach was used called theme analysis. Responses were examined for common phrases, themes, and points of discussion and grouped into specific health needs (i.e. “hunger,” “access to health foods,” and “mental health”). Each health need was then recorded by the number of times that it was identified, and by the county of origin for the response.

Summary of Input Received

Common themes for almost all health departments responding included issues of health access, in particular, interviewees stated that the biggest barriers were access to free or low cost primary medical care and preventative services, and mental healthcare. Many counties in the service area also referenced the need for access to reproductive health services and the challenges of teen pregnancy and prevention of sexually transmitted infections. Other common themes present in all responses included high blood pressure, mental health disorders and their prevalence, substance use issues, and nutrition. Specific references to vulnerable populations and the medically underserved, especially those who experience poverty, food insecurity, and homelessness were also common concerns noted by health department officials.

Community Input: *Medically Underserved*

Medically Underserved & Low Income: *Secondary & Survey Data*

Both secondary and survey data were collected to examine health access, utilization, and outcomes for the medically underserved and low income populations in the hospital service area. Secondary data from OASIS, HPSA, & AHRF were examined at the county level by sub-groups that included racial and ethnic minorities, low income populations, and insurance payor (self pay, Medicaid, Medicare, and privately insured), and rural residency. Secondary sources were downloaded in January 2019 and analyzed through March 2019.

A household survey was developed by utilizing questions from the Athens Wellbeing Project (AWP) survey, each of which is a validated measure. Survey items related to health and demographics were used to create a health-specific survey for all primary counties in the hospital service areas outside of Athens-Clarke. Additional measures were added based on iterative feedback from the St. Mary's Healthcare System Community Benefits Team. In particular, measures on transportation, physical activity, and financial challenges were added to the measures taken from the AWP survey to compose a comprehensive survey instrument. This survey, designed to specifically complement the existing secondary data, included questions related to healthcare access, chronic conditions, health behaviors (including risky behaviors and healthy behaviors), benefit utilization, preventive health measures (e.g. vaccines).

The survey was designed and administered using the *Qualtrics* platform. The survey was accessible through St. Mary's website, redirecting respondents to the *Qualtrics* site. Promotion to garner respondents was done by handing out information cards at St. Mary's, Good Samaritan, and Sacred Heart campuses, as well local businesses, health departments, libraries, and doctor's offices. The cards explained how to access the survey, and advertised the \$100 weekly raffle drawing for survey respondents. Promotion was also done through AWP Facebook, Instagram, and Twitter accounts. Survey data collection began in Athens-Clarke County on October 15, 2018 and surrounding service area counties on November 15, 2018. The survey officially closed on February 1, 2019.

Community Input: *Medically Underserved*

Community input from survey data was used to identify health needs by calculating descriptive statistics from responses across all variables and by sub-populations. Survey data measures were compared to secondary data sources by health area where possible. For example, self-reported prevalence of household conditions (*i.e. anxiety and depression*) were examined in conjunction with population health measures from the Department of Health's OASIS data on county-level health data (*i.e. ER visits and hospitalizations due to mental health disorders*). Triangulation of cross-sectional survey data with longitudinal secondary data increased confidence and validity of identification of health needs. A copy of the survey instrument is included in the Appendix of this CHNA document.

Demographic Measures

- Age
- Race/ethnicity
- Socioeconomic status
- Education
- Household composition
- Insurance status
- Benefits received

Health Measures

- Chronic conditions
- Health status
- Healthcare access
- Experience with healthcare utilization
- Risky health behaviors
- Preventive health measures (e.g. vaccinations)

Social Determinant Measures

- Transportation access and utilization
- Housing status
- Housing condition
- Social capital

Community Input: *Medically Underserved*

Summary of Input Received

A total of 272 completed surveys were received across the Good Samaritan service area: this includes 208 surveys from Greene County, 47 surveys from Putnam County and 17 surveys from surrounding counties. Survey respondent demographic trends reflected the demographics of the population across a variety of characteristics (for demographic information from American Community Survey please see the county profiles in the Community Served section of this report).

Data on specific health conditions from secondary and survey sources are presented in the section on the Top 10 Health Needs, but a few indicators capturing vulnerability of medically underserved populations are important to highlight here. Surveys asked families, for example, if they would be worried about being able to pay if they were presented with an unexpected medical bill. The overwhelming majority of respondents indicated (>70%) that they were at least somewhat worried.

Respondents were also asked if they had trouble finding a general doctor in the last 12 months. Results showed one in five (~20% of low income families) had trouble finding a doctor, and of these 25% did not get the care they needed. More data on healthcare access are provided throughout the next section on health needs.

