



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



WellStar West Georgia Medical Center

EIN: 20-5497506
1514 Vernon Rd.
LaGrange, GA 30240

Located in LaGrange, Georgia, WellStar West Georgia Medical Center has served Troup County for nearly 80 years. With about 60,000 patients served each year, this 276-bed facility has focused on delivering high-quality healthcare to its community through top-rated services. Recently, WellStar West Georgia was named the top large hospital in Georgia by Georgia Trend Magazine. WellStar West Georgia is proud to be part of WellStar, the largest health system in Georgia, known nationally for its innovative care models and focus 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 additional inpatient hospitals.

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This report serves to identify and assess the health needs of the community served by WellStar West Georgia Medical Center. 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 West Georgia Medical Center. Located in LaGrange, Georgia, WellStar West Georgia Medical Center has served Troup County for nearly 80 years. With about 60,000 patients served each year, this 276-bed facility has focused on delivering high-quality healthcare to its community through top-rated services. Recently, WellStar West Georgia was named the top large hospital in Georgia by Georgia Trend Magazine. WellStar West Georgia Medical Center is a not-for-profit hospital under the Internal Revenue Code Section 501(r).

Community Health Needs Assessment

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

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



Secondary data specific to the populations and geographic area served



9 individual key informant interviews with stakeholders



One listening session with the hospital's Regional Health Board



One focus group with residents



16 participants at a Health Summit with community and hospital leaders

The primary focus of data collection for this assessment was on under-resourced, high-need and medically underserved populations living in four zip codes concentrated in the primary service area of Coweta, Meriwether, Harris and Troup counties.

Priority Health Needs

WellStar West Georgia Medical Center worked with community and hospital leaders to identify the top community health priorities based on the data included in this assessment. The community health priorities identified for the service area include improving:



Key Findings

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

- Black and Latino residents
- Single parents
- People without legal immigration status
- Residents from zip codes 30230, 30240, 30241 and 31833

In general, the community served by WellStar West Georgia Medical Center is slightly older, less diverse and lower-income earning. Among the four primary counties in the service area, Coweta and Harris counties are less diverse, while Coweta and Meriwether counties are higher-income earning.

Social Determinants of Health

Social determinants of health¹ influence residents in the areas served by WellStar West Georgia Medical Center. Meriwether County residents experience the greatest socioeconomic barriers related to income, employment and education when compared to residents of the other counties in the service area. Racial and ethnic disparities in socioeconomic status also are prevalent across the service area.

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

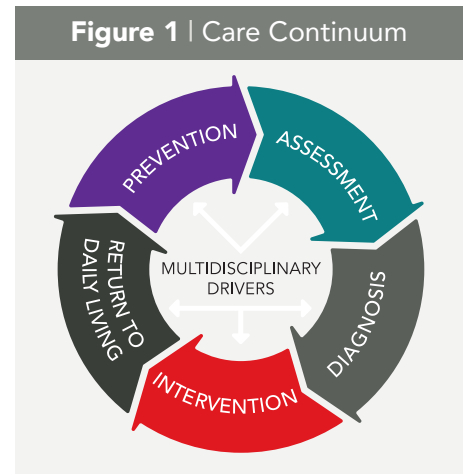
- Health professional shortage areas
- High rates of emergency department (ED) visits
- High hospitalization rates for preventable issues
- High mortality rates





¹ 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."

Health Outcomes

There are several undesirable health outcomes in the service area. Most of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, lung cancer, mental and behavioral disorders and COPD). When considering county-level data, morbidity (disease burden) and mortality (death) rates are high in Harris, Meriwether and Troup counties. Coweta County shows the lowest rates of morbidity and mortality, while Meriwether and Troup counties show the highest rates. Whites show higher rates of mortality, while Black residents show the highest disease burden when the data are considered by race, though there is limited racial/ethnic data available for these counties.

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



 <p>Cancer incidence and mortality <i>Breast, colon, lung and prostate cancers</i></p>	 <p>Heart disease <i>Obstructive heart disease</i></p>	 <p>Poor birth outcomes <i>Low-birth-weight (LBW) births and infant mortality</i></p>	 <p>Behavioral health issues and intentional self-harm <i>Suicide</i></p>	 <p>Drug-related mortality</p>
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Investments in addressing these issues would influence the health of communities served by WellStar West Georgia Medical Center.

Limitations to Findings

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

Community Is **Commitment**

WE EXIST TO SERVE



Community Definition

WellStar West Georgia Medical Center is located in LaGrange, Georgia, approximately 70 miles southwest of Atlanta. For the purposes of this CHNA, the primary service area for the hospital is defined as the four zip codes from which 75 percent of discharged patients originated during the previous year. The bulk of patients are from Coweta, Meriwether, Harris and Troup 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 four residential zip code areas regardless of the use of services provided by WellStar or any other provider. More specifically, this assessment focuses on residents in the service area that are medically under-resourced or at risk of poor health outcomes.

Map 1 | Primary Service Area of West Georgia Medical Center

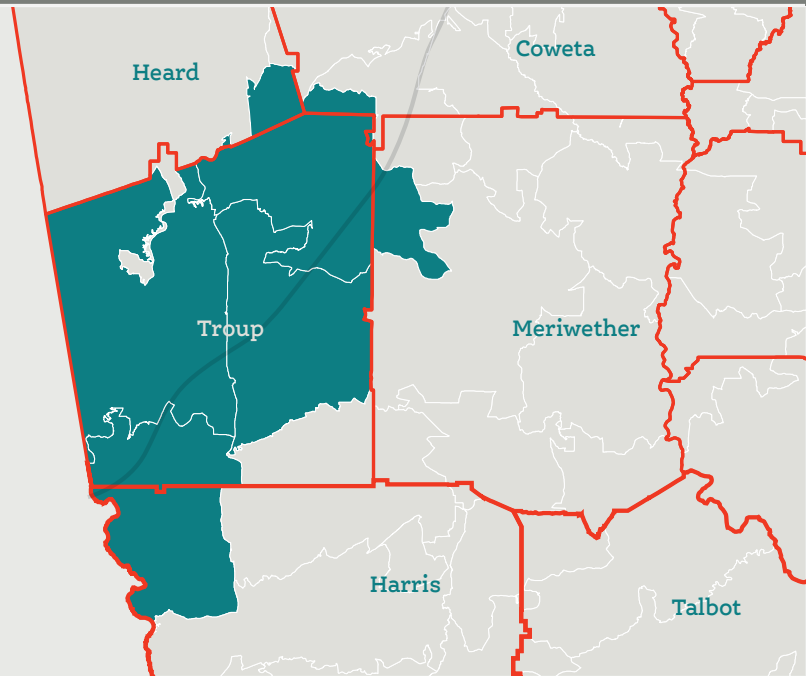


Table 1 | Primary Service Area of WellStar West Georgia Medical Center[†]

County	Zip Codes (4)	Population (2018)
Troup	30230, 30240, 30241, 31833	72,716
Harris		
Coweta		
Meriwether		

[†] Truven Health Analytics, Community Needs Index

Demographic Data

by County and State (2018)*

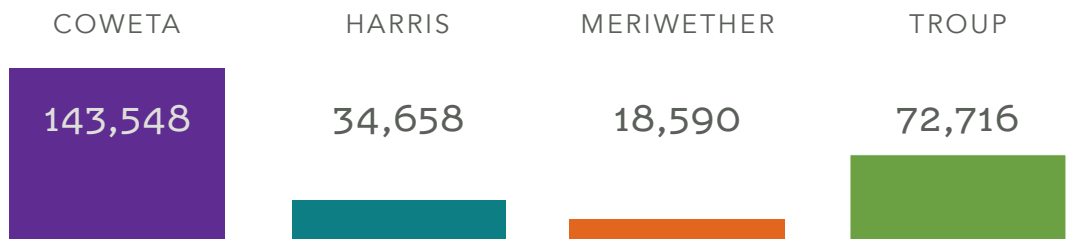
WellStar West Georgia Medical Center

The population in Georgia is one of the fastest growing in the nation. When compared to Georgia, the community served by WellStar West Georgia Medical Center is slightly older, less diverse and lower-income earning. Among the counties in the service area, Coweta and Meriwether counties are higher-income earning, while Meriwether and Troup counties are more diverse.

Total Population

U.S. TOTAL POPULATION

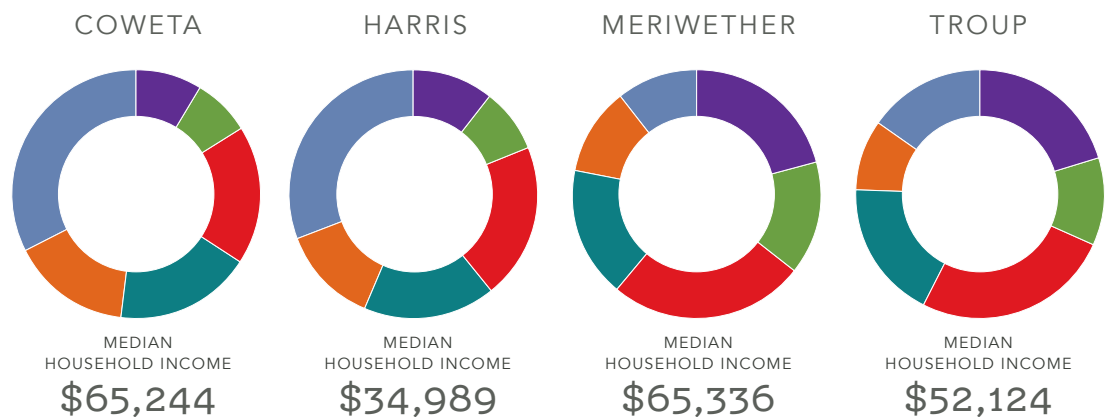
326,533,070



Income Distribution

U.S. MEDIAN HOUSEHOLD INCOME

\$55,511.00

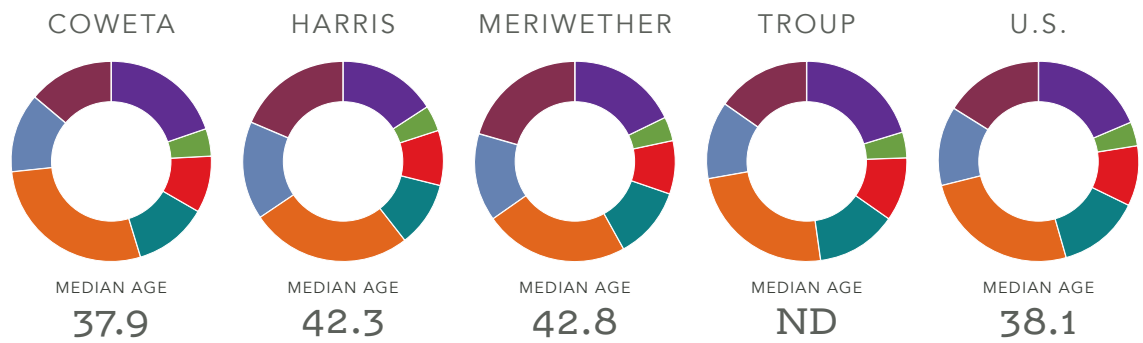


Income Bracket	COWETA	HARRIS	MERIWETHER	TROUP
Less than \$15,000	8.80%	10.60%	20.90%	20.30%
\$15,000-\$25,000	7.60%	8.40%	14.90%	11.50%
\$25,001-\$50,000	18.00%	20.40%	25.40%	25.70%
\$50,001-\$75,000	17.70%	17.00%	17.20%	18.10%
\$75,001-\$100,000	15.60%	12.90%	11.20%	9.30%
Over \$100,000	32.40%	30.70%	10.50%	15.00%

* 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/>

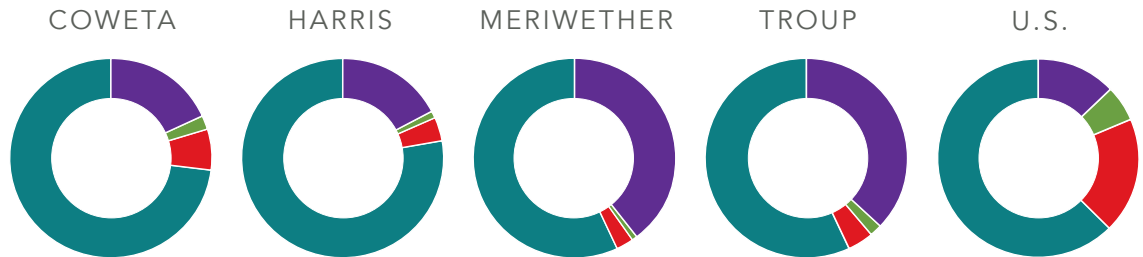
Age Distribution

MEDIAN AGE IN YEARS
(2012-16)



		Projected change by 2023		Projected change by 2023		Projected change by 2023		Projected change by 2023		
0-14 years old	19.9%	-1.6%	16.1%	-1.8%	17.9%	-0.9%	20.4%	-0.8%	18.7%	
15-17 years old	4.5%	0.0%	4.1%	-0.1%	4.0%	+0.1%	4.3%	+0.1%	3.9%	
18-24 years old	9.1%	+0.7%	8.9%	+0.4%	8.6%	+0.5%	10.1%	0.1%	9.7%	
25-34 years old	11.8%	+0.2%	10.4%	+1.1%	11.5%	-0.2%	13.2%	0.0%	13.4%	
35-54 years old	28.0%	-2.3%	26.2%	-3.1%	23.3%	-1.3%	24.4%	-0.9%	25.5%	
55-64 years old	12.8%	+0.8%	15.8%	+0.6%	14.4%	-0.4%	12.4%	-0.4%	12.9%	
65+ years old	13.8%	+2.3%	18.5%	+2.9%	20.3%	+2.3%	15.2%	+1.9%	15.9%	

Racial/Ethnic Distribution



Black	17.90%	16.90%	39.00%	36.40%	12.40%
Asian & Pacific Islander	2.00%	1.20%	0.70%	1.90%	5.80%
Hispanic [‡]	6.70%	3.70%	2.70%	4.00%	18.20%
White	71.20%	75.90%	55.80%	55.70%	60.40%
Limited English	3.50%	0.30%	0.80%	ND	10.00%

ND represents Not Defined

* 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/>

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

Community Is **Contribution**

ASSESSING THE NEEDS



Data Collection

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

The secondary data included in this assessment were compiled from a variety of sources that are both reliable and representative of the communities served by WellStar West Georgia Medical Center. Quantitative data sources included, but were 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 available at the county level and not in smaller segments. However, where possible, the data were analyzed at the zip code or census tract level to get a more comprehensive understanding of community needs. Data sources reviewed for this assessment can be found with the associated data tables.

To better understand the experience and needs of residents served by the hospital, several types of qualitative data were used. Qualitative data used in this assessment included a focus group with residents, one-on-one interviews with key stakeholders, a listening session with the hospital 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.²

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
- Health behaviors
- Access to and use of appropriate care
- Health outcomes

Community health is measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings, 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 the hospital, Meriwether County shows the highest rate of mortality and the poorest quality of life, while Harris County shows a lower mortality rate and the best quality of life. Across the service area, Meriwether and Troup counties often have the poorest outcomes. It is important to note that Coweta and Harris counties are consistently ranked in the top quartile (better than 75 percent of the counties in the state), whereas Meriwether and Troup counties are consistently ranked in the bottom two quartiles in the state.

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

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Coweta	10	17	12	14	18	18	24	85
Harris	8	8	9	10	17	19	6	147
Meriwether	133	107	136	120	96	105	112	113
Troup	75	69	85	78	71	39	75	122

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

† County Health Rankings and Roadmaps: countyhealthrankings.org

The leading causes of death in the hospital service area are similar when compared to those in the state. Death rates throughout the service area are much higher when compared to the state's rate. The top cause of death in both the service area and throughout the state is related to heart disease (i.e., coronary artery disease).³ The remaining top four causes of death are cerebrovascular disease (stroke), lung cancer, mental and behavioral disorders and COPD (except asthma).⁴

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

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

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

Social Determinants of Health

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

Unemployment has decreased across the area in the last 10 years. Coweta, Harris and Troup counties saw an increase in median household incomes of \$6,020, \$2,521 and \$1,827, respectively. Meriwether County saw a decrease in median household income by \$1,477.⁵

One resident explained how residents are finding employment opportunities outside of the region.

“But you still have locals commuting to Newnan, Hapeville, Manchester, Atlanta, Auburn, where they can’t find jobs here.”

One hospital leader noted:

“Those in lower-income situations and poverty face more challenges in all areas.”

Poverty is a pervasive challenge in Coweta, Harris, Meriwether and Troup counties, particularly among families with children and people of color. Table 3 shows that over the last decade, poverty in the general population has increased in Meriwether County at a much faster pace (5.9 percent) than other counties in the service area.

While single-parent families experience the highest rates of poverty throughout the service area, Coweta and Troup counties show increases between 2006 and 2015 in the percentage of single-female head-of-household families in poverty (3.4 percent and 3.6 percent, respectively) when compared to other service area counties. Both Harris and Meriwether counties saw decreases during the same period (–8.9 percent and –2.9 percent, respectively).

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

	Coweta		Harris		Meriwether		Troup	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	44,137	48,777	11,056	11,570	8,453	7,943	23,690	24,645
All people	10.20%	13.20%	9.00%	9.30%	16.80%	22.70%	19.80%	21.40%
All families	7.70%	11.00%	6.00%	6.50%	12.80%	16.40%	15.50%	17.20%
Married couple families	16.00%	24.30%	2.50%	3.30%	3.20%	9.30%	6.60%	5.80%
Single female head of household families	34.50%	37.90%	31.70%	22.80%	38.30%	35.40%	37.70%	41.30%

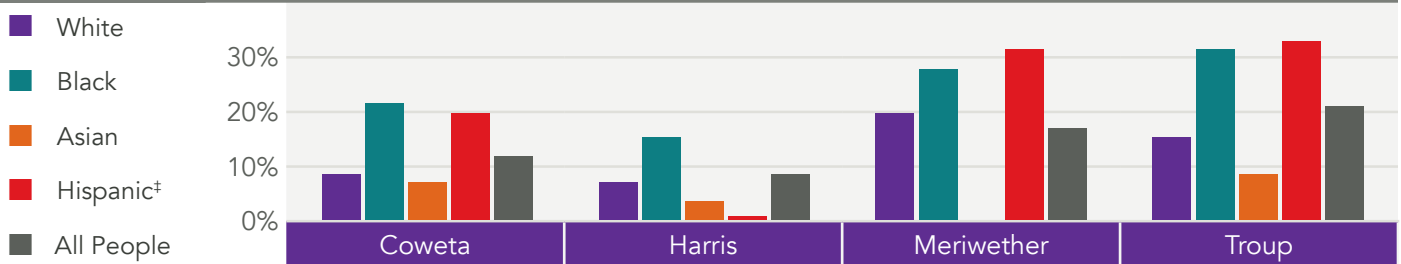
[†] Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org

⁵ Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org

Community leaders and residents discussed the low educational attainment in the service area – with health summit participants prioritizing and relating poverty to low educational attainment and poor employment options. One stakeholder noted that schools are still mostly segregated and there is a “White” and a “Black” school. Another stakeholder noted that communities of color have the poorest quality of life and health outcomes.

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

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

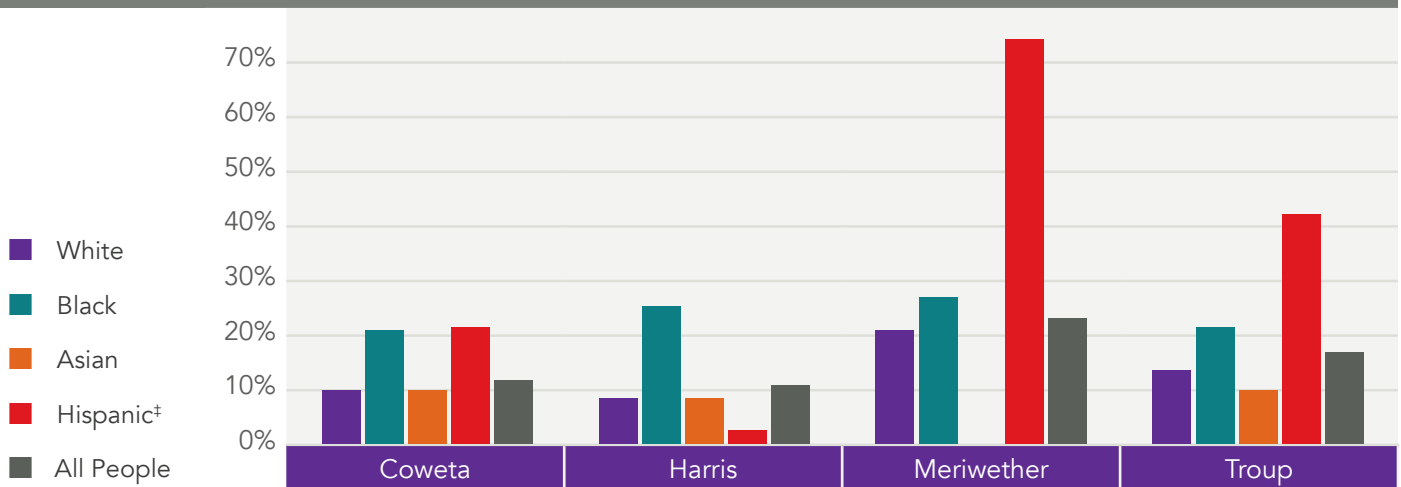


[†] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates: <http://www.census.gov/acs/www/>

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

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

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



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

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

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

Housing

The quality, age, availability and affordability of housing influence community health. Community input suggests that there is a growing homeless population, with no homeless shelter for women. During interviews, community leaders discussed two government housing units where there is a concentration of residents that are under-resourced. In the last 10 years, home values have declined in Meriwether and Troup counties. Households paying more than 30 percent of their monthly income for mortgage and rent have increased in Harris County during the same period. All counties in the service area showed increases in the percentage of households paying more than 30 percent of monthly income for rent.

