Community Health Needs Assessment
Fiscal Year 2019

Piedmont NEWNAN

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

- People tend to lead longer lives in Coweta County, with a rate of 6,300 years of potential life lost, as compared to the state rate of 7,500 in 2017.
- Rates of preventable hospital stays among Medicare enrollees were better than both state and national averages that year.
- Rates of infant mortality, low birth weight and teen births were also better than state and national averages.
- There is a noted lack of both mental and dental health care providers in the community.
- Heart disease, stroke and lung cancer continued to pose detrimental risks to county residents.
- Healthy behaviors were an issue in Coweta County in 2017, especially in regards to alcohol and substance use. Like with most of the state, opioid use is a critical issue.
- Health disparities are significant, and social determinants of health create serious inequities that translate to worse health outcomes.
- Diabetes rates have remained steady over the last six years, though were still high at one in ten county residents having the disease in 2017.

2020, 2021 and 2022 health priorities

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

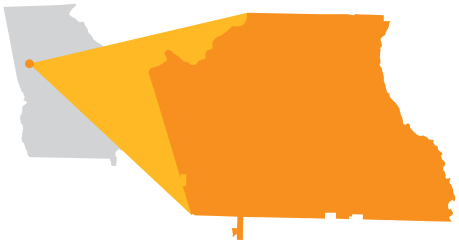
- Increase access to appropriate and affordable health and mental care for all community members, and especially those who are low income and/or uninsured
- Decrease deaths from all cancers and increase access to cancer programming, with a focus on lung cancer and breast cancer
- Reduce opioid and related substance abuse and overdose deaths
- Reduce instances of and deaths from heart disease
- Reduce preventable instances of diabetes and increase access to care for those living with the disease
- Reduce rates of obesity and increase access to healthy foods and recreational activities

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

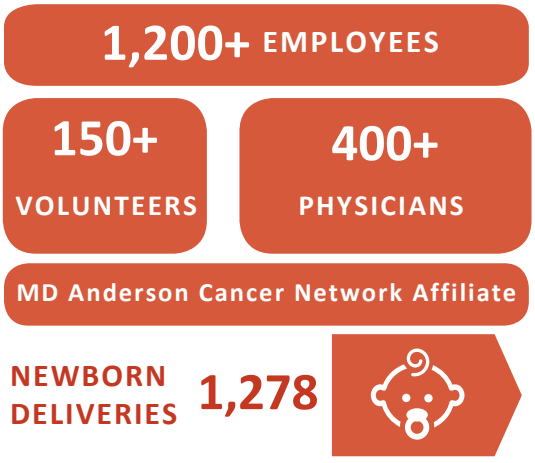
While we serve patients from many parts of Georgia, for the purposes of this CHNA, we only examined the hospital's home county of Coweta County.

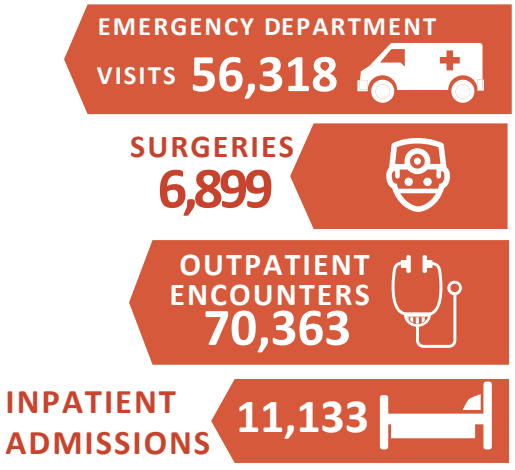


- In 2017, approximately 138,015 people lived in Coweta County's 440.92 square miles. Three-fourths of the population was white and the majority lived in a urban community. The county skews slightly female. The median age is 38.
- Coweta is also growing. Between 2000 and 2010, the county grew by about 43 percent. Hispanic or Latino populations alone grew by 204 percent during that time.
- In 2017, the median household income was $60,856, much higher than both state and national averages.
- Most people owned their homes in Coweta County -about 73 percent in 2017, a rate much higher than state and national averages.
- Of the total county population, 66,983 were employed at least a majority of 2017.
- In 2017, the top industries for employed residents were, in order: manufacturing, retail, transportation and warehousing, health care and social assistance, and educational services.
- 3 percent of adults were unemployed in 2018, a figure that's a percentage point better than state and national averages.
- There were 9,732 veterans living in Coweta County in 2017. Seventy-five percent of veterans were white, 15 percent lived with a disability and 13 percent lived below poverty. Most were non-elderly adults.

