Community Health Needs Assessment
Fiscal Year 2019

As a designated 501(c)(3) nonprofit hospital, Piedmont Henry Hospital is required by the Internal Revenue System to provide to conduct a triennial community health needs assessment (CHNA), in accordance with regulations put forth by the IRS following the 2010 Patient Protection and Affordable Care Act (ACA). In its simplest definition, a CHNA is a measurement of the relative health or well-being of a given community. It's both the activity and the end-product of identifying and prioritizing unmet community health needs, which is accomplished by gathering and analyzing data, soliciting the feedback of the community and key stakeholders and evaluating our previous work and future opportunities. Through this assessment, we hope to better understand local health challenges, identify health trends in our community, determine gaps in the current health delivery system and craft a plan to address those gaps and the identified health needs.

Key findings

- Diabetes rates are high in Henry County, as are indicators related to heart disease. Added to this are high rates of obesity, a key contributor to both diabetes and heart disease.
- Despite being a metropolitan area, there are communities within the county that have limited or no access to healthy foods.
- County residents self-report relatively high levels of poor physical and mental health.
- Unhealthy behaviors are a critical issue in the county.
- Indicators related to mental health prove devastating to many Henry County residents, and especially those related to self-harm, drug use and car crashes.
- Poverty issues are persistent in the county and likely impact other areas, including the high rate of uninsurance among non-elderly adults.

2020, 2021 and 2022 health priorities

A key component of the CHNA is to identify the top health priorities we'll address over fiscal years 2020, 2021 and 2022. These priorities will guide our community benefit work. They are, in no order:

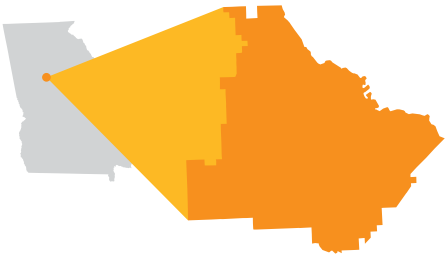
- Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes
- Decrease deaths from cancer and increase access to cancer programming for those with living the disease, with a focus on lung and breast cancer
- Decrease preventable instances of heart disease, stroke, diabetes, hypertension and other related chronic conditions by promoting healthy weights and behaviors
- Reduce opioid and related substance abuse and overdose deaths

With each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators. You can find more detail on how priorities were chosen and our overall process, including our sources, on page 15.

Community snapshot

OUR COMMUNITY

Piedmont Henry Hospital serves patients from all over the region, however, for purposes of this CHNA, we consider our community to be Henry County.



- In 2017, 207,506 million people lived in Henry County's 319 square miles. The majority of the community is white, though rates of minorities are increasing. The median age is 37.
- Henry is also growing. Between 2000 and 2010, the population increased by 71 percent, one of the highest rates in the state. Hispanic or Latino populations alone grew by 339 percent during that time.
- In 2017, the median household income was $64,752, much higher than both state and national averages.
- Even so, 30 percent of the county lived in substandard housing in 2017.
- 11.4 percent of the county lives at or below the poverty level. African Americans and Hispanic or Latino populations were much more likely to live in poverty.
- 72 percent of county residents owned their own home in 2017, a rate much higher than state and national averages.
- 4 percent of adults were unemployed in 2018, a figure slightly better than state and national averages.
- There were 16,522 veterans living in Henry County in 2017. The majority were non-elderly adults, and approximately 25 percent lived with some sort of disability.

Key hospital stats

Piedmont Henry Hospital is a 236-bed, acute-care, community hospital on a tobacco-free campus in Stockbridge, Georgia. Cutting-edge technology and first-class care come together in cardiovascular care, orthopaedics, surgery, critical care, women's health, emergency services, radiation oncology and diagnostic imaging. The hospital joined Piedmont Healthcare in 2012, and is a trusted source of compassionate, high-quality care for residents of Henry County. Piedmont Henry offers educational programs including diabetes education, rehabilitation and support groups.

1,500+ EMPLOYEES

150+ VOLUNTEERS

700+ PHYSICIANS

Affiliate of MD Anderson Cancer Network

NEWBORN DELIVERIES 2,324

EMERGENCY DEPARTMENT VISITS 87,171

SURGERIES 9,207

OUTPATIENT ENCOUNTERS 59,516

INPATIENT ADMISSIONS 15,198

Community rankings

In 2018 and in comparison with the other 159 Georgia counties, the University of Wisconsin's County Health Rankings placed Henry County:

- **22nd for health outcomes,** with overall health being better than most other counties in the state.
- **17th in length of life**, as Henry County residents tend to live slightly longer than the average life span of all Georgians.
- **40th for quality of life**, particularly when it comes to residents self-reporting their physical and mental health as on par with the Georgia average.
- **26th for healthy behaviors**, with most indicators - except for drinking - as higher than most other Georgia counties.
- **10th for clinical care**, with key clinical factors, such as provider to patient ratios, slightly better than state averages
- **19th for social and economic factors**, a ranking large in part due to the county being on par or slightly better than state averages.
- **121st for physical environment**, with long, solo commutes, air pollution and inefficient public transportation.

With the exception for physical environment and social and economic factors, Henry County ranks fairly well in comparison to other Georgia communities.

Mortality

In Henry County, like with the rest of Georgia, heart disease is the number one cause of both age-adjusted and premature death, and this holds true for all races. Age-adjusted death rates allows communities with different age structures to be compared. In comparison, premature death is when death happens before the average age for a given community.

Ranking	Age-adjusted death rate, in aggregate, 2013 to 2017
1	Ischemic heart and vascular disease
2	All COPD except asthma
3	Primary hypertension and hypertensive renal and heart disease
4	Cerebrovascular disease
5	Trachea, bronchus and lung cancer
6	Alzheimer’s Disease
7	All other mental and behavioral disorders
8	Septicemia
9	Nephritis, nephrotic syndrome and nephrosis
10	Diabetes

Between 2013 and 2017, motor vehicle crashes were the number one cause of premature death. Other top causes, in order, included accidental poisoning, heart disease, suicide, hypertension, homicide, lung cancer, disease of the central nervous system and breast cancer. As evidenced in this list, the impact of issues related to mental health conditions and unhealthy behaviors are staggering, and indicates a clear need for more aggressive interventions.

