APPENDICES: 2016 Community Health Needs Assessment

HEALTH NEED THEMES BY COUNTY FROM PRIMARY DATA

These health needs are not listed in order of perceived importance.

BARTOW

Public Health/ Resident / Key Informant Priorities
Tobacco use
Maternal and infant health
Mental health
Chronic disease
Access to affordable care
Prevention/wellness education
Heart disease / stroke
Cancer
Obesity
Transportation

CHEROKEE

Public Health/ Resident / Key Informant Priorities
Mental health
Teen suicide
Chronic disease – Type 2 diabetes
Access to affordable care
Teen pregnancy and low birth weight
Substance abuse – heroin
Heart disease

COBB

Public Health/ Resident / Key Informant Priorities
Access to affordable care
Chronic disease
Obesity
Sexually transmitted diseases
Maternal/Infant health
Mental health
Cancer
Heart disease
Lack of safe and affordable housing
Substance abuse

DOUGLAS

Public Health/ Resident / Key Informant Priorities
Access and affordability of primary care
Quality of care
Chronic disease
Obesity
Mental health
Transportation
COPD
Substance abuse

PAULDING

Public Health/ Resident / Key Informant Priorities
Mental Health
Obesity
STDs
Chronic disease – Type 2 diabetes
Access to care
Transportation
Cancer
Heart disease / hypertension
Substance abuse

COUNTY PROFILES

County: Bartow (63rd) County Health Ranking 2015 **Population: 100,382** US CENSUS BUREAU 2010-13

Public Health /Resident Priorities
Teen Pregnancy and low birth weight
Tobacco use
Mental health
Chronic disease
Access to care (under and uninsured)

Age Group (2009-13)[a]	%	Racial/Ethnic (2009-13)[a]	%
0-17 yrs	26.22	Black	10.39
18-64 yrs	62.52	Hispanic	7.80
65+ yrs	11.26	Non-Hispanic White	79.04

Socioeconomic	Measure	Health Care Access	Measure
Poverty Rate (< 100% FPL) (2009-13)[a]	17.1%	Primary Care Providers / 100,000 (2012)[a]	43.7
High School Graduation Rate (2011-12)[a]	70.6%	Dental Providers / 100,000 (2013)[a]	28.6
Students Eligible for Free / Reduced Lunch (2013-14)[a]	50.7%	Mental Health Providers / 100,000 (2014)[b]	85
Unemployment Rate (2015)[a]	7.6%	% of Adults with No Regular Doctor (2011-2012)[a]	30.2%
Uninsured Population (2009-13)[a]	19.3%	Federally Qualified Health Centers / 100,000 (2014)[a]	1
Uninsured Children (2013)[a]	10.1%	% Population in Health Professional Shortage Area (2015)[a]	100%
Health Determinants	**Measure**	**Clinical Care & Prevention**	**Measure**
Tobacco Use - Cigarette Smokers (2006-12)[a]	21.3%	Households Receiving SNAP (2009-13)[a]	13.6%
Inadequate Fruit & Vegetable Consumption (2005-09)[a]	78.6%	HIV Screening Rate (2011-12)[a]	42.5%
Access to Exercise Facilities (2010/2013)[b]	82.1%	% Smokers Attempting to Quit (2011-12)[a]	58.8%
Travel to work by transit, walk, or bicycle (2009-13)[c]	0.5%	Physical Inactivity – 18+ yrs (2012)[a]	26.1%
Commute over 60 Minutes (2009-13)[c]	10.2%	Preventable Hospitalization (2012)[a]	65
% Traffic Deaths Involving Alcohol (2009-13)[b]	15.8%	Teen Birth Rate (2013)[d]	16

Other Health Indicators	County	Georgia/Region
Poor physical health days (2006-12)[b]	4.1	3.5
Poor mental health days (2006-12)[b]	4.6	3.3
% Reporting poor dental health (2006-10)[a]	23.2%	12.9%
Years of Potential Life Lost (YPLL75) (2013)d	8,391.6	6,330.5
Mental health ER rate per 100,000 (2013)[d]	1,344.90	902.9
Self harm age adjusted discharge rate per 100,000 (2009-13)[d]	56.3	33
Assault age adjusted discharge rate per 100,000 (2009-13)[d]	9.4	21.4
Obs. Heart Disease/Heart Attack age adjusted discharge rate per 100,000 (2009-13)[d]	529.0	317.2
Hypertensive Heart Disease age adjusted discharge rate per 100,000 (2009-13)[d]	94.7	81.7
Asthma ER visit rate per 100,000 (2013)[d]	493.7	551.6
Motor Vehicle Crash ER visit rate per 100,000 (2013)[d]	1,151.3	973.7
HIV prevalence rate per 100,000 (2013)[e]	246.5	36.7
Low birth weight (< 2500g) per 1,000 births (2009-13)[d]	8.2	9.5

Infant mortality (total; non-Hispanic White; Black) (2009-13)[d]	8.1; 6.4; 15.1	6.1; 4.9; 10

Summary:
Bartow County is a relatively challenged area of the metro Atlanta/Athens CHNA community of practice extended region. Levels of poverty (17.1%), near poverty (38.3%), unemployment (11.3%), lack of health insurance (19.3%), and low college attendance (46.2%) are higher than in other counties. The county profile is relatively rural and matches closely with overall socio-economic indicators for the state of Georgia. For instance, the percentage of children in poverty is roughly the same as the statewide percentage, but nearly double the rate of nearby Cherokee County. Nearly 20% of adults over 25 years lack a high school diploma or equivalent, compared with 12.8% regionally and 15.3% statewide. While the Black population is relatively small compared with the state or region, this portion of the population is not doing as well as the rest of the county, experiencing higher unemployment rates. Rates of smoking are high (21.3%) compared with the rest of the region (15%), as is physical inactivity is (26.1% of adults report no leisure time physical activity). At the same time, the county reports high rates of inadequate fruit and vegetable consumption (78.6% compared with 74.2% regionally). Additionally, there are very few opportunities to get incidental physical activity through active transportation, relative to adjacent counties (even in the area with highest rate, 1.8% vs 12.4% in Cherokee County). Some of these behaviors manifest in elevated rates of heart disease, with county residents hospitalized at the rate of 529 per 100,000 compared with 317.2 regionally. Diabetes rates are above average as well. The county also has some of the highest rates of infant mortality, especially for Black and Hispanic babies. Teen births, suicides and attempted suicide, and ER utilization for mental and behavioral health needs are very high compared with regional rates (16 vs. 12; 56.3 vs 33; and 1344 vs 903). A very high percentage of Medicare enrollees suffer from depression relative to other counties. Additionally, the percentage of people reporting poor physical health is much higher than the region (19.7% vs 12.2%) as well as those reporting poor dental health (23.2% vs 12.9%). Lack of services may be a factor, as there is a lower than average rate of primary care providers (43.7 as opposed to 65.8 per 100,000 regionally) and dental care providers (28.6 vs 49.7 regionally). Just over 30 % of adults report not having a regular doctor, which is twice the rate in Paulding County. A hundred percent of the county is designated as a health professional shortage area, although it is served by a federally qualified health center as a result. Just over 20% of the population is enrolled in Medicaid, which is double the rate of Cherokee County. About one in eight members of the population has a disability, which is above average. Some bright spots are lower than average rates of sexually transmitted infections and assaults. Drunk driving fatalities are also lower than the state. However, the premature death rate remains elevated, at 8391 versus 6330 for the region. Overall, chronic disease, mental health, unintentional injury, and teen pregnancy appear to be the leading drivers of health needs here. Nine Census tracts in Bartow County exhibit the highest rates of the county's leading causes of morbidity and mortality, while five are located in Georgia Department of Public Health Demographic Clusters with elevated rates of premature death; two Census tracts meet both criteria.

References

a. *Community Commons CHNA Portal: CHNA.org*
b. *County Health Rankings and Roadmaps: countyhealthrankings.org*
c. *US Census Bureau, American Community Survey 5-Year Dataset: census.gov*
d. *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
e. *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

County: Cherokee (6th) County Health Ranking 2015 **Population: 218,277** US CENSUS BUREAU 2010-13

Public Health/Resident Priorities
Teen Pregnancy and low birth weight
Tobacco use
Mental health
Chronic disease
Access to care (under and uninsured)

Age Group (2009-13)[a]	%	Racial/Ethnic (2009-13)[a]	%
0-17 yrs	27.07	Black	5.87
18-64 yrs	62.92	Hispanic	10.06
65+ yrs	10.01	Non-Hispanic White	80.39

Socioeconomic	Measure	Health Care Access	Measure
Poverty Rate (< 100% FPL) (2009-13)[a]	9.8%	Primary Care Providers / 100,000 (2012)[a]	32.1
High School Graduation Rate (2011-12)[a]	73.0%	Dental Providers / 100,000 (2013)[a]	49.3
Students Eligible for Free / Reduced Lunch (2013-14)[a]	25.1%	Mental Health Providers / 100,000 (2014)[b]	81
Unemployment Rate (2015)[a]	6.1%	% of Adults with No Regular Doctor (2011-2012)[a]	20.4%
Uninsured Population (2009-13)[a]	15.5%	Federally Qualified Health Centers / 100,000 (2014)[a]	0.47
Uninsured Children (2013)[a]	10.4%	% Population in Health Professional Shortage Area (2015)[a]	0%
Health Determinants	**Measure**	**Clinical Care & Prevention**	**Measure**
Tobacco Use - Cigarette Smokers (2006-12)[a]	16.7%	Households Receiving SNAP (2009-13)[a]	6.7%
Inadequate Fruit & Vegetable Consumption (2005-09)[a]	74.5%	HIV Screening Rate (2011-12)[a]	39.9%
Access to Exercise Facilities (2010/2013)[b]	81.0%	% Smokers Attempting to Quit (2011-12)[a]	54.9%
Travel to work by transit, walk, or bicycle (2009-13)[c]	1.5%	Physical Inactivity – 18+ yrs (2012)[a]	21.5%
Commute over 60 Minutes (2009-13)[c]	14.4%	Preventable Hospitalization (2012)[a]	57.9
% Traffic Deaths Involving Alcohol (2009-13)[b]	16.9%	Teen Birth Rate (2013)[d]	8.5

Other Health Indicators	County	Georgia/Region
Poor physical health days (2006-12)[b]	2.9	3.5
Poor mental health days (2006-12)[b]	2.7	3.3
% Reporting poor dental health (2006-10)[a]	12.3%	12.9%
Years of Potential Life Lost (YPLL75) (2013)[d]	5,527.3	6,330.5
Mental health ER rate per 100,000 (2013)[d]	824.1	902.9
Self harm age adjusted discharge rate per 100,000 (2009-13)[d]	32.4	33
Assault age adjusted discharge rate per 100,000 (2009-13)[d]	7	21.4
Obs. Heart Disease/Heart Attack age adjusted discharge rate per 100,000 (2009-13)[d]	335.7	317.2
Hypertensive Heart Disease age adjusted discharge rate per 100,000 (2009-13)[d]	43.2	81.7
Asthma ER visit rate per 100,000 (2013)[d]	271	551.6
Motor Vehicle Crash ER visit rate per 100,000 (2013)[d]	710.8	973.7
HIV prevalence rate per 100,000 (2013)[e]	156.4	36.7
Low birth weight (< 2500g) per 1,000 births (2009-13)[d]	7.3	9.5
Infant mortality (total; non-Hispanic White; Black) (2009-13)[d]	5.5; 4.9; 9.1	6.1; 4.9; 10

Summary:
Cherokee County is a relatively healthy and advantaged part of the CHNA region, due in large part to a concentration of wealth. Nonetheless, there are three socio-demographically challenged Census tracts in the county and four tracts that contribute to elevated rates of morbidity and mortality; two Census tracts meet both criteria. Advanced age and rurality are two of the primary risk factors present for county residents, while isolated pockets of low resource areas suffer the highest rates of premature illness and mortality. Leading causes of hospitalization include falls, mental illness, and drug overdose. Unintentional poisoning is also a concern. The county enjoys some of the lowest levels of poverty (9.8%), unemployment (8.1%), and reliance on public assistance, and high levels of educational attainment and health insurance coverage. But even as a high performer in the state and region, one in ten county residents lives in poverty, one in ten relies on Medicaid, the high school graduation rate is ten percentage points behind high-performing counties in the rest of the nation, and the Black unemployment rate is 50% higher than the average rate for the county. About one third of households pay over 30% of their income for housing, which is lower than the state average. The county enjoys a high ratio of fitness facilities (11.2) and some walkable areas where more than one in ten commuters can walk, bicycle, or take transit to work. Healthy behavior rates, such as smoking, eating fruits and vegetables, and partaking in physical activity are average. However, the number of smokers who have attempted to quit in the last year is relatively low (54.9% vs 64.5% regionally). Although the county does not constitute a health professional shortage area, the ratio of primary care providers is about half the regional average (32.1 vs 65.8). Compared with the rest of the region, Cherokee County enjoys very low rates of poor physical, dental, or mental health, and a premature death rate below the regional average.

References

a. *Community Commons CHNA Portal: CHNA.org*
b. *County Health Rankings and Roadmaps: countyhealthrankings.org*
c. *US Census Bureau, American Community Survey 5-Year Dataset: census.gov*
d. *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
e. *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

County: Cobb (4th) County Health Ranking 2015 **Population: 699,235** US CENSUS BUREAU 2010-13

Public Health/Resident Priorities
Access to primary care
Chronic disease and obesity reduction
Infectious disease (HIV, syphilis)
Teen pregnancy
Mental health

Age Group (2009-13)[a]	%	Racial/Ethnic (2009-13)[a]	%
0-17 yrs	25.29	Black	25.59
18-64 yrs	65.43	Hispanic	12.64
65+ yrs	9.28	Non-Hispanic White	54.78

Socioeconomic	Measure	Health Care Access	Measure
Poverty Rate (< 100% FPL) (2009-13)[a]	12.8%	Primary Care Providers / 100,000 (2012)[a]	68.6
High School Graduation Rate (2011-12)[a]	75.2%	Dental Providers / 100,000 (2013)[a]	63.9
Students Eligible for Free / Reduced Lunch (2013-14)[a]	39.6%	Mental Health Providers / 100,000 (2014)[b]	133
Unemployment Rate (2015)[a]	6.6%	% of Adults with No Regular Doctor (2011-2012)[a]	21.6%
Uninsured Population (2009-13)[a]	18.3%	Federally Qualified Health Centers / 100,000 (2014)[a]	0.73
Uninsured Children (2013)[a]	11.6%	% Population in Health Professional Shortage Area (2015)[a]	0%

Health Determinants	Measure	Clinical Care & Prevention	Measure
Tobacco Use - Cigarette Smokers (2006-12)[a]	14.1%	Households Receiving SNAP (2009-13)[a]	8.6%
Inadequate Fruit & Vegetable Consumption (2005-09)[a]	70.6%	HIV Screening Rate (2011-12)[a]	44.9%
Access to Exercise Facilities (2010/2013)[b]	88.5%	% Smokers Attempting to Quit (2011-12)[a]	64.9%
Travel to work by transit, walk, or bicycle (2009-13)[c]	2.2%	Physical Inactivity – 18+ yrs (2012)[a]	18.5%
Commute over 60 Minutes (2009-13)[c]	9.7%	Preventable Hospitalization (2012)[a]	53.1
% Traffic Deaths Involving Alcohol (2009-13)[b]	26.1%	Teen Birth Rate (2013)[d]	8.8

Other Health Indicators	County	Georgia/Region
Poor physical health days (2006-12)[b]	2.7	3.5
Poor mental health days (2006-12)[b]	2.8	3.3
% Reporting poor dental health (2006-10)[a]	9.6%	12.9%
Years of Potential Life Lost (YPLL75) (2013)d	5,442.0	6,330.5
Mental health ER rate per 100,000 (2013)[d]	857.0	902.9
Self-harm age adjusted discharge rate per 100,000 (2009-13)[d]	31.7	33
Assault age adjusted discharge rate per 100,000 (2009-13)[d]	11.3	21.4
Obs. Heart Disease/Heart Attack age adjusted discharge rate per 100,000 (2009-13)[d]	272.3	317.2
Hypertensive Heart Disease age adjusted discharge rate per 100,000 (2009-13)[d]	74.6	81.7
Asthma ER visit rate per 100,000 (2013)[d]	529.8	551.6
Motor Vehicle Crash ER visit rate per 100,000 (2013)[d]	900.5	973.7
HIV prevalence rate per 100,000 (2013)[e]	350.7	36.7
Low birth weight (< 2500g) per 1,000 births (2009-13)[d]	8.3	9.5
Infant mortality (total; non-Hispanic White; Black) (2009-13)[d]	5.9; 4.2; 11	6.1; 4.9; 10

Summary:
Cobb County is a diverse and rapidly growing county. Just over 12% of the population is Hispanic, high for the region, and 25.6% identify as Black. Less than 5% of households are reported as being linguistically isolated, meaning that no one in the household over 5 years old is proficient in English. The county performs on par or slightly better than the region in many social measures, such as poverty, lack of insurance, and unemployment. Almost 3 in every 4 adults over 25 years have attended college versus 60.8% statewide. Only 12.5% of residents have Medicaid versus 17.3% region-wide. At 9.7%, far fewer county residents have commutes over an hour than adjacent counties. As many as 22.8% of households lack access to a car in one Census tract. The county has a very high index of fast food establishments, but also a very high proportion of fitness facilities. The county also has relatively low rates of physical inactivity (18.5% vs 22.3% regionally) and inadequate fruit and vegetable consumption (70.6% vs 74.2%). In some areas, over 16% of commuting adults get additional physical activity through active transportation modes. Tobacco usage, 14.1%, is far lower than the regional rate, 18.1%. The county has above average rates of primary care providers (68.6 for every 100,000 residents) as well as dental providers (63.9) and mental health providers (133). Cobb County has very low rates of years of potential life lost (YPLL) at 5442 compared with 6330 in the region. Almost 10% of residents report that they are in fair or poor health compared with 12.2% regionally. Similarly, 9.6% reported poor dental health compared with 12.9% in the region. The county has low rates of hospital usage for mental health, suicide/self-harm, and heart disease. However, the HIV diagnosis rate is extremely high, at 350.7 per 100,000 population. While the overall infant mortality rate is slightly below average (5.9 vs 6.1), it is above average for Black infants (11 vs 10).

References

a. *Community Commons CHNA Portal: CHNA.org*
b. *County Health Rankings and Roadmaps: countyhealthrankings.org*
c. *US Census Bureau, American Community Survey 5-Year Dataset: census.gov*
d. *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
e. *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

County: Douglas (27th) County Health Ranking 2015 **Population: 133,486** US CENSUS BUREAU 2010-13

Public Health/Resident Priorities
Access to primary care
Quality of care
Chronic disease and obesity reduction
Teen pregnancy
Mental health

Age Group (2009-13)[a]	%	Racial/Ethnic (2009-13)[a]	%
0-17 yrs	27.93	Black	41.09
18-64 yrs	63.01	Hispanic	8.87
65+ yrs	9.06	Non-Hispanic White	46.15

Socioeconomic	Measure	Health Care Access	Measure
Poverty Rate (< 100% FPL) (2009-13)[a]	16.1%	Primary Care Providers / 100,000 (2012)[a]	41.8
High School Graduation Rate (2011-12)[a]	72.0%	Dental Providers / 100,000 (2013)[a]	44.7
Students Eligible for Free / Reduced Lunch (2013-14)[a]	50.0%	Mental Health Providers / 100,000 (2014)[b]	71
Unemployment Rate (2015)[a]	7.9%	% of Adults with No Regular Doctor (2011-2012)[a]	25.8%
Uninsured Population (2009-13)[a]	18.3%	Federally Qualified Health Centers / 100,000 (2014)[a]	0
Uninsured Children (2013)[a]	9.7%	% Population in Health Professional Shortage Area (2015)[a]	0%

Health Determinants	Measure	Clinical Care & Prevention	Measure
Tobacco Use - Cigarette Smokers (2006-12)[a]	14.8%	Households Receiving SNAP (2009-13)[a]	14.5%
Inadequate Fruit & Vegetable Consumption (2005-09)[a]	84%	HIV Screening Rate (2011-12)[a]	48.9%
Access to Exercise Facilities (2010/2013)[b]	75.4%	% Smokers Attempting to Quit (2011-12)[a]	78.4%
Travel to work by transit, walk, or bicycle (2009-13)[c]	1.9%	Physical Inactivity – 18+ yrs (2012)[a]	26.1%
Commute over 60 Minutes (2009-13)[c]	13.3%	Preventable Hospitalization (2012)[a]	67.7
% Traffic Deaths Involving Alcohol (2009-13)[b]	28.4%	Teen Birth Rate (2013)[d]	13.2

Other Health Indicators	County	Georgia/Region
Poor physical health days (2006-12)[b]	3.2	3.5
Poor mental health days (2006-12)[b]	3.5	3.3
% Reporting poor dental health (2006-10)[a]	12.1%	12.9%
Years of Potential Life Lost (YPLL75) (2013)[d]	6,998.4	6,330.5
Mental health ER rate per 100,000 (2013)[d]	1,120.40	902.9
Self-harm age adjusted discharge rate per 100,000 (2009-13)[d]	40.2	33
Assault age adjusted discharge rate per 100,000 (2009-13)[d]	12.7	21.4
Obs. Heart Disease/Heart Attack age adjusted discharge rate per 100,000 (2009-13)[d]	420.4	317.2
Hypertensive Heart Disease age adjusted discharge rate per 100,000 (2009-13)[d]	101.4	81.7
Asthma ER visit rate per 100,000 (2013)[d]	773.6	551.6

Motor Vehicle Crash ER visit rate per 100,000 (2013)[d]	1,435.70	973.7
HIV prevalence rate per 100,000 (2013)[e]	201.6	36.7
Low birth weight (< 2500g) per 1,000 births (2009-13)[d]	9.6	9.5
Infant mortality (total; non-Hispanic White; Black) (2009-13)[d]	7.7; 7.4; 9.8	6.1; 4.9; 10

Summary:
Douglas County is similar to the CHNA community of practice region in age distribution and birth rate, as well as educational attainment. It is more diverse than nearby counties at 41.1% Black, 46.2% non-Hispanic White, and 8.9% Hispanic. The percent of children in single parent homes, 38%, is higher than the surrounding area. Poverty rates exceed the regional average, and a quarter of children in the county live in poverty. 18.3% of the population is uninsured and another 19% have Medicaid coverage. The total unemployment rate is high at 13.2%, and within subpopulations, the rate is elevated for both Black and non-Hispanic White. Like the region, over 36% of households are cost-burdened by housing expenses. Douglas County has much lower ratio of fitness facilities per 100,000 residents (4.53 vs 9.3 in the region). At 84%, the county has very high rates of inadequate fruit and vegetable consumption (the regional average is 74.2%). Additionally, 26.1% of adults do not get any physical activity, 4 percentage points above the regional average. Smoking rates are relatively low (14.8%) and 78.4% of smokers had attempted to quit, which is much higher than the regional average and national best performers. However, 28.4% of adults report driving drunk, which could be associated with the rate of ER utilization for motor vehicle crash injuries (1435.7 vs 973.7). The county has below average ratios of mental health, dental health, and primary care providers. Compared with 12.2% of people in the region, 16% of Douglas County residents report fair or poor physical health. The county also reports above average rates of hospital and ER utilization for mental health needs, although the rate of depression among Medicare enrollees matches the regional average. ER utilization for pregnancy and childbirth is much higher than the region (1283.2 per 100,000 vs. 887.1 per 100,000). The county also indicates higher than average rates of teen births, low birth weight, and infant mortality. Compared with the region, the county also has elevated rates of asthma (773.6 vs. 551.6 per 100,000), hypertension (101.4 vs. 81.7, per 100,000), and chlamydia (478 vs. 421 per 100,000).

