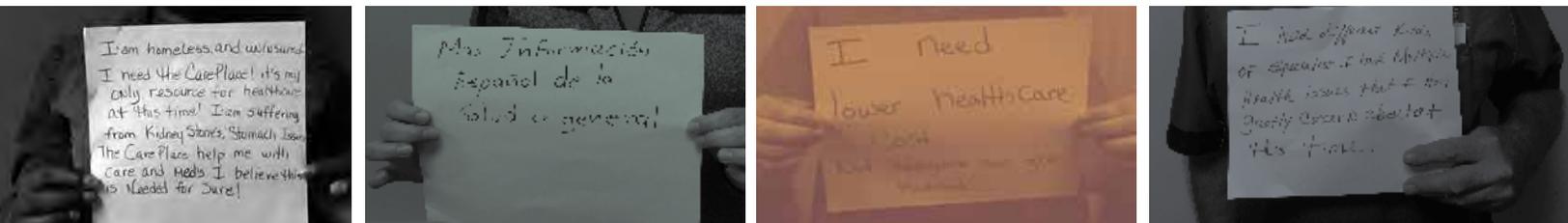




# Your HEALTH. Our MISSION.



# 2016

## Community Health Needs Assessment (CHNA)

**WellStar Cobb Hospital**  
Austell, GA

**WellStar Douglas Hospital**  
Douglasville, GA

**WellStar Kennestone Hospital**  
Marietta, GA

**WellStar Paulding Hospital**  
Hiram, GA

**WellStar Windy Hill Hospital**  
Marietta, GA

Cobb Hospital, Inc.  
EIN#: 58-0968382  
3950 Austell Road SW  
Austell, GA 30106

Douglas Hospital, Inc.  
EIN#: 58-2026750  
8954 Hospital Drive  
Douglasville, GA 30134

Kennestone Hospital, Inc.  
EIN#: 58-2032904  
677 Church Street  
Marietta, GA 30060

Paulding Medical Center, Inc.  
EIN#: 58-2095884  
2518 Jimmy Lee Smith Pkwy.  
Hiram, GA 30141

Kennestone Hospital, Inc.  
EIN#: 58-2032904  
677 Church Street  
Marietta, GA 30060

This report serves to identify and assess the health needs of the community served by WellStar Health System and its five not-for-profit hospitals. Submitted in fiscal year ended June 30, 2016 to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in Code section 501(c)(3).

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Website CHNA report is publicly available: [www.wellstar.org/chna2016](http://www.wellstar.org/chna2016)

Date CHNA adopted by WellStar Board of Trustees: **June 2, 2016**

Date CHNA report made publicly available: **June 30, 2016**

Date CHNA report required to be made publicly available  
(per Notice 2011-52): **June 30, 2016**

Community input is encouraged.

Please address CHNA feedback to [chna@wellstar.org](mailto:chna@wellstar.org).

---

## CHNA Executive Leadership:

### **Kim Menefee**

*Senior Vice President, Strategic Community Development  
Chair, WellStar Community Health Collaborative Task Force and Oversight Committee*

## WellStar Community Health Collaborative Task Force:

### **Vickie Beckler BSN, RN**

*Program Coordinator, Lung Cancer Screening*

### **Brenda Brown BSN, RN**

*Director, WellStar Diabetes Services*

### **Ryan E. Breshears, Ph.D., LP**

*Chief Behavioral Health Officer, Clinical Psychologist*

### **Kristin Caudell**

*Director, WellStar Community Education & Outreach*

### **Darold Etheridge**

*Vice President, Finance and Chief Financial Officer,  
WellStar Cobb Hospital, Hospital Community Benefit Liaison*

### **Steven Fraime, BSN, M.B.A., M.H.A.**

*Director, WellStar Center for Health Transformation*

### **Christopher “Shane” Greene**

*Chief Financial Officer, WellStar Douglas Hospital  
Hospital Community Benefit Liaison*

### **Kristyn Greifer, M.D.**

*Vice President, Population Health Management*

### **Cindy Holcomb, BSN, RN**

*Heart Failure Program Manager*

### **Meridith Kelly**

*Consultant, HighLand Productions, Inc.*

### **Janet Memark M.D., M.P.H., F.A.C.P.**

*Medical Director, WellStar Kennestone Clinic  
Associate Program Director, WellStar Kennestone Hospital  
Internal Medicine Residency Program*

### **Kim Menefee**

*Senior Vice President, Strategic Community  
Development*

### **Elaine Morgan**

*Director, Brand Development and Marketing*

### **Carol O’Connell**

*Assistant Vice President, Long Term Care and  
Support Services, WellStar Paulding Hospital*

### **Renee Owen, M.Div.**

*Director of Pastoral Care, WellStar Kennestone Hospital  
Hospital Community Benefit Liaison*

### **Chirag Patel, M.D.**

*Medical Director, Population Health*

### **Cecelia Patellis**

*Assistant Vice President, Community Education & Outreach*

### **Tyler Pearson**

*Director of Public Relations*

### **Lindsay Rehn, M.B.A.**

*Executive Director of Finance and Operations,  
WellStar Paulding Hospital and Nursing Facility  
Hospital Community Benefit Liaison*

### **Kathy Sitten, RN**

*Manager, Care Coordination, WellStar Kennestone Hospital*

### **Kamela Sooknanan**

*Assistant Vice President, Population Health Management*

### **Julie Stebbins, M.S.**

*Director, WellStar Cardiac Wellness & Rehabilitation*

### **Jeffrey L. Tharp, M.D., M.P.H.**

*Chairman, Board Safety & Quality Committee Chief, Medicine  
Service Line, WellStar East Paulding Primary Care Center*

### **Mary Weatherby, LMSW**

*Supervisor, Care Coordination, WellStar Kennestone Hospital*

### **D. Leigh Webb, M.P.H., CTR**

*Manager, WellStar Cancer Data Center*

## Community Partner Representatives:

### **Belisa Urbina**

*Executive Director, Ser Familia*

### **Kacie McDonnell, M.P.A.**

*Director of Stewardship, Good Samaritan Health  
Center of Cobb*

### **Chris Fields**

*Senior Vice President, Programs and Administration,  
MUST Ministries*

### **Frank Smith**

*Director, The CarePlace*

### **Sandy Ingram, RN**

*Practice Manager, Bethesda Community Clinic*

## WellStar Community Benefit Oversight Committee

**Candice Saunders**, *President & CEO*

**David Anderson**, *Executive Vice President, Human Resources, Organizational Learning and Chief Compliance Officer*

**Stephen Badger**, *Chief Administrative Officer, WellStar Medical Group*

**John Brennan, M.D.**, *Executive Vice President, Chief Clinical Integration Officer*

**Jim Budzinski**, *Executive Vice President and Chief Financial Officer*

**Val Akopov, M.D.**, *Senior Vice President, Hospital Division and Co-President of WellStar Medical Group*

**Joe Brywczyński**, *Senior Vice President, Health Parks Development and Administration*

**Amy Carrier**, *Senior Vice President and WellStar Cobb and Windy Hill Hospital President*

**Jill Case-Wirth**, *Senior Vice President, Nursing Services, Chief Nursing Executive*

**Barbara Corey**, *Senior Vice President, Managed Care*

**Kristyn Greifer, M.D.**, *Vice President, Population Health Management*

**Mark Haney**, *Senior Vice President and WellStar Paulding Hospital President*

**Kim Menefee**, *Senior Vice President, Strategic Community Development*

**Kem Mullins**, *Executive Vice President, Ambulatory and Business Development*

**Jon Morris, M.D.**, *Senior Vice President, Chief Information Officer*

**Alan Muster, M.D.**, *Senior Vice President, Specialty Division and Co-President of WellStar Medical Group*

**Craig Owens**, *Senior Vice President and WellStar Douglas Hospital President*

**Carrie Plietz**, *Executive Vice President and Chief Operating Officer, Hospital Division*

**Leo Reichert**, *Executive Vice President and General Counsel*

**Dan Woods**, *Senior Vice President and WellStar Kennestone Hospital President*

<b>Executive Summary   Community is CARE</b>	<b>6</b>
Community Benefit Defined	
Triple Aim Framework	
Research Methods and Process	
Key Findings and Themes	
Priority Health Needs	
Community Health Needs Research	
Implementation and Outcome Goals	
Tracking WellStar Progress	
<b>WellStar and the Community Served   Community is COMMITMENT</b>	<b>16</b>
The Enterprise	
The Entity	
Expansion for Innovation and Access	
Community Profile	
WellStar Hospitals' Community At A Glance	
Socioeconomic Gradient in Health	
County Level Data Links	
<b>Needs Assessment Overview   Community is CONTRIBUTION</b>	<b>32</b>
Process	
Research Methods and Timeline	
CHNA Collaboration	
Data Collection and Analysis	
Data Sources	
<b>Community Input   Community is CONNECTION</b>	<b>38</b>
Community Collaborators	
<b>Community Health Needs   Community is COMPASSION</b>	<b>42</b>
Major Health Challenges and Drivers	
Significant Needs	
Prioritization Process	
Priority Needs	
Needs Not Addressed	
<b>Community Health Assets   Community is COLLABORATION</b>	<b>50</b>
Strategic Community Partnerships	
Potentially Available Community Resources	
<b>Evaluation of Impact: Tracking WellStar's Progress   Community is CHANGE</b>	<b>60</b>
2013 Implementation Update	
Tracking System-Wide Progress	
Tracking Hospital-Specific Progress	
<b>Report References</b>	<b>72</b>
<b>Significant Health Needs Data Summaries</b>	<b>79</b>



COMMUNITY IS  
**CARE**

BUILDING A BIGGER TABLE

# IT TAKES A **GREAT WORK** TO MEET **GREAT NEEDS**.

A snapshot of community health needs.

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*WellStar’s culture of health is as strong as our ability to instill a shared value of health in the community. Resilience is a skill when your aim is to impact community health.*

*As a community-based not-for-profit health system, WellStar Health System’s (“WellStar”) vision to provide world-class healthcare extends beyond the patients we treat to the community we serve.*

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## **COMMUNITY BENEFIT DEFINED**

Delivered by the **WellStar Community Health Collaborative**<sup>1</sup> and WellStar’s five hospitals, community benefit is an organized and measured approach WellStar takes to respond to identified community health needs.<sup>2</sup> The term implies collaboration with a “community” to “benefit” its residents. We provide community benefit by creating better access to healthcare and services, advancing medical and health knowledge through research, education and outreach and forging collaborative partnerships that reduce the burden on government and other tax-exempt organizations.

In compliance with federal tax laws under the Affordable Care Act<sup>3</sup>, WellStar tracks and reports community benefit in the following categories:

- 1: Financial Assistance (*Charity Care*)
- 2: Government-Sponsored Means-Tested Health Programs  
(*Provided in hospitals and hospitals’ outpatient facilities*)
- 3: Community Benefit Services (*As an integrated health system, most services are delivered at a System-level in our hospital communities via the WellStar Community Health Collaborative and its partners; not by individual hospitals.*)

The provision of community benefit<sup>4</sup> is essential to the mission of WellStar to deliver the most advanced level of care to the community we serve. It also is a requirement to sustain WellStar’s status as Georgia’s largest not-for-profit healthcare system. In fiscal year 2015, WellStar invested 11 percent of total operating expenses in community benefit financial assistance, unreimbursed care and services totaling more than \$220 million.

## TRIPLE AIM FRAMEWORK

WellStar is the community's lead investor in facilities, services and programs to achieve the Institute of Healthcare Improvement's (IHI) "Triple Aim" framework<sup>5</sup> to:

- (1) Improve the patient care experience<sup>6</sup>
- (2) Improve the health of a population<sup>7</sup>
- (3) Reduce healthcare costs

This framework provides the criteria for actionable community benefit services to address priority health needs and for collaboration with vital community partners whose assets enhance and broaden the scope of WellStar and its hospitals' capacity and expertise.

## COMMUNITY HEALTH NEEDS RESEARCH

WellStar deployed a systematic approach<sup>8</sup> to collecting, analyzing and using data and community input to identify significant health needs and determine where current assets of WellStar and community partners enable action to help improve the health of the community, especially among the most vulnerable:



From September to December 2015, Community Health Needs Assessment (CHNA) research was conducted by a third-party consultant and the Georgia Health Policy Center<sup>9</sup> on behalf of WellStar's five not-for-profit hospitals - WellStar Cobb, Douglas, Kennestone, Paulding, and Windy Hill hospitals.<sup>10</sup>

To capture the health status of more than 1.4 million residents in WellStar's five-county primary service area<sup>11</sup> (Bartow, Cobb, Cherokee, Douglas, and Paulding counties), the following questions guided the process:

1. What is the current health status of the community WellStar serves?
2. What are the major risk factors and causes of poor health in our community?
3. What actions by WellStar and its partners are needed to address the risk factors and causes?
4. What are the existing WellStar and community assets, programs and services that can help address the needs?
5. Who are the partners or potential partners with the expertise and resources to help expedite a connection to healthcare, education and resources?

## RESEARCH METHODS AND PROCESS

A broad spectrum of primary (qualitative) and secondary (quantitative) research methods were used including:

- Surveys and interviews with multi-sector key stakeholders
- Web-based health status survey of the community-at-large
- Community focus groups in high need areas
- Photo testimonies
- Health status and resource assessment survey of the WellStar Medical Group
- Extensive community health and utilization data across multiple sites and databases
- Listening sessions with safety net clinic patients and uninsured/underserved members of faith-based organizations

The full body of research was aggregated by the predominance of key findings and themes. Significant health needs were reviewed by leaders in WellStar Population Health Management and Strategic Community Development, the Georgia Health Policy Center, and Kennesaw State University's (KSU) A.L. Burruss Institute of Public Service and Research.<sup>12</sup> This was done in preparation for the WellStar Community Health Collaborative's Health Needs Summit held on Feb. 25, 2016 – the platform for prioritizing significant health needs.

## KEY FINDINGS AND THEMES

Although the five counties in the WellStar primary service area rank in Georgia's top quartile for health,<sup>13</sup> there are pockets of poor health in every county. Many of affected communities are those we call "**vulnerable populations**" which include and may have the following attributes: the underinsured/uninsured, low income,<sup>14</sup> lower education attainment, limited English proficiency, poor health literacy, minorities, the elderly, and those who are transient and/or live in an unsafe physical environment and/or food desert.<sup>15</sup>

Many of the health challenges identified in the 2013 CHNA remain relevant for each hospital. These include the **disease burden from chronic disorders**<sup>16</sup> (including cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and cancer) and chronic disease **primary drivers - obesity, tobacco use, poor nutrition, and physical inactivity.**

**Economic security** is either the greatest door or barrier to access healthcare and preventive services to keep people healthy. Income is a key driver of health status and where you live can largely determine how healthy you are.

Underemployment and unemployment, due to low education attainment or other factors, challenge the mind, body and spirit of indigent and low-income residents. Community safety net clinic patients testify to the fiscal barriers which cause frustration and hopelessness which often leads to unhealthy behaviors and mental health issues, a health concern growing in prevalence.

With unaffordable healthcare costs, the most vulnerable in our community feel disqualified from the **preventive side of health**, including tests and screenings. They seek care as a last resort. “Why spend money if nothing is wrong?” This is not just a sentiment among the 20 percent uninsured adult population in the five-county region<sup>17</sup>, but also for those who have rising Affordable Care Act premiums and other high deductible plans.

Many “last resort” residents present in WellStar Emergency Departments (ED) with ambulatory care sensitive conditions and preventable hospital readmissions. According to internal data, approximately 22 percent of WellStar’s total ED visits in FY2015 were for non-emergent conditions that potentially could have been treated in an outpatient setting.

There is a growing concern among key stakeholders representing vulnerable populations about the **underuse of primary care** (due to both access and cost barriers), unaffordable medication and specialist care, mental health issues, and substance abuse (specifically the rise of opioids/heroin). In addition to health disparities, transportation and physical environment factors like a lack of parks/sidewalks and neighborhood safety also were commonly cited among residents living in vulnerable areas. These factors also contribute to physical inactivity which increases the risk for obesity and chronic disease.

Health disparities are compounded by the low **provider-resident ratio** in Bartow, Douglas and Paulding counties, although it’s still a level of concern community-wide. **Underuse of primary care** remains a barrier to navigating healthcare including accessing affordable medications and insurance / financial assistance programs.

Health fairs, education and free screenings in the community are deemed beneficial, but with the lack of or awareness of low or no cost resources for follow-up care to manage a revealed or unmanaged condition, the services may be a point of stress among the vulnerable population. “Then what?” was a common question amplifying the need for a more **seamless prescription of resources and self-management education**. These needs were echoed by key stakeholders who serve this population.

Many cite more **collaborative efforts** among the public health system<sup>18</sup> as the biggest catalyst for change and improvement in community health. Stakeholders noted the need to leverage the expertise of organizations that already address significant health needs and strategically pool funding and resources to maximize outcomes.

# PRIORITY HEALTH NEEDS

After a thematic analysis of health needs data, priorities were identified by the WellStar Community Health Collaborative Task Force at a February 2016 Health Needs Summit. The task force, made up of a broad spectrum of WellStar team members and community stakeholders representing vulnerable populations, used the Triple Aim framework and current assets / capacity measures<sup>19</sup> to prioritize significant health needs.

The overriding question:

*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 most vulnerable?*

*The task force identified the following as priority health needs for the WellStar community's five hospitals:*

# WELLSTAR®



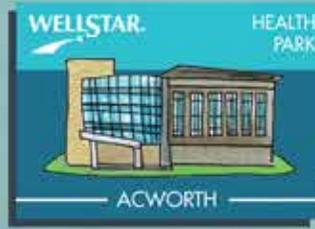
## PRIORITY HEALTH NEEDS

### Access to Care

- Underuse of primary care
  - Lack of care capacity in community safety net clinics
  - Overuse of Emergency Department for non-emergent needs

### Healthy Lifestyles<sup>20</sup>

- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease / Asthma
- Type 2 Diabetes
- Obesity



WELLSTAR®

Paulding Hospital

WELLSTAR®

Kennestone Hospital

120

278



WELLSTAR®

Douglas Hospital

20

WELLSTAR FUTURE HEALTH PARK

SOUTH CHEROKEE

WELLSTAR HEALTH PARK

EAST COBB

575

75

120

41



WELLSTAR  
Windy Hill Hospital



WELLSTAR  
Cobb Hospital

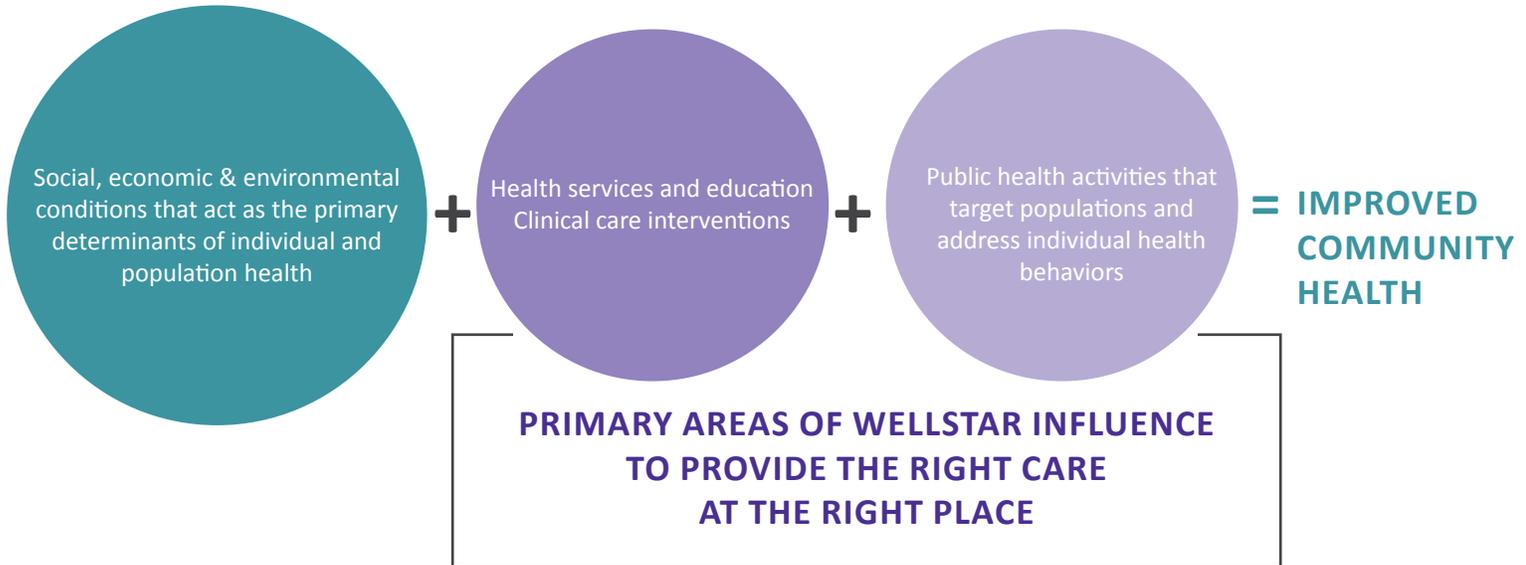
285

WELLSTAR UNDER CONSTRUCTION HEALTH PARK

VININGS

**IMPLEMENTATION  
AND OUTCOME  
GOALS**

Recognizing health and social factors are closely intertwined, the priority health needs require collaborative public health and primary care interventions (see the figure below) to help prevent disease and injury, promote health and well-being, assure conditions in which people can be healthy, and provide timely, effective and coordinated healthcare. <sup>21</sup>



Galvanizing efforts and resources to achieve optimal community health outcomes is vital to:

- **Improve access to care.**  
Help break access barriers (includes cost of care) and bridge service gaps, especially for the most vulnerable.
- **Improve community health status.**  
Support a healthier community by providing health needs-specific preventive health services and education focused on reducing the incidence and prevalence of chronic disease.
- **Strengthen and build strategic community partnerships<sup>22</sup>.**  
Collaborate to leverage and maximize assets/capacity and prescribe resources to address priority health needs, drivers and disparities.