Health factors

Access to care

- There were no designated health professional shortage areas in the community in 2016. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. This means that isn't as much of a problem in Henry.
- However, it is important to note that even if there isn't a shortage, there still can be issues of access to care.
- Throughout Georgia, more than a fifth of all women and a third of all men report having no personal doctor or health home. This was particularly true for minorities, whose rates of not having a doctor are much higher than that of their white counterparts.
- There were 34 dentists and 206 mental health providers for every 100,000 people in 2015, figures far below above average and national rates.

Health status

- Community members have reported an average 3.8 poor or fair physical and mental health days. 17 percent of Henry County residents reported their health as poor or fair. All three indicators have worsened since our last CHNA.
- Statewide, race matters when it comes to poor health status. Approximately 26 percent of Hispanics reported being in poor health in 2017, as compared to their white and African-American counterparts (18 percent and 19 percent, respectively). Information on other races was not available.

Quality and length of life

- Preventable hospital stays among Medicare enrollees averaged 39 preventable stays per every 1,000 enrollees in 2015. This figure is better than state and national averages.
- Medicare enrollees tend to receive proper health screenings, with overall rates above state and national averages.
- 11 percent of the population lived with at least one disability in 2017, which was lower than the state average of 12 percent. The highest concentration of disabled populations in the northwest part of the county.
- The infant mortality rate in Henry County is on par with state and national averages, at 7.3 infant deaths per every 1,000 births in 2017. That year, 9 percent of all babies born were at a low birth weight, and with African American infants most likely to be born at a low birth weight.

In Henry County, **12 percent of the total population was uninsured in 2017, and almost 16 percent of the adult population was uninsured in 2017.** Rates for children and elderly populations were much lower at 6 percent for children and 1 percent for those 65+.

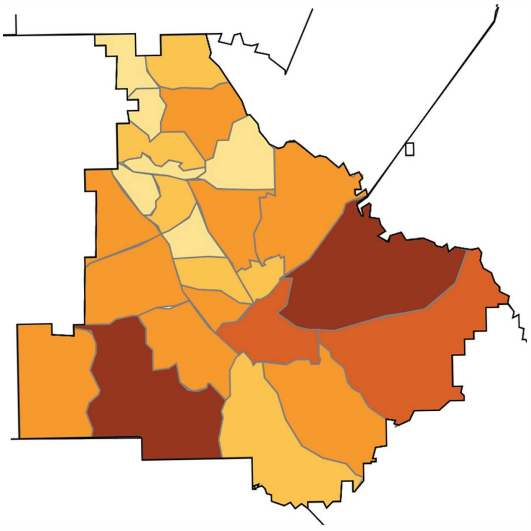
Statewide, one in five uninsured adults in 2017 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases. Additionally, these patients are less likely to be able to afford necessary medicine and ongoing chronic condition management. Lower-income patients are more likely to have increased health issues due to social determinants of health.

There is one charitable clinic in Henry County: the Hands of Hope Clinic. The hospital provides the clinic with lab services free of charge, space for its services, access to our patient health records and grant funds for the clinic's health programming.

There are no Federally Qualified Health Centers in Henry County, which limits access for low-income patients. Like charitable clinics, FQHCs are community assets that provide health care to low-income populations. FQHCs receive extra funding from the federal government to promote access to community-based care for everyone.

Heart disease

The number one cause of age-adjusted deaths and premature deaths for both men and women each year between 2013 and 2017 in Henry County was ischemic heart and vascular disease. During that time, an average 475 people died from heart disease annually.



To the left is a breakdown of premature deaths related to ischemic heart and vascular disease by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue. This allows us to see exactly where we have the most instances so we can more directly target interventions to this community in the future.

The prevalence of heart disease in the United States is expected to rise 10 percent between 2010 and 2030. This change in the trajectory of cardiovascular burden is the result not only of an aging population but also of a dramatic rise over the past 25 years in hypertension, diabetes, physical inactivity and obesity.

Extensive research from the American Heart Association has also demonstrated a strong correlation between social determinants of health (SDHs) and heart disease. Issues related to SDHs include higher rates of smoking, obesity, lack of physical activity and poor diets, all key contributors to heart disease.

Stroke

Between 2013 and 2017, an average 366 Henry County community members died from stroke each year, making it the third leading cause of age-adjusted death.

Stroke can be caused from several reasons, including a blocked artery, high blood pressure, diabetes, high cholesterol, certain heart conditions, obesity and unhealthy lifestyle choices. While stroke impacts all patients, like with most health measures, the lower income and less educated a person is, the more likely he or she is to experience more severe repercussions, such as death, for several reasons, including limited health literacy, difficulty affording care and necessary prescriptions and unhealthy behaviors.

Diabetes

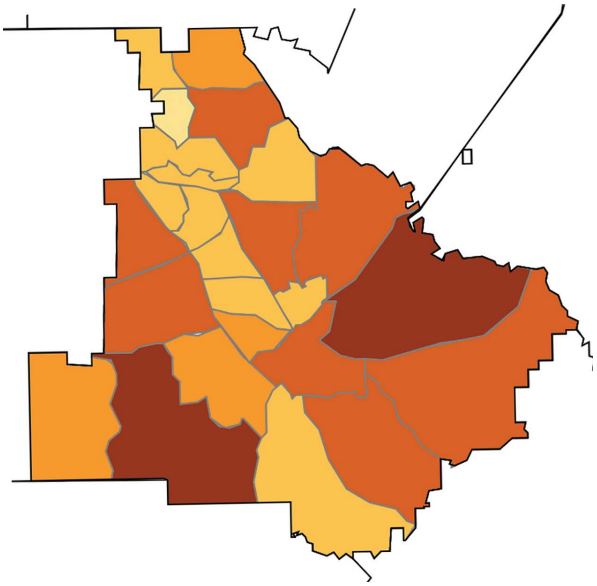
Approximately 13 percent of adults lived with diabetes in Henry County in 2015, a figure higher than state and national averages (11 percent and 9 percent, respectively). That year, a staggering 30 percent of Medicare recipients had diabetes. The number of people living with diabetes has steadily increased annually. For example, in 2004, about 8 percent of county residents lived with the disease.