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

	Coweta		Harris		Meriwether		Troup	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	44,137	48,777	11,056	11,570	8,453	7,943	23,690	24,645
Family households	76.60%	74.70%	79.90%	77.40%	69.50%	71.00%	71.10%	68.90%
Nonfamily households	23.40%	25.30%	20.10%	22.60%	30.50%	29.00%	28.90%	31.10%
Vacant housing units	8.90%	5.20%	15.80%	15.00%	15.40%	20.00%	13.80%	12.70%
Homes more than 20 years old	38.70%	64.10%	49.40%	72.20%	72.10%	82.60%	68.40%	80.90%
Median value of homes	\$177,900	\$181,000	\$196,000	\$201,100	\$95,600	\$89,800	\$130,300	\$116,300
Households paying more than 30% of income for monthly mortgage	30.60%	27.10%	28.80%	31.00%	39.30%	34.10%	34.10%	32.80%
Households paying more than 30% of income for monthly rent	46.20%	48.00%	39.30%	50.70%	53.60%	60.70%	52.30%	52.70%

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

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

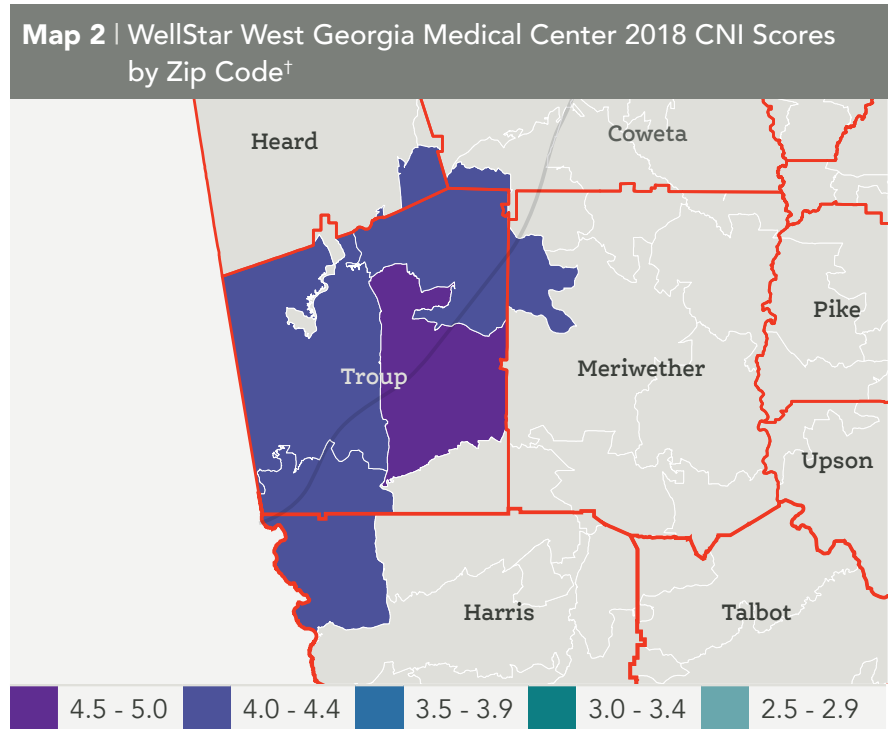
- Single-parent poverty is high throughout the service area, with more than 40 percent of single-parent homes experiencing poverty.
- One zip code area (30230) contains more than 20 percent of residents that do not have a high school diploma.
- Unemployment is higher than state averages (4.6 percent) throughout the service area, with four (30230, 30240, 30241 and 31833) zip codes showing more than double the state rate.

There are existing resources throughout the service area that address 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 the CHNA.

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 needs. Often, there are a variety of factors associated with the access residents have to appropriate care, such as insurance status, residents' ability to navigate available services, number of providers, quality of care and transportation.



[†] Truven Health Analytics: Community Need Index

Community residents discussed the connection between employment opportunities and the access that residents have to affordable health insurance options. Most notably, residents and community leaders talked about the temporary or part-time employment options that do not offer a path to health insurance benefits. They spoke of the difficulty they experience when trying to maintain and use affordable health insurance. Residents in the focus group noted that affordable insurance (Medicaid or Marketplace insurance) often is not accepted by providers in their area, or has such expensive copays and deductibles that they cannot afford to use the insurance benefits.

Socioeconomic Factors

The CNI ranks each zip code in the United States against all other zip codes on five socioeconomic factors that are barriers to accessing healthcare: income, culture, education, insurance and housing.⁷ 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). A score of three is the scale median.

According to the 2018 CNI (see Map 2 and Table 5), all of the zip codes served by WellStar West Georgia Medical Center have above average socioeconomic barriers to accessing healthcare.

A closer look shows:

- When compared to the rest of the service area, Meriwether and Troup counties both present the highest socioeconomic barriers, while Coweta and Harris counties present the lowest socioeconomic barriers to accessing healthcare.

- All four zip codes show CNI scores higher than four, which indicate high socioeconomic barriers to accessing healthcare.
- All four zip codes show higher rates of uninsured residents than the state (17.1 percent), with one in five residents uninsured.

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

Table 5 | 2018 Community Need Index (CNI): WellStar West Georgia Hospital†

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
30241	Troup	-0.2	4.6	18%	31%	49%	1%	55%	17%	13%	25%	44%
30230	Troup	0.0	4.4	15%	30%	53%	0.4%	32%	20%	12%	22%	28%
30240	Troup	0.2	4.2	14%	21%	40%	1.5%	39%	13%	8%	23%	38%
31833	Troup	-0.2	4.2	19%	23%	31%	0.6%	45%	16%	15%	23%	30%
Coweta Total		0.0	3.4	6%	17%	45%	1%	28%	10%	5%	12%	25%
Harris Total		0.1	2.9	9%	11%	24%	0.4%	24%	11%	7%	12%	15%
Meriwether Total		0.0	4.6	18%	28%	49%	0.3%	44%	25%	12%	26%	29%
Troup Total		0.0	4.4	16%	26%	44%	1%	44%	16%	11%	23%	38%

† 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. The percentage of uninsured residents in the four counties is higher than average for the state. One hospital leader noted:

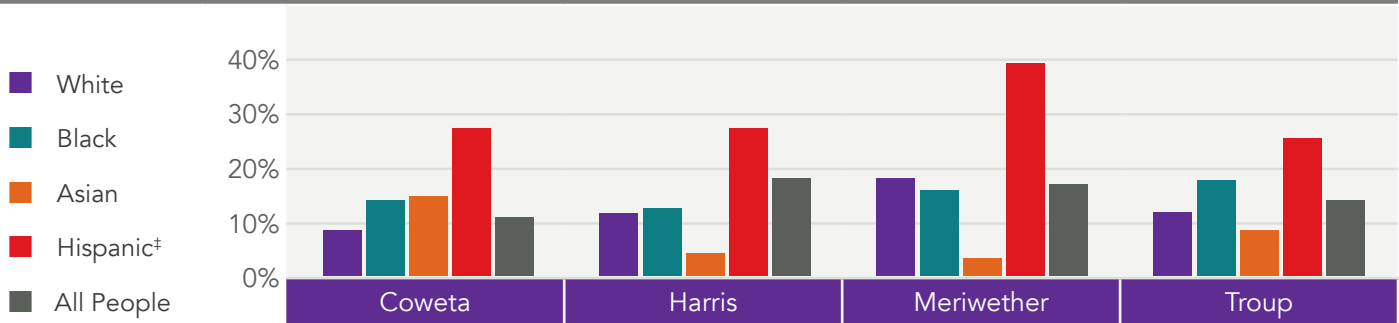
“There is a poverty population and a growing aging population that cannot afford regular healthcare [and] prescriptions, so I feel sure their quality of healthcare is less than the majority of people in our area.”

Uninsured

Figure 4 shows the disparities in the rates of uninsured residents 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.

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

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



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

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

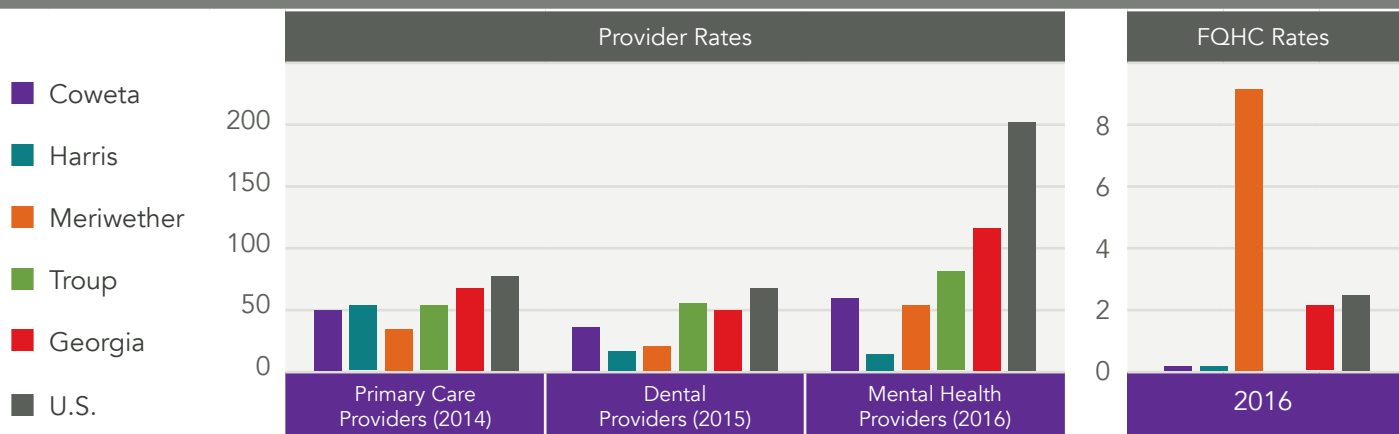
[‡] "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Provider Shortage

There is a shortage of healthcare providers throughout the service area, particularly among safety-net providers that offer free or reduced-cost healthcare based on income (see Map 3 for a geographic representation). While the entire service area has fewer providers than is average in the state and the nation, Meriwether County has the fewest primary care providers, while Harris County has the fewest dental and mental health providers when compared to other counties in the service area. Meriwether County has an above average rate of Federally Qualified Health Centers (FQHCs) and the surrounding counties in the service area have very little FQHC access. Residents that require safety-net services would have to travel to Meriwether County to secure such services.

Community input suggests that there is a shortage of primary care providers, safety-net providers, specialists and trauma care. Residents explained that uninsured care is not readily available. Community leaders noted that local specialists will not make an appointment with residents who do not have some type of insurance other than Medicaid or Marketplace insurance.

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



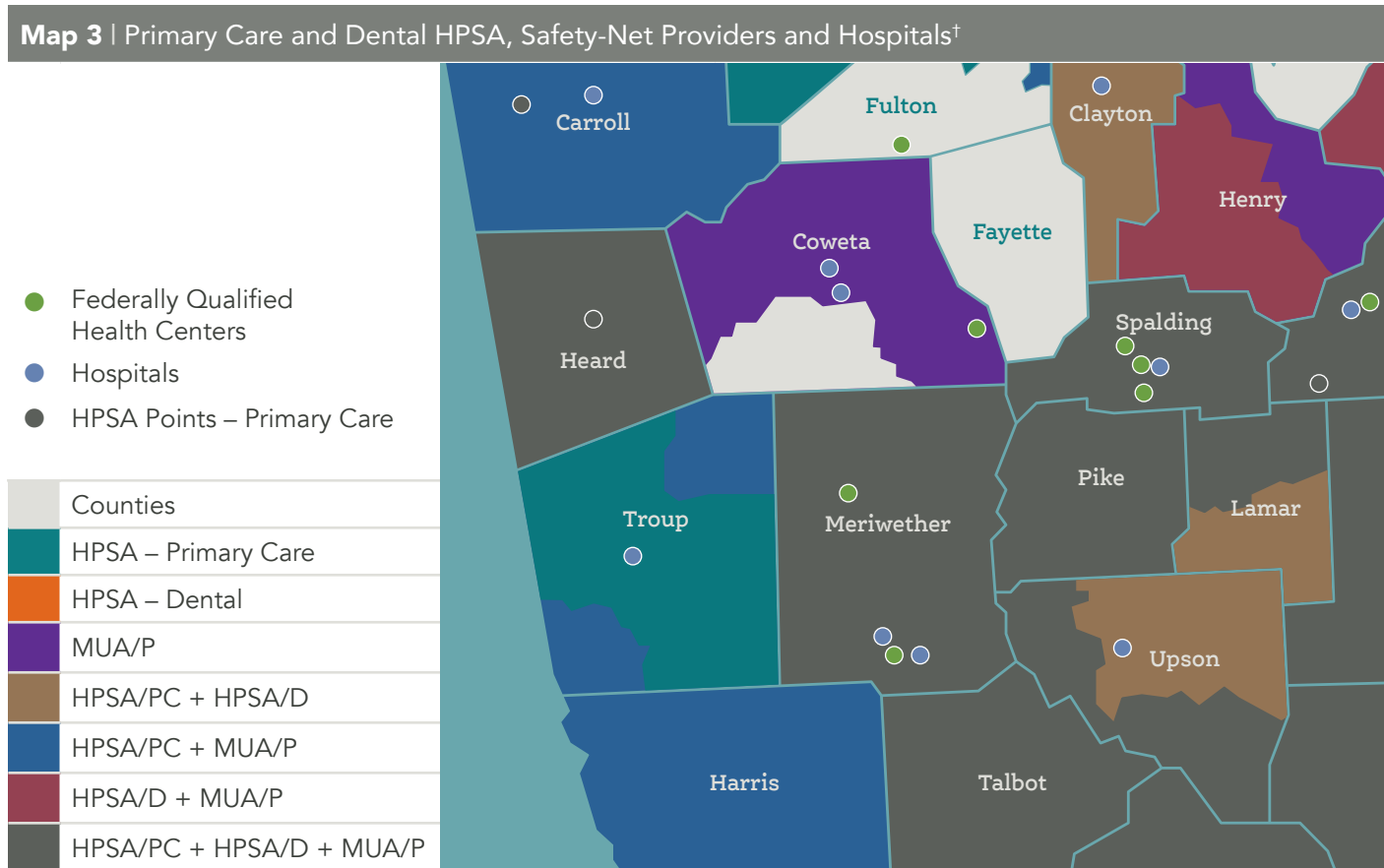
[†] Health Resources & Services Administration: Area Health Resource File through County Health Rankings: <https://datawarehouse.hrsa.gov/topics/ahrf.aspx>

U.S. Census Bureau, 2010 Decennial Census, POS Provider of Services File:

<https://www.census.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html>

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

- Coweta, Harris, Meriwether and Troup counties all have geographical areas that are considered Medically Underserved Areas (MUAs).
- Most safety-net providers are located in the center of each county, with the exception of Harris County whose Federally Qualified Health Center is located in the western part of the county.



† 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)

Community input suggests that the limited transportation options that residents have restricts access to medical, dental and mental healthcare. Transportation is one of the most pressing access issues in the service area when coupled with the rural nature of the area. The hospital regional board discussed the impact that limited transportation options have on health outcomes. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of public transportation that is reliable (including Medicaid transportation) and the distance residents must travel to secure necessities.

There are existing resources throughout the service area that offer access to care.⁸ 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.

⁸ 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 resident described local awareness about healthy eating this way:

“But one thing this town is lacking regarding healthy eating is education. We don’t teach people how to eat right.”

One hospital leader described the connection between social determinants of health and healthy choices this way:

“Lower-income citizens have more issues related to a healthy lifestyle due to access to healthcare, transportation issues, etc.”

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.⁹ Coweta and Harris counties show signs of food insecurity, while Coweta residents have lower access to grocery stores.

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

Healthy Eating, Active Living Indicators	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Total Population (2013-17)	138,015	33,198	21,152	69,433	10,201,635	321,004,407
Percent Population Below 100% FPL (2013-17)	11.60%	7.29%	23%	21.33%	16.91%	14.58%
Grocery Stores per 100,000 population (2016)	16.49	12.49	40.92	19.39	18.12	21.18
Percent Population with Low Food Access (2015)	43.46%	0.09%	3.00%	10.80%	30.82%	22.43%

[†] Per 100,000 population

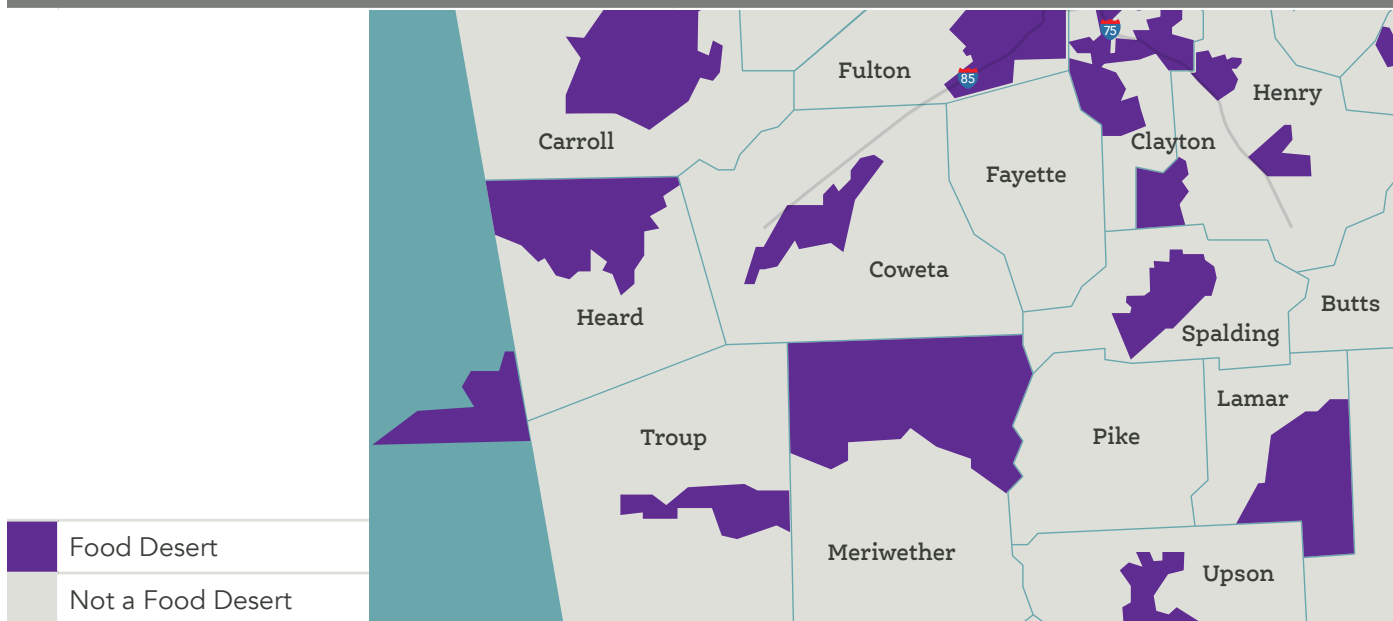
U.S. Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2015.

U.S. Census Bureau, American Community Survey. 2013- 17.

U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016.

⁹ 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[†]



[†] (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp

Hospital leaders felt that high rates of obesity in the service areas are related to poor food choices, limited awareness of health outcomes and lack of access to regular opportunities to be physically active. Community input suggests that residents have more access and awareness of unhealthy options (fast food and convenience stores) than they have to and about healthy options (community gardens and farmer’s markets). One of the most discussed barriers to healthy eating and active living in the hospital’s service area was the amount of time residents spend commuting to and from work, which input suggests leaves little time for shopping and preparing healthy foods, or participating in physical activity.

Long Commute Times

Table 7 shows that there is limited access to exercise facilities across the service area, with Meriwether County residents having the lowest access. Additionally, more residents in all counties spend more than one hour commuting, when compared to the state and national averages.

Table 7 | Selected Healthy Eating, Active Living Indicators[†]

	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Healthy Food Stores (Low Access)	43.46%	0.10%	3.00%	45.0%	30.80%	22.40%
Exercise opportunities – Access	60.50%	53.50%	24.50%	ND	75.00%	84.30%
Physical Inactivity – Adults	22.00%	22.10%	27.80%	26.20%	23.10%	21.80%
Driving Alone to Work, Long Distances (>60 mins)	46.50%	41.20%	51.10%	6.10%	40.00%	34.80%

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

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

County Health Rankings and Roadmaps: countyhealthrankings.org

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

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

Education and Health Literacy

Health Summit participants prioritized education and health literacy as one of the most pressing health issues that could improve health outcomes in their community if effectively addressed. They felt residents need more effective outreach that is culturally and linguistically relevant to be provided in the areas where residents are (school, stores, work, etc.). There is no measure of education or awareness in the context of healthy options, availability of resources or health literacy.

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

There are existing resources throughout the service area addressing health behaviors in the community.¹⁰ Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors noted in this assessment.

¹⁰ See the *Community Facilities, Assets and Resources* section of the Appendix for a list of resources.

Health Outcomes

Most of the top five causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, lung cancer, mental and behavioral disorders and COPD). When considering county-level data, morbidity (disease burden) and mortality (death) rates are high in Harris, Meriwether and Troup counties. Coweta County shows the lowest rates of morbidity and mortality, while Meriwether and Troup counties show the highest rates. Whites show higher rates of mortality, while Black residents show the highest disease burden when the data are considered by race, though there is limited racial/ethnic data available for these counties.

Top Causes of Premature Death

The top five causes of premature death are derived from the Years of Potential Life Lost 75 (YPLL 75) and represents the number of years of potential life lost due to death before age 75, as a measure of premature death. In the communities served by the medical center, premature death seems to be caused by heart disease, motor vehicle crashes, suicide, lung cancer and poisoning. The rate of premature death due to heart disease is high across the CHNA region served by WellStar West Georgia Medical Center. Meriwether and Troup counties show the highest rates of premature death when compared to the state and other counties in the service area. There are notable inequities when premature death is considered by race, with White residents showing much higher rates when compared to all other races (when data are available).

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

By Region	Ischemic Heart and Vascular Disease	Motor Vehicle Crashes	Intentional Self-Harm (Suicide)	Malignant Neoplasms of the Trachea, Bronchus and Lung	Accidental Poisoning and Exposure to Noxious Substances
Georgia	524.80	491.40	429.80	309.70	477.90
Coweta	357.90	431.40	409.70	244.00	547.50
Harris	1042.40	502.30	ND	135.40	0.00
Meriwether	2076.10	883.10	ND	266.00	ND
Troup	1076.30	543.80	292.80	391.00	533.90
By Race**					
White	740.00	528.10	464.80	301.30	601.30
Black	1025.90	523.50	ND	274.30	ND
Hispanic‡	ND	ND	ND	ND	0.00
Asian	ND	ND	ND	0.00	0.00
Native American	ND	0.00	0.00	0.00	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial§	0.00	0.00	0.00	0.00	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

** Four-county aggregate

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

§ Multiracial is a person declaring two or more of these races.

Top Causes of Death

Reported causes of death are based on the underlying cause of death. The underlying cause of death is defined by the World Health Organization as the disease or injury that initiated the sequence of events leading directly to death, or as the circumstances of the accident or violence that produced the fatal injury. 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 COPD). The top cause of death is coronary heart disease. Georgia is well known to have poor outcomes related to cardiovascular disease and Harris, Meriwether and Troup counties show higher rates of mortality than the state. White residents show higher rates of death for two of the top causes, while Black residents have higher rates for three of the top causes when compared to all other races (when data are available).

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

	Ischemic Heart and Vascular Disease	Cerebrovascular Disease	Malignant Neoplasms of the Trachea, Bronchus and Lung	All Other Mental and Behavioral Disorders	All COPD Except Asthma
By Region					
Georgia	73.10	43.40	38.90	30.80	81.70
Coweta	70.40	33.80	31.30	37.80	88.80
Harris	116.30	44.70	35.00	26.50	77.60
Meriwether	196.80	38.30	33.50	41.60	65.80
Troup	117.20	36.80	40.50	49.70	78.00
By Race**					
White	94.70	34.60	33.40	41.50	92.20
Black	130.10	46.10	43.90	37.90	38.50
Hispanic‡	ND	0.00	ND	ND	ND
Asian	ND	ND	0.00	0.00	ND
Native American	ND	0.00	0.00	0.00	0.00
Pacific Islander	0.00	0.00	0.00	0.00	0.00
Multiracial§	0.00	0.00	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

** Four-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 ER for a variety of reasons, such as lack of insurance, limited availability of after hours care or acute symptoms. Three of the top causes of ER visits in the service area are all related to accidents. Overall, Meriwether and Troup counties have ER visit rates higher than the state averages. Black residents have higher ER visit rates when compared to other races. They also show rates higher than the state averages.

