



2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)
Your Health. Our Mission.



WellStar Atlanta Medical Center

EIN: 81-0837031
303 Parkway Dr. NE
Atlanta, GA 30312

Founded in 1901, WellStar Atlanta Medical Center is a 762-bed acute care hospital with campuses in downtown Atlanta and East Point, Georgia. It is the second largest licensed-bed hospital in Georgia. A teaching hospital, AMC is a Level 1 Trauma Center and Advanced Primary Stroke Center, earning many national awards for its treatment of stroke. It is recognized for

its women's services program, including water births, and the hospital's weight-loss program is designated as a Bariatric Surgery Center of Excellence. Through a community partnership, AMC provides sports medicine coverage to Atlanta Public Schools student athletes.

We are proud to be part of WellStar, the largest health system in Georgia, known nationally for its innovative care models and focused on improving quality and access to healthcare. WellStar also includes WellStar Medical Group, 240 medical office locations, outpatient centers, health parks, a pediatric center, nursing centers, hospice, homecare, as well as 10 additional inpatient hospitals: WellStar Atlanta Medical Center South, WellStar Kennestone Regional Medical Center (anchored by WellStar Kennestone Hospital), WellStar West Georgia Medical Center, WellStar Cobb, WellStar Douglas, North Fulton, Paulding, Spalding Regional, Sylvan Grove and Windy Hill hospitals.



WellStar Atlanta Medical Center South

EIN: 81-0837031
1170 Cleveland Ave.
East Point, GA 30344

WellStar Atlanta Medical Center South, located in East Point, Georgia, has been serving the healthcare needs of South Fulton for more than 50 years. In 2013, AMC South merged with WellStar Atlanta Medical Center, forming one hospital with two campuses. With a combined 762 beds, AMC and AMC South now make up the second-largest licensed-bed hospital in Georgia.

A community-based hospital, AMC South's 24-hour Emergency Department is one of the busiest in the region. We also offer such services as robotic surgery, orthopedics, bariatric surgery and an emerging percutaneous coronary intervention program. Our imaging services, located at AMC South and Camp Creek, offer the latest diagnostics tools, including the widest MRI scanner in Georgia. AMC South is the largest employer in East Point.

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

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This report serves to identify and assess the health needs of the community served by WellStar Atlanta Medical Center and WellStar Atlanta Medical Center South. 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 Atlanta Medical Center (AMC). Founded in 1901, WellStar AMC is a 762-bed acute care hospital with campuses in downtown Atlanta (WellStar AMC) and East Point, Georgia (WellStar AMC South). It is the second-largest licensed-bed hospital in Georgia. A teaching hospital, AMC is a Level 1 Trauma Center and Primary Stroke Center, earning numerous national awards for its treatment of stroke. It is recognized for its women's services program, including water births, and the hospital's weight-loss program is nationally accredited. Through a community partnership, AMC provides sports medicine coverage to Atlanta Public Schools student athletes. Both campuses are designated not-for-profit hospitals under the Internal Revenue Code (IRC) Section 501(r).

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 AMC and WellStar AMC South 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) in 2018 and again in 2019 to complete a comprehensive CHNA process, which includes synthesis of:



Secondary data specific to the populations and geographic area served



10 individual key informant interviews with stakeholders



Two listening sessions with each hospital's Regional Health Board



Three focus groups with residents



30 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 56 zip codes concentrated in the primary service area of Fulton, DeKalb and Clayton counties. The primary differences that can be found in this assessment are:

- The service area grew from 46 zip codes to the 56 zip code areas included in this assessment,
- 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 AMC and WellStar AMC South worked with community and hospital leaders to identify the top community health priorities based on the data.¹ The community health priorities identified for the service area include improving:



Key Findings

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

- Residents in Clayton County
- Residents from zip codes 30315 and 30310
- People without legal immigration status
- Single parents
- Black and Latino residents

Social Determinants of Health

In general, residents who live in Fulton and DeKalb counties tend to be older, higher-income-earning, more educated and less diverse when compared to residents of Clayton County. All three counties have high population counts, with the largest population in Fulton County, which is expected to grow at a more rapid pace than Clayton and DeKalb counties. Social determinants of health² influence residents in the community served by WellStar AMC and WellStar AMC South.

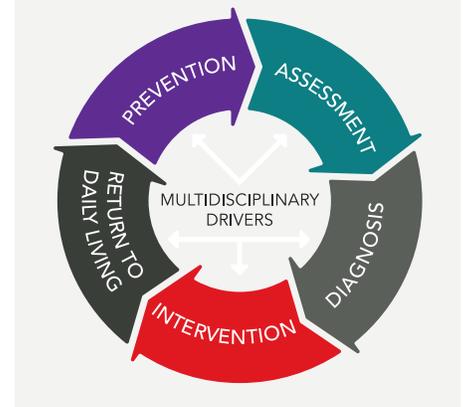
When analyzing data by race, ethnicity and income, evidence shows that Fulton County has geographic pockets where the burden of social determinants of health rivals that found in Clayton County. An example of this is the rate of poverty among single-parent families. While single-parent families experience the highest rates of poverty throughout the service area, Fulton County shows the starkest contrast between single-parent poverty when compared to all other types of families (see Table 3 and Table 5). Clayton County residents experience the greatest barriers to accessing healthcare related to income, employment, insurance, housing and education when compared to residents of DeKalb and Fulton counties.

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, residents' ability to navigate available services, number of providers, quality of care and transportation. 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."

Figure 1 | Care Continuum



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

- Health professional shortage areas,
- Higher than average rates of emergency department (ED) visits,
- Hospitalization for preventable issues and
- Inequities in morbidity and mortality rates.

During the last three years there has been a shift in the socioeconomic status of the communities included in this assessment due to improvements in the overall economy, an influx of higher-income-earning residents and a decrease in populations with limited English skills. These changes have decreased the socioeconomic barriers to accessing healthcare in several ways:

- Poverty and uninsured rates have decreased slightly
- Educational attainment has improved slightly
- Unemployment has decreased drastically

Health Outcomes

There are several undesirable health outcomes in the service area. Most of the top 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). Clayton County residents have the highest disease burden and death rates in the service area. Similarly, Black and Multiracial residents have the highest rates when compared to any other racial or ethnic cohort in the service area.

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

 Human immunodeficiency virus (HIV) <i>new and existing</i>	 Prostate cancer incidence and mortality	 Sickle cell anemia incidence	 ED visits for asthma	 ED visits for behavioral health issues	 Hospital discharge for assault	 Drug-related mortality
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Investments in addressing these issues would influence the health of the community served by WellStar AMC and WellStar AMC South.

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 assessment is available only at the county level. Where smaller chunks 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, there is no population measure of educational awareness in the context of healthy options and availability of resources. In the absence of secondary data, this assessment 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 under- and uninsured residents.

Community Is **Commitment**

WE EXIST TO SERVE



Community Definition

WellStar Atlanta Medical Center (WellStar AMC) and WellStar Atlanta Medical Center South (WellStar AMC South) are located in Atlanta approximately eight miles from each another. 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 56 zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of patients are from Fulton, DeKalb and Clayton 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 56 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.

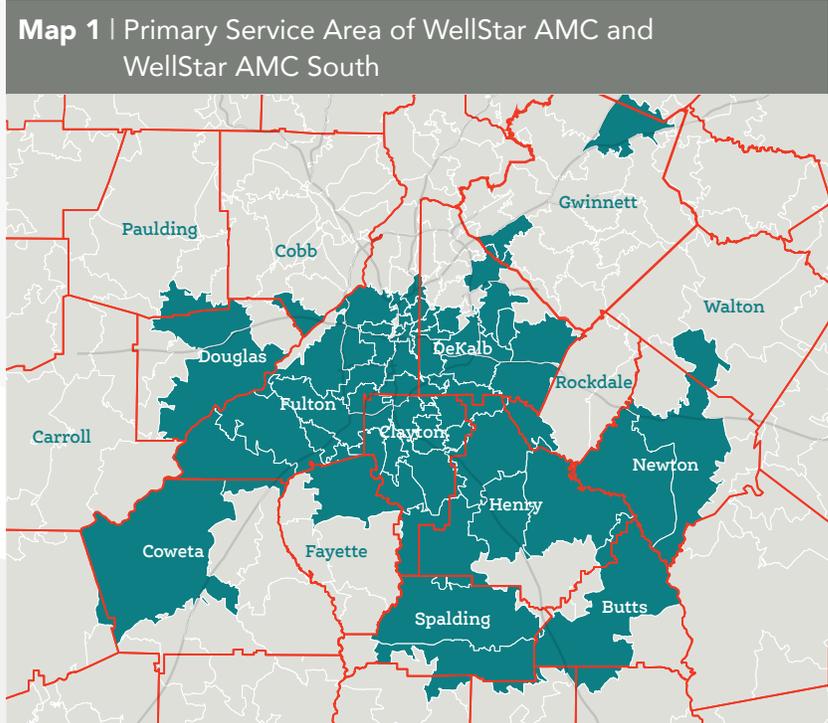


Table 1 | Primary Service Area of WellStar AMC and WellStar AMC South

County	Zip Codes (56)	Population (2018)
Fulton	30213, 30268, 30291, 30303, 30306, 30308, 30309, 30310, 30311, 30312, 30314, 30315, 30318, 30331, 30337, 30344, 30349, 30354	1,110,620
DeKalb	30030, 30032, 30034, 30035, 30038, 30058, 30083, 30084, 30088, 30294, 30307, 30316, 30317, 30324	820,822
Clayton	30236, 30238, 30260, 30273, 30274, 30288, 30296, 30297	223,566
Gwinnett	30093, 30519	927,828
Cobb	30168	761,725
Henry	30228, 30252, 30253, 30281	245,957
Douglas	30134, 30135	147,264
Coweta	30263	143,548
Fayette	30214	116,145
Newton	30014, 30016	108,276
Spalding	30223, 30224	63,054
Butts	30233	28,923

Demographic Data

by County and State (2018)*

WellStar AMC and WellStar AMC South

The population in Georgia is one of the fastest-growing in the nation. The community served by WellStar AMC and WellStar AMC South also is projected to grow at a rapid pace. When compared to Georgia, the community is also younger and more diverse, with a higher percentage of limited English-speaking skills. Among the three primary counties served by WellStar AMC and WellStar AMC South, DeKalb and Fulton counties are higher-income-earning, slightly older and less diverse than Clayton County.

Total Population

US TOTAL POPULATION

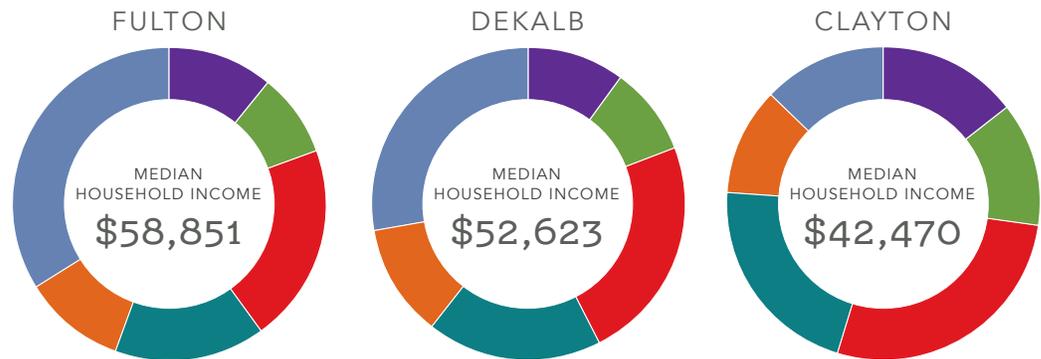
326,533,070



Income Distribution

U.S. MEDIAN HOUSEHOLD INCOME

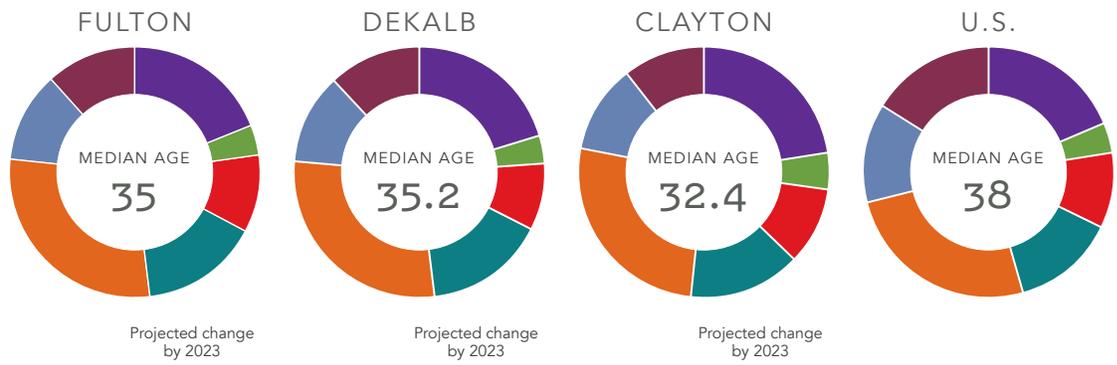
\$55,510



Income Bracket	FULTON	DEKALB	CLAYTON
Less than \$15,000	11.10%	10.20%	14.60%
\$15,000 - 24,999	8.60%	9.00%	12.90%
\$25,000 - 49,999	20.60%	23.40%	27.50%
\$50,000 - 74,999	15.40%	18.00%	21.30%
\$75,000 - 99,999	10.60%	11.80%	11.10%
\$100,000 and over	33.80%	27.60%	12.70%

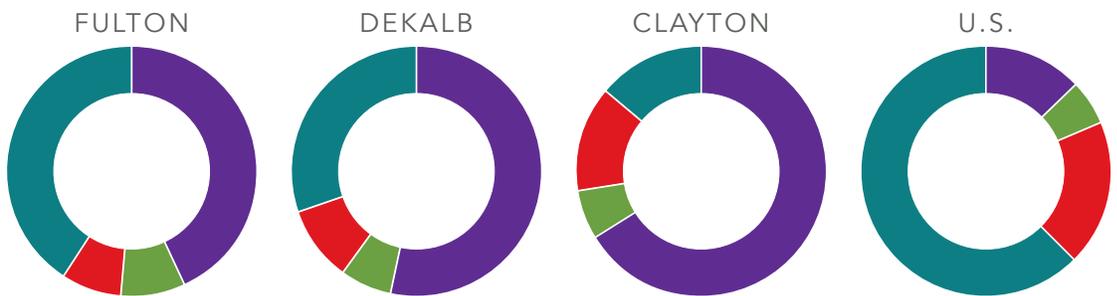
* Demographics Expert 2.7, 2018 Demographic Snapshot
 U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: <http://www.census.gov/acs/www/>

Age Distribution



	FULTON	DEKALB	CLAYTON	U.S.
0-14 years old	19.0%	20.4%	22.6%	18.7%
15-17 years old	3.9%	3.6%	4.6%	3.9%
18-24 years old	10.1%	8.5%	10.0%	9.7%
25-34 years old	15.3%	15.6%	14.5%	13.4%
35-54 years old	28.5%	28.3%	26.4%	25.5%
55-64 years old	11.6%	11.8%	11.4%	12.9%
65+ years old	11.6%	11.7%	10.4%	15.9%

Racial/Ethnic Distribution



Racial/Ethnic Group	FULTON	DEKALB	CLAYTON	U.S.
Black	42.10%	52.10%	64.80%	12.40%
Asian	8.10%	6.60%	6.10%	5.80%
Hispanic†	7.60%	9.40%	13.40%	18.20%
Non-Hispanic White	39.70%	29.40%	13.40%	60.40%
Limited English	5.60%	9.00%	9.30%	10.00%

* County Health Rankings and Roadmaps: countyhealthrankings.org

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

Truven Health Analytics, Community Need Index

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

Community Is **Contribution**

ASSESSING THE NEEDS



Data Collection

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

The secondary data was compiled from a variety of sources that are reliable and representative of the community served by WellStar AMC and WellStar AMC South. Data sources include, but are not limited to:

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

Many publicly available data sources are 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 health needs. Data sources reviewed for this assessment can be found in the associated data tables.

To better understand the experience and needs of residents served by the hospitals, several types of qualitative data were used. Qualitative data included:

- Focus groups with residents,
- One-on-one interviews with key stakeholders,
- Listening sessions with the WellStar AMC Regional Health Board and
- A Health Summit with hospital and community leaders.

An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community Is Connection

YOUR STORY IS OUR STORY



Health Needs of the Community

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

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

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

Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing community health. The County Health Rankings, a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. County Health Rankings health outcomes measure length of life and quality of life. Among the counties served by both hospitals, Clayton County shows higher rates of mortality and the poorest quality of life, while DeKalb and Fulton counties show lower mortality rates and better quality of life. This theme is seen throughout the CHNA. Clayton County often has the poorest outcomes when compared to other counties in the service area and the state. This remains unchanged from the 2018 report.

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
Fulton	14	19	19	19	10	3	66	95
DeKalb	18	24	15	28	12	8	64	103
Clayton	59	131	37	84	106	95	130	139

* 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

As stated in the 2018 report, the leading causes of death in the hospital service area are similar when compared to the state. The top two causes of death in both the service area and throughout the state are related to heart disease (i.e., coronary artery disease and hypertension).⁴ The remainder of the top five causes of death are behavioral health causes (unrelated to psychoactive substance use), cerebrovascular disease (stroke) and lung cancer.⁵

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

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

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

Social Determinants of Health

According to Healthy People 2020, “Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-outcomes and risks.” Community and hospital leaders prioritized equitable revitalization at the community Health Summit, noting the need to improve the socioeconomic status of residents in their community through revitalization, job training and education. This addresses the disparities seen in the social determinants of health (e.g., income, employment, education, affordable housing, language skills, etc.) throughout the service area.

Poverty in the areas served by WellStar AMC and WellStar AMC South is a pervasive and growing challenge, particularly among families with children and people of color.

Unemployment has decreased across the area in the last 10 years. However, during the same period the household incomes in DeKalb and Fulton counties were stagnant, rising \$27 and \$498, respectively, and declining in Clayton County by \$2,373.[†]

Over the last decade, poverty in the general population has increased at a faster pace in Clayton County (8.4 percent) than in DeKalb and Fulton counties (3.2 percent and 2.2 percent, respectively). 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, Fulton County shows the starkest contrast between single-parent poverty when compared to all other types of families. This also is supported by zip code-level data (see Table 3). This data remains unchanged from the 2018 report.

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

	Fulton		DeKalb		Clayton	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	357,463	379,957	264,837	267,396	86,546	88,793
All people	15.30%	17.60%	16.10%	19.30%	16.70%	25.10%
All families	12.00%	13.00%	12.40%	15.00%	13.60%	21.20%
Married couple families	3.60%	4.40%	5.50%	8.00%	7.10%	11.30%
Single female head of household families	31.80%	33.20%	25.30%	28.80%	24.20%	35.80%

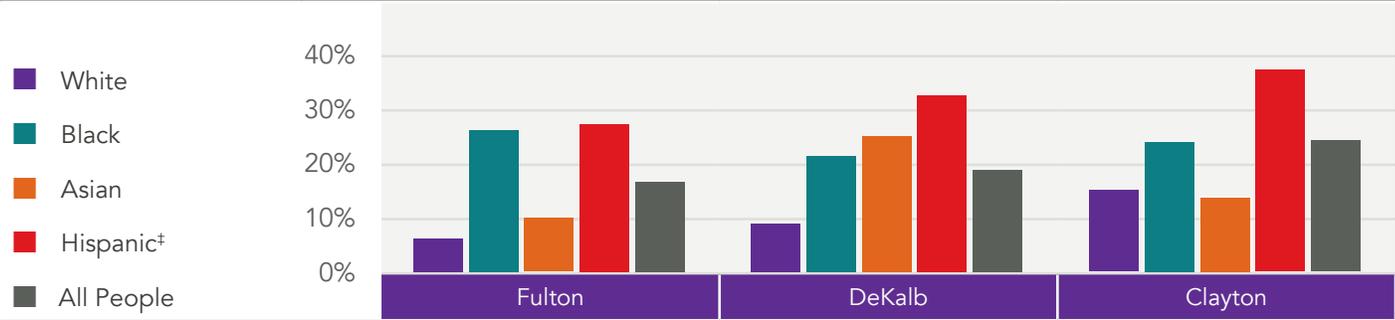
[†] Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org

Community leaders and residents drew connections between education and poverty in their discussions about health. One resident put it this way:

“Education drives what type of job you get, what type of job you get drives what community you stay in, and the community you stay in dictates what type of education you get. So it’s a cycle of education.”

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 Latino residents showing the highest rates of poverty, while Asian and Latino residents show the lowest rates of educational attainment when compared to the general population. Clayton and Fulton counties both show higher rates of poverty among Black and Latino residents when compared to their White and Asian counterparts, while DeKalb County shows higher rates of poverty among all people of color when compared to their White counterparts. Clayton and DeKalb counties show lower rates of educational attainment among Asian and Latino residents.

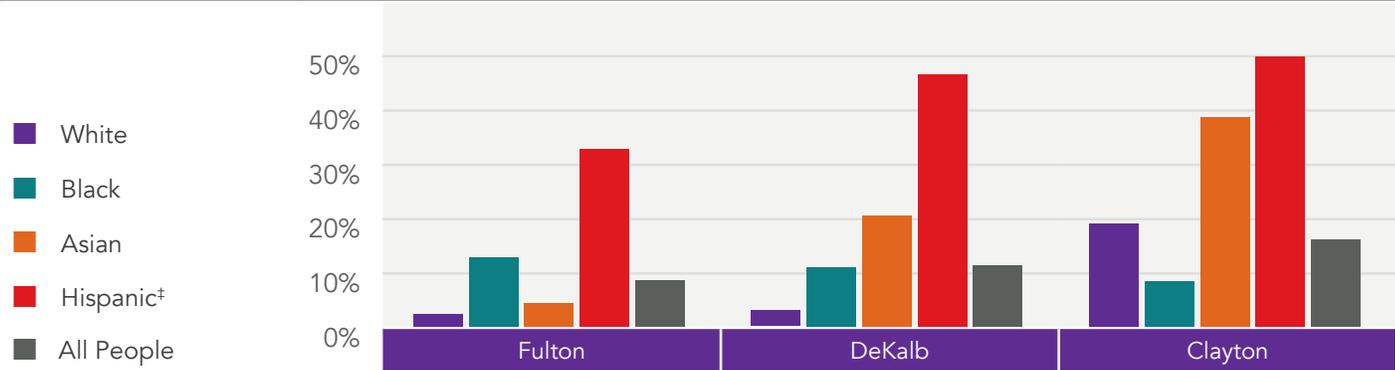
Figure 2 | Population Below Federal Poverty Level by Race/Ethnicity and County (2012-2016)[†]



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

[‡] “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 | Percentage of Population Without a High School Diploma by Race/Ethnicity and County (2012-2016)[†]



[†] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

[‡] “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. Input provided by residents noted unhealthy housing conditions in areas where poverty rates are highest (e.g., overcrowding, safety issues related to structure and poor adherence to building codes), gentrification causing displacement, rising cost of housing, and closing of homeless shelters as facilitating factors in the poor health of residents in their community. In the last 10 years, home values and homeownership have declined, with homeownership replaced by renting. This fact alone does not indicate health challenges and is likely related to both the housing crisis and the younger median age of the service area.

As Atlanta rebounds from the housing crisis, older homes are replaced by newer dwellings such as larger apartment units. This coupled with the population growth and decreasing vacancy rates may be setting the community up for challenges related to unaffordable housing and displacement. One resident described the housing situation among the three counties this way:

“[In] the past 10 to 20 years, the development in the downtown area is like the heart of Fulton County. ... It’s pushing people out because they can’t afford the cost of living in a house.”

Input provided by community leaders during the community Health Summit noted that major development efforts are not engaging residents and often lead to displacement and economic instability. This may be what is driving the increases in the percentage of residents paying more than 30 percent of their monthly income for rent.