In Georgia, the less educated you are, the more likely you are to have diabetes. In 2017, Georgians who did not graduate high school were more than twice as likely to be diagnosed with the disease than Georgians with a college diploma. The same holds true for lower incomes versus higher incomes. According to the CDC, in 2017, the highest percentage of Georgians with diabetes earned less than $25,000.

Cancer

Cancer continues to have a devastating impact in Henry County. In 2017 alone, 308 people died from cancer.

To the right is a map of age-adjusted cancer deaths by census tract between 2013 and 2017. The darker the color, the more deaths that occurred in that area of the county. Of all cancers, lung cancer is the deadliest. It is the fifth leading cause of age-adjusted death and the eighth leading cause of premature death. Breast cancer is the tenth leading cause of premature death, having killed 31 people in 2017. Colon cancer, prostate and pancreatic cancer killed 29, 20 and 20 people, respectively.



The female breast cancer incidence rate is higher than state and national averages, with a rate of 133.3 incidences per every 100,000 people. There are an average 150 new cases diagnosed annually, and about 11,252 women lived with the disease in 2015.

The lung cancer incidence rate is lower at 57.4 incidences per every 100,000 people. An estimated 18,118 people had lung cancer in 2015.

Cancer and health equity

Both in Georgia and in the nation, the gap in the cancer rates widens between racial and socioeconomic groups, particularly in preventable cancers, according to the American Cancer Society.

For example:

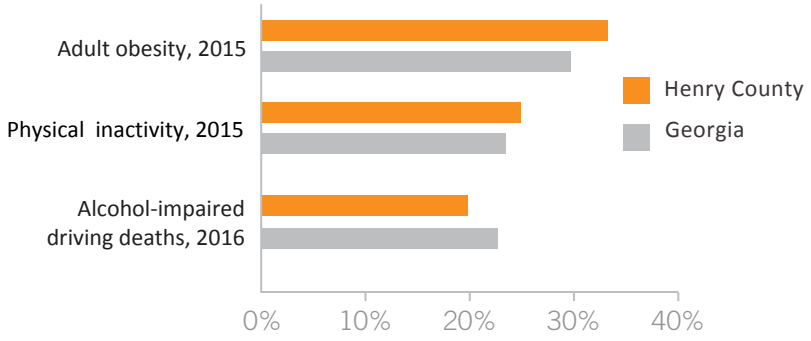
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 percent higher in poor men compared to affluent men.
- White females in Georgia are 8 percent more likely than black females to be diagnosed with cancer.
- Black males in Georgia are 8 percent more likely than white males to be diagnosed with cancer, and black males are 25 percent more likely than white males to die from cancer.
- Cancer survivors carry greater financial burdens related to medical debt payments and bills vs patients without a cancer history, and younger survivors face the greatest hardships.

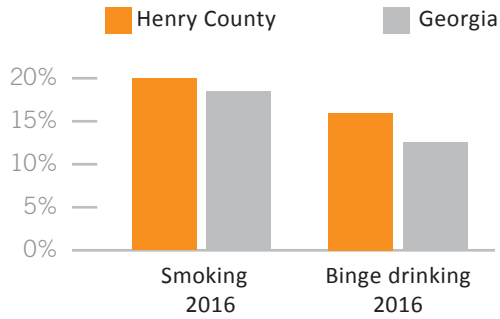
Unhealthy behaviors, such as tobacco use, poor diet, physical inactivity and obesity continue to heavily contribute to cancer rates and tend to disproportionately impact low-income populations. For example, although overall smoking rates have declined statewide, high rates still persist among lower educated, lower income populations. Also, low income populations tend to have less access to healthy foods.

Additionally, this population is far less likely than the rest of the community to have a primary care physician, receive annual testing and preventative care, including cancer screenings. They are statistically more likely to be diagnosed due to hospitalization or an emergency department visit once the disease has progressed, meaning their condition is generally far more advanced and will require significant intervention.

Healthy behaviors

While poor health and chronic conditions are caused by a number of factors, a key contributor is healthy behaviors. All years below are for the latest time frame for which data was available.





- Obesity rates were high in Henry County in 2015, and contributes to a number of diseases, including heart disease, stroke and diabetes.
- Smoking rates were higher than the state average, and smoking is a key factor in causing cancer, and in particular lung cancer, which has a devastating effect on Henry County residents.
- 15 percent of residents commute more than 60 minutes most work days in 2016. The majority of commuters from Henry County drive alone, a situation that is linked to depression and stress.
- The violent crime rate was 179 incidents per every 100,000 county residents, a figure better than state and national averages.

