WELLSTAR Health System

2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

Your **Health.** Our **Mission.**

WellStar North Fulton Hospital

WellStar North Fulton Hospital

EIN: 81-0851756
3000 Hospital Blvd.
Roswell, GA 30076

WellStar North Fulton Hospital is a 202-bed facility located in Roswell, Georgia. North Fulton is recognized for its Accredited Cancer Program and Primary Stroke Center designations and for being one of only three state-designated Level II Trauma Centers in metro Atlanta. North Fulton Hospital is known for providing a continuum of services through its centers and programs, including neurosciences, pain management, cardiology, women's services, rehabilitation, surgical services and oncology. With this combination of commitment and expertise, North Fulton Hospital caters services to the unique healthcare needs of all patients in the north Fulton area.

North Fulton Hospital is a proud member of the WellStar Health System. WellStar, the largest health system in Georgia, is known nationally for its innovative care models and is focused on improved quality and access to healthcare. WellStar is dedicated to reinvesting back into the community with innovative treatments and state-of-the-art technology and facilities. Its vision is to deliver world-class healthcare.

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This report serves to identify and assess the health needs of the community served by WellStar North Fulton Hospital. Submitted in fiscal year ended June 30, 2019, to comply with federal tax law requirements set forth in Internal Revenue Code Section 501(r) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in IRC Section 501(c)(3).

A digital copy of this CHNA is publicly available:
www.wellstar.org/chna

Date CHNA adopted by the WellStar board of trustees:
June 6, 2019

Date CHNA made publicly available:
June 30, 2019

Community input is encouraged. Please address CHNA feedback to
chna@wellstar.org

Community Is **Care**

BEING THE BRIDGE

Executive Summary

This report utilizes a data-driven approach to better understand, identify and prioritize the health needs of the community served by WellStar North Fulton Hospital, a not-for-profit hospital under the Internal Revenue Code (IRC) Section 501(r). WellStar North Fulton Hospital is a 202-bed facility recognized for its Accredited Cancer Program and Primary Stroke Center designations and for being one of only three state-designated Level II Trauma Centers in metro Atlanta. Known for providing a continuum of services through its centers and programs, including neurosciences, pain management, cardiology, women's services, rehabilitation, surgical services and oncology, the hospital caters its services to the unique healthcare needs of all patients in the north Fulton area.

Community Health Needs Assessment

The 2010 Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a community health needs assessment (CHNA) and implementation plan every three years to better meet the health needs of under-resourced populations living in the communities they serve. What follows is a comprehensive CHNA that meets industry standards, including Internal Revenue Service regulations set forth in the Additional Requirements for Charitable Hospitals section of IRC 501(r).

WellStar partnered with the Georgia Health Policy Center (GHPC) to complete a comprehensive CHNA process, which includes synthesis of:

Similar to the 2018 assessment, the primary focus of data collection for this assessment was on under-resourced, high-need and medically underserved populations living in 17 zip codes concentrated in the primary service area of Cherokee, Cobb, Dawson, DeKalb, Forsyth, Fulton, Gwinnett and Pickens counties. The primary differences that can be found in this assessment are:

- The footprint of the service area is slightly smaller, going from 20 zip code areas to 17 zip code areas, while the counties included in this assessment increased from three (Cherokee, Cobb and Fulton) to eight (adding Dawson, DeKalb, Forsyth, Gwinnett and Pickens),
- The service area has become more diverse, with slightly more health needs than in 2018,
- Comparisons are made between the two assessments when possible and
- The primary and secondary data have been updated and more data have been included when possible.

Priority Health Needs

In 2018, WellStar North Fulton Hospital worked with community and hospital leaders to identify the top community health priorities based on the data included in this assessment.[1] The community health priorities identified for the service area include improving:

1. Behavioral healthcare
2. Parental education and support
3. Access to appropriate care
4. Overuse and abuse of opioids

Key Findings

There are specific populations identified in this assessment that experience greater barriers to being healthy, along with higher disease burden and death. This assessment has identified the following populations as the focus of further study and targeted investment to address persistent disparities:

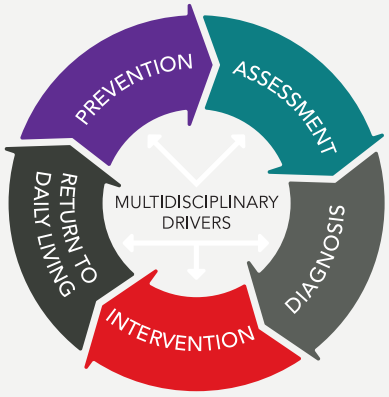
- Black and Latino residents
- Single parents
- People without legal immigration status
- Residents from zip codes 30096 and 30076

In general, the community residents served by WellStar North Fulton Hospital are of average age, higher-income-earning and more diverse than is average for the state. Cobb and Gwinnett counties have a larger population of Hispanic residents, while DeKalb and Fulton counties have larger populations of Black residents. Forsyth and Gwinnett have larger Asian populations. Among the eight counties served by WellStar North Fulton Hospital, DeKalb and Gwinnett counties have higher populations of residents with limited English-speaking skills when compared to all other counties in the service area.

Social Determinants of Health

At first glance, the community served by WellStar North Fulton Hospital appears to have few health needs related to social determinants of health.[2] However, a closer look at the data by race, ethnicity and income shows evidence of pockets where the burden of social determinants of health are higher than in the rest of the service area. An example of this is seen in the rate of poverty among single-parent families. While single-parent families experience the highest rates of poverty throughout the service area, Cherokee and Pickens counties show the sharpest increase in single-parent poverty when compared to all other types of families (see Table 3, Population Below the Federal Poverty Level by Family Status and County). Another example is seen in Figure 2, where Latino/Hispanic residents are three times more likely and Black residents are nearly twice as likely to be in poverty when compared to their White and Asian counterparts. This was also reflected in the 2018 report.

Figure 1 | Care Continuum



This assessment also found that many residents do not have access to the most appropriate care to meet their needs due to insurance status, immigration status, the inability to navigate available services, the number of providers, quality of care and lack of transportation. Residents have access to appropriate care when there is a properly functioning continuum of care available to them. See Figure 1 for one example of a care continuum. There is evidence in both the secondary and primary data of disruptions in the care continuum throughout the service area. Often, examples of these disruptions are identified through anomalies in data such as:

- Health professional shortage areas
- Hospitalization for preventable issues
- Higher-than-average mortality rates

1 *See the Primary Data and Community Input, Community Health Summit, section of the Appendix for more detailed information about the community health priorities.*

2 *According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."*

These anomalies warrant further investigation to better understand and address the causes.

During the last three years, there has been a shift in the socioeconomic status of the communities included in this assessment. These changes are reflected in the percentage of the population that:

- Is unemployed, uninsured and has limited English-speaking skills, which has decreased slightly,
- Experiences poverty, which has increased for families, and
- Are single parents and experiencing poverty, which has increased in many Fulton County zip codes.

Health Outcomes

There are several undesirable health outcomes in the service area. Most of the top five causes of death in the service area are related to chronic conditions, lifestyle, behaviors (i.e., heart disease, stroke, lung cancer and kidney disease) or behavioral health and substance abuse issues. Across the service area, residents of Dawson and Pickens counties have a higher disease burden and death rate. Black, Hispanic and Multiracial residents have the highest rates of poor health outcomes (often higher than state rates) when compared to any other racial or ethnic cohort in the service area. These health disparities are most notable among the following conditions:

Health Issues

There are several health issues that are prevalent regardless of race or ethnicity throughout the service area. These include:

Investments in addressing these issues would improve the health of the community served by WellStar North Fulton Hospital.

Data Limitations

There are several limitations to be aware of when considering the CHNA findings:

- Most of the data included in this assessment are available only at the county level. County-level data are an aggregate of large populations and does not always capture or accurately reflect the nuances of health needs. This is particularly important for WellStar North Fulton Hospital, because the service area includes north Fulton County, which data shows has higher socioeconomic status, as well as much lower morbidity and mortality rates than the central or southern regions of Fulton County. Where smaller data points were available (i.e., for census tracts or zip codes), they were included.
- Secondary data are not always available. For example, there is no secondary data source that offers a valid measure of educational awareness in the context of healthy options and availability of resources. In absence of secondary data, this assessment has noted relevant anecdotal data gathered from residents and stakeholders with lived experience during primary data collection. It is important to note that primary data are limited by individual vocabulary, interpretation and experience.
- There is no measure of the accessibility and effectiveness of available services listed in the Community Facilities, Assets and Resources section of the Appendix, particularly for underinsured and uninsured residents.

Community Is **Commitment**

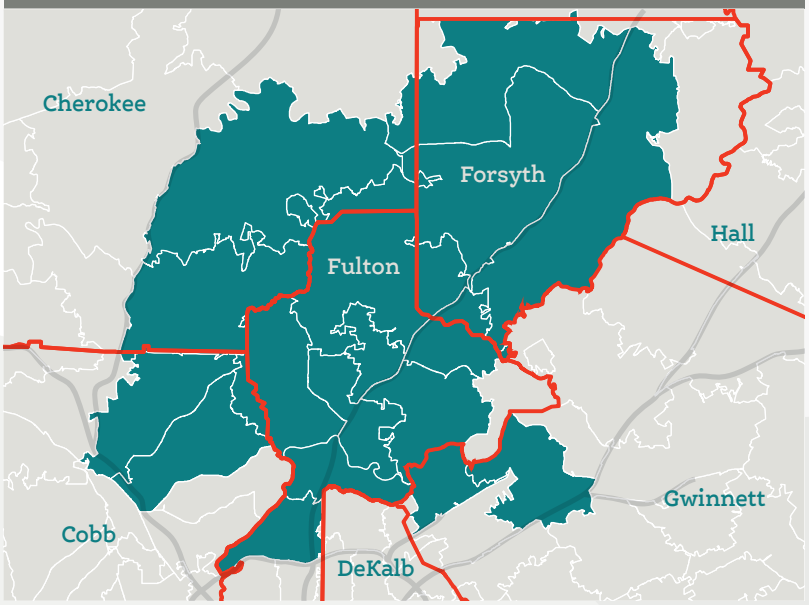
WE EXIST TO SERVE

Community Definition

WellStar North Fulton Hospital is located in Roswell, Georgia, approximately 30 miles north of Atlanta. For the purposes of the CHNA, the primary service area for the hospital is defined as the 17 zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of the zip codes are from Forsyth and Fulton counties. Additional counties were added by WellStar Community Health Collaborative members to provide a more comprehensive understanding of the geographical region surrounding the primary service area.

The CHNA considers the population of residents living in the 17 residential zip code area regardless of the use of services provided by WellStar or any other provider. More specifically, this assessment focuses on residents in the service area who are medically under-resourced or at risk of poor health outcomes.

Map 1 | Primary Service Area of WellStar North Fulton Hospital†



† *Truven Health Analytics, Community Needs Index*

Table 1 | Primary Service Area of WellStar North Fulton Hospital†

County	Zip Codes (17)	Population (2018)
Fulton	30004, 30005, 30009, 30022, 30075, 30076, 30328, 30350	351,504
Cobb	30062, 30066	122,387
Cherokee	30115, 30188	108,170
Gwinnett	30092, 30096	102,423
Forsyth	30028, 30041, 30040	171,956
Dawson		
DeKalb		
Pickens		

† *Truven Health Analytics, Community Needs Index*

Demographic Data

by County and State (2018)*

WellStar North Fulton Hospital

When compared to Georgia, the community served by WellStar North Fulton Hospital is of average age, higher-income earning and more diverse. Cobb and Gwinnett counties have a larger population of Hispanic residents, while DeKalb and Fulton counties have larger populations of Black residents. Forsyth and Gwinnett have larger Asian populations. Among the eight counties served by WellStar North Fulton Hospital, DeKalb and Gwinnett counties have higher populations of residents with limited English-speaking skills.

Total Population

US TOTAL POPULATION

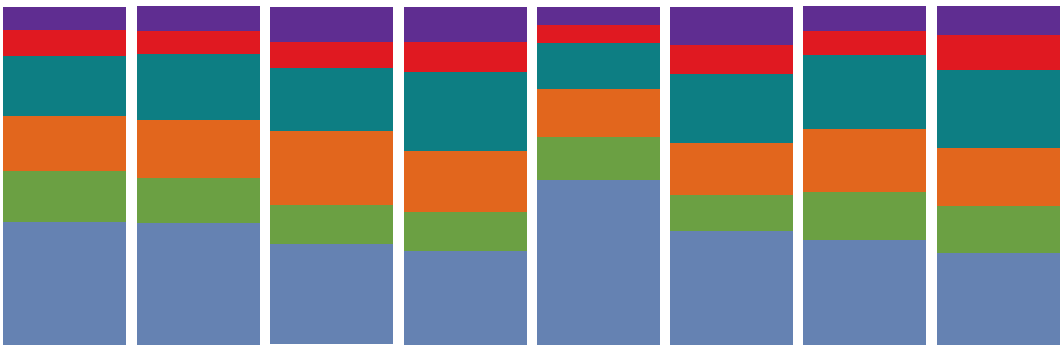
326,533,070

CHEROKEE	COBB	DAWSON	DEKALB	FORSYTH	FULTON	GWINNETT	PICKENS
266,801	761,725	27,520	820,822	171,956	1,110,620	927,828	31,103

Income Distribution (2012-16)

U.S. MEDIAN HOUSEHOLD INCOME

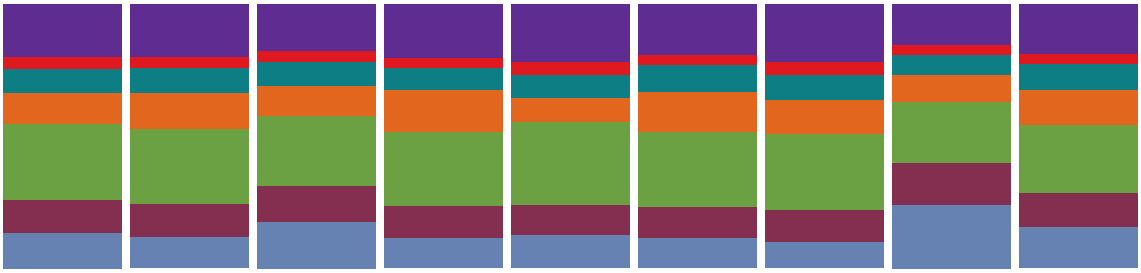
$55,511.00



	CHEROKEE	COBB	DAWSON	DEKALB	FORSYTH	FULTON	GWINNETT	PICKENS
Median household income (2012-16)	$72,586	$68,818	$59,265	$52,623	$91,842	$58,851	$61,865	$56,769
Less than $15,000	6.70%	7.20%	10.30%	10.20%	5.30%	11.10%	7.20%	8.30%
$15,000 - $24,999	7.80%	6.80%	7.90%	9.00%	5.30%	8.60%	6.90%	10.40%
$25,000 - $49,999	17.70%	19.40%	18.60%	23.40%	13.70%	20.60%	22.00%	23.00%
$50,000 - $74,999	16.50%	17.20%	21.70%	18.00%	14.30%	15.40%	18.70%	17.40%
$75,000 - $99,999	15.00%	13.40%	11.70%	11.80%	12.60%	10.60%	14.10%	13.70%
$100,000 and over	36.40%	36.00%	29.70%	27.60%	48.90%	33.80%	31.10%	27.20%

* *Truven Health Analytics, Community Need Index*
Demographics Expert 2.7, 2018 Demographic Snapshot
U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: www.census.gov/programs-surveys/acs/
Community Commons CHNA Portal: CHNA.org

Age Distribution



	CHEROKEE	COBB	DAWSON	DEKALB	FORSYTH	FULTON	GWINNETT	PICKENS	U.S.
Median age in years (2012-16)	37.7	36.2	42.8	35.2	38.1	35.0	34.8	44.8	38.1
0-14 (2018)	20.00%	19.90%	17.80%	20.40%	21.80%	19.00%	21.70%	15.40%	18.70%
Change 2018-23	-1.70%	-1.10%	-1.20%	-0.30%	-2.60%	-0.80%	-2.00%	-1.10%	ND
15-17 (2018)	4.50%	4.10%	4.10%	3.60%	4.80%	3.90%	4.80%	3.60%	3.90%
Change 2018-23	0.00%	+0.10%	0.00%	+0.30%	+0.20%	+0.10%	0.00%	0.00%	ND
18-24 (2018)	9.10%	9.30%	8.80%	8.50%	8.80%	10.10%	9.80%	7.60%	9.70%
Change 2018-23	+0.90%	+0.20%	+0.50%	0.00%	+1.70%	-0.20%	+0.50%	+0.40%	ND
25-34 (2018)	11.60%	13.70%	11.70%	15.60%	9.10%	15.30%	12.60%	10.40%	13.40%
Change 2018-23	-0.10%	-1.20%	-0.10%	-2.40%	+0.80%	-1.70%	+0.10%	+0.20%	ND
35-54 (2018)	28.70%	28.80%	26.40%	28.30%	31.30%	28.50%	29.10%	23.10%	25.50%
Change 2018-23	-2.40%	-1.20%	-1.90%	-0.20%	-4.00%	-0.30%	-2.20%	-2.00%	ND
55-64 (2018)	12.70%	12.20%	13.70%	11.80%	11.50%	11.60%	11.80%	15.90%	12.90%
Change 2018-23	+0.90%	+0.70%	+0.30%	+0.30%	+2.30%	+0.80%	+1.20%	-0.50%	ND
65+ (2018)	13.50%	12.00%	17.50%	11.70%	12.60%	11.60%	10.20%	24.00%	15.90%
Change 2018-23	+2.40%	+2.40%	+2.40%	+2.30%	+1.70%	+2.10%	+2.40%	+3.00%	ND

ND: Comparable data representing national age categories were available for 2018 only. As a result "percent change 2018-23" are not available for the U.S.

Racial/Ethnic Distribution

	CHEROKEE	COBB	DAWSON	DEKALB	FORSYTH	FULTON	GWINNETT	PICKENS	U.S.
White	77.90%	50.80%	91.70%	29.40%	74.30%	39.70%	39.70%	91.90%	60.40%
Black	7.10%	27.60%	1.20%	52.10%	3.60%	42.10%	26.30%	1.60%	12.40%
Hispanic‡	10.50%	13.20%	4.40%	9.40%	10.00%	7.60%	19.70%	3.90%	18.20%
Asian and P.I.	2.10%	5.40%	0.80%	6.60%	10.10%	8.10%	11.40%	1.00%	5.80%
Limited English	5.17%	7.62%	1.67%	9.01%	6.49%	5.61%	15.05%	1.24%	10.00%

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Community Is **Contribution**

ASSESSING THE NEEDS

Data Collection

The Georgia Health Policy Center (GHPC) partnered with WellStar to implement a collaborative and comprehensive CHNA process.

The secondary data included in this assessment are from a variety of sources that are both reliable and representative of the community served by WellStar North Fulton Hospital. Data sources include, but are not limited to:

- Centers for Disease Control and Prevention,
- Community Commons,
- Community Needs Index,
- County Health Rankings and Roadmaps,
- Georgia Department of Public Health,
- Georgia Prevention Project and
- U.S. Census Bureau.

Many of the publicly available data sources are only available at the county level, not in smaller segments. However, where possible, the data was analyzed at the zip code or census tract level to get a more comprehensive understanding of the needs in the community. Data sources reviewed for this assessment can be found with the associated data tables.

To better understand the experience and needs of the residents living in the areas served by the hospital, several types of qualitative data were used, including focus groups with residents, one-on-one interviews with key stakeholders, a listening session with the WellStar North Fulton Regional Health Board and a health summit with hospital and community leaders. An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community Is **Connection**

YOUR STORY IS OUR STORY

Health Needs of the Community

Understanding the health of a community and what residents need to be healthier requires consideration of a variety of factors. According to the World Health Organization, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[3]

This assessment includes a consideration of the following factors from the perspectives of community and hospital leaders, residents and secondary data:

- Social determinants of health
- Access to and use of appropriate care
- Health behaviors
- Health outcomes

Community health can be measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings, a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. County Health Rankings health outcomes measure length of life and quality of life. With the exception of Dawson County, the counties included in this assessment have county health rankings in the top quartile in each measure. Rankings in the top quartile represent the best mortality and morbidity measures when compared to counties throughout the rest of the state. Among the counties served by WellStar North Fulton Hospital, Dawson, DeKalb, Fulton and Pickens counties all show the poorest rankings, with the exception of clinical care in Fulton and DeKalb counties.

Table 2 | County Health Rankings by County (2018)*†

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Cherokee	3	6	4	3	6	28	5	148
Cobb	7	5	6	11	2	22	8	82
Dawson	23	13	64	7	9	57	13	133
DeKalb	18	24	15	28	12	8	64	103
Forsyth	1	2	1	1	1	9	2	53
Fulton	14	19	19	19	10	3	66	95
Gwinnett	5	9	2	8	3	38	16	128
Pickens	16	10	45	6	13	27	17	30

* *There are 159 counties in Georgia. According to America's Health Rankings, in 2018 the state of Georgia is ranked 39th when compared to other states: www.americashealthrankings.org/explore/annual/state/GA*

† *County Health Rankings and Roadmaps: countyhealthrankings.org*

The leading causes of death in the hospital service area are similar to the 2018 report when compared to those in the state. The top cause of death in both the service area and throughout the state is coronary artery disease.[4] The remainder of the top five causes of death are (1) cerebrovascular disease (stroke); (2) lung cancer; (3) behavioral health causes (unrelated to psychoactive substance use); and (4) essential (primary) hypertension and hypertensive renal and heart disease (kidney disease).[5]

3 *World Health Organization, Constitution of WHO: principles, http://www.who.int/about/mission/en/*

4 *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

5 *See the Secondary Data section of the Appendix for a ranked list of causes of death in Georgia*

Social Determinants of Health

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." While poverty is not pervasive in the service area, this assessment offers evidence of populations with high socioeconomic barriers to being healthy.

During key informant interviews, community leaders noted areas where families do not have legal immigration status and where there are high rates for unemployment, poverty and uninsured, specifically in Cherokee County (30115 and 30188) and south Cobb County. Additionally, secondary data show high socioeconomic barriers to being healthy in the Gwinnett County zip code area of 30096. Community input cited a lack of economic security in some areas, poor employment options and homelessness as contributing factors to the health needs in the WellStar North Fulton Hospital community. One focus group participant noted:

> "Some people choose to live in certain areas based on affordability and what their finances allow but, you know, their job and the job market and where they're able to find employment is impacted as well."

Unemployment has decreased across the area in the last 10 years. During the same period, household income in Cherokee County increased $2,606 and remained stagnant in Cobb and Fulton counties, rising only $351 and $498, respectively.[6]

Over the last decade, poverty in the general population has increased slightly in the service area (change ranged between 0.9 percent and 3.4 percent). This pattern is replicated across the service area regardless of family status, especially in the case of single-parent families. Single-parent families have experienced the highest rates of poverty. This trend also is found in zip code-level data (see Table 3). Single-parent families in Cherokee and Pickens counties saw the greatest increase in poverty during the last 10 years when compared to the rest of the service area.

6 *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

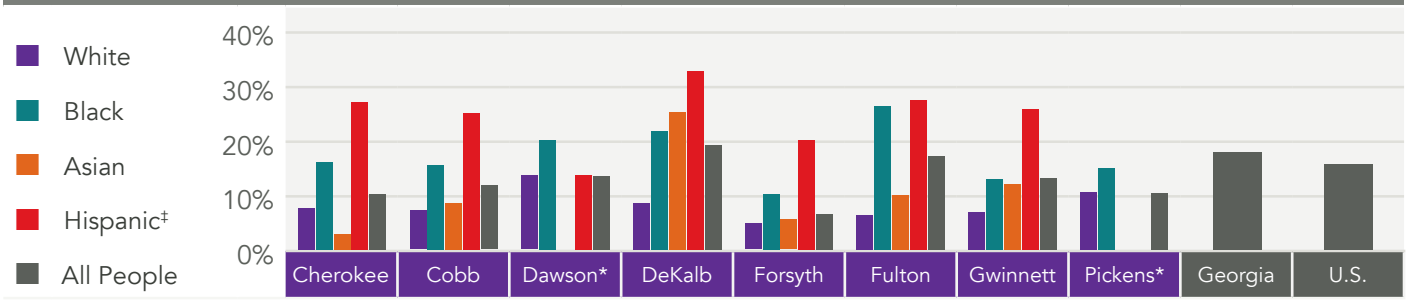
Table 3 | Population Below the Federal Poverty Level by Family Status and County (2006-2015)†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens
Total Households								
2006-10	74,339	256,741	8,163	264,837	55,380	357,463	260,375	11,268
2011-15	79,133	268,616	8,213	267,396	62,295	379,957	274,017	11,286
All people								
2006-10	7.40%	10.60%	12.00%	16.10%	6.00%	15.30%	11.00%	11.60%
2011-15	10.80%	12.40%	14.20%	19.30%	6.90%	17.60%	13.80%	11.60%
All families								
2006-10	5.50%	7.60%	7.80%	12.40%	4.50%	12.00%	8.70%	8.90%
2011-15	8.50%	9.40%	9.60%	15.00%	5.00%	13.00%	11.30%	8.60%
Married couple families								
2006-10	3.80%	3.50%	5.10%	5.50%	2.60%	3.60%	5.10%	7.30%
2011-15	5.10%	5.20%	7.70%	8.00%	3.40%	4.40%	7.70%	6.50%
Single female head of household families								
2006-10	15.80%	22.10%	25.50%	25.30%	19.50%	31.80%	22.90%	24.10%
2011-15	24.90%	23.00%	12.30%	28.80%	16.90%	33.20%	24.70%	43.40%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles*

Figures 2 and 3 show the disparities in the poverty and education rates of various racial and ethnic communities throughout the service area, with Latino, Black and Asian residents showing the highest rates of poverty and lowest rates of educational attainment when compared to their White counterparts. Latino/Hispanic residents are three times more likely and Black and Asian residents are nearly twice as likely to be in poverty when compared to their White counterparts. Latino/Hispanic residents are nearly four times more likely not to have a high school diploma when compared to their White counterparts. Black and Asian residents are nearly twice as likely as their White counterparts not to have a high school diploma.

Figure 2 | Population Below Federal Poverty Level by Race/Ethnicity and County (2012-2016)†

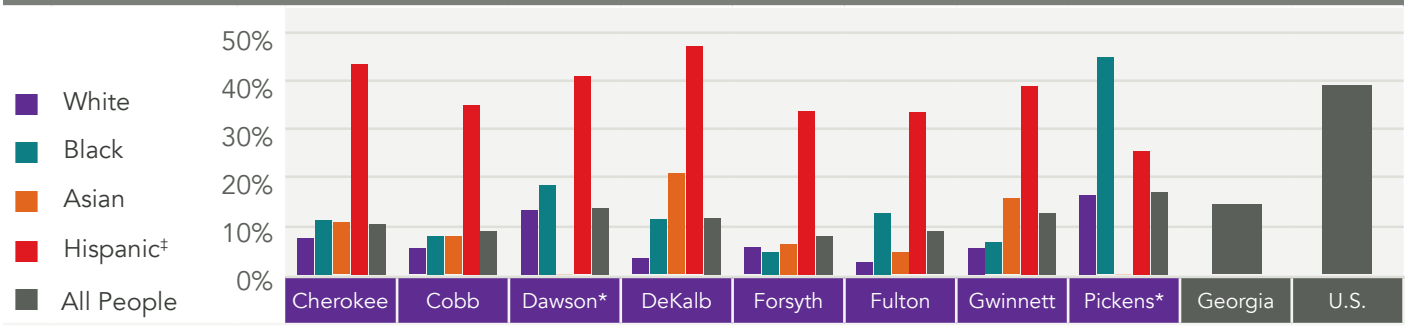


† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/ Community Commons CHNA Portal: CHNA.org*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

* *0.00% can result from sample size and margin of error*

Figure 3 | Percentage of Population Without a High School Diploma by Race/Ethnicity and County (2012-2016)†



† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/ Community Commons CHNA Portal: CHNA.org*

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* *0.00% can result from sample size and margin of error*

Housing

The quality, age, availability and affordability of housing influence the health of residents in the community. One focus group participant said:

> "It just depends on what area you're in as to what the prices are. And when you get to the areas inside the Perimeter, where you have the big pockets of the lower economic status, you're gonna find substandard apartments (and) substandard facilities."

In the last 10 years, home values and homeownership have declined, with home ownership replaced by renting.

As the Atlanta metropolitan area rebounds from the housing crisis, older homes are replaced by newer dwellings, many of which are larger apartment units. This, coupled with the population growth and decreasing vacancy rates, may be setting the community up for challenges related to unaffordable housing and displacement. Input provided by community leaders during the Health Summit noted homelessness as a growing concern in the community.

Table 4 shows that approximately 31 percent of households throughout the service area spend more than 30 percent of their income on mortgages, while approximately 50 percent of households spend more than 30 percent of their income on rent each month.

