FY23

# PIEDMONT AUGUSTA

## COMMUNITY HEALTH NEEDS ASSESSMENT

Piedmont AUGUSTA

# TABLE OF CONTENTS

# Introduction

Our purpose, our promise is to make a positive difference in every life we touch.
We deliver the highest quality and safest patient-centered care and services, known as “The Piedmont Way.” We maintain the highest ethical standards and treat our patients, their families and each other with compassion, courtesy, transparency and respect to create the one-of-a-kind experience we would want for ourselves.

In our commitment as a not-for-profit health system, Piedmont Healthcare studied the region’s community health needs for its Community Health Needs Assessment (CHNA), a triennial process required by the Internal Revenue Service due to our tax-exempt status. 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 done 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. This is the fourth Piedmont CHNA, with the others having been conducted in 2013, 2016 and 2019. The 2022 Piedmont CHNA will serve as a foundation for developing our community benefit strategies and further strengthening our community-focused work.

**About the Hospital**
Piedmont Augusta is the oldest and largest hospital in our region and the second oldest in Georgia. This 812-bed, not-for-profit community hospital provides acute-care services to residents in 25 counties across two states.

Piedmont Augusta is governed by a Board of Trustees, which serves voluntarily to help ensure our patients have quality medical services. Founded in 1818 as City Hospital, the hospital was first located on the 100 block of Greene Street. Piedmont Augusta has since moved through four facilities to its present location, which opened in 1970, and includes its Summerville Campus on Wrightsboro Road. Over the years, the campus has expanded to include the Heart & Vascular Institute, renamed Piedmont Heart, and office buildings that house more than 600 private practice physicians and various treatment centers. Piedmont Augusta's second hospital, Piedmont McDuffie, moved to its new location in 2015 to serve the residents of Thomson and McDuffie County. The former University Health Care System joined the Piedmont family on March 1, 2022, and leads the region in safety, quality and price transparency. Piedmont Augusta gives back to our community in other ways, including generating more than $1 billion in revenue annually to the local and state economy, according to the Georgia Hospital Association Economic Outlook. Piedmont Augusta also provides our community more than $41 million in indigent and charity care at cost each year, not including bad debt.

**About Piedmont Healthcare**
Piedmont has more than 31,000 employees caring for 3.4 million patients across 1,400 locations and serving communities that comprise 80 percent of Georgia’s population. This includes 22 hospitals, 55 Piedmont Urgent Care centers, 25 QuickCare locations, 1,875 Piedmont Clinic physician practices and more than 2,800 Piedmont Clinic members. Piedmont has provided $1.4 billion in uncompensated care and community benefit programming to the communities we serve over the past five years.

# Community Benefit

Piedmont Augusta is a not-for-profit hospital, meaning it is exempt from paying certain taxes. In exchange for those exemptions, federal and some state laws require that communities receive from their hospitals certain benefits, appropriately called community benefit. These programs are generally meant as programs intended to increase access to care and boost the health of the community, with a focus on low-income populations and others who face unique challenges to being healthy. Since our last CHNA, in FY20 and FY21 combined, Piedmont Augusta provided over $137 million in community benefit. Specifically, Piedmont Augusta provided:

| | 2020 | 2021 |
|---|---|---|
| Indigent and Charity Care | $ 21,663,951 | $ 18,287,838 |
| Cost of Physician Services | $ 19,995,479 | $ 19,750,123 |
| Direct Community Clinic & Pharmacy Support | $ 1,114,696 | $ 713,170 |
| Bad Debt | $ 27,998,361 | $ 28,224,391 |
| Total cost of indigent and charity care services | $ 70,772,487 | $ 66,975,522 |

Key programs include: support for labs for community health clinics, community-focused health education, and COVID-19 vaccination clinics.

Piedmont Augusta's Survivorship Program provides free support programs available to anyone affected by cancer at any phase in his or her journey, regardless of whether they are a Piedmont patient.