Mental health

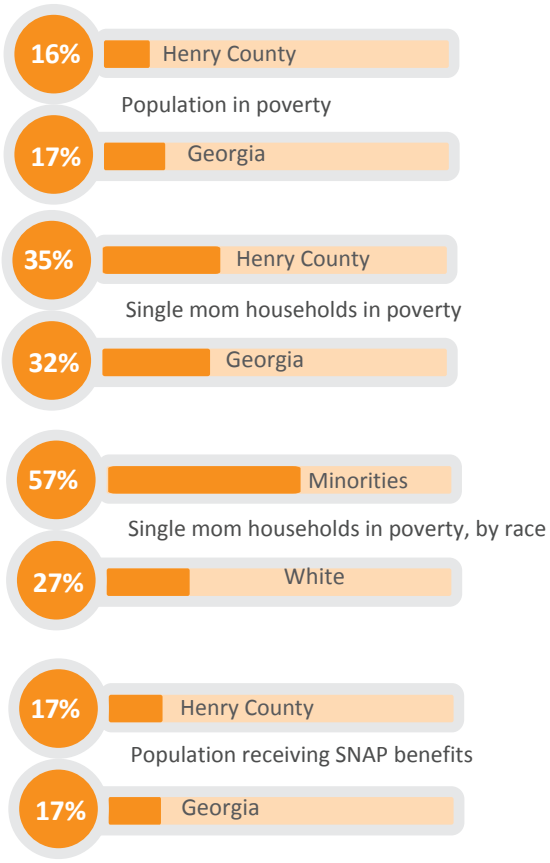
- Mental health and behavioral disorders, not including suicide, was the seventh leading cause of age-adjusted death for all county residents between 2013 and 2017.
- Suicide was the fourth leading cause of premature deaths for all races between 2013 and 2017, in which a total 3,500 people took their own lives. It was most common among white males aged 25 to 34 years of age.
- There was one mental health providers for every 133 residents in the county in 2017, a rate slightly better than the state and national averages of one provider for every 813 and 493 residents, respectively.

Opioid use and substance abuse

- Like in the rest of the state, opioid prescriptions are an issue in the Henry County community, with a total 70.6 opioids prescriptions written per every 100 people in 2017. Please note we aren't able to tell how many scripts were written to a single person. We only know the overall figure, meaning a single person could have several prescriptions.
- Statewide, the age-adjusted opioid death rate was 9.7 per every 100,000 people, a 10 percent change in rate from 2016. This shows the issue is worsening.
- There were 28 deaths from all overdoses in Henry County in 2017. This number has more than doubled in the last decade.

Social determinants of health

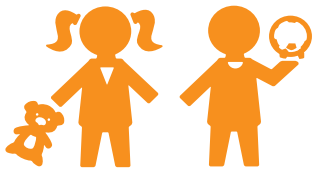
As defined by the World Health Organization, social determinants of health (SDHs are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Included among these is economic stability, housing stability, food security, adequate income to pay for core services such as utilities, literacy, access to healthy food, access to safe recreational spaces, access to health care and access to services in languages the person understands. SDHs often carry negative health impacts, including increased risk of mortality, poor health and increased cardiovascular disease risks.



- 33 percent of those living in poverty in the county did not graduate high school in the 2015-2016 school year. Minorities were twice as likely to not have a high school diploma.
- In 2016, 48 percent of the population had limited access to healthy foods and an additional 13 percent have no access to healthy foods. These patients live in what's called a food desert, meaning there is no food outlet with healthy food options, such as produce, within a reasonable travel time.
    - Of the 25 census tracts in Henry County, 20 were in a food desert.
- There were 79 fast food restaurants in Henry County in 2016, a figure that's far more, per capita, than state and national averages. There are 27 grocery stores, and they tend to be concentrated in the same communities.
- 30 percent of households had housing costs that exceeded more than 30 percent of total household income in 2017, indicating a cost burdened household more likely to face overall financial difficulty.
- 1,910 Henry County households had no motor vehicle in 2017, which can present significant barriers to accessing care and other primary needs, such as groceries, due to very limited public transportation options in the county.

Families and children

- 37 percent of children lived in single-parent homes in 2017, a statistic that can indicate financial insecurity at home.
- 51 percent of children qualified for free or reduced cost lunch in the 2015-2016 school year, a statistic that represents poverty and food instability. Henry County is less than the 2017 state average of 62 percent.
- For every 1,000 teen girls aged 15 to 18 in Henry County, 30 gave birth to a child on average each year between 2010 and 2016. Children born to teen are statistically much more likely to experience adverse health and socioeconomic issues as they grow older. In Henry, African Americans and Hispanic or Latina teen birth rates were 31 and 51 births per every 1,000 teen women, respectively.

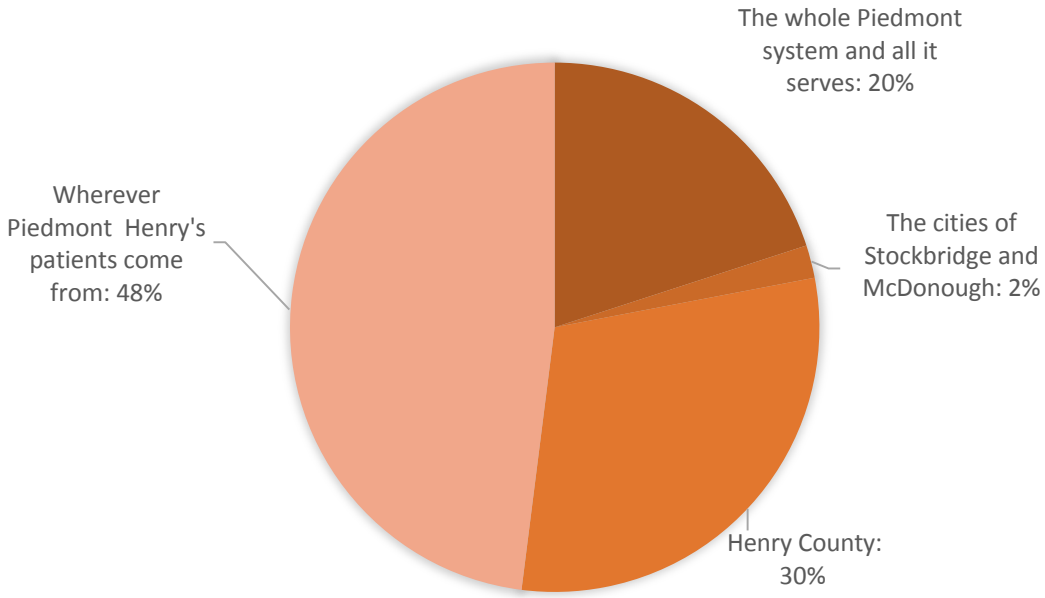


16 percent of children in Henry County lived in poverty in 2017. Poor children are statistically less likely to graduate high school and are nearly twice as likely to become poor adults and, should they have children, continue a circle of poverty that's difficult to break. These children are also more likely to experience dental issues, anxiety problems and higher rates of accidental injury.

