2013

Community Health Needs Assessment (CHNA) Report

WELLSTAR PAULDING HOSPITAL

Identification and assessment of the health needs of the community served by WellStar Paulding Hospital. Submitted in fiscal year ended June 30, 2013 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 Code section 501(c)(3).

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Community Health Needs Assessment (CHNA) Report / 2013

WellStar Paulding Hospital

600 West Memorial Drive | Dallas, GA 30132

WellStar CHNA Principal Assessor:

Allen M. Hoffman, MD, Executive Director, WellStar Community HealthCare

52 Tower Road, Marietta, GA 30060

Organization Operating Hospital Facility:

Paulding Medical Center, Inc./ EIN#: 58-2095884

600 West Memorial Drive, Dallas, GA 30132

Senior Leadership Oversight:

Kim Menefee, Senior Vice President, Public and Government Affairs, WellStar Health System

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A Community Health Needs Assessment (CHNA) was conducted in order 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 at least once every three years. The required written plan of implementation strategy is set forth in a separate written document. This written plan is intended to satisfy each of the applicable requirements set forth in IRS Notice 2011-52 regarding conducting the CHNA for the Facility.

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Executive Summary 1

Overview:

Recognized as the fifth most integrated healthcare delivery system in the country, **WellStar Health System** is one of the largest not-for-profit health systems in Georgia and serves a population of nearly 1.3 million residents in five counties. The vision of WellStar is to deliver world-class healthcare. A national leader in the transformation of healthcare delivery, WellStar launched two initiatives in late 2012 – the Center for Health Transformation and the Georgia Health Collaborative – that will have far reaching effects on healthcare both locally and nationally.

WellStar includes WellStar Kennestone Regional Medical Center (anchored by WellStar Kennestone Hospital) and WellStar Cobb, Douglas, Paulding and Windy Hill hospitals; the WellStar Medical Group; Urgent Care Centers; Acworth Health Park; Health Place; Homecare; Hospice; Atherton Place; Paulding Nursing Center; and the WellStar Foundation.

To assess the current health and well-being of the communities served, **WellStar Paulding Hospital** conducted a Community Health Needs Assessment (CHNA),[1] a collaborative effort involving hospital leadership, public health agencies,[2] Cobb2020, and a diverse coalition of community stakeholders. Partners represented a broad knowledge based of the hospital's primary service area of Paulding County and some outlying zip codes determined by utilization.

Online posting of this written report detailing the evidence-based CHNA process spanning from April 2011 to June 2013, means WellStar Paulding Hospital has complied with the public display of this written report with the Internal Revenue Service and the Affordable Care Act (ACA) tax law requirements section 501(r). The law requires hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment once every three years.

To assess the current community health status and capture a broad base of input, collaborators engaged a strategic process called Mobilizing for Action Through Planning and Partnerships (MAPP)[3] launched by

[1] "A community health needs assessment is a systematic process involving the community, to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs." *Assessing and Addressing Community Health Needs*, Discussion Draft March 2011, Catholic Health Association.

[2] The CHNA process for WellStar Health System included Cobb and Douglas Public Health, Cherokee Public Health, Bartow Public Health, Northwest Georgia Health District (Rome)(Bartow and Paulding County), North Georgia Health District (Dalton)(Cherokee County).

[3] MAPP developed by the National Association of County and City Health Officials (NACCHO) and the federal Centers for Disease Control and Prevention(CDC) to provide a framework for community-driven strategic planning for improving community health. Since its inception in 2001, MAPP is used by more than 700 local health departments nationwide.

Cobb & Douglas Public Health (CDPH). MAPP provides the framework for creating a community-driven health improvement plan through different assessments to evaluate:

- Prevalent health issues
- Health issues that are important to the community members
- Availability of health services
- Forces that impact community health

This process enabled WellStar Paulding Hospital to collaborate with public health experts, the private sector and the community to fulfill community benefit[4] requirements and assess health needs.

To enact these health needs assessments, a coalition was formed in Cobb County called the Cobb2020 partnership,[5] the springboard for WellStar Paulding Hospital's CHNA work. It consists of partners from more than 20 sectors including:

- Local and State Public Health
- Hospitals
- Community mental health
- Existing healthcare alliances and groups
- Federally Qualified Health Clinics (FQHCs), free and community-based clinics
- Community and business leaders
- State and national organizations- Georgia Department of Public Health and the Centers for Disease Control and Prevention (CDC)
- Other organizations and individuals serving vulnerable populations: faith-based, medically underserved, low-income, minority, seniors, and chronic diseases

Much of the data in this written report was gleaned from research collected and processed by the Cobb2020. WellStar Paulding Hospital's lead needs assessor served in numerous capacities with Cobb 2020 and provided leadership in engaging Public Health and community stakeholders from Paulding County and overlapping service area counties in the process.

CHNA collaborators served in critical roles including assessment implementation team and workgroup members, key informants, consultants, and community focus group facilitators and surveyors. The community collaborative was foundational in designing an innovative and integrated partnership among health sectors and providing a broader channel for communication.

[4] Community benefit is central to the mission of non-profit hospitals and is the basis for their tax exemption. New revisions to the Internal Revenue Code now require hospitals to take a more strategic approach with CHNA and implementation strategy requirements. Source: *MAPP and Non-Profit Hospitals: Leveraging Community Benefit for Community Health Improvement*. National Association of County & City Health Officials, Fact Sheet, July 2010.

[5] **Cobb2020** is a partnership of community organizations and individuals that contribute to the delivery of essential health service in Cobb County. Their mission is to promote wellness, prevention and sustain quality of life of the community. Funded through the Cobb & Douglas Public Health Department by a federal Community Transformation Grant supported by the Centers for Disease Control and Prevention (CDC).

To meet the assessment and analysis objectives, more than 25 meetings encompassing close to 200 hours were invested from July 2011 (initial needs assessment meeting with CDPH) to June 2013 (WellStar Health System's Board of Trustees meeting).

As a 501(c)(3) not-for-profit hospital organization, many of WellStar Paulding Hospital's resources are allocated and reinvested to improve community health and care for the uninsured. To meet mandated federal requirements, the prioritized health needs of the community assessed in this written report must intersect with an outcomes-based, strategic community benefit plan.

This report serves as the bedrock for a community-wide implementation strategy[6] for this plan to address how the assessed, prioritized healthcare needs of the community served by WellStar Paulding Hospital will be enacted.

For the implementation plan to effectively improve outcomes, the ability to influence the community stakeholders to move from rows to circles is required. This subtle shift in posture represents a new model of cooperation to more effectively and cost-efficiently meet the complex health needs and issues of vulnerable populations.

WellStar Paulding Hospital began the reorientation process by examining the following community benefit ACA qualifiers:[7]

- *Identifying community health needs*
- *Improving access to healthcare services*
- *Enhancing health of the community*
- *Advancing medical or health knowledge*
- *Reducing the burden of government or other community efforts*

By helping connect the fragmented local public health system into a unified coalition for a healthier community, WellStar Paulding Hospital and its assessment partners have collaboratively and proactively taken the first step toward innovating and improving the community's model for care. Together, increasing the investment into preventing and managing chronic disease ultimately leads to decreasing need for unreimbursed care which totaled $231 million for WellStar Health System in 2012. Nearly $100 million was spent on indigent and charity care in 2012, with over $5 million provided by WellStar Paulding Hospital.[8]

[6] An implementation strategy is the hospital's plan for addressing community health needs, including health needs identified in the community health needs assessment. The implementation strategy is also known as the hospital's overall community benefit plan.

[7] Qualifiers for meeting the new Patient Protection and Affordable Care Act (ACA) "community benefit" law.

[8] Historically, the majority of community benefit funds are spent on charity care (WellStar Paulding Hospital invested over $5 million on charity care), while a smaller portion is invested in community-based efforts such as community health improvement planning. Ten percent of all care WellStar Health System provided in FY2012 was to the uninsured population.

Health leaders reported that leveraging a full spectrum of community-based resources will yield higher quality and more accessible care. This, in turn, will help drive costs down to help the hospital achieve better population health management.

This is the linchpin for a successful community benefit program as WellStar Paulding Hospital and its community partners build and strengthen a collaborative, multi-sectorial care access team to make an indelible, sustainable mark on the community's health. This is aligned to the Internal Revenue Service definition of community benefit - "the promotion of health for a class of persons sufficiently large so the community as a whole benefits."

Community Overview:

Residents of Paulding make up the community served by WellStar Paulding Hospital with surrounding counties geographically designated to other WellStar Health System hospitals. There's no clear line of delineation as residents in surrounding counties also utilize the hospital's services.

Paulding County's population in 2012 was 151,046[9] and continues to trend upward with a projected 2017 population of 174,782, a 15.7 percent increase. According to the 2010 Census, Paulding County experienced the largest boom of the WellStar Health System five-county service area with a 74.25 percent population increase from the 2000 Census. The median age of the service area 33.9 and is 50.99 percent female.

Research shows people who live in poverty, are uninsured and did not graduate high school have poorer health outcomes. Those three level key drivers[10] are reflective of a vulnerable population's health behaviors and level of clinical care access as outlined in the table below.

Table 1:[11]
Key Drivers of Health and Related Vulnerable Populations

Key Driver of Health		**Paulding**	**GA**	***National benchmark***
Poverty	**Children under the age of 18 in Poverty**	16%	27%	14%
	Total population in poverty* *(Living below 200% of FPL)*	24.22%	35.29%**	Overall poverty is 15% (2011)
Uninsured	**Uninsured population under the age of 65**	18%	22%	11%
Undereducated	**Low educational attainment** *(% of 9th grade cohort graduating in 4 years)*		71%	76%

[9] U.S. Census Bureau statistic.

[10] Key drivers are powerful predictors of population health reflecting WellStar Paulding Hospital's primary service areas counties of Paulding County.

[11] *Data Sources:* County Health Rankings, 2013. University of Wisconsin's Population Health Institute. *U.S. Census Bureau, 2006-2010, American Community Survey 5-Year Estimates. **American Community Survey Brief: http://www.census.gov/prod/2012pubs/acsbr11-01.pdf.

Objectives and Key Findings:

The paramount objective of WellStar Paulding Hospital's written report is to provide the groundwork and data to help transform the health of the community served.

Transformational community benefit programming reflects a healthcare model that is community-based, patient-centered, equitable, accessible, prevention-focused, efficient, timely, measurable, and safe.[12]

The community input and data reveals that in order to achieve this there must be a coordinated and unified hospital and community-wide shift from reactive care to proactive care to:

- Connect vulnerable populations to more resources *to improve outcomes and lower costs*
- Translate research findings into community action *to improve outcomes and lower costs*

WellStar Paulding Hospital CHNA objectives coupled with an overview of key findings are:

Table 2:
WellStar Paulding Hospital CHNA Objectives and Key Findings

Objectives	***Key Findings***
I. **To identify community collaborators** to engage, invest and become stakeholders in the community assessment and long-term community benefit programs	See *Community Collaboration and Process* section, page 26.
II. **To assess the local public health system**[13] *The Cobb MAPP activities and findings were shared with Paulding County Health Department – Northwest Georgia Public Health. Representatives concurred the findings were generalizable to Paulding County's health needs.*	The MAPP *Local Public Health Systems (LPHS) Assessment* answered the questions: *What are the components, activities, competencies and capacity of local public health system and how are the essential services being provided to the community?* High priority/low performance of the LPHS' Essential Services performance score areas were: 1. Evaluate services (better profiling of population-based community health and identifying populations with barrier to personal health service to avoid gaps) 2. Assure workforce 3. Link to health services (connecting community to needed services) The MAPP *Forces of Change Assessment* examined what is occurring that affects the LPHS. Ranked factors included: • Health equity • Public policies

[12] Institute of Medicine. *Crossing the Quality Chasm*. 2001 National Academy Press, Washington D.C.

[13] Appendix: Local Public Health System egg diagram: *How it contributes to health and delivery of Essential Public Health Services in the community,* page 50.

	• Access to quality education • Unstable economy • Transient populations • Technology • Access to quality healthcare • Reducing high risk behaviors • Aging population ***Additional Paulding County-specific insights from Key Informant interviews:*** • There has been a general downward trend over recent years in Paulding County largely due to erosion in economic vitality, but proximity to Metro Atlanta has brought with it improvements associated with growth such as increasing business and retail options. • Nearly every respondent mentioned lack of access in some form including: -lack of insurance -few providers willing to accept patients via Medicaid or Tricare -an inadequate supply of low or no cost medical services especially mental health services -limitations of public transportation -a combination of insufficient information or knowledge on health
Objectives	***Key Findings***
III. **To assess the health needs of the community served**[14] *WellStar Paulding Hospital's target populations were derived from this assessment.*	***Paulding Key Informant interviews revealed:*** • Perceived health and quality of life are largely good, though there is acknowledgement that this does not extend to those who for various economic or other reasons are excluded from the benefits of the larger community • Primary conditions of concern include obesity and nutrition, diabetes, teen pregnancy, drug and alcohol use, asthma, and dental care • Care access is a dominant issue with similar barriers and challenges revealed through the Cobb MAPP strategic process • Noted gaps in services such as pediatric medicine and other specialties *Secondary and primary data guided by health indicators*[15] *and Cobb MAPP data:* • Health issues were not rated by residents as highly as other issues (like highly ranked issue of transportation in Cobb). 50 percent of respondents from the Cobb MAPP Survey[16] didn't have a response or didn't know what the community biggest health issue was. • Across the board, obesity and poor nutrition, health disparities and access to care were mentioned by Key Informants as primary areas and conditions of concern. • Only two health outcomes and leading causes of death were named as the biggest health issue - five percent of respondents said cancer and two percent of respondents said heart disease.

[14] See comprehensive health needs assessment covered in Data Process & Methods section, page 30 and Community Health Needs list, page 42.

[15] "A characteristic of an individual, population or environment which is subject to measurement and can be used to describe one or more aspects of the health of an individual or population." *Health Promotion Glossary*, World Health Organization, 1998.

[16] Respondents answered the phone survey from Nov. 21, 2011 – Jan. 19, 2012 conducted by the A.L. Burruss Institute of Public Service and Research at Kennesaw State University.

	• Fair to good quality of life among the majority of community polled with Hispanic, non-white, less education and income populations ranking lower. This is also indicative of the how the availability of medical care rated among populations. Statistical data: • High incidence of lung cancer, cardiovascular disease and stroke ***Cancer:*** Paulding County incidence of lung cancer ranked higher than state and national statistics. -Of interest is the lung cancer incidence rate in Paulding County which ranks higher than state or national benchmarks at 93.90 per 100,000 population – the county ranks number one among the five-county WellStar Health System service area. ***Heart disease:*** Prevalence of heart disease surpasses the state and national rates. ***Stroke:*** Mortality rates in Paulding surpass both the state and the Healthy People 2020 <33.8 national benchmark ranking 42.82 per 100,000 population. • Self-reported tobacco use in adults in Paulding County is 20 percent. • 26 percent of adults in Paulding County are obese. The overweight population is another 36.29 percent. • 24 percent of ninth graders don't graduate high school in four years[17] • The matters of health barriers and limited access to healthcare for disparately affected populations were dominant themes among both counties' Key Informants • Low income, low education population reported more health issues that other demographic groups
Objectives	***Key Findings***
5. **To determine priorities**	Thematic analysis from survey, focus group and Key Informant interviews, the *County Health Rankings*[18]model and secondary data were methods used to prioritize health needs: **HIGH** priority needs[19] *Related to* ***access to care:*** 1. Cardiovascular disease 2. Cancer (lung, breast, colon, prostate) 3. Stroke 4. Diabetes 5. Chronic obstructive pulmonary disease 6. Mental health *Related to* ***healthy lifestyles:*** 1. Healthy eating 2. Obesity

[17]Education levels positively influence a variety of social and psychological factors. Increased education improves an individual's self-perception and sense of personal control and social standing, which also have been shown to predict higher self-reported health status.

[18]The *County Health Rankings & Roadmaps* program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, 2013. www.countyhealthrankings.org.

[19]See ***Community Health Needs*** section, page 42.

	3. Smoking 4. Physical activity 5. Education *(These assessed priorities address the community's leading causes of death)* Related to improving health disparities and inequities: 1. Access to care disparity among the medically uninsured and underserved Medium priority needs: 1. Prenatal care 2. Breast cancer (screening) 3. Prostate cancer (screening) 4. Colon cancer (screening) 5. Alcohol Low priority needs: 1. Transportation 2. Air quality 3. Dental care 4. Sexually transmitted infections 5. Teen pregnancy
Objectives	***Key Findings***
6. **To develop and implement strategies** to meet the prioritized needs of the community served	To be outlined in the ***Implementation Strategy***. Centered on promoting healthy lifestyles and increasing access to care with a collaborative, community-wide approach.

Methodology:

To meet the cardinal objective of identifying community partners, WellStar Paulding Hospital sought the input and assistance of representatives of the Paulding County Health Department – Northwest Georgia Public Health.

The multi-year assessment process yielded more than 150 community collaborators and key stakeholders in five counties (including Paulding public health representatives and Key Informants) who demonstrated dedication to the health of the community and to future implementation strategies to reduce health disparities[20] and costs while improving access to preventive care, education and services.

The MAPP strategic process for community assessments to identify where policy, systems and environmental changes are needed was funded by CDPH in the initial planning and development stages (fall of 2010). A multi-million, five-year CDC Community Transformation Grant[21] was awarded to CDPH in September 2011 to help address the barriers and determinants to chronic disease prevention and improve community health with more robust assessments. Granting writing was a collaborative effort between CDPH, WellStar Health System and Cobb County.

[20]*"The differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist in among specific population groups."* National Institute of Health Working Group on Health Disparities, Draft Trans-NIH Strategic Research Plan on Health Disparities, Bethesda, MD: National Institute of Health, 2000.

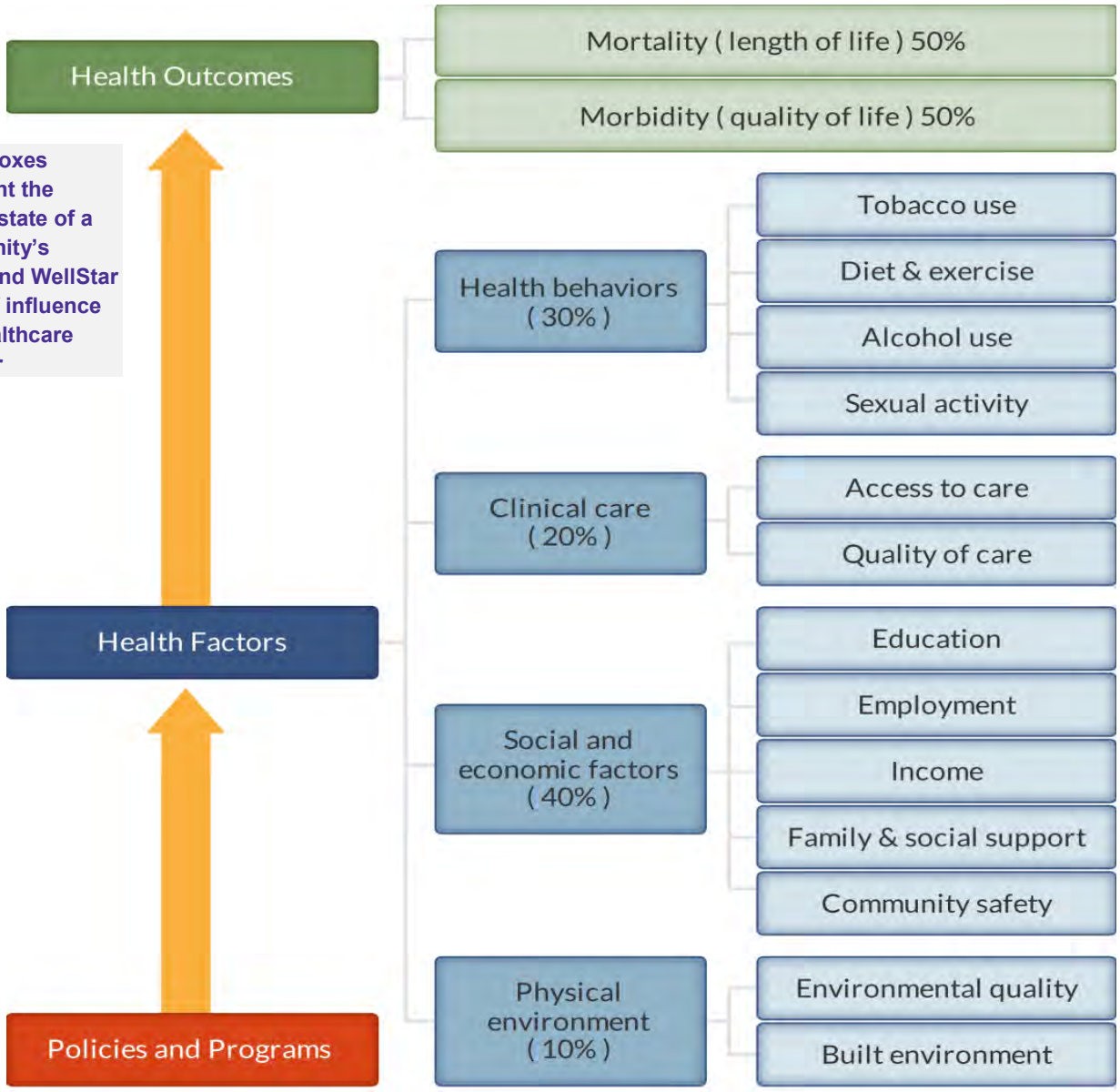
[21]The CDC awarded $103 million to 61 state and local government agencies, tribes and territories, and non-profit organizations in 36 states, along with nearly $4 million to six national networks of community-based organizations. Awardees are engaging partners from multiple sectors, such as education, transportation, and business, as well as faith-based organizations to improve the health of their communities' approximately 120 million residents. Awardees also provide funding to community-based organizations to ensure broad participation in creating community change.

An evidence-based model for population health developed by the University of Wisconsin Population Health Institute provided WellStar Paulding Hospital with a baseline to assess factors, that when improved, can greatly impact a community's health (Figure 1).

Figure 1:

Model of Population Health: WellStar Paulding Hospital CHNA[22]

Illustrates how the community where people live, work and play has a direct impact on overall health



County Health Rankings model ©2012 UWPHI

Blue boxes are predictors of a community's future health – modifiable areas for improving population health, but not necessarily a hospital priority when it's cultural and/or policy-driven. **WellStar can best affect Health Behaviors (prevention) and Clinical Care (focus on access to care).**

[22]This model of population health used by WellStar Paulding Hospital emphasizes the many factors that, if improved, can help make communities healthier. From the University of Wisconsin Population Health Institute, www.countyhealthrankings.org.

How WellStar Paulding Hospital counties (designated as its community served) rank in health outcomes and health factors as compared to other Georgia counties:

Table 3: **County Health Outcomes and Factors** *(Rankings based on Georgia's 159 counties)*	
	Paulding
Health Outcomes:[23] How healthy is the county *(Ranked based upon an equal weight of mortality and morbidity measures)*	25/159
Health Factors:[24] What influences the health of a county *(Factors: behavioural, clinical, social and economic, and environmental)*	16/159

Data Sources and Methods:

Community stakeholders contributed to the CHNA through various quantitative[25] and qualitative[26] research methods:

Quantitative or Secondary Data -*Sources included: (not all-inclusive)*

1. Georgia Department of Public Health, OASIS - Online Analytical Statistical Information System
2. Centers for Disease Control and Prevention (CDC), National Vital Statistics System
3. Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health & Human Services
4. U. S. Census Bureau
5. U.S. Department of Health and Human Services
6. Kaiser Permanente Web-Based CHNA Platform
7. Catholic Health Association CHNA resources
8. *County Health Rankings & Roadmaps*, University of Wisconsin Population Health Institute
9. Healthy People 2020[27]
10. Behavorial Risk Factor Surveillance System (BRFSS)
11. WellStar Health System – WellStar Douglas Hospital's FY2012 utilization data to assess service area zip codes accounting for 90 percent of hospital admissions and visits and primary service areas

[23] Appendix: County Health Factor Rankings: Map of Georgia Outcomes, page 51.

[24] Appendix: County Health Outcomes: Map of Georgia, page 51.
Complete Georgia 2013 Rankings available: http://www.countyhealthrankings.org/sites/default/files/states/CHR2013_GA.pdf

[25]Quantitative data is gathered in numerical form (statistics, percentages) for demographic and census data, risk factors and health incidences that can be generalized to a larger population.

[26]Qualitative research is gathered first hand and asks broad questions and collects word data from participants. The researcher looks for themes and describes the information in themes and patterns exclusive to that set of participants in a manner that does not involve mathematical models.

[27]Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans – www.healthypeople.gov.

Qualitative or Primary Data

Sources include:

1. Cobb County Focus Group Report.[28] 58 people participated in six focus group representing 14 zip codes. Demographics varied among the groups indicative of the zip codes represented. Two groups were conducted in Spanish and reflected low-income, low education attainment and medically underserved populations.