## TRACKING WELLSTAR'S PROGRESS

Since the inaugural 2013 CHNA, WellStar has made a seismic shift from a volume-based care delivery system to an integrated, value-based care delivery system<sup>23</sup>. With a focus on prevention and wellness, we're transforming care delivery and recalibrating System-wide community benefit strategy to more effectively and efficiently align with the health priorities of our residents, Public Health (public and private-sector partners) and key stakeholders.

Progress made on WellStar's two-phased community benefit implementation strategy<sup>24</sup> has created a more sustainable framework for actionable community benefit services, yet was too broad in scope. More work is needed in the structure, delivery and evaluation of these activities and to replicate the community benefit model across multiple hospitals in an expanding Georgia footprint.

*A more detailed progress report based on community benefit categories is on page 60.*

In other areas, WellStar's taken a non-linear approach to addressing health needs by initiating evidence-based care models, such as developing an integrated behavioral health network to address growing mental health issues and the expansion of prevention-based education and clinical care services. This includes clinical training for smoking cessation and a Comprehensive Care Clinic focused on chronic disease management and treatment of high-risk patients.

Partnerships with community safety net clinics are being redefined and expanded laying the groundwork for more collaborative and affordable community benefit services and education. This includes leveraging the compassion, expertise and health knowledge of team members and care providers via the new **WellStar 4-1 Care Network**<sup>25</sup>. The network is a conduit for reducing Emergency Department utilization through hospital-based care coordination, navigation to the right care at the right place and WellStar Medical Group (WVG) physicians and advanced practice professionals volunteerism in community safety net clinics to help build needed care capacity to serve more medically underserved and uninsured residents.

We established two more hospital outpatient community clinics in areas of high need to provide access to OB/GYN and internal medicine. Care will be delivered by attending physicians and residents participating in the new Graduate Medical Education program.

Through the WellStar Center for Health Transformation, we innovated ways to improve care delivery in alliance with multi-sector partners, leading research institutes and technology to energize and enable cutting-edge solutions that improve care and reduce healthcare costs<sup>26</sup>.

We brought quality community-based outpatient care and services to more neighborhoods via our convenient and cost-efficient Health Park model – a lauded concept for improving care access modeled nationwide – with two operational parks and one currently under construction in Vinings.

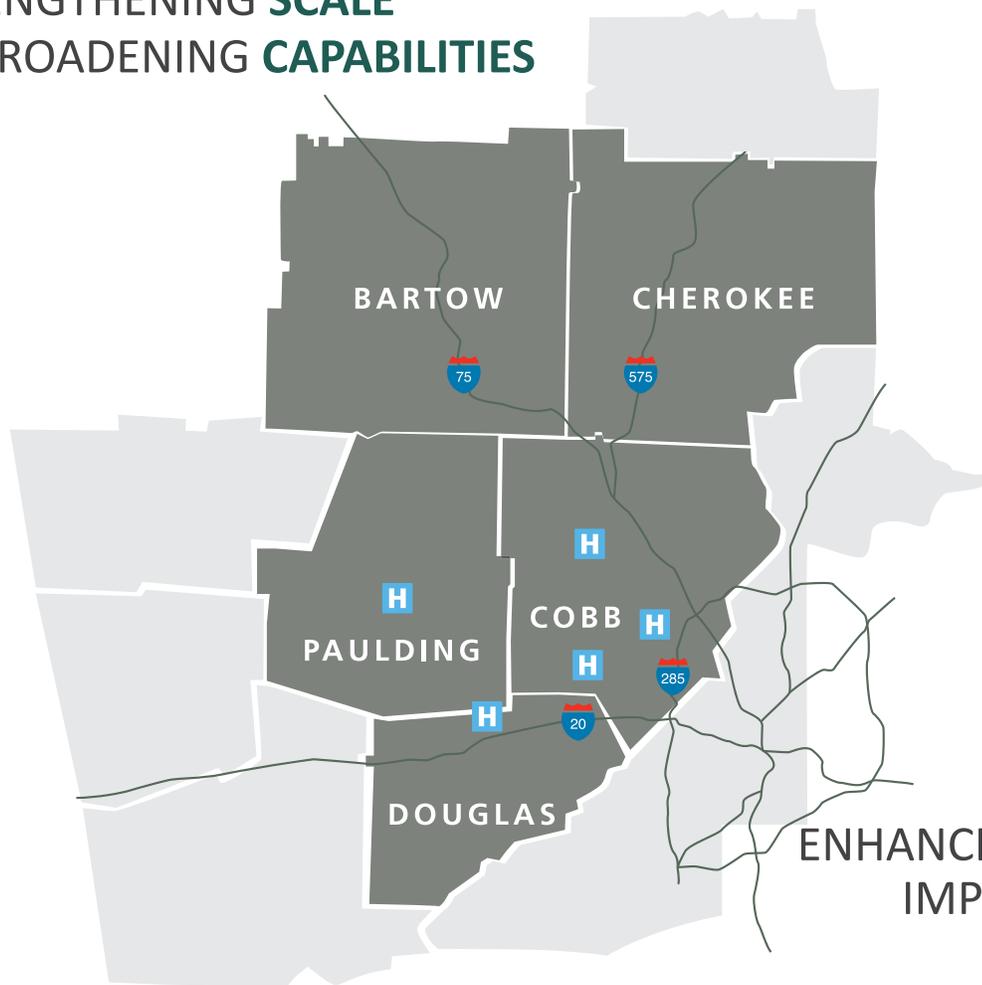
We instituted WellStar Clinical Partners, a physician-led, clinically integrated organization, to help optimize the wellbeing of the community. Its collaborative health management focus is foundational to maximize value for patients and improve the delivery of and access to world-class care. To date, the organization is comprised of 1,167 affiliated physicians, including nearly 600 WVG physicians in more than 220 practice locations.

We established disease-specific clinics for leading causes of death (e.g. heart disease and COPD) to provide more comprehensive care management and behavior/lifestyle modification tools and education to improve community health.



COMMUNITY IS  
**COMMITMENT**  
WE EXIST TO SERVE

## STRENGTHENING SCALE BROADENING CAPABILITIES



ENHANCING EFFICIENCY  
IMPROVING QUALITY

---

*WellStar is Georgia's largest not-for-profit health system, a national leader in the transformation of healthcare delivery<sup>27</sup> and recognized as the fifth most integrated healthcare delivery system<sup>28</sup> in the nation.*

---

### THE ENTERPRISE

#### **The WellStar Mission for our community:**

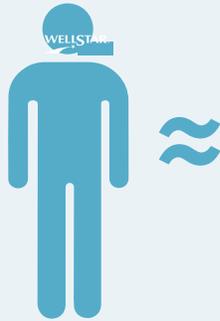
To create and deliver high quality hospital, physician and other healthcare-related services that improve the health and well-being of the individuals and community we serve.

#### **The WellStar Vision for our community:**

To deliver world-class healthcare to our community. Our vision manifests itself through a wide variety of supportive endeavors by which we provide excellent, compassionate and holistic care. That means making preventive health screenings, educational support and the highest quality of medical care available to everyone.

## WE CARE

An "extended family" delivers comprehensive and clinically integrated care & services.



14,000 team members

1 team member for nearly every 100 residents

## WE SERVE



153,000 community members had access to health fairs and community education.

FY2015

<b>70+</b> CONGREGATIONS	Comprise the WellStar Congregational Health Network, a bridge for faith-based support and care
<b>362,729</b> visits	To the four Emergency Department (EDs) in FY2015, more than any other health system in Georgia



That would fill the Georgia Dome to capacity more than 5 times

## WE GIVE BACK

FY2015

**\$7.8**  
MILLION

WellStar Foundation contributions from team members, physician partners, businesses and community members to advance healthcare.

**\$101**  
MILLION

in charity care - a 15.5 percent increase from the initial 2013 CHNA reporting year

**100%**  
of every surplus dollar

IS REINVESTED IN ENHANCED SERVICES FOR THE BENEFIT OF OUR COMMUNITY

One of the FORTUNE 100 Best Companies to Work For®  
and  
Top 10 honors on *Working Mother's* 100 Best Companies



The only Metro-Atlanta-based company  
and health system in the country on the  
national *Companies That Care Honor Roll*



The only health system in Metro Atlanta selected  
as a member of the *Mayo Clinic Care Network*.



WellStar providers leverage Mayo physician expertise  
for second opinions/consultations at no cost to patients.



Partnerships with community safety net clinics allow  
medically underserved and uninsured patients to receive  
WellStar lab and radiology services at no or reduced cost.



Health-related sponsorships, partnerships and  
volunteerism by WellStar team members help  
strengthen and support our community in  
research and awareness of health needs.



**11 percent**

of all healthcare & services  
delivered by WellStar in FY2015  
was to the medically underserved  
& uninsured community members.

**MORE THAN \$220 MILLION A YEAR  
IN UNREIMBURSED CARE**

**65,000**

**MEDICARE PATIENTS**

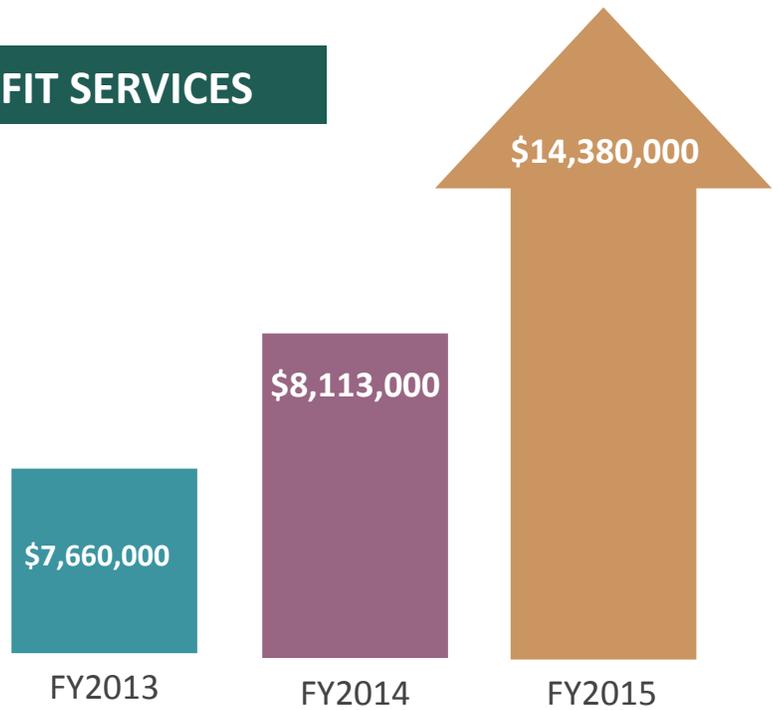
have benefited from WellStar's  
eighth in the nation-ranked  
Accountable Care Organization  
(ACO) <sup>29</sup>

The value of WellStar's community benefit investment outweighs  
the value of our tax-exempt status.

## DELIVERY OF COMMUNITY BENEFIT SERVICES

### Categories:

- Community Health Improvement Services
- Subsidized Health Services
- Health Professions Education
- Research
- Cash and In-Kind Contributions
- Community Building Activities



**88%**  
INCREASE

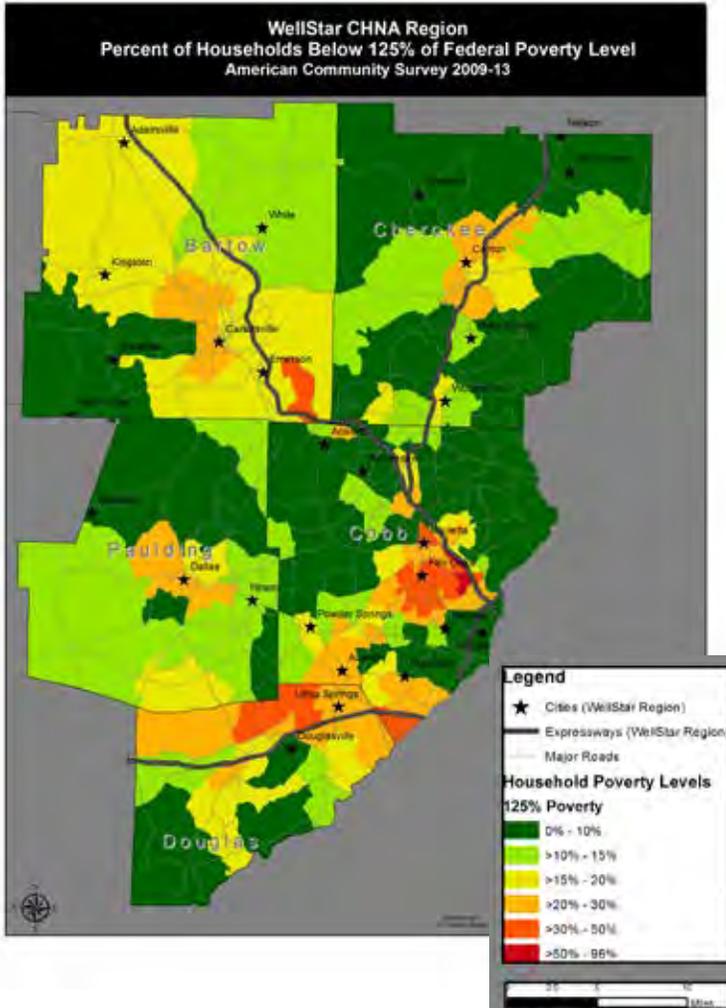
IN THE INVESTMENT IN COMMUNITY BENEFIT PROGRAMS AND SERVICES DESIGNED TO IMPROVE HEALTH AND ACCESS TO CARE SINCE 2013<sup>30</sup>

**THE ENTERPRISE (CONTINUED)**

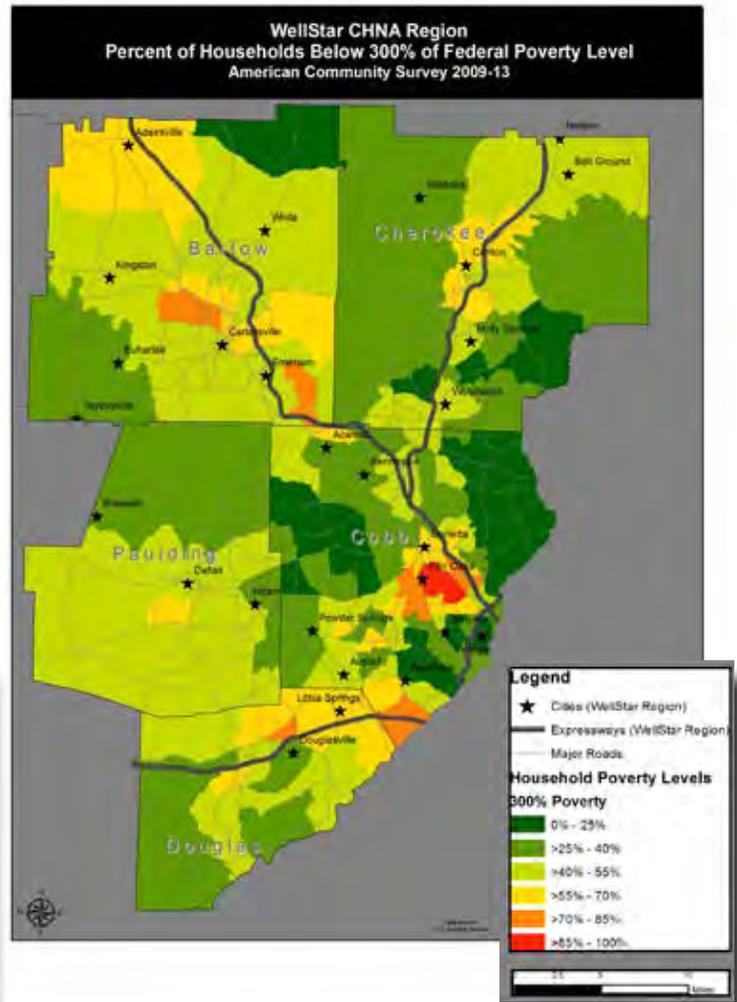
The majority of WellStar’s community benefit dollars provide indigent (below 125 percent of the Federal Poverty Level (FPL)<sup>31</sup> and charity care (between 125 and 300 percent FPL) to eligible patients<sup>32</sup> at all hospital and hospital-based facilities.

WellStar also provided an additional \$47.5 million in unreimbursed care in FY2015 to those who didn’t apply for charity care, but were unable to pay for services (the cost of delivering care). The amount is a 27.3 percent decrease from 2014 after a significant increase (23.3 percent) in care provision from 2013 to 2014<sup>33</sup>.

**“Hotspot” Maps: Population Below 125% FLP – Indigent**



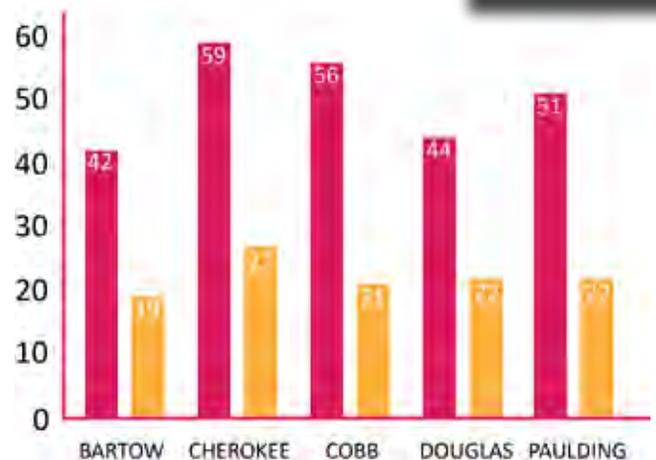
**Below 300% FPL - Charity**



Population percentage at or above 300 FPL

Percentage of that population at or above 300 FPL that is uninsured

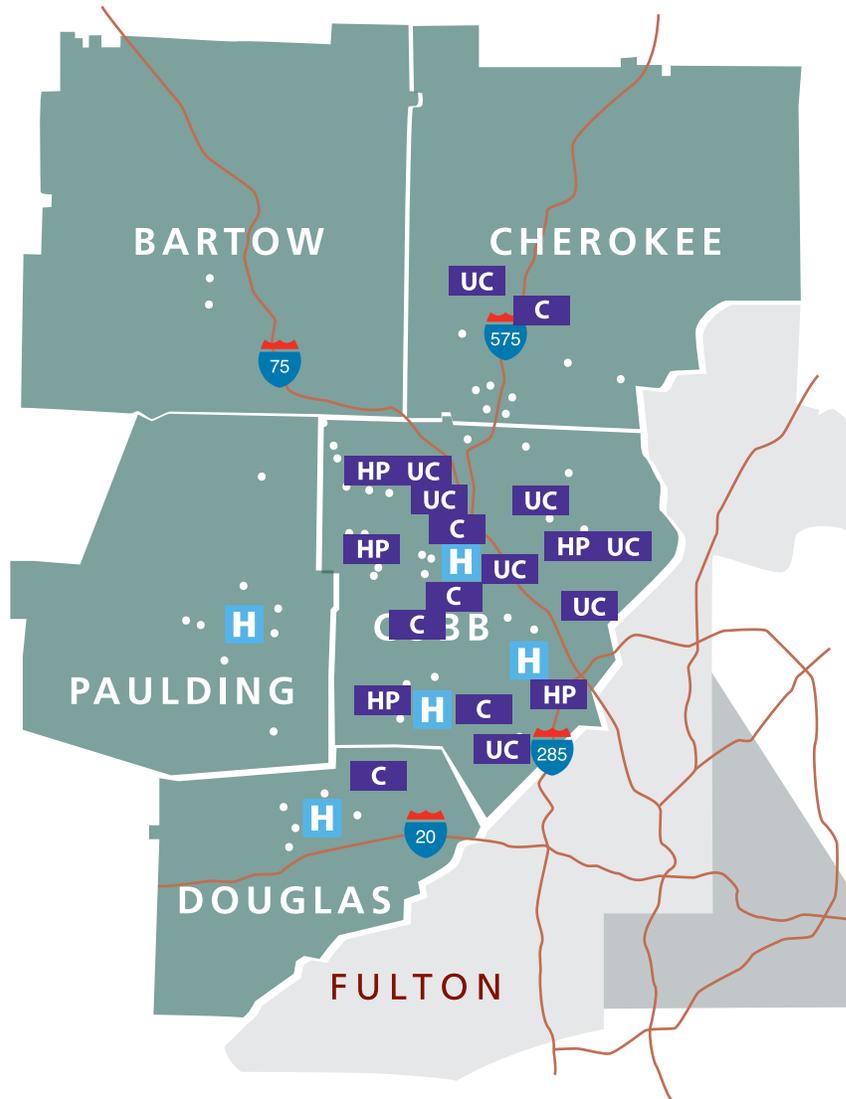
*Do not qualify for WellStar Community Financial Assistance*



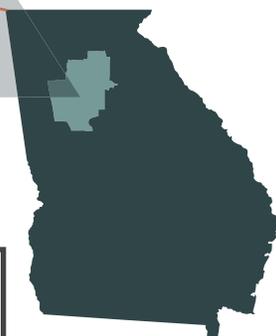
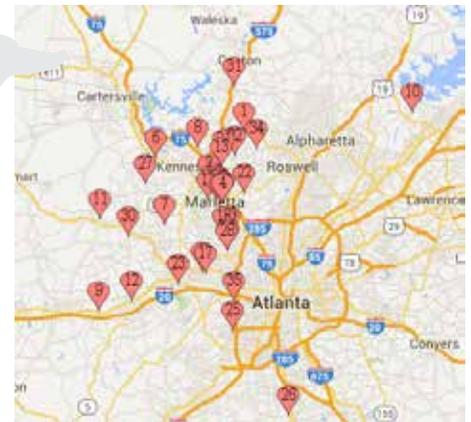
**THE ENTITY**

Geographically enlarging the community's access to care and clinically integrating the way healthcare is provided improves patient satisfaction, health outcomes and overall community health.