Table 4 | Selected Housing Indicators by County (2006-2015)†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens
Total households								
2006-10	74,339	256,741	8,163	264,837	55,380	357,463	260,375	11,268
2011-15	79,133	268,616	8,213	267,396	62,295	379,957	274,017	11,286
Family households								
2006-10	76.80%	67.80%	75.90%	58.90%	80.10%	56.00%	75.60%	72.80%
2011-15	74.80%	68.20%	75.30%	58.50%	81.20%	54.60%	76.40%	76.20%
Nonfamily households								
2006-10	23.20%	32.20%	24.10%	41.10%	19.90%	44.00%	24.40%	27.20%
2011-15	25.20%	31.80%	24.70%	41.50%	18.80%	45.40%	23.60%	23.80%
Vacant housing units								
2006-10	7.30%	9.30%	19.60%	12.30%	9.30%	16.90%	9.20%	17.10%
2011-15	6.50%	7.70%	22.10%	12.70%	9.70%	14.60%	7.50%	17.50%
Homes more than 20 years old								
2006-10	36.60%	59.10%	42.20%	69.30%	22.90%	61.40%	41.20%	48.50%
2011-15	60.60%	79.50%	66.90%	80.70%	52.40%	73.50%	69.30%	63.50%
Median value of homes								
2006-10	$201,900	$211,000	$201,400	$190,000	$276,700	$253,100	$194,200	$170,600
2011-15	$190,500	$197,400	$188,300	$163,000	$267,300	$241,300	$167,700	$175,000
Households paying more than 30% of income for monthly mortgage								
2006-10	37.50%	33.30%	47.60%	40.20%	30.90%	37.20%	38.50%	40.00%
2011-15	28.60%	26.50%	35.40%	35.00%	26.30%	31.70%	33.50%	32.50%
Households paying more than 30% of income for monthly rent								
2006-10	49.90%	49.60%	47.30%	53.70%	47.80%	50.60%	50.70%	55.30%
2011-15	48.20%	49.20%	49.40%	54.10%	44.90%	50.40%	54.20%	48.40%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

Zip code-level data shows that most of the zip codes served by WellStar North Fulton Hospital have below-average socioeconomic barriers (see Table 5 for Community Need Index [CNI] data in selected zip code areas). A closer look at the data shows a geographic pocket in Gwinnett County where educational attainment and English language skills are low and unemployment and poverty are high, specifically in the 30096 zip code. In the 30096 zip code:

- Over 20 percent of single-parent families are in poverty,
- Almost one in 10 residents has limited English-speaking skills and
- Nearly 12 percent of residents have no high school diploma.

There are existing resources throughout the service area that address the social determinants of health.[7] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the social determinants of health noted in the CHNA.

7 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

Access to Appropriate Care

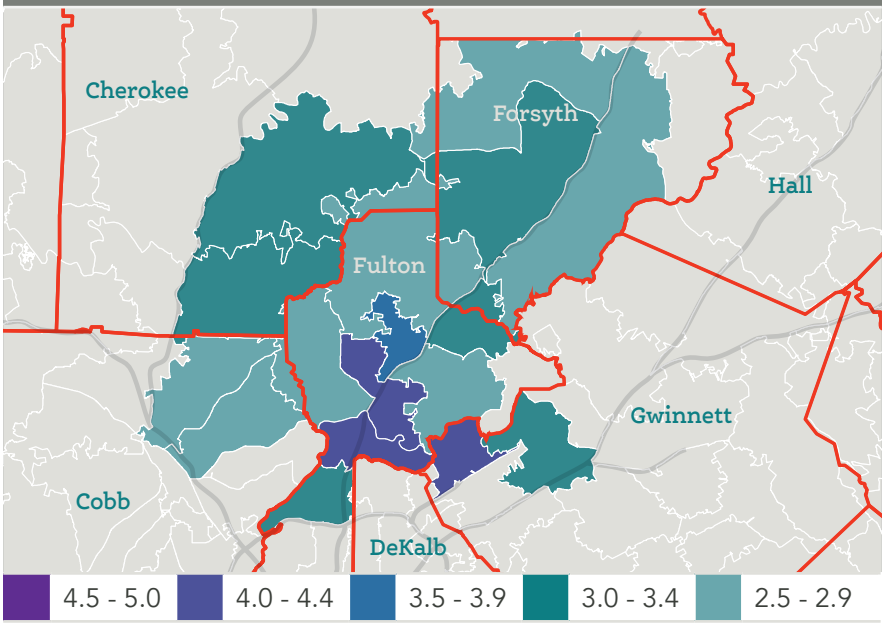
Having access to the right care at the right time influences health outcomes as well as healthcare-seeking behavior, according to the input provided by residents and community leaders. Community Health Summit participants identified access to appropriate care as one of the top community health priorities to address. Often, there are a variety of factors associated with the access residents have to appropriate care, such as insurance status, legal status, residents' ability to navigate available services, number of providers, quality of care and transportation.

Input from community residents noted several safety-net providers have closed recently and, as a result, there are not adequate safety-net services, and the services that are available are not culturally and linguistically relevant to meet the needs of all residents. One example is the limited access that residents without legal immigration status have to any form of healthcare.

Socioeconomic Factors

The CNI ranks each zip code in the United States against all other zip codes on five socioeconomic factors that are barriers to accessing healthcare: income, culture, education, insurance and housing.[8] Each factor is rated on a scale of 1 to 5 (1 indicates the lowest barrier to accessing healthcare and 5 indicates the most significant). A score of 3 is the median for the scale.

Map 2 | WellStar North Fulton Hospital 2018 CNI Scores by Zip Code†



The previous CHNA for WellStar North Fulton Hospital included 2015 CNI data. Since the last assessment, five counties have been added to the service area, and the number of zip codes has been decreased to 17. During the last four years, the community served by WellStar North Fulton Hospital has experienced the following notable changes:

- Three zip code areas showed improvement in overall CNI score, while seven zip code areas showed an increase,[9]
- There were decreases in the percentage of the population who were unemployed,
- Poverty among single-parent households increased in seven zip code areas, with the greatest increase in 30076 (18%) and
- It is notable that Fulton County continues to show a stark contrast between areas with the greatest and those with the least amount of socioeconomic barriers to accessing healthcare.

8 See the Secondary Data section of the Appendix for complete CNI data.

9 Increases in CNI scores between 2014-18: Cobb (30062 and 30066) and Fulton (30004, 30022, 30075, 30328 and 30350).

Map 2 and Table 5 depict the 2018 CNI scores for the WellStar North Fulton Hospital service area. According to the 2018 CNI, most of the zip codes served by the hospital have below-average socioeconomic barriers to accessing healthcare. A closer look shows:

- The zip code with the highest CNI score was 30096 (4.2), which is in Gwinnett County,
- 71 percent of zip code areas show barriers that are lower than median for the scale,
- One primary county covered in this assessment showed a decrease in barriers, DeKalb (0.1), while two counties showed increases, Pickens (0.1) and Forsyth (0.1),
- Five zip codes showed increases in the barriers to accessing healthcare between 2017 and 2018,[10]
- 12 zip codes showed no change in the barriers to accessing healthcare between 2017 and 2018 and
- All the zip codes areas have lower rates of uninsured than the state (15.8 percent).

Each factor is rated on a scale of one to five (one indicates the lowest barrier to accessing healthcare and five indicates the most significant).

Table 5 | 2018 Community Need Index (CNI): 5 Highest Barrier vs. 5 Lowest Barrier Zip Codes†

Geography		Scores		Income			Culture		Education	Insurance		Housing
Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	LES	Minority	No High School Diploma	Unemployed	Uninsured	Renting
5 Areas With the Highest CNI Scores												
30096	Gwinnett	0.0	4.2	11%	22%	40%	9%	71%	12%	7%	14%	52%
30076	Fulton	0.0	3.6	5%	14%	36%	7%	46%	9%	4%	9%	40%
30092	Gwinnett	0.2	3.6	3%	13%	24%	6%	52%	7%	5%	10%	44%
30350	Fulton	0.2	3.6	10%	15%	35%	3%	53%	5%	6%	13%	64%
30009	Fulton	0.0	3.2	9%	9%	28%	3%	42%	5%	5%	8%	48%
5 Areas With the Lowest CNI Scores												
30062	Cobb	0.0	2.4	5%	5%	20%	4%	33%	6%	4%	7%	20%
30066	Cobb	0.0	2.4	6%	7%	18%	2%	32%	4%	5%	7%	20%
30004	Fulton	0.0	2.2	6%	6%	19%	2%	36%	4%	3%	5%	22%
30075	Fulton	0.2	2.2	5%	6%	27%	2%	22%	4%	4%	6%	19%
30041	Forsyth	0.0	2.0	5%	4%	19%	2%	27%	6%	5%	6%	14%
	Cobb Total	**0.2**	**3.4**	**7%**	**17%**	**34%**	**4%**	**47%**	**9%**	**10%**	**12%**	**32%**
	Fulton Total	**0.1**	**3.7**	**14%**	**21%**	**37%**	**3%**	**60%**	**10%**	**12%**	**18%**	**45%**
	Gwinnett Total	**0.0**	**3.5**	**9%**	**17%**	**32%**	**7%**	**59%**	**12%**	**10%**	**12%**	**29%**

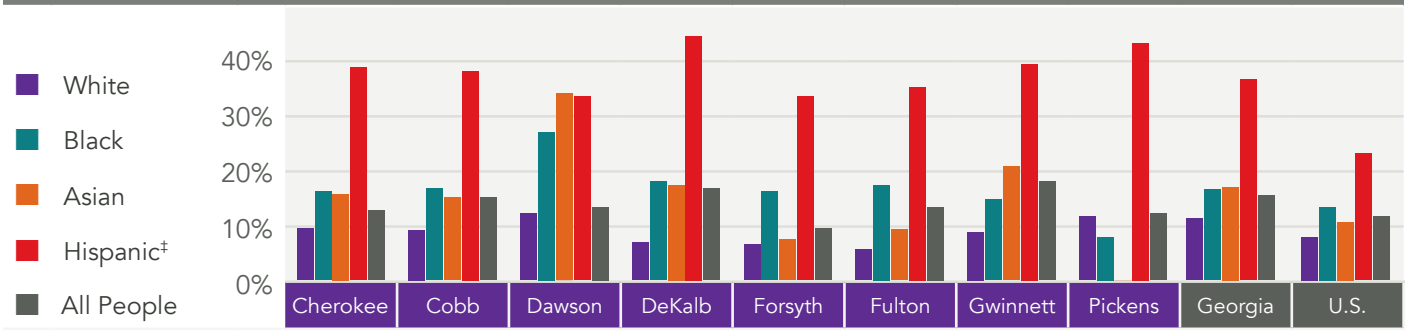
† *Truven Health Analytics, Community Needs Index (2018)*

10 Increases in CNI scores between 2017-18: Forsyth (30028), Fulton (30005, 30350 and 30075) and Gwinnett (30092).

Uninsured

A greater percentage of Georgia residents are uninsured than the national average due to the lack of Medicaid expansion. As reflected in the 2018 report, the percentage of uninsured residents in DeKalb and Gwinnett counties is higher than the state average when considering the general population. Figure 4 shows the disparities in the rates of uninsured when considering the data by racial and ethnic groups throughout the service area, with Latino, Black and Asian residents showing the highest rates of uninsured when compared to their White counterparts. Latino/Hispanic residents are four times more likely to be uninsured, while Black and Asian residents are more than twice as likely when compared to their White counterparts. These findings are similar to those in the 2018 report.

Figure 4 | Percentage of Uninsured Population by Race/Ethnicity and County (2012-2016)†



0.00% can result from sample size and margin of error

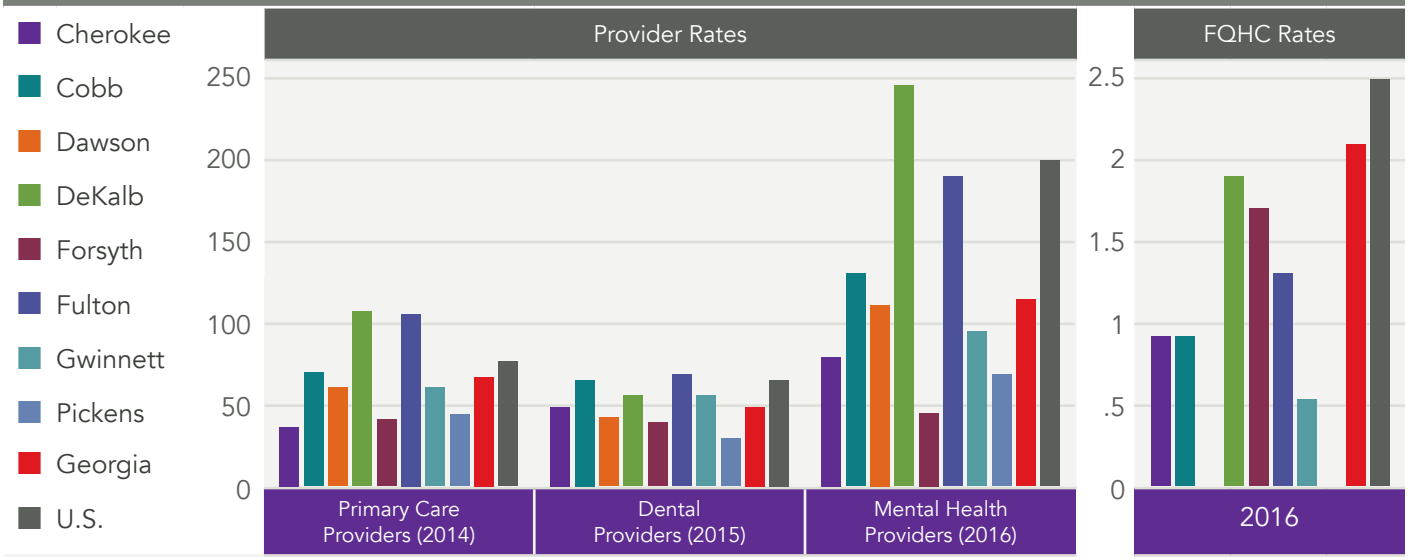
† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Provider Shortage

There is a shortage of healthcare and dental providers throughout the community, particularly among safety-net providers offering free or reduced-price care based on income (see Map 3 for a geographic representation). Cherokee County has the fewest primary care providers, Pickens County has the fewest dental care providers and Forsyth County has the fewest mental health providers in the service area. Community stakeholders discussed the need to increase adult and pediatric services, particularly for under- and uninsured residents. While Fulton and DeKalb counties have higher rates of primary care providers when compared to the service area and the state, there are fewer Federally Qualified Health Centers (FQHCs) in the service area when compared to the state and national rates.

Figure 5 | Provider Rates by County Per 100,000 Population†



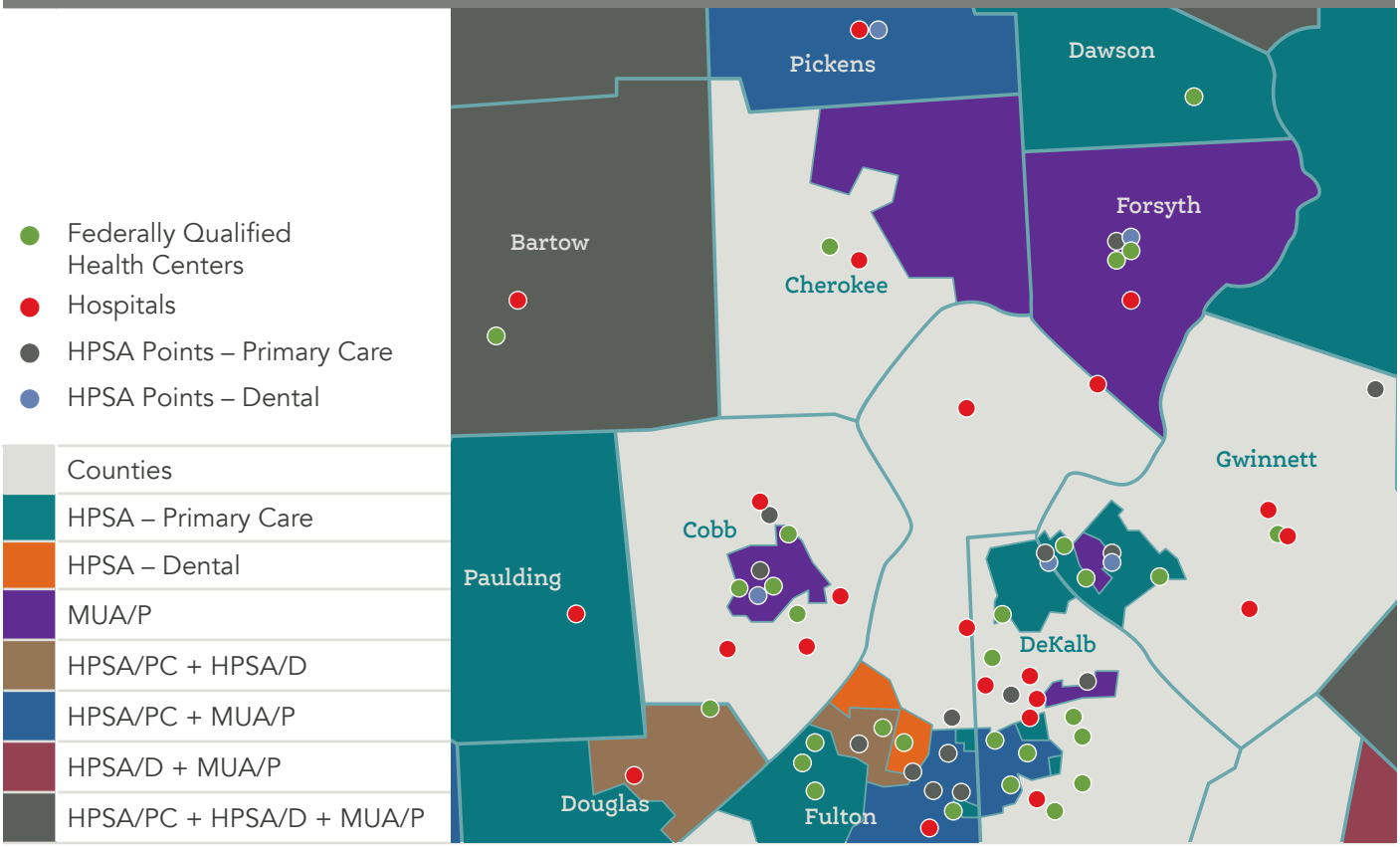
0.00% can result from sample size and margin of error

† *Health Resources & Services Administration: Area Health Resource File through County Health Rankings: datawarehouse.hrsa.gov/topics/ahrf.aspx*
U.S. Census Bureau, 2010 Decennial Census, POS Provider of Services File: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html

According to the Health Resources and Services Administration (HRSA):

- Health Professional Shortage Areas (HPSAs) exist in all counties in the service area,
- Each county, with the exception of Dawson, has areas that are designated as geographically Medically Underserved Areas (MUAs), and
- Most safety-net providers are located in the downtown area of Atlanta and central Cobb County, leaving few safety-net providers to serve the northern and southern regions of the service area.

Map 3 | Primary Care and Dental HPSAs, Safety-Net Providers and Hospitals†



† *U.S. Department of Health and Human Services, The HRSA Data Warehouse, Primary Dataset: Health Professional Shortage Areas (HPSAs), Secondary Dataset: Medically Underserved Areas/Populations (MUA/P)*

Health Behaviors

To better understand behaviors impacting health, it is important to consider factors influencing the choices residents make that cause them to be either healthy or unhealthy. Often these choices are influenced by access to, awareness of and preference for healthy or unhealthy options.

Food Insecurity

According to the U.S. Department of Agriculture (USDA), food security is access by all people at all times to enough food for an active, healthy life, which is one of several conditions necessary for a population to be healthy and well-nourished. In 2016, the USDA found that 14 percent of households in Georgia experience low food security and 5.6 percent experience very low food security.[11]

Table 6 shows that most counties included in this CHNA show signs of food insecurity and low access to grocery stores (data were not available for Dawson and Forsyth counties). Overall, residents in Gwinnett County have the lowest access to supermarkets and grocery stores when compared to the rest of the service area. However, Fulton County low-income residents, seniors and children have the lowest access to grocery stores in the service area. The geographic areas where low-income populations have the lowest access to grocery stores are central to the service area and downtown Atlanta (see Map 4). A closer look at the data shows the area where low-income residents have low access to a supermarket is in Cherokee County (30188).[12]

Table 6 | Selected Populations With Low Access to a Supermarket or Large Grocery Store by County (2010-2015)†

Healthy Eating, Active Living Indicators	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens
Residents with low access to a supermarket	37.50%	41.40%	ND	32.20%	ND	58.10%	62.60%	26.10%
Low-income residents with low access to a supermarket	2.20%	6.80%	ND	4.70%	ND	17.40%	9.00%	2.70%
Children with low access to a supermarket	9.60%	11.80%	ND	7.70%	ND	18.20%	16.70%	6.20%
Seniors with low access to a supermarket	3.70%	1.90%	ND	1.60%	ND	4.20%	3.00%	3.80%

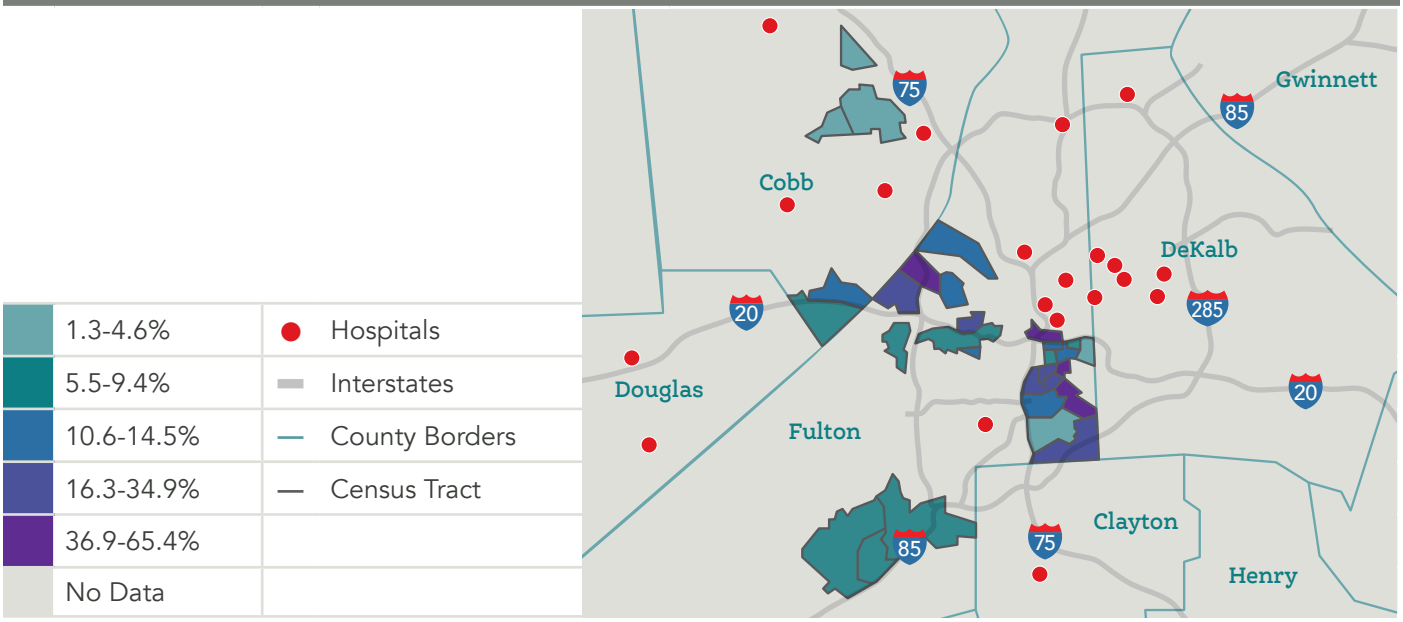
ND: Data was unavailable due to a lack of data reporting or data suppression

† Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp

11 USDA Economic Research Service, Household Food Security in the United States in 2016, ERR-237

12 Census Tracts 13057091001, 13135050418, 13135050421

Map 4 | Percentage of Low-Income Population With Low Access to a Supermarket or Large Grocery Store†



† *Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp*

Most of the primary data sources discussed obesity, healthy nutrition or physical activity as community health needs. Their input suggests that residents do not have time to shop for and prepare meals or exercise in a healthy way. Residents discussed lengthy commutes and traffic as the primary reason they did not shop for and prepare healthy meals or exercise in a healthy way.

Long Commute Times

The data in Table 7 shows more people than the state average are spending over an hour during their commute in every county except Fulton. Community input suggests that the amount of time residents spend in traffic commuting is a trade-off of the time that could be spent on healthier activities (e.g., grocery shopping, exercising and cooking healthy foods).

Table 7 | Selected Healthy Eating, Active Living Indicators†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Healthy Food Stores (Low Access)	42.70%	4.20%	.50%	23.40%	55.60%	ND	37.20%	8.50%	3.80%	22.40%
Exercise opportunities (Access)	79.70%	88.80%	84.70%	96.20%	8.70%	9.0%	79.60%	56.80%	75.00%	84.30%
Physical Inactivity (Adults)	19.70%	18.40%	2.50%	2.20%	2.10%	18.00%	2.20%	21.10%	23.10%	21.80%
Driving Alone to Work, Long Distances (>60 mins)	55.80%	51.30%	57.20%	48.80%	5.20%	37.90%	53.30%	45.20%	4.00%	34.80%

ND Data were unavailable due to a lack of data reporting or data suppression

† *USDA Food Access Research Atlas (FARA), http://www.ers.usda.gov/data-products/food-access-research-atlas*
County Health Rankings and Roadmaps: countyhealthrankings.org
NCCDPHP National Center for Chronic Disease Prevention and Health Promotion: http://www.cdc.gov/nccdphp/dnpao/index.html
U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/

Health Knowledge

Health Summit participants prioritized educational awareness, specifically among parents, as one of the most pressing health issues that could improve health outcomes in the community if effectively addressed. One resident spoke about the importance of teaching children healthy habits at a young age by saying:

> "I think that it's easier to educate a child on healthy habits, especially when you think about Georgia and the obesity of children in Georgia. I think that, you know, if you start to teach better habits as young adults, it's easier to teach it as a child than it is to break old habits as a grown person. I think if you teach an education at a younger age versus somebody that's forced to get it because a life event happened, there's a difference."

While there is no measure of educational awareness in the context of healthy options, parental awareness or family support, key informants discussed a lack of awareness of available services and poor health literacy related to healthy behaviors. One resident spoke about the need for parents to have correct information to make healthy decisions:

> "It's all about education – giving them the right information so the person can make sound decisions. Don't guess, get education."

There are existing resources throughout the service area that address healthy behaviors, parent education and family support.[14] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors, parent education and family support noted in this assessment.

14 See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.

Health Outcomes

Most of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, lung cancer, mental and behavioral disorders and kidney disease). When considering county-level data, Pickens County shows the greatest morbidity (disease burden) when compared to the rest of the service area. Black residents have the highest mortality rates in the service area while Multiracial residents throughout the service area show the highest disease burden when the data are considered by race. While data for Latino residents are limited, there is anecdotal evidence Latino residents experience high rates of morbidity and mortality related to chronic conditions as well.

Top Causes of Premature Death

The top five causes of premature death are derived from the Years of Potential Life Lost 75 (YPLL 75), which represents the number of years of potential life lost due to death before age 75 as a measure of premature death. In the communities served by the hospital, premature death seems to be caused by poisoning, perinatal conditions, heart disease, suicide and assault/homicide. The rate of premature death due to poisoning is high across the CHNA region served by WellStar North Fulton Hospital. Dawson and DeKalb counties show the highest rates of premature death when compared to the state and other counties in the service area. There are notable inequities when premature death is considered by race, with Black residents showing much higher rates when compared to all other races (when data are available).

Table 8 | Years of Potential Life Lost Rates (Premature Death) (2017)*†

By Region	Accidental Poisoning and Exposure to Noxious Substances	Certain Conditions Originating in the Perinatal Period	Ischemic Heart and Vascular Disease	Intentional Self-Harm	Assault (Homicide)
Cherokee	620.20	220.70	431.70	442.00	99.50
Cobb	603.50	380.70	330.70	421.80	176.50
Dawson	1,057.50	0.00	982.60	674.20	0.00
DeKalb	356.70	558.70	307.40	328.80	583.50
Forsyth	510.80	170.70	196.00	437.30	ND
Fulton	477.40	291.70	321.30	384.90	490.80
Gwinnett	366.80	343.20	188.40	319.70	230.30
Pickens	982.10	0.00	903.30	865.60	ND
Georgia	477.90	360.00	524.80	429.80	338.60
By Race**					
White	800.00	169.30	350.60	20.80	58.40
Black	275.80	625.10	366.50	80.20	789.30
Hispanic‡	172.20	342.10	86.10	ND	268.90
Asian	ND	222.50	115.50	69.20	103.70
American Indian	ND	0.00	ND	0.00	0.00
Pacific Islander	0.00	ND	0.00	0.00	0.00
Multiracial‡	ND	406.60	ND	ND	0.00

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted per 100,000 population*

** *Eight-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes of Death

Reported causes of death are based on the underlying cause of death. The underlying cause of death is defined by the World Health Organization as the disease or injury that initiated the sequence of events leading directly to death or as the circumstances of the accident or violence that produced the fatal injury. As noted in the 2018 report, all of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, lung cancer, mental and behavioral disorders and kidney disease). It is important to note that the top cause of death is cardiovascular in nature. Georgia is well known to have poor outcomes related to cardiovascular disease and Dawson and Pickens counties both show higher rates of mortality than the state in this area. Black residents show higher rates of death compared to their racial counterparts (when data are available).

