Community Health Needs Assessment
Fiscal Year 2019

Piedmont
NEWTON

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

Key findings

- Newton County is generally ranked within the top half of counties in most key areas of health.
- Preventable hospital stays for Medicare beneficiaries have decreased over the last ten years, though still remain about state and national averages.
- The county has no designated health care provider shortage areas.
- Issues related to social determinants of health are prevalent in all areas we examined.

- Obesity is a critical issue for community members, and this is evidenced in high rates of obesity-related issues, such as diabetes and heart disease.
- Cancer is also a killer in the community, and in particular, lung cancer.
- Mental health remains a top unmet need, evidenced by high rates of suicide and deaths from other mental issues.
- The county has high opioid prescription rates and related incidences in the emergency department.

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 points for 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 all cancers, with a focus on lung cancer
- Reduce preventable instances of and deaths from heart disease
- Reduce preventable emergency department re-encounters and hospital readmissions
- 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

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

- In 2017, approximately 99,958 people lived in Newton County.
- That year, about 54 percent of all Newton County residents were white, 41 percent were African American, about 5 percent were Hispanic.
- The median household income was $52,784 in 2017, lower than both state and national averages.
- The median age of people living within the county was 36 in 2017.
- In 2017, an estimated 85 percent of county residents graduated high school, right on par with the state average of 86 percent.
- 61 percent of county residents have attended at least some college in 2017, a statistic on par with the state but far below the national average.

- Of the estimated 46,324 who were employed in 2017, most worked in educational services/health care/social assistance, manufacturing and retail, in that order.
- There were about 7,277 veterans living in the county in 2017, with half having served in the Gulf War and nearly a third having served in Vietnam.
- 19 percent of those veterans lived with a disability, and about 14 percent lived below the poverty level.
- About 6 percent of households spoke a language other than English at home in 2017, with the majority of those households speaking Spanish.
- Most people -- about 70 percent percent -- owned their home in 2017, a number higher than the state average of 63 percent.

Key hospital stats

Piedmont Newton Hospital is a 103-bed, acute-care, community hospital in Covington, Georgia, offering 24-hour emergency services, women's services, a special care nursery and general medical and surgical services. Serving Newton County and surrounding communities for over 60 years, Piedmont Newton Hospital offers high-quality, patient-centered care. Key Piedmont Newton statistics for FY18 include:

680+ EMPLOYEES

160+ VOLUNTEERS

290+ PHYSICIANS

MD Anderson Cancer Network Affiliate®

675 NEWBORN DELIVERIES

EMERGENCY DEPARTMENT VISITS 49,922

SURGERIES 3,604

OUTPATIENT ENCOUNTERS 38,563

INPATIENT ADMISSIONS 5,336

Community rankings

In comparison with the other 159 Georgia counties, Newton County ranks:

- **61st in length of life**, with an estimated 8,500 years of life lost by all community members due to health factors.
- **53rd for quality of life**, with indicators for poor or fair health, poor physical health days, poor mental health days and low birthweight rates hovering right at state averages.
- **52nd for healthy behaviors**, with higher than average rates for smoking, obesity, physical inactivity, excessive drinking, motor vehicle crashes, sexually transmitted infections and teen births.
- **62nd for clinical care**, with slightly lower that average uninsured rates, higher than average rates for diabetes monitoring and mammography screenings, but high rates of preventable hospital stays and low rates of primary care physicians for community members though there are no federally designated physician shortage areas in the county.
- **68th for social and economic factors**, with lower than average rates of violent crime, rates on par with the state for social support and children in single-parent households, though high rates of unemployment and children living in single-parent households.
- **127th for physical environment**, with limited access to healthy foods and access to parks and recreational facilities, and a high rate of fast food restaurants and long commutes.

Overall, Newton ranks in the top half of Georgia counties in most all categories, with the exception of physical environment.

Mortality

In Newton 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 allows communities with different age structures to be compared. Premature death is when death happens before the average age for a given community.

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

Motor vehicle crashes were the top cause of premature death in Newton County between 2013 and 2017, with a total staggering 3,341 community members having died due to a motor vehicle accident. Heart disease was the second top cause of premature death and homicide the third. Suicide and lung cancer were the fourth and fifth leading causes of premature death between 2013 and 2017, respectively.

Most indicators for premature death are related to unhealthy behaviors and mental health and indicate a need for further community-based interventions for high-risk community members, including efforts to curb tobacco use and resources for those struggling with depression, anxiety and other mental health issues.

Access to care

- There were no designated health professional shortage areas in the community in 2016, as defined by the U.S. Department of Health and Human Services.

- That does not mean that all patients have equal access to a doctor, though, due to income and insurance constraints (see sidebar).

- Throughout Georgia, more than a fifth of all women and a third of all men report having no personal doctor or health home.

  o This was particularly true for minorities, whose rates of not having a doctor are much higher than that of their white counterparts.

- Access to dental care also presents issues. There were 17 dentists for every 100,000 people in 2015, a figure nearly three times below the state average and four times below the national average.