## Delivering Care In Your Neighborhood



### WellStar Congregational Health Network



<b>H</b>	Hospitals
<b>UC</b>	Urgent Care Center
<b>HP</b>	Health Park
<b>C</b>	Community Clinic or Partner Safety Net Clinic <sup>34</sup>
<b>●</b>	WellStar Medical Group locations

**EXPANSION FOR  
INNOVATION  
AND ACCESS**

On April 1, 2016, WellStar Health System expanded its footprint beyond its historic Northwest Georgia base. WellStar brought its vision of world-class healthcare to new communities and patients, following due diligence, regulatory review and thorough integration planning.

With the acquisition of Tenet Healthcare’s five Georgia-based hospitals (in Butts, Fulton, Jackson and Spalding counties) and a new partnership with West Georgia Health in LaGrange (Troup County), WellStar becomes the largest health system in Georgia and one of the largest not-for-profit health systems in the country. With approximately 20,000 team members, the new 11 hospital system will expand upon its proven clinical care models and patient safety programs that have resulted in increased quality and improved access to healthcare in its new communities.

Joining WellStar’s existing five hospitals are: WellStar Atlanta Medical Center, WellStar Atlanta Medical Center South, WellStar North Fulton Hospital, WellStar Spalding Regional Hospital, WellStar Sylvan Grove Hospital and WellStar West Georgia Medical Center. All facilities will now be operated as not-for-profits.

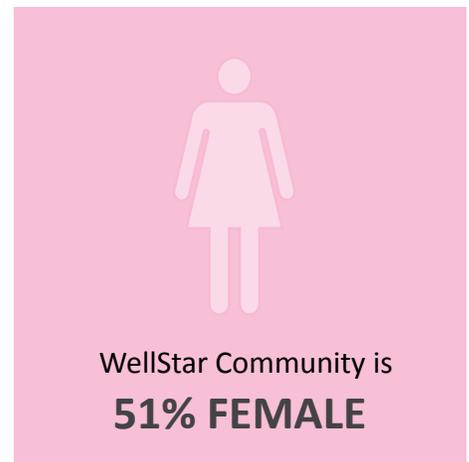
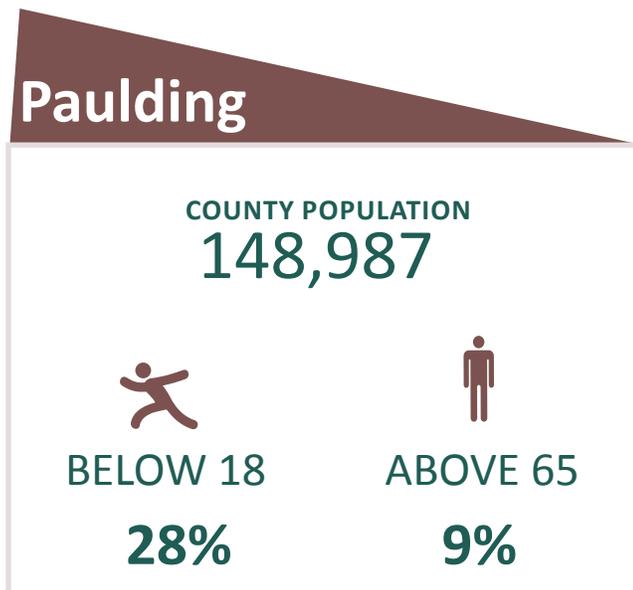
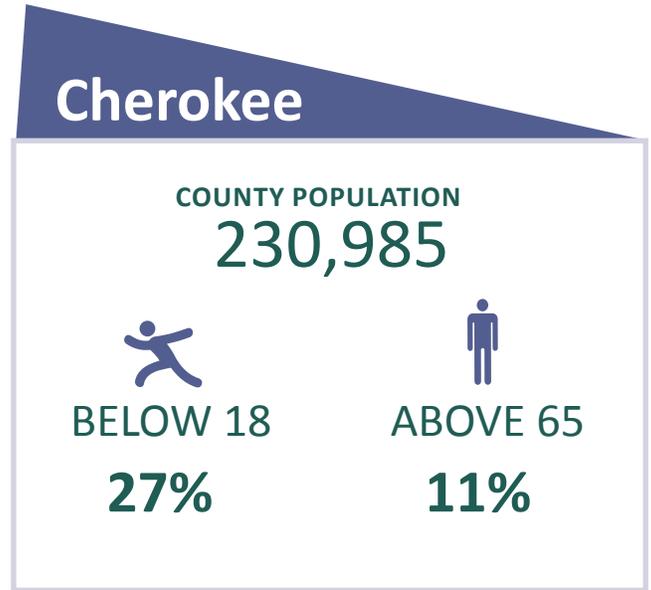
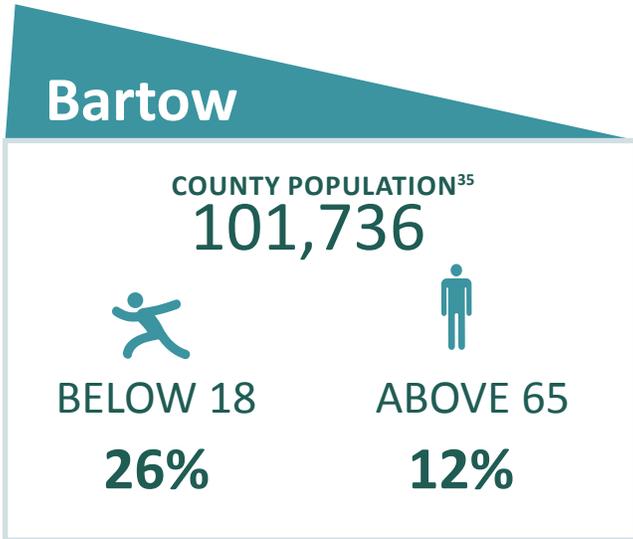
WellStar Medical Group, one of the largest employed physician groups in the Southeast, will expand to more than 1,000 physicians and advanced practice professionals across more than 220 medical office locations and numerous outpatient facilities.

With ever-changing government regulations and reimbursement pressures, health systems across the country are looking for new efficiencies. To better serve its patients, WellStar chose to be proactive to secure the future of high-quality care in its communities. The geography of West Georgia Health and Tenet’s five Georgia hospitals complements WellStar’s current footprint. With a larger integrated system, WellStar will continue its strategic focus on the Triple Aim—higher quality, improved access and affordable healthcare.



# COMMUNITY PROFILE

Residents living in a five-county region (Bartow, Cobb, Cherokee, Douglas, and Paulding counties) comprise the primary community served by WellStar Cobb, Douglas, Kennestone, Paulding, and Windy Hill hospitals. Community is defined geographically, by WellStar hospitals' intersecting 90 percent catchment areas irrespective of county lines, and statistically, by the demographics and determinants of health reported in the CHNA.



## Cobb

COUNTY POPULATION  
**730,981**



BELOW 18  
**25%**



ABOVE 65  
**10%**

## Douglas

COUNTY POPULATION  
**138,776**



BELOW 18  
**27%**



ABOVE 65  
**10%**

County	Bartow	Cherokee	Cobb	Douglas	Paulding	GA
Percentage of uninsured adults 18-65 <sup>36</sup>	22%	19%	21%	21%	18%	21%
Median age of the uninsured is <b>34</b>						
Total Number of uninsured <sup>37</sup>	18,408	33,169	124,371	23,771	20,712	
Percentage of uninsured Hispanic/Lation	16	28	31	18	10	
Population on Medicaid/means tested public coverage <sup>38</sup>	13,506	15,895	58,383	16,161	13,382	

Georgia was among 39 states whose uninsured rate dropped by more than three percentage points after the insurance changes debuted in 2014, yet the state's percentage of people without coverage is still among the highest in the nation.<sup>39</sup>

# WellStar Health System: Hospital Community At A Glance<sup>40</sup>

Demographic data based on 90 percent catchment areas and 2016 estimates from The Nielson Company, Pop Facts Demographics.

## Hospital Population 2016 Estimate

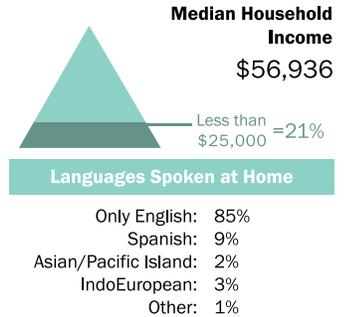
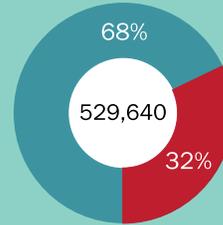
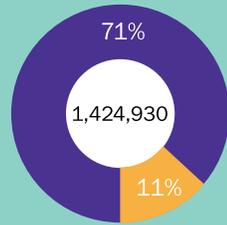
■ Age 21+ ■ Age 65+

## Total Households

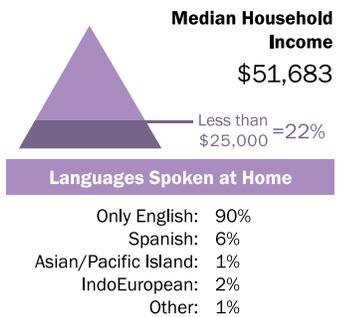
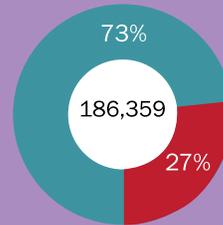
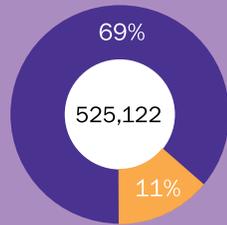
■ Family ■ Non-Family



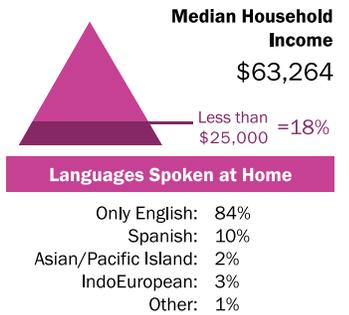
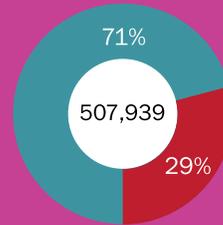
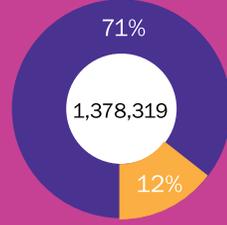
**Cobb Hospital**  
(Cobb County)



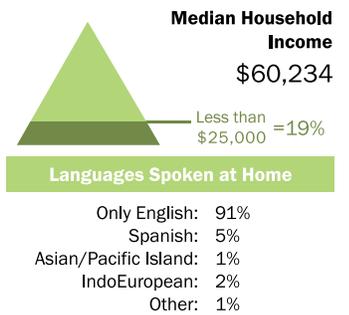
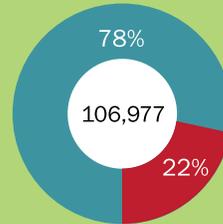
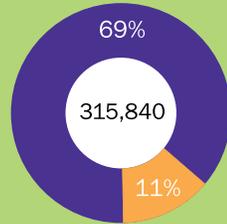
**Douglas Hospital**  
(Douglas County)



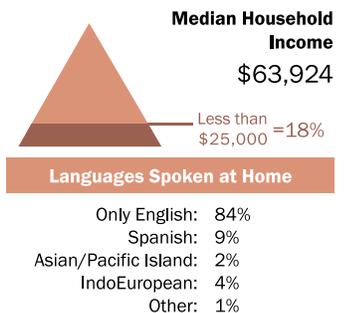
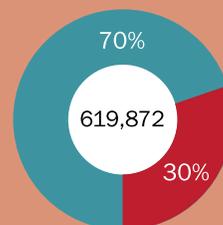
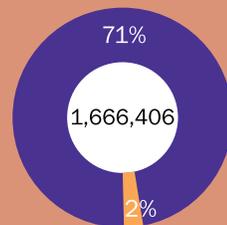
**Kennestone Hospital**  
(Cobb County)



**Paulding Hospital**  
(Paulding County)



**Windy Hill Hospital**  
(Cobb County)



Catchment Area Map Key

Cobb Hospital

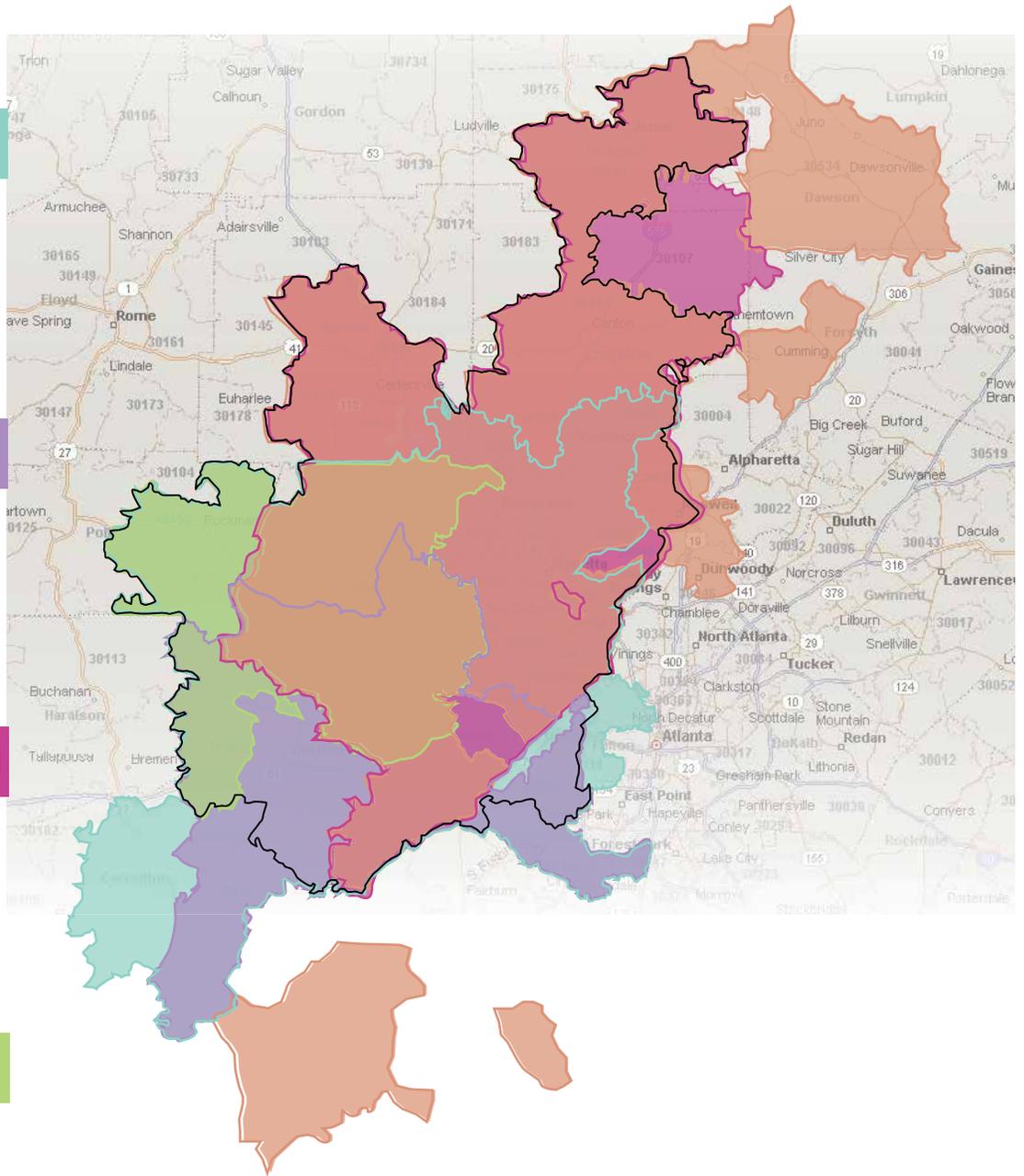
Douglas Hospital

Kennestone Hospital

Paulding Hospital

Windy Hill Hospital

WellStar System



Four Emergency Departments  
July 2014 - June 2015

**215,285**  
Total Patients

**362,729**  
Total Visits

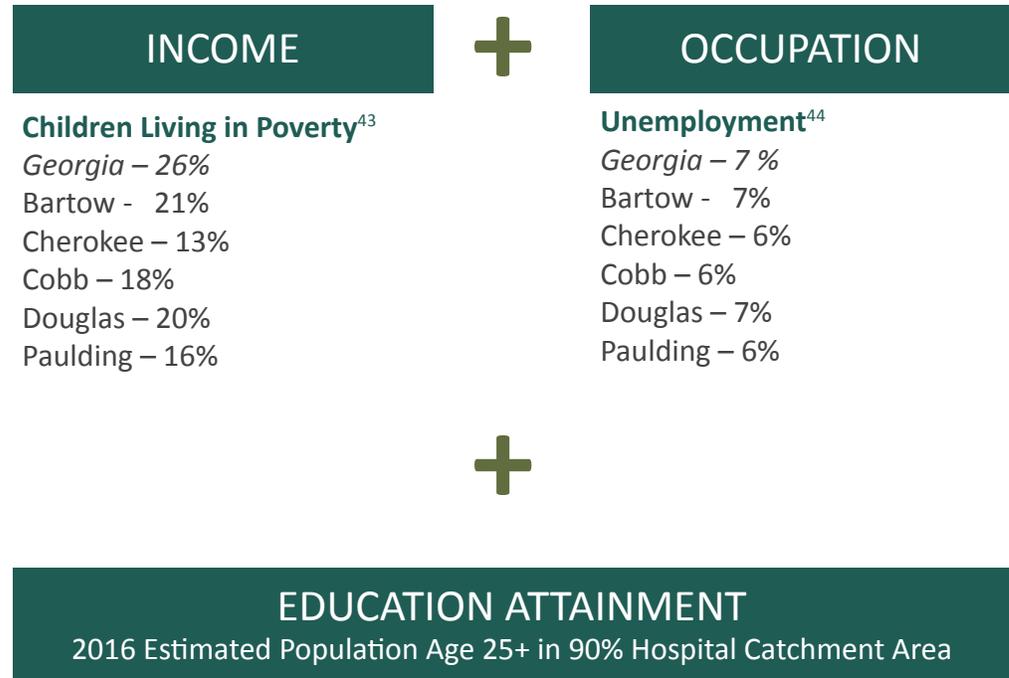


7.28%  
of all patients  
made four or  
more visits

## SOCIOECONOMIC GRADIENT IN HEALTH

A mission-driven approach to profile a community's health is to encapsulate it by the "socioeconomic gradient in health." This refers to the stepwise fashion health outcomes improve as socioeconomic position improves. This gradient can be measured by:

1. Income<sup>41</sup>
2. Occupation
3. Level of education achieved<sup>42</sup>



**Cobb**  
 Some High School, no diploma 7%  
 High School Graduate (or GED) 26%  
 Some College, no degree 22%  
 Bachelor's Degree 22%  
 Other 24%

**Paulding**  
 Some High School, no diploma 8%  
 High School Graduate (or GED) 31%  
 Some College, no degree 24%  
 Bachelor's Degree 17%  
 Other 21%