References

a. *Community Commons CHNA Portal: CHNA.org*
b. *County Health Rankings and Roadmaps: countyhealthrankings.org*
c. *US Census Bureau, American Community Survey 5-Year Dataset: census.gov*
d. *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
e. *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

County: Paulding (14th) County Health Ranking 2015 **Population: 143,845** US CENSUS BUREAU 2010-13

Public Health/Resident Priorities
Mental Health
Obesity
STDs
Chronic disease reduction
Access to care

Age Group (2009-13)[a]	%	Racial/Ethnic (2009-13)[a]	%
0-17 yrs	29.47	Black	17.18
18-64 yrs	62.73	Hispanic	5.35
65+ yrs	7.80	Non-Hispanic White	74.39

Socioeconomic	Measure	Health Care Access	Measure
Poverty Rate (< 100% FPL) (2009-13)[a]	11.4%	Primary Care Providers / 100,000 (2012)[a]	12.4
High School Graduation Rate (2011-12)[a]	75.0%	Dental Providers / 100,000 (2013)[a]	14.3
Students Eligible for Free / Reduced Lunch (2013-14)[a]	32.9%	Mental Health Providers / 100,000 (2014)[b]	33
Unemployment Rate (2015)[a]	6.6%	% of Adults with No Regular Doctor (2011-2012)[a]	15.5%
Uninsured Population (2009-13)[a]	14.3%	Federally Qualified Health Centers / 100,000 (2014)[a]	0
Uninsured Children (2013)[a]	10.1%	% Population in Health Professional Shortage Area (2015)[a]	0%

Health Determinants	Measure	Clinical Care & Prevention	Measure
Tobacco Use - Cigarette Smokers (2006-12)[a]	19.9%	Households Receiving SNAP (2009-13)[a]	9.4%
Inadequate Fruit & Vegetable Consumption (2005-09)[a]	73.7%	HIV Screening Rate (2011-12)[a]	42.0%
Access to Exercise Facilities (2010/2013)[b]	81.1%	% Smokers Attempting to Quit (2011-12)[a]	42.3%
Travel to work by transit, walk, or bicycle (2009-13)[c]	1.1%	Physical Inactivity – 18+ yrs (2012)[a]	26.7%
Commute over 60 Minutes (2009-13)[c]	21.1%	Preventable Hospitalization (2012)[a]	77.6
% Traffic Deaths Involving Alcohol (2009-13)[b]	13.2%	Teen Birth Rate (2013)[d]	9.9

Other Health Indicators	County	Georgia/Region
Poor physical health days (2006-12)[b]	4.8	3.5
Poor mental health days (2006-12)[b]	4.2	3.3
% Reporting poor dental health (2006-10)[a]	17.7%	12.9%
Years of Potential Life Lost (YPLL75) (2013)d	5,711.0	6,330.5
Mental health ER rate per 100,000 (2013)[d]	1,007.10	902.9
Self-harm age adjusted discharge rate per 100,000 (2009-13)[d]	40.9	33
Assault age adjusted discharge rate per 100,000 (2009-13)[d]	9.1	21.4
Obs. Heart Disease/Heart Attack age adjusted discharge rate per 100,000 (2009-13)[d]	443	317.2
Hypertensive Heart Disease age adjusted discharge rate per 100,000 (2009-13)[d]	70.4	81.7
Asthma ER visit rate per 100,000 (2013)[d]	452.5	551.6
Motor Vehicle Crash ER visit rate per 100,000 (2013)[d]	1,253.50	973.7

HIV prevalence rate per 100,000 (2013)[e]	46.1	36.7
Low birth weight (< 2500g) per 1,000 births (2009-13)[d]	7.1	9.5
Infant mortality (total; non-Hispanic White; Black) (2009-13)[d]	3.6; 3; 6.9	6.1; 4.9; 10

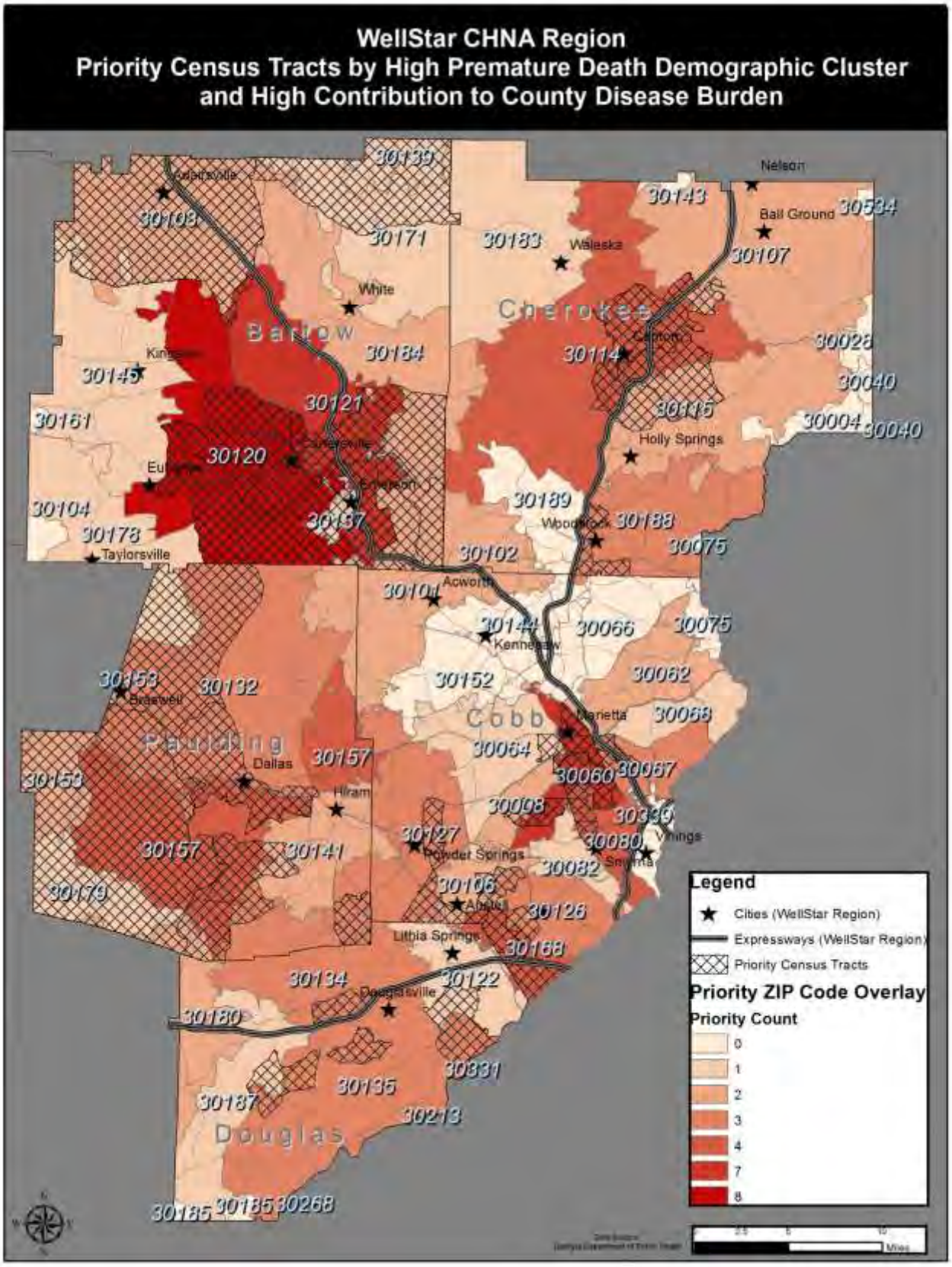
Summary:

Paulding County has a high index of children (29.7%) compared with 26% regionally, and a lower than average index of older adults (7.8% vs 9.6%). It has few linguistically isolated households. The county has relatively low poverty rates especially for children, although 11.4% of county residents and 14.9% of children still live in poverty. At 60.6%, the percent of adults who have attended college is comparable with the statewide average but lower than many of the adjacent counties. Along with low poverty rates, there are also lower rates of un-insurance, Medicaid enrollment, and other public benefits. However, unemployment is still prevalent, particularly for Black (14.2%) and Hispanic (12.4%) residents. Notably, over 21% of county commuters spend over an hour traveling each way to work. Paulding County residents are less likely to report participating in a civic or social association (5.3% vs 9.0% statewide). The county also posts the one of the highest rates of physical inactivity, 26.7% of all adults (versus 22.3% regionally). Smoking rates are above average at 19.9% versus 15%, and just 42.3% of smokers had tried to quit compared with 64.5% region-wide. There are relatively few fast food outlets relative to the population. Relatively few adults report driving drunk (13.2%). The rate of healthcare providers is very low per 100,000 residents, at 12.4 primary care providers (vs 65.8 regionally), 14.3 dental providers (vs 49.7), and 33 mental health providers (vs 109). However, there are no health professional shortage areas in the county and only 15.5% of residents lack a regular doctor, compared with 25.7% regionally. The preventable hospitalization rate is high at 77.6 per 1,000 population, compared with a statewide average of 60.6. Although the county's rate of premature death or years of potential life lost is on the low end, county residents report a very high number of days of poor physical health per month, with 4.8 days per month versus 3.5 days statewide and just 2.9 days in nearby Cherokee County. They also report almost one additional day per month of poor mental health (4.2 vs 3.3). Infant mortality rates, sexually transmitted infections, and teen birth rates are low. However, emergency room (ER) utilization rates for pregnancy and for mental health are both above average. Suicide or self-harm rates (40.9) are also higher than the regional average (33). The county also demonstrates elevated rates of diabetes (12.7% vs 10%) and hospitalization for obstructive heart disease or heart attack (443 vs 317 per 100,000 population). The rate of ER visits for traffic-related injuries is above average as well. Diseases of advanced age tend to be leading causes of death and hospitalization, while suicide and unintentional poisoning are elevated causes of premature death. Mental and behavioral health needs are elevated.

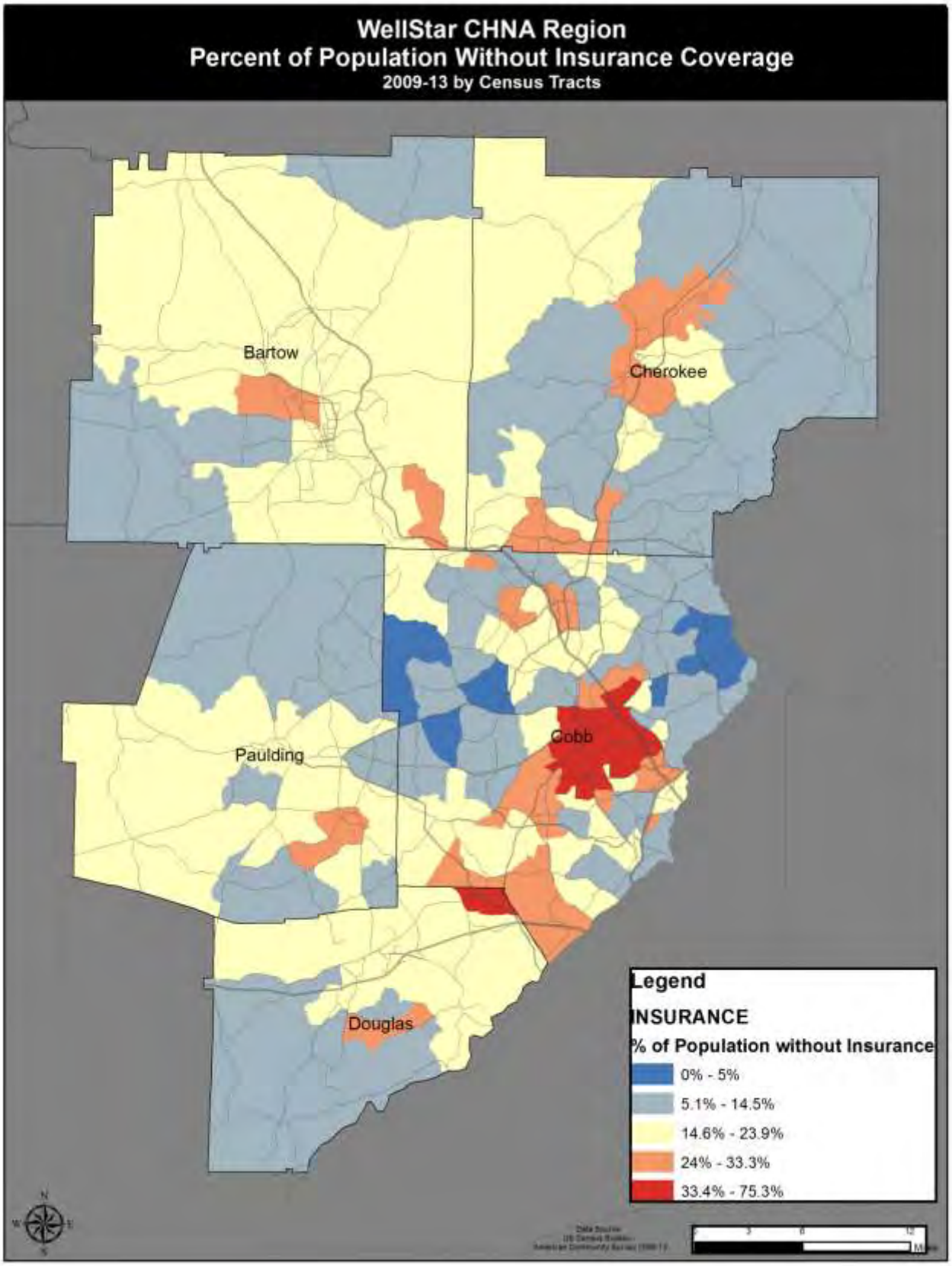
References

a. *Community Commons CHNA Portal: CHNA.org*
b. *County Health Rankings and Roadmaps: countyhealthrankings.org*
c. *US Census Bureau, American Community Survey 5-Year Dataset: census.gov*
d. *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
e. *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

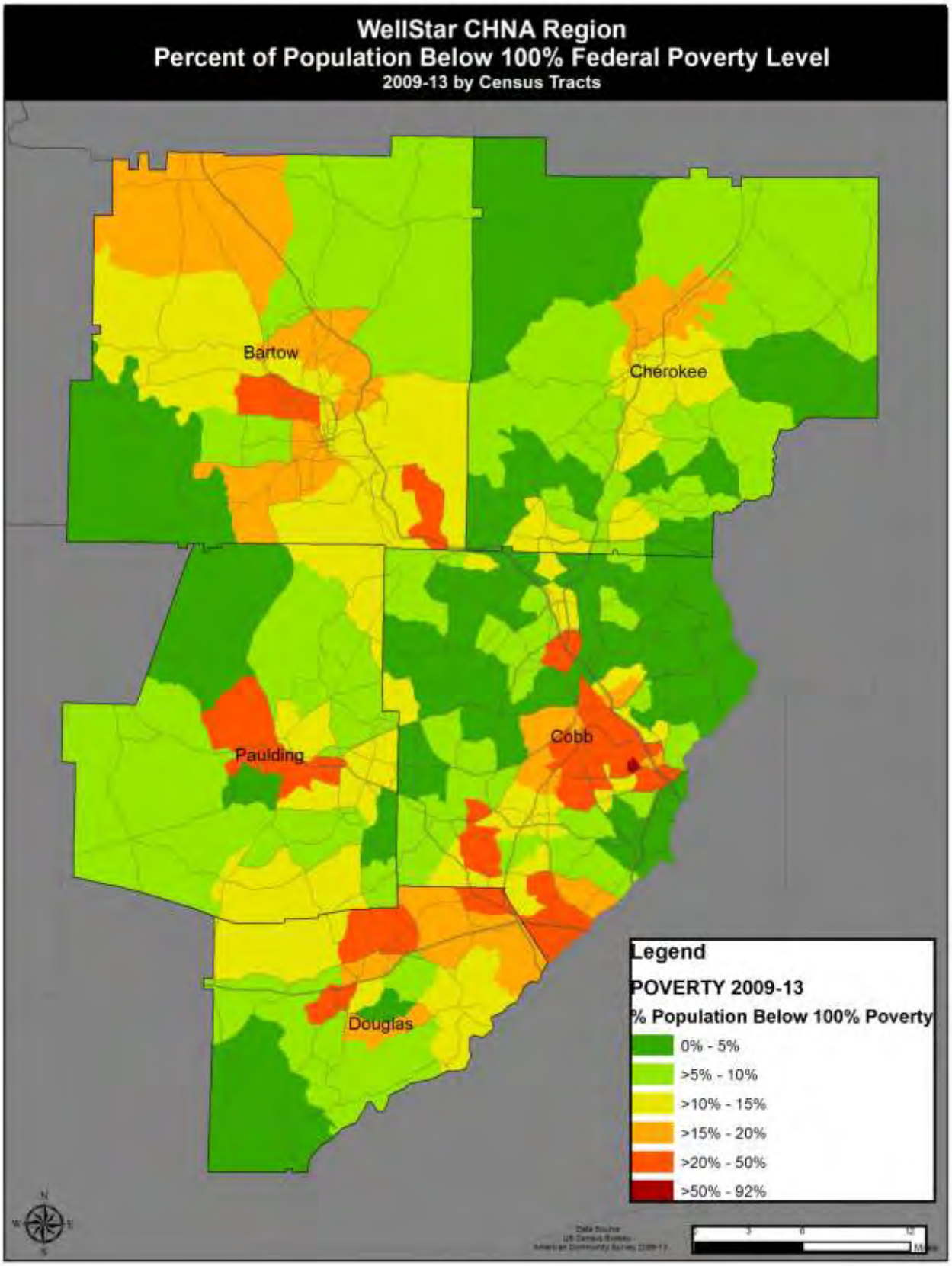
MAP 1


WellStar CHNA Region
Priority Census Tracts by High Premature Death Demographic Cluster
and High Contribution to County Disease Burden
Bartow
Cherokee
Cobb
Paulding
Douglas
Nelson
Ball Ground
Waleska
White
Kingston
Euharlee
Taylorsville
Acworth
Kennesaw
Marietta
Dallas
Hiram
Braswell
Powder Springs
Austell
Lithia Springs
Douglasville
Holly Springs
Woodstock
Canton
Smyrna
Vinings
30139
30108
30171
30183
30143
30534
30107
30184
30114
30028
30040
30145
30121
30161
30120
30004
30104
30178
30137
30189
30188
30075
30102
30101
30144
30066
30152
30062
30153
30132
30068
30064
30157
30060
30067
30008
30339
30127
30080
30141
30082
30179
30106
30126
30168
30134
30122
30180
30331
30135
30187
30213
30185
30268
Legend
Cities (WellStar Region)
Expressways (WellStar Region)
Priority Census Tracts
Priority ZIP Code Overlay
Priority Count
0
1
2
3
4
7
8
Miles

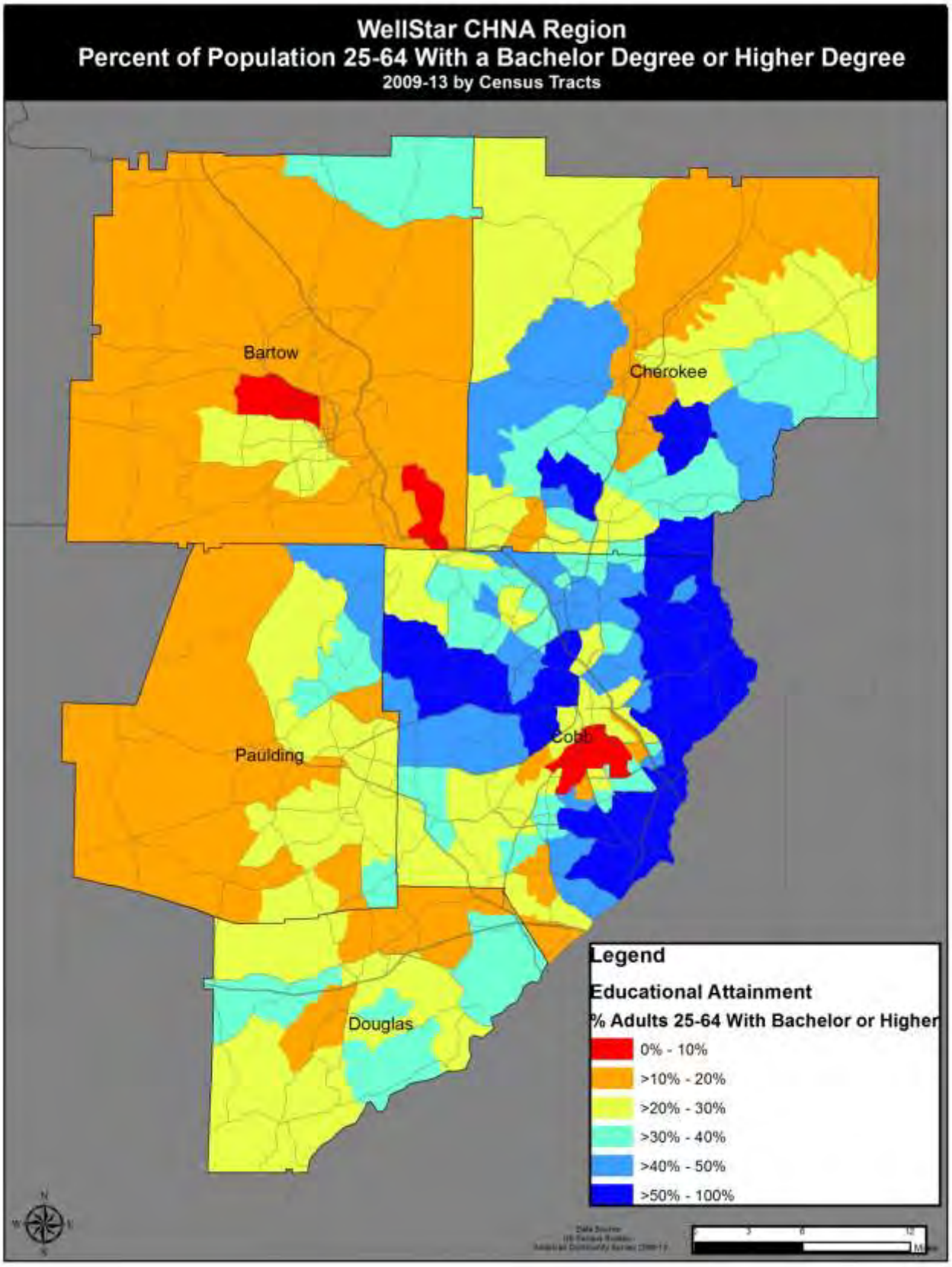
MAP 2


WellStar CHNA Region
Percent of Population Without Insurance Coverage
2009-13 by Census Tracts
Bartow
Cherokee
Paulding
Cobb
Douglas
Legend
INSURANCE
% of Population without Insurance
0% - 5%
5.1% - 14.5%
14.6% - 23.9%
24% - 33.3%
33.4% - 75.3%

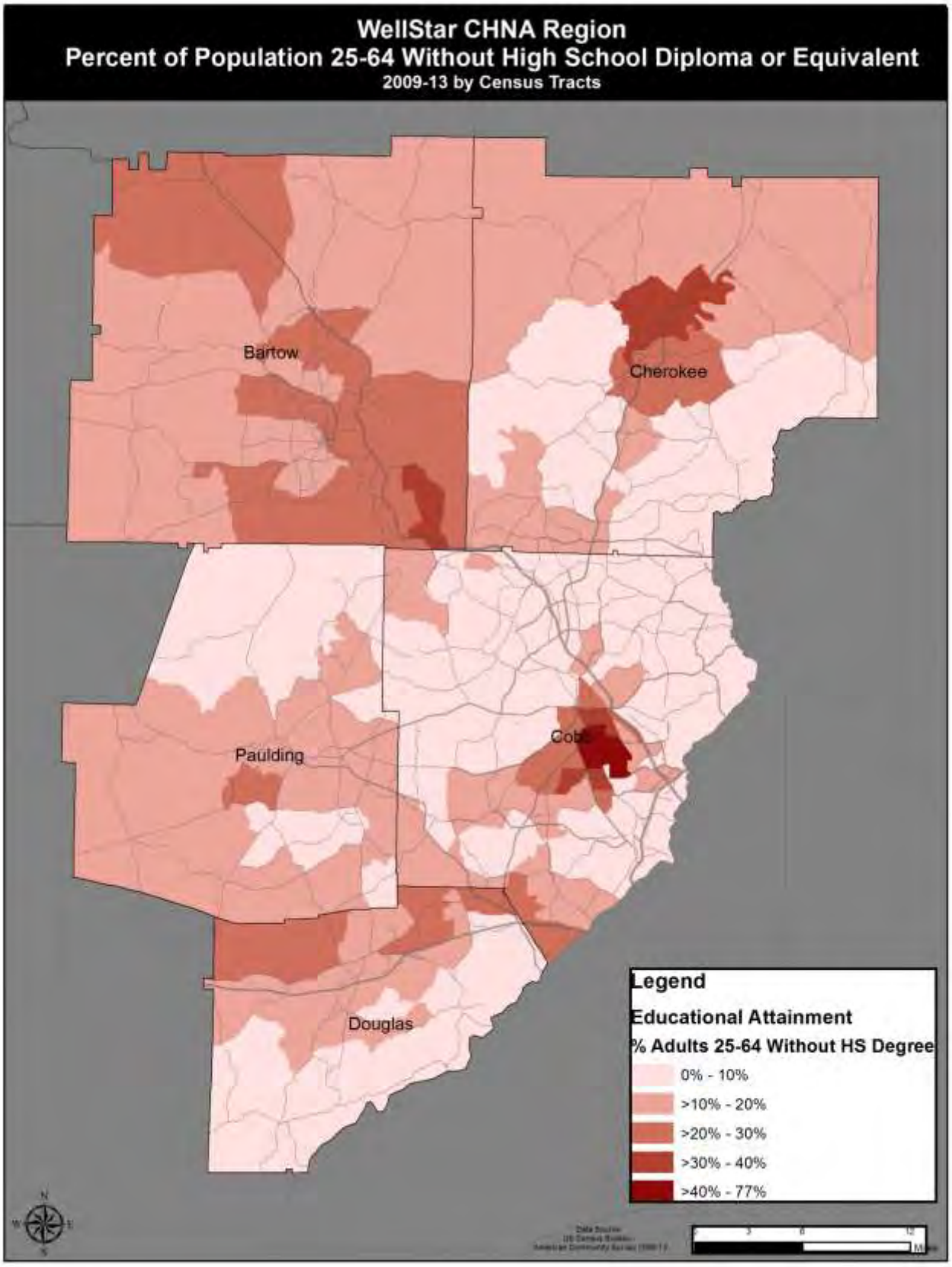
MAP 3


WellStar CHNA Region
Percent of Population Below 100% Federal Poverty Level
2009-13 by Census Tracts
Bartow
Cherokee
Paulding
Cobb
Douglas
Legend
POVERTY 2009-13
% Population Below 100% Poverty
0% - 5%
>5% - 10%
>10% - 15%
>15% - 20%
>20% - 50%
>50% - 92%