Table 9 | Age-Adjusted Death Rates (2017)*†

By Region	Ischemic Heart and Vascular Disease	Cerebrovascular Disease	Malignant Neoplasms of the Trachea, Bronchus and Lung	All Other Mental and Behavioral Disorders	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
Cherokee	58.00	49.80	39.70	21.70	17.10
Cobb	53.90	53.70	32.20	17.90	9.90
Dawson	92.80	36.10	43.20	37.60	20.20
DeKalb	48.40	35.90	29.10	22.80	170.00
Forsyth	49.90	30.40	32.70	23.90	7.70
Fulton	50.00	40.90	30.60	24.90	22.20
Gwinnett	44.50	33.40	33.10	20.50	17.40
Pickens	83.60	37.00	49.30	64.60	ND
Georgia	73.10	43.40	42.40	30.80	18.10
By Race**					
White	51.10	37.80	30.80	21.90	13.50
Black	57.20	51.20	33.10	31.30	25.50
Hispanic‡	24.80	19.70	11.00	4.50	6.40
Asian	24.80	24.60	15.10	7.20	11.40
American Indian	ND	0.00	0.00	0.00	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial‡	ND	24.80	ND	ND	0.00

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes for Emergency Department Visits

There is anecdotal evidence that residents are seeking care in the emergency department (ED) for a variety of reasons, such as lack of insurance, limited availability of after-hours care or acute symptoms. Three of the top causes of ED visits in the service area are all related to accidents. The rate of ED visits in the service area is lower than the state averages, except in Pickens County. Pickens County has rates higher than the state average for each cause of ED visits. Multiracial residents have significantly higher rates than other races and the state for each cause of ED visits in the service area.

Table 10 | Age-Adjusted Emergency Room Visit Rates (2017)*†

By Region	All Other Unintentional Injury	Diseases of the Musculoskeletal System and Connective Tissue	All Other Diseases of the Genitourinary System	Falls	Motor Vehicle Crashes
Cherokee	2,467.30	1,706.10	1,858.90	1,918.10	869.00
Cobb	1,919.50	2,002.10	1,630.40	1,455.40	1,020.80
Dawson	3,104.40	2,099.50	2,528.10	2,219.70	1,321.40
DeKalb	1,552.80	3,272.30	1,964.50	1,054.30	1,035.70
Forsyth	1,970.90	1,191.60	1,332.60	1,658.70	766.60
Fulton	1,906.80	3,261.30	2,027.80	1,272.20	991.10
Gwinnett	1,817.10	1,737.00	1,431.70	1,375.30	995.70
Pickens	6,185.20	3,830.80	3,829.10	4,143.10	1,538.40
Georgia	3,030.00	3,276.90	2,394.20	1,918.40	1,168.80
By Race**					
White	1,506.60	1,194.00	1,140.70	1,338.60	504.20
Black	2,380.30	4,711.80	2,705.10	1,282.10	1,654.20
Hispanic‡	ND	ND	ND	ND	ND
Asian	536.20	425.30	379.50	454.70	317.10
Native American	2,240.70	1,772.10	1,823.90	1,636.40	1,017.80
Pacific Islander	1,642.50	978.60	1,038.10	1,325.70	463.40
Multiracial‡	8,347.20	8,787.30	7,995.10	6,378.70	5,341.40

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Top Causes for Hospital Discharges

The number of inpatients discharged from nonfederal acute-care inpatient facilities who are residents of Georgia and seen in a Georgia facility is considered in the following table. Uninsured residents are not always admitted to the hospital without some form of payment and may not be represented heavily in this measure. Hospital discharge rates are highest for childbirth, diseases of the musculoskeletal system and connective tissue and mental and behavioral disorders. Overall, residents of Pickens County have higher hospital discharge rates when compared to the service area and state. Multiracial residents have significantly higher rates than other races and the state for each cause of hospital discharge in the service area.

Table 11 | Age-Adjusted Hospital Discharge Rates (2017)*†

By Region	Pregnancy, Childbirth and the Puerperium	Diseases of the Musculoskeletal System and Connective Tissue	All Other Mental and Behavioral Disorders	Septicemia	Ischemic Heart and Vascular Disease
Cherokee	1,297.00	522.00	433.10	292.30	209.80
Cobb	1,286.30	456.60	4610	353.70	170.70
Dawson	1,261.00	512.10	771.50	541.10	272.40
DeKalb	1,499.90	409.90	553.60	413.20	188.80
Forsyth	1,392.70	484.80	416.90	282.30	209.50
Fulton	1,160.70	429.80	553.30	500.10	190.60
Gwinnett	1,381.60	408.40	318.40	444.50	172.40
Pickens	1,315.50	606.50	644.70	731.00	293.50
Georgia	1,289.50	489.30	531.50	514.50	255.30
By Race**					
White	982.40	463.90	384.10	347.20	170.00
Black	1,365.30	408.70	633.40	550.30	211.40
Hispanic‡	ND	ND	ND	ND	ND
Asian	1,118.40	136.80	45.40	189.40	94.80
Native American	2,077.80	604.50	140.70	425.00	218.30
Pacific Islander	1,439.40	513.00		403.80	671.10
Multiracial‡	8,113.10	8,113.10	1,738.90	2,045.70	1,039.00

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Obesity

At the time of this CHNA, high body mass index (BMI) is a health issue throughout the country, with this community as no exception. Nearly one in three adults is obese. Residents of Forsyth and Pickens counties have diabetes diagnoses that are higher than the state average. Also, Black residents show higher rates of hospital discharge and death than any other race.

Table 12 | Selected Adult BMI and Diabetes Indicators by County and Race†

By Region	Adult Obesity (2014)	Diagnosed Diabetes (2013)	Diabetes discharge rate* (2013-17)	Diabetes mortality* (2013-17)
Cherokee	28.00%	8.70%	110.80	14.40
Cobb	25.00%	8.50%	158.00	16.60
Dawson	28.00%	10.50%	156.10	ND
DeKalb	27.00%	10.00%	235.60	24.00
Forsyth	30.00%	10.80%	84.50	9.20
Fulton	26.00%	8.70%	207.50	17.10
Gwinnett	28.00%	8.30%	131.10	20.20
Pickens	28.00%	14.20%	163.40	19.20
Georgia	30.00%	10.60%	188.10	21.50
By Race**				
White	ND	ND	100.80	11.90
Black	ND	ND	314.30	31.60
Hispanic‡	ND	ND	ND	14.60
Asian	ND	ND	37.20	18.80

ND Data: Unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† *County Health Rankings and Roadmaps: countyhealthrankings.org*
Centers of Disease Control and Prevention, Diagnosed Diabetes Prevalence: https://www.cdc.gov/diabetes/data/countydata/countydataindicators.html
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, some counties reflect elevated cardiovascular disease when compared to the state average. In particular, Dawson and Pickens counties show higher rates of morbidity and mortality from obstructive heart disease. DeKalb, Fulton and Gwinnett residents have higher rates of morbidity from hypertensive heart disease. When compared to the state, Black residents show higher rates of heart disease morbidity and mortality, while Asian resident show higher rates of stroke mortality.

Table 13 | Selected Cardiovascular Condition Indicators by County and Race (2013-2017)†

By Region	Obstructive Heart disease/ Heart Attack Discharge rate*	Obstructive Heart Disease Mortality*	Hypertensive Heart Disease Discharge Rate*	Hypertensive Heart Disease Mortality*	Stroke Mortality*	Stroke Prevalence (2015)
Cherokee	224.20	56.50	27.90	15.30	39.80	4.50%
Cobb	180.00	51.40	28.40	7.60	44.00	4.30%
Dawson	305.50	73.10	26.30	19.10	39.30	3.80%
DeKalb	205.70	53.20	47.20	14.90	40.50	4.60%
Forsyth	222.60	55.80	27.80	8.30	39.90	4.20%
Fulton	195.30	56.30	47.80	24.40	39.20	4.00%
Gwinnett	197.50	54.50	49.70	13.00	36.60	3.80%
Pickens	360.60	92.50	28.10	12.70	36.20	3.40%
Georgia	265.00	76.40	39.00	16.30	43.00	4.20%
By Race**						
White	193.10	55.70	23.70	11.40	36.50	ND
Black	1,365.30	408.70	633.40	550.30	211.40	ND
Hispanic‡	225.40	60.30	66.80	27.10	30.90	ND
Asian	94.20	31.60	8.70	7.30	50.30	ND
Native American	2,077.80	604.50	140.70	425.00	218.30	ND

ND Data: Unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse: http://www.cms.gov/

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Cancer

As noted in the 2018 report, cancer rates are also elevated in Georgia when compared to the national average. There are higher morbidity rates for breast and prostate cancers across the service area. Pickens County shows higher morbidity rates for lung and colon cancer and overall cancer mortality.

Table 14 | Selected Cancer Indicators by County and Race (2011-2017)*†

By Region	Breast Cancer Incidence (2011-15)	Cervical Cancer Incidence (2011-15)	Colon and Rectum Cancer Incidence (2011-15)	Prostate Cancer Incidence (2011-15)	Lung Cancer Incidence (2011-15)	Cancer Mortality (2013-17)
Cherokee	123.2	6.4	37.0	114.9	66.0	148.0
Cobb	135.2	6.0	40.2	131.7	57.1	143.5
Dawson	97.7	ND	25.2	84.7	74.7	162.7
DeKalb	136.0	6.7	40.6	143.9	51.2	150.1
Forsyth	127.4	4.3	39.1	116.3	54.6	138.3
Fulton	132.1	6.9	38.1	143.8	51.2	144.6
Gwinnett	128.8	7.2	37.4	122.8	50.0	138.4
Pickens	126.3	ND	44.7	111.0	81.5	163.1
Georgia	123.2	6.4	37.0	114.9	66.0	148.0
U.S.	124.7	7.5	39.2	109.0	60.2	148.0
By Race**						
White	ND	ND	36.8	116.1	55.5	143.0
Black	ND	ND	32.5	44.0	25.6	83.4
Hispanic‡	ND	ND	32.6	98.4	33.0	75.4
Asian	ND	ND	44.3	193.5	54.5	170.2

ND for rates: Rates based on 1-4 events are not shown

† *CARES Engagement Network: National Cancer Institute and Center for Disease Control and Prevention, State Cancer Profiles: statecancerprofiles.cancer.gov*
Community Commons CHNA Portal: CHNA.org
Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse: http://www.cms.gov

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

Asthma

Asthma is common in densely populated urban areas for a variety of reasons. Residents living in DeKalb, Fulton and Pickens counties also suffer from higher morbidity rates for asthma. Residents from Dawson and Forsyth counties show fewer hospitalizations and ED visits for asthma.

Table 15 | Selected Respiratory Indicators by County and Race (2013-2017)†

By Region	Asthma Discharge Rate*	Asthma ED Visit Rate*
Cherokee	58.40	274.90
Cobb	79.30	513.80
Dawson	53.60	259.30
DeKalb	124.60	754.90
Forsyth	45.40	185.70
Fulton	104.90	657.20
Gwinnett	80.60	430.20
Pickens	100.50	450.70
Georgia	87.50	551.60
By Race**		
White	58.00	235.60
Black	29.30	97.70
Hispanic‡	ND	ND
Asian	155.80	1,050.00

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Age adjusted, per 100,000 population*

** *Eight-County aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

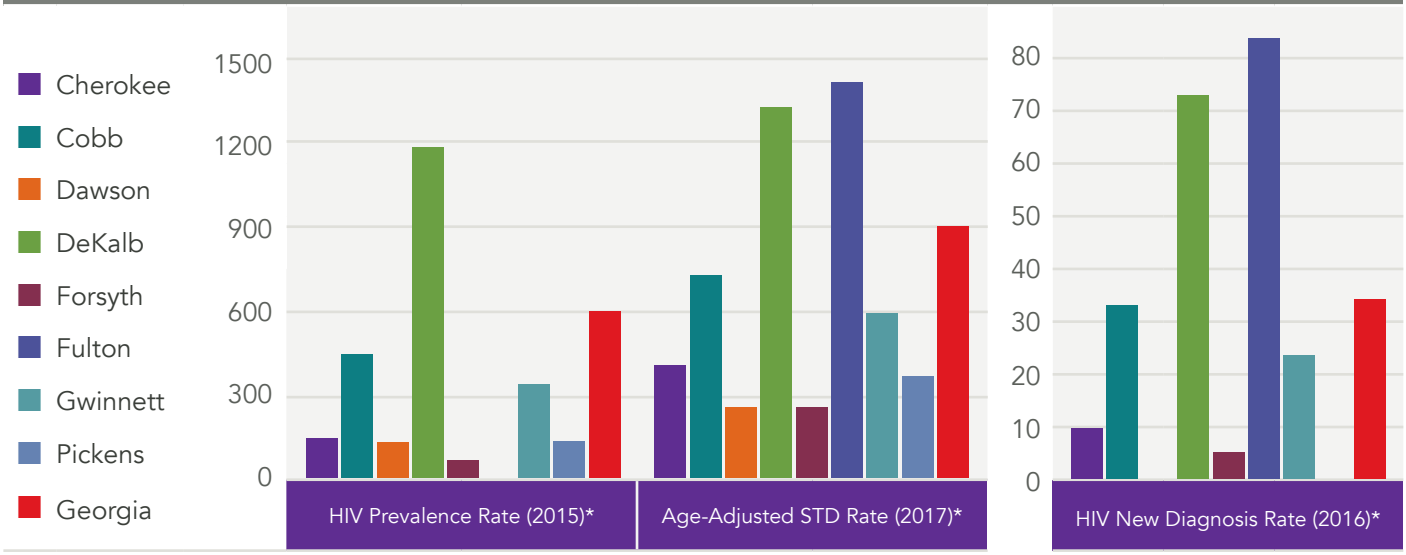
Sexually Transmitted Infections (STIs)

The Atlanta metropolitan area has some of the highest morbidity rates for human immunodeficiency virus (HIV) and AIDS in the nation. DeKalb and Fulton counties show higher rates of new HIV diagnoses when compared to the state. A closer look at zip code-level data show a more complex picture of HIV in this region.[15, 16]

While HIV screening rates are high in the service area, annual diagnostic rates remain high among certain populations, according to a database called AIDSVu managed by the Rollins School of Public Health at Emory University. Specifically, in the service area:

- The highest rates of prevalence and new cases are found in Fulton County.[17]
- Seven zip codes have higher rates of new cases than the state (30.7 per 100,000 population).[18]
- Black men are being diagnosed with HIV at a much higher rate than any other racial or ethnic group.[19]

Figure 6 | Prevalence and Diagnoses Rates for HIV and All Other STIs†



ND for rates: Rates based on 1-4 events are not shown

† *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted per 100,000 population*

15 *HIV data are not available at the zip code level for 30114 and 30028.*

16 *See the Secondary Data section of the appendix for zip code–level data on HIV prevalence and new cases.*

17 *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

18 *30062, 30076, 30092, 30093, 30096, 30328, 30350, 30350*

19 *AIDSVu. Emory University, Rollins School of Public Health. Atlanta (www.aidsvu.org)*

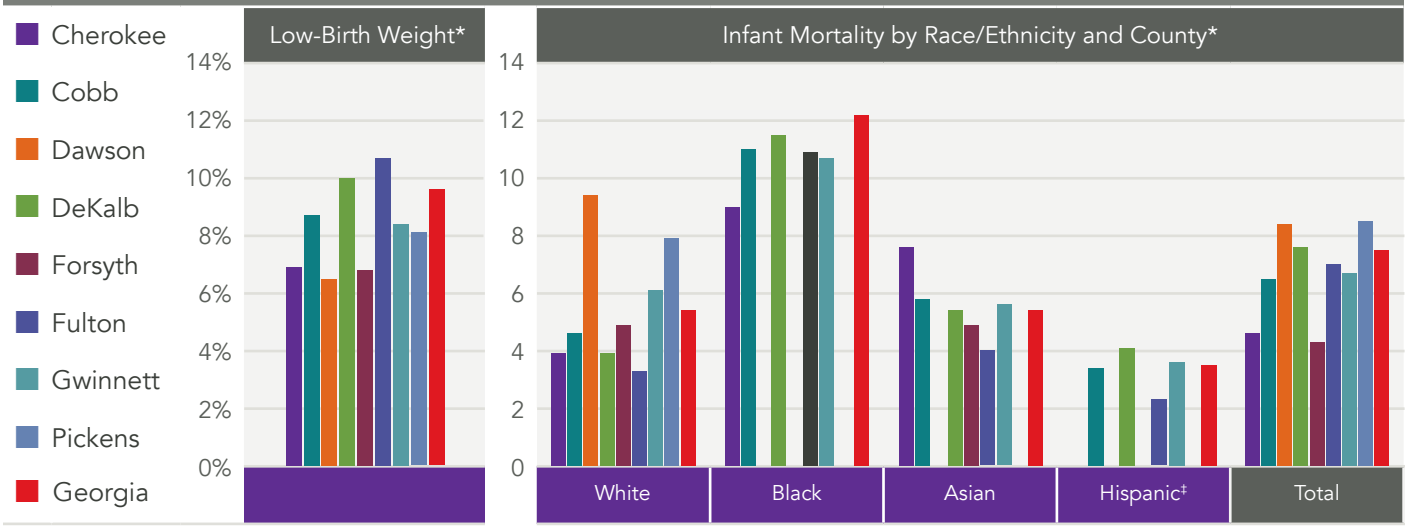
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation, and presentation of complete data related to childbirth across the state. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birth-weight infants and infant mortality, among other issues.[20]

Input gathered from resident focus groups noted the limited education offered to youth about risky sexual behaviors and the lack of adult supervision of youth as driving forces behind teen pregnancy and the rate of sexually transmitted infections (STIs). Latino residents noted that cultural norms related to childbirth often lead to higher rates of teen pregnancy and STIs in the Latino community. In addition, community leaders noted that women without legal immigration status are not seeking prenatal care.

Figure 7 shows that the general population in Dawson, DeKalb and Pickens counties has higher infant mortality rates than the state. Black residents in all counties are nearly twice as likely to experience infant mortality as any other race, except in Forsyth and Pickens counties, where complete data are not available.

Figure 7 | Birth Outcomes (2013-2017)†



ND for rates: Rates based on 1-4 events are not shown

Number of infant deaths per 1,000 live births

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *0.00% can result from sample size and margin of error*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

20 *Healthy Mothers, Healthy Babies Coalition of Georgia, 2016 State of the State of Maternal and Infant Health in Georgia https://drive.google.com/file/d/0BxndQpkPFFfySm5aNmdkYXZYQm8/view*

Injury and Assault

Table 16 shows that assault rates are high in Fulton County.

Table 16 | Selected Injury Indicators (2013-2017)†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia
Assault discharge rate (2013-17)*	5.30	10.00	ND	36.40	3.90	42.60	9.40	21.90	18.60
Motor vehicle crash ED visit rate (2013-17)*	830.70	972.70	1,236.70	1,008.80	711.90	898.0	928.40	1,471.20	1,099.90
Impaired driving deaths (2011-15)	18.80%	24.80%	9.10%	22.40%	23.20%	22.80%	22.50%	27.30%	23.40%

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
Health Resources & Services Administration: Area Health Resource File through County Health Rankings: datawarehouse.hrsa.gov/topics/ahrf.aspx

* *Age adjusted, per 100,000 population*

Behavioral Health

The need for behavioral health resources, particularly for under- and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in the community that, if addressed, could influence the health of residents. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia's hospitals for mental health issues in 2016.[21]

According to anecdotal information gathered from community input, behavioral health issues impact all demographics. Focus group residents and Health Summit participants indicated that there is a shortage of psychiatric and inpatient services (crisis care and substance abuse) for adults and children.

Table 17 depicts a need for behavioral health providers, with an estimated 83,965 residents living in areas with professional shortages. Meanwhile, mental and behavioral disorders is one of the top five causes of death in the service area, and intentional self-harm (suicide) is one of the top five causes of premature death. Hospital and community leaders discussed the resistance of residents to seek behavioral healthcare when it is needed for themselves or their children due to limited awareness about signs and symptoms, as well as fear of stigma.

Table 18 shows low provider rates across the service area and elevated mortality due to behavioral disorders and suicide in Dawson and Pickens counties when compared to the rest of the service area. It is important to note there is no measure of the rate of behavioral health providers that offer care to uninsured patients. Table 18 also shows a much higher rate of ED use in Fulton County when compared to all other counties in the service area and the state. This may point to barriers to accessing treatment in more appropriate settings.

Input from community residents related to behavioral health also suggested that residents might resist seeking care due to stigma, lack of insurance, unaffordable cost of care and providers being located too far away from home.

21 *Overwhelmed In The ER: Georgia's Mental Health Crisis (Feb. 28, 2018), Elly Yu, https://www.wabe.org/overwhelmed-er-georgias-mental-health-crisis/*

Table 17 | Selected Characteristics of Health Professional Shortage Areas for Mental Health by County†

	Cherokee County	Cobb County–Central Marietta	Fulton County Correctional Facilities	South Central Fulton
Number of people in mental health HPSA	ND	0	19,278	64,687
Number of mental health FTE needed	ND	1.00	9.64	0.10

ND: Data were unavailable due to a lack of data reporting or data suppression

† *The HRSA Data Warehouse, Primary Dataset: Health Professional Shortage Areas (HPSAs), Secondary Dataset: Medically Under-resourced Areas/Populations (MUA/P) https://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx*

Table 18 | Selected Behavioral Health Characteristics by County†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia
Mental health providers (2016)*	79.70	130.60	111.50	247.00	45.20	191.20	86.30	69.30	115.00
Poor mental health days (2015)	3.50	3.40	3.50	3.70	3.10	3.60	3.40	3.70	3.80
Mental health ED rate (2017)*	864.40	965.10	1,181.30	1,015.70	664.60	1,502.40	656.20	1,234.60	1,094.60
Mental and behavioral disorder mortality (2013-17)*	31.40	29.50	46.20	34.30	30.50	33.30	22.80	59.10	37.40
Self-harm age-adjusted discharge rate (2013-17)*	27.60	30.40	40.40	28.20	19.50	25.40	22.10	69.60	32.70
Age-adjusted suicide mortality (2013-17)*	14.40	11.50	28.30	7.90	12.70	10.40	11.40	21.90	12.70

† *County Health Rankings and Roadmaps: countyhealthrankings.org*
Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System through County Health Rankings: www.cdc.gov/brfss/
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Per 100,000 population*

Substance Abuse

Substance abuse has become an increasing concern in many parts of the United States in the last decade specifically related to opioid abuse and overdose. Every primary data source discussed substance use, particularly opioid abuse and overdoses, as a community health priority, including the WellStar North Fulton Hospital Regional Health Board and community leaders attending the Health Summit. One resident said this about the presence of drugs in Cherokee County:

> "Most time those people with kids, they move out of the city to get their kids away from that environment. Regardless of where you go, it's there. It might be a little more discreet, because Woodstock got a lot of stuff going on. You would be surprised. I've seen plenty of nights of drug overdoses in the parking lot."

Death due to accidental poisoning and exposure to noxious substances, which includes drug overdoses, is one of the top five causes of premature death in the service area. Table 19 shows that the mortality rate due to drug overdose has increased across the service area, where data is available.

Table 19 | Rate of Drug Overdose by County (2007-2017)†

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia
Drug overdoses (2007)*	11.2	6.2	ND	6.0	12.0	10.9	4.5	ND	8.6
Drug overdoses (2017)*	16.7	18.1	30.0	10.2	14.3	14.5	10.3	31.4	14.6
	18.80%	24.80%	9.10%	22.40%	23.20%	22.80%	22.50%	27.30%	23.40%

ND for rates: Rates based on 1-4 events are not shown

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

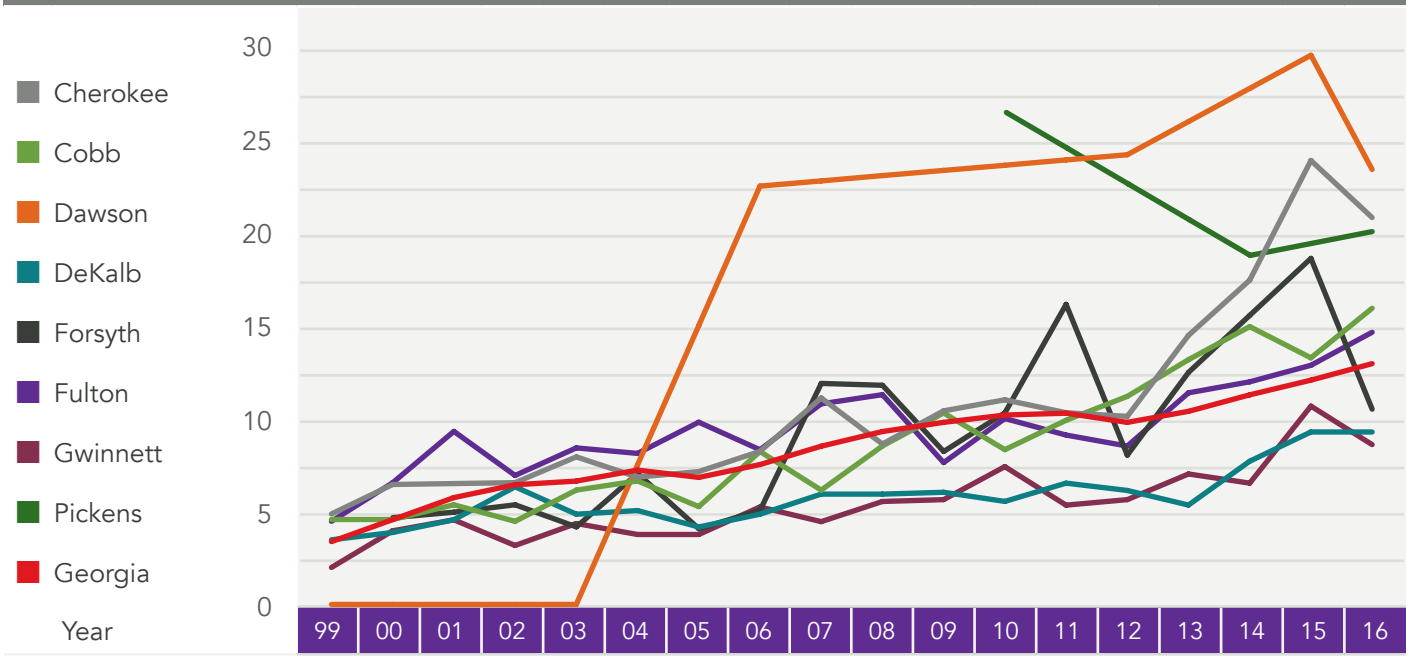
* *Per 100,000 population*

According to a white paper written and presented to the State Senate by the Georgia Prevention Project's Substance Abuse Research Alliance:

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses, including heroin,
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014 and
- Overdose deaths tripled between 1999 and 2013 in Georgia.[22]

Figure 8 shows the increase of substance abuse overdoses across the service area since 1999. Pickens County shows the highest rate when compared to the rest of the counties in the service area and state.

Figure 8 | Age-Adjusted Death Rate by Drug Overdose Per 100,000 Population (1999-2016)†



Rates/Percents based on 1-4 events are not shown.

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

There are existing resources throughout the service area that address the common health outcomes noted in this section.[23] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the health issues.

22 *Georgia Prevention Project: Substance Abuse Research Alliance, Prescription Opioids and Heroin Epidemic in Georgia (2017), http://www.senate.ga.gov/sro/Documents/StudyCommRpts/OpioidsAppendix.pdf*

23 *See the Community Facilities, Assets, and Resources section of the Appendix for a list of resources.*

Community Is **Compassion**

RALLYING PEOPLE AND RESOURCES

Community Input

This assessment engaged residents and leaders from the community who provide services in the community served by WellStar North Fulton Hospital. An in-depth description of the participants, methods used and collection period for each qualitative process is located in the Primary Data and Community Input section of the Appendix.

Listening Session

A listening session was conducted with the WellStar North Fulton Regional Health Board and key informant interviews were conducted with 11 community leaders. Hospital and community leaders encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health-related data and (3) representatives of under-resourced populations. The listening session and interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to CHNA.

Focus Groups

Five focus groups were conducted to gather input from more than 20 residents living and working in the community served by WellStar North Fulton Hospital. Focus group participants were asked to discuss their opinions related to health status and outcomes; context, facilitating and blocking factors of health; and what is needed to be healthier in their community. The following pages are a summary of the community input gathered for the CHNA process.