PHH stakeholder survey

In December 2018 and December 2019, 60 key stakeholders within the Piedmont Henry community provided their thoughts on community health, community assets and the role of the hospital in addressing unmet community health needs via a web survey. Below are the results of that survey.

How would you best define Piedmont Henry 's community?



What do you think are the most pressing health problems in Piedmont Henry's community?

Top ten answers ranked very important, out of 25 potential interventions:

1. Cost of health care
2. Ability to pay for care
3. Mental health care
4. Lack of health insurance
5. Obesity in adults
6. Lack of transportation to health care services
7. Heart disease
8. Additional access points to affordable care within the community
9. Drug abuse - prescription substances
10. Obesity in children and teenagers

What issues do you think may prevent community members from accessing care?

Top ten answers:

1. No insurance and unable to pay for the care
2. Unable to pay co-pays and deductibles
3. Language barriers
4. Transportation
5. Unable to use technology to help schedule appointments, find a doctor, etc.
6. Fear
7. Don't understand the need to see a doctor
8. Don't know how to find doctors
9. Cultural/religious beliefs
10. Lack of availability of doctors

PHH stakeholder survey (continued)

How important are the following actions in improving the health of Piedmont Henry's communities?

Top 10 answers ranked most important:

1. Financial assistance for those who qualify
2. Access to local inpatient behavioral health facilities
3. Access to low-cost mental health services
4. Access to health care services
5. Access to dental care services
6. Free or affordable health screenings
7. Additional access points to affordable care within the community
8. Partnerships with local charitable clinics
9. Safe places to walk/play
10. Curbing tobacco use

Q What is your vision for a healthy community?

Some answers:

"People educated to make sound decisions about their health."

"One where barriers to quality healthcare and medical services are non-existent."

"A place where there are access to fresh vegetable/food, a good social network and access to public transportation."

"Adequate, affordable housing; meaningful employment opportunities; health care services that are accessible and affordable; citizen participation in local decision making; quality education at all levels; justice reform."

"Everyone should be able to access resources to educate them on how to improve their health."

"Jobs!"

"Community that offers resources to promote healthy lifestyles as well as availability to care for diseases and addictions."

"A community where healthcare is available to all and underprivileged people don't have to use emergency services for routine care."

Q What is the single most pressing issue you feel our patients face?

Some answers:

"Access to good caring psychiatric care. Mental health in our area and our nation is generally pathetic."

"Affordable health care."

"Lack of money."

"Lack of education related to importance of wellbeing."

"Potential repeal of the ACA."

"Knowledgeable doctors who see a patient, not dollar signs."

"Mental health services and substance abuse treatments that are effective long term."

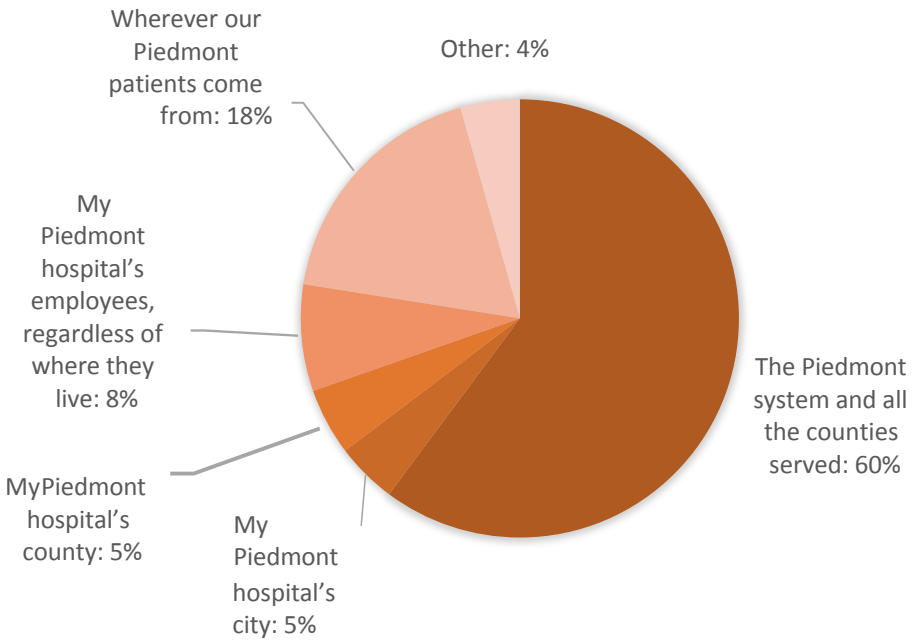
"Cancer. I feel so many community members are impacted. Either as a patient fighting or as a caregiver helping. When you factor in the expense for treatment, insurance, caregivers, transportation, lack of doctors, slow processes; the fight becomes even more stressful and impacts all loved ones."

"Lack of awareness of health problems and delayed diagnosis."

PHC employee survey

Ninety-four Piedmont Henry Hospital employees completed an internal CHNA assessment. Questions focused on issues facing community members, as well as how Piedmont staff feels the hospital should address those issues. Below are the results from all who answered the surveyed throughout the system, which had a total 897 responses.

How would you best define Piedmont's community?



What do you think are the most pressing health problems in Piedmont's community?

Top ten answers:

1. Ability to pay for care
2. Lack of health insurance
3. Cost of health care
4. Mental health
5. Prescription medicine too expensive
6. Lack of transportation to health care services
7. Drug abuse - prescription medications
8. Cancer
9. Obesity in adults
10. Lack of supportive services for patients

What issues do you think may prevent community members from accessing care?