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

	Fulton		DeKalb		Clayton	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	357,463	379,957	264,837	267,396	86,546	88,793
Family households	56.0%	54.6%	58.9%	58.5%	66.6%	66.5%
Nonfamily households	44.0%	45.4%	41.1%	41.5%	33.4%	33.5%
Vacant housing units	16.9%	14.6%	12.3%	12.7%	16.9%	15.2%
Homes more than 20 years old	61.4%	73.5%	69.3%	80.7%	61.1%	74.9%
Median value of homes	\$253,100	\$241,300	\$190,000	\$163,000	\$127,800	\$85,200
Households paying more than 30% of income for monthly mortgage	37.2%	31.7%	40.2%	35.0%	43.6%	35.0%
Households paying more than 30% of income for monthly rent	50.6%	50.4%	53.7%	54.1%	57.3%	59.7%

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

As noted in the 2018 report, 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 and language skills are lower, and unemployment and poverty are higher than county averages:

- Poverty is pervasive and single-parent poverty is high across the entire service area.
- In eight zip codes, over 20 percent of residents do not have a high school diploma.
- There are four zip code areas where more residents than is average have limited English-speaking skills.

Community residents spoke of the difficulty they experience when trying to find and use affordable health insurance. One group noted that affordable insurance is not often accepted by providers in their area or has such expensive copays and deductibles that they cannot afford to use their insurance benefits. One resident explained that unaffordable copays are a barrier to using their insurance:

“Each year, I can’t even use my healthcare now because I can’t afford to pay it.”

There are existing resources throughout the service area that address the social determinants of health.⁶ 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 this assessment.

⁶ See the *Community Facilities, Assets and Resources* section of the Appendix for a list of resources.

Access to Appropriate Care

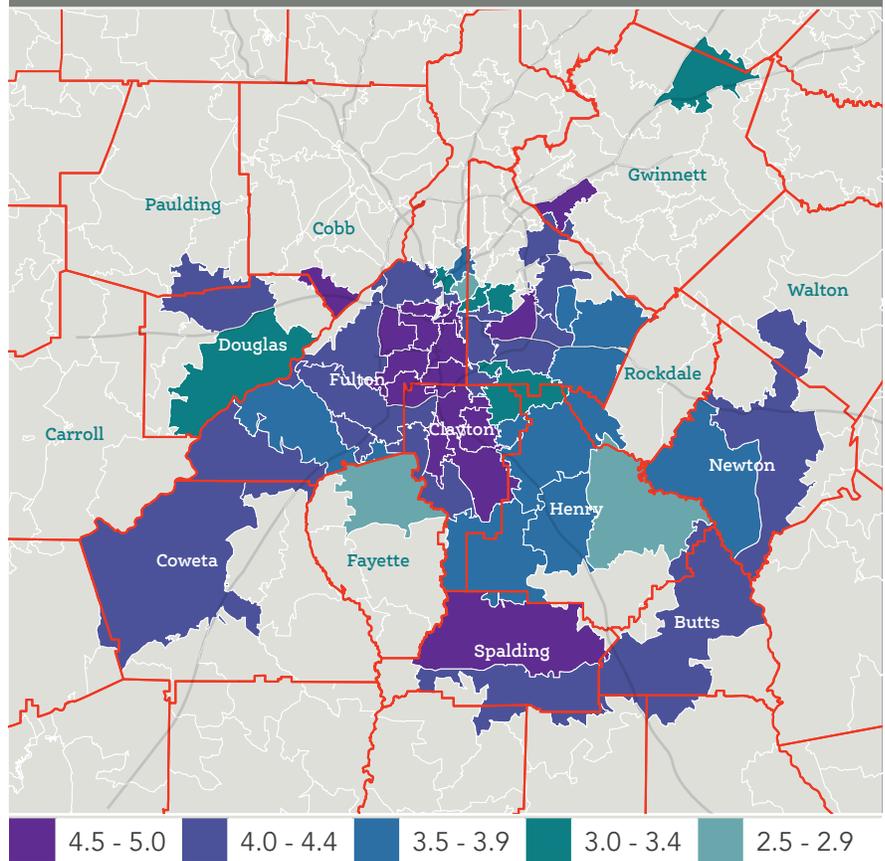
Having access to the right care at the right time influences health outcomes as well as healthcare-seeking behavior, according to the input provided by residents and community leaders. Community Health Summit participants identified access to appropriate care as one of the top community health priorities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

Input from community residents noted inadequate safety-net services. Services available are not culturally or linguistically relevant to meet the needs of all residents. One example is the limited safety-net services targeting the unique health concerns of men, particularly in Clayton County. Residents told stories about showing up for a dental clinic, only to be turned away after waiting all day or waiting years on a list to receive specialty care at local clinics.

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.⁷ 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.

Map 2 | WellStar AMC and WellStar AMC South 2018 CNI Scores by Zip Code[†]



⁷ See the Secondary Data section of the Appendix for complete CNI data.

The previous CHNA for WellStar AMC and WellStar AMC South included 2015 CNI data. During the last three years the communities served by these two hospitals have experienced a decrease in socioeconomic barriers to accessing healthcare. Some of the most notable changes are:

- Three of five zip code areas with significant barriers (5) showed improvement in overall CNI score,⁸
- There were drastic decreases in the percentage of the population with limited English skills and unemployment,
- It is notable that the decrease in uninsured is not commensurate with the decrease in unemployment, which may be due to limited growth in high-wage and full-time opportunities and
- It is notable that Fulton County continues to show a stark contrast between areas with the greatest and those with the least amount of socioeconomic barriers to accessing healthcare.

According to the 2018 CNI (see Map 2 and Table 5), most of the zip codes served by WellStar AMC and WellStar AMC South have above-average socioeconomic barriers to accessing healthcare. A closer look shows:

- There are two zip codes with CNI scores of 5 (highest barriers measured by the scale), both of which are in Fulton County.⁹
- 91 percent of zip code areas show barriers that are higher than median for the scale.
- Two primary counties covered in this assessment showed decreases in barriers, Clayton (-0.1) and DeKalb (-0.1). Fulton County showed no change (3.6).
- Five zip codes showed increases in the barriers to accessing healthcare between 2017 and 2018.¹⁰
- Twenty zip codes showed decreases in the barriers to accessing healthcare between 2017 and 2018.¹¹
- 42 percent of the zip code areas have higher rates of uninsured than the state (17.1 percent).
34 percent of the service area has more than one in five uninsured residents.

⁸ Scored 5 on CNI Index in 2015 and showed improvements in 2018 (30297, 30314 and 30354)

⁹ Scored 5 on CNI index: Fulton County (30310 and 30315)

¹⁰ Increases in CNI Scores between 2017-2018: Butts (30233), Cobb (30168), Clayton (30296), DeKalb (30317) and Fulton (30268)

¹¹ Decreases in CNI Scores between 2017-2018: Clayton (30273, 30297, 30238), DeKalb (30030, 30294, 30316, 30288, 30038, 30058), Douglas (30134), Fulton (30318, 30337, 30291 and 30354), Gwinnett (30359), Henry (30253, 30252, 30281), Newton (30014 and 30016).

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): 10 Highest Barrier vs. 10 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
10 Areas With the Highest CNI Scores												
30310	Fulton	0	5	25%	43%	54%	0.5%	93%	20%	14%	38%	61%
30315	Fulton	0	5	30%	47%	61%	2%	87%	21%	16%	44%	63%
30297	Clayton	-0.2	4.8	14%	37%	49%	14%	85%	31%	14%	33%	56%
30032	DeKalb	0	4.8	17%	36%	47%	1%	87%	20%	14%	24%	48%
30303	Fulton	0	4.8	37%	36%	57%	0.5%	57%	18%	17%	29%	73%
30311	Fulton	0	4.8	19%	55%	69%	2%	97%	17.1%	17%	40%	58%
30314	Fulton	0	4.8	15%	43%	51%	0.5%	97%	16%	16%	33%	65%
30337	Fulton	-0.2	4.8	18%	39%	62%	2%	85%	18%	12%	30%	67%
30236	Clayton	0	4.6	6%	32%	52%	5%	79%	14%	11%	23%	42%
30260	Clayton	0	4.6	10%	19%	33%	11%	85%	22%	11%	23%	50%
10 Areas With the Lowest CNI Scores												
30306	Fulton	0	2.8	5%	6%	27%	1%	16%	3%	3%	8%	48%
30309	Fulton	0	3	12%	6%	20%	0.3%	34%	2%	2%	10%	57%
30030	DeKalb	-0.2	3.2	15%	10%	23%	2%	28%	5%	5%	14%	40%
30294	DeKalb	0.2	3.2	8%	13%	24%	2%	92%	11%	9%	11%	17%
30307	DeKalb	0	3.2	9%	11%	39%	0.5%	21%	3%	3%	9%	42%
30273	Clayton	-0.2	3.6	9%	21%	24%	5%	87%	12%	8%	16%	21%
30038	DeKalb	-0.2	3.8	17%	14%	23%	0.4%	97%	8%	9%	15%	39%
30058	DeKalb	-0.2	3.8	19%	16%	24%	1%	97%	8%	11%	14%	35%
30088	DeKalb	0	3.8	7%	21%	33%	1%	96%	9%	13%	14%	34%
30213	Fulton	0	3.8	9%	14%	21%	1%	89%	11%	8%	14%	30%
Clayton Total		-0.1	4.4	9%	30%	45%	6%	87%	16%	11%	24%	41%
DeKalb Total		-0.1	3.9	12%	21%	35%	6%	71%	12%	9%	15%	42%
Fulton Total		0	3.6	12%	19%	35%	2%	60%	9%	8%	16%	45%

† Truven Health Analytics, Community Needs Index (2018)

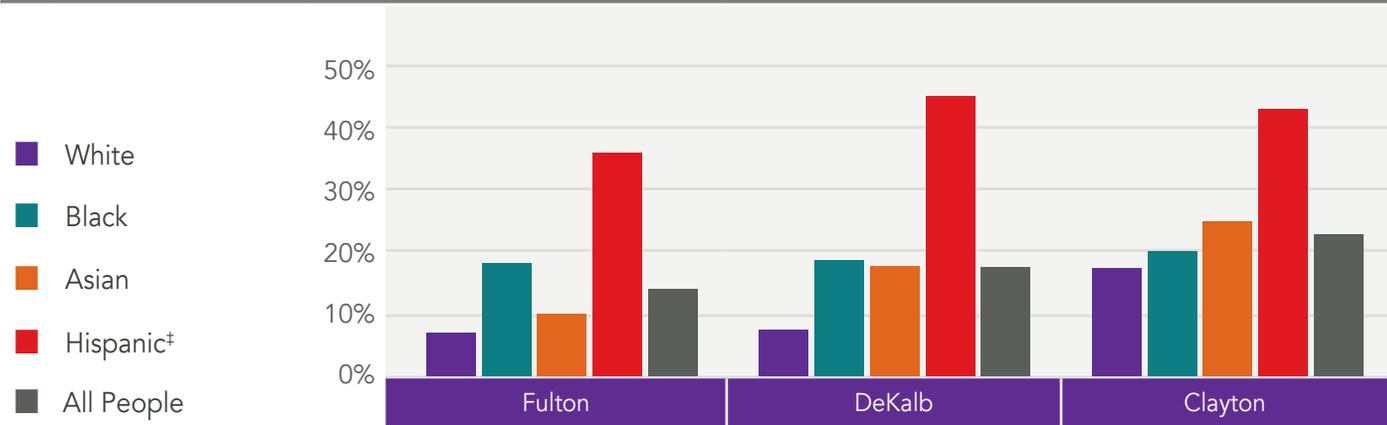
A greater percentage of Georgia residents are uninsured than the national average due to the lack of Medicaid expansion. At the time this assessment is being written, the percentage of uninsured people has been decreasing across the state as the economy improves and employment increases. The percentage of uninsured residents in DeKalb and Fulton counties is average for the state and higher in Clayton County. Private insurance options are not always affordable for residents who do not have access to insurance through employment. One resident described her experience:

"I remember when I didn't have Medicare and not working, no income; every plan that I called, it was \$400 or more a month [for insurance]. That's not affordable."

Uninsured

Figure 4 shows the disparities in the rates of uninsured when considering the data by racial and ethnic groups throughout the community, with Latino and Black residents showing the highest rates of uninsured when compared to their White and Asian counterparts. Latino residents are four times more likely to be uninsured, when compared to their White counterparts. This data remains unchanged from the 2018 report.

Figure 4 | Percentage of Uninsured Population by Race/Ethnicity and County (2011-2015)[†]



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

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

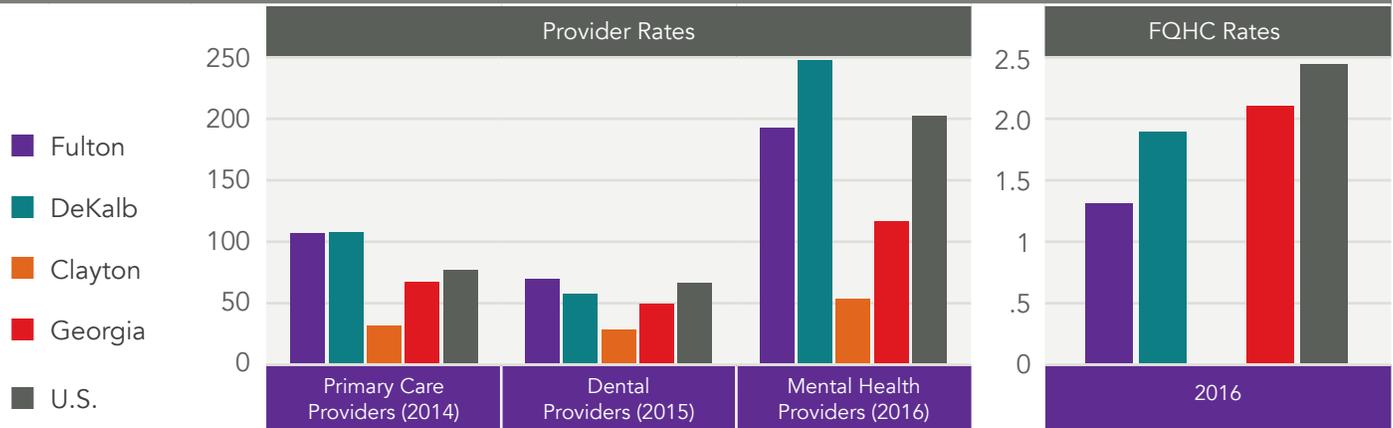
Provider Shortage

There is a shortage of healthcare and dental providers throughout the service area, particularly among safety-net providers that offer free or reduced-cost healthcare based on income (see Map 3 for a geographic representation). Clayton County has the fewest primary care, mental health and dental care providers. One Clayton County resident described her experience seeking healthcare:

"In order for me to go see a doctor, I really have to go to Gwinnett County or I have to go to Fulton County to go to the hospital. Like, yeah, there might be the medical care somewhere, but it's nowhere close to me."

While Fulton and DeKalb counties have higher rates of primary care and dental care providers, there are fewer Federally Qualified Health Centers (FQHCs) in both counties when compared to the state and national rates.

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



† Health Resources & Services Administration: Area Health Resource File through County Health Rankings: <https://datawarehouse.hrsa.gov/topics/ahrf.aspx>

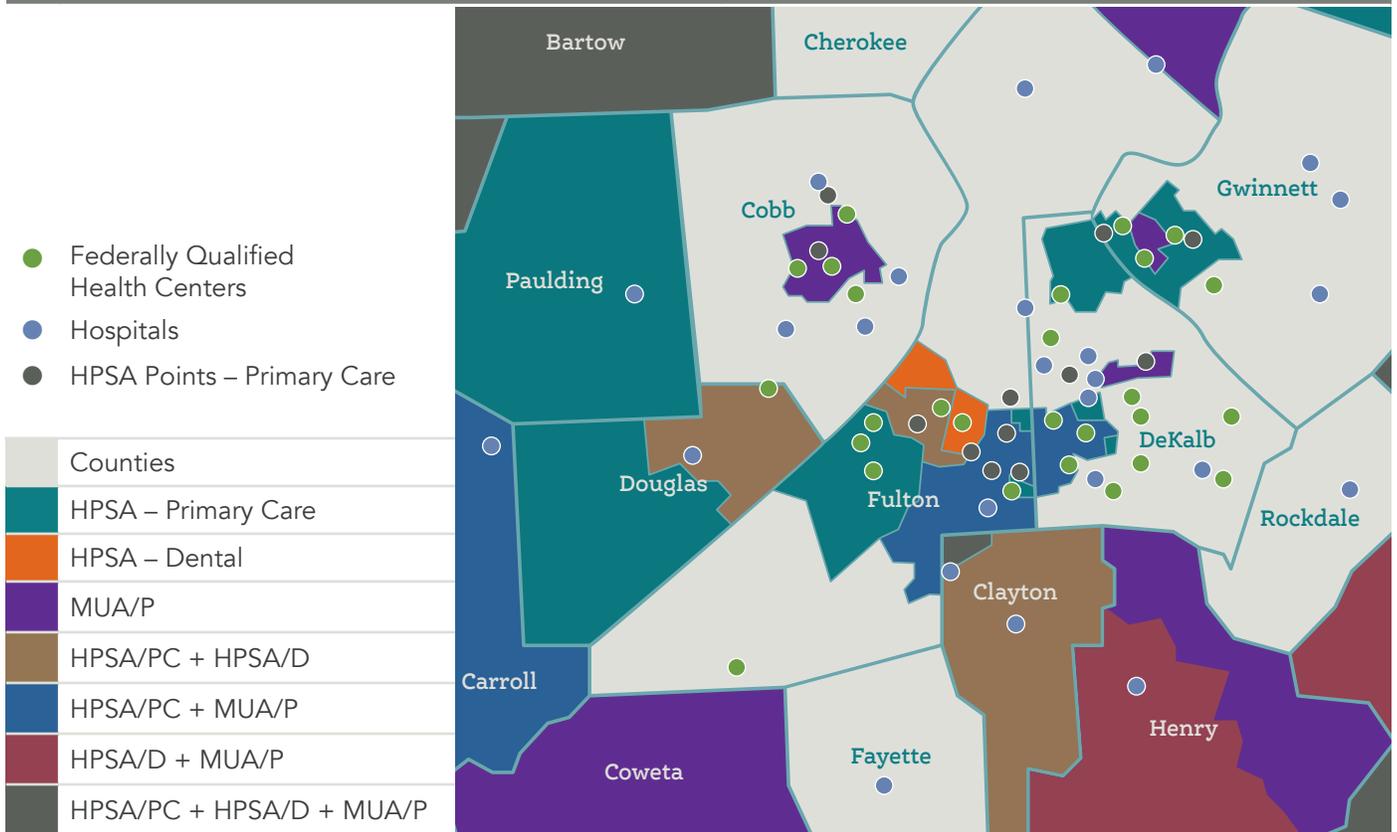
U.S. Census Bureau, 2010 Decennial Census, POS Provider of Services File: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html>

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

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

- There are Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) in Fulton, DeKalb and Clayton counties, and
- Most safety-net providers are located in downtown Atlanta, leaving very few safety-net providers to serve the northern and southern regions of the service area.

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



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

A resident talked about the barriers posed by technology to healthcare and social benefits by saying:

“I see a lot of seniors that can’t go online to renew things because they’re not computer savvy. Might be able to find a teenager and if you could get somebody to give you help. I don’t see any community service that is focused toward helping seniors do things [online].”

Another resident talked about the limited access that many low-income areas have to the Internet:

“Well, it’s gone farther than that. A lot of people in our neighborhoods can’t afford Wi-Fi.”

There are existing resources throughout the service area that offer access to care.¹² 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.

¹² 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 residents are dying because they do not have access to healthy options like healthy produce and safe places to exercise.

One focus group participant described the relationship between poverty and healthy behaviors in this way:

“I think it’s more financial than education because it is what it is. I know what to cook, I know what to eat but I can’t afford that.”

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.¹³

As noted in the 2018 report, all counties included in this assessment show signs of food insecurity and low access to grocery stores. The geographic areas with lowest access to grocery stores are central to the service area and downtown Atlanta (see Map 4). Residents in Clayton and Fulton counties have the lowest access to supermarkets and grocery stores when compared to DeKalb. The percentage of low-income residents with low access to grocery stores in Fulton County is more than three times that of Clayton or DeKalb counties. One resident explained:

“Well, you can get a dollar burger, but try to buy a cup of fruit, it’s \$6.99.”

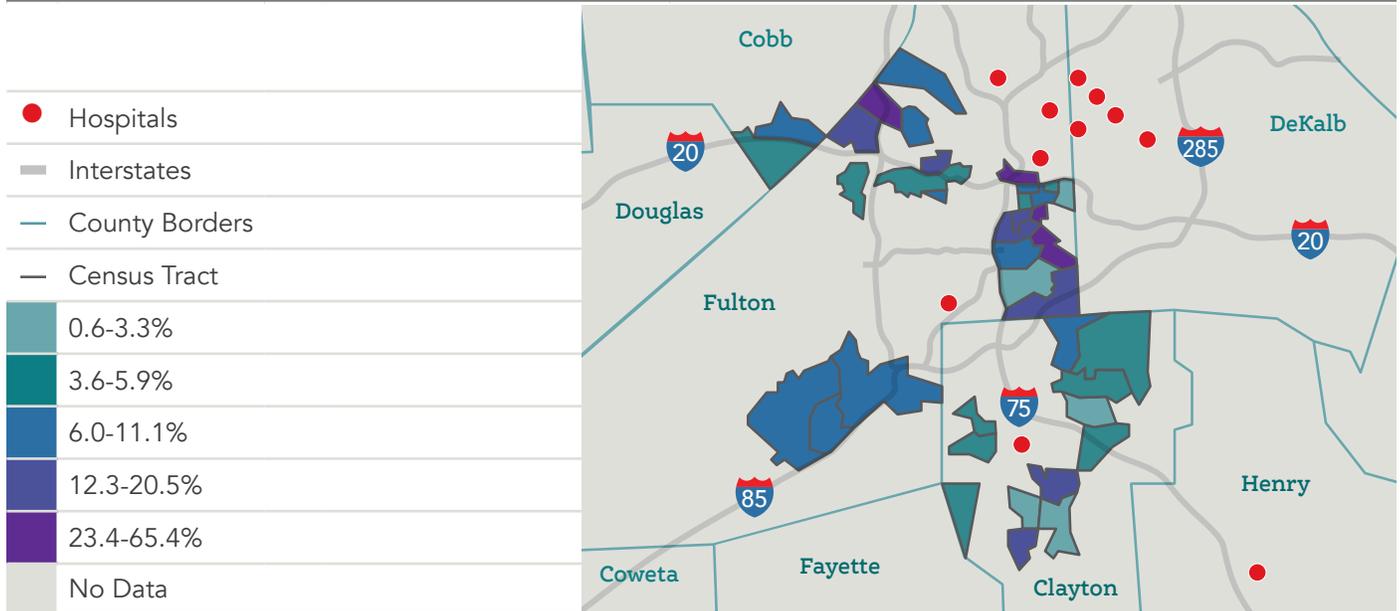
Table 6 | Selected Populations With Low Access to a Supermarket or Large Grocery Store by County (2010-2015)[†]

Healthy Eating, Active Living Indicators	Fulton	DeKalb	Clayton
Residents with low access to a supermarket	57.80%	32.20%	42.40%
Low-income residents with low access to a supermarket	17.10%	4.70%	5.10%
Children with low access to a supermarket	18.20%	7.70%	13.00%
Seniors with low access to a supermarket	4.10%	1.60%	2.40%

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

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

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

One of the top priorities identified by community and hospital leaders during the community Health Summit was obesity. Community input suggests that residents do not have or make time to shop and prepare meals or exercise in a healthy way. As noted in the 2018 report, the data shows adults are physically inactive in Clayton and DeKalb counties, which also are counties where more people than average are spending over an hour on their work commute. Additionally, community residents indicated that while exercise facilities are readily available, the memberships to these facilities are not always affordable. One resident noted that:

“Fulton County’s recreation opportunities are less than before and may have been free in the past.”