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

By Region	All Other Unintentional Injury	Diseases of the Musculoskeletal System and Connective Tissue	All Other Diseases of the Genitourinary System	Falls	Motor Vehicle Crashes
Georgia	3,030.00	3,276.90	2,394.20	1,918.40	1,168.80
Coweta	2,934.20	2,299.70	2,233.40	2,002.70	1,133.50
Harris	2,582.10	1,843.60	1,783.30	1,729.60	886.20
Meriwether	5,476.10	4,309.90	3,410.40	2,942.80	1,993.40
Troup	5,021.70	5,721.70	3,865.60	2,937.50	1,722.60
By Race**					
White	3,064.40	2,230.10	2,237.50	2,273.50	907.00
Black	5,346.80	6,672.30	4,129.30	2,314.20	2,561.50
Hispanic‡	ND	ND	ND	ND	ND
Asian	1,256.20	430.90	591.80	869.50	434.70
Native American	1,368.00	630.20	696.80	818.40	642.40
Pacific Islander	N/A	N/A	N/A	N/A	N/A
Multiracial§	4,023.20	4,610.20	3,663.70	2,082.10	1,193.10

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

N/A Rates indicate that no population exists for the query selected.

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

* Age adjusted, per 100,000 population

** Four-county aggregate

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

§ Multiracial is a person declaring 2 or more of these races.

Top Causes for Hospital Discharges

The number of inpatients discharged from non-Federal acute-care inpatient facilities that are residents of Georgia and seen in a Georgia facility are considered in the following table. Uninsured residents are not always admitted to the hospital without some form of payment and may not be represented heavily in this measure. Hospital discharge rates are highest for childbirth, diseases of the musculoskeletal system and connective tissue and mental and behavioral disorders. Hospitalization rates due to ischemic heart and vascular disease are higher than the state average in both Meriwether and Troup counties. Multiracial residents show higher rates of hospital discharges for three of the top causes when compared to all other races (when data are available).

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

By Region	Pregnancy, Childbirth and the Puerperium	Diseases of the Musculoskeletal System and Connective Tissue	All Other Mental and Behavioral Disorders	Septicemia	Ischemic Heart and Vascular Disease
Georgia	1,289.50	489.30	531.50	514.50	255.30
Coweta	1,413.20	469.40	325.10	973.90	227.10
Harris	1,216.90	458.30	501.50	287.50	159.60
Meriwether	1,443.90	474.70	527.10	890.90	270.20
Troup	1,461.90	393.10	869.80	715.40	378.10
By Race**					
White	1,365.80	469.60	486.60	754.70	262.90
Black	1,480.50	390.70	569.10	955.50	236.90
Hispanic‡	ND	ND	ND	ND	ND
Asian	963.00	162.00	ND	457.70	297.70
Native American	518.80	ND	ND	772.10	ND
Pacific Islander	N/A	N/A	N/A	N/A	N/A
Multiracial§	2,895.80	454.80	1,007.50	571.70	430.70

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

N/A Rates indicate that no population exists for the query selected.

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

* Age adjusted, per 100,000 population

** Four-county aggregate

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

§ Multiracial is a person declaring 2 or more of these races.

Obesity

At the time of this report, high body mass index (BMI) is a health issue throughout the country, with this community as no exception. More than one in four adults are obese. Diabetes is a health concern in Meriwether and Troup counties, where morbidity rates are elevated and mortality rates are higher than in the rest of the service area. Hospital discharge and mortality rates for diabetes are both higher for Black residents than their White counterparts.

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

	Coweta	Harris	Meriwether	Troup	White**	Black**	Asian**	Hispanic**‡	Georgia
Adult obesity (2014)	27.10%	30.40%	34.80%	29.90%	ND	ND	ND	ND	29.30%
Diagnosed diabetes (2013)	10.60%	13.20%	18.80%	12.60%	ND	ND	ND	ND	10.60%
Diabetes discharge rate* (2013-17)	162.20	109.50	347.90	294.30	141.60	422.40	40.70	ND	188.10
Diabetes mortality* (2013-17)	20.00	21.50	28.20	29.70	21.30	38.00	0.00	ND	21.50

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

† County Health Rankings and Roadmaps: countyhealthrankings.org

Centers of Disease Control and Prevention, Diagnosed Diabetes Prevalence: <https://www.cdc.gov/diabetes/data/countydata/countydataindicators.html>

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

* Age adjusted, per 100,000 population

** Four-county aggregate

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

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, Meriwether and Troup counties show higher morbidity and mortality related to obstructive heart disease (where data are available). Residents living in Troup County experience higher than average hospital discharge rates due to hypertensive heart disease. And residents in Coweta and Troup counties experience higher stroke-related mortality when compared to the state average.

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

	Coweta	Harris	Meriwether	Troup	White**	Black**	Asian**	Hispanic**‡	Georgia
Obstructive heart disease/heart attack discharge rate*	248.40	189.80	295.30	370.10	282.00	244.70	152.20	ND	265.00
Obstructive heart disease mortality*	79.90	92.50	183.50	92.20	91.90	117.00	59.10	29.70	76.40
Hypertensive heart disease discharge rate*	29.80	23.00	39.00	46.10	26.60	58.70	ND	ND	39.00
Hypertensive heart disease mortality*	29.00	12.10	10.30	21.40	19.00	36.40	ND	ND	16.20
Stroke mortality*	33.30	40.40	47.90	46.40	35.40	58.70	ND	ND	43.00
Stroke prevalence (2015)	4.50%	3.60%	4.80%	ND	ND	ND	ND	ND	4.20%

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

* Age adjusted, per 100,000 population

** Four-county aggregate

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

Cancer

Cancer rates are elevated in Georgia when compared to the national average. There are higher morbidity rates for breast, colon and prostate cancers throughout the service area where data are available. Meriwether and Troup counties have the highest cancer mortality rates when compared to the state and nation.

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

	Coweta	Harris	Meriwether	Troup	White**	Black**	Asian**	Hispanic**‡	Georgia
Breast cancer incidence (2011-15)*	117.70	133.60	131.70	128.10	123.00	132.50	ND	ND	125.20
Cervical cancer incidence (2011-15)*	7.60	supp.	supp.	supp.	ND	ND	ND	ND	7.80
Colon and rectum cancer incidence (2011-15)*	41.20	33.50	63.10	45.00	90.00	27.00	ND	ND	41.80
Prostate cancer incidence (2011-15)*	99.40	129.80	109.80	130.20	91.50	206.10	ND	ND	123.30
Lung cancer incidence (2011-15)*	64.70	55.40	53.90	70.40	66.00	62.10	ND	ND	64.90
Cancer mortality (2013-17)*	162.00	145.90	168.90	176.30	163.80	185.70	69.90	75.80	160.70

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

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

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

* Age adjusted, per 100,000 population

** Four-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

Adult residents of Troup County suffer from higher morbidity rates for asthma.

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

	Coweta	Harris	Meriwether	Troup	White**	Black**	Asian**	Hispanic**‡	Georgia
Asthma discharge rate*	57.80	34.80	81.30	82.50	59.10	80.00	ND	ND	87.50
Asthma ED visit rate*	348.00	239.70	526.70	709.60	260.20	964.80	98.20	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

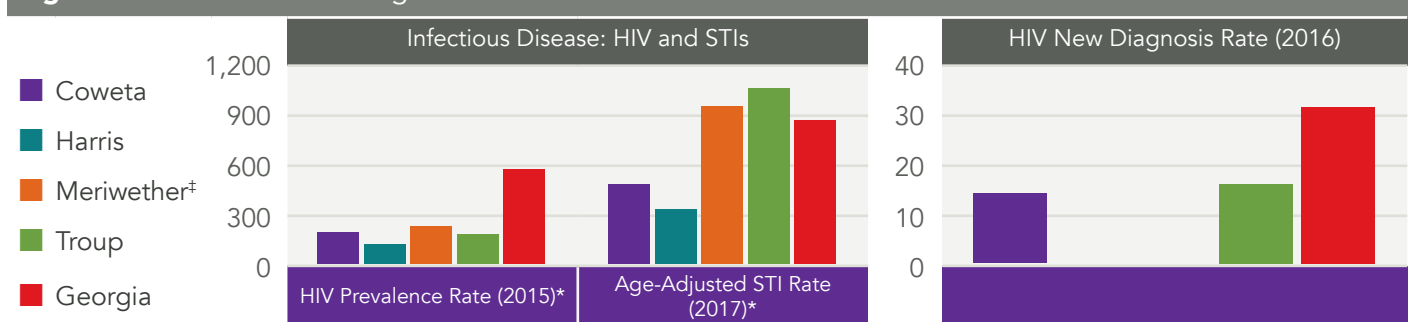
** Four-county aggregate

‡ "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. In Oasis, Hospital Discharge rates are not available for ethnic groups, only race.

Sexually Transmitted Infections

Where data are available, Coweta and Meriwether counties show higher rates of HIV when compared to the rest of the service area. Residents in Troup County have sexually transmitted infection (STI) rates higher than the service area and state. Meriwether and Harris counties did not have available rates for new diagnosis of HIV.

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



0.00% can result from sample size and margin of error

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

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

* Age adjusted, per 100,000 population

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

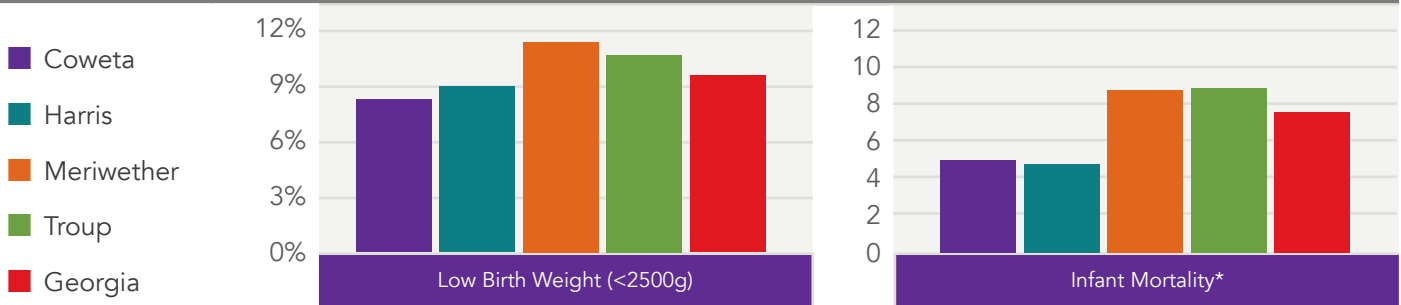
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birthweight infants and infant mortality, among other issues.¹¹

Community leaders cited the limited education offered to youth addressing risky sexual behaviors and lack of adult supervision of youth as driving forces behind poor birth outcomes and higher rates of STIs.

Figure 7 shows Meriwether and Troup counties have higher rates of low birthweight births and infant mortality than the state average. Black residents have higher rates of low-birthweight births and infant mortality when compared to other races and the state.

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



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

* Number of infant deaths per 1,000 live births

Table 16 shows that injury and assault rates are higher than average in Troup County. Residents of Meriwether and Troup counties also experience higher than average emergency department (ED) visit rates for motor vehicle crashes.

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

	Coweta	Harris	Meriwether	Troup	Georgia
Assault discharge rate (2013-17)*	13.10	6.40	16.40	24.90	18.60
Motor vehicle crash ED visit rate (2013-17)*	1,133.50	886.2	1,993.40	1,722.60	1,168.80
Impaired driving deaths (2011-2015)	23.20%	28.60%	21.70%	ND	23.40%

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

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

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

* Age adjusted, per 100,000 population

¹¹ Healthy Mothers, Health Babies Coalition of Georgia, 2016 State of the State of Maternal and Infant Health in Georgia <https://drive.google.com/file/d/0BxndQpkPFFfySm5aNmdkYXZYQm8/view>

Behavioral Health

The need for behavioral health resources, particularly for underinsured and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. Summit participants discussed the lack of behavioral health providers and stigma associated with a behavioral health diagnosis as challenges to improving poor behavioral health outcomes.

According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia hospitals for mental health issues in 2016.¹² The data show that behavioral health is a significant community health need in Troup County, with higher than average rates of ED use and suicide mortality.

Table 17 shows low behavioral health provider rates in all counties. Harris County has the fewest providers and Troup County shows the highest ED use. Input from community residents related to behavioral health suggested that residents may resist seeking care due to stigma, lack of insurance, unaffordable cost of care and the location of providers being too far away from home. Additionally, the hospital's regional board noted that behavioral health resources are limited in the community.

Table 17 | Selected Behavioral Health Characteristics by County[†]

	Coweta	Harris	Meriwether	Troup	Georgia
Mental health providers (2016)*	57.80	12.00	51.90	79.10 [§]	115.00
Poor mental health days (2015)	3.50	3.40	4.10	ND	3.80
Mental health ED rate (2017)*	800.80	748.90	983.40	1,835.60	1,094.60
Mental and behavioral disorder mortality (2013-17)*	36.20	25.80	59.60	71.80	37.40

* Per 100,000 population

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

† 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

§ For the year 2018

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

Substance Abuse

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

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses, including heroin
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014
- Overdose deaths tripled between 1999 and 2013 in Georgia.¹³

Table 18 shows the increase of substance abuse overdoses in Coweta and Troup counties between 2007 and 2017 (where data are available). Both counties show the highest rates when compared to other service area counties and the state. Each primary data source talked about substance abuse in the community, noting that marijuana, alcohol, methamphetamines, cocaine and opioids are the most common drugs used. The hospital's regional board noted that one of the most critical health problems in the communities they serve is related to substance abuse.

Table 18 | Rate of Drug Overdose by County (2007-17)[†]

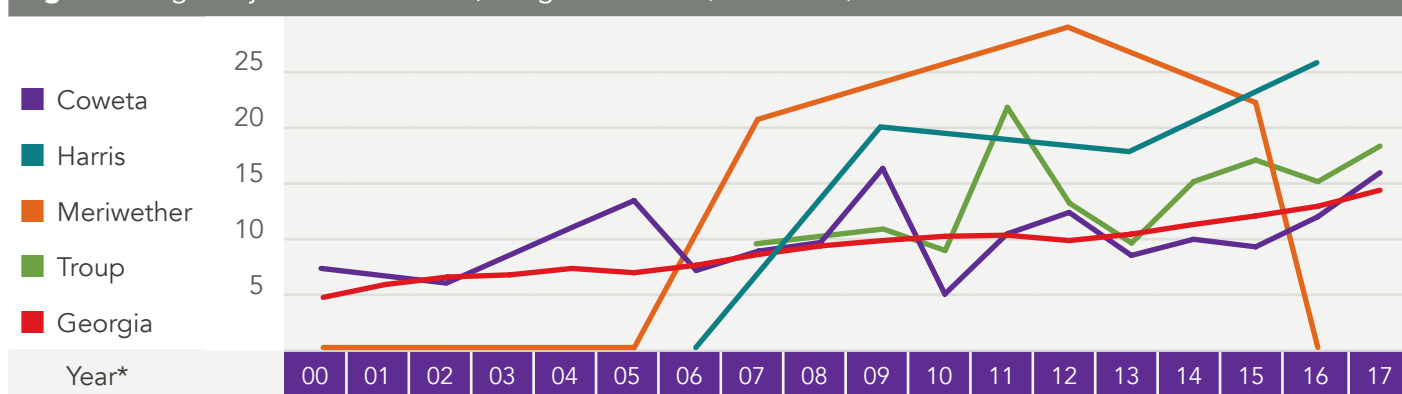
	Coweta	Harris	Meriwether	Troup	Georgia
Drug overdoses (2007)*	8.90	ND	21.10	10.00	8.60
Drug overdoses (2017)*	16.20	ND	ND	18.60	14.60

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

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

* Per 100,000 population

Figure 8 | Age-Adjusted Death Rate, Drug Overdoses (2000-2017)[†]



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

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

* Per 100,000 population

There are existing resources throughout the service area that address the common health outcomes noted in this section.¹⁴ 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.

¹³ 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>

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

Community Is Compassion

RALLYING PEOPLE AND RESOURCES



Community Input

This assessment engaged residents and leaders from the community that provide services in the community served by WellStar West Georgia Medical Center. 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 West Georgia Medical Center Regional Health Board and individual key informant interviews were conducted with nine 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

One focus group was conducted to gather input from nine residents living and working in the community served by WellStar West Georgia Medical Center. 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 West Georgia Medical Center

Commonly Discussed Health Issues

Disparities among people of color
Substance abuse, addiction and overdose (marijuana, alcohol, methamphetamines, cocaine and opiates)
Chronic disease:
Respiratory issues (COPD and Asthma)
Diabetes
Obesity
Cancer
Cardiovascular disease (Hypertension and heart attacks)
Respiratory issues (COPD and Asthma)
Stroke
Tobacco use/vaping among youth
Unsafe sex
Not going to the doctor
Overutilization of the ER (Medical and behavioral health needs)
Undiagnosed or untreated mental health (Suicide, depression, anxiety, serious mental illness)
Sexually transmitted infections (HIV)
Poor dental health
Drug resistance to antibiotics, etc. (STIs and TB)

Commonly Discussed Causes

Access to care (medical, dental and behavioral):
Uninsured care can be unaffordable and there are limited safety-net services in the area.
Many employers are not offering full-time jobs with medical benefits.
Many providers do not accept Medicaid or Marketplace insurances and residents have to seek care outside of the area.
Many specialty providers will not treat residents without insurance.
Medicaid requires reapplication and may lapse if residents do not reapply.
There have been cuts to public health funding and reduced services.
Adults do not have access to uninsured dental care.

There is limited awareness about what services are available.
Transportation:
Many residents have limited access to private modes of transportation.
There are no public transit systems in the area.
Medicaid transportation is not reliable or user friendly.
Racial and ethnic challenges:
Some residents have limited English speaking skills.
Information is not always offered in a way that is culturally or linguistically relevant.
Some communities are segregated and people of color are perceived to have a lower quality of life.

Common Recommendations

Increase access to care:
An affordable public transportation system
Leverage the 340 B Prescription program
Offer culturally and linguistically relevant education to residents to address health needs; e.g., common illnesses, treatment options, preventive care, healthy choices, etc.
Increase funding for seniors to increase access to prescription drugs, healthy behaviors, etc.
Increase funding for safety-net clinics and health departments in the area.

Train medical practitioners about how to administer drugs in a way that avoids resistance.
Offer a resource directory that is relevant to the community and regularly updated.
Medical practitioners should increase the time spent in dialogue with patients.
Offer transportation to medical appointments in communities where the need is high.
Hospitals could discount self-pay services for residents that are uninsured.

Vulnerable Populations Geographic Areas of Interest

Uninsured and under-insured
Residents without access to transportation
People diagnosed with behavioral health challenges or chronic disease
Low socioeconomic status (poverty and education)
People of color – African Americans and Hispanics
Seniors on a fixed income

Southeast Troup County
LaGrange (30241 and 30240) – there are pockets of poverty mixed with affluent communities
Hamilton Rd.
Whitesville Rd.
S. Greenwood St.

Zip codes 30320, 30133 and 30341
Two public housing communities
West Point
Hoganville City has a large disabled population
Rural areas

Undocumented residents do not have proper documentation to secure medical services.
Low socioeconomic status:
Many of the employment opportunities offer low wages and no health benefits.
The employment opportunities that are available are not always stable or long-term due to the use of temporary employment.
Poverty is high in this area.
Children are not healthy today:
Schools are not teaching health education or physical education anymore.
Overexposure to technology (phones, games, TV) and limited physical activity
Poor diet

Housing:
The housing authority has not been able to open their waiting list for applications in more than a year.
There is a large homeless population and no homeless shelters for women in the area; the closest is in Atlanta.
There are families living in extended-stay motels and children do not have stable housing.
Behavioral health:
There are not enough providers treating uninsured residents and those that exist do not have capacity to meet the need for behavioral health services.
There are no long-term behavioral health services for youths.
There is a stigma associated with seeking mental health treatment.
There are limited psychiatrists in the area.

Substance abuse:
Adolescents have access to illegal substances and peer pressure to use drugs.
Nutrition:
Unhealthy options (e.g., fast food) are readily available and healthy options (e.g., community gardens) are scarce.
Residents cannot always afford healthy food options.
Many residents are not aware of how to eat healthy or prepare healthy foods.
Many residents do not have the time to shop for or prepare healthy meals due to time spent commuting and working.
Residents are not always making healthy choices when they are available (healthy foods, physical exercise, etc.).

Support community development and program:
Identifying key organizations that assist seniors in the community; e.g., Meals on Wheels.
Invest in promoting healthy options like healthy eating, exercise and behavioral health.
Improve transportation options.
Invest in programs to disrupt generational poverty.
Increase efforts to build trust and address racial injustices in communities that have experienced historical racism.

Hospitals could collaborate with the faith community to reach more community members.
Restrict the number of fast food restaurants allowed and increase the number of healthy options available (e.g., support farmer's markets, food banks, etc.).
Hospitals could change the smoking policies on their campuses by restricting smoking to a confined area that is not next to the front door.
A health navigator could help with renewals for Medicaid, service linkages, care coordination and system navigation challenges.

Address the need to offer information outside of traditional technologies (web, cell phone, etc.) for residents that do not have access to (or know how to use) these types of technologies.
School curriculums could include home economics and tangible life lessons about money, savings, education, etc.
Increase the amount of affordable dental care available to adults using sliding-scale fees and donated services.

Community Is Collaboration

STRONGER TOGETHER

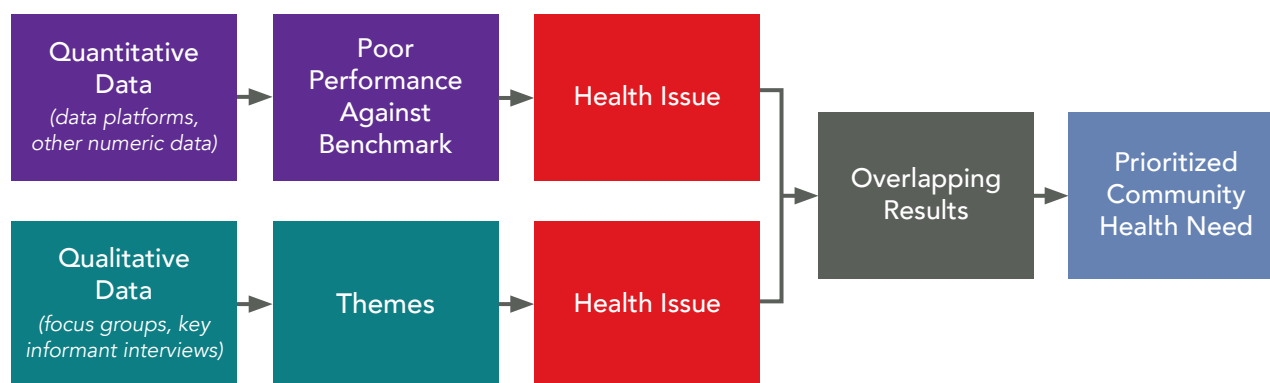


Community Health Priorities

WellStar West Georgia engaged 16 community and hospital leaders to help establish the community priorities for the areas served by both hospitals during a community Health Summit, held on December 4, 2018, at LaGrange-Troup County Chamber of Commerce. 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.



1

Access to appropriate care

Health Summit attendees discussed the limited access that residents have to appropriate care when and where they need it. As the top priority in the service area, attendees discussed the need for transportation, preventive care, insurance coverage options, providers (primary, dental, behavioral healthcare and specialty providers, including pediatrics), diagnostic labs and chronic disease management.



2

Education and health literacy

Health Summit discussions addressed the importance of education and health literacy in the communities served by WellStar West Georgia Medical Center. Attendees discussed the lack of awareness and understanding of preventive measures (e.g., various screenings and regular visits with a physician) as a catalyst for numerous health needs such as chronic disease and other poor health outcomes.