Top ten answers:

1. No insurance and unable to pay for the care
2. Unable to pay co-pays/deductibles
3. Transportation
4. Fear (e.g., not ready to face/discuss health problem)
5. Don't understand the need to see a doctor
6. Unable to use technology to help schedule appointments, find the doctor, etc.
7. Don't know how to find doctors
8. Language barriers
9. Lack of availability of doctors
10. Cultural/religious beliefs

PHC employee survey (continued)

How important are the following actions in improving the health of Piedmont's communities?

Top 20 answers ranked most important:

1. Access to low-cost mental health services
2. Access to local inpatient behavioral health
3. Free or affordable health screenings
4. Local outpatient mental health services
5. Additional access points to affordable care within the community
6. Financial assistance for those who qualify
7. Expanded access to specialty physicians
8. Affordable healthy food
9. Services to help physically or developmentally disabled children and adults
10. Safe places to walk/play
11. Community-based health education
12. Community-based programs for health
13. Cancer awareness and prevention
14. Increased social services
15. Opioid awareness and prevention campaigns
16. Transportation for care
17. Substance abuse rehabilitation services
18. Programs to address SDHs
19. Access to dental care services
20. Partnerships with local charitable clinics

Q What do you think works well in how Piedmont supports the community?

Answers centered on the following themes:

Health education

Financial assistance program

Support for local charitable services and community partnerships

The Cancer Wellness Program

Continued growth with beds and services

The Walk with a Doc program

Sixty Plus Program

Giving Epic to local clinics

Care coordination services

Breast feeding training for new moms

Q What do you think is missing in how Piedmont works with the community?

Answers centered on the following themes:

More Piedmont-sponsored low-cost clinics

More visible community involvement, especially with minorities

More outreach and free services for preventative care

Increased access to specialty physicians

More attention to mental health

More attention to opioid and substance abuse

Screenings that are free for community members, especially for cancers

A better system for referring patients to the services they need that are outside the hospital

PHC stakeholder interviews

As a part of our process, we interviewed 31 state and regional stakeholders and policy makers that represent public health, low-income populations, uninsured and uninsured persons, minorities, chronic conditions and older adults, as well elected officials and lawmakers. These interviews were conducted for people representing the entire region, including Henry County. Answers carried certain themes. Below is a summary of comments.

Affordability and access

- Health insurance coverage was identified among almost every interviewee as a key pressing health need, and 84 percent of interviewees felt the hospitals could play a larger role in promoting public policies that could expand coverage (such as Medicaid eligibility expansion) or in promoting local activities to encourage enrollment in existing programs. As one interviewee stated: **"Hospitals tend to wait until the patient shows up sick to consider how that patient can afford their care or if he or she can get coverage. If they supported more outreach for getting coverage, the patient would probably have been able to get care before they were so sick they needed hospital care."**
- Some interviewees suggested programs such as expanded scope of service for nurse practitioners and physician assistants could broaden access to affordable care, as well as the expanded use of telehealth. Each interviewee cited the role that Federally Qualified Health Centers (FQHCs) and low-cost clinics currently play in addressing the needs of uninsured patients, and all encouraged further investment in these organizations through the provision of free labs and imagery and shared EMRs.
- Several interviewees noted the need for increased access to follow up and specialty care for all patients. One patient advocate interviewee stated she fielded questions daily from publicly insured patients who didn't understand how their network worked and uninsured patients who were directed to follow up with a specialist but didn't know who would take them.
- Affordability is a barrier, as many private physicians do not provide financial assistance. As one interviewee stated: **"The patient then just decides they can't get to that specialist and, most likely, their condition gets worse and they are back in the emergency department, sicker and needing even more care now."**
- Almost every interviewee noted transportation issues as a key barrier to access, particularly for older adults and those who are disabled.

Local investment and care coordination

- Most interviewees stated a need for stronger hospital intervention and investment in local communities. While most acknowledged the positive role Piedmont hospitals currently play in the community, some were critical of how Piedmont handles patients and programs that don't pay well.
- Several interviewees noted the need for Piedmont hospitals, including Piedmont Henry, to better coordinate with surrounding rural communities, including the expansion of primary and specialty care physicians into underserved areas, perhaps through the use of telehealth.

Mental and behavioral health

- Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize the role of behavioral health in diagnoses and make appropriate referrals.
- Interviewees also stated a need for hospital investment in substance abuse, addiction and prevention services, including its own approach to issues like opioid prescriptions, due to the health impacts addiction have on patients.

PHC stakeholder interviews (continued)

Social determinants and root causes of poor health

- All interviewees discussed the role of social determinants of health (SDHs) as a critical issue Piedmont is well-positioned to address. As one interviewee stated: **"Piedmont is... in a great position to create programs and referral systems to help address the underlying issues that many patients face. Piedmont could lead all hospitals in this space."**
- Some interviews noted that SDHs are issues that impact everyone, and are a key cost driver due to the role SDHs play in preventing people from staying well.
- Most interviewees felt that the issues facing our community members were not just solely the responsibility of the hospital, but all acknowledged the outsized role hospitals can play in triggering and sustaining long-term positive change, particularly when working in partnerships with others in the community.

CHNA approval

This community health needs assessment was unanimously approved by the Piedmont Henry Hospital board of directors on May 13, 2019. The board approved the CHNA implementation strategy on September 16, 2019.

Methodology

The Piedmont Henry CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Henry board of directors at a March 2018 meeting, the hospital's chief executive officer and the hospital's director of community outreach.

Process

The CHNA started first with a definition of our community. We looked at our entire Piedmont Healthcare service region, which spans the majority of the state. We paid particular attention to the home counties of our hospitals, which is reflected in the individual hospital CHNAs, including this one, due to the impact of our tax-exempt status.

Generally, nonprofit hospitals do not pay four types of taxes: property, state and local income, sales and use, and bond financing. Of these, property taxes make up the largest segment of a hospital’s tax exemption – about one-quarter. Because of this, we want to ensure that we are providing equal benefit to our local community. Additionally, we take into consideration patient origin, and especially that of our lower-income patients, such as those who qualify for financial assistance or receive insurance coverage through Medicaid.