Summary of CHNA Community Input

WellStar North Fulton Hospital

Commonly Discussed Health Issues

- Disparities among people of color
- Substance abuse and overdosing (opioid/heroin, alcohol and methamphetamines)
- Poor mental health:
  - Untreated/undiagnosed
  - Self-harm and suicide
- Chronic conditions:
  - Cardiovascular disease
  - Congestive heart failure
  - Hypertension
  - Diabetes (type I and II)
  - Obesity (adult and child)
  - Cancer (colon, gastric, breast)
  - Asthma
  - Allergies
  - Sexually transmitted infections (HIV)
  - Fibromyalgia
  - Blood clots
  - Kidney disease

Commonly Discussed Causes

- Geographic location of health services, coupled with limited transportation options that are fragmented
- Low health literacy/awareness of:
  - Available services
  - Healthy practices
  - Prevention
  - Insurance options and uses
- Limited services available for:
  - Under- and uninsured (primary, care coordination, dental and prenatal care)
  - Specialty care
  - Behavioral health (psychiatric and crisis)
  - After-hours care
  - Engaging residents (education and prevention)
- Unaffordable cost:
  - Prescriptions
  - Insurance
  - Healthy food options
  - Uninsured care
  - Healthy housing
- Economic insecurity
- Poor employment options (low wage)
- Lack of time to be healthy (time spent working and commuting)
- Prevalence of fast food
- Poor access to:
  - Healthy nutrition
  - Physical activity
  - Health education
- Limited culturally and linguistically relevant health services – Black and Latino
- Homelessness
- Lack of safety (crime and poor infrastructure)
- Unhealthy cultural preferences and traditions

Geographic Areas of Interest

- Canton and north of Canton
- Public housing in Canton and Woodstock
- Rural areas
- Housing issues in Pickens, rural Cherokee, tent cities, and in trailer parks in Acworth and Woodstock

Vulnerable Populations

- People of color – African-Americans and Hispanics
- Rural areas
- Uninsured and underinsured
- Previously incarcerated
- Undocumented
- People with behavioral health challenges
- Low socioeconomic status
- Homeless
- Residents living in food deserts, without access to transportation
- Single parents
- Children

Common Recommendations

- Engage community partners:
- Expand community engagement
- Disseminate educational material about healthy habits that is culturally and linguistically relevant
- Conduct health seminars that will promote health education
- Increase the use of mobile medical and dental programs:
- To teach healthy habits to youth and their families
- Offer remote services (i.e., telehealth or satellite medical centers)
- Focus on diversity when addressing health needs
- Begin to screen and refer patients negatively impacted by social determinants of health
- Increase the number of bilingual providers to offer culturally and linguistically relevant health services
- Advocate for policies that improve health (payment reform, etc.)
- Increase access to care:
- Increase the number of providers (i.e., safety-net clinics, FQHCs)
- Offer alternative transportation options for medical services
- Implement national best practices locally
- Increase funding for dental clinics and care
- Increase insurance options and ability to navigate them
- Increase provider acceptance of insurance
- Collaborate with local farmers' markets to increase access to healthy produce
- Invest in local infrastructure to increase walkability
- Increase education, outreach and health services available in schools

Community Is **Collaboration**

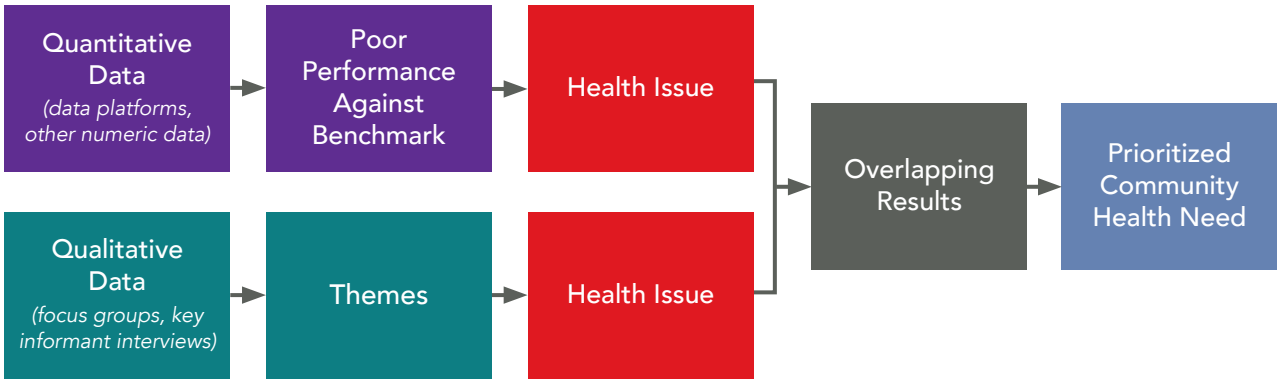
STRONGER TOGETHER

Community Health Priorities

WellStar North Fulton Hospital engaged 19 community and hospital leaders to help establish the community priorities for the community served during a Health Summit, held February 26, 2018, on the hospital campus. Stakeholders represented organizations serving residents in the primary service area of WellStar North Fulton Hospital. An in-depth summary of the results, along with a description of theparticipants, methods used and collection period, is located in the Primary Data and Community Input section of the Appendix.

GHPC presented to community leaders findings from the CHNA generated from analysis of secondary data, key informant interviews, focus groups and listening sessions (see Figure 9).

Figure 9 | Process Used to Identify the Most Pressing Health Needs



The most pressing health needs presented during the Health Summit included:

- Uninsured
- Poverty
- Educational attainment
- Provider rates
- Hospital utilization rates
- HIV and STI
- Cardiovascular disease
- Birth outcomes
- Cancer
- Obesity/BMI
- Diabetes
- Healthy eating, active living indicators
- Behavioral health
- Substance use

Community leaders were then asked to discuss the health needs of the community they serve and encouraged to add any needs that may have been absent from the data presented. Grouped by self-selected tables, participants were asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the most vulnerable populations. Needs that were identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface the community health priorities, listed in the order they were prioritized.

1 Behavioral healthcare

Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. Concerns included lack of awareness and education, stigma, limited behavioral health providers, fragmented referral system, and inadequate resources and protocols for mental health crisis episodes.

2 Parental education and support

Health Summit participants addressed the importance of parental education and the need to offer parents the knowledge and access to resources to make healthier choices, support healthy child development and improve child health.

3
Access to appropriate care

Health Summit participants discussed limited access residents have to appropriate care when and where it is needed. Several of the challenges discussed were transportation, awareness of available services, the number of providers and affordability.

4
Overuse and abuse of opioids

Health Summit participants discussed the opioid epidemic in the WellStar North Fulton Hospital service area. Several of the issues discussed were the increase in opioid abuse, limited awareness about the risk of opioid addiction and the stigma associated with prescribing and using opioids.

Appendix

Consultant Qualifications

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development and policy guidance locally, statewide and nationally to improve communities' health status. With more than 21 years of service, GHPC focuses on solutions to the toughest issues facing healthcare today, including insurance coverage, long-term care, children's health and the development of rural and urban health systems.

GHPC draws on more than a decade of combined learnings from its experience with 100-plus projects supported by 75 diverse funders. The studies span the layers of the socioecological model and include individual, multisite and meta-level assessments of communities, programmatic activities and provision of technical assistance.

GHPC has guided a national expert team in the design of the Federal Office of Rural Health Policy's Network and Outreach Program evaluations, been commissioned by communities as external evaluators and conducted assessments and community engagements that include the following:

- GHPC conducted a regional community health needs assessment (CHNA) process to meet the IRS regulations of Schedule H, which included 29 Georgia counties and metro Atlanta between 2015 and 2016. Partners included Grady Health System, Piedmont Healthcare, WellStar, Mercy Care and Kaiser Foundation Health Plan of Georgia (KFHPGA). The regional assessment project served as the foundation for the CHIP process employed by GHPC to generate the implementation plan in partnership with Grady Health System and KFHPGA. GHPC has conducted similar assessments and plans to address needs for Grady Health System and KFHPGA in 2009 and 2013.
- GHPC managed the community engagement and conducted the county-level CHNA for which the results will serve as the foundation for Clayton County Board of Health's application to the Public Health Accreditation Board (PHAB) for accreditation. GHPC remains engaged as Clayton County prepares for the next stages of accreditation.
- GHPC evaluated seven metro Atlanta counties to measure the demand on and capacity of the urban healthcare "safety net." The study addresses the issue of shrinking access for those who face the most significant barriers to healthcare and examines the health needs and safety-net services in Fulton, DeKalb, Cobb, Forsyth, Gwinnett and Henry counties. The project is funded by a grant from the KFHPGA through the Community Foundation of Greater Atlanta.
- GHPC conducted an assessment of Georgia's public health system to more clearly define public health's "core business" related to the broader system of health and healthcare in the state, gain an accurate understanding of the public's perception of the role of public health, examine the areas of existing service overlap and investigate opportunities for increased collaboration with various healthcare providers and stakeholders.

Secondary Data

(July 2018–November 2018)

County Health Rankings† (2018)	
Cherokee	3
Cobb	7
Dawson	23
DeKalb	18
Forsyth	1
Fulton	14
Gwinnett	5
Pickens	16

Age Distribution

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens
0-14	20.0%	19.9%	17.8%	20.4%	21.8%	19.0%	21.7%	15.4%
15-17	4.5%	4.1%	4.1%	3.6%	4.8%	3.9%	4.8%	3.6%
18-24	9.1%	9.3%	8.8%	8.5%	8.8%	10.1%	9.8%	7.6%
25-34	11.6%	13.7%	11.7%	15.6%	9.1%	15.3%	12.6%	10.4%
35-54	28.7%	28.8%	26.4%	28.3%	31.3%	28.5%	29.1%	23.1%
55-64	12.7%	12.2%	13.7%	11.8%	11.5%	11.6%	11.8%	15.9%
65+	13.5%	12.0%	17.5%	11.7%	12.6%	11.6%	10.2%	24.0%

Racial Distribution

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens
White	77.9%	50.8%	91.7%	29.4%	74.3%	39.7%	39.7%	91.9%
Black	7.1%	27.6%	1.2%	52.1%	3.6%	42.1%	26.3%	1.6%
Hispanic‡	10.5%	13.2%	4.4%	9.4%	10.%	7.6%	19.7%	3.9%
Asian	2.1%	5.4%	0.8%	6.6%	10.1%	8.1%	11.4%	1.%
All Others	2.4%	3.%	1.9%	2.4%	2.1%	2.5%	2.9%	1.6%

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Socioeconomic

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
On-time high school graduation (2014-15)*	86.%	80.7%	89.%	71.8%	94.%	72.6%	76.2%	91.%	80.%	88.2%
Free and reduced price lunch (2014-15)*	8.4%	45.6%	46.2%	69.%	16.5%	ND	53.9%	53.5%	62.4%	52.6%
Unemployment rate (2017)*	3.4%	3.7%	3.6%	4.4%	3.5%	4.4%	3.9%	3.9%	4.3%	4.%
Population below 1% fpl (2012-16)*	10.%	11.6%	13.4%	19.%	6.4%	17.%	13.%	10.3%	17.8%	15.7%
Children below 1% FPL (2012-16)*	13.8%	16.5%	18.6%	30.1%	7.2%	24.7%	19.1%	12.%	25.4%	23.6%
Adults with no high school diploma (2012-16)*	10.2%	8.8%	13.5%	11.4%	7.8%	8.7%	12.5%	16.8%	14.2%	38.4%
Uninsured population (2012-16)*	13.3%	15.4%	13.4%	17.2%	9.9%	13.7%	18.3%	12.7%	15.8%	11.8%

Healthcare Access

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Primary care providers* (2014)	35.5	69.2	61.0	106.3	40.1	105.5	59.8	43.3	72.9	87.8
Dentists* (2015)	48.7	65.4	42.9	56.6	39.1	68.4	56.5	29.7	49.2	65.6
Mental health providers* (2016)	79.7	130.6	111.5	247.0	45.2	191.2	86.3	69.3	115.0	200.7
Recent primary care visit (2014)	82.9%	ND	82.7%	76.6%	83.6%	76.3%	79.7%	84.7%	81%	78.9%
Federally Qualified Health Centers* (2016)	0.9	0.9	0.0	1.9	1.7	1.3	0.5	0.0	2.1	2.4
Health Professional Shortage Area – dental (2016)	0.0%	0.0%	0.0%	0.0%	0.0%	9.9%	0.0%	0.0%	37.9%	37.8%
Uninsured population (2012-16)	13.3%	15.4%	13.4%	17.2%	9.9%	13.7%	18.3%	12.7%	15.8%	11.8%

ND for rates: Rates based on 1-4 events are not shown ND Data: Unavailable due to a lack of data reporting or data suppression
Center for Disease Control and Prevention: https://www.cdc.gov/diabetes/data/countydata/countydataindicators.html
Kaiser Permanente CHNA Data Platform: http://kp-chna.ip3app.org/login?redirect=%2F
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
Center for Disease Control and Prevention - NCHHSTP Atlas Plus: https://www.cdc.gov/nchhstp/atlas/index.htm
Community Commons CHNA Portal: CHNA.org
* *Per 100,000 population*

Health Determinants

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Current smokers (2015)	15.1%	14.9%	15.3%	16.1%	12.2%	16.%	15.5%	14.7%	17.%	15.7%
Healthy food stores (low access) (2014)	42.7%	40.2%	0.5%	23.4%	55.6%	ND	37.2%	8.5%	30.8%	22.4%
Exercise opportunities – access (2010/2014)	79.7%	88.8%	84.7%	96.2%	80.7%	ND	79.6%	56.8%	75.9%	84.3%
Driving alone to work, long distances (>60 mins) (2012-2016)	55.8%	51.3%	57.2%	48.8%	50.2%	37.9%	53.3%	45.2%	40.%	34.8%

Clinical Care & Prevention

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Snap benefits (2012-2016)	7.1%	9.3%	10.6%	15.8%	4.4%	13.3%	11.2%	12.5%	15.3%	19.1%
Physical inactivity – adults (2013)	19.7%	18.4%	20.5%	20.2%	20.1%	18.%	20.2%	21.1%	23.1%	21.7%
Preventable hospital events* (2014)	55.6	52.0	59.5	38.6	47.7	40.5	45.9	45.1	52.3	50.4
Teen births* (15-19) (2008-14)	21.5	3.8	37.2	38.1	12.5	34.6	23.9	43.2	38.5	32.1

Other Health Indicators

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Population with any disability (2012-16)	9.37%	8.47%	12.48%	10.18%	7.35%	9.94%	7.2%	16.38%	12.4%	12.6%
Impaired driving deaths (2011-15)	18.8%	24.8%	9.1%	22.4%	23.2	22.8%	22.5%	27.3%	23.4%	†
Poor physical health days (2015)	3.4	3.5	3.4	3.7	2.9	3.4	3.4	3.5	3.9	3.7
Poor mental health days (2015)	3.5	3.4	3.5	3.7	3.1	3.6	3.4	3.7	3.8	3.7
Stroke prevalence (2015)	4.5%	4.3%	3.8%	4.6%	4.2%	4.0%	3.8%	3.4%	4.2%	4.0%
Age-adjusted drug overdoses (2007)	11.2	6.2	ND	6.0	12.0	10.9	4.5	ND	8.6	†

* *Per 100,000 population*

Other Health Indicators (continued)										
	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Years of potential life lost (YPLL75) (2017)	13,053	40,761	1,871	51,725	9,620	63,386	45,017	2,920	763,397	†
Mental health ER rate* (2017)	864.4	965.1	1181.3	1015.7	664.6	1502.4	656.2	1234.6	1,094.6	†
Mental and behavioral disorder mortality (2013-17)*	31.4	29.5	46.2	34.3	30.5	33.3	22.8	59.1	37.4	†
Self-harm age-adjusted discharge rate* (2013-17)	27.6	30.4	40.4	28.2	19.5	25.4	22.1	69.6	32.7	†
Suicide age-adjusted mortality (2013-17)*	14.4	11.5	28.3	7.9	12.7	10.4	11.4	21.9	12.7	†
Age-adjusted opioid overdoses (2007)	6.3	1.0	ND	2.7	7.5	4.5	2.6	ND	3.4	†
Age-adjusted opioid overdoses (2017)	15.1	14.7	ND	6.3	11.1	9.3	7.9	21.3	9.7	†
Assault age-adjusted discharge rate (2013-17)	5.3	10.0	ND	36.4	3.9	42.6	9.4	21.9	18.6	†
Diagnosed diabetes-prevalence (2013)	8.7%	8.5%	10.5%	10.0%	10.8%	8.7%	8.3%	14.2%	10.6%	9.2%
Diabetes age-adjusted discharge rate (2013-17)	103.1	147.1	96.4	219.7	67.8	186.6	114.9	202.1	188.1	†
Diabetes age-adjusted mortality rate (2013-17)	13.0	14.2	6.7	21.0	10.8	17.5	18.5	14.3	21.7	†
Adults obesity (2014)	28.0%	25.0%	28.0%	27.0%	30.0%	26.0%	28.0%	28.0%	30.0%	†
Obs. Heart disease/ heart attack age-adjusted discharge rate* (2013-17)	224.2	180.0	305.5	205.7	222.6	195.3	197.5	360.6	265.0	†
Hypertensive heart disease age-adjusted discharge rate* (2013-17)	27.9	28.4	26.3	47.2	27.8	47.8	28.1	30.9	39.0	†

* *Per 100,000 population*

Other Health Indicators (continued)										
	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia	U.S.
Asthma ER visit rate* (2017)	263.0	461.9	196.9	727.9	167.1	738.8	395.3	411.5	525.5	†
Motor vehicle crash age-adjusted ER visit rate* (2013-17)	830.7	972.7	1236.7	1008.8	711.9	898.0	928.4	1471.2	1099.9	†
HIV prevalence rate (2015)	140.9	436.4	126.0	1167.3	63.6	1599.2	331.2	131.1	588.0	362.3
HIV new diagnosis rate (2016)	9.0	29.9	ND	66.0	5.1	75.6	21.3	ND	31.8	14.7
STD age-adjusted rate except congenital syphilis (2017)	399.5	716.1	250.8	1310.3	250.1	1398.8	582.9	357.6	890.4	†
% low birth weight (< 2500g) (2013-17)	6.9%	8.7%	6.5%	10.%	6.8%	10.7%	8.4%	8.1%	9.6%	†
Infant mortality (total) (2013-17)	4.6	6.5	8.4	7.6	4.3	7	6.7	8.5	7.5	
Infant mortality (non-hispanic White) (2013-17)	3.9	4.6	9.4	3.9	4.9	3.3	6.1	7.9	5.4	
Infant mortality (Black) (2013-17)	9	11	0	11.5	ND	10.9	10.7	0	12.2	

ND for rates: Rates based on 1-4 events are not shown ND Data: Unavailable due to a lack of data reporting or data suppression
Centers for Disease Control and Prevention: www.cdc.gov/diabetes/data/countydata/countydataindicators.html
Kaiser Permanente CHNA Data Platform: kp-chna.ip3app.org
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
Centers for Disease Control and Prevention - NCHHSTP Atlas Plus: www.cdc.gov/nchhstp/atlas/index.htm
† This data set includes Georgia data, and does not include an equivalent data set for the U.S.

2017–2018 Community Need Index (CNI) – WellStar North Fulton Hospital

Zip Code	County	Change (2017-18)	2015 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/kids	Income Score	Limited English	Minority	Culture Score	No High School Diploma	Education Score	Unemployed	Uninsured	Insurance Score	Renting	Housing Score
30004	Fulton	0.0	2.2	5.9%	6%	19%	1	1.9%	36%	4	4%	1	3%	5%	2	22%	3
30005	Fulton	0.2	2.8	11.9%	4%	23%	2	2.2%	45%	5	3%	1	5%	5%	2	28%	4
30009	Fulton	0.0	3.2	8.9%	9%	28%	2	2.9%	42%	5	5%	1	5%	8%	3	48%	5
30022	Fulton	0.0	2.4	4.4%	4%	16%	1	3.2%	39%	4	4%	1	5%	6%	2	27%	4
30028	Forsyth	0.4	2.4	6.5%	9%	21%	2	2.7%	13%	3	11%	3	6%	8%	3	13%	1
30040	Forsyth	0.0	2.6	10.1%	7%	23%	2	4.2%	30%	4	9%	2	4%	8%	3	16%	2
30041	Forsyth	0.0	2.0	4.7%	4%	19%	1	1.7%	27%	4	6%	1	5%	6%	3	14%	1
30062	Cobb	0.0	2.4	5.3%	5%	20%	1	3.5%	33%	4	6%	1	4%	7%	3	20%	3
30066	Cobb	0.0	2.4	5.9%	7%	18%	1	1.8%	32%	4	4%	1	5%	7%	3	20%	3
30075	Fulton	0.2	2.2	4.9%	6%	27%	2	2.4%	22%	4	4%	1	4%	6%	2	19%	2
30076	Fulton	0.0	3.6	5.3%	14%	36%	3	6.6%	46%	5	9%	2	4%	9%	3	40%	5
30092	Gwinnett	0.2	3.6	3.1%	13%	24%	2	5.5%	52%	5	7%	2	5%	10%	4	44%	5
30096	Gwinnett	0.0	4.2	11.1%	22%	40%	3	9.4%	71%	5	12%	3	7%	14%	5	52%	5
30115	Cherokee	0.0	2.6	6.2%	12%	38%	3	2.2%	16%	3	8%	2	5%	9%	3	16%	2
30188	Cherokee	0.0	2.6	11.1%	11%	33%	2	2.9%	24%	4	6%	1	4%	9%	4	20%	2
30328	Fulton	0.0	2.8	7.3%	7%	15%	1	2.3%	36%	4	3%	1	4%	9%	3	42%	5
30350	Fulton	0.2	3.6	9.9%	15%	35%	3	2.6%	53%	5	5%	1	6%	13%	4	64%	5
Cherokee Total		**0.0**	**2.9**	**8.2%**	**12%**	**32%**	**2**	**2.9%**	**22%**	**4**	**9%**	**2**	**5%**	**10%**	**4**	**21%**	**3**
Cobb Total		**0.0**	**3.2**	**9.2%**	**13%**	**25%**	**2**	**4.5%**	**49%**	**5**	**10%**	**3**	**6%**	**10%**	**4**	**32%**	**4**
Dawson Total		**0.0**	**3.0**	**14.9%**	**14%**	**18%**	**2**	**0.6%**	**8%**	**2**	**15%**	**4**	**9%**	**12%**	**4**	**21%**	**3**
DeKalb Total		**-0.1**	**3.9**	**12.5%**	**21%**	**35%**	**3**	**5.6%**	**71%**	**5**	**12%**	**3**	**9%**	**15%**	**4**	**43%**	**5**
Forsyth Total		**0.1**	**2.3**	**7.3%**	**6%**	**21%**	**2**	**2.9%**	**26%**	**4**	**8%**	**2**	**5%**	**7%**	**3**	**15%**	**1**
Fulton Total		**0.0**	**3.6**	**11.6%**	**19%**	**35%**	**3**	**2.3%**	**60%**	**5**	**9%**	**2**	**8%**	**16%**	**4**	**45%**	**5**
Gwinnett Total		**0.0**	**3.4**	**8.0%**	**15%**	**29%**	**2**	**6.9%**	**60%**	**5**	**12%**	**3**	**6%**	**11%**	**4**	**28%**	**3**
Pickens Total		**0.1**	**3.3**	**9.3%**	**15%**	**43%**	**3**	**1.1%**	**8%**	**2**	**16%**	**4**	**8%**	**11%**	**4**	**21%**	**3**

Racial/Ethnic Disparities by County

	Cherokee	Cobb	Dawson	DeKalb	Forsyth	Fulton	Gwinnett	Pickens	Georgia
% Uninsured population (2012-16)	15.50%	15.40%	13.40%	17.20%	9.90%	13.70%	18.30%	12.70%	15.80%
Annual cervical cancer incidence rate*	6.40	6.00	ND	6.70	4.30	6.90	7.20	ND	7.80
Breast cancer incidence (2011-15)*	123.20	135.20	97.70	136.00	127.40	132.10	128.80	126.30	125.20
Annual colon and rectum cancer incidence rate (2011-15)*	37.00	40.20	25.20	40.60	39.10	38.10	37.40	44.70	41.80
Annual prostate cancer incidence rate (2011-15)*	114.90	131.70	84.70	143.90	116.30	143.80	122.80	111.00	123.30
Annual lung cancer incidence rate (2011-15)*	66.00	57.10	74.70	51.20	54.60	51.20	50.00	81.50	64.90
Coronary heart disease mortality, age-adjusted death rate (2012-16)*	53.90	51.90	66.60	55.00	55.60	61.10	57.10	92.00	79.10
Infant mortality rate (2013-17)***	4.60	6.50	8.40	7.60	4.30	7.00	6.70	8.50	7.50
Asthma age-adjusted discharge rate*	58.40	79.30	53.60	124.60	45.40	104.90	80.60	100.50	87.50
Asthma age-adjusted ED visit rate*	274.90	513.80	259.30	754.90	185.70	657.20	430.20	450.70	551.60
Stroke mortality, age-adjusted death rate*	39.80	44.00	39.30	40.50	39.90	39.20	36.60	36.20	43.00
Breast cancer mortality, age-adjusted death rate*	10.30	11.90	7.20	13.50	8.40	13.40	11.90	6.50	12.30
Diabetes age-adjusted discharge rate* (2013-17)	110.80	158.00	156.10	235.60	84.50	207.50	131.10	163.40	188.10
Diabetes age-adjusted mortality* (2013-17)	13.00	14.20	6.70	21.00	10.80	17.50	18.50	14.30	21.70
Obstructive heart disease/heart attack discharge rate*	224.20	180.00	305.50	205.70	222.60	195.30	197.50	360.60	265.00
Obstructive age-adjusted heart disease mortality*	56.50	51.40	73.10	53.20	55.80	56.30	54.50	92.50	76.40
Hypertensive heart disease age-adjusted discharge rate*	27.90	28.40	26.30	47.20	27.80	47.80	49.70	28.10	39.00
Hypertensive heart disease age-adjusted mortality*	15.30	7.60	19.10	14.90	8.30	24.40	13.00	12.70	16.20
Cancer mortality, age-adjusted death rate	148.00	143.50	162.70	150.10	138.30	144.60	138.40	163.10	160.70

ND for rates: Rates based on 1-4 events are not shown ND Data: Unavailable due to a lack of data reporting or data suppression

Community Commons CHNA Portal: CHNA.org

Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Per 100,000 population*

** *Eight-County Aggregate*

*** *Per 1,000 live births*

Racial/Ethnic Disparities				
	White**	Black**	Asian**	Hispanic**‡
% Uninsured population (2012-16)	8.20%	17.30%	15.80%	39.20%
Annual cervical cancer incidence rate*	ND	ND	ND	ND
Breast cancer incidence (2011-15)*	ND	ND	ND	ND
Annual colon and rectum cancer incidence rate (2011-15)*	36.80	44.30	32.50	32.60
Annual prostate cancer incidence rate (2011-15)*	116.10	193.50	44.00	98.40
Annual lung cancer incidence rate (2011-15)*	55.50	54.50	25.60	33.00
Coronary heart disease mortality, age-adjusted death rate (2012-16)*	58.10	60.20	34.50	22.80
Infant mortality rate (2013-17)***	4.60	11.00	3.10	5.50
Asthma age-adjusted discharge rate*	58.00	155.80	29.30	ND
Asthma age-adjusted ED visit rate*	235.60	1,050.00	97.70	ND
Stroke mortality, age-adjusted death rate*	36.50	50.30	30.90	21.60
Breast cancer mortality, age-adjusted death rate*	10.20	19.00	5.00	5.70
Diabetes age-adjusted discharge rate* (2013-17)	100.80	37.20	314.30	ND
Diabetes age-adjusted mortality* (2013-17)	12.00	30.50	14.30	10.40
Obstructive heart disease/heart attack discharge rate*	193.10	94.20	225.40	ND
Obstructive age-adjusted heart disease mortality*	55.70	31.60	60.30	21.80
Hypertensive heart disease age-adjusted discharge rate*	23.70	8.70	66.80	ND
Hypertensive heart disease age-adjusted mortality*	11.40	7.30	27.10	4.90
Cancer mortality, age-adjusted death rate	143.00	170.20	83.40	75.40

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* *Per 100,000 population*

** *Eight-County Aggregate*

*** *Per 1,000 live births*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Ranked Causes: Age-Related Death Rate, State and County Comparison (2013–2018)					
	All Races	White	Black	Asian	Georgia
Prioritized	All Other Diseases of the Nervous System	Parkinson's Disease	Accidental Poisoning and Exposure to Noxious Substances	ND	ND
#1	Ischemic Heart and Vascular Disease – 9,669	Ischemic Heart and Vascular Disease – 6,295	Ischemic Heart and Vascular Disease – 3,075	Ischemic Heart and Vascular Disease – 274	Ischemic Heart and Vascular Disease – 41,242
#2	Cerebrovascular Disease – 6,041	All Other Mental and Behavioral Disorders – 3,815	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease – 2,436	Cerebrovascular Disease – 227	Malignant Neoplasms of the Trachea, Bronchus and Lung – 22,349
#3	Malignant Neoplasms of the Trachea, Bronchus and Lung – 5,538	Malignant Neoplasms of the Trachea, Bronchus and Lung – 3,681	Cerebrovascular Disease – 2,110	Malignant Neoplasms of the Trachea, Bronchus and Lung – 155	All COPD Except Asthma – 22,123
#4	All Other Mental and Behavioral Disorders – 5,259	Cerebrovascular Disease – 3,680	Malignant Neoplasms of the Trachea, Bronchus and Lung – 1,686	Diabetes Mellitus – 111	Cerebrovascular Disease – 20,481
#5	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease – 4,602	All COPD Except Asthma – 3,606	Diabetes Mellitus – 1,430	Intentional Self-Harm (Suicide) – 101	All Other Mental and Behavioral Disorders – 17,375

ND for rates: Rates based on 1-4 events are not shown ND Data: Unavailable due to a lack of data reporting or data suppression
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
This tool does not report data by ethnicity. As a result, there are not comparable data reported for Hispanic or Latino death rates.