Community Input: *Broader Community*

Community Stakeholders: Focus Groups with Individuals Representing Broader Interests of the Communities

Faculty from the J.W. Fanning Institute for Leadership designed and facilitated focus groups to collect data from counties in the secondary service areas. The focus group instrument was created using instruments from other health organizations across the country using a best practices analysis. Questions were selected from many of these instruments, similar or overlapping questions were thrown out or condensed, and ultimately an instrument with six questions was agreed upon.

Focus Group Instrument

What makes a community healthy?

Where does the community usually get healthcare when they need it?

Probe: What about specialty care?

What about mental and behavioral care?

What about the uninsured and underinsured in your community?

What are the most significant barriers that keep people in the community from accessing health care? (i.e. insurance, availability of providers, transportation, cost, language/cultural barriers, accessibility, awareness of services)

Focusing on specific health issues, what would you say are the biggest health problems in the community?

In terms of being a healthier community, how would you like your community to be different in 3 years?

After the instrument was created, counties in the secondary service areas were contacted. For Good Samaritan in Greene County, the secondary counties included Hancock, Morgan and Taliaferro. To begin recruitment for the focus groups, the team at Fanning contacted stakeholders in each county. St. Mary's also publicized these focus groups on their Facebook page and website. Invitations were sent out via email and phone. In most counties, ten to fifteen community organizations were recruited to participate in the focus groups.

Community Input: *Broader Community*

Focus Group Data Collection Details.

County	Date	Time	Location
Hancock	February 27, 2019	12:00-1:30pm	Hancock Central High School
Morgan	February 15, 2019	12:00-1:30pm	Morgan County Library
Taliaferro	March 4, 2019	5:00-6:30pm	116 Monument Street, Crawfordville

At almost all of the focus groups, community stakeholders and representatives from local agencies attended. Several focus groups also had residential community members who were not in health or social services professions. At the focus group meetings, food and beverages were provided and the focus group instrument was used to lead the discussion with participants. Detailed notes were taken with each focus group, and notes were then compiled to create a master document for the St. Mary's service area.

Thematic analysis was conducted after each focus group was completed. Notes were taken during the focus group, and theme analysis extracted common topics from focus group participants. Themes and findings were shared across College of Public Health and Fanning teams to integrate into the identification and prioritization of health needs. Once theme analysis was complete, focus group data were compared to secondary quantitative measures and primary survey data.

Summary of Input Received

The data collected from focus groups provided a valuable counterpart to the primary and secondary data analysis that we conducted using quantitative data. After aggregating the notes from each focus group in the service area, we looked for themes in the notes and recurring topics that were brought up in each of the focus groups. Though these counties vary in some measures according to the secondary data, the focus group dialogues revealed that they all face many of the same health issues and concerns, and they also share the same goals and aspirations for the future of their community and its health. The focus group findings also helped connect health needs that were found in the secondary data. Health needs do not typically exist in isolation of one another, and the focus group data made a lot of these connections clear. Through the focus group findings, we also gleaned deeper understanding on some of the more complex issues around healthcare access (e.g. transportation and ambulance transports). Overall, the focus group findings gave depth and dimension to survey and secondary data.

Community Input: *Broader Community*

As the secondary data suggests, some of the larger, most prevalent issues facing these communities are around nutrition and access to healthy foods. Focus group participants cited obesity and diabetes as some of the largest health issues facing their communities. Behind these issues are a more general lack of education and awareness of healthy foods, but also lack of access to those healthy foods. These claims can be corroborated by the food environment indices in these counties, along with rates of obesity and diabetes.

Another central finding from the focus groups was a general lack of access to health care services, particularly around a lack of access to transportation. Many of these counties have no public transportation system, and individuals without a car are often unable to receive the healthcare that they need as a result. This issue is compounded by insufficient numbers of clinics, primary care offices, dentist offices and urgent care clinics in these counties--almost all counties in the service area are technically Health Provider Shortage Areas (HPSAs) as defined by the U.S. federal government. This means that the supply of health care professionals are not adequately proportional to the population in these counties.

Thus, even with reliable transportation, patients have nowhere to go in these communities and they are often forced to travel outside the county to seek services. Connected to the issue of access to care, focus group attendees lamented the lack of mental health providers in their counties and the issues patients face if they need therapy or counseling. Substance abuse is a growing concern in these counties. The comorbidity of substance abuse and mental health issues are highlighted in Behavioral Health in the Top Ten Health Needs section, and is bolstered by significant quantitative and clinical empirical evidence.

Though the focus group participants discussed many specific clinical issues that their community members faced, the social determinants of health and wellbeing were discussed far more frequently and highlighted as the most pressing concerns in their communities. Issues such as income inequality and education were discussed at length as reasons that preventable diseases take lives in their communities. From the focus groups, it was clear that rural communities are particularly vulnerable and underserved. The rural nature of many of these communities also contributes to poorer health outcomes and lower county health rankings. And despite measures taken, such as telemedicine systems installed in Hancock County, issues persist and health needs continue to arise in these communities due to deeper issues pertaining to the social determinants of health.