Key hospital stats

Piedmont Newnan Hospital is a 136-bed, acute-care, community hospital in Newnan, Georgia. Piedmont Newnan is a cornerstone of wellness as the only acute-care facility in Coweta County. Since joining Piedmont Healthcare in 2007, the hospital generated more than $1 billion in revenue for the local and state economy in the first five years, while at the same time providing nearly $44 million in uncompensated care. As a not-for-profit organization, hospital earnings go directly back into maintaining and improving services and facilities, and to educational outreach.





Community rankings

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

- **10th for health outcomes,** which includes positive indicators for mortality and morbidity for all its community members.
- **12th in length of life**, with an estimated 6,300 years of life lost by all community members due to health factors, far less than the state average of 7,500.
- **14th for quality of life**, with indicators for overall health, poor physical health days, poor mental health days and low birth weight rates better than state averages.
- **18th for healthy behaviors**, with slightly better than average rates of smoking, physical inactivity, excessive drinking, motor vehicle crashes and teen births, and very low rates of sexually transmitted diseases.
- **18th for clinical care**, with better than average uninsured rates and preventable hospital stays, though relatively poor ratios of clinicians to residents.
- **24th for social and economic factors**, with better than average rates of violent crime, injury deaths, children in single-parent households, unemployment and children living in poverty.
- **85th for physical environment**, with rates worse than the state average for long commutes and access to recreational facilities.

With the exception for physical environment, Coweta County ranks in top quarter of all Georgia counties.

Mortality

In Coweta 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 causes of death, in aggregate, 2013 to 2017
1	Ischemic heart and vascular disease
2	All COPD except asthma
3	Trachea, bronchus and lung cancer
4	Primary hypertension and hypertensive renal and heart disease
5	Mental and behavioral disorders
6	Alzheimer’s Disease
7	Cerebrovascular disease
8	All other diseases of the nervous system
9	Diabetes
10	Nephritis, nephrotic syndrome and nephrosis

Between 2013 and 2017, leading cause of premature death were, in order, ischemic heart and vascular disease, motor vehicle crashes, suicide, accidental poisoning, primary hypertension, hypertensive renal and heart disease, lung cancer, COPD and diabetes. These particular issues are driven heavily by health behaviors, and indicate a need for further intervention on these behaviors (such as smoking and healthy eating) to help curb premature death rates. Additionally, screening for these conditions could help reduce mortality rates due to early detection and management.

Health factors

Access to care

- There were no designated health professional shortage areas in the community in 2016, meaning that all communities were considered to have adequate access to a physician.
- 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 were much higher than that of their white counterparts.
- There is a noted lack of dentists in the area. There was only 35 dentists for every 100,000 people in 2015, a figure far below average and national rates.

Health status

- Community members have reported an average 3.5 and 3.6 poor or fair physical and mental health days, respectively, and 15 percent of county residents reported their health as poor or fair in 2015. This indicator has worsened since our last CHNA.
- Statewide, race matters when it comes to poor health status. Approximately 26 percent of Hispanics reported being in poor health in 2017, as compared to their white and African-American counterparts (18 percent and 19 percent, respectively). Information on other races was not available.

Quality and length of life

- 11 percent of the population lived with at least one disability in 2017, which was lower than the state average of 12 percent. The majority of those disabled were between 18 and 64, though that's likely due to there being more people in that age group in the county.
- Preventable hospital stays among Medicare enrollees was at a rate equal to 43.1 preventable stays per every 100,000 people. This is better than both state and national averages.
- The infant mortality rate in Coweta County is much better than than state and national averages at 3.7 infant deaths per every 1,000 births in 2017. Minorities tended to be more impacted by infant mortality rates.
- During that same time, 7 percent of all babies born were at a low birth weight, with minority children most likely to be born at a low birth weight. This indicator, though, is still better than state and national averages.

In Coweta County, **10 percent of the total population was uninsured in 2017, and 14 percent of the adult population was uninsured that year.** Minorities in Coweta County were also more likely to be uninsured than their white counterparts.