Health status

- Community members have reported an average 4.3 and 4.0 poor or fair physical and mental health days, respectively, and 19 percent of Newton County residents reported their health as poor or fair. All three indicators have worsened since our last CHNA.

- Statewide, race matters when it comes to poor health status. Approximately 26 percent of Hispanics reported being in poor health in 2017, as compared to their white and African-American counterparts (18 percent and 19 percent, respectively). Information on other races was not available.

Quality and length of life

- Preventable hospital stays among Medicare enrollees has steadily decreased over the last few years, from 96 preventable stays per every 1,000 enrollees in 2007 to 58 preventable stays per every 1,000 enrollees in 2015. This is still higher than state and national averages.

- 15 percent of the population lived with at least one disability in 2017, which was higher than the state average of 12 percent. The highest concentration of disabled populations in the southern part of the county.

- The infant mortality rate in Newton County is on par with the state averages, at 7.5 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 Newton County, **19 percent of the adult population was uninsured in 2018, and 13 percent of the total population was uninsured that year.** People without insurance coverage have less access to care than people who are insured. Statewide, in 2017, one in five uninsured adults 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 Newton County-- the Willing Helpers Clinic, which serves low-income uninsured patients. Piedmont Newton actively partners with Willing Helpers to support their work, including the provision of free lab services and funds for programs.

There is no Federally Qualified Health Center (FQHC) in Newton 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 deaths for both men and women each year in 2017 in Newton County was ischemic heart and vascular disease. In that year alone, 246 people died from heart disease.
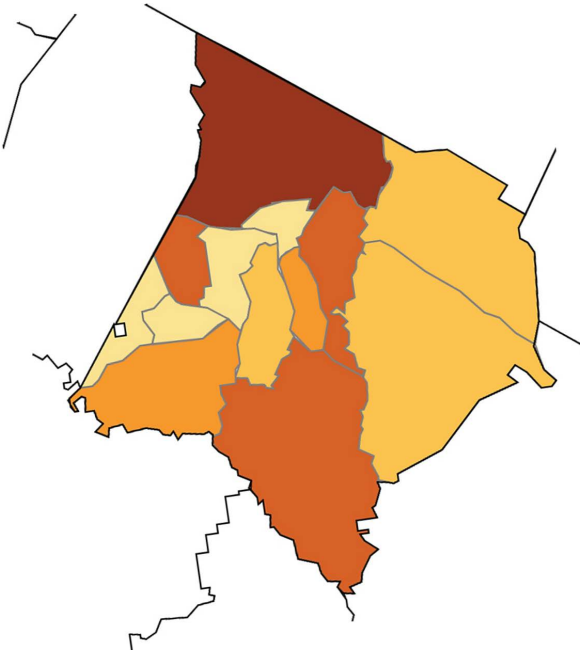
To the left is a breakdown of premature deaths related to ischemic heart and vascular disease by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue. This allows us to see exactly where we have the most instances so we can more directly target interventions to this community in the future.

The prevalence of heart disease in the U.S. is expected to rise 10 percent between 2010 and 2030. This change in the trajectory of cardiovascular burden is the result not only of an aging population but also of a dramatic rise over the past 25 years in obesity and the hypertension, diabetes and physical inactivity that accompany weight gain. Extensive research from the American Heart Association has also demonstrated a strong correlation between social determinants of health (SDHs) and heart disease. Issues related to SDHs include higher rates of smoking, obesity, lack of physical activity and poor diets, all key contributors to heart disease.

Stroke

In 2017, 40 Newton County community members died from stroke. Between 2012 and 2016, the death rate from stroke averaged 44.5 people per every 100,000 people annually, which 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 necessary prescriptions and unhealthy behaviors.

Diabetes

Approximately 13.3 percent of adults lived with diabetes in Newton County in 2015, a figure slightly higher than 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, less educated individuals are more likely to have diabetes. According to the CDC, 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. In 2017, the highest percentage of Georgians with diabetes earned less than $25,000.

Cancer continues to have a devastating impact in Newton County. In 2017, 210 people died from cancer. Of those, lung cancer kills the most county residents.

To the right is a map of 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.

Breast cancer ranked 11th and colon, rectum and anal cancers ranked 13th in age-adjusted deaths between 2013 and 2017. Overall, while breast cancer death rates have declined over the last several years, so has prevention. In 2015, only 59 percent of eligible Medicare enrollees said they had a mammogram sometime within the previous two years, a figure down by about 13 percent from three years previous.

