WellStar Spalding Regional Hospital | WellStar Sylvan Grove Hospital

WellStar Spalding Regional Hospital

EIN: 81-0864789
601 S. 8th St.
Griffin, GA 30224

For over a century, the wellness of our community has been our primary focus. WellStar Spalding Regional Hospital supports the medical/health needs of over 110,000 patients annually.

Fully accredited by the Joint Commission on Accreditation, our medical specialties include Emergency Services, Cardiac Health, Primary Stroke Center, Orthopedic & Joint Health, Women's Services and Oncology. The hospital also operates several specialized outpatient facilities among four counties: Center for Rehabilitation, Center for Sleep Medicine, and Center for Wound Healing and Hyperbaric Medicine. We are accredited by the American College of Radiology (ACR) in CT, mammography, MRI, nuclear medicine and ultrasound.

WellStar Spalding Regional Hospital has received several awards and recommendations, including multiple Joint Commission accreditations and distinctions from the American Heart Association, Georgia Association of Emergency Medical Services, and American College of Surgeons. The Center for Wound Healing and Hyperbaric Medicine has been named a National Center of Distinction. Our Primary Stroke Center was presented with the Gold Plus Target: Stroke Honor Roll Elite award by the American Heart/American Stroke Association. The hospital's Emergency Medical Services was named "Best in the State" and given the Gold Award for Cardiac Services from the prestigious American Heart Association. Recently, WellStar Spalding Regional Hospital was bestowed with a statewide Quality and Patient Safety Award in the Infection Prevention and Control category from Partnership for Health and Accountability (PHA).

WellStar Sylvan Grove Hospital

EIN: 81-0875069
1050 McDonough Road
Jackson, GA 30233

For more than 50 years, the wellness of our community has been top priority. WellStar Sylvan Grove Hospital supports the health/medical needs of over 15,800 patients annually.

Fully accredited by the state of Georgia, our medical specialties at WellStar Sylvan Grove include Emergency Services, inpatient Center for Rehabilitation, swing beds and diagnostics and pulmonary evaluation programs. WellStar Sylvan Grove Hospital offers 24-hour Emergency Services and provides inpatient programs focused on adult/pediatric occupational, physical and speech therapy. Programs are designed for recovery regarding diverse conditions, including joint replacement, various surgeries, stroke, cardiac and resistant wounds that cannot be treated through outpatient means. The hospital also offers post-acute, extended-care and personalized nursing care and treatment.

WellStar Sylvan Grove Hospital is nationally recognized for patient safety and quality and locally known for its friendliness, personalized care and community involvement. Recently, the hospital was named a 2017 Top Rural Hospital by The Leapfrog Group. The Leapfrog Top Hospital award is widely acknowledged as one of the most competitive honors American hospitals can receive. Performance measurements for this award include infection rates, quality care and the hospital's capacity to prevent medication errors.

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

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

Date CHNA adopted by the WellStar Board of Trustees: **June 6, 2019**

Date CHNA made publicly available: **June 30, 2019**

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

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Community Is **Care**

BEING THE BRIDGE

Executive Summary

This report utilizes a data-driven approach to better understand, identify and prioritize the health needs of the community served by WellStar Health System's (WellStar's) WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Based in Griffin, Georgia, WellStar Spalding Regional Hospital is a 160-bed hospital that provides comprehensive care. Located in the adjacent town of Jackson, WellStar Sylvan Grove Hospital has 25 inpatient beds and successfully serves the medical and health needs through a 24-hour emergency department (ED). Both hospitals are designated not-for-profit hospitals under the Internal Revenue Code Section 501(r).

Community Health Needs Assessment

The 2010 Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a community health needs assessment (CHNA) and implementation plan every three years to better meet the health needs of under-resourced populations living in the communities they serve. WellStar Spalding Regional and WellStar Sylvan Grove hospitals serve the same geographical community and have chosen to complete a joint CHNA and implementation planning process. What follows is a comprehensive CHNA that meets industry standards, including Internal Revenue Service final regulations of Section 501(r) titled "Additional Requirements for Charitable Hospitals."

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

Secondary data specific to the populations and geographic area served

13 individual key informant interviews with stakeholders

Two listening sessions with each hospital's Regional Board

Two focus groups with community residents

24 participants at a Health Summit with community and hospital leaders

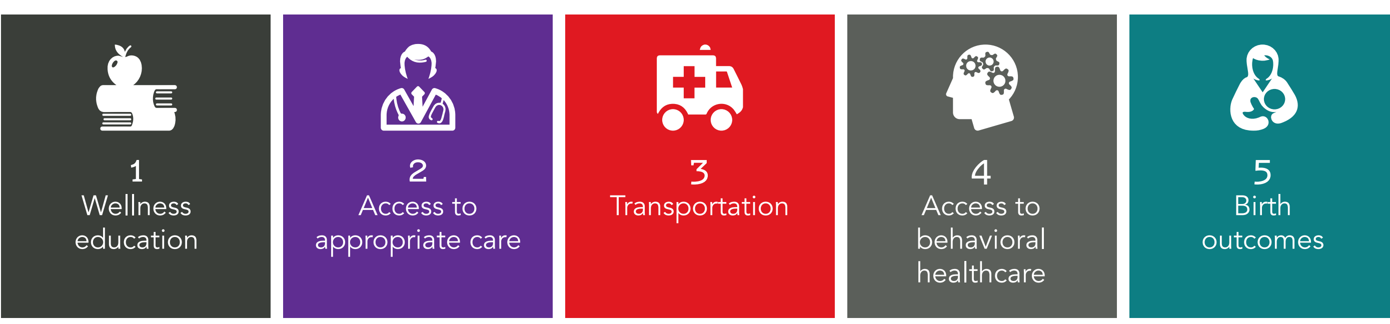
Similar to the 2018 assessment, the primary focus of data collection for this assessment was on under-resourced, high-need, and medically underserved populations living in six zip codes concentrated in the primary service area of Butts, Henry, Lamar, Newton, Pike and Spalding counties.

The primary differences that can be found in this assessment are:

- The service area grew
  - From five zip codes to the six zip code areas included in this assessment
  - From three primary counties to six, adding Henry, Lamar and Newton counties
- Comparisons are made between the two assessments when possible and
- The primary and secondary data have been updated, and more data has been included when possible.

Priority Health Needs

In 2018, WellStar Spalding Regional and WellStar Sylvan Grove hospitals worked with community and hospital leaders to identify the top community health priorities based on the data included in this CHNA.[1] The community health priorities identified for the service area include improving:



Key Findings

There are specific populations identified in this CHNA that experience greater barriers to being healthy and, as a result, have higher disease burden and death rates. The following populations need to be the focus of further study and targeted investment to address persistent health disparities:

- Residents living in Butts, Lamar and Spalding counties
- Black, Latino and Asian residents
- Single parents
- Residents with behavioral health needs
- Residents from zip codes 30204, 30223 and 30233

In general, the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals is slightly older, less diverse and lower-income-earning. Among the three primary counties in the service area, Butts and Spalding counties are slightly younger, more diverse and lower-income-earning than Pike County.

Social Determinants of Health

Social determinants of health[2] influence residents in the areas served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. In the last 10 years, the community served by both hospitals has experienced significant wage loss and low educational attainment. Spalding County residents experience the greatest socioeconomic barriers related to income, employment, insurance, housing and education when compared to residents of Butts and Pike counties. Butts County also experiences above-average socioeconomic barriers when compared to Pike County and the state. Racial and ethnic disparities in socioeconomic status also are the greatest in Spalding County when compared to the service area and the state.

This assessment also found that many community members do not have access to the most appropriate care to meet their needs due to insurance status, number of providers, transportation, residents' ability to navigate available services and quality of care. Residents have access to appropriate care when there is a properly

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

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

functioning continuum of care available to them. See Figure 1 for one example of a care continuum. There is evidence in both the secondary and primary data of significant gaps in the care continuum throughout the service area. Often, examples of these disruptions are identified through anomalies in data that warrant further investigation to better understand and address the causes, such as:

- Health professional shortage areas
- High rates of Emergency Department (ED) visits
- High hospitalization rates for preventable issues
- High mortality rates

Figure 1 | Care Continuum

PREVENTION
ASSESSMENT
DIAGNOSIS
INTERVENTION
RETURN TO DAILY LIVING
MULTIDISCIPLINARY DRIVERS

Health Outcomes

The data shows that behavioral health is a significant community health need in the service area, with higher-than-average-rates of ED use, hospital discharge for self-harm and mortality for suicide.

There are several other undesirable health outcomes in the service area. As noted in the 2018 report, most of the top five causes of death in the service area are related to restricted access to healthcare, chronic conditions, lifestyle and behaviors (e.g., heart disease, chronic obstructive pulmonary disease [COPD], lung cancer, stroke and kidney disease). When considering county-level data, morbidity and mortality rates are high throughout the service area. Butts and Spalding counties show higher prevalence and death rates when compared to Pike County. Similarly, White residents have the highest rates when compared to any other racial or ethnic cohort in the service area, though there is limited racial/ethnic data available for these counties.

There are several health issues prevalent throughout the service area, including high rates of:

Investments in addressing these issues would influence the health of communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

Limitations to Findings

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

- Most of the data included in this CHNA is available only at the county level. Where smaller pieces of data were available, they were included. County-level data is an aggregate of large populations and does not always capture or accurately reflect the nuances of community health needs.
- Secondary data is not always available. For example, Pike County often has unreportable data, meaning the sample size is too small to be validated or the data was not reported. Another example would be that there is no population measure of educational awareness in the context of healthy options, availability of resources or health literacy. In the absence of secondary data, the CHNA notes relevant anecdotal data gathered during primary data collection. It is important to note that primary data is limited by individual vocabulary, interpretation and experience.
- There is no measure of the accessibility and effectiveness of available services listed in the Community Facilities, Assets and Resources section of the Appendix, particularly for underinsured and uninsured residents.

Community Is **Commitment**

WE EXIST TO SERVE

Community Definition

WellStar Spalding Regional and WellStar Sylvan Grove hospitals are located approximately 20 miles from each another in Griffin and Jackson, Georgia, respectively. The hospitals serve the same geographic areas because of their proximity. For the purposes of this community health needs assessment (CHNA), the primary service area for both hospitals is defined as the six zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of patients are from Butts, Pike and Spalding counties. This geographic region shown in Map 1 is defined as the service area throughout the remainder of this report. Additional counties were added by WellStar Community Health Collaborative members to provide a more comprehensive understanding of the geographical region surrounding the primary service area.

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

Map 1 | Primary Service Area of WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

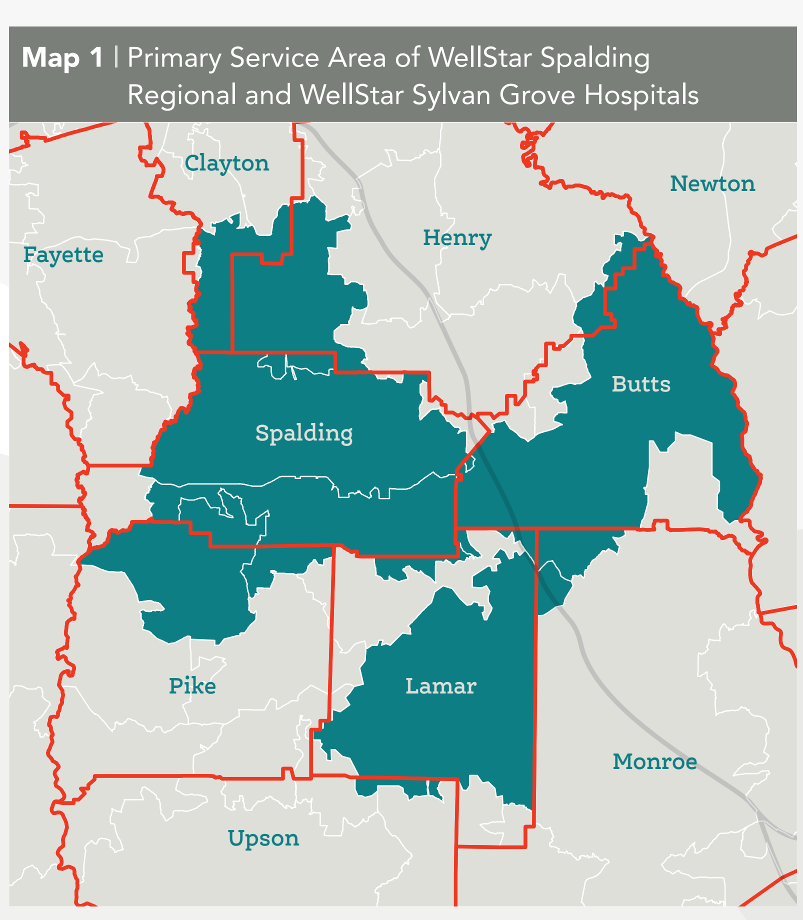


Table 1 | Primary Service Area of WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

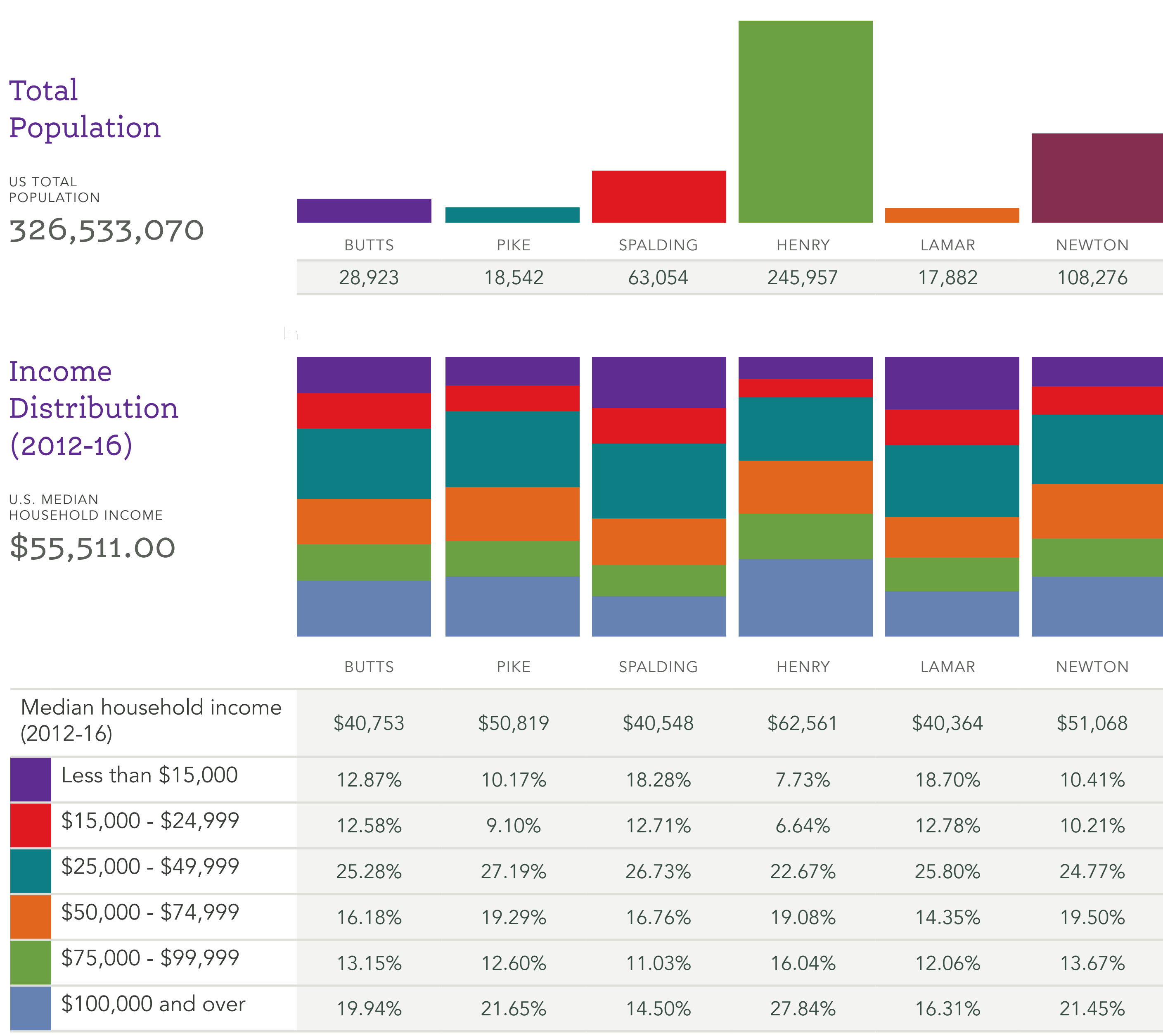
County	Zip Codes (6)	Population (2018)
Spalding	30223, 30224	63,054
Pike	30292	5,975
Butts	30233	25,278
Henry	30228	45,515
Lamar	30204	13,309
Newton		

Demographic Data

by County and State (2018)*

WellStar Spalding Regional Hospital and Sylvan Grove Hospital

The population in Georgia is one of the fastest growing in the nation. When compared to Georgia, the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals is slightly older, less diverse and lower-income-earning. Among the counties in the service area, Henry and Newton counties are younger, more diverse and higher-income-earning.