Statewide, one in five uninsured adults in 2017 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

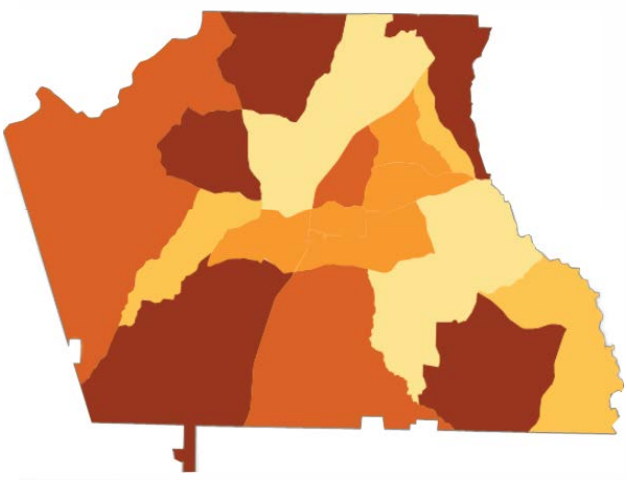
Additionally, these patients are less likely to be able to afford necessary medicine and ongoing chronic condition management. Lower-income patients are more likely to have increased health issues due to social determinants of health.

There is one charitable clinic in Coweta County - the Coweta Samaritan Clinic, which primarily serves low-income uninsured patients. Piedmont Newnan, actively partners with the clinic to support its work, including the provision of free lab services and a part-time licensed medical social worker.

There is one Federally Qualified Health Center in Coweta County - YourTown Health. 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 Coweta County was ischemic heart and vascular disease. During that time, 536 people have died from this 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

Between 2013 and 2017, 205 Coweta County community members died from stroke, making it the 7th leading cause of age-adjusted death. This equals a death rate of 35 people per every 100,000 people. This is higher than both state and national averages.

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

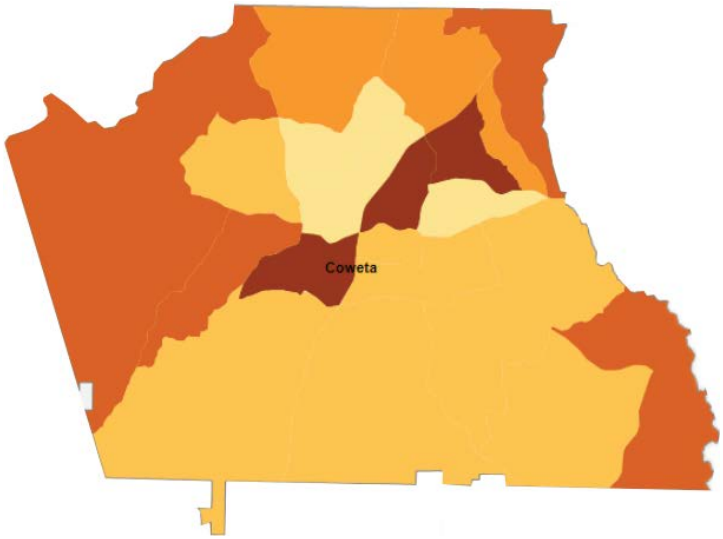
Approximately 10 percent of adults lived with diabetes in Coweta County in 2015, a figure relatively in line with state and national averages (11 percent and 9 percent, respectively). In 2015, 25 percent of Medicare beneficiaries lived with diabetes. The numbers may be higher for Medicare beneficiaries 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 CDC, in 2017, the highest percentage of Georgians with diabetes earned less than $25,000.

Cancer

Cancer continues to have a devastating impact in Coweta County. In 2017 alone, 225 people died from cancer. Of those, lung cancer kills the most Coweta County members. It is the third leading cause of age-adjusted death and the sixth leading cause of premature death.

To the right is a map of age-adjusted lung cancer deaths by census tract between 2013 and 2017. The darker the color, the more deaths that occurred in that area of the county.



During those years, colon, rectum and anal cancers were the 11th leading cause of death, pancreatic cancer was the 14th and breast cancer was the 15th leading cause of death.

The female breast cancer incidence rate is slightly lower than state and national averages, with a rate of 117.7 incidences per every 100,000 people. There are an average 89 new cases diagnosed annually, and about 7,500 women lived with the disease in 2015.

The lung cancer incidence rate is lower at 64.7 incidences per every 100,000 people, however this is higher than national averages. An estimated 13,137 people had lung cancer in 2015.