Once we established our primary community, we then conducted an analysis of available public health data. This included resources from: US Census, US Health and Human Services’ Community Health Status Indicators, US Department of Agriculture, Economic Research Service, National Center for Education Statistics, Kaiser Family Foundation's State Health Facts, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2017, unless otherwise noted. Health indicators are estimates provided by County Health Rankings and hospital data was provided by the hospital.

An internal survey was also conducted throughout the healthcare system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Nearly 900 employees spanning the system responded. Additionally, we conducted a community-based survey in which local stakeholders were asked their thoughts on unmet community health needs and the hospital's role in addressing those needs. These stakeholders included local leaders, nonprofit representatives, elected officials and those with a unique knowledge of the challenges vulnerable populations face.

Finally, we conducted direct interviews with 31 state and regional stakeholders and policymakers, with each representing a specific group that tends to be adversely impacted by issues of health equity. These groups included but are not limited to: Georgians for a Healthy Future, Georgia Watch, ConsiderHealth, the Community Foundation for Greater Atlanta, the Georgia Charitable Care Network, the Medical Association of Georgia and Healthy Mothers, Healthy Babies.

How we determined our priorities

Several key community health needs emerged during the assessment process. The chosen priorities to be addressed were recommended by the community benefit department with sign-off from hospital and board leadership. The following criteria were used to establish the priorities:

- The number of persons affected;
- The seriousness of the issue;
- Whether the health need particularly affected persons living in poverty or reflected health disparities; and,
- Availability of community and/or hospital resources to address the need.

The priorities we chose reflected a collective agreement on what hospital leadership, staff and the community felt was most important and within our ability to positively impact the issue. While the priorities reflect clinical access and certain conditions, all priorities will be viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race.

About community benefit

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These programs increase access to health care and improve community health, with a focus on vulnerable populations, such as those that are low-income, uninsured, underinsured, those with chronic conditions, the disabled, the elderly and any others who face additional barriers and health inequity. By federal mandate, community benefit programs must:

- Generate a low or negative margin;
- Respond to the needs of vulnerable populations;
- Supply services or programs that would likely be discontinued if the decision to offer this program was made on a purely financial basis;
- Respond to an identified public health need; and/or,
- Involve education or research that improves overall community health.

The CHNA guides Piedmont's community benefit work.

Piedmont Henry Hospital
CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022

On September 16, 2019, Piedmont Henry's board of directors approved the hospital's community health needs assessment, which measured the relative health and well-being of our community. Through this process, we identified key health priorities we'll address over the next three fiscal years. This below strategy was developed to address those identified priorities.

Priority: Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes			
Vision	**Goal**	**Tactics**	**How to measure**
Low- and no-income patients receive assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	• Financial assistance is available for eligible low- and no-income populations • Patients are adequately alerted that financial assistance is available • Patients are given tools, resources and ample opportunity to apply for assistance • Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals • Actively screen all potential patients for Medicaid coverage	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income patients have access to community-based care	Support Hands of Hope charitable clinic through the provision of free services; provide space and utilities for clinic	• Provide diagnostics and other services currently provided for patients of Hands of Hope, including: bloodwork, x-rays, CT scans; echocardiograms; MRIs; stress tests; wound care; physical therapy; and, diabetes education classes	Review the relationship each quarter to identify any issues, opportunities for growth

		• Provide clinical and office space on-site for clinic at no charge	
Local efforts to increase access to care are strengthened and grown	Provide funding that will support specific programmatic activities of Hands of Hope and/or other agencies who target low-income patients	Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients	• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PHH • Progress evaluated by PHC and PHH every six months
Patients have an increased awareness of local resources	Provide resource guide to vulnerable community members	• Update guide annually • Publish online and in print • Distribute widely throughout hospital and community	Annual distribution number of guides. Approximately 3.5K distributed throughout Henry community in FY19, will aim for a 10% year over year increase for FY20 to FY22
Future health workers are trained	Provide health professions education to students as to further build the health workforce	Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate	Regularly monitor and evaluate program, students
Awareness of community-based resources is increased	Create and deploy an online, searchable database that catalogs resources available regionally and systemwide	• Create website and database from existing resources • Solicit input from state, regional and community partners • Widely advertise among nonprofit partners and Piedmont patients	• Yes/no on creation • Establish initial user/visit goals and aim to increase annually by 7% to 10%
Older adults have increased access to care and community-based resources	Collaborate with community partners in order to provide improved access to, and better coordination among, existing community resources for the aging	Provide Sixty Plus programming for all community members, including: end of life planning and palliative care education at home and healthy aging communities; and, presentations and dementia caregiver support and workshops	• Monitor number of outreach presentations • Monitor number of clients served • Aim to annually grow clients served

Low-income patients receive timely follow-up care	Develop a mechanism to immediately schedule follow-up appointments	Evaluate internal and external resources and create project plan, which could include: Request approximately five (5) appointments available each week for PHH patients to schedule follow-up appointments post discharge for low-income, uninsured patients at Hands of Hope	• Track referrals via case management (or other designated referral mechanism) and validate with clinic that patient received follow-up care
Low-income populations have access to specialty care	Create a managed care program for low-income patients that utilizes a licensed medical social worker to work with high-risk, low-income income patients who have presented at the ED with a condition that will need ongoing care	• Need to list what we do now, which could include using Tableau, identify high-risk, low-income patients who have been recently discharged and have a health need that will be ongoing • Address issues with patient, including placement in an appropriate care setting	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities for growth
Patients and their families have meaningful input in their care; preventable readmissions and re-encounters are reduced	Grow the internal patient and family advisory council to provide meaningful input on key areas of care	• Regularly convene a council of approximately 10 to 20 advisors comprised of patients, their families and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers • Define specific scope and goal of council, which could include internal initiatives to improve patient care and quality	• Expand current Patient/ Family Advisory Committee • Other evaluation tactics to be determined by specific goals of council
Provide obstetrics (OB) clinic to serve all patients, including those with no insurance and those with Medicaid	Provide a physician to provide OB care for patients currently covered through Medicaid	Providing funding one to two OB physicians to regularly treat patients	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities for growth