Table 7 | Selected Healthy Eating, Active Living Indicators†

	Fulton	DeKalb	Clayton	Georgia	U.S.
Healthy food stores (low access)	ND	23.40%	39.70%	30.80%	22.40%
Exercise opportunities – access	ND	96.20%	82.50%	75.90%	84.30%
Physical inactivity – adults	18.00%	20.20%	25.70%	23.10%	21.80%
Driving alone to work, long distances (>60 mins)	37.80%	48.80%	47.10%	40.00%	34.80%

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

† USDA Food Access Research Atlas (FARA), <http://www.ers.usda.gov/data-products/food-access-research-atlas>

County Health Rankings and Roadmaps: countyhealthrankings.org

NCCDPHP National Center for Chronic Disease Prevention and Health Promotion: <http://www.cdc.gov/nccdphp/dnpao/index.html>

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

Health Knowledge

Community Health Summit participants prioritized educational awareness as one of the most pressing health issues that could improve health outcomes in their community if effectively addressed. There is no measure of educational awareness in the context of healthy options and availability of resources.

Community leaders discussed the need for residents to be aware of the impact their choices have on personal and family health. More specifically, leaders felt that residents are not always fully aware of positive parenting practices, the need for prenatal care, how to shop for and prepare healthy nutrition and resources available in their community. One resident said:

“Honestly, I have health issues now because of poor choices that I made when I was younger.”

Residents spoke about the need to increase educational outreach in their community related to healthy options and preventive practices like health screenings.

There are existing resources throughout the community addressing health behaviors.¹⁴ Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors noted in the CHNA.

¹⁴ 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 causes of mortality and hospital use (emergency department [ED] and hospitalization) in the service area are related to chronic conditions, lifestyle and behaviors. When considering county-level data, Clayton County shows the greatest morbidity (disease burden) and mortality (death) when compared to Fulton and DeKalb counties. Throughout the service area, Black residents show the highest mortality rates when the data are considered by race, and Multiracial residents experienced higher rates of ED visits and hospital discharges compared to other racial groups. While data for Latino residents are limited, there is anecdotal evidence that Latino residents experience high rates of morbidity and mortality related to chronic conditions as well.

Top Causes of Premature Death

The top five causes of premature death are derived from the Years of Potential Life Lost 75 (YPLL 75), which represents the number of years of potential life lost due to death before age 75 as a measure of premature death. In the communities served by both hospitals, premature death seems to be caused by accidents, infant mortality, homicide and heart disease. The rate of premature death due to assault is high across the CHNA region served by WellStar AMC and WellStar AMC South. Clayton County shows the highest rates of premature death when compared to the state and Fulton and DeKalb counties. There are notable inequities when premature death is considered by race, with Black and Multiracial residents showing much higher rates when compared to all other races.

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

By Region	Assault (Homicide)	Certain Conditions Originating in the Perinatal Period	Ischemic Heart and Vascular Disease	Accidental Poisoning and Exposure to Noxious Substances	Motor Vehicle Crashes
Fulton	490.80	291.70	321.30	477.40	311.10
Clayton	799.40	672.50	629.40	362.70	613.50
DeKalb	583.50	558.70	307.40	356.70	366.90
Georgia	338.60	360.00	524.80	477.90	491.40
By Race**					
White	154.20	72.30	335.10	694.90	154.20
Black	541.50	655.90	466.40	330.90	541.50
Hispanic ‡	458.70	421.10	106.70	269.70	458.70
Asian	103.20	444.30	95.00	ND	103.20
Native American	0.00	0.00	0.00	ND	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial ‡	0.00	845.50	0.00	ND	0.00

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

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

* Age adjusted, per 100,000 population

** Three-county aggregate

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

Top Causes of Death

Reported causes of death are based on the underlying cause of death. The underlying cause of death is defined by the WHO 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 three of the top five causes of death are cardiovascular in nature. Georgia is well known to have poor outcomes related to cardiovascular disease, and Clayton County is the only county that shows much higher rates of mortality than the state in these areas. While Black residents show higher rates of death when compared to all other races (when data is available), rates are not significantly higher when compared to the state.

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

By Region	Ischemic Heart and Vascular Disease	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease	Cerebrovascular Disease	Malignant Neoplasms of the Trachea, Bronchus, and Lung	All Other Mental and Behavioral Disorders
Fulton	50.00	22.20	40.90	30.60	24.90
DeKalb	48.40	17.00	35.90	29.10	22.80
Clayton	79.50	37.00	57.20	35.90	24.70
Georgia	73.10	18.10	43.40	42.40	30.80
By Race**					
White	47.30	16.80	32.20	26.60	19.10
Black	61.60	29.00	50.80	32.40	32.70
Hispanic ‡	32.10	ND	18.90	ND	8.20
Asian	22.20	14.10	22.50	16.20	ND
Native American	0.00	0.00	0.00	0.00	ND
Pacific Islander	0.00	0.00	ND	0.00	0.00
Multiracial ‡	0.00	0.00	ND	ND	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

** Three-county aggregate

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

Top Causes for Emergency Department Visits

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

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

By Region	Diseases of the Musculoskeletal System and Connective Tissue	All Other Unintentional Injury	All Other Diseases of the Genitourinary System	Falls	Motor Vehicle Crashes
Fulton	3,261.30	1,906.80	2,027.80	1,272.20	991.1
DeKalb	3,689.80	2,505.10	2,456.10	1,307.50	1,658.80
Clayton	3,272.30	1,552.80	1,964.50	1,054.30	1,035.70
Georgia	3,276.90	3,030.00	2,394.20	1,918.40	1,168.80
By Race**					
White	1,090.00	1,154.00	912.40	1,087.60	362.50
Black	5,339.40	2,434.90	3,024.60	1,249.90	1,673.30
Asian	496.20	501.60	359.90	410.40	231.10
Native American	2,748.70	2,453.70	1,982.90	1,554.30	1,580.70
Pacific Islander	1,564.80	1,529.10	1,051.60	1,503.00	ND
Multiracial‡	6,530.40	5,183.70	5,095.20	3,439.10	3,569.00

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

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

* Age adjusted, per 100,000 population

** Three-county aggregate

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

Top Causes for Hospital Discharges

The number of inpatients discharged from nonfederal acute-care inpatient facilities 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 child birth, mental illness and septicemia. Hospitalization rates due to septicemia are high in Clayton County when compared to all other counties and the state, while mental and behavioral disorders are slightly elevated in DeKalb and Fulton counties. Similar to ED visit rates, rates for Black and Multiracial residents are the highest rates 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	All Other Mental and Behavioral Disorders	Diseases of the Musculoskeletal System and Connective Tissue	Septicemia	Ischemic Heart and Vascular Disease
Fulton	1,160.70	553.30	429.80	500.10	190.60
DeKalb	1,499.90	553.60	409.90	413.20	188.80
Clayton	1,491.60	450.80	425.20	848.50	237.80
Georgia	1,289.50	531.50	489.30	514.50	255.30
By Race**					
White	933.30	401.50	425.40	376.70	152.10
Black	1,421.70	677.50	432.20	636.60	235.60
Hispanic ‡	ND	ND	ND	ND	ND
Asian	1,137.50	50.00	138.90	188.60	82.80
Native American	1,369.00	214.20	669.30	816.00	351.10
Pacific Islander	1,194.40	ND	ND	657.30	1,089.30
Multiracial ‡	5,932.90	1,488.80	773.10	1,482.10	640.20

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

** Three-county aggregate

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

Obesity

At the time of this CHNA, high body mass index (BMI) is a health issue throughout the country, and this community is no exception. More than one in three adults is overweight, and more than one in four adults is obese (with the exception of Fulton County). It is important to note that obesity is showing signs of slowed growth within the last three years. In correlation with obesity, diabetes remains a health concern in Clayton County, where morbidity rates are elevated and mortality rates are higher than the rest of the area. DeKalb County also shows higher hospital discharge rates for diabetes, which could possibly point to barriers to effective preventive and primary care.

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

	Fulton	DeKalb	Clayton	White**	Asian**	Black**	Hispanic***	Georgia
Adult obesity (2014)	25.80%	27.20%	36.40%	ND	ND	ND	ND	30.20%
Diagnosed diabetes (2013)	8.70%	10.00%	11.00%	ND	ND	ND	ND	10.60%
Diabetes discharge rate* (2013-17)	186.60	219.70	232.20	82.20	36.20	324.30	ND	188.10
Diabetes mortality* (2013-17)	17.50	21.00	30.00	10.00	11.90	32.40	ND	21.70

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

* County Health Rankings and Roadmaps: countyhealthrankings.org

Centers of Disease Control and Prevention, Diagnosed Diabetes Prevalence:

<https://www.cdc.gov/diabetes/data/countydata/countydataindicators.html>

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

** Three-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 noted in the 2018 report, this community reflects higher cardiovascular disease when compared to the nation. When asked what the most common health issues are in their community, residents often told stories about family, friends and neighbors living with and dying from heart disease. Clayton County residents experience higher morbidity and mortality related to both obstructive heart and cerebrovascular disease, and Fulton County shows higher rates of hypertensive heart disease. It is notable that Clayton County shows higher rates of mortality but lower rates of morbidity for hypertensive heart disease, which again may point to barriers to effective preventive and primary care.

Table 13 | Selected Cardiovascular Condition Indicators by County and Race (2016)[†]

	Fulton	DeKalb	Clayton	White**	Asian**	Black**	Hispanic**‡	Georgia
Obstructive heart disease/heart attack discharge rate*	195.30	205.70	236.10	159.20	87.60	242.80	ND	265.00
Obstructive heart disease mortality*	56.30	53.20	71.20	50.30	31.30	65.20	25.90	76.40
Hypertensive heart disease discharge rate*	47.80	47.20	55.30	21.60	10.70	75.70	ND	39.00
Hypertensive heart disease mortality*	24.40	19.90	32.20	13.20	9.40	31.90	5.10	16.20
Stroke mortality*	39.20	40.50	48.80	31.80	50.80	28.90	17.80	43.00
Stroke Prevalence (2015)	4.00%	4.60%	4.80%	ND	ND	ND	ND	4.20%

ND: Data was 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

Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse: <http://www.cms.gov/>

[‡] "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.

* Age adjusted, per 100,000 population

** Three-county aggregate

Cancer

Cancer rates are elevated in Georgia when compared to the national average. There are higher morbidity rates for breast and prostate cancers across the service area, with Clayton County showing highest morbidity rates for lung, cervical, prostate, colon and rectal cancers. It is notable that Latino residents show much higher rates of cervical cancer than any other race, which may be related to human papillomavirus.

Table 14 | Selected Cancer Indicators by County and Race (2012-2016)[†]

	Fulton	DeKalb	Clayton	White**	Asian**	Black**	Hispanic***†	Georgia	U.S.
Breast cancer incidence*	132.10	136.00	134.20	126.70	80.60	127.80	99.00	125.20	124.70
Cervical cancer incidence*	6.90	6.70	9.80	8.00	5.60	8.00	9.50	7.80	7.50
Colon and rectum cancer incidence*	38.10	40.60	46.80	33.80	28.60	47.30	29.60	41.80	39.20
Prostate cancer incidence*	143.80	143.90	155.30	114.20	44.90	190.60	90.01	123.30	109.00
Lung cancer incidence*	51.20	51.20	62.00	49.70	26.70	57.30	32.10	64.90	60.20
Cancer mortality*	155.10	149.90	164.80	137.80	85.60	178.50	64.20	164.92	160.90

[†] CARES Engagement Network: National Cancer Institute and Center for Disease Control and Prevention, State Cancer Profiles: statecancerprofiles.cancer.gov

* Age adjusted, per 100,000 population

** Three-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

Asthma is common in densely populated urban areas for a variety of reasons. Residents living in the urban areas included in this assessment also suffer from higher morbidity rates for asthma.

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

	Fulton	DeKalb	Clayton	White**	Asian**	Black**	Hispanic***†	Georgia
Asthma discharge rate*	104.90	124.60	88.20	52.40	166.30	29.00	ND	86.50
Asthma ED visit rate*	657.20	754.90	725.50	244.00	116.70	1103.90	ND	551.60

ND: Data was 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

* Age adjusted, per 100,000 population

** Three-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.

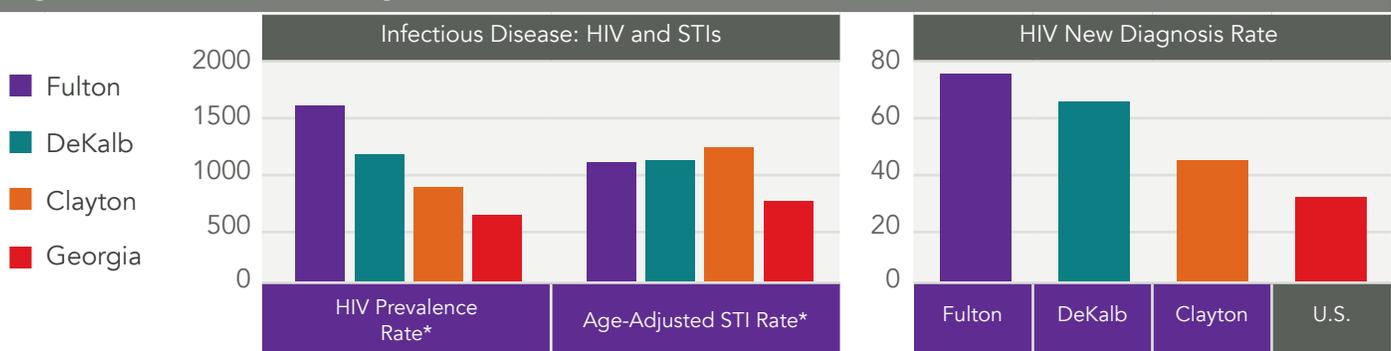
Sexually Transmitted Infections

As noted in the 2018 report, the metro Atlanta area has some of the highest morbidity rates for HIV and AIDS in the nation. All three counties show higher rates of HIV when compared to the state, with Fulton County showing the highest rates. The prevalence of HIV throughout the service area was discussed by every primary data source (key informant interviews, resident focus groups, Regional Health Board listening session and during the Health Summit).

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

- Prevalence and new cases in all three counties are higher than in the state,
- 39 zip codes have higher prevalence rates than the state (564 per 100,000 population),
- 41 zip codes have higher rates of new cases than the state (28 per 100,000 population),
- Black men are being diagnosed with HIV at a much higher rate than any other racial or ethnic group and
- Senior diagnosis rates have been on the rise in recent years.¹⁵

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



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

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

* Per 100,000 population

Birth Outcomes

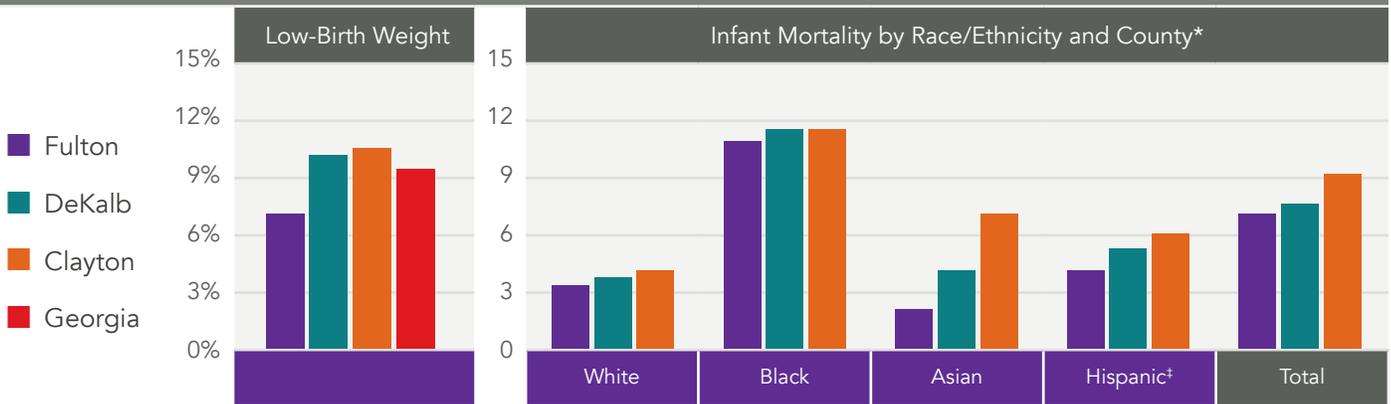
Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth. Anecdotal information from community input indicates a lack of prenatal care and high rates of low-birth-weight (LBW) infants across the hospitals' service area. Access to and appropriate use of prenatal care were identified as priorities during the WellStar AMC Regional Health Board listening session and the Health Summit.

According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of LBW infants, infant mortality and maternal mortality, among other issues. Input gathered from resident focus groups often cited limited access to comprehensive medical insurance, 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). Latino residents noted that cultural norms related to childbirth often lead to higher rates of teen pregnancy and STIs in the Latino community. This also is reflected in secondary data.

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

According to the 2018–2021 Strategic Plan for the Atlanta Perinatal Region, Clayton County is one of five counties and Fulton and DeKalb counties are among 15 counties with the highest infant mortality rates among the 35 counties included in the Atlanta Perinatal Region.¹⁶ Figures 7 and 8 show Clayton County's higher rates of LBW and infant mortality when compared to the other counties in the service area and the state. Table 16 shows that injury rates are elevated in Clayton County, and assault rates are high across the service area.

Figure 7 | Birth Outcomes (2013-2017)[†]



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

* Infant mortality defined 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.

Table 16 | Selected Injury Indicators (2012-2017)[†]

	Fulton	DeKalb	Clayton	Georgia
Assault discharge rate (2013-17)*	42.60	36.40	28.70	18.60
Motor vehicle crash ED visit rate (2013-17)*	898.00	1,008.80	1,448.60	1,099.90
Impaired driving deaths (2011-15)	22.80%	22.40%	19.70%	23.40%

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

* Number of infant deaths per 1,000 live births

Behavioral Health

The need for behavioral health resources, particularly for under- and uninsured patients, is a challenge across the state of Georgia. Community Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia hospitals for mental health issues in 2016.¹⁷ Anecdotal information gathered from community input revealed behavioral health issues impact all demographics. Residents also indicated that there is a shortage of psychiatric and inpatient services (crisis, substance abuse, etc.) for adults and children.

¹⁶ Healthy Mothers, Healthy Babies Coalition of Georgia, 2016 State of the State of Maternal and Infant Health in Georgia <https://drive.google.com/file/d/0BxndQpkPFFfySm5aNmdkYXZYQm8/view>

¹⁷ Overwhelmed In The ER: Georgia's Mental Health Crisis (Feb. 28, 2018), Elly Yu, <https://www.wabe.org/overwhelmed-er-georgias-mental-health-crisis/>

Table 17 depicts the need for behavioral health providers, with more than 358,405 residents living in areas with professional shortages. Community input also noted that the limited capacity to serve under- and uninsured behavioral health patients often leads to longer wait times for residents seeking services, increased ED use and higher rates of injury. This data remains unchanged from the 2018 report.

Table 18 shows low provider rates in Clayton County when compared to Fulton and DeKalb counties. However, there is no measure of the rate of behavioral health providers that offer care to uninsured patients. It also shows there is a much higher rate of ED use in Fulton County when compared to all other counties in the service area and the state, which may point to barriers to accessing treatment in more appropriate settings. Note that WellStar AMC and WellStar AMC South both offer uninsured care, including behavioral healthcare, to uninsured residents in Fulton and DeKalb counties but is located in Fulton County. 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 providers being located too far away from home.

Table 17 | Selected Characteristics of Health Professional Shortage Areas by County (2016)[†]

Region Designated	South Central Fulton	Fulton County Correctional Facilities	Cobb County–Central Marietta	Cherokee County
Number of People in Mental Health HPSA	64,687	19,278	0.00	ND
Number of Mental Health FTE Needed	0.10	9.64	1.00	ND

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

[†] The HRSA Data Warehouse, Primary Dataset: Health Professional Shortage Areas (HPSAs), Secondary Dataset: Medically Underserved Areas/Populations (MUA/P) <https://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx>

Table 18 | Selected Behavioral Health Characteristics by County[†]

Healthcare Access	Fulton	DeKalb	Clayton	Georgia
Mental health providers (2016)*	191.20	247.00	53.30	115.00
Poor mental health days (2015*)	3.60	3.70	4.10	3.80
Mental health ED rate (2017)*	1,258.60	918.10	874.50	1,069.10
Mental and behavioral disorder mortality (2013-17)*	39.50	42.80	37.80	42.50
Self-harm age-adjusted discharge rate (2013-17)*	25.40	28.20	24.80	32.70
Age-adjusted suicide mortality (2013-17)*	10.40	7.90	8.90	12.70

[†] County Health Rankings and Roadmaps: countyhealthrankings.org

Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System through County Health Rankings: <http://www.cdc.gov/brfss/>

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

* Per 100,000 population

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
- Overdose deaths tripled between 1999 and 2013 in Georgia¹⁸

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

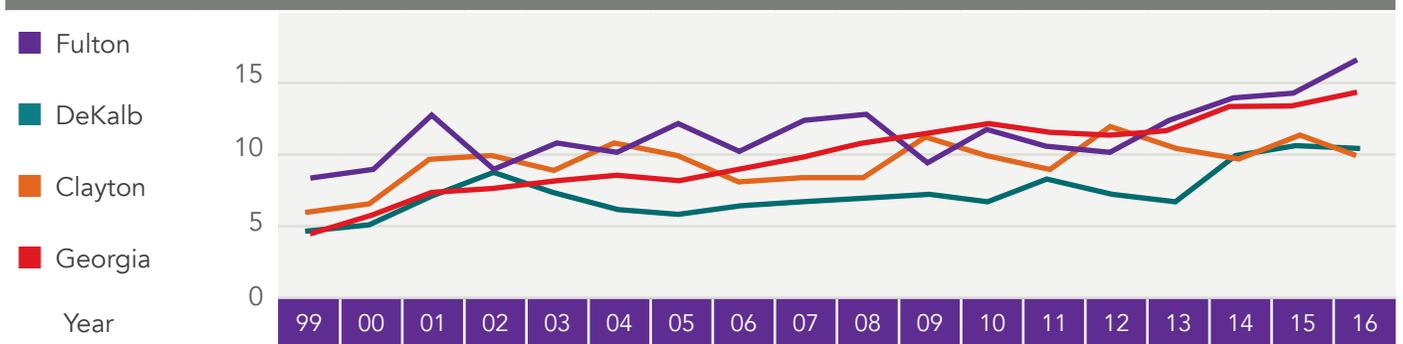
	Fulton	DeKalb	Clayton	Georgia
Drug overdoses (2007)*	10.90	6.00	7.70	8.60
Drug overdoses (2017)*	14.50	10.20	12.00	14.60

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

* Per 100,000 population

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

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

There are existing resources throughout the service area that address the common health outcomes noted in this section. See the Community Facilities, Assets and Resources section of the Appendix for a list of resources. 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.

¹⁸ 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>

Community Is Compassion

RALLYING PEOPLE AND RESOURCES



Community Input

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

Listening Session

A listening session was conducted with the WellStar AMC Regional Health Board, and individual key informant interviews were conducted with 10 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 assessment.

Focus Groups

Three focus groups were conducted to gather input from more than 35 residents living and working in the community served by WellStar AMC and WellStar AMC South. Focus group participants were asked to discuss their opinions related to the health status and outcomes – context and facilitating and blocking factors of health – and what is needed to be healthier in their community. The following pages are a summary of the community input.