Cancer and health equity

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

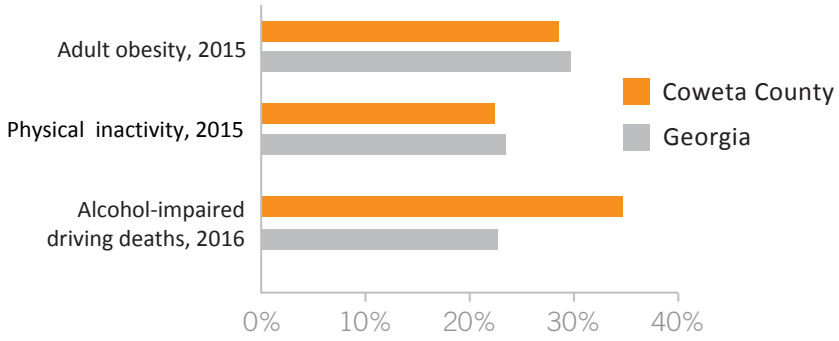
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 percent higher in poor men compared to affluent men.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

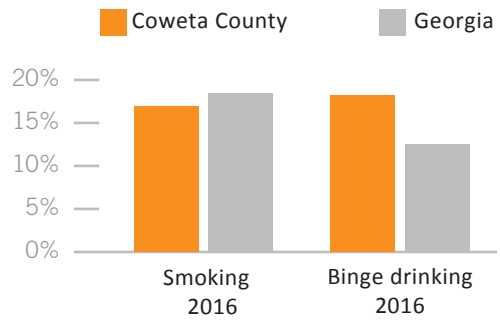
Unhealthy behaviors, such as tobacco use, poor diet, physical inactivity and obesity continue to heavily contribute to cancer rates and tend to disproportionately impact low-income populations. For example, although overall smoking rates have declined statewide, high rates still persist among lower educated,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

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

Healthy behaviors

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





- **Obesity rates were high in Coweta County,** and 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 Coweta County residents.
- Long commutes were also higher in Coweta County than in the rest of the state. Thirteen percent drove more than 60 minutes in 2016, and the majority of commuters from Coweta County drive alone.
- Binge drinking rates and the number of alcohol-impaired driving deaths are much higher than state averages.

Mental health

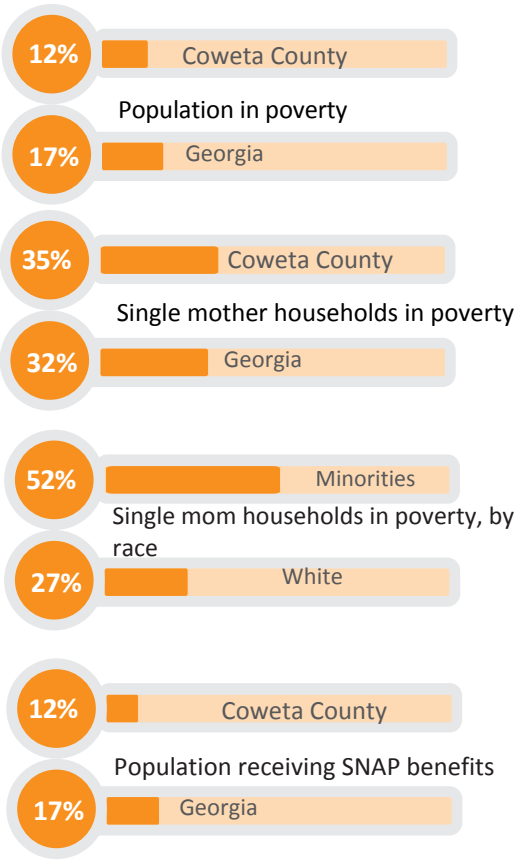
- **Mental health and behavioral disorders was the 5th leading cause of age-adjusted death for all county residents between 2013 and 2017.**
- **Suicide was the third cause of premature deaths for all races between 2013 and 2017.** It was most common among white males aged 25 to 34 years of age.
- **There was one mental health providers for every 1,653 residents in the county in 2017**, a rate far worse the state and national averages of one provider for every 813 and 493 residents, respectively.