MAP 4

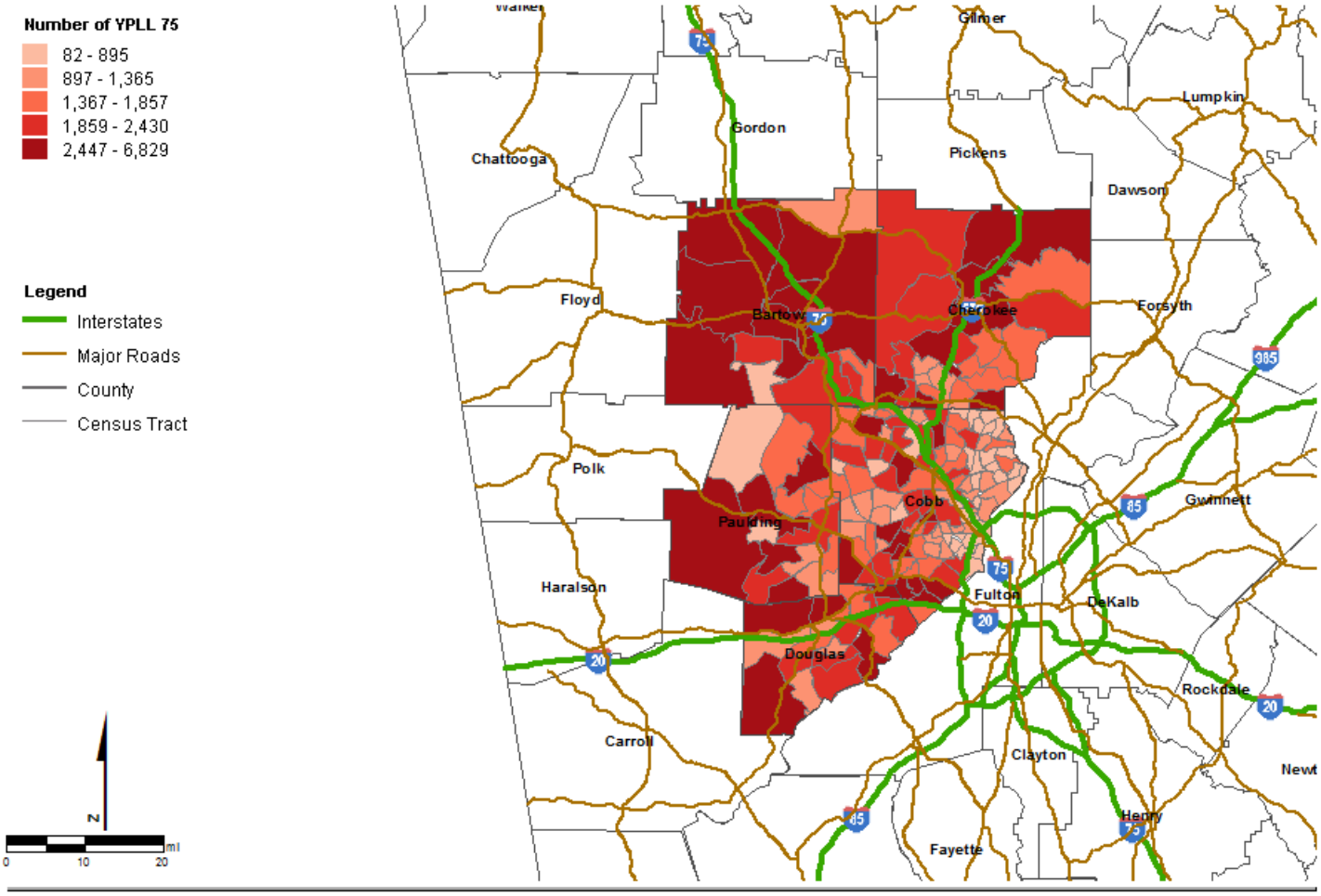

WellStar CHNA Region
Percent of Population 25-64 With a Bachelor Degree or Higher Degree
2009-13 by Census Tracts
Bartow
Cherokee
Paulding
Cobb
Douglas
Legend
Educational Attainment
% Adults 25-64 With Bachelor or Higher
0% - 10%
>10% - 20%
>20% - 30%
>30% - 40%
>40% - 50%
>50% - 100%

MAP 5


WellStar CHNA Region
Percent of Population 25-64 Without High School Diploma or Equivalent
2009-13 by Census Tracts
Bartow
Cherokee
Paulding
Cobb
Douglas
Legend
Educational Attainment
% Adults 25-64 Without HS Degree
0% - 10%
>10% - 20%
>20% - 30%
>30% - 40%
>40% - 77%

MAP 6

Number of YPLL 75 by Census Tract of Residence, Bartow, Cherokee, Cobb, Douglas and Paulding Counties, 2010-2014



Georgia Department of Public Health
Office of Health Indicators for Planning (OHIP)

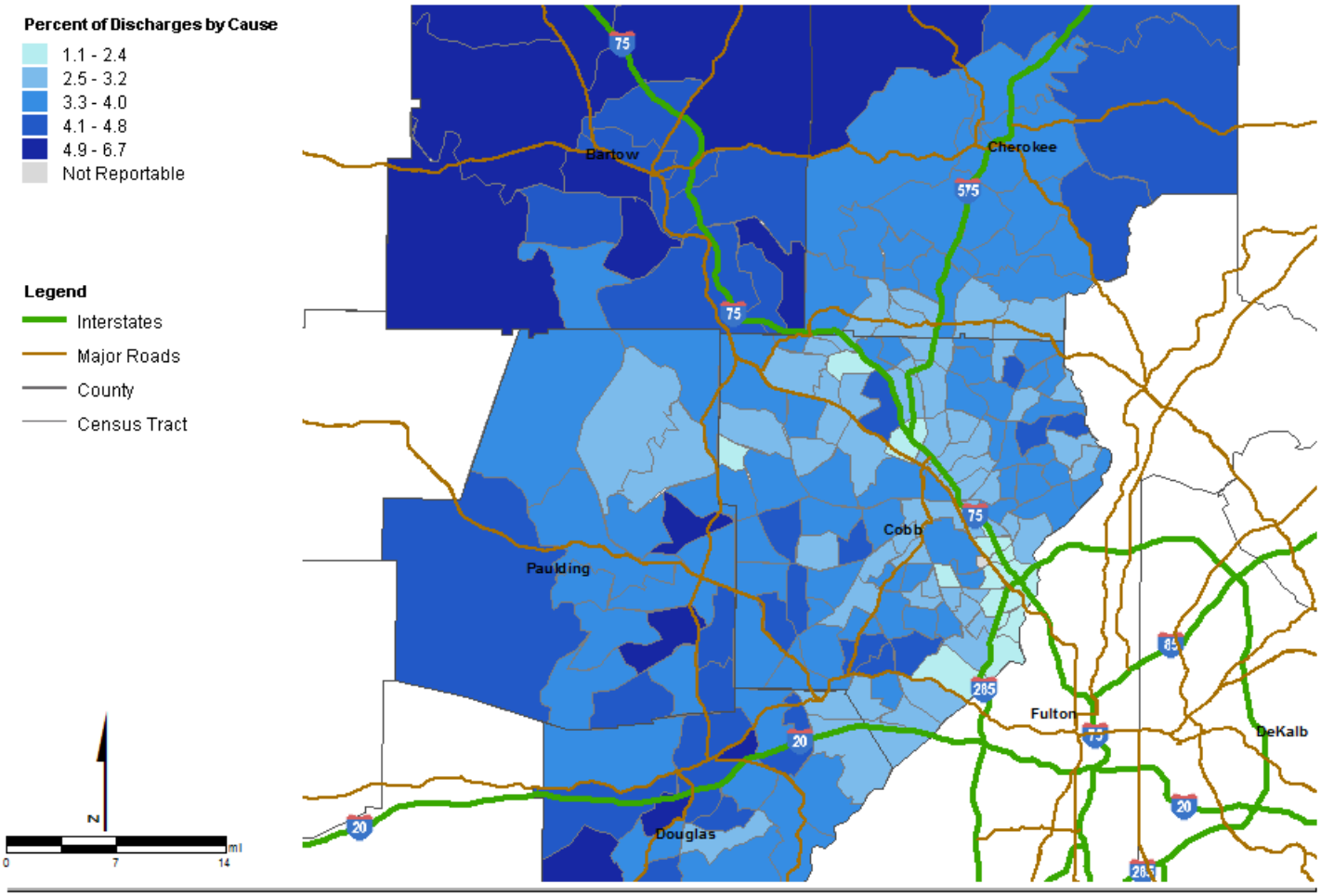
Map Created: 12/16/2015 11:16:24 AM
Data Classification Method: Quantile

Note: This is a color map.

YPLL: Years of potential life lost involves estimating the average time a person would have lived had he or she not died prematurely. This measure is used to help quantify social and economic loss owing to premature death, and it has been promoted to emphasize specific causes of death affecting younger age groups.

MAP 7

Percent of Discharges by Cause by Census Tract of Residence, Bartow, Cherokee, Cobb, Douglas and Paulding Counties, High Blood Pressure, Hypertensive Heart Disease, Obstructive Heart Disease (incl. Heart Attack), 2010-2014



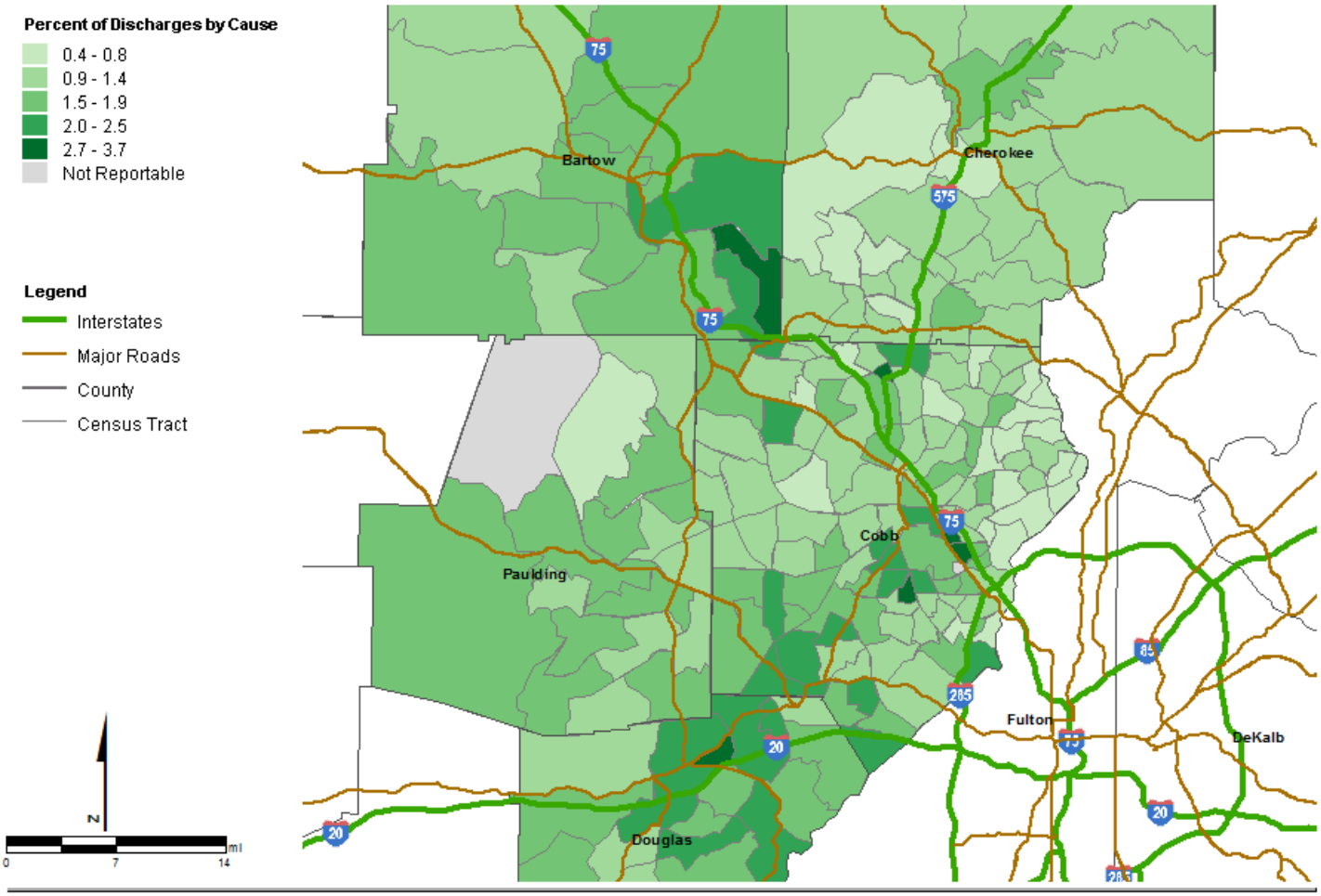
Georgia Department of Public Health
Office of Health Indicators for Planning (OHIP)

Map Created: 12/16/2015 11:24:14 AM
Data Classification Method: Quantile

Note: This is a color map.

MAP 8

Percent of Discharges by Cause by Census Tract of Residence, Bartow, Cherokee, Cobb, Douglas and Paulding Counties, Diabetes, 2010-2014

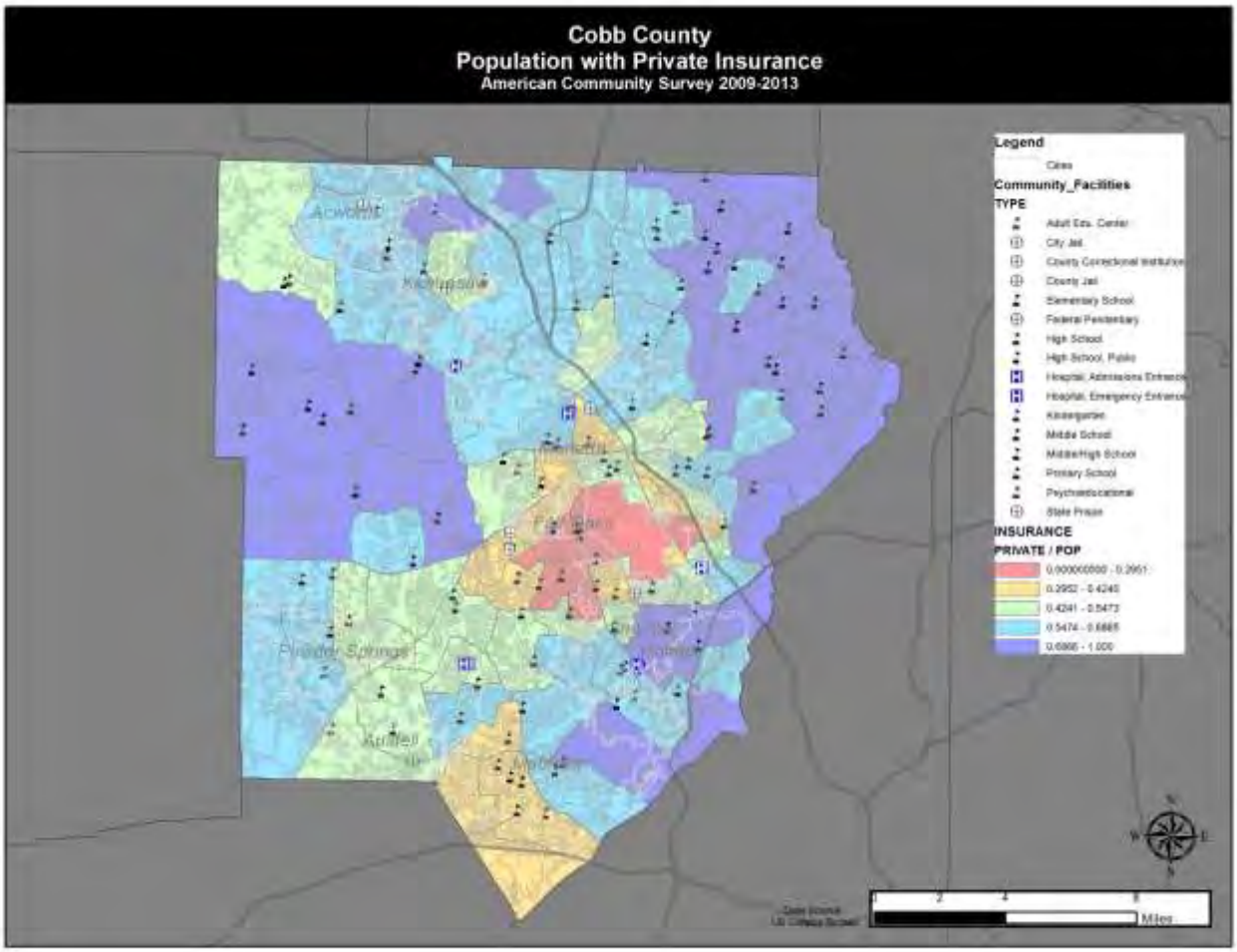


Georgia Department of Public Health
Office of Health Indicators for Planning (OHIP)

Map Created: 12/16/2015 11:23:10 AM
Data Classification Method: Quantile

Note: This is a color map.

MAP 9


Cobb County
Population with Private Insurance
American Community Survey 2009-2013
Legend
Cities
Community_Facilities
TYPE
Adult Edu. Center
City Jail
County Correctional Institute
County Jail
Elementary School
Federal Penitentiary
High School
High School, Public
Hospital, Admissions Entrance
Hospital, Emergency Entrance
Kindergarten
Middle School
Middle/High School
Primary School
Psychoeducational
State Prison
INSURANCE
PRIVATE / POP
0.000000000 - 0.2951
0.2952 - 0.4240
0.4241 - 0.5473
0.5474 - 0.6865
0.6866 - 1.000
Acworth
Kennesaw
Marietta
Powder Springs
Austell
Miles

COMMUNITY INPUT RESEARCH SUMMARY REPORTS:

KEY INFORMANT SUMMARY (STATE AND ORGANIZATIONAL LEADERS)

As part of a broader network of key informant interviews with health stakeholders in Atlanta, the GHPC interviewed individuals from the following organizations regarding their assessment of health and opportunities for health improvement in the WellStar service area:

- Nursing Director (Bartow), and Donna Stafford, Nursing Director (Paulding) – District 1-1
- North Georgia Health District Director (District 1-2)
- Deputy Director to John Kennedy, District Health Director (Cobb & Douglas, District 3-1)
- Georgia Department of Education
- United Way
- Center for Pan Asian Community Services
- Atlanta Regional Commission
- Community Foundation of Greater Atlanta

Major Health Challenges and Drivers

- Chronic disorders
- Access and affordability of health insurance or viable alternatives
- Health equity, and literacy; lack of resources that are linguistically and culturally appropriate
- Inequalities in determinants of health
- The need for increased investment in prevention
- Health education programs built on behavior change and physical activity are not equal across all counties in the state
- Transportation to care
- Preventive care among men
- Good health in early childhood
- Workforce development

Recommended Interventions:

- Implement models focused on care coordination
- Disease management approaches that facilitate better eating and active living
- Attempt interventions that tackle social inequities; stabilizing people's lives so that they can get and hold good jobs
- Address language barriers, lack of transport, and resources for preventive care for underrepresented communities
- Support efforts to collect and analyze data about disaggregated communities
- Get preventive care resources to targeted at-risk populations to prevent/reduce unnecessary use of emergency care and development of disease.
- Establish more safety net care facilities.
- Invest in community health workers

- Health education in all areas (mental health, substance abuse etc.) behavioral change, comprehensive health education
- Direct resources to ensuring good health in early childhood –
    - address parents' issues before children are born, access to good food, language nutrition
    - Facilitate quality education opportunities in health and physical education, including access to physical activity opportunities before, after and during school within communities
    - Safe playgrounds, places to play outside
    - Participate in comprehensive health education movement for student K 12.
    - Make it easy for kids and families to access healthy food at a reasonable price, recreation programs and live in walkable communities
    - Use messages that focus on "improving children's health", as opposed to "obesity prevention"

	Cobb/Douglas	Cherokee	Bartow	Paulding
Major Health Challenges	• Access to primary care • Chronic disease • Infectious disease (HIV and syphilis) • Infant mortality and low birth weight in minority populations	• Teen pregnancy and low birth weight • Tobacco use • Mental health and substance abuse • Access to care • Chronic disease	• Access to care • Minority men's health • Hypertension • Diabetes	• Low access to affordable care • Relatively high numbers of uninsured and under-insured
Context and Drivers	• System focus on episodic care • Pockets of poverty throughout district • Growing diversity and language barriers • Limited and diminishing funding of public health programs	• Engrained unhealthy behaviors • Insufficient number of healthcare providers	• Partners are overwhelmed by extent of need • Reduced funding to chronic disease programs	• Transportation to care in rural areas • Low education attainment • Ongoing cycle of poverty • Poor eating habits
Recommendations	• Reimbursement rates for Medicare and Medicaid populations • Invest in prenatal and youth education programs • Promote self - responsibility • Connect health plans and hospitals in addressing issues	• Teen education programs and long-acting reproductive contraceptives (LARCs) • School and college-based programs aimed at preventing tobacco use • Smoking cessation programs for low income communities • More mental health providers	• Teaching healthy behaviors (e.g. tobacco prevention/cessation, obesity, nutrition) • SHAPE program for youth • Addressing safe sleep – high mortality among infants, basic prevention through education • More affordable and accessible primary prevention efforts	

Bartow County:

Health and Quality of Life:

- Poor / declined as many people can't afford ACA and no providers accept it or Medicaid
- Very few resources
- Pockets of high employment, drug use, poverty and crime (Emerson, Allatoona Elementary School area -30101, 30137), Adairsville and 30137 and 30102.

Major Health Challenges:

- Access to healthcare
- Diabetes
- Hypertension
- Obesity
- Heart disease / stroke
- Breast, cervical and lung cancer screening
- Dental
- Poor nutrition
- Drug use
- Alcohol use
- Tobacco use
- Infant mortality
- Men's health

Context and Drivers:

- Cartersville Medical Center is a for profit hospital and accepts patient to a limit - "demand exceeds supply"
- Limited resources and employment opportunities
- Lack of transportation is a major barrier to care access and education
- Bartow pays nurses less and funding is down at the Health Department
- Co-sleeping is common in lower income families
- Inadequate/unaffordable housing
- Lack of insurance

Recommended Interventions:

- Primary prevention through education and access to affordable healthcare

[1] Stakeholders representing public health, school system, safety net clinics, county senior services, governmental agencies, Children's Healthcare of Atlanta, higher education, small business, non-profits, mental health, fire, police, Chamber of Commerce, emergency services, Hispanic health non-profit, children's advocacy, etc.

- Engage faith-based community
- Nutrition education and other programs
- Health screenings with a follow-up process in place
- Prescription assistance program
- Youth programs
- WellStar engagement by paying for a NP to assist

Cited Health Assets:

- Allatoona Resource Center
- Bartow Access Health
- Schools, congregations, social media
- Keith Saddling, CEO of Cartersville

Cherokee County:

Health and Quality of Life:

- Improved from an increase of medical facilities and healthcare providers
- Good economic growth
- Expanded hospital services with the new Northside Cherokee, WellStar Health System and CHOA urgent care locating to Cherokee
- 30114 and 30189 cited as low-income and the Bethesda population predominantly from 30114, 30115, 30188, 30189, and 30102.

