

As a designated 501(c)(3) nonprofit hospital, Piedmont 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

- Poverty is a critical issue in Athens-Clarke County, with some of the highest rates in the state.
- There are three federally designated provider shortage areas, meaning not all community members may have access to necessary physical, mental and dental care.
- Self-reported physical and mental health days are significantly worse than the state average.
- Uninsured rates are high, with nearly one-fifth of the adult population going without coverage in 2017.
- The average rate of preventable hospital stays among Medicare enrollees is better than state and national averages.
- Infants tend to fare better in Athens-Clarke, as infant mortality rates are lower than state and national averages.
- Diabetes rates are on par with state and national averages, with a little more than a tenth of the population suffering from the disease.
- Heart disease remains the top killer in Athens-Clarke County, claiming nearly 300 people each year.

2020 to 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:

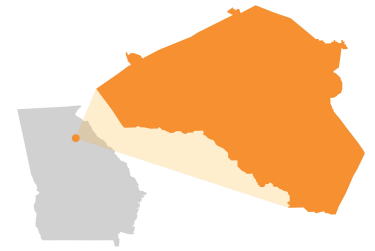
- Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes
- Decrease deaths from cancer and increase access to cancer programming for those with living the disease, with a focus on lung and breast cancer
- Promote healthy weights and behaviors as to decrease preventable instances of heart disease, stroke, diabetes, hypertension and other related chronic conditions
- 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 Athens serves patients from all over north Georgia, however, for purposes of this CHNA, we consider our community to be Clarke County. We do this in consideration of our status as a county authority-owned hospital and in recognition of the direct impact of our tax-exempt status on county residents.



- In 2017, approximately 123,554 people lived in Clarke County's 119 square miles. The majority of the community is white- more than twice of all other minorities combined. The county slightly skews female. The median age is 27, much younger than the rest of the state.
- Clarke County is also shrinking, with a drop of about 6 percent in population between 2000 and 2010. Hispanic or Latino populations alone grew by 51 percent during that time.
- In 2017, the median household income was \$34,557, much lower than both state and national averages of \$52,977 and \$57,652, respectively.
- In 2017, 34 percent of the county lived at or below the poverty level - about 38,618 people.
- A majority of people rent their homes in Clarke County-about 61 percent in 2017, a rate much higher than state and national averages.
- 3.7 percent of adults were unemployed in 2018, a figure slightly better than state and national averages.
- There were 4,513 veterans living in Clarke County in 2017. The majority were non-elderly adults, and approximately 17 percent lived with some sort of disability.

Key hospital stats

Piedmont Athens Regional Medical Center is one of northeast Georgia's largest not-for-profit hospitals. The 359-bed, acute care hospital joined the Piedmont family in 2016 and features a regional Level II trauma center and Level III neonatal ICU. As the second largest employer in the region, Piedmont Athens Regional contributes more than \$800 million dollars annually to the economy. Founded by physicians in 1919, the hospital has garnered national acclaim in patient experience, comprehensive cardiac care including open heart and thoracic surgery, orthopedics, neurosciences, minimally invasive surgeries, obstetrics and gynecology, pediatrics, oncology and gastroenterology. The hospital has a second campus in Oconee County.

2,650+ EMPLOYEES

500+
NURSING
STUDENTS

130+
PHYSICIANS

45 RESIDENTS - INTERNAL MEDICINE

**NEWBORN
DELIVERIES 2,631**



EMERGENCY DEPARTMENT
VISITS **85,458**



**SURGERIES
13,966**



**OUTPATIENT
ENCOUNTERS
186,871**



**INPATIENT
ADMISSIONS 21,247**



Community rankings

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

- **56th for health outcomes**, with overall health being better than most other counties in the state.
- **17th in length of life**, as Clarke County residents tend to live slightly longer than the average life span of all Georgians.
- **108th for quality of life**, particularly when it comes to residents self-reporting their physical and mental health.
- **51st for healthy behaviors**, with most indicators - except for drinking - as higher than their counterparts in most other Georgia counties.
- **16th for clinical care**, with key clinical factors such as provider to patient ratios better than state averages.
- **56th for social and economic factors**, a ranking large in part due to the county's high rates of violence, income inequality and substandard housing.
- **150th for physical environment**, with long, solo commutes, drinking water violations and inefficient public transportation.

Clarke County ranks fairly low in two key areas - quality of life and physical environment - and relatively average in other indicators, such as social and economic factors and health outcomes.