Opioid use and substance abuse

- **Opioid prescriptions are a significant issue in the Coweta County community**, with a total 74.1 opioids prescriptions written per every 100 people in 2017. This figure is down from 2007, when there were 86.2 retail opioid prescriptions dispensed per every 100 persons. 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.
- **Even so, in 2017, Coweta remained above both state and national averages of 70.9 and 58.7 per every 100 people, respectively.**
- 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.
- T**otal deaths from all overdoses in Coweta County was 16.1 per every 100,000 people in 2017**, a figure that has steadily increased year over year. For example, in 2010, the death rate was 5.5.

Social determinants of health

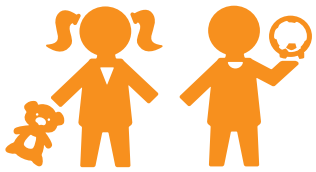
As defined by the World Health Organization, social determinants of health (SDHs are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Included among these is economic stability, housing stability, food security, 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.



- **26 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, **42 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 20 census tracts in Coweta County, 13 were in a food desert.
- There were 76 fast food restaurants in Coweta County in 2019, a figure that's less, per capita, than state and national averages. That said, there is a noted absence of grocery stores, with only 17 per every 100,000 people.
- **27 percent of households had housing costs that exceeded more than 30 percent of total household income in 2017**, indicating a cost burdened household more likely to face overall financial difficulty.
- **1,925 Coweta 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

- **Nearly a third of children lived in single-parent homes in 2017**, a statistic often tied to lower graduation rates.
- **42 percent of children qualified for free or reduced cost lunch in the 2015-2016 school year,** a statistic that represents poverty and food instability. Coweta County is less than the 2017 state average of 62 percent.
- **For every 1,000 teen girls aged 15 to 18 in Coweta County, 39 gave birth to a child** on average each year between 2010 and 2016. Children born to teen are statistically much more likely to experience adverse health and socioeconomic issues as they grow older. In Coweta, African Americans and Hispanic or Latina teen birth rates were 65 and 49 births per every 1,000 teen women, respectively.

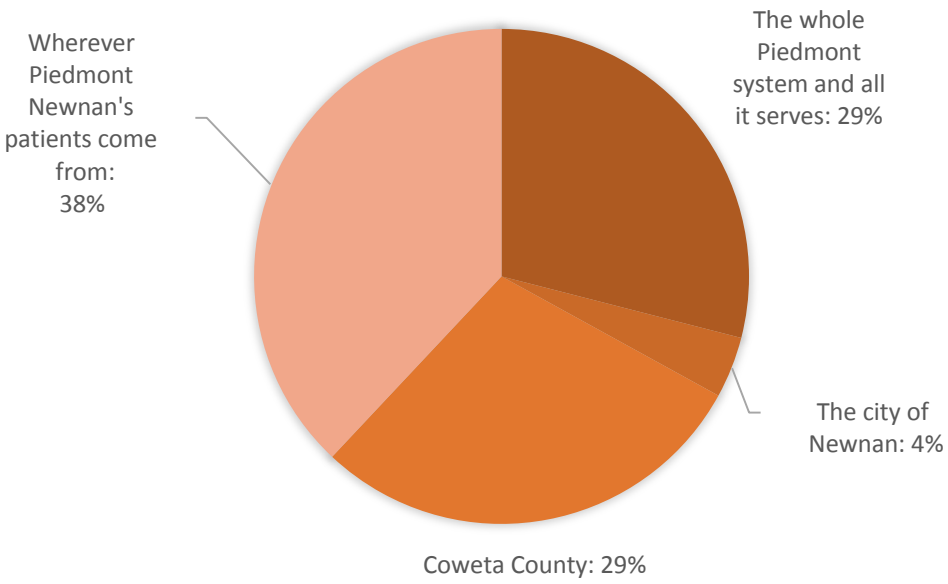


17 percent of children in Coweta County lived in poverty in 2017. Poor children are statistically less likely to graduate high school and are nearly twice as likely to become poor adults and, should they have children, continue a circle of poverty that's difficult to break. These children are also more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

PNH stakeholder survey

In December 2018 and December 2019, 24 key stakeholders within the Piedmont Newnan 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 Newnan's community?



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

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

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

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

Top ten answers:

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

PNH stakeholder survey (continued)

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

Top 10 answers ranked most important:

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

Q What is your vision for a healthy community?

Some answers:

"More services for the infirm and the poor."

"To have an active healthy community focused on mental, physical, spiritual and social wellbeing."

"Better education from an early age about benefits of exercise and a good diet, along with an infrastructure of high quality parks and recreation."

"All citizens able to afford the care they need."