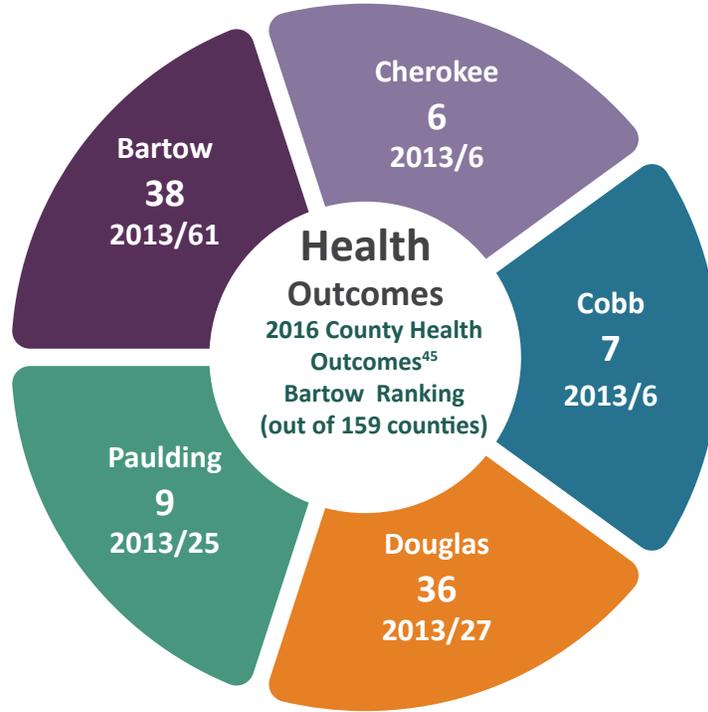
**Douglas**  
 Some High School, no diploma 8%  
 High School Graduate (or GED) 31%  
 Some College, no degree 24%  
 Bachelor's Degree 16%  
 Other 21%

**Windy Hill**  
 Some High School, no diploma 6%  
 High School Graduate (or GED) 24%  
 Some College, no degree 21%  
 Bachelor's Degree 24%  
 Other 24%

**Kennestone**  
 Some High School, no diploma 6%  
 High School Graduate (or GED) 24%  
 Some College, no degree 22%  
 Bachelor's Degree 24%  
 Other 24%

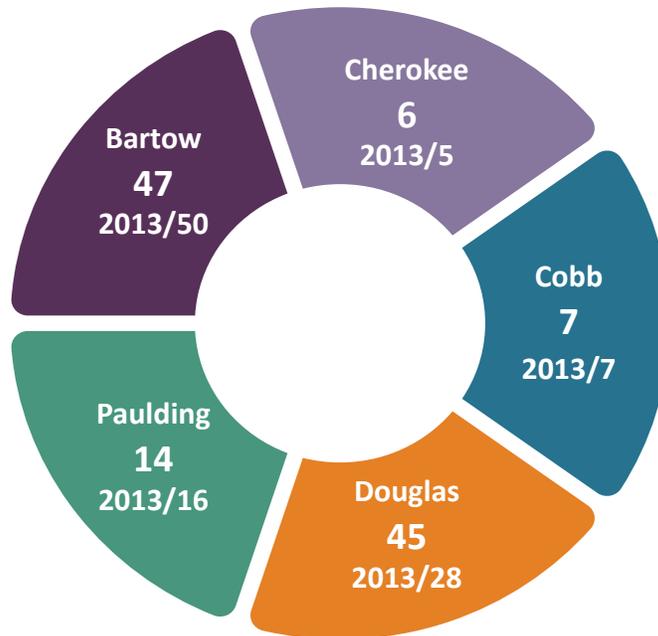
*"You have families with a lot of health issues, a lot of problems, struggling... Why finish high school when (you) can get a job and help your family?"*  
 - Good Samaritan Health Center of Cobb patient

## HEALTH OUTCOMES



In addition to socioeconomic factors, health outcomes also are based on three other determinants of health factors:

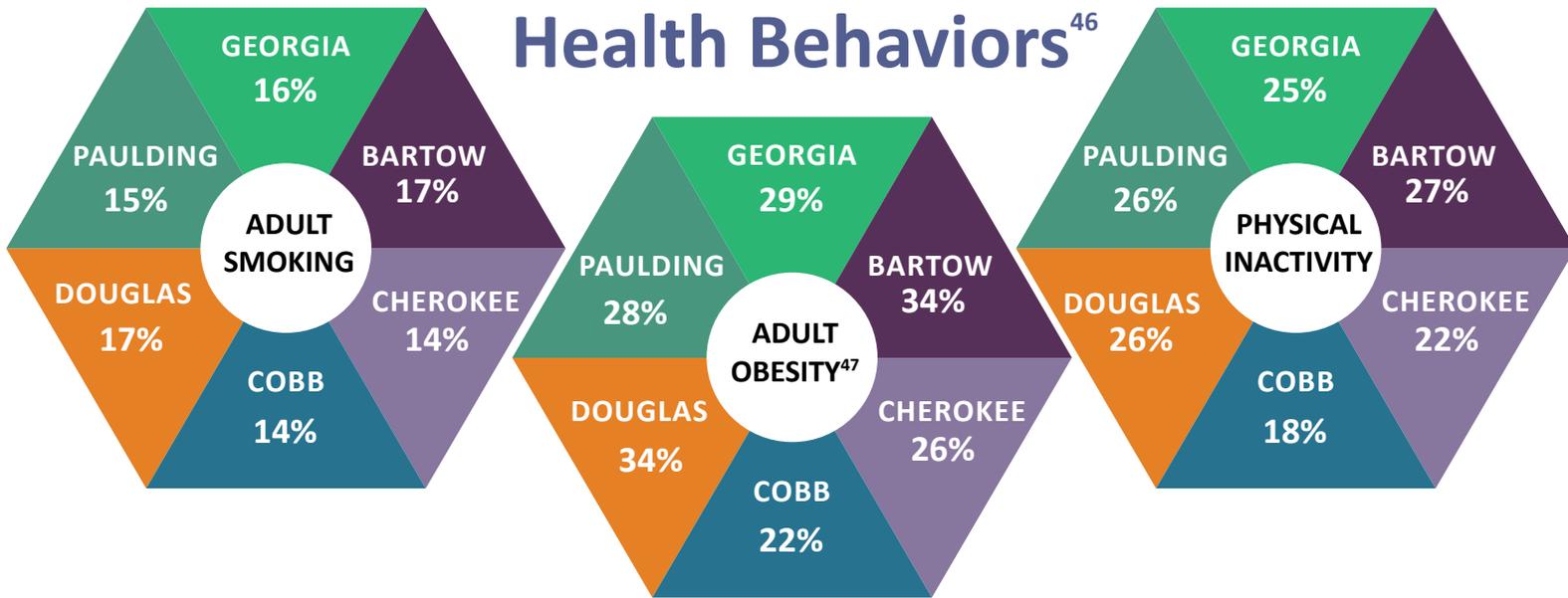
- Health Behaviors**
- Clinical Care**
- Physical Environment**



## Health Factors

2016 County Health Factors Ranking

# Health Behaviors<sup>46</sup>



# Clinical Care

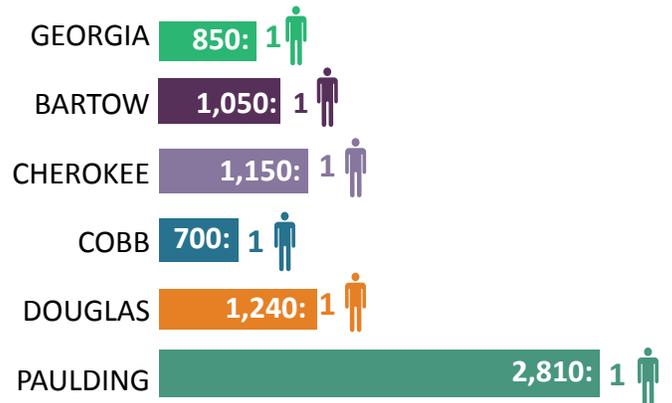
## Primary Care Physicians<sup>48</sup>

Residents to One Provider Ratio

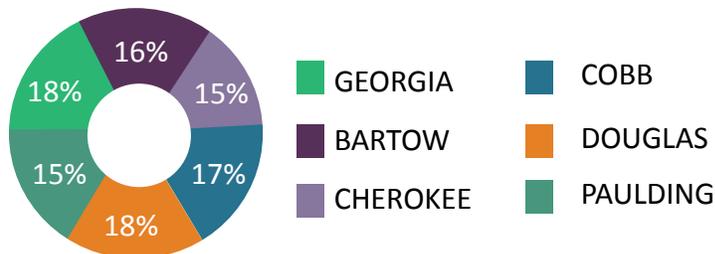


## Mental Health Providers

Residents to One Provider Ratio



# Physical Environment



## Severe Housing Problems<sup>49</sup>

# Top 5

## Leading Causes of Death<sup>50</sup>

### BARTOW



### CHEROKEE



### COBB



### DOUGLAS



### PAULDING



## County Level Data

### DIG IN

For more in-depth county health status profiles,<sup>51</sup> send a request to [chna@wellstar.org](mailto:chna@wellstar.org).

- Bartow
- Cherokee
- Cobb
- Douglas
- Paulding



**COMMUNITY IS  
CONTRIBUTION  
ASSESSING THE NEEDS**

WELLSTAR COBB HOSPITAL

**CHNA PROCESS**

The broad spectrum of qualitative and quantitative data collected in this CHNA report reflect the health needs of the WellStar community. For assessment planning and gathering community input, the following steps were taken:

- Created a timeline for gathering and obtaining community input
- Located and obtained existing community health data
- Secured commitment from strategic community partners for data collection (e.g. sites and patient recruitment for focus groups/listening sessions, partners to distribute online survey and as key informants)
- Developed research tools based upon health indicators, input from other health systems/organizations and the MAPP process used for the 2013 CHNA<sup>52</sup>
- Identified populations from which to obtain data (e.g. low-income population, faith community, care providers, minorities, medically underserved and uninsured)
- Considered language barriers for data collection (Spanish translation of community survey provided and three Spanish-language focus groups conducted)
- Developed quantitative survey tools and a distribution plan
- Determined and developed qualitative methodology of focus groups/listening sessions
- Secured approval of research tools/guides and participant consent forms
- Collected community input data via email, phone, web-based survey reports, group meetings (focus groups/listening sessions), onsite interviews, WellStar hospital president meetings, Facebook links, and surveys posted on community partner and agency websites
- Solicited assistance to gather health indicator data mirroring Healthy People 2020<sup>53</sup> (including demographic data, social and economic factors, education attainment, health behaviors, and access to clinical care) - assessed using databases of national and state agencies, public health and non-profit health systems.

## RESEARCH METHODS AND TIMELINES

- Quantitative data mining (multiple sources): November – March 2016
- Focus groups in high need areas: November – December 2015
- Listening sessions with low-income residents (safety nets and congregations): October 2015
- Key informant interviews and surveys: September – December 2015
- Photo testimonies: October 2015
- Online community health status survey: September – November 2015
- Online WellStar Medical Group survey: October 2015

## CHNA COLLABORATION

To support the development of the 2016 CHNA and to foster broad collaboration among health systems and hospitals, WellStar engaged Georgia Health Policy Center (GHPC)<sup>54</sup> in the Andrew Young School of Policy Studies at Georgia State University to work with its third-party CHNA consultant to leverage the research it does for Kaiser Permanente. As a result, GHPC's data collection and analysis contributed to the CHNAs of four health systems (WellStar Health System, Grady Health System, Kaiser Permanente, and Piedmont Healthcare), a health plan and an urban county health department.

Specific tasks of WellStar's third-party consultant with assistance from the GHPC included:

- Collecting, analyzing, and synthesizing state, county-specific and local level data
- Soliciting community input
- Coordinating WellStar team members for internal data and program information
- Assimilating stakeholder, community member and clinical team recommendations
- Leading the prioritization process with WellStar team members and community partners
- Identifying community-based organizations and other institutional assets engaged in health improvement
- Ensuring 501(r) regulations are met

WellStar also partnered with KSU's Burruss Institute to help facilitate the health needs prioritization summit of the WellStar Community Health Collaborative Task Force which includes key community stakeholders.

## **DATA COLLECTION AND ANALYSIS**

Insights from 99 WellStar Medical Group (WVG) representatives<sup>55</sup> regarding patient health status and community resources were gleaned from an online survey tool sent to WVG providers (MDs and nurse practitioners) and registered nurses.

A wide net was cast for community input using a similar online survey tool (English and Spanish) capturing demographics and overall personal health status and behaviors of 447 community members.<sup>56</sup> Community clinics, health e-newsletters, workplace partners, a Public Health Department, a school system, a Hispanic non-profit, and faith-based organizations disseminated the online link via email and social media. It's approximated the survey link was distributed to 5,000 people.

61 key informant surveys/interviews (all WellStar driven except eight by GHPC) were conducted with multi-sector leaders representing diverse organizations including Public Health Departments, governmental agencies, community safety net clinics, business leaders, and regional health board representatives. Collecting information from a wide range of experts with first-hand knowledge about the community provided insight on health issues and care barriers along with recommended interventions.

To provide a broader base of input and use the CHNA process as a means to strengthen community partnerships, seven listening sessions (three in Spanish) were conducted with 58 medically underserved and uninsured community members. Sessions were with partnering community safety net clinic patients (Bethesda Community Clinic in Cherokee, Good Samaritan Health Center in Cobb, The CarePlace in Douglas), Latino community members (WellStar Congregational Health Network members Iglesia de Dios in South Cobb and McEachern UMC in Powder Springs), Ser Familia community members<sup>57</sup>, and the Paulding County Health Department<sup>58</sup>. Two of the three sessions conducted in Spanish were facilitated by the Hispanic Health Coalition of Georgia. The Executive Director of Ser Familia co-conducted the third session with WellStar's third-party consultant. In each listening session, a few community members provided a photo testimony to communicate their greatest health-related need.

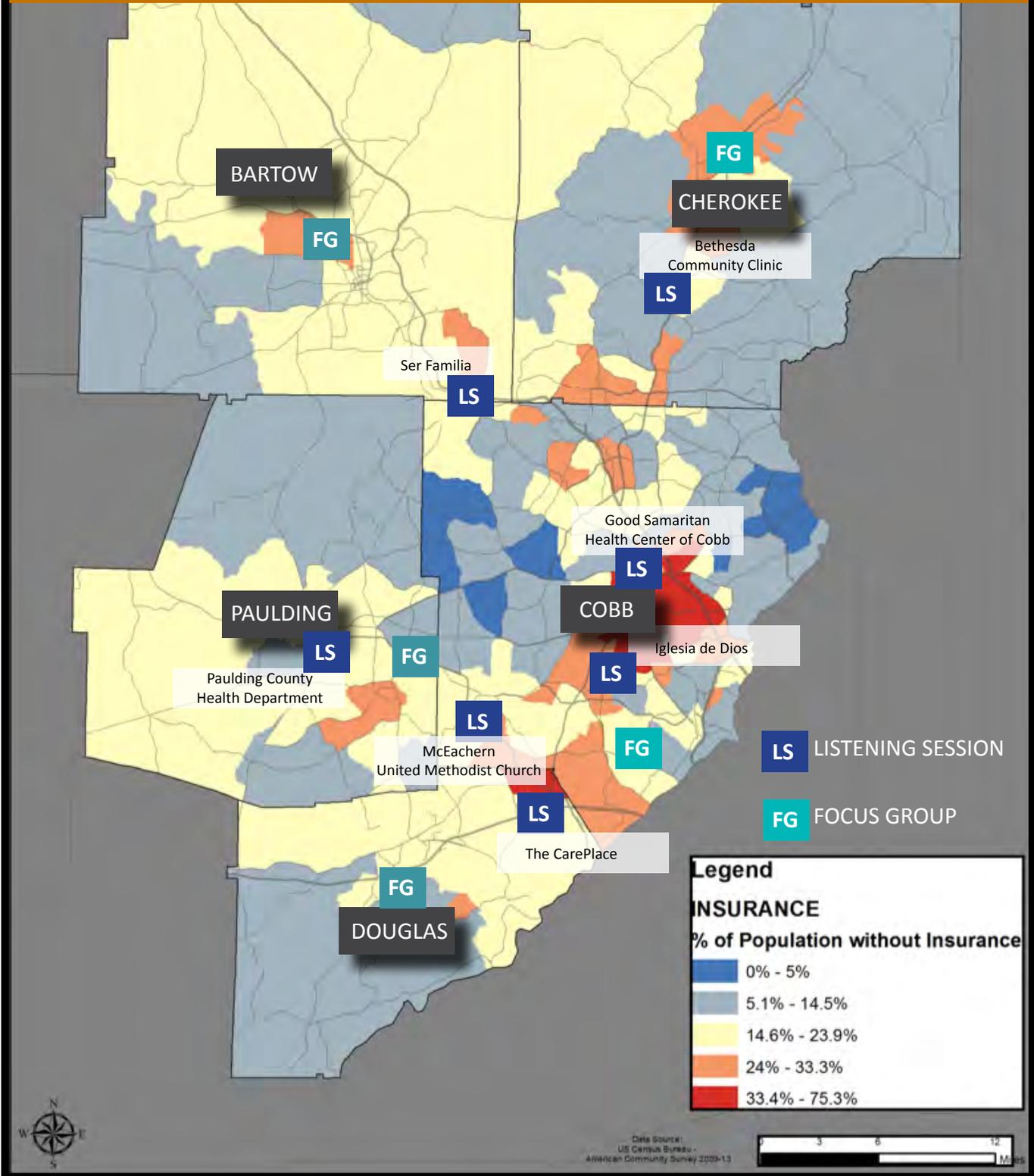
To fortify the seven listening sessions and gain a broader base of input, GHPC also conducted five focus groups with 41 participants in high need areas in each county in WellStar's primary service area. Locations of this primary research are mapped out on the following page.

# WellStar CHNA Region

## Percent of Population Without Insurance Coverage

2009-13 by Census Tracts

Approximated Locations of the CHNA Listening Sessions and Focus Groups at Safety Nets and in High Need Areas



## DATA SOURCES

### **Secondary Data** (*Quantitative county-level summaries of demographic and health information for the hospitals' service area*)

Assigning statistics to core health indicators gave a broader, overarching view of the community's health status.

#### **WellStar:**

- Georgia Student Health Survey (Behavioral Risk Survey)
- Centers for Disease Control and Prevention Community Health Improvement Navigator<sup>59</sup>
- Cobb & Douglas Public Health data
- Community Commons
- County Health Ranking and Roadmaps - includes data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS)<sup>60</sup>
- Georgia Department of Public Health
- WellStar Enterprise Intelligence for Emergency Department utilization
- Catholic Health Association
- Vulnerable and At-Risk Populations Resource Guide<sup>61</sup>

#### **GHPC sources included publicly available datasets<sup>62</sup>:**

- Community Commons CHNA Portal<sup>63</sup>
- Georgia's Online Analytical Statistical Information System (OASIS)<sup>64</sup>
- U.S. Census Bureau, American Community Survey 5-Year Dataset<sup>65</sup>
- Area Resource File
- County Health Rankings and Roadmaps which utilizes myriad of data sources
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

#### **Primary Data**

In addition to the community safety net clinic patients and residents in high need areas, an extensive list of leaders and community members representing Public Health and multi-sector and non-profit organizations serving the broader community are listed in the **Community Input** section that follows.

The background is a green-tinted illustration of a town. It features several buildings with windows, some trees, and a fence in the foreground. The style is simple and sketchy.

COMMUNITY IS  
**CONNECTION**  
YOUR STORY IS OUR STORY

## COMMUNITY COLLABORATORS

Requests for input from individuals with a stake in community health representing the broad interests of the community<sup>66</sup> began in August 2015 with feedback continuing through December 2015. Some stakeholders solicited for input did not respond<sup>67</sup>.

The CHNA contributions of the following organizations were vital to gather a wide array of insight, expertise and data to identify community health needs, assets and barriers to care.

WellStar acknowledges and thanks the following for their participation. All were key informants except where noted. Organizations in italics were contacted by the GHPC as part of the collaborative CHNA research conducted by Grady, Kaiser Permanente, Piedmont Healthcare, and WellStar.