Mortality

In Clarke 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 other mental and behavioral disorders
3	Cerebrovascular disease
4	All COPD except asthma
5	Alzheimer's disease
6	Trachea, bronchus and lung cancer
7	Hypertension, hypertensive renal and heart disease
8	Nephritis, nephrotic syndrome and nephrosis
9	Diabetes
10	All other diseases of the nervous system

Between 2013 and 2017, the number one cause of premature death were certain conditions during the perinatal period. Other top causes, in order, included heart disease, suicide, accidental poisoning, motor vehicle accidents, hypertension/hypertensive renal and heart disease, lung cancer, cerebrovascular disease, all other diseases of the nervous system 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.

Health factors

Access to care

- There were three designated health professional shortage areas in the community in 2016: one primary care shortage area, one mental health shortage area and one dental shortage area.
- 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 54 dentists and 238 mental health providers for every 100,000 people in 2015, figures above average and national rates. Even so, mental and dental providers are often priced out of reach for many consumers and, generally speaking, consumers are less likely to have insurance coverage for these services.

Health status

- Community members have reported an average 4.6 poor or fair physical and 4.3 poor mental health days. A total 23 percent of Clarke County residents reported their health as poor or fair. All three indicators have worsened since our last CHNA, and all are worse than 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). Information on other races was not available.

Quality and length of life

- Preventable hospital stays among Medicare enrollees averaged 39.5 preventable hospital events 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 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 western part of the county.
- The infant mortality rate in Clarke County is far less than state and national averages, at 5.2 infant deaths per every 1,000 births in 2017. That year, 10 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 Clarke County, **15 percent of the total population was uninsured in 2017, and 19 percent of the adult population was uninsured in 2017.** Rates for children and elderly populations were much lower at 9 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.

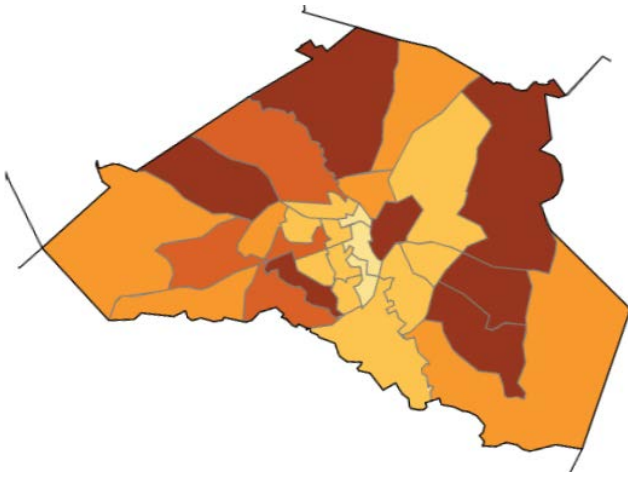
Additionally, these patients are less likely to be able to afford necessary medicine and ongoing chronic condition management. Finally, lower-income patients are more likely to have increased health issues due to social determinants of health.

There are several charitable clinics in Clarke County and Piedmont actively partners with all, including the provision of labs, staffing and funding to support relevant health programming.

There are two Federally Qualified Health Centers in Clarke County. 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 Clarke County was ischemic heart and vascular disease. During that time, an average 284 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 obesity, hypertension, diabetes and physical inactivity.

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 216 Clarke 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 11 percent of adults lived with diabetes in Clarke County in 2015, a figure in line with state and national averages (11 percent and 9 percent, respectively). In 2015, 24 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.

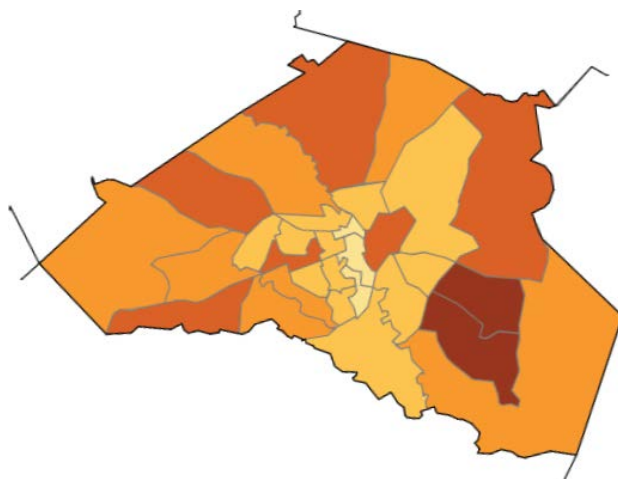
In Georgia, the less educated you are, the more likely you are to have diabetes. In 2017, Georgians who did not graduate high school were more than twice as likely to be diagnosed with the disease than Georgians with a college diploma. The same holds true for lower incomes versus higher incomes. According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

Cancer continues to have a devastating impact in Clarke County. In 2017 alone, 156 people died from cancer. Of those, lung cancer kills the most Clarke County community members - 44 in 2017. Overall, between 2013 and 2017, it was the fourth leading cause of age-adjusted death and the 7th leading cause of premature death.