"A true system of care where the common aim is focused on patient outcomes and not profitability."

"Excellent health care for the entire community."

"Active people with healthy eating habits."

"Services for the homeless rise in numbers."

"Affordable and accessible health care for all members of a community."

"Preventive care ongoing for all."

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

Some answers:

"Obesity and the health issues that go with it, coupled with high cost of care."

"Inability to pay co-pays and deductibles for procedures."

"Affordable quality healthcare."

"Access to affordable, high quality health care services."

"Cost of healthcare."

"The ability to pay for care with even without health insurance."

"Lack of preventive medical knowledge because of inabilities to access such knowledge."

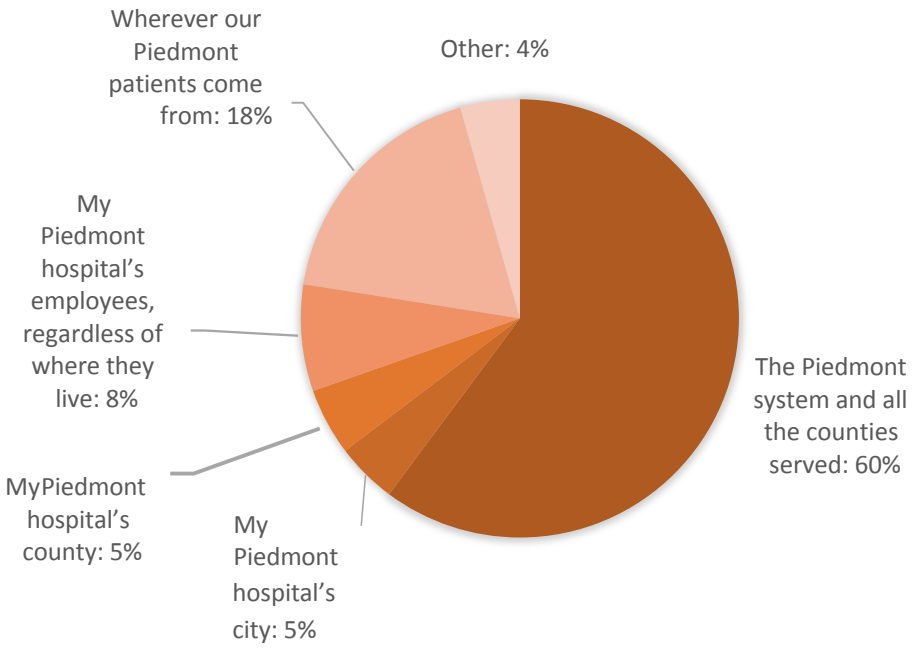
"People need to find where to go to access health care and get frustrated with the process."

"Lack of knowledge concerning funding their health care and who provides free services."

PHC employee survey

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

How would you best define Piedmont's community?



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

Top ten answers:

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

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

Top ten answers:

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

PHC employee survey (continued)

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

Top 20 answers ranked most important:

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

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

Answers centered on the following themes:

Health education

Financial assistance program

Support for local charitable services and community partnerships

The Cancer Wellness Program

Continued growth with beds and services

The Walk with a Doc program

Sixty Plus Program

Giving Epic to local clinics

Care coordination services

Breast feeding training for new moms

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

Answers centered on the following themes:

More Piedmont-sponsored low-cost clinics

More visible community involvement, especially with minorities

More outreach and free services for preventative care

Increased access to specialty physicians

More attention to mental health

More attention to opioid and substance abuse

Screenings that are free for community members, especially for cancers

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

PHC stakeholder interviews

As a part of our process, we interviewed 31 state and regional stakeholders and policy makers that represent public health, low-income populations, uninsured and uninsured persons, minorities, chronic conditions and older adults, as well elected officials and lawmakers. These interviews were conducted for people representing the entire region, including Coweta 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 Newnan, 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 Newnan Hospital Board of Directors on May 23, 2019. The implementation strategy, which begins on page 16, was approved September 12, 2019.

Methodology

The Piedmont Newnan CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Newnan leadership and direct input from board members both at a March 2018 board meeting and through individual meetings.

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 Newnan Hospital
Community Health Needs Assessment Implementation Strategy – Fiscal Years 2020, 2021 and 2022

On September 12, 2019, FY19, Piedmont Newnan's board of directors approved the hospital's community health needs assessment, which measured the relative health and well-being of our community. Through this process, we identified key health priorities we'll address over the next three fiscal years. This below strategy was developed to address those identified priorities.