Rates of new breast cancer diagnoses rates are high at 133 per every 100,000 residents in 2015, a figure above the state and national average of 125 per every 100,000 residents. In Newton, white women are more likely to be diagnosed with the disease than their minority counterparts.
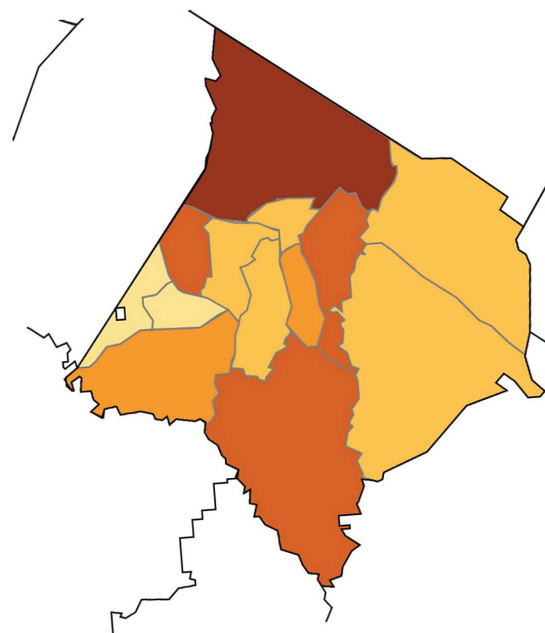
Cancer and health equity

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

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

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

Additionally, this population is far less likely than the rest of the community to have a primary care physician, and 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. When dealing with cancer, this could translate to a diagnosis at a later stage and a worse prognosis. In other words, it could mean life or death for the patient.

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.
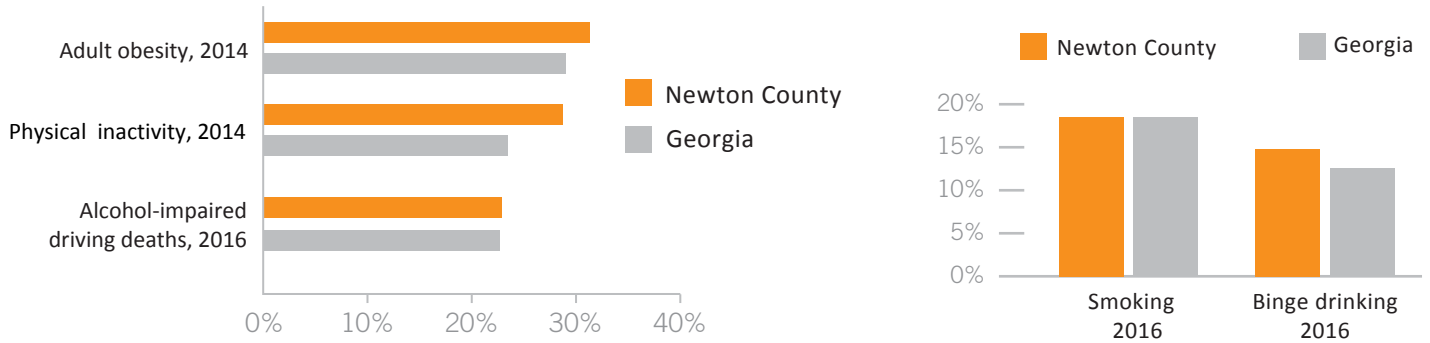
- **Chronic obstructive pulmonary disease was the fifth leading cause of age-adjusted death between 2013 and 2017.** The most common cause of the disease is smoking and long-term exposure to other lung irritants.

- **Obesity rates are higher than state and national averages in Newton County,** and likely contributes to a number of diseases, including heart disease, stroke and diabetes.

- Smoking rates are the same as the state average, as is binge drinking.

- **Long commutes are also higher in Newton County than in the rest of the state -- 16 percent drove more than 60 minutes to work in 2016, and most drive alone.** A 2017 study showed that those with long commutes tend to be more depressed, have more work-related stress, get less sleep and are more likely to be obese.

- The violent crime rate was 381.8 per every 100,000 county residents, a figure relatively on par with the state average of 378 and the national average of 380 per every 100,000 residents.

Mental health

- **Mental health and behavioral disorders (not including suicide) was the third leading cause of age-adjusted death for all county residents between 2013 and 2017.**

- **Suicide was the fouth cause of premature deaths for whites and the 8th leading cause of premature death for other races between 2013 and 2017.** It was most common among males aged 25 to 34 years of age.

- There was one mental health provider for every 1,114 county residents in the county in 2017, a rate much worse than the state and national averages of one provider for every 813 and 493 residents, respectively.
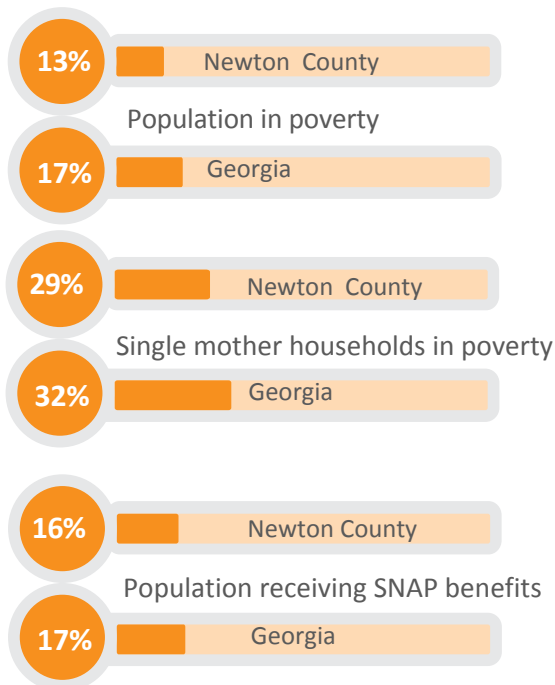
Opioid and substance abuse