Total Population

US TOTAL POPULATION

326,533,070

BUTTS	PIKE	SPALDING	HENRY	LAMAR	NEWTON
28,923	18,542	63,054	245,957	17,882	108,276

Income Distribution (2012-16)

U.S. MEDIAN HOUSEHOLD INCOME

$55,511.00

	BUTTS	PIKE	SPALDING	HENRY	LAMAR	NEWTON
Median household income (2012-16)	$40,753	$50,819	$40,548	$62,561	$40,364	$51,068
Less than $15,000	12.87%	10.17%	18.28%	7.73%	18.70%	10.41%
$15,000 - $24,999	12.58%	9.10%	12.71%	6.64%	12.78%	10.21%
$25,000 - $49,999	25.28%	27.19%	26.73%	22.67%	25.80%	24.77%
$50,000 - $74,999	16.18%	19.29%	16.76%	19.08%	14.35%	19.50%
$75,000 - $99,999	13.15%	12.60%	11.03%	16.04%	12.06%	13.67%
$100,000 and over	19.94%	21.65%	14.50%	27.84%	16.31%	21.45%

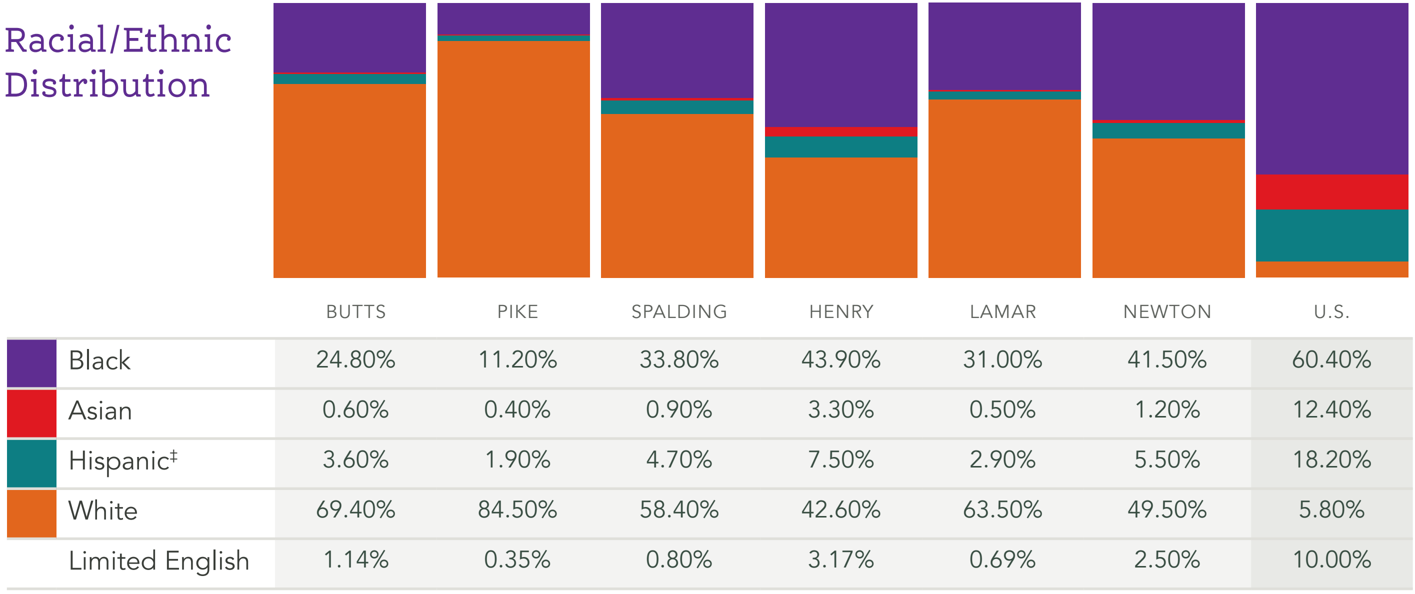
* *Truven Health Analytics, Community Need Index Demographics Expert 2.7, 2018 Demographic Snapshot*
U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: www.census.gov/programs-surveys/acs/

Age Distribution

	BUTTS	PIKE	SPALDING	HENRY	LAMAR	NEWTON	U.S.
Median age in years (2012-16)	38.50	38.90	38.20	36.50	38.40	36.10	38.1
0-14 (2018)	17.20%	18.00%	19.90%	20.10%	16.80%	20.90%	18.70%
Change 2018-23	-0.90%	-1.90%	-0.60%	-2.40%	-0.50%	-1.60%	ND
15-17 (2018)	3.90%	4.80%	4.00%	5.10%	4.30%	4.80%	3.90%
Change 2018-23	0.00%	-0.40%	+0.10%	-0.30%	-0.20%	-0.10%	ND
18-24 (2018)	9.60%	9.80%	8.80%	10.40%	12.70%	10.20%	9.70%
Change 2018-23	+0.40%	+0.60%	+0.20%	+0.40%	-0.60%	+0.50%	ND
25-34 (2018)	13.50%	11.00%	12.70%	12.20%	12.30%	12.10%	13.40%
Change 2018-23	-0.10%	+1.40%	-0.20%	+1.10%	+0.50%	+0.50%	ND
35-54 (2018)	26.90%	26.80%	24.50%	28.50%	23.10%	27.10%	25.50%
Change 2018-23	-1.60%	-2.50%	-1.00%	-2.50%	-1.10%	-2.00%	ND
55-64 (2018)	12.80%	13.20%	12.50%	12.00%	13.00%	11.70%	12.90%
Change 2018-23	-0.10%	+0.40%	-0.50%	+1.30%	-0.60%	+0.80%	ND
65+ (2018)	16.00%	16.50%	17.60%	11.70%	17.90%	13.30%	15.90%
Change 2018-23	+2.30%	+2.40%	+2.00%	+2.30%	+2.50%	+1.90%	ND

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

Racial/Ethnic Distribution



	BUTTS	PIKE	SPALDING	HENRY	LAMAR	NEWTON	U.S.
Black	24.80%	11.20%	33.80%	43.90%	31.00%	41.50%	60.40%
Asian	0.60%	0.40%	0.90%	3.30%	0.50%	1.20%	12.40%
Hispanic‡	3.60%	1.90%	4.70%	7.50%	2.90%	5.50%	18.20%
White	69.40%	84.50%	58.40%	42.60%	63.50%	49.50%	5.80%
Limited English	1.14%	0.35%	0.80%	3.17%	0.69%	2.50%	10.00%

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

Community Is **Contribution**

ASSESSING THE NEEDS

Data Collection

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

The secondary data included in this assessment was compiled from a variety of sources that are both reliable and representative of the communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Quantitative data sources included but were not limited to:

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

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

To better understand the experience and needs of residents served by the two hospitals, several types of qualitative data were used. Qualitative data used in this assessment included a focus group with residents, one-on-one interviews with key stakeholders, listening sessions with the hospitals' Regional Health Boards, and a Health Summit with hospital and community leaders. An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community Is **Connection**

YOUR STORY IS OUR STORY

Health Needs of the Community

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

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

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

Community health is measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings (CHR), a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. CHR health outcomes measures length of life and quality of life. Among the counties served by both hospitals, Butts, Lamar and Spalding counties show higher rates of mortality and the poorest quality of life, while Henry County shows lower mortality rates and Pike County shows a better quality of life. This theme is seen throughout the assessment. Butts and Spalding counties often have the poorest outcomes when compared to other counties in the service area and the state.

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

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Butts	102	71	132	60	54	100	77	112
Pike	39	25	77	18	19	96	14	132
Spalding	137	111	134	133	87	49	131	141
Henry	22	20	17	40	26	10	19	121
Lamar	92	56	105	86	45	79	71	70
Newton	54	60	61	53	52	62	68	127

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

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

The leading causes of death in the hospital service area are similar when compared to those in the state. Death rates throughout the service area are much higher when compared to the state's rate. The top causes of death in both the service area and throughout the state are related to heart disease (i.e., coronary artery disease).[4] The rest of the top five causes of death are COPD (except asthma), lung cancer, cerebrovascular disease (stroke) and essential (primary) hypertension and hypertensive renal and heart disease.[5]

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

4 *See the Secondary Data section of the Appendix for a ranked list of causes of death in Georgia and in Butts, Pike, and Spalding counties*

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

Social Determinants of Health

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." Each primary data source discussed the low educational attainment, lack of stable employment options, low-wage jobs and resulting poverty among residents. This addresses the disparities seen in the social determinants of health (e.g., income, employment, education, affordable housing, etc.) throughout the hospitals' community.

Unemployment has decreased across the area in the last 10 years. However, Butts, Pike and Spalding counties saw a decrease in median household incomes of $10,590, $1,875 and $854, respectively.[6] One resident explained the shift in industry and available employment this way:

> "This was known as a mill town. And there's only like … one, maybe two mills left. And some people, like myself, cannot maintain in that field anymore. For carpal tunnel, in both my hands. I've done wore it out working with my hands. Yeah, this was like a ghost town with jobs. They're popping up stores and stuff, but that's not a career for everyone."

Another resident talked about their experience with temporary employment in this way:

> "Yeah, that's the quickest and most reliable way to get a job. … I was working through a temp service, they'll let you work but then … they start letting people go. When you're supposed to be hired on, 50 hours away from being hired on, they let you go."

Poverty is a pervasive challenge in Butts, Lamar and Spalding counties, particularly among families with children and people of color. Table 3 shows that over the last decade, poverty in the general population has increased in Butts County at a much faster pace (8.4 percent) than in other counties in the service area. This pattern is replicated across the service area regardless of family status.

While single-parent families experience the highest rates of poverty throughout the service area, Butts County shows a significant increase between 2006 and 2015 in the percentage of single-female-head-of-household families in poverty (17.8 percent) when compared to other service area counties. Both Pike and Spalding counties saw decreases during the same period (10.7 percent and 4.1 percent, respectively).

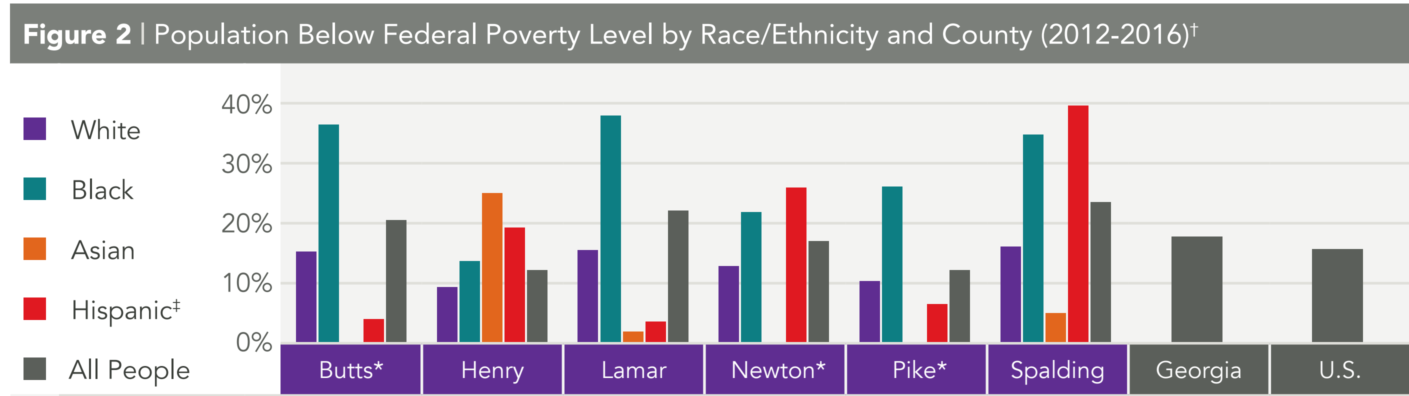
6 *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

Table 3 | Population Below the Federal Poverty Level by Family Status and County (2006-2015)†	Butts	Henry	Lamar	Newton	Pike	Spalding
Total Households						
2006-10	7,789	66,327	6,377	33,536	5,957	23,105
2011-15	7,774	70,281	6,431	34,641	6,017	22,717
All People						
2006-10	12.40%	8.30%	20.40%	12.70%	10.50%	21.20%
2011-15	20.80%	12.90%	22.10%	17.10%	12.20%	22.70%
All Families						
2006-10	9.00%	6.30%	19.40%	10.80%	9.40%	17.20%
2011-15	18.90%	10.40%	17.90%	13.20%	10.00%	17.90%
Married Couple Families						
2006-10	5.30%	3.00%	11.40%	5.10%	4.70%	4.80%
2011-15	9.40%	4.70%	10.40%	6.20%	6.50%	7.00%
Single Female Head of Household Families						
2006-10	25.90%	18.80%	33.90%	24.60%	33.10%	45.80%
2011-15	43.70%	27.10%	41.70%	26.70%	22.40%	41.70%

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

Figures 2 and 3 show that there also are disparities in the poverty and education rates of various racial and ethnic groups throughout the service area, with Black and Hispanic/Latino residents showing the highest rates of poverty and lowest rates of educational attainment when compared to the general population. Educational attainment is low throughout the service area, with one in 10 residents without a high school diploma (or equivalent).

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

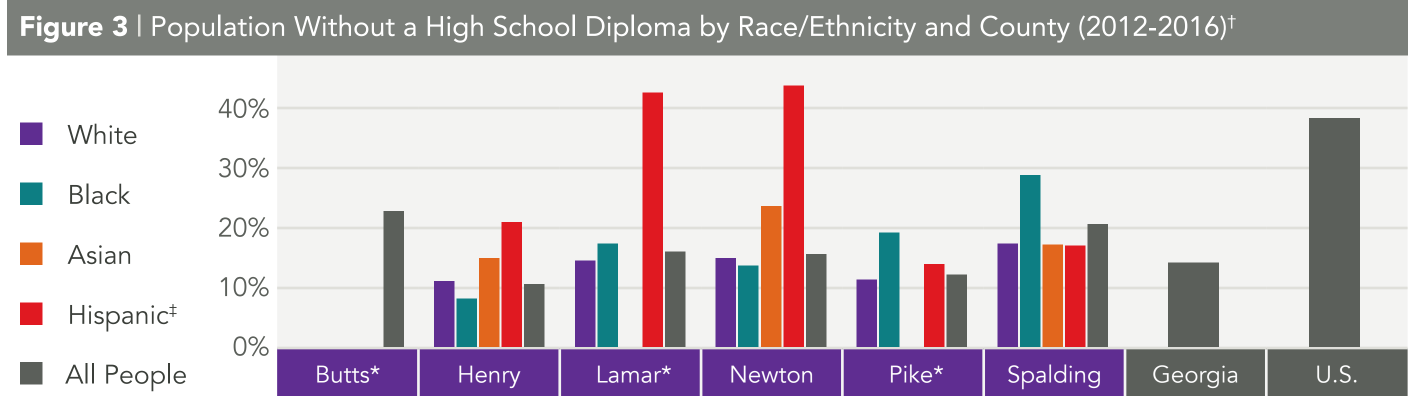


† *U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: http://www.census.gov/acs/www/*

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

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

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



† Community Commons CHNA Portal: CHNA.org

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

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

Housing

The quality, age, availability and affordability of housing influence community health. Community input suggests that the housing stock is poor and becoming unaffordable for residents. During interviews, community leaders discussed the impact that unaffordable housing is having on residents' ability to afford other necessities, such as healthy food and transportation. In the last 10 years, home values have declined in every county in the service area, except Pike. Also, homeownership has declined in every county except Henry and Newton counties. Subsequently, home ownership is being replaced by renting in most counties in the service area. This fact alone does not indicate health challenges and likely is related to both the housing crisis and the younger median age of the service area.

As the region rebounds from the housing crisis, older homes are being replaced by newer dwellings. This, coupled with the decreasing vacancy rates, may be setting the community up for challenges related to unaffordable housing and displacement. This may be what is driving the increases in the percentage of residents paying more than 30 percent of their monthly income for rent in Butts and Spalding counties.

Table 4 | Selected Housing Indicators by County (2006-2017)[†]

	Butts	Henry	Lamar	Newton	Pike	Spalding
Total Households						
2006-10	7,789	66,327	6,377	33,536	5,957	23,105
2011-15	7,774	70,281	6,431	34,641	6,017	22,717
Family households						
2006-10	72.5%	76.6%	70.6%	76.5%	82.1%	70.2%
2011-15	75.9%	77.4%	28.6%	71.7%	79.9%	71.0%
Nonfamily households						
2006-10	24.1%	23.4%	29.4%	23.5%	17.9%	29.8%
2011-15	27.5%	22.6%	30.9%	28.3%	20.1%	29.0%
Vacant housing units						
2006-10	16.0%	10.5%	13.5%	10.6%	10.5%	12.6%
2011-15	16.3%	9.1%	14.5%	9.7%	11.8%	15.6%
Homes more than 20 years old						
2006-10	63.1%	26.6%	66.3%	37.9%	55.0%	66.5%
2011-15	51.1%	24.8%	60.6%	37.0%	46.4%	63.4%
Median value of homes						
2006-10	$142,900	$171,500	$114,100	$148,600	$153,300	$124,400
2011-15	$113,900	$140,300	$124,300	$115,500	$155,200	$111,500
Households paying more than 30% of income for monthly mortgage						
2006-10	36.1%	37.9%	36.8%	37.6%	43.0%	36.2%
2011-15	37.2%	30.8%	37.3%	36.5%	33.8%	35.8%
Households paying more than 30% of income for monthly rent						
2006-10	44.1%	50.1%	52.9%	62.1%	49.1%	56.4%
2011-15	54.2%	49.9%	52.4%	54.7%	46.5%	59.3%

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

Zip code-level data shows a greater influence of the social determinants of health on the area both hospitals serve than county-level data can portray (see Table 5 for Community Need Index [CNI] data in selected zip code areas). Specifically, there are geographic pockets where educational attainment is lower and unemployment and poverty are higher than county averages:

- Single-parent poverty is high throughout the service area, with nearly 50 percent of single-parent homes experiencing poverty,
- In two zip codes (30223 and 30233), over 20 percent of residents do not have a high school diploma, and
- Unemployment is higher than state averages (4.6 percent) throughout the service area, with four (30204, 30223, 30224 and 30233) of six zip codes showing more than double the state rate.

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

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

Access to Appropriate Care

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

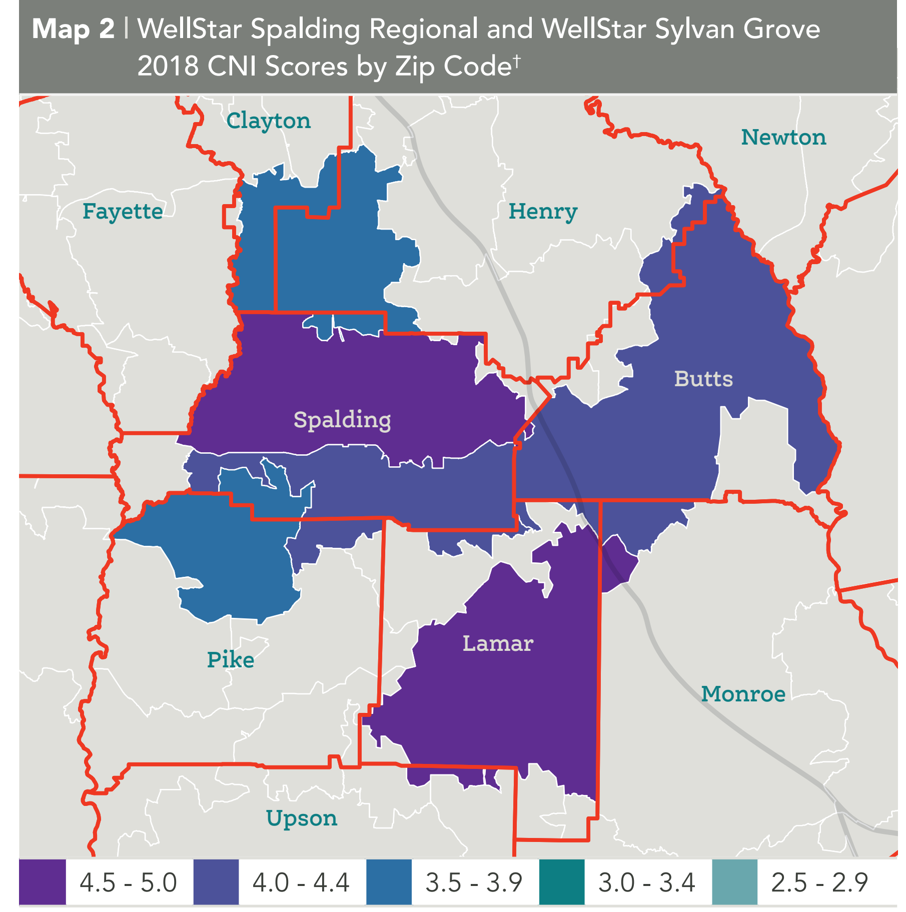
Community residents spoke of the difficulty they experience when trying to maintain and use affordable health insurance. One group noted that affordable insurance often is not accepted by providers in their area or has such expensive copays and deductibles that they cannot afford to use the insurance benefits.

Socioeconomic Factors

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

The previous CHNA for WellStar Spalding Regional and WellStar Sylvan Grove hospitals included 2015 CNI data. During the last year, the communities served by these two hospitals have experienced an increase in socioeconomic barriers to accessing healthcare. The most notable changes are that the socioeconomic barriers to accessing healthcare in the two Spalding zip codes remained high (30223 and 30224), and at the same time increased in the zip code areas in Lamar (30204), Butts (30233) and Pike (30292) counties.

Map 2 | WellStar Spalding Regional and WellStar Sylvan Grove 2018 CNI Scores by Zip Code†



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

According to the 2018 CNI (see Map 2 and Table 5), all of the zip codes served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals have above-average socioeconomic barriers to accessing healthcare.

A closer look shows:

- There are four zip codes with CNI scores of 4 or higher, two of which are in Spalding and one in Butts and Lamar counties.
- When compared to the rest of the service area, Lamar and Spalding counties both present the highest, while Henry and Pike counties present the lowest socioeconomic barriers to accessing healthcare.
- 66 percent (four out of six) of the zip codes show higher rates of uninsured than the state (17.1 percent), and 55 percent of the service area has more than one in five residents uninsured.