# Financial Assistance

Piedmont Augusta provides financial assistance to qualifying low-income patients at or below 200 percent the Federal Poverty Level. Patients qualify for financial assistance in one of two ways: either through presumptive eligibility, in which the patient's file is automatically scanned for certain indicators that mean he or she would qualify for financial assistance, or via manual application by the patient or his or her representative. Below is a list of the top 10 ZIP codes by volume of patients receiving financial assistance at the hospital during the past two fiscal years.

| ZIP Code | 2020 | | 2021 | |
|---|---|---|---|---|
| | Number of Pts | All Visits | Number of Pts | All Visits |
| 30809 | 20 | 111 | 11 | 42 |
| 30813 | 26 | 95 | 13 | 38 |

| | | | | |
|---|---|---|---|---|
| 30814 | 16 | 99 | 14 | 86 |
| 30815 | 65 | 173 | 56 | 147 |
| 30830 | 19 | 89 | 13 | 58 |
| 30901 | 77 | 267 | 53 | 221 |
| 30904 | 85 | 267 | 53 | 244 |
| 30906 | 159 | 560 | 107 | 479 |
| 30907 | 41 | 171 | 29 | 77 |
| 30909 | 56 | 250 | 35 | 112 |
| **Indigent Total** | **564** | **2082** | **384** | **1504** |

Please note we provided financial assistance to patients outside of these 10 ZIP codes as well. Examining ZIP code data can help us to better target specific communities that may have unique challenges due to social determinants of health, such as having a low income, poor housing conditions, or limited access to healthy foods.

## Medicaid

Piedmont Augusta provides services to patients who receive benefits through the state/federal public insurance program Medicaid, which covers the cost of care for low-income patients who: are pregnant, are a child or teenager, are 65 and older, are legally blind, have a disability, or need nursing home care. Below is a list of the top 10 ZIP codes by volume of patients receiving care at the hospital as a Medicaid beneficiary during the last two fiscal years.

| ZIP Code | 2020 | | 2021 | |
|---|---|---|---|---|
| | Number of Pts | All Visits | Number of Pts | All Visits |
| 30809 | 93 | 321 | 73 | 244 |
| 30813 | 151 | 374 | 140 | 412 |
| 30815 | 383 | 1031 | 300 | 890 |
| 30824 | 168 | 368 | 153 | 329 |
| 30830 | 99 | 287 | 90 | 265 |
| 30901 | 516 | 1855 | 447 | 1471 |
| 30904 | 481 | 1626 | 395 | 1544 |
| 30906 | 905 | 2891 | 811 | 2432 |
| 30907 | 155 | 486 | 140 | 420 |
| 30909 | 280 | 830 | 243 | 915 |
| **Medicaid Total** | **3231** | **10069** | **2792** | **8922** |

Please note we provided care to Medicaid beneficiaries outside of these ten ZIP codes as well. Examining ZIP code data can help us to better target specific communities that may have unique challenges due to social determinants of health, such as having a low income, poor housing conditions, or limited access to healthy foods.

**Training Tomorrow's Caregivers**

In 2021 we opened our doors to 68 residents, who were able to perform or assist with 4,531 cases to further their education, along with 242 senior practicum nursing students, 528 junior and senior nursing students and 225 allied health students. Piedmont Augusta provided these services at its cost of $1.4 million, combined with training students in Piedmont's Schools of Radiography and Cardiovascular Technology.

**COST** PIEDMONT AUGUSTA

School of Radiography - **$247,626**
School of Cardiovascular Technology - **$11,014**
Internes and Residents - **$59,639**

In January 2021 Piedmont Augusta signed a partnership with Augusta Technical College to grow the local healthcare labor force by developing an Augusta Technical College Health Science Campus on the Piedmont Augusta Summerville Campus. The goal is to increase the capacity to educate and graduate future health professionals predominantly in nursing, but also other clinical roles to include patient care assistants, patient care technicians, certified medical assistants and others.

# Progress Since Last CHNA

In the hospital's FY19 CHNA, three health priorities were identified to address over the following three years. These priorities were:

- Heart Attack and Stroke - Identify women at risk for cardiovascular disease and diabetes and provide education and connections to primary care services to develop a prevention plan.
- Diabetes - UH Diabetes Services will launch a Diabetes Prevention Program. During the first year, we will offer this program to UH employees – education will focus on healthy food choices, fitness, and ways to incorporate healthy lifestyle changes into their daily routine. We are modeling the launch of a successful DPP program out of another large health system, which started their DPP program with employees the first year. They have since begun offering the DPP to the community.
- Maternal Health and Morbidity - Review AWHONN POST-BIRTH warning signs with every mother post-delivery. This will be incorporated with patients' prenatal curriculum and hospital discharge information, externally through social media and internally through appropriate communication channels.

**To address these priorities, we,** like many hospitals during the COVID-19 pandemic, had to pivot in a different direction to accommodate the needs of the community, and many goals put forth in the hospital's FY19 Implementation Strategy were placed on hold.