Priority: Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes			
Vision	**Goal**	**Tactics**	**How to measure**
Low- and no-income patients receive assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	• Financial assistance is available for eligible low- and no-income populations • Patients are adequately alerted that financial assistance is available • Patients are given tools, resources and ample opportunity to apply for assistance • Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals • Actively screen all potential patients for Medicaid coverage	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income patients receive necessary laboratory tests	Ensure that patients at partner not-for-profit charitable clinics have access to the care needed to get – and stay – healthy	• Provide lab services at no charge to charitable clinic Coweta Samaritan Clinic • Provide full access to Epic electronic medical records at no charge to the clinic	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

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 PH • Progress evaluated by PHC and PNH every six months
Low-income patients have access to community-based care	Utilize a shared hospital/clinic skilled staff member to work with low-income, uninsured patients with ongoing needs and appropriate follow-up care	• Through a hospital/clinic shared licensed medical social worker, connect recently discharged hospital patients to community-based care at Coweta Samaritan Clinic • Provide ongoing support to these patients to address issues related to socioeconomic factors	• 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	• 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	Utilize a patient and family advisory council to provide meaningful input on key areas of care	• 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	Evaluation tactics to be determined by specific goals of council

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, including resources aimed at mental health services	• 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 5.5K distributed throughout the Coweta County community in FY19)
Older adults have increased access to care and community-based resources	Through our Sixty Plus program, provide services that support healthy aging and resources for family caregivers	Provide classes and resources free of charge to all community members, regardless of whether they are a Piedmont patient	Regularly monitor program and patient self-reported information to evaluate programs and classes for effectiveness, opportunities for growth

Priority: Reduce opioid and related substance abuse and overdose deaths			
Vision	**Goal**	**Tactics**	**How to measure**
Hospital-based prescriptions for opioids and related drugs are reduced	Patients are at low risk of misusing opioids	• Track opioid prescribing by hospital and physician • Use Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients ways to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach
Patients are supported in recovery from their opioid addiction	All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery	• Develop relationships with community resources to which patients can be transitioned	Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are

		• Make these community resources known and available to our caregivers	increased, measured by program participation and qualitative measures
Opioid addiction is viewed as a disease	All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma	• Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction • Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities	Regularly monitor percentage of PHC employees who report that they view opioid use disorders as a medical condition, free of stigma are increased, measured by qualitative mechanisms
Hospital-based prescriptions for opioids and related drugs are reduced	PHC adopts and uses appropriate non-opioid pain management strategies	• Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont • Offer multi-modal pain module to caregivers to provide options for opioid in treating pain • Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy)	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PNH 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	• 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

Local stakeholders are actively engaged in addressing the opioid epidemic	Meaningfully engage in the Coweta Substance Abuse Program (C-SAP)	• Distribute educational materials to physician provider offices to help patients understand the risks of addiction and how to prevent it • Sponsor and promote drug take-back days • Implement school curriculum educating children of the dangers of opiate addiction/substance abuse in middle school, high school and college classes	• Measure the number of children educated through the Coweta County School System • Measure number of prescriptions turned in during drug take-back days • Measure distributed educational materials • Regularly solicit community feedback on effectiveness, opportunities to improve programming
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 PNH • Progress evaluated by PHC and PNH 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 and increase access to cancer programming for those with living the disease, with a focus on lung and breast cancer			
Vision	**Goal**	**Tactics**	**How to measure**
Cancer patients receive needed comprehensive services for their recovery	Provide support services free of charge to cancer patients through Cancer Wellness	• Provide supportive services to any cancer patient, regardless of where they receive care; services include cancer education, nutrition workshops and demos, support group, psychological counseling and exercise classes, among other programs • Continue to explore opportunities to expand offerings and services	• Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness
High-risk community members receive lung cancer screenings	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 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 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 scans for heavy smokers, general community • Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system

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, early detection and education	• 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 receive appropriate cancer screenings	Create and a provide a free and/or low-cost mammogram screening program for underserved and/or underinsured women	Free or reduced-cost mammograms are provided to women that do not have insurance to receive diagnostic care	• Regularly monitor and evaluate program to determine if enough eligible women are receiving necessary mammograms • Solicit foundation and grant support to increase funding, community support
More community members are screened for cancer	Overcome challenges of barriers to screenings and Increase cancer screening awareness through community-based partnerships	• Identify community partners who can help provide necessary outreach and messaging • Establish a mechanism for screening referrals • Establish a mechanism for appropriate follow-up care that takes insurance status, income and other barriers, such as transportation, into consideration	• Establish baseline of current activities and partnerships • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