2. MAPP Assessment Workgroups (with participating Cobb and Douglas MAPP partners and implementation team members) conducted four community assessments that helped develop the Cobb2020 Community Health Improvement Plan. This included the 2011 Field Test Local Public Health System Assessment by the National Public Health Performance Standards Program (NPHPSP)[29]

3. Cobb and Douglas Key Informant Interview Reports.[30] Participants identified by Douglas MAPP and Cobb 2020's *Community Strengths and Themes Workgroup* to represent different sectors of the community who possessed above average knowledge of healthcare issues, healthcare system or the community.

4. Cobb MAPP Community Survey Report.[31] 44-question telephone surveys of 1,244 adults ages 18-94 in Cobb and Douglas counties performed by the A.L. Burruss Institute for Public Service and Research, Kennesaw State University. A smaller sampling was conducted for Douglas MAPP.

5. Cobb County 2010 – *How Healthy Are We?*[32]

6. Cobb County MAPP Forces of Change Assessment Summary Report[33]

7. Paulding County Key Informant[34] interviews* of five community stakeholders primarily focused on children's needs facilitated by Magnetic North, LLC

[28]MAPP Cobb County Focus Group Report:
http://cobb2020.com/images/mapp/MAPP%20Focus%20Groups%20Report%20Website%20Final%201.24.13.pdf

[29]NPHPSP partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association, Association of State and Territorial Health Officials; National Association of State and Health Officials; National Association of Local Board of Health; National Network of Public Health Institutes; and the Public Health Foundation.

[30]MAPP Cobb Key Informant Report, Spring 2012:
http://cobb2020.com/images/mapp/Community_Themes_Strengths_Assessment_Report.pdf Douglas report available upon request.

[31] Cobb MAPP Survey Report, 2012: http://cobb2020.com/images/mapp/Cobb_MAPP_Report_FINAL.pdf

[32]Cobb MAPP *How Healthy Are We?,* 2010: http://cobb2020.com/documents/The_Cobb_County_Health_Status_Report.pdf

[33]Cobb MAPP Forces of Change Assessment Summary, January 2012:
http://cobb2020.com/images/mapp/Forces_of_Change_Assessment_Report.pdf

[34] Paulding Key Informants are included in the WellStar CHNA Collaborator List. Appendix, page 58.

*Substantial findings from Cobb and Douglas MAPP data were generalizable to Paulding County given geographical and demographic similarities. Data was presented and discussed with the Paulding County Health Department – Northwest Georgia Public Health representatives in meetings held January 2013. Public health officials were in general agreement as to the validity of the findings from Cobb and their applicability to the Paulding health districts.

Targeted Key Informant interviews, following a similar Cobb MAPP *Community Strengths & Themes* survey template, further validated the findings while adding valuable information on variations and gaps from the unique perspectives of key county stakeholders.

Information Gaps:

- Inaccessibility of reliable, consistent and current data caused some information gaps. Some statistics are not current indicators of the current health status and socio-economic state of the community since data was gathered before the 2007 recession.

- Conflicting numbers from myriad resources made it difficult to extrapolate reliable and timely statistics or the data descriptors did not include a broad population base. *For example:* Available county data regarding number of women getting a mammography screening was based on women age 65 or older on Medicare.

- What the community cited as a top issue or need (ex: transportation and economy status) sometimes conflicted with WellStar Paulding Hospital's ability to modify or improve upon the area of need.

- Paulding County's Key Informants were disproportionately focused on children's needs.

Emergent Themes from the Findings:

Themes centered on lack of care access, education, transportation, health disparities, and a robust willingness to partner to improve health issues in the community. They included:

1. Optimism from the community about perceived health and quality of life though it was acknowledged this doesn't extend to those who are excluded from the benefits of the larger community

2. Inequitable health services (barriers to care access)[35] due to the disparate numbers of primary care physicians, unwillingness of providers to accept Medicare/Medicaid and TRICARE and lack or limited transportation, insurance or money

[35] *Access to Health Services* Report, Cobb MAPP Steering Committee, March 5, 2013

3. Health disparities among people living in poverty, the uninsured and minority, young and linguistically isolated populations

4. Lack of access to healthcare[36] to at-risk populations due to an inadequate supply of low or no cost medical services (especially dealing with the care, treatment and interventions required to manage chronic disease and mental health) and insufficient information or knowledge of available health options

5. Disconnect of community perceptions and community statistics between leading causes of morbidity and mortality and top cited community issues

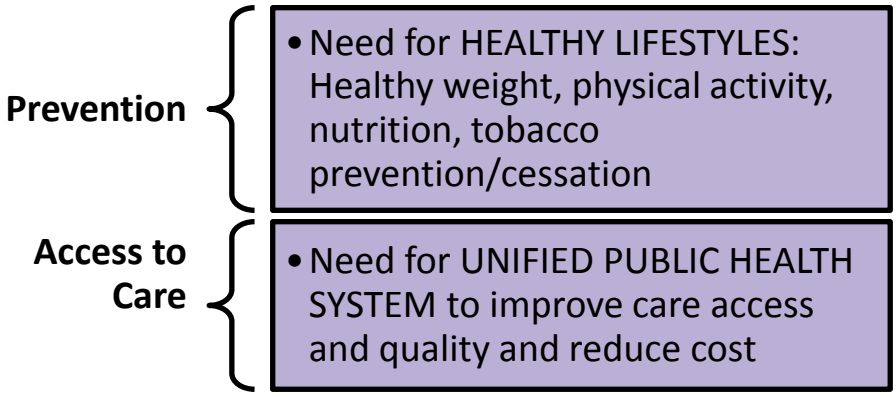
6. Importance of healthcare education focused on prevention especially among vulnerable populations with socioeconomic disparities

7. Alarming increases in obesity and related factors such as physical inactivity and poor nutrition

8. High tobacco use and its impact on chronic disease

With strategic, overarching goals of prevention and improved access to health services,[37] the cost and accountability of meeting the mounting needs of the medically uninsured and underserved[38] will be shared among stakeholders.

Figure 2:
Target areas of change: **Basis of Implementation Strategy & Community Benefit Plan**[39]



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[36] Paulding County Key Informant Interview Report. Appendix, page 53.

[37] These goals are also Healthy People 2020's top two health indicators – high priority health issues representing significant threats to the public's health. Source: U.S. Department of Health & Human Services website: healthypeople.gov. Link to http://healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020_brochure_with_LHI_508.pdf

[38] U.S. Department of Health and Human Services Health Resources and Services Administration: *Medically underserved (people) who face economic, cultural or linguistic barriers to health care.* www.hrsa.gov/shortage.

[39] Based upon the Cobb2020 findings for its Community Improvement Plan, 2012.

Prevention/Healthy Lifestyles:

Preventive care helps reduce the risk factors for approximately half of morbidity and mortality.[40]

1. *Primary prevention*– Avoids health issues by behavior and lifestyle modifications[41]
2. *Secondary prevention* – Provides education and resources for disease management / control
3. *Tertiary prevention*– Manages complications to avoid unnecessary healthcare

Access to Care *(through a seamless continuum of care):*

1. Connects vulnerable populations to care by building community capacity to serve and cooperate to achieve a synergistic, cost-efficient model of care
2. Reduces health disparities through improved access to primary care physicians and other specialty medical services to vulnerable populations
3. Educates the community about available health resources and facilities to serve the medically uninsured and underserved

Conclusion:

WellStar Paulding Hospital's CHNA laid the groundwork to:

- Achieve a high level of success at population health management by identifying pressing health needs that have the most influence on improving health outcomes and lowering healthcare costs.
- Transform the care delivery model by building collaborative coalitions to help navigate and deliver care to best serve the needs and improve the health of the community, especially its vulnerable populations.

A prevention and access to care focus leans on the local public health system and community stakeholders for expertise and multiplication of efforts. It also aligns with and supports the Affordable Care Act strategy, its National Prevention Strategy[42] and the National Quality Strategy Framework.

# # #

[40] Despite spending more than twice what most other industrialized nations spend on health care, the U.S. ranks 24th out of 30 such nations in terms of life expectancy. A major reason for this startling fact is that only 3 percent of our healthcare dollars is spent on preventing diseases (as opposed to treating them), when 75 percent of our healthcare costs are related to preventable conditions.

[41] The World Health Organization estimates that 80 percent of all heart disease, stroke, and type 2 diabetes, as well as more than 40 percent of cancer, would be prevented if Americans would stop using tobacco, eat healthy and exercise. From the Harvard School of Public Health slide on the cost of non-communicable diseases.

[42] http://www.surgeongeneral.gov/initiatives/prevention/strategy/

Introduction 2

Data and thematic analysis from the Community Healthcare Needs Assessment (CHNA) report revealed a mounting responsibility and opportunity to proactively meet healthcare needs, improve the overall health of the community and offset government expense of caring for the uninsured and underserved in the community.

WellStar Paulding Hospital leadership and community collaborators worked to uncover the barriers to care and to assess the community health status and needs with the goal of coordinating its efforts for evidence-based practices and outcomes for the medically uninsured and underserved.

This written report is foundational to redesigning how preventive healthcare is delivered and accessed in the WellStar Paulding Hospital community for this population. The hospital's role is integral to leveraging its broad reach and history in the community and working with and supporting the efforts of the local public health system.

With healthcare providers working at the height of their licensure within a new community benefit model of coordinated and accessible care, achieving better health outcomes at lower costs to vulnerable populations is attainable.

Community benefit activities must have accountable oversight and integrate into the hospital's overall strategic planning process. WellStar Health System's senior management team, WellStar Paulding Hospital's President Mark Haney, Board of Trustees, the Paulding County Hospital Authority, WellStar Paulding Regional Health Board and Foundation Boards continually evaluate the community's emerging needs to improve accessibility and quality delivery of healthcare, education and services.

Community Served 3

Community Defined, Determined and Described:

WellStar Paulding Hospital determined the definition and scope of its community served in two ways:

1) Assessing the zip codes of community members with hospital admissions / visits in 2012. *This determination is data-driven rather than a geographically-driven. Compiling service statistics provides an unequivocally accurate snapshot of the community served.*

2) Assessing the zip codes within the hospital's pre-determined market determined by the geographic area served by the hospital, known as WellStar Paulding Hospital's primary service area.

*WellStar Paulding Hospital's primary and secondary service areas (see Table 4) are not exclusive of "pockets of poverty" - low-income and medically underserved populations. If so, it would be contrary to WellStar Health System's mission to create and deliver high quality hospital, physician and other healthcare related services that improve the health and well-being of the individuals and communities we serve. This includes uninsured and medically underserved populations.

More than 10 percent of all healthcare provided by WellStar Health System in fiscal year 2012 was to the medically uninsured providing nearly $100 million in charity care. More than $5 million of this care was delivered at WellStar Paulding Hospital.

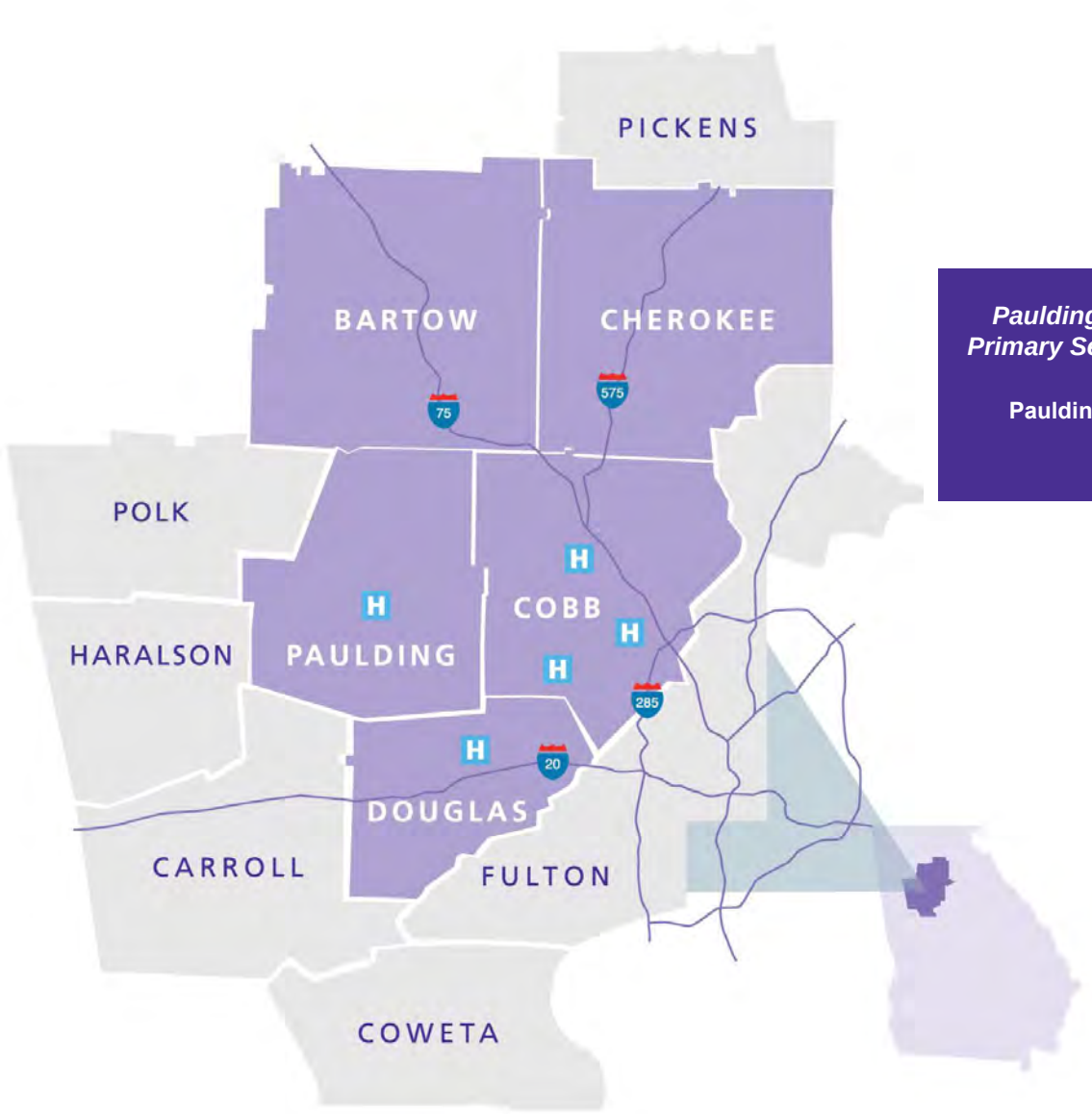
The target populations assessed include both vulnerable populations and the top chronic disease needs of the community. Methods to uncover the health needs of WellStar Paulding Hospital's targeted populations included secondary data gathering and well-informed input from multi-sectorial representatives of the community serving these people groups.

As expected, most community members came from zip codes within the hospital's pre-determined market determined by geographic proximity. WellStar Paulding Hospital primarily serves the geographic area comprising Paulding County, its primary service area. *(The area is represented by zip codes and includes cities outlined below in Table 4.)* Surrounding counties inside and outside other designated WellStar hospital service areas also utilize WellStar Paulding Hospital's services (known as the secondary service area).

Last year, WellStar Paulding Hospital delivered care during 77,712 inpatient admissions and outpatient visits. Out of the grand total, 70,689 represented 90 percent of all admissions and visits from 10 zip codes.

Map 1:

Primary Services Area – County Map



Paulding Hospital Primary Service Area:

Paulding County

As part of an integrated health system,[43] WellStar Paulding Hospital's overlap with other WellStar hospitals is common (see Map 2). This cross-over's impact is not easily determined by a county by county analysis, but all are included within a health system-wide community benefit program (see Map 3). .

[43]See WellStar's 2012 Community Benefit Report: http://wellstar.org/about-us/documents/wellstar-community-benefits-report.pdf

Map 2:

WellStar Paulding Hospital Service Area Overlap

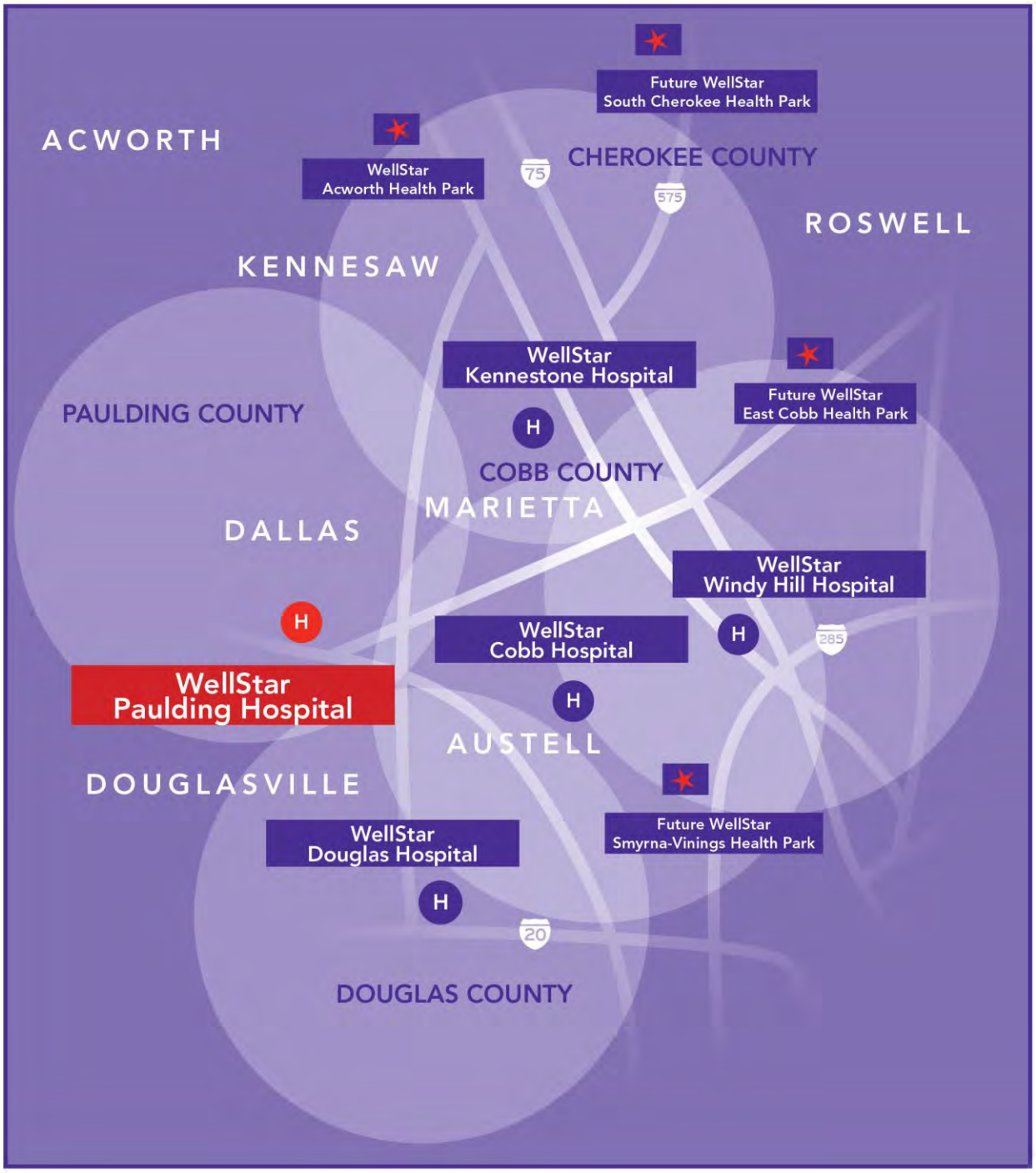


Table 4:

WellStar Paulding Hospital Primary Service Area[44]

COUNTY	CITY	ZIP CODE	2012	2017
Paulding	Dallas	30132	33,538	38,977
		30157	48,732	55,837
	Hiram	30141	23,170	26,452

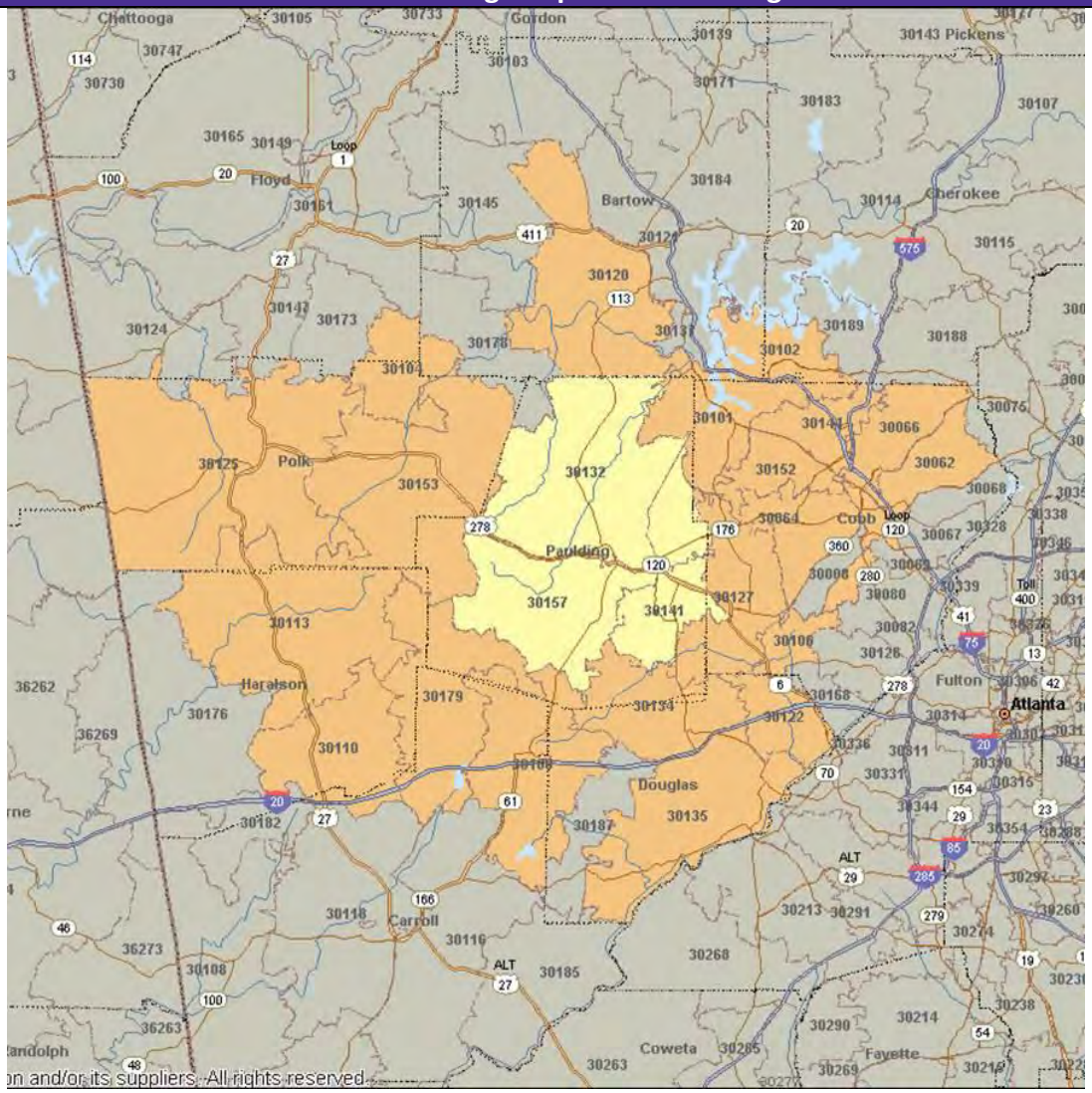
WellStar Paulding Hospital Secondary Service Area

COUNTY	CITY	ZIP CODE	2012	2017
Bartow	Cartersville	30120	38,863	42,004
Carroll	Temple	30179	17,817	20,226
	Villa Rica	30180	36,570	42,368
Cherokee	Acworth	30102	37,629	39,542
Cobb	Acworth	30101	58,499	65,453
	Austell	30106	21,375	22,589
	Kennesaw	30144	52,556	55,797
		30152	42,975	47,722
	Marietta	30060	34,082	33,431
		30062	62,333	63,811
		30064	45,384	47,268
		30066	55,048	57,286
	Powder Springs	30127	62,055	67,500
Douglas	Douglasville	30134	44,084	48,341
		30135	64,564	72,389
	Lithia Springs	30122	24,210	26,482
Haralson	Bremen	30110	12,924	13,555
	Buchanan	30113	6,690	6,986
Polk	Aragon	30104	4,616	4,828
	Cedartown	30125	24,320	24,838
	Rockmart	30153	18,960	20,720

[44] Internal WellStar Health System data, April 2013.