In closing, it is important to note that many focus group attendees were unaware that St. Mary's Health Care System served their community, and were hopeful that St. Mary's Health Care System would build facilities in their county. This particular finding is useful for St. Mary's Health Care System in thinking about how to serve the counties in their service area--especially those that are more rural in nature and experience greater health disparities as a result.

Community Input: *Broader Community*

Though the focus group participants discussed many specific clinical issues that their community members faced, the social determinants of health and wellbeing were discussed far more frequently and highlighted as the most pressing concerns in their communities. Issues such as income inequality and education were discussed at length as reasons that preventable diseases take lives in their communities. The rural nature of many of these communities also contributes to poorer health outcomes and lower county health rankings.

From the focus groups and conversations with the community members present, it was clear that these rural communities are particularly vulnerable and underserved. Very few attempts have been made to improve health outcomes in some of these rural counties, and some suffer from even the most basic issues such as lack of emergency care and ambulances. One participant told a personal story about an allergic reaction she suffered from as a result of a new medication. This reaction happened outside of business hours, and because her county did not have a proper supply of ambulances or emergency care, she nearly died before she was taken to a hospital in a surrounding county and given an emergency tracheotomy. The doctors later told her that she had been minutes from death. If her county had sufficient ambulances and an urgent care facility available to its residents, she could have avoided this traumatic experience entirely. This is one participant's story--and the mixed methods approach used in this study resulted in findings that suggest healthcare access (albeit complex) is the ubiquitous theme in the service area as being the largest barrier to healthy communities.

In closing, it is important to note that many focus group attendees were unaware that St. Mary's served their community, and were hopeful that St. Mary's would build facilities in their county. This particular finding is useful for St. Mary's in thinking about how to serve the counties in their service area--especially those that are more rural in nature and experience greater health disparities as a result.

Appendix A: Resource Guide



County	Agency	Description of Services	Address	Number
Banks	Banks County Health Department	Family planning, immunizations, chronic disease management, STI testing, dental, physical activity, tobacco use prevention	667 Thompson St. Homer, GA 30547	706-677-2296
Banks	Medlink Banks	Chronic disease management, immunizations, family planning, cancer prevention, diabetes management, nutrition education, STI testing	1244 Historic Homer Hwy. Homer, GA 30547	706-677-4568
Elbert	Teen Matters	Family planning, STI testing, health education, immunizations, nutrition and exercise education	618 Jones St. Elberton, GA 30635	706-283-3775
Elbert	Elbert County Behavioral Health Center	Individual therapy, drug court program, AOD group programs	50 Chestnut St. Elberton, GA 30635	706-213-2048
Franklin	University Cancer and Blood Center	Integrative oncology care	355 Clear Creek Pkwy. Lavonia, GA 30553	706-356-2934
Franklin	Medlink Royston	Chronic disease management, immunizations, STI testing, drug and alcohol testing, medication assistance	930 Franklin Springs Ste. A Royston, GA 30662	706-245-5050
Hart	UGA Cooperative Extension	Nutrition classes and assistance	200 Arthur St. Hartwell, GA 30643	706-376-3134
Hart	Medlink Hartwell	Chronic disease management, immunizations, family planning, cancer prevention, diabetes management, nutrition education, STI testing	63 West Gibson St. Hartwell, GA 30643	706-376-6100
Hart	Hart County Health Department	Family planning, immunizations, chronic disease management, STI testing, dental, physical activity, tobacco use prevention	64 Reynolds St. Hartwell, GA 30643	706-376-5117
Hart	Heart Ministries	Drug and alcohol counseling and education, relapse prevention, spiritual guidance	1150 Bear Creek Rd. Lavonia, GA 30553	706-453-7929
Hart	Rainbow Pantry	Food assistance	191 Campbell St. Royston, GA 30662	706-245-0965
Hart	Ninth District Opportunity	Emergency food assistance, rent and utility assistance, family development counseling, transportation assistance, SNAP application, community resource coordination	500 North Richardson St	706-376-4150
Stephens	Stephens County Health Department	Family planning, immunizations, chronic disease management, STI testing, dental, physical activity, tobacco use prevention	64 Boulevard, Ste 102 Toccoa, GA 30577	706-282-4507
Stephens	University Cancer and Blood Center	Integrative oncology care	1656 Falls Rd, Suite B Toccoa, GA 30577	706-353-2990
Stephens	Stephens County Food Bank	Food assistance	W Whitman St. Toccoa, GA 30577	706-886-9075