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: Reduce preventable instances of and deaths from heart disease			
Vision	**Goal**	**Tactics**	**How to measure**
Community-based heart survival rates are increased	Provide Early Heart Attack Care (EHAC)/Hands-only CPR to community	• Utilizing data from CHNA, determine priority areas for free CPR training to nonprofit partners • Deploy programming, in partnership with community-based groups and emergency medical services	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 • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	• Establish baseline of current messaging • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year

Primary 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 education classes are taught monthly and slots are open to outside medical facilities as well as to West Georgia Technical College nursing students	• 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 hypertensive patients at partner clinic through pilot program	• Deploy pilot program that aims to reduce high blood pressure through the provision of blood pressure monitors to those who would not be able to afford them otherwise • Identify patients who have received a diagnosis of hypertension • Provide home blood pressure monitor with subsequent education and follow-up	Monitor hypertension levels among patients who received monitors, request self-reported usage data; continually seek out ways to improve programming and scale from pilot to standard programming
Women have the necessary information to prevent or survive heart disease	Educate women on preventing and managing heart disease through multimodal traditional and complimentary/alternative education; focus efforts on African American Women and uninsured women	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	Will monitor and track education results through readiness to change surveys, screening results and coaching results through SF-36 survey

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, 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
Maintain Chest Pain Center Accreditation through the American College of Cardiology by educating the community at large to reduce preventable instances of heart disease	Provide ongoing resources and education to community members as to maintain high level of chest pain care at hospital	• 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	Conduct yearly review to ensure we are maintaining CPCA designation Opportunities to engage and work with the community are regularly evaluated and implemented
Low income community members receive necessary cardiac care	Provide cardiac specialty services at charitable clinic Coweta Samaritan Clinic	Regularly provide ongoing cardiac services at no charge to Coweta Samaritan Clinic patients, both on-site and in provider offices	Regularly assess partnership and program for effectiveness, opportunities for improvement

Priority: Reduce rates of obesity and increase access to healthy foods and recreational activities			
Vision	**Goal**	**Tactics**	**How to measure**
Older adults maintain healthy weights, better control of chronic conditions	Through the evidenced-based Exercise is Medicine program, older adults with chronic conditions are able to regularly exercise in safe ways that promote healing and healthy weights	Provide Exercise is Medicine programming to the community at large	• Monitor participation through attendance logs • Monitor effectiveness through qualitative surveys and participant interviews • Continually seek out ways to improve programming
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

Support food access to low-income children	Provide funding to support healthy food access for low-income children	In partnership with the Coweta County School System, provide annual support to ensure that low-income children have access to healthy foods during times school is not in session	Will develop ongoing, specific measurement tactics with the Coweta County School System to ensure program effectiveness and evaluate opportunities for growth and improvement
Support healthy eating for high-risk community members	Deploy a fresh prescription program for low-income patients in which we provide vouchers for healthy foods at a local Farmer's Market or food bank	• In partnership with relevant community-based groups, determine scope of programming, eligibility requirements • Design program • Deploy initial programming • Continually monitor for issues, areas to improve	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement

Priority: Reduce preventable instances of diabetes and increase access to care for those living with the disease			
Vision	**Goal**	**Tactics**	**How to measure**
Community members are able to self-manage their diabetes	Conduct group diabetic education sessions and one-on-one counseling to help patients learn about diabetes and how to manage the disease	• Provide ongoing diabetes education includes information on diabetes management, physical activity, medication usage, complication prevention and how to cope with this chronic disease • Provide nutrition education that focuses on food choices and improving blood sugar control. • Provide education to reduce negative impact of diabetes reduce heart disease risk factors and improve weight management • Provide diabetes-during-pregnancy education through individualized instruction and intensive diabetes self-management instruction on insulin therapy	Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve programming
Support healthy eating for diabetic community members	Deploy a fresh prescription program for those living with diabetes in which we provide vouchers for healthy foods at a local Farmer's Market or food bank	• In partnership with relevant community-based groups, determine scope of programming, eligibility requirements • Design program • Deploy initial programming	Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement

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.