To the right 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.

Knowing that cancer is so closely tied to unhealthy behaviors, including tobacco use, programs that support smoking cessation and healthy eating targeted to specific areas of the county could have a big impact.



Breast cancer was the 12th leading cause of age-adjusted death and colon, rectum and anal cancers were the 14th leading cause of death. Even though fewer women now die from the disease, female breast cancer incidence rate is higher than state and national averages, with a rate of 134 incidences per every 100,000 people. There are an average 68 new cases diagnosed annually, and about 5,078 women lived with the disease in 2015. The lung cancer incidence rate is lower at 58 incidences per every 100,000 people, however this is higher than national averages. An estimated 9,169 people had lung cancer in 2015, and there are an average 53 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:

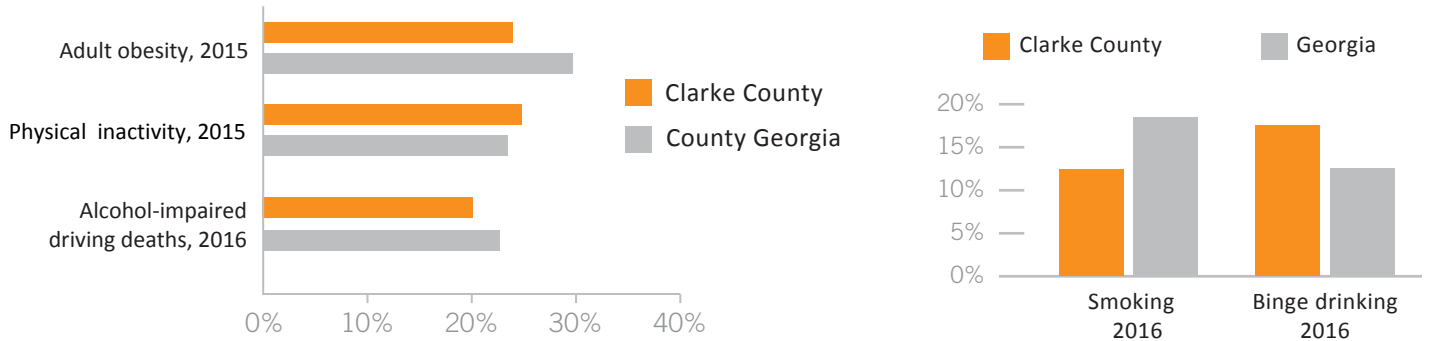
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 percent higher in poor men compared to affluent men.
- 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 Clarke County, with one-quarter of county residents as obese.** This contributes to a number of diseases, including heart disease, stroke and diabetes.
- Smoking rates were 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 Clarke County residents.
- Long commutes aren't as big of an issue in Clarke County as it is in the rest of the state. Approximately 5 percent of residents drove more than 60 minutes in 2016. The majority of commuters from Clarke County drive alone, which contributes to depression.
- **The violent crime rate was 372 per every 100,000 county residents,** a figure in line with state and national averages.

Mental health

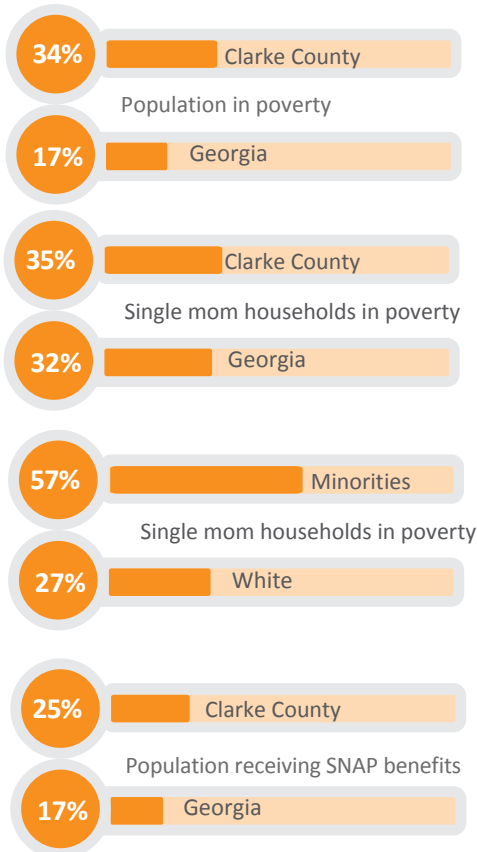
- **Mental health and behavioral disorders was the second leading cause of age-adjusted death for all county residents between 2013 and 2017.**
- **Suicide was the third leading cause of premature deaths for all races between 2013 and 2017, and the 11th leading cause of age-adjusted death.** It was most common among white males aged 25 to 34 years of age.
- **There was one mental health providers for every 402 residents in the county in 2017,** a rate much 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 Clarke County community,** with a total 90.9 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 12 deaths from all overdoses in Clarke County in 2017, and eight 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.



