Community Health Needs Assessment
Fiscal Year 2019

As a designated 501(c)(3) nonprofit hospital, Piedmont Walton Hospital is required by the Internal Revenue System to conduct a triennial community health needs assessment (CHNA), in accordance with regulations put forth by the IRS pursuant to 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

- Mental health issues are particularly detrimental in Walton. For example, mental and behavioral disorders are the 4th leading cause of age-adjusted death and suicide is the 2nd leading cause of premature death.
- Substance abuse is also a concern, as are prescription drugs. In 2017, enough opioids were prescribed in the community for every man, woman and child to have a prescription, in theory.
- Lung cancer deaths continue to increase.

- About a third of the county is obese and a quarter are notably inactive, factors likely leading to the high rates of diabetes and heart disease.
- Even so, people tend to self-report their health than Georgians living in many other communities.
- While poverty remains a key issue, and particularly so among minorities, more people own their home and are employed than state and national averages.

2020, 2021 and 2022 health priorities

An important part of this process is to determine how we prioritize our community benefit work over the next three years. Please note that with each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators. Our priorities are, in no order:

- Increase access points for appropriate and affordable health, dental 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 cancer
- Promote healthy weights and behaviors as to decrease preventable instances of heart disease and diabetes
- 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, our overall process and our data sources beginning on page 14. You can find our implementation strategy beginning on page 16.
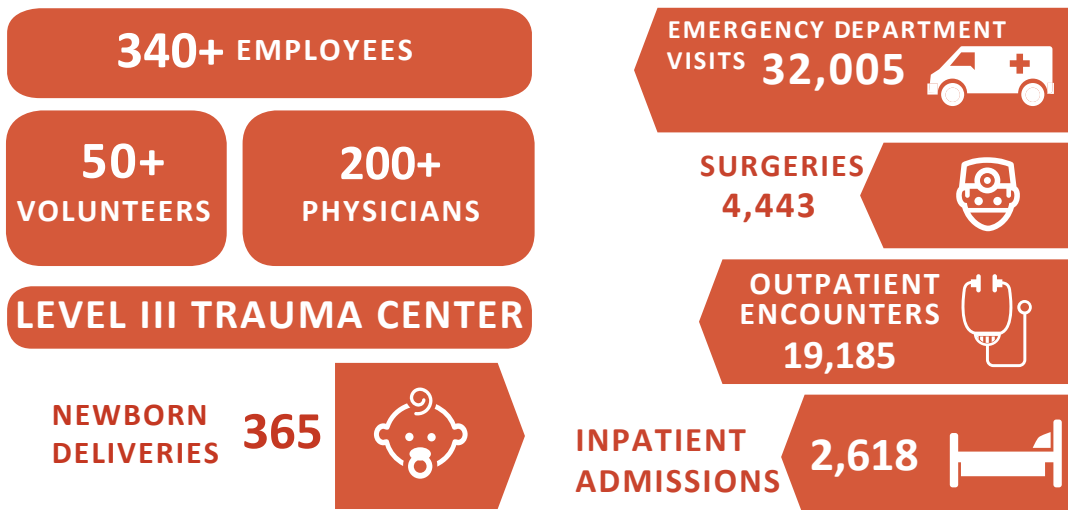
Community snapshot

OUR COMMUNITY

Piedmont Walton serves patients from all of Georgia, however, for purposes of this CHNA, we consider our community to be Walton County.
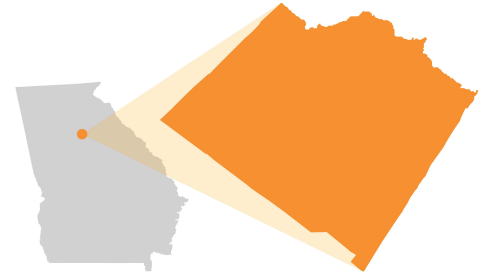
- In 2017, approximately 88,695 people lived in Walton County's 327 square miles. The majority of the community is white -- about 80 percent. The county slightly skewed female.

- Walton County is growing, with an increase of about 38 percent in population between 2000 and 2010. Hispanic or Latino populations alone grew by 131 percent during that time.

- In 2017, the median household income was $55,876, in line with the state and national averages of $52,977 and $57,652, respectively.