3

Healthy lifestyles
*Diet, nutrition and
smoking*



4

Poverty



5

Behavioral
healthcare

Health Summit attendees discussed the need for residents to have healthy options and be aware of the importance of healthy choices. Concerns among summit attendees included the need for healthy food options, physical activity opportunities, awareness and educational opportunities related to healthy nutrition and physical activity for residents. Summit attendees also felt that smoking rates are high and influencing the rate of cardiovascular disease and cancer rates in the communities served by WellStar West Georgia Medical Center.

Health Summit attendees discussed a lack of educational attainment and poor employment options as significant drivers of poverty in their communities. According to attendees, while health providers may not be well positioned to address all of the various underlying causes of poverty in the area, they have resources to address some issues.

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.

Community **Impact**

BUILDING AND ALIGNING FOR HEALTH EQUITY



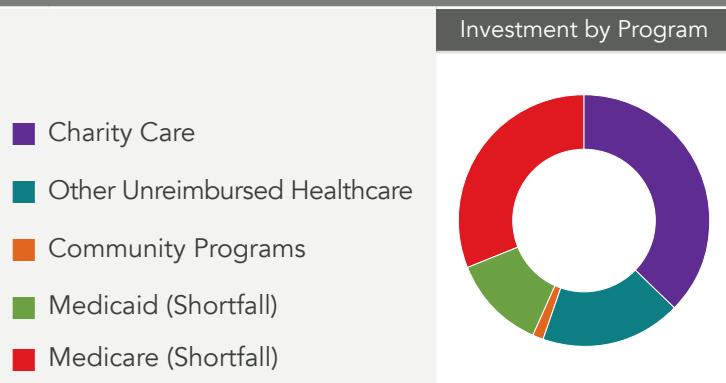
Community Benefit Through the Years

At WellStar, the Community Benefit strategy has moved beyond IRS requirements – from compliance to strategic alignment – which allows the system to improve community health and demonstrate return on investment for Community Benefit activities. Maintaining efforts beyond the three-year Community Health Needs Assessment (CHNA) cycle will help WellStar address persistent community health issues and ensure continuity from one Implementation Plan to the next.

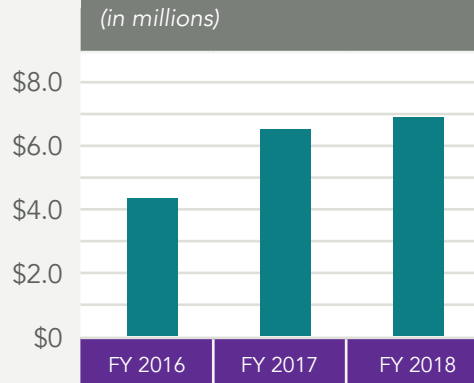
Investing in Community Benefit

Improving the health of vulnerable populations, including those with financial need, is an essential part of WellStar’s Community Benefit efforts and our momentum in building a healthier community continues to grow. For the past three years, we have invested almost \$2.0 billion in community benefit. This amount has increased dramatically due to our 2016 expansion. As the graph below illustrates, WellStar incurred more than \$657 million in cost to provide charity care to patients. Patients who meet the criteria are deemed eligible for charity care, with no obligation to pay, according to state regulations and WellStar policy. We also provided an additional \$316 million to care for those who, for various reasons, did not apply for charity care, but were unable to pay for services. Finally, our physicians and facilities made up a significant shortfall in reimbursements for patients on Medicaid (\$214 million) and on Medicare (\$547 million).

Community Benefit Financial Investment, 2016–2018*

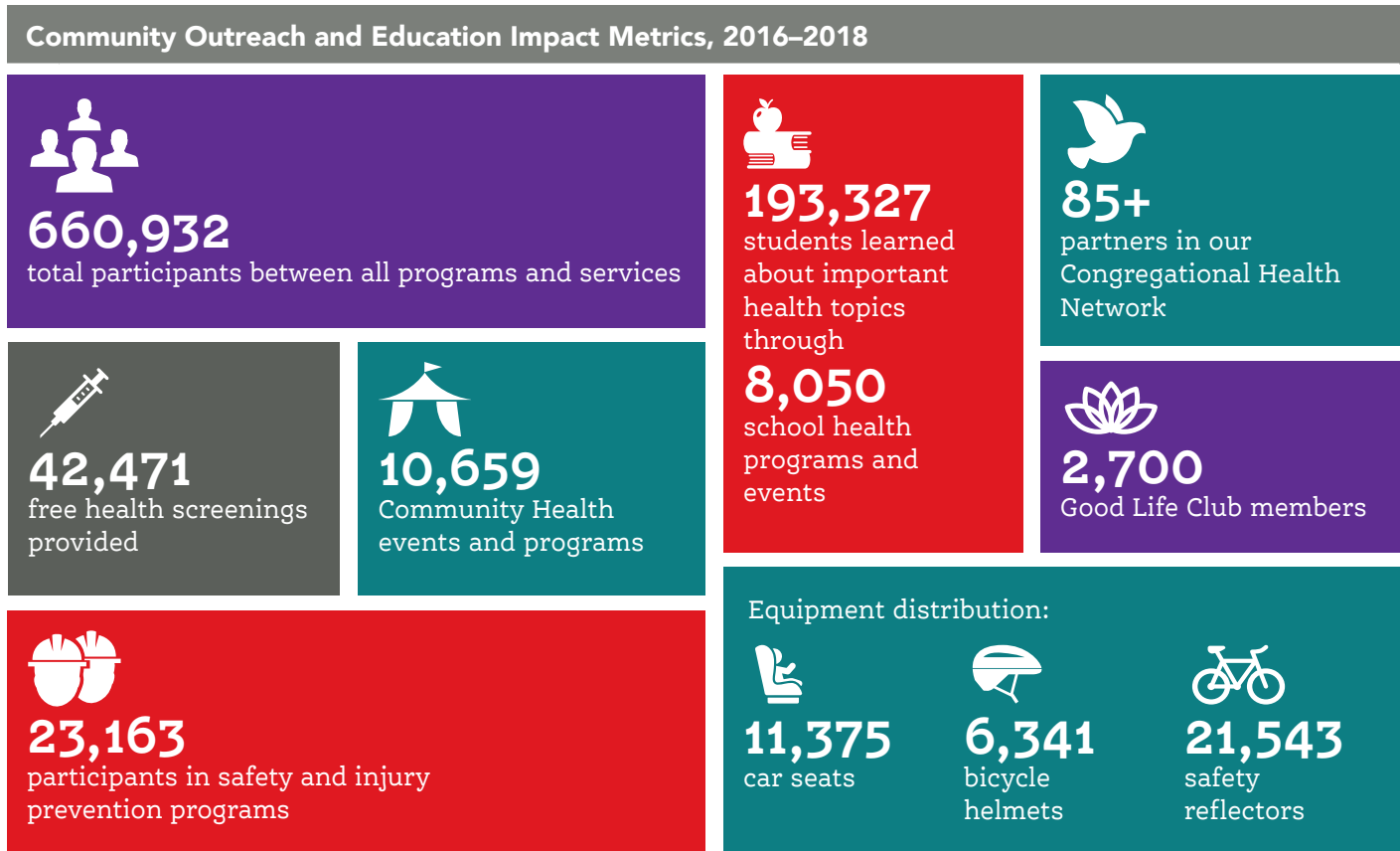


Financial Investment Growth



* Net Community Benefit at Cost. For reporting purposes, WellStar follows federally mandated and other guidelines for patients, including: Indigent: Patients at or below 125 percent of the federal poverty level. Charity: Patients between 125 and 300 percent of the federal poverty level. Medicaid: A federal- and state-administered program providing access to care for certain low-income and/or disabled individuals. On average, Medicaid reimburses physicians, hospitals and other providers less than the cost of care. For 2017, the U.S. Census Bureau defined the federal poverty level as \$12,060 for an individual and \$24,600 for a family of four.

In the past three years, WellStar has invested approximately \$25 million in community programs. We believe prevention and early detection provide the best approach to maintaining health and avoiding disease. WellStar provides 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, WellStar has built a tremendous network of strategic community partnerships on behalf of WellStar to collectively impact the health status of our community.



Policy, System and Environmental Changes Success Stories

It is WellStar's policy to support our mission by improving the overall health and wellbeing of the communities we serve by focusing our Community Benefit Strategies on the priority health needs identified in the CHNA process. These strategies are executed across the entire health system and through a variety of initiatives. Every three years, the CHNA process allows for WellStar to take a systematic approach to ensuring that our resources improve the health of our communities in the most efficient way. In addition, the CHNA provides a unique opportunity for WellStar to engage community members and community-based organizations in strategy development.

Findings from the 2016 CHNA heightened WellStar's efforts to navigate the challenges of effectively linking community and clinical services to improve health outcomes in the long term. Much of WellStar's success in addressing priority health needs relied on our ability to make critical policy, systems and environmental (PSE) changes that better support our Implementation Plan. These PSE changes are centralized on our need to have a comprehensive approach – with WellStar working with internal stakeholders; local governments; community organizations; and businesses, employers and families – to implement initiatives that impact health and quality of life. These changes have also helped WellStar break down organizational silos, consolidate resources and continue our momentum toward value-based models.

PSE Success Story: Establishing the WellStar Community Benefit Department

In response to 2016 CHNA findings and the diversity of WellStar communities, a more precise shift and allocation of resources was done each year to better align strategies to address prioritized health needs. For instance, WellStar's first Community Benefit Department was established to drive initiatives and outreach that address community health needs, health equity and disparities. In addition, this Department assists with auditing services and building an infrastructure for accountability and realignment. The Community Benefit Department governs the WellStar Community Health Collaborative.

PSE Success Story: Expanding WellStar Community Health Collaborative

Community Benefit is led by the WellStar Community Health Collaborative (WCHC), a cross-functional team that represents multiple facets of WellStar Health System. In response to CHNA findings and the diversity of WellStar communities, WCHC was expanded to increase WellStar's capacity to support Community Benefit strategies. By engaging a more diverse selection of WellStar leadership and subject matter experts, Community Benefit priorities and initiatives can best reflect the capacity of the organization to impact and meet the community's needs.

This expansion also helps WCHC increase coordination of efforts, leverage partnerships and maximize efficiency and strategic alignment, within and across WellStar Health System. This is done by WCHC members guiding and informing the community benefit CHNA and strategic planning process for greater institutional alignment and impact. WellStar Health System has also included community needs and community benefit programs in strategic and operational plans across the entire health system.

PSE Success Story: Moving Upstream

Social determinants of health – where we live, work and play – have a tremendous effect on one's health and they can affect anyone, regardless of age, race or ethnicity. The American Hospital Association reported that socioeconomic factors are responsible for approximately 40 percent of a patient's health, while just 20 percent was tied to care access and quality of care.¹⁵ Addressing social determinants of health has also been highlighted as the key to promoting good health for all. For instance, Healthy People 2020 highlights the importance of addressing the social determinants of health as one of the four overarching goals for the decade.¹⁶ This emphasis is shared by the World Health Organization, whose Commission on Social Determinants of Health in 2008 published the report, *Closing the gap in a generation: Health equity through action on the social determinants of health*.¹⁷ Finally, this emphasis is also shared by other national health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy.^{18,19}



15 American Hospital Association. *Hospitals and Health Systems Addressing Social Determinants of Health*. Available from: <https://www.aha.org/addressing-social-determinants-health-presentation>

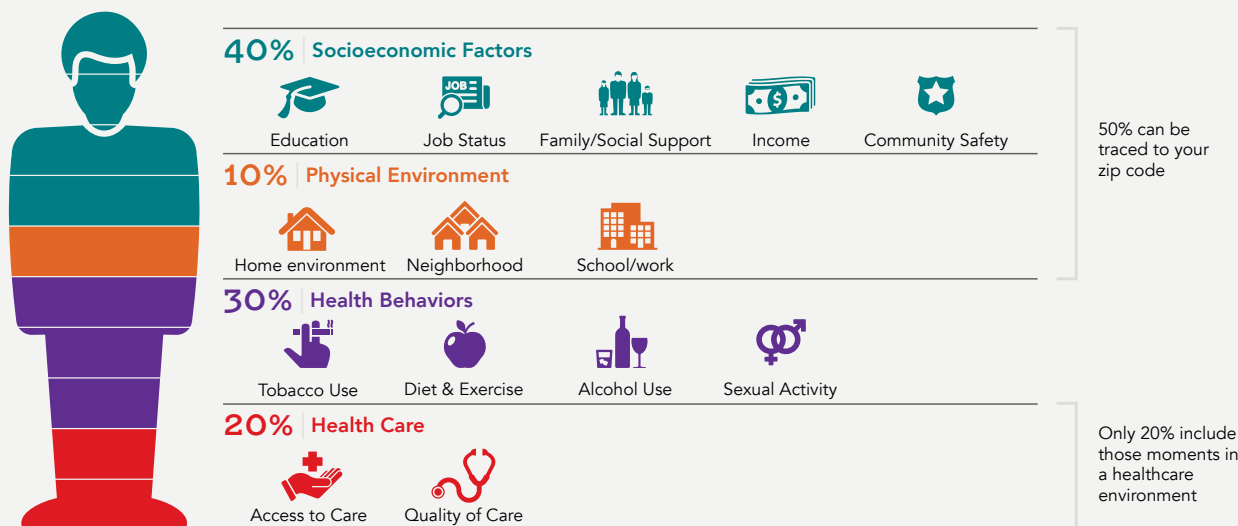
16 Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. *Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States*. July 26, 2010. Available from: <http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm>

17 World Health Organization, Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. Available from: http://www.who.int/social_determinants/en External Web Site Policy

18 National Partnership for Action: *HHS Action Plan to Reduce Racial and Ethnic Health Disparities, 2011*; and *The National Stakeholder Strategy for Achieving Health Equity, 2011*. Available from: <http://minorityhealth.hhs.gov/npa>

19 The National Prevention and Health Promotion Strategy. *The National Prevention Strategy: America's Plan for Better Health and Wellness*, June 2011. Available from: <https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html>

Social Determinants of Health

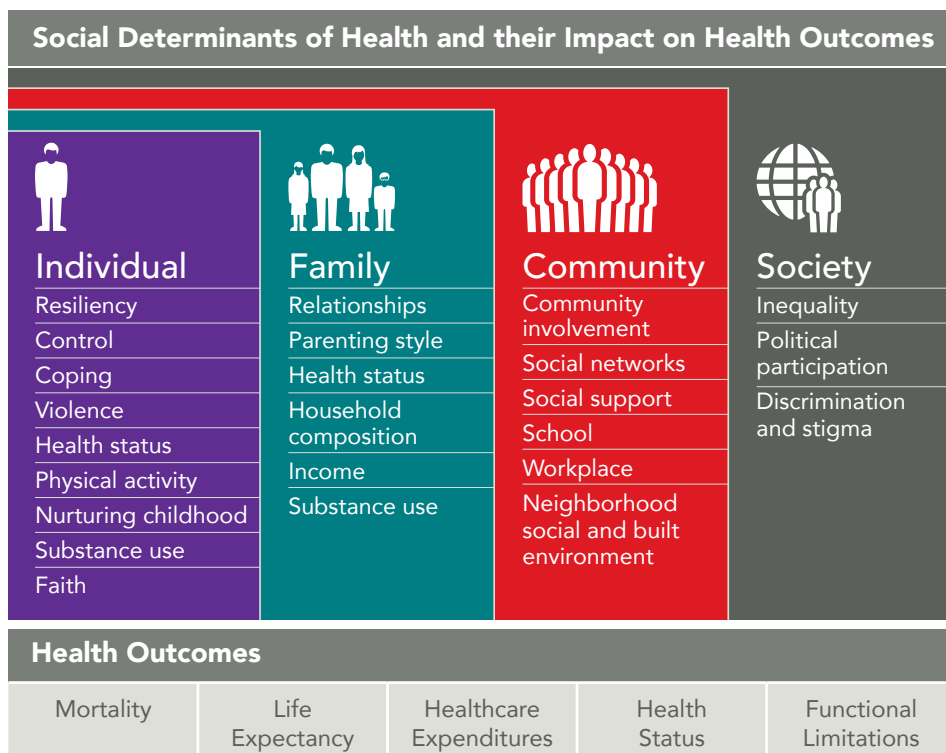


Adaption from Institute for Clinical Systems Improvement. *Going Beyond Walls: Solving Complex Problems*, 2014.

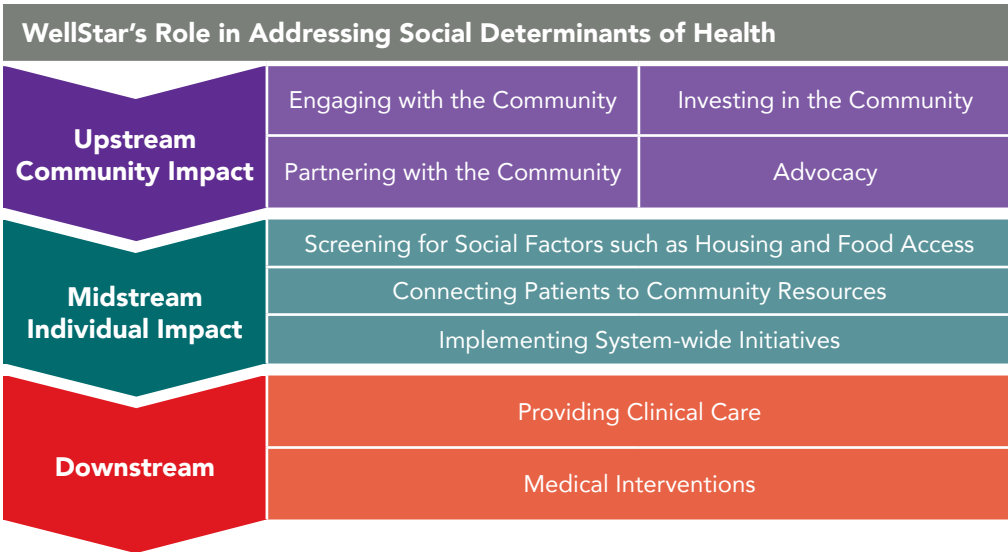
In addition, WellStar acknowledges that each community has different needs when addressing social determinants of health. WellStar's geographical footprint lends to communities that have various strengths and challenges when it comes to access to social and economic opportunities; the resources and supports available in homes, neighborhoods and communities; the quality of schooling; the safety of workplaces; the cleanliness of water, food and air; and the nature of social interactions and relationships. These conditions in which our communities live explain in part why some groups are healthier than others and why some groups more generally are not as healthy as they could be. This is demonstrated in the similarities and differences in the identified priority health needs in 2016.

Finally, WellStar acknowledges that there are multiple ways WellStar can address social determinants of health – both within our own walls and outside in the community.

In response to the 2016 CHNA findings, WellStar has continued to enhance our internal policies and systems to better support the individual social needs of patients and the community needs for social need support. These approaches are centered around both upstream and midstream strategies. The midstream strategies helped mitigate the acute social and economic challenges of individual patients by



Adapted from Kaiser Family Foundation. *Beyond Healthcare: The Role of Social Determinants in Promoting Health and Health Equity*, 2015



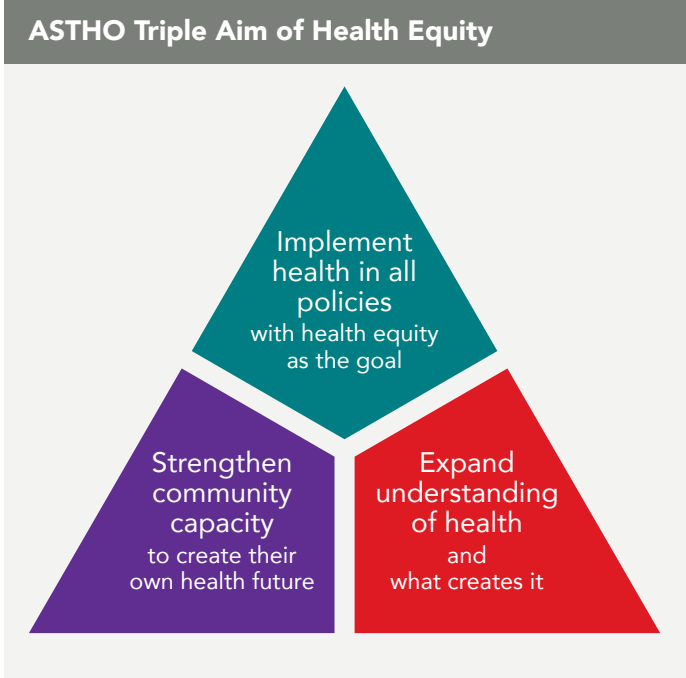
(1) screening patients for social needs; (2) connecting patients to community resources; and (3) implementing system-wide population health initiatives.²⁰ While targeted, small-scale social interventions provide invaluable assistance for individual patients, we also remained focused on the social determinants that perpetuate poor health at the community level. Our external processes recognized that the

demand for social needs interventions will not stop until the true root causes are addressed. Our upstream strategies sought to improve community conditions by (1) engaging with the community; (2) partnering with community-based organizations; (3) investing in the community; and (4) advocacy for laws, policies and regulations that create community conditions that support health for all people. As we continue to evolve as a health system, WellStar is constantly researching public health practice models to ensure that we are aligned with evidence-based strategies. This is why our 2019 Implementation Plan has evolved to a prescribed two-prong approach that focuses on internal (midstream) and external (upstream) community benefit interventions that can work synergistically to address priority health needs.

PSE Success Story: Health Equity Pledge

Along with hundreds of hospitals and health systems across the nation, WellStar Health System signed onto the American Hospital Association's #123forEquity Pledge to Act Campaign.²¹ By signing onto this campaign, WellStar is reinforcing our commitment to address the priority health needs that are identified in the 2016 and future CHNAs through a health equity lens.

The Health Equity Pledge campaign seeks to build on and accelerate the efforts of the National Call to Action to Eliminate Health Disparities launched in 2011 by the American Hospital Association and other partner organizations. This campaign focuses on increasing the collection and use of race, ethnicity and language preference data; cultural competency training; and diversity in leadership and governance. In addition, this campaign seeks to improve and advance



²⁰ Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health. Available from: <https://www.healthaffairs.org/doi/10.1377/hblog20190115.234942/full>

²¹ Hospitals pledge to eliminate healthcare disparities. American Hospital Association. <https://www.aha.org/news/headline/2015-09-22-hospitals-pledge-eliminate-health-care-disparities>

community partnerships to help WellStar better understand the unique concerns and challenges of the populations we serve. In response to 2016 CHNA findings, tenets of achieving health equity are intertwined throughout existing Community Benefit strategies and will be an integral part of future Community Benefit initiatives. These strategies and initiatives are anchored in the Association of State and Territorial Health Officials (ASTHO) Triple Aim of Health Equity.

PSE Success Story and Lessons Learned: WellStar 4-1 Care

In the 2016 Implementation Plan, WellStar documented the establishment of a new initiative – WellStar 4-1 Care. This program relied considerably on the need to change both internal and external processes through formalized partnership agreements between WellStar and the partnering community clinic. To date, WellStar has established a dynamic partnership with CareLink of Northwest Georgia Community Clinic, which serves members of Paulding County. CareLink is a 501(c)(3) nonprofit organization governed by engaged citizens, business owners, healthcare professionals and members of the faith-based community in Paulding. Results of the most recent CHNA for Paulding County commanded a deliberate focus on Prevention and Access to Care. In Paulding County, 18 percent of residents are uninsured limiting their ability to obtain crucial preventive and routine health services. This statistic is most profoundly manifested in Paulding’s elevated rates of chronic disease and preventable illness with heart disease, lung disease, cancer and stroke at the top of the list. In partnership with WellStar Health System; CareLink was created to provide healthcare and other necessary resources to our county’s uninsured and underserved residents. We are confident that through the provision of safe and compassionate high-quality care, CareLink will effectively strengthen individuals, families and the Paulding Community at large enabling all residents to live a happier, healthier lifestyle.