- **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, **41 percent of the population had limited access to healthy foods and an additional 14 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 30 census tracts in Clarke County, 18 were in a food desert.**
- There were 114 fast food restaurants in Clarke County in 2016, a figure that's far more, per capita, than state and national averages. There are 23 grocery stores, though they tend to be concentrated in the same communities.
- **42 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.
- **4,127 Clarke 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

- **43 percent of children lived in single-parent homes in 2017,** a statistic that can indicate financial insecurity at home.
- **93 percent of children qualified for free or reduced cost lunch in the 2015-2016 school year,** a statistic that represents poverty and food instability. Clarke County's rate is much higher than the 2017 state average of 62 percent.
- **For every 1,000 teen girls aged 15 to 18 in Clarke County, 24 gave birth to a child** on average each year between 2010 and 2016. In Clarke County, African Americans and Hispanic or Latina teen birth rates were 59 and 83 births per every 1,000 teen women, respectively.

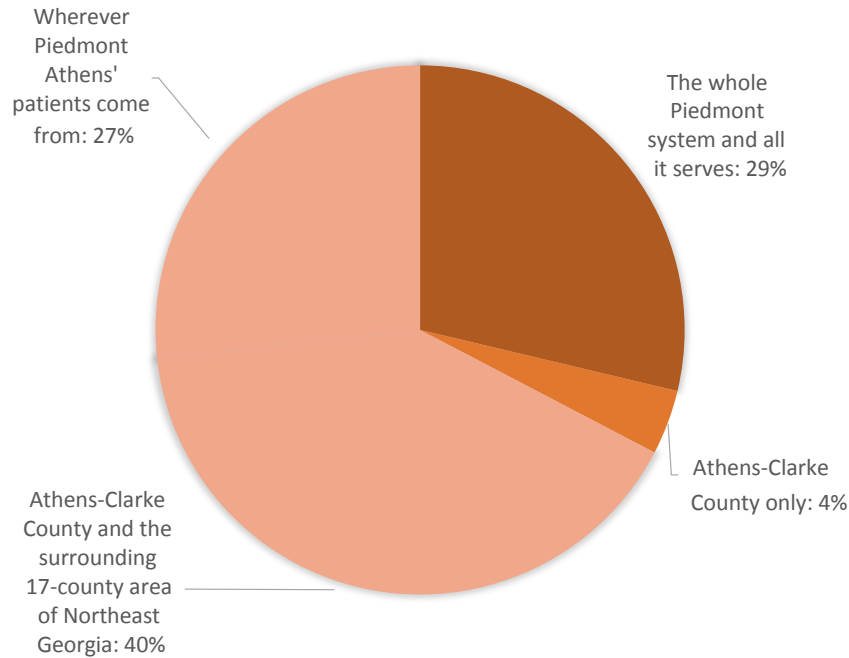


40 percent of children in Clarke County lived in poverty in 2017. Poor children are statistically less likely to graduate high school and are nearly twice as likely to become poor adult. These children are also more likely to experience dental issues, anxiety problems and higher rates of accidental injury.

PAR stakeholder survey

In December 2018 and December 2019, 50 key stakeholders within the Piedmont Athens Regional 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 Athens' community?



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

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

1. Ability to pay for care
2. Mental health care
3. Lack of health insurance
4. Drug abuse - prescription medications
5. Sexually transmitted diseases
6. Lack of transportation to health care services
7. Uninsurance
8. Difficulty getting an appointment
9. Drug abuse - illegal medications
10. Tobacco use

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

PAR stakeholder survey (continued)

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

Top 10 answers ranked most important:

1. Financial assistance for those who qualify
2. Additional access points to affordable care within the community
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. Access to affordable inpatient behavioral care
8. Partnerships with local charitable clinics
9. Safe places to walk/play
10. Promoting healthy behaviors among all residents



What is your vision for a healthy community?

Some answers:

"Providing affordable, quality healthcare to all individuals."

"Able to get healthcare regardless of economic status."

"Free community screenings and educational classes for heart disease and diabetes; partnerships with pharmaceutical companies to offer reduced medication costs when participating in classes; increased awareness for prevention of disease."

"A community where all individuals have access and resources to be self sustaining and mentally and physically healthy."

"Stronger, healthier, more active community."

"My vision for a healthy community is one in which people can afford and access health services that lay the foundation for prevention and for healthy habits starting prenatally, they know where to go throughout their life cycle, and they have no fear or reservations about accessing available services."