**A.L. Burruss Institute for Public Service & Research** – *CHNA health needs review/ feedback, facilitation of health needs prioritization*

**Allatoona Resource Center**

**American Cancer Society** – *Cobb2020<sup>68</sup> Steering Committee member*

**American Cancer Society** – Marietta Health Department, Client Navigation Program  
**Atlanta Regional Commission**

**Austell Community Task Force** – *Cobb2020 Steering Committee member*

**Bartow Public Health Department**

**Bethesda Community Clinic** (Cherokee County) – *key informant, listening session site and community representative on WellStar Community Health Collaborative Task Force*

**The CarePlace** (Douglas County) – *key informant, listening session site and community representative on WellStar Community Health Collaborative Task Force*

**Center for Pan Asian Community Services**

**Chattahoochee Technical College** – *Cobb2020 Steering Committee member*

**Cherokee County Department of Family & Children Services**

**Cherokee County Health Department**

**Cherokee County School District**

**Children’s Healthcare of Atlanta** – *Cobb2020 Steering Committee member*

**City of Marietta Police Department**

**Clarke County Commissioner**

**Clarkston Community Center**

**Cobb Chamber of Commerce** – *Cobb2020 Steering Committee member*

**Cobb County Board of Commissioners (District 4)** – *Cobb2020 Steering Committee member*

**Cobb County Fire and Emergency Services**

**Cobb County Government** – *Cobb2020 Steering Committee member*

**Cobb County Public Services Agency**

**Cobb County Safety Village**

**Cobb County Sheriff’s Office** – *Cobb2020 Steering Committee member*

**Cobb 2020 Leadership (Cobb & Douglas Public Health)** – *distribution of key informant survey*

**Cobb Douglas Public Health**

**Cobb Senior Services**

*Community Foundation of Greater Atlanta*

**Community Health Center in Austell**

**Davis Direction Foundation**  
*DeKalb County Commissioner*  
*District Health Director, Assistant, District 1-2 North Georgia*  
*District Health Director District 2*  
*District Health Director District 3-4*  
*District Health Director District 3-3*  
*District Health Director District 4*  
*District Health Director District 3-5*  
**Douglas CORE – A Community Organizing Resources for Excellence, Inc.**  
**Douglas County School System** – *key informant and online community survey distribution*  
**Fulton County Commissioner**  
**Fulton County Policy Analyst, District 302**  
**Georgia Department of Education**  
**Georgia Health News** – *health news relating to community served*  
**Georgia Health Policy Center at Georgia State University** – *CHNA collaboration and research*  
**Grady Health System** – *CHNA research collaboration*  
**Good Samaritan Health Center of Cobb** – *key informant, site of listening session, Cobb2020 Steering Committee member, and community representative on WellStar Community Health Collaborative Task Force*  
**Helping Hands of Paulding County**  
**Hispanic Health Coalition of Georgia** – *key informant and facilitator of two Hispanic listening sessions*  
**Kaiser Permanente** – *CHNA research collaboration*  
**Kennesaw State University** – *Cobb2020 Steering Committee member*  
**Kennesaw State University, Center for Health Promotion and Wellness**  
**Marietta City Schools** – *Cobb2020 Steering Committee member*  
**Marietta Kiwanis Club** – *Cobb2020 Steering Committee member*  
**MUST Ministries** – *key informant and community representative on WellStar Community Health Collaborative Task Force*  
**North Georgia Health District (1-2)**  
**Northeast Health District Director, 10 Athens**  
**NorthStar Psychological Services**  
**Northwest Georgia Health District**  
**Paulding Community Health & Resource Center Steering Committee members**  
**Paulding County Health Department** – *key informant, site for listening session and distribution of online community health survey*  
**Paulding County Sheriff's Office**  
**Piedmont Healthcare** – *CHNA research collaboration*  
**SafePath Children's Advocacy Center, Inc.**  
**Senior Citizens Council of Cobb County**  
**Ser Familia** – *key informant, site for listening session, Cobb2020 Steering Community Health Collaborative Task Force, and community representative on the WellStar Community Health Collaborative Task Force*

**Smyrna Fire/Emergency Management**

**T. Lee Associates / City of Marietta**

***United Way of Metro Atlanta***

**WellStar Center for Health Transformation – *internal data***

**WellStar Cobb Hospital President**

**WellStar Cobb and Kennestone Community Clinics – *internal data***

**WellStar Community Education & Outreach – *internal data***

**WellStar Congregational Health Network:**

*Hickory Flatt UMC – Canton, GA - online survey participants*

*Iglesia de Dios – Austell, GA - listening session site*

*McEachern United Methodist Church – listening session site*

**WellStar Douglas Hospital President**

**WellStar Enterprise Intelligence – *internal data***

**WellStar Regional Health Board Trustees including:**

*Bethel Gardens Assisted & Memory Care (Cobb)*

*Caldwell Insulation, Inc. (Cobb)*

*Community Bank of the South (Cobb)*

*John L. Stone – (Douglas)*

*Keep Paulding Beautiful – (Paulding)*

*Paulding Quick Bail, Inc. (Paulding)*

*Puckett EMS – (Douglas)*

*Southeast Cooler – (Douglas)*

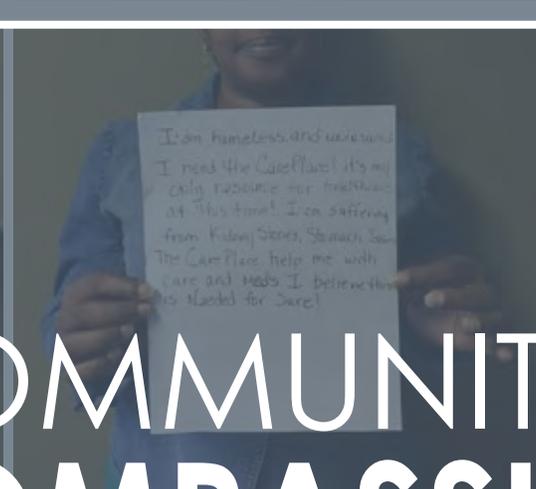
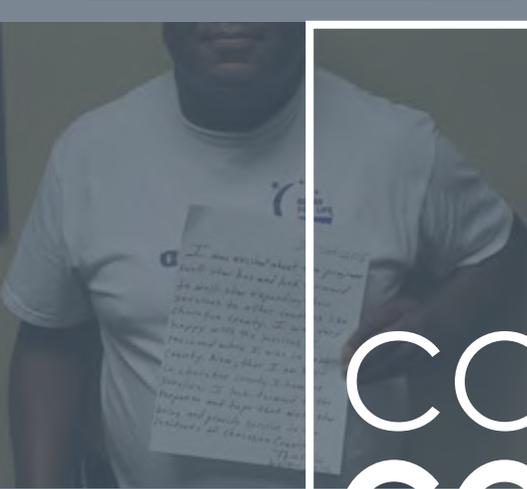
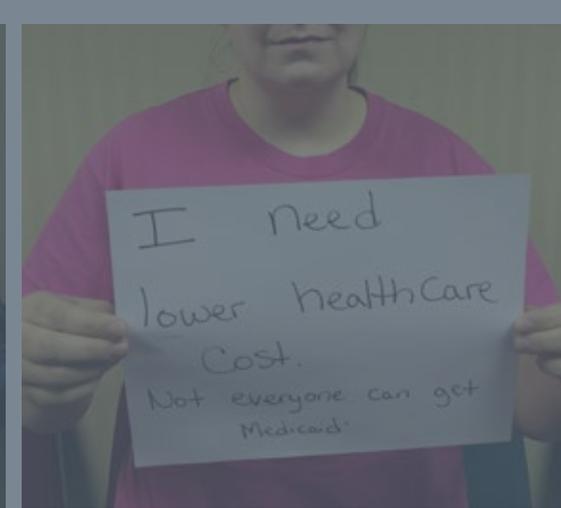
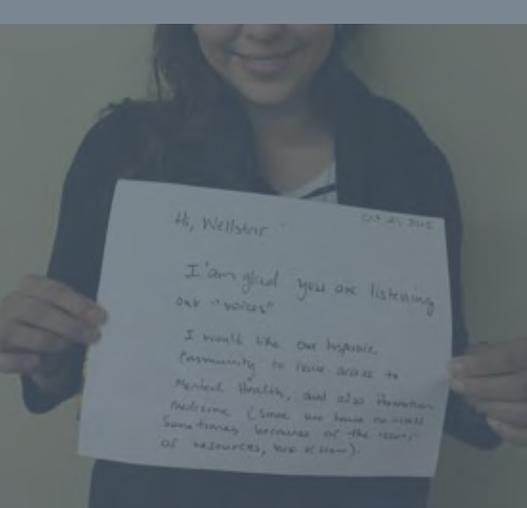
**WellStar Kennestone Hospital President**

**WellStar Medical Group, Director of Practice Operations**

**WellStar Paulding Hospital President**

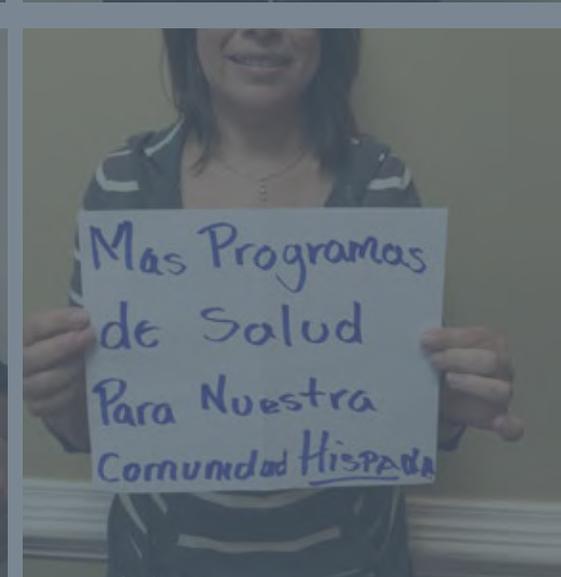
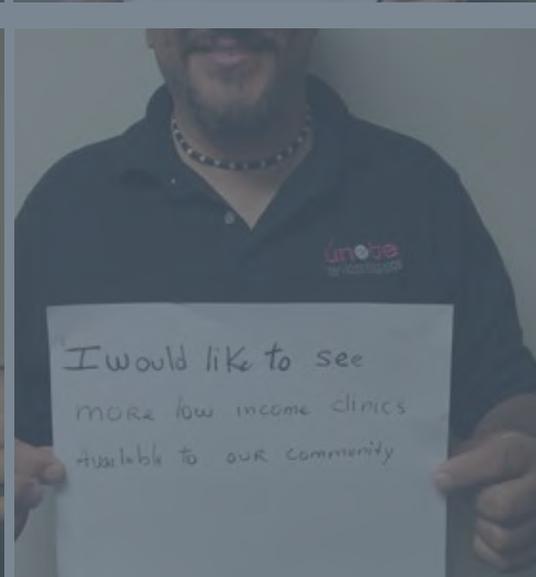
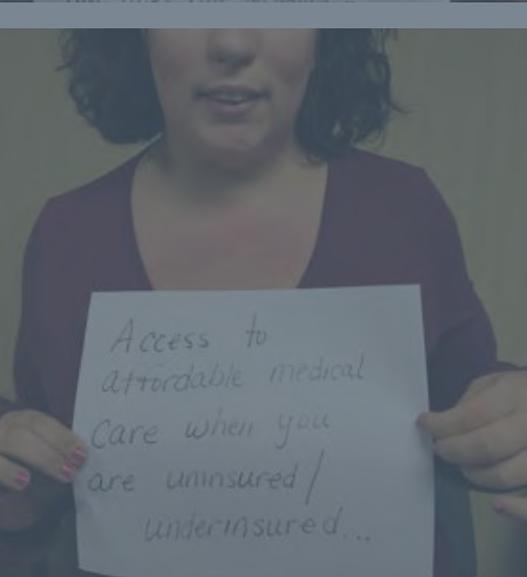
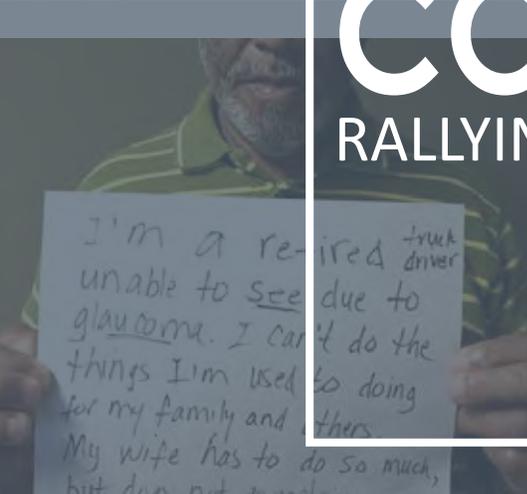
**WellStar PR, Marketing and Internal Communications – *production of survey tools***

**YMCA – Northwest Georgia - *posting of online community health survey***



# COMMUNITY IS COMPASSION

RALLYING PEOPLE AND RESOURCES



## MAJOR HEALTH CHALLENGES AND DRIVERS

Since the initial 2013 health assessment across the WellStar community, health needs remained consistent and similar health challenges and drivers were cited:

- Chronic disease prevention and management
- Access and affordability of healthcare, health insurance or viable alternatives<sup>69</sup> (those that have insurance can't afford rising premium costs and deductibles)
- Health equity and literacy; lack of resources that are linguistically and culturally appropriate
- A concern about the prevalence of patient education and health fairs/ events with health screenings without a connection to needed follow-up care
- Lack of knowledge of available health resources, services and navigation assistance
- A decrease in Public Health Department funding and staffing
- Low-income residents and those who are fearful of their illegal status (undocumented Hispanics) are slow to seek medical attention
- Inequalities in determinants of health<sup>70</sup>
- Medication access and affordability
- Targeted, prevention-based education to address health needs to combat the lack of understanding of how lifestyle choices affect health
- Health education programs built on behavior change and physical activity are not equal across all counties
- Transportation for care access
- Increase of heroin use by teenagers and young adults
- Lack of healthy food options in areas where vulnerable populations live
- Underuse of preventive care among men
- Lack of good health in early childhood / maternal and infant health
- Lack of affordable dental care
- Culture of violence and stress among vulnerable populations



## ACCESS TO CARE

Underuse of Primary Care  
(Adults & Children)

Lack of Care Capacity  
in Community Safety  
Net Clinics

Overuse of Emergency  
Department for  
Non-Emergent Needs

High Cost of Medication

Underuse of Behavioral/  
Mental Healthcare

Underuse of Dental Care

Language and Cultural  
Barriers

Underuse of Mental/  
Infant Care

Lack of Transportation  
to Medical Care

The significant health needs related to **access to care** stem from socioeconomic and clinical care barriers. These barriers create health disparities in the communities WellStar serves especially among the most vulnerable populations (low-income, uninsured, low education attainment, elderly). Underuse denotes lack of capacity /access and cost of the care.

## HEALTHY LIFESTYLES

Type 2 Diabetes

Cancer

Tobacco Use

COPD/Asthma

Cardiovascular Disease/  
Stroke

Obesity

Substance Abuse

Underuse of Preventive  
Cancer Screenings

Lack of Physical Activity/  
Poor Nutrition

STDs

Violence

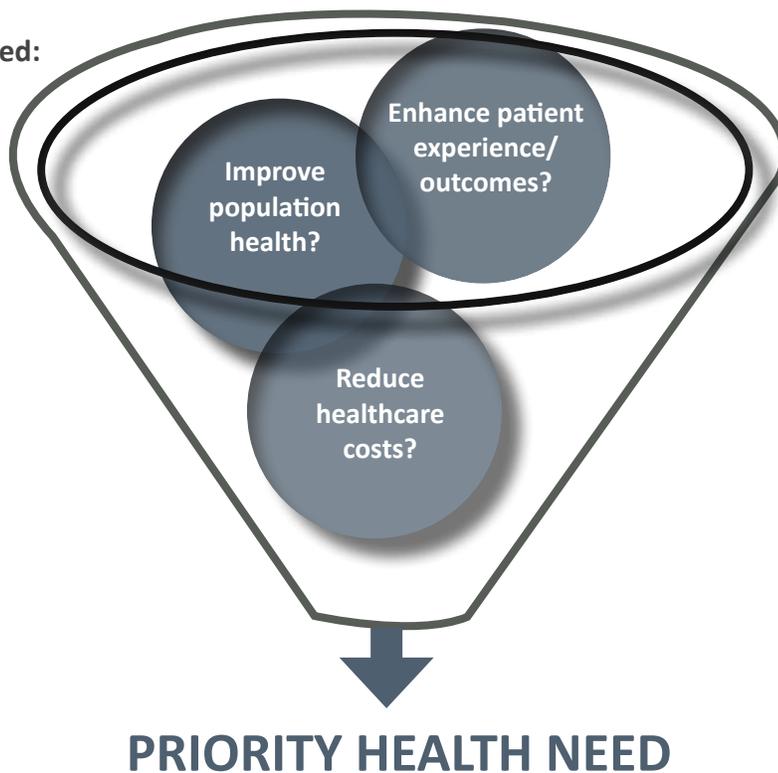
Suicide

The significant health needs related to **healthy lifestyles** primarily stem from health behaviors causing chronic disease and/or behavioral health issues. These needs require intervention and management through clinical care, lifestyle modification (primary prevention) and education and “prescribing resources” (secondary prevention).

**PRIORITY  
HEALTH NEEDS  
PROCESS**

Focused on preventable health behaviors and access to care, priority health needs were identified by the WellStar Community Health Collaborative task force using the Triple Aim criteria.

Does the need:



Health needs were plotted by A.L. Burruss Institute of Public Service and Research during the Summit using a Qualtrics survey that measured the severity of need and capacity to address the need assigned by each task force member. The health needs with the highest need and highest capacity were identified as the priority needs.

Implementation-driven questions were considered as task force members brainstormed actionable strategies for addressing the needs:

- How severe is the issue against benchmarks?
- Are there clear disparities/inequities?
- Are there existing assets, facilities and resources dedicated to the issue?
- Is there an opportunity to intervene at the prevention level?
- Do feasible and effective evidence-based interventions exist?
- Do we have a solution that has the potential to solve multiple problems leveraging existing and/or potential collaborative community partners and assets?

**PRIORITY NEEDS**

The following 2016 access to care and healthy lifestyles (for chronic disease prevention) priority health needs, with the exception of underuse of primary care, track with the trends and research findings in the inaugural 2013 CHNA report:

**UNDERUSE OF PRIMARY CARE - ED UTILIZATION - CARE CAPACITY IN CLINICS**

**CANCER**

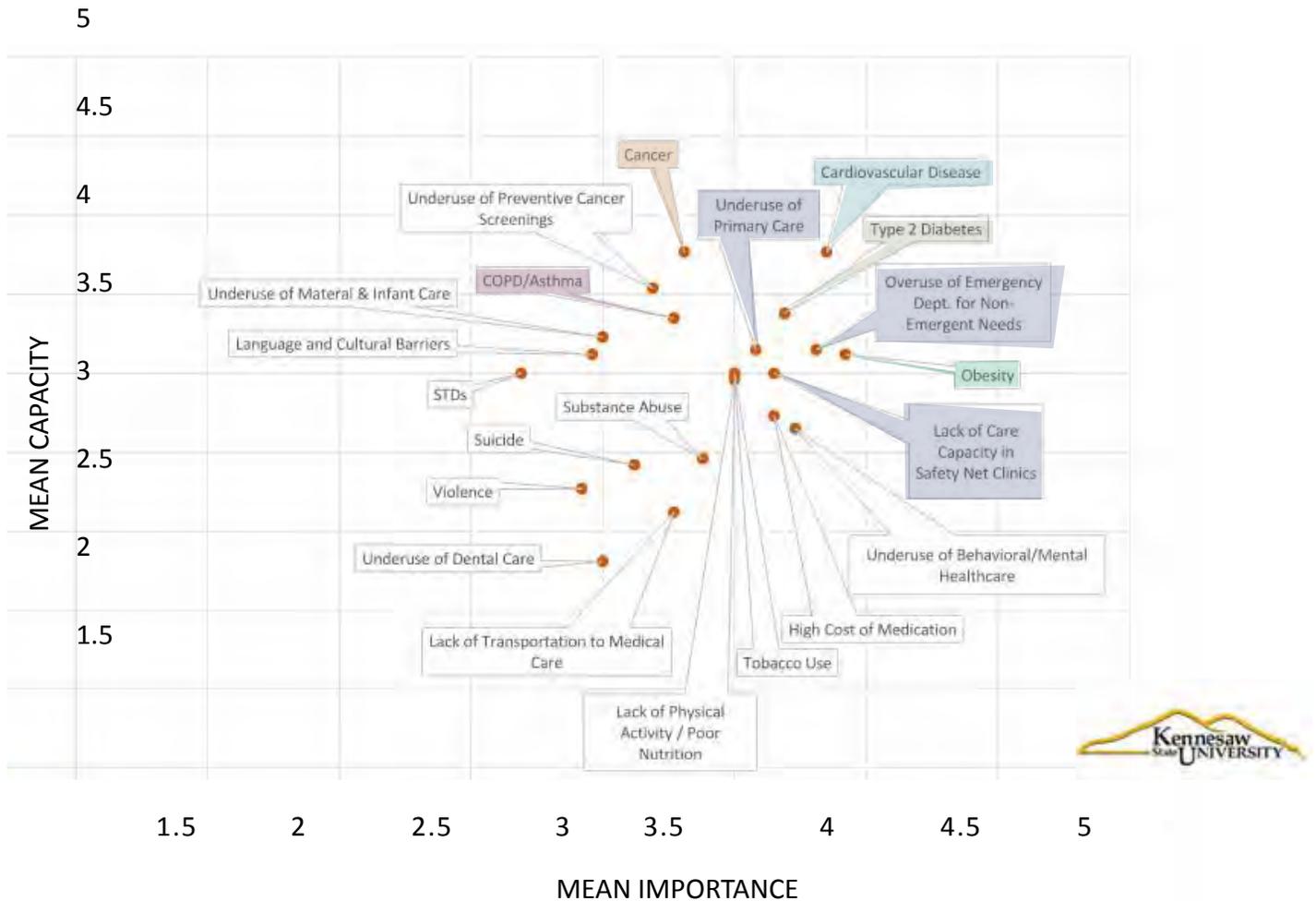
**CARDIOVASCULAR DISEASE**

**COPD & ASTHMA**

**OBESITY**

**TYPE 2 DIABETES**

**Community Health Needs Rated by Importance & Capacity**



When implementing strategies to address priority health needs, many other significant needs also will be addressed as a byproduct of meeting community benefit objectives. Examples of intersecting needs include:

- The underuse of preventive screenings and tobacco use are actionable areas to help reduce cancer's prevalence (also COPD / asthma).
- Increased access to more affordable medications results from more low-income community members receiving primary care in community clinics with prescription assistance programs.
- Physical inactivity / poor nutrition are addressed with obesity-related, heart disease and diabetes initiatives.
- Also, behavioral health is an integral part of all care WellStar provides – from mental health assessments conducted in the EDs to the new oncology integrated behavioral health services program designed to optimize management of the emotional, behavioral, and cognitive challenges experienced by patients following cancer diagnosis and treatment.