2015 Zip Code 5-Year Cumulative New Diagnoses Data – AIDSVu											
Zip Code	Zip Code Cases	Male Cases	Female Cases	Black Cases	White Cases	Hispanic‡ Cases	Asian Cases	Age 13-24 Cases	Age 25-44 Cases	Age 45-59 Cases	Age 60+ Cases
30004	20	12	8	7	7	-1	-1	-1	9	7	-1
30005	10	6	-1	-1	-1	-1	-1	-1	-1	-1	-1
30009	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1
30022	26	24	-1	13	9	-1	-1	5	15	5	-1
30040	15	12	-1	-1	8	-1	-1	-1	7	-1	-1
30041	10	8	-1	-1	8	-1	-1	-1	5	-1	-1
30062	33	31	-1	13	12	8	-1	7	18	5	-1
30066	29	25	-1	11	11	5	-1	6	14	7	-1
30068	9	8	-1	-1	-1	-1	-1	-1	-1	-1	-1
30075	27	21	6	14	6	7	-1	-1	15	7	-1
30076	42	36	6	18	11	13	-1	5	27	10	-1
30092	50	39	11	36	9	-1	-1	10	32	7	-1
30093	87	64	23	54	9	22	-1	19	56	9	-1
30096	69	61	8	47	5	14	-1	22	38	9	-1
30115	10	8	-1	-1	6	-1	-1	-1	-1	-1	-1
30188	21	19	-1	7	8	-1	-1	6	8	7	-1
30328	46	43	-1	25	9	8	-1	11	24	10	-1
30350	107	95	12	85	10	6	-1	30	69	8	-1

Missing 30114 and 30028

AIDSVu. Emory University, Rollins School of Public Health. Atlanta (www.aidsvu.org)

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring two or more of these races.*

2015 Zip Code Prevalence Data – AIDSVu											
Zip Code	Zip Code Rate	Male Rate	Female Rate	Black Rate	White Rate	Hispanic‡ Rate	Asian Rate	Age 13-24 Rate	Age 25-44 Rate	Age 45-59 Rate	Age 60+ Rate
30004	177	280	79	996	89	197	-1	-1	185	246	219
30005	139	209	73	420	117	340	-1	-1	129	226	-1
30009	247	339	166	931	148	-1	-1	-1	209	484	210
30022	171	313	41	768	104	231	-1	-1	212	230	139
30040	137	223	55	649	100	265	-1	-1	152	209	105
30041	71	114	29	813	55	172	-1	-1	82	121	-1
30062	243	420	76	964	143	391	-1	-1	374	309	115
30066	231	354	115	969	110	369	-1	71	288	343	127
30068	198	339	66	1,360	113	455	-1	-1	278	318	-1
30075	225	372	85	1,233	116	416	-1	71	208	374	146
30076	424	654	198	1,502	225	369	-1	118	463	732	210
30092	733	1,316	184	2,228	277	467	-1	145	1,007	905	421
30093	865	1,267	417	2,021	688	463	205	156	977	1,558	713
30096	564	845	299	1,629	273	420	62	102	640	936	289
30115	152	258	49	476	125	346	-1	-1	107	316	-1
30188	194	311	86	980	114	456	-1	-1	218	313	95
30328	590	1,116	130	2,216	288	740	-1	172	751	983	192
30350	1,262	2,166	473	3,207	274	942	-1	314	1,770	1,700	311

Missing 30114 and 30028

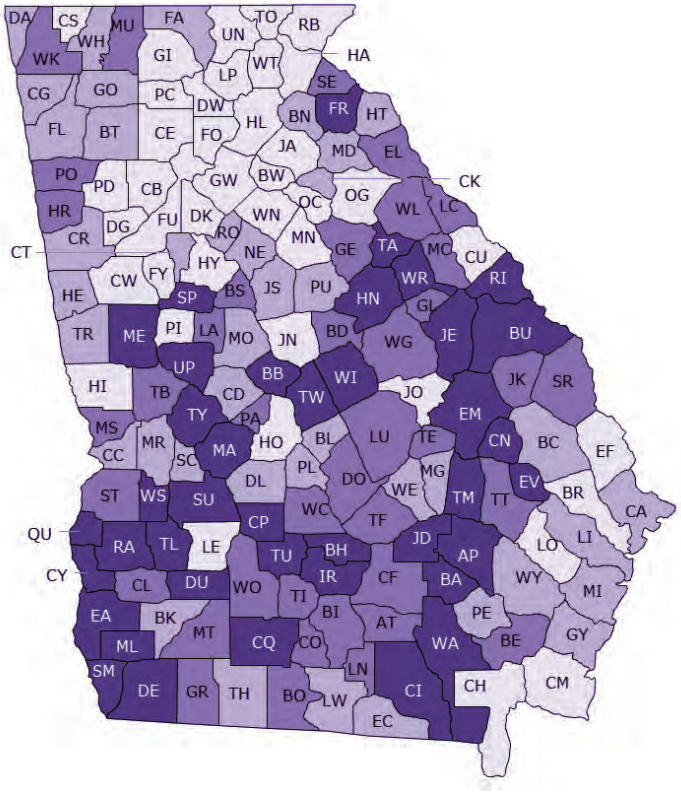
AIDSVu. Emory University, Rollins School of Public Health. Atlanta (www.aidsvu.org)

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Maps

Health Outcomes

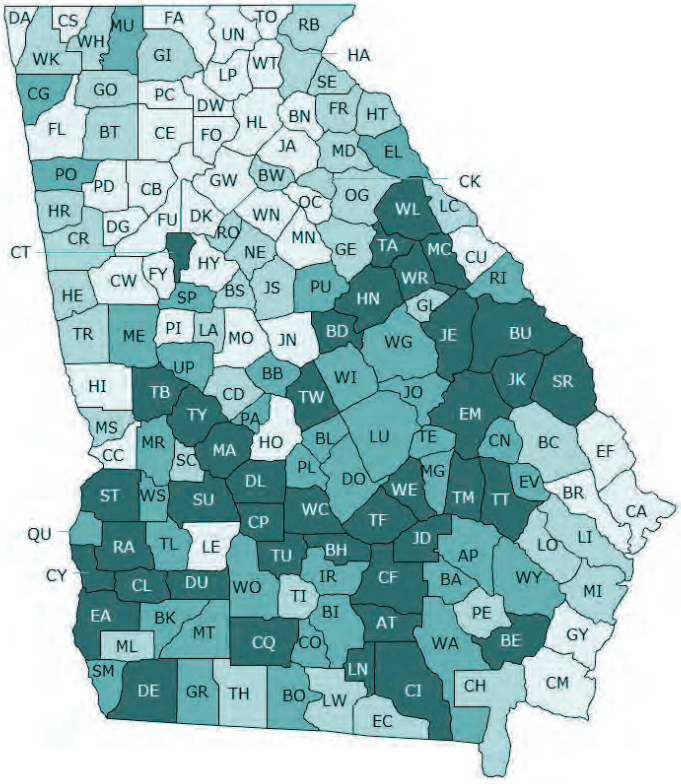
The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.



Rank
1-40
41-80
81-119
129-159

Health Factors

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.



Rank
1-40
41-80
81-119
129-159

http://www.countyhealthrankings.org/app/georgia/2018/overview

Primary Data and Community Input

Regional Health Board Listening Sessions, Community Health Summit, Key Informant Interviews and Focus Groups

CHNA Collaborators

Collaborator	Areas of Service
Atlanta Beltline Marla Oros, *Deputy Executive Director*	Key Informant
Bethesda Community Clinic Karen Fegely, *Chief Executive Officer*	Key Informant
Caravita Homecare Beth Cayce, *CEO*	Summit Attendee
Center for Pan Community Services, Cobb and Douglas Public Health Karuna Ramachandran, *Health Programs Director* Keun Kim, *Director of Marketing & Development*	Key Informant
Cherokee Christian Ministerial Association Fred Goodwin, *President*	Key Informant
Cherokee County Board of Education Barbara Jacoby, *Director of Public Information, Communication and Partnerships*	Key Informant
Cherokee County Chamber of Commerce Pamela Carnes, *Executive Director*	Key Informant
Cherokee County Division of Family and Children Services Charity Kemp, *Director*	Key Informant
Cherokee County Senior Services Nathan Brandon, *Director*	Key Informant
Cherokee FOCUS Sonia Carruthers, *Chief Executive Officer*	Key Informant

Collaborator	Areas of Service
Children's Hospital of Atlanta Emily VanderWiele, *Physician Practice Operations Leader* Dr. Lennon	Key Informant
City of Canton Lorrie Waters, *Manager – Human Relations*	Key Informant
Cobb and Douglas Public Health Lisa Crossman, *Deputy Director*	Key Informant
Community Foundation of Greater Atlanta Lesley Grady, *Senior Vice President-Community*	Key Informant
East Cobb Business Association	Key Informant
Fulton County Board of Commissioners Marvin Arrington, *District 5*	Key Informant
G. Cecil Pruett Community Center Family John Hicks, *Executive Director* Jessica Ascenzo, *Wellness Director*	Key Informant
Georgia Department of Public Health Dr. Zachary Taylor, *District Health Director District 1-2 North GA*	Summit Attendee
Georgia House of Representatives Rep. Roger Bruce, *District 61*	Key Informant
Homeless Initiative Cathryn Marchman, *Executive Director of Partners for H.O.M.E*	Key Informant

Collaborator	Areas of Service
Mercy Care Salvador Arias, *Board Member* Tom Andrews, *President*	Key Informant
National Alliance on Mental Illness Neill Black, *Program Director*	Key Informant
North Fulton Community Charities Barbara Duffy, *Executive Director*	Key Informant
North Star Church	Key Informant
Partners for H.O.M.E Cathryn Marchman, *Executive Director*	Key Stakeholder
Providence Women's Healthcare Shelley Dunson Allen, M.D	Summit Attendee
Resurgens Orthopaedics Angelo Difelice, M.D., *North Fulton Regional Health Board Member*	Summit Attendee
Revved Up Kids, Inc. Alli Neal, *Executive Director*	Summit Attendee
Roswell Inc.	Summit Attendee
Senior Services North Fulton Heather Terry, *Community Relations Director* Tanya Morris, *Client Services Director*	Summit Attendee
Smyrna City Government	Key Informant
STAR House Foundation, Inc. Monica Oliveira, *Executive Director*	Summit Attendee
Summit Counseling Shawn Murphy, *Director of Development* Cathy Murphy, *Director of Community Outreach*	Summit Attendee

Collaborator	Areas of Service
United Way Demetrius Jordan, *Regional Director* Ginneh Baugh, *Sr. Director – Measurement & Knowledge*	Key Informant
WellStar Health System and WellStar North Fulton Hospital Lori Allen, *Regional Development Director* Jacque Alt, *VP Chief Nursing Officer* Kristen Caudell, *Director, Community Education & Outreach* Jon-Paul Croom, *SVP, North Fulton Hospital President* Jenna Garber, *Vice President-Human Resources* Karim Godamunne, M.D., *VPMA / North Fulton Regional Health Board Member* Mark Gravlee, M.D., *North Fulton Regional Health Board Member* Allen M. Hoffman, M.D., *Executive Director* Lindsey Petrini, VP, *North Fulton Hospital Chief Operations Officer* Joyce Robinson, *Regulatory Manager* Diane Sanders, *Community Education Coordinator* Shara Wesley, *Director, Community Benefit*	Listening Session and/or Summit Participant
WellStar Community HealthCare Allen M. Hoffman, M.D., *Executive Director*	Key Informant
WellStar Health System	Summit Attendee
West End Clinic Karen Williams, *Associate Vice President-Programs*	Key Informant
YMCA	Key Informant
Young Women's Christian Association	Key Informant

WellStar North Fulton Hospital

Community Health Summit

The following is a summary of the WellStar North Fulton Hospital Health Summit held February 26, 2018, on the hospital campus. The Health Summit was facilitated by GHPC in partnership with WellStar and lasted approximately three hours. The 19 participants included WellStar team members and community stakeholders. Community stakeholders represented organizations serving residents in the primary service area of WellStar North Fulton Hospital.

The organizations that took part in the Health Summit included:

- STAR House Foundation Inc.
- Senior Services North Fulton
- Revved Up Kids, Inc.
- Resurgens Orthopaedics
- WellStar North Fulton Hospital
- Summit Counseling
- North Fulton Community Charities
- Providence Women's Healthcare
- Caravita Homecare

GHPC presented findings of the CHNA generated from secondary data analysis, key informant interviews, focus groups and listening sessions. Health Summit participants were asked to discuss community health needs and were encouraged to add any needs that may have been absent from the assessment's data collection thus far. Participants were then asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the community health, especially in vulnerable populations. The needs identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface community health priorities.

Group Recommendations and Problem Identification

Participants prioritized four community health needs of residents within WellStar North Fulton Hospital's primary service area: behavioral health, parental education and support, access to care and overuse and abuse of opioids.

The following is a summary of the input participants offered when asked about contributing factors, potential solutions and community resources to address the health priorities.

Behavioral Health

Health Summit participants prioritized behavioral health as one of the most pressing issues in their communities. Concerns included lack of awareness and education, stigma, limited behavioral health providers, a fragmented referral system and inadequate resources and protocols for mental health crisis episodes.

Contributing Factors:

- There is limited awareness among residents about behavioral health diagnoses, symptoms, treatment options and preventive measures (i.e., early detection), which may contribute to stigma and a resistance to seeking care.
- Residents may resist seeking care until symptoms are acute and they present in an emergency situation.
- Residents often seek care for behavioral health symptoms in the ED, where behavioral health resources may not be available.
- There is a general lack of behavioral health and substance abuse services to meet adult and pediatric needs. WellStar North Fulton Hospital does not offer behavioral health beds.
- The referral system for behavioral health services is fragmented and poses challenges in service navigation and care continuity for patients.
- The lack of behavioral health providers limits the access residents have, both insured and uninsured, to appropriate care.

Recommendations:

- Increase the services available for adults and children in crisis situations who need hospitalization in order to decrease the use of local EDs for behavioral health needs.
- Increase educational resources that are culturally and linguistically sensitive and targeted at youth and under-resourced communities.
- Hospitals could host health fairs focused on behavioral health in geographic areas where traditionally under-resourced and high-risk populations live. WellStar hospitals could include behavioral health in their health fair materials.
- Hospitals could partner with local nonprofit organizations and homeless liaisons to increase awareness and outreach.
- Offer an anonymous hotline focused on promoting preventive behaviors and resources to avoid crisis care.
- WellStar North Fulton Hospital could integrate behavioral health into their services for adults and children.
- Integrate behavioral health screenings into routine screenings to improve early detection and diagnosis, while reducing stigma.

Parental Education and Support

Health Summit discussions addressed the importance of parental education in the community. Participants discussed the need to offer parents the knowledge and access to resources to make healthier choices, support healthy child development and improve child health.

Contributing Factors:

- Families do not always have the support they need to provide protective and preventive care to their children.
- Limited health literacy among parents contributes to unhealthy behaviors among youth, i.e., poor food choices, physical inactivity, untreated behavioral health, etc.
- Parents are unaware of available resources and services, resulting in delayed care-seeking and the use of inappropriate resources (i.e., ED overutilization).
- Parents do not always know how to address issues in a way that promotes healthy child development.

Recommendations:

- Develop partnerships with local schools, community centers and faith-based organizations in under-resourced areas to reach more parents.
- Increase the use of mobile programs in schools, grocery stores, churches and community centers to teach healthy habits to youth and their families.
- Linguistically and culturally sensitive community education should be designed to inform parents and children about nutrition, physical activity, behavioral health and available resources that best address these subjects.
- Offer health education using software applications integrated into electronic devices provided to all students in public schools within the service area.
- Record and live stream health education events and classes into patient waiting rooms (e.g., pediatric offices, departments of health and human services, etc.).

Overuse and Abuse of Opioids

Health Summit participants discussed the opioid epidemic in the WellStar North Fulton Hospital service area. Several of the issues related to opioids discussed were the increase in opioid abuse, limited awareness about the risk of opioid addiction and the stigma associated with prescribing and using opioids.

Contributing Factors:

- There is an increased prevalence of opioid abuse among residents regardless of socioeconomic status or demographics.
- Participants delineated opioid abuse into two populations: (1) younger users, who are most often not using their own prescription for recreational purposes and (2) older populations that may have had surgery and become dependent on opioids that were prescribed for pain management.
- Some users have limited knowledge of the risks and addictive side effects of opiates.
- Some providers may be unknowingly overprescribing opioids.
- Opioid prescriptions are not being properly disposed of, which is increasing access to the drug for recreational users.
- Opioid use is being highly publicized and stigmatized, which may deter users from seeking assistance.

Recommendations:

- Offer education and outreach in a community-based setting (e.g., schools, hospital waiting rooms, etc.) to inform residents about appropriate use, storage and disposal of opiates. This also includes side effects, treatment options and the uses of Narcan.
- Require educational sessions prior to receiving an opiate prescription in an attempt to reduce overprescribing and dependence on opiates.
- Promote alternative treatments (nonaddictive) for pain management.
- Marketing resources for behavioral health and substance abuse should be distributed in locations where parents can access them (grocery stores, schools, etc.).

Access to Appropriate Care

Health Summit participants discussed the limited access residents have to appropriate care when and where it is needed. Several of the challenges discussed were transportation, awareness of available services, the number of providers and affordability.

Contributing Factors:

- There are not enough safety-net providers in the area, leaving under- and uninsured residents with limited options for care.
- Underinsured residents are finding it difficult to afford deductibles, copays and overall healthcare costs.
- Residents do not fully understand their insurance options, which affects their ability to access the right care in the right place at the right time.
- Providers do not always accept all insurance options. Residents may have to travel outside of their area to a provider that will accept the type of insurance they have.
- Technology is becoming more necessary to access some healthcare elements, such as lab results, after-hours care, telemedicine, emailing the physician, etc.
- Some residents may not be able to navigate the health resources in their community or do not possess technological skills or devices needed to effectively navigate them.
- There is a need for comprehensive transportation among seniors who experience extensive wait times and families that have unreliable transportation resources.

Recommendations:

- WellStar North Fulton Hospital could advocate for improved insurance and affordability.
- Further develop partnerships with local providers and community organizations to better meet the needs in the area.
- There was dialogue about making healthcare mobile by supplying resources to the community (i.e., schools and community-based organizations) and dispatching mid-level providers to assist with fulfilling healthcare needs. This model would reach limited English-speaking residents and those who would otherwise have barriers to healthcare.
- WellStar could host health fairs in under-resourced communities (i.e., apartment complexes).
- Transparency in healthcare costs would encourage preventive care and allow individuals to understand their fiscal responsibilities prior to seeking care.

Listening Sessions

WellStar North Fulton Regional Health Board (January 2018)

1. In your opinion, what are the most serious health problems/needs in our community? What are some of the causes?

Youth mental health

- Specifically, anxiety issues. Many parents are afraid of their kids – induced by chemical use.
- Cyber bullying is a growing problem and puts additional pressure on students.
- It would be wise to address mental health issues of aging population.
- At North Fulton, inpatient mental health is coming soon with two psychologists onboarding at hospital.

Opioid use

- Not so much seen in the schools, but we know it's a problem in the cities.
- The city of Alpharetta is engaged in a heroin addiction crisis that started from opioid use. Some pain clinics in the city have been raided to get opioids.
- College clinics are quick to prescribe anti-anxiety meds to students, a potential pathway to abuse. Where have we lost track?

Some barriers to these health problems cited:

- iPhone – a vehicle for comparison, cyber bullying, depression.
- Lack of resources for families to get confidential help – not sure parents know how to navigate through mental health issues – many don't know what is normal behavior and what is not – need education and a way for parents to be able to talk for support and help. Suicide often comes as a surprise to parents.
- The stigma of dealing with mental health or substance abuse is a barrier to getting needed help.
- Lack of awareness of health coverage (what's covered/available).

2. Who are the community leaders and partners WellStar could collaborate with to help reach under-resourced people with preventive care and education and to improve overall community health?

Mental Health

Parent to Parent Program

- Parent to Parent of Georgia offers a variety of services to Georgia families impacted by disabilities or special healthcare needs.
- They have a Fulton County Hispanic Support Group, facilitated by Parent to Parent of Georgia. Meetings are held once a month.

3070 Presidential Parkway, Suite 130
Atlanta, GA 30340-3720
770-451-5484
Toll Free: 800-229-2038
www.p2pga.org

The Summit Counseling Center

- Affiliated with Mount Pisgah Methodist Church
- Mental health resources for students and families
- David Smith, Executive Director
- Partnering with North Fulton High School and three middle schools
- Subsidized by the United Way
- With over 30 years of nonprofit leadership experience, Shawn Murphy is Summit Counseling's ambassador to our surrounding community. His primary role is to assess needs and cultivate strategic "Partner in Caring" relationships while working together with Summit's therapists to address the growing mental health challenges facing our community.

2750 Old Alabama Rd.
Suite 200
Johns Creek, GA 30022
678-893-5300
http://summitcounseling.org/

Police Departments

- Take many mental health calls and follow a de-escalation model now

Will To Live Foundation

- Teen suicide awareness and prevention
- They do school presentations
- Strategies:
  - Raising awareness of teen suicide in our communities
  - Increasing education around mental illnesses and their stigmas
  - Delivering hope to teens everywhere via our Life Teammates concept and program

5805 State Bridge Road, No. G212
Johns Creek, GA 30097
https://will-to-live.org/

North Fulton Mental Health Collaborative

- Quarterly meetings
- Katha Stuart with Fulton County Schools participates
- Summit Counseling is the integrator
- Mission: Connecting and energizing our community stakeholders to provide a life span behavioral healthcare system for north Fulton County. This group is open to all behavioral healthcare stakeholders in our community.
- Per Facebook page, the North Fulton Mental Health Collaborative received a generous grant from United Way of Greater Atlanta in north Fulton County. Funds from this grant will be used to engage Cindy Cheatham, senior adviser and president, Good Advisors LLC, to help us identify strategic opportunities and address critical needs that can bring meaningful improvement to mental health services in north Fulton County.

678-893-5300

Partner with community psychiatrists

Collective Impact Program regarding school performance and how life affects it (overlap map/tools)

Collective Impact, the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Collaboration is nothing new. The social sector is filled with examples of partnerships, networks and other types of joint efforts. However, Collective Impact initiatives are distinctly different. Unlike most collaborations, Collective Impact initiatives involve a centralized infrastructure, a dedicated staff and a structured process that leads to a common agenda, shared measurement, continuous communication and mutually reinforcing activities among all participants.

Source: https://ssir.org/articles/entry/collective_impact

Ministerial component with youth and adults

- Possible involvement of the WellStar Congregational Health Network

Opioid

"Old Ellis Point" – The Insight Drug Program

- Drug rehabilitation (inpatient and outpatient)
- They have parent support groups

Clint Stonebreaker
5110 Old Ellis Pt
Roswell, GA 30076
770-751-8383
http://theinsightprogram.com/georgia-locations/

Justice System

- They punish but don't address root cause
- See City of Atlanta's diversion program

North Fulton Rotary Club Task Force

- Clubs partnering and working with Roswell High School
- Developing "shock and awe" video for students
- Board members Katha Stuart and Brian Hansford and WellStar Foundation Development Officer Lori Smith on task force
- The Roswell Rotary is coordinating the awareness and education segment geared toward the high schools. They commented that there is so much misinformation within the schools, this age group and by parents ("not-my-kid" attitude). The committee plans to produce a video campaign and educational seminars/meetings. (Local rotary clubs are taking other topics to focus on like the recovery piece).

Under-Resourced

No Longer Bound

- Offers a 12-month-long residential regeneration process to rescue addicts, regenerate men and reconcile families.
- They offer family recovery support classes for addiction

Edward Bailey, Executive Director
770-886-7873 ext. 200
edward@nolongerbound.com
2725 Pine Grove Road
Cumming, GA 30041
https://nolongerbound.com/

North Fulton Community Charities

- NFCC serves the Fulton County portions of the following zip codes: 30004, 30005, 30009, 30022, 30024, 30075, 30076, 30076, 30092 and 30097.
- To build self-sufficiency and prevent homelessness and hunger in our community by providing emergency assistance and enrichment programs. List of services: https://nfcchelp.org/services/overview/ includes mobile outreach and food bank

11270 Elkins Rd.
Roswell, GA 30076

https://nfcchelp.org/

For information about education and enrichment programs contact:

Eden Purdy
epurdy@nfcchelp.org
678-387-4458

For classes and registration information, contact the Education Center at 678-387-4478.

3. Is there anything you would like to add or you think would be helpful for us to know to help?

- Meet cited priority health needs
- Expand community outreach and engagement
- Advocate on key policies to promote better health
- It's how we do things in addition to what we do that's important – we must change paradigm.
- We must have a diversity focus when we address health needs.
- Partnerships with nonprofits can provide an inroad to diversity. Roswell has a high Jewish population and Alpharetta has a mosque and a high population of people from India.

Safety-net clinics in North Fulton

North Fulton Regional Health Center
3155 Royal Drive
Alpharetta, GA 30022
404-332-1876

North Fulton Government Service Center
7741 Roswell Road
Sandy Springs, GA 30350
404-612-CARE (2273)

Key Informant Summary

(August 2018-November 2018)

GHPC conducted interviews with community leaders. Leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including (1) those with public health expertise, (2) professionals with access to community health–related data and (3) representatives of under-resourced populations. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the study.

Methodology

The following qualitative data were gathered during individual interviews with 11 stakeholders in communities served by WellStar North Fulton Hospital. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents in the community served by WellStar North Fulton Hospital, as well as ways to address those concerns.

There was a diverse representation of community-based organizations and agencies among the 11 stakeholders interviewed. The organizations represented included:

- Bethesda Community Clinic
- Center for Pan Asian Community Services
- Cherokee Christian Ministerial Association
- Cherokee County Chamber of Commerce
- Fulton County Schools – Student Health Services
- Good Samaritans
- Highland Rivers Behavioral Health
- MUST Ministries
- National Alliance on Mental Illness
- Partners for H.O.M.E
- G. Cecil Pruett Community Center Family YMCA

When asked what has improved, declined or remained unchanged in the past three years, stakeholders said the following:

Improved

- For those that have access to increased job opportunities, health has improved
- New parks and trails
- Addressing mental health needs in schools
- New hospital in Cherokee County
- New FQHCs in Pickens and DeKalb counties
- Center for Pan Asian Community Services (CPACS) offers access to healthcare and prevention in Korean, Chinese–Mandarin, Vietnamese, Nepalese, Burmese and Spanish

Stayed the same

- Access for uninsured — no new providers
- Data shows there are no real improvements for uninsured
- Not addressing social determinants of health in Fulton County
- There are limited providers for those on Medicaid
- Limited access to behavioral health and substance abuse services

Declined

- Those remaining in poverty, health has declined (i.e., indigent population, Medicaid and Medicare, those on SSI)
- Uninsured primary and dental care

Major Health Challenges:

- Common health issues:
  - Obesity
  - Cardiovascular diseases
  - Diabetes (type I and II)
  - Hypertension
  - Kidney disease
  - Cancer (colon, gastric, breast)
  - HIV
  - Respiratory issues among homeless populations (COPD and asthma)
- Mental health:
  - High prevalence of untreated/ undiagnosed mental issues
  - Self-harm/suicide
  - Substance abuse (opioid/heroin, alcohol, and methamphetamines)
- Poor dental health
- Disparities among people of color

Context and Drivers:

- Access to care
  - Lack of affordable insurance options for residents without employer-funded insurance.
  - Limited access to affordable uninsured care (e.g., OBGYN care is not readily available for uninsured women). Uninsured residents diagnosed with cancer or kidney disease do not have access to the ongoing treatment that they require, which often leads to frequent ED visits and higher medical bills over time.
  - Uninsured specialty care is available at Grady Memorial Hospital for Fulton County residents, and unavailable/ unaffordable for residents from other counties in the service area.
  - Many primary care providers do not accept Medicaid or Marketplace insurance.
  - Many uninsured residents delay seeking treatment until their symptoms become an emergency, which often limits treatment options for advanced illnesses.
  - The healthcare system is difficult to navigate due to out-of-date directories and a lack of transparency related to insurance acceptance.
- Low socioeconomic status related to low-wage employment, poor educational attainment and poor job skills and training.
- Low health literacy related to low educational attainment and a lack of literacy.
- Racial and ethnic disparities
  - African-Americans experience higher rates of incarcerations and lower wages in most industries.
  - Undocumented residents do not have access to insurance. They avoid medical treatment and public establishments due to a fear of deportation. Barriers related to language and low literacy levels make effective communication difficult.
- Housing issues
  - Healthy housing is becoming less affordable, and residents are having to make choices between healthy options (food, preventive care, medications, etc.) and the cost of their housing because they cannot afford everything.
  - Homelessness in increasing, and the population of homeless people is aging. Homelessness has a negative impact on health, and older homeless people tend to have undiagnosed and unmanaged chronic health issues.
  - The housing stock is not always healthy (e.g., trailer parks and government housing in Cherokee and Pickens counties)
- Healthy food
  - In under-resourced communities there are a limited number of grocery stores, coupled with high rates of fast food restaurants.
  - There is limited promotion of healthy foods and the need to eat healthy.
  - Cultural and traditional preferences can be unhealthy.
  - Not all residents know how to prepare foods in a healthy way.
  - Healthy foods are often unaffordable and do not last long enough for under-resourced households.
  - Many residents do not have time to shop for and prepare healthy foods due to work schedules and traffic.
  - Children do not always have access to healthy foods outside of school hours.
- Transportation
  - There is limited access to public transportation in many counties. The public transportation that does exist can be unreliable (e.g., often behind schedule) and disconnected from county to county.
  - Many under-resourced residents do not have access to private transportation and may not be able to afford public transportation.
  - Undocumented residents are not able to drive legally, due to a lack of documentation.
- Limited access to affordable dental care due to limited funding for dental clinics. Residents view dental insurance and care as a luxury. Youth do not have a lot of access to dental care.
- Behavioral health can be difficult to secure in a timely fashion due to a lack of local behavioral health providers, limited uninsured care (inpatient, outpatient and psychiatry), a general lack treatment options for co-occurrence (substance use and behavioral health), and limited awareness about the services that are available.