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

Table 5 | 2018 Community Need Index (CNI): 3 Highest Barrier vs. 3 Lowest Barrier Zip Codes†

Geography		Scores		Income			Culture		Education	Insurance		Housing
Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/ kids	Limited English Skills	Minority	No High School Diploma	Unemployed	Uninsured	Renting
3 Areas With the Highest CNI Scores												
30204	Lamar	0.2	4.8	19.1%	29.2%	62.9%	0.2%	43.7%	14.8%	14.7%	22.4%	36.9%
30223	Spalding	0.0	4.8	14.1%	31.5%	51.1%	0.9%	47.1%	23.1%	13.7%	25.2%	42.2%
30224	Spalding	0.0	4.4	5.4%	20.4%	35.9%	1.9%	68.8%	10.2%	8.5%	10.7%	20.6%
3 Areas With the Lowest CNI Scores												
30233	Butts	0.2	4.2	12.3%	24.4%	47.4%	0.6%	30.1%	23.6%	10.2%	17.1%	24.8%
30228	Henry	0.0	3.6	5.4%	20.4%	35.9%	1.9%	68.8%	10.2%	8.5%	10.7%	20.6%
30292	Pike	0.4	3.6	6.3%	13.3%	48.6%	0.1%	16.0%	13.5%	7.8%	10.0%	20.1%
Butts Total		**0.2**	**4.2**	**12.5%**	**24.5%**	**49.0%**	**0.5%**	**30.6%**	**22.8%**	**14.6%**	**20.5%**	**32.1%**
Henry Total		**-0.2**	**3.4**	**7.4%**	**16.4%**	**35.4%**	**1.5%**	**57.4%**	**10.3%**	**7.9%**	**10.9%**	**24.7%**
Lamar Total		**0.2**	**4.5**	**21.5%**	**26.3%**	**62.3%**	**0.1%**	**36.5%**	**15.0%**	**14.6%**	**20.5%**	**32.1%**
Newton Total		**-0.3**	**3.8**	**12.0%**	**19.6%**	**34.3%**	**1.0%**	**50.5%**	**15.2%**	**9.2%**	**14.1%**	**24.4%**
Pike Total		**0.0**	**3.4**	**12.8%**	**17.2%**	**44.6%**	**0.2%**	**15.5%**	**14.4%**	**10.0%**	**12.5%**	**18.9%**
Spalding Total		**0.0**	**4.6**	**14.4%**	**27.8%**	**50.4%**	**0.7%**	**41.6%**	**20.7%**	**12.0%**	**23.4%**	**38.9%**

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

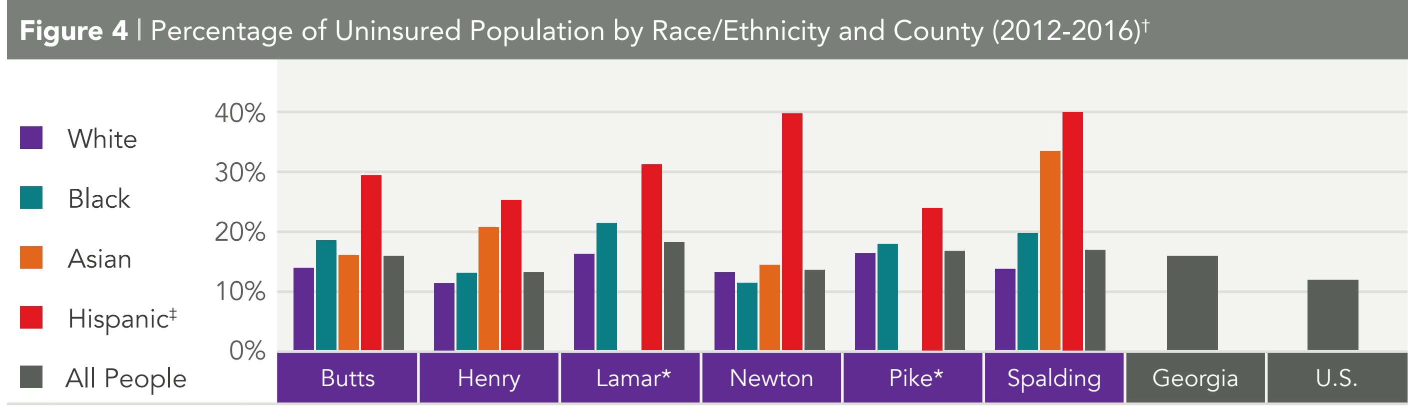
Uninsured

A greater percentage of Georgia residents are uninsured than the national average, due to the lack of Medicaid expansion. The percentage of uninsured residents in all three primary counties is average for the state. One resident recounted their experience trying to maintain self-paid insurance in Spalding County:

> "I've been buying insurance on my own, 'cause I'm not Medicare age yet. And my first year, I was under a certain healthcare plan being a resident of Spalding County; they dropped the whole plan. … [I] got a new plan last year; it was dropped at the end of the year. So now, I'm on the third plan in three years because they keep dropping insurance for Spalding County. Now, there's one provider I have access to. I have very little access to any doctors."

Figure 4 shows disparities in the rates of uninsured in the service area when considering the data by racial and ethnic groups, with Asian, Black and Latino residents showing the highest rates of uninsured when compared to their White counterparts. While there are slight variances among White and Black residents between counties, Asian residents face high uninsured rates in Henry and Spalding counties. Across all counties, Latino residents are twice as likely to be uninsured when compared to their White and Black counterparts

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



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

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

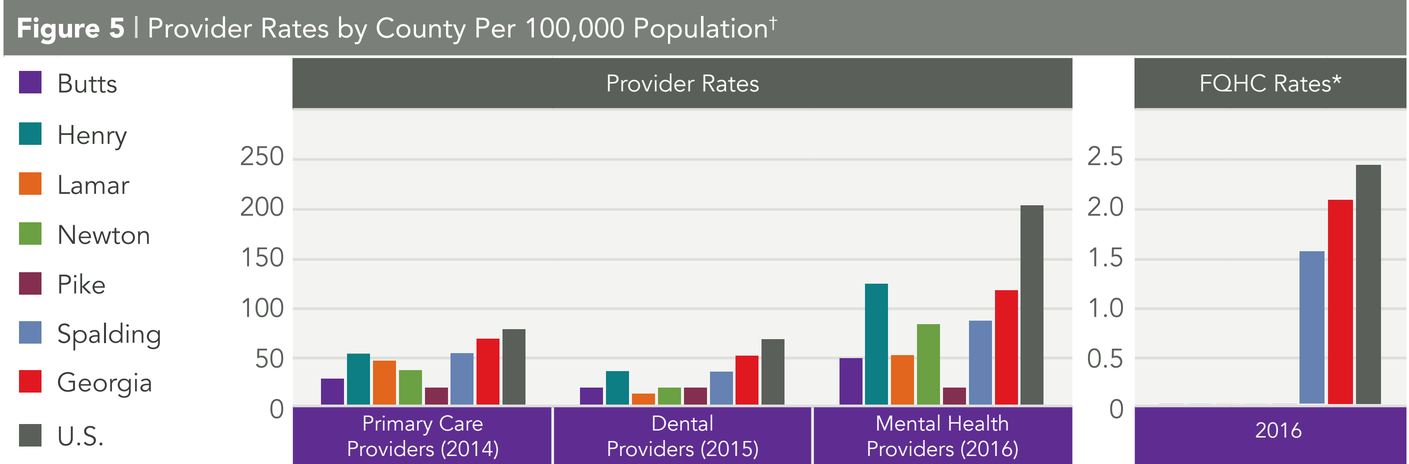
‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring 2 or more of these races.*

Provider Shortage

There is a shortage of healthcare and dental providers throughout the service area, particularly among safety-net providers that offer free or reduced-cost healthcare based on income (see Map 3 for a geographic representation). While the entire service area has fewer providers than is average in the state and the nation, Pike County has the fewest providers when compared to other counties in the service area.

Community input suggests that there is a shortage of primary care providers, safety-net providers, specialists and trauma care. Residents explained that the closest specialists are at least a 45-minute drive away from their community.

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



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

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

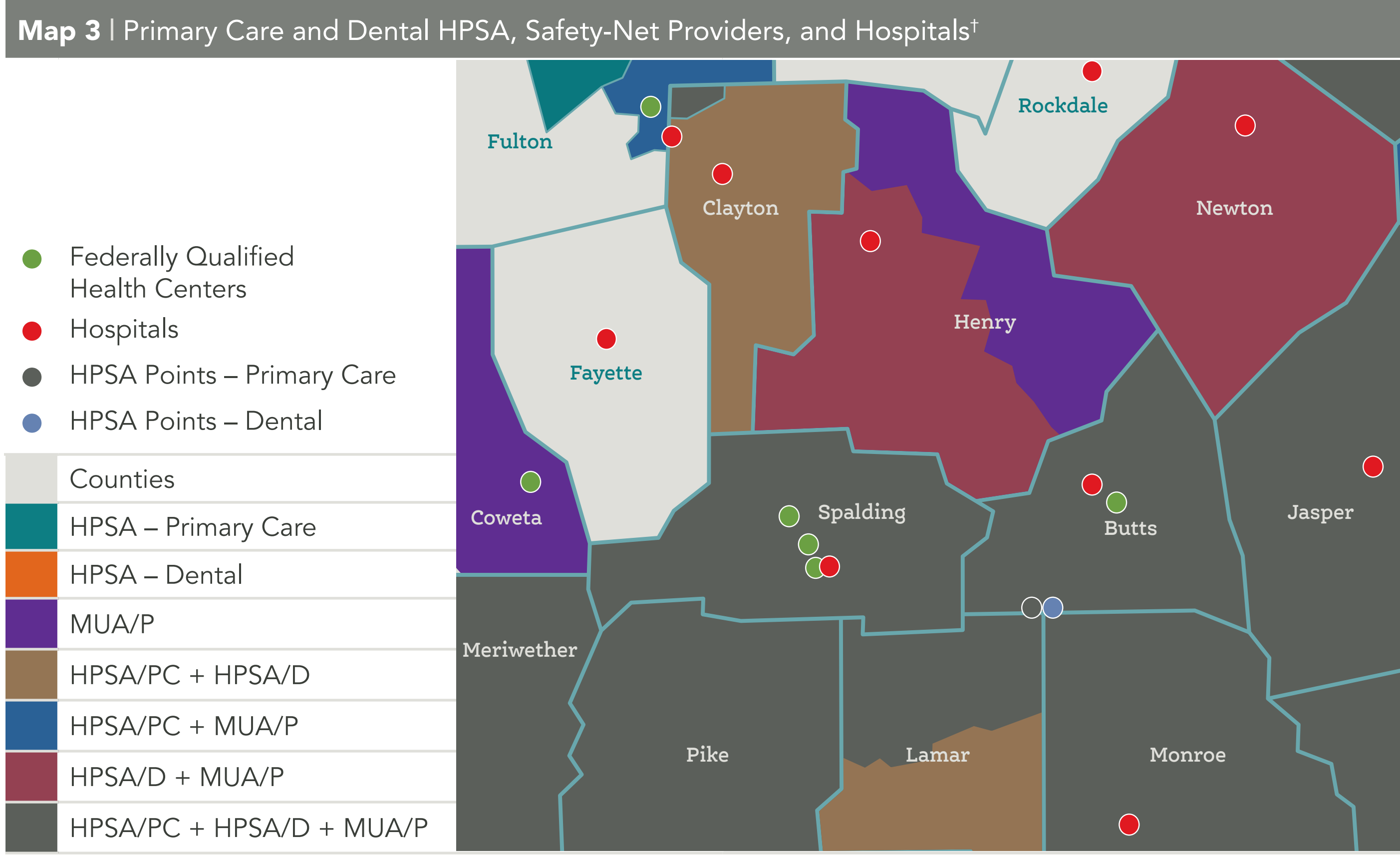
In addition, community input suggests that care coordination for residents seeking care in the ED is not readily available. One hospital leader noted:

> "Many people that go to our ER are better served in a primary care setting. They call 911 and we get them. Some patients aren't compliant with their discharge orders and need education – they may not know about other healthcare options before they go home."

Map 3 shows that each county is considered a professional shortage area according to the Health Resources and Services Administration (HRSA). Additionally:

- Butts, Henry, Newton, Pike, and Spalding counties are all considered Medically Underserved Areas (MUAs), while all counties in the service area except Newton are Health Professional Shortage Areas (HPSAs).
- Most safety-net providers are located in the center of each county, with the exception of Lamar and Pike counties with no safety-net providers noted.

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



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

Health Summit participants discussed the limited transportation options that residents have as one of the most pressing priorities in the service area when coupled with the rural nature of the area. Community input suggested that the lack of transportation restricts access to employment options, health services, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of comprehensive public transportation that is reliable and the distance residents must travel to secure necessities. The limited transportation options can facilitate poor health outcomes.

There are existing resources throughout the service area that offer access to care.[9] Unfortunately, it is difficult to determine the reach and effectiveness of these collective services in addressing most of the barriers to accessing appropriate care noted in this assessment.

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

Health Behaviors

To better understand behaviors that impact health, it is important to consider factors influencing choices residents make that cause them to be either healthy or unhealthy. Often these choices are influenced by access to, awareness of and preference for healthy or unhealthy options. Community input noted that residents often have low awareness about healthy choices and limited access to affordable healthy options (nutrition and exercise).

One resident had this to say about the quality of food available in under-resourced areas:

> "I'm frustrated by grocery stores in low-income areas that offer unhealthy choices."

Food Insecurity

According to the U.S. Department of Agriculture (USDA), food security is access by all people at all times to enough food for an active, healthy life. It is one of several conditions necessary for a population to be healthy and well nourished. In 2016, the USDA found that 14 percent of households in Georgia experience low food security, and 5.6 percent experience very low food security.[10]

Spalding and Butts counties show signs of food insecurity and low access to grocery stores. The geographic areas with the lowest access to grocery stores are closest to each hospital (see Map 4).[11] Residents in Henry, Lamar, Newton and Spalding counties have the lowest access to supermarkets and grocery stores when compared to Pike and Butts residents. The highest rates of low-income, food-insecure populations are in zip codes 30223, 30224 and 30233.

Table 6 | Selected Populations With Low Access to a Supermarket or Large Grocery Store by County (2013-2017)†

Healthy Eating, Active Living Indicators	Butts	Henry	Lamar	Newton	Pike	Spalding
Total population	23,556	217,506	18,282	105,042	17,919	64,192
Percent population below 100% FPL	23.54%	11.42%	20.75%	16.74%	12.26%	21.64%
Grocery stores (2016)*	8.45	13.24	21.84	15.01	5.60	18.73
Percent population with low food access (2015)	16.55%	49.31%	24.63%	32.64%	0.03%	26.36%

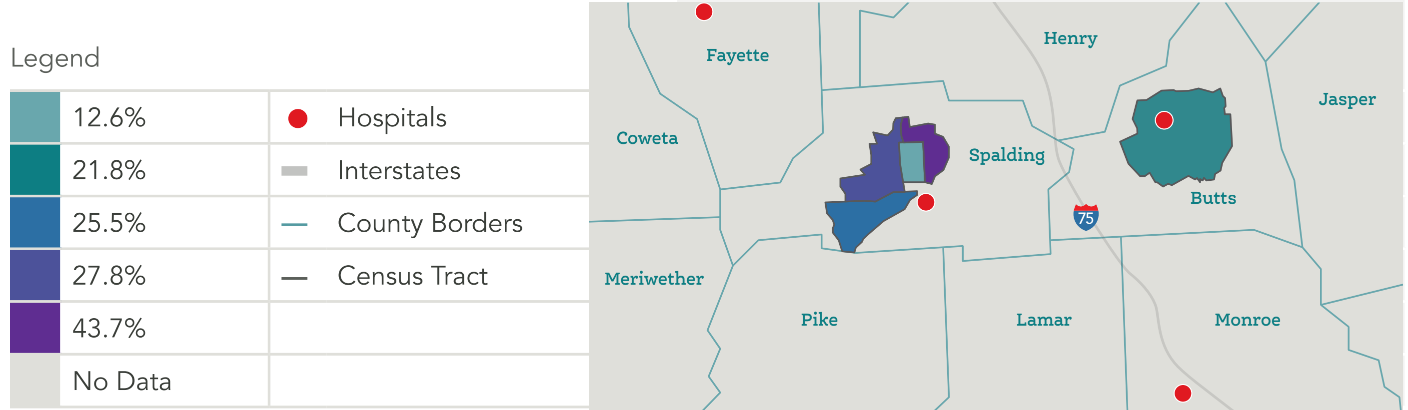
† *U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015*
U.S. Census Bureau, American Community Survey. 2013-17
U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016

* *Per 100,000 population*

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

11 *WellStar Spalding Regional Hospital is closest to census tracts 13255160500, 13255160400 and 13255160300, and WellStar Sylvan Grove Hospital sits in the middle of census tract 13035150200.*

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



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

Hospital leaders felt that high rates of obesity in the service areas are related to poor food choices, limited awareness of health outcomes and lack of access to regular opportunities to be physically active. Community input suggests that residents do not have access to healthy nutrition or facilities to be physically active. Focus group participants noted that there are very few places to exercise safely outside due to crime and the lack of infrastructure (sidewalks, parks, green space, etc.).

Long Commute Times

Table 7 shows that there is limited access to exercise facilities in Butts and Pike counties when compared to the rest of the service area and the state. Additionally, more residents in all counties spend more than an hour commuting, when compared to the state and national average time spent commuting.

Table 7 | Selected Healthy Eating, Active Living Indicators†

	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
Healthy Food Stores (Low Access)	16.6%	49.3%	24.6%	32.6%	0.0%	26.4%	30.8%	22.4%
Exercise opportunities – Access	40.0%	86.0%	68.2%	75.7%	46.7%	73.7%	75.9%	84.3%
Physical Inactivity – Adults	28.0%	22.6%	26.2%	28.5%	25.7%	28.0%	23.1%	21.7%
Driving Alone to Work, Long Distances (>60 min)	82.5%	81.6%	77.8%	82.3%	86.1%	85.8%	79.6%	76.4%

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

Health Knowledge

Health Summit participants prioritized wellness education and awareness as one of the most pressing health issues that could improve health outcomes in their community if effectively addressed. They felt residents need more effective outreach in the areas where they live, work and play. There is no measure of education and/or awareness in the context of healthy options, availability of resources or health literacy.

Health Summit participants and community leaders interviewed discussed low educational attainment coupled with a lack of outreach as barriers to health literacy in the community. Community input suggests that residents are not aware of the services that exist in the community due to challenges in effectively disseminating information throughout their rural community.

There are existing resources throughout the service area addressing health behaviors in the community.[12] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors noted in this assessment.

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

Health Outcomes

As noted in the 2018 report, most of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, COPD, lung cancer, stroke and kidney disease). When considering county-level data, morbidity (disease burden) and mortality (death) rates are high throughout the service area. Henry County shows the lowest rates, while Spalding County shows the highest rates. Whites show higher rates of mortality, while Black residents show the highest disease burden when the data is considered by race, though there is limited racial/ethnic data available for these counties.

Top Causes of Premature Death

The top five causes of premature death are derived from the Years of Potential Life Lost 75 (YPLL 75), which represents the number of years of potential life lost due to death before age 75 as a measure of premature death. In the communities served by both hospitals, premature death seems to be caused by heart disease, poisoning, vehicle crashes, mortality, suicide and kidney disease. The rate of premature death due to heart disease is high across the CHNA region served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Butts County shows the highest rates of premature death when compared to the state and other counties in the service area. There are notable inequities when premature death is considered by race, with White residents showing much higher rates when compared to all other races (when data is available).

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

By Region	Ischemic Heart and Vascular Disease	Accidental Poisoning and Exposure to Noxious Substances	Motor Vehicle Crashes	Intentional Self-Harm (Suicide)	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
Georgia	524.5	477.9	491.4	429.8	178.8
Butts	765.5	805.3	873.9	935.9	369.5
Henry	305.5	441.0	403.4	365.2	328.1
Lamar	647.6	ND	ND	ND	ND
Newton	473.0	382.3	761.7	465.8	126.6
Pike	149.3	ND	ND	0.0	204.9
Spalding	902.4	468.0	681.1	531.1	241.8
By Race**					
White	599.2	817.3	723.0	656.4	222.8
Black	358.7	138.0	441.7	220.7	316.6
Hispanic‡	ND	0.0	ND	0.0	ND
Asian	ND	0.0	ND	0.0	0.0
Native American	0.0	0.0	0.0	ND	0.0
Pacific Islander	0.0	0.0	0.0	0.0	0.0
Multiracial‡	ND	0.0	ND	0.00	ND

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

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring 2 or more of these races.*

Top Causes of Death

Reported causes of death are based on the underlying cause of death. The underlying cause of death is defined by the World Health Organization as the disease or injury that initiated the sequence of events leading directly to death or as the circumstances of the accident or violence that produced the fatal injury. As noted in the 2018 report, most of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, lung cancer and kidney disease). It is important to note that two of the top five causes of death are cardiovascular in nature. Georgia is well known to have poor outcomes related to cardiovascular disease, and Butts, Henry, Lamar, Newton, and Spalding counties show higher rates of mortality than the state in at least one of these areas. White residents show higher rates of death for three of the top causes, while Black residents have higher rates for two of the top causes when compared to all other races (when data is available).