Major Health Challenges:

- Access to care (especially wellness and preventative care such as vaccinations among the Latino population and for children requiring services at home / school)
- Language barrier
- Diabetes
- Hypertension
- Cardiovascular disease
- Obesity
- Physical inactivity
- Teen pregnancy / suicide
- Cancer
- Tobacco use
- Poor nutrition
- Mental health
- Dental
- Substance abuse (prescription and illegal drugs, especially heroin)

- Asthma/COPD
- Children's health and wellbeing

Context and Drivers:

- Lack of affordable health services - many people are using the community clinics because they can no longer afford the ACA insurance plan or find a provider that will take the insurance. Also, those who are insured with high deductibles can't afford to meet the deductible.
- Large Latino population in the county (many undocumented)
- Uninsured and underinsured due to low socioeconomic status and unemployment
- Lack of health / nutrition education
- Transportation issue
- Decreased staffing a local health department

Recommended Interventions:

- Centralized process to access resources in county and help to access Peach Care and employment services (currently Cherokee residents have to go to Marietta)
- Access to affordable mental health services and counseling
- More health education in clinics / community / schools – diabetes, cardiac, mental health, tobacco cessation, dental
- More collaboration between clinics, hospitals, physicians, dentists, and social workers to fill care gaps
- Transportation to health resources.
- Teen suicide initiatives as rate is extremely high in county
- Center to house medically fragile students to meet needs under one roof
- Sliding scale services and education targeted to low-income families
- More education relating to noted health challenges incorporated in the county through partnerships with clinics, schools and faith-based organizations/congregations

Cited Health Assets:

- Drug-Free Cherokee
- Schools and school nurses – first line of medical care for many children
- Bethesda Community Clinic
- Cherokee Focus – meets monthly to share resources and connect the needs of the community with available resources
- Kaiser Permanente – provides specialty referrals at no cost at Bethesda
- WellStar Health System – provides labs and imaging which has helped manage chronic disease and medications at Bethesda
- Children's Healthcare of Atlanta urgent care
- Cherokee Health Department provides some sliding scale community services with tracking and follow-up
- Cherokee County Service League

Cobb County:

Health and Quality of Life:

- Good / very good with improvements to health and quality over the last three years with Cobb / Douglas Health District faring better than the state of Georgia in many health indicators
- Hospital closed (Emory Adventist) resulting in care shrinkage
- More focus on health and wellness with Chamber's involvement, public-private partnerships and Cobb2020 work

Major Health Challenges:

- Lack of affordable healthcare / resources
- Cardiovascular disease (high blood pressure/high cholesterol)
- Cancer screenings
- Obesity
- Tobacco use
- Infant mortality
- Tobacco use
- Chronic disease
- Diabetes (Type 2)
- Asthma
- Physical inactivity
- Poor nutrition
- Mental health
- Substance abuse (alcohol and opioids/heroin and prescription drugs)
- Lack of affordable housing for low-income and elderly
- Transportation
- Language barrier
- Sexually transmitted diseases
- Dental care
- Violence

Context and Drivers:

- More health facilities equals more access to care and convenience for the broader population and insured, but there's been no increase in facilities for the indigent, low-income population (Good Samaritan Health Center of Cobb is centrally located in Cobb's only official Medically Underserved Area and Health Professional Shortage Area)
- Community clinics are understaffed, closing, relocating and a Cobb hospital has closed and lack needed access to specialists and primary care
- Undiagnosed mental health issues underlie chronic disease management which is often overlooked
- Lack of amenities to address health and fitness in lower income areas
- Unemployment and underemployment

- Not going to the doctors for check-ups /screenings
- Food scarcity/deserts in Cobb (South Cobb/Austell) have not been adequately addressed although more options are available via local farmer's markets, community grocery stores and in school lunches
- Lack of affordable healthcare / insurance options despite the advent of the ACA, Cobb continues to see the same amount of uninsured which limits or eliminates medical care and preventative care visits/screenings
- Rising deductibles of most insurance policies are making it difficult for many people to pay which self-imposes a lack of care access
- Lack of health literacy and awareness of available resources
- Rising population of Latino population in county and the lack of access to culturally and linguistically appropriate services
- Need for more recreational infrastructure and amenities
- Lack of recognition and treatment of addiction as a disease and limited recovery support
- Health disparities track with areas with a significant number of individuals and families who are at or below the federal poverty level, low education attainment, mixed ethnicity, limited English proficiency and poor health literacy.
- Emergency department utilization for primary care
- Affordability factor of health services makes lack of money as the primary barrier to care due to unemployment and underemployment
- Reconsider patient education flyers and one-day health fairs where a community member finds out they have high blood pressure, but have no physician for medication or follow-up care

Recommended Interventions:

- More collaboration among healthcare providers, communities, public health and community-based organizations targeting health challenges. Create policy to positively impact the socioeconomic determinants of chronic disease requires collaboration of multi stakeholders.
- Partner with faith-based congregations and other organizations to educate and assist with healthcare initiatives and preventative care
- Increase funding and resources for mental health services
- Create grant funding for local community-based programs/health fairs/education with appropriate follow-up to address health needs in communities with health disparities to show commitment to community benefit services
- More challenging wellness education (not just chronic disease management) and outreach campaigns (web-based) surrounding issues such as exercise / diet because of obesity's direct correlation to health issues like hypertension, cancer, Type 2 diabetes, etc.) especially in the schools and continuing throughout high school and in the workplace
- More access to primary care, specialty and mental health providers in Good Samaritan and other community clinics
- Hire a nurse practitioner to help increase patient load of community clinics (do urgent care or Coumadin checks)
- Utilize community health workers to educate high-risk communities
- Increase tobacco tax (Georgia has one of the lowest in the country) and use funds for healthy lifestyle programming in high-risk communities
- Creating lifelong communities (http://www.atlantaregional.com/aging-resources/lifelong-communities)

Cited Health Assets:

- Power Up for 30 in Cobb and Marietta schools
- Community clinics – Good Sam and Community Health Center in Austell
- Farm Fresh Farmer's Markets
- Faith-based community
- Cobb Community Services Board
- WellStar Health System
- Ser Familia
- SafePath Children's Advocacy Centers
- Culinary Sustainability within Culinary Services at Kennesaw State University (focused on farm to table and lower food waste)
- American Cancer Society's Client Navigators (Georgia Breast and Cervical Cancer Program) – Breas Test Program
- Georgia's CORE services program – allowed for people to qualify for health/mental healthcare insurance coverage and funding for home-based care is vital to removing the access issue
- Fit City Kennesaw
- Smyrna Tobacco Free Parks
- Children's Healthcare of Atlanta
- MUST Ministries
- Cobb Resource Center
- Cobb Senior Services
- Chronic Disease Council under the Chronic Disease Prevention Section of the Georgia Department of Public Health
- Cobb Community Transit FLEX
- Cobb2020
- WellStar Health Park (Vinings – South Cobb)
- Alive Ministries
- "Maestros Nanos" pediatric clinic (run by NPs to provide pediatric services to most vulnerable)
- YWCA
- Wal-Mart/Walgreen pharmacies
- WellStar Cobb and Kennestone hospitals' Emergency Department
- Kaiser Permanente

Douglas County:

Health and Quality of Life:

- More accessibility, services and awareness of the services
- Still lacking access necessary to manage chronic conditions

Major Health Challenges:

- Affordability and access to healthcare
- Obesity
- Diabetes
- Hypertension
- Drug abuse (illegal and prescription)
- COPD
- Poor nutrition
- Mental health
- Physical inactivity
- Transportation
- Unhealthy/unsafe home conditions

Context and Drivers:

- Low-income and homeless population are prevalent
- Unemployment and underemployment – high number of minimum wage employees
- Lack of transportation to and from services
- Lack of health education
- Lack of primary care providers

Recommended Interventions:

- Increase awareness of healthy living services/education/activities for children and adults – partnership with county schools and businesses to reduce drug abuse, poor eating and lack of exercise
- Provide more funding / resources for free clinics
- School-based health centers

Cited Health Assets:

- The CarePlace

Paulding County:

Health and Quality of Life:

- Good to fair with some improvements to specialty and emergency care due to the opening in 2014 of the new WellStar Paulding Hospital that's more centrally located in county
- Some decline due to lack of jobs and insurance

Major Health Challenges:

- Lack of access to affordable healthcare services, especially primary care providers and labs for chronic disease management / medications
- Transportation

- Obesity
- Diabetes
- Cancer
- Substance abuse (alcohol, illegal and prescription drug)
- Tobacco use
- COPD
- Cardiovascular disease
- Hypertension
- Mental health
- Sex education
- Domestic violence

Context and Drivers:

- Underinsured and underemployed and the children of these people who need medical services - high deductibles - associated with a lower monthly premium plans – are too high for low-income residents
- Pockets of poverty evident by government housing, run-down mobile home parks and inadequate housing
- Lack of healthy food choices
- Not going to the doctor for check-ups and screenings
- Lack of jobs in Paulding – many people have to commute
- Lack of transitional housing and homeless shelters in county
- Vulnerable populations need no cost education (homeless, low-income, mentally ill, disabled not yet receiving benefits, drug abusers, Latinos)
- Failure of Georgia to expand Medicaid is a barrier to improving health
- Lack of primary care and mental health providers and no low-cost options for these services
- No safety net clinic to see indigent patients and provide access to needed medications at a free or reduced cost

Recommended Interventions:

- Partnership with the Paulding Community Health & Resource Center as the first safety net clinic in the county
- More community collaboration between governmental health agencies, non-governmental healthcare organizations and faith-based community organizations and congregations
- Prevention education (i.e. health fairs) to address behaviors (nutrition, exercise, smoking) in community and schools
- More access to preventative screenings, mental health interventions and immunizations
- More supportive resources for alcohol and drug abusers
- More recreational spaces and facilities
- Public transportation
- A birthing center in Paulding

Cited Health Assets:

- WellStar Paulding Hospital
- Paulding Community Health & Resource Center
- Georgia Shape program
- Paulding Family Connection Children's Cabinet

- Helping Hands of Paulding and its collaboration with Community Supplemental Food Program for Senior Citizens 60+ years of age
- Paulding Meth Alliance / Family Alliance of Paulding
- Ser Familia
- Creating Communities of Hope (Paulding is a part of the Northwest Georgia Region of Hope)
- Paulding County Health Department
- Rapha Clinic in Temple (Carroll County)
- Paulding County Community Support Services
- Children's Medical Services
- Children's Cabinet

FOCUS GROUPS

Focus groups were conducted by the Georgia Health Policy Center with insured and uninsured adults living in the high need areas in the service area using a series of questions aimed at understanding perceptions of health needs and solutions/resources to improve health.

County	**Venue**	**Number of Participants**
Cobb (Spanish)	South Cobb Regional Library 805 Clay Rd. Mableton, GA 30126	10
Douglas	Holiday Inn Express 7101 Concourse Parkway Douglasville, GA 30134	8
Cherokee	Best Western Mountain Villa 705 Transit Avenue Canton, GA 30114	7
Bartow	Goodyear Clubhouse 3 Goodyear Avenue Cartersville, GA 30120	9
Paulding	Best Western 1340 Pace Rd Hiram, GA 30141	7

Overall	Male	Female	25-34	34-44	45-64	65+	African American	Asian	Caucasian	Hispanic/Latino
Total	**12**	**29**	**7**	**17**	**17**	**0**	**18**	**1**	**13**	**10**

Major Health Challenges:

1. Obesity
2. Tobacco
3. Cancer
4. Diabetes
5. Mental health/substance abuse

Context and Drivers:

- Unhealthy food in schools
- Healthy foods are expensive
- Cultural norm of consuming a lot of meat and carbohydrates
- Busy lives - not enough time available for meal preparation at home
- Not enough resources available for family caregivers
- Life stressors
- Decreased ability to move and exercise in some members of the population whose health is already poor
- Health philosophy that is centered on care - "*Here in the United States, the western world, we see the human body as if everything was separated by sector*"
- Safety concerns
- Pervasive drug culture and use among youth
- Youth sexual hyperactivity
- Unaffordable access to care; limited availability of care providers during weekend
- Linguistically appropriate engagement and community health workers only available during week days
- Health department seen as primary care home for many without insurance

Recommendations:

- More targeted educational campaigns aimed at promoting health and wellbeing - WellStar and Kaiser already facilitating coaching classes
- Engage churches, libraries and businesses
- Go beyond trying to connect with parents through children using communications (notes, pamphlets etc.) sent from school
- Consider innovative ways to get families getting healthier together - e.g. bicycle day in cities
- Encourage doctors to take more time at visits to educate patients

Major Health Challenges:

1. Mental health and substance abuse
2. Obesity
3. Sexually transmitted diseases (STDs)
4. Heart disease
5. Diabetes

Context and Drivers:

- Unhealthy eating habits
- Limited choices for healthy foods
- Poor public transportation system
- Long working hours affectability to exercise
- Difficult to change unhealthy behaviors
- Many parks around but access may be challenging because of distance
- Family history and culture of tobacco use (smoking)
- Liquor and meth use prevalent
- Youth risky sexual behavior and early initiation seeming more commonplace
- Poor healthcare provider quality
- Hard to be own advocate
- Many battling despair and stress
- Immigrants (Asian, Hispanic and Caribbean) have challenges adjusting and navigating health system

Recommendations:

- Environment changes that will facilitate youth socialization and physical activity -
    - Accessible basketball/other courts
    - YMCA
- Improve transportation system to allow access to health and wellness resources
- Address access to healthy foods - more quality restaurants and grocery stores
- Work with other partners to assist community members in finding jobs
- Encourage the Arts, and support of the Arts in the community

Major Health Challenges:

1. Cancer
2. Mental health and substance abuse
3. Obesity
4. Diabetes
5. Hypertension/stroke

Context and Drivers:

- Hectic schedules and stress influence insufficient physical activity and poor eating
- Confusion about what is healthy (e.g. organic vs. canned vegetables)
- Lack of parental involvement and poor or no social connections influence drug abuse and risky sexual behavior
- Drugs are something to do and look cool
- Few sidewalks and parks in neighborhoods for walking

Recommendations:

- A safe community center for community activities
- Health classes-eating and cooking
- Public transportation options

Major Health Challenges:

1. Obesity, (unhealthy eating habits and insufficient physical activity)
2. Affordability of healthcare and insurance
3. Substance abuse
4. Tobacco use
5. Risky sexual behavior among teens

Context and Drivers:

- Unhealthy food is cheaper and readily available
- High cost of insurance and healthcare
- Hard to find time to do physical activity and cook/eat healthy because of time spent at work and other family obligations
- High levels of stress
- Less parental involvement (drug abuse & risky sexual behavior)
- Some disappointment with quality of care at Cartersville Medical Center

Recommendations:

- Facilitate the establishment of more farmers' markets in the community
- Support a neighborhood/civic center that offers community activities
- Consider opening a gym or recreational facility that is open or free to the public;
- Invite YMCA to participate
- Work with other stakeholders to reduce the number of uninsured residents

Major Health Challenges:

1. Mental health and substance abuse
2. Obesity
3. Sexually transmitted diseases (STD)
4. Hypertension/Stroke
5. Cancer

Context and Drivers:

- Change means going against the grain
- Unable to find time and discipline to exercise; hard to find motivation
- Costly gym membership
- Easy and convenient access to fast foods
- Unawareness of how to cook and prepare meals
- Tobacco use (smoking) still an issue; many who try to stop smoking, gain weight
- Established drug culture with seemingly increasing use of heroin
- Early sexual initiation in youth
- Busy schedules resulting in diminished parenting; television reinforcing unhealthy behaviors
- Drug and alcohol poisoning putting burden on emergency rooms
- Poverty, lack of insurance, child abuse (including trafficking) and family breakdown are also believed to be driving health challenges

Recommendations:

- Focus on addressing root causes of drug abuse and mental health conditions
- Pattern drug use policy for Ritalin and Prozac to help control abuse of prescription meds
- Promote teen pregnancy prevention programs that work
- Engage churches and hospitals as information hubs
- Support the use of joint use agreements especially with schools to be encourage youth and adults in the community to exercise

Community Listening Session – COBB COUNTY (Latino)
Third-Party Consultant with assistance by Ser Familia Executive Director

Major Health Challenges:

- Lack of affordable healthcare and insurance
- Language barriers
- Mental health among youth
- Suicide
- Domestic violence
- Lack of available pediatricians
- Diabetes
- Dental

Context and Drivers:

- Scarce family support services
- Little bi-lingual school personnel and medical providers
- Lack of cultural proficiency
- Fear a diagnosis of a mental health disorder may disqualify them from attaining permanent resident status so they go untreated
- Low socio-economic status
- High utilizers of CVS Minute Clinics, ED and Kennesaw Urgent Care ($45/visit)
- Feelings of isolation and identify issues from "culture clash"
- Ser Familia identified only five Spanish-speaking mental health counselors in Cobb County
- As children are "Americanized," parents feel a loss of parental authority resulting in tension and family dysfunction especially in homes where parents speak little to no English

Recommended Interventions:

- Resource list
- WellStar training in cultural proficiency related to domestic and family violence
- Need culturally appropriate workshops on healthy lifestyles and prevent to be conducted in schools and churches (doing these in "safe environments is the key")

Community Listening Sessions – COBB COUNTY (Latino)*

Facilitated by a representative from the Hispanic Health Coalition of Georgia

Summary of two Latino sessions at Iglesia de Dios (South Cobb) and McEachern UMC (West Cobb)

Major Health Challenges:

1. Poor nutrition
2. Tobacco use
3. Hypertension
4. Diabetes
5. Transportation
6. Lack of affordable and accessible healthcare
7. Access to dental care
8. Transportation

Context and Drivers:

- Cultural and language barriers hinder adaptation to healthy lifestyles
- Lack of transportation, sidewalks and access to the gyms is prevents this community from exercising
- Unhealthy habits such as tobacco use is due to youth trying to assimilate into culture
- Low-income / unemployed can't afford insurance
- No prevention or management of chronic disease – see doctor but no follow-up
- "Purchasing medicine is expensive" – it restricts or reduces availability of money for other costs like food or transportation
- No awareness of resources and services for better health (although both congregations are a part of the WellStar Congregational Health Network)
- The first barrier to health service is the cost. They want to go to the health checkup but health services are too expensive, and the insurance is not seen like the answer because half of them don't have access, or despite its services are too expensive.
- Community is aware about preventive services and when they recognize them like good services with reasonable cost, they are willing to go for them paying and looking for them in any location.
- WellStar is on mind of the community but like a hospital and medical center, not a System, and is mostly related with expensive services.
- Don't know how to follow a healthy diet and lack time and motivation for physical activity – "doctors recommend indications for a healthy life, but without questioning and considering culture and customs"
- High ED utilization when they get sick - there is not education and resources there to help redirect them
- Those with insurance noted the expense and prevent access "deductibles are high and unattainable and services are expensive"
- Good Sam is not easily accessible to get an appointment

Recommendations:

- Utilize Latino faith-based congregations as a vehicle to educate and provide resources to the community (pastors are considered leaders in their community)
- Provide list of resources and health information in Spanish to help improve health knowledge and accessibility to services
- More options in neighborhood for physical activity and education to achieve a healthy lifestyle
- Health Fairs (low cost or free) but with the availability of follow-up health services
- Family counseling

.

Community Listening Session – DOUGLAS COUNTY (The CarePlace)
Third-Party Consultant

Major Health Challenges:

- Lack of affordable healthcare, service and insurance
- Substance abuse
- Chronic disease – diabetes
- Obesity
- Mental health
- Poor nutrition
- Physical inactivity
- Medication access
- Transportation

Context and Drivers:

- Low income, homeless – "We are not the sorry and lazy."
- Unemployment/disability
- Free screenings without follow-up is useless ("What's after?")
- Poor diet and environment contribute to poor health
- "Obamacare…it's terrible" – premiums increase and options decrease
- Nutritious food is the most expensive
- Hard to get access to specialty care

Recommendations:

- Outpatient services on a sliding scale
- Primary care and specialists need to volunteer at The CarePlace to "show somebody compassion" – increasing care capacity

Community Listening Session – CHEROKEE COUNTY (Bethesda Community Clinic)

Third-Party Consultant

Major Health Challenges:

- Diabetes
- Mental health (depression)
- Heart/stroke
- Obesity
- Poor nutrition
- Physical inactivity
- COPD
- Lack of medical access for chronic disease ("30 day supply then go back to the ED")
- Lack of insurance ("We are in the wrong state.")
- Physical / family abuse
- Prescription drug abuse

Context and Drivers:

- Lack of resources and education
- Hard to get access to specialty care
- Patients have developed personal relationships and trust and perceive it to be better care
- Exercising is like "tying a weight around a person's ankle and telling them to run a 50 yard dash"
- Job loss is a defining moment (no money / homeless)
- Mental health issues stem from circumstances / hopelessness
- Importance of the spiritual side of a person for getting and staying well
- Lack of awareness of preventative screenings – "We need to be educated about what we need and when."
- Funds are limited from Georgia Charitable Care Network for services (60-90 days out)

Recommendations:

- More engagement with Bethesda as they "help me with more than just medical stuff) education / resources / referrals)
- "Wellness coaching" education provided by WellStar onsite at clinic
- Engagement of faith-based community (mentioned First Baptist Woodstock's "Love Loud" initiative and start with prevention via health educators
- Men's health is an area of improvement cited by Bethesda nurse manager

Community Listening Session – COBB COUNTY (Good Samaritan Health Center)

Third-Party Consultant

Major Health Challenges:

- Substance abuse
- Lack of affordable services and insurance
- Mental health
- Tobacco use
- Cancer
- Hypertension
- Diabetes
- Obesity
- Cardiovascular disease
- Transportation
- Physical inactivity
- Poor nutrition

Context and Drivers:

- Waiting list for Good Sam limits accessibility and addition of new patients
- Low income and education attainment ("You feel stuck.")
- "Mental health resources don't exist."
- People want out of their neighborhood – drugs, violence – don't feel safe to exercise, kids exposed to drugs
- Healthy habits are more expensive (food and gym memberships)
- Affordable dental care at Good Sam helps
- Unemployment / underemployment
- They feel trapped - If you don't have a job or you make too much money you can't get Obamacare. "You decide whether or not you're gonna eat or get the medicine."
- Distrust of system / State

Recommendations:

- Need to add mental health services at Good Sam
- More providers to serve the community - "People are willing to pay according to their income."
- Getting faith-based congregations to help fill transportation gaps (cited Milford Church Baptist)
- Resource list that's up-to-date and distributed in community – media/radio
- Northwest Women's health and WellStar screening mammogram referrals

Community Listening Session – PAULDING COUNTY (Paulding County Health Department)
Third-Party Consultant

Major Health Challenges:

- Lack of affordable healthcare and screenings
- Uninsured
- Transportation
- Poor nutrition
- Physical inactivity
- Women and children's health
- Lack of specialty care

Context and Drivers:

- "We have to choose between a doctor visit or medicine."
- A healthy lifestyle is too expensive ("Eating healthy costs a lot of money" and there's "no safe place to exercise.")
- Education – don't know how to be healthy
- Unemployment – low income prevents access to care
- Paulding County Health Department doesn't take appointments because of failure to show rates
- Screening are unattainable because of cost

Recommendations:

- Need for more community clinics like Rapha in Temple, GA
- More preventative education – group, classroom setting
- Work with Warehouse of Hope (cited food bank)
- Expand Medicaid in Georgia
- Resources – no one knew about WellStar's 770-956-STAR
- Need a women's center at the new WellStar Paulding Hospital

RESEARCH TOOLS

GHPC KEY INFORMANT QUESTIONNAIRE CHNA
2015

Name: _____

Title and Organization: _____

Date of Interview: _____

CONTEXT

1. What in your opinion are the district's/county's/community's biggest health issues or challenges that need to be addressed?
2. What do you think are some of the root causes for these challenges?
3. How important an issue to the district/county/community is the reduction/elimination of health disparities? *What is your perception of current disparities?*
4. How would you describe the present level of public/private partnerships that are occurring to improve health and reduce health disparities in the county/community?
5. What are the challenges to beginning and sustaining such partnerships?
6. What specific programs and local resources have been used in the past to address health improvement/disparity reduction?*(might cite examples of programs by disease state, life stage or otherwise)*

COMMUNITY CAPACITY

1. Who/What are some of key individuals/organizations/programs to health and health care in the community?
2. Which community based organizations are best positioned to help improve the community's health?
    a. Private sector agencies
    b. Public sector agencies
3. Are there individuals, agencies or organizations you'd like to see more engaged in your community's health improvement journey?

MOVING THE NEEDLE

1. If you could only pick 3 of these health issues, which are the most important ones to address either now (short term) or later (long term)? *What should be the focus of intervention by county/district/community?*
2. Why did you pick these?
3. What interventions do you think will make a difference? *Probe for different types of interventions related to:*
    a. Policy
    b. Environment

c. Program

4. Do you have any other recommendations that you would make to the health system (Kaiser/Piedmont/Grady/WellStar/Mercy Care) as they develop intervention strategies?

GHPC Focus Group Discussion Guide
WellStar Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

- Facilitator introduces self and thanks those in attendance for participating
- Facilitator explains purposes of discussion:

The project is being undertaken by Kaiser Permanente/ WellStar/Piedmont/Mercy Care. The health systems are seeking ways to improve the health of residents in 34 counties in Georgia. They would like to hear from people who live in these counties. They are particularly interested in your feelings about the health and health needs of the community, how the health-related challenges might be addressed and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

- Explain about focus groups:
  - ⇒ Give and take conversation
  - ⇒ I have questions I want to ask, but you will do most of the talking
  - ⇒ There are no right or wrong answers
  - ⇒ You are not expected to be an expert on health care, we just want your opinion and your perspective as a member of this community
  - ⇒ You don't have to answer any questions you are uncomfortable answering
  - ⇒ It is important to speak one at a time because we are recording this conversation
  - ⇒ Your names will not be used when the tapes are transcribed, just male or female will appear on any transcript
  - ⇒ I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to “hold on a minute” while I hear from someone else, so don’t take offense
  - ⇒ Here is an informed consent form for you to read along with me and then sign. (READ INFORMED CONSENT, COLLECT SIGNATURES)

Participant Introductions

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

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

Thoughts on Health for Your Family and Community

1. What does the term "healthy lifestyle" mean to you?
2. Do you think you and your family have healthy lifestyles?
    a. Why or why not? What affects your ability to be healthy? What prevents you from being as healthy as you would like to be?
3. Do you think that most people in your community are healthy?
4. Do you think that there is something about your community that contributes to people having these types of issues?