Summary of CHNA Community Input

WellStar AMC and WellStar AMC South

Commonly Discussed Health Issues

Overutilization of the ED	Substance abuse and overdoses	Chronic conditions:			Infant mortality	
		Heart disease	Hypertension	HIV/AIDS	Diabetes	Cancer
Disparities among people of color	Medication noncompliance	Teen pregnancy	Kidney disease	Sexually transmitted infections		
		Asthma	Allergies	Obesity (adult and child)	Low birth weight	

Commonly Discussed Causes

Geographic location of health services coupled with limited transportation options	Limited services available for:			
	Under- and uninsured (primary, care coordination, dental and prenatal care)			
	Behavioral health (psychiatric and crisis)		Substance abuse (in- and outpatient medical stabilization)	
High rates of uninsured	Engaging residents (education and prevention)			
Low health literacy/ awareness of: Available services Healthy practices Prevention Importance of prenatal care Appropriate use of health services	Unaffordable cost:	Poverty	Single parenthood	Immigration status
	Prescriptions	Low educational attainment		Homelessness
	Uninsured care	Poor access to:		
	Lack of green space	Healthy nutrition		Race/ethnic challenges:
	Air pollution	Physical activity		Stress levels for people of color
	Poor employment options	Unhealthy cultural preferences and traditions		Distrust for the medical community
Lack of safety (high crime rates, gang activity and poor infrastructure)	Limited culturally and linguistically relevant health services (Black, Asian, Latino and LGBTQ residents)			
	Lack of appropriate supervision/ risky behavior of youth	Substandard/ unaffordable housing		

Common Recommendations

Increase access to care:		Expand community engagement to address local needs identified by residents:	
Offer adult care in pediatric settings	Collaborate with local transportation providers to address transportation issues	Create community gardens in neighborhoods	Ensure linguistic and cultural relevancy
Provide mobile health services			Encourage social support networks
Increase safety-net providers offering uninsured care (medical, dental and behavioral healthcare)	Increase awareness about what services are available	Increase the availability of community health workers	Educational opportunities targeted at improving health
	Increase the availability of community health workers		Offer healthy cooking classes using inexpensive foods
Increase awareness about behavioral health:		Healthcare workforce training to better recognize and manage behavioral health issues	
Integrate medical, dental and behavioral health service into one-stop locations			
Increase acceptance of all insurance options	Expand school-based health clinics		

Vulnerable Populations

People of color — African-Americans and Hispanics	
Rural areas	Uninsured and underinsured
	Undocumented
Previously incarcerated (mostly men)	People with behavioral health challenges
	Low socioeconomic status

Geographic Areas of Interest

College Park	Metropolitan Avenue near Georgia State Stadium
Fairburn	
Morrow	Forest Park
Union City	Jonesboro

Community Is Collaboration

STRONGER TOGETHER

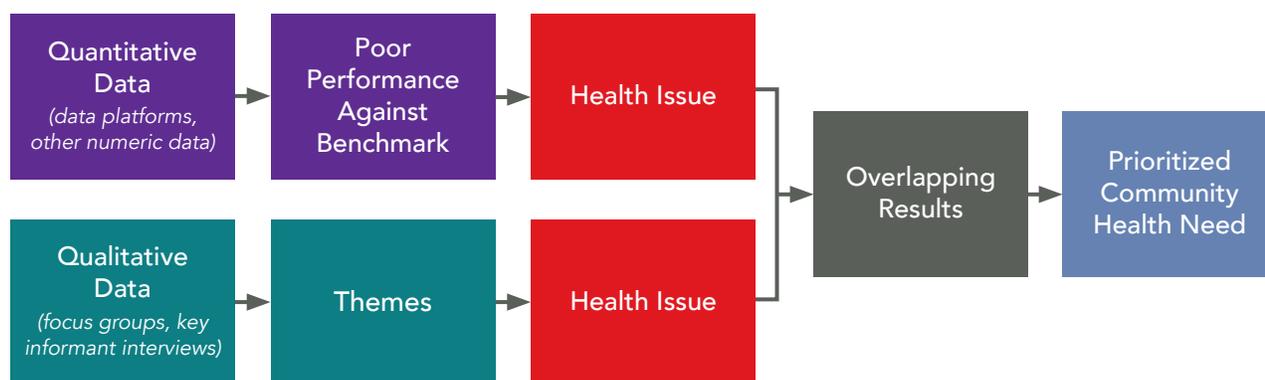


Community Health Priorities

WellStar AMC and WellStar AMC South engaged 30 community and hospital leaders to help establish the community priorities for the areas served by both hospitals during a community Health Summit, held on Feb. 28, 2018, at Atlanta Technical College in Atlanta. Community stakeholders represented organizations serving residents in the community in the primary service area of the hospitals. 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

After the presentation of both primary and secondary data, participants were asked to discuss the community health needs and 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 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 among the under-resourced populations. Health needs identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface the community health priorities, listed below in the order they were prioritized.



Health Summit participants considered obesity to be the most pressing health issue within the WellStar AMC and WellStar AMC South service area. Concerns included limited healthy food options, physical activity opportunities, utilization of community gardens and awareness of and educational opportunities related to healthy nutrition and physical activity for residents.



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



3

Behavioral healthcare

Health Summit participants prioritized behavioral health as one of the most pressing issues in the community. Poor behavioral health was attributed to stigma; a fragmented referral system; and limited behavioral health education, community outreach and services for under- and uninsured and homeless residents.



4

Educational awareness

Health Summit discussions addressed the importance of educational awareness within the community. Participants discussed the lack of education as a catalyst for numerous health issues like chronic disease and other poor health outcomes.



5

Equitable revitalization, employment and job training

Participants felt job training and equitable economic revitalization could result in improved health. Summit discussions focused on low socioeconomic status resulting from limited opportunities for education, income and employment. Participants indicated these barriers are correlated with health outcomes.

Appendix



Consultant Qualifications

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

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

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

- GHPC conducted a regional community health needs assessment (CHNA) process to meet the Internal Revenue Service regulations of Schedule H, which included 29 Georgia counties and metro Atlanta between 2015 and 2016. Partners included Grady Health System, Piedmont Healthcare, WellStar, Mercy Care and Kaiser Foundation Health Plan of Georgia (KFHPGA). The regional assessment project served as the foundation for the community health improvement planning process employed by GHPC to generate the implementation plan in partnership with Grady Health System and KFHPGA. GHPC 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 Out of 159 (2018) [†]		Age Distribution [†]			Racial Distribution [†]				
		Fulton	DeKalb	Clayton	Fulton	DeKalb	Clayton		
Fulton	14	0-14 yrs	19%	20.4%	22.6%	Non-Hispanic Black	42.1%	52.1%	64.8%
DeKalb	18	15-17 yrs	3.9%	3.6%	4.6%	Non-Hispanic White	39.7%	29.4%	13.4%
Clayton	59	18-24 yrs	10.1%	8.5%	10%	Hispanic	7.6%	9.4%	13.4%
		25-34 yrs	15.3%	15.6%	14.5%	Asian/PI	8.1%	6.6%	6.1%
		35-54 yrs	28.5%	28.3%	26.4%	All Others	2.5%	2.4%	2.3%
		55-64 yrs	11.6%	11.8%	11.4%				
		65+ yrs	11.6%	11.7%	10.4%				

[†] County Health Rankings and Roadmaps: countyhealthrankings.org
Demographics Expert 2.7, 2018 Demographic Snapshot

Socioeconomic	Fulton	DeKalb	Clayton	Georgia	U.S.
On-time high school graduation (2014-15)	72.60%	71.80%	61.50%	80.00%	88.20%
Free and reduced price lunch (2014-15)	58.10%	68.90%	93.20%	62.40%	52.60%
Unemployment rate (2017)	4.40%	4.40%	5.40%	4.30%	3.90%
Population below 100% fpl (2012-16)	16.90%	18.90%	24.30%	17.80%	15.60%
Children below 100% fpl (2012-16)	24.70%	30.10%	37.20%	25.40%	23.50%
Adults with no high school diploma (2012-16)	8.70%	11.40%	16.40%	14.20%	38.40%
Uninsured population (2011-15)	13.70%	17.10%	22.60%	15.80%	11.80%
Health Care Access	Fulton	DeKalb	Clayton	Georgia	U.S.
Primary care providers* (2014)	105.50	106.30	31.00	66.10	75.80
Dental providers* (2015)	68.40	56.60	27.00	49.20	65.50
Mental health providers* (2016)	191.20	247.00	53.30	115.00	200.00
Recent primary care visit (2014)	76.30%	76.60%	73.10%	81.00%	78.90%
Federally Qualified Health Centers* (2016)	1.30	1.90	0.00	2.10	2.40
Health Professional Shortage Area - Dental (2016)	9.90%	0.00%	100.00%	37.90%	37.80%

* Per 100,000 population

Health Determinants	Fulton	DeKalb	Clayton	Georgia	U.S.
Current smokers (2015)	16.10%	16.10%	20.50%	17.00%	15.70%
Healthy food stores (low access) (2014)	ND	23.40%	39.70%	30.80%	22.40%
Exercise opportunities – access (2010/2014)	ND	96.20%	82.50%	75.90%	84.30%
Driving alone to work, long distances (>60 mins) (2012-2016)	37.80%	48.80%	47.10%	40.00%	34.80%

ND: Data was not available

Clinical Care & Prevention	Fulton	DeKalb	Clayton	Georgia	U.S.
SNAP Benefits (2012-2016)	13.30%	15.80%	25.00%	15.30%	19.00%
Physical inactivity – 18+ yrs (2013)	18.00%	20.20%	25.70%	23.10%	21.80%
Preventable hospital events* (2014)	40.50	38.60	40.10	52.30	50.40
Teen births* (15-19) (2008-14)	34.60	38.10	46.60	38.50	32.10

Other Health Indicators	Fulton	DeKalb	Clayton	Georgia	U.S.
Population with any disability (2012-16)	10.00%	10.20%	10.60%	12.40%	12.60%
Impaired driving deaths (2011-2015)	22.80%	22.40%	19.70%	23.40%	30.00%
Poor physical health days (2015)	3.40	3.70	4.40	3.85	3.70
Poor mental health days (2015)	3.60	3.70	4.10	3.70	3.70
Stroke prevalence (2015)	4.00%	4.60%	4.80%	4.20%	4.00%
Age-adjusted drug overdoses (2007)	14.50	10.20	12.00	14.60	†
Years of potential life lost (YPLL75) (2017)	63,386.00	51,725.50	27,077.50	763,397.00	†
Mental health ER rate* (2016)	1,502.40	1,015.70	893.20	1,094.60	†
Mental and behavioral disorder mortality (2013-17)*	33.30	34.30	19.70	37.40	†
Self-harm age-adjusted discharge rate* (2013-17)	25.40	28.20	24.80	32.70	†
Suicide age-adjusted mortality (2013-17)*	10.40	7.90	8.90	12.70	†
Age-adjusted opioid overdoses (2007)*	4.50	2.70	3.70	3.40	†
Age-adjusted opioid overdoses (2017)*	9.30	6.30	6.30	9.70	†
Assault age-adjusted discharge rate* (2013-17)	42.60	36.40	28.70	18.60	†
Diagnosed diabetes-prevalence (2013)	8.70%	10.00%	11.60%	11.00%	10.00%
Diabetes age-adjusted discharge rate (2013-17)	186.60	219.7	232.20	188.10	†
Diabetes age-adjusted mortality rate* (2013-17)	17.50	21.00	30.00	21.70	†
Adult obesity (2014)	25.80%	27.20%	36.4%	30.20%	28.00%
Obs. heart disease/heart attack age-adjusted discharge rate* (2013-17)	195.30	205.70	236.10	265.00	†

* Per 100,000 population

Other Health Indicators (continued)	Fulton	DeKalb	Clayton	Georgia	U.S.
Hypertensive heart disease age-adjusted discharge rate* (2013-17)	47.80	47.20	55.30	39.00	†
Asthma ER visit rate* (2017)	738.80	727.90	763.80	525.50	†
Motor vehicle crash age-adjusted ER visit rate* (2013-17)	898.00	1,008.80	1,448.60	1,099.90	†
HIV prevalence rate* (2015)	1,599.20	1,167.30	852.20	588.00	†
HIV new diagnosis* (2015)	76.20	62.10	60.80	30.70	†
Age-adjusted STD rate except congenital syphilis* (2017)	1398.80	1310.30	1430.70	890.40	†
Low birth weight (< 2500g) per 1,000 births (2013-17)	10.70	10.00	11.70	9.60	†
Infant mortality (total; non-Hispanic White; Black) (2012-16)	7.00; 3.30; 10.90	7.60; 3.90; 11.50	9.20; 7.80; 10.90	7.50; 5.40; 12.20	†

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

Kaiser Permanente CHNA Data Platform: <http://kp-chna.ip3app.org/login?redirect=%2F>

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

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

* Per 100,000 population

† 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 AMC and WellStar AMC South

Zip	County	Change (2017 - 18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	Income	English as a Second Language	Minority	Culture	No High School Diploma	Education	Unemployed	Uninsured	Insurance	Renting	Housing
30236	Clayton	0	4.60	6.5%	32%	52%	4	4.9%	79%	5	14%	4	11%	23%	5	42%	5
30238	Clayton	0.2	4.20	11%	33%	53%	4	3%	88%	5	16%	4	11%	21%	5	31%	4
30260	Clayton	0	4.60	10%	19%	33%	3	11%	85%	5	22%	5	11%	23%	5	5%	5
30274	Clayton	0	4.60	7%	34%	44%	4	5%	92%	5	15%	4	12%	27%	5	47%	5
30273	Clayton	0.2	3.60	9%	21%	24%	2	5%	87%	5	12%	3	8%	16%	5	21%	3
30296	Clayton	0.2	4.20	9%	27%	44%	4	3%	94%	5	9%	3	11%	21%	5	33%	4
30297	Clayton	0.2	4.80	14%	37%	49%	4	14%	85%	5	31%	5	14%	33%	5	56%	5
30032	DeKalb	0	4.80	17%	36%	47%	4	1%	87%	5	20%	5	14%	24%	5	48%	5
30030	DeKalb	0.2	3.20	15%	10%	23%	2	2%	28%	4	5%	1	5%	14%	4	40%	5
30034	DeKalb	0	4	14%	24%	33%	3	0.3%	98%	5	9%	3	13%	17%	5	33%	4
30035	DeKalb	0	4.20	18%	23%	31%	3	1%	97%	5	11%	3	10%	18%	5	45%	5
30038	DeKalb	0.2	3.80	17%	14%	23%	2	0.4%	97%	5	8%	2	9%	15%	5	39%	5
30058	DeKalb	0.2	3.80	19%	16%	24%	2	1%	97%	5	8%	2	11%	14%	5	35%	5
30083	DeKalb	0	4.40	15%	30%	42%	4	5%	90%	5	13%	3	13%	21%	5	49%	5

Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	Income	English as a Second Language	Minority	Culture	No High School Diploma	Education	Unemployed	Uninsured	Insurance	Renting	Housing
30084	DeKalb	0	4.20	7%	24%	45%	4	10%	60%	5	13%	4	8%	12%	4	34%	4
30088	DeKalb	0	3.80	7%	21%	33%	3	1%	96%	5	9%	2	13%	14%	5	34%	4
30288	DeKalb	-0.2	4	14%	19%	26%	2	3%	93%	5	14%	4	14%	14%	5	30%	4
30294	DeKalb	0.2	3.2	8%	13%	24%	2	2%	92%	5	11%	3	9%	11%	4	17%	2
30307	DeKalb	0	3.40	9%	11%	39%	3	0.5%	21%	4	3%	1	3%	9%	3	42%	5
30316	DeKalb	0.2	4.2	20%	21%	42%	3	1%	58%	5	12%	3	8%	17%	5	35%	5
30317	DeKalb	0.2	4.4	19%	19%	41%	3	0.6%	49%	5	13%	4	7%	17%	5	40%	5
30213	Fulton	0	3.8	9%	14%	21%	2	1%	89%	5	11%	3	8%	14%	5	30%	4
30268	Fulton	0.2	4.2	9%	20%	56%	4	3%	57%	5	15%	4	8%	11%	4	29%	4
30291	Fulton	0.2	4.2	9%	24%	38%	3	1%	93%	5	12%	3	10%	20%	5	49%	5
30303	Fulton	0	4.8	37%	36%	57%	5	0.5%	57%	5	18%	4	17%	29%	5	73%	5
30306	Fulton	0	2.8	5%	6%	27%	2	1%	16%	3	3%	1	3%	8%	3	48%	5
30308	Fulton	0	4.2	16%	33%	64%	5	2%	47%	5	6%	1	6%	16%	5	66%	5
30309	Fulton	0	3	12%	6%	20%	1	0.3%	34%	4	2%	1	2%	10%	4	57%	5
30310	Fulton	0	5	25%	43%	54%	5	0.5%	93%	5	20%	5	14%	38%	5	61%	5
30311	Fulton	0	4.8	19%	55%	69%	5	2%	98%	5	17%	4	17%	40%	5	58%	5
30312	Fulton	0	4.6	32%	35%	57%	5	1%	56%	5	10%	3	7%	24%	5	64%	5
30314	Fulton	0	5	15%	43%	51%	5	0.5%	97%	5	16%	4	16%	33%	5	65%	5
30315	Fulton	0	5	30%	47%	61%	5	2%	87%	5	21%	5	16%	44%	5	63%	5
30318	Fulton	0.2	4.4	17%	32%	54%	4	1%	66%	5	11%	3	9%	25%	5	58%	5
30324	Fulton	0	3.8	9%	18%	31%	3	8%	50%	5	7%	2	5%	12%	4	68%	5
30331	Fulton	0	4.2	13%	23%	34%	3	1%	98%	5	11%	3	13%	21%	5	45%	5
30337	Fulton	0.2	4.8	18%	39%	62%	5	2%	85%	5	18%	4	12%	30%	5	67%	5
30344	Fulton	0	4.6	17%	33%	48%	4	2%	86%	5	14%	4	14%	25%	5	55%	5
30349	Fulton	0	4.2	8%	22%	37%	3	1%	97%	5	10%	3	10%	19%	5	41%	5
30354	Fulton	0.4	5	10%	43%	50%	4	5%	88%	5	19%	4	14%	33%	5	62%	5
Fulton Total		0	3.6	12%	19%	35%	2.8	2%	60%	4.7	9%	2.2	8%	16%	3.8	45%	4.5
DeKalb Total		0.1	3.9	12%	21%	35%	3	6%	71%	4.8	12%	3	9%	15%	4.3	42%	4.5
Clayton Total		0.1	4.4	9%	30%	45%	3.7	6%	87%	5	16%	3.9	11%	24%	5.0	41%	4.5

Truven Health Analytics, Community Needs Index (2018)

Racial/Ethnic Disparities*									
	Fulton	DeKalb	Clayton	White	Asian	Black	Hispanic†	Georgia	U.S.
% Uninsured population	13.70%	17.10%	22.60%	6.90%	18.30%	14.10%	40.40%	15.80%	11.70%
% Population below 100% FPL	16.90%	18.90%	24.30%	10.60%	23.90%	15.80%	31.30%	17.70%	15.10%
% Children below 100% FPL	24.70%	30.10%	37.20%	5.90%	35.80%	19.30%	45.10%	25.40%	21.20%
% Population with less than high school diploma (or equivalent)	8.70%	11.40%	16.40%	7.70%	11.30%	14.20%	41.00%	14.20%	13.00%
% Population with any disability	9.90%	10.20%	10.70%	8.40%	12.40%	4.10%	0.80%	12.30%	12.50%
Coronary heart disease mortality, age-adjusted death rate*	61.10	55.00	67.80	54.6	66.4	37.70	22.90	79.10	99.60
Motor vehicle crash death, age-adjusted death rate*	8.80	10.20	10.40	5.70	12.7	10.80	8.80	13.7	11.30
Annual breast cancer incidence rate *	132.10	136.00	134.20	ND	ND	ND	ND	125.20	124.70
Cancer mortality, age-adjusted death rate*	155.10	149.90	164.80	137.80	178.50	85.60	64.20	164.90	160.90
Annual cervical cancer incidence rate*	6.90	6.70	9.80	8.00	5.60	8.00	9.50	7.80	7.50
Annual colon and rectum cancer incidence rate*	38.10	40.60	46.80	33.80	47.30	28.60	29.60	41.80	39.20
Annual prostate cancer incidence rate*	143.80	143.90	155.30	114.20	190.60	44.90	90.00	123.30	109.00
Annual lung cancer incidence rate*	51.20	51.20	62.00	49.70	57.30	26.70	32.10	64.90	60.20

Racial/Ethnic Disparities (continued)*									
	Fulton	DeKalb	Clayton	White	Asian	Black	Hispanic†	Georgia	U.S.
Infant mortality rate***	7.00	7.60	9.20	3.70	11.10	3.60	5.00	7.50	†
Asthma discharge rate	104.90	124.60	88.20	52.40	166.30	29.00	ND	86.50	†
Asthma ED visit rate*	657.20	754.90	725.50	244.00	1,103.90	116.70	ND	551.60	†
Stroke mortality, age-adjusted death rate*	39.20	40.50	48.80	32.60	50.70	29.00	17.80	43.0	†
Breast cancer, age-adjusted mortality rate*	13.40	13.50	13.20	9.30	19.10	4.10	5.50	12.30	†
Diabetes age-adjusted discharge rate*	186.60	219.70	232.20	82.20	324.30	36.20	ND	188.10	†
Diabetes age-adjusted mortality*	17.50	21.00	30.00	10.30	ND	11.90	5.60	21.70	†
Obstructive heart disease/heart attack age-adjusted discharge rate*	195.30	205.70	236.10	159.20	242.80	87.60	ND	265.00	†
Obstructive heart disease age-adjusted mortality*	56.30	53.20	71.20	51.90	65.20	31.30	25.90	76.40	†
Hypertensive heart disease age-adjusted discharge rate*	47.80	47.20	55.30	21.60	75.70	10.70	ND	†	†
Hypertensive heart disease age-adjusted mortality*	24.40	14.90	32.20	13.70	32.20	9.50	5.10	†	†
Cancer mortality, age-adjusted death rate*	144.60	150.10	169.60	133.90	176.30	82.00	66.30	†	†