- The median age is 39.

- In 2017, 13 percent of the county lived at or below the poverty level -- about 11,200 people.

- 73 percent of people owned their own home in 2017, a rate much higher than state and national averages.

- 3.4 percent of adults were unemployed in 2018, a figure better than state and national averages.

- There were 5,075 veterans living in Walton County in 2017. The majority served in Vietnam, and approximately 30 percent lived with some sort of disability.

Key hospital stats

Piedmont Walton Hospital is a 77-bed hospital in Monroe, Georgia, serving Walton County and its surrounding areas. Offering 24-hour emergency services with a designated level III trauma center plus major medical, surgical and diagnostic care, Piedmont Walton is known for delivering high-quality patient-centered care close to home, and the hospital's employees are committed to making a positive difference in every life they touch.

340+ EMPLOYEES

50+ VOLUNTEERS

200+ PHYSICIANS

LEVEL III TRAUMA CENTER

NEWBORN DELIVERIES 365

EMERGENCY DEPARTMENT VISITS 32,005

SURGERIES 4,443

OUTPATIENT ENCOUNTERS 19,185

INPATIENT ADMISSIONS 2,618

Community rankings

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

- **30th for health outcomes,** with overall health being better than most other counties in the state.

- **46th in length of life**, with life expectancies a little shorter than that of the state average.

- **25th for quality of life**, with residents self-reporting their physical and mental health as better than the Georgia average.

- **34th for healthy behaviors**, with most indicators, including drinking and obesity, as higher than their counterparts in most other Georgia counties.

- **37th for clinical care**, with key clinical factors such as provider to patient ratios better than state averages.

- **31st for social and economic factors**, a ranking large in part due to the county's high rates of violence, income inequality and substandard housing.

- **130th for physical environment**, with long, solo commutes and inefficient public transportation for county residents.

Walton County ranks fairly low in one key area - physical environment - and relatively average in other indicators, such as social and economic factors and health outcomes.

Mortality

In Walton County, like with the rest of Georgia, heart disease is the number one cause of both age-adjusted and premature death. 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	Trachea, bronchus and lung cancer
3	All COPD except asthma
4	Mental and behavioral disorders, other than suicide
5	Cerebrovascular disease
6	Alzheimer's disease
7	Hypertension, hypertensive renal and heart disease
8	Diabetes
9	Colon, rectum and anal cancer
10	Accidental poisoning and exposure to noxious substances

Between 2013 and 2017, the second leading cause of premature death was accidental poisoning and exposure to noxious substances. Other top causes, in order, were suicide, motor vehicle accidents, lung cancer, certain conditions originating in the perinatal period, hypertension/hypertensive renal and heart disease, all COPD except asthma, cerebrovascular disease and diabetes. As evidenced in this list, the impact of issues related to unhealthy behaviors was significant, indicating a clear need for more aggressive interventions

Access to care

- There were no designated health professional shortage areas in the community in 2016. This does not mean, though, that all community members have 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 31 dentists and 60 mental health providers for every 100,000 people in 2015, figures far below state and national average rates.
    - Approximately 16 percent of county residents 18 or older have had six or more of their permanent teeth removed due to tooth decay, gum disease or infection.

Health status

- Community members have reported an average 3.7 poor or fair physical and 3.8 poor mental health days. A total 15 percent of Walton County residents reported their health as poor or fair. These are all on par with the state average.

- 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).

Quality and length of life

- Preventable hospital stays among Medicare enrollees averaged 55 preventable hospital events per every 1,000 enrollees in 2015. This figure is worse than state and national averages.

- 12 percent of the population lived with at least one disability in 2017. The highest concentration of disabled populations in the central part of the county.

- The infant mortality rate in Walton County is far less than state and national averages, at six infant deaths per every 1,000 births in 2017.
    - That year, 8.3 percent of all babies born were at a low birth weight, and with African American infants far more likely to be born at a low birth weight than any other race.

In Walton County, **12 percent of the total population was uninsured in 2017, and 18 percent of the adult population was uninsured in 2017.** Rates for children and elderly populations were much lower at 5 percent for children and 2 percent for those 65+. This equals about 10,676 people who have no form of insurance coverage to pay for necessary care.