## **NEEDS NOT ADDRESSED**

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

- 1) Beyond the scope of WellStar services, e.g. dental care which is addressed by safety nets clinics
- 2) Needs further intervention, but no plans for expanding current community benefit services at this time, e.g. maternal/infant health
- 3) Relying on community partners with expertise to lead efforts in these areas with WellStar in a supportive role, e.g. substance abuse, violence, suicide, STDs, transportation

If you have any additional feedback regarding the identified  
and prioritized health needs, please email  
**[chna@wellstar.org](mailto:chna@wellstar.org)**.

The background features a stylized, hand-drawn illustration of a community scene. It includes several buildings with windows, some with awnings, and several trees of varying shapes and sizes. The entire scene is rendered in a muted, earthy color palette, primarily shades of brown and olive green. A white square is superimposed over the center of the image, containing the text.

COMMUNITY IS  
**COLLABORATION**  
STRONGER TOGETHER

**STRATEGIC  
COMMUNITY  
PARTNERSHIPS**

Community assets are people, places, and relationships that may be used to achieve the most equitable and optimal functioning of a community. WellStar is on a continuous quest to transform the healthcare community’s culture of working independently (mutual awareness) toward collaborative interdependence (partnership). It’s the optimal way to ensure WellStar, public health, governmental agencies, non-profits, community safety net clinics, and other community stakeholders share the responsibility of care and costs while offering access to a full continuum focused on prevention and wellness.

**Access to Care**

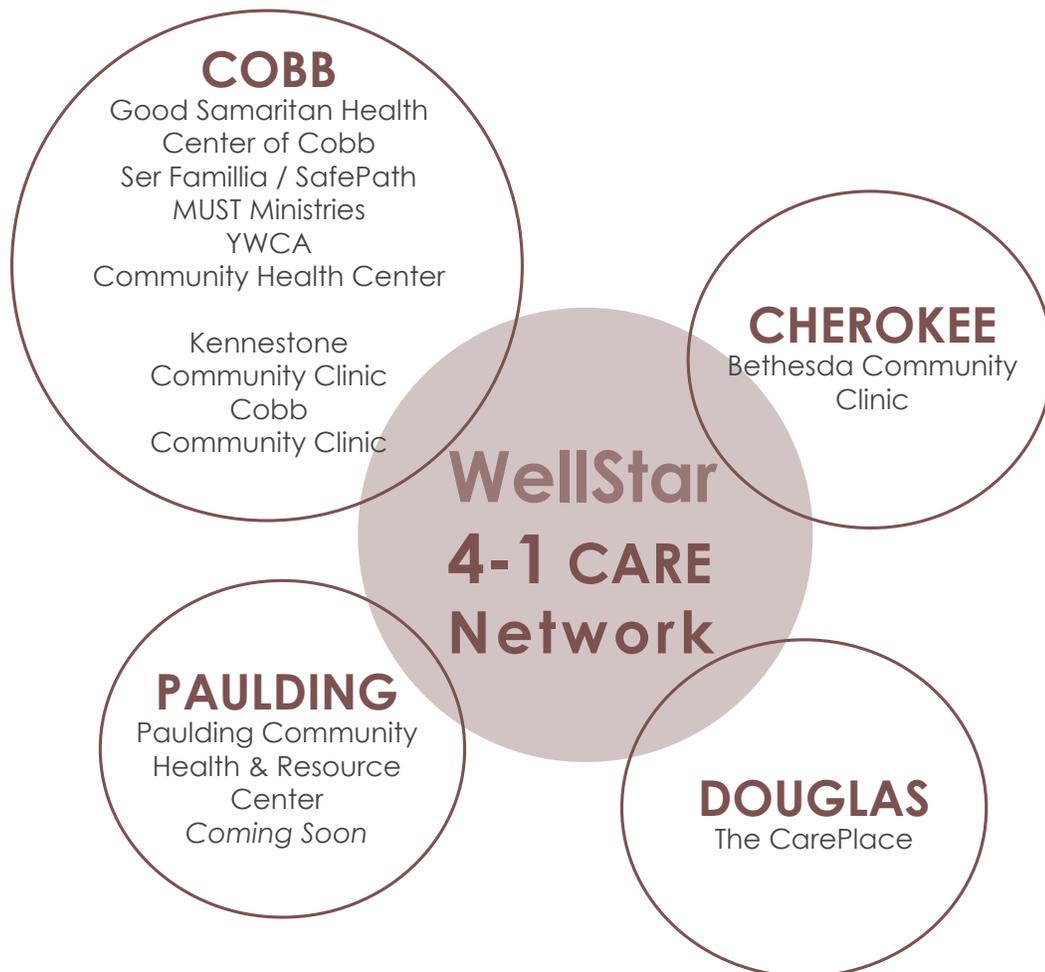
There are deficits and demands in our community for primary care, behavioral health and specialty care/services to vulnerable populations. WellStar will help fill the gap with the WellStar 4-1 Care Network, providing needed services and creating a conduit for physicians and advanced practice professionals to serve community safety net clinics to increase care capacity. Providing vulnerable community members with the “right care at the right place” helps maximize and leverage partnerships outside of WellStar facilities and optimize patient outcomes.

The diagram shows WellStar’s care partnerships serving the medically underserved and uninsured populations. Through these partnerships, more community members can be served.<sup>71</sup>

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*Forging well-defined collaborative partnerships helps build a comprehensive low-cost health delivery system.*

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Strengthening these partnerships creates a more comprehensive and sustainable low-cost healthcare system. By coordinating medical services and community resources to leverage assets and bridge care gaps, the WellStar Community Health Collaborative can serve as an organizational launching pad for partners to meet growing and costly healthcare needs.

To address mounting behavioral health needs in the community, the WellStar Behavioral Health Network (WBHN) initiative was introduced in 2015. The network's aim is to organize and coordinate a coalition of behavioral health service providers to increase access to care for community members with mental health and substance abuse conditions, including the most vulnerable. It also aims to reduce unnecessary Emergency Department utilization and readmissions for those needing behavioral health services.

Comprised of formal partnerships with the WellStar Behavioral Health Service Line<sup>72</sup>, mental health services are accessed through a centralized Behavioral Health Assessment & Resource Center (ARC) to expedient care access and assure quality consistency in care delivery standards. WBHN partnerships<sup>73</sup> will be forged to fill service gaps and address key behavioral health needs in a manner that creates access across WellStar's expanding community.

## **Healthy Lifestyles**

Community partnerships are vital to improving access to care and healthy lifestyle interventions through public health policies, referral processes, community-based care and services, health education programs, and other community benefit initiatives.

WellStar's Community Education & Outreach Department is a conduit for outreach and delivery of community benefit services to help meet priority health needs in communities with health disparities.

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*Creating partnerships helps maximize collective resources to maximize community health improvement efforts.*

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Community Education & Outreach has forged local community partnerships for community health education, programs and services (including screenings and immunizations): THIS MAY NOT BE AN ALL-INCLUSIVE LIST.

American Cancer Society	Georgia Healthcare Decisions
American Diabetes Association	Goshen Valley Boy's Ranch
American Heart Association	Graduate Marietta Student Success Center
American Lung Association	It's the Journey
Atlanta Blaze	Kennesaw State University
Atlanta Community Food Bank	LakePoint Sports Complex
Atlanta Regional Commission	Live Healthy Douglas
Bright Horizons Foundation	March of Dimes
Camp Kudzu	Marietta City Schools
Cherokee County School District	Medical Association of Georgia
Cherokee Senior Services	MUST Ministries
Children's Haven Inc.	Nobis Works
City of Kennesaw	Osher Lifelong Learning Institute
City of Marietta	Paulding County School District
Cobb 2020 Healthy Lifestyles Committee	Paulding Senior Services
Cobb County Department of Public Safety	Positive Athlete Georgia
Cobb County Safety Village	Safe Kids Cobb County
Cobb County School District	Safe Kids Georgia
Cobb & Douglas Public Health	SafePath
Cobb Master Gardeners	Susan G. Komen Greater Atlanta
Cobb Senior Services	Town Center at Cobb
Congregations/Faith Based Organizations	Wal-Mart
Davis Direction Foundation	YWCA of Northwest Georgia
Douglas County School District	
Douglas Senior Services	
Family Life Resource Center	
Family Promise of Cobb County	
Georgia Faith Community Nurses Association	

**National/International Partnerships:**

Safe Kids Worldwide  
Spirit of Women

## WellStar Congregational Health Network Partners

70+ congregations and faith-based organizations are conduits for community-based continuing care, screenings and education:

Acworth United Methodist, Acworth  
Allen Temple AME, Woodstock  
Antioch Loving Spirit Missionary Baptist, Mableton  
Bethel AME Church, Acworth  
Beulah Baptist Douglasville  
Bible Way Ministries International, Atlanta  
Calvary Baptist Church, Austell  
Calvary Christian Ministries, Powder Springs  
Catholic Church of St. Ann, Marietta  
Cedarcrest Church, Acworth  
Christians Networking Training Center, Kennesaw  
Clarkston International Bible Church, Clarkston  
Cornerstone Baptist Church, Lithia Springs  
Divine Order Church, Marietta  
Douglasville SDA Church, Douglasville  
East Cobb Church of Christ, Marietta  
East Cobb United Methodist, Marietta  
Ewing Road Baptist, Austell  
Faith Christian Center, Smyrna  
Galilee Missionary Baptist Church, Marietta  
Golden Memorial United Methodist, Douglasville  
Gospel Nation Christian Fellowship, Powder Springs  
Grandview Seventh Day Adventist, Austell  
Hickory Flat United Methodist, Canton  
Highpoint Christian Tabernacle, Smyrna  
Hiram Seventh Day Adventist, Hiram  
Holy Family Catholic, Marietta  
Holy Trinity Lutheran, Marietta  
Iglesia de Dios Nueva Vida, Marietta  
Judah Family Worship Center, Austell  
Kennesaw United Methodist, Kennesaw  
Kenyan American Community Church, Marietta  
Larger Than Life Christian Ministries, Douglasville  
Liberty Church, Marietta  
Lithia Springs Assembly of God, Lithia Springs  
Little River United Methodist, Woodstock  
Mableton First Christian, Mableton  
Marietta Adventist, Marietta  
Marietta Christian, Marietta  
Marietta First Christian (Disciples of Christ), Marietta  
Mars Hill Presbyterian, Acworth  
McEachern Memorial United Methodist,  
Powder Springs  
Mt. Zion AME, Kennesaw  
New Mountain Top Baptist Church, Winston  
Nurses Changing Communities, Inc., Sugar Hill  
Oasis Family Life Church, Dallas  
Philadelphia Seventh Day Adventist, Douglasville  
Piedmont Baptist, Marietta  
Pine St. Missionary Baptist Church, Marietta  
Pleasant Grove Missionary Baptist, Marietta  
Roswell Street Baptist, Marietta  
Salem Seventh Day Adventist, Mableton  
Shiloh Seventh Day Adventist, Smyrna  
Smyrna First United Methodist, Smyrna  
Smyrna Life Church Assembly of God, Smyrna  
St. Andrew United Methodist, Marietta  
St. Catherine's Episcopal, Marietta  
St. John Vianney Catholic, Lithia Springs  
St. Joseph Catholic Church, Marietta  
St. Mark AME, Atlanta  
St. Phillip Benizi Catholic Church, Jonesboro  
St. Teresa's Episcopal, Acworth  
St. Thomas the Apostle Catholic, Smyrna  
StoneBridge Church, Marietta  
Sweet Home Missionary Baptist, Hiram  
The Pointe Church, Canton  
Transfiguration Catholic, Marietta  
Turner Chapel AME, Marietta  
Unity North Atlanta, Marietta  
Walker Tabernacle Baptist Church, Atlanta  
Zion Baptist Church, Marietta

**OTHER  
POTENTIALLY  
AVAILABLE  
COMMUNITY  
RESOURCES**

The WellStar region has a multitude of community and organizational assets including local healthcare facilities, faith-based institutions and independent community groups.<sup>74</sup> This section identifies resources that exist to provide low or no cost care access points for the most vulnerable and provide prevention education and health improvement services to the broader community. This list provided by the GHPC is not all-inclusive of the myriad health assets in Georgia or in the WellStar legacy hospitals' community nor does it capture the full scale of ongoing and potential partnerships to meet community needs.

Documented health assets fall into three primary focus categories: healthcare, community-focused, and education. The analysis of community assets<sup>75</sup> in the WellStar service area was focused on those providing health and health-related services. A priority is placed on representing organizations that provide services to vulnerable populations, as well as organizations that provide free or sliding scale services in order to better meet the identified health needs of the community.

Community assets and resources include existing health care facilities as access is a major factor to achieving and sustaining good health. Each of the region's counties has within its boundaries or is proximate to the basic community assets of schools, parks and healthcare facilities. Several areas of the region have a high number of facilities to enhance access to care, while other areas are medically underserved such as Bartow County.

**HOSPITALS**

**Acute Care Hospitals in the WellStar Region**

Cartersville Medical Center (HCA)	Cartersville	Bartow
Northside Hospital – Cherokee	Canton	Cherokee
WellStar Cobb Hospital	Austell	Cobb
WellStar Douglas Hospital	Douglasville	Douglas
WellStar Kennestone Hospital	Marietta	Cobb
WellStar Paulding Hospital	Dallas	Paulding
WellStar Windy Hill Hospital	Marietta	Cobb
Higgins General Hospital (Tanner Health System)	Bremen	Haralson
Piedmont Mountainside (Piedmont Healthcare)	Jasper	Pickens

STATE-WIDE  
RESOURCES

**Boys and Girls Club** - Provides a structured and positive environment and programs for young people. <http://bgcncg.org/>

**SERVES:** Bartow, Cherokee, Cobb, Douglas, Paulding

**The Center for Family Resources** - Works to stabilize and empower families so they may become self-sufficient. <http://thecfr.org/about-cfr/>

**SERVES:** Cobb and Metro Atlanta

**Communities in Schools** - The nation's largest dropout prevention organization champions the connection of needed community resources with schools to help young people successfully learn, stay in school and prepare for life.

<http://www.communitiesinschools.org>

**SERVES:** Cobb, Douglas

**Georgia Family Connection** - Collaborative organizations operating independently in counties bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Georgia's children and families. <http://www.gafcp.org>

**SERVES:** All Counties

**Georgia Head Start** – Provides early childhood and family development services to children from birth to five-years-old, pregnant women and families including medical, dental, and mental health; nutrition; parent involvement and family support. <http://www.georgiaheadstart.org>

**SERVES:** All Counties

**United Way** - Seeks to provide for the immediate needs of those in crisis situations, meet long-term needs through the educational, emotional and moral guidance of children and enable financially or physically disabled people to become self-supporting.

Websites are regional, e.g. <https://www.unitedwayatlanta.org>

**SERVES:** Bartow

**YMCA** - Focuses on youth development, healthy living and social responsibility. Website are regional, e.g. <http://www.ymcaatlanta.org>

**SERVES:** Bartow, Cherokee, Cobb

**YWCA of NW Georgia** - Delivers programs and services that increase the awareness and reduce the occurrence of domestic violence and sexual assault to victims over the age of 13. [www.ywca.org](http://www.ywca.org)

**SERVES:** Cobb, Cherokee, Paulding

## BARTOW

**Advocates for Children** is dedicated to preventing and treating child abuse. A national program, CASA trains volunteers to help abused and neglected children in the juvenile court system. <http://www.AdvoChild.org>

**Allatoona Community Action** Partnership assists low income individuals and families to acquire useful skills and knowledge, to gain new opportunities, and achieve self-sufficiency. Programs include: adult basic education/GED assistance, job readiness training, holistic case management, and emergency housing assistance. <http://www.tallatoonacap.org/>

**Allatoona Resource Center** provides the residents of South Bartow with assistance programs and educational and employment resources/opportunities. Features a gym facility providing programs and recreation for youth. [http://www.bartowga.org/departments/social\\_services\\_indigent\\_care/allatoona\\_resource\\_center/arc\\_links.php](http://www.bartowga.org/departments/social_services_indigent_care/allatoona_resource_center/arc_links.php)

**Good Neighbor Homeless Shelter** provides men, women, and families with temporary shelter and physical, emotional, and spiritual support. They assist guests with developing and prioritizing goals for their return to the community as productive members. <http://www.goodneighborshelter.org>

## CHEROKEE

**Bethesda Community Clinic** delivers healthcare to the underserved, uninsured and underinsured populations of Cherokee County and the surrounding areas. They offer physical exams, well-woman exams, limited dental care, acute care, chronic disease management, diabetes education and nutrition classes, wellness coaching, prescription assistance, and blood lab testing including STD/HIV testing. <http://www.bethesdacommunityclinic.org>

**Cherokee Day Training Center** assists Cherokee County residents with developmental disabilities by providing training services, recreational activities and community based employment opportunities. <http://cherokeetrainingcenter.com/>

**Cherokee Family Violence Center** provides free services to meet the needs of victims of domestic violence, educate stakeholders, and hold batterers accountable so victims and the community are safe. <http://cfvc.org/>

**Georgia Breast Cancer Coalition** is a non-profit education and advocacy organization founded by breast cancer survivors to focus the attention of Georgians on the epidemic proportions of breast cancer. <http://www.gabcc.org/>

**LEAD (Launch, Expose, Advise, Direct)** provides at-risk, inner city, male youth with access to higher education and civic engagement. Using the sport of baseball as the motivating tool, LEAD provides young men with programming that shows them how to be productive citizens. <http://lead2legacy.org/>

## **COBB**

**Anchor of Hope** is a Christian organization providing financial and spiritual support, encouragement, community resources and services to families with disabilities. <https://www.anchorofhopefoundation.com/>

**Adaptive Learning Center for Infants and Children, Inc.** maximizes the potential of young children with disabilities, and creates awareness and acceptance between non-disabled people and people with disabilities. <http://www.adaptivelearningcenter.org>

**The Adult Disability Medical Home (ADMH)** is an innovative and comprehensive program providing health and wellness to teens and adults with developmental disabilities. <http://www.adaptivelearningcenter.org>

**The Community Health Center (CHC) / Grassroots Dental** is a nonprofit organization whose mission is to provide quality, affordable medical and dental healthcare to the communities in north-west metro Atlanta. <http://www.chcaustell.org/>

**Good Samaritan Health Center of Cobb** is a Federally Qualified Health Center (FQHC) that provides a comprehensive range of medical, dental, prescription, and select social services for patients without health insurance or the means to afford care. <http://www.goodsamcobb.org/>

**Cobb Community Collaborative** is a membership of nonprofit organizations, local government, businesses, faith-based organizations, educational institutions, professional organizations, associations and citizens who share ideas, expertise and resources to meet the needs of Cobb County. <http://www.cobbcollaborative.org/>

**MUST Ministries** cares for those in need in the Marietta, Smyrna and Canton/ Cherokee communities. <http://www.mustministries.org/>

## DOUGLAS

**Good Samaritan Center of Douglas County** assists needy families in the Douglasville area with utility bills, prescriptions, food, and spiritual counsel. The Center is a food bank and emergency assistance center for Douglas County residents.

<http://www.goodsamaritancenter-douglasville.com>

**Douglas C.O.R.E.** (Community Organizing Resources for Excellence) focuses on teen pregnancy, physical and mental health disparities, childhood immunization, and truancy rates. [Douglas.gafcp.org/](http://Douglas.gafcp.org/)

**The D.A.N.N.Y.** (Developing and Nurturing Needy Youth) Center, Inc. serves as a centralized resource for the community for both Douglas and Cobb counties to enrich the lives of the youth in our community and serve as facilitators that provide education, career, and recreational opportunities for all youth who can benefit from them.

<http://www.dannycenter.org>

## PAULDING

**The Paulding Community Health & Resource Center** has received 501(c)(3) status and has a working Board and Standing Committees comprised of multi-sector community leaders. Its mission is to serve as a community wellness resource and safety net solution for those who are underserved and most vulnerable at a centralized location. ***Board and committee members represent county-specific organizations that are potential community partners.***

Other potential partners were recommended by WellStar key informants and are included in the supplemental appendices under Key Informant Input.



# COMMUNITY IS **CHANGE**

EMPATHY CONNECTS US.  
ACTION DEFINES US.