Map 3:

WellStar Paulding Hospital Patient Origin[45]



Total population:

The total population for Paulding County in 2012 was 151,046[46] with a projected 2017 population of 174,782. According to the 2010 Census, Paulding County experienced the largest population boom with a 74.25 percent increase from the 2000 Census.

[45]Source: Internal WellStar Health System data, April 25, 2013.

[46]U.S. Census Bureau Quickfacts. Updated March 2013 & 2010 Census 2006-2010, American Community Survey 5-Year Estimates. Source: Kaiser Permanente's CHNA Data Platform, March 2013. Unless noted, other statistics come from same source, but are based on a three county population total of 971,612 not current 2012 estimated population.

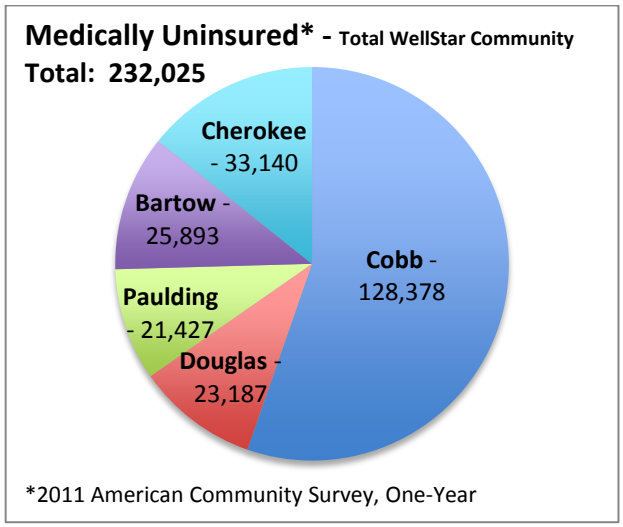
WellStar Paulding Hospital Targeted Vulnerable Populations:

These population groups include those identified by Key Informants as groups affected by health disparities. ***Designates the targeted population as also a priority population of the Agency for Healthcare Research and Quality.*[47]

➢ Impoverished

- **Uninsured** - 18 percent of the people residing in Paulding County under the age of 65 are uninsured which is well above the national benchmark of 11 percent and within close range of Georgia at 22 percent.[48]

  Low-income populations generally are uninsured and have less access to primary care and therefore a lack of access to broader healthcare services including specialty care and outpatient procedures. Even among individuals with private insurance coverage, those with low incomes were less likely to have regular healthcare providers and less likely to access preventive care.



- **Underserved** – The medically underserved are people that face multiple barriers to primary care including lack of insurance and associated financial difficulties, language and culture, transportation as well as lack of access to physicians willing to treat them.[49] Access to care issues due to being uninsured or stemming from barriers such as language, legal status or lack of education about available resources were frequently cited in Key Informant interviews. Paulding County ratio of population to primary access is the highest in the WellStar Health System service area at 7,933:1.

  Another measure of an underserved community is the percentage of population ages five and older who speak a language other than English at home or speak English less than "very well." This is not a dominant issue in Paulding County ranks below state and national averages at 1.88 percent.

[47] See www.ahrq.gov

[48] Data from *County Health Rankings.* www.countyhealthrankings.org. April 2013.

[49] National Association of Community Health Centers, The Robert Graham Center, and Capital Link." *Access Denied: A Look at America's Medically Underserved*. August 2007. www.nachc.com/research-reports.cfm.

***Low-income** – This indicator is relevant because poverty creates barriers to access including health services, healthy food and other necessities that contribute to poor health status.

Measured by living below 200 percent of the Federal Poverty Level (FPL) – *thresholds set based on size and age of family members:* In Paulding County, 24.22 percent of people are living under 200 percent of the FPL.[50]

Poverty is directly correlated to poorer health outcomes. According to a Cobb2020 report, children and adults with incomes at or below the poverty line often face issues including inadequate nutrition, substandard housing, environmental hazards, unhealthy lifestyles, and decreased access to and use of healthcare services.

- **Children***

School-aged children under 18 make up 26.97 percent of total four-county population ranking higher than state and national percentages.[51] This is a notable opportunity area to impact the population with health education and prevention.

County Health Ranking cites 16 percent as the number of Paulding County children living in poverty.[52] This is another notable indicator of the need for better education and access to care.

- **Women:***

Key influencers: Women make approximately 80 percent of the healthcare decision for their families and utilize most health services due to reproductive health accounting for 60 percent of all expenses incurred at doctors' offices in 2004.[53]

Breast cancer prevalence in Paulding County (118.60 per 100,000 population)[54] closely reflects state and national levels.

- **Overweight/Obese:**

26 percent of the population in Paulding County ages 18 and under self-reports a Body Mass Index (BMI) of more than 30 signifying obesity. A higher number of adults – 36.29 percent - report being overweight (BMI between 25-30).

- **Smokers:**

Tobacco use in adults is high in Paulding County at 20 percent. This is a notable and measureable area of opportunity especially via smoking cessation programs in primary care offices, the community and

[50] U.S. Census Bureau, 2006-2010 American Community Survey, 5 Year Estimates.

[51] *County Health Rankings*, April 2013 - Census Bureau's Population Estimates Program
[52] Percentage living below 100 percent Federal Poverty Level.

[53] United States Department of Labor, General Facts on Women and Job-Based Health, http://www.dol.gov/ebsa/newsroom/fshlth5.html

[54] *County Health Rankings*. Source: The Centers for Disease Control and Prevention and the National Cancer Institute, State Cancer Profiles, 2005-2009.

schools. Smoking is a leading contributor to cancer, especially lung cancer, the leading cause of cancer mortality in Paulding County.

Also, tobacco use is a contributing factor to the high incidence of vascular/heart disease, the leading cause of death in all counties served by WellStar Health System (see Table 5). 16 percent of the deaths in Georgia (from 2003-2007) among adults age 35 and older from 2003-2007 were attributed to smoking with deaths resulting from cardiovascular disease (30 percent), respiratory diseases (27 percent) and cancer (43 percent.)[55]

- **Under-educated:**

The county has a 76 percent on-time graduation rate[56] which is below the 82.4 percent Healthy People 2020 Target[57] and above the state of Georgia and national rate of 67.80 and 75.50 respectively.

A glaring health disparity is associated with low education attainment. The years of schooling a person has is linked with health knowledge and behaviors, employment and income, and social and psychological factors. Individuals with higher education are likely to have a longer life span, to have better health outcomes and to practice healthy behaviors.

- **Physically Inactive:**

23.80 percent of people in Paulding County are physically inactive. When physical environments factors are reviewed by County Health Rankings, access to recreational facilities is lacking and falls below the national benchmark of 16 with 11.2 facilities per 100,000 population.[58]

- **Unhealthy Diet/Lack of Nutrition:**

74.60 percent of Paulding County residents over 18 years of age surveyed reported eating less than five servings of fruits and vegetables per day surpassing state and national averages by almost 10 percent.

- **Chronic disease population:**[59] ***Reflects leading causes of death in the community served***

More than one in four Americans have multiple (two or more) concurrent chronic conditions (MCC),[60] including, for example, arthritis, asthma, chronic respiratory conditions, diabetes, heart disease, human

[55]From Georgia Department of Public Health, 2012 Georgia Tobacco-related Cancers Report. Source: http://health.state.ga.us/pdfs/epi/Tobacco-Related%20Cancer%20Report_111612.pdf.

[56] The University of Wisconsin, Population Health Institute, County Health Rankings, 2012 and the U.S. Department of Education, National Center for Education Statistics, Common Core of Data, Public School Universe Survey Data, 2005-6, 2006-7 and 2007-8.

[57]Healthy People 2020 benchmarks established by the U.S. Department of Health & Human Services.

[58]Data Source: County Business Patterns provides data on the total number of establishments, mid-March employment, first quarter and annual payroll, and number of establishments by nine employment-size classes by detailed industry for all counties in the United States and the District of Columbia.

[59]Chronic illnesses are "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living." Warshaw G. *Introduction: advances and challenges in care of older people with chronic illness*. Generation 2006; 30(3):5-10.

immunodeficiency virus infection, and hypertension. In addition to comprising physical medical conditions, chronic conditions also include problems such as substance use and addiction disorders, mental illnesses, dementia, and other cognitive impairment disorders.

- *__Heart disease__: Heart disease is the overall leading cause of death in the community served. Paulding County surpasses the national and state percentages of heart disease prevalence at 5.12 percent.[61] Health behaviors such as smoking, obesity, physical inactivity and poor nutrition are contributing factors to heart disease.

- ***Cancer:** Lung cancer is second leading cause of cancer death in the primary service area. Lung cancer incidence is high in Paulding with the age-adjusted incidence rate at 93.90 per 100,000 population. Cancer (all types) mortality in Paulding County is above the Healthy People 2020 target (< =160.6) and current Georgia and United States levels at 191.50 per 100,000 population. The age-adjusted incidence of colon cancer in Paulding County is above the Healthy People 2020 benchmark (<38.6) and above the state statistic at 53 cases per 100,000 population. Prostate cancer incidence ranks lower than in other WellStar Health System counties served.

- ***Stroke:** Stroke (cerebrovascular disease) is the fourth leading cause of death in the community served (see Table 5) and a byproduct of unmanaged hypertension which can be related to physical inactivity and obesity. The age-adjusted death rate from stroke per 100,000 population[62] in Paulding is 44.8, above the Healthy People 2020 benchmark (<33.8).

- **Diabetes:** The percentage of adults age 20 and older with a diabetes diagnosis is 10.9 percent in Paulding County.[63] The statistics don't take into accounting the daunting number of undiagnosed diabetes (7 million) and people with prediabetes (79 million) in the United States,[64] specifically type 2, in obese children and adults, a prevalent health factors in the community served.

  As diabetes is a cardiovascular disease, it increases the risk of death from heart disease or stroke two to four times higher than in people without the chronic disease.

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[60] As the number of chronic condition in an individual increases the risks of the following outcomes also increase: mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice. The resource implications for addressing MCC are immense: 66 percent of total health care spending is directed toward care for the approximately 27 percent of Americans with MCC and is a key factor in the overall growth in spending on American's healthcare. *Citation:* U.S. Department of Health and Human Services. *Multiple Chronic Conditions-A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions*. Washington, DC. December 2010.

[61] People over the age 18 who have been told they have angina or heart disease.

[62] *Source:* OASIS, Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Causes of Death, 2006-2010. Accessed through CDC WONDER.

[63] County Health Rankings Data Source: The National Diabetes Surveillance System provides county-level estimates of obesity, physical inactivity, and diabetes using three years of data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau's Population Estimates Program.

[64] 2011 National Diabetes Fact Sheet uses both *fasting glucose and A1C levels* to *derive estimates for undiagnosed diabetes and pre-diabetes*. From the American Diabetes Association website: http://www.diabetes.org/diabetes-basics/diabetes-statistics/.

Table 5: Top Five Leading Causes of Death[65]	
Paulding	
1	Heart Disease
2	Lung Cancer
3	Chronic Obstructive Pulmonary Disease
4	Stroke
5	Mental and Behavioral Disorders

Table 6: Community-Specific Demographics			
	Paulding	**Georgia**	**U.S.**
Years of Potential Life Lost (YPLL)[66] - Premature Death	7,465	8,050	7,131
Total population **2012 estimates from the US Census Bureau*	151,046	9,919,945	303,956,271
Female	50.99%	51.14%	50.85%
Median age	33.90	35	26.90
Age 65 or older	6.71%	10.26%	12.75%
Linguistically isolated population: *Language other than English spoken at home*	1.88%	5.87%	8.70%
Georgia School District rankings[67] *Interesting disparity between county and city school rankings*	Paulding County: #78/164	n/a	n/a

Unless noted, county-specific data sourced from the Kaiser Permanente CHNA Data Platform, April 2013.

[65] Georgia Department of Public Health statistics, *Ranked Causes and State/County Comparisons, Age-Adjusted Death Rate, Last 5 Year Aggregate*(National Center for Health Statistics), OASIS, CHNA Dashboard.

[66]YPLL before age 75 per 100,000 for all causes of death age adjusted to the 2000 standards. This measure provides a unique look at health status of a community. Centers for Disease Control and Prevention, National Vital Statistics System, 2008-2010 (as reported in the 2012 County Health Rankings).

[67]Source: National Center for Education Statistics, U.S. Dept. of Education and Georgia Department of Education.

Internal:

Allen M. Hoffman, MD, Executive Director, WellStar Community HealthCare, spearheaded WellStar Health System's Community Health Needs Assessment (CHNA) process commencing in the fall of 2010. Using the aforementioned MAPP process and other primary and secondary data gathering methods to meet assessment requirements, Dr. Hoffman was a catalyst for engaging the local public health systems and recruiting community health stakeholders from all five counties for the five non-profit, community-based hospitals in the WellStar Health System service area.[68]

Dr. Hoffman served in multiple capacities including Cobb MAPP Steering Committee member representing WellStar Health System hospitals and as a Cobb2020 advisory group member providing assessment oversight and team member in assessment workgroups. He also procured and managed third-party consultants to help generate a wider base of community input and was assisted in the strategic planning process by Caroline Aultman, Executive Director of Strategic Planning, WellStar Health System. Dr. Hoffman reports to Robert Jansen, MD, Senior Vice President, WellStar Medical Group President and Chief Administrative Medical Officer.

The WellStar Health System CHNA Steering Committee, representing WellStar Paulding Hospital, met from December 2012 to June 2013 to provide assessment input and oversight. Committee members included Kim Menefee, Senior Vice President, Public and Governmental Affairs; Dr. Hoffman; Jimmy Swartz, Vice President, Accounting; Ebenezer Erzuah, Director of Reimbursement; and David Englett, Reimbursement Project Manager.

External:

Input from numerous people representing the broad interests of the five-county WellStar Health System community and who have a robust knowledge base concerning healthcare needs and disparities were sought to provide:

- Expertise in local and state public health
- Resources- current data and relevant information regarding community health needs
- Advocacy and leadership for the targeted, vulnerable populations - medically underserved, low income, chronic disease, and minority groups

[68] See WellStar Health System's website for a list of hospitals and other locations: http://www.wellstar.org/locations/pages/default.aspx

These community-based representatives from organizations and public health / government agencies, community representatives of high need populations and third party consultants represented a wide array of sectors including:

Local and state health departments	National health agency
Health care systems / hospitals	Employers
Children's health	Community health centers
Health providers	Pharmaceuticals
Community-based coalitions	Minority organizations
Behavioral health	Education
Parks and recreation departments	Faith-based organizations
Senior services	Transit services
State public health	Economic Development
Fire, Police, Corrections	Mass Transit
Schools	Civic Groups
Managed Care organizations	Elected Officials

Cobb2020:

Originating from Cobb & Douglas Public Health's MAPP strategic process, Cobb2020 was funded by a five-year federal Community Transformation Grant[69] to help transform the health of the community with a focus on chronic disease. In addition to Cobb2020's sphere of influence on the health needs assessment process led by Jay Dillon, Director of Communications for Cobb County School District and Jack Kennedy, MD, MBA,[70] District Health Director, Cobb & Douglas Public Health, additional collaborators conjoined multiple layers of public health data and shared expertise, experience and input regarding health needs and community benefits programming. They also developed questions for MAPP focus groups, Key Informant interviews, surveys, and, along with a sampling of Cobb2020 partner representatives, hosted four local public health system days.

Paulding County:

In January 2013, representatives of the Paulding County Health Department – Northwest Georgia Public Health were presented key Cobb2020 MAPP findings in which they concurred aligned with the health needs of their counties. Public health officials provided a list of well-informed key stakeholders in order to supplement data with county-specific Key Informant interviews. Key informants included representatives from the county senior center, transit services, school district, juvenile court, and children's health.

Public Health debriefings on the findings were held in April 2013 with Paulding County Health Department representatives, Northwest Georgia Public Health Director C. Wade Sellers, MD, MPH; and Paulding County Nurse Manager Teresa Knight, RN, PHNS.

[69] Appendix: CDC Community Transformation Grant Awards – map of recipients, page 57.

[70] Dr. Kennedy, as District Health Director 3-1, Cobb & Douglas Public Health, has been a driving force behind the MAPP process for purposes of Cobb/Douglas accreditation from the independent accrediting body, Public Health Accreditation Board (PHAB).See http://www.cdc.gov/stltpublichealth/accreditation/. The ACA and PHAB are aligned in their goals and outcomes to engage community stakeholders to perform a community health assessment, identify priority health issues and develop a community health improvement plan/implementation strategy for community benefit.

To reference CNHA collaborators, their names, titles, represented organizations or agencies, capacities served and a description of expertise/focus, see Appendix – page 58.[71]

Areas of collaboration:

- **MAPP partners/steering committee and implementation team members**:
  Influential health and community leaders within Cobb and Douglas County served as partners/steering committee members and on the *Access to Health Services* implementation team for Cobb2020's MAPP strategic process. They represented different sectors of the Douglas community including public health, healthcare providers, community clinics, higher education, transportation, employers, faith-based and non-profits organizations, and government.

- **Paulding Key Informants (KIs):**
  Key Informants from Paulding County were identified by representatives from the county health department. The survey instrument was a slightly modified version of the one developed and validated in Cobb County.[72]

- **Cobb2020 Advisors/Steering Committee:**
  Organization and individual partners/key leaders from many parts of the community on a state, regional and local level who contributed resources and time to the Cobb MAPP process.

- ***Community Strengths and Themes Workshop*** **participants'** (one of the four community assessments conducts by MAPP) work resulted in the Cobb2020 focus group report.

- **Cobb and Douglas MAPP Implementation Teams -** ***Healthy Lifestyles*** **&** ***Access to Health Services*** formed in the summer 2012 worked to improve access to quality services for the medically underserved population in Cobb and Douglas counties.

- **Cobb MAPP Survey Committee Members**-Developed the 44-question telephone survey conducted by Kennesaw State University's A.L. Burruss Institute for Public Service and Research polling 1,244 adults ages 18-94.

- **Community Transformation Grant (CTG) Leadership Team** gave oversight to the grant awarded from the Centers for Disease Control and Prevention (CDC) in October 2011 to Cobb & Douglas Public Health in support of community level efforts to reduce chronic disease such as heart disease,

[71] Appendix: List of WellStar CHNA Collaborators, page 58.

[72] Appendix: Key Informant Report from Paulding County, page 53.

cancer, stroke, and diabetes. The CTG promotes healthy lifestyles especially to population groups experiencing the greatest burden of chronic disease, to improve health, reduce health disparities and control healthcare spending.

- **The *Forces of Change* Assessment** Day (Sept. 30, 2011) and ***Local Public Health Systems*** Assessment Day (Oct. 4, 2011) community participants. Attendee rosters are included in the appendix.[73]

- **WellStar Health System Advisors** - Senior leadership representing WellStar's five non-profit, community-based hospitals.

[73] Appendix, page 72.

Data Collection, Process and Methods 5

WellStar Paulding Hospital's more than two-year process for gathering information involved integrating multiple sources of data from national and state web-based data platforms with multiple primary data gathering methods.

As a partner in the strategic planning process utilized by Cobb & Douglas Public Health (CDPH), Mobilizing for Action through Planning and Partners (MAPP),[74] the hospital leveraged the findings from community health needs assessments conducted in 2012. A substantial part of Cobb MAPP findings were agreed to be generalizable following a CDPH presentation in January 2013 to representatives of the District and County Public Health Departments for Paulding County.

WellStar Paulding Hospital expanded its reach by using a slightly modified version of an interview instrument developed and validated in Cobb and Douglas counties for its Key Informant interviews. The representatives agreed to identify well-informed key stakeholders for interviews by a third-party consultant.

In April 2013, the Key Informant report reviewed and confirmed to be an accurate snapshot of the health, quality of life, barriers to health, primary conditions of concern, disparately affected populations, and key actions, policies and funding priorities for Paulding County.

Table 7:
Description of WellStar Health System CHNA Data Sources and Dates

Source	Data Description	Date(s) Accessed or Conducted
Secondary Data		
Georgia Department of Public Health	OASIS – Online Analytical Statistical Information System – tool for public health and public policy data analysis *http://oasis.state.ga.us/oasis/*	2012-2013
Centers for Disease Control and Prevention (CDC)	National Vital Statistics System	2011-2013
Agency for HealthCare Research and Quality (ADRQ) – U.S. Department of Health and Human Services	Identifies preventive service and interventions| *www.ahrq.gov* Quality indicators: *www.qualityindicators.ahrq.gov/pqi_overview.htm*	2011-2013
WellStar Health System	Hospital utilization data for the community served	March 29, 2013

[74] MAPP is designed to improve public health and a method to help communities prioritize public health issues, identify resources for addressing them, and take action. The MAPP tool was created in 2001 by a workgroup of local public health practitioners and several national partners including the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Since its creation, over 700 local health departments have implemented the MAPP process and over 300 have successfully shown improvements in community health as a result of their initiatives.

Source	Data Description	Date(s) Accessed or Conducted
U.S. Department of Health and Human Services	Community Health Status Indication Report	2011-2013
Healthy People 2020	Healthy People 2020 provides national benchmarks for health indicators | *www.healthypeople.gov*	2011-2013
Behavioral Risk Factor Surveillance System (BRFSS)	Data on health risk behaviors, preventive health practices and health care access | *www.cdc.gov/BRFSS*	2011-2013
National Health and Nutrition Examination Survey	Assessment of the health and nutritional status of adults and children | *www.cdc.gov/nchs/nhanes.htm*	2013
Kaiser Permanente Web-Based CHNA Platform	A web-based resource to facilitate community health needs assessments and foster community collaboration. *www.chna.org/kp*	2013
County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute	The *County Health Rankings & Roadmaps* program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The web-based data provided rankings of counties in the community served.	2013
Catholic Health Association	*Assessing and Addressing Community Health Needs* – discussion draft document outlining the CHNA process	March 2011
Primary Data		
Cobb/Douglas MAPP Assessments	Results of four assessments facilitated by Cobb2020: Examined: • Community Strengths and Themes • Forces of Change • Community Health Status • Local Public Health System	2012
Cobb MAPP Focus Groups	58 people participated in six focus group representing 14 zip codes. Demographics varied among the groups indicative of the zip codes represented. Two groups were conducted in Spanish and reflected low-income, low education attainment and medically underserved populations. Conducted by the Cobb and Douglas Public Health Department and Cobb MAPP. Facilitated by Kennesaw State University Associate Professors Drs. Anne Hicks-Coolick and Janice Long. Rosana Farias Ayala, KSU Spanish lecturer, served as translator and data transcribe for two of the groups with a high Spanish-speaking population.	June 21, 2012 – Sept. 13, 2012 *Report published:* October 2012
Cobb Key Informant Interviews	20 participants were identified by Cobb 2020's *Community Strengths and Themes* Workgroup to represent different sectors of the Cobb community who are well-informed regarding healthcare issues, the healthcare system or the community.	2012
MAPP Community Survey – Cobb *(Douglas MAPP conducted a Key Informant online survey)*	44-question telephone surveys of 1,244 adults ages 18-94 performed by the A.L. Burruss Institute for Public Service and Research, Kennesaw State University revealed: ▪ 16.9 percent No Health Insurance ▪ 26 percent High Blood Pressure ▪ 11.8 percent Smoking	Nov. 21, 2011 – Jan. 19, 2012

	▪ 32.9 percent High Cholesterol ▪ 19.1 percent No Exercise ▪ 36 percent Overweight ▪ 22.3 percent Obese ▪ 26.7 Average BMI ▪ Health Disparities	
Source	**Data Description**	**Date(s) Accessed or Conducted**
Cobb & Douglas Public Health: Cobb County Health Policy Scan Report	Report addressing: ▪ tobacco free living ▪ active living and health eating ▪ increased use of high-quality clinical preventive services ▪ social and emotional wellness ▪ healthy and safe physical environment	August 16, 2012
WellStar Health System	WellStar Paulding Hospital's FY2012 utilization data to assess service area zip codes accounting for 90 percent of hospital admissions and visits and maps	March 2013
Paulding County Key Informant interviews	Five community stakeholder interviews identified by local public health officials led by Ron Chapman, Principal, Magnetic North, LLC, a third-party consultant	March 2013

Description of Analytical Processes Applied to Identify Community Health Needs

1. **MAPP strategic process using the "Action Cycle"**- designed to plan, implement and evaluate for sustainable health improvement.

   As a community-wide health improvement process, WellStar Paulding Hospital's involvement in Cobb2020's MAPP process demonstrated community collaboration and accomplishes the following:

   - Includes a comprehensive assessment phase that identifies local public health strengths, challenges, and unmet healthcare needs;
   - Emphasizes primary prevention;
   - Strengthens partnerships among healthcare providers, public health professionals, and other stakeholders;
   - Mobilizes community members to identify and act on strategic health issues; and
   - Institutionalizes a collaborative approach to planning, implementing, and evaluating community health improvement strategies.[75]

   MAPP workgroups, focus groups, survey, Key Informant interviews, and implementation teams identified strategic issues in the community served via four assessments portrayed in the MAPP "Action Cycle" (Figure 3).