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

ND percentages: 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

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

Ranked Causes: Age-Adjusted Death Rate, State and County Comparison (2013-2017)*

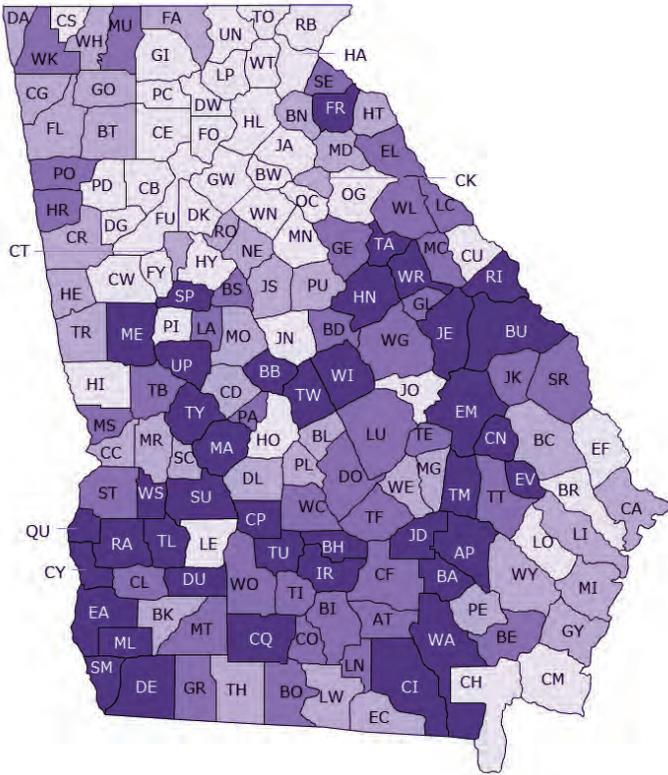
	Fulton	DeKalb	Clayton	Georgia
#1	Ischemic Heart and Vascular Disease (2,800)	Ischemic Heart and Vascular Disease (1,884)	Ischemic Heart and Vascular Disease (742)	Ischemic Heart and Vascular Disease (41,242)
#2	Essential Hypertension and Hypertensive Renal, and Heart Disease (1,856)	Cerebrovascular Disease (1,239)	Essential Hypertension and Hypertensive Renal, and Heart Disease (479)	Malignant Neoplasms of the Trachea, Bronchus and Lung (22,349)
#3	Cerebrovascular Disease (1,705)	Essential Hypertension and Hypertensive Renal, and Heart Disease (1,148)	Cerebrovascular Disease (432)	ALL COPD Except Asthma (22,123)
#4	All other Mental and Behavioral Disorders (1,503)	All other Mental and Behavioral Disorders (1,095)	Malignant Neoplasms of the Trachea, Bronchus and Lung (416)	Cerebrovascular Disease (20,481)
#5	Malignant Neoplasms of the Trachea, Bronchus and Lung (1,422)	Malignant Neoplasms of the Trachea, Bronchus and Lung (1,038)	ALL COPD Except Asthma (352)	All other Mental and Behavioral Disorders (17,375)
#6	Alzheimer's Disease (1,186)	Alzheimer's Disease (811)	Diabetes Mellitus (286)	Alzheimer's Disease (16,607)
#7	ALL COPD Except Asthma (1,062)	ALL COPD Except Asthma (762)	Septicemia (260)	Essential Hypertension and Hypertensive Renal, and Heart Disease (14,733)
#8	All Other Disease of the Nervous System (800)	Diabetes Mellitus (710)	Nephritis, Nephrotic Syndrome and Nephrosis (239)	Diabetes Mellitus (11,137)
#9	Diabetes Mellitus (787)	All Other Disease of the Nervous System (592)	All other Mental and Behavioral Disorders (235)	Nephritis, Nephrotic Syndrome and Nephrosis (9,002)
#10	Nephritis, Nephrotic Syndrome and Nephrosis (733)	Nephritis, Nephrotic Syndrome and Nephrosis (542)	Alzheimer's Disease (219)	Malignant Neoplasms of Colon, Rectum and Anus (8,293)
Not Top Ten but Significantly High	Accidental Poisoning and Exposure to Noxious Substances (678)	Malignant Neoplasms of the Breast (465)	Assault/Homicide (201)	
	Malignant Neoplasms of the Breast (631)	Assault/Homicide (442)	Malignant Neoplasms of Colon, Rectum and Anus (187)	
	HIV (406)	HIV (240)	Malignant Neoplasms of the Breast (151)	
	Assault/Homicide (584)		Mental and Behavioral Disorders Due to Psychoactive Substance Use (160)	

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

Maps

Health Outcomes

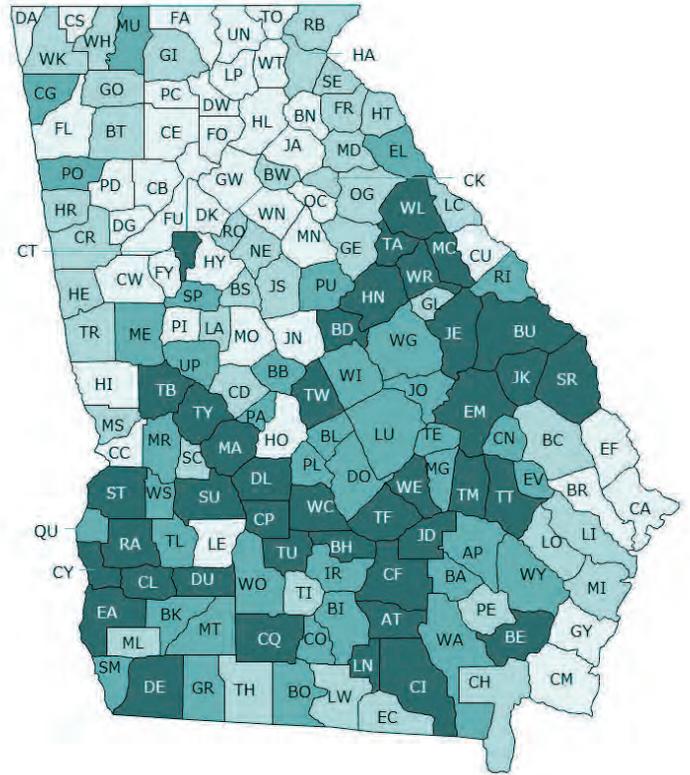
The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.



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

Health Factors

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



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

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

Primary Data and Community Input

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

CHNA Collaborators

Collaborator	Input Provided
American Medical Response	Summit Attendee
Atlanta Fulton Family Connection Janet Adams, <i>Executive Director</i>	Summit Attendee
Beltline Marla Oros, <i>Deputy Executive Director</i>	Key Informant
Center for Pan Asian Community Services (PACS) Karuna Ramachandran, <i>Health Programs Director</i> Keun Kim, <i>Director of Marketing & Development</i>	Key Informant
C.H.O.I.C.E.S.	Summit Attendee
Children's Healthcare of Atlanta Emily VanderWiele, <i>Physician Practice Operations Leader</i> Dr. Lennon	Key Informant
City of East Point, Georgia Regina Carter, <i>Economic Development Specialist</i>	Summit Attendee
City of Morrow, Georgia Hang Tran, <i>Councilwoman</i>	Key Informant
City of Chamblee, Georgia Adam Causey, <i>Economic Development Manager</i>	Key Informant
Clayton Center Lee Adams	Key Informant
Clayton Center Community Service Board Dr. Aundria Cheevers, <i>CEO</i>	Key Informant
Clayton Collaborative Authority John Brinson	Key Informant
Clayton County Commission Jeffery E. Turner, <i>Chairman</i> Shana M. Rooks, <i>Commissioner, District 3</i>	Key Informant
Clayton County DFCS Andre Chambers, <i>County Director</i>	Key Informant

Collaborator	Input Provided
Clayton County Head Start Malinda Mauldin	Key Informant
Clayton State University Janelle Charles	Key Informant
Community Foundation of Greater Atlanta Lesley Grady, <i>Senior Vice President</i>	Key Informant
Critical Point Consulting	Summit Attendee
CTN Global Chauffeured Services Eric Jeffries, <i>Vice President of Sales</i>	Summit Attendee
DeKalb County Commissioner Jeff Rader, <i>District 2 Commissioner</i>	Key Informant
DeKalb Senior Affairs – Senior Connections Debra Furtado, <i>Chief Executive Officer</i>	Key Informant
Doute'-Hughes Counseling and Consulting Stefanie Hughes, <i>LMFT</i>	Key Informant
Eagles Economic Community Development Corporation John Reed, <i>Director of Programs</i>	Summit Attendee
Federal Reserve Bank of Atlanta	Summit Attendee
Fort Mac LRA	Summit Attendee
Fulton County Board of Commissioners Cleta Winslow, <i>District 4 Council member</i> Joan Garner, <i>District 4 Commissioner</i> Marvin Arrington, <i>District 5 Commissioner</i> Mitsah Henry, <i>District 5 Commissioner</i>	Summit Attendee Key Informant
Fulton County Schools	Summit Attendee
Georgia Department of Public Health Alpha Bryant, <i>District 3-3 Health Director</i>	Key Informant

Collaborator	Input Provided
Georgia Equality Jeff Graham, <i>Executive Director</i>	Key Informant
Georgia House of Representatives Roger Bruce, <i>District 61 Representative</i> Stacey Abrams, <i>District 89 Representative</i>	Key Informant
Great Start Georgia Michelle A. Lanier	Key Informant
HDCI Metro Atlanta Helen Slaven, <i>Regional Sector Partnership Director</i>	Summit Attendee
Healthcare Georgia Foundation Andrea Kellum	Key Informant
Health Promotion Action Coalition Inc.	Summit Attendee
Home Healthcare Dr. Montaña	Key Informant
Homeless Initiative Cathryn Marchman, <i>Executive Director of Partners for H.O.M.E</i>	Key Informant
House of Dawn Taralyn Keese, <i>Program Director</i>	Key Informant
Mercy Care Salvador Arias, <i>Board Member</i> Tom Andrews, <i>President</i>	Key Informant
MLK Sr. Community Resources Collaborative Detria Russell, <i>Executive Director</i> Stacey Massey Logan, <i>VISTA Governance & Leadership Coordinator</i>	Summit Attendee
Office of Congressman David Scott Chandra Harris, <i>District Director</i>	Summit Attendee
Operation PEACE Inc. Toya Tann, <i>Director</i> Marcel Benoit, <i>Director</i>	Summit Attendee
REACH Georgia Foundation Inc. Archie Bouie II, <i>Executive Director</i>	Summit Attendee
Reaching Our Sisters Everywhere Betty Neal	Key Informant
Safe America Foundation Mary Lou Pagano, <i>COO</i> Stephen George Jr., <i>MPA, Senior Fellow</i>	Summit Attendee

Collaborator	Input Provided
Sisters Empowerment Network Inc. Veda Brown	Key Informant
Southside Church/Martinez Life Help Ministries Anthony Martin, <i>Pastor</i>	Key Informant
SU-KOR Inc.	Summit Attendee
The Georgia Lions Lighthouse Foundation Inc. Morgan Alexander, <i>Program Director</i>	Key Informant
TIME-ER Inc. Roosevelt Muhammad, <i>President and CEO</i>	Key Informant
United Way of Greater Atlanta Helen McCroskey Kim Addie, <i>Director of Health</i> Demetrius Jordan, <i>Regional Director</i> Ginneh Baugh, <i>Senior Director, Measurement & Knowledge</i>	Key Informant
Urban League of Greater Atlanta Patrice Barlow, <i>Education & Health Advocate</i>	Summit Attendee
WellStar Foundation Jill Patel, <i>Development Officer</i>	Summit Attendee
WellStar Health System, WellStar AMC and AMC South Kristin Caudell, <i>Director, Community Education & Outreach</i> Nicole Gustin, <i>Director of Public Relations & Marketing</i> Rashan Noble, <i>Community Education Coordinator</i> Rick Ornelas Jill Patel, <i>Development Officer</i> Cecelia Patellis, <i>Assistant Vice President – Community Education & Outreach</i> Teresa Pounds, <i>Clinical Pharmacy Manager</i> Kim Ryan, <i>Senior Vice President and President of AMC/AMC South</i> Lynne Scroggins, <i>Vice President Community Development</i> Shara Wesley, <i>Director, Community Benefit</i>	Listening Session and/or Summit Participant
Wingates Management Company	Summit Attendee
Woman to Woman April Laland	Key Informant

Community Health Summit

The following is a summary of the WellStar AMC and WellStar AMC South Health Summit held on Feb. 28, 2018, at Atlanta Technical College in Atlanta. The Health Summit was facilitated by GHPC in partnership with WellStar and lasted approximately three hours. The 30 participants included WellStar team members and community stakeholders.

The organizations that took part in the Health Summit included:

- Operation PEACE Inc.
- HDCI Metro Atlanta
- WellStar Atlanta Medical Center
- Georgia Government
- Atlanta Fulton Family Connection
- CTN Global Chauffeured Services
- WellStar Foundation
- Urban League of Greater Atlanta
- City of East Point
- WellStar Health System
- MLK Sr. Community Resources Collaborative
- Safe America Foundation
- Office of U.S. Rep. David Scott
- Eagles Economic Community Development Corp.
- REACH Georgia Foundation Inc.
- Federal Reserve Bank of Atlanta

GHPC presented to community leaders 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 communities they serve and encouraged to add any needs that may have been absent from the data presented. Grouped by self-selected tables, 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 vulnerable populations. Needs that were identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface the following five community health priorities, listed in the order they were prioritized.

Group Recommendations and Problem Identification

During the Health Summit, participants prioritized five community health needs: obesity; access to appropriate care; behavioral health; educational awareness; and equitable revitalization, employment and job training. What follows is a summary of the input participants offered when asked about contributing factors, potential solutions and community resources to address the health priorities.



Obesity

Health Summit participants considered obesity to be the most pressing health issue in the WellStar AMC and WellStar AMC South community. Concerns for summit participants included limited healthy food options, physical activity opportunities, utilization of community gardens and awareness of and educational opportunities related to healthy nutrition and physical activity.

Contributing Factors:

- There are limited grocery stores that offer healthy foods (e.g., fresh vegetables); also, if these grocery stores offer these options, often food is not fresh and does not last.
- Fast food and unhealthy food choices are more readily available than healthy options in this area.
- Residents are making unhealthy food choices because of time constraints and convenience of options like fast food.
- Obesity rates are increasing among adults and children. Childhood obesity is influencing increasingly younger populations.
- Physical activity is not always available, affordable, or a priority.

Recommendations:

- Increase physical activities in the community by involving residents in activities in public spaces like the Atlanta Beltline.
- Broaden the number of individuals engaged in the hospitals' community outreach efforts through continued development of partnerships and collaborations with community and faith-based organizations.
- Promote the use of community gardens to improve access to healthy foods.
- Incorporate health education and exercise opportunities into school settings during school hours or after-school programs.
- Host community education activities in venues where residents are most likely attend, such as schools, youth centers and churches. Participants suggested that WellStar could sponsor free game nights or movie nights and integrate health education into the event.
- Increase healthy food access by creating a distribution system in partnership with the Atlanta Community Food Bank and/or Food Well Alliance or by incorporating inexpensive, healthy food options into existing food marts and convenience stores.
- Host healthy cooking classes at the hospitals to promote healthy food preparation and overall nutrition education.



Access to Appropriate Care

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

Contributing Factors:

- There are a limited number of available primary and specialty providers in the service area.
- There is a lack of access to and limited use of affordable prenatal care, which is viewed as a contributing factor to infant mortality.
- Navigation issues related to insurance coverage and awareness of services have an influence on residents' ability to secure care in appropriate settings compared to inappropriate settings (e.g., use of the ED for nonemergency issues).
- Senior health services in the community are limited and/or have extensive wait times.
- There is a need for increased safety-net facilities for the under- and uninsured and homeless population.

Recommendations:

- Meeting participants discussed ways to mobilize services and meet the health needs of the community in locations convenient to residents (e.g., work sites, neighborhoods and entertainment arenas). Participants suggested increasing the use of paramedic care to offer prevention services to underserved populations.
- Develop partnerships with local schools to increase pediatric services in the community.
- WellStar could increase access to care by increasing the number of providers strategically throughout the service area.
- Offer educational outreach on topics related to insurance, like how to acquire insurance, covered benefits and costs associated with specific plans.
- Underserved populations often face challenges related to affordable or reliable transportation. Participants felt this could be accomplished by advocating for a regional transit system and developing partnerships with MARTA, Uber and other entities to provide transportation resources.
- Participants felt that WellStar could improve and promote linguistically and culturally sensitive resources in the communities they serve.



Behavioral Healthcare

Health Summit participants prioritized behavioral health as one of the most pressing issues in the community. Poor behavioral health was attributed to stigma; a fragmented referral system; and limited behavioral health education, community outreach and services for under- and uninsured and homeless residents.

Contributing Factors:

- There is a stigma associated with mental illness that deters residents from seeking the help they need and often a delay in treatment results.
- Lack of awareness about early detection and prevention contributes to patients with more acute symptoms upon presentation.
- Participants discussed the overutilization of EDs among patients with behavioral health needs, which often disrupts the continuity of care.
- Substance abuse and its cascading adverse effects (economic instability and barriers to employment) were considered as a bidirectional component of mental health.

Recommendations:

- Offer behavioral health education as a vital component of improving health.
- It is important to offer a tailored approach to youth that includes school, hospital officials and community leaders to better address needs. This could include offering youth wellness classes in a school setting and in the community.
- Offer education that is substance abuse-focused to better increase knowledge about the potential effects of abuse of illicit and prescription substances.
- Identify high-risk individuals and conduct outreach in the community (i.e., neighborhoods and local faith-based organizations) to increase early detection.
- Refine the behavioral health referral system to promote continuity of care.
- More mental health resources should be developed, promoted and implemented for residents that are under- or uninsured and/or homeless.
- Implement an integrated care model to improve providers' ability to meet the behavioral health needs of residents seeking relief from behavioral health symptoms, including in the primary care setting and the ED.



Educational Awareness

Health Summit discussions addressed the importance of educational awareness within the community. Participants discussed the lack of education as a catalyst for numerous health needs like chronic disease and other poor health outcomes.

Contributing Factors:

- Educational resources are not readily accessible in locations that are convenient for underserved communities.
- Parents are not always able to address the health needs of their families, including themselves, due to limited awareness or lack of resources.
- Education related to senior health is not always available in the community.

Recommendations:

- Summit participants suggested WellStar AMC and WellStar AMC South partnering with local schools to address health education for both parents and children.
- Community outreach was broadly discussed to better connect with target populations on all the priority needs identified during the summit (i.e., obesity, behavioral health, workforce training, etc.).
- Develop effective marketing strategies to better engage high-risk and high-need audiences.
- Parenting education in schools or hospitals should be implemented to increase knowledge and age-appropriate resource awareness.



Equitable Revitalization, Employment and Job Training

Participants felt that job training and equitable economic revitalization could result in improved health. Summit discussions focused on low socioeconomic status resulting from limited opportunities for education, income and employment. Participants indicated these barriers are correlated with health outcomes.

Contributing Factor:

- There are limited GED programs that assist in improving educational attainment.

Recommendations:

- Participants proposed initiating collaborations with workforce development programs, community resource centers and faith-based organizations to assist with outreach and needed resources.
- Summit participants noted that WellStar could benefit under-resourced populations by providing community benefit grants to organizations assisting with work readiness and job training.
- Develop job training and recruitment programs in the high-need zip codes within the WellStar AMC and WellStar AMC South service area.
- To broaden the scope of job readiness, participants considered that the hospitals' involvement with healthcare career training would increase the hospitals' involvement in community revitalization.
- It was suggested that WellStar AMC consider developing programs that promote youth enrichment to readily integrate job training.
- "Lunch and learn" models were suggested to supply the community with necessary employment skills.

Listening Session

Notes from the WellStar AMC Regional Health Board Listening Sessions (February 2018)

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

Pressing health needs cited:

- Chronic diseases – hypertension and diabetes mentioned by name.
- Lack of prenatal care – low birth weight.
- Opioid epidemic – How can we change culture/ reduce use?
- How can we make communication and medicine align to change the psychology of opioid use? Treatment and medical usage must be reduced. Is there gender data on opioid usage?
- Health education is lacking (must focus on prevention — it's the biggest thing). Health literacy in general is low here.
- People need to understand their own biology – they have little understanding of medicine and that there are better health outcomes with better health literacy.
- An underlying problem to health issues is prescription noncompliance and the cost of meds (for seniors, when Medicare costs more than they thought). Part of the issue is transportation.
- Food access/limited access to healthy food. Many residents can walk to a food mart; it's a cultural place where you can buy single cigarettes, Lotto, etc. No fresh produce. Community gardens in neighborhoods are a solution.
- Culture and poor nutrition are causes for chronic disease.
- Women and children's health, because in East Point there are many single moms.
- Very little primary care (how to access the system) so residents use ED as primary care.
- Environmental struggles/issues – substandard housing leads to prevalence of asthma and is a contributing factor to chronic disease (physical inactivity [lack of parks/recreation] and food desert).
- Behavioral health — substance abuse. People dealing with substance abuse are less likely to seek support without someone to empower them. (It's an issue in the Old Fourth Ward downtown.)
- "Life stressors" – quality of education suffers because money has to go elsewhere.
- Need better access to prevention, treatment and recovery resources.
- Fulton County is highest in the state for HIV

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?

For seniors/children:

- Christian City — 7345 Red Oak Road, Union City, GA 30291, 770-964-3301
- The Children's Village (family-style group homes) for youth who are victims of abuse, abandonment, or neglect. Each home is staffed by full-time house parents who provide a nurturing family environment.
- A Safe Place agency: Children in crisis can go to over 70 locations in the metro area if they feel they are in danger. They are on call 24/7 to bring these children to safety at the Children's Village, where the staff works with their parents to reunite them.
- An affordable independent living community for adults aged 60-plus in a serene and convenient location with amenities to encourage a vibrant lifestyle. This includes 287 subsidized apartments for senior citizens and 212 life-lease patio homes.
- A highly rated healthcare facility, operated by PruittHealth, that includes 150 assisted living units and a 200-bed skilled nursing and rehabilitation facility. Memory care and Alzheimer's support units are included.
- An active volunteer program that provides hundreds of opportunities for residents of Christian City and the nearby communities to serve on our campus.

For behavioral health:

- Community Services Board (College Park)
Clayton Center
Administrative Office:
157 Smith St.
Jonesboro, GA 30236
770-478-2280
www.claytoncenter.org
- Odyssey Family Counseling Center
1919 John Wesley Ave.
College Park, GA 30337
404-762-9190
www.odysseycounseling.org
- The site lists community partners (no health system) including Atlanta Regional Collaborative for Health Improvement (WellStar is a member)
- Shelters
- Fulton County restructured its behavioral health programs/services

Healthy Food:

- Carver Neighborhood Market
(although took awhile to onboard)
www.carvermarket.com

Access to Care:

- WellStar AMC's Sheffield Clinic
(and other safety-net clinics)

Education/Outreach:

- Atlanta Public Schools
- Youth sports leagues
- Churches/faith-based organizations
- Collaborate with large workplaces in the community like Delta Air Lines and Mercedes
- Small-business owners
- Technical colleges
(for job placement partnerships with healthcare, like Johns Hopkins; may be an opportunity at the Fort McPherson redevelopment project)

HIV/AIDS:

- Atlanta Harm Reduction Coalition Inc.
1231 Joseph E. Boone Blvd. NW
Atlanta, GA 30314
404-817-9994

Key Informant Summary

(July 2018-January 2019)

GHPC conducted interviews with community leaders. Leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including those with public health expertise, professionals with access to community health-related data, and 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 was gathered during individual interviews with 10 stakeholders in the communities served by WellStar AMC and WellStar AMC South. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents in the community served by the hospitals, as well as ways to address cited concerns.

There was a diverse representation of community-based organizations and agencies among the 410 stakeholders interviewed, including:

- Atlanta Community Food Bank
- Atlanta Regional Commission
- Center for Pan Asian Community Services
- City of East Point
- Community Voices – Morehouse School of Medicine
- Clarkston Community Center
- Fulton County Schools – Student Health Services
- Mercy Care
- Southside Medical Center
- United Way of Metropolitan Atlanta
- Woodward Academy

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

Improved

- There has been an increase in preventive care that is available at Southside Medical Center (SMC) and Center for Pan Asian Community Services (CPACS).
- Some schools are addressing mental health needs of the community in schools.
- CPACS offers access to healthcare and prevention in Korean, Chinese–Mandarin, Vietnamese, Nepalese, Burmese, and Spanish.
- There have been increases in the number of FQHCs.

Stayed the same

- The economy is improving, which translates into better access to care for some people.
- Lack of services and high costs have remained unchanged for many residents.
- Not addressing social determinants of health in Fulton County.

Declined

- The rates of uninsured are decreasing.
- Disparities in the health outcomes and access to care remain.
- Not enough local data is available to assist with decision-making (e.g., the health disparities that exist between populations in North Fulton and South Fulton are muted in county-level data).