Healthy Behaviors

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

5. Let's start with healthy eating. Most of the time, do you and your family eat as healthily as you would like?
    a. What prevents you from eating healthily? (Probe for cultural issues, access to healthy food)
6. Now let's talk about physical activity. What kinds of physical activity do you and your family engage in?
    a. Do you think you get enough physical activity to be healthy?
7. What keeps you and your family from being as physically active as you would like to be?
    a. What would help you and your family get more exercise?
8. If you could make 2 or 3 changes that would promote better health, what would they be?
9. How about tobacco use?
    a. How prevalent is tobacco use among your family and friends? Do you think most people are aware of the risks related to tobacco use? What do you think it would take to change people's habits when it comes to tobacco use?
10. Are drug and alcohol abuse a problem in your community?
    a. What contributes to this problem? What could be done to address the problem?
11. Another health issue of concern is risky sexual behavior among teens.
    a. Do you see this as prevalent in your community? Are there support services to help teens deal with this type of issue?
12. When you think about the health concerns we have discussed –do you know of any resources/programs/services in your community that help with these issues?
    a. Are there different types of services that would be more appropriate or effective?

Health Outcomes and Access

13. Do you and your family have somewhere or someone that you go to for routine medical care?
    a. When you go there, does anyone ever talk to you or provide you with information about the health issues we have been discussing – weight, exercise, healthy eating, tobacco, drug and alcohol use, sexual behavior? Do you think your primary care provider should ask you about these issues? Provide you with information? Help you to change your habits?

Facilitator: Present community-appropriate data summary to participants.

14. What is your reaction to this information?
    a. Does it ring true to what you know about your community? Is there anything missing from these data that you believe to be true about your community?
15. What do you think is the best/most effective way to begin to address these issues?
16. What do you see as the role of the hospital or health system to address these issues?

17. Considering the information that I just presented to you, along with your own experience with critical health needs here, which 1 or 2 of these health issues should be the priorities for addressing over the next three years?

Health Concerns in the Community

18. Now let's talk about what about your community. Please tell me about the strengths/positives in your community.
19. In communities, people often talk about community leaders- these are organizations or individuals that everyone knows, places/people that you seek out when you need information that is trusted. Do you know of these types of organizations or people who are concerned about health issues and serve as leaders in trying to improve health in your community?
    a. Who are they – what are they doing? Are their efforts successful? Why or why not?
20. Would these organizations or people be good leaders for addressing other health issues in the community?
    a. If not them, then who?
21. What should be done to ensure that children in your community finish their education and can find jobs?

Closing:

22. How would you like your community to be different in 5 years in order to be a healthier place for you and your family to live?

# # #

Community Health Needs – KEY INFORMANT SURVEY

Thank you for assisting WellStar Health System with its upcoming Community Health Needs Assessment (CHNA) research. Your expertise and insight is valued and appreciated.

NAME	
SURVEY DATE	
ORGANIZATION/ AFFILIATION:	
TITLE:	
ZIP CODE OF AFFILIATED ORG.:	
COUNTY:	*Circle one:* **Bartow Cherokee Cobb Douglas Paulding Other:_____**
PERMISSION TO LIST YOUR PARTICIPATION IN CHNA REPORT?	We are required to list the organization/affiliation of the key informants we survey in our CHNA report to be published online at wellstar.org by June 30, 2016. Your personal information will not be published. *Please circle or highlight your selection.* YES, I grant permission to list my organization/affiliation / NO

1. **How would you rate health and quality of life in the county you live?** *(Circle or highlight your selection.)*

   Very Good Good Fair Poor Very Poor

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

   Improved Stayed the same Declined Don't know

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

3. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

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 problems?**

6. **What needs to be done to address these issues?**

7. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse	Not going to the doctor for check-ups / screenings
Illegal drug abuse	Not getting prenatal care
Prescription drug abuse	Not washing hands
Unsafe sex	Poor eating habits
Lack of exercise	Drunk driving
Not getting immunizations	Smoking / tobacco use
Not using seat belts	Suicide
Not going to the dentist	Violent behavior

OTHER:_____

8. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

9. **In your opinion, what else will improve health and quality of life in the county?**

10. Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What differentiated it from other programs designed to improve access to care and overall health? Why did it work? *(If you have supporting materials or a website link, please share.)*

11. Where does your community get most of their health-related information? *Choose up to 3 by circling or highlighting.*

Friends and family
Doctor/nurse/pharmacist
Internet
Public Health Department
Television
Hospital
Help lines (telephone)

Books/magazines
Free Care Clinic
Social media
School
Congregation
Newspaper
Other:_____

12. What do you think are the top issues that have the largest impact on quality of life in your community? *Pick up to 5 by circling or highlighting.*

Animal control
Availability of child care
Affordability of health services
Availability of healthy food choices
Bioterrorism
Dropping out of school
Homelessness

Inadequate / unaffordable housing
Lack of / inadequate health insurance
Lack of culturally appropriate health services
Lack of health providers
*What kind?*_____

Mental health issues
Lack of recreational facilities
Unhealthy / unsafe home conditions
Rape / sexual assault
Domestic violence
Youth crime

Lack of law enforcement
Literacy
Secondhand smoke
Work safety
Availability of healthy family activities
Availability of positive teen activities
Neglect and abuse
Elder ___ Child ___

Pollution (water, air, land)
Low income / poverty
Racism
Lack of transportation options

Unemployment
Unsafe, unmaintained roads
Violent crime
Gang issues
Others: _____

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

14. **In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?**

15. **In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?**

Would you like us to contact you to further discuss topics in this survey? Yes / No

If yes, what is the best method to contact you?

Thank you for your time!

Other comments:

Community Health Needs Assessment 2016
Listening Session GUIDE

Equipment and Supplies

- Focus group guide and surveys
- Tape recorder or other recording device
- Name tags or tent cards
- Legal pad and 10-12 pens or pencils for notes (assistant)
- Sign in sheet for participants (optional) – can double as *informed consent form*
- Manila envelope for completed surveys
- Copies of surveys – pre-placed with pens at table ******Encourage participants to begin completing survey upon arrival******

AT START TIME:

Overview of Purpose of Discussion and Rules of a Focus Group

- Facilitator introduces self and thanks those in attendance for participating
- Facilitator explains purposes of discussion:

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

Information gathered will help determine:

- *Current community practices for maintaining health*
- *Kinds of health problems that you think occur most often in your community*
- *Barriers people have to good health*
- *Community ideas for solutions to health problems*
- *Identification of groups of people underserved for health needs*

Explain about focus groups:

- Give and take conversation
- I have questions I want to ask, but you will do most of the talking
- There are no right or wrong answers
- You are not expected to be an expert on health care, we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation (and taking notes)

- Your names will not be used
- I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to "hold on a minute" while I hear from someone else, so don't take offense

*Here is an **informed consent form** for you to read along with me and then sign. (INFORMED CONSENT, COLLECT SIGNATURES)*

Participant Introductions

1. Please go around the table and tell me your name, how long you have lived in [this county/community] and the best thing about living in this county/community.

I am going to ask you all a series of questions about health. This discussion time will be capped at 1.5 hours.

Introductory Question:

1. **Where do you go to get information about health?**

Prompts: Resources? Providers? Internet?

2. **In this group's opinion, what are the serious health problems in your family and community? What are some causes of these problems?**

Prompts: What about physical health problems? What about social problems that affect health (like violence, substance abuse, etc.) What about mental health problems?

Facilitator: Probe for causes for each health problem identified right after it is mentioned.

3. **What keeps you and other people in your community from being healthy?**

Facilitator: You are helping to elicit participants' views of barriers and challenges that prevent them from maintaining good health and accessing healthcare services.

Prompts: What about costs of medical visits? Medicine? Health insurance? Other types of health services like mammograms and other screenings?

Facilitator: Before asking this question, summarize what you heard in question #3 to help the group focus on their discussion of solutions in this question:

4. **What could be done to solve these problems?**

5. **In your opinion, who are the people not receiving enough health care or access to care? Why not?**

Facilitator: This question allows participants to share their views of possible solutions to the health problems, their causes and barriers that they have discussed in previous questions.

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

Facilitator: Thank you for participating. Your responses will be summarized along with those of other community groups. The results will be shared publicly in WellStar's Community Health Needs Assessment report to be on their website by summer 2016. This information helps determine the most important health issues in your county.

Please note: **SOME COMMUNITY RESPONSES MAY NOT REFLECT THE OPINION OR PRIORITIES OF WELLSTAR.**

2016 Key Informant Survey Input – *WellStar procured*

County	Bartow 2	Cherokee 4	Cobb 31	Douglas 6	Paulding 10
Zip	30121 30102	30114 30188 30115 1	30064 1 30217 30168 30062 1 30144 111 30080 1 30060 1111 30339 30068 30090 1 30008 11 *30303,30008,30060,* *30101, 30064, 30127* 30127 30152 30066 30061	30157 30168 30122 30135 30134 1	30141 1 30132 111111 30101 1
Sectors	Health District Safety net – resource center	School System County Health Department Department of Family & Children Services Safety net community clinic	Senior Services Austell Community Taskforce WHS Board Member Small business Fire Police Chamber Finance Community member Hispanic Health Public Services Agency CHOA Public Health FQHC Children's Advocacy Higher education ACS ACS – Marietta Health Dept. Small business County government School system Drug prevention	Emergency services Community clinic Business Hospital board School System Non-profit organization for family and children	Regional Hospital Board Business (bail) Non-profit Community clinic advocates Health System Law enforcement Hispanic non-profit County Health Department County government

			organization Mental Health Health System Faith-based resource center		
How would you rate the health and quality of life in the county you live?	Very good Good 1 Fair Poor Very Poor 1	Very good Good 11 Fair 1 Poor Very Poor	Very good 1111111111 Good 11111111111111111 Fair 11 Poor 1 Very Poor	Very good Good 11111 Fair 1 Poor Very Poor	Very good 1 Good 11111 Fair 111 Poor 1 Very Poor
In the past three years, has the health and quality…	Improved Stayed the same 1 Declined 1 Don't Know	Improved 11 Stayed the same 1 Declined Don't Know	Improved 111111111111111 Stayed the same 11111111 Declined 11111 Don't Know 111	Improved 11 Stayed the same 1111 Declined Don't Know	Improved 11111 Stayed the same 11 Declined 1 Don't Know 1
Please explain why you think the health and quality of life has improved, stayed the same or declined and any factors informing your answer.	Higher demand for services and at our free clinic. With economic downturn, many people can't afford ACA – If do, no providers accept. Medicare reimbursements down and no longer accepts Medicaid. Very few resources in the area until now. Our facility is the first for residents in South Bartow.	In Cherokee County, the addition of community clinics has prepared to serve the less fortunate and improved children's health, resulting in a faster return to school time for children who are sick. The community clinic also offers gift cards for free office visits for anyone in need. At times there is access	It looks like Cobb Douglas fairs better than the state of GA. Cobb also has a higher median income that most counties. According to CDPH's 2014 Annual Report, Cobb County population continues to grow (4.5 percent from 2009-2013) and cardiovascular disease is the number one cause of death in adults (2008-2012) even though the death rate is lower than the state. Cobb fairs	More accessibility and more services and awareness of those services. People are still lacking access necessary to manage chronic conditions such as COPD, hypertension and diabetes. No real visible public efforts that the citizens participate in consistently.	Access to specialized and emergency care have improved due to opening new hospital more centrally located, with more specialists and expanded emergency services. New Paulding Hospital added great benefit and shopping and recreational opportunities are bountiful. Declined due to

		to free medication such as lice shampoo. Also expanded hospital services in the near future – new Northside Cherokee, WellStar Health System and CHOA Urgent Care locating to Cherokee County. An increase in medical facilities, healthcare providers and economic growth. I think many people were hopeful that there would be improvements with the new Affordable Care Plans, however we have found that many people are returning to the clinic because they can no longer afford the insurance plan, cannot find a provider that will take the insurance or give up due to frustration from trying to navigate the	betters with several health indicators (obesity, smoking, infant mortality, prevalence of diabetes, asthma) however within those health disparities exist. More sites available. More services for children using appropriate size instruments. More updates to facilities. Declined because a hospital was closed and remains vacant. This action results in a shrinkage of care. There are more health facilities within a reasonable travel distance at a reasonable price. A dedicated focused attention on health and wellness. The Chamber's involvement – public-private partnerships and the Cobb2020 work. Stayed the same even though meds/txs/procedures have improved because we continue to suffer from long-term unhealthy issues like obesity. Kennestone is now a	Stayed the same – A major issue that is about the same is the access to primary care physicians. Douglas does not have sufficient primary care physicians which cause an overuse of Emergency Rooms and a strain on the only free clinic the CarePlace. This has been an ongoing problem for many years. Not much has changed.	the lack of jobs for manual labor and lack of insurance. New hospital services in our community. Stayed the same – no data that indicates improvement at this time. As we develop the Paulding Community Health & Resource Center into a charitable healthcare clinic and one-stop community services center, I have talked with many people around the community who agree that the uninsured and underinsured are in much greater need of health care: medical, dental, behavioral and nutritional. My conclusion is that the health and quality of life is adequate in the community, but will be made much better and be made

		insurance, Medicaid, VA, and hospital systems. There is also a large Hispanic population in Cherokee County who cannot obtain specialty care unless they pay cash in the system if they are not documented.	Level 2 trauma center and provides better access to medical care. Numerous parks are situated throughout the county for exercise. Police and Fire are outstanding and provide rapid response to issues. I think the county is working to increase health parks, trails, health awareness and education, but I think due to the fact that we are eating more and moving less it has not made much of a difference. Kennestone has continued to expand its campus and has added valuable medical services such as a special Pediatric facility. Additionally the WellStar system has added two medical campuses off the main campus in East Cobb and North Cobb. This expansion makes it more convenient to residences living in those areas of the county to receive medical tests, imaging and physician services without traveling to the main campuses of WellStar. While residents of		more widespread with the opening of a charitable healthcare clinic. In addition, a one-stop services center associated with the clinic and under the same corporate entity will also aid in the betterment of the residents by providing more convenient access to government agencies, as well as providing easier access to aid organizations. Improved because of the new Paulding Hospital. Improved – I think that with the new hospital it has opened more opportunities for quality services not available at the old facility.

			certain areas of Cobb enjoy disposable income that allows them to access foods conducive to healthy lifestyles, as well as safe neighborhoods to play and exercise and access healthcare, many parts of Cobb do not enjoy those same qualities of life. There are food deserts in Cobb that have not been addressed. I have been a resident and worked in Cobb County for the last 10 years. Ultimately, I see the overall health and quality of life in the county has stayed the same. Pockets see improvement, but the general overall county seems to stay the same. I've moved from South Cobb, where community resources and support are needed to now living in northwest Cobb County where resources are plentiful and growing. Health and quality of life has declined in Cobb County because of Obama Care, in my opinion. Many who are		

			required to pay for insurance don't have it because they can't afford it. Improved b/c added facilities by WellStar and continued upgrades along with constant influxes of quality caregivers have caused our communities overall healthcare to improve. Improved – There are in increase in activities promoting healthy lifestyles including: additional walking trails, addition of sidewalks to promote more walking, additional 5k and other exercise sponsored events including the Walk GA/Cobb 2020 initiative. In addition the local farmer's market and community grocery stores seem to offer more options of seasonal fresh fruits and vegetables. Improved - The major reasons are: economy has improved so healthy food choices are available; efforts to have more fruits/vegetables in school cafeterias; fewer teen		

			pregnancies; reduction in smoking by young folks; nonprofit organizations in Cobb dedicated to improving the welfare of its citizens (MUST, Cobb Resource Center); more men getting prostate testing; emphasis on good prenatal care; more emphasis on moving about (exercise) vs sitting; and, more stress reduction opportunities in the work place. Declined – due to the number of citizens who have become addicted to opioids/heroin. In 2014, we had 56 overdose deaths directly related to heroin alone, most of whom were young adults. Improved – Overall expansion of care sites in county. Stayed the same – with the advent of the ACA, which was supposed to improve access, we continue to see the same amount of uninsured, placing the burden of healthcare on our health system to care		

			for everyone. Improved – More education has been provided to many and people are more health conscious - companies providing fit bits, fitness centers, etc. Declined – 1) Rates of obesity 2) Rise of suburban poverty since 2008 3) Gap of healthcare coverage		

BARTOW

16. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

    Emerson/Allatoona ES – 30101, 30137

    Poorest population in Adairsville – 30103

    30137 and 30102 are the primary zip codes and the overall quality of life and health are very bad due to high unemployment, drug use, poverty, and crime.

17. **What barriers, if any, exist to improving health and quality of life in the county?**

    Declined – need coverage and can't access care. Demands exceeds supply. Cartersville Medical Center is a for profit hospital – accept patients to a limit. Screen patients, but if you find something – then what? Biggest areas of concern at diabetes, hypertension meds – Publix offers free antibiotics, but people are not aware. People can't afford medications and insulin for diabetics. Can we get expired meds?

    Little to no access to resources, employment opportunities, healthcare and transportation.

18. **In your opinion, what are the most critical health problems and > what needs to be done to address these issues?**

    Obesity. Heart disease and stroke in Bartow is high. Cancer – breast cancer Medicaid and cervical cancer screening (gap in cancer – lung cancer screening. High smoking area. Diabetes. Dental – hardest need to meet. > Primary prevention through education and access to healthcare and men's health information

    We pay nurses less. Funding down in health department.

    Poor eating, drug use > access to nutrition education, employment efforts to better provide, transportation.

19. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse	Not going to the doctor for check-ups / screenings
11	1
Illegal drug abuse	Not getting prenatal care
11	
Prescription drug abuse	Not washing hands
Unsafe sex	Poor eating habits
1	1
Lack of exercise	Drunk driving
Not getting immunizations	Smoking / tobacco use
	11
Not using seat belts	Suicide
Not going to the dentist	Violent behavior

OTHER:_____co-sleeping – child fatality rate higher – lower economic – trying to educate

20. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

    Real affordable and accessible healthcare

    If we screen, then follow-up process

    Need a PAP to get meds to people in need

Nutrition education. Clinic access. Dental assistance programs. Prescription medication assistance.

21. In your opinion, what else will improve health and quality of life in the county?

Public health – prevention focused but you must take on the basic needs – get people well first

Employment opportunities. Youth programs.

22. Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What differentiated it from other programs designed to improve access to care and overall health? Why did it work? *(If you have supporting materials or a website link, please share.*

Bartow Health Access

Allatoona Resource Center – we have just begun serving the residents of South Bartow in just the last four months. We are providing educational opportunities, employment opportunities as well as assistance programs to residents. We also have a gym facility on-site providing youth programs and recreation.

23. Where does your community get most of their health-related information? *Choose up to 3 by circling or highlighting.*

Friends and family	Books/magazines
Doctor/nurse/pharmacist	Free Care Clinic
Internet	Social media
1	1
Public Health Department	School
1	1
Television	Congregation
	1
Hospital	Newspaper
1	
Help lines (telephone)	Other:_____

24. What do you think are the top issues that have the largest impact on quality of life in your community? *Pick up to 5 by circling or highlighting.*

Animal control	Lack of law enforcement
Availability of child care	Literacy
Affordability of health services	Secondhand smoke

11
Availability of healthy food choices
Bioterrorism
1
Dropping out of school

Homelessness

Inadequate / unaffordable housing
1
Lack of / inadequate health insurance
1
Lack of culturally appropriate health services
Lack of health providers
*What kind?*_____

Mental health issues
1 (overwhelmed – trying to revive) 1
Lack of recreational facilities
Unhealthy / unsafe home conditions
1
Rape / sexual assault
Domestic violence
Youth crime
1

Work safety
Availability of healthy family activities
1
Availability of positive teen activities
1
Neglect and abuse
Elder ___ Child ___

Pollution (water, air, land)

Low income / poverty
1
Racism
Lack of transportation options
1 (takes a 24 hour notice for Bartow Transit no bus system elderly cost $1.50 each way) 1
Unemployment
1
Unsafe, unmaintained roads
Violent crime

Gang issues
Others: _____working poor_____

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

We need to pull people together to provide quality healthcare and engage faith-based community. Trinity (church) feeds a lot of people.

26. In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?

Work and volunteer – Pay for NP, Hep-C medication.

By providing programs in our specific area as transportation is such an issue.

27. In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?

No one – we're not meeting the needs.

Not sure.

CHEROKEE

1. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

   There continues to be a lack of wellness/preventative medical care such as vaccinations among the Hispanic population. Fear of being sent back to one's home country interferes with the willingness to seek medical care. Also, the communication gap is an obstacle in providing information to parents with children who have medical needs such as diabetes. Maintaining an understanding of what nurses need to care for their children at school is frustrating.

   Populations with insufficient transportation. Uninsured population . Underinsured. Population who lack access to the health system. Low socio-economic status.

   Low-income families, specifically River Ridge and Bells Ferry area (30114/30189)

   The zip codes Bethesda serves are predominantly 30114, 30115, 30188, 30189, 30102. 40 percent of the population is Hispanic. We discover that many of them have diabetes when they come in for a visit and are unaware. We feel a lot of this is dietary, funding to purchase food, lack of health/nutrition education, language barrier and access to care due to non-citizenship and transportation. We are also seeing an increasing number of clients with hypertension and depression/anxiety.

2. **What barriers, if any, exist to improving health and quality of life in the county?**

   Transportation, lack of dental care for the uninsured, decreased staffing at the local health department, communication differences, lack of basic supplies such as soap, water, toothbrush, thermometers at home are all barriers that exist and contribute to the quality of life in Cherokee County.

   Need sufficient transportation. Deficient in insurance and/or insurance coverage. Mental healthcare at no or low cost.

   Limited resources. Resources low income families cannot afford. Unknown resources that need more exposure.

   Access to affordable, primary and specialty care for those that do not have insurance or for those that have insurance but cannot afford the deductibles. A way to route follow-up care from ER to clinic can

help decrease ER costs and assist patient in continuity of care, maintain their medication, begin education for success. Access to affordable mental healthcare and counseling. Health education. Social Work Network for clinics to help clients access PeachCare for their children, food stamps, employment services (all the way in Marietta), mental health services, counseling, etc. Transportation.

3. **In your opinion, what are the most critical health problems and > what needs to be done to address these issues?**

   Children born with fragile medical needs such as respiratory/heart issues that require one/one nursing services, medical equipment at home and at school. Some families do not realize resources are available by filling out proper paperwork or contacting agencies that can help > Someone to facilitate the paperwork process from hospital to home to school.

   Substance abuse. Hypertension/diabetes. Obesity. Lack of physical activity. Teen pregnancy. Resources for cancer care > Solutions for substance abuse (support of Drug-Free Cherokee). Increase options for population to receive low or no cost case for all health issues – primary care, prevention care, wellness, cancer, chronic illness, and dental care.

   Extreme mental health issues. Chronic substance abuse. Teen suicide. > Increased community resources on a sliding scale fee or acceptance of Medicaid. Increased awareness.

   Diabetes, HTN, mental health, dental health, cardiac/neuro, GI, asthma/COPD (need for smoking cessation – meds too costly) > collaboration between clinics, hospitals, physicians, dentists, social workers to fill these gaps and do what is right in your heart.

4. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse
1
Illegal drug abuse
111
Prescription drug abuse
111
Unsafe sex
1
Lack of exercise

Not getting immunizations
1

Not going to the doctor for check-ups / screenings
1
Not getting prenatal care

Not washing hands
1
Poor eating habits
1
Drunk driving
1
Smoking / tobacco use
11

Not using seat belts	Suicide 111
Not going to the dentist 1	Violent behavior 1

OTHER:_____

5. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

   A special center within Cherokee to house medically fragile students. All needs could be met under one roof – educational, medical, therapeutic services.

   A designated place to go for dental/eye care services.

   Transportation to health resources. Open access clinics that the community can benefit with services in all areas of health (prevention, acute care and chronic disease)

   Teen suicide rate initiatives increasing as the rate is extremely high in Cherokee County. Local substance abuse treatment options.

   Diabetes prevention/education program. Cardiac health education program (to include HTN, cholesterol, exercise program). Mental health program (to include opportunities for resources, education, counseling). Tobacco cessation. Dental health. ***It's important to start as a child – let's do something with children and teach them along with their parents. Adults will learn through the eyes of their child. There are health programs in the school but not with the parents.

6. **In your opinion, what else will improve health and quality of life in the county?**

   Healthy lifestyle awareness/preventative care.

   Funding.

   A community of hope that embraces the identified citizens in need and works together to address the unhealthy behaviors from a preventive and treatment/support perspective. We need to collaborate to increase the support network for low income families.

   This may seem simple but it is… It's the simple act of caring and showing it to one another. A smile, patience, a kind word and a moment of your time can go a long way.

7. **Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What differentiated it from other programs designed to improve access to care and overall health? Why did it work?** *(If you have supporting materials or a website link, please share.)*

   School nurses on every school campus. It has helped because the school nurse is sometimes the first line of medical care a child receives.

   Cherokee Focus – The Family Connection Grant and community efforts with a strong, collaborative group which supports a healthy county. Groups meet monthly to share resources and connect the needs of the community with the available resources.