[75]National Association of County & City Health Officials (NAACHO) Fact Sheet, July 2010: *MAPP and Non-Profit Hospitals: Leveraging Community Benefit for Community Health Improvement.*

Figure 3:
MAPP "Action Cycle" / Assessments

From the MAPP strategic process using the four assessments, the following key issues and themes were revealed:

Table 8:
MAPP Assessment and Emergent Themes

Assessment Focus Areas	Key issues to uncover	Emergent Themes
Community Themes and Strengths[76] *(Prevalent health issues)*	• What is important to the community? • How is quality of life perceived in the community? • What assets exist that can be used to improve community health?	Community needs to be educated and informed about health issues. Education and transportation were identified as a top needs. Existing collaborative organizations and community cooperation were cited as a plus to improving care.
Local Public Health system[77] *(Availability of health services)*	• What are the components, activities, competencies, and capacities of the local public health system?	Community needs affordable and accessible access to healthcare and services. ***(Paulding County Key Informants noted gaps in pediatric and specialty services and the need for more no***

[76] Appendix: Top Communities Issues graph: page 50.

[77] Appendix: Local Public Health System Assessment (LPHSA) chart: page 77.

	• How are the essential services being provided to the community?	***or low cost medical options.)*** Clinics are not located in many areas and are overcrowded. Most, if not all, of the health disparities cited by WellStar community stakeholders were attributed to low income, low educational attainment, lack of care access and education, and being medically underserved and uninsured. Unhealthy behaviors lead to unfavorable health outcomes, which greatly affect morbidity and mortality rates[78] among these populations.
Community Health Status *(Health issues important to the community)*	• How healthy is the community? • What does the health status of the community look like?	Community has barriers to seeking healthcare due to lack of information, insurance/finances and education. Chronic disease is prevalent due to unhealthy lifestyles and limited access to care.
Forces of Change[79] *(Things that affect the context in which the community and its public health system operate)*	• What is occurring or might occur that affects the health of the community or the local public health system? • What specific threats or opportunities are generated by these occurrences?	Forces that affect the local public health system: ▪ *Health inequity* ▪ *Transient population* ▪ *High-risk behaviors* ▪ *Lack of access to quality care and education* ▪ *Technology infrastructure for healthcare* ▪ *Unstable economy* ▪ *Public policies* ▪ *Aging population*

2. **Thematic analysis**: Conducted by categorizing qualitative data to discover patterns and emergent themes (frequently mentioned topics, issues or needs).The results, coupled with statistical data, helped inform community needs and, along with quantitative data revealed health disparities.(Health disparities were assessed by socioeconomic status, geography, language barriers from ethnicity, access to care, and age.)

   This analytical process was used to assimilate primary data gathered via key informant interviews, community surveys and focus groups upon review of the notes, survey results or recorded transcripts. Through Kaiser Permanente's CHNA Data Platform, *County Health Rankings* and other national and Georgia-specific web-based tools, robust secondary data provided statistical evidence to primary data thematic analysis.

3. **Establishment of baseline data points:**

   - Core health indicators (see below)
   - Health drivers (uninsured, low education attainment and living in poverty)

[78] Many of these indicators reflect the Healthy People 2020 Leading Health Indicators which represent significant threats to the public's health. For a more exhaustive list of indicators to gather additional community statistics, see Appendix, page 75.

[79] Appendix: Forces that impact community health: page78.

- Model of population health to identify prioritized community health needs

This enabled assessors to compare the prevalence of chronic disease to selected indicators (ex: physically inactive people in Paulding County) with health outcomes (ex: high rates of obesity and premature death in Paulding County) to identify health needs.

Using an evidence-based population health model[80] helped WellStar Paulding Hospital assign assessed community needs to health factors and outcomes that, when addressed in an implementation strategy, will improve the community's health outcomes[81] summarized by morbidity (quality of life) and mortality (length of life/measured by premature death).

4. **Strategy Grid data processing tool** for assessing the local public health system was used by Cobb2020 collaborators.[82] This method facilitates refocusing efforts by shifting emphasis toward addressing problems yielding maximum results with limited resources. This is accomplished by categorizing and prioritizing findings in high and low performance and priority quadrants.

Rationale for Core Health Indicators:

When selecting core indicators for the assessment the following were considered:

- Indicators with national benchmarks
- Indicators which reflect issues of known importance to the community generated from primary data gathering
- Indicators which inform about target geographic areas, priority populations and social determinants of health
- Quality and usability of data indication

Selected indicators are organized using the University of Wisconsin's Population Health Institute's model and include socio-economic factors affecting health which are directly associated with unhealthy behaviors.

The indicators used combine some of the Cobb MAPP indicators with the hospital's chosen indicators reflecting those included in the County Health Rankings and the CHNA Data Set. Assigning recent statistical findings to the indicators supported gathered qualitative data and in the future will enhance WellStar Paulding Hospital's ability to track progress and measure success.

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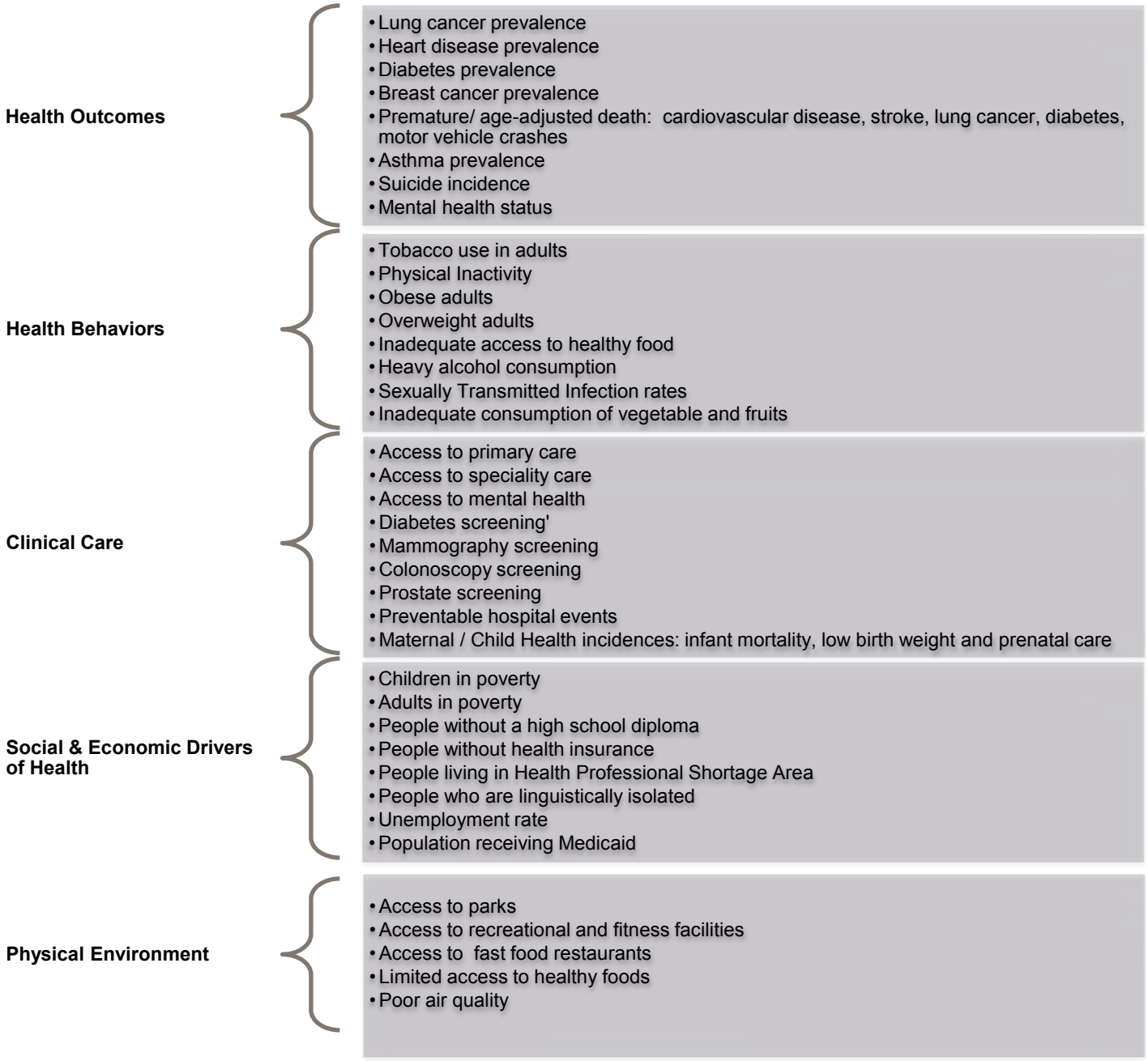
[81] Health outcomes are snapshots of diseases in a community that can be described in terms of morbidity and mortality. They are measurable health indicators that may be used to identify and prioritize health needs. Catholic Health Association (March 2011) *Assessing & addressing community health needs.*

[82] Appendix: Local public health system assessment – priority/performance strategy grid, page 78.

Figure 4:

Core Health Indicators[83]

Organized using the Population Health Model



The list of common indicators were measured and compared to state and national benchmarks to identify the community's health status, assess health needs and determine gaps in care. Supplemented with primary data by engaging the MAPP process, community leaders, residents and key informants, the

[83] "A characteristic of an individual, population or environment which is subject to measurement and can be used to describe one or more aspects of the health of an individual or population." *Health Promotion Glossary*, World Health Organization, 1998.

collective data revealed emergent themes and areas of improvement backed by fact and anecdotal evidence.

Refer to the revised **Cobb2020 Health Indicator Comparison Chart**[84] per county and the **Core Health Indicators** below for a snapshot on how the WellStar Paulding Hospital community fairs against benchmarks. Baselines and targets for core health indicators are expressed as rates and percentages to compare and track current and future standings.

Demographics of the community served described in Section 3 of this written report also are indicators but are descriptive only and not compared to benchmarks or viewed as negative or positive.

Table: 9

WellStar Paulding Hospital Core Health Indicators[85]

Underlined, RED statistics indicate poor performance as compared with benchmarks / national data

Indicator	Paulding	GA	Benchmark or National Statistic
Lung Cancer Incidence *(per 100,000 population)*	**93.90**	71.60	67.20
Prostate Cancer Incidence *(per 100,000 population)*	132.10	167.80	151.40
Heart Disease Prevalence *(percent of people age 18 or older told they have angina or heart disease)*	**5.12%**	3.83%	4.26%
Diabetes Prevalence *(% of adults age 20 or older with diabetes diagnosis)*	**10.90%**	10.32%	8.77%
Breast Cancer Incidence *(per 100,000 population)*	118.60	119.7	122
Colon and Rectum Cancer Incidence *(age-adjusted incidence rate - cases per 100,000 population per year)*[86]	**53**	45	40.20 <38.6 (HP2020)

[84] Appendix: Page 75. Slightly modified and updated from the original Cobb2020 indicator list, 2012. Updates made April 2013.

[85] Statistics derived from Kaiser Permanente CHNA data platform in April 2013 unless otherwise noted. Includes data sources such as CDC BRFSS and National Vital Statistics, U.S. Census Data, American Community Survey, National Traffic 48.7 Safety Administration Fatality Analysis, CDC National Diabetes Surveillance System, the National Environment Public Health Tracking Network, and the Dartmouth Atlas of Healthcare Selected Measures of Primary Care Access

[86] The Centers for Disease Control and Prevention, and the National Cancer Institute: State Cancer Profiles, 2005-2009.

Indicator	Paulding	GA	Benchmark or National Statistic
Premature Death *(Years of Potential Life Lost (YPLL) before age 75 per 100,000 population)*	7,465	8,050	7,131
Age-Adjusted Death Rate[87] *(per 100,000 population)*			
-Cardiovascular Disease	181.7	252.1	252.1
-Stroke	38.2	44.8	39.05
-Lung Cancer	57.6	48.7	48.7
-Diabetes	19.1	22.7	22.7
-Motor Vehicle Crash Rate	9.04	13.70	11.13 <12.4 (HP 2020)
Suicide Incidence *(per 100,000 population – an Indicator of mental health)*	12.61%	11.02%	11.57 <10.2 (HP2020)
Asthma Prevalence *(age 18 or older reporting they have asthma)*	12.16	12.11%	13.09%
Mental Health Status *(measured in number of days out of 30 ranked as poor mental health days)*	2.9	3.4	2.3 (90th percentile)
Physical Inactivity *(County Health Rankings)*	23.80%	24%	24.66% (CHNA data)
Tobacco Use in Adults	20%	19%	13% (90th percentile)
Obesity in Adults *(adults age 18 and older reporting a Body Mass Index above 30)*	26%	28.18%	27.35%
Prevalence of Overweight Adults	36.29	36.18%	36.31%
Heavy Alcohol Consumption *(2 drinks daily for men – 1 drink per day women)*	10.30%	13.20%	16.61%

[87]Data from the Georgia Department of Community Health, Division of Public Health, Office of Information and Policy. Online Analytical Statistical Information System (OASIS) - 2010

Indicator	Paulding	GA	Benchmark or National Statistic
Sexually Transmitted Infection Incidence *(County Health Rankings – chlamydia rate[88] per 100,000 population)*	224	466	92* (90TH percentile)
Inadequate consumption of vegetables and fruits *(adults 18 or older reporting less than 5 servings daily)*	74.60	76%	75.92%
People with Access to Primary Care *(County Health Rankings)*	7,933:1	1,611:1	1,067:1
Per 100,000 population	13.34	69.10	84.70
-**People who didn't see see a doctors in past 12 months months due to cost[89]**	15%/434	16%	n/a
Diabetes Screening *(County Health Rankings – percentage of Medicare enrollees that receive HbA1c screening in 2010)[90]*	84%	84%	n/a
Mammography Screening *(percentage of female Medicare enrollees ages 67-69 who had at least one mammogram over a two-year period)*	64.21%	64%	73%
Prostate Screening[91] *(Statewide - men age 40 and up)*			
Colon Cancer Screening *(men age 50 and older who have had a sigmoid/colonoscopy)*	62.40%	48.42%	51.79%

[88]Chlamydia is the most common bacterial Sexually Transmitted Infection (STI) in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death.

[89]BRFSS. Self-reported by people ages 18 and up. National Center for Health Statistics and the CDC – aggregated over seven years.

[90]Weakness in data as it indicates only Medicare claims which limits population evaluated to mostly ages 65 and older and may miss trends and disparities in younger age groups.

[91]OASIS Behavorial Risk Factors – *BRFSS survey*: prevalence of adult men over the age of 40 who have had a prostate screening in the last two years in the state of Georgia.

Indicator	Paulding	GA	Benchmark or National Statistic
Preventable Hospital Events[92] *(Discharge rate per 1,000 Medicare enrollees for conditions that are ambulatory care sensitive)*	**93.23**	68.39	66.54
Maternal/Child Health Incidences per 1,000 Population			
-Teen Birth (ages 15-19 giving birth)	33.40	68.39	66.54
-Infant Mortality	**6.26**	8.10	6.71 <6.0 HP2020
-Low Birth Weight	7.38%	9.36%	8.10%
-Late or No Prenatal Care (2011 – OASIS)	1.7%	4.1%	-
Poor Dental Health *(percentage who report having lost teeth from decay, infection and disease)*	**17.71%**	16.72%	15.57%
Poor Dental Utilization *(percentage who report not going to the dentist within the year)*	23.22%	29.12%	30.14%
Access to Mental Health Providers[93]	**5,979:1**	3504:1	-
Children in Poverty *(percentage living below 100% Federal Poverty Level)*	**16%**	27%	14%
People in Poverty[94] (percentage living below 200%FPL) **KEY DRIVER OF HEALTH**	24.82%	35.29%	31.98%

[92]Conditions that are ambulatory care sensitive (ACS) are conditions that could have been prevented if adequate primary care were available and accessed. ***This statistic is relevant because ACS discharges demonstrate a possible return on investment from interventions that reduce admissions of uninsured or Medicare patients through better access to primary care, specialty care and preventive resources.***

[93]Ratio of population to mental health providers – County Health Rankings. *Source:* HRSA Area Resource File, 2011-2012 - a collection of data from more than 50 sources, including: American Medical Association, American Hospital Association, US Census Bureau, Centers for Medicare & Medicaid Services, Bureau of Labor Statistics, and the National Center for Health Statistics.

[94] U.S. Census Bureau, 2006-2010 American Community Survey 5 Year Estimates

Indicator	Paulding	GA	Benchmark or National Statistic
People with No High School Diploma *(total population age 25 or older)* **KEY DRIVER OF HEALTH**	14.13%	16.52%	14.97%
People without Health Insurance[95] *(percentage of total county population under age 65 who are uninsured)* **KEY DRIVER OF HEALTH**	22%	27%	15.7% in US (2011)[96]
People Living in a Health Professional Shortage Area[97] (HPSA)	0%	63.13%	60.80%
People who are unemployed[98]	7.80	8.50	8.10
Population receiving Medicaid[99]	10.86%	15.44%	16%
Linguistically Isolated People[100]	1.88%	5.87%	8.70%
Access to Parks *(park accessibility with a half a mile from home)*	**3.32**	13.39%	-
Access to Fast Food Restaurants *(percentage of fast food per 100,000 population)*	40.75%	71.17%	69.14%
Limited Access to Healthy Foods[101] *(County Health Rankings –percentage of people living in a "food desert")*	**6%**	8%	1%
Poor Air Quality *(% of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter yr.)*	**2.94%**	2.32%	1.16%

[95]County Health Rankings, www.countyhealthrankings.org . *Data resource:* U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of health insurance coverage for all states and counties.

[96] U.S. Census Bureau, Health Insurance, 2011.

[97] A HPSA is an area with a shortage of primary care, dental or mental health professionals.

[98]Percentage of civilian non-institutionalized population age 16 and older that is unemployed. *Source:* U.S. Bureau of Labor Statistics, Local Area Statistics, December 2012.

[99]*Source:* U.S. Census Bureau 2006-2010 American Community Survey, 3-Year Estimate.

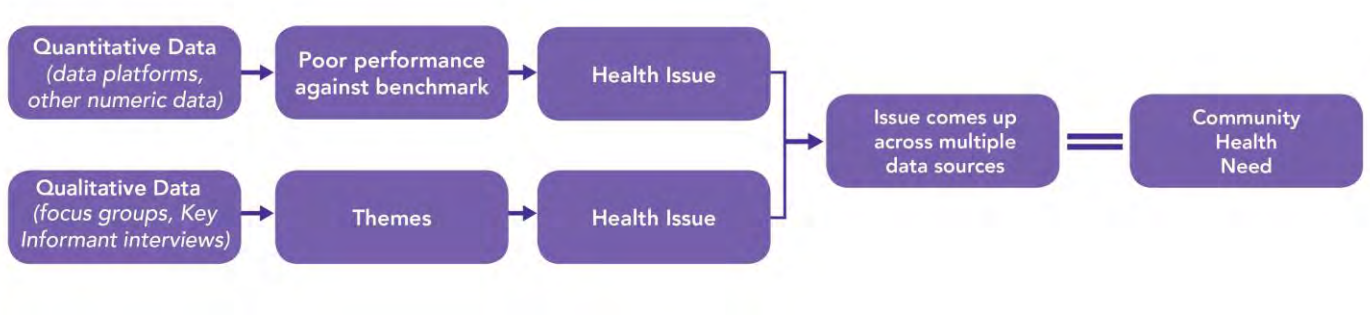
[100]Percentage of the population ages five and older who speak a language other than English at home and speak English less than "very well."

[101]Defined as the percentage of low-income people living less than 10 miles from a grocery store, whereas in non-rural areas, it means less than one mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the Federal Poverty Level for the family size. *Data source:* United States Department of Agriculture (USDA) Food Environment Atlas.

The MAPP strategic process followed in all counties served by WellStar Paulding Hospital was the conduit for identifying health indicators and collecting primary data to expose community health needs and winnable battles to achieve better population health, improve patient satisfaction and reduce cost.

Health needs[102] were identified through interpretation and analysis of secondary and primary data utilizing the following CHNA assessment process and criteria:

Figure 5:
Process and Criteria Used to Assess Community Health Needs[103]



Quantitative Data – Top Community Needs

Assigning statistics to core health indicators gave a broader, overarching view of the health status of the community served.[104]

Qualitative Data – Top Community Needs

Health disparities from socio-economic factors, low education attainment and limited access to care were overarching themes. The necessity for more education about available resources, preventive care and care access also was thematic across all counties. *A sampling of expressed needs:*

Paulding:

- Obesity and nutrition
- Diabetes
- Lack of insurance and inadequate supply or low or no cost medical services especially mental health
- Easy to use, accessible public transportation
- Lack of information or knowledge on health

[102] Health outcomes that are disproportionately impacting a population identified through secondary and primary data.

[103] From Kaiser Permanente CHNA Toolkit Part 2: Identifying Community Needs (page 10).

[104] See WellStar Indicators list on page 37 and in Appendix, page 75.

- Lack of pediatric and specialty services
- Increased mental health services
- Teen pregnancy
- Drug and alcohol abuse services
- Asthma
- Dental care

Health Needs

All identified health needs are grouped by how they impact the overall health of the community, not by importance:

Links to leading causes of death

- **Cardiovascular Disease** is a health need as it's the leading cause of death, premature death and illness in the communities served and is often a by-product of physical inactivity, poor nutrition, obesity, smoking, and diabetes.

- **Stroke** is a health need based on mortality rates and is caused by obesity and being overweight, smoking, high blood pressure and cholesterol, poor nutrition, diabetes, cardiovascular disease, and heavy consumption of alcohol.

  Nine modifiable risk factors account for more than 90 percent of the population attributable risk for cardiovascular disease and stroke: smoking, dyslipidemia, hypertension, diabetes, abdominal obesity, psychosocial factors, daily consumption of fruits and vegetables, excess alcohol consumption and lack of physical activity.

- **Lung cancer** is a health need since it's a leading cause of death and is linked to behaviors like smoking and even environmental factors like poor air quality. Incidence of lung cancer exceeds national levels in Paulding County. The CDC notes two-thirds of cancer deaths are associated with behavioral and lifestyle factors like tobacco use, diet, obesity, and lack of exercise.

- **Breast Cancer** is a health need based on incidence rates in the communities served. It's related to the rates of mammography screenings – an effective tool for early diagnosis for a better prognosis. Some modifiable risks for breast cancer are reduction in daily alcohol consumption, avoidance of tobacco, weight management, and an increase in physical activity.

- **Prostate Cancer** is a health need based on incidence levels in Cobb and Cherokee and the lower rates of prostate screenings – an effective tool for early diagnosis for a better prognosis. May indicate a lack of access to preventive care.

- **Colon Cancer** is a health need since all counties rank above the Healthy People 2020 benchmark of <38.6 per 100,000 population. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

- **Chronic obstructive pulmonary disease** is a health need since it's a top five leading cause of death in the WellStar five-county service area and may be related to smoking and environmental factors.

Current behaviors that are determinants to future health

- **Physical Activity** is a health need since the lack of physical inactivity may lead to significant health issues like obesity and chronic conditions such as poor cardiovascular health, diabetes and cancer. Healthy lifestyle prevention-based priorities like physical activity address 75 percent of the preventable deaths and illness, especially the leading cause of deaths - heart disease, cancer and stroke. Community members cited the need to do more education about healthy lifestyle choices and offer incentives and more opportunities and resources to promote change.

- **Healthy Eating** is a health need since poor eating choices and inadequate consumption of healthy foods is a cause of significant issues like obesity and diabetes, along with other chronic diseases. Poor nutrition was cited as a primary concern in Paulding County. The lack of accessibility to healthy foods (also noted in the indicators) makes it difficult to make healthy food choices.

- **Smoking** is a health need because it's significant factor to causing future health issues and possibly premature death from the leading causes of death including lung cancer, chronic obstructive pulmonary disorder, and cardiovascular disease. Hypertension and coronary artery disease leading to heart attacks is more likely to happen in smokers. It was cited as a winnable battle for public health.

- **Obesity (and overweight)** is a health need because it indicates unhealthy lifestyle choices of poor nutrition and physical inactivity and puts the community at risk for other issues like chronic disease, especially cardiovascular disease and stroke, and mental health (depression) conditions. Obesity is related to unhealthy eating, mental health, the lack of community access to grocery stores, parks, recreational facilities, and the over- abundance of fast food restaurants. Obesity was the first specific "biggest health need" among MAPP survey respondents and mentioned as a priority in Key Informant interviews. The estimated average hospital length of stay for obese individuals is 60 percent longer than for normal-weight individuals nationwide.[105]

- **Alcohol** is a health need since heavy consumption[106] can lead to health issues like cirrhosis, motor vehicle death and cancers. It also may indicate untreated mental and behavioral health issues which are cited as being underserved areas in the community.