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. Finally, lower-income patients are more likely to have increased health issues due to social determinants of health.

There is one charitable clinic in Walton County - the FISH Medical Clinic. Piedmont partners with the clinic by providing funding to support health care programming related to Piedmont's FY16 Community Health Needs Assessment.

There is one Federally Qualified Health Center in Walton County - MedLink. 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 Walton County was ischemic heart and vascular disease. In 2017 alone, 249 people died from major cardiovascular disease.
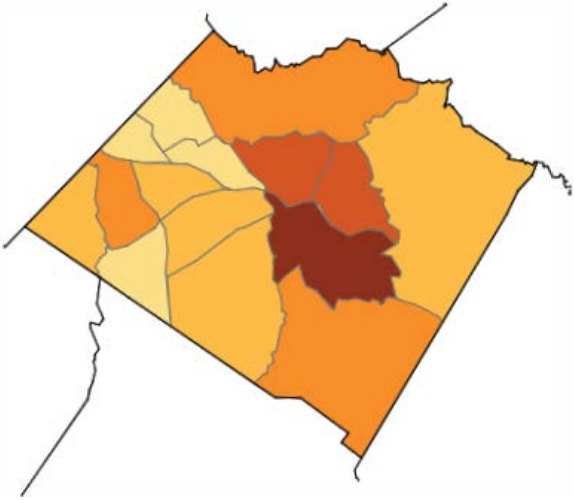
To the left is a breakdown of premature deaths related to ischemic heart and vascular disease by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue. This allows us to see exactly where we have the most instances so we can more directly target interventions 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 obesity and the hypertension, diabetes and physical inactivity that accompany weight gain.

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

In 2017, 45 Walton County community members died from stroke. 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 11 percent of adults lived with diabetes in Walton County in 2015, a figure in line with state and national averages (11 percent and 9 percent, respectively). In 2015, 29 percent of Medicare beneficiaries lived with diabetes. The numbers may be higher for Medicare beneficiaries because that population is more likely to be tested routinely for 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 Centers for Disease Control and Prevention, in 2017, the highest percentage of Georgians with diabetes had not graduated high school and earned less than $25,000.

Cancer continues to have a devastating impact in Walton County. In 2017 alone, 165 people died from all forms of cancer. Of those, lung cancer kills the most Walton County community members -- 51 in 2017.

Overall, between 2013 and 2017, lung cancer was the 2nd leading cause of age-adjusted death and the 4th leading cause of premature death. Colon, rectum and anal cancers were the 11th leading cause of premature death and breast cancer was the 13th leading cause of premature death. Below is a map of age-adjusted cancer deaths by census tract those years. The darker the color, the more deaths that occurred in that area of the county. Knowing where these deaths occur helps us focus our efforts on screening and care for patients at high-risk for cancer, as there are likely underlying social determinants of health contributing to death rates.

In Walton County:
- Female breast cancer incidence rate is lower than state and national averages, with an average rate of 120 incidences per every 100,000 people between 2010 and 2015.
- There are an average 61 new breast cancer cases diagnosed annually, and about 5,087 women lived with the disease in 2015.
- The lung cancer incidence rate is higher at 70 incidences per every 100,000 people, which is above both state and national averages.
- An estimated 9,566 people had lung cancer in 2015, and there are an average 64 new cases annually.
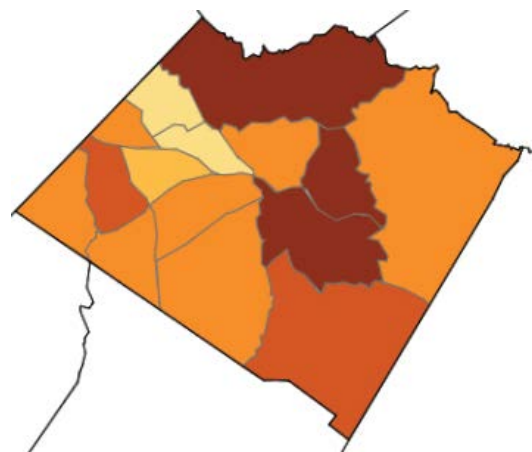
Cancer and health equity

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 versus patients without a cancer history, and younger survivors face the greatest hardships.