During the pandemic, the hospital focused on patient care, providing reliable COVID-19 information and vaccinations for the community. The hospital held 246 vaccine clinics targeting hospital employees, the elderly and at-risk community members. Hospital employees and administrators volunteered to administer more than 31,000 vaccinations in community clinics. The hospital was the first locally to open a Monoclonal Antibody Clinic, serving more than 1,800 MAB patients.

| | **2019** | **2020** | **2021** |
|---|---|---|---|
| Diabetic EDU referrals | 935 | 801 | 624 |
| Sweet Success (under & uninsured) | 85 | 31 | 47 |
| DPP | 13 started program & 8 graduated | | |
| Women Wellness | 52 days; 136 women | 3 days; 6 screened | |
| Community COVID Line calls | na | 13901 | 3675 |
| COVID Vaccines | na | 1864 | 27998 |
| COVID Monoclonal Antibody Infusions | | 38 | 1795 |
| AWHONN post Birth Flyers | 3282 | 3102 | 3117 |
| Child Birth Classes | 2312 attendees | 2658 attendees | 3400 attendees |
| Lactation Outpatient Visits | 157 | 41 | 1 |
| Heart Attack &Stroke Prevention talks | 41 talks;<br>2305 attendees | 16 talks;<br>1156 attendees | |
| Stroke Awareness Events | 9 events;<br>over 2670 participants | 2 events;<br>135 participants | 2 events;<br>75 participants |
| Health Fairs (with and without HASP screening) | 22 events; 2482 people interactions | 4 events; 144 people interactions | |

The hospital prioritized access to appropriate and affordable health and mental care for all community members, especially the uninsured, and those with low income. The hospital accomplished this in part by supporting charitable clinics such as Christ Community Health, Harrisburg Family Healthcare and others, who serve uninsured, underinsured, low-income residents in Richmond County. The hospital provides monthly financial support for the clinics, as well as shared access to patient medical records through the Epic Electronic Health Record (EHR) system. The hospital's Chief Operating Officer meets with the clinics' Executive Directors periodically to discuss opportunities and issues. The hospital also provides the clinics with laboratory services and some diagnostic tests, either at no charge or a prorated fee.

We also provide the area's only accredited mobile mammography unit. Our mobile unit is equipped with digital mammography equipment and is staffed by an all-female team of registered technologists with advanced training in the disciple of mammography. This allows Piedmont Augusta to make access to breast health care readily available to the CSRA and surrounding areas. Through funds raised at the Miracle Mile Walk and through other philanthropic giving to Piedmont Augusta Foundation, no woman who needs a screening mammogram is ever turned away regardless of her ability to pay.

# FY23 Priorities

A key component of the CHNA is to identify the top health priorities we'll address over fiscal years 2023, 2024 and 2025. These priorities will guide our community benefit work. They are, in no order of importance:

### Ensure affordable access to health and mental health care

We will work to further ensure our community members have access to affordable health and mental care, regardless of income. This includes partnerships with community-based organizations, as well as internal programming to increase access to services.

### Reduce preventable instances and death from heart disease

We will promote both the prevention and treatment of heart disease and will emphasize early detection and healthy behaviors to help reduce risk. We will pay particular attention to populations most at risk for heart disease.

### Promote healthy behaviors to reduce preventable conditions and diseases

We will actively promote healthy behaviors and encourage community members to stop risky behaviors, such as smoking. This includes widespread health education and programming.

### Reduce preventable instances and death from cancer

We will promote both the prevention and treatment of all cancers, especially among those most vulnerable to the disease. This includes community-based screenings and the promotion of programming meant to support community members with cancer and their families.

With each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators for that priority. This means we will prioritize programming and investment in areas that directly address issues related to income and poverty, and others who face particular challenges in accessing care due to disability, race, English proficiency, educational attainment and other areas of socioeconomic status.

When possible, we will work to address other issues that arose during the CHNA even though those are not listed in the above priority list.

FY23

# Community Health Needs Assessment

# Community Snapshot

While Piedmont Augusta serves patients from Richmond, Columbia and Aiken counties, however, for purposes of this CHNA, we consider our community to be Richmond County. We do this in recognition of the direct impact of our tax-exempt status on county residents.