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

By Region	Ischemic Heart and Vascular Disease	All COPD Except Asthma	Malignant Neoplasms of the Trachea, Bronchus and Lung	Cerebro-vascular Disease	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
Georgia	73.1	45.2	42.4	43.4	18.1
Butts	69.6	85.6	56.7	45.1	28.2
Henry	45.5	51.7	41.7	55.2	41.9
Lamar	83.1	65.9	18.8	41.8	ND
Newton	65.2	46.1	55.9	39.0	21.8
Pike	37.7	74.9	71.7	58.5	0.0
Spalding	86.3	72.9	56.7	55.0	24.9
By Race**					
White	67.1	134.2	52.8	48.4	26.3
Black	48.7	78.0	29.9	53.5	43.3
Hispanic‡	ND	ND	0.0	ND	ND
Asian	ND	ND	0.0	ND	0.0
Native American	0.0	0.0	0.0	0.0	0.0
Pacific Islander	0.0	0.0	0.0	0.0	0.0
Multiracial‡	ND	0.0	0.0	0.0	ND

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

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring 2 or more of these races.*

Top Causes for Emergency Department Visits

There is anecdotal evidence that residents are seeking care in the ED for a variety of reasons, such as lack of insurance, limited availability of after-hours care or acute symptoms. Three of the top causes of ED visits in the service area are all related to accidents. Overall, the rate of ED visits in the service area is higher than the state averages. Black residents have higher rates than other races and the state for three of the top causes of ED visits in the service area.

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

By Region	All Other Unintentional Injury	Diseases of the Musculoskeletal System and Connective Tissue	All Other Diseases of the Genitourinary System	Falls	Motor Vehicle Crashes
Georgia	3,030.0	3,276.9	2,394.2	1,918.4	1,168.8
Butts	5,149.4	4,066.6	3,525.1	2,962.1	1,829.3
Henry	2,166.9	2,153.7	1,908.2	1,390.3	1,347.9
Lamar	3,475.8	4,044.1	2,870.6	2,412.9	1,167.6
Newton	4,087.0	3,957.0	3,161.7	2,280.0	1,823.4
Pike	2,685.0	2,224.5	2,108.9	2,124.2	1,387.6
Spalding	3,736.1	5,112.8	4,631.5	2,590.8	1,946.0
By Race**					
White	3,007.9	2,499.4	2,517.6	2,136.7	1,075.4
Black	3,321.5	4,302.0	3,142.2	1,679.0	2,246.6
Hispanic‡	N/A	N/A	N/A	N/A	N/A
Asian	624.4	431.8	352.2	469.2	323.3
Native American	2,957.6	3,474.4	2,682.3	1,984.1	2,486.4
Pacific Islander	ND	0.0	ND	ND	ND
Multiracial‡	2,223.5	2,369.3	1,811.5	1,125.9	1,556.8

ND for rates: Rates based on 1-4 events are not shown N/A Rates indicate that no population exists for the query selected.

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring 2 or more of these races.*

Top Causes for Hospital Discharges

The number of inpatients discharged from nonfederal acute-care inpatient facilities that are residents of Georgia and seen in a Georgia facility is considered in the following table. Uninsured residents are not always admitted to the hospital without some form of payment, and may not be represented heavily in this measure. Hospital discharge rates are highest for childbirth, diseases of the musculoskeletal system and connective tissue and septicemia. Hospitalization rates due to mental health are lower than the state average across the service area. White residents show higher rates of hospital discharges for three of the top causes, while Multiracial residents have higher rates for two of the top causes when compared to all other races (when data is available).

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

By Region	Pregnancy, Childbirth and the Puerperium	Diseases of the Musculoskeletal System and Connective Tissue	Ischemic Heart and Vascular Disease	Septicemia	All Other Mental and Behavioral Disorders
Georgia	1,289.5	489.3	255.3	514.5	531.5
Butts	1,082.1	481.7	349.1	530.5	228.7
Henry	1,175.3	457.4	247.4	564.3	213.9
Lamar	1,121.9	539.3	253.0	349.4	379.7
Newton	1,385.5	530.7	414.5	417.5	311.4
Pike	1,293.9	547.1	279.2	430.9	347.2
Spalding	1,467.4	501.7	382.8	558.0	353.4
By Race**					
White	1,179.10	542.40	354.30	516.20	274.50
Black	1,336.30	385.10	254.80	514.00	263.50
Hispanic‡	ND	ND	ND	ND	ND
Asian	885.60	251.40	ND	209.80	ND
Native American	1,124.20	661.40	271.20	505.60	ND
Pacific Islander	ND	ND	ND	ND	0.00
Multiracial‡	2,332.30	416.80	301.90	468.90	529.10

ND for rates: Rates based on 1-4 events are not shown N/A Rates indicate that no population exists for the query selected.

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Multiracial is a person declaring 2 or more of these races.*

Obesity

At the time of this report, high body mass index (BMI) is a health issue throughout the country, with this community as no exception. More than one in four adults is obese. Diabetes is a health concern in Butts, Lamar and Spalding counties, where morbidity rates are elevated and mortality rates are higher than in the rest of the area.

Table 12 | Selected Adult BMI and Diabetes Indicators*†

By Region	Adult Obesity (2014)	Diagnosed Diabetes (2013)	Diabetes discharge rate* (2013-17)	Diabetes mortality* (2013-17)
Georgia	30.0%	10.6%	188.1	21.7
Butts	30.2%	11.7%	197.9	31.6
Henry	32.8%	13.5%	155.3	18.8
Lamar	30.0%	11.7%	253.8	51.5
Newton	31.8%	10.4%	186.0	28.7
Pike	27.6%	11.7%	155.5	21.1
Spalding	31.9%	12.9%	258.5	34.9
By Race**				
White	ND	ND	160.5	24.3
Black	ND	ND	241.3	34.2
Hispanic‡	ND	ND	ND	0.0
Asian	ND	ND	77.7	ND

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

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

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

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, this community reflects higher cardiovascular disease when compared to the nation and shows higher morbidity and mortality related to obstructive heart disease (where data is available). Community input suggests that it is difficult to secure cardiology services, which may be related to higher mortality rates. Residents living in Newton County experience higher-than-average hospital discharge rates due to hypertensive heart disease. All residents in the service area experience higher stroke-related mortality when compared to the state average.

Table 13 | Selected Cardiovascular Condition Indicators (2013-2017)*†

By Region	Obstructive heart disease/heart attack discharge rate*	Obstructive heart disease mortality*	Hypertensive heart disease discharge rate*	Hypertensive heart disease mortality*	Stroke mortality*	Stroke Prevalence (2015)
Georgia	265.0	76.4	39.0	16.2	43.0	3.97%
Butts	373.9	122.0	19.7	8.8	45.4	4.50%
Henry	243.7	48.7	33.6	32.6	47.2	4.20%
Lamar	357.9	98.7	29.4	9.9	60.2	3.30%
Newton	360.3	64.5	69.0	18.9	43.7	4.90%
Pike	329.9	58.5	17.8	5.3	64.8	3.60%
Spalding	388.9	92.2	20.8	22.8	54.7	4.40%
By Race**						
White	343.5	72.6	31.7	22.1	46.4	ND
Black	254.0	63.4	49.8	29.4	55.4	ND
Hispanic‡	ND	36.8	ND	16.1	33.0	ND
Asian	106.0	ND	ND	ND	30.9	ND

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

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

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

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

Cancer

Cancer rates are elevated in Georgia when compared to the national average. There are higher morbidity rates for all types of cancer throughout the service area where data is available.

Table 14 | Selected Cancer Indicators (2011-2017)*†

By Region	Breast cancer incidence (2011-15)	Cervical cancer incidence (2011-15)	Colon and rectum cancer incidence (2011-15)	Prostate cancer incidence (2011-15)	Lung cancer incidence (2011-15)	Cancer mortality (2013-17)
Georgia	125.2	7.8	41.8	123.3	64.9	160.7
Butts	112.0	ND	39.9	122.3	86.1	183.5
Henry	133.3	7.1	41.9	161.2	57.4	155.3
Lamar	121.1	ND	49.5	140.4	81.2	184.6
Newton	132.8	10.4	46.5	126.3	74.9	183.9
Pike	106.5	ND	47.3	127.6	66.6	191.3
Spalding	131.3	12.7	48.2	151.5	79.5	196.1
By Race**						
White	129.2	ND	41.3	115.7	75.8	179.0
Black	ND	ND	56.1	235.9	51.4	176.4
Hispanic‡	146.0	ND	ND	190.1	ND	75.7
Asian	131.9	ND	ND	ND	ND	69.9

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

† *CARES Engagement Network: National Cancer Institute and Center for Disease Control and Prevention, State Cancer Profiles: statecancerprofiles.cancer.gov*
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

* *Age adjusted, per 100,000 population*

** *Six-county aggregate*

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

Asthma

Residents of Spalding County suffer from higher morbidity rates for asthma.

Table 15 | Selected Respiratory Indicators (2013-2017)*†

By Region	Asthma discharge rate*	Asthma ER visit rate*
Georgia	86.5	551.6
Butts	70.5	578.6
Henry	60.2	396.5
Lamar	58.8	546.5
Newton	83.9	745.4
Pike	61.9	266.5
Spalding	129.8	770.1
By Race**		
White	68.2	334.0
Black	96.6	853.4
Hispanic‡	ND	ND
Asian	12.4	93.4

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

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

* *Age adjusted, per 100,000 population*

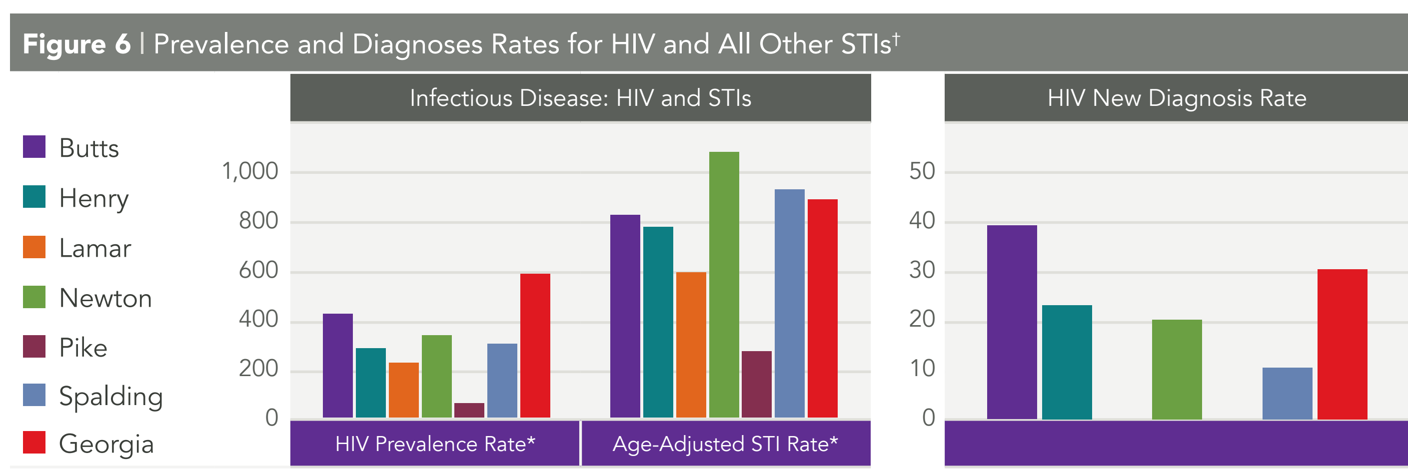
** *Six-county aggregate*

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

Sexually Transmitted Infections

The metro Atlanta area has some of the highest morbidity rates for HIV and AIDS in the nation. Where data is available, Butts and Newton counties show higher rates of HIV when compared to the rest of the service area. Residents in Butts County have higher diagnostic and prevalence rates of HIV than residents in any other county in the service area.

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



0.00 can result from sample size and margin of error

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

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

* *Per 100,000 population*

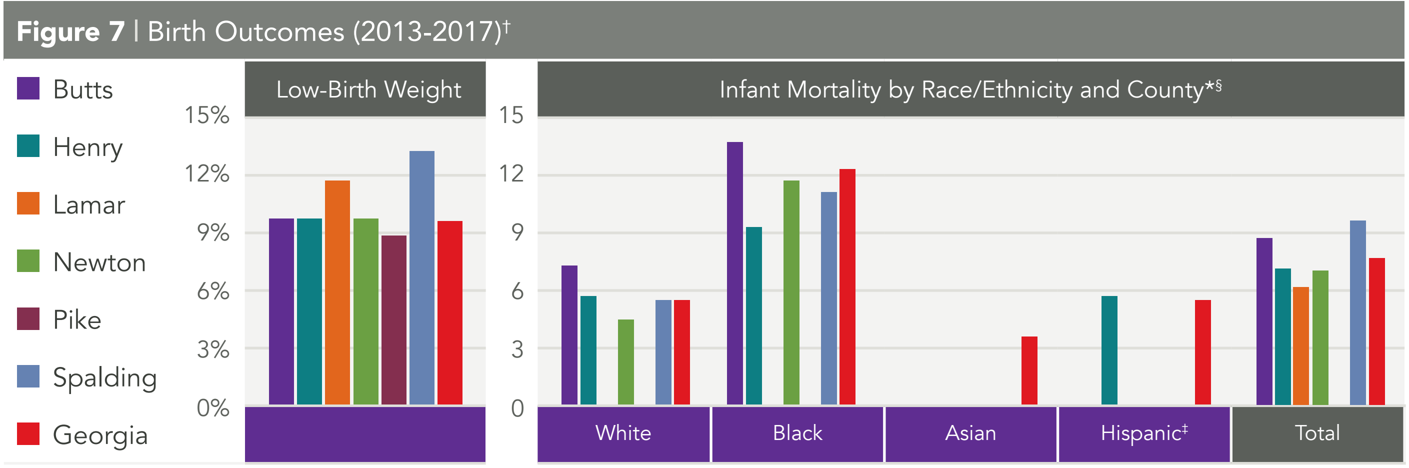
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birth-weight infants and infant mortality, among other issues.[13]

Health Summit participants prioritized birth outcomes as one of the most pressing issues in their community. Also, access to and appropriate use of prenatal care and birthing services were identified as pressing health needs during the hospitals' Regional Health Board listening sessions and the Health Summit. In interviews, community leaders discussed the lack of health education as a facilitating factor for risky sexual behaviors, which leads to teen pregnancy and a cycle of economic hardships. Input gathered from residents during a focus group also cited the limited education offered to youth about risky sexual behaviors and lack of adult supervision of youth as driving forces behind poor birth outcomes and higher rates of sexually transmitted infections (STIs).

Figure 7 shows all counties in the service area have higher rates of low-birth-weight births than the state average, while Butts and Spalding counties have higher rates of infant mortality. Infant mortality data was not available for Pike County.

Figure 7 | Birth Outcomes (2013-2017)†



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

* Number of infant deaths per 1,000 live births

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

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

Injury and Assault

Table 16 shows that injury and assault rates are higher than average in Butts and Spalding counties, as reflected in the 2018 report. Residents discussed high crime rates as one reason residents do not feel safe exercising outside. Residents of the service area also experience higher-than-average ED visit rates for motor vehicle crashes.

Table 16 | Selected Injury Indicators (2011-2017)†

	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia
Assault discharge rate (2013-17)*	25.8	10.8	12.4	15.3	ND	20.4	18.6
Motor vehicle crash ED visit rate (2013-17)*	1,743.5	1,234.2	1,447.1	1,679.1	1,254.9	2,021.5	1,099.9
Impaired Driving Deaths (2011-15)	14.3%	18.0%	23.1%	24.3%	27.3%	14.0%	23.4%

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

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

* *Age adjusted, per 100,000 population*

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

Behavioral Health

The need for behavioral health resources, particularly for underinsured and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. Summit participants discussed the prevalence of adverse childhood experiences (ACEs), lack of behavioral health providers and lack of family support as root causes for poor behavioral health outcomes.

Additionally, community leaders noted that residents with undiagnosed behavioral health issues often end up incarcerated due to limited resources. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia hospitals for mental health issues in 2016.[14] The data show that behavioral health is a significant community health need in the service area, with higher-than-average rates of ED use, hospital discharge for self-harm and suicide mortality.

Table 17 shows low behavioral health provider rates in all counties except Henry and higher-than-average ED utilization in Lamar and Spalding counties. Similar to the 2018 report, Pike County has the fewest providers and Spalding County shows the highest ED use. Input from community residents related to behavioral health suggested that residents may resist seeking care due to stigma, lack of insurance, unaffordable cost of care and the location of providers too far away from home.

Table 17 | Selected Behavioral Health Characteristics by County†

	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia
Mental health providers (2016)*	46.6	121.7	49.4	80.6	16.7	84.3	115.0
Poor mental health days (2015)**	3.7	3.6	4.0	3.8	3.6	4.1	3.8
Mental health ED rate (2017)*	864.4	965.1	1,181.3	1,015.7	664.6	1,502.4	1,094.6
Mental and behavioral disorder mortality (2013-17)*	31.4	29.5	46.2	34.3	30.5	33.3	37.4
Self-harm age-adjusted discharge rate (2013-17)*	27.6	30.4	40.4	28.2	19.5	25.4	32.7
Age-adjusted suicide mortality (2013-17)*	14.4	11.5	28.3	7.9	12.7	10.4	12.7

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

* *Age adjusted, per 100,000 population*

** *Age-adjusted average number of self-reported mentally unhealthy days per month among adults.*

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

Substance Abuse

In the last decade, substance abuse has become an increasing concern in many parts of the United States, specifically related to opioid abuse and overdose. According to a white paper written and presented to the State Senate by the Georgia Prevention Project's Substance Abuse Research Alliance:

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses including heroin,
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014 and
- Overdose deaths tripled between 1999 and 2013 in Georgia.[15]

Table 18 shows the increase of substance abuse overdoses in Henry, Newton and Spalding counties between 2007 and 2017. Butts and Spalding counties show the highest rates when compared to other service-area counties and the state. Each primary data source talked about substance abuse in the community, noting that methamphetamine is the most common drug used. Health Summit participants noted that opioid abuse is a present and growing challenge in their community, but not yet the sizeable challenge that it has become in surrounding areas.

Over the past 10 years, the rate of opioid-related overdoses in Butts and Spalding counties has been much higher than in Pike County and the state.

Table 18 | Rate of Drug Overdose by County (2007; 2017)†

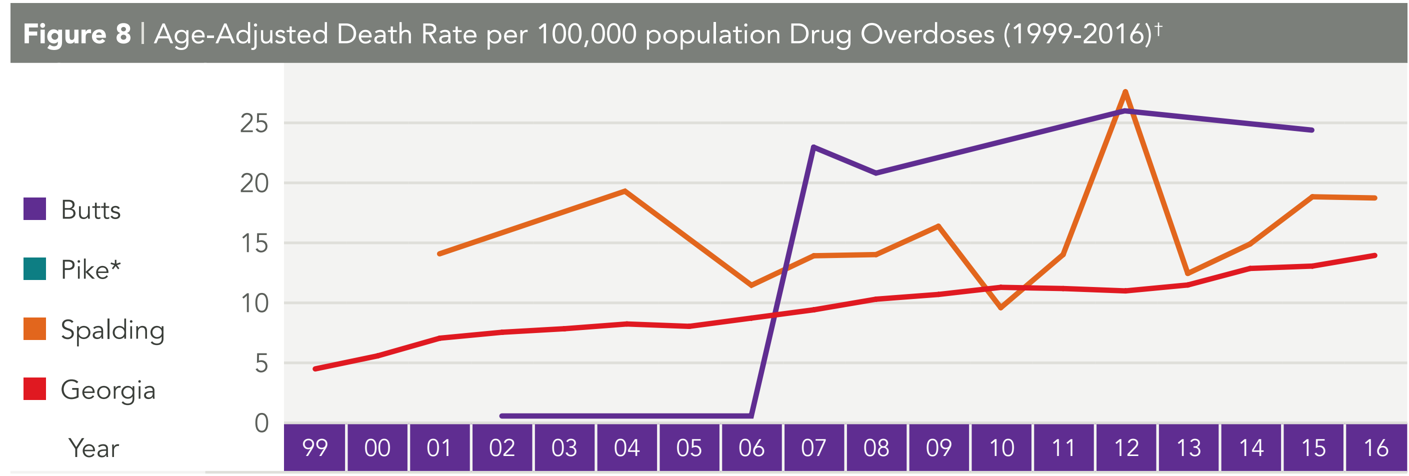
	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia
Drug overdoses (2007)*	22.8	5.9	ND	12.4	ND	13.6	8.6
Drug overdoses (2017)*	21.9	12.7	ND	13.8	ND	15.7	14.6

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

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

** Age adjusted, per 100,000 population*

Figure 8 | Age-Adjusted Death Rate per 100,000 population Drug Overdoses (1999-2016)†



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

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

There are existing resources throughout the service area that address the common health outcomes noted in this section.[16] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the health issues noted in this assessment.