**IMPLEMENTATION STRATEGY UPDATE**

Phase 1 of the five-year 2013 CHNA Implementation Strategy to expand access to care and improve healthy lifestyles through collaborative partnerships and via existing and proposed WellStar facilities, providers, resources, and programs is still underway with a more targeted approach to delivering community benefit services.

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*Community benefit expansion takes people, resources and partners.*

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Since 2013, WellStar audited its delivery of essential prevention, education and wellness programs and adapted to changes in regulations, laws and technology to meet the demands of our growing population. With the addition of community benefit liaisons appointed by the hospital presidents, each facility is able to measure its specific community benefit services not captured at a System level.

Phase II's stated goal has shifted. In lieu of creating an independent non-profit, WellStar is developing defined, outcomes-driven partnerships with community safety net clinics and other non-profit organizations to provide more affordable and accessible care to the most vulnerable. These WellStar Community Health Collaborative's Partners in Health also will share responsibility for the health of the community by promoting healthy lifestyles focused on the priority health needs.

*Areas Needing Improvement*

No public comments were received after publication of the 2013 CHNA report although feedback was received that the report was reviewed and data was utilized by other health-related organizations. As soliciting public input was part of the final CHNA requirements (December 2015), an email for feedback is now available: **chna@wellstar.org**.

Continued process improvements are needed to better track, measure and report community benefit services, exclusive of indigent, charity and unreimbursed care, for evaluation purposes and to better tell our story<sup>76</sup>.

Evaluation of community benefit services is an area of improvement for WellStar as much Phase 1 work was focused on auditing services and building an infrastructure for accountability and realignment. Baseline data and outputs to assist in stating the anticipated impact of implementation strategies is a necessity. Processes are either in place or being developed for these evaluation methods in the 2016 Implementation Strategy.

A more precise shift and allocation of resources to better align services and education with prioritized health needs and in areas with health disparities also is needed. This will be done in strategic collaboration with WellStar's new community benefit services programs and community assets already serving to bridge health disparity gaps through initiatives and outreach.

**TRACKING  
COMMUNITY  
BENEFIT  
SERVICES**

The initiatives outlined in the 2013 Implementation Strategy were organized using community benefit categories outlined by the Catholic Health Association<sup>77</sup> and tracked by the community benefit software, CBISA. The stated 2013 goals were to improve access to care to vulnerable populations and promote healthy lifestyles via preventive care, programs and activities. The categories now highlight progress in the delivery of community benefit services and initiatives underway.

This is not an all-inclusive list of the community benefit services provided System-wide or by the hospitals. Also, WellStar discloses that some of the stated 2013 initiatives were not implemented or fully implemented due to either its ongoing, five-year approach to the 2013 implementation plan, competing priorities, or limited staffing / resources.

**COMMUNITY  
HEALTH  
IMPROVEMENT  
SERVICES**

**COMMUNITY HEALTH EDUCATION:**

WellStar’s aim to promote healthy lifestyles via preventive care, programs and activities is primarily accomplished through the education and clinical services categories.

- Community Education & Outreach intersected with the lives of more than 153,000 people in FY2015 providing education, screenings and services.
- More than 15,000 free health screenings via Community Education & Outreach health fairs and events in FY2015 at congregations, workplaces, civic organizations, and community events provided opportunity for education and follow-up care with those with identified health risks. Screenings/services provided:
  - Blood pressure
  - Glucose
  - Total cholesterol
  - Weight assessment
  - Bone density
  - Flu shots

**2013 Implementation Strategy Goal:** *Improve prevention-focused education resources and the referral process to free or reduced cost healthcare clinics for continuity of care. Still in progress.*



- 2,800 school-based health programs provided education to more than 62,000 students in Cherokee, Cobb, Douglas, and Paulding counties on nutrition, safety, personal hygiene, and physical activity.
- Child injury programs reached more than 17,000 children and parents through partnership with Safe Kids Cobb County in FY2015.

- Health information and educational opportunities are communicated to more than 13,000 community subscribers of demographic and disease-specific e-newsletters.
- Women’s health education is prevalent in the WellStar community via Spirit of Women<sup>78</sup>/Speaking about Wellness for Women outreach. 2016 marks the 10th anniversary of the women-centered programming, including a robust speaker series, free health screenings, national signature events, and a health and wellness eNewsletter.
- Healthy aging is promoted by The Good Life Club to more than 4,000 seniors in the community including Speaking about Wellness for Healthy Aging and via community partnerships.
- The Population Health Management team collaborates with Cobb Senior Services to help enroll patients in Cobb Senior Center programs, volunteers in outreach projects and provides education and screenings. Also, to bridge care access gaps in the senior population, the outpatient case management team engages with patients in the community and works with other community agencies to find resources to help with mental health, medication assistance, transportation, meals at home and other needs that are identified. The case managers work in a geographically aligned model with physicians to support the senior patients in all aspects of their care.
- Worksite wellness program aligns with the Affordable Care Act's national public health strategy to help address the prevalence of chronic disease in the workplace.

## COMMUNITY-BASED CLINICAL SERVICES:

These are health services and screenings, provided on a one-time basis or as a special event in the community, to meet identified health needs.

- Wellness and health promotion programs (self-help groups) abound for the community creating a supportive network of preventive care. Support groups are available for heart health, stroke, diabetes, COPD, weight management, nutrition, and cancer survivors and caregivers.
- Clinical engagement in tobacco cessation and prevention education is underway. Providers and case managers at multiple WellStar locations are undergoing smoking cessation training in partnership with Pfizer utilizing its “Advise to Quit” curriculum. In the community, WellStar participated in the American Lung Association’s state-wide “Nobody Quits Like Georgia” campaign.

**2013 Implementation Strategy Goal:** *Increase cancer prevention and education community outreach (including smoking cessation program) utilizing the WellStar Cancer Program team.*



- To address mental health issues and substance abuse, WellStar is developing the WellStar Behavioral Health Network, a coalition of behavioral health service providers/partnerships to increase access to care for community members, including the most vulnerable. The network will expand WellStar’s capacity with referrals to partnering agency mental health providers, resources and education via the telesite Behavioral Health Assessment & Resource Center (ARC).

**2013 Implementation Strategy Goal:** *Develop a more collaborative delivery system for behavioral health services/resources through partnerships.*



- To expedite examinations and assessments of alleged child abuse, WellStar has embedded a nurse practitioner at Cobb County’s SafePath Children’s Advocacy Center.
- Primary care delivered by WellStar Community Clinics on the Cobb and Kennestone hospital campuses helps reduce hospital Emergency Department visits and hospital admissions among low-income, uninsured patients needing non-emergent care.
- Endorsed by the Lung Cancer Alliance as a Screening Center of Excellence,<sup>79</sup> lung cancer screenings are provided to low-income, high-risks patients in needs via the WellStar Foundation at nine WellStar imaging centers.
- Grant-funded vouchers from community partners provide free mammogram screenings to women in need. Partners include the Susan B. Komen Atlanta Chapter, East/West Church in Austell, Biker’s Battling Breast Cancer, It’s the Journey, National Breast Cancer Foundation, and generous gifts from WellStar team members through the WellStar Foundation.

**2013 Implementation Strategy Goal:** *Expand free health screenings to the underinsured and uninsured through WellStar Community Education & Outreach.*



- The impact of WellStar Community Clinics’ (Cobb and Kennestone outpatient service) referrals from the Emergency Departments (ED) is a more than 50 percent reduction in ED visits and a 40 percent reduction in hospital admissions.

**2013 Implementation Strategy Goal:** *Reduce preventable hospital admissions, readmissions and Emergency Department visits by redirecting care to community clinics and primary care via the hospital-based care management program.*



- Partnerships with community safety net clinics that provide free or low cost health care to the medically underserved and uninsured<sup>80</sup> receive support via free or reduced costs labs and radiology services and limited specialist care. Revised collaboration agreements are in effect to better track and measure outcomes of patients served and referred by WellStar to partnering clinics.

**2013 Implementation Strategy Goal:** *Strengthen collaborative partnerships with community stakeholders to increase access to preventative and primary care, improve quality and reduce cost.*



- The new **4-1 Care Network** will leverage the expertise and skill of WMG providers as care partners in community safety net clinics.

**2013 Implementation Strategy Goal:** *Increase the number of hospital-affiliated / WMG providers and specialists providing free or reduced cost healthcare.*



## HEALTHCARE SUPPORT SERVICES:

*Provided to increase access and quality of care to individuals, especially those in vulnerable populations.*

- WellStar's Accountable Care Organization (ACO) ranks in the nation's Top 10 as a pioneer in managing the care and improving the clinical outcomes of its aging Medicare community of more than 65,000 people. A focus on prevention and chronic disease management decreases costs and improves health and quality of life.

**2013 Implementation Strategy Goal:** *Provide community benefit leadership/consultation for the prevention and management of diabetes, cancer and cardiovascular disease.*



- Established in 2016 to meet the multi-faceted needs of high-risk Medicare and other community members with chronic disease, the Comprehensive Care Clinic provides fully-integrated care featuring self-help programs and clinical management to help reduce ED utilization and preventable hospital admissions.
- Hospital-based care coordinators have increased the number of referrals of frequent Emergency Department visitors with chronic disease to outpatient community clinics to receive needed primary care services and management. This is an area of needed process improvement.

**2013 Implementation Strategy Goal:** *Reduce preventable hospital admissions, readmissions and Emergency Department visits by redirecting care to community clinics and primary care via the hospital-based care management program.*



- The “Green Belt Project” has boosted hospital, WMG referrals and community clinic referrals for outpatient Diabetes Self-Management Education (DSME). DSME is available at no cost to patients below 125 percent FPL, those considered indigent, and at a reduced cost to patients qualifying for Community Financial Assistance.

**2013 Implementation Strategy Goal:** *Expand the accessibility to hospital inpatient and outpatient Diabetes Self-Management Education and services to the medically underserved and uninsured.*



- The WellStar Congregational Health Network’s upcoming pilot program at WellStar Paulding Hospital will take patient care beyond routine discharge planning. Adaptation of the MEMPHIS Model for better health navigation and care transitions from hospital to home will assist patients to better manage chronic disease and, as a result, decrease hospital readmissions. The model builds congregational health ministries and trains liaisons to help with education, prevention and continuum of care post-discharge.

**2013 Implementation Strategy Goal:** *Engage faith-based organizations in coordination and provision of care (MEMPHIS Model).*



- To help eliminate language barriers in the EDs, medical interpreters are onsite to help the Latino population communicate with care providers.
- Expanding low-cost medication access through centralized reduced cost Pharmaceutical Patient Access Programs (PAP) and the Federal 340B Drug discount Program<sup>81</sup> are under evaluation. Currently, there are no structured PAPs at the hospitals, but Paulding is looking into a discount card program in the ED to reduce costs to the patients and the health system. Vouchers are used in the WellStar retail pharmacies to reduce drug cost for certain brand medications.

**2013 Implementation Strategy Goal:** *Improve medication access through centralized reduced cost Pharmaceutical Patient Access Programs and the Federal 340B Drug Pricing Program for the management of chronic disease and to reduce complications.*



- **770-956-STAR** provides referrals to community services and registration for free or low-cost community health education programming.
- WellStar Cardiovascular Medicine (CVM) wellness coaches are available in the CVM practices to offer mentoring, risk modification strategies and navigate patients to other heart health services.
- The WellStar Cardiac Network’s outpatient diagnostic team at WellStar Kennestone Hospital provides free heart screenings at the start of each semester for Kennesaw State University athletes using the American Heart Association’s 14-element checklist to determine if an athlete has a higher risk of sudden cardiac death. All incoming student athletes receive an electrocardiogram or echocardiogram read by a cardiologist as part of their physical. This provides an extra layer of safety for the student athletes.

## HEALTH PROFESSIONS EDUCATION

- Recognized as a Certified Advanced Comprehensive Stroke Center by The Joint Commission in February 2015, WellStar Kennestone Hospital meets the highest standards for treating the most complex stroke cases with advanced imaging, staff capability and the presence of neuro-trained intensive care unit. WellStar's commitment to treating stroke is evident by the recent addition of WMG Neuroscience.
- WellStar Connect, the Epic electronic health record, is implemented across the entire System and community clinics for integrated, seamless and safe patient care. Its Open Notes functionality shares outpatient provider notes with patients who have activated a MyChart account (patient portal). WMG's participation in this important and innovative step makes WellStar the first and only organization in Georgia to bring patients the benefit of online access to provider notes.
- Groundwork is set for the accredited Graduate Medical Education (GME) Residency Program to launch in 2017<sup>82</sup>. The GME program will provide evidence-based training programs in internal medicine, emergency medicine, OB/GYN, family medicine, and general surgery. The GME program undergirds WellStar's commitment to improve access to family-centered, prevention-focused care and protect the health status of the community WellStar serves by helping ensure top medical talent stays in the community. Medical residents will provide primary care support in outpatient community clinics to expand low-cost care capacity.

**2013 Implementation Strategy Goal:** *Increase the number of hospital-affiliated / WMG providers and specialists providing free or reduced cost healthcare and clinics via a Graduate Medical Education program. Upcoming.*



- Each year, WellStar's number of academic partnerships continues to grow. Currently, 165 partnerships exist to help mentor, train and provide more than 1,850 clinical rotations to medical students, undergraduate nursing students, allied health students, graduate nursing students, physician assistants, anesthesia assistants, graduate pharmacy students, and others including observers.
- Pediatric care is a top priority with WellStar hosting national and state American Academy of Pediatrics leaders and pediatricians across Georgia in a quality improvement initiative training to improve ADHD diagnosis and treatment processes (January 2016).

*Evaluate hospital-based subsidized health services to more effectively and efficiently allocate assets addressing prioritized health needs of the medically underserved and uninsured.*

- Since the last CHNA, subsidized health services investments have leaped \$8.7 million totaling more than \$10.6 million in uncompensated cost in FY 2015 primarily attributed to assisting elderly community members living in skilled nursing facilities and the expansion in hospice services.

## SUBSIDIZED HEALTH SERVICES

- Women’s Health and Specialty Services at WellStar Kennestone Hospital provides complimentary new mom coaching and education and helps navigate Medicaid moms to needed resources.
- In 2016, all the hospitals and outpatient hospital facilities, including Cobb and Kennestone hospitals’ community clinics for the medically underserved and/or uninsured, expanded Community Financial Assistance (CFA)<sup>83</sup> eligibility requirements to 300 percent FPL. This adjustment helps broaden access to primary care to low-income community members.
- With the largest research staff of any Georgia community cancer program and the highest clinical trial participation rate in the state, the WellStar Cancer Network offers advanced education to reduce cancer risk by promoting early detection. Clinical trials for many cancer types are offered through the network’s partnering practice, Northwest Georgia Oncology Centers.<sup>84</sup>

## RESEARCH

**2013 Implementation Strategy Goal:** *Increase cancer prevention and education community outreach (including smoking cessation program) utilizing the WellStar Cancer Network team.*



- The WellStar Research Institute conducts research targeting community health needs for patient care innovation and safety. Current studies focus on priority health needs of cardiovascular conditions, COPD/asthma and stroke to promote optimal clinical outcomes and ensure the highest standard of care for the community.
- Since 2013, investigators from the WellStar Center for Nursing Excellence have completed more than 20 nursing research studies, many of which have been published, to improve the practice environment and to deliver the highest standards of nursing care to patients.
- To better define a process for partnerships (community benefit) and sponsorships (marketing), requests are formally vetted via an online application process with prioritized community health needs objectives as the bellwether. Contributions are given as part of existing relationships, but the majority of granted requests now are a result of prioritized health needs. Current partnerships focus on a variety of health issues aimed at improving the health of the community.
- Contributions to the WellStar Foundation are invested in vital community services including health screenings, education, safety programs for children and adults in addition to funding advancements in healthcare in the EDs and in cardiac, diabetes and cancer research arenas. WellStar Kennestone Cancer Center’s Survivorship and Support Services was newly renovated through a generous gift from the Foundation. It features a wellness kitchen for nutrition education, a chapel and a Patient Resource Center, the nation’s first IT collaboration with the American Cancer Society to provide access to web-based cancer information resources for the community.

## CASH & IN-KIND CONTRIBUTIONS

## COMMUNITY BUILDING ACTIVITIES

- Participation in multiple coalitions in task-specific projects<sup>85</sup> addressing health needs is an important part of WellStar's People-Citizenship initiative. It encourages and recognizes team leaders' community service and support to organizations focusing on skyrocketing needs such as:
  - Opioids / heroin use (Davis Direction Foundation)
  - Economic development (Cobb Chamber of Commerce)
  - Live Well, Marietta partnership between WellStar Kennestone Hospital and the City of Marietta strengthens the health and wellness of residents via health resources and information focused on women's and men's health, diabetes, nutrition, cancer, and heart health at the monthly Marietta Square Farmer's Market
  - Environmental improvements (Green Prints Trail at Woodstock Elementary and Bright Space build out with CASA<sup>86</sup>)
  - YWCA – provision of clinical care for victims of sexual assault/domestic violence
  - Community support for Goshen Valley Boys Ranch in Cherokee
  - SafePath - helps children who are victims of sexual assault
  - Kennesaw State University's Project IDEAL helps train WellStar Promotores to educate the Hispanic population with diabetes prevention, management and support
  - Advocacy for community health improvement and safety (i.e. Cobb & Douglas Public Health's Cobb2020 Partnership,<sup>87</sup> Live Healthy Douglas, Fit City Kennesaw, Cobb County Senior Services' Health and Wellness Advisory Committee, Safe Kids Cobb County, and Cobb County Safety Village)

**2013 Implementation Strategy Goal:** *Collaborate with Cobb2020 Healthy Lifestyles initiatives.*



- WellStar team members participate in health-related community fundraising and awareness events during work hours tallying hundreds of coordination hours for events such as The Heart Association's Heart Walk, the Atlanta Cancer Society's Relay for Life and the March of Dimes' *March for Babies*.

## COMMUNITY BENEFIT OPERATIONS

*Community benefit operations include costs associated with assigned staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.*

- The WellStar Community Health Collaborative was established to lead community and clinical engagement in community benefit strategy and operations to address prioritized health needs. Overseen by the executive leadership of Strategic Community Development and Population Health Management.

# Tracking Hospital-Specific Progress

GOALS:	Improve access to care to vulnerable populations						
OBJECTIVES	Strengthen collaborative partnerships with community stakeholders to increase access to preventative and primary care, improve quality and reduce costs	Increase the number of primary care providers and specialists providing free or low-cost healthcare programs/clinics via a Graduate Medical Education (GME) program	Reduce preventable hospital admissions, readmissions & Emergency Department visits by redirecting care to community clinics and primary care	Develop a more collaborative delivery system for behavioral health services and resources	Participate as a Cobb Access Health integrator to build a low-income healthcare delivery system in Cobb County	Improve medication access through centralized reduced cost Pharmaceutical Patient Access Programs and the Federal 340B Drug Pricing Program for the management of chronic disease and to reduce complications	
<p style="text-align: center;"><b>System-Wide</b></p>	Created a community benefit services framework deploying task force leaders & hospital community benefit liaisons to meet priority health needs via collaborative partnerships: WellStar Community Health Collaborative	GME based out of WellStar Kennestone Hospital	<p>In progress, part of new 4-1 Care Network.</p> <p>Referrals made to current capacity for WellStar clinics at Cobb and Kennestone.</p> <p>Process and partnerships for more same day referrals in progress with community clinics. Improvements underway for resources and referrals to community safety net clinics for continuity of care.</p>	Developing a WellStar Behavioral Health Network	Establishing the WellStar 4-1 Care Network, a new community benefit services program.	Hospital-based care management provides medication assistance and resources.	
		Good Samaritan Health Center of Cobb					<p>Under evaluation to expand 340B program beyond Cobb.</p> <p>ED and community clinic provides low-cost medication resources</p>
		The CarePlace - Douglasville					
		Established the Comprehensive Care Clinic for management and treatment of chronic disease – partnership with Pfizer for smoking cessation education	Program (2017) will expand low-cost primary care and OB/GYN access				<p>Discharge Lounge team assists patients post discharge with getting their medications filled.</p> <p>Community clinic provides low-cost medication resources.</p>
		Upcoming: Paulding Community Health and Resource Center - Dallas					Pilot hospital for discount drug card.
				Long- term acute care hospital. No Emergency Department.			

# on 2013 Implementation Strategy

## Promote healthy lifestyles via preventive care, programs & activities

<p>Engage faith-based organizations in coordination and provision of care</p>	<p>Expand free health screenings to the underserved and uninsured through WellStar Community Education &amp; Outreach</p>	<p>Provide community benefit leadership/consultation for the prevention and management of chronic disease</p>	<p>Increase cancer prevention/early detection via screenings and education (including smoking cessation program)</p>
<p>Led by Community Education &amp; Outreach and WellStar Paulding Hospital.</p> 	<p>Realigning health-needs specific education to high-need areas via Live Well, a new community benefit services program.</p> 	<p>Ongoing via participation in Cobb2020 and Live Healthy Douglas and other coalitions formed by Community Education &amp; Outreach</p>	<p>In progress utilizing WellStar Cancer Network and hospital-based outpatient imaging centers and via Live Well (cancer prevention and screening).</p> 
<p>Integrating MEMPHIS Model into post-discharge - Pilot program being assessed</p>		<p>Live Well, Marietta</p>	
			

The background is a stylized illustration of a hospital building. The building is multi-storied with many windows. In the foreground, there is a sign that reads "WELLSTAR COBB HOSPITAL". There are several green trees and bushes scattered around the building. The entire illustration is overlaid with a semi-transparent grey filter. A white rectangular box is centered over the text.