Some of the matters that have impacted our completing more formalized partnerships with community clinics include (1) community clinics are currently in negotiation with WellStar to clearly identify roles and responsibilities to establish a formalized memorandum of understanding; (2) targeted community clinic’s financial and time commitments outweigh potential benefits of establishing WellStar 4-1 Care at their site at this time; and (3) targeted community clinics are no longer open or have considerable operational challenges to establish WellStar 4-1 Care at their site.

In the 2019 Implementation Plan, WellStar has carried over the WellStar 4-1 to grow as a Community Benefit initiative. We will continue to navigate the complexities of establishing a formalized memorandum of understanding between the health system and community clinics. We are also looking forward to using the process lessons learned to expedite the agreement process. WellStar recognizes that community clinics are a key component of our healthcare system, providing essential access to comprehensive primary care in underserved communities.

Lessons Learned: Live Well

In 2016, WellStar documented in our Implementation Plan the establishment of a new initiative – Live Well. Live Well was a health education initiative that sought to offer chronic disease management and healthy lifestyle education at local community worksites and community clinics. This initiative was launched while WellStar was systematically diffusing our other health education programs and initiatives across WellStar’s entire geographical footprint. During the same time, the Community Benefit Department was created. The latter two occurrences created an opportunity for WellStar to have a greater impact in all the communities we serve. Therefore, the Live Well strategy was circumvented to more effectively rely on existing infrastructures, capacities and resources. Through this transition, the importance of strategically aligning future Community Benefit efforts was reinforced as the newly created Community Benefit Department works to optimize WellStar’s existing assets.

Today, our current health education offerings encapsulate the essence of Live Well, which is centered on promoting wellness within the community, including chronic disease awareness and prevention; maternal and infant health; tobacco use and substance abuse; injury and violence prevention; mental and behavioral health; and nutrition, exercise and obesity prevention. In addition, WellStar's health education offerings continue to seek out and leverage opportunities to increase access to culturally appropriate health education for communities that are in greatest need of resources and support.

Lessons Learned: Evaluation and Impact Reporting

WellStar Health System tracks, monitors and reports our Community Benefit investment to transparently share how we address the needs of our community. To assist with this process, WellStar utilizes Community Benefit Inventory for Social Accountability (CBISA) and internal tracking systems. To date, a considerable amount of tracking and monitoring has focused on productivity, performance and investment metrics. These metrics help WellStar create a snapshot of our efforts and help us understand what our health system has accomplished and is capable of. In addition, these metrics inform important benchmarks for strategic planning.

However, we recognize that continued process improvements are needed to better evaluate and monitor our community health programs for evaluation purposes and to better tell our story. Establishing a stronger evaluation and monitoring system will enhance WellStar's ability to innovate and align with the ideas, networks, resources, capacity and interests of our diverse partners when struggling through complex community health issues, intervention options and implementation decisions. In addition, this will create opportunities to share leading practices that will be critical in helping WellStar make the most of our community health efforts. In 2019, WellStar's Community Benefit Department is researching how to increase our internal data and monitoring capacity through new internal resources and key external partnerships.

Appendix



Consultant Qualifications

Georgia Health Policy Center (GHPC), housed within Georgia State’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, the 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.

- The GHPC draws on more than a decade of combined learnings from its experience with 100+ projects supported by 75 diverse funders. The studies span the layers of the socioecological model and include individual, multi-site and meta-level assessments of communities, programmatic activities and provision of technical assistance.
- The 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 process to meet the IRS regulations of Schedule H, which included 29 Georgia counties and Metro-Atlanta between 2015 and 2016. Partners included Grady Health System, Piedmont Healthcare, WellStar Health System, Mercy Care and Kaiser Foundation Health Plan of Georgia (KFHPGA). The regional assessment project served as the foundation for the community health improvement planning process employed by GHPC to generate the implementation plan in partnership with Grady Health System and KFHPGA. GHPC has conducted similar assessments and plans to address needs for Grady Health System and KFHPGA in 2009 and 2013.
- GHPC managed the community engagement and conducted the county-level CHNA for which the results will serve as the foundation for Clayton County Board of Health’s application to the Public Health Accreditation Board (PHAB) for accreditation. GHPC remains engaged as Clayton County prepares for the next stages of accreditation.
- GHPC evaluated seven metro-Atlanta counties to measure the demand on and capacity of the urban health care “safety net.” The study addresses the issue of shrinking access for those who face most significant barriers to health care and examines the health needs and safety-net services in Fulton, DeKalb, Cobb, Forsyth, Gwinnett, Fulton 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 health care 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 health care providers and stakeholders.

Secondary Data

(July 2018–November 2018)

County Health Rankings (2018) [†]	
Coweta	10
Harris	133
Meriwether	8
Troup	75

Age Distribution [†]				
	Coweta	Harris	Meriwether	Troup
0-14 yrs	20%	16%	18%	20%
15-17 yrs	5%	4%	4%	4%
18-24 yrs	9%	9%	9%	10%
25-34 yrs	12%	10%	12%	13%
35-54 yrs	28%	26%	23%	24%
55-64 yrs	13%	16%	14%	12%
65+ yrs	14%	19%	20%	15%

Racial/ Ethnicity [†]				
	Coweta	Harris	Meriwether	Troup
White NH	71.0%	76.0%	56.0%	55.7%
Black NH	18.0%	17.0%	39.0%	36.4%
Hispanic	7.0%	4.0%	3.0%	4.0%
Asian/PI NH	2.0%	1.0%	1.0%	1.9%
All Others	2.0%	2.0%	2.0%	2.1%

Socioeconomic (per 100,000 pop.)	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
On-time high school graduation (2014-15)	69.60%	90.00%	84.00%	77.10%*	80.00%	88.20%
Free and reduced price lunch (2014-15)	41.50%	38.70%	89.70%	66.40%	62.40%	52.60%
Unemployment rate (2017)	3.70%	4.00%	5.00%	4.40%	4.30%	4.00%
Population below 100% FPL (2012-16)	12.00%	8.40%	23.70%	21.30%	17.80%	15.70%
Children below 100% FPL (2012-16)	17.70%	10.10%	30.70%	31.00%	25.40%	23.60%
Adults with no high school diploma (2012-16)	11.40%	10.20%	22.90%	16.40%	14.20%	38.40%
Uninsured population (2012-16)	10.70%	11.30%	16.80%	13.90%	15.80%	11.80%

* 2015-16

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

Healthcare Access (per 100,000 pop.)	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Primary care providers** (2014)	48.70	51.70	33.00	51.80	72.90	87.80
Dentists* (2015)	34.70	15.00	18.90	54.50	49.20	65.60
Mental health providers* (2016)	57.80	12.00	51.90	79.10*	115.00	200.70
Recent primary care visit (2014)	79.30%	84.30%	80.20%	51.80%	81.00%	78.90%
Federally Qualified Health Centers** (2016)	0.79	0.00	9.09	0.00	2.10	2.40
Health Professional Shortage Area – Dental (2016)	0.00%	0.00%	100.00%	0.00%	37.90%	37.80%

Health Determinants	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Current smokers (2015)	14.80%	14.40%	18.70%	14.80%†	17.00%	15.70%
Healthy food stores (low access) (2014)	43.50%	0.10%	3.00%	45.00%	30.80%	22.40%
Exercise opportunities – access (2010/2014)	60.50%	53.50%	24.50%	ND	75.90%	84.30%
Driving alone to work, long distances (>60 mins) (2012-2016)	46.50%	41.10%	51.10%	6.10%	40.00%	34.80%

Clinical Care & Prevention	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
SNAP Benefits (2012-2016)	9.80%	8.80%	25.50%	18.50%	15.30%	19.10%
Physical inactivity – adults (2013)	0.22	0.22	0.28	0.26	0.23	0.22
Preventable hospital events** (2014)	48.70	32.70	57.50	48.10‡	52.30	50.40
Teen births (15-19) (2008-14) per 1,000	31.80	25.70	49.40	65.00	38.50	32.10

Other Health Indicators (per 100,000 pop.)	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Population with any disability (2012-16)	0.11	0.17	0.21	0.17	0.12	0.13
Impaired driving deaths (2011-2015)	0.23	0.29	0.22	ND	0.23	†
Poor physical health days (2015)	3.50	3.20	4.50	ND	3.90	3.70
Poor mental health days (2015)	3.50	3.40	4.10	ND	3.80	3.70
Stroke prevalence (2015)	0.05	0.04	0.05	ND	0.04	0.04
Age-adjusted drug overdoses (2007)	8.90	ND	21.10	10.00	8.60	†
Age-adjusted drug overdoses (2017)	16.20	ND	ND	18.60	14.60	†
Years of potential life lost (YPLL75) (2017)	8,119.00	2,485.50	2,479.50	6,149.00	763,397.00	†

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

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

* 2018

** 2006-12

‡ 2015

Other Health Indicators [‡]	Coweta	Harris	Meriwether	Troup	Georgia	U.S.
Mental health ER rate* (2017)	800.80	748.90	983.40	1,835.60	1,094.60	†
Mental and behavioral disorder mortality (2013-17)*	36.20	25.80	59.60	71.80	37.40	†
Self-harm age-adjusted discharge rate* (2013-17)	33.60	22.60	37.10	60.80	32.70	†
Age-adjusted suicide mortality (2013-17)*	12.40	16.40	16.10	12.50	12.70	†
Age-adjusted opioid overdoses (2007)	ND	ND	ND	ND	3.40	†
Age-adjusted opioid overdoses (2017)	13.00	ND	ND	8.80	9.70	†
Assault-age adjusted discharge rate (2013-17)	13.10	6.40	16.40	24.90	18.60	†
Diagnosed diabetes-prevalence (2013)	10.60%	13.20%	18.80%	12.60%	10.6%	†
Diabetes age-adjusted discharge rate (2013-17)	162.2	109.5	347.9	294.3	188.1	†
Diabetes age-adjusted mortality rate (2013-17)	20.00	21.50	28.20	29.70	21.70	†
Adults obesity (2014)	27.10%	30.40%	34.80%	29.90%	30.00%	†
Obs. heart disease/heart attack age-adjusted discharge rate* (2013-17)	248.40	189.80	295.30	370.10	265.00	†
Hypertensive heart disease age-adjusted discharge rate* (2013-17)	29.80	23.00	39.00	46.10	39.00	†
Asthma ER visit rate* (2017)	349.40	182.80	465.60	719.30	525.50	†
Age-adjusted motor vehicle crash ER visit rate* (2017)	1,133.50	886.20	1,993.40	1,722.60	1,168.80	†
HIV prevalence rate (2015)	196.40	123.70	235.70	187.00	588.00	362.30
HIV new diagnosis (2016)	13.80	supp.	supp.	15.60	31.80	14.70
Age-adjusted STD rate except congenital syphilis (2017)	493.60	339.40	975.70	1,088.80	890.40	†
% Low birth weight (< 2500g) (2013-17) ^d	8.30%	9.00%	11.40%	10.70%	9.60%	†
Infant mortality (total; non-Hispanic White; Black) (2013-17)	4.9; 3.7; 11.2	4.8; ND; ND	8.7; ND; 16.5	8.8; 3.9; 13.6	7.5; 5.4; 12.2	†

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

* Per 100,000 population

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

‡ 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>

2017–2018 Community Need Index (CNI) – WellStar West Georgia Medical Center†

Zip	County	Change (2017-18)	2018 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	Income Score	Limited English	Minority	Culture Score	No High School Diploma	Education Score	Unemployed	Uninsured	Insurance Score	Renting	Housing Score
30230	Troup	.00	4.40	16%	30%	54%	4	.4%	32%	4.0	21%	.05	12%	23%	5.0	29%	4.0
30240	Troup	.20	4.20	15%	21%	40%	3	1.5%	39%	4.0	14%	.04	9%	23%	.05	39%	5.0
30241	Troup	-.20	4.60	19%	31%	50%	4	1.6%	55%	5.0	18%	.04	13%	25%	.05	44%	5.0
31833	Troup	-.20	4.20	20%	23%	31%	3	.6%	45%	5.0	16%	.04	16%	23%	.05	31%	4.0
Coweta Total		.00	3.40	7%	17%	45%	3	1.6%	28%	3.7	11%	2.7	6%	13%	.04	26%	3.2
Harris Total		.10	2.90	10%	11%	25%	2	.4%	24%	3.8	11%	.82	7%	13%	4.1	15%	1.7
Meriwether Total		.00	4.60	18%	28%	49%	4	.3%	44%	4.7	26%	.05	12%	26%	.05	30%	4.1
Troup Total		.00	4.40	17%	26%	45%	3	1.3%	44%	4.4	16%	4.1	12%	24%	.05	39%	4.8

† Truven Health Analytics, Community Needs Index (2018)

Racial/Ethnic Disparities (2013-2017)

	Coweta	Harris	Meriwether	Troup	White	Black	Asian	Hispanic†	Georgia	U.S.
% Uninsured population (2012-16)	0.11	0.11	0.17	0.14	0.10	0.15	0.13	0.25	0.16	0.12
Annual cervical cancer incidence rate*	7.60	supp.	supp.	supp.	ND	ND	ND	ND	7.80	7.50
Breast cancer incidence (2011-15)*	117.70	133.60	131.70	128.10	123.00	132.50	ND	ND	125.20	124.70
Annual colon and rectum cancer incidence rate (2011-15)*	41.20	33.50	63.10	45.00	90.00	27.00	supp.	supp.	41.80	39.20
Annual prostate cancer incidence rate (2011-15)*	99.40	129.80	109.80	130.20	91.50	206.10	ND	ND	123.30	109.00
Annual lung cancer incidence rate (2011-15)*	64.70	55.40	53.90	70.40	66.00	62.10	ND	ND	64.90	60.20
Coronary heart disease mortality, age-adjusted death rate (2012-16)*	78.50	85.10	175.40	91.60	90.10	104.20	ND	ND	79.10	99.60
Infant mortality rate (2013-17)**	4.90	4.80	8.70	8.80	3.70	12.70	ND	6.90	7.50	
Age-adjusted adult asthma discharge rate*	57.80	34.80	81.30	82.50	59.10	80.00	ND	ND	87.50	
Age-adjusted adult asthma ED visit rate*	348.00	239.70	526.70	709.60	260.20	964.80	98.20	ND	551.60	
Stroke mortality, age-adjusted death rate*	33.30	40.40	47.90	46.40	35.40	58.70	ND	ND	43.00	
Age-adjusted breast cancer mortality, death rate*	12.00	12.20	11.60	12.70	12.70	12.30	ND	ND	12.30	
Age-adjusted diabetes discharge rate*	162.20	109.50	347.90	294.30	141.60	422.40	40.70	ND	188.10	
Age-adjusted diabetes mortality*	20.00	21.50	28.20	29.70	21.30	38.00	ND	ND	21.70	
Age-adjusted obstructive heart disease/heart attack discharge rate*	248.40	189.80	295.30	370.10	282.00	244.70	152.20	ND	265.00	
Age-adjusted obstructive heart disease mortality*	79.90	92.50	183.50	92.20	91.90	117.00	59.10	29.70	76.40	
Age-adjusted hypertensive heart disease discharge rate*	29.80	23.00	39.00	46.10	26.60	58.70	ND	ND	39.00	
Hypertensive heart disease age-adjusted mortality*	29.00	12.10	10.30	21.40	19.00	36.40	ND	ND	16.20	
Cancer mortality, age-adjusted death rate*	162.00	145.90	168.90	176.30	163.80	185.70	69.90	75.80	160.70	

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

Community Commons CHNA Portal: CHNA.org

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

* Per 100,000 population

** Four-county aggregate

*** Per 1,000 live births

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

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

	All Races	White	Black	Asian	Georgia
Prioritized	<ul style="list-style-type: none"> Ischemic Heart and Vascular Disease - 1,385 All Other Mental and Behavioral Disorders - 570 Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease - 475 	<ul style="list-style-type: none"> Ischemic Heart and Vascular Disease - 1,051 All Other Mental and Behavioral Disorders - 478 Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease - 312 	<ul style="list-style-type: none"> Ischemic Heart and Vascular Disease - 352 Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease 210 Septicemia - 90 	ND	ND
#1	All COPD Except Asthma - 682	All COPD Except Asthma - 619	Cerebrovascular Disease - 164	Ischemic Heart and Vascular Disease - 9	Ischemic Heart and Vascular Disease - 41,242
#2	Malignant Neoplasms of the Trachea, Bronchus and Lung - 625	Malignant Neoplasms of the Trachea, Bronchus and Lung - 494	Malignant Neoplasms of the Trachea, Bronchus and Lung - 129	Malignant Neoplasms of Liver and Intrahepatic Bile Ducts - 3	Malignant Neoplasms of the Trachea, Bronchus and Lung - 22,349
#3	All Other Mental and Behavioral Disorders - 570	Alzheimers Disease - 382	Diabetes Mellitus - 102	Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease - 3	All COPD Except Asthma - 22,123
#4	Cerebrovascular Disease - 530	Cerebrovascular Disease - 363	All Other Mental and Behavioral Disorders - 101	Malignant Neoplasms of Colon, Rectum and Anus - 2	Cerebrovascular Disease - 20,481
#5	Alzheimers Disease - 456	Diabetes Mellitus - 225	Nephritis, Nephrotic Syndrome and Nephrosis - 78	Malignant Neoplasms of the Trachea, Bronchus and Lung - 2	All Other Mental and Behavioral Disorders - 17,375

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

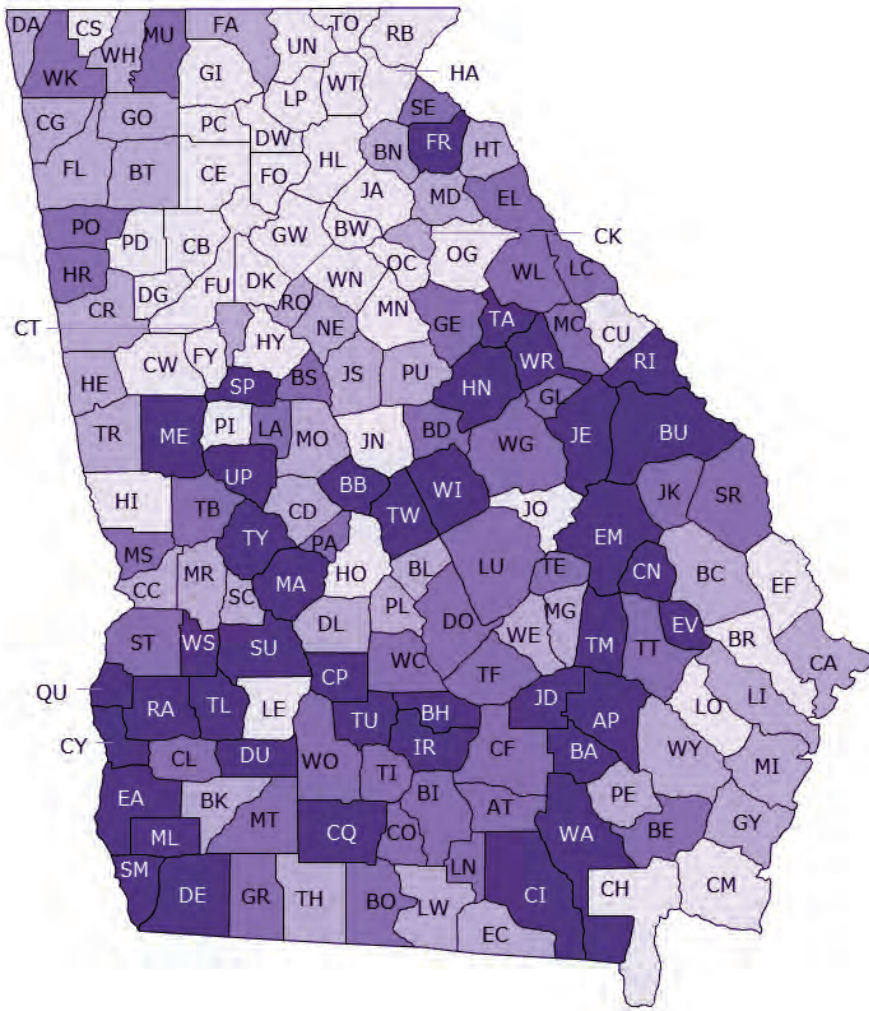
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

This tool does not report data by ethnicity. As a result, there are not comparable data reported for Hispanic or Latino death rates.

Maps

Health Outcomes

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

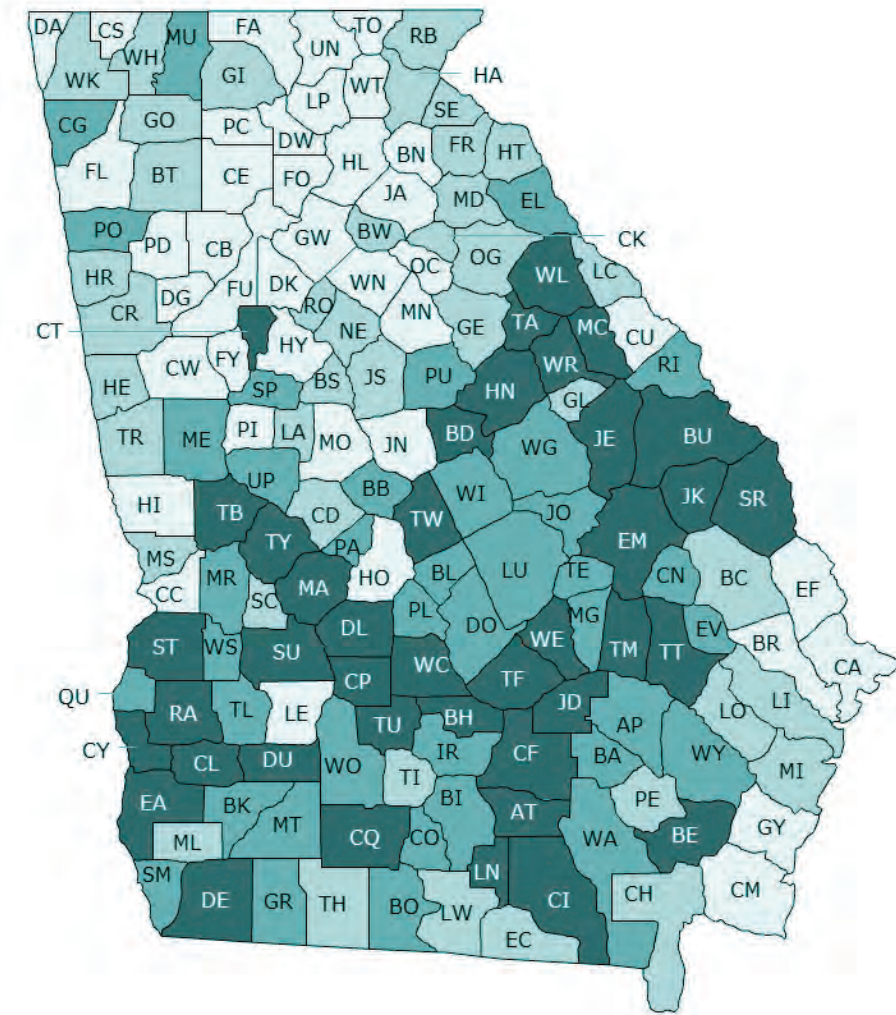


Rank
1-40
41-80
81-119
129-159

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

Health Factors

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



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

Primary Data and Community Input

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

CHNA Collaborators

Collaborator	Area of Service
Build The Crowd, LLC Curtis Brown, <i>Civic Entrepreneur</i>	Summit Attendee
Circles of Troup County Sherri Brown, <i>Director</i> Holly Roberts, <i>Circles Coach</i>	Key Stakeholder Interview Summit Attendee Summit Attendee
City of Hogansville William Stankiewicz, <i>Mayor</i>	Summit Attendee
City of LaGrange	Listening Session
Conifer Health Services Janet Edwards, <i>Patient Access Supervisor</i>	Key Stakeholder Interview
Emory Healthcare Brent Addison, <i>Director of Operations</i> Kenneth Horlander, <i>MD, FACP, FCCP</i>	Summit Attendee
Georgia Department of Public Health Olugbenga O. Obasanjo, <i>M.D., Ph.D., District 4 Health Director</i>	Key Stakeholder Interview
LaGrange Police Department Natalie McKinley, <i>Patrolman</i>	Key Stakeholder Interview
Troup Cares Donna Cherry, <i>Executive Director</i>	Key Stakeholder Interview
Troup County Center for Strategic Planning Kathryn Tilley, <i>Executive Director</i>	Summit Attendee
Troup County Chamber of Commerce Page Estes, <i>President of Chamber/ Tourism/Economic Development Organization</i>	Summit Attendee

Collaborator	Area of Service
Troup County Schools Charlotte Flores, <i>Counselor, PBIS Coach, Tier 3 Co-Chair</i>	Key Stakeholder Interview
Troup Family Connection Authority Mandy Hill, <i>Executive Director</i>	Key Stakeholder Interview
Twin Cedars Youth and Family Services, Inc. Shannon Lawson, <i>Project Coordinator</i>	Key Stakeholder Interview Summit Attendee
United Way of West Georgia, Inc. Patty Youngblood, <i>President</i>	Key Stakeholder Interview Summit Attendee
WellStar Health System Missy Laura Gutelius Kamela Sooknanan, <i>Assistant Vice President Population Health Management</i> Jerry Fulks, <i>President WellStar Georgia Medical Center WellStar West Georgia Regional Board</i> Patricia Rogers, <i>Public Relations Specialist WellStar West Georgia Medical Center</i> Cecelia Patellis, <i>Assistance Vice President Community Education & Outreach</i> Shara Wesley, <i>Director, Community Benefit</i>	

Community Health Summit

The following is a summary of the WellStar West Georgia Medical Center health summit held on December 4, 2018, at the LaGrange-Troup County Chamber of Commerce in LaGrange, GA. WellStar West Georgia Medical Center is a 276-bed facility. The Health Summit was facilitated by Georgia Health Policy Center (GHPC) in partnership with WellStar Health System and lasted approximately three hours. The 16 attendees included employees of WellStar Health System and community stakeholders. Community stakeholders represented organizations serving residents in communities included in the primary service area of WellStar West Georgia Medical Center.