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

Some answers:

"Not having the funds or the transportation to get the medical help they need."

"Affordable health care even with health insurance. I know for me i can barley afford to go to the doctor when I am sick do to have to pay the extra costs of testing and such since I have to hit my deductible before it because free. I have never hit it and \$2,000 is a lot of money."

"Income pressures leading to anxiety and unhealthy strategies to cope with stress of living with a limited income. If you want to afford healthy food and doctor's visits, but you can't you need the knowledge and motivation to reduce the barriers to doing so. More people need to be aware of the support systems available to them and the support systems also need to be culturally appropriate and supported by the community as well."

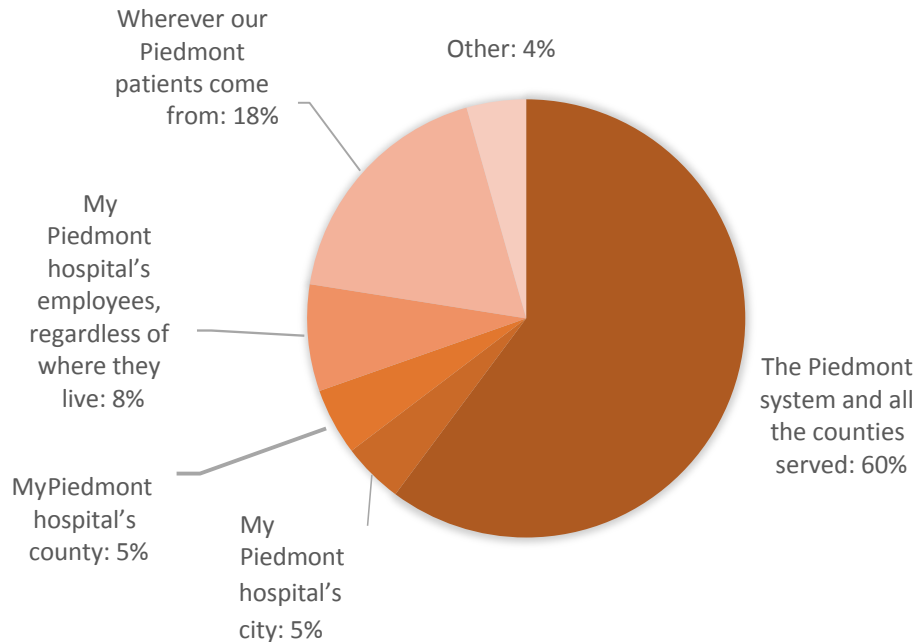
"Heathcare affordability."

"Lack of access to adequate mental health services. This affects all income levels."

PHC employee survey

Ninety-seven Piedmont Athens Regional 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
- 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

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 as elected officials and lawmakers. These interviews were conducted for people representing the entire region, including Clarke 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 Athens Regional, 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 Athens Regional Medical Center Board of Directors on May 23, 2019. The CHNA implementation strategy was unanimously approved October 24, 2019.

Methodology

The Piedmont Athens Regional CHNA was led by the Piedmont Healthcare community benefits team, with significant input and direction from Piedmont Athens leadership, including the Director of Community Relations and the Piedmont Athens Board of Directors, which formed a subcommittee to help determine final priorities.

The CHNA started first with an analysis of available public health data. 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. We focused on the home counties in the individual CHNAs 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. Consequently, the county feels the most impact from the hospital's tax exemption, as the forgone tax revenue might have instead been used to support government-funded services, such as public schools, fire departments and police. Because of this, we want to ensure that we are providing commiserate benefit to our local community.

From there, we interviewed key stakeholders who have a particular expertise or knowledge of our communities. Specifically, we interviewed representatives of local and regional public health entities, minority populations, faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and individuals representing our most vulnerable patients. The Piedmont Healthcare board of directors and leadership from all 11 hospitals were actively informed and engaged throughout this process.

Methodology (continued)

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 Athens Regional Medical Center
CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022**

On October 24, 2019, Piedmont Athens' 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 points for 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service 	<ul style="list-style-type: none"> • Goals of funded programs are to be determined by the individual organizations and approved by PHC and PARMC