# REPORT REFERENCES

- 1 The WellStar Community Health Collaborative is the name of WellStar’s Community Benefit Department (co-led by executive leadership of Strategic Community Development and Population Health Management) and its official Partners in Health who have agreed to collaborate and share responsibility to address community health needs. Its mission is to create innovative, low-cost ways to address health needs of vulnerable populations and to improve overall community health through community-based outreach, education and preventive health services.
- 2 More specifically, community benefit is a clinical or non-clinical program, service or activity with a low or negative margin that would likely be discontinued if the decision were made on a purely financial basis that is: (1) Responsive to identified health needs (access to care / healthy lifestyles). (2) Focused on people who are impoverished, elderly, disenfranchised and/or located in an area with disproportionate unmet health-related needs. (3) Integrated into WellStar’s strategic planning and budgeting process to increase access to care while lowering costs through preventative programming and services. (4) Planned and implemented with program objectives and measurable outcomes that are beneficial to community stakeholders and the community as a whole.
- 3 Conducting a Community Health Needs Assessment (CHNA) is a federal tax law requirement in section 501(r) of the Internal Revenue Code for non-profit hospitals to maintain tax-exempt 501 (c)(3) status. The requirement was added by the Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010 in Section 9007. Community benefit reporting for WellStar’s not-for-profit hospitals is required via Form 990, Schedule H. Under the ACA, hospitals are required to conduct community health needs assessments every three years and implement strategies to address those needs.
- 4 ACA “...legislation contains numerous provisions aimed at improving community health through direct investments in wellness and prevention at the individual and community levels and by making population health improvement an integral part of efforts to improve the quality and efficiency of healthcare.” From “Principles to Consider for the Implementation of the Community Health Needs Assessment Process, June 2013, Sara Rosenblum, Department of Health Policy, The George Washington University School of Public Health Services.
- 5 The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement ([www.ihl.org](http://www.ihl.org)) and often functions as a statement of purpose for healthcare system transformation that will better meet the needs of people and patients. Its successful implementation results in fundamentally new systems contributing to the overall population health while reducing the cost to society.
- 6 Patient experience encompasses the following Institute of Medicine dimensions: safe, effective, patient-centered, timely, efficient, and equitable.
- 7 “True Triple Aim improvement cannot be realized by healthcare systems acting alone, or by solely delivering high-quality care at lower costs. Improving health is a challenge that requires the engagement of partners across the community to address the broader determinants of health.” IHI Leadership Blog, “A Primer for Defining the Triple Aim,” Sept. 23, 2015.
- 8 Process informed by the Catholic Health Association, the Georgia Department of Public Health (Chronic Disease University PowerPoint, August 13, 2015, presented by Melissa Kinkoph, MPH, CHES, Program Manager, Healthy Communities) and valued input by the Cobb & Douglas Public Health’s Department of Epidemiology.
- 9 WellStar joined forces with Kaiser Permanente, Grady Health System and Piedmont Healthcare to leverage the Georgia Health Policy Center’s CHNA research conducted for Kaiser’s 32-county service area footprint. Targeted data reports were provided for the shared counties served.
- 10 Hospital facility census as of December 2015 at the close of CHNA research.
- 11 As an integrated health system, the majority of WellStar’s community benefit services is managed and delivered System-wide by WellStar Community Health Collaborative’s community engagement arm, Community Education & Outreach. WellStar’s service area is deemed one community for this joint CHNA as hospital catchment areas overlap within the five-county primary service area and identified health needs are the same or similar.
- 12 <http://burruss.kennesaw.edu/about-institute.php>
- 13 [www.countyhealthrankings.org](http://www.countyhealthrankings.org) – Health Outcomes based on length and quality of life out of 159 Georgia counties.
- 14 Income inequality gaps are growing in the United States. Despite advances in medicine and education, the difference in life span after age 50 between richest and poorest has more than doubled since the 1970s with smoking, the single biggest cause of preventable death, helping to drive the disparity. Obesity is more ambiguous with the gap narrowing according to the National Academy of Sciences from 1990 to 2010 from 37 percent among the poorest to 31 percent among those on the higher end of the income ladder. Excerpts from The New York Times, “Disparity in Life Spans of the Rich and the Poor Is Growing,” Sabrina Tavernise, Feb. 12, 2016.
- 15 Signifies limited access to healthy foods.
- 16 Chronic diseases—such as asthma, cancer, diabetes and heart disease—cost Georgia approximately \$40 billion dollars each year, keep kids out of school, cost Georgia employers, and results in more than 200,000 thousands of years of life lost. <https://dph.georgia.gov/chronic-disease-prevention>

17 www.countyhealthrankings.org averaged data, 2016

18 The public health system includes government and public health agencies, public sector agencies (schools, Medicaid) and private sector organizations whose actions have significant consequences for the health of the population.

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

20 Healthy lifestyle needs primarily stem from unhealthy behaviors, which can lead to chronic disease. “High-cost patients are twice as likely as the rest of the population to have a chronic condition and four times as likely to have two or more chronic illnesses. In 2012, the top five most costly medical conditions in terms of healthcare expenditures were heart disease, trauma-related disorders, cancer, mental disorders, and COPD/asthma.” Excerpts from the Huffington Post blog post, “Healing the Sickest Patients: How ‘Hot Spotters,’ ‘Frequent Fliers,’ and ‘Super-Utilizers’ Impact Health Care in America” - August 18, 2015.

21 Taken from the Institute of Medicine’s “Primary Care and Public Health” (Washington, D.C., 2012) p. S-1.

22 “While the primary goal of the health system is improving health, another important goal is ensuring responsiveness to the legitimate expectations of the population.” (World Health Organization) This can be achieved with the help and expertise of the Public Health System as a whole and through formalized strategic community partners.

23 “Government and private insurers are increasingly emphasizing quality of care in reimbursements, instead of just paying for the quantity of services delivered.” Excerpt from “Broader strategy: From local hospitals to regional players,” Georgia Health News, Dec. 10, 2015.

24 From the 2013 Implementation Strategy Report: “To implement a five-year, two-phased Community Benefit program that is sustainable and strategically aligned with the WellStar Health System mission and vision to address the prioritized health needs of the uninsured and low-income populations. This is accomplished through expanding provider participation, education, outreach and prevention activities/programs to promote healthy lifestyles and access to care (Phase 1: 2013-2015) and creating a collaborative safety net organization for shared accountability to leverage and maximize complementary skills and capacity building (Phase 2: 2015-2018).”

25 Expected rollout of the WellStar 4-1 Care Network is the fall of 2016. The network relies on WMG physicians and advanced practitioners to help build care capacity in partnering community clinics. The name reflects the goal to treat and prescribe resources one person at a time to improve primary care access to the most vulnerable.

26 WellStar’s Center of Health Transformation is the catalyst for developing pathways for improving patient safety, care efficiency and technology by bringing together not-for-profit health systems, universities and technology organizations to develop real-world health solutions through collaboration, research and innovation. It also serves as an incubator for promising new solutions to medical challenges in Northwest Georgia and beyond.

## COMMUNITY IS COMMITMENT

16

27 An example is WellStar’s Center for Health Transformation builds a collaborative network of start-up tech, higher education and research institutes to develop new, innovative solutions to improve care delivery and lower costs.

28 An integrated healthcare delivery system is not just comprised of acute care hospitals. WellStar provides access to comprehensive rehabilitation, education, outpatient services, and post-acute services to its patients.

29 Since the inception of WellStar’s ACO in July 2012, providing better care at a lower cost has saved more than \$37 million.

30 These IRS defined community benefit categories are exclusive of uncompensated indigent care, charity care and bad debt.

31 Federal poverty level is a measure of income level issued annually by the Department of Health and Human Services. FPLs are used to determine eligibility for certain programs and benefits. [https://dch.georgia.gov/sites/dch.georgia.gov/files/related\\_files/document/2015\\_Federal\\_Poverty\\_Guidelines.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/2015_Federal_Poverty_Guidelines.pdf)

32 Guided by government policy, indigent care is care provided to those who do not have insurance and are not eligible for other healthcare coverage such as Medicare or Medicaid. Charity care is guided by hospital policy and is care provided for free or reduced prices to low-income patients. Community Financial Assistance (CFA) is available for qualifying community members.

33 The reduction reflects the full implementation of the propensity to pay system which automatically identifies indigent patients and classifies them as charity without waiting for the completion of the CFA process.

34 Memorandums of Understanding (MOUs) are in effect with community safety net clinics to help serve the uninsured, underserved and most vulnerable populations to improve community health. The MOUs are being reviewed and revised as part of the WellStar Community Health Collaborative.

35 U.S. Census Bureau, 2014. Note population totals don’t align with the county profile data generated by the Georgia Health Policy Center who used 2010-2013 data.

36 County Health Rankings, 2016

37 U.S. Census Bureau, American Fact Finder. 2010-2014 American Community Survey 5-year estimates. [www.factfinder.census.gov](http://www.factfinder.census.gov).

38 U.S. Census Bureau American Fact Finder, 2010-2014 American Community Survey- 5-year estimates. [www.factfinder.census.gov](http://www.factfinder.census.gov)

39 Excerpt from “Georgia’s Low Health Ranking Sinks Even Lower,” Georgia Health News, Dec. 9, 2015, Andy Miller

40 Hospital community demographic data based on 90 percent hospital catchment areas and 2016 estimates from The Nielsen Company, Pop-Facts Demographics, generated on 2/5/16 by WellStar Strategic Planning.

41 In addition to providing means for purchasing healthcare, higher incomes can provide better nutrition, housing, schooling, and recreation. Independent of actual income levels, the distribution of income within countries and states has been linked to rates of mortality.

42 “To the extent that education is key to health inequality, policies encouraging more years of schooling and supporting early childhood education may have health benefits. When policymakers debate the merits of increasing access to education, they rarely consider improvements in the health of the population. Other virtues—increasing human capital, boosting productivity, augmenting lifetime earnings, and improving the socialization of the next generation—follow from improvements in educational attainment as in others, collateral benefits such as decreasing health care costs also might emerge from increased investment in education.” Socioeconomic Disparities In Health: Pathways and Policies, Health Affairs blog. <http://content.healthaffairs.org/content/21/2/60.full>

43 County Health Rankings, 2016

44 County Health Rankings, 2016

45 The county’s health outcomes ranking is where it ranks overall among Georgia’s 159 counties as measured by how long people live and how healthy people feel while alive. [www.countyhealthrankings.org](http://www.countyhealthrankings.org) NOTE: Because ranks are relative, they aren’t as helpful in isolation – a county’s rank depends not only on what is happening in the county, but also on what happens in all the other counties in Georgia. In fact, if every county improved its health equally, the ranks would all stay the same. These ranks inform the county’s progress measurement, not drive it.

46 All health factor statistics from County Health Rankings, 2016.

47 Percentage of adults that report a Body Mass Index (BMI) of 30 or more signifying obesity.

48 Primary Care Physicians and Mental Health Providers is the ratio of the population to total primary care physicians. For primary care, the top US performers are 1,045:1 (90th percentile) and mental health is 385:1 (90th percentile).

49 Severe Housing Problems is the percentage of households with at least one or more of the following housing problems: (1) housing unit lacks complete kitchen facilities, (2) housing unit lacks complete plumbing facilities, (3) household is severely overcrowded; and (4) household is severely cost burdened. County Health Rankings and Roadmaps used the U.S. Department of Housing Development (HUD) which periodically receives “custom tabulations” of data from the U.S. Census Bureau that are largely not available through standard Census products. This data, known as the “CHAS” data (Comprehensive Housing Affordability Strategy), demonstrates the extent of housing problems and housing needs, particularly for low income households.

50 Georgia Department of Public Health, OASIS – Age-Adjusted Death Rate, Last 5-Year Aggregate, 2010-2014 CHNA Dashboard. A remarkable finding since the 2013 CHNA is the upward move of mental and behavioral disorders in the top five leading causes of death reflecting the disparity in all counties served.

51 County health status summary sources: Community Commons CHNA Portal, County Health Rankings and Roadmaps, U.S. Census Bureau - American Community Survey 5-Year Dataset, Georgia Department of Public Health Online Analytical Statistical Information System (OASIS), and Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP): [www.cdc.gov/NCHHSTP/Atlas/](http://www.cdc.gov/NCHHSTP/Atlas/)

## COMMUNITY IS CONTRIBUTION

32

52 For this report, the Cobb & Douglas Public Health’s Community Health Assessment did not align with WellStar’s CHNA timeline, so the resources and funding previously procured for the 2013 CHNA were not available for this health needs assessment cycle. An initial meeting in July 2015 with Cobb Douglas Public Health’s Epidemiology helped to define data sources and methodology

53 <https://www.healthypeople.gov/>

54 GHPC provides evidence-based research, program development and policy guidance locally, statewide, and nationally to improve communities’ health status.

55 A total of 172 WellStar Medical Group representatives engaged with the survey – 73 of which partially completed the tool and are not represented in the results in the supplemental appendices.

56 A total of 559 community members engaged with the survey - 112 of which partially completed the tool and are not represented in the results in the supplemental appendices.

57 Ser Familia is a social services community organization that gives Latino youth, couples, parents and families the tools they need for successful daily living through better relationships, leadership and life/communication skills to become emotionally strong and healthy.

58 A listening session was conducted at the Paulding Health Department as there currently is no operating safety net clinic in Paulding County.

59 <http://www.cdc.gov/chinav/tools/index.html> and Database of Interventions: <http://www.cdc.gov/chidatabase>

60 Some data from the 2013 CHNA cannot be compared to the 2015 data as the BRFSS telephone survey has been traditionally done with people using land lines. An increasing number of people are only using cell/mobile phones. CDC recognized the need to include cell phone users in the survey in order to obtain data that better represents the diverse populations. Since the way information is gathered and processed, new data cannot be accurately compared to previous findings.

<http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html>

61 <http://www.varpguide.com/>

62 Over a two-month period in the fall of 2015, the GHPC compiled service-area data including demographics, socioeconomic factors, health behaviors, health outcomes, workforce adequacy and assets. The latest U.S. Census data (2010-2014) was not yet released.

63 [www.chna.org](http://www.chna.org)

64 [www.oasis.state.ga.us](http://www.oasis.state.ga.us)

65 [www.census.gov](http://www.census.gov)

## COMMUNITY IS CONNECTION

38

66 Federal regulations emphasize involvement by people who represent the “broad interests” of the communities served by nonprofit hospitals, including people with “special knowledge of or expertise in public health.” 78 Fed Reg at 20541 (to be codified at 26 CFR 1:501(r)-3(b)(5)).

67 WellStar solicited more county-specific sources than noted for input. Representatives either didn’t respond to the inquiry, failed to fulfill to provide the requested information or declined due to competing priorities.

68 The Cobb2020 Partnership is a partnership of community organizations and individuals dedicated to promoting healthy lifestyles and the delivery of essential health services in Cobb County.

## COMMUNITY IS COMPASSION

42

69 An August 2015 report by the National Association of Insurance Commissioners found that Georgia had the highest percentage of “narrow” insurance networks (limited choice of doctors) in the 2014 health exchanges. “State senator expects legislation on insurance reform,” Georgia Health News, 12/15/15.

70 Determinants of Health: (1) Biology and genetics. (2) Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, and smoking (3) Social environment. Examples: discrimination, income, and gender (4) Physical environment. Examples: where a person lives and crowding conditions (5) Health services. Examples: Access to quality health care and having or not having health insurance

## COMMUNITY IS COLLABORATION

50

71 Revised Memorandums of Understandings were implemented in 2016 to provide more definitive processes to help refer patients, build capacity and measure/track outcomes. These partnerships help WellStar meet the primary care needs of the medically underserved and uninsured who qualify for WellStar’s Community Financial Assistance (indigent care <125 FPL and charity care <300 FPL) by providing physician and nurse practitioner volunteers, limited access to specialists and no or reduced cost labs and radiology services.

72 The Behavioral Health Service Line (BHSL) encompasses acute inpatient, hospital-based and outpatient psychiatric and psychological services. The BHSL strategy is to develop coordinated access to services for our community members who have mental health and substance abuse conditions, engage in health behaviors contributing to chronic medical illnesses and experience stress-related physical symptoms and behavioral crises. The services and model of care delivery are patient-centered and evidenced-based, consistent with WellStar’s mission and values.

73 Prerequisites for WBHN membership include a demonstrated history of patient advocacy for behavioral health patients, a commitment to quality and patient safety, the ability to provide expeditious access to patients in need of behavioral health care, and the capacity to work with patients who have diverse financial needs.

74 Assets were prioritized based on their scope and level of activity so far as could be determined. Organizations without a functioning website or food banks that do not distribute food or meals are not listed. If your organization would like to be considered as a potential partner to help address the priority health needs of this CHNA, contact us at [chna@wellstar.org](mailto:chna@wellstar.org).

75 County-specific organizations are documented from the National Center for Charitable Statistics, the Georgia Center for Nonprofits and Community Commons data.

- 76 Better storytelling focuses not only on the patient experience but also on compelling stories of the heroes of health in our community.
- 77 WellStar uses the Catholic Health Association's categories of community benefit which tracks with the reporting software CBISA. <https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4>
- 78 WellStar is a member of Spirit of Women, an elite coalition of hospitals and healthcare providers across the United States that ascribe to the highest standards of excellence in women's health education and community outreach.
- 79 WellStar is endorsed by the Lung Cancer Alliance as a Screening Center of Excellence because it's committed to the principles identified in the National Framework. The Framework was modeled after the WellStar lung cancer screening program and is now used as the standard for screening centers across the country. <http://www.lungcanceralliance.org/am-i-at-risk/national-framework-for-lung-screening-excellence.html>. East Cobb Health Park and Douglas Imaging Center have received Lung Cancer Screening Center accreditation from the American College of Radiology.
- 80 This also addresses the 2013 Implementation Strategy to Participate as a Cobb Access Health integrator/partner to build a low-income healthcare delivery system in Cobb County. The proposed non-profit organization, Cobb Access Health, is not being pursued. Instead, WellStar has formalized its community benefit services by creating a department, the WellStar Community Health Collaborative, and is improving access to care via partnerships with community safety net clinics and other non-profit organizations.
- 81 The federal government's 340B Drug Discount Card enables eligible healthcare organizations/covered entities to provide medications at significantly reduced prices through participating retail locations.
- 82 <http://gme.wellstar.org/>
- 83 Also known as a Financial Assistance Policy or FAP.
- 84 [www.ngoc.com](http://www.ngoc.com)
- 85 This is not an all-inclusive list.
- 86 In collaboration with Bright Horizons Foundation for Children, the Bright Space was created for children with open abuse and neglect cases through CASA - Court Appointed Special Advocates for Children In Canton (Cherokee County).
- 87 Cobb2020 is a partnership of community organizations and individuals dedicated to providing healthy lifestyles and the delivery of essential health services in Cobb County. [www.cobb2020.com](http://www.cobb2020.com)



2016 Community Health Needs Assessment (CHNA)

ACCESS TO CARE

HEALTHY LIFESTYLE

Use of Primary Care (Adults & Children)

Type 2 Diabetes

Use of Care Capacity (Safety Net Clinics)

Cancer

# SIGNIFICANT HEALTH NEEDS DATA SUMMARIES

Tobacco Use

Use of Emergency Department for Emergent Needs

COPD/Asthma

DATA SUMMARIES

Cardiovascular Disease  
Stroke

Cost of Medication

Obesity

Use of Behavioral/Mental Healthcare

Substance Abuse

Use of Dental Care

Underuse of Preventive Cancer Screening

## ACCESS TO CARE

Underuse of Primary Care  
(Adults & Children)

Lack of Care Capacity  
in Community Safety  
Net Clinics

Overuse of Emergency  
Department for  
Non-Emergent Needs

High Cost of Medication

Underuse of Behavioral/  
Mental Healthcare

Underuse of Dental Care

Language and Cultural  
Barriers

Underuse of Mental/  
Infant Care

Lack of Transportation  
to Medical Care

The significant health needs related to **access to care** stem from socioeconomic and clinical care barriers. These barriers create health disparities in the communities WellStar serves especially among the most vulnerable populations (low-income, uninsured, low education attainment, elderly). Underuse denotes lack of capacity /access and cost of the care.

## HEALTHY LIFESTYLES

Type 2 Diabetes

Cancer

Tobacco Use

COPD/Asthma

Cardiovascular Disease/  
Stroke

Obesity

Substance Abuse

Underuse of Preventive  
Cancer Screenings

Lack of Physical Activity/  
Poor Nutrition

STDs

Violence

Suicide

The significant health needs related to **healthy lifestyles** primarily stem from health behaviors causing chronic disease and/or behavioral health issues. These needs require intervention and management through clinical care, lifestyle modification (primary prevention) and education and “prescribing resources” (secondary prevention).