The organizations that took part in the Health Summit included:

- Build the Crowd
- Circles of Troup County
- City of Hogansville
- Emory Healthcare
- Georgia Department of Labor
- LaGrange-Troup County Chamber of Commerce
- Mackey-Wilson-Jennings Funeral Home Inc.
- Troup Cares
- Twin Cedars Youth and Family Services
- United Way of West Georgia
- WellStar West Georgia Medical Center

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

Group Recommendations and Problem Identification

During the Health Summit, attendees prioritized six community health needs of residents within WellStar West Georgia Medical Center's primary service area. The following is a summary of the input attendees offered when asked about contributing factors, potential solutions and community resources to address the health priorities.



Access to Appropriate Care

Health summit attendees discussed the limited access that residents have to appropriate care when and where they need it. As the top priority in the service area, attendees discussed the need for transportation, preventive care, insurance coverage options, providers (primary, dental, behavioral healthcare and specialty providers, including pediatrics), diagnostic labs and chronic disease management.

Contributing Factors:

- The number of providers is low in the region. This means residents must travel to secure care (i.e., specialty and pediatric care, any services for residents with Medicaid insurances, diagnostic labs, genetic counseling, etc.) or wait long periods of time to secure appointments in the area (if available). Care coordination is not always happening for residents who are seeking care at the ER or outside of the area.
- There are not enough safety-net providers in the area, leaving underinsured and uninsured residents with limited options for care.
- Medicaid has not been expanded in the state, which limits access to affordable insurance coverage.
- Many physicians in the area do not accept Medicaid or Marketplace insurances. Residents may have to travel outside of their area to a provider that will accept the type of insurance they have.
- Cost of uninsured care can be unaffordable for residents earning a low income, including healthcare, behavioral healthcare, dental care and prescription medications.
- The distance between providers requires a vehicle to get to and from the doctor. Public transit is not readily available and disconnected from county to county in this area. Cars are not always affordable for residents.
- Residents are not always receiving the right level of care, which can lead to poor outcomes for diagnoses that require ongoing care coordination and management (e.g., chronic diseases and terminal illnesses such as diabetes, cancer, etc.).

Recommendations:

- Normalizing billing practices and lowering the negotiated rate for uninsured residents would encourage preventive care and care compliance and allow individuals to understand their fiscal responsibilities prior to seeking care.
- WellStar West Georgia Medical Center could advocate for improved insurance options and affordability of health services for vulnerable patient populations, including federal- and state-funded open-access clinics and Medicaid expansion.
- WellStar can further develop partnerships with local providers and community organizations to better meet the needs in the area and increase navigation. For example, WellStar could support local public health programs or senior service organizations when there is alignment between services or health programming.
- WellStar could offer health services (e.g., immunizations) in local school settings such as a school-based health center or medical clinic.



Education and Health Literacy

Health summit discussions addressed the importance of education and health literacy in the communities served by WellStar West Georgia Medical Center. Attendees discussed the lack of awareness and understanding of preventive measures (e.g., various screenings and regular visits with a physician) as a catalyst for numerous health needs such as chronic disease and other poor health outcomes.

Contributing Factors:

- 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.
- Educational resources are not readily accessible in locations that are convenient for underserved communities.
- Information and educational materials that are available are not always written in a way that residents can understand due to low educational attainment, literacy challenges and language barriers.
- Health education is not always exemplified in public schools. For example, schools may teach the science or mechanics of physical education and then not offer an active recess period.

Recommendations:

- Summit attendees suggested partnering with the school system to provide additional health literacy information and education, such as the role of nutrition in a healthy diet, the negative impact of smoking on health outcomes and other healthy lifestyle choices.
- Community outreach was discussed broadly to better connect with target populations on all of the priority needs identified during the summit. For example, WellStar West Georgia Medical Center could engage mentors to teach healthy behaviors to adults and children.
- WellStar could offer or sponsor health information about exercise and nutrition in prominent locations on the Thread, a local system of trails.
- Local schools could offer education related to health and nutrition coupled with healthy meals in schools.



Healthy Lifestyles

Health summit attendees discussed the need for residents to have healthy options and be aware of the importance of healthy choices. Summit attendees discussed the significance of nutrition, physical exercise and smoking cessation in a healthy lifestyle. Concerns among summit attendees included the need for healthy food options, physical activity opportunities, awareness and educational opportunities related to healthy nutrition and physical activity for residents. Summit attendees also felt that smoking rates are high and influencing the rate of cardiovascular disease and cancer rates in the communities served by WellStar West Georgia Medical Center.

Contributing Factors:

- Fast food and unhealthy food choices are more readily available than healthy options in this area. As a result, residents are making unhealthy food choices because of time constraints and convenience of options such as fast food.
- Physical activity is not always available, affordable or a priority for residents.
- Physical education is not always offered in local public schools and children are not being active during the school day.
- Smoking rates are higher than average in the area.

Recommendations:

- Communities could implement improvements in their community planning related to the built environment – sidewalks, bike lanes and transportation.
- Schools, communities and hospitals could implement community gardens to increase access to fresh produce in communities that have limited access.
- Insurance companies and employers could incentivize not smoking or quitting smoking.
- Communities could disseminate information about free smoking cessation resources (e.g., the Georgia Tobacco Quit Line) to residents in a variety of locations at regular intervals. Hospitals could make this information available to patients.
- Hospitals could establish smoke-free campuses and make designated smoking areas less accessible to staff and patients.
- Municipalities could incentivize stores to donate healthy foods to food banks and other programs that address food insecurity.
- Leaders could establish a mobile produce or food distributor that would offer healthy foods in food deserts.
- Hospitals could offer high-quality healthy options in meal services and cafeterias.
- Communities could offer educational classes and demonstrations related to nutrition, healthy cooking, etc.



Poverty (related to healthcare environment)

Health summit attendees discussed a lack of educational attainment and poor employment options as significant drivers of poverty in their communities. According to attendees, while health providers may not be well positioned to address all of the various underlying causes of poverty in the area, they have resources to address some of issues – for example, as a major employer, WellStar can train and employ local residents.

Contributing Factors:

- Educational attainment is low in many communities.
- Many employment options offer low wages and do not offer affordable health insurance benefits.

Recommendations:

- WellStar can offer job training in healthcare professions, mentorship opportunities through internships and summer programs for high school students.
- WellStar can offer affordable options for uninsured residents that would allow them to secure preventive and specialty care.
- WellStar can use the political resources they have to advocate on behalf of uninsured and unemployed residents.
- WellStar can connect residents to social workers that are able to make referrals to necessary Connection Social Work.



Behavioral Healthcare

Health summit attendees prioritized behavioral health as one of the most pressing issues in their communities. Attendees noted that addressing behavioral health needs in their communities will require collaboration among many organizations and institutions and numerous resources. Their concerns included stigma, limited behavioral health providers and limited resources.

Contributing Factors:

- The lack of behavioral health providers limits the access residents have, both insured and uninsured, to appropriate care.
- Residents often seek care for behavioral health symptoms in the ER, where behavioral health resources may not be available.
- The stigma associated with seeking behavioral healthcare may pose a barrier to residents seeking care in some of the rural communities served by WellStar West Georgia Medical Center.

Recommendations:

- It is important to find a way to increase recruitment and retention of mental health providers to increase access to mental health services.
- There are limited Federally Qualified Health Centers that offer behavioral health services to residents that are underinsured or uninsured in the area.
- The health department could use additional support to address behavioral health in the community.
- Continue mental health court – a judicial diversion program for residents with behavioral health diagnoses who have been charged with a crime – and redirect community services to support this process.
- Increase behavioral health resources available in homeless shelters in the area.
- WellStar could increase the number of mental health providers they hire to address community needs.
- There could be an increase in investment in physical activity outlets that offer positive stress management.
- WellStar could increase the number of community-wide education programs that they offer.
- Increase the services available for adults and children in crisis situations who need hospitalization in order to decrease the use of local ERs for behavioral health needs.

Listening Session

Notes from the WellStar West Georgia Regional Health Board Listening Session

(October 2018)

Counties represented: Coweta, Meriwether and Troup

How would you rate health and quality of life in your area?

- Those in lower-income situations and poverty face more challenges in all areas
- Cost and care issues

In your opinion, over the past three years, has health and quality of life in your area improved, stayed the same or declined?

- I feel like it has improved with more good doctors joining West Georgia Medical Center and watching the efforts of the hospital to improve all aspects of healthcare both in the hospital and in the community.
- We offer more to the community as it relates to better healthcare.

In your opinion, what are the most critical health problems in your area?

- Substance abuse (prescription and illegal drugs alcohol and addiction)
- Lack of exercise
- Poor eating habits
- Obesity
- Diabetes
- Cardiovascular disease (heart attacks and high blood pressure)
- Smoking
- Unsafe sex
- Not going to the doctor

What unhealthy behaviors and social determinants of health have the largest impact on health and quality of life?

- Lack of/inadequate health insurance
- Availability of child care
- Dropping out of school
- Inadequate/unaffordable housing
- Affordability of healthy food choices
- Homelessness
- Lack of culturally appropriate health services
- Mental health issues
- Many health concerns are derived from there being too much excess (food, tobacco, alcohol, etc.)
- Poverty is a major social determinant of health. It impacts nutrition, transportation, access to care and lack of chronic disease management
- West Georgia serves one of the poorest communities in Georgia
- Behavioral health resources in the community are limited
- There is a considerable aging community that needs support for in-home care needs such as baths, medication management and transportation

What else will improve the health and quality of life in your area?

- Meals on Wheels does support many seniors and people who are in need
- Community residents sometimes leverage the 340B Prescription Program
- Identifying key organizations that are assisting seniors in the community
- Education to the public about causes, symptoms, help available and possible solutions
- Better nutrition, exercise and transportation
- Better enforcement and treatment
- An affordable public transportation system
- Try and keep cost down when possible

- Making sure a doctor is involved in all decisions of healthcare. Physician assistants are not doctors and the community is aware of this level of care.
- Funding for the elderly population for prescription drugs, more education to the public about alcoholism/drug abuse
- Rededicating ourselves to providing the best healthcare possible
- Additional funding for free clinics and health department programs
- Programs to address generational poverty

Please list the people or groups of people in your area whose health or quality of life may not be as good as others. Why?

- There is a poverty population and a growing aging population that cannot afford regular healthcare/ prescriptions, so I feel sure their quality of healthcare is less than the majority of people in our area.
- Lower-income citizens have more issues related to a healthy lifestyle due to access to healthcare, transportation issues, etc.
- 30240, 30222 and 30230
- People without insurance are the ones who suffer the most; the high cost of an ER visit outweighs the emergency.

What organizations are best at taking care of the health needs of vulnerable populations? What makes them effective?

- LaGrange College has a robust physical therapy program that could be a great resource for rehabbing patients.
- The local public health department works hard to address the needs of the community and understand its needs.
- The faith community is very connected in this community and an integral part of the community connectivity.
- Troup Cares provides care to those lacking the means to pay for care. A free health clinic with volunteer doctors and others who are committed to serving the community and improving the health of those in our area.
- Circles of Troup County (a poverty initiative of Move the Mountain). Troup Cares (a program to provide healthcare for those working persons who are under-insured).

Key Informant Summary

(August 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 were gathered during individual interviews with nine stakeholders in the communities served by WellStar West Georgia Medical Center. 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 nine stakeholders interviewed, including:

- Troup Cares
- Troup County Schools
- Georgia Department of Public Health – District 4
- Conifer Health Services – West Georgia
- Troup Family Connection Authority
- LaGrange Police Department
- United Way of West Georgia
- Twin Cedars Youth and Family Services Inc.
- Circles of Troup County

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

Improved

- Walking trails (plans to expand) –THREAD
- Variety of healthcare options (also expanding)
- Lots of local resources in LaGrange
- Quality of life improving for residents
- Coweta and Troup counties have seen industrial and economic improvements
- More jobs are offering health insurance

Stayed the same

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

Declined

- Access to behavioral health services

Major Health Challenges:

- Chronic disease
 - Diabetes
 - Obesity
 - Cardiovascular disease
- Undiagnosed or untreated mental health (depression, anxiety, serious mental illness)
- Suicide
- Overutilization of the ER (medical and behavioral health needs)
- Smoking
- Substance abuse and overdose (marijuana, alcohol, methamphetamines, cocaine and opioids)
- STIs (HIV)
- Teen pregnancy
- Undocumented women showing up in labor having received no prenatal care
- Health disparities
- Drug resistance to antibiotics, etc. (STIs and TB)

Context and Drivers:

- Access to care (medical, dental and behavioral)
 - There is a lack of affordable uninsured preventive care available in the area.
 - Medicaid requires reapplication and may lapse if residents do not reapply.
 - Residents do not always have access to dependable transportation to and from medical appointments.
 - There have been cuts to public health funding and reduced services.
 - Adults do not have access to uninsured dental care, which impacts health and quality of life.
- There is limited awareness about what services are available.
- Racial and ethnic challenges
 - Some residents have limited English speaking skills and information is not always offered in a way that is culturally or linguistically relevant.
 - Some communities are segregated and people of color are perceived to have a lower quality of life.
 - African Americans have poor health outcomes.
- Undocumented residents do not have proper documentation to secure medical services.
- Transportation
 - Many residents have limited access to private modes of transportation.
 - There are no public transit systems in the area.
 - Medicaid transportation is not reliable or user friendly.
- Low socioeconomic status
 - Many of the employment opportunities offer low wages and no health benefits.
 - The employment opportunities that are available are not always stable or long-term due to the use of temporary employment agencies at local plants.
 - Residents are likely to lose their jobs if they take off from work.
 - Poverty is high in this area.
 - Cliff effect – after an income threshold is met, families lose benefits (child care, food stamps, health insurance, etc.), which costs more to replace than the income they are making.
- Educational attainment is low due to high dropout rates
 - Health literacy is low
 - Employment skills are poor
- Housing
 - The housing authority has not been able to open their waiting list for applications in more than a year.
 - There is a large homeless population and no homeless shelters for women in the area; the closest is in Atlanta
 - There are families living in extended-stay motels and children do not have stable housing.

- Behavioral health
 - There are not enough providers treating uninsured residents and those that exist do not have capacity to meet the need for behavioral health services.
 - There are no long-term behavioral health services for youths.
 - There is a stigma associated with seeking mental health treatment.
 - There are limited psychiatrists in the area.
- Substance abuse
 - Adolescents have access to illegal substances and peer pressure to use drugs.
- Nutrition
 - There are food deserts in the area with limited access to healthy food.
 - Residents cannot always afford healthy food options.
- Residents are not always making healthy choices when they are available (healthy foods, physical exercise, etc.)
 - Traditional and generational cycles may facilitate unhealthy choices.

Recommended Interventions:

- There should be effort to build trust and heal racial injustices in communities that have experienced historical racism.
- Hospitals could offer more community education and awareness and collaborate with the faith community to reach more community members.
- Restrict the number of fast food restaurants allowed and increase the number of healthy options available (e.g., support farmer's markets, food banks, etc.).
- Offer information about healthy preparation of food.
- Hospitals could change the smoking policies on their campuses by restricting smoking to a confined area that is not next to the front door.
- A health navigator would help with renewals for Medicaid, service linkages, care coordination and system navigation challenges.
- Communities must maintain information dissemination systems outside of technology for those residents who do not have access to a computer or know how to use a computer.
- Schools should incorporate home economics back into the required curriculum.
- Mental health and housing challenges must be addressed before health can improve in the community.
- The community could benefit from a resource list or directory of services available in the area.
- Train medical practitioners about how to administer drugs in a way that avoids resistance.
- Medical practitioners should increase the time spent with and dialogue with patients.
- Increase the amount of affordable dental care available to adults using sliding-scale fees and donated services.
- Offer transportation to medical appointments in communities where the need is high.

Resident Focus Group Summary

(January 2018 – September 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 West Georgia Medical Center.

Methodology

GHPC recruited and conducted four focus groups among residents living in the community served by WellStar West Georgia Medical Center. 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 nine 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 group was conducted by GHPC in October 2018:

■ WellStar West Georgia Medical Center Service Area Residents – LaGrange, GA (September 26, 2018)

Focus groups and a listening session were recorded and transcribed with the informed consent of all participants. GHPC analyzed and summarized data from the focus groups and listening session 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 West Georgia Medical Center Service Area Residents

Venue:

LaGrange Memorial Library
115 Alford St.
LaGrange, GA 30240

Number of Participants:

9

Major Health Challenges:

- Tobacco use/vaping among youth
- Behavioral health issues related to stress
- Substance abuse (alcohol, methamphetamines, opiates, cocaine/crack)
- Cardiovascular disease (high blood pressure, heart attack and stroke)
- Respiratory issues (COPD and asthma)
- Diabetes
- Obesity
- Cancer
- Poor dental health
- Brain injury
- Back issues

Context and Drivers:

- The perception about the local hospital varied based on insurance status. Insured residents felt the service was okay or good and uninsured residents felt they receive poor service, which at times resulted in delayed diagnosis and worsened health. Residents do not trust the ED to diagnose and treat ailments.
- Residents seek emergency care outside of the area (e.g., Newnan, Columbus, Atlanta, Hamilton, etc.).
- Access to care
 - There are limited medical services available for under-insured or uninsured residents.
 - Uninsured care can be unaffordable.
 - Employment status influences residents' access to affordable health insurance options and many employers are not offering full-time jobs with medical benefits.
- Many providers do not accept Medicaid or Marketplace insurances and residents have to seek care outside of the area.
- Many specialty providers will not treat residents without insurance.
- Nutrition
 - Unhealthy options (e.g., fast food) are readily available, and healthy options (e.g., community gardens) are scarce.
 - Many residents are not aware of the options that are available in their communities (e.g., farmer's markets, etc.).
 - Many residents are not aware of how to eat healthy or prepare healthy foods.
 - Many residents do not have the time to shop for or prepare healthy meals due to time spent commuting and working.
- Educational attainment
 - Schools are not teaching health education or physical education anymore.
 - Schools are not requiring students to excel. Children are passing grades without the basic knowledge and skills they should have.
- Children are not healthy today
 - Overexposure to technology (phones, games, TV) and limited physical activity
 - Poor diet
- Employment opportunities are growing, but many residents are also commuting long distances to secure employment.
 - Industrial plants are causing poor health outcomes (respiratory illness).
 - Industrial plant jobs are often temporary employment without benefits.

Recommendations:

- Hospitals could discount self-pay services by at least 10 percent or more.
- Institute a town-centered initiative that promotes fresh fruits and vegetables.
- Support community gardens.

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 zip codes/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 purpose 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 use, drug and alcohol use and 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)

Adult Education, Employment and Training

Adecco Employment Services

100 Longley Place, Suite A
LaGrange, GA 30240
706-884-9110
www.adeccousa.com

Here's the deal: we have connections at some of the best places to work in this town. As one of the leading temp agencies in La Grange, we know who is hiring and the types of workers they need. If you're looking for La Grange jobs – temp jobs, contract jobs, temp-to-hire, or permanent jobs—this is the best place to start.

Just send us an application, check out our La Grange, Georgia jobs below, or get in touch with one of our recruiters today so we can try to find your next job here.

Did you come here looking for staffing services? That's OK. You can also use the branch contact info below to get in touch with us.

Troup County Certified Literate Community Program

1 College Circle
LaGrange, GA 30240
706-756-4645
www.trouplcp.org
debbie.burdette@westgatech.edu

Chartered in 2002, Troup County Certified Literate Community Program (CLCP) promotes community-wide literacy and enhances the quality of literacy in accordance to the guidelines of the State of Georgia. The CLCP encourages a love of reading as a foundation for lifelong learning and supports those programs with similar goals. CLCP promotes literacy awareness and programs to assist students in need of basic literacy education.

Express Employment Professionals – Personnel Services

1 College Circle
LaGrange, GA 30240
706-756-4645
www.trouplcp.org
debbie.burdette@westgatech.edu

Express Employment Professionals is one of the top staffing companies in the U.S. and Canada. Every day, we help people find jobs and provide workforce solutions to businesses. Express provides a full range of employment solutions that include full-time, temporary, and part-time employment in a wide range of positions, including professional, commercial, and administrative.

209 Ridley Avenue, Suite A
LaGrange, GA 30240
706-884-9003
www.expresspros.com

Kelly Services

380 S. Davis Road, Suite B
LaGrange, GA 30241
706-883-7771
<https://kelly-services.jobs/>

Founded by William R. Kelly in 1946, Kelly Services has provided workforce solutions to customers in a variety of industries throughout its history. Our range of workforce solutions and geographic coverage has grown steadily over 70 years to match the needs of our customers. It began with office services, call center, light industrial, and electronic assembly staffing. Today, Kelly expertise also spans an array of outsourcing and consulting solutions, including recruitment, human resource management, vendor management and outplacement services on a global basis.