Recommendations:

- Begin to identify and refer patients with needs related to social determinants of health.
- Advocate for Medicaid expansion.
- Provide behavioral health crisis beds, counseling services and psychiatric care to under-resourced residents.
- Implement national best practices to address local health needs.
- Increase culturally and linguistically relevant outreach and education about the need to secure a medical home, manage chronic disease, secure preventive care, the value of treatment, prescription assistance programs, etc.
- Assist patients with navigating healthcare resources like prescription assistance, uninsured care, insurance options, etc.
- Collaborate with local farmers' markets to offer fresh produce in communities where it is not readily available.
- Offer mobile medical and dental options (e.g., physicians seeing patients in the community, mobile medical unit for screening and referrals, etc.).
- Offer transportation to and from medical services weekly or monthly, specifically in under-resourced communities.
- Increase information that is available about the need for healthy physical activity and the resources that are available in local communities.
- Increase funding for dental clinics that offer care to uninsured (i.e., FQHCs and free clinics).
- WellStar can support local nonprofit clinics by offering reduced-rate services (e.g., surgery, special tests and screenings, etc.) and providing volunteer physicians to staff clinics and see patients.
- Increase the number of bilingual patient navigators.
- Increase education and training of providers related to cultural, racial and ethnic sensitivity. Talk with community leaders and representatives of various populations to better understand what the barriers and issues are for communities in seeking and securing effective treatment options.
- Work directly with churches to offer up-to-date information and referral directories.

Resident Focus Group Summaries

(January 2018-October 2018)

Purpose

This assessment engaged community residents to develop a deeper understanding of the health needs of the community WellStar North Fulton Hospital serves, as well as the existing opinions and perspectives related to health status.

Methodology

GHPC recruited and conducted two focus groups among residents living in the community served by WellStar North Fulton Hospital. GHPC designed facilitation guides for focus group discussions. Residents were recruited using a third-party recruiting firm. Recruitment strategies focused on residents that had characteristics representative of the broader service area, specifically, areas that experience disparities and low socioeconomic status.

Focus groups lasted approximately 1.5 hours, during which time trained facilitators led six to 12 participants through a discussion about the health of their community, health needs, resources available to meet health needs and recommendations to address community health needs. All participants were offered appropriate compensation ($50) for their time and a light meal. The following focus groups were conducted by GHPC between January 2018 and October 2018:

- WellStar North Fulton Hospital Service Area Residents – Duluth, Georgia (Jan. 10, 2018)
- WellStar North Fulton Hospital Service Area Residents – Duluth, Georgia (Oct. 3, 2018)

Focus groups and listening sessions were recorded and transcribed with the informed consent of all participants. GHPC analyzed and summarized data from the focus groups and listening sessions to determine similarities and differences across populations related to the collective experience of healthcare, health needs and recommendations, which are summarized in this section.

Target Population:
North Fulton Residents

Location:
Duluth, Georgia

Number of Participants:
9

Major Health Challenges:

- Obesity/overweight (adult and child)
- Poor mental health
- High blood pressure
- Asthma/allergies
- Congestive heart failure (cardiovascular disease)
- Cancer

Context and Drivers:

- Economic instability (affordability of food and housing, poor job market, cost of medicines)
- Low health literacy
- Physical inactivity (affordability, distance to recreational center/ park, poor infrastructure, low walkability, time constraints due to excessive traffic, unconducive school curriculum, resource quality is influenced by area demographics, cultural preference)
- Traffic (time constraints, stress influences food choices)
- Access to healthy foods (time constraints, affordability, prevalence of fast food in proximity, food quality in schools)
- Limited resources in lower socioeconomic areas
- Access to care (affordability for under- and uninsured, low number of specialists)
- Insurance (limited options, affordability)
- Transportation (fragmented)

Recommendations:

- Invest in projects/developments that will increase walkability of the area (i.e., future development that spans over GA 400)
- Prioritize education dissemination in youth to encourage healthy habits before adulthood

Target Population:
WellStar North Fulton Hospital Service Area Residents

Location:
Duluth, Georgia

Number of Participants:
11

Major Health Challenges:

- Obesity/overweight (adult and child)
- Mental health
- High blood pressure
- Fibromyalgia
- Asthma
- Allergies
- Blood clots
- Congestive heart issues
- Mast cell disorder
- Breast cancer

Context and Drivers:

- Access to care
  - Uninsured healthcare is not always affordable, and there are limited free (or reduced-price) clinics available.
  - Deductibles and copays can be unaffordable for insured residents.
  - Uninsured medications are unaffordable.
  - Residents do not always have access to employer-provided insurance due to unemployment or part-time status.
  - Providers do not accept Medicaid or insurance offered on the ACA exchange.
  - The type of insurance you have influences the quality of care.
  - Wait times can be lengthy to secure a primary care appointment.
  - Providers are not discussing symptoms and treatment options with patients.
  - Specialty providers are limited, particularly for chronic diseases that are not the most common.
- Residents do not always choose healthy options when they are accessible.
- Limited awareness of residents about healthy choices (food and exercise), availability of resources, importance of preventive care and long-term implication of individual choices.
- Residents do not always exercise due to poor infrastructure (no sidewalks, poor lighting, etc.) that does not facilitate physical activity, poor street design that makes communities not walkable, etc.
- Residents do not always have the time to make healthy choices (spending time with family, grocery shopping, physical activity, cooking, etc.) due to work obligations and traffic. Additionally, these issues increase stress and influence behavioral health.
- Housing is not affordable, which impacts commute time (living further outside the city to afford costs), ability to afford healthy options.
- Parents are concerned for the safety of children and do not let them play outside as a result. Public schools are not always offering physical activity during the school day.
- Residents are not always eating healthy. There is a high rate of fast food restaurants in the area. Schools do not always serve healthy foods.
- The socioeconomic status of a community determines the amount of resources that are locally available. There are more healthy resources available in communities with high socioeconomic status and less in communities with low socioeconomic status.
- Transportation is not always readily available. Public transportation is more available in Atlanta. Gwinnett County's transportation is not comprehensive.

Recommendations:

- Increase education among children about healthy choices and habits in schools.

Primary Data Collection Tools

Key Informant Questionnaire

(2018–2019)

Before we begin, please remember not to use any names or identifying information about yourself or other people.

Context

In your opinion, over the past three years, has health and quality of life in your county:
(Circle or highlight your selection.)

Improved Stayed the same Declined Don't know

Please explain why you think the health and quality of life in the county has improved, stayed the same, or declined and any factors informing your answer.

- What in your opinion are the district's/county's biggest health issues or challenges that need to be addressed? Gaps? Strengths?
- In your opinion, who are the people or groups of people in your county whose health or quality of life may not be as good as others? Why? Please note any zips/areas where there are health disparities/pockets of poverty.
- What do you think are some of the root causes for these challenges? What are the barriers to improving health and quality of life?
- How important an issue to the district/county is the reduction/elimination of health disparities? What is your perception of current disparities?
- What specific programs and local resources have been used in the past to address health improvement/disparity reduction? (To what extent is healthcare accessible to members of your community? Might cite examples of programs by disease state, life stage or otherwise.)

Community Capacity

- Which community-based organizations are best positioned to help improve the community's health?
- Do you see any emerging community health needs, especially among under-resourced populations, that were not mentioned previously? (Please be as specific as possible.) (How does this impact the health of residents?)

Moving the Needle

- If you could only pick three of these health issues, which are the most important ones to address either now (short term) or later (long term)? What should be the focus of intervention by county/district/community?
- Supportive network to help residents in a one-stop place. How do we address these issues in a comprehensive way using existing resources and stitching together a safety net for residents most at risk?
- Why did you pick these?
- What interventions do you think will make a difference? Probe for different types of interventions.
- Do you have any other recommendations that you would make as they develop intervention strategies?

Wrap Up

- Is there anything we left out of this survey that we need to know about the most pressing health needs of the community you serve?

Focus Group Discussion Guide

Community Health Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

Facilitator introduces self and thanks those in attendance for participating

Facilitator explains purposes of discussion:
The project is being undertaken by WellStar Health System. They are seeking ways to improve the health of residents in your community. They would like to hear from people who live in these counties. They are particularly interested in your feelings about the health and health needs of the community, how the health-related challenges might be addressed, and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

Explain about focus groups:

- Give-and-take conversation
- I have questions I want to ask, but you will do most of the talking
- There are no right or wrong answers
- You are not expected to be an expert on healthcare; we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation
- Your names will not be used when the tapes are transcribed; just male or female will appear on any transcript
- I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to "hold on a minute" while I hear from someone else, so don't take offense
- Please remember that what people say in this group is confidential. I ask that you do not share what you heard from others outside of this group.
- You will be asked to talk about yourself, your family and your friends today. Please do not use anyone's name in your comments.
- Here is an informed consent form for you to read along with me and then sign if you decide to participate today. It is important for you to know that your participation today is completely voluntary. You can stop your participation now, or at any time. *(Read informed consent, collect signatures)*

Participant Introductions

Please go around the table and introduce yourself and tell us how long you have lived in [this county/community].

I am going to ask you all a series of questions about your own family's health first, and then some questions about what you see happening in your larger community related to health and well-being.

Health Concerns for Your Family

1. What does the term "healthy lifestyle" mean to you?
2. Do you think you and your family have healthy lifestyles? Why or why not? What affects your ability to be healthy? What prevents you from being as healthy as you would like to be?

   I want to go a bit deeper in a few areas related to your and your family's health.

3. Let's start with healthy eating. Most of the time, do you and your family eat as healthily as you would like? What prevents you from eating healthily? (Probe for cultural issues, access to healthy food.)
4. What do you think would make you change your eating habits? What could make it easier for you and your family to eat healthier?
5. Now let's talk about physical activity. What kinds of physical activity do you and your family engage in? Do you think you get enough physical activity to be healthy?
6. What keeps you and your family from being as physically active as you would like to be? What would help you and your family get more exercise? What could be done in your community to help you and your family to become more physically active?
7. How about tobacco use? How prevalent is tobacco use among your family and friends? Do you think most people are aware of the risks related to tobacco use? Knowing those risks, why do you think people continue to use tobacco products? What do you think it would take to change people's habits when it comes to tobacco use?
8. Are drug and alcohol abuse a problem in your community? What contributes to this problem? What could be done to address the problem?
9. Another health issue of concern is risky sexual behavior among teens. Do you see this as prevalent in your community? Are there support services to help teens deal with this type of issue? What more could be done?
10. When you think about the health concerns we have discussed – healthy eating, physical activity, tobacco use, drug and alcohol use and risky sexual behavior – do you know of any resources/programs/services in your community that help with these issues? Are the services that are available adequate to meet the need? Are there different types of services that would be more appropriate or effective?
11. Do you and your family have somewhere or someone that you go to for routine medical care? When you go there, does anyone ever talk to you or provide you with information about the health issues we have been discussing – weight, exercise, healthy eating, tobacco, drug and alcohol use, sexual behavior? Do you think your primary care provider should ask you about these issues? Provide you with information? Help you to change your habits?

Health Concerns in the Community

12. Now let's talk about your community. Please tell me about the strengths/positives in your community.
13. Do you think that most people in your community are healthy? Do you know many people that have chronic diseases such as diabetes, high blood pressure, heart disease?
14. Do you think that there is something about your community that contributes to people having these types of issues?
15. Do you think that people with chronic illnesses have access to the health services they need in order to control their diseases? Why or why not? What services are needed in your community to support those with chronic disease?
16. What do you see as the role of the hospital or health system to address these issues?

Facilitator: Present community-appropriate data summary to participants.

17. What is your reaction to this information? Does it ring true to what you know about your community? Is there anything missing from these data that you believe to be true about your community?
18. What do you think is the best/most effective way to begin to address these issues?
19. Considering the information that I just presented to you, along with your own experience with critical health needs here, which one or two of these health issues should be the priorities for addressing over the next three years?
20. What suggestions do you have for making specific changes in your neighborhood or community? This is another opportunity to make suggestions about needed programs, changes in the community, educational campaigns, etc., that would best meet the needs of this particular community.
21. In communities, people often talk about community leaders; these are organizations or individuals that everyone knows, places/people that you seek out when you need information that is trusted.

    Do you know of these types of organizations or people who are concerned about health issues and serve as leaders in trying to improve health in your community? Who are they? What are they doing? Are their efforts successful? Why or why not?
22. Would these organizations or people be good leaders for addressing other health issues in the community? If not them, then who?
23. What should be done to ensure that children in your community finish their education and can find jobs?

Closing

24. How would you like your community to be different in five years in order to be a healthier place for you and your family to live? If you could make two or three changes that would promote better health, what would they be?

Community Facilities, Assets and Resources

Not an all-inclusive list (November 2018–January 2019)

Health Departments

East Cobb Public Health Center 4958 Lower Roswell Road, Suite 120 Marietta, GA 30068 678-784-2180 **Acworth Public Health Center** 4489 Acworth Industrial Drive Acworth, GA 30101 770-974-3330 **Marietta Public Health Center** 1650 County Services Parkway Marietta, GA 30008 770-514-2300 **Cobb County Health Center** 1650 County Services Parkway Marietta, GA 30008 770-514-2300	Cobb & Douglas Public Health, with our partners, promotes and protects the health and safety of the residents of Cobb and Douglas counties. We work to achieve healthy people in healthy communities by: ■ Preventing epidemics and spread of disease ■ Protecting against environmental hazards ■ Preventing injuries ■ Promoting and encouraging healthy behaviors ■ Responding to disasters and assisting in community recovery ■ Assuring the quality and accessibility of healthcare
Cherokee County Health Department Canton Office: 1219 Univeter Road Canton, GA 30115 770-345-7371 Woodstock Office: 7545 North Main Street, Suite 100 Woodstock, GA 30188	Provides some sliding scale community services with tracking and follow-up.
Fulton County Department of Health and Wellness (FCDHW) Fulton County Public Health 10 Park Pl S.E., 5th Floor Atlanta, GA 30303 404-613-1205 **Fulton County Department Of Behavioral Health & Developmental Disabilities** Fulton County Government Center 141 Pryor Street, Suite 1031 Atlanta, GA 30303 404-613-7013 www.livebetterfulton.org	Fulton County Department of Health and Wellness (FCDHW) is the largest testing site in the state of Georgia. Over 700 people each year learn that they have been infected with HIV in our clinic. Our clients are introduced to the HIV Clinic physicians on the same day they may learn their HIV positive status. Enrollment in the HIV Clinic offers an individual a full service outpatient clinic with a TEAM approach to educate and support the patient and families living with HIV. ■ Mental Health – Our behavioral health centers offer a wide range of services & addictive disease treatment at community-based locations. ■ Developmental Disabilities – Three regional centers provide clients with life skills training tailored to their particular disability. Mobility training and day habilitation are also provided. ■ Addictive Diseases – We provide a variety of specialty outpatient treatment services for adults with chronic chemical dependencies. Treatment is also available for individuals who have both mental health and substance abuse ("co-occurring") disorders.

Primary Care: Safety-Net Clinics & Federally Qualified Health Centers

The Family Health Center at Cobb

805 Campbell Hill Street
Marietta, GA 30060
770-919-0025

Focuses on outreach, disease prevention and patient education regardless of insurance status or a patient's ability to pay.

United Way

40 Courtland St., N.E.
Atlanta, GA 30303
404-527-7200
info@unitedwayatlanta.org

United Way of Greater Atlanta invests in more than 200 programs in 13 counties through the United Way Child Well-Being Impact Fund. But, that's not all. We bring together people and resources to tackle complex community issues and drive sustainable positive change to help our community thrive.

Vision: Greater Atlanta is a community where all individuals and families thrive – a community where everyone has the opportunity to live a healthy life, acquire the education and skills they need to earn a good living and have a roof over their heads.

Mission: Engage and bring together people and resources to drive sustainable improvements in the well-being of children, families and individuals in the community.

Mercy Care

424 Decatur Street
Atlanta, GA 30312
678-843-8500
Fax: 678-843-8501

Community Outreach Inquires:
Contact Monique Winters
678-843-8657

Media Inquiries:
Contact Diana Lewis
678-843-8509

Mercy Care's 11 Clinic Locations:
www.mercyatlanta.org/LOCATIONS

HIV Testing Inquiries:
Contact Denise White
678-843-8656

Furthering the healing ministry of the Sisters of Mercy, Mercy Care gives tangible expression to Christ's merciful love by providing compassionate, clinically excellent healthcare in the spirit of loving service to those in need, with special attention to the poor and vulnerable.

We value compassion, commitment to the poor, excellence, integrity, justice, stewardship and reverence for the dignity of each person.

A federally qualified health center and Atlanta's only healthcare for the homeless program (330h), Mercy Care accepts most insurances plans, Medicare and Medicaid and offers a sliding fee scale based on household income for the uninsured.

Mercy Care is a member of Saint Joseph's Health System and Trinity Health.

1. Primary Care
2. Pediatrics
3. Dental & Vision
4. Health Education
5. Behavioral Health
6. HIV Integrated Treatment

Healing Community Center

2600 Martin Luther King Jr. Dr., SW
Atlanta, GA 30311
404-564-7749
Fax: 404-758-1216

Health Education, Assessment & Leadership (HEAL), Inc. We are a Federally Qualified Health Center. We offer a sliding fee scale.

Services:

- Adult Medicine
- Behavioral Health
- Cardiology
- Dental
- Health Education
- Health Enrollment Assistance
- HIV Testing and Counseling
- OB/GYN
- Otolaryngology (ENT)
- Pediatrics
- Podiatry
- Prescription Assistance
- Social Services
- Vision Care

Primary Care: Safety-Net Clinics & Federally Qualified Health Centers (continued)

Ser Familia/ SafePath

209 Northridge Dr.
Acworth, GA 30101
678-363-3079
info@serfam.org
www.serfamilia.org

Ser Familia offers a variety of programs that help Latino families develop stronger bonds and nurture their potential. The purpose of our programs is to have Latino children, youth and adults thrive and become constructive members of their communities.

Our programs include:

- Workshop for couples
- Workshop for youth
- Programs for parents
- Workshop Strengthening Families Program
- Family Counseling Services
- Community and Advocacy Programs
- Cultural and Linguistic Proficiency

MUST Ministries

6 Locations (Program Locations in Canton, Marietta and Smyrna)

Marietta
1407 Cobb Parkway NW
Marietta, GA 30062
770-427-9862

Canton
111 Brown Industrial Parkway
Canton, GA 30114
770-479-5397

Smyrna
460 Pat Mell Road
Smyrna, GA 30080
770-436-9514

MUST addresses the basic needs of individuals, families and children with facilities in the Cobb and Cherokee counties and programs in numerous other counties. MUST brings people of many faiths together to respond to God's challenge to minister to others with compassion and love, without judgment of the beliefs, background or circumstances of those who serve or are being served.

Vision: Serving our neighbors in need…transforming lives and communities in response to Christ's call.

Mission: To become Georgia's most respected Servant Leader – Restoring lives one person and one community at a time.

YWCA Community Health Center

1275 Peachtree St NE
Atlanta, GA 30309
404-249-8801
www.ywca.org

YWCA USA is on a mission to eliminate racism, empower women, stand up for social justice, help families and strengthen communities. We are one of the oldest and largest women's organizations in the nation, serving over 2 million women, girls and their families.

YWCA has been at the forefront of the most pressing social movements for more than 160 years – from voting rights to civil rights, from affordable housing to pay equity, from violence prevention to health care reform. Today, we combine programming and advocacy in order to generate institutional change in three key areas: racial justice and civil rights, empowerment and economic advancement of women and girls and health and safety of women and girls.

Mission: YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all.

Primary Care: Safety-Net Clinics & Federally Qualified Health Centers (continued)

Bethesda Community Clinic 111 Mountain Brook Dr., Suite 100 Canton, GA 30115 678-880-9654 www.bethesdacommunityclinic-cherokee.com	Our mission is to demonstrate the compassion of Christ by providing quality healthcare to those in need. Bethesda Community Clinic is a Christ-centered 501(c)3 nonprofit dedicated to providing quality, affordable health care services to Cherokee County's "working poor" (based on family size and income at or below 150% of the national poverty guidelines), as well as the uninsured and underinsured (people who can only afford major medical insurance). Through a partnership with the Georgia Volunteer Health Care Program, we are committed to improving the health status of the entire community. The key focus is to provide primary medical coupled with health promotion and wellness programs that aim to motivate positive changes in order to prevent, control and reverse chronic illnesses in this at-risk population. Services are based on the values of advocacy, compassion, dignity, faith, kindness and stewardship.
The CarePlace 1707 N. Blairs Bridge Rd. Austell, GA 30168 678-945-0700 678-945-0701 Info@thecareplacedc.com	**Mission:** To be the most loving healthcare facility in our community! **Vision:** The CarePlace exists to provide free but quality healthcare to the working poor of Douglas County. Our call is to touch the hurting with Jesus' love and compassion. **Values**: Compassion and Respect for every patient Team members will demonstrate through their behavior, words and lifestyle a deepening faith that is expressed in love Volunteers will believe that their time has been effectively and efficiently spent in their service to our patients and our savior. Services delivered will be of the highest possible quality, reflecting the importance of who we serve. Our donors will sense that we are being good stewards of the resources they have entrusted to us.

Transportation

Transportation Options Program for Seniors (TOPS) TOPS Program Manager: 770-993-1906 ext. 234 www.ssnorthfulton.org/senior-services/transportation/	The TOPS program is designed to provide medical transportation for seniors age 60+ in the Senior Services North Fulton service area: Alpharetta, Johns Creek, Milton, Mountain Park, Roswell and Sandy Springs. Trips can be arranged for appointments with doctors, dentists, eye doctors, for treatments ordered by your doctor – or to get a flu shot.
Get Around Town Easily (GATE) Program GATE Mobility Manager: 770-993-1906 ext. 242	Seniors and adults with disabilities who are unable to drive need the ability to pick up prescriptions, grocery shop, visit the bank, or simply get a haircut. Our grant funded GATE (Get Around Town Easily) Transportation Program allows north Fulton seniors and adults with disabilities to purchase a transportation account that can be used with selected drivers in the GATE program.
Non-Emergency Medical Transportation (NEMT) Schedule Transportation: Logisticare: 1-888-224-7981 (Central) 1-888-224-7985 (Southwest) 1-888-224-7988 (East) Medicaid Member Call Center: 866-211-0950	The Non-Emergency Medical Transportation (NEMT) program provides eligible members transportation needed to get to their medical appointments. To be eligible for these services, members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program.

Transportation (continued)

CobbLinc

Customer Service:
431 Commerce Park Drive
Marietta, GA 30060
770-427-4444
770-427-2222
cobbtransit@cobbcounty.org

CobbLinc is your number one public transportation option throughout Cobb County and to Downtown Atlanta via Fixed, Express or Paratransit services. CobbLinc strives to provide a transit network that is convenient, accessible, customer-focused, safe, reliable and efficient.

CATS: Cherokee Area Transportation System
County Wide Dispatch:
770-345-6238

Fixed Routes:
770-345-6238

Van Pool:
800-826-4967

EXPRESS Service:
404-463-4782

Our mission at CATS is to provide excellence in all areas of service that we provide to the citizens of Cherokee County.

Behavioral Health

The Summit Counseling Center
2750 Old Alabama Rd., Suite 200
Johns Creek, GA 30022
678-893-5300
summitcounseling.org

The Summit Counseling Center provides professional counseling, consultation and education services utilizing an integrated approach to care for the whole person – Body, Mind, Spirit and Community.

Genesis Ministries
262 Hawkins Store Road NE,
Kennesaw, GA 30144
770-926-4686
www.genesisministries.org

Mission & Vision: With proven techniques and latest advances in neuroscience, we approach recovery with education, Bible studies, group counseling and vocational therapy.

Recovery: Through love, care and education, Genesis provides for the emotional and spiritual needs of those with substance abuse disorders. Our goal is to restore our community one life at a time.

Our Program: Leveraging texts, manuals, films and other materials, we are able to facilitate the healing process. Every client receives individual attention to provide an opportunity to overcome destructive behavior.

Will-To-Live Foundation
5805 State Bridge Rd. #G212
Johns Creek, GA 30097
will-to-live.org

We are dedicated to preventing teen suicide by improving the lives and the "Will To Live" of teenagers everywhere through education about mental health and encouraging them to recognize the love and hope that exists in each other.

Ridgeview Institute
844-350-800 for immediate assistance and assessments

Smyrna Location:
3995 South Cobb Drive
Smyrna, Georgia 30080

Monroe Location:
709 Breedlove Drive
Monroe, Georgia 30655

Ridgeview Institute, two private hospitals treating people with addiction and mental health problems, has earned a national reputation for care and service. Since 1976, more than 90,000 people have turned to Ridgeview Institute Smyrna during crisis, despair and in hope. Now Ridgeview Institute Monroe is offering services in eastern Atlanta.

Programs:
- Adult Addiction Program
- Adult Psychiatric Program
- Senior Adult Program
- Recovering Professionals
- Women's Connection
- Young Adult Addiction Program
- Youth Program

Services:
- Family Workshop
- Recovery Residences
- Support Groups
- Resources

Behavioral Health (continued)

The Insight Drug Program 5110 Old Ellis Pt. Roswell, Georgia 30076 770-751-8383 theinsightprogram.com/georgia-locations/	The Insight Program has provided substance abuse treatment for teens and young adults since 1987. The Insight Program provides all its services through a philosophy called Enthusiastic Sobriety. Making sobriety attractive to teens and young adults is challenging. Insight has been successful in creating a program that reaches young people in a way that is inviting and fun. The Insight Program offers a number of services including: intensive outpatient substance abuse treatment, outpatient substance abuse treatment, individual counseling, family counseling, support group meetings, parent support groups and sober social functions. Insight staff members are also available for speaking engagements. Insight treatment programs are licensed in Georgia and North Carolina.
No Longer Bound 2725 Pine Grove Road Cumming, GA 30041 770-886-7873 nolongerbound.com	No Longer Bound has created organized opportunities for hurting families to recover from the damage of addiction. We assist families with restoring trust, releasing expectations and repairing broken relationships in order to reconcile them to health and wholeness.
Highland Rivers Health Appointments: 800-729-5700 (Note this is a non-emergency contact; calls received after-hours will be returned the next business day.) After-hours Georgia Crisis and Access Line: 800-715-4225 Administrative Offices 1401 Applewood Dr., Suite 5 Dalton, GA 30720 1011 Abutment Rd., Suite 108 Dalton, GA 30721 706-270-5000 Fax: 706-270-5124 TYY: 706-529-6771 Medical Records 1401 Applewood Dr., Suite 1 Dalton, GA 30720 706-529-4131 Fax: 706-529-7439 Email: records@highlandrivers.org	**Vision:** To provide superior community-based neurobehavioral health care services and resource collaboration for individuals and families to improve quality of life. **Mission:** To be a community-based system of care focused on strengthening personal recovery through the advancement of a healthy lifestyle for mind and body. **Values:** In order to fulfill our mission and vision, we hold the following values as central to our success: ■ Recovery: We are committed to providing services in a continuum of care that is community-based, strengths-based, empowering and outcomes-driven, guided by best practices. ■ Empowerment: We encourage our staff to have passion, creativity and optimism through a flexible and innovative atmosphere and we empower individuals served to take an active part in their treatment. ■ Collaboration: We foster good relationships with individuals served, families, community resources, partners and internal customers. ■ Fiscal Responsibility: We each use Highland Rivers Health resources effectively and efficiently. ■ Integrity: We ensure we are professional, honest, respectful, responsive and accountable in all our transactions between vendors, families, providers, communities, staff, partners and individuals served. ■ Respect: We treat each individual served and family member with respect and dignity. ■ Compassion: We respond to the needs of others with a spirit of advocacy and understanding. ■ Transparency: We ensure our interactions with community stakeholders, internal and external customers, individuals served and families are transparent and ethical.
Kaleidoscope 2615 Cleveland Hwy Dalton, GA 30721 706-270-5050 Fax: 706-270-5052	Kaleidoscope is a CARF International accredited program designed to promote independent advancement for persons with intellectual and/or developmental disabilities (I/DD). In keeping with Lookout Mountain Community Services' (LMCS) mission to serve and enhance the lives of every member of our community, Kaleidoscope offers many opportunities for those with I/DD.
The ROC Clubhouse 1 Goodyear Ave. Cartersville, GA 30120 770-334-8544	The ROC Clubhouse helps youth with mental health issues build self-esteem, resiliency and life skills in a fun and safe environment. The ROC Clubhouse serves youth ages 11 to 17 who have a documented mental health diagnosis.

Behavioral Health (continued)	
Adolescent Clubhouse 706-233-9023 Fax: 706-235-1585 6 Mathis Dr. Rome, GA 30165	The Clubhouse is a supportive environment where consumers are members. Staff and members work together to perform the jobs of the clubhouse and participate in social outings, educational supports, employment supports, transitional services and other specific clubhouse activities.
Women's Outreach 6 Mathis Dr. Rome, GA 30165 706-291-7201 Fax: 706-291-7198	Our Women's Outreach Program includes both residential and intensive outpatient services that address risk factors for relapse and support women in achieving abstinence, maintaining recovery, avoiding illegal activity, obtaining gainful employment, meeting parenting roles and responsibilities and transitioning into safe and stable housing. We know that keeping families together and in their communities promotes and helps to sustain recovery. Program offers hope, love and assistance for pregnant or postpartum women in recovery by removing substance abuse as a barrier to employment and integrating into the community.
Highland Recovery Center 323 Roland Rd. Jasper, GA 30143 706-253-1169 Fax: (706) 253-1113	Men's residential addiction treatment.
Cobb County & Douglas County Community Services Boards Administrative Office 3830 South Cobb Drive, Suite 300 Smyrna, GA 30080 770-429-5000 Outpatient Locations: 1650 County Services Parkway Marietta, GA 30008 5905 Stewart Parkway Douglasville, GA 30135 Access Line (Appointments) 770-422-0202 Hartmann Center Appointments 770-971-7801 between 9am-2pm	The Cobb and Douglas counties Community Services Boards (CSB) provide citizens challenged by mental health, developmental disabilities and/or addictive disease issues with appropriate care and resources. The agency serves children, adolescents and adults and offers a wide array of clinical and support services. The CSB serves individuals in multiple agency locations in the two county area. Services: ■ Child and Adolescent Services ■ Developmental Disabilities ■ Mental Health ■ Substance Abuse (addictive disease) ■ Residential Services ■ Pharmacy Services
Avita Community Partners – Behavioral Health 671 Lumpkin Camp Ground Rd S Suite 100 Dawsonville, GA 30534 678-866-8777 3920 Ivy Summit Ct Apt 4105, Cumming, GA 30041 770-887-5008	At Avita Community Partners, we envision communities that act responsibly toward all citizens by providing support and comprehensive services to individuals and families in crisis. Our competent, committed and compassionate staff believes individuals served should: ■ be treated with dignity and respect ■ be educated about disabilities, rights and options ■ have access and opportunity to participate in the community and be served by that community ■ have access to confidential and ethical services ■ have a responsibility to participate in services

Behavioral Health (continued)

DeKalb Community Service Board

Mailing Address
PO Box 1648
Decatur, GA 30031

Main Phone Number
404-294-3836

Appointments, Referrals
& Crisis Support
404-892-4646

Our Mission: DeKalb Community Service Board strives to provide the right service, for the right person, at the right time.