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

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

Community Is **Compassion**

RALLYING PEOPLE AND RESOURCES

Community Input

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

Listening sessions were conducted with each hospital's Regional Health Board and individual key informant interviews were conducted with 13 community leaders. Hospital and community leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including public health, community health, epidemiology, social services and health disparities. The listening session and interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the CHNA.

Two focus groups were conducted to gather input from more than 20 residents living and working in the communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Focus group participants were asked to discuss their opinions related to the health status and outcomes; context, facilitating, and blocking factors of health; and what is needed to be healthier in their community. What follows is a summary of the community input gathered during this assessment process.

Summary of CHNA Community Input

WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital

Commonly Discussed Health Issues

Overutilization of the ED

Substance abuse (marijuana, methamphetamine, cocaine)

Medication noncompliance

Chronic conditions:

- Cardiovascular (i.e., hypertension and congestive heart failure)
- Diabetes (unmanaged and undiagnosed)
- Obesity (adult and child)
- Cancer
- COPD
- STIs
- Teen pregnancy

Commonly Discussed Causes

Geographic location of health services coupled with limited transportation options, with no formal public transportation (e.g., babies born in ED at Sylvan Grove)

Low health literacy/awareness of:

- Available services
- Prevention
- Healthy practices
- Appropriate use of health services
- Medication management

Low health literacy/awareness of:

- Primary and specialty providers
- Walk-in/same-day appointments
- Behavioral health (psychiatric and crisis)
- Engaging residents (education and prevention)
- Substance abuse (in- and outpatient medical stabilization)
- After-hours urgent care
- Prenatal care
- Care coordination for residents seeking primary care in the ED
- Trauma care

Restricted insurance options that change from year to year

Lack of safety (high crime rates, gang activity and poor infrastructure)

Unhealthy cultural preferences and traditions

Unaffordable cost:

- Prescriptions
- Uninsured care

Poor access to:

- Healthy nutrition
- Physical activity

Undocumented residents do not have access to primary care or prenatal care and resist seeking care due to fear of deportation

Lack of appropriate supervision/ risky behavior of youth

Challenges related to race and ethnicity — e.g., racism, health disparities

Low educational attainment

Poverty

Substandard/unaffordable housing

Decision-makers do not always have adequate information.

Poor employment options (temp agencies)

Common Recommendations

Engage community partners to:

- Better understand health needs
- Improve health literacy
- Expand community engagement

Disseminate educational material about healthy habits to youth (i.e., sex, nutrition, behavioral health awareness, physical education and drug education)

Conduct health seminars that will promote health education

Develop a local homeless shelter to address drug abuse and family welfare

Improve the readability of educational materials by decreasing the reading level and translating into most common languages spoken in the service area

Increase transportation options

Increase the use of mobile programs to:

- Teach healthy habits to youth and their families
- Offer remote services (i.e., mobile medical centers, paramedic outreach)

Offer a hotline for residents that find navigating services problematic

Advocate for policies that improve health (payment reform, etc.)

Increase access to care:

- Increase the number of providers (i.e., safety-net clinics, primary care, dental, etc.)
- After-hours care

Vulnerable Populations

- People of color — African-Americans and Hispanics
- Residents without access to transportation
- Low socioeconomic status (poverty and education)
- People diagnosed with behavioral health challenges or chronic disease
- Uninsured and underinsured
- Undocumented residents

Geographic Areas of Interest

- Barnesville
- Northwest Griffin – trailer parks
- East Griffin
- The Heights
- Fairmont community
- Pockets in Jackson

Community Is **Collaboration**

STRONGER TOGETHER

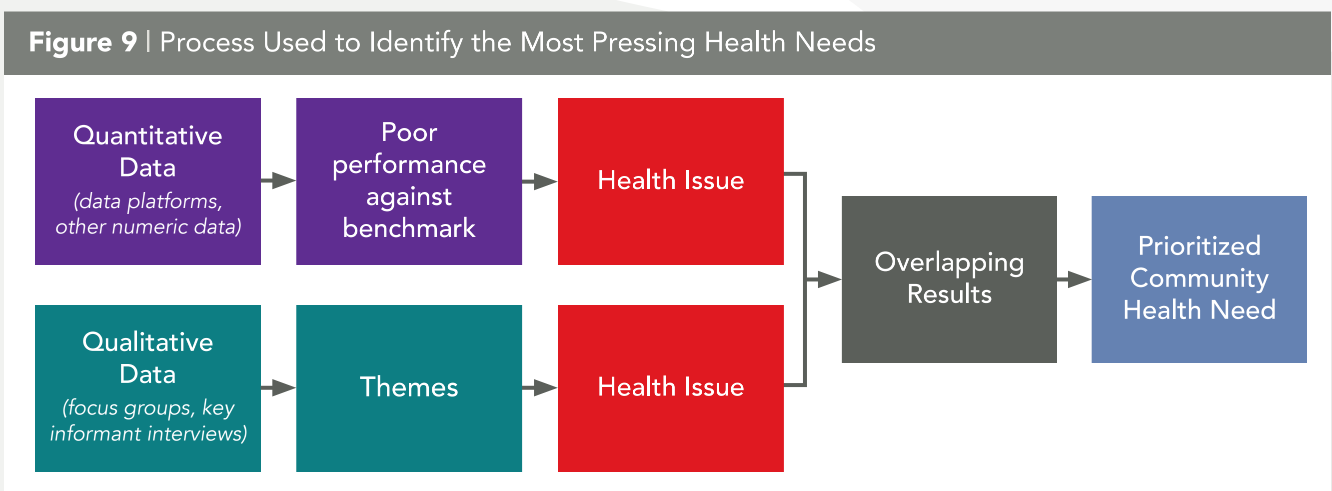
Community Health Priorities

WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital engaged 24 community and hospital leaders to help establish the community priorities for the areas served by both hospitals during a community Health Summit held on March 1, 2018, at the Griffin Regional Welcome Center.

Community stakeholders represented organizations serving residents in the WellStar Spalding Regional and WellStar Sylvan Grove hospitals' community. An in-depth summary of the results, along with a description of the participants, methods used and collection period, is located in the Primary Data and Community Input Section of the Appendix.

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

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



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

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

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

1 Wellness education

Health Summit participants considered education to be the most pressing health issue within the hospitals' community. Some concerns discussed were related to low levels of health literacy, language barriers, poor reading comprehension, limited information dissemination and lack of awareness.

2 Access to appropriate care

Health Summit participants discussed the limited access that residents have to appropriate care when and where it is needed. Several of the concerns discussed were access to safety-net providers, number of providers in the community (safety net, primary care, dental, etc.) and access to and affordability of insurance options.

3 Transportation

4 Access to behavioral healthcare

5 Birth outcomes

Participants discussed the limited transportation options that residents have, coupled with the rural nature of the area restricting access to employment options, healthcare, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of comprehensive public transportation that is reliable and the distance residents must travel to secure necessities.

Health Summit participants prioritized behavioral health as one of the most pressing issues in their communities. Poor behavioral health in this service area was attributed to the limited number of behavioral health professionals in the area, the number of ACEs, limited family supports, substance abuse and stigma.

Lastly, poor birth outcomes were attributed to the limited number of providers (e.g., OB/GYN and planned parenting), lack of affordable insurance options available to women before becoming pregnant and lack of awareness about healthy practices.

Appendix

Consultant Qualifications

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

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

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

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

Secondary Data

(July 2018 – November 2018)

County Health Rankings (2018)	Butts	Henry	Lamar	Newton	Pike	Spalding
	102	22	92	54	39	137
Age Distribution	Butts	Henry	Lamar	Newton	Pike	Spalding
0-14	17.2%	20.1%	16.8%	20.9%	18.0%	19.9%
15-17	3.9%	5.1%	4.3%	4.8%	4.8%	4.0%
18-24	9.6%	10.4%	12.7%	10.2%	9.8%	8.8%
25-34	13.5%	12.2%	12.3%	12.1%	11.0%	12.7%
35-54	26.9%	28.5%	23.1%	27.1%	26.8%	24.5%
55-64	12.8%	12.0%	13.0%	11.7%	13.2%	12.5%
65+	16.0%	11.7%	17.9%	13.3%	16.5%	17.6%
Racial/Ethnic Distribution	Butts	Henry	Lamar	Newton	Pike	Spalding
White	69.4%	42.6%	63.5%	49.5%	84.5%	58.4%
Black	24.8%	43.9%	31.0%	41.5%	11.2%	33.8%
Hispanic‡	3.6%	7.5%	2.9%	5.5%	1.9%	4.7%
Asian	0.6%	3.3%	0.5%	1.2%	0.4%	0.9%
All Others	1.6%	2.7%	2.1%	2.3%	2.1%	2.2%

County Health Rankings and Roadmaps: countyhealthrankings.org

Demographics Expert 2.7, 2018 Demographic Snapshot

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

Socioeconomic[a] (per 100,000 pop.)	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
On-time high school graduation (2014-15)	86.0%	84.0%	92.5%	81.0%	84.0%	69.0%	80.0%	88.2%
Free and reduced price lunch (2014-15)	86.9%	51.4%	71.2%	69.3%	40.5%	76.2%	62.4%	52.6%
Unemployment rate (2017)	5.1%	4.5%	5.0%	4.9%	4.1%	5.2%	4.3%	4.0%
Population below 100% fpl (2012-16)	20.5%	12.1%	22.2%	17.0%	12.1%	23.6%	17.8%	15.7%
Children below 100% fpl (2012-16)	31.8%	18.0%	31.5%	25.1%	16.2%	35.1%	25.4%	23.6%
Adults with no high school diploma (2012-16)	22.8%	10.6%	16.0%	15.6%	12.1%	20.7%	14.2%	38.4%
Uninsured population (2012-16)	23.1%	13.1%	18.1%	13.5%	16.6%	16.9%	15.8%	11.8%
Healthcare Access[a] (per 100,000 pop.)	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
Primary care providers* (2014)	25.7	51.0	43.9	34.7	16.9	51.6	72.9	87.8
Dentists* (2015)	17.0	33.5	11.0	17.1	16.7	32.8	49.2	65.6
Mental health providers * (2016)	46.6	121.7	49.4	80.6	16.7	84.3	115.0	200.7
Recent primary care visit (2014)	82.4	81.4	82.9	84.1	81.5	83.7	82.4	81.4
Federally Qualified Health Centers* (2016)	0.0	0.0	0.0	0.0	0.0	1.6	0.0	2.4
Health Professional Shortage Area - Dental (2016)	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	37.9%	37.8%

Health Determinants	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
Current smokers (2015)	17.5%	16.5%	18.0%	16.8%	15.3%	18.9%	17.0%	15.7%
Healthy food stores (low access) (2014)	16.6%	49.3%	24.6%	32.6%	0.0%	26.4%	30.8%	22.4%
Exercise opportunities – access (2010/2014)	40.0%	86.0%	68.2%	75.7%	46.7%	73.7%	75.9%	84.3%
Driving alone to work, long distances (>60 mins) (2012-16)	48.1%	54.3%	44.8%	46.4%	52.7%	43.9%	40.0%	34.8%
Clinical Care & Prevention	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
SNAP Benefits (2012-2016)	7.1%	9.3%	10.6%	15.8%	4.4%	13.3%	15.3%	19.1%
Physical inactivity – adults (2013)	28.0%	22.6%	26.2%	28.5%	25.7%	28.0%	23.1%	21.7%
Preventable hospital events* (2014)	66.6%	42.2%	67.1%	58.6%	59.1%	59.1%	52.3%	50.4%
Teen births* (15-19 yrs.) (2008-14)	4.5%	26.2%	31.7%	38.8%	32.1%	63.7%	38.5%	32.1%
Other Health Indicators (per 100,000 pop.)	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
Population with any disability (2012-16)	15.1	10.7	15.8	14.9	13.6	16.6	0.1	0.1
Impaired driving deaths (2011-2015)	14.3	18.0	23.1	24.3	27.3	14.0	0.2	†
Poor physical health days (2015)	4.0	3.4	4.2	3.9	3.6	4.5	3.9	3.7
Poor mental health days (2015)	3.7	3.6	4.0	3.8	3.6	4.1	3.8	3.7
Breast cancer incidence* (2011-15)	106.0	129.4	125.4	124.0	107.2	122.8	125.2	124.7
Stroke prevalence (2015)	4.5	4.2	3.3	4.9	3.6	4.4	0.0	0.0
Age-adjusted drug overdoses (2007)	22.8	5.9	ND	12.4	ND	13.6	8.6	†
Age-adjusted drug overdoses (2017)	21.9	12.7	ND	13.8	ND	15.7	14.6	†
Years of potential life lost (ypll75) (2017)	2,450.5	15,378.0	1,774.0	9,473.5	1,270.5	7,081.0	763,397.0	†
Mental health ER rate* (2017)	1,355.6	791.9	1,422.2	1,019.4	1,257.6	2,242.5	1,069.1	†
Mental and behavioral disorder mortality (2013-17)*[d]	36.6	32.7	42.6	60.5	33.0	37.2	42.5	†
Self-harm age-adjusted discharge rate* (2013-17)	46.1	18.0	40.6	31.3	24.2	39.0	32.7	†
Age-adjusted suicide mortality (2013-17)*	16.5	9.9	14.7	14.0	13.6	12.6	12.7	†
Age-adjusted opioid overdoses (2007)	ND	ND	ND	6.2	ND	ND	3.4	†
Age-adjusted opioid overdoses (2017)	ND	9.5	ND	8.6	ND	8.2	9.7	†
Assault age-adjusted discharge rate (2013-17)	25.8	10.8	12.4	15.3	ND	20.4	18.6	†
Diagnosed diabetes prevalence (2013)	11.7%	13.5%	11.7%	10.4%	11.7%	12.9%	10.60%	†
Diabetes age-adjusted discharge rate (2013-17)	197.9	155.3	253.8	186	155.5	258.5	188.1	†
Diabetes age-adjusted mortality rate (2013-2017)	31.6	18.8	51.5	28.7	21.1	34.9	21.7	†
Adults obesity (2014)	30.2%	32.8%	30.0%	31.8%	27.6%	31.9%	30.0%	†
Obs. Heart disease/heart attack-age adjusted discharge rate* (2013-17)	373.9	243.7	357.9	360.3	329.9	388.9	265.0	†

Other Health Indicators (per 100,000 pop.)	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
Hypertensive heart disease age-adjusted discharge rate* (2013-17)	19.7	33.6	29.4	69.0	17.8	20.8	39.0	†
Asthma ER visit rate* (2017)	70.5	60.2	58.8	83.9	61.9	129.8	551.6	†
Motor vehicle crash ER visit rate* (2017)	1743.5	1234.2	1447.1	1679.1	1254.9	2021.5	1099.9	†
HIV prevalence rate (2015)	424.7	283.8	224.9	336.3	59.5	301.2	588.0	†
HIV new diagnosis (2016)	39.4	23.6	ND	20.7	ND	11.2	30.7	†
Age-adjusted STD rate except congenital syphilis (2017)	827.5	779.0	592.9	1085.9	271.9	933.1	890.4	†
% Low birth weight (< 2500g) (2013-17)	9.7%	9.9%	11.6%	9.7%	8.8%	13.1%	9.6%	†
Infant mortality – total (2013-17)	8.6	7.0	6.0	6.9	ND	9.5	7.5	†
Infant mortality – non-Hispanic (2013-17)	7.2	5.6	ND	4.4	ND	ND	5.4	†
Infant mortality – Black (2013-17)	13.6	9.2	ND	11.6	ND	ND	12.2	†

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

Center for Disease Control and Prevention: www.cdc.gov/diabetes/data/countydata/countydataindicators.html

Kaiser Permanente CHNA Data Platform: kp-chna.ip3app.org

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

Center for Disease Control and Prevention - NCHHSTP Atlas Plus: www.cdc.gov/nchhstp/atlas/index.htm

† *This data set includes Georgia data, and does not include an equivalent data set for the U.S.*

2017-2018 Community Need Index (CNI) - WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	Income Score	Limited English	Minority	Culture Score	No High School Diploma	Education Score	Unemployed	Uninsured	Insurance Score	Renting	Housing Score
30204	Lamar	0.2	4.8	19%	29%	63%	5.0	0.2%	44%	5.0	15%	4.0	15%	22%	5.0	37%	5.0
30223	Spalding	0.0	4.8	14%	32%	51%	4.0	0.9%	47%	5.0	23%	5.0	14%	25%	5.0	42%	5.0
30224	Spalding	0.0	4.4	15%	22%	50%	4.0	0.4%	34%	4.0	17%	4.0	10%	21%	5.0	34%	5.0
30228	Henry	0.0	3.6	5%	20%	36%	3.0	1.9%	69%	5.0	10%	3.0	9%	11%	4.0	21%	3.0
30233	Butts	0.2	4.2	12%	24%	47%	4.0	0.6%	30%	4.0	24%	5.0	10%	17%	5.0	25%	3.0
30292	Pike	0.4	3.6	6%	13%	49%	4.0	0.1%	16%	3.0	14%	4.0	8%	10%	4.0	20%	3.0
	Butts Total	**0.2**	**4.2**	**13%**	**25%**	**49%**	**4.1**	**0.5%**	**31%**	**4.0**	**23%**	**4.9**	**10%**	**17%**	**5.0**	**24%**	**3.0**
	Henry Total	**-0.2**	**3.6**	**7%**	**16%**	**35%**	**2.5**	**1.5%**	**57%**	**4.7**	**10%**	**2.8**	**8%**	**11%**	**4.0**	**25%**	**2.9**
	Lamar Total	**0.2**	**4.5**	**22%**	**26%**	**62%**	**5.0**	**0.1%**	**37%**	**4.5**	**15%**	**4.0**	**15%**	**21%**	**5.0**	**32%**	**4.2**
	Newton Total	**-0.1**	**3.9**	**13%**	**21%**	**35%**	**3.0**	**5.6%**	**71%**	**4.8**	**12%**	**3.0**	**9%**	**15%**	**4.3**	**43%**	**4.5**
	Pike Total	**-0.3**	**4.1**	**12%**	**20%**	**34%**	**2.8**	**1.0%**	**51%**	**4.8**	**15%**	**3.9**	**9%**	**14%**	**4.4**	**25%**	**3.2**

Truven Health Analytics, Community Needs Index (2018)