Major Health Challenges:

- Common health issues:
 - Hypertension
 - Diabetes
 - Obesity (adult and child)
 - Asthma
 - HIV/STIs
- Infant mortality
- Heart disease
- Cancer
- Kidney disease
- Undiagnosed/untreated behavioral health challenges, including substance abuse
- Overutilization of ED
- Disparities for Black and Latino residents
- High rates of teen pregnancy

Context and Drivers:

- Geographic location
 - Transportation – public transportation is not effective, and private transportation is not always an affordable option
 - Hospitals in more rural areas (South Fulton, parts of Clayton and DeKalb counties) offer less comprehensive care. The nearest full-service hospital can be several miles away.
- Residents do not always make healthy choices related to parenting, physical activity, nutrition, etc.
 - Traffic and time spent commuting has an impact on residents' ability to make healthy choices
 - Educational attainment, income and awareness influence health choices and health literacy
 - HIV rates are high in some areas due to substance abuse, men who have sex with other men and prostitution
- Limited awareness of what services are available and where they are located
- Poor socioeconomic status
 - There is a lack of stable/good-paying jobs in areas where poverty rates are highest
 - Temporary or part-time employment offers limited access to comprehensive insurance
- There are fewer social supports in areas where high poverty is coupled with high affluence (e.g., Fulton County)
- Need for affordable healthcare, including for underinsured and uninsured residents (adults and children)
 - South Fulton County has high barriers to accessing healthcare
 - Uninsured rates are high
 - Care coordination is limited for residents without a medical home
 - Costs of prescription medications are too high
- When residents are uninsured, they will delay seeking care until symptoms become acute because the cost is often unaffordable
 - Residents are seeking care in the ED for preventable medical issues that have become emergencies
 - There are limited specialty providers offering care to residents with Medicaid and Marketplace insurance
 - Providers have restricted hours of operation (limited walk-in appointments and after-hours care)
- Poor nutrition
 - Residents do not always have consistent access to healthy foods due to cost and the location of grocery stores
 - Residents are not always aware of how to prepare and enjoy healthy foods
- Cultural and traditional dietary preferences (e.g., fried and sugary foods) can be unhealthy
- Need for behavioral health services (adults and children) that reduce barriers related to social and cultural stigma
 - There are not enough providers, and even fewer that offer uninsured services
 - Residents resist seeking behavioral healthcare due to a fear of the stigma associated with such a diagnosis
- Need for uninsured dental care, due to very few providers offering dental care to uninsured residents
- Need for substance abuse services
 - The opioid crisis is killing people
 - Substance abuse is a growing problem among residents
 - Many residents abuse substances to cope with high stress and other undiagnosed/untreated behavioral health symptoms
- Need for increased physical activity
 - The built environment is not conducive to physical activity in communities where poverty is high (poor lighting, sidewalks in disrepair, limited crosswalks, etc.)

- Race/ethnic challenges
 - There are higher stress levels among people of color
 - Distrust for the medical community
 - Limited culturally and linguistically relevant health services for Black, Asian, Latino and LGBTQ residents
- Undocumented residents do not always seek or have access to basic health services due to fear of deportation, no insurance, lack of transportation and cultural preference for alternative remedies
- Housing issues
 - Homelessness
 - Limited access to affordable housing in the communities served by both hospitals
- Building and development has led to displacement of residents
- Lack of appropriate supervision of youth
 - Single parents may not be able to provide adequate supervision of youth
 - There are a limited number of affordable programs for youth outside of school hours

Recommended Interventions:

- Expand community engagement to address explicit needs
- Create a linguistically and culturally sensitive platform (including education and outreach) to encourage trust-building necessary for servicing undocumented and immigrant residents
- Allocate more attention to social support networks
- Integrate fresh food trucks, food pantries and urban/community gardens into neighborhoods with low access to healthy food
- Disseminate additional educational resources (i.e., gardening and cooking advice and classes, programs to increase exercise and healthy behaviors among various demographics, education on STIs in the senior community)
- Train healthcare and educational professionals to recognize indications of declining behavioral health and make appropriate treatment referrals
- Develop partnerships among healthcare facilities to better emphasize the significance of community education
- Increase the prevalence of Community Navigators in vulnerable populations
- Assimilate available transportation systems with healthcare facilities and decipher how to plan healthcare delivery from another approach (i.e., clinics near the Atlanta BeltLine or street car)
- Provide mobile healthcare services (i.e., satellite centers that offer remote access to healthcare professions, telehealth, service in vulnerable populations)
- Offer preventive care to underserved adults during pediatric routine visits
- Increase awareness of local services, especially in County Board of Health facilities (i.e., substance abuse, behavioral health, outreach and education, screening, etc.)
- Offer a class to parents receiving Supplemental Nutrition Assistance Program benefits related to the value of healthy nutrition, affordability and healthy food preparation techniques
- Expand school-based health clinics

Resident Focus Group Summaries

(January 2018–October 2018)

Purpose

This assessment engaged community residents to develop a deeper understanding of the health needs of residents they serve as well as the existing opinions and perspectives related to the health status and health needs of the populations in communities served by WellStar AMC and WellStar AMC South.

Methodology

GHPC recruited and conducted four focus groups among residents living in the community served by WellStar AMC and WellStar AMC South. 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 AMC and WellStar AMC South Service Area Residents — College Park, Georgia (Jan. 11, 2018)
- WellStar AMC and WellStar AMC South Service Area Residents — Atlanta (Oct. 1, 2018)
- Clayton County Residents — Forest Park, Georgia (Oct. 16, 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 is summarized in this section.

Target Population:

WellStar AMC and WellStar AMC
South Service Area Residents

Venue:

Club E Atlanta
3707 Main St.
College Park, GA 30337

Number of Participants:

11

Major Health Challenges:

- Dental health
- Behavioral health (violence, overall substance abuse, opioid use)

Context and Drivers:

- Geographic location
- Limited access to care (there are limited resources for underinsured and uninsured people; uninsured care, private insurance, copays and deductibles can all be unaffordable; many providers do not accept Medicaid and Marketplace insurance; there is no care continuity for uninsured residents with no medical home; wait times for primary and specialty care appointments are excessive; residents are going to the ED with acute symptoms before being seen by a primary care physician; the cost of medication is not always covered by insurance; navigating the health system can be challenging and feels impossible to some residents)
- Residents do not always trust physicians due to a change in longtime providers to a new (maybe younger) physician or the lack of a relationship, or race
- Transportation is a barrier to seeking care, healthy options (grocery shopping and working out) and employment.
- Technology (limited access, inability to navigate Internet)
- Undocumented residents have challenges securing any type of support (no proof of identification)
- Lack of education or knowledge of resources
- Dental healthcare is unavailable for underinsured and uninsured residents
- There are fewer places for homeless people to receive support due to the homeless shelter closing

Recommendations:

- Supply more dental services for those who are under- or uninsured to stop the exacerbation of other ailments
- Integrate medical and dental services in clinics
- Disseminate more resource education
- Provide access to free or low-cost neighborhood clinics
- Increase community providers to serve more residents
- Develop a payment system that will empower the community

Target Population:

WellStar AMC and WellStar AMC South Service Area Residents

Venue:

Atlanta Technical College
Metropolitan Parkway SW
Atlanta, GA 30310

Number of Participants:

9

Major Health Challenges:

- Inflammation/swelling of extremities
- Obesity
- Diabetes
- Behavioral health (stress and depression)
- Addiction issues and substance use (e.g., marijuana, heroin, cocaine, prescription medication, alcohol and tobacco)
- Cardiovascular issues (e.g., hypertension and high cholesterol)
- Undiagnosed illnesses
- Poor dental health

Context and Drivers:

- Limited access to care (lack of affordable insurance options, limited healthcare facilities in certain areas like South Fulton County, preventive care measures are unaffordable, medication is unaffordable, there are not many clinics offering affordable care, and very few clinics offer after-hours care to underinsured and uninsured residents, copays and deductibles can be unaffordable, not all providers take Medicaid and Marketplace insurance)
- Many people do not have transportation they need to meet basic needs (e.g., medical appointments, grocery shopping, work, etc.). MARTA is unreliable and not conveniently located to most communities. Commuting becomes more difficult when there are children
- People of color are treated differently at healthcare facilities in south Fulton County
- Limited educational facilities in south Fulton County that are high quality and consistently accredited
- Lack of exercise (children are watching TV or on their phones, schools do not offer recess anymore, crime and violence make communities unsafe, sports can be unaffordable for some families)
- Wait times for dental appointments are lengthy
- There are limited social service supports for residents in Fulton County compared to DeKalb County
- Many of the employment options for residents with lower educational attainment are temporary, part-time, and offer low wages
- Many parents have to work more than one job, and children are not always supervised
- Poverty is highest among single parents, particularly in Fulton County
- Convenience stores are more readily available than grocery stores
- Marketing is on cigarettes and lottery in many communities. Children are vaping now
- People do not always have access to healthy choices, and they do not always select healthy options when they are available
- There is a large population of Hispanic people in Clayton County, many of whom are concerned about their legal status

Recommendations:

- The community used to have a mobile clinic. Just having that back would be helpful
- Increase the amount of advertising that is done for healthy foods and decrease the amount that unhealthy options are advertised
- Promote health literacy among all populations, including about physical activity

Target Population:
Clayton County Residents

Venue:
Forest Park Library
4812 West St.
Forest Park, GA 30297

Number of Participants:
9

Major Health Challenges:

- Cardiovascular disease (hypertension)
- Cancer (colon, liver and ovarian)
- Diabetes
- Asthma
- Behavioral health
- Substance abuse (tobacco/vaping, marijuana, alcohol, heroin, methamphetamines, crack/cocaine and opioids/prescription pills)

Context and Drivers:

- Access to care (geographic location of providers, limited insurance options, navigating providers with out-of-date provider lists, many providers do not take Medicaid and Marketplace insurance, insurance does not always cover necessary procedures, uninsured care is unaffordable, wait times can be too long for primary care appointments)
- There are limited behavioral health services, and people with mental illnesses are going to jail or prison. There are very few providers that offer underinsured and uninsured behavioral health services. There is limited care coordination for people with behavioral health and substance abuse comorbidities
- There are limited dental health services for underinsured and uninsured residents. Many residents seek treatment for dental pain in the ED, where they receive pain medication, which could lead to addiction
- Health literacy is low, and there are limited educational resources related to healthy eating in Clayton County
- There are limited grocery stores that offer affordable and fresh healthy produce. Many residents do their grocery shopping outside of Clayton County when they can
- Unhealthy options (fast food, liquor stores, etc.) are readily available in low-income communities, whereas healthier options are more readily available in affluent communities in Clayton County
- Residents are not always making healthy choices, which can be related to culture, income, awareness, etc. In addition, the built environment is not conducive to physical activity in many communities (e.g., sidewalks and lighting)
- Schools are not always serving healthy food or giving kids time to be physically active due to limited time for lunch and student preference for unhealthy foods. There are limited programs for children outside of school hours that are affordable
- Poverty rates are high
- Single-parent families often have higher poverty rates and work more than one job, which leaves little time for parenting
- Traffic and commuting can take a significant amount of time and leave little time for healthy habits (cooking healthy foods, exercise, positive parenting)
- Residents do not always trust providers (there is a perceived lack of care from providers for patients, and reliance on pharmaceutical solutions versus alternative methods)
- Residents expressed concern that there is a racial component to the amount of attention and resources that are invested in wellness. They discussed the fact that opioid addiction is concentrated in White communities whereas crack was primarily an addiction found in communities of color. Residents feel like the opioid crisis is receiving more attention, resources, and concern from professionals than crack did when it was an issue

Recommendations:

- The healthcare system can invest more heavily in educational programs in underserved communities
- Bring back free community health clinics that can serve as a provider and source of information

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].

Focus Group Discussion Guide (continued)

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			
<p>Clayton County Board of Health (CCBOH)</p>	<p>The Clayton County Board of Health (CCBOH), located at 1117 Battle Creek Road in Jonesboro, Ga., seeks "A Healthier Clayton in One Generation." Our comprehensive offering of health services, health education and outreach programs address a wide variety of community health issues, including infant mortality, child and youth development, obesity, sexually-transmitted infections (STIs), food safety, unintentional injuries, infectious diseases and emergency preparedness.</p>		
<p>Clayton County Board of Health Comprehensive Health Facility 1117 Battle Creek Road Jonesboro, GA 30236 678-610-7199 www.claytoncountypublichealth.org</p>			
<p>DeKalb County Board of Health</p>	<p>At the DeKalb County Board of Health, we envision safe, healthy communities in which all individuals have access to quality, affordable health services.</p> <p>We offer many clinical, case management and outreach health services for children, adults and seniors.</p>		
<p><i>Health Centers:</i></p> <p>Clifton Springs 3110 Clifton Springs Road Decatur, GA 30034 404-244-2200</p> <p>East DeKalb Health Center 2277 S. Stone Mountain-Lithonia Road Lithonia, GA 30058 770-484-2600</p> <p>North DeKalb Health Center 3807 Clairmont Rd., NE Chamblee, GA 30341 770-454-1144</p> <p>Richardson Health Center 445 Winn Way Decatur, GA 30030 404-294-3700</p> <p>T.O. Vinson Health Center 440 Winn Way Decatur, GA 30030 404-294.3762</p> <p>dekalbhealth.net</p>	<p>Clinical services and programs:</p> <table border="0"> <tr> <td data-bbox="641 913 990 1339"> <p>Maternal and child health</p> <ul style="list-style-type: none"> ■ Perinatal care/Obstetrics ■ Women, Infants and Children (WIC) ■ Dental health ■ Immunizations ■ Vision and hearing screenings ■ Well child check-ups ■ Children's Medical Services ■ Children with Special Needs ■ Babies Can't Wait ■ Children 1st Program ■ School health programs ■ Adolescent health </td> <td data-bbox="1039 913 1469 1339"> <p>Adult health</p> <ul style="list-style-type: none"> ■ BreasTest and More ■ Dental health ■ Family planning ■ Hypertension ■ Refugee health ■ Immunizations ■ Travel medicine ■ Tuberculosis (TB) ■ HIV/AIDS (Ryan White Early Care Clinic) ■ Sexually transmitted diseases (STDs) ■ Primary care (at some locations) </td> </tr> </table>	<p>Maternal and child health</p> <ul style="list-style-type: none"> ■ Perinatal care/Obstetrics ■ Women, Infants and Children (WIC) ■ Dental health ■ Immunizations ■ Vision and hearing screenings ■ Well child check-ups ■ Children's Medical Services ■ Children with Special Needs ■ Babies Can't Wait ■ Children 1st Program ■ School health programs ■ Adolescent health 	<p>Adult health</p> <ul style="list-style-type: none"> ■ BreasTest and More ■ Dental health ■ Family planning ■ Hypertension ■ Refugee health ■ Immunizations ■ Travel medicine ■ Tuberculosis (TB) ■ HIV/AIDS (Ryan White Early Care Clinic) ■ Sexually transmitted diseases (STDs) ■ Primary care (at some locations)
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<p>Fulton County Department of Health and Wellness (FCDHW)</p>	<p>Fulton County Department of Health and Wellness (FCDHW) is the largest testing site in the state of Georgia. Over 700 people each year learn that they have been infected with HIV in our clinic. Our clients are introduced to the HIV Clinic physicians on the same day they may learn their HIV positive status. Enrollment in the HIV Clinic offers an individual a full service outpatient clinic with a TEAM approach to educate and support the patient and families living with HIV.</p>		
<p>Fulton County Public Health at 10 Park Place 10 Park Pl S.E., 5th Floor Atlanta, GA 30303 404-613-1205 (main)</p> <p>Fulton County Department of Behavioral Health & Developmental Disabilities</p> <p>Fulton County Government Center 141 Pryor Street, Suite 1031 Atlanta, GA 30303 404-613-7013 www.livebetterfulton.org</p>	<p>Mental Health - Our behavioral health centers offer a wide range of services & addictive disease treatment at community-based locations.</p> <p>Developmental Disabilities - Three regional centers provide clients with life skills training tailored to their particular disability. Mobility training and day habilitation are also provided.</p> <p>Addictive Diseases - We provide a variety of specialty outpatient treatment services for adults with chronic chemical dependencies. Treatment is also available for individuals who have both mental health and substance abuse ("co-occurring") disorders.</p>		
<p>Fulton County Cooperative Extension</p> <p>Central Office (Downtown) Central Atlanta Library 1 Margaret Mitchell Square Atlanta, GA 30303 404-332-2400</p>	<p>The mission of the Fulton County Cooperative Extension Service is to respond to citizens' needs and interest in agriculture and natural resources, families, 4-H and youth through education and information.</p>		

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

Family Health Centers of Georgia

West End | Main Center
868 York Avenue, SW
Atlanta, GA 30310
404-752-1400

Lake Forest | Lake Forest School-Based Health Center
5920 Sandy Springs Circle
Sandy Springs, GA 30060
770-254-0001

Adamsville Regional Health Center
3700 Martin Luther King Jr. Drive, SW Atlanta, GA 30331
404-613-6384

North Clayton High School | North Clayton School-Based Health Center
1525 Norman Drive
College Park, GA 30349
678-426-2800

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

The Family Health Centers of Georgia, Inc. is one of more than 1,500 Federally Qualified Community Health Centers (FQHC) operating in the United States. FQHCs use a healthcare delivery system that has proven success with improving healthcare outcomes and reducing healthcare costs. Several recent studies have found that patients who regularly use community health centers, like FHCGA, have lower total annual healthcare costs when compared to patients who use other primary care providers, such as HMOs, hospital outpatient units or private physicians. On an average, these studies show that the cost associated with using a community health center is 22% to 33% less expensive than using other healthcare models.

Healing Community Center

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

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

Services:

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

The Good Shepherd Clinic

6392 Murphy Drive
Morrow, GA 30260
770-968-1310
Fax: 770-968-2701

Good Shepherd Clinic provides free healthcare, of both acute and chronic illnesses, to uninsured residents of Clayton County who have limited financial resources.

Services:

- Acute Care
- Chronic Care Management: Diabetes, Hypertension, High Cholesterol, etc
- Laboratory Services
- EKGs
- Prescription Assistance Program
- Health Education Classes
- Nutrition, Hypertension, Diabetes & High Cholesterol
- One-on-One training
- Specialty Clinics
- Podiatry
- Eye Care
- Specialty Referrals, as available

MSM H.E.A.L. Clinic

1800 Howell Mill Road, 2nd Floor, Suite 275
Atlanta, GA 30318
404-756-5019

We exist to contribute to health equity of the underserved and uninsured populations in Georgia. We strive to provide concise patient education to promote disease prevention. We intend to increase the diversity of healthcare through clinical experience and dynamic medical training.

The MSM HEAL clinic serves the underserved, homeless and uninsured.

The Good Samaritan Health Center

1015 Donald Lee Hollowell Pkwy
Atlanta, GA 30318
404-523-6574

The Good Samaritan Health Center offers medical, dental, health education, mental health, and social services. Patients pay on a reduced sliding fee scale based on income and household size with the remaining costs provided by donations. At The Good Samaritan Health Center, the entire family receives quality healthcare in an atmosphere of dignity and respect, regardless of race, ethnicity, or religion.

Lilly Cares Foundation, Inc.

Lilly Cares provides free Lilly medications for patients who meet program eligibility requirements.

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

Mercy Care

Mercy Care at City of Refuge
1300 Joseph E. Boone Blvd.
Atlanta, GA 30314
678-843-8790

Mercy Care at Gateway Center
275 Pryor Street SW
Atlanta, GA 30303
678-843-8840

Mercy Care at St. Jude's Recovery Center
160 Pine Street
Atlanta, GA 30308
678-843-8544

As your medical home, Mercy Care offers comprehensive services that meet the majority of primary physical and mental health and wellness needs. Services are planned and delivered by a team that works together for your health. These services include primary medical care for adults and children, primary dental care, vision care, mental and behavioral health assessment and counseling, prescriptions, health screenings and health education.

Physicians' Care Clinic

T.O. Vinson Health Center
440 Winn Way
Decatur, GA 30033
404-501-7940
www.physicianscareclinic.org

Physicians' Care Clinic is the oldest and largest free clinic serving residents of DeKalb County, offering healthcare to thousands of patients each year. Our mission is to provide low-income and uninsured adults with access to quality, comprehensive, non-emergency medical care delivered with excellence, compassion and dignity.

Family Medical Center

30 Warren Street
Atlanta, GA 30317
404-373-6614
whitefoord.org

Whitefoord is the centralized community resource that connects diverse children and families to quality healthcare and education services that form a strong foundation of learning and support for long-term success.

Healthcare:

- Family Planning
- Dental
- Pediatrics
- Behavioral Health
- Health Education
- Adult Medicine

Center for Black Women's Wellness

477 Windsor Street SW, Suite 309
Atlanta, GA
404-688-9202
cbww.org

The Wellness Program strives to broaden awareness of the many health issues affecting Black women; encourage change in personal behaviors to prevent unnecessary illnesses; and provide preventive healthcare and early detection and treatment of conditions before health problems arise.

Wellness Clinic

The Wellness Clinic provides women's health (GYN) care, including the following services:

- Well woman visits, including Pap Test, Pelvic exam and clinical breast exam
- Pregnancy testing, preconception counseling and family planning
- Physical examinations and health screenings
- Laboratory services, including total blood chemistry profile
- Confidential HIV testing
- Mammogram referrals and follow-up
- STD/STI screening and treatment
- Employment drug testing

All services are based on a sliding fee scale while accepting Medicaid.

Safety-net Clinic

The Safety-net Clinic provides no cost services for uninsured women and men ages 18 & older. Services include:

- Primary Healthcare
- Non-Emergency Care
- Chronic Disease Management including but not limited to:
 - Hypertension (high blood pressure) management
 - Confidential HIV testing
 - High Cholesterol management
 - Diabetes management
 - Mental Health Referrals and Services

Teen Clinic

On-site teen clinical services provided to male and female youth by the Fulton County Department of Health and Wellness.

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

Oakhurst Medical Centers

Main Office / Stone Mountain Location

5582 Memorial Drive
Stone Mountain, GA 30083

Decatur Location

1760 Candler Road
Decatur, GA 30032
404-286-2215

Northlake location

2295 Parklake Drive, Suite 500
Atlanta, GA 30345

Other Locations

2140 Peachtree Road NW, Suite 232
Atlanta, Georgia 30309
550 Peachtree Street
Atlanta, GA 30303

Oakhurst is a community based, not for profit, primary healthcare center. Since 1980, we have been providing quality, affordable, culturally sensitive and accessible healthcare to the residents of DeKalb County. We also serve Fulton County.

Southside Medical Center

1046 Ridge Avenue, SW
Atlanta, GA 30315

404-688-1350

southsidemedical.net

Southside Medical Center has centers throughout metro Atlanta in Norcross, East Point, Riverdale, Hampton and Forest Park.

Offering affordable healthcare and related services including Pediatrics, Adult Medicine, Women’s Health, Dentistry, Optometry and Specialty Services

Also offered:

Southside Behavioral Lifestyle Enrichment Center (SBLEC) serves all men and women, aged 18 and older, who seek to overcome the use of any type of drug or alcohol.

Susan G. Komen Greater Atlanta

3525 Piedmont Rd., Building 5, Suite 215
Atlanta, GA 30305

404-814-0052

Helpline: 1-877 GO KOMEN (1-877-465-6636)
komenatlanta.org

Offering Breast Cancer Screening, Education and Resources

Susan G. Komen Greater Atlanta is the local resource for women who need breast cancer screening, diagnostic and support services. Through annual events, including the Race for the Cure and Bubbles & Bling and individual contributions, Komen Atlanta raises funds that enable women and men to detect and survive breast cancer.

Fulton-DeKalb Hospital Authority

50 Hurt Plaza, Suite 803
Atlanta, GA 30303

404-334-3680

The Fulton DeKalb Hospital Authority exists primarily to ensure that the indigent residents of Fulton and DeKalb Counties receive quality healthcare through the Grady Health System. Our goal is to reduce the number of visits to Grady’s emergency room by improving the health status of Fulton and DeKalb County residents.

Transportation

Transportation Options Program for Seniors (TOPS)

TOPS Program Manager:
770-993-1906 x234

www.ssnorthfulton.org/senior-services/transportation

Get Around Town Easily (GATE) Program
GATE Mobility Manager: 770-993-1906 x242

The TOPS program is designed to provide medical transportation for seniors age 60+ in the Senior Services North Fulton service area: Alpharetta, Johns Creek, Milton, Mountain Park, Roswell and Sandy Springs. Trips can be arranged for appointments with doctors, dentists, eye doctors, for treatments ordered by your doctor – or to get a flu shot.