Our Vision: The DeKalb Community Service Board envisions a community in which disabilities no longer limit potential.

Our Values:

- Providing inspirational leadership in marshaling resources to achieve our vision
- Being an industry leader in public sector service delivery
- Having talented and well trained staff that is client and mission focused
- Offering a full service continuum with a collaborative spirit
- Being the provider of choice, the employer of choice and the board of choice

View Point Health Services

24-Hour Access to Care
678-209-2411
or 800-715-4225 (after hours)
Monday – Friday, 8:30 a.m. to 5 p.m.

Locations in: Gwinnett, DeKalb, Newton, Rockdale, Chatham, Clark, Richmond counties

Vision: Building healthy lives and healthy families through high quality comprehensive care.

Mission: To promote overall health and improve quality of life by ensuring the delivery of effective behavioral and physical health care that meets the needs of communities we serve.

Services:

- Assertive Community Treatment (ACT)
- Addictive Diseases Program
- Community Rehabilitation
- Community Support
- Developmental Disabilities
- Pharmacy
- Crisis Respite
- Intensive Case Management
- Outpatient Services
- Residential Services
- Youth and family
- Clubhouses

Resource Assistance

North Fulton Community Charities (NFCC)

11270 Elkins Rd.
Roswell, GA 30076
nfcchelp.org

NFCC is a leader in North Fulton offering assistance to over 4,200 families. Annually, food is distributed over 23,000 times, over 1,300 families utilize clothing vouchers and $1.2 million is expended for direct aid to our clients in need of financial assistance. Our Education Center offers an array of classes and opportunities to help 1,200 adults move toward financial stability and self-sufficiency.

Although the demand for these services has increased significantly since its founding, NFCC continues to help hands on, one family at a time.

The Drake House

10500 Clara Drive
Roswell, GA 30075
www.thedrakehouse.org

The Drake House works with many agencies to identify mothers and children in need in North Fulton. Once accepted into The Drake House, these mothers and children are supported with every resource necessary to move them toward financial self-sufficiency, employment and stable housing.

HomeStretch

89 Grove Way
Roswell, GA 30075
770-642-9185
homestretch.org

HomeStretch guides working homeless families with minor children in north metro Atlanta toward increased self-reliance and stability by providing life skills education, mentoring and supportive housing.

STAR House Foundation, Inc.

890-F Atlanta Street, #138
Roswell, Georgia 30075
678-384-4550
info@starhousefoundation.org

STAR House Foundation is a non-profit organization in Roswell, Georgia that makes a difference in kids' lives by providing an after school tutoring and mentoring program for at-risk children throughout North Fulton County.

Resource Assistance (continued)

Revved Up Kids

P.O. Box 5145
Alpharetta, GA 30023-5145
678-526-3335
contact@revvedupkids.org
www.revvedupkids.org

Revved Up Kids offers personal safety and self-defense training classes for boys and girls through 8th grade and for teen girls age 11 and older.

Gwinnett Coalition for Health and Human Services

750 S. Perry Street, Suite 312
Lawrenceville, GA 30046
770-995-3339
info@gwinnettcoalition.org

The Gwinnett Coalition for Health and Human Services is a public/private partnership whose mission is to facilitate collaboration that improves the well-being of the community.

We accomplish this mission by identifying needs and resources, setting priorities, planning solutions, focusing on results and educating and motivating the community to action.

- Coalition Programs
- Gwinnett Great Days of Service
- Gwinnett Neighborhood Leadership Institute
- Gwinnett Helpline
- Gwinnett CEO Roundtable
- Gwinnett Veterans Resource Center

Decatur Housing Authority

Central Office
750 Commerce Drive, Suite 400
Decatur, GA 30030

Office Phone 404-270-2100
TTD/TTY 1-800-545-1833 ext 852

Admin/Finance
Fax 404-270-2123

Section 8/Public Housing
Fax 404-270-2122
www.decaturhousing.org

To support the strength and diversity of the Decatur community by providing a wide range of housing opportunities with a focus on affordable housing, promoting community and economic development and administering its program in a creative, cooperative, responsive and effective manner.

Below is a list of types of housing or helpful tools regarding housing that we offer at the Housing Authority of the City of Decatur, GA. Go online to see what each one has to offer.

- Public Housing
- Resident Services
- Work Force Housing
- Assisted Housing
- Housing Choice Vouchers
- Landlord Information
- Portability
- Payment Standards
- Housing Lists
- Lifecycle Housing
- Talley Street
- Other Programs

Northeast Georgia Health System

743 Spring Street
Gainesville, GA 30501
770-219-9000
www.nghs.com
(Forsyth, Dawson, Gwinnett countiesand etc.)

Access to assistance with:

- Disability
- Financial Assistance
- Medicaid Forms
- Medical Supplies
- Mental Health Services
- Prescription Assistance
- Senior Services
- Support Groups
- Temporary Assistance
- Transportation

Franklin County Community Resource Center – Dawson County

54 Hwy. 53, W
Dawsonville, GA 30534
Main: 706-265-3744
Additional Number: 770-864-9420
Fax: 706-265-4555
www.ndo.org

This agency assists with financial assistance, food vouchers, job assistance, Medicaid applications, financial counseling, prescription drug information, subsidized housing and SSI applications.

Service hours: 8:15 am to 5:00 pm, Monday – Friday

Eligibility: must meet income guidelines (125% poverty level)

Intake procedure: telephone, appointment

Documents: Social Security card, proof of residence or lease, proof of income, eviction notice, utility cut-off notice, proof of legal status

Fees: none

Resource Assistance (continued)

Buckhead Christian Ministry, Inc.
2847 Piedmont Rd., NE
Murray Building
Atlanta, GA 30305

Main: 404-239-0038
Administrative: 404-239-0058
Fax: 404-239-0871

www.buckheadchristianministry.org

Services: Electric Service Payment Assistance, Gas Service Payment Assistance, Medicaid Applications, Personal Financial Counseling, Prescription Drug Information Clearinghouses, Prescription Expense Assistance, Rent Payment Assistance, SSI Applications

This agency operates an emergency assistance program, grooming supplies, a thrift store, a food pantry, job information, clothing voucher and a transitional housing program for homeless families.

Eligibility: Financial assistance: residents of service area only who have lived at address and paid rent for at least three months and are employed or have been employed in the last twelve months; unemployed due to age or disability and must have experienced an emergency within the past twelve months; assist food stamps recipients; assist clients in subsidized housing (if qualify); can receive food six times per calendar year

Transitional housing: Families must have at least one child of school age; working at least 3 weeks before applying to the program

All other services: Residents of service area only

Intake procedure: Financial assistance: telephone, appointment

Documents: Picture ID/driver license for all household members, current lease or mortgage documents, proof of income, proof of emergency, social security cards, birth certificate or social security card for each child

Fees: Transitional housing: sliding scale

All other services: none; clients receiving financial assistance may be required to match BCM's financial pledge

YMCA of Metro Atlanta
101 Marietta St NW #1100
Atlanta, GA 30303
(Multiple Locations in schools and the community throughout Atlanta)
www.ymcaatlanta.org/locations/

- Languages: Spanish
- YMCA Youth Programs
- Afterschool
- Early Learners
- Teen
- Overnight, Summer and Holiday/School Break Camps
- Youth and Adult Fitness programs and activities
- Ministry Overview

Papa's Pantry
Main Office Woodstock
770-591-4730
Monday & Friday: 9:30am to 2:30pm
Tues, Wed, & Thurs: 9:30am to 4:30pm
Saturday: 9:00am to 1:00pm

Grocery Assistance is by appointment only

Some evening appointments available
Call us to schedule a tour for you or a group!

Our Vision: To have a community where everyone has the tools to achieve stability and where no one goes to bed hungry.

Our Mission: Help families reach sustainability by offering essential "Stability Solutions Training," hands on support, mentoring and life coaching alongside food assistance as needed. The Solution to end Childhood Hunger.

Our Values: Christ-Centered, Intentional, Compassionate and Committed.

Over the next decade, we will train and unleash hundreds of men and women to lead thousands of people on the journey of a lifetime to experience the adventure-filled good life in Jesus through worship, training & service TOGETHER. We think the good life is experienced in self-sacrificing community where people choose to be real and experience transformation. This transformation will result in us looking more and more like Christ.

Resource Assistance (continued)

Campus Church
(Next Steps – Local ministries)
1525 Indian Trail Lilburn Road
Norcross, GA 30093
770-923-0449
Mon-Fri 8:00 am to 4:00 pm
hello@campuschurch.org
campuschurch.org/next-steps/

Local Missions:
- Project Kids Eat
- Helping Hands
- Thanksgiving Community Meal
- Recovery Ministry
- Jail Ministry
- Atlanta Inner City Ministry
- Georgia Agape
- Meadowcreek Elementary
- Norcross Co-Op

Our Service Goals:
- Care with dignity and compassion
- Hope for thriving at home
- Long and short term care needs met in the home
- Living beyond wellness to total well being

Bridgebuilders, Incorporated
2818 East Point Street Suite 2B East Point GA 30344 US
404-765-4300

Office Hours:
Monday - Friday: 8:00 - 5:00 pm
Saturday: 8:00 - 2:00 pm
Sunday: Closed

Our Service Goals:
- Care with dignity and compassion
- Hope for thriving at home
- Long and short term care needs met in the home
- Living beyond wellness to total well being

Additional Resources

Goshen Valley Foundation
Canton Office
505 Brown Industrial Pkwy, Suite 200
Canton, GA 30114
770-345-9535

Goshen Valley Boys Ranch
387 Goshen Church Way
Waleska, GA 30183
770-796-4618

The Goshen Valley Foundation was established in 1998 after God moved on the hearts of the Blend family to donate their ranch property as a way to care for foster children. Through the leadership of founder John Blend, in 2001 the Goshen Valley Boys Ranch was created to care for young men in foster care. Over the past 16 years Goshen Valley has expanded and now has three programs, Goshen Valley Boys Ranch, Goshen New Beginnings and Goshen Homes. Each program has a unique focus and ministry to foster children in Georgia.

Our Vision: Goshen Valley aspires to provide sustainable, trauma informed service models for communities.

Our Mission: Goshen Valley provides an array of services to vulnerable youth and families while deepening its commitment to communities.

Our Purpose: The Goshen Valley Foundation provides safe and purposeful environments for young men, women and children while seeking permanency through family reunification, adoption and transitional growth.

Implementation Plan

Building a Culture of Health

This Implementation Plan for WellStar North Fulton Hospital has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a Community Health Needs Assessment (CHNA) at least once every three years and adopt an Implementation Plan to meet the community health needs identified through the CHNA written reports per hospital facility. This Implementation Plan is intended to satisfy each of the applicable requirements set forth in proposed regulations.

Background

After an analysis of primary and secondary data gathered for the 2018 WellStar North Fulton Hospital's Community Health Needs Assessment (CHNA), priority health needs were identified at a Community Health Summit. This Summit was comprised of a broad spectrum of hospital leaders and community stakeholders. Using current assets/capacity measures[1] as key indicators to improve community health, the summit participants answered this overriding question reflecting the patient-centered Triple Aim[2] framework: Which health needs, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the under-resourced?

To deliver more comprehensive, collaborative and value-based community benefit initiatives, services, education and events, a task force, the WellStar Community Health Collaborative (WCHC), was created in the fall of 2016 at the system level to address Legacy WellStar's priority health needs.[3]

The WCHC is now expanded to encompass all WellStar hospital communities/strategic markets after the April 2016 acquisition of six hospitals in Georgia, five of which were converted to not-for-profit in 2017, including WellStar North Fulton Hospital. This cross-functional task force enables WellStar to better implement community benefit initiatives and measure outcomes of collaborative efforts to improve community health.

1 *Other considerations: (1) The burden, scope, severity and urgency of the need. (2) The estimated feasibility and effectiveness of possible interventions. (3) Health disparities associated with the need or the importance the community places on addressing the need.*

2 *The Institute of Healthcare Improvement's (IHI) "Triple Aim" framework to optimize a health system's performance: (1) Improve the patient care experience (2) Improve the health of a population (3) Reduce healthcare costs.*

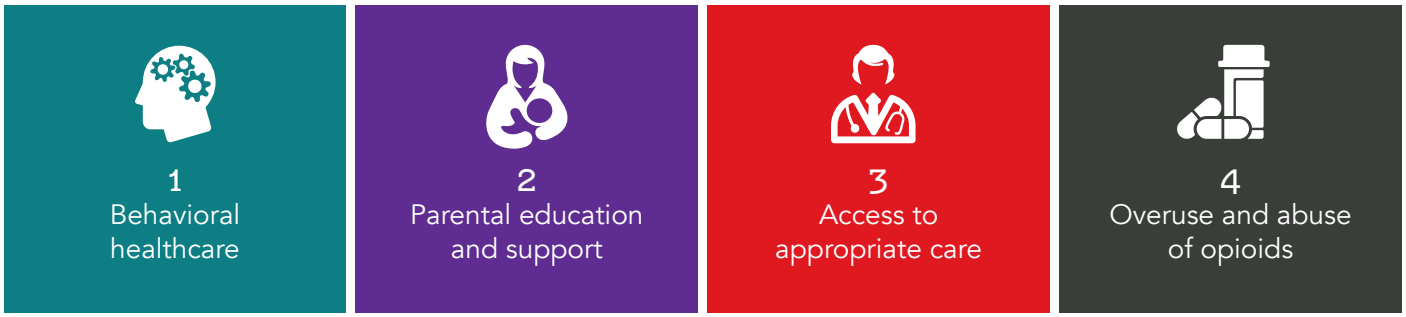
3 *Legacy WellStar is defined as the community where WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital and WellStar Windy Hill Hospital are located. Legacy WellStar is the entity prior to the acquisition of WellStar West Georgia Medical Center and former Tenet hospitals – WellStar Atlanta Medical Center and Atlanta Medical Center South, WellStar North Fulton Hospital, WellStar Spalding Hospital and WellStar Sylvan Grove Hospital.*

WCHC ensures that WellStar's community benefit initiatives are designed to:

- Provide organization, framework and leadership to the delivery of community benefit services, which enables WellStar to more effectively evaluate and measure the impact on community health,
- Strengthen WellStar's strategic community partnerships in public and private sectors through formalized engagement that leverages shared expertise, resources and services to help build capacity, bridge intervention gaps and address health disparities,
- Boost WellStar's ability to replicate and deliver community benefit services across an expanding health system footprint,
- Maximize the investment in WellStar's safety-net clinic/nonprofit partners by better aligning our services and resources to address priority health needs and
- Improve overall community health, especially among the under-resourced community members.

Review of Priority Health Needs

Leaders of Georgia State University's Georgia Health Policy Center helped guide WellStar North Fulton Hospital through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research conducted, the following health needs were valuated as priority for the community WellStar North Fulton Hospital serves:



Implementation strategies for each need were recommended during group exercises. The strategies were later reviewed by WellStar's Senior leadership and vetted by the WellStar board of trustees' Community Advocacy and Engagement Committee and the WCHC task force, the conduits for system-wide delivery of community health improvement services and education.

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar North Fulton Hospital plays a vital role:[4,5]

Socioeconomic Factors: Interventions that address social determinants of health, such as income, education, occupation, class or social support. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age. These determinants contribute to a wide range of health, functioning and quality of life outcomes.

Physical Environment: Interventions addressing structural and environmental conditions that have an impact on health, including the built environment, as well as the community environment. This category includes policy changes that support individuals in making healthy choices.

Health Behaviors: Interventions that promote and reinforce positive individual health behaviors and seek to enable people to increase control over their health and its determinants. They include actions that address the knowledge, barriers and facilitators that can affect behavior.

Clinical Care: Innovative interventions focused on clinical approaches to health improvement that go beyond traditional one-on-one patient care. These activities are upstream or systems-based, and include examples of clinical providers working in teams or providing direct care in a non-traditional setting.

4 *Centers for Disease Control and Prevention, Community Health Improvement Navigator tool. http://wwwn.cdc.gov/chidatabase*

5 *WellStar North Fulton Hospital's greatest influence to address priority health needs identified in the CHNA is in the intervention areas of health behaviors and clinical care, but have a collaborative role in all determinants of health.*

The scope of WellStar's healthcare footprint and its commitment to its mission makes WellStar North Fulton Hospital a linchpin and integrator in the community for delivering care, interventions and education to improve overall population health and health equity in the community we serve. This involves providing community benefit programming to address priority health needs via collaborative partners who provide care access, services and resources to under-resourced populations.

Health Needs Addressed

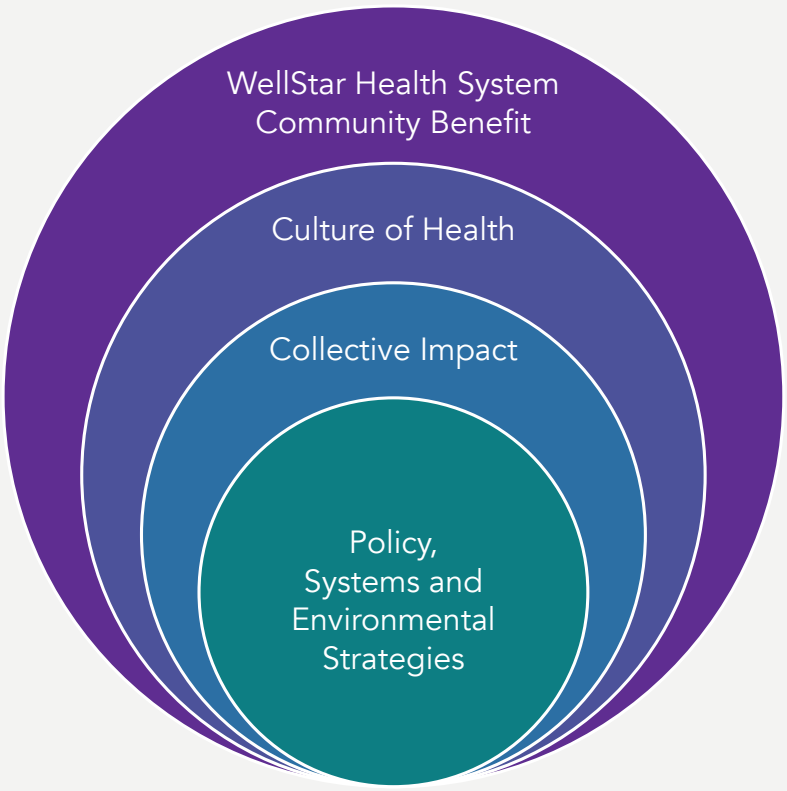
	 Behavioral healthcare	 Parental education and support	 Access to appropriate care	 Overuse and abuse of opioids
Cancer Screening and Prevention				
Community Education & Outreach				
Community Transformation Grants				
Public Health Policy and Advocacy				
Screening for Food Insecurity				
The Health of All Women				
WellStar 4-1 Care				
WellStar Day of Service				
WellStar Opioid Steering Committee				
WellStar Research Institute				
Zero Suicide Initiative				

Implementation Plan Framework and Guiding Principles

To address the priority health needs of the 2019 CHNA, WellStar North Fulton is initiating and adapting components of the Robert Wood Johnson Culture of Health Framework with influence from the Collective Impact approach and policy, systems and environmental (PSE) change strategies. The aim is to proactively transform data-driven CHNA results into actionable and measurable community benefit programs and services to optimize patient outcomes and improve overall community health.

These efforts flow from the WellStar mission and vision, and to meet the requirements of the federal government (Affordable Care Act Section 9007) of systemwide oversight and guidance regarding tracking community benefit activities, assessing community health needs and developing strategic plans that prioritize the delivery of community benefit.

Framework and Guiding Principles



An Evidenced-Based Framework, Research-Based Recommendations and Public Health Policy were used to anchor the Implementation Plan in proven strategies to improve community health.

The Robert Wood Johnson Culture of Health Framework is informed by rigorous research on the multiple factors that affect health. It recognizes the many ways to build a Culture of Health and provides numerous entry points for all types of organizations to become collaborative Partners in Health.[6, 7]

6 *https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html*

7 *A critical aspect of a Culture of Health is health equity, which in essence means we all have the basics to be as healthy as possible. Yet at present, for too many, prospects for good health are limited by where we live, how much money we make or discrimination we face.*

Culture of Health Action Framework

To achieve better health for all, the Culture of Health framework leverages the interconnection of health and social issues, the link between population well-being and life expectancy and collaboration across many different sectors.[8]

A Culture of Health will not be achieved by focusing on each action area alone, but by recognizing the interdependence of each area. Implementing the framework will take time and involve collaboration across multiple sectors beyond the traditional public health field.

Adopting this Culture of Health framework, with health equity at the center, will inform every aspect of community benefit at WellStar North Fulton Hospital — from our safety-net clinic partnerships and community grant focus areas to the types of initiatives funded and how we assess the effectiveness of programs and services addressing priority health needs.

Health Equity Pledge

At WellStar Health System, we strive and commit to achieving healthcare equity and eliminating healthcare disparities across our diverse communities we serve. In 2017, WellStar Health System signed the American Hospital Association Health Equity Pledge, which aligns with the CHNA Implementation Plan. Recognizing that there are areas for improvement is a first step, but it must be followed by actionable strategies and tactics to make sustainable improvements. The 2019 CHNA demonstrated the impact and complexities of health disparities as they are affected by factors related to individuals, communities, society, culture, and the environment. In alignment with the Health Equity Pledge, WellStar's CHNA Implementation Plan emphasizes cross-sector collaboration to plan and carry out strategies that provide impact to local communities. These collaborations will seek to actively engage those most affected by disparities in future identification, design, implementation and evaluation of promising solutions. An equity-focused system of health offers everyone an opportunity to have a healthy life regardless of race, gender, culture or income.

8 *Building a Culture of Health https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html*

There are four Action Areas with 12 underlying principles for the Culture of Health framework:

Action Area 1: Making Health a Shared Value: How can individuals, families and communities work to achieve and maintain health?		
Underlying Principles:		
Mindset and Expectations Prioritizing and promoting health and well-being	**Civic Engagement** Participating in activities that advance the public good	**Sense of Community** Cultivating social connections that help us thrive

Action Area 2: Fostering Cross-Sector Collaboration: How can we encourage cooperation across all sectors?		
Underlying Principles:		
Quality of Partnerships Organizations working together and seeing successful outcomes	**Investment in Collaboration** Adequate financial support to enable more successful partnerships	**Policies that Support Collaboration** Creating incentives and methods to encourage ongoing coordination

Action Area 3: Creating Healthier, More Equitable Communities: How can we develop safe environments that nurture children, support aging adults and offer equitable access to healthy choices?		
Underlying Principles:		
Built Environment Creating safe, affordable environments that support our well-being	**Social and Economic Environment** Providing improved public resources and economic opportunity for everyone	**Policy and Governance** Establishing policies to create healthy environments through collaboration

Action Area 4: Strengthening Integration of Health Services and Systems: How can healthcare providers work with institutional partners to address the realities of patients' lives?		
Underlying Principles:		
Access to Care Making comprehensive, continuous care and healthy choices available to all	**Balance and Integration** Improving care when public health, social services and healthcare systems work together	**Consumer Experience** Providing safe, equitable, accessible, efficient and timely care

Collective Impact Approach

Collective Impact is an approach to tackle deeply entrenched and complex social problems like social determinants of health. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.

The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to adopt a common agenda, shared measurement and alignment of effort.

WellStar recognizes and values our partnerships with local public health departments and organizations. These entities have a longstanding commitment to addressing the top contributors to disparities in morbidity and mortality rates in Georgia and providing opportunities for WellStar to provide comprehensive, community-based health initiatives. Improvement in long-term health outcomes requires that these relationships are sustained beyond the CHNA process. Therefore, WellStar remains an active partner on a variety of public health task forces and initiatives.

Collective Impact Approach

Collective Impact is a systemic approach to social impact that focuses on the collaborative relationships between organizations and the progress toward shared objectives. The five conditions that drive this approach work together to produce true alignment and can lead to powerful results.[9]

9 *Stanford Social Innovation Review (2011) Retrieved from: https://ssir.org/articles/entry/collective_impact*

Policy, Systems and Environmental Change Strategies

Policy, systems and environmental (PSE) change is a way of modifying the environment to make healthy choices practical and available to all community members. PSE changes in communities, schools, workplaces, parks, transportation systems, faith-based organizations and healthcare settings can significantly shape lives and health. Access to affordable fruits and vegetables, design of sidewalks and bike lanes within communities, and smoke-free policies in workplaces and businesses directly increase the likelihood that people can eat healthy and nutritious food, walk to school or work and avoid exposure to second-hand smoke.[10]

PSE changes in communities that make healthy choices easy, safe and affordable can have a positive impact on the way people live, learn, work and play. Cross-sector partnerships with community leaders in education, government, transportation and business are essential in creating sustainable change to reduce the burden of chronic disease. PSE change is instrumental in creating and encouraging healthy behaviors in the community that WellStar North Fulton Hospital serves.

Defining Policy, Systems and Environmental Change†	
Type of Change	Definition
Policy	Interventions that create or amend laws, ordinances, resolutions, mandates, regulations or rules
Systems	Interventions that impact all elements of an organization, institution or system
Environmental	Interventions that involve physical or material changes to the economic, social or physical environment

† *National Association of County and City Health Officials*

Implementation Plan to Address Priority Health Needs

WellStar North Fulton Hospital is dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework, the Implementation Plan focuses on two key areas.

Two-Pronged Approach	
1. Community-Driven Solutions	Partnering with communities to drive locally determined solutions and policies that influence systems, services and practices to create equitable conditions that improve well-being. In addition, promoting the capacity of local communities to develop, implement and sustain their own solutions to problems in a way that helps them shape and exercise control over their physical, social, economic and cultural environments.
2. Sustainable Infrastructure	Building community benefit capacity and competency within WellStar North Fulton Hospital to streamline business practices and reporting.

10 *Centers for Disease Control and Prevention. (2011). Policy, Systems, and Environmental Change. Retrieved from http:// www.cdc.gov/communitiesputtingpreventiontowork/policy/ index.htm#strategies.*

Community-Driven Solutions		Sustainable Infrastructure
Community Education & Outreach	Moving Upstream: WellStar Community Transformation Grants and Day of Service	Screening for Food Insecurity
WellStar 4-1 Care	WellStar Opioid Steering Committee	Hospital's Roles and Responsibilities
Zero Suicide Initiative	The Health of All Women	Public Health Policy and Advocacy
Cancer Prevention and Screening		WellStar Research Institute

Community-Driven Solutions:

Community Education & Outreach

To address the priority health needs identified in the CHNA, WellStar's Community Education & Outreach (CE&O) Department plays an integral role in the Implementation Plan. In addition to supporting community programs and services provided by other non-profit organizations, CE&O provides several signature community programs and initiatives that benefit our communities. These programs and initiatives focus on health and wellness programs and services in community and worksite settings, to targeted populations, to improve the health, safety and well-being of the individuals we serve.

In addition, CE&O has built a tremendous network of strategic community partnerships on behalf of WellStar to collectively impact the health status of our community. These partnerships include both internal and external community partners, such as community safety-net clinics, congregations, schools and other community-based organizations and companies serving under-resourced populations. Through these programs, services and partnerships, WellStar strategically improves the overall health and well-being of individuals and communities.