		<ul style="list-style-type: none"> • Areas can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of mental health care 	<ul style="list-style-type: none"> • Progress evaluated by PHC and PARMC every six months
Low-income, uninsured community members have access to necessary lab services	Provide lab services free of charge to partner clinic Mercy Health Center	Continue to provide lab services free of charge to patients of partner clinic Mercy Health Center	Clinic to provide a quarterly report on how many patients received labs, how many labs were processed, the top twenty labs utilized, and relevant trends in patient care
All patients, and especially low-income patients, have access to community-based care, including specialty services	Through the Community Care Specialty Clinic, provide specialty services to all patients, and particularly low-income, high-need patients	<ul style="list-style-type: none"> • Patients who do not have a primary care doctor are referred to the Community Care Clinic upon discharge • Provide Community Care Specialty Clinic patients with access to care for patients who need endocrinology, diabetes education, infectious diseases, pulmonology, nephrology, hematology-oncology, geriatrics and ophthalmology • Provide ongoing support to these patients to address issues related to socioeconomic factors 	<ul style="list-style-type: none"> • Regularly monitor program and patient data to evaluate program for effectiveness, opportunities for growth • Utilize staff member feedback to create stronger mechanisms for support for these vulnerable patients
Future health workers are trained	Provide health professions education to students as to further build the health workforce	<ul style="list-style-type: none"> • Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate • Provide annual funding to Athens Technical College 	Regularly monitor program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth

<p>Patients and their families have meaningful input in their care</p>	<p>Regularly convene the Patient Family Advisory Council to provide meaningful input on key areas of care</p>	<ul style="list-style-type: none"> • Regularly convene approximately 10 to 15 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 • Set specific scope and goal of council, which could include internal initiatives to improve patient care and quality 	<p>Evaluation tactics to be determined by specific goals of council</p>
<p>Barriers to hospital-based care is reduced for low-income patients and their families</p>	<p>Provide free parking to patients who qualify for financial assistance or Medicaid and are receiving inpatient care</p>	<p>Utilize a voucher or reimbursement program to provide free parking to patients who qualify for a means-test program</p>	<p>Regularly monitor program to determine effectiveness in reaching patients needing assistance, track number of vouchers provided to low-income patients, utilize staff and patient feedback to determine gaps in program</p>
<p>Low-income patients receive primary and specialty care</p>	<p>Promote care for low-income populations through support of local charitable clinics</p>	<p>Provide ongoing financial support to local charitable clinic Athens Nurses' Clinic to support care for low-income, uninsured community members</p>	<p>Review partnership every six months and evaluate for opportunities for improvement and address any issues between hospital and clinic; continually explore ways to increase collaboration between hospital and clinic</p>
<p>Patients have an increased awareness of local resources</p>	<p>Provide resource guide of state and local health-related services and other relevant information to vulnerable community members</p>	<ul style="list-style-type: none"> • Update guide annually • Publish online and in print • Distribute widely throughout hospital and community 	<p>Annual distribution number of guides 10% year over year increase for FY20 to FY22 (approximately 1.5K distributed throughout the Athens community in FY19)</p>
<p>Vulnerable patients have access to community-based care</p>	<p>Explore opportunities to provide place-based care, such as a mobile unit targeting high-risk patients</p>	<p>Evaluate and create project plan to provide place-based, which could include: utilize CHNA to determine locations to focus efforts, such as public housing; consider best way to provide care;</p>	<p>Metrics and evaluation would be dependent on programming</p>

		create appropriate referral and follow-up information mechanisms	
Low- and no-income patients receive prescribed medications	Provide support for obtaining prescribed medications	<ul style="list-style-type: none"> • Support pharmacy services at the Community Care Clinic (CCC) • Support a pharmacy buyer at CCC whose job responsibility will be completing paperwork for prescription assistance for prescribed medications • Provide monthly support to Mercy Health Center for medications 	Regularly monitor program to determine effectiveness in reaching patients needing assistance; meet with clinics regularly to evaluate opportunities to improve programming and hospital-clinic collaboration
Low-income students receive primary care	Build new school clinic at Gaines Elementary and Hilsman Middle School	Provide financial donation for new school clinic to serve low-income children with sick visits, well visits, immunizations, dental services and counseling services	Review partnership every six months and evaluate for opportunities for improvement and address any issues between hospital and schools; continually explore ways to increase collaboration between hospital and schools
Low-income patients are able to access primary and specialty care	Support transportation services to necessary care	<ul style="list-style-type: none"> • Provide transportation services to cancer services for low-income patients • Pay for transportation to primary and specialty care appointments for low-income patients, in partnership with seven community-based transportation providers 	Track transportation services and regularly evaluate mechanisms to improve services
Low-income and/or high-risk community members receive health education, screenings and referrals for relevant programming	Place-based prevention education, chronic disease management education, screenings, and referrals to health and social services	<ul style="list-style-type: none"> • Provide education and referrals for patients/clients of strategic community partners including: Our Daily Bread of Action Ministries, Diversion Center of Athens-Clarke 	Set target # people reached, using current baseline metrics, and aim for an increase in both number of people reach (10% to 15%) and strategic locations targeted (one to two) year over year