Seniors and adults with disabilities who are unable to drive need the ability to pick up prescriptions, grocery shop, visit the bank, or simply get a haircut. Our grant funded GATE (Get Around Town Easily) Transportation Program allows north Fulton seniors and adults with disabilities to purchase a transportation account that can be used with selected drivers in the GATE program.

MARTA

Route & Schedule Info:
404-848-5000

Customer Service: 404-848-5000
MARTA Mobility: 404-848-5826

www.itsmarta.com

MARTA serves Fulton and DeKalb Counties through a bus and rail system. MARTA maps are available online or at any station.

To advocate and provide safe, multi-modal transit services that advance prosperity, connectivity and equity for a more livable region.

Transportation (continued)

Non-Emergency Medical Transportation (NEMT)

Schedule Transportation:

Logisticare:

1-888-224-7981 (Central)

1-888-224-7985 (Southwest)

1-888-224-7988 (East)

Medicaid Member Call Center:

866-211-0950

The Non-Emergency Medical Transportation (NEMT) program provides eligible members transportation needed to get to their medical appointments. To be eligible for these services, members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program.

Behavioral Health

The Summit Counseling Center

2750 Old Alabama Rd., Suite 200

Johns Creek, GA 30022

678-893-5300

summitcounseling.org

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

Will-To-Live Foundation

5805 State Bridge Rd. #G212

Johns Creek, GA 30097

will-to-live.org

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

The Insight Drug Program

5110 Old Ellis Pt.

Roswell, Georgia 30076

770-751-8383

theinsightprogram.com/georgia-locations

The Insight Program has provided substance abuse treatment for teens and young adults since 1987. The Insight Program provides all its services through a philosophy called Enthusiastic Sobriety. Making sobriety attractive to teens and young adults is challenging. Insight has been successful in creating a program that reaches young people in a way that is inviting and fun.

The Insight Program offers a number of services including: intensive outpatient substance abuse treatment, outpatient substance abuse treatment, individual counseling, family counseling, support group meetings, parent support groups and sober social functions. Insight staff members are also available for speaking engagements. Insight treatment programs are licensed in Georgia and North Carolina.

CaringWorks

2785 Lawrenceville Hwy, Suite 205

Decatur, Georgia 30033

404-371-1230

www.caringworksinc.org/behavioral-health-programs

CaringWorks Treatment and Recovery Services (CTRS) provides exceptional mental health supports and addiction treatment to those in need because we believe everyone, no matter their circumstance, should have access to quality behavioral healthcare.

Since the primary causes of chronic homelessness are mental illness and addictions – sometimes at the same time – targeted therapy and services help get at the root causes that repeatedly return people to the streets. Through CTRS, we offer a full array of behavioral health services. CTRS has social workers, therapists, counselors, medical professionals and case managers with special training and expertise in the evaluation and treatment of these challenging conditions at three locations across metro Atlanta for individuals, couples and families. We believe it is vital to treat the whole person, providing the most individualized, comprehensive and compassionate services possible, thus offering every opportunity for a full recovery and path to a more fulfilling and productive life.

St. Jude's Recovery Center, Inc.

139 Renaissance Pkwy NE

Atlanta, GA 30308

www.sjrcatl.org

Serving metro Atlanta, St. Jude's Recovery Center provides an integrated system of care that sustains recovery from the disease of addiction and co-occurring mental health disorders and returns under-resourced individuals to their families and communities as healthy, self-sufficient, productive individuals. Treatment services are based on the belief that addiction is a disease and that treatment must focus on the whole person. Our evidence-based programs and services are designed to support the client over a lifetime of recovery.

Behavioral Health (continued)

DeKalb Community Service Board (CSB)

dekcsb.org

DeKalb Community Service Board (CSB) is an innovative, community-based behavioral health and developmental disabilities services organization located in metropolitan Atlanta, Georgia, offering a full range of mental health services, developmental disabilities programs and substance abuse treatment to more than 11,000 citizens annually who are uninsured and underinsured.

Services:

- Behavioral Health
- Substance Use
- Crisis
- Child & Adolescent
- Developmental Disabilities
- Residential
- Consultative

Families First-Counseling

Main Office

80 Joseph E. Lowery Boulevard, NW
Atlanta, GA 30314-3421

Decatur Office

4298 Memorial Drive
Decatur, GA 30032

North Fulton Office

89 Grove Way
Roswell, GA 30075

404-853-2844

Since 1942, Families First has been providing counseling services to metro Atlanta families, supporting the agency's mission to ensure the success of children in jeopardy by empowering families. The Counseling and Support Services program targets children and youth in families facing chronic economic, social or health challenges so that they will succeed in stable, nurturing homes with self-sufficient families.

Adults, Teens and Children: From a young age, children can be faced with stress and hardships based on their living conditions, their family structure and school. These stresses don't go away as they age: unfortunately, they increase. At Families First, we recognize the growing need in our community to offer supportive and professional counseling services to children, teens and adults. Individuals and families can receive counseling in both English and Spanish.

Counseling services offered by Families First

- Individual Counseling
- Family Counseling
- Couples Counseling
- Group Counseling

For clients to:

- Heal from emotional pain and trauma
- Stabilize mental health symptoms
- Develop coping skills to deal with life's stressors
- Strengthen their family and social relationships
- Achieve greater sense of health, quality of life and well-being

The Odyssey Family Counseling Center

1919 John Wesley Ave.
College Park, GA 30337

404-762-9190

www.odysseycounseling.org

Odyssey Family Counseling Center is a community-based nonprofit organization that provides mental health and substance abuse treatment as well as prevention and education services to individuals and families. We serve all age groups, from children as young as three years old to seniors over 65, and people from all cultures and backgrounds.

Metropolitan Counseling Services

2801 Buford Hwy, NE, Suite 470
Atlanta, GA 30329

404-321-1794

mcsatlanta.org

Metropolitan Counseling Services is a leader in providing affordable mental health services and serves as a model for other programs seeking to reach underserved populations.

HIV

AID Atlanta

1605 Peachtree Street NE
Atlanta, GA 30309-2955

404-870-7700

www.aidatlanta.org

AID Atlanta offers a broad range of services and has grown to be the most comprehensive AIDS service organization in the Southeast. AID Atlanta currently offers HIV/AIDS prevention and care services, including (but not limited to) Primary Care, HIV/STD Screening, PrEP, Community HIV Prevention Programs, Linkage Services, Case Management and a state-wide Information Hotline. The mission of AID Atlanta is to reduce new HIV infections and improve the quality of life of its members and the community by breaking barriers and building community.

HIV (continued)

Aniz Inc.

Garnett Station Place
236 Forsyth Street, SW
Atlanta, GA 30303
404-521-2410
www.aniz.org

Our services:

- HIV Testing
- Prevention & Wellness
- Substance Use Counseling
- Holistic Harm Reduction Support Group
- Peer Support
- Open Empowerment Group
- Clean Syringe Access
- Research & Evaluation
- Case Management
- Behavioral Health Services
- Sexual Health

Empowerment Resource Center

230 Peachtree Street NW, Suite 1800
Atlanta, GA 30303
404-526-1145
www.erc-inc.org

The mission of Empowerment Resource Center is to provide programs, services and community-level solutions that improve the health-related quality of life of people infected and affected by HIV and other sexually transmitted infections (STI).

The Comprehensive Intervention Clinic is an STI screening and acute treatment clinic.

The Behavioral Health & Outreach Services (BHOS) is a non-residential substance abuse treatment and mental health services facility.

Fulton County Government

141 Pryor St.
Atlanta, GA 30303
404-612-4000

The Fulton County Task Force on HIV/AIDS will develop, promote and monitor the implementation of a Strategy to End AIDS in Fulton County in order to improve the quality and length of life for persons living with HIV and prevent new HIV infections.

Ponce De Leon Center

341 Ponce De Leon Avenue
Atlanta, GA 30308
404-616-2440
www.gradyhealth.org/specialty/
ponce-de-leon-center

The Ponce De Leon Center is one of the largest, most comprehensive facilities dedicated to the treatment of advanced HIV/AIDS in the United States. Founded in 1986, the Ponce Center and its onsite affiliates provide various medical and support services to approximately 5,000 eligible men, women, adolescents and children living with HIV/AIDS.

The Ponce Center integrates primary internal medicine and infectious disease subspecialty care in the Main, Family and Transition Clinics. Staffed by doctors, nurse practitioners and physician assistants, nurses and more than 100 interagency staff. Our care teams seamlessly provide onsite medical, support and community services.

To qualify for care in the Ponce Center, adult referrals must have a previous AIDS diagnosis and/or a Nadir CD4 count below 200. Pediatric and adolescent patients have no such restrictions.

Services offered:

Primary medical care for men, women, adolescents and children living with HIV/AIDS. Transition centers for HIV-infected individuals with <200 CD4 cells. Subspecialty care in Dermatology, Hepatitis C, Mental Health/Substance Abuse Treatment, Ophthalmology and Oral Health. Case management, adherence counseling, nutrition, on-site radiology, laboratory, pharmacy and peer counseling.

Under-Resourced

North Fulton Community Charities

11270 Elkins Rd.
Roswell, GA 30076
nfcchelp.org

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

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

Under-Resourced (continued)

Atlanta Community Services, Inc.

2144 Buford Highway, Ste 110
Buford, GA 30518
770-904-5270
Fax: 770-904-5269

Atlanta Community Services (ACS) will provide the services and support to build a strong and stable community association.

Our professional and personal approach will help improve the lives of families in your neighborhood. Tell us how we can work for you!

Our services include Accounting and Administrative as well as Property Management and Facility Maintenance. Our experts will help your community stay on top of Covenant Violations and Modification Requests.

Atlanta Community Food Bank

732 Joseph E. Lowery Blvd., NW
Atlanta, GA 30318
404-892-9822

The mission of the Atlanta Community Food Bank is to fight hunger by engaging, educating and empowering our community. While our core work is food distribution, our efforts extend far beyond that. Our mission is lived out every day through seven projects that help engage, educate and empower both people in need and those who want to help. From supporting community gardens to assisting people in finding economic security, the Food Bank covers a wide range of opportunities for people to learn and get involved. Our seven projects are Atlanta Prosperity Campaign, Atlanta's Table, Community Gardens, Hunger 101, Hunger Walk/Run, Kids In Need and Product Rescue Center.

Employment Training

The Center for Working Families, Inc.

477 Windsor Street, Suite 101,
Atlanta, GA 30312
404-223-3303

Employment Services

We work to help unemployed and underemployed individuals gain family-supporting jobs and advance within careers. TCWFI leverages a robust network of Atlanta's employers in various sectors, serving as a resource to meet industry demands for a well-trained workforce.

Individual Coaching

Different from traditional case management models, the TCWFI coaching model uses a personalized approach, pairing each participant with a pathway coach who works one-on-one with individuals to identify strengths, match interests with opportunities, set goals and develop strategies to overcome barriers and move towards family economic success.

Training & Education

Our training and education division helps individuals gain the edge to be competitive in today's job market with a focus on resume development, interview mastery, soft and hard skills, literacy and digital literacy, and financial literacy and asset building. Programs range from four - six weeks equipping graduates with various industry certifications that accelerate opportunities for employment and advancement.

Two Generation Approach

In partnership with Sheltering Arms Educare Atlanta, TCWFI provides childcare vouchers and wraparound services to more than 125 families with children ages 0 to three through our Two-Generation (2Gen) approach. 2Gen is an innovative model focused on providing simultaneous, intentional services to both parent and child to accelerate and maximize family outcomes.

Atlanta Center for Self Sufficiency

460 Edgewood Ave NE #700,
Atlanta, GA 30303
404-874-8001
www.atlantacss.org

To empower financially vulnerable individuals in our community to become self-sufficient, sustainably employed and economic contributors to society.

Who we serve: Men and women, including veterans, who are experiencing homelessness, are at imminent risk of homelessness, or residing in subsidized housing.

CareerWorks

Offering employment readiness and job placement to homeless individuals, CareerWorks is our cornerstone program. CareerWorks includes a three-week employment readiness training course, personalized case management, job search assistance, professional clothing, transportation assistance, housing placement assistance and individual action plans.

CareerWorks Access

CareerWorks Access is an e-learning initiative that uses cloud technology to stream CareerWorks curriculum to shelters and homeless service programs throughout the city.

Employment Training (continued)

Work Source Georgia

1300 Commerce Drive
Decatur, GA 30030
404-371-2000
www.dekalbworkforce.org

Jobseeker Services:

- Resource materials for career exploration and planning.
- Computer hardware and software for resumé cover letter writing.
- High-speed internet access for internet-based job searches.
- Copy and fax machines to respond to job listings.
- Information on local companies' hiring needs.
- Regularly scheduled workshops on: conducting your job search, resume writing and career development.
- Expert advice from experienced career advisors and information specialists
- Training and education information
- Self-assessment software for typing and other skills

Bobby Dodd Institute

221 Stockbridge Rd.
Jonesboro, GA 30236
770-473-0071
www.bobbydodd.org

Job Training & Employment Services

BDI is an Atlanta workforce development leader with over 25 years of experience in connecting people with disabilities and barriers to employment to jobs. We believe in the power of work to transform a person's life, and each year, we help over 1,000 people take the first steps toward employment.

Whatever challenges job candidates face, our Workforce Resources programs prepare them to enter the workforce or to adapt their experience to a new career path.

BDI and our supporters equip people with the skills, experience and support they need to be competitive in the job market and build their careers. Our focus is not just on connecting people to jobs—we place priority on ensuring they have the tools needed to remain employed for the long term. Specialize in career planning, job placement and job training for people with disabilities in metro Atlanta.

BDI works with people who have physical and/or developmental disabilities, as well as people with disabilities due to chronic illness such as diabetes, arthritis and mental illness. BDI also works with people who have other barriers to employment, such as veterans. Our clients come to us with a wide range of work experience and educational levels.

Our services include:

- Evaluation and career planning
- Specialized job training
- Job connections services

The Urban League of Greater Atlanta

229 Peachtree Street NE, Suite 300
Atlanta, GA 30303-1600
404-659-1150
ulgatl.org

Job Readiness (CORE) Training

A workforce job readiness training program offering courses in job searching techniques, resume writing, interview skills, mock interviews and job sustainability. The Step Up to Work Program includes the following courses:

- Successful Job Searching & Creating an Employment Action Plan
- Creating a Dynamic Resume
- Mastering the Interview
- Job Sustainability
- Mock Interview
- Job Coaching
- Financial Literacy

Westside Works

261 Joseph E. Lowery Blvd. NW
Atlanta, GA 30314
404-458-6413
www.westsideworks.org

Westside Works is a long-term neighborhood program focused on creating employment opportunities and job training for residents of the Westside community, including Vine City, English Avenue, Castleberry Hill and other contiguous neighborhood.

Programs:

- Construction
- CNA
- Education
- Culinary
- Office Operation
- Information Technology

Youth Programs

<p>YMCA of Metro Atlanta 101 Marietta St NW #1100 Atlanta, GA 3030 www.ymcaatlanta.org/locations</p>	<p>YMCA Youth Programs:</p> <ul style="list-style-type: none"> ■ Afterschool ■ Early Learners ■ Teen ■ Overnight, Summer and Holiday/School Break Camps ■ Youth and Adult Fitness programs and activities <p>Multiple Locations in schools and the community throughout Atlanta</p>
<p>2020 Vision for School Nutrition</p>	<p>The 2020 Vision for School Nutrition is a joint, collaborative initiative between the Georgia Departments of Agriculture, Education and Public Health. The goals of this program are to:</p> <ol style="list-style-type: none"> 1. Provide quality foods that are safe and nutritious to Georgia’s students. 2. Support agriculture by strengthening local markets. 3. Make students aware of the origins of foods they enjoy. 4. Reduce the carbon footprint of foods utilized.
<p>Boys and Girls Clubs of Metro Atlanta Metro Atlanta Headquarters 1275 Peachtree Street NE, Suite 50 Atlanta, GA 30309 404-527-7100 www.bgcma.org/local-clubs</p>	<p>Boys & Girls Clubs of Metro Atlanta works to save and change the lives of children and teens, especially those who need us most, by providing a safe, positive and engaging environment and programs that prepare and inspire them to achieve Great Futures.</p> <p>Our 25 Clubs, located in some of our city’s most underserved communities, open their doors every day to more than 3,300 kids and teens. We provide a safe, positive and engaging environment for kids with a focus on helping them reach their full potential.</p> <p>Programs include afterschool, summer camp, holiday camps and teen programs. Multiple locations throughout Atlanta</p>
<p>City of Atlanta Office of Recreation 233 Peachtree Street, NE, Suite 1700 Atlanta, Georgia 30303 www.atlantaga.gov/government/departments/parks-recreation/office-of-recreation</p>	<p>Our mission is to provide quality professional recreational services and programs to all citizens of Atlanta through balanced, enjoyable and affordable activities. Our vision is to enhance the quality of life for all citizens through nationally acclaimed recreation programs and activities.</p> <p>Youth Services include:</p> <ul style="list-style-type: none"> ■ Afterschool Program (Ages 5 - 17) ■ Culture Club (Ages 5 - 12) ■ Afterschool All - Inclusive Therapeutic Center (Ages 5 - 17) ■ Camp Best Friends Summer Camp ■ Atlanta Teen Leaders (ATL) Afterschool Programming (Ages 13-18) <p>Multiple Locations throughout Atlanta</p>
<p>Fulton County Government Office of Parks and Recreation 141 Pryor St. Atlanta, GA 30303 404-612-4000</p>	<p>Afterschool Program and Summer Camps at Burdett Gym, Clifftondale Park, Sandtown Park and Welcome All Park</p> <p>Multiple locations throughout Fulton County</p>
<p>Fulton County Cooperative Extension Central Office (Downtown) Central Atlanta Library 1 Margaret Mitchell Square Atlanta, GA 30303 404-332-2400</p>	<p>The mission of the Fulton County Cooperative Extension Service is to respond to citizens' needs and interest in agriculture and natural resources, families, 4-H and youth through education and information.</p>

Youth Programs (continued)

DeKalb County Georgia Department of Recreation, Parks & Cultural Affairs

1300 Commerce Drive
Decatur, GA 30030

404-371-2000

www.dekalbcountyga.gov/parks/recreation-center-locations

Afterschool and Camp programs offered at various locations
Multiple Locations throughout DeKalb County

Clayton County Georgia Department of Parks and Recreation

2300 Highway 138 SE
Jonesboro, GA 30236

770-603-4159

www.claytonparks.com/recreation-services.aspx

Afterschool programs and Teen Club at various locations
Multiple Locations throughout Clayton County

City of College Park, Department of Recreation and Cultural Arts

3667 Main Street
College Park, GA 30337

404-669-3767

www.collegeparkga.com

The Department of Recreation and Cultural Arts consists of three centers today: Wayman and Bessie Brady, Hugh C. Conley and Tracey Wyatt, formerly known as the Godby Road Center. Each center offers various activities for both youth and adults.

City of East Point, Department of Parks and Recreation

404-270-7054

www.eastpointcity.org/parks-recreation

The City of East Point Parks and Recreation Department provides a variety of recreation, leisure and cultural activities for the community. We are home to twenty three (23) parks, a recreation center, playgrounds, tennis courts, sand volleyball, basketball courts and trails. Enhance quality of life of each resident by providing affordable activities and programs.

City of Hapeville Recreation Department

3444 North Fulton Ave
Hapeville, GA 30354

404-669-2136

www.hapeville.org

Hapeville Recreation Department has learning and leisure time programs, a wide variety of facilities and dozens of services available including sports and athletics, children and teen programs, fitness and leisure as well as adult and senior programs

Union City Parks and Recreation

5285 Lakeside Drive
Union City, GA 30291

770-964-1236

unioncityga.org

Offering parks, trails, youth sports and leisure services for older adults

Atlanta BeltLine, Inc.

100 Peachtree Street NW, Suite 2300
Atlanta, GA 30303

404-477-3003

Fax: 404-477-3606

Email: info@atlbeltline.org

beltline.org

The Atlanta BeltLine offers walking trails, parks and healthy activities (for example, group fitness such as aerobics, and instructional classes such as swim and bicycling). For people of all ages.

The South Fulton Arrow Youth Council

4910 Jonesboro Rd. Suite 301,
Union City, GA 30291

678-545-2139

www.thesfayc.org

The South Fulton Arrow Youth Council is a nonprofit organization that provides rigorous educational leadership training for students K-12 (Elementary through Secondary Education) and young adults up to age 22. The program is designed to inspire, empower and educate our students to target their potential as 21st century leaders in today's global economy and changing world.

Youth Programs (continued)

Year Up Atlanta

730 Peachtree St., Suite 900
Atlanta, GA 30308

404-249-0300

www.yearup.org

Year Up combines hands-on skills development, courses eligible for college credit and corporate internships to prepare students for success in professional careers and higher education.

Our one-year program includes:

- 6 months professional training in IT, Financial Operations, Sales & Customer Support, Business Operations, or Software Development
- 6 month corporate internship with a respected company
- Coursework eligible for college credit
- Weekly educational stipend throughout the program
- Guidance and support from a staff advisor and professional mentor
- 90 percent of Year Up graduates are employed and/or enrolled in postsecondary education within four months of completing the program.
- Earn a stipend throughout the program (both while you train and during your internship) and complete courses eligible for college credit.

C.H.O.I.C.E.S.

Program Site:
125 Ellis Street NE
Atlanta GA 30303

404-996-2362

Admin Office:
1275 Shiloh Road NW, Suite 2660
Kennesaw GA 30144

678-819-3663

Fax: 678-401-7121

www.choicesforkids.org

Health officials are encouraging more physical activity and better nutrition as ways to combat childhood obesity. For many years it was perceived that obesity was simply about overeating. Through research we have learned that it is really about the changing times of technology, diminished safe places for children to play, fast food marketing and needing better meal choices in schools. If children are to become healthier, we must all start following former First Lady Michelle Obama in the Let's Move! Initiative.

Program components:

- Physical fitness/training
- Dietary/Nutritional Education
- Counseling/Coaching
- Community Collaboration

Senior Services

Quality Living Services

4001 Danforth Rd.
Atlanta, GA 30331

404-699-1686

Fax: 404-505-5788

Quality Living Services Incorporated strives to ensure that seniors gain greater accessibility to the services necessary to lead meaningful dignified lives. Offering a kaleidoscope of programs, Quality Living Services seeks to empower and serve the senior population of metropolitan Atlanta using a self-help program of seniors helping seniors to remain independent and productive community members.

Additional Resources

American Cancer Society

Global Headquarters
250 Williams Street NW
Atlanta, GA 30303

www.cancer.org

24-7 Cancer Helpline: 1-800-227-2345

Knowledge Resource

Cancer resources and 24-hour phone support

Sisters By Choice

501(c)(3) Organization
5910 Hillandale Drive, Suite 10,
Lithonia, GA 30058

770-987-2951

Fax: 678-418-3995

sistersbychoice.org

Mission Statement:

To significantly reduce the incidence and severity of breast cancer by delivering innovative programs that:

- Increase breast cancer awareness, education and early detection
- Provide treatment programs for underserved and uninsured men and women
- Establish a network of support group chapters that provide resources, information and counsel to individuals diagnosed with breast cancer and their families

Additional Resources (continued)

The Health Initiative

The Phillip Rush Center,
1530 DeKalb Avenue, NE, Suite A
Atlanta, GA 30307

404-688-2524

Fax: 404-688-2638

info@thehealthinitiative.org

The Health Initiative provides education, advocacy, support and improved access to care to Georgia's Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community. Founded in 1996, we are the largest non-profit organization in the southeast devoted solely to the health and wellness of LGBTQ people.