Cause significant health issues

- **Diabetes** is a health need as it causes significant health issues if left unmanaged and contributes to other chronic illness including cardiovascular disease, stroke and hypertension. The risk for type 2 diabetes increases with obesity, being overweight and poor nutrition and is related to lack of care access in underserved communities, a lack of health knowledge, insufficient provider outreach,

[105] Zizza C, Herring AH, Stevens J, et.al. Length of Hospital Stays Among Obese Individuals. *Am J Public Health*, 2004; 94: 1587-91.

[106] Heavy consumption is defined as more than two drinks per day for men and one drink per day for women.

and/or social barriers preventing utilization of services. It commonly is an underlying factor in premature death from other chronic diseases.

- **Mental Health** is a health need since overall health depends on both physical and mental wellbeing. An indicator of poor mental health is based on suicide incidence rates which surpass national benchmarks in Paulding County which often are a sign of poor mental health. Key Informants also cited the lack of accessible mental health services as a health need and community concern. Overall health depends on physical and mental wellbeing.

- **Air Quality** is a health need indicated by poor air quality levels in the communities served contributes to respiratory issues and overall poor health. This environmental factor, along with safety, could possibly keep people indoors and not engage in physical activity.

- **Asthma** is a health need because it's a prevalent problem often exacerbated by poor environmental conditions (related to poor air quality levels in all counties).

Highlights a lack of access to preventive care

- **Breast Cancer Screening** is a health need as the community is below national measures and is link to early diagnosis of breast cancer for better survival rates. Preventive care was mentioned by Key Informants as a privilege for those with insurance – those without had no access to get proper screening and healthcare check-ups.

- **Colon Cancer Screening (sigmoid/colonoscopy)** is a health need because engaging in preventive behaviors allows for early detection and treatment of health problems. The lack of preventive screening for colon cancer highlights a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

- **Prostate cancer screening** is a health need since it points to a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.Without appropriate screening and early intervention, prostate mortality rates will increase.

- **Dental Care** is a health need as it's a sign of a medically underserved area and disengagement from preventive behaviors which decrease the likelihood of developing future problems**.** It also highlights possible social barriers to utilization.

Highlights a lack of health knowledge

- **Teen Pregnancy** is a health issue since it indicates unsafe sex which may or may not be linked to a lack of education. In many cases, teen parents have unique social, economic and health support services. Teen pregnancy was cited as a key winnable battle area for public health.

- **Education** is a health issue since a lack of health promotion and literacy contributes to a decrease use of preventive care and unhealthy lifestyle choices. Insufficient information or knowledge on health was cited in the Paulding Key Informant report as barrier to health and quality of life.

This reflects the common theme among focus group participants in Cobb for the need for more education and information about available services in the county. MAPP Key Informants noted the lack of continued adult education on daily lifestyle choices with nutrition and exercise. Education and prevention programs were seen as equally important.

- **Sexually Transmitted Infection** is a health issue since it's a measure of poor health status and the prevalence of unsafe sex practices which may or may not be linked to a lack of education. It is cited as a key winnable battle for public health.

Highlights the existence of health disparities

- **Transportation** is a health need since limited transportation is a barrier for accessing health services. Paulding County Key Informants cited the county's public transportation as limited and the need for it to be more affordable and easier to use.

- **Access to care** is a health need since it contributes to health disparities and is a leading barrier to improving the health of the community. Affecting access is the supply and accessibility of facilities and primary care physicians causing preventable hospital stays which could otherwise be prevented if adequate primary care, specialty care and preventive resources were available and accessed. Across the board, Paulding County exemplified the differences in health that exist between urban and more rural counties due in large part to care access issues.

  The uninsured population surpasses the national benchmark in the communities served and is a key driver of poor health. It affects access to care with many uninsured people refusing doctor visits due to financial hardship. For people who do have coverage, many cited frustration with coverage limitations - non-acceptance of Medicaid and Medicare. An uninsured community is limited to receiving needed primary and specialty care which directly relates to poor health status.

  Economic barriers (low-income, employment, lack of insurance in Paulding County) were mentioned as major barriers to care access. MAPP focus group participants noted the excessive cost of medical expenses and health insurance along with the inequities in healthcare services as external impediments to living a healthy life.

- **Prenatal care** is a health issue since infant mortality in Paulding County surpasses the Healthy People 2020 benchmark and indicates the existence of broader issues pertaining to access to care and maternal and child health. The prevalence of maternal and child health issues are higher with women who are medically underserved, uninsured, under-educated, and without adequate access to care.

Health needs not assessed and why

All sexually transmitted infections (STI) and teen pregnancy were not assessed leaving awareness education with schools, family and churches. From a health system standpoint, STI education can be offered, but the issue is more cultural and societal.

Improvement to health needs stemming from socioeconomic and physical environmental issues get traction from public policy and education. A health system can complement efforts to impact policy, but

has to rely on public health, state and local municipalities and federal governmental agencies to drive these types of health improvements.

Prioritized Health Needs:

Selection criteria for WellStar Paulding Hospital's prioritized health needs was primarily based upon the bandwidth to build a sustainable community benefit model focused on preventable health behaviors and access to care. The goal – to make the largest impact on the overall health of the community, including vulnerable populations. Other criteria included:[107]

- Severity of issue/degree of poor performance against the benchmark
- Clear disparities/inequities
- Existing attention, facilities and resources dedicated to the issue
- Effective and feasible interventions exist
- A successful solution has the potential to solve multiple problems
- Opportunity to intervene at the prevention level

WellStar Paulding Hospital used the CHNA Prioritization Matrix[108] to choose priority health needs by rating identified health needs against the above criteria using 3 = criterion met well; 2 = criterion met; 1 = criterion somewhat met; 0 = criterion not met. A health needs' priority score was the sum of the ratings for each criterion. The resulting prioritized needs are ranked by the priority score – high, medium and low:

Table 10:
WellStar Paulding Hospital's Prioritized Health Needs

HIGH		MEDIUM	LOW
Access to Care		Breast Cancer (Screening)	Transportation
Chronic Disease*	Cardiovascular Disease	Prostate Cancer (Screening)	Air Quality
	Cancer ▪ Lung ▪ Colon ▪ Breast ▪ Prostate	Colon Cancer (Screening)	Dental Care
	Stroke	Alcohol	Sexually Transmitted Infections
	Chronic Obstructive Pulmonary Disease	Prenatal Care	Teen Pregnancy
	Diabetes		
Healthy Lifestyles	Physical Activity		
	Healthy Eating		
	Obesity		
	Smoking		
	Education		
Mental / Behavioral Health			

[107] Guidelines found in the Kaiser Permanente CHNA Toolkit 2, September 2012.

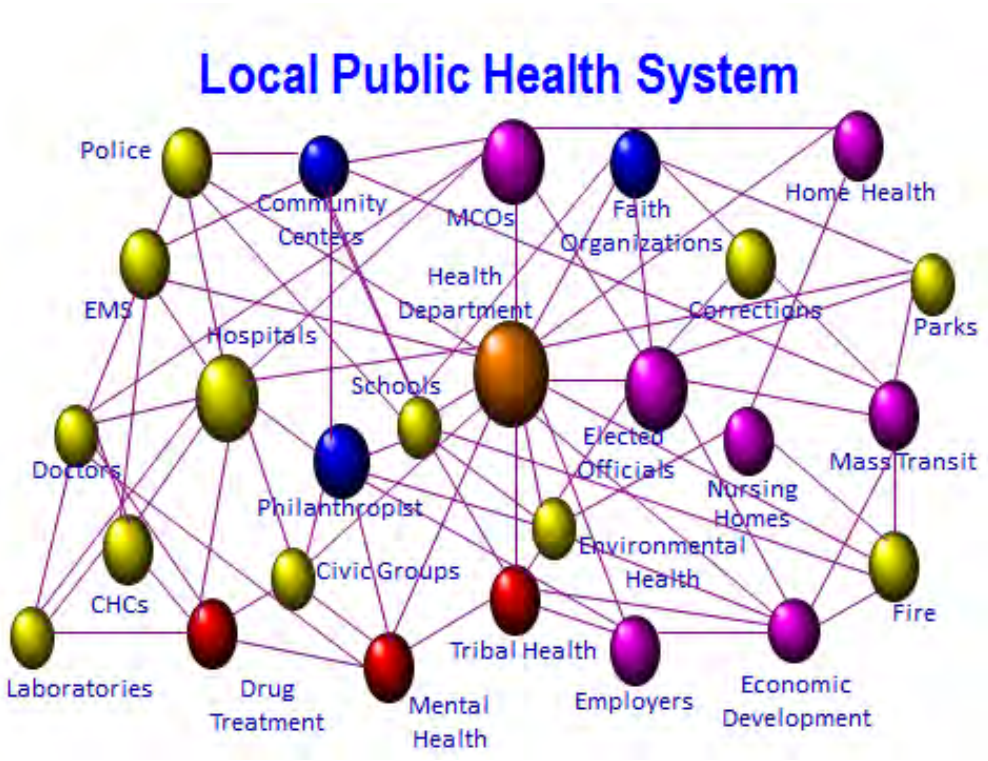
[108] Appendix: Prioritization Toolbox template, Kaiser Permanente CHNA Toolkit Part 2, September 2012, page 80.

The WellStar Paulding Hospital community has myriad facilities, assets and resources to serve the needs of its community. One of the most valuable assets to achieve a sustainable community benefit model is a collaborative, integrated local public health system (see Figure 6).

A **list of community facilities, assets and resources** (many CHNA collaborators) available to respond to the health needs of the communities served include can be found in the Appendix on **page 95**. This list will be periodically updated for accuracy and inclusiveness.

Also, the Atlanta Regional Commission compiled a comprehensive catalogue list of services in the WellStar Health System five-county service area. Click to access the resource list for Paulding County.

Figure 6:
Integrated Local Public Health System[109]



[109] This egg diagram shows the many contributors to health and delivery of the Essential Public Health Services in the community and the benefits of CHNA coalitions and collaborations.

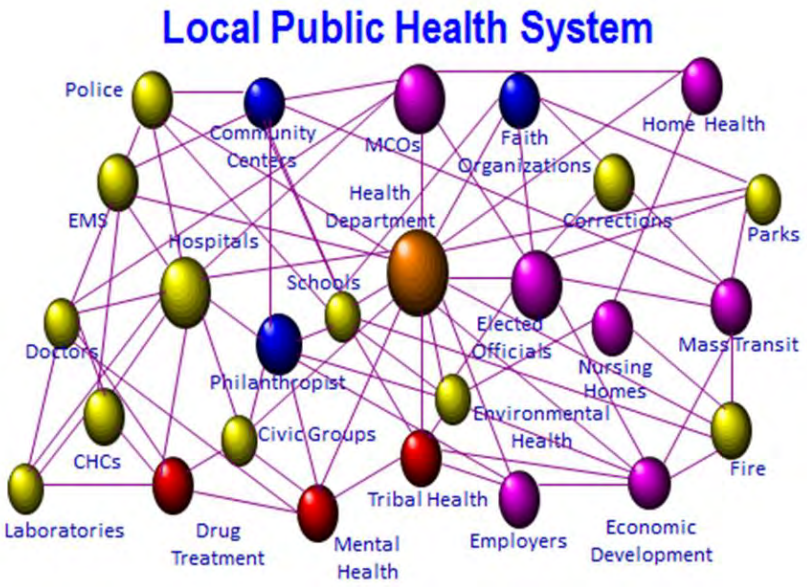
Appendix 8

Table Citations:

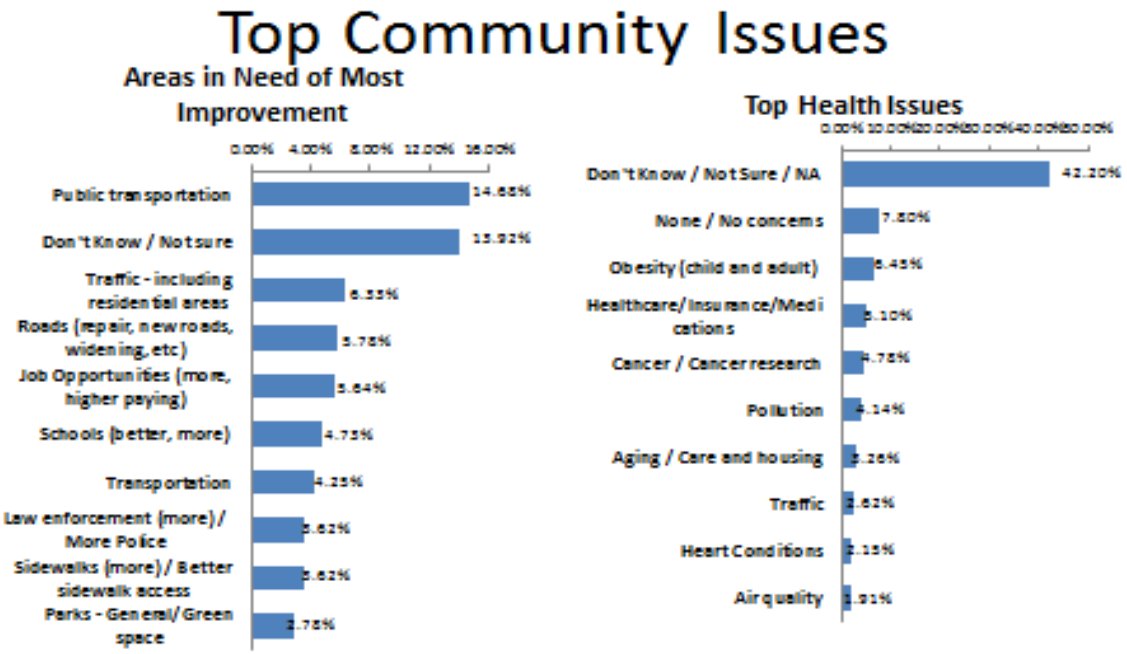
Map Citations

Figure Citations:

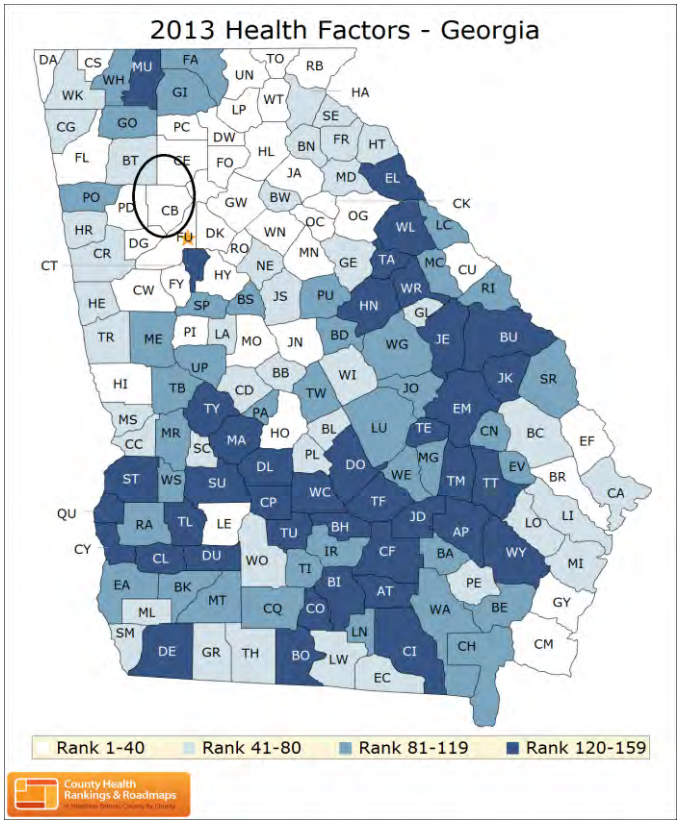
1- Local Public Health System Egg Diagram



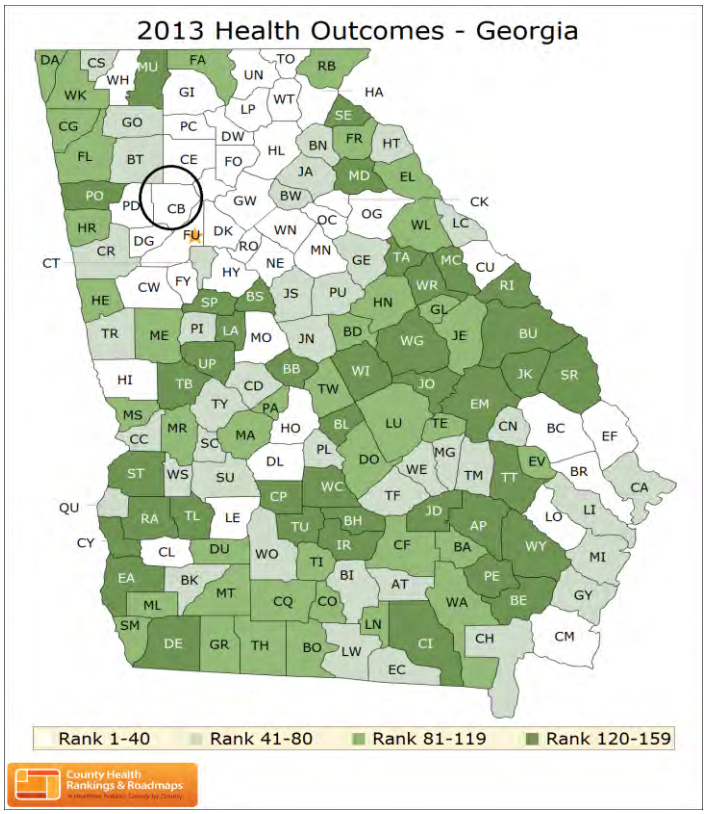
2 - Top Community Health Needs Chart – Cobb County



3 - County Rankings 2013 Health Factors: Map of Georgia *(Service areas highlighted)*



4 - County Ranking 2013 Health Outcomes: Map of Georgia (*Service area highlighted)*



5 - *Community Strengths & Themes* Assessment – Key Informant Interview Survey Template for Paulding County and Report *(follows Cobb MAPP template for Cobb County)*

KEY INFORMANT INTERVIEW

Community Themes & Strengths Assessment

Paulding County

Interviewer's Initials: _____

Date: _____ Start time: _____ End time: _____

Name: _____ Title: _____

Agency/Organization: _____

#of years living in county: _____ # of years in current position: _____

Introduction: Good morning/afternoon. My name is [interviewer's name]. Thank you for taking time out of your busy day to speak with me. I would like to remind you that your participation in this interview is completely voluntary. I'll try to keep our time to 30 minutes only.

WellStar is gathering local data as part of developing a plan to improve health and quality of life in Bartow/Cherokee/Paulding County. Community input is essential to this process.

You have been selected for a key informant interview because of your knowledge, insight and familiarity with the community. The themes that emerge from these interviews will be summarized and made available to the public; however, individual interviews will be kept strictly confidential.

To get us started, can you tell me briefly about the work that you and your organization do in the community?

Thank you. Next I'll be asking you a series of questions about health and quality of life. As you consider these questions, keep in mind the broad definition of health adopted by 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,' while sharing the local perspectives you have from your current position and from experiences in this community.

Questions:

1. In general, how would you rate health and quality of life in Bartow/Cherokee/Paulding County?
2. In your opinion, has health and quality of life in the County improved, stayed the same, or declined over the past few years?
    a. Can you briefly explain why you think the health and quality of life in the County has improved, stayed the same, or declined over the past few years?
3. Are there people or groups of people in the County whose health or quality of life may not be as good as others?
    a. Who are these persons or groups (whose health or quality of life is not as good as others)
    b. Why do you think their health/quality of life is not as good as others?
4. What barriers, if any, exist to improving health and quality of life in the County?
5. In your opinion, what are the most critical health and quality of life issues in the County?
6. What needs to be done to address these issues?
7. What specific actions, policy or funding priorities would you support because they would contribute to a healthier County?
8. In your opinion, what else will improve health and quality of life in the County?
9. What support systems currently exist within the County during times of need and stress?

Close: Thanks so much for sharing your concerns and perspectives on these issues. The information you have provided will contribute to develop a better understanding about factors impacting health and quality of life in the County. As a reminder, summary results will be made available by WellStar and used to develop a community-wide health improvement plan.

Community Health Needs Assessment (CHNA) – Paulding County, Georgia
Process and Key Informant Reporting for WellStar Health System
Prepared by Ron Chapman, Consultant and Facilitator
April 12, 2013

Overview and Background

In 2012, the Public Health Department of Cobb and Douglas Counties (Georgia) performed a comprehensive Community Health Needs Assessment (CHNA) for the purpose of developing a Community Health Improvement Plan (CHIP). WellStar Health System participated in that process as part of the

Steering Committee established to oversee the CHNA, the CHIP and its implementation. This consultant has been involved in that process as a designer and facilitator as well as in targeted consultative activities.

Late in 2012, WellStar explored the possibility of expanding the reach of the assessment performed in Cobb and Douglas into adjacent counties (Bartow, Cherokee, and Paulding) in which it operates. The basic premise was that a substantial part of the findings from Cobb and Douglas should be generalizable to these additional areas given the many geographical and demographic similarities. Furthermore, that targeted key informant interviews in the counties could further validate the findings while adding valuable information on variations and gaps unique to these additional communities.

In order to validate the premise, in January 2013 WellStar and the consultant met with representatives of the District and County Public Health Departments for Cherokee and Paulding Counties. During that session, a representative from Cobb and Douglas presented their results, which are included as a supplement to this report. On the whole, the group concurred in large part with the findings as well as the planned key informant approach. In February, a similar briefing occurred with a public health representative in Bartow County.

This total body of information will be used by WellStar in strategic planning to determine how best to respond to the needs in all five counties. This strategic dialogue would take place between April and June 2013.

Process Overview

Representatives from the Public Health Departments in Bartow, Cherokee and Paulding Counties agreed to each identify ten to twelve well-informed key stakeholders in their communities. Subsequently, the consultant interviewed as many as possible using a slightly modified version of the instrument developed and validated in Cobb Douglas. That tool is also provided as a supplement to this report.

This report will be reviewed for feedback and enhancement with the representatives from the Public Health Departments in Bartow, Cherokee and Paulding Counties. Their comments will be incorporated into this reporting. That final compilation will be provided to the Public Health Departments as well as the key informants. WellStar will then incorporate the information into their strategic processes.

Recommendation: WellStar has engaged in enhancing their collaboration and partnership with these Public Health Departments through this process, which in turn extends to key informants. To further that community partnership, WellStar would benefit from reporting the results of their strategic dialogue to the departments and communities. Indeed, it would be extremely beneficial to all parties and the public's health for the reporting to expand into community dialogue.

Paulding County – Findings

Only five key informants were able to provide interviews. Those respondents were disproportionately focused on children's needs with representatives from education, children's and juvenile services,

community-based organizations and children's health. In addition senior and transit services were represented.

- Overall Health and Quality of Life
    - Perceived health and quality of life are largely good, though there is acknowledgment that this does not extend to those who for various economic or other reasons are excluded from the benefits of the larger community.
    - Key factors in this positive perspective include:
        - Appreciation of the rural and scenic character of the area with some small city benefits, and
        - A fair amount of comfort with overall economic conditions and realities.

- Trending for Health and Quality of Life
    - Consistently, the respondents believe there has been a general downward trend over recent years. This is largely due to erosion in economic vitality. Note: This is not apparently at odds with the relative comfort of overall economic conditions in the county, rather a recognition that those conditions have weakened.
    - There is acknowledgment that economic growth due to proximity to the metropolitan Atlanta area has brought with it improvements associated with growth such as increasing business and retail options, and improvements in education.
    - Several references pointed to gaps in services such as pediatric medicine and other specialties.

- Disparately Affected Populations or Sub-Populations
    - Those lacking medical, dental and vision insurance,
    - Persons of low socio-economic status, and
    - Children and elders who lack access to health systems

- Barriers to Health and Quality of Life
    - Nearly every respondent mentioned lack of access in some form or another including:
        - Lack of insurance,
        - Few providers willing to accept patients via Medicaid and Tricare,
        - An inadequate supply of low or no cost medical services especially mental health services,
        - Limitations of public transportation, and
        - A combination of insufficient information or knowledge on health, as well as some historical reluctance to seek care except when the need is significant or dire.

- Primary Conditions of Concern
    - Obesity and nutrition
    - Diabetes
    - Teen pregnancy
    - Drug and alcohol use
    - Asthma
    - Dental care

- Key Actions, Policies or Funding Priorities
    - Increased medical solutions that are no or low cost including better access to specialty care.
    - Approaches to increase health knowledge as well as the options that are available.
    - Easy to use, affordable public transportation.
    - Increased mental health services including substance abuse.

Consultant Observations

While the purpose of this report is not to interpret the findings, a few points seem to be appropriate.

- While the sample of key informants is small and biased toward the needs of children, the tenor and content of the responses is very consistent with that in Bartow, Cherokee, Cobb and Douglas Counties especially when compared to more rural aspects.
- The matters of access are dominant, with very similar barriers and challenges.
- Likewise the array of conditions of concern is very comparable to the other counties.