		<p>County Jail, Women's Services of Advantage Behavioral Health, Mercy Health Center, Athens Nurses' Clinic, Athena Gardens Older Adult Residence, Columbia Brookside Senior Residence, Oconee County Senior Center, Athens Community Council on Aging, and public school systems</p> <ul style="list-style-type: none"> • Education and referral provided to local night shift workers, in partnership with employers 	
<p>Public is alerted to risks and ways to reduce harm from heart disease, hypertension and stroke</p>	<p>Create public service announcements aimed at reaching at-risk populations on various health topics</p>	<ul style="list-style-type: none"> • 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 • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy 	<ul style="list-style-type: none"> • Establish baseline of current messaging • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year
<p>Primary Stroke Center designation is maintained; local community members are aware of stroke risks and are appropriately screened</p>	<p>Offer stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain stroke certification</p>	<ul style="list-style-type: none"> • Stroke education is provided to local EMS and paramedics • Two stroke educational classes are taught monthly and slots are open to outside medical facilities 	<ul style="list-style-type: none"> • Establish baseline of current outreach, aim for an increase year over year • Measure efficacy of program through qualitative mechanisms (surveys, other participant feedback)

<p>Community members are better able to self-manage heart condition</p>	<p>Provide blood pressure monitors to partner clinic patients who have been diagnosed with hypertension</p>	<ul style="list-style-type: none"> • Identify patients who have received a diagnosis of hypertension • Provide home blood pressure monitor and subsequent education 	<p>Monitor hypertension levels among patients who received monitors, request self-reported usage data</p>
<p>Women have the necessary information to prevent or survive heart disease</p>	<p>Educate women on preventing and managing heart disease through multimodal traditional and complimentary/alternative education; focus efforts on African American Women and uninsured women</p>	<p>Continue to look for opportunities for community outreach, connect with physicians for referrals to coaching, host community education sessions (lectures, cooking classes, farmers market tours, etc.), involve a vast array of stakeholders and building on work already in place</p>	<p>Will monitor and track education results through readiness to change surveys, screening results and coaching results through SF-36 survey</p>
<p>Heart disease education and outreach to the Hispanic/Latino community is increased</p>	<p>Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community</p>	<ul style="list-style-type: none"> • 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, early detection and education • Utilize website, social media, community partners to distribute information 	<ul style="list-style-type: none"> • 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

<p>Maintain Chest Pain Center Accreditation through the American College of Cardiology by educating the community at large to reduce preventable instances of heart disease</p>	<p>Provide ongoing resources and education to community members as to maintain high level of chest pain care at hospital</p>	<ul style="list-style-type: none"> • Provide quarterly cardiovascular disease screenings to those community populations identified at risk for heart disease. • Offer an Early Heart Attack Care (EHAC) and Hands Only CPR course at least twice a year to the community-at-large • Collaborate with our local EMS agency at least annually to jointly offer an Early Heart Attack Care (EHAC) and Hands-Only CPR course to the community at large 	<p>Conduct yearly review to ensure we are maintaining CPCA designation; regularly evaluate opportunities to engage and work with the community</p>
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<p>Priority: Reduce opioid and related substance abuse and overdose deaths</p>			
<p>Vision</p>	<p>Goal</p>	<p>Tactics</p>	<p>How to measure</p>
<p>Hospital-based prescriptions for opioids and related drugs are reduced</p>	<p>Patients are at low risk of misusing opioids</p>	<ul style="list-style-type: none"> • 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 	<p>Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach</p>

<p>Patients are supported in recovery from their opioid addiction</p>	<p>All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery</p>	<ul style="list-style-type: none"> • Develop relationships with community resources to which patients can be transitioned • Make these community resources known and available to our caregivers 	<p>Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are increased; program measured by participation and qualitative measures</p>
<p>Opioid addiction is viewed as a disease</p>	<p>All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma</p>	<ul style="list-style-type: none"> • 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 	<p>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</p>
<p>Hospital-based prescriptions for opioids and related drugs are reduced</p>	<p>PHC adopts and uses appropriate non-opioid pain management strategies</p>	<ul style="list-style-type: none"> • 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) 	<p>Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies</p>
<p>Community-based efforts to curb opioid addiction and overdose deaths are increased</p>	<p>PARMC provides meaningful leadership in its community by partnering with others in combating opioid abuse</p>	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • Support local DEA-approved prescription drug take-back days through partnership and patient awareness 	<ul style="list-style-type: none"> • Measure take-back day participation, creating a baseline from FY19 activities, and aim to increase local awareness and involvement 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Goals of funded programs are to be determined by the individual organizations and approved by PHC and PARMC • Progress evaluated by PHC and PARMC 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	<ul style="list-style-type: none"> • 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
Increase community knowledge of opioid-centric information	Host community forum with expert panel	Host annual expert panel in partnership with College of Public Health and St. Mary's	Monitor participation in panel and seek meaningful input from participants on ways to improve programming