Unhealthy behaviors, such as tobacco use, poor diet, physical inactivity and obesity heavily contribute to cancer rates and tend to disproportionately impact low-income populations. For example, although overall smoking rates have decline 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.
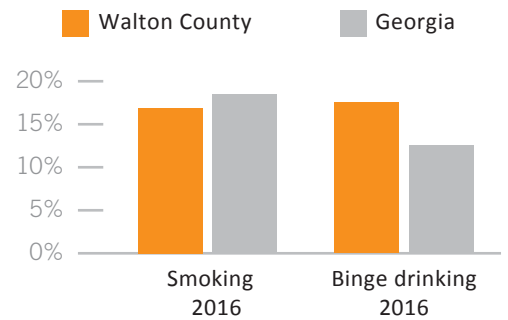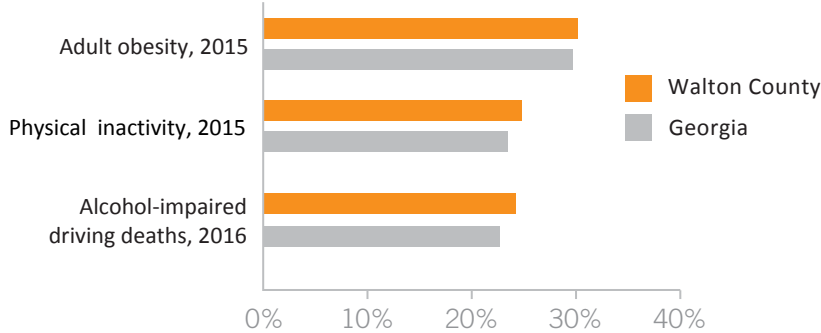
- **Adult obesity rates were high in Walton County, with nearly a third of all county residents as obese.** This contributes to a number of diseases, including heart disease, stroke and diabetes.
- Smoking rates were slightly lower than the state average, though smoking is still an issue as it is a key contributor to cancer, and in particular lung cancer, which has a devastating effect on Walton County residents.
- **17 percent of county residents commute more than 60 minutes or more to work**, a rate far higher than state and national averages. The majority of commuters from Walton County drive alone, which contributes to depression.
- **The violent crime rate was 302 per every 100,000 county residents,** a figure in line with state and national averages.

Mental health

- **Mental health and behavioral disorders was the 4th leading cause of age-adjusted death for all county residents between 2013 and 2017.**
- **Suicide was the 2nd leading cause of premature deaths for all races between 2013 and 2017, and the third leading cause of age-adjusted death.** It was most common among white males aged 25 to 34 years of age.
- **There was one mental health providers for every 1,666 residents in the county in 2017**, a rate far worse than the state and national averages of one provider for every 813 and 493 residents, respectively.
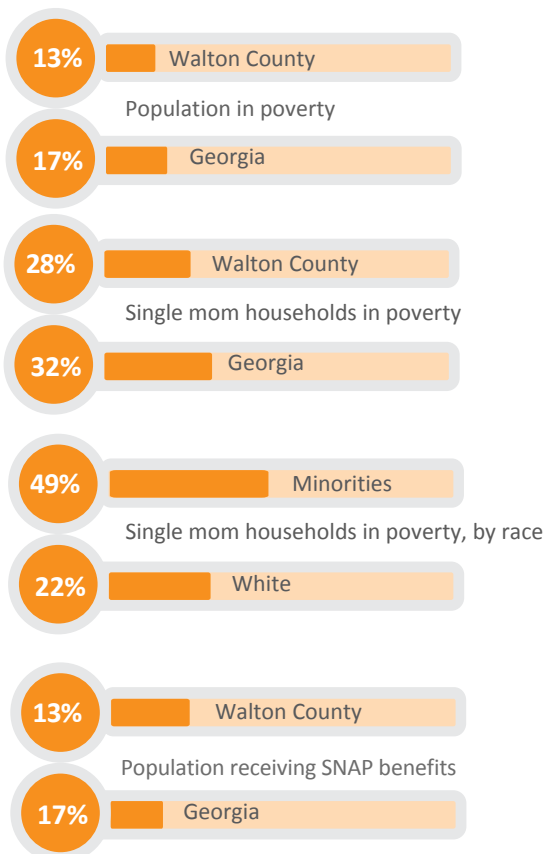
Opioid use and substance abuse

- **Like in the rest of the state, opioid prescriptions are an issue in the Walton County community**, with a total 100.9 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 only continuing to worsen.
- There were 15 deaths from all overdoses in Walton County in 2017, and ten were directly related to opioids.