Ranked Causes: Age-Adjusted Death Rate, State and County Comparison (2013-2017)					
	All Races	White	Black	Asian	Georgia
Prioritized	1. All COPD Except Asthma 2. Cerebrovascular Disease 3. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease 4. Diabetes Mellitus 5. Nephritis, Nephrotic Syndrome and Nephrosis	1. All COPD Except Asthma 2. Cerebrovascular Disease 3. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease 4. Diabetes Mellitus 5. Pneumonia	ND	ND	ND
#1	Ischemic Heart and Vascular Disease – 1,493	Ischemic Heart and Vascular Disease – 1,114	Ischemic Heart and Vascular Disease – 371	Cerebrovascular Disease – 10	Ischemic Heart and Vascular Disease – 41,242
#2	All COPD Except Asthma – 1,159	All COPD Except Asthma – 1,025	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease – 298	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease – 5	Malignant Neoplasms of the Trachea, Bronchus and Lung – 22,349
#3	Malignant Neoplasms of the Trachea, Bronchus and Lung – 1,014	Malignant Neoplasms of the Trachea, Bronchus and Lung – 784	Cerebrovascular Disease – 281	Ischemic Heart and Vascular Disease – 5	All COPD except Asthma – 22,123
#4	Cerebrovascular Disease – 955	Cerebrovascular Disease – 661	Malignant Neoplasms of the Trachea, Bronchus and Lung – 224	Malignant Neoplasms of the Trachea, Bronchus and Lung – 4	Cerebrovascular Disease – 20,481
#5	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease – 838	Alzheimers Disease – 576	Diabetes Mellitus – 196	Diabetes Mellitus – 4	All Other Mental and Behavioral Disorders – 17,375

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

Racial/Ethnic Disparities by County	Butts	Henry	Lamar	Newton	Pike	Spalding	Georgia	U.S.
% Uninsured population (2012-16)	15.78%	13.06%	18.08%	13.49%	16.63%	16.86%	15.80%	11.70%
Annual cervical cancer incidence rate (2011-15)*	Supp.	7.1	Supp.	10.4	Supp.	12.7	7.8	7.5
Annual colon and rectum cancer incidence rate (2011-15)*	39.90	41.90	49.50	46.50	47.30	48.20	41.80	39.20
Annual prostate cancer incidence rate (2011-15)*	122.30	161.20	140.40	126.30	127.60	151.50	123.30	109.00
Annual lung cancer incidence rate (2011-15)*	86.10	57.40	81.20	74.90	66.60	79.50	64.90	60.20
Coronary heart disease mortality, age-adjusted death rate (2012-16)*	91.70	50.80	94.20	70.60	69.90	99.20	79.08	99.60
Infant mortality rate (2013-17)***	8.60	7.00	6.00	6.90	ND	9.50	7.50	ND
Age-adjusted asthma discharge rate (2013-17)*	70.50	60.20	58.80	83.90	61.90	129.80	86.50	ND
Age-adjusted asthma ER visit rate (2013-17)*	578.60	396.50	546.50	745.40	266.50	770.10	551.60	ND
Stroke mortality, age-adjusted death rate (2013-17)*	45.40	47.20	60.20	43.70	64.80	54.70	43.00	ND
Breast cancer mortality, age-adjusted death rate (2013-17)*	10.40	13.80	10.50	19.10	12.60	18.00	12.30	ND
Diabetes discharge age-adjusted rate* (2013-17)	197.90	155.30	253.80	186.00	155.50	258.50	188.10	ND
Diabetes age-adjusted mortality (2013-17)*	31.60	18.80	51.50	28.70	21.10	34.90	21.70	ND
Obstructive heart disease discharge rate (2013-17)*	373.90	243.70	357.90	360.30	329.90	388.90	265.00	ND
Obstructive age-adjusted heart disease mortality (2013-17)*	122.00	48.70	98.70	64.50	58.50	92.20	76.40	ND
Hypertensive heart disease age-adjusted discharge rate (2013-17)*	19.70	33.60	29.40	69.00	17.80	20.80	39.00	ND
Hypertensive heart disease age-adjusted mortality (2013-17)*	8.80	32.60	9.90	18.90	5.30	22.80	16.20	ND
Cancer mortality, age-adjusted death rate (2013-17)*	183.50	155.30	184.60	183.90	191.30	196.10	160.70	ND

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

Community Commons CHNA Portal: CHNA.org

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

* *per 100,000 population*

*** *per 1,000 live births*

Racial/Ethnic Disparities (continued)	White**	Black**	Asian**	Hispanic**‡
% Uninsured population (2012-16)	12.76%	13.83%	20.20%	12.76%
Annual cervical cancer incidence rate (2011-15)*	ND	ND	ND	ND
Annual colon and rectum cancer incidence rate (2011-15)*	41.30	56.10	ND	ND
Annual prostate cancer incidence rate (2011-15)*	115.70	235.90	ND	190.10
Annual lung cancer incidence rate (2011-15)*	75.80	51.40	ND	ND
Coronary heart disease mortality, age-adjusted death rate (2012-16)*	74.50	54.90	ND	ND
Infant mortality rate (2013-17)***	5.20	11.00	ND	5.20
Age-adjusted asthma discharge rate (2013-17)*	68.20	96.60	12.40	ND
Age-adjusted asthma ER visit rate (2013-17)*	334.00	853.40	93.40	ND
Stroke mortality, age-adjusted death rate (2013-17)*	46.40	55.40	30.90	33.00
Breast cancer mortality, age-adjusted death rate (2013-17)*	14.10	18.20	ND	8.50
Diabetes discharge age-adjusted rate* (2013-17)	160.50	241.30	77.70	ND
Diabetes age-adjusted mortality (2013-17)*	24.30	34.20	ND	0.00
Obstructive heart disease discharge rate (2013-17)*	343.50	254.00	106.00	ND
Obstructive age-adjusted heart disease mortality (2013-17)*	72.60	63.40	ND	36.80
Hypertensive heart disease age-adjusted discharge rate (2013-17)*	31.70	49.80	ND	ND
Hypertensive heart disease age-adjusted mortality (2013-17)*	22.10	29.40	ND	16.10
Cancer mortality, age-adjusted death rate (2013-17)*	179.00	176.40	69.90	75.70

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

Community Commons CHNA Portal: CHNA.org

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

* *per 100,000 population*

** *Six-County Aggregate*

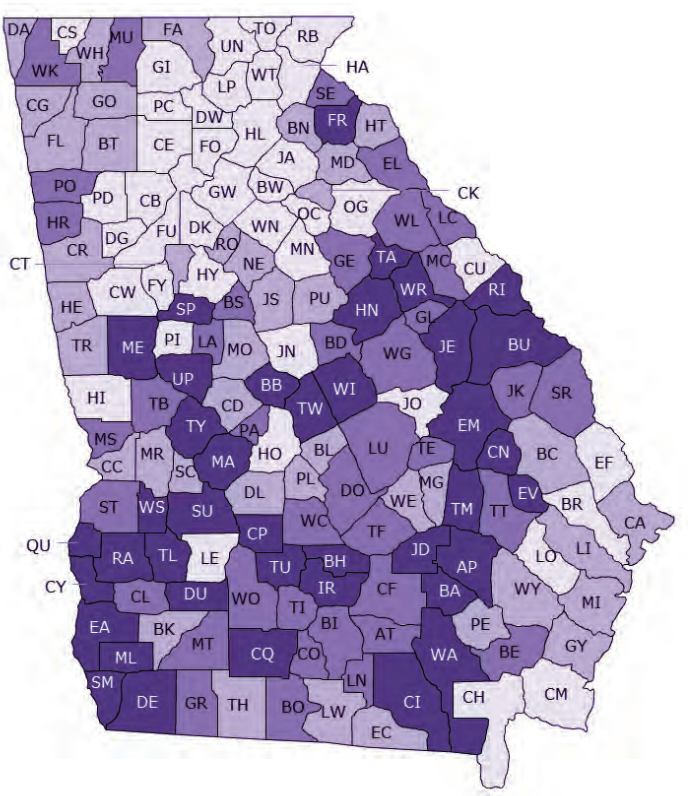
*** *per 1,000 live births*

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

Maps

Health Outcomes

The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked No. 1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

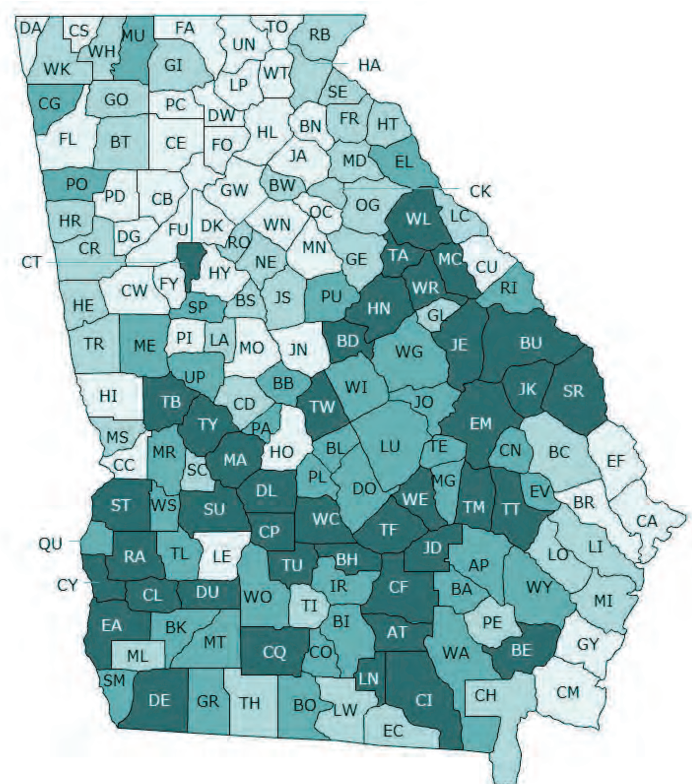


	Rank
	1-40
	41-80
	81-119
	129-159

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

Health Factors

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



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

Primary Data and Community Input

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

CHNA Collaborators

Collaborator	Areas of Service
Butts Collaborative	Key Informant
Butts County Hospital Authority Jean Dodson, *Former Administrator/ Board Member*	Key Informant Summit Attendee
City of Jackson Mayor Kay Pippin Don Cook, *City Council*	Summit Attendee Key Informant
Georgia Association for Positive Behavior Support Jason Byars, *President/District Coordinator*	Key Informant
Georgia Department of Public Health	Key Informant
Griffin Housing Authority	Summit Attendee
Griffin-Spalding County Board of Education Zach Holmes, *Chairman*	Key Informant
Griffin-Spalding County Health Department Cynthia Tidwell, *Nursing Director*	Key Informant
Jackson Police Department Chief James Morgan	Key Informant
Jackson United Methodist Church Pastor Chris Shurtz	Key Informant
Lamar County and Upson County Health Departments Sherry Farr, *County Nurse Manager*	Summit Attendee Key Informant
NAACP	Summit Attendee
Project AWARE	Key Informant
Rock Springs Clinic Bobbi Riley, *Administrative Director*	Key Informant
Southside Medical Center Katherine Lovell, *Corporate Editor/Grants Management* Carl Henry, *Practice Administrator*	Summit Attendee Key Informant
Spalding Collaborative Regina Abbott, *Executive Director*	Key Informant
Spalding County Fire Department Glenn Polk, *Deputy Chief-Administration*	Key Informant

Collaborator	Areas of Service
State Farm Insurance Tim Broyles, *Agent*	Summit Attendee
The Emergency Preparedness Group Sandra Hone, *President*	Summit Attendee
United Way *Denise Quick, Executive Director*	Summit Attendee Key Informant
University of Georgia Archway Partnership Kristen Miller, *Archway Professional*	Summit Attendee
WellStar Health System, WellStar Spalding Regional and WellStar Sylvan Grove Kristin Caudell, *Director, Community Education & Outreach* Geraldine Chandler, *Operations Manager – Food Services* Clay Davis, *Board Member* Jean Dodson, *Retired Director of Nursing/Sylvan Grove Regional Health Board Member* Stacey Hancock, *Vice President – Human Resources* Sherry Henson, *Navigator* David Hitson, *M.D. / Spalding Regional Health Board Member* Tamara Ison, *SVP, Hospital President* Kem Mullins, *Executive Vice President / Sylvan Grove Regional Health Board Member* Philip Osehobo, *CMO/VPMA* Cecelia Patellis, *Assistant Vice President, Community Education & Outreach* Bonnie Pfrogner, *Regional Health Board Member* Carrie Plietz, *Executive Vice President & Chief Operating Officer / Spalding Regional Health Board Member* Kim Stephens, *Community Education and Outreach* Sandy Stovall, *Community Paramedic* Shara Wesley, *Director, Community Benefit*	Listening Session and/or Summit Participant
Unknown Affiliation Lucy Cawthon Turner Duffey	Summit Attendee

WellStar Spalding Regional Hospital and Sylvan Grove Hospital

Community Health Summit

The following is a summary of the WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital Health Summit held on March 1, 2018, at Griffin Regional Welcome Center. The Health Summit was facilitated by Georgia Health Policy Center (GHPC) in partnership with WellStar Health System and lasted approximately three hours. The 24 participants included employees of WellStar and community stakeholders. Community stakeholders represented organizations serving residents in the primary service areas of WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

The organizations that took part in the Health Summit included:

- WellStar Spalding EMS
- Lamar County and Upson County Health Departments
- WellStar Spalding Regional and WellStar Sylvan Grove Hospitals
- Southside Medical Center at Hope Health Clinic
- University of Georgia Archway Partnership
- State Farm Insurance
- Griffin-Spalding County Board of Education
- Griffin-Spalding County United Way
- The Emergency Preparedness Group
- City of Jackson

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

Group Recommendations and Problem Identification

During the Health Summit, participants prioritized five community health needs of residents within the primary service area served by both hospitals: wellness education, access to appropriate care, transportation, access to behavioral healthcare and birth outcomes. The following is a summary of the input participants offered when asked about contributing factors, potential solutions and community resources to address the health priorities.

Wellness Education

Health Summit participants considered education to be the most pressing health issue within the WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital community. Some concerns that Health Summit participants discussed were related to low levels of health literacy, language barriers, poor reading comprehension, limited information dissemination and lack of awareness.

Contributing Factors:

- Health literacy is low among youth and adults, and there are limited efforts to address this issue in the public setting (e.g., public schools, etc.).
- Residents in the community served by both hospitals are not always aware of how to be healthy (e.g., services available in the community, healthy behaviors, preventive practices, etc.).
- Residents could benefit from having more resources that offer educational information in the places they normally go (e.g., church, grocery stores, work, school, etc.). Recommended topics included family planning, HIV prevention, healthy eating, active living, insurance options, financial stability and other topics residents might value if asked.
- It is difficult to reach residents in rural areas due to limited access to methods and outlets that can and will effectively disseminate health information to broader audiences.
- Health information can be difficult to comprehend for some residents who have limited reading, vocabularies or English-speaking skills.

Recommendations:

- Develop partnerships among medical schools, residents, local schools, faith-based organizations and senior centers to better disseminate health knowledge, improve health literacy and understand ongoing health needs.
- Integrate health education into all school settings (primary to tertiary) to educate students and their parents. Several topics mentioned were related to overall wellness (nutritional education and chronic diseases), substance abuse, HIV/STIs, healthy coping mechanisms and life skills.
- Develop a marketing strategy to address the consequences of poor diet, lack of exercise, premarital sex, substance abuse, etc.
- Both hospitals could work to increase residents' awareness of local resources.
- All reading materials should be translated to an eighth-grade reading level, and into languages that are most commonly spoken, to broaden their application and effectiveness.
- Expand the use of mobile methods to reach residents with education and prevention efforts (e.g., mobile medical units, paramedic outreach, etc.).
- Coordinate community volunteers to educate residents in their areas of expertise (i.e., healthcare professionals, nutritionists, insurers, financial advisers, physical fitness trainers, etc.).
- Integrate health education into the workplace as a benefit offering to employees through workplace wellness programs and mobile health services.
- Increase the level of hospital participation in community seminars and health fairs that focus on health issues affecting residents in the area.

Access to Appropriate Care

Health Summit participants discussed the limited access that residents have to appropriate care when and where it is needed. Several of the concerns discussed were access to safety-net providers, number of providers in the community (safety net, primary care, dental, etc.) and access to and affordability of insurance options.

Contributing Factors:

- The number of providers is low in the region, which either means residents must travel to secure care (i.e., specialty care – OB/GYN, cardiology, endocrinology, etc.) or wait long periods of time to secure appointments in the area (if available). Care coordination is challenging when residents are seeking care at the ED and/or outside of the area.
- Uninsured residents have limited care options with few Federally Qualified Health Centers (FQHCs) and safety-net clinics in the region.
- There are very few local walk-in care options that offer residents access to convenient and affordable care for non-emergency issues after hours.
- Insurance options are limited and may be unaffordable for residents who are not able to secure full-time employment with medical benefits.
- Residents are using the ED to address nonemergency issues (i.e., primary care, behavioral health, dental, etc.).

Recommendations:

- Develop a long-term plan to recruit and retain more providers and specialists to the service area.
- Increase the number of safety-net clinics in the community to give under- and uninsured residents access to more affordable care.
- Increase the number of primary and urgent (walk-in and after-hours) care clinics.
- Provide care to residents in their current locations by offering services like mobile clinics equipped with Advanced Practice Providers, telehealth and paramedic outreach programs.
- Explore and try different approaches to educate people on available resources and how to access appropriate services and providers, including tapping into the network of leaders in local communities.
- Increase partnerships with existing providers to better meet the needs of the community.
- Advocate for tort reform at the state level to lower the overall cost of healthcare in the long run.

Transportation

Health Summit participants discussed the limited transportation options that residents have, coupled with the rural nature of the area restricting access to employment options, healthcare, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of a comprehensive public transportation that is reliable and the distance residents must travel to secure basic necessities.

Contributing Factors:

- Many families with limited incomes do not have access to reliable private transportation options (e.g., personal vehicles, ride sharing, etc.).
- The local transit system is not comprehensive or reliable enough for residents to get to and from the places they need to go (i.e., medical appointments, work, grocery store, etc.).
- The rural nature of the region presents health challenges to residents who do not have ready access to comprehensive and reliable methods of transportation due to the distance they must travel.

Recommendations:

- Hospitals could collaborate with community providers and resources to provide mobile clinics to serve low-income areas.
- Collaboratively develop a transportation resource that uses a variety of community resources (e.g., hospitals, community businesses, faith-based organizations, Three Rivers Regional Commission, ride-sharing programs and others with the capacity to address transportation).
- WellStar hospitals could work with companies (i.e., Uber, Lyft, or local taxis, Three Rivers Regional Commission) to provide transportation to and from medical appointments.
- Offer incentives to small businesses to encourage offering transportation to community residents.

Access to Behavioral Healthcare

Participants prioritized behavioral health as one of the most pressing issues in the community. Poor behavioral health in this service area was attributed to the limited number of behavioral health professionals in the area, the number of adverse childhood experiences (ACEs), limited family supports, substance abuse and stigma.

Contributing Factors:

- There are a limited number of behavioral health providers and facilities in the service area, which leads to lengthy waits for appointments and the need to leave the area for care.
- Residents who have undiagnosed or untreated behavioral health issues often end up in the penal system.
- Many children in the area have experienced ACEs, which can be an indication of increased use of healthcare resources among adults.
- Families are not always able to offer the protection and support needed to prevent behavioral health issues that may result from life experience.
- Substance abuse is widespread in the region, and methamphetamines are the primary substance. Participants indicated that opioid abuse is a present and growing challenge in their community, but not yet the sizeable challenge that it has become in surrounding areas.

Recommendations:

- Integrate behavioral health services into healthcare and school settings.
- Advocate insurance coverage of behavioral health services among insurers.
- Increase access to and use of WellStar behavioral health services through greater partnership with community organizations.
- Expand the use of telepsych services and paramedic outreach programs where possible to further meet behavioral health needs.
- Increase resident awareness of behavioral health, prevention, symptoms, and local treatment options.
- Collaborate with local for-profit behavioral health providers to offer "enhancement opportunities" to their available services that could effectively build upon existing resources.

Birth Outcomes

Health Summit participants prioritized birth outcomes as one of the most pressing issues in their communities. Poor birth outcomes in this service area were attributed to the limited number of providers (e.g., OB/GYN and planned parenting), lack of affordable insurance options available to women before becoming pregnant and lack of awareness about healthy practices.

Contributing Factors:

- There are limited providers (e.g., OB/GYN and planned parenting) in the area. This causes residents to seek prenatal and other types of maternal, along with child, health services outside of the area.
- Uninsured women of childbearing age do not have access to insurance (Medicaid) before becoming pregnant, which often translates into undiagnosed and untreated health issues that cause poor birth outcomes.
- Residents are not always aware of what is required along the continuum of preconception, prenatal, post-natal and interconception to give birth to a healthy baby.