Literacy Volunteers of America – Troup County

200 Main Street, Suite 201
LaGrange, GA 30240
706-883-7837
<https://www.facebook.com/LiteracyVolunteersofTroupCounty/>

Our approaches to intervention, rehabilitation and prevention work together to ensure that people in crisis don't stay that way. During personal hardships and emergencies, Volunteers of America addresses immediate needs, offers long-term support when necessary and educates with prevention outreach programs.

Adult Education, Employment and Training (continued)

Malone Staffing – LaGrange

1302 Lafayette Parkway, Suite C
LaGrange, GA 30240
706-882-5300

Malone Staffing – West Point
405 West 8th Street
West Point, GA 31833
706-645-1321
www.malonesolutions.com

Malone knows we stand in a privileged position to make positive changes for our clients' businesses and our employees' lives. This knowledge drives our approach to crafting client-tailored flexible workforce solutions.

Manpower

102 Corporate Plaza Drive
LaGrange, GA 30241
706-882-1839
www.manpower.com

Our vision is to lead in the creation and delivery of innovative workforce solutions and services that enable our clients to win in the changing world of work.

People: We care about people and the role of work in their lives. We respect people as individuals, trusting them, supporting them, enabling them to achieve their aims in work and in life. We help people develop their careers through planning, work, coaching and training. We recognize everyone's contribution to our success - our staff, our clients and our candidates. We encourage and reward achievement.

Knowledge: We share our knowledge, our expertise and our resources so that everyone understands what is important now and what is happening next in the world of work – and knows how to respond. We actively listen and act upon this information to improve our relationships, solutions and services. Based on our understanding of the world of work, we actively pursue the development and adoption of the best practices worldwide.

Innovation: We lead in the world of work. We dare to innovate, to pioneer and to evolve. We never accept the status quo. We constantly challenge the norm to find new and better ways of doing things. We thrive on our entrepreneurial spirit and speed of response – taking risks, knowing that we will not always succeed, but never exposing our clients to risk.

MAU Workforce Solutions

201 Calumet Center Rd, Suite D
LaGrange, GA 30241
706-298-4690
Fax: 706-298-4695
www.mau.com/lagrange-ga

Our Mission: To be the leading provider of designed Workforce Solutions recognized for its commitment to:

- Honor God in all we do
- Treat others as we would like to be treated
- Grow profitably to the benefit of all employees
- Further its leadership position in Workforce Solutions
- Continuously improve the quality of our service delivery system
- Provide for and encourage employee growth and development

Core Values

- We live safety
- We provide exceptional customer service
- We conduct ourselves with honesty and integrity at all times and at all costs
- We honor the unique worth of each person and the relationship we develop with them
- We are known for our principles of responsible stewardship
- We empower the development of our people
- We work together as a results oriented team

Adult Education, Employment and Training (continued)

New Ventures

306 Fort Drive
LaGrange, GA 30240
706-882-7723
www.newventures.org

New Ventures, Inc. provides both on-site and off-site production services for several local industries as well as services for the state and federal governments. NVI can produce significant cost savings and other benefits to your business by providing services including, but not limited to, the following:

- Cost Effective Packaging
- Skilled Assembly & Disassembly
- Efficient Collation
- Detailed Inspection
- Trained and Supervised Personnel
- Facilities modified to meet individualized needs of contracts
- Guaranteed Quality

One Smart Cookie

(formerly Troup County Works)
706-298-3639
www.onesmartcookie.jobs

OneSmartCookie.jobs is restricted to local Troup County residents. If you're a resident of Troup County, register for the website to get started. If you've already registered on this site or on TroupCountyWorks.com, your account information is still there – just request a new password. Once you're logged into your job seeker account, you can browse the full description of hundreds of job opportunities, build your online resume and submit applications – all at NO COST to you.

Resource MFG

102 Corporate Plaza Dr.
LaGrange, GA 30240
706-884-9494
www.resourcemfg.com/

Founded by a manufacturing veteran who was frustrated by his experience with the traditional staffing services that didn't understand "his world," ResourceMFG is the first and, with more than 145 locations in 25 states and over 10,000 workers on assignment, the largest national staffing company to specialize in manufacturing. We recruit and screen for more than 200 manufacturing-specific skills and have more than 30 proprietary screening tools.

University of Georgia Troup County Extension

114 Church Street
LaGrange, GA 30240
706-883-1675
extension.uga.edu/county-offices/troup.html

Our mission is to extend lifelong learning to Georgia citizens through unbiased, research-based education in agriculture, the environment, communities, youth and families.

Normal Operating Hours: Monday through Friday: 8:00am - 12:00pm and 1:00pm to 5:00pm. We observe UGA Holidays.

West Central Georgia Workforce Development

(Three Rivers Regional Commission)
1710 Highway 16 West
Griffin, GA 30223
770-229-9799
877-633-9799
www.careerconnections.org/ftf.php

The Three Rivers Regional Commission (TRRC), is a 10-county regional planning commission that includes the West Central Georgia counties of Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup and Upson. As a regional planning commission, TRRC works with local governments in areas such as:

Aging Services – senior centers, adult day care, meals at home and in group settings, caregiver support, transportation, senior job training, health screenings, and more.

Workforce Development – One Stop Career Centers, skills assessments, youth services, veteran services, employer services

Transportation – on demand, low-cost public transit, mobility management, transit planning

Local/Regional Planning – comprehensive plans, transportation plans, land use planning, West Georgia broadband planning, economic development, demographics, historic preservation, revolving loan funds, affordable housing tourism, defense conversion, geographic information systems, disaster mitigation planning, community development, grant writing and administration

Adult Education, Employment and Training (continued)

West Georgia Technical College

1 College Circle
LaGrange, GA 30240
678-821-3800
855-887-9482
www.westgatech.edu/lagrange-campus/Student Success

Our Mission: West Georgia Technical College, a unit of the Technical College System of Georgia, supports student success, economic development and the community by providing a skilled workforce through the delivery of relevant education and training opportunities.

Our Vision: We envision West Georgia Technical College as a model of innovation and excellence in technical education, recognized as an outstanding pathway to rewarding careers.

Our Core Values: Integrity, Professionalism, Academic Excellence

Westaff

104 Church St.
LaGrange, GA 30241
706-882-4952
www.westaff.com

Serving the staffing industry since 1948, Westaff matches talent with opportunity. Whether you're a job seeker looking for work or a business with recruiting needs, we've got you covered.

At Westaff, we understand what it takes to help people get a great job that matches their interests and career goals. We know how to recruit top performers for our clients that will minimize workforce costs and protect their bottom lines. It is through our industry-leading expertise in on-site programs, risk management, human resources, and employment law that we are able to do all of this.

As a leader of staffing services, we provide our clients and associates with the most up-to-date technology and practices. We are the first to offer video resume technology, a service that benefits both our job seekers and clients by allowing a shorter interview process and allowing candidates to stand out among competition.

Behavioral Health/Alcohol and Substance Abuse

Addiction Recovery Services

100 Smith Street, Suite 1
LaGrange, GA 30240
706-594-4735
www.addictionrecoverylagrange.com/

Addiction Recovery Services offers confidential assistance to individuals and families who live in the spiraling downfall that comes from abusing alcohol and other drugs. Thoroughly evaluating and assessing provide insight into what is happening and what strengths are there to stop the frenzy. Individual, group, educational and family counseling are available to assist the individual and family to make changes that are needed.

AFSAN, Inc.

321 Greenville Street
LaGrange, GA 30241
706-884-0987

Afsan Inc. practices at 321 Greenville Street, Lagrange, GA 30241. Marriage and family therapists diagnose and treat mental and emotional issues and concerns within marriages, couples and families.

Family Psychology Associates

516 Ridley Avenue
LaGrange, GA 30240
706-845-1601

Family Psychology Associates offers counseling at 516 Ridley Avenue in Lagrange, GA. Please call Family Psychology Associates at 706-845-1601 to schedule an appointment in Lagrange, GA, and to get more information about the counseling services offered.

Counseling and Psychology Services of LaGrange, Inc.

610 Ridley Avenue
LaGrange, GA 30240
706-884-5050
www.cps-lagrange.com

Counseling and Psychology Services of LaGrange, Inc. is a counseling and psychology clinic serving LaGrange, Troup County, and the surrounding areas in West Georgia and East Alabama. We offer psychotherapy and counseling services, as well as assessment and evaluation services with the goal of helping people to meet, manage, and overcome life's challenges. Some of our specialties include the treatment of depression, anxiety disorders, trauma, substance abuse, grief, and relationship problems. Our counselors and psychologists work in partnership with clients to develop personalized treatment plans designed specifically to meet clients' goals.

Hope Harbor

LaGrange, GA 30240
706-333-0000
hopeharbarga.com

Hope Harbor is a twelve-month, residential, Christian recovery program serving women who struggle with the destructive forces of addiction. Women with addictions face unique challenges. Whether managing a marriage, family, work or home, many seek the chance to change but continue to struggle with drugs and alcohol.

Behavioral Health/Alcohol and Substance Abuse (continued)

Alcoholics Anonymous

Fellowship Group
Self Help Harbor
909 Stonewall Street
LaGrange, GA 30240
706-884-6993

Stonewall Group
Self Help Harbor
909 Stonewall Street
LaGrange, GA 30240
706-884-6993

IMLAC Group
Greenville Baptist Church
1706 Church Street
Greenville, GA 30222

IMLAC Group
Jones Chapel Church
12973 State Route 85
Woodbury, GA 30293

Pine Mountain Group
First Baptist Church
100 McDougald Street
Pine Mountain, GA 31822
www.aageorgia.org/10c-meetings.html

Animus Center for Therapeutic Services
1191 Franklin Parkway
Franklin, GA 30217
706-675-6076
www.facebook.com/AnimusCenter/

Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, multiracial, apolitical and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.

Pathways Center

122 Gordon Commercial Drive, Suite C
LaGrange, GA 30240
706-845-4045
www.pathwayscsb.org

Carroll/Heard County
153 Independence Drive
Carrollton, GA 30116
770-836-6678

Meriwether County
756 Woodbury Road
Greenville, GA 30222
706-672-1118

Troup County
122 Gordon Commercial Drive, Suite C
LaGrange, GA 30240
706-845-4054

Pathways Center takes pride in hiring the best clinicians and direct care providers who truly have a passion for helping people.

We are a team of unique individuals caring deeply about each other and those we serve. Integrity and respect for consumers and co-workers are a key component of our core values. We empower our consumers to take charge of their lives and accomplish their dreams. We work together to spearhead a powerful community partnership to continuously improve health, quality of life, and satisfaction.

Services:

- Outpatient Services
- 24/7 Crisis Residential Services
- Intellectual & Developmental Disabilities Services

Self-Help Harbor

909 Stonewall Street
LaGrange, GA 30240
706-884-6993
www.facebook.com/pages/Self-Help-Harbor/133065916743466

Self-Help Harbor offers Mentoring at 909 Stonewall St Lagrange, GA - Troup County and is a business specialized in Addictions, Substance Abuse, ADC, Alcoholism, Chemical Abuse, Drug & Alcohol Abuse, Substance Abuse Counseling and Chemical Dependency. Self Help Harbor Inc is listed in the categories Outpatient Services, All Other Outpatient Care Centers and Specialty Outpatient Facilities, Nec and offers Information.

Specialties: Addictions, Substance Abuse, ADC, Alcoholism, Chemical Abuse, Drug & Alcohol Abuse, Substance Abuse Counseling, Chemical Dependency

Behavioral Health/Alcohol and Substance Abuse (continued)

WellStar West Georgia Psychiatric Center

104 Harwell Avenue
LaGrange, GA 30240
706-885-0111
Fax 706-885-0607

Kenneth Genova, MD, Psychiatry

Assistance Program Services

Alabama Department of Human Resources

Chambers County Department of Family & Children Services
410 9th Avenue South West
LaFayette, AL 36862
334-864-4000
dhr.alabama.gov/counties/county_results.aspx?id=ChambersChildSupport

Randolph County Department of Family & Children Services
865 Hillcrest Avenue
Wedowee, AL 36278
256-357-3000
dhr.alabama.gov/counties/county_results.aspx?id=Randolph

The Alabama Department of Human Resources will help families receive the least disruptive services they need, when they need them, and for only as long as they need them in order to maintain children in or return them to a safe, stable home.

Services:

- Adult Protective Services
- Child Protective Services
- Food Assistance
- Adoption
- Foster Care
- Family Services
- Family Assistance
- Child Care

Circles of Troup County

Office Parks and Rec Center
1220 Lafayette Parkway
LaGrange, GA 30241
706-883-1687

Thursday Meetings
Troup Baptist Association
1301 Washington Street
LaGrange, GA 30240
706-883-1687
circlesoftroup.org

Circles exists to identify and eliminate the causes of poverty and support those wishing to lift themselves out of poverty. We use a relational strategy to support both parents and children moving out of poverty while inspiring and equipping the community to reduce its poverty rate.

Georgia Food Stamp Program

Supplemental Nutrition Assistance Program (SNAP)
Troup County DFCS Office
1220 Hogansville Road
LaGrange, GA 30241
877-423-4746
dfcs.dhs.georgia.gov/food-stamps

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program (SNAP)), is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. A household may be one (1-person living alone, a family, or several unrelated individuals cohabitating who routinely purchase and prepare meals together.

Heard County Women, Infant and Children Nutrition Center

1191 Franklin Parkway
Franklin, GA 30217
706-298-6080
www.district4health.org/wic/wic-clinic-locations/

The Special Supplement Nutrition Program for Women, Infants, and Children (WIC) provides nutrition education and healthy foods to eligible:

- Pregnant, breastfeeding, and postpartum women
- Infants
- Children under the age of five

Our local nutritionists discuss healthy family habits through individual counseling sessions and group discussion classes. Along with nutrition information, you can receive breastfeeding support, immunization screening, and referrals to other community programs.

Assistance Program Services (continued)

Highland Baptist Church Food Bank

409 Askew Avenue
 Hogansville, GA 30230
 706-637-4217
www.facebook.com/HighlandBaptist/

Hogansville Empty Stocking Fund

Hogansville, GA 30230
 706-882-9291
www.facebook.com/Pilot-Club-of-Hogansville-301761163338655/info/?tab=page_info

Our Mission is to serve by furthering Pilot International's humanitarian efforts through charitable, educational and research programs in communities. Administered by the Hogansville Pilot Club

LaGrange Personal Aid Association

416 Pierce Street
 LaGrange, GA 30240

Mission: We are a non-profit organization, established to provide temporary assistance to residents of the Troup County / West Georgia area during time of distress, illness or disability. Assistance is provided at the time of need, in whatever form is suitable to the client's situation.

Programs:

- Personal aid program
- SHARE & Round-Up Programs
- Charles C. Maddox Veteran's Assistance Program
- Church Benevolence Fund
- Screening Services

Empty Stocking Fund

416 Pierce Street
 LaGrange, GA 30240
 706-882-9291

Interfaith Food Closet

416 Pierce Street
 LaGrange, GA 30240
 706-882-9291

Women, Infant and Children Nutrition Center

Meriwether County
 51 Gay Connector
 Greenville, GA 30222
 706-298-6080

Troup County
 900 Dallis Street
 LaGrange, GA 30240
 706 845-4035
www.district4health.org/wic/wic-clinic-locations/

The Special Supplement Nutrition Program for Women, Infants, and Children (WIC) provides nutrition education and healthy foods to eligible:

- Pregnant, breastfeeding, and postpartum women
- Infants
- Children under the age of five

Our local nutritionists discuss healthy family habits through individual counseling sessions and group discussion classes. Along with nutrition information, you can receive breastfeeding support, immunization screening, and referrals to other community programs.

Assistance Program Services (continued)

<p>Saint Peter's Catholic Church</p> <p>St. Vincent De Paul 200 LaFayette Parkway LaGrange, GA 30240 Contact Person: Mike Hurst (chiefhurst@charter.com) 706-884-0076 www.stpeterslagrange.net</p>	<p>St. Vincent de Paul Society has been a part of St. Peter's for a number of years. They help people not only in our parish, they also help those in most need within our community.</p> <p>If your interested in volunteering for StVdP please contact them through the church office or call the 706-884-0076.</p>
<p>The Salvation Army LaGrange Corps</p> <p>202 Church Street LaGrange, GA 30240 706-845-0197 salvationarmygeorgia.org/lagrange/ Disaster Relief Services</p>	<p>Services offered:</p> <ul style="list-style-type: none"> ■ Utilities Assistance ■ Rent Assistance ■ Clothing & Food Assistance <p>Schedule:</p> <p>Sunday: 9:30am Sunday School, 11:00am Morning Worship Tuesday: 11:00am Women's Ministries (Home League) Wednesday: 7:10am Men's Fellowship Coffee, 12:00pm Adult Bible Study Bring-a-Lunch</p>
<p>Troup County Department of Family & Children Services</p> <p>1220 Hogansville Road LaGrange, GA 30241 770-830-2178 dfcs.georgia.gov/location/troup-county</p>	<p>The Georgia Division of Family and Children Services (DFCS) investigates reports of child abuse; finds foster and adoptive homes for abused and neglected children; issues SNAP, Medicaid, TANF and child care assistance to low-income families; helps out-of-work parents get back on their feet; and provides numerous support services and innovative programs to help families in need.</p>
<p>Unity Baptist Church</p>	<p>Unity Baptist Church has a heart for people...we seek to serve others through outreach and evangelism; for example...our Food Closet Ministry is open to all Troup county residents and our goal is to show God's love through our compassion for those who find themselves in need. We strive to treat everyone who is involved in this ministry with respect, dignity and the love of Jesus Christ.</p>
<p>Food Closet Ministry</p> <p>715 South Greenwood Street LaGrange, GA 30240 706-882-7714 ubclagrange.org</p>	<p>We have a large number of volunteers who assist in this outreach, some donate funds to purchase food, others visit and shop at the local food bank. Some help shelve the food closet items; other help to pack boxes. Still others show up every month with kind, loving hearts, helping hands and hugs!</p>
<h2>Assisted Living/Personal Care Facilities</h2>	
<p>Elvonia Personal Care Home</p> <p>5365 Whitesville Road West Point, GA 31833 706-882-1183</p>	<p>Elvonia Personal Care blesses seniors with a wonderful lifestyle that has a strong emphasis on style. Our affectionate caregivers encourage residents to pursue their favorite interests, embark on new endeavors, and indulge in their passions in a favorable and friendly group home setting. Health professionals are always awake round the clock in order to address any issue that might arise either at night or during the day.</p>
<p>Hollis House</p> <p>407 Boulevard LaGrange, GA 30240 706-882-2241</p>	<p>Hollis House is located in Lagrange at 407 Boulevard and classified as a Assisted Living facility. Hollis House provides Assisted Living services for each of its residents and if needed, assists them with bathing, grooming, meal preparation, dressing and much more. Hollis House aims to provide a safe, nurturing and caring environment to its residents in a facility-style setting that is similar to being in the comfort of their own home.</p>

Assisted Living/Personal Care Facilities (continued)

Bright Way Personal Care Home

8984 Hamilton Road
Pine Mountain, GA 31822
706-489-3038

Settle into Bright Way and relish a comfortable life, where residents can trade anecdotes and forge new alliances. You'll find a comprehensive assisted living services and a hospitable place. Supplying assistance with everyday activities, along with health services, nutritious meals, and a range of other conveniences, assisted living allows seniors to thrive. Why choose assisted living? Studies reveal that living near peers and participating in social activities leads to a happier life. Assisted living offers senior-friendly residences and a warm staff. Communities have additional services that include 24-hour supervision and security, emergency response systems, access to licensed nursing care, chef-prepared meals, and assistance with grooming, dressing, and bathing. Laundry, housekeeping, social programs, and local transportation are typically provided as well. Bright Way helps seniors find the worry-free lifestyle they want. In this community, residents have complete assisted living services, as well as a hospitable environment. Within assisted living communities, you'll find help as you need it, with the goal of giving the aid required to stay as autonomous as possible. Call today and discover how Bright Way is the perfect fit for seniors requiring assisted living services.

Juniper Street Personal Care Home

1313 Juniper Street
LaGrange, GA 30240
706-884-7880

Juniper Street Personal Care Home is located in Lagrange at 1313 Juniper Street and classified as a Assisted Living facility. Juniper Street Personal Care Home provides Assisted Living services for each of its residents and if needed, assists them with bathing, grooming, meal preparation, dressing and much more. Juniper Street Personal Care Home aims to provide a safe, nurturing and caring environment to its residents in a facility-style setting that is similar to being in the comfort of their own home.

Vernon Woods Retirement Community

101 Vernon Woods Drive
LaGrange, GA 30240
706-250-7739
www.vernonwoods.com/living-options#assisted-living

Enrich everyday experiences and receive care that stands out from the rest at Vernon Woods Retirement Community. In our assisted living lifestyle, residents enjoy the comforts of a place to call their very own while getting the personalized assistance they need throughout their daily routines. From planned activities to social events, assisted living residents participate in fulfilling experiences throughout the day and have 24/7 help at their fingertips.

TLC Personal Home Care

2861 Greenville Road
LaGrange, GA 30241
706-885-0210

TLC enriches your life with the very best in assisted living through a caring community. Assisted living is a good solution for seniors who require a little help but desire to preserve their self-reliance. What are a few of the benefits of assisted living? Studies reveal that living near peers and participating in social activities leads to a more fulfilling life. With assisted living, you'll find senior-friendly living options and a dedicated staff. Communities have additional services that include 24-hour supervision and security, emergency response systems, access to licensed nursing care, chef-prepared meals, and assistance with grooming, dressing, and bathing. Housekeeping, laundry, social programs, and local transportation are usually provided, too. TLC provides a low-maintenance lifestyle and the assistance seniors need to enjoy retirement. With comprehensive assisted living services, and with a caring environment, seniors can feel relaxed and secure. An assisted living community provides help when necessary with the goal of giving the services required to stay as autonomous as possible. Call for more information on how you can become part of the TLC community.

Opal's Personal Care Home

100 Oakridge Drive
LaGrange, GA 30240
706-882-1081

Matrel's Personal Care Home

1008 East 12th Street
West Point, GA 31833
706-645-5591

Assisted Living/Personal Care Facilities (continued)

Poplar Creek Senior Home

114 Old Airport Road
LaGrange, GA 30240
706-845-1500
poplarcreekseniorcare.com

Our mission is to provide warm, personalized care that focuses on the individual's well-being and safety, enhances their independence, and promotes dignity and quality of life. We seek to make a positive impact every day for seniors in our community. We live our core values and communicate them simply as CARE – Compassion, Attitude, Respect and Ethics.

Assistive Technology

Georgia Tech Center for Assistive Technology and Environmental Access (CATEA)

512 Means Street NW, Suite 300
Atlanta, GA 30318
404-894-4960
Fax: 404-894-9320
www.catea.gatech.edu

CATEA, the Center for Assistive Technology and Environmental Access, is a multidisciplinary research center devoted to enhancing the lives of people with all levels of ability. Rather than focusing on disability, seeing people as "disabled," we believe that the limitations of current technologies and the design of the built environment account for an individual's inability to perform activities and participate in society. We seek to minimize those limitations through applied research and the development of assistive and universally designed technologies.

Georgia Department of Education (GPAT)

Georgia Project for Assistive Technology
470-218-1382
www.gpat.org/Georgia-Project-for-Assistive-Technology/Pages/default.aspx

The mission of GPAT is to improve student achievement, productivity, independence and inclusion by enhancing educator knowledge of assistive technology and increasing student access to appropriate assistive technology devices and services.