- While there was a drop in overall rates of poisoning by substance abuse at Piedmont Newton between 2017 and 2018, there was a significant increase in almost all diagnoses related to opioid use between those years for inpatients and those presenting at the emergency department, combined. This shows that the problem is worsening for our patients.

- Opioid prescriptions are down. In 2007, there were approximately 88.3 retail opioid prescriptions dispensed per 100 persons, according to the CDC. That number has dropped to 75.8 in 2017. Even so, Newton County remains much higher than the national average of 58.7 per 100 people and state average of 70.9. We aren't able to tell how many prescriptions are going to a single person, just the overall figure.

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, healthy food, safe recreational spaces, 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. According to the American Hospital Association, socioeconomic factors are responsible for approximately 40 percent of a patient's health, while just 20 percent is tied to quality of care.

13% Newton County

Population in poverty

17% Georgia

29% Newton County

Single mother households in poverty

32% Georgia

16% Newton County

Population receiving SNAP benefits

17% Georgia

- For the 2015-2016 school year, the graduation rate was 94 percent, much higher than the state average of 82 percent. That said, **about 16 percent of the county's adult population does not have a high school diploma.**

- In 2016, **a third of county residents did not have access to a large grocery store in 2017,** meaning there are limited places for county residents to buy healthy foods. This is worse than the state average of 22 percent.

- In 2016, **11 percent of the population has limited access to healthy foods** and 17 percent report having extended periods when they aren't sure how their families will eat.

- **There were 62 fast food restaurants in Newton County in 2019,** a figure that's lower, per capita, than state and national averages.

- **33 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.

Families and children

- **43 percent of children lived in single parent homes in 2017,** which is statistically linked to lower graduation rates and higher poverty rates. The majority of these single parent homes are led by women, and 29 percent of those households are at or below the federal poverty level.

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

- **For every 1,000 teen girls aged 15 to 18 in Newton County, 32 gave birth to a child** on average each year between 2010 and 2016. This impacts minorities more than their white counterparts. In Newton, African American and Hispanic or Latina teen birth rates were 15.2 and 35.8 teen births per every 1,000 teen women, respectively.

24 percent of children in Newton County lived in poverty in 2017, a figure that has steadily gotten worse over the last ten years. Poor children are statistically less likely to graduate high school or complete college. They are nearly twice as likely to become poor adults. These children are also more likely to experience dental issues, anxiety problems and higher rates of accidental injury.
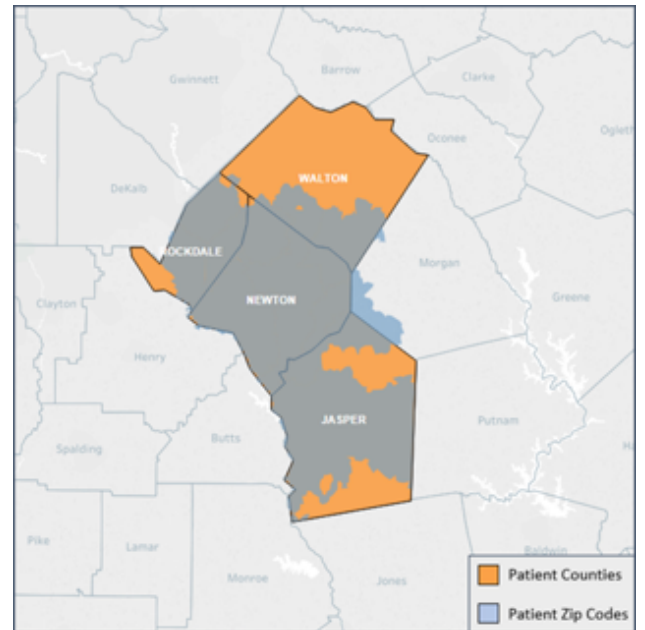
At the hospital