Recommendations:

- Offer community-based health classes that raise awareness about prenatal, post-natal, interconception health, sex education and life skills that will lead to healthy birth outcomes.
- Partner with local institutions and agencies (e.g., the local school systems, Division of Family and Children Services [DFCS], local neighborhood programs) to integrate sex education in the curriculum and educate youth and their parents early about healthy choices.
- Increase the number and availability of specialists focused on birth outcomes (e.g., OB/GYN) offering care to under- and uninsured residents.
- Ensure access to prenatal, post-natal and interconception services through local safety-net clinics and FQHCs.
- Increase the number of local pregnancy centers to provide services and programs to those seeking prenatal care.

Listening Sessions

WellStar Spalding Regional Health Board (February 2018)

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

- Diabetes – both unmanaged and undiagnosed. The biggest problem surrounding this problem is the lack of education. We are raising a population who are prone to diabetes because of improper nutrition. Many are untreated and/or noncompliant, and the population with diabetes is growing because of lack of education.
- This is related to high rates of obesity – poor food habits – and it also boils down to education. The community does have access to parks and playgrounds for recreational activities.
- We need resources for the school system – middle school partnerships. We know we must change the behavior, not just educate.
- I'm frustrated by grocery stores in low-income areas that offer unhealthy choices. Relates to food insecurity.
- We could have a meaningful impact on community health by helping people manage their medications. They don't understand how to be compliant with their meds, especially if they are on multiple medications. It causes confusion in the chronically ill and elderly who use the ED as their primary care. They also don't understand how to properly take medications.
- Spalding has a community paramedic program. They identify patients who are high-risk at readmissions and they educate at home. Currently, only 10 patients are in the program post discharge. There is an opportunity to expand.
- There are two resources in the community that are underutilized:

  1) Health clinic – Southside. They close doors at 6 p.m.; then patients come to the Spalding ED.

  2) Sun City has approximately 3,000 homes and a classroom in community for health education events.
- King Food – a food pantry-type program at the next level where people buy their food at a discounted rate. Residents have to be qualified to access the food pantry.

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

- School nurses/clinics: Butts County has two schools that have telemedicine.
- Southside: Butts County Medical Center, 176 Lyons St., Jackson, Georgia

  http://www.jacksonprogress-argus.com/news/local/butts-county-medical-center-expands-services/article_57350522-301f-50d4-8397-f3f3105fc0f1.html

  Article excerpt: "The Butts County Medical Center has served Butts County since March 1, 2014. It recently added pediatrics and teen care, HIV testing and a discount prescription program to its offerings," Southside Medical Center Director of Marketing Keisha Williams said.

  There is also a new lab on-site and the clinic now has buses that can provide free, nonemergency medical transportation to and from appointments. The clinic continues to provide family medicine, senior care, behavioral counseling, and women's health services.
- Spalding is an Archway community – UGA partnership. Has a health issue work group that currently needs an initiative that everyone can rally around. http://www.archwaypartnership.uga.edu/communities/spalding-county/
- Spalding Collaborative – http://spalding.gafcp.org/.
- Southside partners with McIntosh Trail for mental health/Dr. Hitson, WellStar IM doc is the medical director for the NPs at Southside – http://www.mctrail.org/spalding.html.
- Pine Woods Mental Health is also utilized – Pine Woods Behavioral Health Crisis Center, 1209 Greenbelt Drive, Griffin, GA 30223. 770-358-8338
- Local churches have counseling. First Baptist, First Assembly – have a counseling program with certified psychologists.
- The hospital has a social worker.

WellStar Sylvan Grove Hospital
(February 2018)

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

- Overuse of ED – Education regarding options and resources
- Access to affordable care
- Better access to medication
- Transportation
- Many people who go to our ER are better served in a primary care setting. They call 911 and we get them (for lack of transportation). Some patients aren't compliant with their discharge orders and need education – they may not know about other healthcare options before they go home.
- We have a relationship with a clinic – Butts County Medical Center (formerly Southside). We use a flyer referral – nothing formalized.
- Transportation is an issue – there's no public transport – bus, cabs available. Uber is available but not consistent. There are babies born in the ED at Sylvan Grove that were supposed to be born at Spalding, but no transport or gas.

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

- We have many one-off partnerships to try and engage the community – special events, health fairs. Jackson Alive – a medication take-back day, Jackson High School Career Fair, Butts County Counseling Center.
- Worked with Butts County fire, police, health departments, Butts County Life Enrichment Team (LET). http://butts.gafcp.org/files/Butts-Co-Resources_4-14-16.pdf (part of Georgia Family Connection, region 4).
- We need something between ED and doctor's office where people can go to get healthcare without a trip to the ED, such as Urgent Care.
- Would be great if physicians did home visits.
- We need an opportunity to better communicate to the community the value WellStar adds to the community. Many people aren't aware of the services we have and the "give back" to the community. An example: Butts County residents pay a 1 percent tax: "What are we getting out of it?" We have an opportunity there.
- "How can we do that more? We're open to speaking in the community more."

Key Informant Summary

(December 2017–December 2018)

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

Methodology

The following qualitative data were gathered during individual interviews with 13 stakeholders in communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents, as well as ways to address those concerns.

There was a diverse representation of community-based organizations and agencies among the 13 stakeholders interviewed. The organizations represented included:

- Griffin-Spalding County Health Department
- Georgia Department of Public Health*
- Spalding Collaborative
- Rock Springs Clinic
- Spalding County Fire Department
- Griffin-Spalding County Board of Education
- United Way*
- Butts Collaborative
- Jackson Police Department
- City of Jackson
- Jackson United Methodist Church
- Butts County Hospital Authority*
- Georgia Association for Positive Behavior Support
- Project AWARE
- Griffin-Spalding County School System
- Southside Medical Center*
- Georgia Department of Public Health – Health District 4

** Denotes organizational participation in key informant interview and WellStar Health Summit*

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

Improved

- Walking trails (plans to expand), e.g., THREAD
- Variety of healthcare options (also expanding)
- Lots of local resources in LaGrange
- Quality of life improving for residents, specifically in Troup County
- Leaders are trying to coordinate and work together

Stayed the same

- No increase in health service to this community, particularly children's health services
- Health outcomes have remained the same

Declined

- NA

Major Health Challenges:

- Infectious disease and STIs (HIV in Spalding and Butts counties)
- Drug resistance (STIs and TB)
- Mental health – e.g., suicides
- Diabetes
- Cancer
- Obesity
- Cardiovascular disease/ congestive heart failure
- COPD
- Hypertension
- Teen pregnancy
- Substance abuse (meth, marijuana) and overdosing due to opioids
- Respiratory illnesses

Context and Drivers:

- Low health literacy
- Poor community outreach
- Transportation (there is no public transportation)
- Low educational attainment
- Access to healthy foods (affordability, distance, cultural preference, presence of food deserts with high rates of unhealthy options — convenience stores and fast food)
- Economic instability (under- and unemployment, disenfranchised community, inadequate job market, poverty affects housing and insurance opportunities, diluted job market, temp-to-hire are the primary options)
- Access to care (affordability for under- and uninsured, limited primary and specialty providers, distance/transportation, extended wait times, high rates of uninsured and underinsured residents)
- Limited specialty care (prenatal care, OB/GYN)
- Risky sexual behaviors (teens and adults, lack of parental oversight)
- Inadequate housing
- Limited access to exercise opportunities outside of LaGrange
- Undocumented residents do not have access to primary care or prenatal care and resist seeking care due to fear of deportation. The hospital is the primary provider for this group
- Challenges related to race and ethnicity – e.g., racism, health disparities
- Decision-makers do not always have adequate information

Recommendations:

- As a collaborative effect, improve education dissemination (sex education and job skills) by increasing resource marketing across various media
- Increase the prevalence of primary, specialty (esp. women's services) and behavioral health providers/facilities in the community
- Develop a comprehensive transportation method to assist residents with accessing appropriate care
- Advance in payment reform by assisting residents with medical costs
- Design a confidential hotline for residents who find navigating services problematic
- Involve affected residents in healthcare plans and strategies
- Develop a local homeless shelter to address drug abuse and family welfare
- Offer vulnerable populations mobile services at places in the community like schools, etc. These services can be offered by nurse practitioners
- Address access to care in a systematic way by partnering with public health more – e.g., representation on organization boards and increased interaction
- Educate people on the locations and usefulness of parks and trails
- Begin to measure the impact of community resources
- Increase the amount of time providers spend with patients and offer increased education around prescribing antibiotics

Resident Focus Group Summaries

(January–October 2018)

Purpose

This assessment engaged community residents to develop a deeper understanding of the health needs as well as the existing opinions and perspectives related to the health status and health needs of the populations in communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

Methodology

GHPC recruited and conducted two focus groups among residents living in the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. GHPC designed facilitation guides for focus group discussions. Residents were recruited using a third-party recruiting firm. Recruitment strategies focused on residents who had characteristics representative of the broader communities in the service area, specifically communities that experience disparities and low socioeconomic status. Focus groups lasted approximately 1.5 hours, during which time trained facilitators led six to 12 participants through a discussion about the health of their communities, health needs, resources available to meet health needs and recommendations to address community health needs. All participants were offered appropriate compensation ($50) for their time and a light meal. The following focus groups were conducted by GHPC between January 2018 and October 2018:

- WellStar Spalding Regional and WellStar Sylvan Grove Hospitals Service Area Residents – Griffin, Georgia (Jan. 9, 2018)
- WellStar Spalding Regional and WellStar Sylvan Grove Hospitals Service Area Residents – Barnesville, Georgia (Sept. 25, 2018)

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

Target Population:
Butts, Pike, and Spalding Residents

Location:
Spalding County Senior Center
885 Memorial Drive,
Griffin, GA 30223

Number of Participants:
13

Major Health Challenges:

- Heart disease
- Cancer
- Mental health
- Substance abuse (meth, cocaine)
- Obesity
- High blood pressure
- Dental health

Context and Drivers:

- Economic instability (low income, under- or unemployed)
- Diluted workforce (lack of jobs, no job security, employers hire mostly temp positions, undereducated, underskilled, underexperienced)
- Access to healthy foods (dense fast food market)
- Disenfranchised community (used for film industry, dumping ground)
- Access to care (limited primary and specialty providers, distance – half-hour car ride to closest providers, local referrals to prestigious specialists, forced to use out-of-network providers, poor hospital quality, no trauma care)
- Insurance (gap in certain demographics, restricted choices, barriers with acceptance)
- Limited resources for youth (gangs, crime, drugs, poor parental oversight)

Recommendations:

- Develop a youth-based program that ensures local children have access to a centralized, productive environment (i.e., YMCA and Boys & Girls Club). This improves parental oversight and creates a platform for mentorship and resource dissemination.
- Encourage a system that supplies resources, similar to the Supplemental Nutrition Assistance Program, to residents who don't currently fit criteria for benefits.

Target Population:
WellStar Spalding Regional and WellStar Sylvan Grove Hospitals Service Area Residents

Location:
E.P. Roberts Center
188 Mill St., Barnesville, GA 30204

Number of Participants:
11

Major Health Challenges:

- Overutilization of the ED
- Health issues
  - Cancer (i.e., prostate)
  - Chronic pain
  - Respiratory illnesses (emphysema, COPD and asthma)
  - Diabetes
  - Blood pressure (too high or low)
  - Anemia
- Substance abuse (prescription drugs – opiates and overdosing)
- Behavioral health (stress, anxiety, depression and suicide)

Context and Drivers:

- Low access to care (location of providers, low numbers of providers primary and specialty – e.g., maternal and child health, there is no hospital in town – closest is Griffin or Macon, uninsured care is unaffordable)
- Residents do not always trust their providers (prescribing unnecessary medications, lack of medication management, second opinions have revealed inaccuracy and outdated practices)
- Mental health (limited providers, unaffordable uninsured care, untreated illness may increase crime, residents resist seeking care due to stigma)
- Transportation (not all residents have access to private transportation, there is no public transportation)
- Limited access to affordable healthy foods (healthy produce is unaffordable, fruits and vegetables are not readily available, delivered food donations [boxes] are not always healthy)
- Residents are not always making healthy choices (cultural and traditional preferences related to types of food and food preparation, influence of stress on food choices, smoking, physical inactivity)
- Pollutants (air and water) from the local cotton mill is believed to cause residents to be unhealthy
- Poor economy (unemployment or underemployment, available employment options offer a low wage, choices between necessities and health)
- Single parents (required to work more, less time available for positive parenting)
- Negative social influences (peer pressure and radio)

Recommendations:

- There are resources in the community that residents could use
- Increase awareness about what resources are available

Primary Data Collection Tools

Key Informant Questionnaire

(2018–2019)

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

Context

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

Improved Stayed the same Declined Don't know

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

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

Community Capacity

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

Moving the Needle

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

Wrap Up

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

Focus Group Discussion Guide

Community Health Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

Facilitator introduces self and thanks those in attendance for participating

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

Explain about focus groups:

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

Participant Introductions

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

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

Health Concerns for Your Family

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

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

Health Concerns in the Community

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

Facilitator: Present community-appropriate data summary to participants.

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

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

Closing

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

Community Facilities, Assets and Resources

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

Health Departments	
Butts County Health Department 463 Ernest Biles Dr., Ste. A Jackson, GA 30233 770-504-2230 **Spalding County Health Department** 1007 Memorial Drive Griffin, GA 30224 770-467-4740 **Pike County Health Department and Environmental Health Office** 541 Griffin Street Zebulon, GA 30295 770-567-8972 www.district4health.org	The Georgia Department of Public Health (DPH) funds and collaborates with eighteen separate public health districts throughout the state. District 4 Public Health is comprised of 12 counties in west Georgia: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson. Mission is to protect and improve the health of our communities through the prevention of disease, the promotion of healthy behaviors, access to quality services, strong community partnerships, and disaster preparedness.

Primary Care: Safety-Net Clinics & Federally Qualified Health Centers	
Southside Medical Center Butts County Medical Center 176 Lyons Street Jackson, GA 30233 404-688-1350 www.southsidemedical.net	Southside Medical Center is a leader in organizing, providing and supporting affordable health care and related services to the public through diversified business activities. Services offered at Butts County Medical Center: Primary Care Dental Care Pediatrics
Willing Helpers Medical Clinic 8111 Brown Bridge Rd., Covington, GA 30014	The medical clinic is a community partner with medical professionals. The mission of the clinic is to provide medical assistance for uninsured patients. The Clinic is able to see patients by appointment only. The clinic takes appointments Tuesday - Thursday from 9AM-12PM. The clinic operates on a variable schedule based on doctor availablility.
Rock Springs Clinic 211 Rock Springs Road Milner, GA 678-688-1950 www.rsclinic.org/index	The Rock Springs Clinic is a non-profit community faith-based health clinic that provides a comprehensive range of services for individuals without insurance or the means to afford such care. Located in Milner, Georgia, the clinic serves those in 34 counties and 31 cities throughout the middle Georgia area. The clinic is staffed with a team of professional medical and clerical volunteers and provides services free of charge.
Griffin-Spalding County United Way Mailing Address: P.O Box 83 Griffin, GA 30224 770-229-4212 E-mail: united_way@bellsouth.net	United Way understands that you really want to make a difference right here in Griffin and Spalding County. We want to help you do that. Our experience tells us that the best way to help the most people is to focus on the underlying causes of the most serious problems. Here in Griffin and Spalding County, we're focused on critical issues like healthcare, education for adults and children, and the rising number of working people living on the edge of poverty.

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

Southside Medical Center at Hope Health Clinic 409 W. Solomon Street Griffin, GA 30223 678-688-8700 www.hopehealthclinic.com	Hope Health Clinic is a medical clinic for Spalding County residents who DO NOT qualify for Medicaid or Medicare and do not have any other type of health insurance. Fees are based on income. Contributions from patients and the community are encouraged. The services provided include the following: ■ Complete medical exams and follow-up exams as needed ■ Routine/general medical care ■ Medical laboratory testing ■ Treatment of infectious disease ■ Provision of medications for clinic patients ■ Referrals to specialists as needed ■ Diabetic screening, testing and treatment ■ Hypertension screening, testing, treatment counseling and education ■ Blood pressure monitors ■ Cholesterol screening testing, treatment, counseling and education ■ Medical records management for disability claims ■ Non-emergent medical treatment for Spalding County Diversion Center ■ Depression screening and therapy ■ Weight loss clinic

Transportation

Non-Emergency Medical Transportation (NEMT) Schedule Transportation: Logisticare: 1-888-224-7981 (Central) 1-888-224-7985 (Southwest) 1-888-224-7988 (East) Medicaid Member Call Center: 866-211-0950 Logisticare: 1-800-486-7647 or 770-907-7596 http://www.logisticare.com/transportation/	The Non-Emergency Medical Transportation (NEMT) program provides eligible members transportation needed to get to their medical appointments. To be eligible for these services, members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program. Drivers pick members up at their homes, take them to their appointments and bring them home in a timely manner. Members, families, social workers, and health care professionals all book rides via our online reservation portals or call centers.
Three Rivers Regional Commission Transportation Service Call 706-883-1670 to schedule a trip 24 hours in advance http://www.threeriversrc.com/transportation-services.php	The regional public transportation program provides public transportation for residents of Butts, Lamar, Meriwether, Pike, Spalding, and Upson counties, and has operated in the region since 1999. The regional public transportation program is administered by the Three Rivers Regional Commission on behalf of its participating governments. The regional public transportation program operates under a "demand response" model, which means that there are no fixed routes, bus stops, or pick-up times. With a demand response model residents call in and order a trip 24 hours in advance, and daily routes are generated based on the destinations requested.

Behavioral Health	
McIntosh Trail CSB MTCSB Administrative Office 1435 North Expressway, Suite 301 Griffin, GA 30223 Locations in Butts, Spalding and Pike counties Call Center 770-358-5252	The McIntosh Trail Community Service Board is a public entity created by the Georgia legislature in 1993 to provide mental health, developmental disability and addictive disease services. Services are available to residents of Butts, Fayette, Henry, Lamar, Pike, Spalding and Upson counties. Services: ■ Addictive Diseases ■ Developmental Disabilities ■ Mental Health ■ Specialty
Pathways Centers 244 O'Dell Road, Suite 3 Griffin, GA 30223 770-229-3407 www.pathwayscsb.org	Pathways Center provides mental health, developmental disabilities and addictive disease services in the west central Georgia region to include the following counties – Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, and Upson. Services include: ■ Outpatient Services ■ Community Support ■ Peer Support ■ Psychosocial Rehabilitation ■ Supportive Living ■ Developmental Disabilities ■ Crisis Stabilization Programs – Second Seasons – HOPE'S Corner ■ Mobile Crisis Services
Promise Place 410 East Taylor St. Suite K-6, Griffin, GA 30223 770-692-3333	Offers emergency shelter, 24-hour crisis hotline, crisis intervention, safety planning, legal advocacy, weekly support groups, children's programs, emergency needs assistance, and community education.
Georgia Project AWARE 205 Jesse Hill Jr. Drive SE Atlanta, GA 30334 Rebecca Blanton Project Coordinator 404-463-0712 Fax: 404-651-6457 Email: rblanton@doe.k12.ga.us	Georgia Project AWARE Goals: **Goal 1:** Increase participation of the community (including families and youth) and mental health providers (including school-based and community-based providers) in efforts to identify the mental health resources available to meet the needs of the students and families in each LEA. **Goal 2:** Increase awareness and identification of mental health and behavior concerns, and student and family access to mental health providers through the PBIS framework in GPA schools. **Goal 3:** Increase the percentage of Georgia youth and families receiving needed mental health services through collaboration between LEAs and community mental health providers. **Goal 4:** Train educators, first responders and parents to respond to mental health needs of youth.