Programmatic Productivity
Number of innovative, evidence-based health education classes and programs related to health promotion and disease prevention to enhance health
Number of participants in innovative, evidence-based health education classes and programs related to health promotion and disease prevention to enhance health
Number of community events and programs completed
Number of prevention screenings completed

Programmatic Outcomes
Percentage of participants who are willing to recommend future community education activities and classes to others
Percentage of participants who comprehend concepts related to health promotion and disease prevention to enhance health
Percentage of participants who demonstrate the ability to use decision-making skills to enhance health
Percentage of participants who demonstrate the ability to practice health-enhancing behaviors
Percentage of participants who have improved health screening results
Community partner and participant satisfaction score
Investment in community programs, events and partnership and sponsorship efforts that address a priority health need

Signature Community Programs and Initiatives that Address Priority Health Needs	
Community Education, Screening and Prevention	
Speaker Series and Speakers' Bureau	WellStar's Speaking about Wellness Program provides our community with a multiple speaker series and a robust speakers bureau focused on preventative health and wellness education topics for all life stages. The speaker series component includes: Speaking about Wellness for Healthy Aging and Speaking about Wellness for Women/Spirit of Women®. The speakers' bureau includes: Speaking about Wellness for the Community and Speaking about Wellness for the Workplace.
School Health Programs	WellStar's School Health Program partners with local elementary and middle schools to provide interactive lessons on nutrition, physical activity, internet safety, anger management, dental health, wheel/passenger safety, water safety, personal hygiene and poison prevention. Program staff and supplies are funded in partnership with the WellStar Foundation.
Worksite Wellness	WellStar's Worksite Wellness Program encourages a proactive approach to healthcare by providing the convenience of on-site health and wellness resources to small and medium-sized businesses, customized to meet employers' and employees' specific needs. Services include health screenings, CPR/First Aid training, nutrition consults and Speaking about Wellness for the Workplace.
Screenings and Prevention	WellStar's Screening and Prevention Program provides health education and health screenings for community members and organizations. This program promotes health, assists in preventing disease and offers early detection.
Good Life Club	WellStar's Good Life Club is an organization for people 50 and older who want to learn how to live better, be healthier and stay active. The program focus is on healthy aging including wellness, health education, travel and social activities.
Medication Take-Back	WellStar's Medication Take-Back events are a partnership between WellStar Community Education & Outreach, local police departments and community-based organizations to provide secure drop-off locations for expired and unused medications.
CPR & First Aid Classes	WellStar works in partnership with the American Heart Association to provide CPR and First Aid classes in community, congregation and corporate settings. Classes included are Basic Life Support (BLS) for Healthcare Providers, Family & Friends CPR, Hands Only CPR and Heartsaver First-Aid CPR.
Congregational Health Network	WellStar's Congregational Health Network serves as a bridge between our healthcare system and faith communities. Coordinated by a full-time registered nurse who specializes in Faith Community Nursing, WellStar's program is designed to assist congregations of all faiths to develop or support health ministries.
Community Outreach	
Community Events	WellStar Health System participates in a wide variety of community events throughout the year, including health fairs, expos, road races, festivals, farmers' markets, community walks, congregation events/health fairs and special signature events.
Community Partnerships	Community Education & Outreach is responsible for developing and cultivating strategic community partnerships. Partnerships allow us to focus on prevention and wellness, impact community priority health needs and increase access to healthcare services.
Community Sponsorships	WellStar Health System supports the health and well-being of the communities we serve by actively engaging in sponsorship opportunities. Each year, WellStar supports other nonprofit organizations that align with our mission, vision and community needs assessment to improve the health of citizens in our communities.

Community-Driven Solutions:

Moving Upstream: WellStar Community Transformation Grants and Day of Service

WellStar Health System is committed to building meaningful partnerships with community-based organizations that are addressing the priority health needs of the communities we serve.

As an anchor institution, WellStar is poised to catalyze change, in collaboration with other local partners, in the various conditions that influence health outcomes from education to economic development to the environment, and beyond. Research has shown that anchor strategies can result in the following:[11]

- Lower hospital readmission rates
- Improve employee engagement and satisfaction through stronger community connections
- Further align capital with sustainability, diversity and inclusion, and community benefit priorities
- Create more meaningful connections with our community to build reputation of trust
- Create more meaningful connections with other place-based anchor institutions

As an anchor, WellStar can address a wide range of health, functioning and quality-of-life outcomes and risks by doing the following:[12]

- Place-Based Investment: Designate resources to make local financial investments that specifically address social determinants of health that are identified as barriers in the 2019 CHNA
- Upstream Community Benefit: Address community health needs by allocating people and time resources to support organizations that are implementing initiatives and interventions that address social determinants of health

Therefore, WellStar is launching two new place-based initiatives: the Community Transformation Grant Program and WellStar Day of Service. Both programs focus on policy, systems and environmental (PSE) change that address social determinants of health.

The Community Transformation Grant Program is an annual, competitive micro-grant program that will invest in the capacity of community-based organizations that are implementing PSE changes. This investment will focus on PSE changes that will improve programmatic effectiveness and future sustainability.

11 *Placed-Based Investing: Creating Sustainable Returns and Strong Communities Toolkit. Retrieved from https://hospitaltoolkits.org/investment/*

12 *Norris T & Howard T (nd). Can Hospitals Health America's Communities. Retrieved from https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/CanHospitalsHealAmericasCommunities.pdf*

WellStar Day of Service will create a conduit for WellStar employees to support local, community-based organizations that are addressing social determinants of health. By investing time and resources, Day of Service will support programmatic operations, as well as PSE changes, that will help community-based organizations advance their mission.

Finally, these strategies align with the Robert Wood Johnson Culture of Health Framework and recommendations from the American Hospital Association which emphasize the importance of making health a shared value and cross-sector collaboration as essential entry points for WellStar to become a partner in health. [13, 14]

Programmatic Productivity
Create small and large grant opportunities for eligible organizations to develop and offer innovative programs supporting the mission of improving health outcomes in the WellStar communities
Evaluate and disseminate the impact of health initiatives, programs and investments
Create systemwide employee volunteer opportunities that can accommodate 1,000-plus WellStar employees
Assessment of what the partnership is lacking to truly be effective
Partner satisfaction with WellStar's level of engagement
Partner satisfaction with WellStar's role in partnership

Programmatic Outcomes
Increase in organizational capacity after WellStar investments
Hospital readmissions rates for intervention population
Intervention population has increased access to the support services that they need to address preventable chronic conditions and behavioral health issues
Percentage and number of WellStar leadership volunteering for a local community-based organization addressing social determinants of health
Percentage and number of WellStar employees volunteering for a local community-based organization addressing social determinants of health
Volunteer hours donated to increasing the capacity of community-based organizations that are addressing food access and food insecurity needs
Estimated dollar value of hours donated to increasing the capacity of community-based organizations that are addressing food access and food insecurity needs

13 *Robert Wood Johnson (2014). Hospital-based Strategies for Creating a Culture of Health. Retrieved from https://www.rwjf.org/en/library/research/2014/10/hospital-based-strategies-for-creating-a-culture-of-health.html*

14 *American Hospital Association (2016). 2016 Committee on Research Next Generation of Community Health. Retrieved from https://www.aha.org/system/files/2018-03/committee-on-research-next-gen-community-health.pdf*

Community-Driven Solutions:

WellStar 4-1 Care

According to the 2019 CHNA access to care indicators, many members of WellStar's community have care access challenges in large part due to insurance constraints and provider access shortages. According to Healthy People 2020, "Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity.[15] WellStar is committed to serving our community's most vulnerable and under-resourced populations. In 2016, WellStar 4-1 Care was created to increase access to care and the capacity of partnering community clinics by providing reduced-cost outpatient medical services. Research has shown that when healthcare systems, like WellStar, partner with community safety-net clinics the following can occur.[16, 17]

- Reduction in Emergency Department Visits
- Reduction in Avoidable Readmissions
- Increase in Patient Satisfaction Scores
- Prevent illness by promoting healthy behaviors in people without risk factors (e.g., diet and exercise counseling)
- Prevent illness by providing protection to those at risk (e.g., childhood vaccinations)
- Identify and treat people with no symptoms, but who have risk factors, before the clinical illness develops (e.g., screening for hypertension or diabetes)

Evolution of WellStar 4-1 Care

The WellStar 4-1 Care program will evolve to advance WellStar's ability to support community access to care and social support services. As WellStar's geographical footprint has expanded, WellStar is also committed to forging new partnerships with community clinics (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers) to more collectively achieve optimal outcomes for more medically underserved and uninsured residents.

15 *Healthy People 2020 (n.d.). Access to Health Services. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services*

16 *Health Research & Educational Trust. (2016, August). Creating effective hospital-community partnerships to build a Culture of Health. Chicago, IL: Health Research & Educational Trust. http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf*

17 *Parker, Amanda, "A Program Evaluation of a Peri-Urban, Multi-Location Care Coordination Program in Georgia and Comparative Analysis of Other United States Care Coordination Programs for Uninsured, High-Risk Patients to Develop Promising Practice Recommendations." Georgia State University, 2017. Retrieved https://scholarworks.gsu.edu/iph_capstone/44*

In addition, WellStar 4-1 Care will evolve to include community benefit support of WellStar's three Community Clinics—WellStar AMC Sheffield Community Clinic, WellStar Kennestone Community Clinic and WellStar West Georgia Community Service Clinic. In alignment with WellStar's Financial Assistance Program (FAP), these community-based clinics provide charitable discounted or free care based on socioeconomic factors like a patient's household income, insurance status and/or family size and household income. These clinics help some of WellStar's most under-resourced and vulnerable community members receive medical services like chronic disease management, wellness exams, vaccinations and medication counseling. In partnership with physician leadership, Graduate Medical Education (GME) residents serve patients at the Sheffield and Kennestone clinics. To support these WellStar GME residents, as a part of WellStar 4-1 Care, structured education will be provided to help residents better understand health disparities, health equity and community health priorities. Through 4-1 Care, WellStar will continue to leverage that community-based clinics are long recognized for their ability to effectively improve and expand patient access to medical, dental and mental health services.

Programmatic Productivity
Develop and complete formal memorandums of understanding (MOUs) between (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers) and WellStar Health System
Number of WellStar 4-1 Care partnering community clinics (i.e. Community Safety-Net Clinics, Community Health Centers and Federally Qualified Health Centers)
Develop a Multifaceted Health Disparities Curriculum for Medical Residents
Number of patients served by WellStar Community Clinics
Assist with government-sponsored health insurance enrollment and applications for WellStar's Financial Assistance Program and promote awareness on-site at the hospital
Number of Community Clinic patients that complete Financial Assistant Program applications

Programmatic Outcomes
Investment in community clinics' operational needs
Percentage of residents who report increased preparedness and skill caring for vulnerable patients
Hospital readmissions rates for intervention population
Patient satisfaction scores for intervention population

Community-Driven Solutions:

WellStar Opioid Steering Committee

WellStar's Opioid Steering Committee is planning and implementing an ongoing comprehensive and collaborative response to the public health emergency of opioids by leading and collaborating with WellStar providers, patients and communities to help reduce opioid misuse, abuse and addiction.

Three physician-led work groups committed to prevention, treatment and recovery, champion the steering committee's efforts. Work groups target various populations internally (team-based) and externally (community-based): (1) provider and patient education, (2) clinical initiatives and (3) community awareness and engagement.

This committee is working to limit access to opioids by implementing alternative treatment order sets and care pathways for acute or chronic pain management, educating providers and patients on the risks of opioids and collaborating with community partners for advocacy and awareness events and activities. In addition, this committee is to navigate high-risk patients and community members with a history of long-term opioid use, as well as those struggling with misuse, abuse or addiction, toward safer treatment modalities and behavioral health resources to achieve optimal rehabilitation and recovery outcomes. Finally, the Opioid Steering Committee collaborates with CE&O to increase community awareness through the expansion of the Medication Take Back Day program and strengthening partnerships with community organizations, resources, government, law enforcement and first responders.

Programmatic Productivity
Identify best practices and quality measures to prevent opioid use and overprescribing
Number of provider education sessions that support opioid stewardship
Evaluate team-based prescription practices and community opioid abuse, overdose and addiction rates
Number of new clinical initiatives targeting improved opioid stewardship
Assess the availability and accessibility of behavioral health and substance abuse treatment services and other community and government resources for long-term recovery
Number of education and events conducted in WellStar communities on the risks of opioid use with a focus on teens and parents
Number of opioid prescriptions per 100 prescriptions (measuring across the system, by specialty, by hospital and by provider)
Tracking the morphine equivalence daily dose (MEDD) to reduce the percentage of high-dose opioid prescriptions
Promote public policies that support the prevention, treatment services and recovery programs that make the most impact on community health as it relates to opioid misuse
Programmatic Outcomes
Weight of medications collected through the Medication Take Back Day events
Investment in community programs, events and partnership and sponsorship efforts that address behavioral health and substance abuse

Community-Driven Solutions:

Zero Suicide Initiative

WellStar Health System has committed to implement components of the Zero Suicide framework, which will be a system-wide, organizational commitment to safer suicide care.

Inspired by health care systems that saw dramatic reductions in patient suicide, Zero Suicide began as a key concept of the 2012 National Strategy for Suicide Prevention, and quickly became a priority of the National Action Alliance for Suicide Prevention (Action Alliance) and a project of Education Development Center's Suicide Prevention Resource Center (SPRC), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted healthcare system. A systematic approach to quality improvement in these settings is both available and necessary.

The Zero Suicide framework equips mental health professionals and direct care staff with knowledge of suicidality signs and the necessary next steps, in the event of an unexpected mental health episode.[18] Research shows that implementing comprehensive screening and assessment tools is more effective than clinicians' judgement alone and allows for a better evaluation of risk factors prior to treatment strategy preparation.[19] If treatment is needed, dialectical behavior therapy has shown to decrease treatment attrition, suicide attempts, hospitalization and treatment received from the ED.[20] Furthermore, delegation of patient safety planning requires care management measures, e.g. follow-up contact with patients. Studies show that improving continuity of care by contacting patients post-discharge reduces suicidal ideations and behavior, and the rate of suicide.[21]

For health care systems, this approach represents a commitment to patient safety, the most fundamental responsibility of health care, and the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

18 *Schmitz WM, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, et al. Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. Suicide Life Threat Behav. 2012; 42 (3): 292 – 304.*

19 *Posner K, Brown GK, Stanley B, Brent DA, Yershova K , Oquendo MA, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011; 168 (12): 1266 – 77*

20 *Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 2006; 63 (7): 757 – 66*

21 *Suicide prevention strategies revisited: 10-year systematic review. Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M, Carli V, Höschl C, Barzilay R, Balazs J, Purebl G, Kahn JP, Sáiz PA, Lipsicas CB, Bobes J, Cozman D, Hegerl U, Zohar J Lancet Psychiatry. 2016 Jul; 3(7):646-59.*

Programmatic Productivity
Establish the Zero Suicide framework as a WellStar Health System initiative to address behavioral health needs of the community
Number of trainees that complete Zero Suicide Gatekeeper Training: Question, Persuade and Refer (QPR)
Number of Zero Suicide Training: Question, Persuade and Refer (QPR) classes offered
Number of Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP), and Collaborative Assessment and Management of Suicidality (CAMS)
Safety Planning Intervention (SPI) offered to providers in the community
Number of trainees that complete Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP), Safety Planning Intervention (SPI) and Collaborative Assessment and Management of Suicidality (CAMS)
Number of established community behavioral healthcare and support resources and partnerships

Programmatic Outcomes
Trainees demonstrate an increase in understanding in symptoms of common mental illnesses and substance use disorders based on pre- and post-testing
Trainees demonstrate the skills and ability to conduct a timely referral to mental health and substance abuse resources available in the community based on pre- and post-testing

Community-Driven Solutions:

The Health of All Women

WellStar Health System is committed to providing comprehensive care for women across all life stages within the communities we serve. To address the priority health needs identified in the CHNA process, WellStar Women's Health will address maternal and infant health needs through clinical practices, patient education and community outreach.

Clinical practices have established system-level continuous improvement councils that are both physician and nurse led. These system-level councils monitor clinical practices throughout WellStar Health System and implement care models with evidence-based policies, procedures, protocols and pathways, while local interdisciplinary councils monitor Women's Health practices on-site in individual WellStar hospitals. WellStar Women's Health will also implement a standardized, evidence-based framework to ensure clinical quality in obstetrics. These quality assurance measures will include some of the most common, nationally recognized causes of maternal mortality, such as hypertensive disorders and obstetric hemorrhage. These efforts will influence the care of approximately 45,000 mothers and their babies born at WellStar facilities within the next three years. The implementation of these quality assurance measures has resulted in significant improvements in maternal obstetric hemorrhage, hypertensive crisis and preeclamptic-related injury rates, along with infant birth injury rates, in other organizations similar to WellStar Health System nationwide.

WellStar Women's Health Service Line is expanding its Women and Children Resource Center patient education offerings to reach more than 15,000 families annually. The Women and Children Resource Center provides support for mothers, families and their newborn babies through perinatal support services, family education and breastfeeding support education classes. Also, the WellStar Women's Health Service Line and the CE&O Department will continue to collaborate on initiatives and programs to support prevention education and screenings. The U.S. Preventive Services Task Force (USPSTF) recommends interventions during pregnancy and after birth to promote and support breastfeeding.[22] Evidence suggests that breastfeeding has a positive influence on infants and children (e.g., protection against childhood obesity, type 2 diabetes, asthma and certain types of infections) and women by reducing the prevalence of breast and ovarian cancers, maternal hypertension, diabetes and cardiovascular disease.[23]

22 *US Preventive Services Task Force. Primary care interventions to promote breastfeeding: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2008;149(8):560-564.*

23 *Ip S, Chung M, Raman G, et al. Breastfeeding and maternal and infant health outcomes in developed countries. Evid Rep Technol Assess (Full Rep). 2007;(153):1-186.*

WellStar Women's Health has established a postpartum subcommittee charged with establishing and implementing postpartum screening, follow-up and referral practices for at-risk mothers and babies. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. Compared with controls, counseling interventions were associated with a lower likelihood of an onset of perinatal depression.[24]

Finally, WellStar Women's Health Service Line will continue its support and participation in the development and implementation of local and state public health department programs, maternal health committees and a women's health task force, such as the Georgia Perinatal Quality Collaborative led by the Georgia Department of Public Health, which launched two state-wide initiatives to address the top causes of pregnancy-related deaths in the state. Participation in these and other collective efforts will continue to address health disparity and equity challenges that impact health outcomes for Georgia's mothers and infants.

Programmatic Productivity
Number of perinatal support services, family education and breastfeeding support education classes
Number of participants in perinatal support services, family education and breastfeeding support education classes
Number of committees WellStar Women's Health participates in and the results (e.g., state-wide initiatives, etc.)
Number of women receiving educational materials during prenatal visits

Programmatic Outcomes
Improved outcomes, as measured by quality indicators, in cases of maternal obstetric hemorrhage and hypertensive crisis
Number of mothers screened and referred to behavioral health service for postpartum depression
Maternal and child health public policy that WellStar informs on behalf of women in Georgia
Percentage of breastfeeding class participants that uptake breastfeeding
Percentage of participants that recommend future perinatal support services, family education and breastfeeding support classes to others
Percentage of participants that reported an increase in knowledge, skills and abilities after completing perinatal support services, family education and breastfeeding support classes
Participant satisfaction score

24 *O'Connor E, Senger CA, Henninger ML, Coppola E, Gaynes BN. Interventions to Prevent Perinatal Depression: Evidence Report and Systematic Review for the U.S. Preventive Services Task Force. JAMA. 2019;321(6):588–601. doi:10.1001/jama.2018.20865*

Community-Driven Solutions:

Cancer Prevention and Screening

Cancer is the second leading cause of death in Georgia and can be caused by many things, including exposure to cancer-causing substances, certain behaviors, age, and inherited genetic mutations.[25, 26] According to the Georgia Department of Health's Georgia Cancer Control Consortium (GC3), cancer continues to remain as one of the top causes of death in our state. While the burden of cancer is shared by all Georgians, several disparities exist:[27]

- Cancer incidence and mortality is disproportionately greater among men and among minority and medically underserved populations.
- Black men in Georgia are 14 percent more likely to be diagnosed with cancer and 31 percent more likely to die from the disease than white men.
- Black men are almost three times more likely to die from prostate cancer than white men.
- While white women have a higher incidence of breast cancer than black women, black women are more likely to die of breast cancer.
- Black men and black women have a higher incidence of colorectal cancer and higher mortality rates from colorectal cancer than white men and white women.
- Men living in rural areas are more likely to die from lung cancer than men in more urban parts of the state which follows.

These disparities may be explained by patterns of screening, access to care, poverty patterns of tobacco use and the absence of protections from secondhand smoke. Based on current evidence, screening for breast, colorectal and lung cancers in appropriate populations by age and/or genetic risk can over time:[28]

- Increase a patient's knowledge and understanding of the importance of screening
- Increase the number of early-stage cancer detection
- Decrease the number of late-stage cancers detected
- Decrease the number of deaths from cancer

25 *National Cancer Institute (2019). Research on Causes of Cancer. Retrieved from: https://www.cancer.gov/research/areas/causes*

26 *Centers for Disease Control and Prevention (2017). Stats of the States of Georgia. Retrieved from: https://www.cdc.gov/nchs/pressroom/states/georgia/georgia.htm*

27 *Georgia's Cancer Prevention and Control Priorities. Retrieved from: ftp://ftp.cdc.gov/pub/Publications/Cancer/ccc/georgia_ccc_plan.pdf*

28 *National Cancer Institute Cancer Screening Overview. Retrieved from https://www.cancer.gov/about-cancer/screening/patient-screening-overview-pdq#_17*

Despite the known benefits, cancer screening rates continue to be a challenge throughout the state with minority, low income and rural populations reporting less screening according to recommended guidelines. To address the cancer disparities and increase cancer screening rates across WellStar communities, WellStar is committed to dedicating resources to address these critical gaps. WellStar aims to grow the preventative screening for cancers and increase the current screening by a minimum of 20 percent. WellStar will build a program that supports the patients and physicians through the screening and navigation process with an extended care model that ensures that care is continuous and well-coordinated. This aligns with US Preventive Services Task Force recommendations, Centers for Disease Control and Prevention, American Cancer Society guidelines and Georgia's Cancer Prevention and Control priorities to increase access to the appropriate cancer screening to detect the disease early and prevent morbidity and premature mortality.[26, 29, 30, 31]

Programmatic Productivity
Create the ideal proactive, preventative cancer screening program to support the communities WellStar serves
Create a cancer prevention program that supports the physicians through the screening and navigation process with an extended care model
Number of community cancer prevention screenings by cancer types
Number of participants screened through cancer screening initiatives by cancer types

Programmatic Outcomes
Reduction in advanced cancer cases
Number of participants with positive findings at screening programs that are referred follow-up with appropriate healthcare professionals
Percentage of screened participants that reported an increase in knowledge, skills and abilities after completing cancer prevention screening
Patient satisfaction score

29 *American Cancer Society Prevention and Early Detection Guidelines. Retrieved from https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html*

30 *US Preventive Services Task Force A and B Recommendations. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/*

31 *Centers for Disease Control and Prevention (2018). Reducing Health Disparities in Cance. Retrieved from https://www.cdc.gov/cancer/healthdisparities/basic_info/disparities.htm*

Building a Sustainable Infrastructure:

Screening for Food Insecurity

Food insecurity is an important but often overlooked factor affecting the health of a significant segment of the American population. Poor nutrition is one of the leading causes of the obesity epidemic. The 2019 CHNA revealed that many of WellStar's communities are in the vicious cycle of balancing their housing and healthcare needs with their food needs and the constant sacrifices and trade-offs that must be made to maintain their livelihoods. Individuals and families who lack consistent access to enough healthy food may have a higher risk of developing chronic diseases like obesity, hypertension and diabetes. Food insecurity can also make management of these and other health conditions more challenging.

In 2017, 11.8 percent of households (15 million) in the United States had difficulty at some time during the year providing enough food for all their members due to a lack of resources.[32] There is evidence that efforts to increase access to healthy nutrition in communities has:[33]

- Strengthened local and regional food systems
- Increased access to fruits and vegetables
- Increased fruit and vegetable consumption in low-income communities, including among children and diabetics
- Improved dietary choices; and prevented and reduced obesity

To address this social determinant of health, WellStar Health System will begin incorporating food insecurity screening as a standardized protocol into existing patient intake procedures, a practice recommended by numerous professional societies, including the American Academy of Pediatrics and the American Diabetes Association.[32, 33]

32 *Household food security in the United States in 2017. U.S. Department of Agriculture. Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2018, September). Available at https://www.ers.usda.gov/webdocs/publications/90023/err256_summary.pdf?v=0*

33 *Nutrition prescriptions (2018). County Health Rankings and Roadmaps, What works for Health. Retrieved from http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/nutrition-prescriptions*

In addition, screening for food insecurity is appropriate and warranted in the clinical setting, especially in environments where a significant percentage of the patient population has been identified as low income.[34] Food insecurity screening quickly identifies households at risk for food insecurity, enabling providers to target services and treatment plans that address the health and developmental consequences of food insecurity. Research has found that screening for food insecurity can:[35, 36, 37]

- Connect families to sustainable food access support
- Identify underlying barriers to health conditions, misuse of Emergency Departments and medication adherence
- Improve patient satisfaction scores
- Help reduce the prevalence of food insecurity and its effects on the community

Programmatic Productivity
Identify patients living in food-insecure households while they are in the healthcare setting
Refer those patients and their families to food bank agencies and programs to connect patients with healthy food access as well as application assistance for SNAP and other long-term supports
Create new food distribution programs in the healthcare facility when there is sufficient need and interest, and/or existing community resources are insufficient

Programmatic Outcomes
Hospital readmissions rates for intervention population
Patient satisfaction scores for intervention population
Number of patient referrals to community resources that address food access

34 *Promoting Food Security for All Children (2015). Retrieved from http://pediatrics.aappublications.org/content/136/5/e1431*

35 *Lane, W. G., Dubowitz, H., Feigelman, S., & Poole, G. (2014). The Effectiveness of Food Insecurity Screening in Pediatric Primary Care. International journal of child health and nutrition, 3(3), 130–138. doi:10.6000/1929-4247.2014.03.03.3*

36 *Marpadga, S., Fernandez, A., Leung, J., Tang, A., Seligman, H., & Murphy, E. J. (2019). Challenges and Successes with Food Resource Referrals for Food-Insecure Patients with Diabetes. The Permanente journal, 23, 18-097. doi:10.7812/TPP/18-097*

37 *Health Care Without Harm (2018). Delivering Community Benefit Healthy Food Playbook. Retrieved from https://foodcommunitybenefit.noharm.org/resources/implementation-strategy/food-insecurity-screening*

Building a Sustainable Infrastructure:

Community Benefit Capacity Building

Although the majority of WellStar's community benefit services are delivered systemwide, each of WellStar's 11 not-for-profit hospitals plays a role in addressing the priority health needs identified from its CHNA. Hospital presidents and community benefit liaisons are vital to tracking and assisting in the implementation of WellStar's community benefit programs, most notably for the clinical engagement and care coordination needed to optimize community partnerships and identifying populations for Live Well community-based preventive education and screenings.

To accomplish this, WellStar North Fulton Hospital will build a sustainable and outcomes-driven community benefit program that demonstrates commitment to community health improvement and health equity. Through dedicated leadership, accountability, collaborative partnerships and stewardship of fiscal and human resources, we will create a more healthy community through outreach, education and advocacy focused on priority health needs.

Programmatic Productivity
Identify a community benefit liaison for each hospital
Track and report community benefit activities in the Community Benefit Inventory for Social Accountability (CBISA – community benefit software) and via Community Benefit 101 training
Create and promote an inventory of hospital services, activities and resources that are currently addressing social determinants of health
Assist with government-sponsored health insurance enrollment and applications for WellStar's Financial Assistance Policy and promote awareness on-site at the hospital

Programmatic Outcomes
Increased patient referrals to community resources that address social determinants of health and needed resources
Increased CBISA utilization to more accurately report community benefit investment
Increased primary care access through care coordination with community health clinics

Building a Sustainable Infrastructure:

Public Policy and Advocacy

WellStar's leadership and the Government Relations team interacts with various state agencies responsible for community health needs, regulation and planning, such as the Department of Community Health, the Department of Public Health and the Department of Behavioral Health and Developmental Disabilities. WellStar proactively educates and engages policymakers on the health system's mission, concerns and legislative priorities, which include but are not limited to preservation of Certificate of Need, enhanced levels of Medicaid coverage and reimbursement, access to affordable and high quality coverage and care, addressing social determinants of health and ensuring resources are readily available to treat behavioral health and substance abuse. WellStar Health System's commitment to work jointly with various levels of government, community clinics, community organizations, chambers of commerce and industry coalitions strengthens our ability to effect real change and foster communities of improved health and wellness for the betterment of all Georgians.

Building a Sustainable Infrastructure:

WellStar Research Institute

At WellStar, we believe that a successful clinical research program benefits our patients, physicians and community. WellStar Research Institute (WRI) is the centralized research facility serving WellStar Health System that strives to push the boundaries of current knowledge to uncover new ways to fight disease and keep people healthy. Through research, WRI offers cutting-edge therapies and contributes to the advancement of medical and social behavior science. This helps inform WellStar providers' understanding of the needs of patients, the healthcare industry and society at large.

Health Needs Not Addressed

Health needs not identified as priority to the hospitals fall into one of three categories:

1. Beyond the scope of WellStar services
2. Needs further intervention, but no plans for expanding current community benefit services at this time
3. Relying on community partners to lead efforts with expertise in these areas with WellStar in a supportive role

Evaluation of Action

At WellStar Health System our success is measured by our ability to:[38]

- Reduce health disparities by increasing care access and support services to under-resourced, at-risk community members
- Strengthen community capacity and collaboration for shared responsibility to address the priority health needs of the community the hospitals serve

In addition, did WellStar's Community Benefit initiatives:

- Improve the overall health of the community through improved access to care and a reduction of the incidence and prevalence of chronic disease?
- Serve and advocate for the medically underserved and under-resourced populations with the goal of providing "the right care at the right place?"
- Improve the delivery and reporting of community benefit services to better demonstrate WellStar North Fulton Hospital's commitment to improve overall community health?
- Implement improved financial assistance, billing and collection policies that protect patients and reduce the number of patients relying on charity care?
- Collaborate with multi-sector community partners to relieve or reduce the burden of government?

Next Steps[39]

To inform strategic action plans and strategically align our community benefit initiatives with the needs of our communities, WellStar Health System will:

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnerships and create new health need focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs
11. Share results at WellStar Community Health Collaborative task force meetings and, as needed, with the community

38 Public Health Institute, Kevin Barnett. Quality and Stewardship in Community Benefit, March 11, 2010.

39 County Health Rankings and Roadmaps/Evaluate Actions. http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions

WELLSTAR
Health System

793 Sawyer Road
Marietta, Georgia 30062
770-956-STAR (7827)

wellstar.org