Additional Comments – Department of Health Debriefing

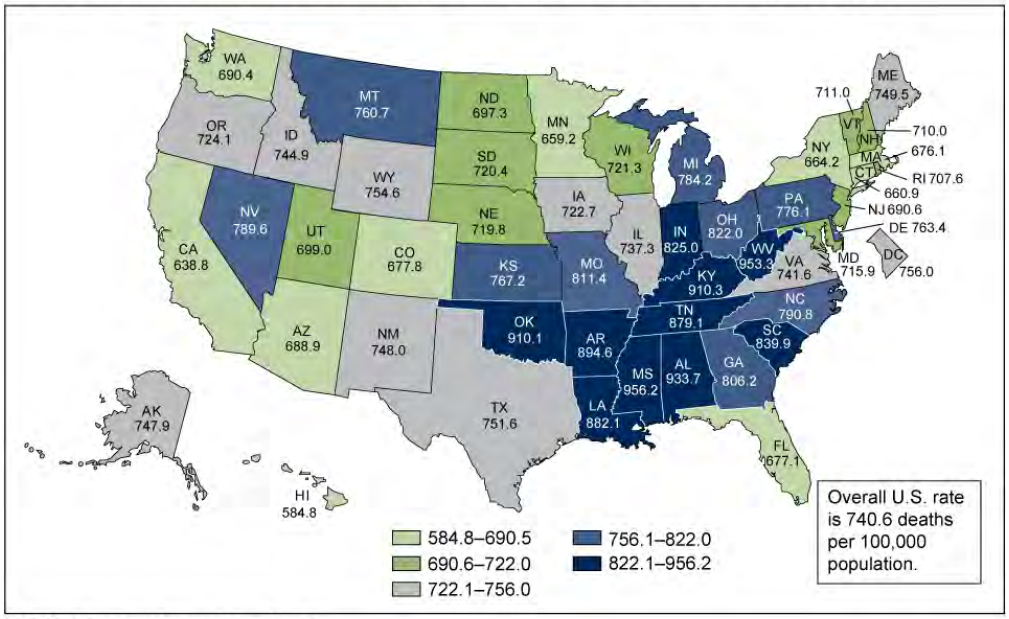
On April 8, 2013, a debriefing was held with district and local public health representatives. The contents above were discussed with additional information contributed in summary as follows:

- While those interviewed were principally involved in children's and youth affairs, the issues and concerns identified are applicable to the adult community as well.
- Paulding County has had exceptional development in the past decade as a bedroom community of the Atlanta metropolitan area. Without rigorous community planning, the result has been underdeveloped collaborative capacity with obvious implications for the local public health system. While some coalition presence exists, there is a need for communication and coordination with regard to health and health services.
- One consequence of that growth has been an upwelling of young couples and families. This creates a particular need for obstetric, gynecological and pediatric specialties. On another note, the lack of adequate oral health care is significant.
- Another priority should be health information and literacy, especially in reproductive health and family planning. This affirms feedback from informants that suggested health knowledge and treatment options are insufficiently understood in the community.
- Unfortunately, state and county funding for public health is significantly less than in comparable communities. This is a consequence of historical allocation mechanisms and formulas that are in the process of modification. However, this history leaves a cumulative deficiency in health and well-being.
- Similarly to Cherokee and Bartow Counties, there is some perception that WellStar is not a significant community partner. This should be a factor in any strategy development.

Community Served

6 - Leading Causes of Death – National Age-Adjusted Death Rate

Figure 3. Age-adjusted death rates for each state and the District of Columbia: United States, preliminary 2011



SOURCE: National Vital Statistics System, Mortality.

Community Collaboration & Process

7 - CDC Community Transformation Grant Recipients 2011 - *Map of National Award Recipients showcasing Cobb County*

8 - WellStar Health System CHNA Collaborators (not an all-inclusive list–*Cobb Key Informant names are undisclosed per an agreement with Cobb & Douglas Public Health*.)

WellStar Health System CHNA Collaborators

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
A.L. Burruss Institute of Health Policy Research, Kennesaw State University Richard Engstrom, Interim Director and Assistant Professor of Political Science and International Affairs Kelleigh Trepanier, Assistant Director	Higher education	• *Community Strengths & Themes* Workshop Participant • Conducted surveys of community stakeholders (Cobb Key Informant interviews)	*Enhances the ability of governmental agencies and non-profit organizations to make informed decisions for the public good by providing relevant data, technical resources and skill development.*
American Cancer Society Barbara Rush, Senior Community Manager*(replaced former employee/collaborator)*	Local/national health organization	• Cobb2020 partner • Cobb MAPP Steering Committee	*Advocates for cancer research, education, prevention and treatment*
Atlanta Regional Commission (ARC) Jennifer Curry, MPH, Health & Wellness Coordinator for the Aging Division Cheryl Mayerik, Lifelong Mableton Manager	Community planning	• Cobb2020 partner • Cobb MAPP Steering Committee	*Unifies the region's collective resources to prepare the metropolitan area for a prosperous future. It does so through professional planning initiatives, the provision of objective information and the involvement of the community in collaborative partnerships*
Austell Community Task Force Michael Murphy, Chairman & Senior Executive Public Health Accountant	Neighborhood organization	• Cobb2020 partner • Cobb MAPP Steering Committee	*Catalysts for positive change movements in education, employment, and justice*
Northwest Georgia Public Health / Bartow County Health Department Cathy Green , RN, BSN, MPH, County Nurse Manager	Public health	• Key Informant - Bartow	*Provides health care to citizens of Bartow County*
Bartow County Board of Health Peggy Martin, President		• Key Informant - Bartow	
Bartow County Commission Lane McMillan, Assistant County Administrator	County government	• Key Informant - Bartow	*Works with the government authority of the county*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
Bartow County Health Department Cathy Green, RN, BSN, MPH, County Nurse Manager	Public Health	• Key Informant - Bartow	*Serves the entire population of Bartow County*

Bartow County Juvenile Court Carolyn Johnson, Program Director	Justice System	• Key Informant - Bartow	*Provides insight into juvenile delinquency matters – treatedcivil or family law matters – deals with truancy or drug dependency issues*
Bartow Health Access Roberta Green, Director J. Paul Newell, MD, Behavioral and Emotional Health Committee	Healthcare provider to vulnerable populations	• Key Informants - Bartow	*Provides accessible health care for those without insurance; more specifically, to create premier health status in our community, by enhancing, coordinating and providing plans and partnerships, which address accessibility, accountability, and prevention, education and information*
Bethesda Community Clinic Karen Fegely, Chief Executive Officer	Clinic serving vulnerable populations	• Key Informant - Cherokee	*Dedicated to providing quality, affordable health care services to Cherokee County's "working poor"*
The Center for Family Resources Jeri Barr, CEO	Non-profit serving vulnerable populations	• Community Transformation Grant Leadership Team	*Provides temporary financial assistance to stabilize families in crisis; housing for low-income and homeless families in a safe and secure environment; and education and training to individuals and communities to increase economic capacity and personal growth*
Centers for Disease Control (CDC) Teresa Daub, Public Health Advisor	Federal health agency	• Cobb2020 Advisor	*Collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.*
Cherokee Christian Ministerial Association Fred Goodwin, President	Faith-based organization	• Key Informant - Cherokee	*Provides a means for the Christian community serve needs in Cherokee County*
Cherokee County Board of Education Barbara Jacoby, Director of Public Information, Communication and Partnerships	Education	• Key Informant - Cherokee	*Represents the K-12 in Cherokee County*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
Cherokee County Chamber of Commerce Pamela Carnes, Executive Director	Employers	• Key Informant - Cherokee	*Promotes business and the community while enhancing the economy and quality of life.*

Cherokee County Division of Family and Children Services Charity Kemp, Director	County agency representing children	•	Key Informant - Cherokee	*Responsible for welfare and employment support, protecting children, foster care and other services to strengthen families.*
Cherokee County Senior Services Nathan Brandon, Director	Non-profit representing elderly	•	Key Informant – Cherokee	*A non-profit serving the needs of Cherokee's senior population*
Cherokee FOCUS Sonia Carruthers, Chief Executive Officer	Non-profit representing families	•	Key Informant - Cherokee	*Exists to improve the lives of the children and families of Cherokee County – a collaborative organization*
The Church at Chapel Hill Frank Smith, Outreach Director and founder of The CarePlace	Faith-based organization	•	MAPP partner- Douglas	*Church with campuses in located in Douglasville and Bremen. Outreach Director oversees and develops ways to connect our church body to ministries and outreaches within the community including The Pantry, Hope Project and The CarePlace – a church initiative.*
City of Canton Lorrie Waters, Manager – Human Relations	Municipality & Employers	•	Key Informant - Cherokee	*Municipal government representative of city employees*
City of Kennesaw LisaRae Jones, Director of Human Resources	Municipality	•	Cobb2020 partner Cobb MAPP Steering Committee	*Provides quality HR services in order to attract, develop and retain a diverse workforce within a supportive and cohesive work environment*
City of Marietta Beth Sessoms, Economic Development Manager	Municipality	•	Cobb2020 partner Cobb MAPP Steering Committee	*Cobb's county seat and has 60,000 residents, five historic districts and its own public school system*
Cobb2020 Partnership Jay Dillon, Chair, Cobb2020 and Director of Communications for Cobb County School District	Community collaborative	•	Cobb2020 Chairman Cobb MAPP Steering Committee	*A multi-sectorial strategic partnership to assess the healthcare needs of Cobb via the MAPP process*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise

Cobb Chamber of Commerce Slade Gulledge, Director, Government Relations Nelson Geter, Economic Development Executive Director David Connell, President & CEO	Employers	• Cobb2020 partner • Cobb MAPP Steering Committee • Community Transformation Grant Leadership Team • Cobb2020 Advisor	*Brings the community and its leaders together to create jobs and strengthen the economy and quality of life so businesses and the community can achieve more*
Cobb Community Foundation Tommy Allegood, Executive Director *(replaced former collaborator Robin Bradley)*	Foundation	• Cobb2020 partner • Cobb MAPP Steering Committee	*Works with individuals and organizations to create endowment funds helping donors connect their charitable interests to a variety of important community needs through grants, specific gifts, and scholarships*
***Cobb County Board of Commissioners** JoAnn Birrell, Commissioner & Tim Lee, Commissioner, District 3 Chairman	County government	• Cobb2020 Advisors	*Works to provide efficient, effective and responsive government that delivers quality services. Cobb County operates under the commission-county manager form of government.*
Cobb and Douglas Community Services Board Bryan Stephens, LPC, MBA, Director of Intake/Access and Outpatient Services	Behavioral health system	• Cobb2020 partner • Cobb MAPP Steering Committee • *Community Themes and Strengths* Workgroup Participant	*Serves in the behavioral healthcare arena spanning Cobb and Douglas counties - provides citizens challenged by mental health, developmental disabilities and/or addictive disease issues with appropriate care and resources. The agency also serves children, adolescents and adults and offers a wide array of clinical and support services.*
Cobb and Douglas Public Health Jack Kennedy, MD, District Health Director and Vice-Chair of Cobb2020 Jennifer Munoz, Planning and Quality Manager Cathy Wendholt-McDade, District Healthy Behaviors Director Lisa Crossman, Director for the Center of Community Health +Rose Bishop, Public Health Nurse Supervisor, Family Support Pregnancy Services Karla Ayers, PH Nursing Supervisor Beverly Kartheiser, Health Educator	Local health department	• Cobb2020 partner • Cobb MAPP Steering Committee • Community Transformation Grant Leadership Team • MAPP partner - Douglas • Cobb MAPP Key Informant Report Writer • Cobb MAPP Implementation Team Members – *Healthy Lifestyles* • *+Access to Health Service* • *Access to Health Services* Implementation Team – Douglas • MAPP partner - Douglas	*Partners, promotes and protects the health and safety of the residents of Cobb and Douglas counties*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
Cobb County Government	County government	• Cobb2020 partner	*Plans, designs, manages and*

Cheryl Mayerik, Mobility Transportation Coordinator, Cobb County Department of Transportation*(previously with ARC as the program manager for Lifelong Mableton)*		• MAPP Steering Committee	*delivers a network of transportation services and travel options to the general public, including older adults, people with disabilities and individuals with lower incomes*
Robert Quigley, Director, Cobb County Government Communications Michael Hughes, Director of Economic Development & Pam Breeden, Executive Director		• Cobb2020 Advisor • Community Transformation Grant Leadership Team	
Cobb County Parks and Recreation Eddie Canon, Director	Parks and recreation	• Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*Provides facilities for Cobb County citizens to use their leisure time in a constructive, healthy, gratifying and inexpensive manner, and give the county's youth the body-building and mind-expanding opportunities*
Cobb County School District Jay Dillon, Director of Communications and Chair of Cobb2020	School system	• Cobb2020 partner • Cobb MAPP Steering Committee • Community Transformation Grant Leadership Team	*Serves all of the school district's stakeholders by providing important information about the district as a whole, especially information about issues that may impact the educational process or result in major change*
Cobb County School District Mark Anderson, Supervisor, Health and Physical Education	School system	• Cobb MAPP Implementation Team Member	"
Cobb County Sheriff's Office Lynda Coker, Chief Deputy Sheriff	Public safety	• Cobb2020 partner • MAPP Steering Committee	*Targets its prevention programs toward the county's youth working cooperatively with the school system to address specific problems such as truancy and drug abuse*
Cobb Senior Services Pam Breeden, Director	County-based senior service agency	• Cobb MAPP Steering Committee Member • Cobb2020 partner • Community Transformation Grant Leadership Team	*Provides an array of services including the operation of eight senior centers which include three neighbourhood centers, four multi-purpose centers, and the Senior Wellness Center*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
The Community Health Center of	Health clinic	• MAPP partner - Douglas	*Provide medical and dental*

Austell **David Aten, Executive Director**			*health services at discounted, affordable rates to everyone who visits by partnering with businesses, community groups, local governments, and individuals*
/**Division of Family and Child Services (DFCS)** Sabrina Watson, Acting Director	Government agency Vulnerable populations	• MAPP Implementation Team Member – *Access to Health Services*	*Investigates child abuse; finds foster homes for abused and neglected children; helps low income, out-of-work parents get back on their feet; assists with childcare costs for low income parents; and provides support services and innovative programs to help troubled families*
Douglas County Chamber of Commerce Kali Boatright, President and CEO	Employers	• MAPP partner - Douglas	*Promotes, supports and attracts business for the advancement of Douglas County community*
Douglas County Government Richard Hagan, Executive Director, Douglas County Senior Services Wes Tallon, Director of Communications & Community Relations & Ron Roberts, Division Manager, Department of Transportation	County government	• MAPP partner – Douglas • *Access to Health Services* Implementation Team Members – Douglas	*Provides services to Douglas County citizens*
Douglas County School System Gordon Pritz, Superintendent Carol Lindstrom, School Board Member, District 9 Renee Davis, Parent Mentor	School system	• MAPP partner – Douglas • *Access to Health Services* Implementation Team Member – Douglas • MAPP partner - Douglas	*Serves K-12 in Douglas County*
Douglas Community Services Board Christine Steadman, MSW, Grants Specialist	Public agency – vulnerable populations	• MAPP Partner – Douglas • *Access to Health Services* Implementation Team Member - Douglas	*A public agency created by state law to provide mental health, developmental disability, and substance abuse services in Douglas County*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
Douglas CORE	Vulnerable populations	• MAPP partner – Douglas	*A community collaborative*

(Community Organizing Resources for Excellence) Amanda Bryant, Executive Director		• *Access to Health Services* Implementation Team Member - Douglas	*representing non-profits, civic organizations, health and human services, education, law enforcement, churches, families and youth. This partnership strives to assess and evaluate present needs and resources for children and families while searching for additional resources to fill in gaps in services and discourage duplication of services*
East Cobb Business Association	Employers	• Key Informant - Cobb	*Seeks to transform East Cobb by developing business leaders through networking and education with an emphasis on community.*
East Marietta Drugs & the Institute of Wellness Jonathan Marquess, PharmD	Pharmaceuticals	• Cobb MAPP Implementation Team Member	*Community pharmacy*
Emory-Adventist Hospital at Smyrna Bob Crowe, Assistant VP, Emergency & Imaging Services	Hospital	• Cobb2020 partner • Cobb MAPP Steering Committee • Cobb MAPP Implementation Team Member – *Access to Health Services*	*Strengthens the communities by extending the healthcare ministry of the Seventh-Day Adventist Church.*
Emory University James Curran, Dean, Rollins School of Public Health	Higher Education	• Cobb2020 Advisor	*One of the world's leading research universities. Its mission is to create, preserve, teach and apply knowledge in the service of humanity.*
Franklin Road Weed & Seed Program	Community collaborative		*Helps rebuild and restructure communities that have suffered because of criminal activity and social decay. The program encourages residents to work with law enforcement agencies to deter crime, identify resources and restore the community.*
G. Cecil Pruett Community Center Family YMCA John Hicks, Executive Director	Non-profit for vulnerable populations	• Key Informant – Cherokee	*Focuses work on three key areas, because nurturing the potential of kids, helping people live healthier, and supporting neighbors are fundamental to strengthening communities.*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise

Georgia Department of Public Health Dan Fesperman, Obesity Project Manager	State health department/ Vulnerable populations	• *Community Strengths & Themes* Workshop Participant • Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*The lead department entrusted by the people of the state of Georgia with the ultimate responsibility for the health of communities and the entire population.*
Brenda Fitzgerald, Commissioner		• Cobb2020 Advisor	
Yvette Daniels, Director of Health Promotion		• Community Transformation Grant Leadership Team	
Bernita Frazier, MPH, PhD, Performance Improvement Manager		• *Community Strengths & Themes* Workshop Participant	
Georgia Family Connection Program *(Cherokee & Paulding counties)* Gaye Morris Smith, Executive Director	Community collaborative targeting children	• Key Informant - Paulding	*Strives to improve the quality of life for their children and families through collaboration.*
GlaxoSmithKline Eric Klein, Senior Executive, Public Health Account Manager	Pharmaceutical company	• Cobb2020 partner • MAPP Steering Committee	*Global healthcare company that researches and develops an innovative medicines and brands in pharmaceuticals, vaccines and consumer healthcare.*
Gold's Gym Tom Butler	Healthy lifestyles	• MAPP partner - Douglas	*Fitness facility in Douglasville – asset for healthy lifestyles*
Good Samaritan Health Center of Cobb Kacie McDonnell, MPA, Chief Executive Officer	Health clinic Vulnerable populations	• Cobb2020 partner • Cobb MAPP Steering Committee • Cobb MAPP Implementation Team Member – *Access to Health Services*	*Exists to provide quality primary care medical and dental services to the working poor of our community delivered at an affordable cost, providing these families with a medical home*
GreyStone Power Corporation Tim Williams, Vice President, Corporate & External Affairs	Employers	• MAPP partner - Douglas	*A member-owned electric cooperative dedicated to providing our members with the best electric service at the lowest possible rates.*
Healthcare Georgia Foundation Andrea Young Kellum, Program Officer	Foundation	• Cobb2020 partner • Cobb MAPP Steering Committee • *Community Strengths & Themes* Workgroup Participant	*Advances the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
HighLand Productions, Inc.	Third-party consultant	• CHNA written report	*A healthcare marketing*

Meridith M. Kelly, President		and Implementation Strategy consultant and writer	*communications and consulting company*
Highland Rivers Health Jason Bearen, Chief Executive Officer Kathleen Varda, Director of Strategy and Business Development	Safety net provider	• Key Informants – Bartow	*Provides community-based neurobehavioral health care services and resource collaboration for individuals and families to improve quality of life.*
Hispanic Health Coalition of Georgia Heidy Guzman, Executive Director	Minority populations	• Community Transformation Grant Leadership Team	*A non-profit organization created to advance health policies that will improve access to services for Hispanic children and adults throughout the state. It was founded in 1990 and currently is Georgia's only state-wide organization focusing on Latino/Hispanic health*
Junior League of Douglas County Kathy Patman, Community Volunteer	Service organization	• MAPP partner - Douglas	*A non-profit organization of women, who have been the driving force behind initiatives to make the Douglas County community healthier and more vital*
Kaiser Permanente Beth Spinning, LMSW, Manager, Medicaid and Special Populations	Managed care system	• Cobb2020 partner • Cobb MAPP Steering Committee • Cobb MAPP Implementation Team Member – *Access to Health Services*	*Provides health care plans to its members nation-wide offering integrated care health care plans*
Kennesaw State University Drs. Anne Hicks-Coolick & Janice Long, Associate Professors	Third-party consultants	• Cobb Focus Group facilitators	*Integrated managed care consortium*
Kaiser Permanente Pat Guerry, Senior Director, Strategic Marketing & Product Development	Managed care system	• Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*Integrated managed care consortium*
Kennesaw State University Dr. Richard Sowell, Dean	Higher Education	• Cobb2020 partner • Cobb MAPP Steering Committee • *Community Strengths & Themes* Workshop Participant	*The third-largest university in Georgia with more than 24,600 undergraduate and graduate students representing 132 countries (2013 stats)*
Kiwanis Club of Marietta Lisa Crossman, Director of Clinical & Prevention Services	Civic organization	• Cobb2020 partner • Cobb MAPP Steering Committee	*Service organization with a special outreach to children in our community*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise

Live Healthy Douglas Coalition *(Cobb & Douglas Public Health)* Bev Kartheiser, Program Chair & Health Educator	Public health	• MAPP partner - Douglas	*Empowers Douglas County to create a drug-free and healthy community – part of Cobb & Douglas Public Health*
Lockheed Martin Rania Washington, Human Resources Director	Employers	• Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*Specializes in research, design, development, manufacture and integration of advanced technology systems, products and services.*
Magnetic North, LLC Ron Chapman, Consultant	Third-party consultant	• Key Informant interview facilitator and report writer – Bartow & Cherokee counties • Cobb MAPP design consultant and facilitator	*Consultant and facilitator*
Marietta City Health Clinic Shannon Barrett, Interim Human Resources Director	Health Clinic	• Cobb MAPP Implementation Team Member – *Access to Health Services*	*Provides healthcare and services to the Marietta community*
Marietta City Schools Donna Ryan, Ph.D., Assistant Superintendent of Special Services Cindy Culver, Director of School Nutrition	School system	• Cobb2020 partner • Cobb MAPP Steering Committee • Cobb MAPP Implementation Team Member – *Healthy Lifestyles* • Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*Develops programs, projects and services designed to meet the unique needs of our diverse student population by using system, school, grade level, and student specific data – benchmarks - to meet the needs of all learners*
Marietta Daily Journal/Neighbor Newspapers, Inc. Otis Brumby, III, Executive Vice President	Public service	• Cobb2020 Advisor • Community Transformation Grant Leadership Team	*Community newspaper*
McCleskey-East Cobb YMCA Rebecca Shipley, Executive Director	Community coalition	• Cobb2020 partner • Cobb MAPP Steering Committee • Cobb MAPP Implementation Team - *Healthy Lifestyles*	*Offers programs for youth development, healthy living and social responsibility*
MUST Ministries Dr. Ike Reighard, President and CEO	Non-profit serving vulnerable populations	• Cobb2020 Advisor • Community Transformation Grant Leadership Team	*Serves neighbors in need by transforming and restoring lives and communities in response to Christ's call.*
COLLABORATOR	**SECTOR**	**AREAS OF SERVICE***	**Description of Expertise**
National Alliance on Mental	Mental Health	• Key Informant - Cobb	*Advocates for access to*

Illness (NAMI)			*services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need*
Ninth District Georgia PTA Terry Fast, Parliamentarian of the Executive Committee	Residents/PTA	• Cobb2020 partner • Cobb MAPP Steering Committee	*Grows and strengthens the organization to better serve the children)*
North Star Church	Faith-based organization	• Key Informant - Cobb	*Exists to show God's love in such a way that people exchange ordinary living for an extraordinary life through the transforming power of Jesus Christ.*
Northwest Georgia Public Health District Lisa Greeby, Health Services Program Manager	Public health	• Key Informant - Bartow	*Protects and improves the health of the more than half million residents of the 10-county Northwest Georgia Public Health district. Through a variety of programs, community partnerships and services, we oversee environmental health, disease control and community and family health.*
Paulding County Health Department Stacey Amsbaugh	Public health	• Key Informant - Paulding	*Takes care of the health needs of the county including screenings, child health checks and immunizations*
Paulding County Juvenile Court Sandra Miller, Juvenile Court Judge	Justice system	• Key Informant - Paulding	*Promotes the protection and safety of children, families, and the community by means of treatment, rehabilitation, and supervision.*
Paulding County School District Christy Ragsdale, Supervising Nurse	School system	• Key Informant - Paulding	*Provides a safe, healthy, supportive environment focused on learning and committed to high academic achievement.*
Paulding County Senior Center Libby Spencer, Director	Senior services	• Key Informant - Paulding	*Conducts programs for those 55 years old and older living in the community. As a nutrition site for the County, over 100 seniors enjoy meals each day, either on-site or through the Meals on Wheels program. Provides transportation to those who need it.*
COLLABORATOR	**SECTOR**	**AREAS OF SERVICE***	**Description of Expertise**