HIV	
AID Atlanta-Haven of Hope 770 Garrison Trail Suite H Newnan, GA 30263 770-252-5418 www.aidatlanta.org/aid-atlanta/services/clinical-care/haven-of-hope	AID Atlanta's Haven of Hope Healthcare Center, which is located in Newnan, Georgia, specializes in providing comprehensive primary care services specifically for patients with HIV. Services at our Newnan clinic include: ■ Primary Medical Care for HIV-Positive Patients ■ Medication and Insurance Co-Pay Assistance ■ On-Site Pharmacy ■ Laboratory Services ■ Medical Case Management
Employment	
Work Source-Three Rivers 1210 Greenbelt Dr. Griffin, GA 30224 Local: (770) 229-9799 www.threeriversrc.com/workforce.php	Local One Stop Career Centers help individuals prepare themselves to meet job requirements and help employers identify suitable job applicants. The Career Connections places additional emphasis on assisting youth and veterans. Serving Spalding, Butts and Pike counties Residents can call 770-229-9799 or TOLL-FREE: 1-877-633-9799 for location serving their area.
Youth Programs	
Summer Food Service Program: **Seamless Summer** Contact: **Georgia Department of Education** 205 Jesse Hill Jr. Drive S.E. 1662 Twin Towers East Atlanta, GA 30334 404-651-9443	School Food Authorities (SFAs) participating in the NSLP or SBP are eligible to apply for the Seamless Summer Option. Once approved through their governing state agency, SFAs serve meals free of charge to children 18 years and under from low-income areas.

Implementation Plan

Building a Culture of Health

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

Background

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

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

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

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

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

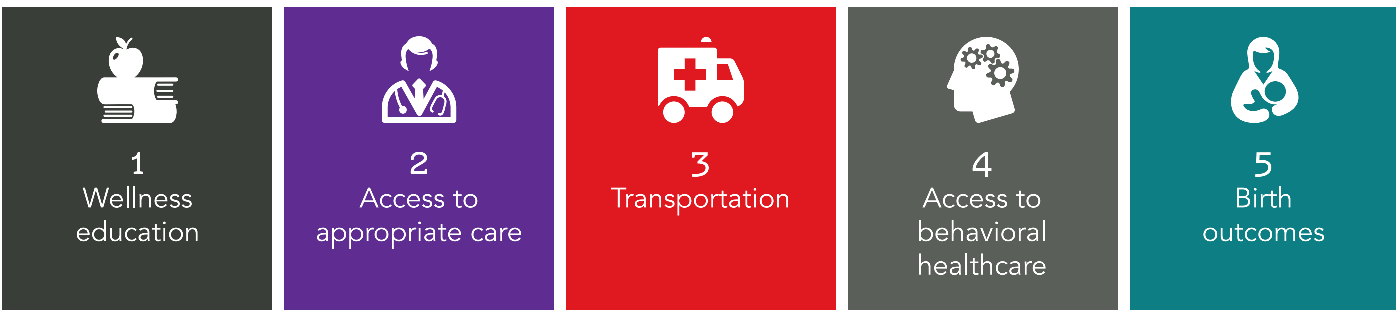
3 *Legacy WellStar is defined as the community where WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital, and WellStar Windy Hill Hospital are located. Legacy WellStar is the entity prior to the acquisition of WellStar West Georgia Medical Center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

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

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

Review of Priority Health Needs

Leaders of Georgia State University's Georgia Health Policy Center helped guide WellStar Spalding Regional and WellStar Sylvan Grove hospitals through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research, the following health needs were valuated as priority for the community the hospitals serve:



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

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar Spalding Regional and WellStar Sylvan Grove hospitals play a vital role:[4, 5]

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

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

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

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

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

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

The scope of WellStar's healthcare footprint and its commitment to its mission makes WellStar Spalding Regional and WellStar Sylvan Grove hospitals linchpins and integrators in the community for delivering care, interventions and education to improve overall population health and health equity in the community we serve. This involves providing community benefit programming to address priority health needs via collaborative partners who provide care access, services and resources to under-resourced populations.

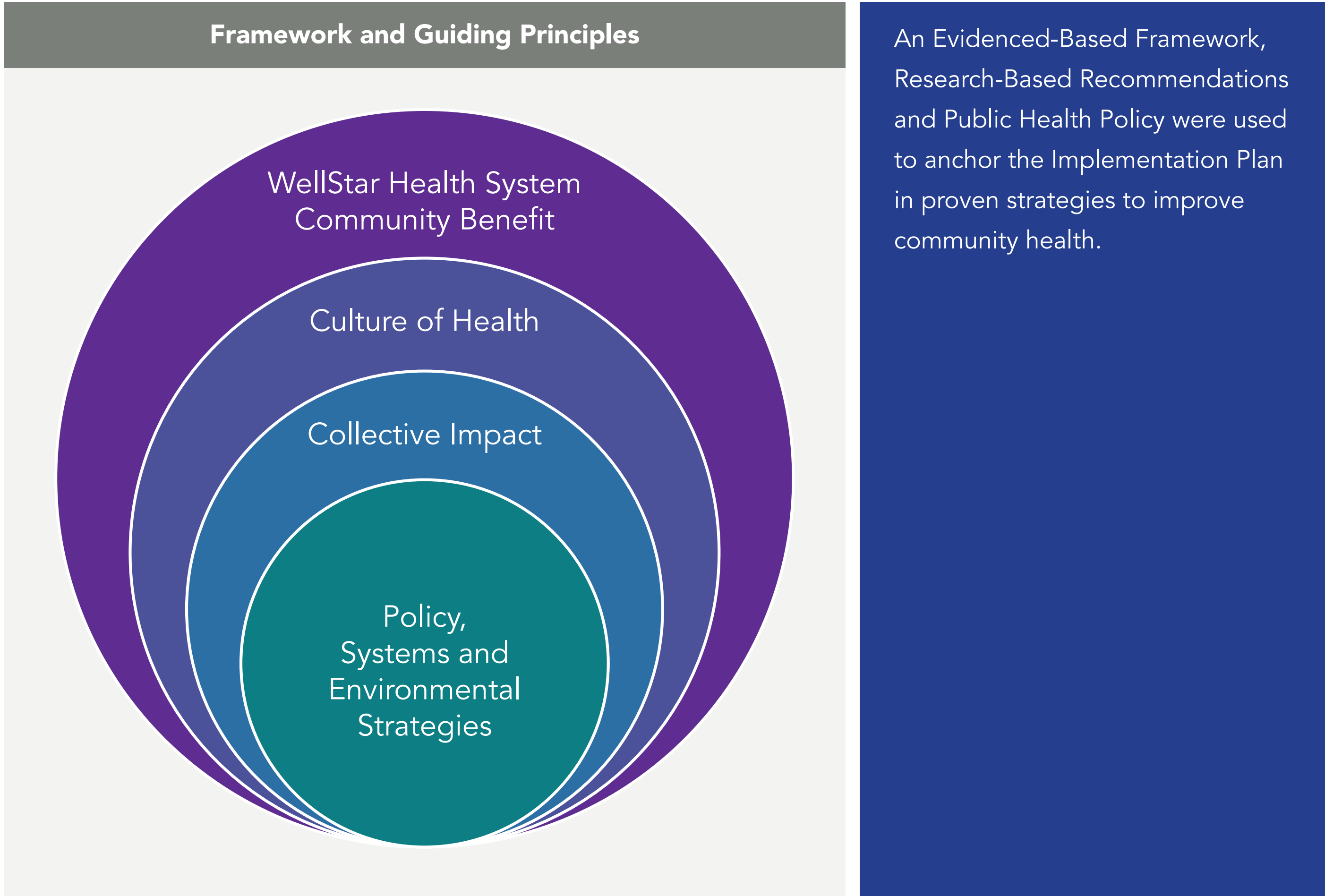
Health Needs Addressed

	Wellness Education	Access to Appropriate Care	Transportation	Access to Behavioral Health	Birth Outcomes
Cancer Prevention and Screening		■			
Community Education & Outreach	■	■		■	■
Community Transformation Grants		■	■	■	■
Public Health Policy and Advocacy		■		■	■
Screening for Food Insecurity	■	■			
The Health of All Women	■	■			■
WellStar 4-1 Care		■			
WellStar Day of Service	■	■		■	■
WellStar Opioid Steering Committee	■	■		■	
WellStar Research Institute		■			■
Zero Suicide Initiative	■	■		■	

Implementation Plan Framework and Guiding Principles

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

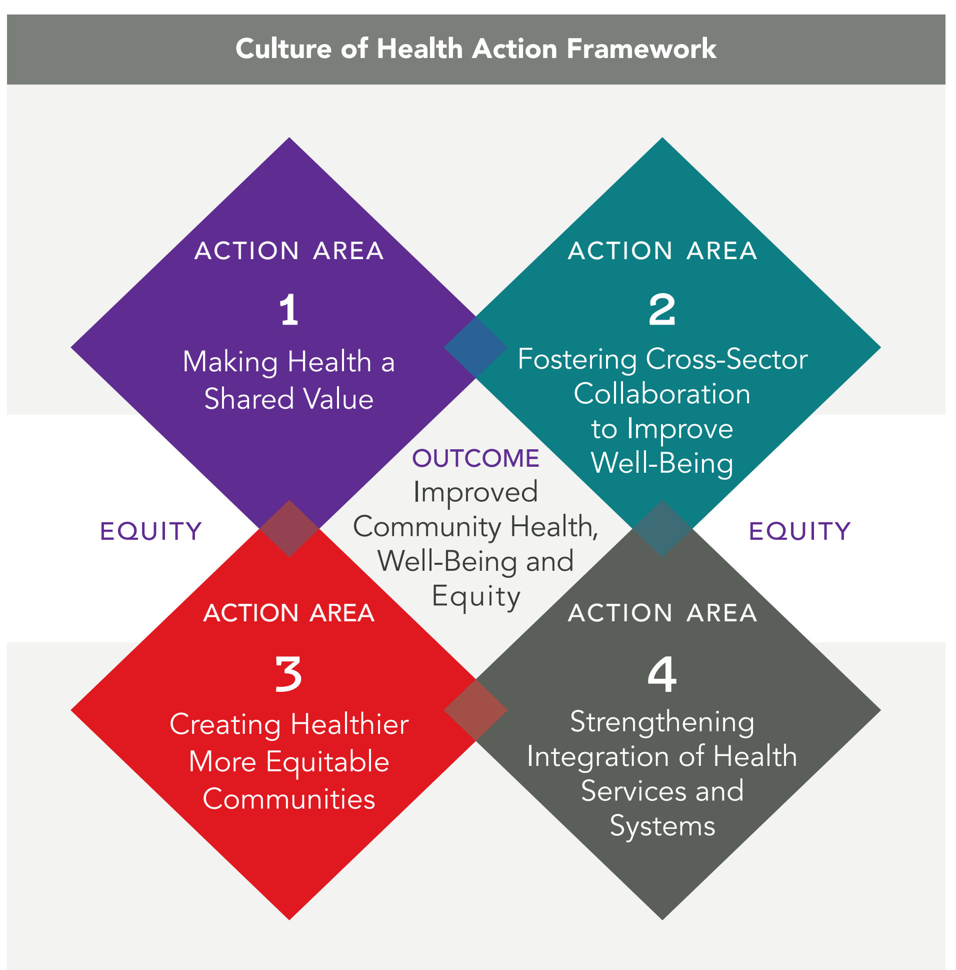
These efforts flow from the WellStar mission and vision, and to meet the requirements of the federal government (Affordable Care Act Section 9007) of systemwide oversight and guidance regarding tracking community benefit activities, assessing community health needs and developing strategic plans that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



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

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

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



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

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

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

Health Equity Pledge

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

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

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

Action Area 1: Making Health a Shared Value: How can individuals, families and communities work to achieve and maintain health?

Underlying Principles:

Mindset and Expectations Prioritizing and promoting health and well-being	**Civic Engagement** Participating in activities that advance the public good	**Sense of Community** Cultivating social connections that help us thrive

Action Area 2: Fostering Cross-Sector Collaboration: How can we encourage cooperation across all sectors?

Underlying Principles:

Quality of Partnerships Organizations working together and seeing successful outcomes	**Investment in Collaboration** Adequate financial support to enable more successful partnerships	**Policies that Support Collaboration** Creating incentives and methods to encourage ongoing coordination

Action Area 3: Creating Healthier, More Equitable Communities: How can we develop safe environments that nurture children, support aging adults and offer equitable access to healthy choices?

Underlying Principles:

Built Environment Creating safe, affordable environments that support our well-being	**Social and Economic Environment** Providing improved public resources and economic opportunity for everyone	**Policy and Governance** Establishing policies to create healthy environments through collaboration

Action Area 4: Strengthening Integration of Health Services and Systems: How can healthcare providers work with institutional partners to address the realities of patients' lives?

Underlying Principles:

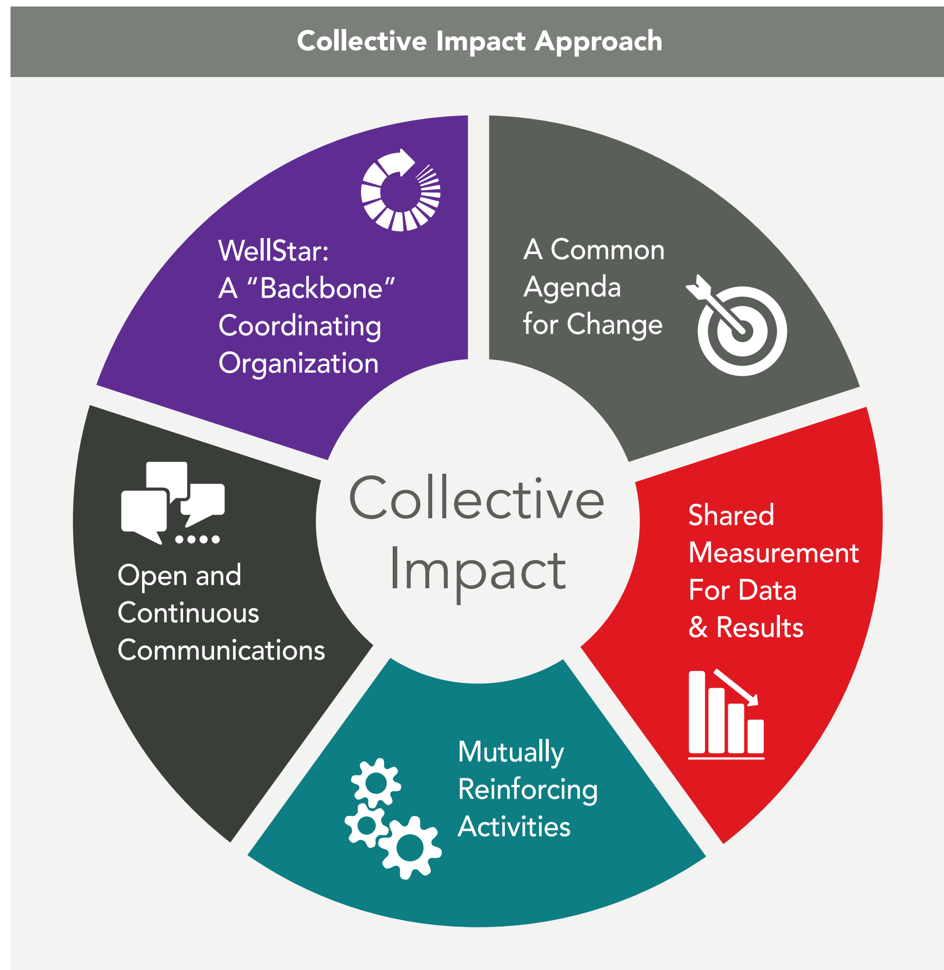
Access to Care Making comprehensive, continuous care and healthy choices available to all	**Balance and Integration** Improving care when public health, social services and healthcare systems work together	**Consumer Experience** Providing safe, equitable, accessible, efficient and timely care

Collective Impact Approach

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

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

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



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

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

Policy, Systems and Environmental Change Strategies

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

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

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

† *National Association of County and City Health Officials*

Implementation Plan to Address Priority Health Needs

WellStar Spalding Regional and WellStar Sylvan Grove hospitals are dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework, the Implementation Plan focuses on two key areas.

Two-Pronged Approach	
1. Community-Driven Solutions	Partnering with communities to drive locally determined solutions and policies that influence systems, services and practices to create equitable conditions that improve well-being. Improving these conditions promotes health equity among people in low-income neighborhoods and fosters health for the hospitals' community.
2. Sustainable Infrastructure	Building community benefit capacity and competency within WellStar Cobb, Douglas, Kennestone, Paulding and Windy Hill hospitals to streamline business practices and reporting.

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

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

Community-Driven Solutions:

Community Education & Outreach

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

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

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

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

Signature Community Programs and Initiatives that Address Priority Health Needs	
Community Education, Screening and Prevention	
Speaker Series and Speakers' Bureau	WellStar's Speaking about Wellness Program provides our community with a multiple speaker series and a robust speakers' bureau focused on preventative health and wellness education topics for all life stages. The speaker series component includes: Speaking about Wellness for Healthy Aging and Speaking about Wellness for Women/Spirit of Women®. The speakers' bureau includes: Speaking about Wellness for the Community and Speaking about Wellness for the Workplace.
Worksite Wellness	WellStar's Worksite Wellness Program encourages a proactive approach to healthcare by providing the convenience of on-site health and wellness resources to small and medium-sized businesses, customized to meet employers' and employees' specific needs. Services include health screenings, CPR/First Aid training and Speaking about Wellness for the Workplace.
Screenings and Prevention	WellStar's Screening and Prevention Program provides health education and health screenings for community members and organizations. This program promotes health, assists in preventing disease and offers early detection.
Good Life Club	WellStar's Good Life Club is an organization for people 50 and older who want to learn how to live better, be healthier and stay active. The program focus is on healthy aging, including wellness, health education, travel and social activities.
Medication Take-Back	WellStar's Medication Take-Back events are a partnership between WellStar Community Education & Outreach, local police departments and community-based organizations to provide secure drop-off locations for expired and unused medications.
Safe Kids Spalding	The Safe Kids program is committed to reducing and preventing injuries to children by hosting safety education events and distributing safety equipment throughout the county. Program equipment, including car seats, bike helmets, life jackets and more, is funded by the WellStar Foundation. WellStar CE&O is currently finalizing an agreement with Safe Kids Worldwide to launch a Safe Kids Spalding program in Spalding County with WellStar Spalding Regional Hospital as the lead agency.
School Health Programs	WellStar's School Health Program partners with local elementary and middle schools to provide interactive lessons on nutrition, physical activity, internet safety, anger management, dental health, wheel/passenger safety, water safety, personal hygiene and poison prevention.
Advance Care Planning Workshops	WellStar's Ethics Steering Committee, Congregational Health Network and CE&O collaborate to provide workshops where participants learn how to talk with loved ones about final healthcare decisions. Each participant receives a free planning guide outlining questions he/she should discuss with family members, as well as forms to record wishes.
Community Outreach	
Community Events	WellStar Health System participates in a wide variety of community events throughout the year, including health fairs, expos, road races, festivals, farmers' markets, community walks, congregation events/health fairs and special signature events such as BRAdazzled.
Community Partnerships	Community Education & Outreach is responsible for developing and cultivating strategic community partnerships. Partnerships allow us to focus on prevention and wellness, impact community priority health needs and increase access to healthcare services.
Community Sponsorships	WellStar Health System supports the health and wellbeing of the communities we serve by actively engaging in sponsorship opportunities. Each year, WellStar supports other nonprofit organizations that align with our mission, vision and community needs assessment to improve the health of citizens in our communities.

Community-Driven Solutions:

Moving Upstream: WellStar Community Transformation Grants and Day of Service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community-Driven Solutions:

WellStar 4-1 Care

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

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

Evolution of WellStar 4-1 Care

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

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

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

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

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

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

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

Community-Driven Solutions:

WellStar Opioid Steering Committee

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

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

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

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

Zero Suicide Initiative

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

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

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

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

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

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

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

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

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

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

Community-Driven Solutions:

The Health of All Women

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

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

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

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

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

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

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

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

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

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

Cancer Prevention and Screening

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Screening for Food Insecurity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Building a Sustainable Infrastructure:

Hospital's Roles and Responsibilities

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

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

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

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

Building a Sustainable Infrastructure:

Public Policy and Advocacy

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

Building a Sustainable Infrastructure:

WellStar Research Institute

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

Health Needs Not Addressed

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

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

Evaluation of Action

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

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

In addition, did WellStar's Community Benefit initiatives:

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

Next Steps[39]

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

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

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

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

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