   Access to numerous healthcare services that are free or on a sliding scale for low income families: Bethesda Community Clinic.

   Here are two because we need them to work together: 1. We partnered with WellStar a couple years ago which allowed us to assist our patients with free labs/imaging who would not be able to afford it otherwise. This has helped our patients tremendously. By doing this, our patient are able to return, keep a check on their labs who have DM, HTN, high cholesterol, etc. and then educate and adjust medication as needed. Through the imaging services, we have been able to help many who would have otherwise may have not been diagnosed with mammography, others who we found needed surgery, etc. I remember one case of a patient who needed imaging. If he had not gone that day and then be sent to the ER by us (he would not go to the ER due to cost even though in pain) his appendix would have ruptured. 2. Kaiser – Assist us with some specialty referrals at no cost. Without these, our patients who we find need specialty services would not receive it due to the increased cost of the physician services. The labs and imaging are utilized to help us determine this need.

8. **Where does your community get most of their health-related information?** *<u>Choose up to 3</u> by circling or highlighting.*

Friends and family 11	Books/magazines
Doctor/nurse/pharmacist 11	Free Care Clinic 11
Internet 1	Social media
Public Health Department 1	School
Television 1	Congregation
Hospital	Newspaper
Help lines (telephone)	Other:_____

9. What do you think are the top issues that have the largest impact on quality of life in your community? *Pick up to 5 by circling or highlighting.*

Animal control
Availability of child care
Affordability of health services
111
Availability of healthy food choices
1
Bioterrorism
Dropping out of school
Homelessness
1

Inadequate / unaffordable housing
1
Lack of / inadequate health insurance
1
Lack of culturally appropriate health services
1
Lack of health providers
1 1
What kind? Dental / chronic disease and primary care
Mental health issues
11
Lack of recreational facilities
Unhealthy / unsafe home conditions
Rape / sexual assault
Domestic violence
Youth crime

Lack of law enforcement
Literacy
Secondhand smoke

Work safety

Availability of healthy family activities
Availability of positive teen activities
Neglect and abuse
1
Elder ___ Child 11
Pollution (water, air, land)

Low income / poverty
1
Racism

Lack of transportation options
1

Unemployment

Unsafe, unmaintained roads
Violent crime
Gang issues
Others: _____Substance abuse_____

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

This county has been an unfortunate leader in substance abuse – heroin. The community at large is mainly unaware of this information except of law enforcement.

11. In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?

Reaching out to those who need care, preventative or acute.

Availability of access to care and education to those cited groups.

Sliding scale education and services related to low income families; in-home services.

Incorporate and maintain programs discussed in #5-8 in Cherokee County in partnership with clinics, schools and churches in the community.

12. **In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?**

Children's Hospital and urgent cares (CHOA), Bethesda Community Clinic, Schools, volunteer organizations such as Cherokee County Service League.

Representing Public Health, based on funding, a good deal of education, prevention and care takes place at the health department. There are limited programs, staffing, etc. however the public looks to the Health Department first many times before seeking care elsewhere.

The Health Department. Sliding scale community services with tracking and follow-up, and some in-home services. Bethesda Community Clinic.

I think every health system does what they can but by partnering together with the local clinics we can do so much more. I believe we are the only clinic open every day in Cherokee County and do what we can with the limited resources that we have been blessed with just like everyone else.

COBB

1. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

Black/African American, Hispanic, low-income older adults due to decreasing housing options, lack of affordable housing, no emergency housing/shelter that is senior friendly in Cobb County. In CD Health District, higher percentage of Blacks reported heart attacks compared to state average (6.0% compared to 3.1% in Georgia, 2011) Lack of access to affordable healthcare, housing and transportation. Lack of volunteers to deliver meals.

30008 Marietta
30060 Marietta (designated S of Dallas Hwy. or Lower Roswell Road)
30064 Marietta (designate S of Dallas Hwy.)
30067 Marietta (designate S of Dallas Hwy. or Lower Roswell Road)

30080 Smyrna
30082 Smyrna
30106 Austell
30126 Mableton
30127 Powder Springs
30168 Austell – working class families unable to afford preventative medicine and healthy options
30339 Atlanta (designate S of Dallas Hwy)

Elderly needing skilled nursing – not enough beds. Cost-prohibitive to many.

Low-income housing complexes such as in and around Franklin Road

South Cobb – Austell – Food deserts.

Low-income areas where access to healthcare continues to be a problem.

I believe the area of South Cobb may have health disparities. There are no health parks that I am aware of in the south Cobb area like the one in Acworth and East Cobb. I don't travel the south Cobb area very frequently so I can't be sure about the health parks.

Obviously, lower income families are hit the hardest. Limited access to healthcare, preventative care and poor diet are factors.

Austell/Powder Springs, pockets of Smyrna – communities of LaBelle ES, Belmont Hill ES and Green Acres ES

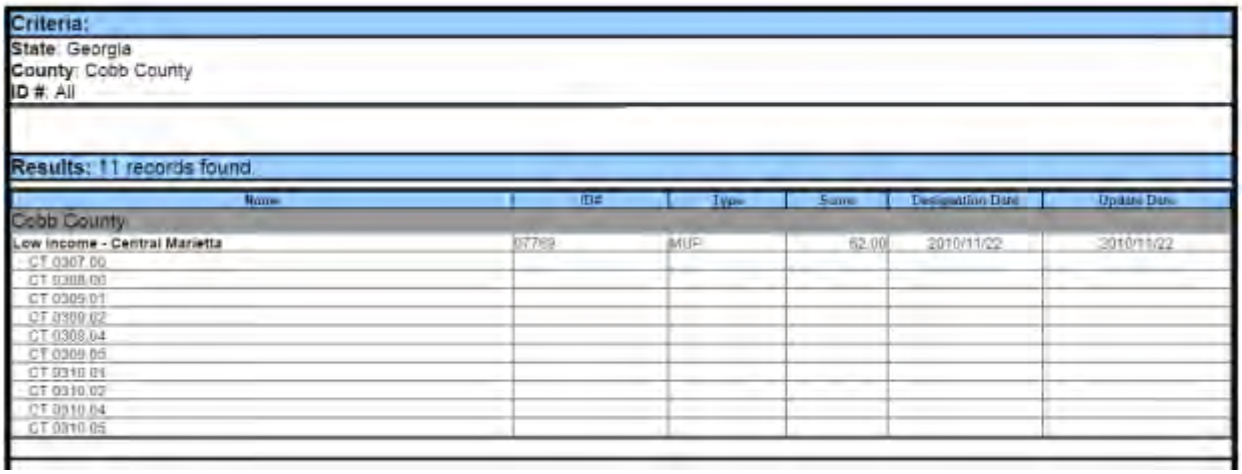
As in most regions, the most visible pockets of health disparities track the areas where the population is most vulnerable, those with a significant numbers of individuals and families at or below poverty level, low educational level, mixed ethnicity, limited English proficiency and poor health literacy. These areas also mirror the known areas where there are large under-insured or uninsured persons. These are areas of food scarcity/food deserts and tend environmental insecurities. These are the pockets of the WHS catchment areas that are neither desirable nor profitable yet were a significant proportion of our patients reside. They are made up of the areas covered by the Zip codes: 30080, 30082, 30069, 30180, 30067, 30134, 30114, and 30143. The transient nature of these population groups creates a fluid situation that cannot be precisely defined.

Those disparate communities throughout Cobb County – particularly those of minority communities – East and South Cobb areas. In addition, the elderly population is often forgotten or omitted in the collection of data as it relates to overall health and quality of life (affordable housing, accessible and available modes of transportation)

Fresh food deserts – southwest Cobb, small pockets of Kennesaw, Marietta, Powder Springs

Franklin Road area. South Cobb/Mableton, Far north Cobb area

People without insurance
People who are 300% of below the federal poverty level (yes 300, not just 200)
All the census tracts as Cobb's only official Medical Underserved Area and Health Professional shortage areas. (Good Sam Cobb sits in the middle of this.)



Criteria:
State: Georgia
County: Cobb County
ID #: All

Results: 11 records found

Name	ID#	Type	Score	Designation Date	Update Date
Cobb County					
Low Income - Central Marietta	07769	MUP	62.00	2010/11/22	2010/11/22
CT 0307.00					
CT 0308.00					
CT 0309.01					
CT 0309.02					
CT 0309.04					
CT 0309.05					
CT 0310.01					
CT 0310.02					
CT 0310.04					
CT 0310.05					

Zip codes include 30008 and areas of town associated with the following:
Fair Oaks, Osbourne High school and neighborhoods in its feeder schools, Austell, 6 Flags area, Mableton, (pretty much all of south or southwest cobb), Pebble Brook High school and its surrounding feeder schools
There is not enough affordable access to medical or dental care in these areas. Transportation is also a barrier to reach other parts of the Atlanta metro area where additional services may be located.

Children and the elderly. They have to rely on others in order to ensure their quality of life is good.

- College student-living on limited income and resources.
- Some students are homeless.
- Students that are veterans.
- Zip Code: 30144

The communities of focus for our disparities work for the American Cancer Society in Cobb County are:

Powder Springs/Mableton/Austell area (South Cobb)

Windy Hill Road area of Marietta/Smyrna – high concentration of Hispanic outreach in this area. Work needs to be culturally sensitive and bilingual. Focus on women's health and screenings is important.

The African American and Hispanic populations are those groups whose health and quality of life is not as good as others. I believe it's because of lack of education, access to services, transportation and resources such as money. Zips included are 30008, 30060, 30027.

Those that are under insured or uninsured; uneducated about health needs; afraid or unaware of health care availability

Elderly and minorities around Mableton and Austell.
Osborne H.S. Feeder Area communities particularly off Austell road between Windy Hill and South Cobb Drive
Old Mableton communities off Mableton Parkway, and off Veterans Memorial between Cooper Lake and the City of Austell City limits
City of Austell
Some Powder Springs communities off Hopkins Road and Forest Hill
Unincorporated off Austell in 30168
Pebblebrook High School Community off between South Gordon, Cardell, and Veterans Memorial.

While physical activity and healthy eating is being encouraged those in the lower socio-economic areas and the elderly still struggle to improve due to expense, lack of transportation and mindset. Changes take time.

Major pockets in the South Cobb Community and Marietta are still experiencing a disproportionate amount of high risk factors which contribute to a lower quality of life. Some areas of 30168, 30126 , 30060 (trailer parks on Sandtown Road); the Riverside area; the Fairground area; and, the old Franklin Rd corridor appear to experience a lower quality of life than other parts of the county.
Data suggests African- American and Hispanics seem to experience a larger number of unhealthy indicators. The major reasons are: food selections; lack of exercise, limited visits to medical care; limited preventative care; lack of sleep; poor socialization; high stress; high levels of crime in some communities; a culture of violence; high cost of housing in Cobb; discrimination; high dissolutions of families; underemployment; unemployment; apathy, drug usage; and alcohol abuse.

In particular, the young adults ages 18-36 are experiencing the highest number of overdose and death directly related to opioids/heroin. Of the 56 deaths due to heroin in 2014, 55% were white male, 29% white females, 47% were in their 20s and 22% in their 30s. So in conclusion, the group of white young adults may not have the best quality of life regarding health.

Lower socio-economic classes continue to be challenged with access and resources. These pockets exist throughout the county with concentrations in the Dobbins area, Campbell/Osborne HS area, Pebblebrook HS area for example.

The poor, the uninsured and the marginalized within our society.

Areas that are in food deserts. Low-income areas.

1) Food deserts in South Cobb – limited access to heathy nutrition options.
2) Informative: the gap between "cheap" fatty foods and more expensive "healthy foods" from a cost standpoint is closing, but still dissimilar.
3) The rates of poverty have increased dramatically in Cobb – example – number of children receiving free/reduced lunch has increased from 35K just 4-5 years ago to over 50K today.
4) While a great place to live, Cobb is not an inexpensive place to live. Mortgage and rent payments as percentage of income are higher in Cobb – roughly 15-20 percent than the State of Georgia – meaning families have less monthly income dollars to allocate beyond housing.

Senior citizens and minorities.

2. What barriers, if any, exist to improving health and quality of life in the county?

Political will fix transportation, lack of walkable/bicycle friendly communities, support systems or infrastructure for aging in place.

Cost to patients. Coordination among providers.

Vending machines loaded with junk items – no salt-free options.

Some facilities are not accessible by public transportation.

Perceptions – people don't think their lifestyle choices affect their health.

Access to healthcare to those not insured.

Access to good medical care. Rising deductibles in most insurance policies make it difficult for many people to pay. People wait until they are very ill before going the doctor because of the costs. Also, some prescription medications are not affordable to many people who are in need across the country. I don't believe this is necessarily true in the Cobb county area, but probably true in parts of the country.

Desk jobs/sitting all day. Commute time. Businesses that do not promote wellness.

I'm concerned about the number of people that come to the emergency rooms at WellStar that simply need to see a physician for what I consider a minor illness. Is there any opportunity to have a facility to treat that type patient separate from those with medical emergencies that are not transported by ambulance?

Money is the primary barrier. Money allows a higher quality of housing which can lead to better indoor air quality as well as feeling of safety about being outside to exercise and play. It also allows individuals to purchase healthcare insurance that affords options. As well as transportation to easily go to the

doctors' appointments and other healthcare appointments. Higher disposable income allows access to stores that offer a variety of fresh foods. Access to food options (both transportation and retail locations)

Barriers and obstacles to health equity range from limited language proficiency, lack of culturally sensitive services, insecurity with the system, limited transportation, health illiteracy, and scarce resources.

Leaders, including elected officials, businesses, healthcare providers, etc. who are committed to improving health and quality of life in Cobb County.

Some groups just don't know what is available to them. It's an education issue.

Personal choices, poverty, access to primary care for uninsured (particularly pregnant women), old habits, lack of health promoting policies and environmental changes

Funds as well as competing priorities for existing health providers and organizations / Lack of affordable transportation, bus lines, or other public transport options

I don't think there are any, other than people working together and dealing with traffic and growth.

- Not aware of resources available
- Limited funding/resources
- Transportation
- Affordable and safe housing
- Language barriers

Barriers include access to quality health care in the communities listed above. There are transportation issues for patients seeking treatment in Cobb County. Many of those who need medical screenings cannot afford to take time off work during the week to schedule those. They also may not have health insurance and/or are undocumented residents.

Barriers such as transportation, language, child care, financial are a few of the barriers that exist which keep the health and quality of life in Cobb County from improving for these populations.

Lack of education. Poverty.

Median income levels are too low to attract top-level physicians into this area.

Access to grocery stores and also to affordable and preventive health care options including mental health care, grocery stores, lower income – moderate income communities
Limited transportation to health care and fitness options.
Lack of amenities like sidewalks, trails, bike paths, parks, playgrounds, fitness centers, gyms and other amenities to address health and fitness in lower income areas
Regular daily exercise or recess in school settings.

Continued efforts are needed to educate and change behaviors. In addition, transportation (public), money/finances, language (Hispanic population) all impact those struggling with health and quality of life issues.

Lifestyle choices are major contributing factors to poor health and quality of life. In some cases, genetics play a role in increasing the predisposition to certain health related problems such as high blood pressure and cholesterol problems. Lack of education attainment, healthy environments, food choice limitations, transportation options, citizenship, and unhealthy sexual behaviors also contribute to problems as well. Good prevention options, proper diets and exercise options are not available to all of the citizens who are homeless, alcoholics, drug users and ex-offenders.

Stigma of addition. Not recognizing and treating addiction as a disease. Not supporting recovery.

Access via transportation is the biggest single barrier.

Access, access, access.

Need to get more fruits and veggies into food pantries and food deserts.

a) Rise of suburban poverty
b) Transportation to healthcare for those living in poverty – the biggest challenge we face in Cobb, and frankly, Metro Atlanta.
c) Mental health – stigma
d) Gap in healthcare coverage – rising healthcare costs
e) Access (different than transportation)

High cost of medical care, even after insurance pays. Lack of clear government vision to help seniors.

3. In your opinion, what are the most critical health problems and > what needs to be done to address these issues?

Cardiovascular disease, diabetes, mental health, access to services and housing for low-income >

- More collaboration among healthcare providers, communities, public health, and community-based organizations targeting health needs
- Create and implement and get local government buy-in for a regional plan to improve public transportation options and reduce traffic congestion for metro areas
- Increase funding for mental health services
- More options for low-income elderly housing

- Create emergency shelter options for disabled and/or elderly

Alzheimer's and other dementias / cancer > More facilities with affordable care

Obesity. Junk diets. No free clinics for blood pressure monitoring and diabetes education > have the county declare walking the official exercise of the county > A neighborhood clinic – free clinics in more communities and a year-round fresh food market.

Obesity, which contributes to heart disease, high blood pressure – diabetes, breast cancer, prostate cancer > education, early screening.

Obesity – lifestyle induced disease. Lack of movement > Increased movement in schools and increased activity with seniors. Work from bottom up – get the kids and you get the adults.

Obesity, because of its direct correlation to so many specific issues (hypertension, cancer, diabetes, etc.) > Continued education, public outreach campaigns that encourage realistic exercise and healthier diets.

Obesity in an overwhelming portion of the population which is causing heart disease, diabetes and other life threatening disease. Also, a dramatic rise in prescription pain medications that are causing addiction which leads to potential illegal narcotics usage. Additionally, mental health issues are a major concern in our community and there needs to be more avenues to treat people with these issues > Better health/nutrition education starting in the elementary school and continuing throughout high school. Public service ads with health related issues playing on TV and radio instead of fast food ads.

Diabetes. Heart disease. Obesity. > Wellness education: eat less/move more! Change work environments.

Emergency room services and medical care of indigent and those without insurance coverage that don't necessarily require emergency room services but go there for medical attention. > Don't know

Obesity and the resulting complications that occur as a result – hypertension, Type 2 diabetes, etc. Growing use of opiates. > Consistent support of the message of choosing healthy lifestyles and making smart choices. From schools to commissioners and libraries to churches.

Chronic disease management issues around the major causes of mortality and morbidity continue at critical to be the major challenges of Public Health within these problems. The complex comorbid conditions around obesity, cardiovascular disease, Type II Diabetes, and cancer are the leading critical health problems. Risk factors management directed at smoking cessation, physical activity and nutrition are established key determinants of health. Mental Health is a serious public health issue that underlies all chronic disease management that is often overlooked. > The issues with health disparities are complex and multidimensional. Understanding and creating policy to positively impact the sociocultural determinants of chronic disease requires collaboration of multiple stake holders with the common goal of improving the public health and reducing health disparities. At the moment the most promising collaboration of that of the Chronic Disease Council under the Chronic Disease Prevention

Section of the Georgia Department of Public Health answering directly to the Commissioner of the Georgia DPH.

Adequate healthcare options and accessibility for seniors and children from disparate families. Diabetes, hypertension, cardiac issues, mental health, dementia and Alzheimer's. > Serious commitment among everyone/all stakeholders to address/fund treatment options.

People going to the ERs instead of the doctors' offices > Better education, probably through schools.

Obesity – Cardiovascular disease, motor vehicle accidents for youth, mental health issues > Better cross-county/city policies and environmental designs to support healthy choices, individuals taking more responsibility for their own health choices (and for their children), affordable access to preventative health activities / services.

Lack of access to specialists / Lack of access to primary care - Therefore poorly managed or untreated chronic disease that turn into major health problems (heart attack, stroke etc.). These life altering event make affect people's permanent ability to work, ability to afford ongoing medical care, ability to afford ongoing life expenses (housing, school, food etc.), and bigger burden on the hospital system and tax payers. (An ICU hospital stay and heart attack is more expense than ongoing physician checks and medication).
Lack of organizations working together for information sharing (records and technology sharing. This includes best practices, medical information, financial information, lab share etc.) > I would like to see the community work together by sharing their organization's real priorities and needs with one another, and then pulling their budgets together to really make a positive impact. There is lots of great conversations and community pride in our county, many organizations work together well. But often, after numerous meetings, the funding to accomplish something realistic gets dropped. We need more primary care providers for safety net clinics. We need more community support (donations) to keep these clinics going (and growing). We need everyone to do a little. We need specialist to do procedures and psychiatrists to provide mental health oversight.

We need people to think creatively about what is the real, long-term cost and consequence by not partnering together. We need leadership to not just think about this year's bottom line, but five years, 10 years from now.

We need to go a step further and promote Wellness to the underserved not just chronic disease management. We need to go above and beyond "patient education" flyers and 1 day health fairs where you tell someone they have high blood pressure and bad vision, but no doc to send them to for medication, and no option for purchasing glasses. Take some health fair money and provide ophthalmology exams and pick-up glasses the following week. Do the same for hearing aids. Or put those marketing funds for a safety night to hire an NP 1 night a week to do urgent care or Coumadin checks. Whether this is through existing health fitness centers, schools sharing track fields and gyms, etc. where more low income families can have safe way to exercise and prevent the development of chronic disease.

Care for children (early childhood care from birth and even before through 18). Care for the elderly. > Access, required basic care prior to babies being released from hospital. Monitoring of care for the elderly.

a. Mental health issues such as depression, anxiety, stress
b. Obesity or overweight
c. Physical inactivity
d. Poor sleep habits
e. Diets low in fruits, vegetables, and whole grains
f. Sexual assault/interpersonal violence
g. Prescription drug abuse

>

h. Affordable mental health care; education to reduce stigma
i. Improve access to healthy foods; make convenient and affordable
j. Safe space for physical activity
k. Bystander training for interpersonal violence prevention

Access to screenings and medical care.
Poor nutrition habits and lack of physical activity.
Transportation to medical care, especially for the elderly and disparate populations.
>
Public funding for screening coverage and healthy food. Organizations have focused on working with children, but also need to focus on parents and employers on the importance of nutrition and physical activity. Work with community health workers to educate the high risk communities on the importance of these issues.

In my opinion the most critical health problems are: STDs and lack of education on how to treat/screen. Lack of health education, Alcohol abuse, Unsafe sex. > Education/navigation, resources to assist the not served/underserved populations.

Diet, exercise. Preventive health ignorance. > Community Outreach and collaboration with community outlets.

Obesity or obesity-related disease > education.

Overweight, obesity, mental health, diabetes, high blood pressure > Stress in lower and moderate communities with minimal recreational opportunities, health options, food options, medical facilities, and opportunities to congregate and fellowship with neighbors and friends exacerbate other social and economic challenges related to limited transportation options, limited higher education and vocational opportunities, employment opportunities, disparate crime and policing practices, etc. The issues are multi-pronged. Access to health care options and balanced grocery options is definitely needed along

with efforts to add additional transportation and recreational infrastructure and amenities. Efforts need to be also included to address crime, employment, and education.

Weight: Being overweight often leads to high blood pressure & diabetes. Those health problems are perpetuated by unhealthy choices: lack of exercise and diet. It is a cycle. Overtaking prescription meds/drugs (specifically those taken in place of prescription meds): Impacts quality of life as this leads to not only the obvious issues but again cycles into poor choices made in terms of food, exercise and an impact on income or even job loss > Free events that promote healthy lifestyle and assistance to those in need. Improvement in public transportation. Programs to educate young people and expose them to healthier options.

The most serious problems are obesity, high blood pressure and high cholesterol leading to heart and other health problems; drug usage; HIV and other sexual transmitted diseases, stress, violence, children's health problems associated with poor prenatal care, kidney failure and cancer. > Focus on proper child care as relates to parenting. Focus on proper diets, breast feeding babies, healthy life styles, importance of education with an emphasis on learning skills for career focus, communication, critical thinking, saving money and not being a consumer only and thinking about future focus events of life (deferred gratification) vs immediate gratification.

Disease of addiction > Support recovery

Obesity and mental health > Unrestricted access to education, access and access to care.

Dental care is huge as well as behavioral health > Access, access, access to low cost care.

Childhood obesity. Prescription drug abuse. Teen suicide. > Education our kids on long-term (what this means for them). Provide healthy alternatives /ideas/recipes. Have more exercise in schools.

a) Chronic disease
b) Obesity – lack of proper nutrition
c) Affordable healthcare for those in poverty

>

a) Prevention is perhaps the hardest message to "sell." We are traditionally a reactive medical care society – we go to the doctor when we have an issue or are sick, not before there is an issue.
b) Food labeling could become more transparent
c) Access to affordable healthcare for the dramatic increase in those living at/below poverty in Cobb.

Medical care is expensive and complicated/demanding timewise (to navigate) > Evaluate single provider solutions

4. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse
111111111
Illegal drug abuse
1111111111
Prescription drug abuse
111111111111
Unsafe sex
111111
Lack of exercise
111111111111111111111111
Not getting immunizations
1111
Not using seat belts

Not going to the dentist
1111

Not going to the doctor for check-ups / screenings
111111111111111111
Not getting prenatal care
1111
Not washing hands

Poor eating habits
11111111111111111111
Drunk driving
1
Smoking / tobacco use
111111111111111
Suicide
11
Violent behavior
1111

OTHER: Lack of healthcare and prevention of child abuse for children / underemployment and unemployment and poor transportation access / stress / over prescribing of opioid medication. Being too ashamed and ridiculed to see a doctor. / Undiagnosed mental health / Unsafe driving / Lack of complete personal health plan

5. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

   Elder abuse registry (?), Medicaid expansion, smoking bans, funding for more transportation option (such as FLEX), improvement in sidewalks and more pedestrian-friendly areas, funding for low-income/mixed use housing, create an emergency shelter program for older adults.