Paudling Family Connection Children's Cabinet* Nina Lauter, Coordinator **Part of Family Connection, a Georgia statewide initiative of 159 community collaborative partnerships committed to making measurable improvements for children and families in Georgia.*	Child advocacy	• Key Informant – Paulding	*Serves as the local decision-making body, bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Georgia's children and families.*
Pricewaterhouse Coopers Matthew D. Petroski Pricewaterhouse Coopers LLP Manager, Exempt Organizations Tax Services	Third-party consultant	• Consultants for outlining CHNA tax law requirements	*Consultants focusing on audit and assurance, tax and consulting services and reviewers of CHNA for compliance with tax law requirements*
Renovacion Conyugal, Inc. (Marriage Renewal) Belisa M. Urbina, Founder/Executive Director	Minority organization	• Cobb2020 partner • Cobb MAPP Steering Committee	*Supports Latino families in marriage building and parenting*
South Cobb Business Association Wayne Dodd, Past-President	Employers	• Cobb2020 partner • Cobb MAPP Steering Committee	*Supports South Cobb's business community*
Smyrna City Government	City government	• Key Informant - Cobb	*Represents more than 50,000 residents in Cobb County*
United Way Catherine Owens, Regional Director	Non-profit organization representing vulnerable populations	• MAPP partner - Douglas	*A non-profit that engages all community segments to drive sustainable change in education, income, health and homelessness*
Cynthia Wainscott, Community Mental Health Advocate	Mental Health	• Key Informant - Bartow	*Mental health expert and advocate*
WellStar Cobb Hospital Kem Mullins, President of WellStar Cobb Hospital	Hospital	• WellStar Health System Advisor	*One of five WellStar non-profit hospitals. Located in Austell primarily serving Cobb, Douglas and Paulding counties.*
WellStar Community HealthCare Allen M. Hoffman, MD, Executive Director	Community clinics • Cobb • Kennestone • Douglas	• Cobb2020 partner • Cobb MAPP Steering Committee • Key Informant - Cobb • Cobb MAPP Implementation Team Member – *Access to Health Services* • Lead CHNA Assessor for WellStar • Community Transformation Grant Leadership Team • Cobb MAPP survey committee team member	*Creates and delivers health improvement designed to reduce the health and economic impact of the most common chronic conditions and focus on their prevention. Advocates the patient-centered medical home (PCMH) to guide quality improvement and disease management to meet the needs of the chronically ill in a more proactive, engaging way to prevent and curb the effects of chronic conditions.*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise

WellStar Douglas Hospital Craig Owens, President of WellStar Douglas Hospital Christopher Shane Greene, Executive Director, Hospital Operations and Finance	Hospital	• WellStar Health System Advisor • MAPP partner - Douglas	*One of WellStar's five non-profit hospitals. Located in Douglasville, GA primarily serving Douglas County.*
WellStar Health Place Allan Bishop, Executive Director, WellStar Retail Services	Healthcare system	• Cobb MAPP Implementation Team Member – *Healthy Lifestyles*	*A medically-based fitness center to promote healthy lifestyles with degreed exercise specialists, registered and licensed dietitians and massage therapists.*
WellStar Health System • Kim Menefee, Senior Vice President, Public and Governmental Affairs • Jimmy Swartz, Vice President, Accounting • David Englett, Manager of Reimbursement • Ebenezer N.Erzuah, Director of Reimbursement • Joe Brywczynski, Senior Vice President, Health Parks Development • Caroline Aultman, Executive Director, Strategic Planning	Health system	• WellStar Kennestone Hospital CHNA Steering Committee members • Community Benefits Program Representatives	*Provided oversight, accountability and work flow timelines for the CHNA process and reporting for WellStar hospitals.*
WellStar Health System Cecelia Wagoner, Assistant Vice President, Corporate & Community Health Donna Kremer, MDiv, RN, WellStar Congregational Nurse Network Melissa Box, Chief Nursing Officer	Health system	• *Community Strengths & Themes* Workshop Participant • Cobb MAPP Implementation Team - *Healthy Lifestyles* • *Community Strengths & Themes* Workshop Participant • *Access to Health Services* Implementation Team Member - Douglas	*A not-for-profit health system recognized as a national leader in comprehensive care. Creates and delivers high quality, hospital, physician, and other healthcare related services that improve the health and wellbeing of individuals and communities.*
WellStar Kennestone Hospital Dan Woods, President of WellStar Kennestone Hospital	Hospital	WellStar Health System Advisor	*One of WellStar's five non-profit hospitals. Located in Marietta, GA primarily serving Cobb, Cherokee, Paulding, and Bartow counties.*

COLLABORATOR	SECTOR	AREAS OF SERVICE*	Description of Expertise
WellStar Paulding Hospital Mark Haney, Senior Vice President of Real Estate and Construction and President of WellStar Paulding Hospital	Hospital	• WellStar Health System Advisor	*One of WellStar's five non-profit hospitals. Located in Dallas, GA primarily serving Paulding county.*
WellStar Windy Hill Hospital Lou Little, President, WellStar Windy Hill Hospital	Long-Term Acute Care Hospital	• WellStar Health System Advisor	*One of WellStar's five non-profit hospitals. Located in Marietta, GA serving all five counties and surrounding counties.*
West End Clinic Karen Williams, Associate Vice President, Programs	Federally Qualified Health Center (FQHC)	• Key informant – Cobb *Access to Health Services* sub-committee member	*Serves a variety of Federally designated medically underserved area/populations*
West Georgia Technical College Lisa Doney, Associate Provost	Higher education	• MAPP partner - Douglas	*A unit of the Technical College System of Georgia (TCSG) providing education for a seven-county service area that includes Carroll, Coweta, Douglas, Haralson, Heard, Meriwether, and Troup.*
Young Women's Christian Association	Vulnerable populations	• Key informant - Cobb	*Dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all through programs, economic empowerment, and health and safety.*

***Areas of Collaboration Defined:**

- **Key informants** (KIs):
  Cobb and Douglas: Influential health and community leaders within Cobb County were identified by Cobb2020's MAPP Steering Committee. Through snowball sampling, 20 Key Informants were interviewed for up to one hour. *Per Cobb & Douglas Public Health, the identities of the Key Informants are not able to be disclosed.* Key Informants represented different sectors of the Cobb community including healthcare, government, business, social service agencies, law enforcement, and the religious community and were in their current job position for an average of 7.42 years and Cobb County residents for an average of 19.56 years.

  Paulding, Cherokee and Bartow: Leaders within these counties were identified by representatives from the Public Health Departments. The survey instrument was a slightly modified version of the one developed and validated in Cobb County.

- **Cobb2020 Advisors/Steering Committee from Cobb and Douglas Counties:** Organization and individual partners/key leaders from many parts of the community on a state, regional and local level who contributed resources and time to the Cobb MAPP process. Led by Jay Dillon, Director of Communications for Cobb County School District and Dr. Jack Kennedy, District Health Director for Cobb & Douglas Public Health.

- ***Community Strengths and Themes Workshop* participants** (one of the four community assessments conducts by MAPP) resulted in the focus group report from Cobb2020

- **Cobb MAPP Implementation Teams - *Healthy Lifestyles* & *Access to Health Services*** formed in summer of 2012 to improve access to quality services for the medically underserved population in Cobb County. Recommendations form the basis for MAPP Stage 6 – Action Planning.

- **Cobb MAPP Survey Committee Members**-Developed the 44-question telephone survey conducted by Kennesaw State University's A.L. Burruss Institute for Public Service and Research polling 1,244 adults ages 18-94.

- **Douglas MAPP partners and Implementation Team Members** – Access to Health Services – community stakeholders representing Douglas County in the MAPP process lead by Cobb2020 and Cobb & Douglas Public Health.

- **Community Transformation Grant (CTG) Leadership Team** gave oversight to the grant awarded from the Centers for Disease Control and Prevention (CDC) in October 2011 to Cobb and Douglas Public Health in support of community level efforts to reduce chronic disease such as heart disease, cancer, stroke, and diabetes. The CTG promotes healthy lifestyles especially to population groups experiencing the greatest burden of chronic disease, to improve health, reduce health disparities and control healthcare spending.

- **WellStar Health System Advisor** –Senior leadership representing WellStar's five non-profit, community-based hospitals.

******Not included are the Forces of Change* Assessment** Day (Sept. 30, 2011) and ***Local Public Health Systems*** Assessment Day (Oct. 4, 2011) community participants. Attendee rosters below.

9 - Additional CHNA Collaborators – MAPP Rosters from *Forces of Change* (Sept. 30, 2011) and *Local Public Health Systems* assessment work days (Oct. 4, 2011)

Partners	Participant	Title
Cobb Community Services Board	Mr. Bryan Stephens	Director Cobb County Outpatient Services
Marietta Kiwanis Club	Ms. Lisa Crossman	Director of Clinical & Prevention Services
Good Samaritan Health Center	Ms. Kacie McDonnell	
Atlanta Regional Commission	Ms. Jennifer Curry	Health & Wellness Coordinator for the Aging Division
City of Marietta	Ms. Beth Sessoms	Economic Development Manager
South Cobb Business Association	Mr. Wayne Dodd	President South Cobb Business Assoc.
Cobb Chamber of Commerce	Mr. Slade Gulledge	Government Relations/ Area Councils Manager
Healthcare Georgia Foundation	Ms. Andrea Young Kellum	Program Officer
Cobb Community Foundation	Ms. Robin Bradley	
Emory-Adventist Hospital	Mr. Bob Crowe	Asst. VP Emergency & Imaging Services
WellStar Health System	Dr. Allen Hoffman	Executive Director WellStar Community Clinics
Cobb & Douglas Public Health	Dr. Jack Kennedy (Vice Chair)	District Health Director
American Cancer Society		Senior Community Manager
Kaiser Permanente	Ms. Beth Spinning	Manager Medicaid and Special Populations
Renovacion Conyugal, Inc.	Ms. Belisa M. Urbina	Founder/Executive Director
City of Kennesaw	Ms. LisaRae Jones	Director of Human Resources
Austell Community Task Force	Mr. Michael Murphy	Chairman
GlaxoSmithKline	Mr. Eric Klein	Sr. Executive Public Health Account Manager
Cobb County Sheriff's Office	Ms. Lynda Coker	Chief Deputy Sheriff
District 9 PTA	Ms. Terry Fast	
Marietta City Schools	Dr. Donna Ryan	Assistant Superintendent for Special Services
Cobb County School District	Mr. Jay Dillon (Chair)	Director of Communications

Kennesaw State University	Dr. Richard Sowell	Dean Kennesaw State University
Cobb County Government	Ms. Cheryl Mayerik	
McCleskey-East Cobb YMCA	Ms. Rebecca Shipley	Executive Director

Name	Organization
Charlotte Fulton	Douglas County Schools
Elizabeth Franco	GA Department of Public Health
Erica Tindell	WellStar
Gordon Freyman	GA Department of Public Health
Jason Milhollin	Douglas County EMA
Joy Wells	Cobb & Douglas Public Health
Kevin Eccles	United Way
Pam Blackwell	Cobb & Douglas Public Health
Sabrina Watson	Division of Children and Family Services
Agnes Brown	Cobb & Douglas Public Health
Alicia Thompson	WellStar
Amanda Bryant	Douglas CORE
Bev Kartheiser	Cobb & Douglas Public Health
Darlene Foote	Cobb & Douglas Public Health
David Jenkins	Motivational Fitness
Dorothy Sparks	Les Soeurs
Gabe Delgado	Douglasville Sentinel
Gordon Pritz	Douglas County Schools
James Harper	First Presbyterian Church
John Barker	Douglasville Patch
Judi Davis	Pregnancy Resource Center
Kathy Patman	Junior League
Kelly Hunter	City of Douglasville
Mattie McClurkin	Head Start of Douglas County
Steve Hord	Boys and Girls Club
Suvess Ricks	Douglas County Schools
Tim Williams	GreyStone
Tom Butler	Gold's Gym
Wes Tallon	Douglas County Communications
Winston Jones	Douglas County Sentinel
Bennett Oliver	City of Douglasville Parks and Recreation
Bernard Griffin	GA Department of Agriculture
Chris Womack	City of Douglasville
Ed Landers	Douglas County Sheriff's Office
Eric Linton	County Manager
Gary Dukes	Douglas County Parks and Recreation
Jack Kennedy	Cobb & Douglas Public Health
Judge Peggy Walker	Douglas County Juvenile Court
Lisa Crossman	Cobb & Douglas Public Health

Robert Gore	Cobb & Douglas Public Health
Scott Spencer	Douglas County Fire/EMS
Tim Collins	Chapel Hill News View
Tom Worthan	Douglas Board of Health
William Osborne	City of Douglasville
Name	**Organization**
Becky Jones	Grace Assisted Living Of Douglas County
Beth Spinning	Kaiser
Christine Steadman	DC Community Services Board
Cindy Richards	The Good Samaritan Center
David Aten	The Community Health Center of Austell
Emily Frantz	Cobb & Douglas Public Health
Frank Smith	The Church at Chapel Hill
Gina Brandenburg	Tanner
Healther Nutter	United Way
Jane Hibbard	Vista Care Hospice of Douglasville
Jaswant Chaddha	Atlanta West Women's Center
Juanita Clay	Gift of Love Services
Karla Ayers	Cobb & Douglas Public Health
Richard Hagan	Douglas County Senior Services
Shane Greene	WellStar
Teresa Smith	SHARE House Family Violence and Crisis Center
Terri Bradley	The Douglas County Homeless Shelter
Bernita Frazier	GA Department of Public Health
Dee Benitz	Cobb & Douglas Public Health
Jop Durrence	Cobb & Douglas Public Health
Karen Stroud	Public Education Trust
Ken Reaves	Georgia Highlands College
Lisa Doney	West Georgia Technical College
Madison Campbell	American Heart Association
Melissa Box	WellStar
Shawn Smith	Sanofi Pasteur
Stephanie Rakestraw	GreyStone Power Foundation
Carol Jakeway	GA Department of Public Health
Debbie Freeman	American Cancer Society

Data Collection Process & Methods

10 - Combined Cobb MAPP and WellStar Health Indicator Comparison Chart

2010 General Population Description	CC*	DC**	PA**	BA**	Ch**	Georgia	US	HP2020 Goal
CRCT Reading Scores 3rd grade meets/exceeds (11-12)[1]	**92.4**	**90**	**91.6**	**93.9**	**96.1**	**90.51**		
Key Drivers of Poor Health	**Cobb**	**Douglas**	**Paulding**	**Bartow**	**Cherokee**	**Georgia**	**US**	**HP2020 Goal**
Percentage without a high school diploma[24]	9.85	13.65	14.13	21.65	11.06	16.52	16.8%	
Percent in Poverty (< or = 100% FPL)[2]	10.62	11.30	8.18	14.01	7.39	15.71	15.3%	
Persons without health insurance[25]	18.4	17.7	13.3	20.6	15.2	19.4	15.2%	0%[3]
Maternal /Child Health (per 1,000)	**Cobb**	**Douglas**	**Paulding**	**Bartow**	**Cherokee**	**Georgia**	**US (09)**	**HP 2020 Goal**
Infant Mortality Rate (2010)[4]	5.6	8.1	5.7	6.7	4.6	6.3	6.14 (10)[5]	6.0[3]
% Low Birth Weight (2011)[4]	8.2%	10.1%	6.8%	7.1%	7.2%	9.4%	8.2[6]	7.8[3]
% Very Low Birth Weight (2011)[4] less than 1500 grams	1.7%	2.0%	1.2%	0.9%	1.2%	1.8%	1.5[6]	1.4[3]
Late or No Prenatal Care (2006)[4]	6.6	15.2	no data	12.2	7.6	1.3	7.1 (07)[7]	
Adolescent Pregnancy Rate (15-17) (2011)[4]	11.3	15.7	8.8	22.1	9.7	18.9	36.8(08)[8]	36.2[3]
% Repeat Births Teens (15-17) (2010)[4]	11.9%	9.9%	14%	12.3%	8.6%	12.4%		
Births & % Reported Tobacco Use (2011)4	1.9	5.8	6.8	13.3	4.9	6.0%		
2008 AA Deaths (per 100,000)	**Cobb**	**Douglas**	**Paulding**	**Bartow**	**Cherokee**	**Georgia**	**US (09)**	**HP 2020 Goal**
Cardiovascular Disease (2010)[4]	207.1	263.9	181.7	263.8	241.5	252.1	234.8 [9]	
Stroke (2010)[4]	34.8	47.8	38.2	59.8	45.7	44.8	39.0[5](10)	33.8[3]
Lung Cancer (2010)[4]	42.2	64.0	57.6	71.6	40.6	48.7	48.5[9]	45.5[3]
Stroke (2010) 4	34.8	47.8	38.2	59.8	45.7	44.8		
Diabetes (2010)[4]	14.8	15.5	19.1	13	11.3	22.7	20.9[9]	65.8[3]
YPLL 75 Motor Vehicle Crashes (2008)[4]	192.6	453.4	363.1	386.9	247.8	420.1	12.5[9]	12.4[3]
2004-2008 AA Cancer Incidence per 100,000	**Cobb**	**Douglas**	**Paulding**	**Bartow**	**Cherokee**	**Georgia**	**US**	**HP2020 Goal**
Lung and Bronchus[11]	58.90	82.60	93.90	100.40	82.30	71.60	67.20 [12]	
2010 Hospitalizations per 100,000	**Cobb**	**Douglas**	**Paulding**	**Bartow**	**Cherokee**	**Georgia**	**US**	**HP 2020 Goal**
Ambulatory Care Sensitive Conditions (% of Discharges)[4]	15.3	17.0	15.6	19.8	14.7	19.1	30.0 (07)[13]	
Diabetes[4] (discharge rate)	129.5	207.7	130.3	241.6	98.1	179.7	226 (09)[14]	
Pneumonia (2010)[4]	194.2	239.6	241.7	361.3	239.4	303.8	374 (09)[14]	

2010 Self-reported BRFSS Data (%)	Cobb	Douglas	Paulding	Bartow	Cherokee	Georgia	US	HP 2020 Goal
Overweight Adults[24]	37.57	39.15	36.29	40.0	32.83	36.18	36.31	
Obese Adults[24]	23.30	30.70	26	25.30	27.20	28.15	27.35	30.6 (age 20+)[3]
Physical inactivity[24]	19.80	23.90	23.80	21.80	19.60	25.30	24.66	
Less than 5 fruits/vegetables daily [24]	70.10	84.40	74.60	77.60	76.60	76	75.92	
Smoking[24]	14.80	15.40	20.60	26.40	17.60	19.40	19.27	12.0[3]
Diabetes (Prevalence)[24]	9.10	10.30	10.90	9.30	7.80	10.32	8.77	
High Blood Pressure Management(not taking medications for High Blood Pressure)[24]	17.33	8.33	31.96	7.95	18.46	19.83	21.74	
High Cholesterol (2009)[24]	36.1	33.7 (04-07,District)[20]	No Data	No Data	No Data	37.0	37.4	13.5[3]
Cholesterol Check (Ever)[24]	87.7	84.75	No Data	No Data	No Data	82.0	80.6	82.1[3]
Heavy Drinking (Adults)[24]	15.90	10	10.3	16.10	16.50	3.8	4.9	
Cervical Cancer Screening (Pap Smear in past 3 years)[24]	85.50	82.30	80	79.80	86.50	74.32	73.97	
Breast Cancer Screening (% female Medicare enrollees who received Mammogram in past two years)[24]	67.65	62.85	64.21	64.28	63.84	63.61	65.37	
Colon Cancer Screening (Sigmoid/Colonoscopy adult men age and older)[24]	62.40	No data	No data	No data	62.40	48.42	51.79	
Access to Primary Care (number primary care physicians per 100,000 population	60.74	40.02	13.34	41.93	36.38	21.7	16.7	
Pneumonia shot, 65+[18]	69.20	No data	74.20	75.90	64.90	38.75	55.68	90.0[3]
2011-12 GA Student Health Survey Data (% 12th)	**CC**	**DC**	**PC**	**BC**	**CC**	**Georgia**	**US**	**HP 2020 Goal**
Alcohol Use, past 30 days[21]	28.11	24.77	31.57	34.39	39.68	29.01	41.8[20]	
Tobacco Use, past 30 days[21]	16.93	14.88	23	28.92	25.45	19.31	19.5[20]	16.0[3]
Marijuana Use past 30 days[21]	19.81	13.44	17.15	19.93	20.13	16.91	20.8[20]	6.0[3]
Other Drugs past 30 days[21]	10.91	8.54	7.42	11.46	11.21	8.64		
5 fruits/vegetables[21]	56.43****	53.60****	46.91****	43.03****	53.92****	51.87****	22.3[20]	
More than 4 hours T.V. time daily[21]	16.41	24.35	22.42	17.82	15.46	19.79	32.8 (3hrs +)[20]	26.1 (2 hrs+)[3]
Students Learning about HIV past year[21]	64.11	53.25	43.03	41.27	40.40	50.48	87.0[20]	
Considered Suicide past year[21]	9.35	9.97	7.91	8.99	10.14	8.92	13.8[20]	

*CC – Cobb County School

** DC - Douglas County Schools

***Answer to question: Strongly Agree + Agree

Sources:

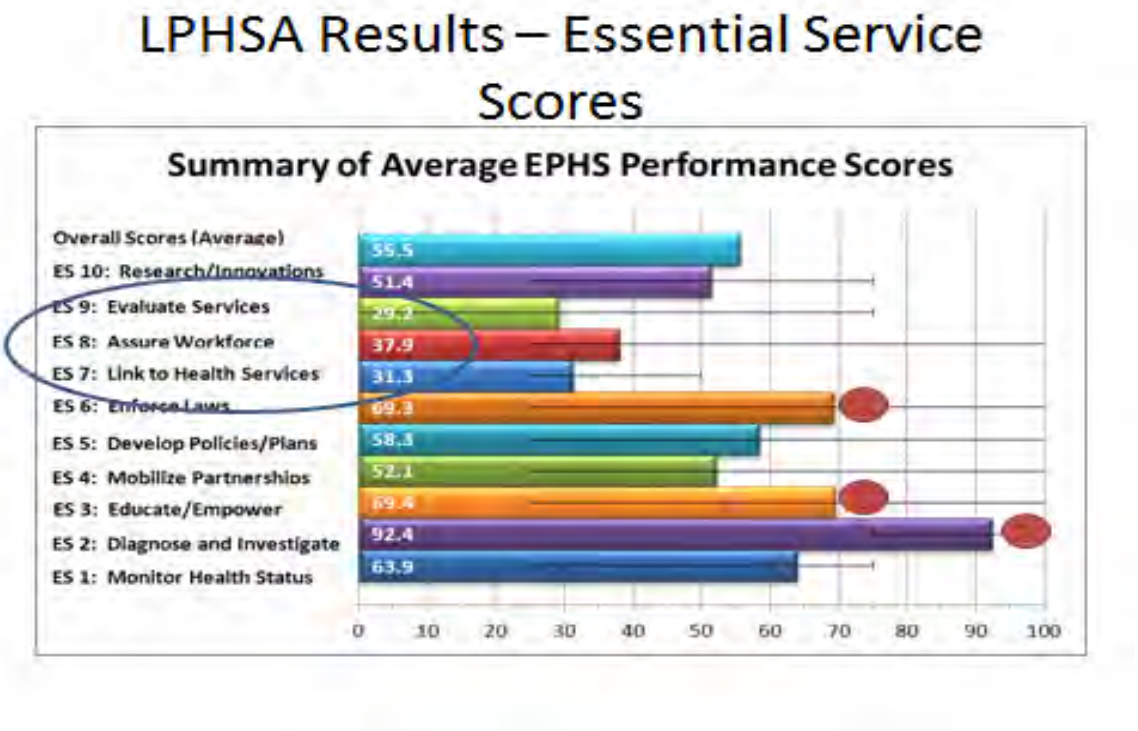
1. Georgia Department of Education, School Reports by District, *2011-2012 Report Card.*
2. U.S. Census Bureau. *American Community Survey 2006-2010, 5 Year Estimates*.
3. Office of Disease Prevention and Health Promotion (ODPHP), U.S. Department of Health and Human Services (HHS). *Healthy People 2020.*
4. Georgia Department of Community Health, Division of Public Health, Office of Information and Policy. *Online Analytical Statistical Information System (OASIS)*.
5. Centers for Disease Control and Prevention, National Vital Statistics System, *Deaths Preliminary Data for*