Priority: Decrease deaths from lung and breast cancer and increase access to cancer programming for those with living the disease

Vision	Goal	Tactics	How to measure
Support appropriate screening for breast cancer	Increase access to screening to mammograms	<ul style="list-style-type: none"> • Provide annual day of free mammogram on-campus at main hospital and the Oconee Health Campus • Utilize mobile mammography unit to provide place-based screening, including screening for low-income women • Accept referrals from charitable care clinic partners 	Monitor referrals and mammograms provided, creating a baseline from FY19 figures; aim for a 12% to 15% increase year over year
Cancer patients and their families receive necessary support for recovery and well-being	Provide comprehensive, evidence-based psychosocial support for cancer patients and their families	<ul style="list-style-type: none"> • Group and individual counseling, education about trusted resources and treatment options, grief and illness-adjustment counseling provided free of charge 	<ul style="list-style-type: none"> • Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness
High-risk community members receive lung cancer screenings	Increase local awareness of and local opportunities for lung cancer screening	<ul style="list-style-type: none"> • Create and deploy local awareness campaign on risks, warning signs and early detection for lung cancer, particularly among high-risk groups • Increase low-dose CT scans for CMS-defined heavy smokers 	<ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> • Increase early identification of suspicious nodules and thereby increase early cancer detection • Understanding low-income populations are more likely to smoke, create mechanism for CT scan referrals for CMS-defined heavy smokers from partner clinic(s) 	for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system
More community members stop smoking	Provide to the community the necessary education and tools to permanently quit smoking	Offer "Courage to Quit" tobacco cessation classes at PARMC, Mercy Health Center, and surrounding county health departments at no charge	Regularly monitor attendance and participant self-reported quitting data
Cancer prevention and screenings to the Hispanic/Latino community is increased	Reduce cultural barriers to cancer prevention and education for Hispanic/Latino community	<ul style="list-style-type: none"> • Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Engage staff to identify cultural barriers • Utilize best practices for engaging the Hispanic/Latino • Identify community agencies/organizations that work with the Latino communities, such as Lazos Hispanos • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, early detection and education, including free mammogram day 	<ul style="list-style-type: none"> • 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

Prevent smoking and vaping among teens	Provide smoking and vaping prevention and cessation programming to teens and their parents	<ul style="list-style-type: none"> • Offer school- and community-based education programs on the dangers of e-cigarette and tools for quitting smoking and vaping for teens and parents • Offer school- and community-based education for teens and parents around chewing tobacco (especially targeting student athletes) 	Regularly monitor attendance and participant self-reported quitting data
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Priority: Promote healthy weights and behaviors as to decrease preventable instances of heart disease, stroke, diabetes, hypertension and other related chronic conditions			
Vision	Goal	Tactics	How to measure
Families have the tools to make behavior changes that lead towards healthier weights	Offer family program for health behavior change	<ul style="list-style-type: none"> • Receive referrals from any pediatrician for child with BMI-for-age 85th percentile or higher • Families meet eight or more times with registered dietitian, registered nurse and certified health education specialist • Staff use motivational interviewing techniques for individual visits to work through barriers to healthy habits and guide families in goal setting 	Aim for a goal of 700 to 800 encounters to meet pediatrician and patient demand; regularly monitor program and solicit provider feedback to identify areas of referral and programmatic improvement

		<ul style="list-style-type: none"> • Provide group classes that cover nutrition, cooking, cardiovascular and strength training exercises 	
Community members have the tools to get - and stay - healthy	Provide ongoing education, training and support to community members to help them manage their weight and weight-related conditions	<ul style="list-style-type: none"> • Continue to provide on-going classes on healthy eating and making positive lifestyle changes through the Athens YMCA • Support the Athens Farmers Market's Food as Real Medicine Rx Program (FARM Rx) • Provide cooking classes through the Loran Smith Center for Cancer Support, Diabetes Education and Outpatient Dietitians. 	Will monitor and track education results through readiness to change surveys and qualitative measurement tools
Low-income community members have access to healthy foods	Connect eligible families to Supplemental Nutrition Assistance Program (SNAP) benefits	Provide funding support for a SNAP navigator at Community Care Clinic to assist patients through application process	FY19 figures from a UGA study estimates that 67% of eligible families in Athens-Clarke County not getting SNAP – Will aim for a decrease in this amount by 7% to 8%, year over year for three years; will track through clinic referral and approval records

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:

- 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.
- Physical environment: The Athens-Clarke community has significant issues related to community infrastructure, including transportation and housing. We will continue to address these issues to the best of our ability, supporting programming for medical transport and, when possible, promoting healthy, affordable housing.