Blood Donations

American Red Cross of Central Midwest Georgia

900 Dallis Street, Suite C
LaGrange, GA 30240
706-884-5818
www.redcross.org/local/georgia/locations/central-midwest

Originally chartered in 1917 as the Troup County Chapter, we have grown to serve 20 counties with a population of approximately 500,000 people. These 20 counties include: Baldwin, Bibb, Butts, Carroll, Coweta, Haralson, Heard, Houston, Jasper, Jones, Lamar, Meriwether, Monroe, Pike, Putnam, Spalding, Troup, Twiggs, Upson, Wilkinson.

Today the American Red Cross of Central Midwest Georgia is hard at work in our community on a daily basis bringing help and hope to neighbors in need. With the same passion and commitment as our volunteer founders, we're empowering a new generation to prevent, prepare for and cope with emergencies that devastate homes, threaten lives and separate loved ones.

LifeSouth Community Blood Center, Inc.

505 East Thomason Circle
Opelika, AL 36801
(334-705-0884
www.lifesouth.org

Our Mission: To provide a safe blood supply that meets or exceeds the needs in each community we serve, and to provide a variety of services in support of ongoing and emerging blood and transfusion-related activities.

Breastfeeding

WellStar West Georgia Medical Center – Lactation Services

1420 Vernon Road
LaGrange, GA 30240
706-880-7416
www.wghealth.org/our-services/maternity-services/lactation-services/

At WellStar West Georgia Medical Center, we believe breastfeeding your baby is your healthiest choice – that's why we offer breastfeeding classes and support for mothers before and after birth. Our Breastfeeding Basics class and breastfeeding support group are offered by international board-certified lactation consultants. Our consultants are also available for one-on-one consultations during your hospital stay or after discharge.

Breastfeeding (continued)

District 4 Public Health

WIC Peer Counselors
301 Main Street
LaGrange, GA 30240
706-298-6080 or 866-636-7942
www.district4health.org/breastfeeding-peer-counselors/

A peer counselor is a WIC mother just like you. She lives in your community and has breastfed her own baby. She has been carefully selected by WIC to help give new mothers information about feeding their babies. She is here to give you support to meet your own goals for feeding your baby.

- Tips for how to breastfeed comfortably and discreetly, even in public
- Ways you can stay close to your baby through breastfeeding after you return to work or school
- Ideas for getting support from your family and friends; Ways to get a good start with breastfeeding; Secrets for making plenty of breast milk for your baby; and
- Help with breastfeeding concerns.

Some of the popular topics we discuss are:

- Why WIC promotes breastfeeding as the healthiest way to feed a baby.
- The differences between breast milk and formula.
- The health benefits of breastfeeding for mothers/babies.
- What to expect the first few days of your baby's life.
- How to know whether your baby is eating enough.
- How to handle common feeding difficulties.
- How dads can be involved in the infant feeding process.
- The WIC food packages available (including the type of formula provided).

Feeding Your Infant FYI Discussion Groups WIC Program

301 Main Street
LaGrange, GA 30240
706-298-6080 or 866-636-7942
www.district4health.org/wic/feeding-your-infant-discussion-groups/

La Leche League

101 Walt Banks Road
Holy Trinity Catholic Church
Peachtree City, GA 30269
866-636-7942
www.llofga.org

La Leche League is an international, non-profit, non-sectarian organization dedicated to providing education, information, mother-to-mother support, and encouragement to women who want to breastfeed.

Cancer Support Services

All Cancer Angels

Wanda Belt
706-505-7601
www.chwg.org/index.php/cancer-resource-guide/support-groups.html

This support group is open to all cancer patients, survivors, and their family in all surrounding areas of Georgia and Alabama.

American Cancer Society

250 Williams Street NW
Atlanta, GA 30303
404-315-1123
www.cancer.org/index

Our Mission: See how, locally and internationally, the American Cancer Society strives to live by a clearly defined set of goals and ideals.

Our Core Values: We use these values as a light to guide our way through our decision making and planning.

Breast Friends For Life Women's Health Center

1420 Vernon Road
LaGrange, GA 30240
706-812-2191

Cancer Support Services (continued)

Curvy Yoga Women's Health Center

1420 Vernon Road
LaGrange, GA 30240
706-812-2191

Curvy Yoga uses movements, stretches and motions to meet the needs of people of all sizes and abilities. The therapy program is available for free to those diagnosed with cancer or for caregivers caring for someone with cancer.

WellStar West Georgia Medical Center (Enoch Callaway Cancer Center-Road to Recovery

111 Medical Drive
LaGrange, GA 30240
706-812-2191
www.wghealth.org/our-services/cancer-clinic/complementary-care/

Another program of the American Cancer Society, Road to Recovery provides patient transportation to and from their scheduled medical appointments using trained volunteers. Referrals are normally made by WellStar WGMC's cancer care navigator to the ACS coordinator, who then contacts volunteers to arrange transportation. Drivers donate their personal time and the use of their personal vehicles to help ensure patients receive the treatments they need.

Look Good – Feel Better: This is a free program that teaches beauty techniques to female cancer patients in active treatment to help them feel better about their appearance during chemotherapy and radiation treatments. LGFB is held the fourth Thursday of the month in the Enoch Callaway Cancer Center. Pat Waugh, a Twin Fountains Home beautician and licensed cosmetologist, received LGFB training by the American Cancer Society several years ago and has been an integral part of this program.

Reach to Recovery: This program provides information and support to anyone facing breast cancer through one-on-one contact with American Cancer Society volunteers. Reach to Recovery volunteers are people who have survived breast cancer and continue to live productive lives. Whenever possible, the program matches the person with a volunteer who is similar in age and who has had a similar breast cancer experience.

Nutrition Therapy: Nutrition and diet play an important role in maintaining health and fighting disease, and recent WellStar West Georgia Medical Center cancer patient and survivor surveys show nutrition is their No. 1 concern. Cancer treatments, such as radiation and chemotherapy, can affect your body's ability to tolerate certain foods. Knowing how to make healthy food choices can make you feel better. For some, it takes extra support to thrive after a cancer diagnosis, and that's why WellStar West Georgia Medical Center's Oncology Services partners with WGMC's Food and Nutrition Services to offer a complementary nutrition therapy class to help you focus on healing beyond medical treatment.

Art Therapy: For some, the healing process after a cancer diagnosis can be more than just physical. Art Therapy, a program offered at the Enoch Callaway Cancer Center at WellStar West Georgia Medical Center, is changing the way patients see therapy and their road to recovery. Studies have found that art therapies are beneficial for the cognitive and emotional state and also can help reduce pain, nausea and anxiety for the cancer patient. The Cancer Center's art therapy program promotes the mind-body connection and encourages patients to engage in creative expression through various art techniques.

West Central Georgia Cancer Coalition (WCGCC)

633 19th Street, #B
Columbus, GA 31901
706-660-0317
wcgcc.org

Staying to true to our vision and mission, The WCGCC set the following goals:

- Improve access to quality care of all Georgians with cancer
- Save more lives in the future
- Train future cancer researchers and caregivers
- Realize economic benefits from eradicating cancer

Cancer Support Services (continued)

West Georgia Cancer Support Group of LaGrange

ECCC Auditorium - Free
1514 Vernon Road
LaGrange, GA 30240
706-812-2191
www.wghealth.org/resources/support-groups/west-georgia-cancer-support-group-of-lagrange

West Georgia Health offers a monthly cancer support and awareness group that provides support/education and information on outreach/awareness activities for our community. The group is held at 7 p.m. on the last Monday of each month except for April, May, November and December.

Case Management

Counseling and Psychology Services of LaGrange, Inc.

610 Ridley Avenue
LaGrange, GA 30240
706-884-5050
www.cps-lagrange.com

Counseling and Psychology Services of LaGrange, Inc. is a counseling and psychology clinic serving LaGrange, Troup County, and the surrounding areas in West Georgia and East Alabama. We offer psychotherapy and counseling services, as well as assessment and evaluation services with the goal of helping people to meet, manage, and overcome life's challenges. Some of our specialties include the treatment of depression, anxiety disorders, trauma, substance abuse, grief, and relationship problems. Our counselors and psychologists work in partnership with clients to develop personalized treatment plans designed specifically to meet clients' goals.

Department of Behavioral Health and Developmental Disabilities

122 Gordon Commercial Drive, Suite C
LaGrange, GA 30240
706-845-4045
www.dbhdd.georgia.gov/community-service-boards-wcgrh

Vision: Easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Mission: Leading an accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic health care environment.

Department of Family and Children Services – Troup County

1220 Hogansville Road
LaGrange, GA 30241
706-298-7100
www.compass.ga.gov
dfcs.georgia.gov/location/troup-county

Mission: We prioritize the safety of Georgia's children in the decisions we make and the actions we take. We partner with families on their path to independence and build stronger communities with caring, effective and responsive service.

Vision: Safe children. Strengthened families. Stronger Georgia.

Harmony House

P.O. Box 2925
LaGrange, GA 3024
24 Hour Crisis Line: 706-885-1525
Shelter Admin Line: 706-885-1526
Admin Office: 706-882-4173
www.harmonyhousega.org
breakthecycle@harmonyhousega.org

Our Mission: Our mission at Harmony House is to provide emergency shelter, crisis intervention, education and advocacy for adults and children who are victims of domestic violence. We raise awareness in the community through education and advocacy for victims of domestic violence. We provide assistance through personal education and training to help our clients break the cycle of domestic violence and regain control of their lives.

Troup County, Georgia – Mental Health Court

100 Ridley Avenue
LaGrange, GA 30240
Coordinator: Tiffany Hutchinson
706-298-3613
www.troupcountyga.org/accountability_courts.html#d

The mission of the Troup County Adult Mental Health Court is to promote a safer community by identifying offenders who are suffering from mental illness and to help them successfully complete a judicially-supervised treatment program. The goal of Mental Health Court is to help the offenders address and treat their mental illness, which results in an improved quality of life for both the offenders and their families. Treatment also results in a reduction in crime, incarcerations, and hospitalizations.

Troup Cares

301 Medical Drive, Suite 501
LaGrange, GA 30240
706-882-1191
www.troupcares.org

Mission Statement: Troup Cares exists to identify opportunities, seek solutions, and organize community resources to improve access to health services resulting in a healthier and more economically viable Troup County.

Case Management (continued)

Pathways Center

122 Gordon Commercial Drive
Suite C
LaGrange, GA 30240
706-845-4045
www.pathwayscsb.org

Pathways Center takes pride in hiring the best clinicians and direct care providers who truly have a passion for helping people.

We are a team of unique individuals caring deeply about each other and those we serve. Integrity and respect for consumers and co-workers are a key component of our core values. We empower our consumers to take charge of their lives and accomplish their dreams. We work together to spearhead a powerful community partnership to continuously improve health, quality of life, and satisfaction.

Services:

- Outpatient Services
- 24/7 Crisis Residential Services
- Intellectual & Developmental Disabilities Services

LaGrange Personal Aid Mission

416 Pierce Street
LaGrange, GA 30240
706-882-9291
www.lpaa.org

We are a non-profit organization, established to provide temporary assistance to residents of the Troup County / West Georgia area during time of distress, illness or disability. Assistance is provided at the time of need, in whatever form is suitable to the client's situation.

Programs:

- Personal aid program
- SHARE & Round-Up Programs
- Interfaith Food Closet
- Charles C. Maddox Veteran's Assistance Program
- Church Benevolence Fund
- Screening Services

Health Departments

Troup County Health Department

900 Dallis Street
LaGrange, GA 30240
706-845-4085
www.troupchealth.org

Meriwether County Health Dept.
Greenville Clinic and Environmental
Health

51 Gay Connector
Greenville, GA 30222
706-672-4974
Fax: 706-672-1065

Coweta County Health Dept.
70 Hospital Rd.
Newnan, GA 30263
770-254-7400
Fax: 770-254-7411

Harris County Health Dept.
210 Forest Hill Drive
P.O. Box 265
Hamilton, GA 31811

Contact Health Department:
Holly Elder, On-Site Manager
706-628-5780

This state agency, under the direction of the local Board of Health, determines the county's health needs and develops programs to meet those needs. This agency administers numerous community health related programs such as children and adult immunizations, hearing, vision, and dental screenings, STD screenings and treatment, TB detection and treatment, tobacco use prevention, teen clinic, women's health programs, emergency preparedness, WIC program, and maintains vital records including birth and death certificates. In addition, this agency has an environmental health unit that reviews plans and inspects tourist accommodations, inspects cleanliness of restaurants, inspects public swimming pools, evaluates and protects private water wells, issues septic tank permits, performs rabies control activities, investigates health and disease related issues, and performs various public education activities. The county provides this agency with a county-owned building and an annual supplement.

Access To Care (FQHCs, Safety-Net Clinics)

YourTown Health Dental

51 Gay Connector
Greenville, GA, 30222-3339
706-672-2041

YourTown Health
3939 White House Pkwy
Warm Springs, GA, 31830-2455
404-929-8824

YourTown Health - Senoia
Operated by Palmetto Health
Council, Inc
48 Main St Ste 3A
Senoia, GA, 30276-1895
678-723-0400

YourTown Health's network of seven non-profit Community Health Centers serves the communities of Meriwether, Pike, Lamar, Carroll, Coweta, and South Fulton counties.

Our Community Health Centers are unique in that they are located in areas facing limited access to affordable, quality healthcare and have a large number of citizens who are uninsured or underinsured.

As such, our mission is to provide comprehensive preventative, curative, and life-enhancing services in a non-judgmental and compassionate environment. Our doctors, physician assistants, nurse practitioners, and support staff are able to provide you and your family with quality, comprehensive medical care every step of the way. We offer pediatric and adolescent care, family practice and internal medicine, obstetrics and gynecology, dentistry, and pharmacy services. Our Community Medical Centers also provide immunizations, diagnostic testing and laboratory services, school and work physicals, and referrals to qualified specialists.

Smoking Cessation

Georgia Department of Public Health

English: 1-877-270-STOP (877-270-7867-

Spanish: 1-877-2NO-FUMEHearing Impaired: 1-877-777-6534
dph.georgia.gov/ready-quit

Which services are provided by the Georgia Tobacco Quit Line?

- Confidential, professional tobacco cessation telephone & web-based counseling to Georgia tobacco users aged 13 years and older
- 5-call program available to all Georgians
- 10-call specialty program available to pregnant and postpartum women
- Cessation services that address the use of all tobacco products, including smokeless tobacco products.
- Qualified interpreters work with specialists to accommodate callers who speak different languages.
- Referral to community resources
- While supplies last, receive a free, 4-week supply of Nicotine Replacement Therapies (NRTs) gum or patch-available to Georgia adults aged 18 years and older.
- While supplies last, receive a free, 4-week supply of NRTs (gum or patch-for Medicaid recipients aged 18 years and older.

Healthy Eating

Healthy Troup

www.healthytroupe.org/get-care/troupe-cares/

The Healthy Troup initiative is built around the concept that residents of Troup County, LaGrange, West Point and Hogansville can work together to provide and promote healthy choices and support the pursuit of healthy lifestyles.

Troup County Health Department

900 Dallis Street
LaGrange, GA 30240
706-845-4085
www.troupecohealth.org

Meriwether County Health Dept.
Greenville Clinic and Environmental Health

51 Gay Connector
Greenville, GA 30222
706-672-4974
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Resource Assistance

Coweta County Family Connection

coweta.gafcp.org

The Coweta County Family Connection (CCFC) Collaborative vision is to ensure all individuals and families of Coweta County become stable and self-sufficient. CCFC's mission is to provide a networking opportunity for all community partners to connect resources and services for Coweta County. CCFC partners include public agencies, nonprofits, civic and faith-based organizations, business partners, local government, family, youth, and consumers.

Implementation Plan



Building a Culture of Health

This Implementation Plan for WellStar West Georgia Medical Center 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 2019 WellStar West Georgia Medical Center Community Health Needs Assessment (CHNA), priority health needs were identified at a Community Health Summit. This Summit was comprised of a broad spectrum of hospital leaders and community stakeholders. Using current assets/capacity 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

The WCHC is now expanded to encompass all WellStar hospital communities/strategic markets after the April 2016 acquisition of six hospitals in Georgia, five of whom were converted to not-for-profit in 2017, including WellStar West Georgia Medical Center. 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 the WellStar West Georgia Medical Center 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 West Georgia Medical Center serves:



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

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar West Georgia Medical Center play a vital role⁴:

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>

The scope of WellStar’s healthcare footprint and its commitment to its mission makes WellStar West Georgia Medical Center 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.

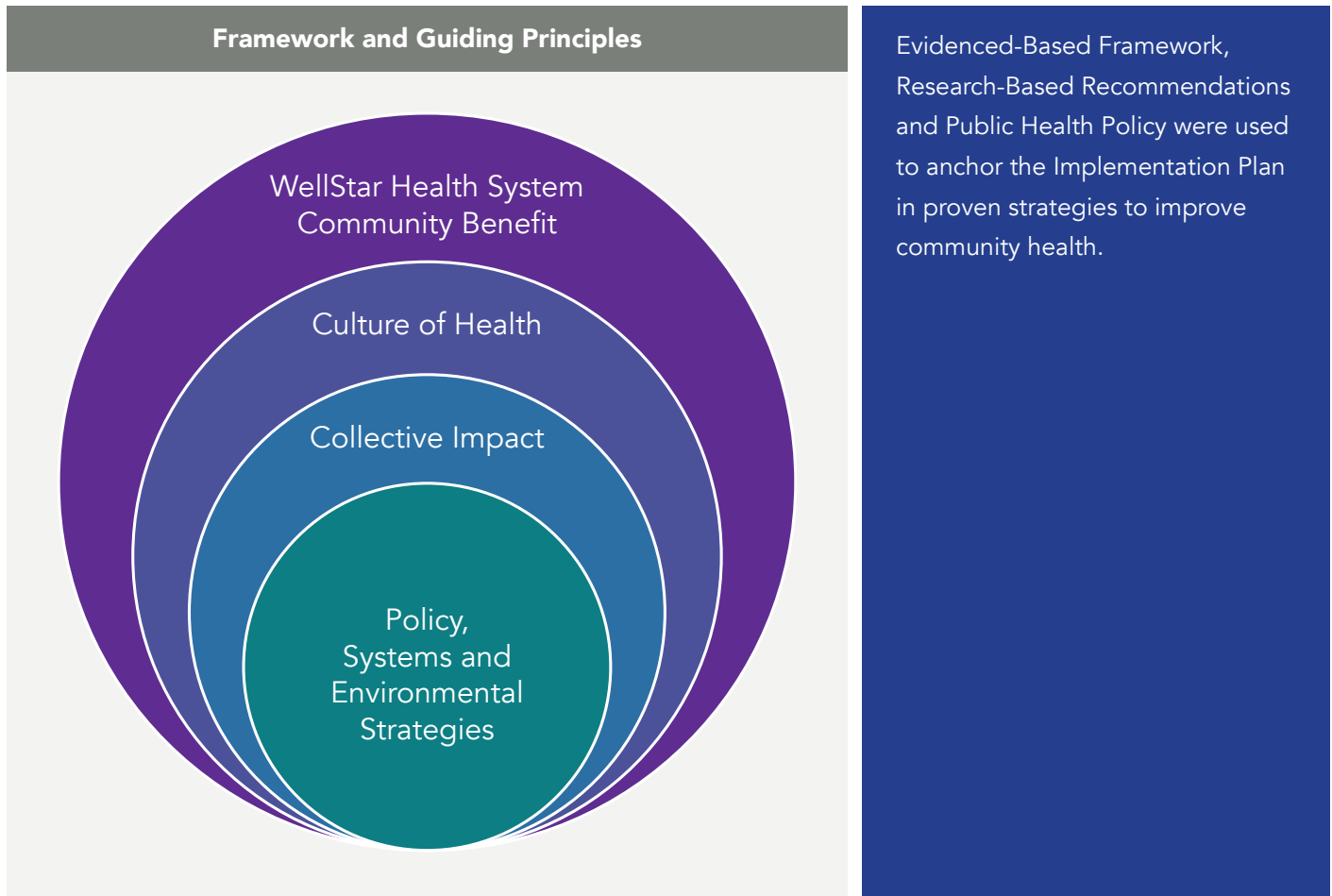
Health Needs Addressed

	 Access to appropriate care	 Education and health literacy	 Healthy lifestyles <i>Diet, nutrition and smoking</i>	 Poverty	 Behavioral healthcare
Cancer Prevention and Screening					
Community Education & Outreach					
Community Transformation Grants					
Public Health Policy and Advocacy					
Screening for Food Insecurity					
The Health of All Women					
WellStar 4-1 Care					
WellStar Day of Service					
WellStar Opioid Steering Committee					
WellStar Research Institute					
Zero Suicide Initiative					

Implementation Plan Framework and Guiding Principles

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

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



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.^{5,6}

5 <https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html>

6 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.⁷

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 West Georgia Medical Center – 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.

⁷ 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.⁸

8 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.⁹

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 communities that WellStar West Georgia Medical Center 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 West Georgia Medical Center is dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework, the implementation plan focuses on two key areas.

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

⁸ Centers for Disease Control and Prevention. (2011). Policy, Systems and Environmental Change. Retrieved from <http://www.cdc.gov/communitiesputtingpreventiontowork/policy/index.htm#strategies>.

Community-Driven Solutions

Sustainable Infrastructure



Community Education & Outreach



Moving Upstream:
WellStar Community Transformation
Grants and Day of Service



Screening for
Food Insecurity



WellStar 4-1 Care



WellStar Opioid
Steering Committee



Hospital's Roles and
Responsibilities



Zero Suicide
Initiative



The Health of
All Women



Public Health Policy
and Advocacy



Cancer Prevention
and Screening



WellStar Research
Institute

Community 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

Screenings and Prevention	WellStar Screening and Prevention Program provides health education, screening and clinical preventive care services 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.

Community Outreach

Community Events	WellStar Health System participates in a wide variety of community events throughout the year, including health fairs, expos, road races, festivals, farmers' markets, community walks, congregation events/health fairs and special signature events.
Community Partnerships	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:¹⁰

- 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:¹¹

- 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.

¹⁰ Place-Based Investing: Creating Sustainable Returns and Strong Communities Toolkit. Retrieved from <https://hospitaltoolkits.org/investment/>

¹¹ 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.^{12, 13}

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

12 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>

13 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."¹⁴ 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.^{15, 16}

- 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.

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

15 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>

16 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.¹⁷ 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.¹⁸ If treatment is needed, dialectical behavior therapy has shown to decrease treatment attrition, suicide attempts, hospitalization and treatment received from the ED.¹⁹ 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.²⁰

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.

- 17 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.
- 18 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
- 19 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
- 20 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.²¹ 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.²²

21 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.

22 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.²³

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

23 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.^{24, 25} 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:²⁶

- 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:²⁷

- 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

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

25 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>

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

27 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.^{25, 28, 29, 30}

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

28 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>

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

30 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.³¹ There is evidence that efforts to increase access to healthy nutrition in communities has:³²

- 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.^{31, 32}

31 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

32 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.³³ 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:^{34, 35, 36}

- 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

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

34 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

35 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

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

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 community-based preventive education and screenings.

To accomplish this, WellStar West Georgia Medical Center 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:³⁷

- 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 West Georgia Medical Center's commitment to improve overall community health?
- Implement improved financial assistance, billing and collection policies that protect patients and reduce the number of patients relying on charity care?
- Collaborate with multi-sector community partners to relieve or reduce the burden of government?

Next Steps³⁸

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

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

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



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