   Inpatient services for elderly with little income. Coordination of services among agencies.

   Medicaid expansion.

   In school movement

   Prescription drug abuse education for medical doctors as well as the public.

   Any program that could successfully find ways to encourage healthier lifestyles and provide education toward access to healthcare.

   I would suggest allocation of our tax dollars to be spent on the education of our children throughout K-12 on proper nutrition and exercise. Additional spending on the dangers of prescription drug abuse.

Allowing people to use benefits at fresh markets and doubling amount of spending power for fruits and vegetables. Free dental exams for children.

Medicaid Expansion for the State of Georgia. Immigration Reform.

Getting fresh food to areas. Educating about immunizations. Having some sort of counseling in the ERs to get folks to go to doctor instead of ER.

Tobacco free policy across all cities and county to include bars. Healthier designs in streets/sidewalks to promote more walking.

Here is my long list. I would support: sharing spaces, schools opening up gyms and fields, more federal and state allocation for primary care, safety nets, tax incentives for hospitals to provide charitable and DSH care, sovereign immunity and tax benefits for specialists (or any provider) who saw charitable patients (under 200% of poverty) for free (even if it was in their own office and not at an FQHC), more tax benefits for outpatient (AND Inpatient) surgery centers to provide charitable care, additional funds or appropriations for FQHCS, hygienist who could see patients in the office even when a dentist wasn't present (like many other states), hygienist who could administer anesthesia, Increase taxes for more public transportation, insurance and claims reform for mental health access, explanation of 340B discount (drug access) program, sharing of information and technology among health partners for better collaboration

Mandatory testing for health risks prior to babies being released from hospitals after birth, accidents, etc.

l. Increase safe places for physical activity; sidewalks and bike lanes separate from highway/roads/streets
m. Healthy eating programs-fruit and vegetable mobile markets
n. Mental health screenings (take to communities)

I would support increase in tobacco tax, as Georgia has one of the lowest in the country. The funds could be used for healthy lifestyle programming in high risk communities. I would advocate for nutrition and physical activity policies at state and local level. I would also support the work of the Breast and Cervical Care Program (Partnership with DPH and ACS) by promoting the screening and education events held throughout the county.

Education and community outreach.

Programs which make use of "wasted" or leftover food items by getting them to those who are going without:

-leftover food from restaurants, markets and schools "donated" to organizations for distribution.
-backpacks home with food sent home with students for weekends/holiday periods
-food giveaway – advertise/promote where to go to get and how/where to take donations

-feeding stations on holidays within the county (volunteer opportunities – lacking options or communication to notify of the needs/options)

-Government reform to allow leftover food in schools to be redistributed.

Programs to increase the opportunity for students to move (i.e. recess, standing desks, extracurricular activities associated with exercise programs)

Policies to insure adequate healthy medical care for children and families; resources for adequate healthy food for children and families; proper housing; birth control; mental health treatment resources; drug treatment programs and violence/bully prevention programs.

Supporting recovery. Educating the public regarding the dangers of prescription medication (including the medical community).

Funding for school-based health centers and mental health care.

Access to low cost healthcare including primary care, specialty, dental, and behavioral health, free immunizations, access to low cost medications.

a) Collaborative/community approach by leaders in non-profit and healthcare community to develop a "healthy cobb" prevention message
b) Any priorities which have stated outcomes and increase access
c) Healthy eating and exercise initiatives – that are not the "same old tired" approaches - unique, eye-catching, and participatory.

Better managed healthcare organizations. Single payer health plans like Kaiser. Integrated health and wellness programs such as Cobb Senior Services. Competition among healthcare providers.

6. In your opinion, what else will improve health and quality of life in the county?

Creating lifelong communities (http://www.atlantaregional.com/aging-resources/lifelong-communities)

More facilities in county – more access. Software programs to share data among some providers.

Partnering with churches and other community organizations to educate and assist with healthcare initiatives and preventative care.

Less traffic on our roadways, more access to affordable health care and placing incentives on insurance premiums for healthy living.

Improve transportation. Improve Obamacare – it's not working. Give incentives to businesses that promote wellness.

Offering educational programs to the general population on drug abuse and smoking as examples. Also to continue offering free health screenings and health fairs.

Sidewalks and lighting in underserved communities.

More economic opportunity, more commitment of major stake holders to invest in community development, green spaces, public health FQHCs, education both for children and parents.

Better access to primary care for uninsured individuals.

For people of influence and affluence to hear the cry of those in need and respond. For businesses and organizations alike to commit to serve the underserved, giving the voiceless a voice and championing their needs to make a better community

Commitment to children and their well-being rather than stopping behaviors.

Not sure.

Additional education and outreach from the health care systems to targeted communities. Including partnership with health organizations to promote and support these events.

Use of internet and social media to promote healthcare to citizens.

Better education.

Community engagement as people who that they have the ability to impact their outcomes can reduce stress levels.

Volunteer programs – communication as to when /where. People are looking for service opportunities – schools/youth groups.

Violence prevention in our communities is so important. Young and old alike are stressed out because of it.

Community support to change the stigma of addiction.

Expanded dialogue with community-based providers.

Education, outreach and access to care.

Mandatory health classes and programs related to receiving benefits, safe driving courses, dental care and vision care must be wrapped into healthcare.

7. Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What

differentiated it from other programs designed to improve access to care and overall health? Why did it work? *(If you have supporting materials or a website link, please share.)*

CCT FLEX (I think it will improve health moving forward)
http://www.cobbcounty.org/index.php?option=com_content&view=article&id=3600&Itemid=1647
Community change: Opening Senior Wellness Center

YMCA's Fresh Food market pilot program of 2014. Unfortunately, in 2015, it did not return to a location closer to the people that needed the items.

Healthcare or community sponsored walks/runs that raise awareness to difference health issues and priorities. These events are effective because it gives participants a bag of information on healthcare, support organizations, and usually activities for the entire family. It also gives participants an opportunity to exercise with promotes lifestyle changes.

Cobb2020

Fit City Kennesaw (fitcitykennesaw.com)

It's not here in Smyrna yet (WHP), but soon will be. I believe the "health park" healthcare delivery model represents modern-day needs.

Alive Ministries which just announced a merger with MUST Ministries – Alive has placed food pantries in 20+ schools in Cobb for families who are food insecure. Children who are hungry cannot learn and thrive. As we try to end the cycle of poverty, hunger and sickness, this service has been a tremendous asset to hundreds of families.

"Nuestros Niños" Pediatric Clinic run by dedicated compassionate nurse practitioners who treat many of the areas children and adolescents without regard to the families' insurance status, language or cultural obstacles or undesirability as patients. They are a selfless group struggling in private practice to deliver high quality pediatric services to the most vulnerable populations in the area. They are a prime example in the Metropolitan Atlanta area of small privately owned clinics that are not asked to be on steering committees, councils or task forces and are often forgotten. They are the real stakeholders along with their patients who continue to care for the most vulnerable populations.

Giving people access to fresh vegetables. Good Samaritan has provided more health services in Cobb.

Farm Fresh Farmer's Markets

There are several projects that I could name here but a few that really stand out: Cobb Services Board and Good Sam working together to get primary care access to their dual diagnosis (substance abuse and mental health disorder) patients a more integrated and interdisciplinary treatment plan for care.
Ser Familia's ability to hire a Spanish speaking counselor to serve the Hispanic population.
Cobb2020/Healthy Lifestyles Farm Fresh initiative to get culturally appropriate, affordable, healthy foods to some of the food deserts, to the underserved.

Children's Advocacy Centers. They include healthcare, screening and risks assessments.

Culinary Sustainability within Culinary Services at Kennesaw State University
http://dining.kennesawstateauxiliary.com/sustainability/culinary/
Focus on farm to table, energy savings, and lower food waste. The initiative involved all levels of our campus community. Great promotion was conducted on what they were doing and the quality of the food ingredients. All of this was launched with the new dining facility, The Commons, which opened approximately 5-6 years ago.

Our American Cancer Society Client Navigators work with the Georgia Breast and Cervical Cancer Program and are based on local health departments or BCCP providers to assist low-income women 21-64 to get breast and cervical cancer screening at low or no cost to them. They also assist the BCCP women over 50 years of age in getting the colorectal cancer screening. Funding for the program comes from United Way, state of GA and ACS. We are always looking for additional funders for the program across GA. For the period of time between July 1, 2014 and June 30, 2015, the Client Navigation team educated 12,357 women about breast, cervical & colorectal cancer education and assisted 1,813 in getting their mammograms – 44 percent of the women who received mammograms are considered never or rarely screened for breast cancer.

The BreasTest Program here in GA, specifically Cobb County has helped 1300 women get screened for Breast Cancer. The program was successful because Client Navigators assisted and educated these women to get services needed.

Health fairs wherein people get free health screenings and advice. There was also a community health clinic in Mableton that seemed to make an impact until it abruptly stopped.

Unknown.

More recreational opportunities.

Walk GA – Cobb2020: Our system competed in several sessions while there was some level of competitiveness overall the encouragement among participants went a long way toward the overall involvement.

Alive Ministries is a program designed to provide food to families over the weekend so that the students will have food to eat. Recently, they became a part of the wonderful MUST Ministries Program. However, so many young folks are not getting adequate food or nutrition so they are subjected to immune system challenges.

Prescription "Take Back" programs. It worked because so many people were unaware of the dangers of left-over medication. It worked because so many people were dying due to "the family medicine cabinet."

The State's CORE services program. This program allowed for numerous consumers to qualify for health/mental health care insurance coverage and is community-based in its approach. Funding for "home based" care is huge in removing the access issue.

Community clinics that have been opened in high-risk areas. They provide access to some healthcare.

a) The fight to eradicate childhood hunger and incorporate some "healthier" eating initiatives.
b) Community clinics and mobile healthcare – access improved for those in poverty who have limited transportation options.

Cobb Senior Services is moving toward responsibility for health and wellness, to include WellStar. Working together is the differentiator.

8. **Where does your community get most of their health-related information?** *Choose up to 3 by circling or highlighting.*

Friends and family
11111111111111
Doctor/nurse/pharmacist
111111111111111
Internet
11111111111111111111
Public Health Department
111111
Television
11111111
Hospital
111
Help lines (telephone)

Books/magazines
111
Free Care Clinic
111
Social media
111111
School
11111
Congregation

Newspaper

Other:_____health fairs / community outreach & health fairs, cancer talks in churches / Blue Cross Blue Shield

9. **What do you think are the top issues that have the largest impact on quality of life in your community?** *Pick up to 5 by circling or highlighting.*

Animal control

Lack of law enforcement

Availability of child care
1

Affordability of health services
111111111111111111

Availability of healthy food choices
11111111111111111

Bioterrorism

Dropping out of school
1111111

Homelessness
111

Inadequate / unaffordable housing
111111

Lack of / inadequate health insurance
1111111111111111

Lack of culturally appropriate health services
11

Lack of health providers 111111
What kind? Dental and mental / primary care / mental health / specialists – endocrinologists, orthopedist, GI, and GYN / addiction / primary care, dental, specialty, behavioral health

Mental health issues
111111111111

Lack of recreational facilities
1 – add lack of community amenities

Unhealthy / unsafe home conditions
111

Rape / sexual assault
1

Domestic violence
1

Youth crime
11

1

Literacy
1111

Secondhand smoke
1

Work safety

Availability of healthy family activities
111

Availability of positive teen activities
111

Neglect and abuse 11
Elder ___ Child ___

Pollution (water, air, land)
1

Low income / poverty
111111111

Racism
11

Lack of transportation options
11111111111

Unemployment
11 - add underemployment + low higher education or vocational training opportunities

Unsafe, unmaintained roads

Violent crime

Gang issues
1

Others: _____

No support for recovery in long-term re-entry.

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

Support for family caregivers

Just want to emphasize that there is a gap in Cobb County driven by zip codes – where you live can largely determine the quality of your health.

There are many NGOs involved in solving these issues that need to be brought to the table. Too many discussions are dominated by the large corporate health systems that by definition are removed from the community.

This survey does not seem to specifically address the large and growing Hispanic population in our community. Access to culturally and linguistically appropriate services is a growing need. Interpreters are needed in every healthcare facility, including mental health.

No.

Not that I can think of at this time.

Not that I can think of.

Low income and lack of education are the key elements.

Not that I can think of at this time.

Schools are the support system for many young people today. The education programs are not challenging the students like they should. Students are dropping out because they are disengaged. WellStar could assist in getting their clients well both: physically and emotionally.

Yes – the availability for detox and substance abuse rehabilitation for those without money or insurance is almost non-existent. We need funded organizations to help those in recovery stay in recovery. The heroin relapse rate is 87 percent.

No.

It has not gone unnoticed the efforts that WellStar labels "Community Benefit." It has been called "marketing" by our competitors and we are eroding the respect of our community partners. As we become an even bigger presence in OUR COMMUNITY, we need to be a better partner. We need to not only help those who have the means, but those who do not and make an effort to make our entire community a healthier one.

11. In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?

Collaborate with community partners to implement evidence-based interventions in the community (not just individual behavior change, but high level interventions such as coalition building to support policy initiatives, lifelong communities, transportation options, etc.)
Create grant funds for local community-based programs to implement above
Share healthcare data to help communities/community partner's plan strategically

Develop/incorporate/create a center to support integrative and/or alternative medicine approaches (meditation, mindfulness, nutrition, acupuncture, etc.)
Develop a transportation program
Create an emergency shelter

More skilled nursing facilities at affordable costs.

Sponsor a focus group or panel discussion.

Health fairs.

Increase efforts toward "public outreach." Find new ways to engage and encourage citizens toward healthier lifestyles (partner with more 5k races within the community, have an even larger presence at pre-planned events within the county and use these examples as a platform to spread the word about WellStar services.)

Possibly hold more community health education screening opportunities throughout the county. They need to be held in areas such as schools and community meeting venues.

WellStar built a large healthcare facility in East Cobb over the objections of many. Can you provide transportation or access to those who don't live close to that facility? I am sure that it would not be economically feasible for WellStar to build a similar facility in South or West Cobb.

Make a statement of commitment to address the vulnerable populations in the community by investing in the community making health disparities a strategic priority.

Invest more in obesity reduction efforts in the community.

Better communication to local partners. As a partner of WellStar's serving the vulnerable, I know there are many more free or discounted education programs that they provide that we don't know about. If my staff is not aware, then we cannot help educate those we serve every day.
Consider putting staff at location where the most vulnerable are already going (existing safety net providers). Think about sharing specialists now and as you are developing your Residency programs.
Open up specialty care for those patients desperate for life altering procedures. Put a cap on how many people it is each month so you know what to expect. Let everyone give a little so the burden is light
-Allow WellStar's malpractice to cover providers who do this - take away the providers' barriers.
-Give other WellStar physicians the decision to see patients and waive THEIR fees if they want. The hospital and facility fees can still go through the normal CFA process.

Tell the (community) story better.

By becoming the experts in the field of child maltreatment in Cobb so that our resources are staying in Cobb and not having to go to Metro Atlanta. Children are a major concern.

Provide grant funding for schools, businesses, universities, churches, etc. to address health needs in their community. It would be a great partnership between WellStar and the community.

WellStar Health System could improve by focusing in on the vulnerable populations for these programs, and promoting them to their partner community organizations.

WellStar can make it easier to help navigate not served or underserved populations. Double down on community presence via health fairs, education to navigate these populations through their health system.

Go where they go. Find out where they congregate and advertise there.

Continued spending of resources to keep facilities up-to-date.

Provide smaller clinics inclusive of urgent care facilities in more underserved areas.

Visit schools – educate students to make better choices; start young but also share options with older HS level. Educational programs in low-economic areas – at community events (sports and cultural events) for all family members. Volunteers – advertise and recruit – there are people looking for opportunities.

Work with homeless shelters: Have special projects for the families and children which can teach them to live healthy given their current predisposition. Create APPS for those involved in domestic violence situations to help them help themselves and families; Support youth oriented programs at the YWCA, Big Brothers Big Sisters and other programs (afterschool) to educate children about what are good life style choices. Work with developing these kids' minds by creating APPS for young folks with incentives for living.

Begin to focus on recovery. 25 million Americans are in recovery. Let's work to keep them there. There is a national movement to support recovery and it has become a huge political platform. I would like to see WellStar and Cobb County continue their cutting edge advocacy by embracing recovery.

Recent expansion via Tenet expansion is a great improvement as it gives a much broader "footprint" through which to reach communities and consumers.

WellStar has an obligation to help not only the insured, but the under and uninsured of their community. They are the biggest, and often the only player in time. With that power, comes duty. Efforts to provide care, outreach and education need not be big ticket items-compared to the $575

million spent on acquiring new hospitals. Efforts need to be strategic to help the system and the community simultaneously.

I believe it's a collaboration of organizations that can make great impact.

WellStar does a great job overall – really noticed an uptick in a "customer service" approach over the last two to three years – for the insured. Solutions to explore: a) expand collaborative partnerships with other substantive non-profits engaging with, but not directly related too, healthcare – like social service organizations; b) community and/or mobile clinics – let's do mobile healthcare intervention and case management!; c) partner with business community, non-profits, and government for a one-of-a-kind, unique, and totally COBB "healthy living" comprehensive and innovative, "replicable" approach.

12. In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?

Community Services Board, YWCA, MUST Ministries

WellStar – access, improvement of services (ongoing), staff

ACT Partnership – health fairs

Wal-Mart / Walgreen pharmacies and clinics – they are in their communities, reasonably prices and accessible.

CHOA's Strong for Life. Alliance for a Healthier Generation. Health Empowers. Lt. Governor's Office.

Kennestone Hospital treats anyone who comes to the ER with outstanding service regardless of their ability to pay or not. They are effective due to excellent doctors and nurses who care about the patients.

Public health departments.

CDPH – multiple locations, free/reduced services and comprehensive services

The FQHC and collaborations such as Good Sam and Cobb 20/20. State-level initiatives. They are all inclusive, engaging and level playing fields for frank discussion on societal issues.

Good Sam. They take care of the uninsured and underserved population.

WellStar – broad health system, community-based, many levels of expertise and resources
Public Health – population-based, public not private, mission to care for low-income, uninsured
Kaiser – prevention focused, experienced with cost control AND quality of care
Good Sam – Christian-based FQHC, mission, passion, federal funding

Good Samaritan Health Center of Cobb-we try to focus on what we do well
Cobb Services Board – although I know they need more funds, their approach to integrated care (primary care and behavioral health) and peer-to-peer program is great
Northside- their version of CFA is very easy for community partners and patients to navigate.
Kaiser- Mixed support of giving out cash grants, seeing patients in-house, specialty care, loaning out providers, joining community partnerships. They seem to have the mix figured out and they tell their story well.

WellStar does a lot of great things-their partnership for Good Sam patients, by providing labs, radiology, and cardiac studies is great. I have found that most people do not know this (except when we share the story and try to publically thank them).

The time is now and WellStar has to become the experts in pediatric care and prevention of child maltreatment and healthy child development!

I'm not sure that I can say one organization stands out over the other. That said, in regards to intentional outreach to vulnerable populations, it seems to be the GA BCCP program as it is housed in the health department and has a patient (client) navigation pathway started from screening to diagnosis. It also collaborates with partner entities outside of itself to help fulfill this process.

Good Samaritan Clinic, in my opinion, is a small clinic in Cobb County that has been successful in taking care of the needs of the underserved populations.

Cobb WellStar ER turns none away. They are the community health provider.

Urgent care facilities are helping to close gaps in access since they tend to be more affordable and more responsive than ER.

Beyond the health department – as I am not a part of the population in need – I am unaware of the best option(s).

Many organizations are working with these populations. County health services, MUST Ministries, and some churches are working with the intent of helping. However, there needs to be a systemic approach to care that is protracted care. Meals help, but the proper life style for feeling hope, peace, safety and love is also required to thrive. Kindness is so important! Feeling CARED ABOUT is so critical to sustainability. *Other comments:*
Veterans are experiencing some of the same problems discussed above—alcoholism, drug usage, suicide, depression and other systems of trauma that are too detailed to discuss here at length.
Discrimination and racism either perceived or real is very threatening to one's health and wellbeing.
Care for the aged is becoming more challenging as this population swells in the county. Services for this vulnerable group will be required as more folks are moving into the 55+ age category.

Proper use of leisure is an important concept that many are not taught. Work is first required, then play. However, when many have been unemployed or underemployed for a long stretch—the concept loses meaning.
Long term care is a major problem for many. Data suggest that the elderly are not prepared for care in the event of major illnesses. Prevention and planning are needed. Alternative methods of communicating need to be utilized. Everyone does not have wireless or computer capabilities.

Non-profits! They are offering free services and oftentimes free medication or counseling. They are helping those who can't afford to help themselves.

Good Samaritan Center (off Austell Road) is a great clinic immersed in an underserved community.

There are several, both the Northeast Georgia and Kaiser systems make significant commitments to help those in their community be healthier and more productive. Politics and profit are left at the door and the community is becoming healthier through their direct assistance.

DOUGLAS

1. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

   Lower income and homeless are always an area of concern.

   Low-income, minimum wage employees, single parents

   Unemployed or underemployed. 30134.

   Lower socioeconomic residents.

   There are pockets of poverty in the 30134, 30122 and some 30135 addresses. The primary issue with regard to health/quality of life is may low to no income citizens are still not insured and there are not enough health care providers in the local area who are accepting new low income clients. Our chronic disease numbers especially for African American males in the 30134 zip code remain exceptionally high for such a small population of citizens. Due to cuts in funding for Youth Pregnancy Prevention, the number of teens who became pregnant increased which had not occurred in previous years.

2. **What barriers, if any, exist to improving health and quality of life in the county?**

Transportation to and from services. Awareness of services. Self-awareness and concern is not present.

Transportation. Access to primary/specialty medical care.

Lack of care or failure to make good health a priority.

County-wide, coordinated effort.

Community apathy is a barrier. Most folk are not overly concerned that chronic diseases are negatively impacting much of our African American male population. There is not much discontent among the average citizenry about our lack of walking paths, bike paths, fresh food vendors, and other free to the public healthy lifestyle choices. Community acceptance of the use of alcohol and other drugs by youth is a barrier to prevention efforts. The number one suppliers of alcohol to youth in Douglas County are family and friends of the youth abusing the illegal substances.

3. **In your opinion, what are the most critical health problems and > what needs to be done to address these issues?**

   Obesity, diabetes, communicable diseases, drug abuse

   COPD, hypertension, diabetes and obesity > Education of the risks and better treatment options

   Cost > Lower health cost

   Obesity. Drug abuse. > More work by more people than just smaller segments.

   Chronic Diseases, healthy lifestyle apathy, the proliferation of molly, heroine, and marijuana abuse among youth. > We need more sidewalks to encourage walking in Douglas County. We need more primary care physicians who are willing to accept new patients. We need WellStar Douglas to require their doctors to volunteer at The CarePlace as those in Kennestone are required to do in their local free clinics in Cobb County. We need parents to be educated about how entry drugs impact how youth view drugs use and abuse as adults.

4. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse 1	Not going to the doctor for check-ups / screenings 11

Illegal drug abuse
1111
Prescription drug abuse
111
Unsafe sex
1
Lack of exercise
111111
Not getting immunizations

Not using seat belts
Not going to the dentist
1

Not getting prenatal care
1
Not washing hands

Poor eating habits
11111
Drunk driving
1
Smoking / tobacco use
111
Suicide
Violent behavior
11

OTHER:_____

5. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

   More focus and services toward health living programs for children and adults. Partnerships that work with county schools and businesses to reduce drug abuse, poor eating and lack of exercise and in increase in drug rehab programs.

   Funding for free clinics.

   Cheaper medical care and services.

   School-based health centers.

   I would support subsidies or tax breaks to doctors to volunteer at the Care Place or treat indigent clients. I would support increase the tax on alcohol and tobacco to raise funds for ATOD prevention initiatives. I would support, a one cent SPLOST to increase the capacity of our hospital to serve clients with strokes. I would support a one cent SPLOST to add sidewalk paths from every neighborhood to every school to encourage youth to walk to school.

6. **In your opinion, what else will improve health and quality of life in the county?**

   No opinion.

   More family doctors.

   Awareness campaign.

There is much prevention education needed.

7. **Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What differentiated it from other programs designed to improve access to care and overall health? Why did it work?** *(If you have supporting materials or a website link, please share.)*

   The CarePlace reduced ER visits by our patients by 52% from prior to their first visit to the CarePlace and thus receiving ongoing primary care.

   Youth getting required shots.

   Health and exercise programs within the school system.

   Douglas Alcohol Prevention Program and CORE sponsor *Power in Truth* every year in October. The fact that they have educated on average 400+ students on ATOD use prevention for over 10 years in a row has been significant in offering both the right amount of information in a consistently yearly dosage to truly impact how our youth view ATOD abuse. The commitment of the community from the Douglas County School System to Cobb/Douglas Public Health, Douglas County Board of Commissioners, City of Douglasville, CORE, United Way, to the Chamber to support *Power in Truth* for over 10 years is the difference and has sustained this program.