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.

13% Walton County

Population in poverty

17% Georgia

28% Walton County

Single mom households in poverty

32% Georgia

49% Minorities

Single mom households in poverty, by race

22% White

13% Walton County

Population receiving SNAP benefits

17% Georgia

- **30 percent of households live in substandard housing**, meaning it has at least one major issue, such as no plumbing or too many occupants.

- In 2016, **33 percent of the population had no reasonable access to healthy foods in 2015.** 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 15 census tracts in Walton County, seven were in a food desert.**

- There were 52 fast food restaurants in Walton County in 2016, a figure that's better, per capita, than state and national averages. There are nine grocery stores, and the per capita rate is worse than state and national averages.

- **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. This is directly linked to having trouble paying medical bills.

- **1,057 Walton 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

- **35 percent of children lived in single-parent homes in 2017**, a statistic that can indicate financial insecurity at home.

- **49 percent of children qualified for free or reduced cost lunch in the 2015-2016 school year,** a statistic that represents poverty and food instability. Walton County is much more than the 2017 state average of 62 percent.

- **For every 1,000 teen girls aged 15 to 18 in Walton County, 44 gave birth to a child** on average each year between 2010 and 2016. In Walton County, African-Americans and Hispanic or Latina teen birth rates were 67 and 131 births per every 1,000 teen women, respectively. Children born to teen are statistically much more likely to experience adverse health and socioeconomic issues as they grow older.
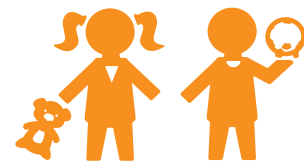
18 percent of children in Walton County lived in poverty in 2017. Poor children are statistically less likely to graduate high school and are nearly twice as likely to become poor adults and, should they have children, continue a circle of poverty that's difficult to break. These children are also more likely to experience dental issues, anxiety problems and higher rates of accidental injury.

PWH stakeholder survey

In December 2018 and December 2019, 50 key stakeholders within the Piedmont Walton 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 Walton's community?

The whole Piedmont system and all it serves: 34%

Walton County: 54%

The city of Monroe: 12%
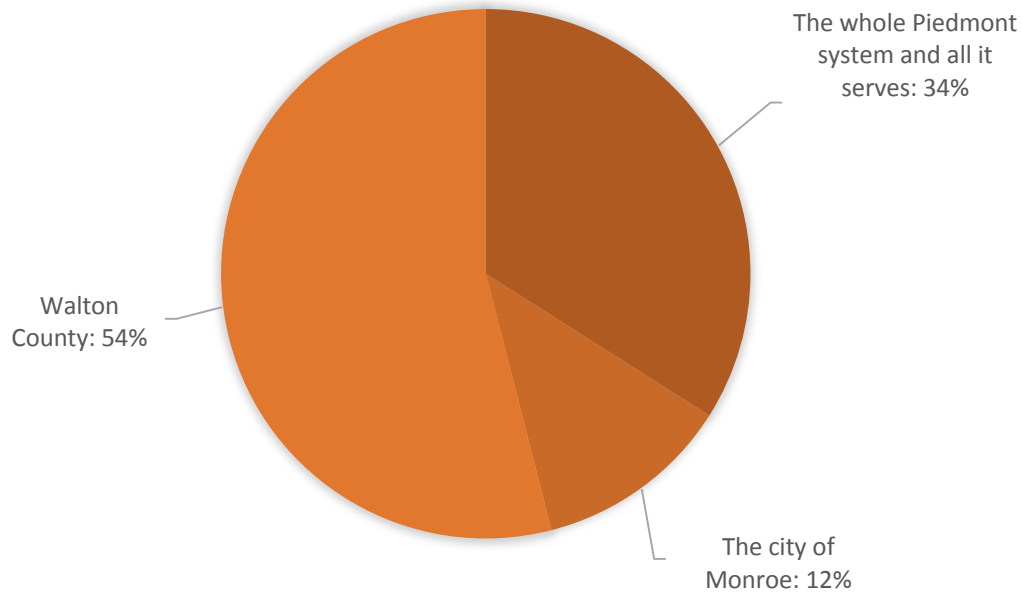
What do you think are the most pressing health problems in Piedmont Walton's community?