Medicaid visit rates

Financial assistance visit rates
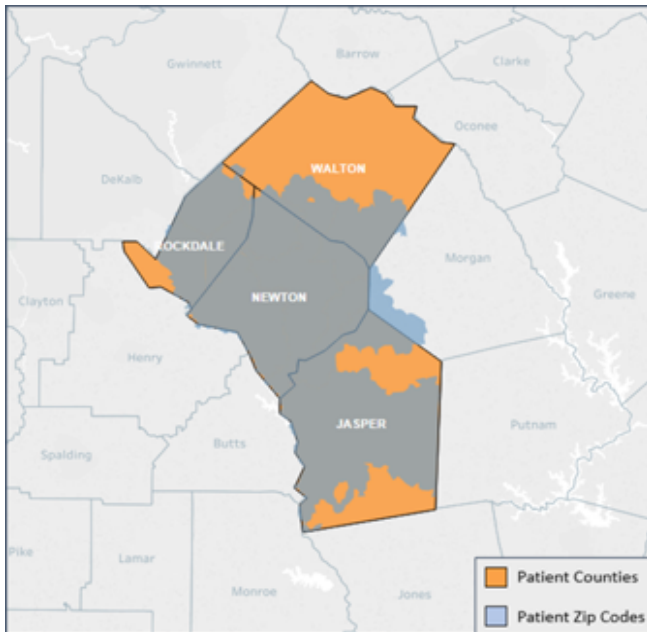
In FY18, 6,721 patients covered through Medicaid made approximately 9,986 visits to the hospital (both at the emergency department and as an admitted patient). The majority came from two zip codes: 30014 and 30016, which includes Covington and Porterdale.

In FY18, 7,963 patients receiving financial assistance made approximately 11,135 visits to the hospital (both at the emergency department and inpatient). The majority came from two zip codes: 30014 and 30016, which includes Covington and Porterdale.

Selected chronic condition diagnosis trends in the emergency department and inpatient admissions:

- Hypertension rates dropped from 1,023 in 2017 to 926 in 2018.
- Chronic obstructive pulmonary disease rates remained somewhat stable at 103 and 105 diagnoses in 2017 and 2018, respectively.
- Heart disease encounters continued to increase among most diagnosis codes, with the only notable decreases being in encounters related to congestive heart failure and in certain instances of coronary heart disease.
- Diabetes was a mixed bag, with certain complications and comorbidities showing some progress and some worsening.
  - The data shows an uptick in complications for those presenting with Type 1 diabetes (such as foot ulcers, hyperglycemia and other unspecified complications) and a decline in visits from Type 1 diabetes patients without complications.
  - The data shows a sharp increase in patients with Type 2 diabetes with a diabetic chronic kidney disease (from 37 patients in 2017 to 193 patients in 2018), as well as an increase for Type 2 diabetes with hyperglycemia; skin ulcers also increased for those with Type 2 diabetes, though foot ulcers decreased.

There were a total 52,332 visits to the emergency department (ED) visits by 36,207 patients in FY18. Of those patients:

- 24 percent were covered by financial assistance
- 23 percent had private insurance
- 19 percent were covered through Medicaid
- 19 percent were covered through Medicare
- 18 percent were either self-pay or pending approval for Medicaid

Publicly-insured, self-pay and patients qualifying for financial assistance overwhelming came from the 30014 zip code (77 percent) and those with private insurance came mainly from the 30016 zip code. This indicates potential opportunity to center community-based care programming in the 30014 zip code, as it contains the prominent communities for low-income patients presenting in the ED. As numerous studies and experts have noted in recent years, a zip code is often a more reliable predictor of a patient's health than their genetic code.
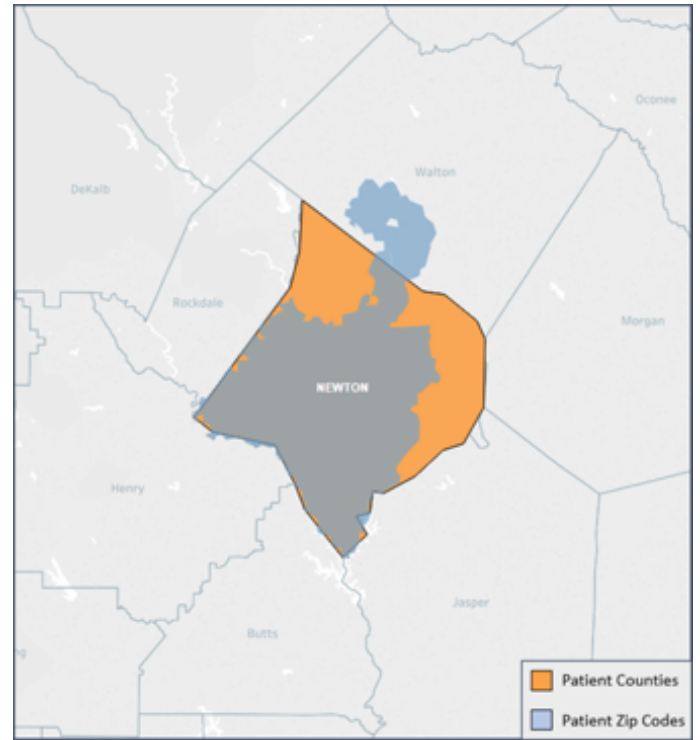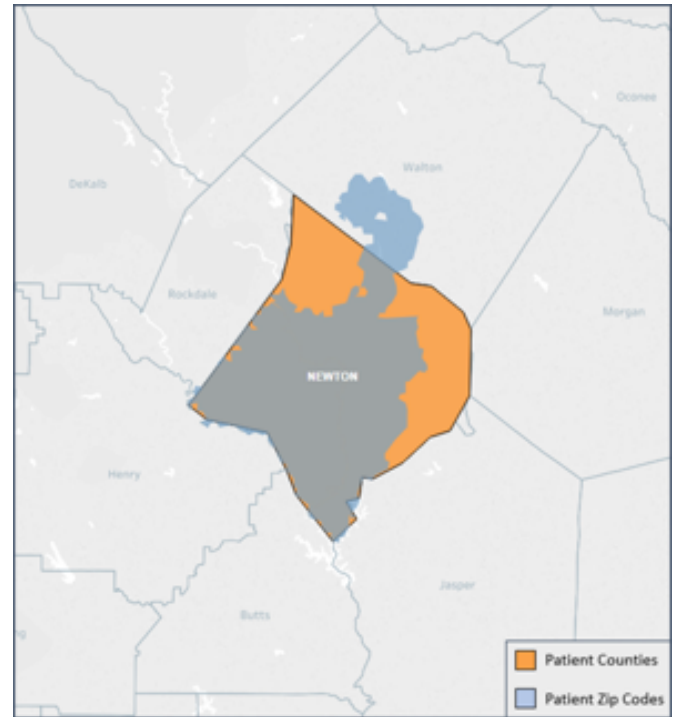
The top ten ED diagnoses were, in order:

Diagnosis code/description	No. of patients	No. of visits	Avg. visits per patient
Chest pain, unspecified	427	1842	4.3
Other chest pain	147	844	5.7
Urinary tract infection, site not specified	146	861	5.9
Syncope and collapse	123	513	4.2
Pneumonia, unspecified organism	100	430	4.3
Sepsis, unspecified organism	98	348	3.6
Chronic obstructive pulmonary disease with exacerbation	97	537	5.5
Low back pain	96	676	7
Primary hypertension	91	444	4.9
Headache	90	516	5.7

There were a total 6,006 inpatient admissions by 4,912 patients in FY18. Of those patients:

- 13 percent were covered by financial assistance
- 18 percent had private insurance
- 16 percent were covered through Medicaid
- 44 percent were covered through Medicare
- 8 percent were either self-pay or pending approval for Medicaid

Publicly-insured, self-pay and patients qualifying for financial assistance overwhelming came from the 30014 zip code (81 percent), and more than half of those were utilizing Medicare as their primary coverage. This indicates potential opportunity to center community-based care programming and efforts to support senior health in the 30014 zip code, as it contains the prominent communities for publicly-insured and low-income patients that are admitted to the hospital.
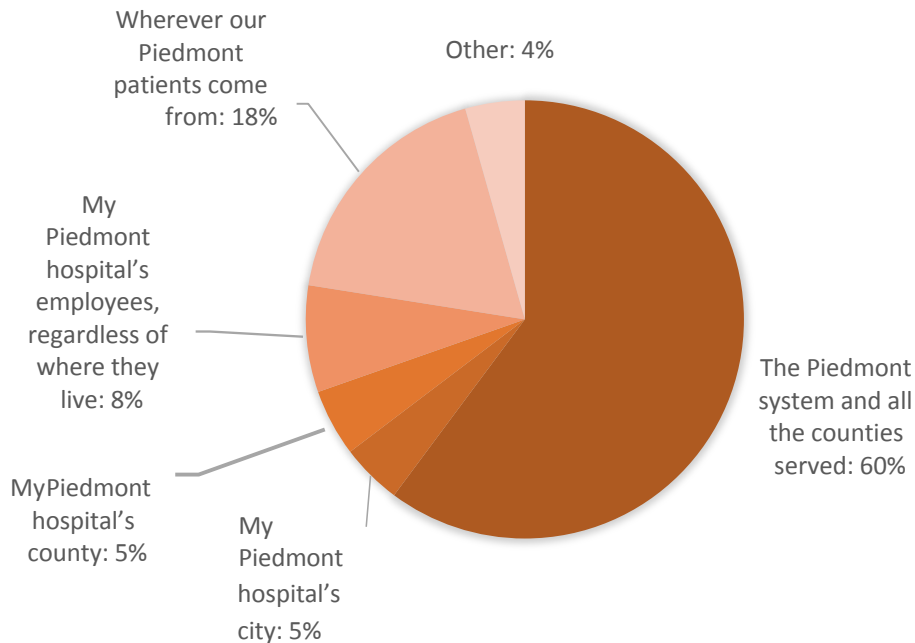

The top ten inpatient diagnoses were, in order:

Diagnosis code/description	No. of patients	No. of visits
Sepsis, unspecified organism	392	415
Hypertensive heart disease with heart failure	196	221
Pneumonia	182	183
Chronic obstructive pulmonary disease with (acute) exacerbation	172	198
Non-ST elevation myocardial infarction	143	147
Acute kidney failure, unspecified	136	141
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	127	155
Maternal care for low transverse scar from previous cesarean delivery	78	78
Acute respiratory failure with hypoxia	76	78
Acute and chronic respiratory failure with hypoxia	61	71

PHC employee survey

Forty-two Piedmont Newton employees completed the internal system-wide survey for our CHNA. Questions focused on issues facing our patients and the community, as well as how employees felt the hospital should address those issues. Below are the results from all employees that answered the survey, which had a total 897 responses.