8. **Where does your community get most of their health-related information?** *<u>Choose up to 3</u> by circling or highlighting.*

Friends and family 111	Books/magazines
Doctor/nurse/pharmacist 11	Free Care Clinic 1
Internet 1111	Social media 111
Public Health Department 11	School 11
Television 111	Congregation
Hospital 1	Newspaper
Help lines (telephone)	Other:_____

9. What do you think are the top issues that have the largest impact on quality of life in your community? *Pick up to 5 by circling or highlighting.*

Animal control
Availability of child care

Affordability of health services
1 (including insurance affordability), 11
Availability of healthy food choices
Bioterrorism

Dropping out of school
11
Homelessness

Inadequate / unaffordable housing
1
Lack of / inadequate health insurance
1
Lack of culturally appropriate health services
Lack of health providers
11
What kind? Primary care / Primary care
Mental health issues
1
Lack of recreational facilities
1
Unhealthy / unsafe home conditions
11
Rape / sexual assault
Domestic violence
1
Youth crime
1

Lack of law enforcement
Literacy
1
Secondhand smoke

Work safety
Availability of healthy family activities
111
Availability of positive teen activities
11
Neglect and abuse
Elder ___ Child ___
Pollution (water, air, land)

Low income / poverty
1
1
Lack of transportation options
11

Unemployment
11
Unsafe, unmaintained roads

Violent crime

Gang issues
Others: _____

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

No.

11. In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?

1. Partnership with school and small businesses.
2. Producing fun and engaging family activities that promote exercise and healthy living

Have clinics in areas around the county.

Must seek out and identify then attempt to provide services.

1. Offer additional classes to the public and advertise them in places that most folk visit.
2. Continue to expand to offer more services locally (stroke care would be great)
3. Continue to collaborate with Douglas CORE to inform the social and human service community about all the wonderful work occurring at WellStar.
4. Continue to fund Safe Kids initiatives.

12. In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?

WellStar and several of the local drug stores**.**

Medical providers – resources. Schools – burden often placed on this entity because of perception we have contact with many.

The Care Place with the assistance of WellStar is best helping with indigent care needs. WellStar is our only local hospital and provides the most indigent care services. Thank you!!! Cobb/Douglas Public Health are doing great public education initiatives and prevention work in the areas of injury prevention (Safe Kids), ATOD prevention (DAPP), chronic disease abatement (Live Healthy Douglas).

PAULDING

1. **Please list the people or groups of people in your county whose health or quality of life may not be as good as others. Why?** *Please note any zips / areas where there are health disparities/pockets of poverty.*

Don't know any geographical pockets of poverty. There are many low wage earners / families county-wide that are challenged to meet living expenses and pay for healthcare.

People who have been released from prison, mentally ill, those on drugs, the very low-income, homeless and those who are disabled but not yet receiving benefits. (Those needing education on their disease at no cost – from where I set it all boils down to people having enough money to be able to pay for the services. When there is no money they do without and in some cases they make choices between paying for housing, utilities, food, etc.)

Underinsured and under-employed. Children of underinsured and under-employed. Those needing medical services.

Areas near downtown Dallas as well as areas in Hiram have pockets of poverty evidenced by government housing, run down mobile home parks, and dilapidated houses. These individuals may lack access to preventive healthcare due to financial barriers, lack of insurance, or lack of adequate insurance coverage.

Uninsured and underinsured throughout the county. Even those who have some form of health insurance through the Patient Protection and Affordable Care Act. This is because of the high deductibles associated with those low monthly payments. These deductibles are too high for low income people to be able to pay. Furthermore, recent studies have indicated that some of those who had signed up for the ACA are no longer enrolled.

People that are at risk are those who live at a lower socio-economic status. These people are either under cared for or don't have the knowledge of how to care for themselves.

Latinos are getting poorer.

People without transportation, health insurance, people with a lower socio-economic status, students who lack positive role models, substance abusers, increased heroin usage

Homeless and seniors

2. What barriers, if any, exist to improving health and quality of life in the county?

Failure of Georgia to expand Medicaid is a barrier to improving health.

Federal government.

Lack of funds to pay for the services of a professional, doctor and/or dentist. Lack of funds to actually get the RX that they need. Even our senior citizens (on fixed income) sometimes choose between their prescriptions, food and paying their utility bill/rent.

Lack of primary care providers, lack of mental health professionals.

Many adults living in Paulding travel outside the county for work spending close to two hours each day in their vehicles. This essentially adds two hours to the workday which is time that could be spent outside with their children or engaging in other activities such as exercise programs or community activities.

The only barrier will be the inability of those in a position to help (volunteering / donating funds, etc.) who do not make the effort.

I think the most important thing that would help the quality of care in our county would be if there was a place they could go that could provide adequate healthcare at a free or reduced cost.

Access to services, transportation issues

Lack of pediatricians accepting new Medicaid patients. Lack of resources for special needs children (i.e. sign language classes). Lack of family support resources. Financial resources. Lack of resources for adult male services (i.e. colonoscopy, prostate exams, etc.)

I think our citizens need to be educated about what is available to them and for WellStar to push more screening.

3. In your opinion, what are the most critical health problems and > what needs to be done to address these issues?

Obesity, diabetes, smoking.

Cancer, diabetes, obesity, prescription drug abuse

Those that are on maintenance medicines for diabetes, high blood pressure, heart and lung issues, and no access to having their labs done. Some of the medicines they can get for free from Publix but they still need a prescription. > Have a clinic that they can not only see a doctor but one that has a prescription program where they can get their RX at free or reduced cost.

Lack of mental health services > More services and better access

Obesity, Diabetes, COPD, Depression and Heart Disease > Prevention. All of these diseases are (for the most part) preventable. More needs to be done to address behaviors. I personally know that my child can purchase a school lunch and bags of chips and cookies and brownies in addition to that lunch. I am very uncertain as to why this is allowed. At our ballparks where our children play sports, smoking should not be allowed. More community groups focused on health and wellness, fun-runs, community workout days in the park….these things would all draw individuals out of their homes and get them active.

An overall whole approach to healthcare needs to be considered. The Paulding Community Health & Resource Center has as its mission and vision statements the following: *Mission* - The Paulding Community Health & Resource Center will serve as a compassionate community wellness resource for those who are underserved and most vulnerable. The Center will also serve as a safety net solution by providing resources and referrals to community and government services while promoting life skills development and life-long wellness at a centralized location. *Vision* - The Paulding Community Health & Resource Center is envisioned as a comprehensive and sustainable community center with the goal of providing long-term health and wellness services leading to healthier lives, healthier families and thus, a healthier community. *Strengthening Individuals – Healthier Families – Community Health*

- A community healthcare and one-stop services center with the widespread support of the Paulding community

One of the main problems I see in my line of work is the excessive amount of people having children that cannot properly take care of them. Many of these people cannot take care of themselves, much less a child. > People need to be educated and show that it is possible to not have a child every time you have sex.

Diabetes, breast cancer, mental health, high blood pressure, autism > comprehensive approach to education and screening.

Hypertension, diabetes, obesity, mental health. Lack of knowledge concerning school immunization requirements (adults as well). Nutritional education lacking. > Access to resources for uninsured, underinsured. Increasing number of providers in the area. Recess/ health education (activity in school) Partner with Georgia Shape program - www.georgiashape.org

Drug and alcohol addictions > I am not sure.

4. **There are unhealthy behaviors that have the largest impact on the health and safety of the community as a whole.** *Pick the top 5 unhealthy behaviors you deem have the largest impact on your community:*

Alcohol abuse
11111
Illegal drug abuse
111111
Prescription drug abuse
11
Unsafe sex
111
Lack of exercise
1111111
Not getting immunizations
11
Not using seat belts

Not going to the dentist
11

Not going to the doctor for check-ups / screenings
1111111
Not getting prenatal care
11
Not washing hands

Poor eating habits
11111111
Drunk driving
11
Smoking / tobacco use
111
Suicide
1 (mental health)
Violent behavior
11111

OTHER:_____

5. **What actions, policy or funding priorities would you support because they would contribute to a healthier county?** *Please be specific.*

   Schools need to encourage exercise and good nutrition. More help needs to be available for food-challenged families. More assistance needs to be given to uninsured or underinsured when dealing with chronic illness.

   We are a non-profit organization feeding the hungry. It takes a lot to keep the doors open.

   Primary care and mental/behavioral health service funding

   Funding priorities: Public tracks with playgrounds, recreation centers for children after school, smoking cessation programs, mental health screenings and referrals

   I would support an extensive support and funding program by the WellStar Health System.

   We need to help those who are alcohol or drug abusers. In my opinion, those are the two most critical problems.

   Ensuring families know where to go for services that are not the ER and improving access.

   Proactive prevention / education.

   Public transportation.

   STI / Family planning education - schools

   Georgia Shape program/initiative – prevention of childhood obesity

   More Federal assistance

6. **In your opinion, what else will improve health and quality of life in the county?**

   A birthing center.

   More industry and jobs – On Job Training – companies willing to educate and train under-educated people who are willing to work.

   Coordination of agency efforts and resource management.

   Jobs in Paulding County.

   Widespread cooperation form government health agencies, non-governmental healthcare organizations and faith-based organizations in the county including the connectivity among these agencies with the Paulding Community Health & Resource Center will work in implementing.

I think if there was a way to educate young people about the dangers of drugs/alcohol and the impact that unsafe sex has on society, it would be helpful. But this would have to be done in a way to really get their attention. You could not teach it in a traditional manner.

Mental health – many physical problems are the result of depression.

More jobs would keep more of our citizens from traveling out of Paulding and lower stress for them.

7. **Please name at least one program or community change that has positively impacted the health of the people you serve or the population of your county in general over the last three years. What differentiated it from other programs designed to improve access to care and overall health? Why did it work?** *(If you have supporting materials or a website link, please share.)*

Encouraging additional specialists to operate clinics in Paulding County has improved overall access. There are twice as many specialists with offices in Paulding as there were three years ago. The new hospital has doubled the inpatient capacity over the old location – with another doubling to occur over the next two years. Inpatient census has been running near capacity. More people are being treated locally and not being transferred.

New WellStar Paulding Hospital.

Community Supplemental Food Program for Senior Citizens 60 plus years of age. Those on fixed income. We (Helping Hands) have been able to collaborate with the ACFB to bring this program to our county. This helps to get our seniors the good food they need for their bodies.

The new Paulding Hospital and outpatient facilities. The location is very accessible and easy to find. The facility is beautiful and welcoming and the design included elements that make the building more cost efficient to run. The additional outpatient buildings have added specialty care access and the system is currently working on a plan to house more primary care.

There are many but the one that specifically stands out is the Paulding Family Connection Children's Cabinet (www.paulding.gafcp.org). This organization is improving the condition of children and families with the metrics to prove their effectiveness.

I think the Paulding Meth Alliance / Family Alliance of Paulding have made some great strides in helping the overall health of our county. They have helped educate drug abusers and turned many of them around in life. It does not work on every person, but it is better than doing nothing at all.

Ser Familia - schools and parent liaisons – churches (80 percent of their referrals come from schools and churches)

In the works – Paulding Community Health & Resource Center. Current program / community change – Creating Communities of Hope – Paulding is part of The Northwest Georgia Region of Hope – partnering with our community, Judge Miller, Casey Family Program.

Not sure about that.

8. **Where does your community get most of their health-related information?** *Choose up to 3 by circling or highlighting.*

Friends and family
1111
Doctor/nurse/pharmacist
111111(for Latinos – doctors not associated with the health system)
Internet
1111111
Public Health Department
Television
1
Hospital
11
Help lines (telephone)
1

Books/magazines

Free Care Clinic
1

Social media
1111
School
Congregation
1
Newspaper

Other:_____

9. **What do you think are the top issues that have the largest impact on quality of life in your community?** *Pick up to 5 by circling or highlighting.*

Animal control
Availability of child care

Affordability of health services
1111
Availability of healthy food choices
1111
Bioterrorism

Dropping out of school
111
Homelessness
11
Inadequate / unaffordable housing
111
Lack of / inadequate health insurance
111111
Lack of culturally appropriate health services
1

Lack of law enforcement
Literacy
11
Secondhand smoke
1
Work safety

Availability of healthy family activities
1
Availability of positive teen activities
11
Neglect and abuse 1
Elder ___ Child ___
Pollution (water, air, land)

Low income / poverty
1111111
Racism
1 (Latinos have no sense of belonging – self-worth issues)

Lack of health providers 111
What kind? Primary care and mental health / primary care/pediatrics and behavioral health / mental health
Mental health issues
11111
Lack of recreational facilities
1
Unhealthy / unsafe home conditions
1
Rape / sexual assault
Domestic violence
111111
Youth crime
1

Lack of transportation options
1111

Unemployment
111
Unsafe, unmaintained roads

Violent crime

Gang issues
Others: _____

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

Transitional housing and homeless shelters.
No – it is well done!
No – comprehensive in scope.
No.

11. In your opinion, how could WellStar Health System improve its access, education, programs, and outreach to the communities it serves, especially the most vulnerable?

Expand clinics for needy.
Set up health fairs in their neighborhoods.
Spearhead a clinic (medical and dental) for those who are financially strapped.
Support the Paulding Health and Resource Center!
Increase primary care, pediatric and behavioral health access
Educational sessions at the boys and girls club and any of the other recreational facilities in the county
Community "Get Moving" days on the grounds at the courthouse.

By implementing its CHNA recommendations with the Paulding Community Health & Resource Center, WellStar Health System can make a marked difference in the healthcare of, and outreach to, the residents in the county.

WellStar could actually go out in the community with teams of people to help educate citizens on what is going on at the hospital and what they offer. This would need to be done in mobile home communities as well as downtown housing projects.

Partnering with Paulding Community Health & Resource Center, Public Health, etc. – community partnerships. Mobile units for mammograms, dental, etc.

Send trained personnel into the community to reach those in need of our services.

12. In your opinion, what organization/agency/clinic/health system is best taking care of the health needs of vulnerable populations? What makes them effective?

The county health department (although I believe the private sector would do a better job. Funded by government). Local hospitals as they are required to assist even those who cannot pay. (I am aware WellStar has budgeted for this area) Not positive about others.

Rapha Clinic in Temple, GA (Carroll County) – the clinic has volunteer professional medical personnel and labs who donate their time to help those in critical need who cannot afford to pay the high doctor's visit.

I'm not sure. I know that WellStar is committed to our communities and is working on a plan in each hospital service area to support our vulnerable populations. We will have one in Paulding County I am sure!

WellStar Health System
Family Alliance of Paulding

It is not apparent in my opinion.

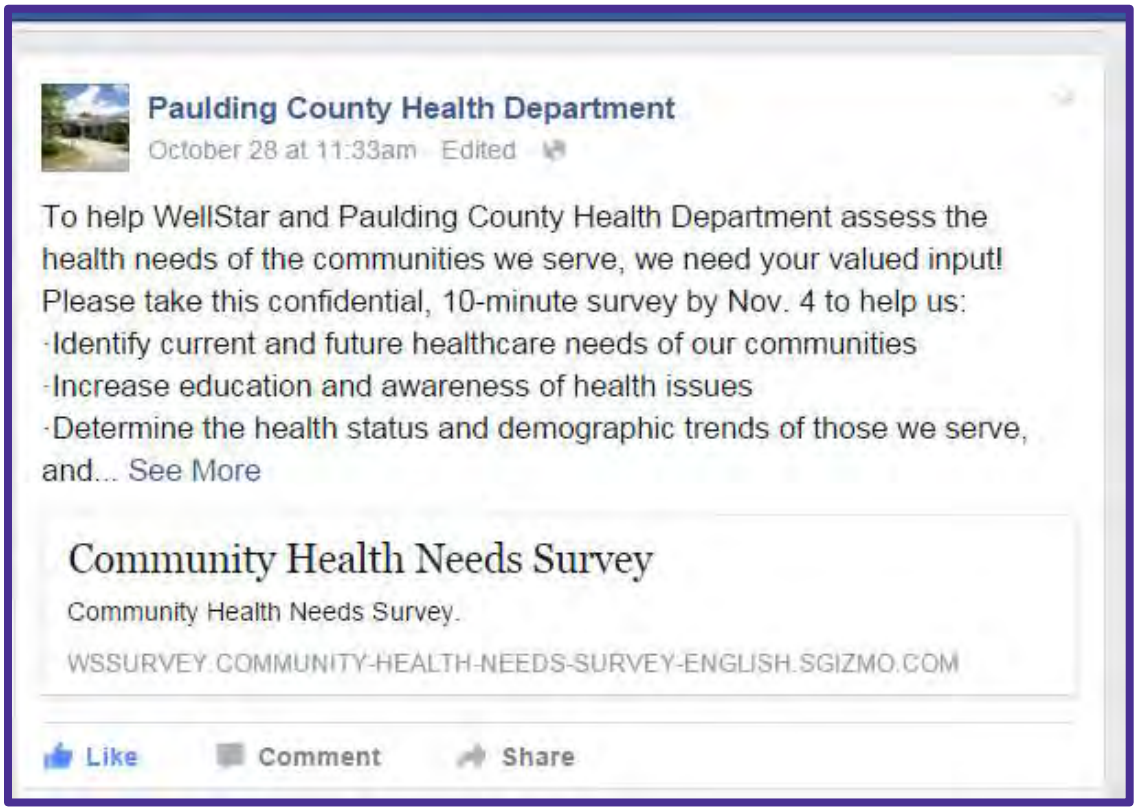
Paulding County does not have a community health clinic that offers services to these vulnerable populations. I think it would be a great thing if we had one. WellStar is a great community partner. I think if WellStar could reach out and assist with a community health clinic that could help the underserved population of people in our county, it would be very beneficial.

CMS (Children's Medical Services). Children's Cabinet. Paulding County Community Support Services.

Our local food banks like Helping Hands of Paulding County provide good nutritional food to those in need. They have wonderful volunteers that donate their time and talents to serve our citizens.

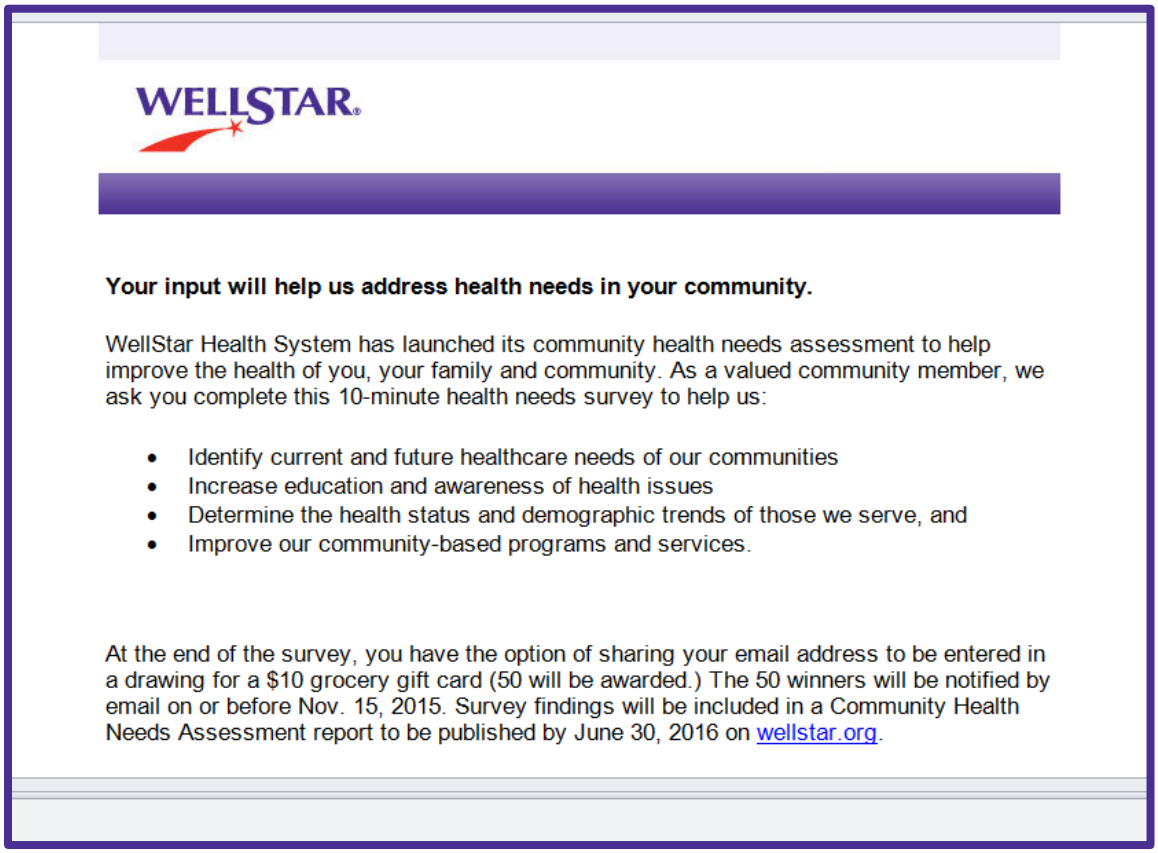
Comments: I am proud of WellStar Health System and am honored to serve on the Regional Board.

Examples of Community Survey Distribution including Social Media:




WellStar Health System
2 hrs
We need your help! As a valued community member, we ask that you complete this brief and confidential health needs survey to help improve our community-based programs and services.
http://spr.ly/6186BulcE
Thank you for your participation!


Northwest Family YMCA
November 9 at 4:09pm
From our friends at WellStar.
Please help us identify and address health needs in our community.
As a valued community member, we ask that you complete this brief and confidential health needs survey by Nov. 20 to help WellStar Health System:... See More
Community Health Needs Survey
Community Health Needs Survey.
WSSURVEY.COMMUNITY-HEALTH-NEEDS-SURVEY-ENGLISH.SGIZMO.COM
Like
Comment
Share
You and 4 others like this.
Write a comment...


WELLSTAR
Your input will help us address health needs in your community.
WellStar Health System has launched its community health needs assessment to help improve the health of you, your family and community. As a valued community member, we ask you complete this 10-minute health needs survey to help us:
• Identify current and future healthcare needs of our communities
• Increase education and awareness of health issues
• Determine the health status and demographic trends of those we serve, and
• Improve our community-based programs and services.
At the end of the survey, you have the option of sharing your email address to be entered in a drawing for a $10 grocery gift card (50 will be awarded.) The 50 winners will be notified by email on or before Nov. 15, 2015. Survey findings will be included in a Community Health Needs Assessment report to be published by June 30, 2016 on wellstar.org.

A.L. Burruss Institute's Prioritization Tool for the Health Needs Summit – Feb. 25, 2016

(1)

WELLSTAR

WellStar Community Health Needs Assessment

Access to Care

Communities in the WellStar service area face a variety of health needs. Please rate the following health needs according to how big an issue they are for the communities WellStar serves.

Please read each issue and let us know if you think each is not an issue, a minor issue, somewhat of an issue, or a major issue

	Not an issue	Minor issue	Somewhat of an issue	Major issue
High Cost of Medication				
Underuse of Behavioral/Mental Healthcare				
Underuse of Dental Care				
Lack of Care Capacity in Safety Net Clinics				
Lack of Transportation to Medical Care				
Underuse of Materal & Infant Care				
Underuse of Primary Care				
Overuse of Emergency Department for Non-Emergent Needs				
Language and Cultural Barriers				

(2)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WellStar Community Health Needs Assessment
Please read each issue and let us know if you think each is not an issue, a minor issue, somewhat of an issue, or a major issue
Not an issue
Minor issue
Somewhat of an issue
Major issue
Violence
Underuse of Preventive Cancer Screenings
Obesity
Type 2 Diabetes
Cardiovascular Disease
COPD/Asthma
Suicide
Lack of Physical Activity / Poor Nutrition
Cancer
Substance Abuse
Tobacco Use
STDs
Next

(3)

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WellStar Community Health Needs Assessment

Healthy Lifestyles

For each of these issues, please rate WellStar's current capacity to address the issue. Please let us know whether you think WellStar currently has a high capacity, medium capacity, low capacity, or no capacity to handle each issue.

	High	Medium	Low	None
Overuse of Emergency Department for Non-Emergent Needs				
Underuse of Materal & Infant Care				
Lack of Transportation to Medical Care				
High Cost of Medication				
Underuse of Behavioral/Mental Healthcare				
Lack of Care Capacity in Safety Net Clinics				
Language and Cultural Barriers				
Underuse of Primary Care				
Underuse of Dental Care				

(4)


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WellStar Community Health Needs Assessment
Again, please let us know whether you think WellStar currently has a high capacity, medium capacity, low capacity, or no capacity to handle each issue.
High
Medium
Low
None
Type 2 Diabetes
Tobacco Use
Substance Abuse
Cancer
Cardiovascular Disease
STDs
Lack of Physical Activity / Poor Nutrition
Obesity
Underuse of Preventive Cancer Screenings
Suicide
Violence
COPD/Asthma
Next

(5)


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WellStar Community Health Needs Assessment
Those are all of the questions we have. Thank you very much for taking the time to complete the survey. If you have any questions or comments regarding the survey or if you feel you have reached this screen in error, please feel free to contact:
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100%
Survey conducted by the A.L. Burruss Institute at Kennesaw State University