Top ten answers ranked very important, out of 25 listed problems:

1. Drug abuse - prescription medications
2. Drug abuse - illegal substances
3. Obesity in adults
4. Ability to pay for care
5. Obesity in children and teenagers
6. Cost of health care
7. Mental health
8. Cancer
9. Lack of transportation to health care services
10. Alcohol - dependency or abuse

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. Don't understand need to see a doctor
4. Transportation
5. Fear (e.g. not ready to face health problem)
6. Unable to use technology to help schedule appointments, find the doctor, etc.
7. Don't know how to find doctors
8. Cultural/religious beliefs
9. Language barriers
10. Lack of availability of doctors

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

Top 10 answers ranked most important:

1. Access to health care services
2. Expanded access to specialty physicians
3. Access to low-cost mental health services
4. Services to help physically or developmentally disabled children and adults
5. Access to local inpatient behavioral health facilities
6. Safe places to walk and play
7. Affordable healthy food
8. Community-based programs for health and wellness
9. Opioid awareness and prevention campaigns
10. Access to dental care services

Q What is your vision for a healthy community?

Some answers:

"Affordable health care, accessible medical staff, available educational programs, and mental health services for inpatient and outpatient treatment as necessary."

"A place where all citizens have equal opportunity to live a healthy lifestyle regardless of socioeconomics or their neighborhood."

"One where everyone that needs and wants to be seen by a doctor can be without having to worry about how they are going to pay for it."

"Education and screenings to teach the importance of health and the benefits of a healthy lifestyle. A true understanding on how unhealthy our nation has become, and help to find a pathway to a better quality of life for all people."

"Help available to meet the needs caused by drugs and poverty. A community that solves problems versus 'kicking the can down the road'."

"Interlocking of resources to meet the healthcare needs of all in the community."

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

Some answers:

"High co-pays and/or deductibles which make going to the doctor something that many people will put off because they do not have the extra money to pay the high co-pays and/or deductibles."

"Lack of realizing self worth. Heads of households do not teach children how to be successful in the world."

"Drug and alcohol abuse."

"Transportation."

"Lack of parks, hiking, biking, trails -- places that encourage and facilitate activity."

"Diabetes."

"Lack of insurance and low pay."

"Unhealthy diets and addiction to prescription medications."
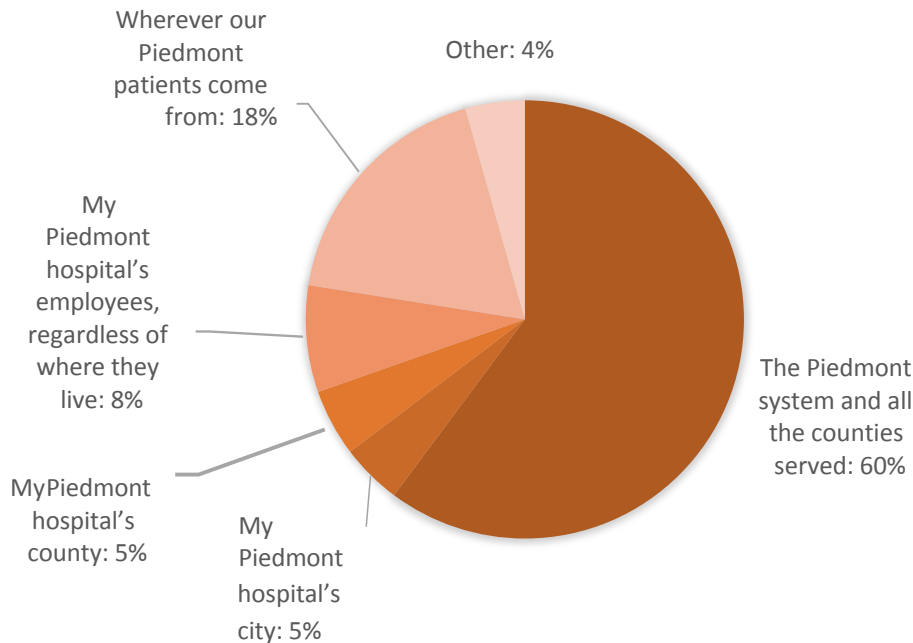
"Transportation and housing."