Avon Foundation for Women

601 Midland Avenue
Rye, NY 10580

info@avonfoundation.org

Our mission is to improve the lives of women globally. In our core cause areas of Breast Cancer and Violence Against Women, we aim to accelerate progress, accountability and discovery, while also reducing the social stigma that sometimes keeps these issues in the shadows.

We take a woman-centric approach on all projects to break traditional barriers and build a better future for women, because we know that the greater the support, the more empowered women feel to take control of their health and safety.

We lead efforts on breast health awareness and prevention through the Avon Breast Cancer Promise, and to help end gender-based violence through the Avon Promise to End Violence Against Women and Girls using four key strategies:

- Funding the most promising work;
- Convening grantees, partners and other thought leaders to collaborate and share best practices for improved outcomes;
- Initiating new directions and innovative projects to accelerate progress; and
- Educating the general public and key audiences to drive and change behavior to achieve its mission goals.

American Heart Association

Atlanta Office:
10 Glenlake Parkway, South Tower,
Suite 400, Atlanta, GA 30328

678-224-2000

National Customer Service:
800-257-6941

www.heart.org

Knowledge Resource

Heart health knowledge and resources

American Diabetes Association

1-800-DIABETES (1-800-342-2383)

askada@diabetes.org

We lead the fight against the deadly consequences of diabetes and fight for those affected by diabetes.

- We fund research to prevent, cure and manage diabetes.
- We deliver services to hundreds of communities.
- We provide objective and credible information.
- We give voice to those denied their rights because of diabetes.

National Kidney Foundation

Serving GA, AL & MS - Georgia Region
270 Peachtree Street, Suite 1040
Atlanta, GA 30303

www.kidneyga.org

nkfga@kidney.org

770.452.1539

Fax: 770.452.7456

Fueled by passion and urgency, National Kidney Foundation (NKF) is a lifeline for all people affected by kidney disease. As pioneers of scientific research and innovation, NKF focuses on the whole patient through the lens of kidney health. Relentless in our work, we enhance lives through action, education and accelerating change.

Additional Resources (continued)

<p>Family Life Ministries 612 College Street Hapeville, GA 30354 404-761-6302 www.familylifehelps.org</p>	<p>Food/Hygiene Resource Assisting those most in need in our community with food, hygiene items and basic life necessities such as toilet paper.</p>
<p>Georgia Department of Community Health 800-436-7442 dch.georgia.gov/programs</p>	<p>Providing online services and state programs such as Medicaid and Peachcare for Kids</p>
<p>Latin American Association Atlanta Outreach Center 2750 Buford Hwy. Atlanta, GA 30324 404-638-1800 Lawrenceville Outreach Center 308 North Clayton St. Lawrenceville, GA 30046 678-205-1018 (Family Well-Being) 770-910-7660 (Immigration only) Fax. 678-205-1027 thelaa.org</p>	<p>The mission of the Latin American Association (LAA) is to empower Latinos to adapt, integrate and thrive. Services include immigration legal services, youth programs, family services, employment services and education</p>
<p>Emory University Urban Health Initiative 201 Dowman Drive Atlanta, GA 30322 404-727-6123</p>	<p>Emory University's Urban Health Initiative provides health disparities education and advocacy, builds collaborative partnerships and develops best practice models with underserved communities and those who work with them in metropolitan Atlanta in order to advance equity in health and well-being.</p>
<p>Atlanta Regional Commission 229 Peachtree St. NE, Suite 100 Atlanta, GA 30303 404-463-3100 Fax: 404-463-3205</p>	<p>The Atlanta Regional Commission advances the national and international standing of the region by leveraging the uniqueness of its evolving communities, anticipating and responding to current realities and driving a data-driven planning process that provides a high quality of life, balancing social, economic and environmental needs of all our communities.</p>
<p>Solomon's Temple 2836 Springdale Rd. SW Atlanta, GA 30315 404-762-4872 solomonstempleinc.org/what-we-do/</p>	<p>Solomon's Temple is a holistic emergency and transitional facility for homeless women and their children. Programs include:</p> <ul style="list-style-type: none"> ■ Emergency/Transitional Housing Programs ■ Education and Training ■ Children's Programs
<p>It's The Journey, Inc. 270 Carpenter Drive Suite 515 Atlanta, GA 30328</p>	<p>It's The Journey, Inc.'s mission is to strengthen Georgia's breast cancer community by raising money and awareness for local organizations that focus on breast cancer education, early detection, awareness and support services, as well as the unmet needs in the breast cancer community.</p>

Community Facilities, Assets and Resources

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

Current WellStar Atlanta Medical Center and Medical Center South Partner Organizations

- Aerotropolis Atlanta Alliance
- AID Atlanta
- American Cancer Society
- American Heart Association
- Aniz Inc. (HIV Testing and more)
- Atlanta Beltline
- Atlanta Career Rise – United Way of Greater Atlanta
- Atlanta Center for Self Sufficiency
- Atlanta Fulton Family Connection
- Atlanta Police Foundation and Department
- Atlanta Regional Commission for Health Improvement
- Atlanta South Nephrology
- Atlanta Technical College
- Center for Black Women’s Wellness
- Center for Working Families
- Center Helping Obesity in Children End Successfully (CHOICES)
- Central Atlanta Progress
- City of Atlanta
- City of College Park
- City of East Point
- City of Hapeville
- City of South Fulton
- City of Union City
- Clayton County Board of Health
- Community Voices and Morehouse School of Medicine
- Council for Quality Growth
- Critical Point Consulting
- DeKalb County Board of Health
- Duke Realty Corp.
- East Point Police Department
- Empowerment Resource Center
- Evonne Yancey Solutions
- Families First
- Family Health Centers of Georgia
- Family Life Ministries
- Favor House Inc.
- Federal Reserve Bank of Atlanta (Atlanta Anchor Institution Initiative)
- Fort McPherson Local Redevelopment Authority
- Fulton County Government
- Fulton County Schools
- Fulton County Sheriff’s Office
- Georgia Department of Community Services
- Georgia House of Representatives
- Georgia Power

- Georgia State University
- Gwinnett Division of Family and Children Services
- Healing Community Center
- Health Promotion Action Coalition
- Healthcare Georgia Foundation
- It's the Journey Foundation
- Latin American Association
- March of Dimes
- MARTA
- Martin Luther King Jr. Community Resources Collaborative
- Mercy Care
- Morehouse School of Medicine
- Multicultural Development Institute Inc.
- My Sister's Keeper
- National Pan-Hellenic Council of Greater Atlanta
- Odyssey House
- Office of Congressman David Scott Representing GA 13th District
- Operation P.E.A.C.E.
- Qiagen Inc.
- Parks and Recreation (Fulton, Tri Cities, Atlanta, DeKalb, Clayton)
- Reach Georgia Foundation
- Resurgens Orthopaedics
- Safe America Foundation
- Saint Philip African Methodist Episcopal Church
- Samaritan's Purse
- Saving Our Sons & Sisters International
- Sickle Cell Foundation of Georgia Inc.
- Smith Gambrell & Russell, LLP
- Solomon's Temple
- Southside Medical Center
- St. Jude Recovery Center
- St. Paul's Episcopal Church
- State of Georgia Department of Community Health
- Susan G. Komen Foundation
- The ATL Airport Chamber
- The South Fulton Arrow Youth Council
- Tri-Cities High School
- Union City Police Department
- Urban League of Greater Atlanta
- Vistar of Georgia – Lawrenceville
- Westside Works
- Wingate Management Co.
- Woodward Academy
- Work Source Georgia
- Year Up Greater Atlanta
- YMCA of Greater Atlanta

Implementation Plan



Building a Culture of Health

This Implementation Plan for WellStar Atlanta Medical Center (WellStar AMC) and WellStar Atlanta Medical Center South (WellStar AMC South) 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 AMC and WellStar AMC South 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 measures¹ as key indicators to improve community health, the summit participants answered this overriding question reflecting the patient-centered Triple Aim² 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

WCHC is now expanded to encompass all WellStar hospital communities after the April 2016 acquisition of six hospitals in Georgia, five of which were converted to not-for-profit in 2017, including WellStar AMC and WellStar AMC South. 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; and (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, and (3) reduce healthcare costs.
- 3 Legacy WellStar is defined as the four-county 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 AMC and WellStar AMC South through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research conducted, the following health needs were valued as priority for the community WellStar AMC and WellStar AMC South 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 AMC and WellStar AMC South hospitals play a vital role:⁴

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 The hospitals’ greatest influence to address priority health needs identified in the CHNA is in the intervention areas of health behaviors and clinical care, but they have a collaborative role in all determinants of health.

The scope of WellStar’s healthcare footprint and its commitment to its mission makes WellStar AMC and WellStar AMC South 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.

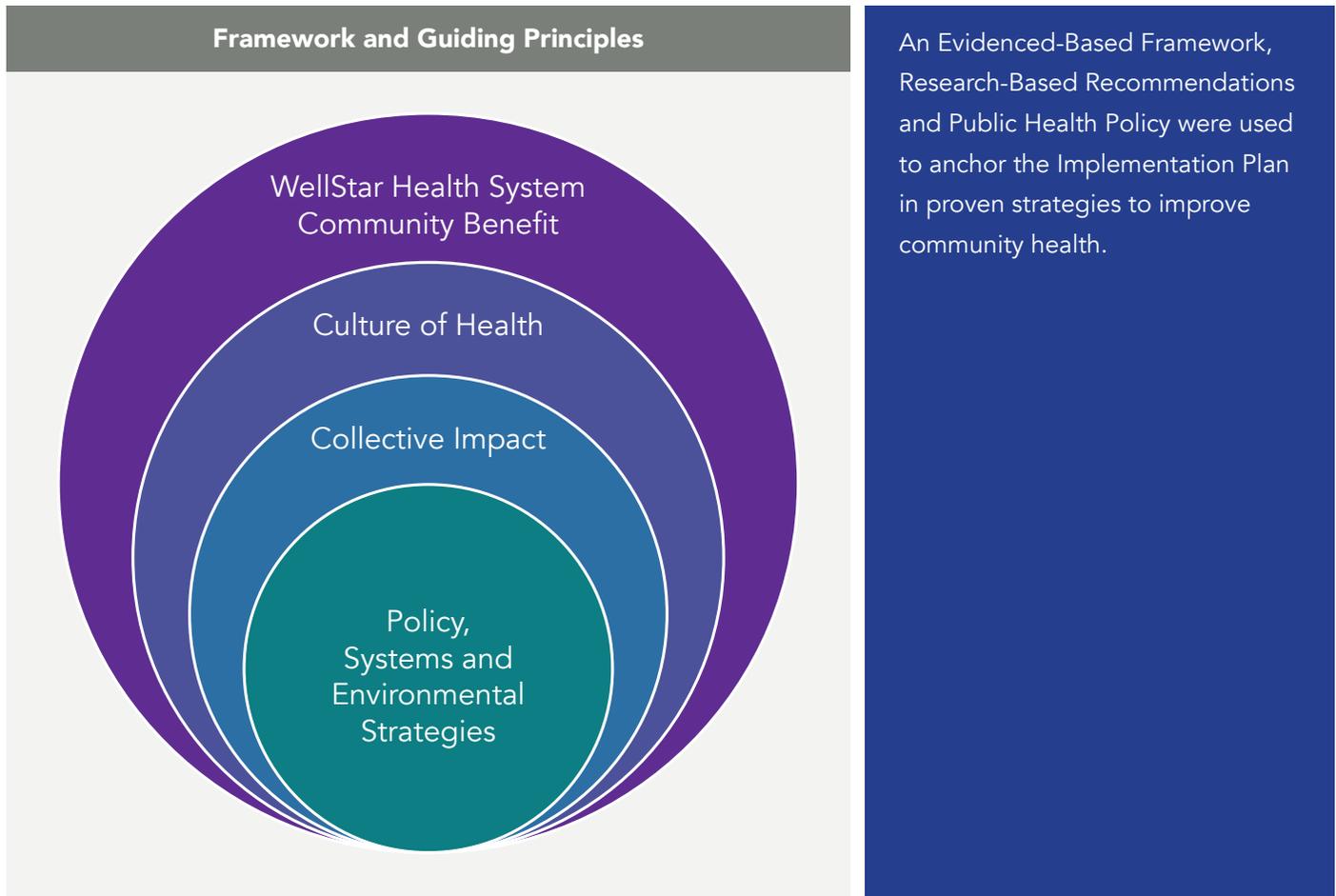
Health Needs Addressed

	 Obesity	 Access to appropriate care	 Behavioral healthcare (including substance abuse)	 Educational awareness	 Equitable revitalization, employment and job training
Cancer Prevention and Screening					
Community Education & Outreach					
Community Transformation Grants					
HIV/AIDS Initiatives					
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 AMC and WellStar AMC South 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 AMC and WellStar AMC South—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

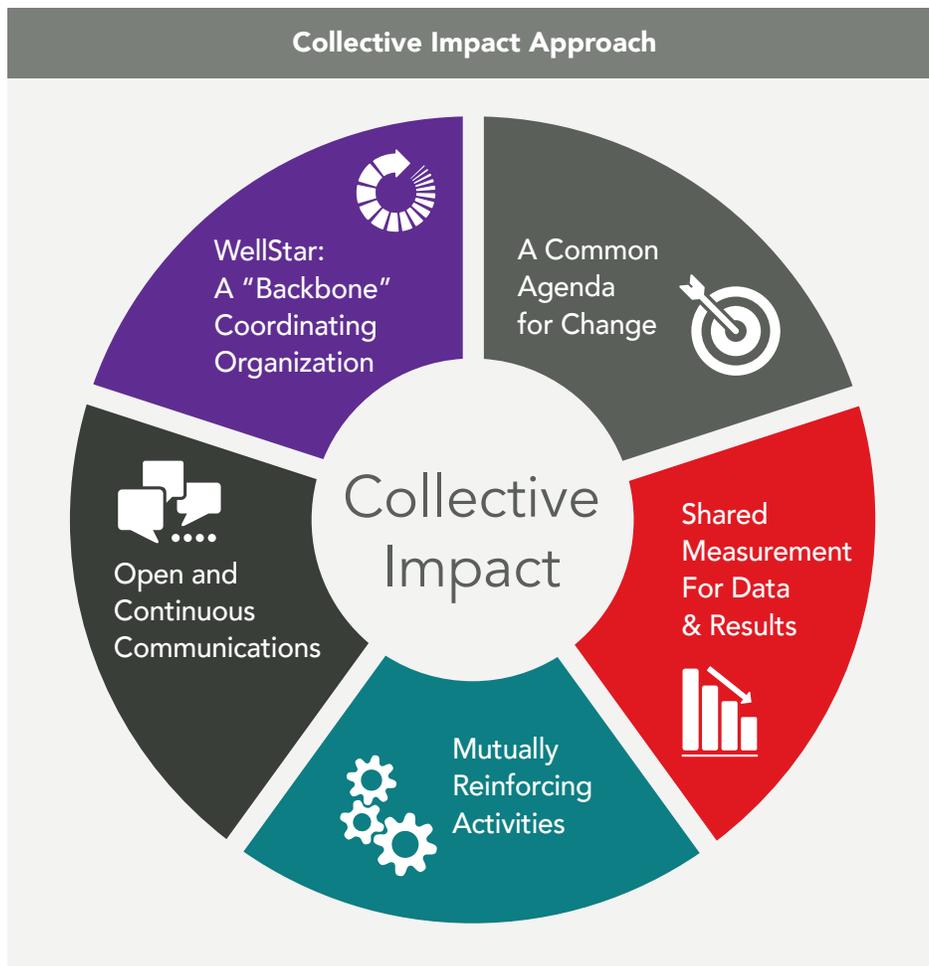
Providing safe, equitable, accessible, efficient and timely care

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 Cobb, Douglas, Kennestone, Paulding and Windy Hill 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 AMC and WellStar AMC South 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 AMC and WellStar AMC South 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



Community Education & Outreach



Moving Upstream:
WellStar Community Transformation
Grants and Day of Service



WellStar 4-1 Care



WellStar Opioid
Steering Committee



Zero Suicide
Initiative



The Health of
All Women



Cancer Prevention
and Screening

Sustainable Infrastructure



Screening for
Food Insecurity



HIV/AIDS
Initiatives



Hospital's Roles and
Responsibilities



Public Health Policy
and Advocacy



WellStar Research
Institute

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

Speakers' Series and Speakers Bureau	WellStar's Speaking about Wellness Program provides our community a multiple speakers' series and a robust speakers bureau focused on preventive 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.
Congregational Health Network	WellStar's Congregational Health Network serves as a bridge between our healthcare system and faith communities. Coordinated by a full-time registered nurse who specializes in Faith Community Nursing, WellStar's program is designed to assist congregations of all faiths to develop or support health ministries.
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.
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 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 Day Events	WellStar's Medication Take Back Day events are a partnership between WellStar CE&O, local police departments and community-based organizations to provide secure drop-off locations for expired and unused medications.

Community Outreach

Community Events	WellStar Health System participates in a wide variety of community events throughout the year, including health fairs, community walks, expos, road races, festivals, farmers' markets, congregation events/health fairs, community walks and special signature events.
Community Partnerships	CE&O is responsible for developing and cultivating strategic community partnerships. Partnerships allow us to focus on prevention and wellness, impact community priority health needs and increase access to healthcare services.
Community Sponsorships	WellStar Health System supports the health and well-being of the communities we serve by actively engaging in sponsorship opportunities. Each year, WellStar supports other nonprofit organizations that align with our mission, vision and community needs assessment to improve the health of citizens in our communities.

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 Place-Based Investing: Creating Sustainable Returns and Strong Communities Toolkit. Retrieved from <https://hospitaltoolkits.org/investment/>

¹² Norris T & Howard T (nd). Can Hospitals Heal 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>

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

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' judgement alone and allows for a better evaluation of risk factors prior to treatment strategy preparation.¹⁹ If treatment is needed, dialectical behavior therapy has shown to decrease treatment attrition, suicide attempts, hospitalization and treatment received from the ED.²⁰ Furthermore, delegation of patient safety planning requires care management measures, e.g. follow-up contact with patients. Studies show that improving continuity of care by contacting patients post-discharge reduces suicidal ideations and behavior, and the rate of suicide.²¹

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

- 18 Schmitz WM, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, et al. Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. *Suicide Life Threat Behav.* 2012; 42 (3): 292 – 304.
- 19 Posner K, Brown GK, Stanley B, Brent DA, Yershova K , Oquendo MA, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry.* 2011; 168 (12): 1266 – 77
- 20 Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry.* 2006; 63 (7): 757 – 66
- 21 Suicide prevention strategies revisited: 10-year systematic review. Zalsman G, Hawton K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M, Carli V, Höschl C, Barzilay R, Balazs J, Purebl G, Kahn JP, Sáiz PA, Lipsicas CB, Bobes J, Cozman D, Hegerl U, Zohar J *Lancet Psychiatry.* 2016 Jul; 3(7):646-59.

Programmatic Productivity

Establish the Zero Suicide framework as a WellStar Health System initiative to address behavioral health needs of the community

Number of trainees that complete Zero Suicide Gatekeeper Training: Question, Persuade and Refer (QPR)

Number of Zero Suicide Training: Question, Persuade and Refer (QPR) classes offered

Number of Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP) and Collaborative Assessment and Management of Suicidality (CAMS)

Safety Planning Intervention (SPI) offered to providers in the community

Number of trainees that complete Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy – Suicidal Patients (CBT-SP), Safety Planning Intervention (SPI) and Collaborative Assessment and Management of Suicidality (CAMS)

Number of established community behavioral healthcare and support resources and partnerships

Programmatic Outcomes

Trainees demonstrate an increase in understanding in symptoms of common mental illnesses and substance use disorders based on pre- and post-testing

Trainees demonstrate the skills and ability to conduct a timely referral to mental health and substance abuse resources available in the community based on pre- and post-testing

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 preeclampsia-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.^{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>

HIV/AIDS Initiatives



In 2015, there were approximately 49,463 people living with HIV in Georgia, the majority of which were concentrated in the Atlanta area at approximately 37,155. There are populations with above average prevalence rates across the WellStar region. Specifically:

- Fulton, DeKalb and Clayton counties show some of the highest prevalence and diagnosis rates in the U.S.
- In Atlanta, Black residents show higher prevalence rates when compared to any other race or ethnicity at 70.4 percent of people living with HIV in 2017
- In Atlanta, transmission rates are highest as a result of male-to-male sexual contact with 83.2 percent of new HIV diagnoses being male
- The rate of Black females living with an HIV diagnosis is 15.0 times that of White females

In the CHNA resident focus groups indicate that risky sexual behavior, a lack of supervision for youth, cultural stigma, and a lack of awareness in the general population are driving HIV transmission rates. HIV screening rates in Georgia are higher than national rates, and urban areas show higher rates than rural areas in general. Community input suggests that residents may resist screening due to a fear of being diagnosed and cultural stigma associated with HIV. While HIV/AIDS was not identified as a priority health need through the Community Health Needs Assessment process. WellStar AMC/AMC South leadership selected HIV/AIDS has an important community health need that should be addressed by the hospital.

Community Partnerships

WellStar AMC/AMC South will continue to support and seek out and build new partnerships and connections to help strengthen education, support services, local healthcare capacity and capabilities, reduce stigma and discrimination towards people living with HIV/AIDS.

Graduate Medical Education (GME) Internal Medicine Residency Elective

AMC has been training residents for more than 50 years. Today, AMC has four residency programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME)—Family Medicine, General Surgery, Internal Medicine, and Orthopedic Surgery. AMC is firmly committed to maintaining a tradition of excellence in teaching, combining knowledge, technique and technology in every area of modern medicine. As a part of the Internal Medicine GME Resident program, AMC offers an Outpatient Infectious Disease rotation that specializes in HIV treatment, screening and prevention at a community-based care setting: AIDS Healthcare Foundation.

This rotation is designed to provide instruction in the following areas of HIV Management via direct patient encounters, didactic sessions and various reading assignments:

- Baseline Screening and Assessment of the HIV Patient
- HIV Treatment Paradigms: Highly-Active Antiretroviral Treatment regimens; Backbone Therapies; Mechanisms of HIV Drug Classes; Haplotype Screening
- Genotype/ Phenotype Interpretation
- AIDS-Defining Conditions/Oppportunistic Infections
- HIV Pre-Exposure Prophylaxis (PrEP)
- HIV Post-Exposure Prophylaxis (PEP)
- Recommended Vaccinations in HIV Patients
- Social Issues Common to HIV Patients: Transgender Issues; Homelessness; Incarceration; Substance Abuse; Family Discord/ Stigma
- Routine Screening Evaluations in HIV Patients (STIs, Cancer, Psychosocial and Infectious)
- Ryan White Care Act and Funding
- Rapid-Entry Test and Treat Model of Care (4th and 5th Generation Screening)
- HIV Continuity of Care/ Care Continuum

HIV Testing in WellStar AMC/AMC South Emergency Department Research Study

In 2006, the Centers for Disease Control and Prevention (CDC) published HIV Testing recommendations that encourage the expansion of HIV testing in clinical settings with streamlined procedures for consent and pretest information. These recommendations seek to increase the number of infected patients who are successfully referred to treatment and prevention services. To support this best practice, the Internal Medicine GME department conducted an internal investigation conducted an internal research project to examine current policies, practices, facilitators, barriers, and opportunities to incorporate HIV testing in hospital settings, particularly emergency departments. The objectives of this research project were:

- Evaluation of current HIV testing practice at WellStar AMC
- Evaluation of provider's perception towards HIV testing in the ED
- Identification of barriers and gaps for integration of HIV testing in the ED
- Establish recommendations specific to WellStar AMC/AMC South

The findings from this research study are now being leveraged to develop routine, opt-out HIV testing and linkage to care protocols for AMC/AMC South patients especially for uninsured/ underinsured patients.

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 AMC and AMC South 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 AMC and WellStar AMC South 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 Steps³⁹

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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