How would you best define Piedmont's community?

Wherever our Piedmont patients come from: 18%

Other: 4%

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

MyPiedmont hospital's county: 5%

My Piedmont hospital's city: 5%

The Piedmont system and all the counties served: 60%

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

Top ten answers:

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

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

Top ten answers:

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

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

Top 20 answers ranked "most important":

1. Access to low-cost mental health services
2. Access to local inpatient behavioral health facilities
3. Free or affordable health screenings
4. Local outpatient mental health services
5. Additional access points to affordable care
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 health programs
13. Cancer awareness and prevention campaigns
14. Increased social services for patients
15. Opioid awareness and prevention campaigns
16. Transportation for care
17. Substance abuse rehabilitation services
18. Programs and resources 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

As part of our process, we interviewed 31 state and regional key stakeholders and policymakers that represent public health, low-income populations, minorities, certain chronic conditions and older adults, as well as lawmakers and others generally considered to be experts in health care delivery in Georiga. Below is a summary of responses.

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.

- 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 Electronic Medical Records (EMRs).

  o This is an area where Piedmont has already made significant gains, as most all hospitals currently have a clinic partner and, as of this report, two have full access to our EMRs and a third has read-only rights. This is an area to continue to explore.

- 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 Newton, to better coordinate with surrounding rural communities, including the expansion of primary and specialty care physicians into underserved areas, perhaps through the use of telehealth.

Mental and behavioral health

- Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize the role of behavioral health in diagnoses and make appropriate referrals.

- Interviewees also stated a need for hospital investment in substance abuse, addiction and prevention services, including its own approach to issues like opioid prescriptions, due to the health impacts addiction have on patients.

Social determinants and root causes of poor health

- All interviewees discussed the role of social determinants of health (SDHs) as a critical issue Piedmont is well-positioned to address. As one interviewee stated: **"Piedmont is... in a great position to create programs and referral systems to help address the underlying issues that many patients face. Piedmont could lead all hospitals in this space."**

- Some interviewees 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 Newton Hospital board of directors on May 16, 2019. The CHNA implementation strategy was approved August 15, 2019.

Methodology

The Piedmont Newton CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Newton leadership.

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

On August 15, 2019, Piedmont Newton'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 potentially patients for Medicaid coverage	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income patients have access to community-based care	Ensure that patients at not-for-profit charitable clinic Willing Helpers have access to the care needed to get – and stay – healthy	• Provide lab services free of charge to Willing Helpers • Provide office and practice to clinic space at nominal charge ($1 annually) • Provide Willing Helpers with specialty care physicians regularly at no charge to the clinic or its patients	• Clinic to provide a quarterly report on how many patients received labs, how many labs were processed, the top twenty labs utilized, trends in patient care, and the number of specialty care appointments during that time

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 PNtH • Progress evaluated by PHC and PNtH every six months
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
Mental health services for high-risk individuals is strengthened	Support the Newton County Resource Court by ensuring participants within the court have access to care	• Participate in the Resource Court events • Provide health screenings and education, including appropriate referrals to community-based providers • Provide household and hygiene items to program participants	Regularly monitor our participation with the court and evaluate opportunities to continually strengthen partnership

Priority: Reduce preventable emergency department re-encounters and hospital readmissions			
Vision	**Goal**	**Tactics**	**How to measure**
Low-income patients receive timely follow-up care	Develop a mechanism to immediately schedule follow-up appointments for patients without a current medical home and without health insurance	Evaluate internal and external resources and create project plan, which could include: Request approximately five (5) appointments available each week for PNtH patient access to schedule follow-up appointments post-discharge for low-income, uninsured patients at Willing Helpers	Track referrals via case management and validate with clinic that patient received follow-up care
Community members are better able to self-manage care	Utilize trained community health workers to address low acuity health needs in community setting	Work with community partner to hire trained local community health needs worker(s) to work with target audience, working towards set goals of patient self-management	Regularly evaluate program to determine efficacy, opportunities for improvement
Patients and their families have meaningful input in their care	Create a patient and family advisory council to provide meaningful input on key areas of care	• Create a council of 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 • Convene first meeting setting specific scope and goal of council, which could include internal initiatives to improve patient care and quality	• Yes/no on creation • Other 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	• Update guide annually • Publish online and in print	Annual distribution number of guides

		• Distribute widely throughout hospital and community	10% year over year increase for FY20 to FY22 (approximately 3.5K distributed throughout Newton community in FY19)