"Access to preventative education and resources."

"Generally unhealthy lifestyle due to lack of access to healthy food, healthcare and physical activity."

PHC employee survey

Thirty-three Piedmont Walton 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?

Wherever our Piedmont patients come from: 18%

Other: 4%

My Piedmont hospital's employees, regardless of where they live: 8%

MyPiedmont hospital's county: 5%

My Piedmont hospital's city: 5%

The Piedmont system and all the counties served: 60%

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

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 serves its 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

The community benefit grants program

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

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 Walton 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 Walton, 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.

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 Walton Hospital Board of Directors on April 17 2019.

Methodology

The Piedmont Walton Hospital CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Walton Hospital leadership and direct input from hospital leadership, including the hospital's chief executive officer.

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

On October 16, 2019, Piedmont Walton'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
Local efforts to increase access to care are strengthened and grown	Provide funding to support specific programs of not-for-profit organizations who provide direct physical and/or mental health services to low-income patients	• Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service • Areas can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of mental health care	• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PWH • Progress evaluated by PHC and PWH every six months

Low-income patients have access to community-based care	Provide funding support for a full-time nurse practitioner to treat low-income, uninsured patients	Continue to provide funding for a full-time nurse practitioner working at local charitable clinic F.I.S.H. Medical and Dental Clinic	Regularly monitor program and patient data to evaluate program for effectiveness, opportunities for growth
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 program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth
Patients and their families have meaningful input in their care	Create a mechanism for patient and family members to provide meaningful input on key areas of care	• Regularly solicit feedback of patients and their families, and especially those who have filed a grievance or complaint • Provide a forum – such as hospital leadership meetings – for patients to provide feedback and insight as to how to improve specific areas of patient care	Yes/no on if hospital is regularly soliciting this feedback and utilizing opportunities to connect patients and families to internal leadership groups, monitor and record any shifts, changes or actions as result of patient and family involvement
Patients have an increased awareness of local resources	Provide resource guide of state and local health-related services and other relevant information to vulnerable community members	• Update guide annually • Publish online and in print • Distribute widely throughout hospital and community	Annual distribution number of guides 10% year over year increase for FY20 to FY22 (approximately 1K distributed throughout the Walton County community in FY19)
Local community members have access to trauma services	Maintain Level III trauma center designation	• Participate in regional disaster management plans and exercises • Provide continuous general surgical coverage	Regularly monitor program and evaluate opportunities for improvement

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	Actively refer patients presenting at the hospital with opioid disorders to appropriate community-based care	Regularly monitor referral program through staff feedback, continually looking for opportunities to increase referral partners and improve internal processes
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	Regularly monitor non-opioid pain management strategies throughout the

		• 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)	hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PWH 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 opioid take-back day opportunities	• 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 • Track prescription take-backs and aim for an outreach increase of 7% to 10% 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 PWH • Progress evaluated by PHC and PWH 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 with living the disease, with a focus on lung cancer			
Vision	**Goal**	**Tactics**	**How to measure**
High-risk community members receive lung cancer screening referrals	Increase local awareness of and local opportunities for lung cancer screening	• Create and deploy local awareness campaign on risks, warning signs and early detection for lung cancer, particularly among high-risk groups • Increase referrals CT scans for CMS-defined heavy smokers • Increase early identification of suspicious nodules and thereby increase early cancer detection • Understanding low-income populations are more likely to smoke, continue mechanism for referrals for CMS-defined CT scans heavy smokers from partner clinic	• Measure current awareness by availability of local resources and a survey of local messaging • Utilizing FY19 figures, aim to increase CT scan referrals 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 • Clinic to provide quarterly referral figures to hospital
Cancer prevention and screenings to the Hispanic/Latino community is increased	Reduce cultural barriers to cancer prevention and education for Hispanic/Latino community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Engage staff to identify cultural barriers • Work with utilize best practices for engaging the Hispanic/Latino • Identify community agencies/organizations that work with the Latino communities • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening,	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