Priority: Reduce opioid and related substance abuse and overdose deaths			
Vision	**Goal**	**Tactics**	**How to measure**
Hospital-based prescriptions for opioids and related drugs are reduced	Patients are at low risk of misusing opioids	• Track opioid prescribing by hospital and physician • Use Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients ways to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach
Patients are supported in recovery from their opioid addiction	All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery	• Develop relationships with community resources to which patients can be transitioned • Make these community resources known and available to our caregivers	Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are increased, measured by program participation and qualitative measures
Opioid addiction is viewed as a disease	All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma	• Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction • Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities	Regularly monitor percentage of PHC employees who report that they view opioid use disorders as a medical condition, free of stigma are increased, measured by qualitative mechanisms

Hospital-based prescriptions for opioids and related drugs are reduced	PHC adopts and uses appropriate non-opioid pain management strategies	• Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont • Offer multi-modal pain module to caregivers to provide options for opioid in treating pain • Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy)	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PHH provides meaningful leadership in its community by partnering with others in combating opioid abuse	• Serve as leaders in community-based programs to address opioid abuse and addiction • Support community-based strategies to combat opioid abuse through partnerships and task forces • Support local community prescription drug take-back day work	• Measure general community awareness of opioid use by charting what resources and partnerships are active now, with a goal to increase those year over year • Measure number of prescriptions gathered during take-back day activities, aim for an increase year over year
Local efforts to decrease opioid abuse and overdose deaths are increased	Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients	• Issue of a notice of available funding to all communities soliciting grant applications to curb opioid addiction and overdose deaths • Award annual funding based on merit of application and group's ability to positively impact issue • Monitor grant progress	• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PHH • Progress evaluated by PHC and PHH every six months

Community members are more familiar with identifying addiction and local resources to help support recovery	Create and widely distribute an opioid-centric Georgia-based resource guide	• Develop an eight- to ten-page guide to address issues of opioid use and prevention • Print and distribute guide throughout Piedmont communities and to patients	Aim for initial communitywide distribution of 1,500 copies locally, to be increased 15% year over year

Priority: Decrease deaths from cancer and increase access to cancer programming for those living with the disease, with a focus on lung and breast cancer			
Vision	**Goal**	**Tactics**	**How to measure**
More community members stop smoking	Support smoking cessation by providing tools and education to all community members	• Assess patients for tobacco abuse upon admission; when smoking is confirmed upon admission, patient receives smoking cessation information upon discharge • Provide ongoing smoking cessation classes to help community members permanently quit	• Track how many patients materials are provided to at Piedmont Henry • Regularly monitor attendance and participant self-reported quitting data
Cancer patients receive needed comprehensive services for their recovery	Provide support services free of charge to cancer patients through Cancer Wellness	• Provide services to any cancer patient, regardless of where they receive care; services include cancer education, nutrition workshops and demos, support group, psychological counseling and exercise classes, among other programs • Continue to explore opportunities to expand offerings and services	• Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness

Low-income community members receive appropriate cancer screenings	Create and a provide a free and/or low-cost mammogram screening program for underserved and/or underinsured women	• Free or reduced-cost mammograms are provided to women that do not have insurance to receive diagnostic care	• Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary mammograms • Solicit foundation and grant support to increase funding, community support
High-risk community members receive lung cancer screenings	Increase local awareness of and local opportunities for lung cancer screening; increase CT scans for smokers; increase early identification of suspicious nodules and thereby increaser early cancer detection	• CMS-defined heavy smokers are actively referred to CT scans • low-cost options available to those without insurance coverage or ability to pay • appropriate follow-up care and referrals for all with any indication of lung cancer	• Measure current awareness by availability of local resources and a survey of local messaging • Utilizing FY19 figures, aim to increase CT scans for heavy smokers, general community • Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system

More community members are screened for cancer	Overcome challenges of barriers to screenings and Increase cancer screening awareness through community-based partnerships	• Identify community partners who can help provide necessary outreach and messaging • Establish a mechanism for screening referrals • Establish a mechanism for appropriate follow-up care that takes insurance status, income and other barriers, such as transportation, into consideration	• Establish baseline of current activities and partnerships • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

Priority: Decrease preventable instances of heart disease, stroke, diabetes, hypertension and other related chronic conditions by promoting healthy weights and behaviors			
Vision	**Goal**	**Tactics**	**How to measure**
Support healthy eating for high-risk community members	Partner with Hands of Hope in their "Loving Life - Living Well" program	Deploy a fresh fruits/vegetables program for low-income patients in which we provide vouchers for healthy foods at a local Eat Right Farmers Market	Successful program completion; quantitative surveying among program participants and partners

Support healthy food options in hospital cafeteria	Provide cheaper prices for healthy food options in the cafeteria	• Food is labeled as healthy and priced cheaper • Provide a weekly fresh food market in the hospital for employees and visitors to purchase fresh foods	• Track the amount of food that is purchased from the designated healthy eating labels • Track the number of people who purchase from the designated healthy labels • Track patient, employee, and visitor attendance at fresh food market
Support healthy eating and weight control by offering classes in the community	Provide community education regarding nutrition and healthy weights at senior centers and various community events	• Provide programming such as Know Your Numbers, stroke prevention, heart attack and healthy eating provide information and education regarding health weights	At least three programs presented to low-income residents

Health issues we will not actively address as a top identified priority:

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle. These include:

- Transportation: Due to limited resources, we cannot address transportation issues in-house, however we will support community- based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them. We will also continue to solicit applications to our community benefit grants program from nonprofits that actively address issues of transportation within the Henry community.
- Chronic Obstructive Pulmonary Disease: We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition and continue to look for ways to positively impact prevention efforts.
- Alzheimer's disease: Alzheimer's disease continues to be a leading cause of death in the community. Although this is not a stated priority of the hospital during the FY20 to FY22 community benefit cycle, the hospital will actively support services aimed at patients and families suffering from the disease.