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

		Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities	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	PNtH provides meaningful leadership in its community by partnering with others in combating opioid abuse	• Promote local prescription take-back day activities, in partnership with local law enforcement • 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	• Monitor attendance for take-back day with an aim to increase participation year over year • 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 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 • Progress evaluated by PHC 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 1,000 copies, to be increased 15% year over year

Priority: Decrease deaths from all cancers and increase access to cancer programming, with a focus on lung cancer			
Vision	**Goal**	**Tactics**	**How to measure**
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, create a mechanism for referrals for CT scans heavy smokers from Willing Helpers	• Measure current awareness by availability of local resources and a survey of local messaging • Utilizing FY19 figures, aim to increase CT scans for heavy smokers, general community • Monitor positive results and continually improve referral process for follow-up care, particularly for low-income community members and others who may face particular issue accessing the health system
More community members stop smoking	Support in-hospital and community-based smoking cessation classes	• Provide free two-week in-hospital Freshstart smoking cessation classes free to the public for adults age 18 and older	• Monitor attendance for classes • Conduct follow-up surveys to determine efficacy in smoking cessation

		• Provide funding to Willing Helpers for free clinic-based smoking cessation classes • Provide general community awareness on tobacco's role in lung cancer and continually seek out opportunities to engage those populations at highest risk for smoking due to socioeconomic issues such as income and education level	• Regularly solicit feedback in determining what could be done better to ensure participants quit smoking • Deploy and monitor messaging to high-risk populations, increasing activity in community areas identified as highest risk for lung cancer death due to socioeconomic factors
Women are better able to recover from breast cancer	Support the Women's Diagnostic Center and Hope Boutique	• Provide information and referrals to all community services for individuals through hospital-based case management social worker • Regularly explore and implement opportunities to engage communities and patients, program measured • Increase compliance of follow-up appointments in vulnerable patients by addressing underlying reason appointments are kept	• Monitor referrals and seek patient input on why appointments weren't kept (such as transportation issues, cost, etc.) • Catalog current engagement strategies and aim for a 12% to 15% increase of those activities by end of FY2021
Low-income community members receive appropriate cancer screenings	Create and a provide a free Mammogram Voucher Program (MVP) to underserved and/or underinsured women	Free or reduced-cost mammograms are provided to women that do not have insurance to receive diagnostic care and prevention of breast cancer	• 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

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

Priority: 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 CPR training • 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 • 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
Community-based heart survival rates are increased	Offer CPR certifications to community partners free of charge as to reduce the impact and potential death from heart and stroke-related issues	• Identify community partners who most benefit from CPR training • Provide classroom-based CPR training to individuals on ongoing basis • Provide re-certification opportunities every 12 to 15 months	Regularly evaluate program to determine efficacy, opportunities for improvement

Hospital maintains stroke certification through community outreach	Offered stroke awareness educational materials and blood pressure screenings at health fairs and community events to achieve and maintain ASR DNV certification	• Utilize community events to provide basic health screenings and education on risk factors for stroke and heart disease BP and the importance of yearly checkups including labs (looking at cholesterol); recommend income and insurance-appropriate local primary care physician, if the patient does not have one • Create and deploy the Stroke Ambassador Program, in which hospital staff teaches a cohort of healthcare-focused students on the signs and symptoms of stroke and the importance of calling 911; these students will then have to teach 20 people each • Provide information in appropriate languages and ensure all messaging is appropriate for lower levels of health literacy	• Establish baseline of current outreach, aim for an increase year over year • Measure participation in Ambassador program • Measure efficacy of ambassador program through qualitative mechanisms
Low-income community members know how to shop for and prepare healthy foods on limited budgets	Create a Cooking Matters program in partnership with Willing Helpers, local FQHC and/or other community-based groups who regularly work with low-income populations, as to combat obesity and promote healthy eating	• Using current blueprint, design and execute programming for healthy eating and shopping for families utilizing food stamps or have limited food budgets, and in consideration of conditions such as heart disease, diabetes and obesity • Recruit patients for a four-week, four-session hour-long program that includes a trip to a convenient and affordable grocery store to learn how to best shop and read labels to encourage healthy eating • Potentially partner with local food banks to ensure ongoing access to healthy foods	• Monitor participation through attendance logs • Monitor effectiveness through qualitative surveys and participant interviews • Continually seek out ways to improve programming

Community members know how to look for heart problems	Increase community outreach to engage local residents in education and screening for cardiovascular problems	• Continue to look for opportunities for community outreach, building on work already in place • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy	Monitor and track education and screening results
Community members are better able to self-manage heart condition	Provide blood pressure monitors to Willing Helpers patients who have been diagnosed with hypertension	• Identify patients who have received a diagnosis of hypertension • Provide home blood pressure monitor and subsequent education	Monitor hypertension levels among patients who received monitors, request self-reported usage data
Heart disease education and outreach to the Hispanic/Latino community is increased	Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community	• Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • 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

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 Newton 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, including our efforts to curb smoking within the community.
- 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.