		early detection and education, with appropriate referrals	
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 • Explore ways to create a provide a free and/or low-cost mammogram screening program for underserved and/or underinsured women	• 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 • Solicit foundation and grant support to increase funding, community support
Community members with cancer have necessary social support	Provide cancer support cancer services	• Identify team members who can assist with formulating support group • Establish how the support group will function • Explore ways to draw awareness to support group and connect members with any needed resources	Establish cancer support group to meet monthly. Measure participation and effectiveness through surveys
More community members stop smoking	Provide to the community the necessary education and tools to permanently quit smoking	Provide ongoing smoking cessation classes to help community members permanently quit	Regularly monitor attendance and participant self-reported quitting data

		Priority: Promote healthy weights and behaviors as to decrease preventable instances of heart disease and diabetes		

Vision	Goal	Tactics	How to measure
Support healthy behaviors through community-based programming	Provide Walk with a Doc programming to community members	Each month, a Piedmont physician will lead a community-based walking program in which the doctor will also answer general health questions and promote overall healthiness	Regularly solicit feedback from community members on way to improve programming
Community-based heart attack survival rates are increased	Provide Early Heart Attack Care (EHAC)/Hands-only CPR to community	- Maintain Chest Pain Accreditation - Deploy programming, in partnership with community-based groups and emergency medical services - Provide hands-only CPR to high school students twice a year	Monitor participation, with aim to increase year over year
Public is alerted to risks and ways to reduce harm from heart disease, hypertension and stroke	Create public service announcements aimed at reaching at-risk populations on various health topics	- Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the general public, in appropriate languages - Distribute via social media, community partners, Piedmont.org website, community events	- Establish baseline of current messaging - Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year

		• Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	
Designated Remote Treatment Stroke Center designation is maintained; local community members are aware of heart risks and are appropriately screened	Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain stroke certification	• Stroke education is provided to local EMS and paramedics • Two stroke educational classes are taught quarterly and slots are open to outside medical facilities	• Establish baseline of current outreach, aim for an increase year over year • Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)
Community members are better able to self-manage heart condition	Provide blood pressure monitors to partner clinic patients who have been diagnosed with hypertension	• Identify patients who have received a diagnosis of hypertension • Provide home blood pressure monitor and subsequent education	Monitor hypertension levels among patients who received monitors, request self-reported usage data

Heart disease education and outreach to the Hispanic/Latino community is increased	Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Work with utilize best practices for engaging the Hispanic/Latino community • Identify community agencies/organizations that work with the Latino communities • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening education, early detection and education • Utilize website, social media, community partners to distribute information	• Establish baseline of current activities • Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys
Low-income community members know how to shop for and prepare healthy foods on limited budgets	Create a Cooking Matters program in partnership with charitable clinics, FQHCs and/or other community-based groups who regularly work with low-income populations, as to combat obesity and promote healthy eating	• Using current blueprint, design and execute programming for healthy eating and shopping for families utilizing food stamps or have limited food budgets, and in consideration of conditions such as heart disease, diabetes and obesity • Recruit patients for a four-week, four-session hour-long program that includes a trip to a convenient and affordable grocery store to learn how to best shop and read labels to encourage healthy eating • Potentially partner with local food banks to ensure ongoing access to healthy foods	• Monitor participation through attendance logs • Monitor effectiveness through qualitative surveys and participant interviews • Continually seek out ways to improve programming

Community members are able to self-manage their weight and/or weight-related issues	Conduct group education sessions and support programs to help patients learn and manage weight-related issues	Provide ongoing weight education and support opportunities, including classes and programming targeted specifically to those with weight-related conditions, such as Type II diabetes	Regularly monitor effectiveness through participant feedback and continually seek out ways to improve programming

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 Newnan 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, and particularly those services offered through our Sixty Plus program.
- **Accidental poisoning:** Accidental poisoning remains one of the top killers in the community. While we did not include this in our list of priorities we'll address, we will take every opportunity to promote poisoning knowledge and local resources that could reduce the risk of poisoning.