2010.http://www.cdc.gov/nchs/nvss.htm

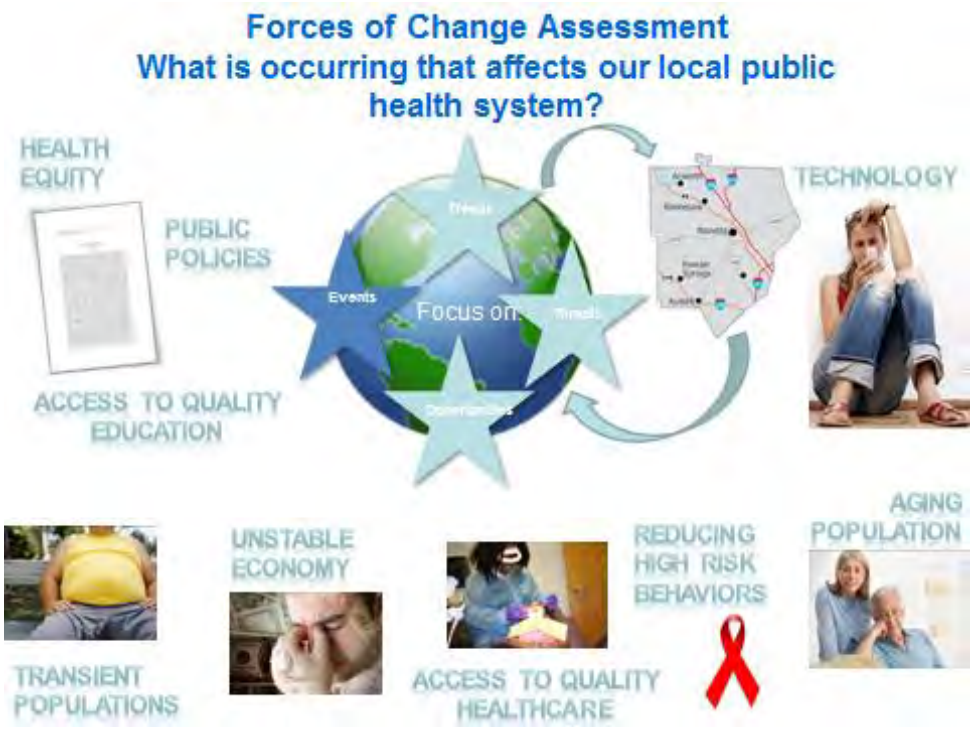
6. Centers for Disease Control and Prevention, National Vital Statistics System, Births: Final Data for 2009.
7. Centers for Disease Control and Prevention, National Vital Statistics System, Births: Final Data for 2007.
8. Guttmacher Institute. *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity.*
9. Centers for Disease Control and Prevention, National Vital Statistics System, *2009 Mortality Multiple Cause Micro-data Files.*
10. Centers for Disease Control and Prevention, Injury Prevention &Control: Data& Statistics (WISQARS), *Years of Potential Life Lost (YPLL) 1999-2009.*
11. Georgia Department of Community Health, Division of Public Health, Georgia Comprehensive Cancer Registry.
12. National Cancer Institute, Surveillance Epidemiology and End Results, *SEER Stat Fact Sheets: Lung and Bronchus, Nov 10, 2011.*
13. Center for Disease Control and Prevention, *National Hospital Discharge Survey, 2009.*
14. Center for Disease Control and Prevention, *Ambulatory Medical Care Utilization Estimates for 2007.*
15. Center for Disease Control and Prevention. *Sexually Transmitted Diseases in the United States, 2010*.
16. Georgia Department of Community Health, Division of Public Health, Epidemiology Branch, HIV/AIDS Epidemiology Unit.
17. Georgia Department of Community Health, Division of Public Health. *Georgia Immunization Study, 2010 Final Report.*
18. Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System (BRFSS).*
19. Georgia Division of Public Health, *Obesity Surveillance Data & Reports, 2010*.
20. Georgia Division of Public Health*, Behavioral Risk Factor Surveillance Report, 2007.*
21. Georgia Department of Education. *Georgia Student Health Survey 2011-2012.*
22. Center for Disease Control and Prevention. *Health Youth! YRBSS: Youth Risk Behavior Surveillance System.*
23. County Health Rankings, University of Wisconsin. www.countyhealthrankings.org. 2012
24. CHNA.org.

U.S. Census Bureau, American Community Survey 2009-2011, 3 Year Estimate

11 - Local Public Health System Assessment Result



12 - *Forces of Change Assessment Results –* *Forces that impact community health*



13 - LPHS Assessment Priority/Performance Strategy Grid

Quadrant A (High Priority/Low Performance) - These important activities may need increased attention.	**Quadrant B (High Priority/High Performance) - These activities are being done well, and it is important to maintain efforts.**
1.1 Population-Based Community Health Profile 7.1 Identification of Populations w/Barriers to Personal Health Service 7.2 Assuring the Linkage of People to Personal Health Services 8.1 Workforce Assessment 8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring 9.1 Evaluation of Population-based Health Services	1.2 Access to and Utilization of Current Technology to Manage, Display, Analyze & Communicate Pop Health Data 1.3 Maintenance of Population Health Registries 2.1 Identification and Surveillance of Health Threats 2.2 Investigation and Response to Public Health Threats and Emergencies 2.3 Laboratory Support for Investigation of Health Threats 3.1 Health Education and Promotion 3.3 Risk Communication 5.4 Plan for Public Health Emergencies 6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances 6.3 Enforce Laws, Regulations and Ordinances
4.2 Community Partnerships	
Quadrant D (Low Priority/Low Performance) - These activities could be improved, but are of low priority. They may need little or no attention at this time.	**Quadrant C (Low Priority/High Performance) - These activities are being done well, but the system can shift or reduce some resources or attention to focus on higher priority activities.**
4.1 Constituency Development 5.2 Public Health Policy Development 5.3 Community Health Improvement Process 8.4 Public Health Leadership Development 9.2 Evaluation of Personal Health Care Services 9.3 Evaluation of the Local Public Health System 10.1 Fostering Innovation	3.2 Health Communication 5.1 Government Presence at the Local Level 6.1 Review and Evaluate Laws, Regulations, and Ordinances 8.2 Public Health Workforce Standards 10.2 Linkage with Institutions of Higher Learning and/or Research 10.3 Capacity to Initiate or Participate in Research

14 - CNHA Prioritization Matrix Template (used in ranking and rating priority health needs)

Health Need	*Severity of issue – performs poorly against benchmark*	*Clear disparities and inequities*	*Community prioritizes the issue over other issues*	*Existing attention, facilities and resources are dedicated to the issue*	*Effective & feasible interventions exist*	*A successful solution has the potential to solve multiple problems*	*Opportunity to intervene at the prevention level*	**Score**
Cardiovascular Disease								
Lung cancer								
Stroke								
Breast Cancer								
Physical Activity								
Healthy Eating								
Smoking								
Obesity								
Alcohol								
Diabetes								
Mental Health								
Air Quality								
Breast Cancer (screening)								
Dental Care								
Education								
Sexually Transmitted Infections								
Access to Care								
Prenatal Care								

15 Community Facilities, Assets & Resources

Facilities:

	Name	Description
COBB & DOUGLAS PUBLIC HEALTH Healthier lives. Healthier community.	*HEALTH CENTERS:* **ACWORTH** 4489 Acworth Industrial Drive Acworth, Georgia 30101 (770) 974-3330 **COBB COUNTY ENVIRONMENTAL HEALTH** 3830 South Cobb Drive, Suite 102 Smyrna, Georgia 30080 770-435-7815 **SMYRNA** 3830 South Cobb Drive, Suite 200 Smyrna, Georgia 30080 770-438-5105 **EAST COBB** 4938 Lower Roswell Road Marietta, Georgia 30068 678- 784-2180 **LAKE PARK** 1955 Lake Park Drive, Suite 300 Smyrna, Georgia 30080 770-432-0012 **SOUTH COBB** 875 Six Flags Drive Austell, Georgia 30168 678-385-1360 **NORTH DOUGLAS** 6457 East Strickland Street Douglasville, Georgia 30134 770-489-9686 **DOUGLAS COUNTY ENVIRONMENTAL HEALTH**	*Promotes and protects the health and safety of the residents of Cobb and Douglas counties.*

8700 Hospital Drive,
1st Floor
Douglasville, Georgia 30134
770-920--7311

WellStar Community Clinics:
Kennestone
Cobb
Douglas
www.wellstar.org
770-793-9250

Pilot nurse-managed health clinic for indigent care

Senior Wellness Center
Cobb County Senior Center
1150 Powder Springs Road
Suite 100B
Marietta, GA 30080
470-956-2500

Serves people ages 55-64 that are uninsured.

Cobb and Douglas Public Health Centers

Cobb County Health Center
1650 County Services Parkway
Marietta, GA 30008 770-514-2300

Douglas County Health Center
6770 Selman Drive
Douglasville, GA 30134
770-949-1970

www.cobbanddouglaspublichealth.com

Provides general health information and public health regulatory information to the residents and businesses of Cobb and Douglas Counties

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Good Samaritan Health Center at Cobb
1605 Roberta Drive SW
Marietta, GA30008
770-419-3120

www.goodsamcobb.org

Federally Qualified Health Center (FQHC)

The Family Health Center at Cobb
805 Campbell Hill Street
Marietta, GA30060
770-919-0025

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

	Affiliated with West End Medical Centers	
	Community Health Clinic (CHC) at Sweetwater Valley 6289 Veterans Memorial Hwy. Austell, GA 30168 678-398-6548	*A community development block grant program-funded health clinic and overseen by the Community Action Mission Program. The CHC is a low-cost medical and dental office committed to providing care for those in our community.*
	Community Health Center – Austell 6289 Veterans Memorial Dr. Suite 12-C Austell, GA 30168 770-819-0062 www.chcaustell.orog	*Community health clinic.*
	Kennesaw State University at MUST (Ministries United in Service) Community Clinic 1407 Cobb Parkway NW Marietta, GA 770-427-98621	*The clinic is a collaborative effort with Kennesaw State University's WellStar College of Health and Human Service, Center for Community Health Care. A wide range of health and wellness services benefit those who are homeless, underserved and/or uninsured. The clinic is an excellent practice site for student nurses and volunteer clinical practice by faculty members from the School of Nursing.*
	Luke's Place Community Wellness Center 948 Front Street Mableton, GA 30126	*Designed to provide programs and services to those in need in Mableton, Georgia and the surrounding areas. The clinic is not currently receiving funds or aid from any local, state or federal organization. Staffed by an all-volunteer group of doctors, nurses, social workers and support personnel to the growing health needs of the community.*
	Life University Outreach Clinics 140 Marble Mill Road Marietta, GA30060 770-426-2946 www.life.edu	*Services include chiropractic care, digital imaging, functional rehabilitation, health care classes and nutritional counselling*
	YWCA of Northwest Georgia 48 Henderson St. SW Marietta, GA 30064 770-427-2902 www.ywcanwga.com	*Domestic Violence Shelter - restricted to females and children who have recently experienced domestic violence in Bartow, Cherokee, Cobb, Douglas and Paulding county*
	Bartow Health Access 31 Pointe North Dr. Cartersville, GA 30120 678-535-7216	*Charitable medical clinic - organized exclusively for charitable, scientific and educational purposes, to provide accessible health care for those without insurance; more specifically, to create premier health status, in our community, by enhancing, coordinating and providing plans and partnerships, which address*

		accessibility, accountability, and prevention, education and information *www.bartowhealthaccess.org*
	Kaiser Permanente Charity Care *(by referral)*	*Managed care organization*
	Emory Adventist Hospital at Smyrna 3949 South Cobb Drive Smyrna, GA30080 770-434-0710	*Hospital in Cobb County.*
	Northside Hospital – Cherokee 201 Hospital Road Canton, GA30114 770-720-5100	*Hospital in Cherokee County*
	Cartersville Medical Center 960 Joe Frank Harris Pkwy. Cartersville, GA30120 770-382-1530	*Hospital in Bartow County*

Assets:

	Name	Description
	Cobb and Douglas Public Health (CDPH) partnerships and coalitions including: *We CAN! In Cobb* *Cobb Community Collaborative* *Cobb Alcohol Task Force* *CATCH Kids Club*	***Ways to Enhance Children's Activity and Nutrition (We Can!)*** *is a nationwide initiative developed by the National Institutes of Health.* ***CATCH Kids Club*** *is a social-based physical activity and nutrition education program designed for elementary school-aged children (grades 3 through 5) in an after-school/summer setting in afterschool programs in Marietta City schools, Cobb County schools, faith-based and non-profit programs in Cobb County.*
	Safe Kids Cobb County 114 Cherry Street Suite G Marietta, GA 30060 770-793-7185	***Safe Kids*** *partners with police and fire departments, insurance companies, and schools to ensure the safety of Cobb's children.* *Lead agencies CDPH and WellStar Health System.*

Georgia Department of Public Health
Two Peachtree Street, NW
Atlanta, Georgia 30303-3186
404-657-2700

www.health.state.ga.us

The lead department entrusted by the people of the state of Georgia with the ultimate responsibility for the health of communities and the entire population.

Cobb and Douglas County Community Services Board
3830 South Cobb Drive
Suite 300
Smyrna, GA 30080
770-429-5000

www.cobbcsb.com

Cobb County Community Services Board and the Douglas County Community Services Board (CSB) are public agencies created by state law to provide mental health, developmental disability, and substance abuse services. The service areas are Cobb, Douglas, and Cherokee Counties, Georgia.

Soul Changers Recovery Foundation
5006 Austell Road
Austell, GA 30106

770-428-9326

A drug addiction treatment center offering transportation assistance, clothing, daily spiritual group meetings and other related services. The organization also provides educational classes on nutrition, life skills and relapse prevention.

The Extension
P.O. Box 793
Marietta, GA 30061

770-590-9075
www.theextension.org

Serves the community through a long-term, comprehensive Residential Recovery Program for homeless, addicted men and women that is also a source of strength for others suffering from addiction within the community.

Good News Counseling Center
2158 Austell Road
Marietta, GA 30008

770-436-3273

Provides practical, biblical support regarding changing attitudes and behaviors in relation to God and others.

Cobb County Community Services Board & Douglas County Community Services Board
3830 South Cobb Drive, Suite 300
Smyrna, GA 30080
770-429-5000
www.cobbcsb.com

Provides mental health, developmental disability, and substance abuse services. The service areas are Cobb, Douglas, and Cherokee Counties, Georgia.

	**Douglas CORE** 8565 Courtland Street Douglasville, GA 30134 770-920-7438	*A partnership among the government, private sector, citizens, educators, and health and human services organizations of Douglas County. Its mission is to improve the well-being of the community, including support for producing both self-sufficient adults, and strong, healthy, educated families.*
	**Healthcare Georgia Foundation** 50 Hurt Plaza Suite 1100 Atlanta, GA 30303 404-653-0990	*Our mission is to advance the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities.*
	**Mobilizing for Action through Planning and Partnerships** (MAPP)	*Developed by the National Association of County and City Health Officials (NACCHO).* *MAPP provides the framework for community-driven strategic planning for improving community health. Facilitated by public health leaders and involving all community stakeholders, this tool helps communities apply strategic thinking to prioritize public health issues and identify resources to address these issues.*
	**Cobb Schools Foundation** 514 Glover St. Marietta, GA 30060 770-426-3390 www.cobbschools foundation.org	*PROJECT 2400, created in 2006, is a strategic partnership between the Cobb Chamber of Commerce and the Cobb County School District to help enhance our students' SAT scores, which is now based on a score of 2400. In 2009, the Cobb Schools Foundation became the fiscal agent of Project 2400.*
	**Mableton Farmers Market** The Mable Complex 5239 Floyd Road Mableton, GA	*Provides the community of Mableton with readily available access to Georgia grown fresh fruits and vegetables. As an incentive for more of the community to utilize the Farmers Market, vouchers are provided to seniors on a fixed income. In addition, the Farmers Market has a wellness component where organizations including WellStar Kennestone Hospital and Emory Adventist Hospital provide free health screenings for cholesterol, glucose and blood pressure. Supported by Cobb County Parks, Recreation and Cultural Affairs, Cobb Public Health's We Can! in Cobb and the Mableton Improvement Coalition. Ways to Enhance Children's Activity and Nutrition (We Can!) is a nationwide initiative developed by the National Institutes of Health.*
	**Cobb Community Transit** 463 Commerce Park Drive Suite 112 Marietta, GA 30060 770-427-2222 www.cobbcounty.org	*County bus system*
	Cobb County Senior Services	*Provides an array of services including the operation of*

	1150 Powder Springs Street Suite 100 Marietta, GA 30064 770-528-5366 www.seniors.cobbcountyga.gov	*eight Senior Centers which include three neighbourhood centers, four multi-purpose centers, and the Senior Wellness Center. List of facilities: http://portal.cobbcountyga.gov/index.php?option=com_content&view=article&id=678&Itemid=383*
	Douglas County Senior Services 6287 Fairburn Rd. Douglasville, GA 30134 770-489-3100	*Committed to creating opportunities that allow older residents of Douglas County to remain independent and active in their homes and communities.*
COBB COMMUNITY COLLABORATIVE SHARING IDEAS, EXPERTISE AND RESOURCES	**Cobb Community Collaborative** 995 Roswell Street, Suite 100 Marietta, GA 30060 770-514-7212 www.cobbcollaborative.org	*Convenes community stakeholders to facilitate the sharing of ideas, expertise and resources to meet needs and resolve issues in Cobb County.*
CCF COBB COMMUNITY FOUNDATION	**Cobb Community Foundation** 240 Interstate North Parkway Atlanta, GA 30339 770-859-2329 www.cobbfoundation.com	*Works with individuals and organizations to create endowment funds which are managed by a team of professional investment advisors. Helps donors connect their charitable interests to a variety of important community needs through grants, specific gifts, and scholarships.*
Marietta city schools A Georgia Charter System	**Marietta City Schools** 250 Howard Street Marietta, GA 30060 770-422-3500 www.marietta-city.org	*Serves some 8,000 students at eight elementary choice schools—one of which is a Science, Technology, Engineering and Math (STEM) Magnet—one middle school, one sixth-grade school, and one high school.*

Resources:

	Name	Description
Cobb2020 Toolkit Resources	**Cobb2020** http://cobb2020.com/cobb2020-toolkit-resources.html	*Online resources, toolkits and next steps for healthy change*
Live Healthy Georgia Community Resources	**OASIS – Online Analytical Statistical Information System** The Georgia Department of Public Health's online data warehouse	*Online resource list for the state of Georgia.*

	oasis.state.gov.us/oasis/	
Paulding Family Connection Children's Cabinet 2011/2012 Resource Directory	**http://www.gafcp.org/fcnetwork/paulding**	*This directory contains family-oriented resources located within Paulding and the metro Atlanta area.*
	Renovacion Conyugal P.O. Box 146 Acworth, GA 30101 678-363-3079 www.renovacionconyugal.com	*The "Renewing Youth" project helps young Latinos to achieve better communication and relationships with family. It provides tools to prevent drug abuse, negative self-esteem, gang involvement, teen pregnancy and alcohol abuse, while helping them adapt to the realities of living in a bicultural society. From the beginning, the program has been prepared, conducted and presented by other teens and young Latinos creating an excellent opportunity for interaction with peers.*
	Cobb County School District Cobb County Family Resource Database	*Resources are not affiliated with the Cobb County School District.* *www.cobbk12.org/FamilyResources.com*
	Cobb County School District Social Workers 514 Glover Street Marietta, GA 30060 770-426-3300	*Cobb County School Social Workers exist to provide services to students, families and schools with the primary focus of removing barriers to academic success. School Social Workers are a vital part of the total educational process. They work in collaboration with school psychologists, school counsellors, school nurses, teachers, administrators, parents and various community agencies. Information obtained through these resources is then integrated to provide social, emotional, behavioural, and adaptive functioning support to the student, his or her family, and the school.* *http://www.cobbk12.org/centraloffice/studentsupport/socialworkers/*
CHILD HEALTH SERVICES	**Project Towards No Tobacco Use (TNT)**	*A classroom-based curriculum designed to prevent or reduce tobacco use in youth aged 10 to 14 years managed by Cobb and Douglas Public Health.*
	Adult and Child Health Services	http://www.cobbanddouglaspublichealth.com/
	Cherokee Family Violence Center 90 North Street Canton GA 30114 770-479-1703 www.cherokeefamilyviolence.org	*Provides emergency shelter and crisis intervention services while fostering affordable housing; offering longer term education and support services; developing community partnerships and institutional awareness of domestic violence issues; and promoting a community standard of zero tolerance for violence in the home.*
	Traveler's Aid 995 Roswell St. Marietta, GA30060	*A social service agencies in Metropolitan Atlanta providing a safety net for low-income travelers, newcomers and residents in crisis.*

	770-428-1883 www.travelersaidatlanta.org	
	New Beginnings Food Outreach 7034 Glade Road SE Acworth, GA 30102 770-529-6353 www.bartowliveunited.org	*A food pantry serving Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Paulding, and Rockdale counties*
	**The Center for Family Resources** 995 Roswell St NE # 100 Marietta, GA 30060 770-428-2601 www.thecfr.org	*Helps low-income families with employment, education, and housing services; leadership development programs; mentoring opportunities; and temporary financial and food assistance Transitional housing*
	Helping Hands of Paulding 228 W Spring St Dallas, GA 30132 770-443-1230 www.helpinghandspauldingga.org	*A non-profit organization made up of church, community and professional people working together to provide temporary emergency aid for those in need residing in Paulding County, Georgia*
	**Osborne Community Coalition** 2050 Austell Rd SW #O2, Marietta, GA 770-433-8810 www.socialwelfareservices.org	*Promote healthy life choices for individuals and families leading to the ownership of positive community development and self-sufficiency.*
	http://www.hhcga.org/	*Advances health policies that will improve access to services for Hispanic children and adults throughout the state. It was founded in 1990 and currently is Georgia's only state-wide organization that focuses on Latino/Hispanic health*
	**Salvation Army** 8460 Courthouse Square E. #100A Douglasville, GA 30134 770-942-7188	*An evangelical part of the universal Christian church. Its message is based on the Bible. Its ministry is motivated by the love of God. Its mission is to preach the gospel of Jesus Christ and to meet human needs in His name without discrimination.*
	**Tallatoona Community Action Mission** 406 Martin Luther King Jr. Dr. Cartersville, GA 30120 770-382-5388 www.tallatoonacap.org	*Assists low income individuals and families to acquire useful skills and knowledge, to gain new opportunities, and achieve self-sufficiency.*
	African American Crisis Assistance Network 1035 Cobb Industrial Drive Marietta, GA 3066	*Feeds the hungry, provides clothing and relief assistance to the less fortunate and orphans, assists the sick and disabled, promotes peace, dignity, and hope for the less advantaged.*

	678-467-7202 www.aacan.org	
	Lighthouse Community Ministries Inc. 5376 Church Street Mableton, GA 30126 770-944-1719	*Provides the community with a food ministry, bread ministry, clothes closet and also furniture for families in need.*
	Must Ministries 1407 Cobb Parkway Marietta, GA 30062 770-427-9862 www.mustministries.org	*Servant leaders in caring for those in need in the Marietta, Smyrna and Canton/Cherokee county communities.*
	Vision Rehabilitation Services of Georgia 3830 South Cobb Drive Suite 125 Smyrna, GA30080 770-432-7280 www.vrsga.org	*Assists individuals who are blind or visually impaired so they may function independently in all of their environments. VRS provides practical tools and proven techniques to help our clients carry out their daily activities.*
	CobbWorks- Workforce Investment Board 463 Commerce Park Drive Suite 100 Marietta, GA30060 **770-528-8066** **www.cobbworks.org**	*A web-enabled career and education resource.*
	Communities In Schools of Marietta/Cobb County 316 Alexander Street, Ste. 5 Marietta, GA 30060 678-503-0901 www.cismcc.org	*The only dropout prevention program in the nation proven to increase graduation rates.*
	The Extension, Inc. P.O. Box 793 Marietta, GA 30061 770-590-9075 www.theextension.org	*Empowers chemically dependent homeless men and women in Cobb County to become sober, accountable members of society and to serve as a recovery resource for the community. Led by a staff of licensed and certified counsellors, holding some of the highest credentials in the addiction recovery field, we serve the community through a long-term, comprehensive Residential Recovery Program for homeless, addicted men and women that is also a source of strength for others suffering from addiction within the community.*
	The Center for Children and Young Adults 2221 Austell Road, Suite A Marietta, GA 30008 770-333-9447 www@ccyakids.org	*Provides safe and nurturing environments with comprehensive services for homeless youth and young adults, who have been abused, abandoned, neglected, or are at risk.*

	**Live Healthy Douglas County Coalition** 6457 East Strickland Street Douglasville, GA 30134 770- 949-3139	*Making Douglas County a drug-free and healthier place to live by reducing youth substance use and improving lifestyle choices through community collaboration, advocacy and education.*
	Douglas Alcohol Abuse Prevention Initiative (DAAPI)	*Formed through a grant to the Cobb and Douglas Public Health, the organization's vision is for healthy, fully realized Georgians living in communities free of the debilitating effects of substance use & abuse.*
	**The Pantry** 5960 Stewart Parkway Douglasville, GA 30135 770-217-0729 Ext 1	*A community food ministry in Douglasville.*

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