According to the U.S. Census Bureau, in 2020:

- In Richmond County, an average 206,607 people lived in the 334 square mile area.
- About 57.7 percent of all Richmond County residents were African American, 33.7 percent were white, 5.1 percent were Hispanic or Latino, 1.8 percent were Asian and 1.7 percent were another race.
- The median household income was $53,033, which is lower than both state and national averages. African Americans specifically had a much lower median household income at $44,726.
- Approximately 18,147 veterans lived in Richmond County, which is about 9% of the population.
- An estimated 85.7 percent of county residents graduated high school, just under the state average.
- The percentage of population living in poverty in Richmond County is 25.5 percent, higher than the national average of 14%.
- About half the population, 51.6% owned their own home, below the state average of 64%

**Community Rankings**

In 2022 and in comparison with the other 159 Georgia counties, Richmond County ranks:

- 139th in length of life
- 103th for quality of life, with indicators for poor or fair health, poor physical health days, poor mental health days and low birthweight rates far above state averages.
- 111rd for healthy behaviors, with high rates of smoking, obesity, physical inactivity, excessive drinking, motor vehicle crashes, teen births, sexually transmitted diseases (STDs) and Food Environment Index.
- 12th for clinical care, with slightly lower-than-average uninsured rates and better than average rates of preventable hospital stays and rates of primary care physicians for community members.
- 136st for social and economic factors, with higher-than-average percentages of children in single-parent households, unemployment, children eligible for free or reduced priced lunch and children living in poverty.
- 134th for physical environment, with rates on par with the state for housing problems and commutes.

# Root Causes of Poor Health

**Poverty and Health**

Poverty is the most significant indicator of health as, in general, poorer people are sicker than their richer counterparts. Those living at or near poverty are most likely to die from cancer, heart disease and diabetes, due to several factors that go beyond income, such as education, housing and simple geography, things commonly dubbed “social determinants of health.” This means that factors outside your immediate physical self can play a huge role in your health, even including how long you live. Richmond County has a poverty rate higher than state average, with about 25.5 percent of the population living at or below poverty.

**Insurance Status and Health Outcomes**

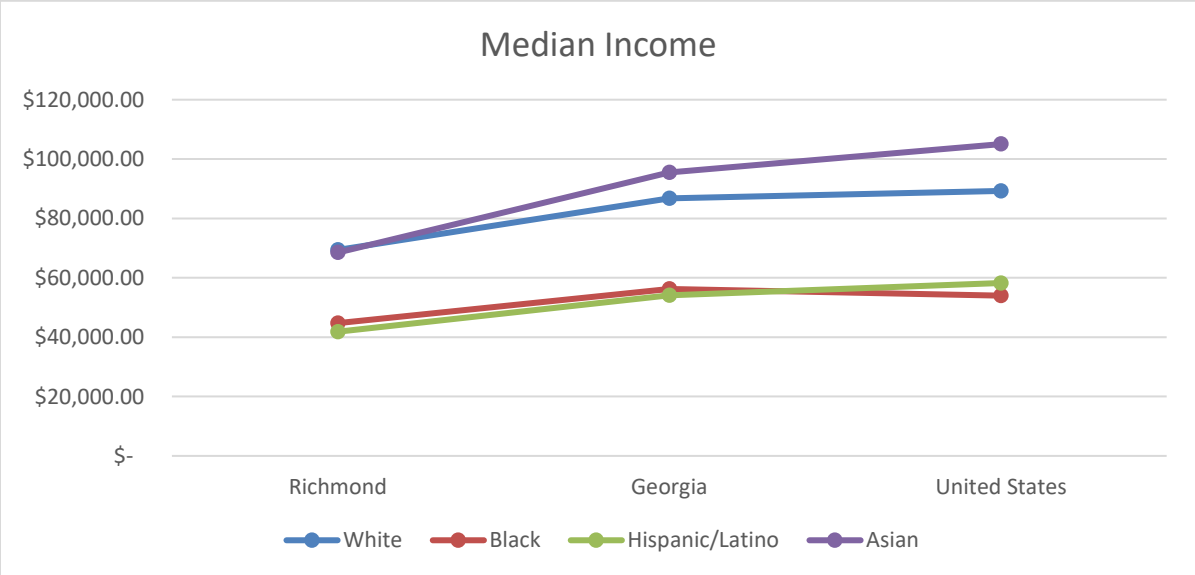
In 2020, in the state of Georgia, 19 percent of the population had no form of insurance. Insurance status and health are inextricably linked. Being uninsured is generally a marker of low-income, as the overwhelming majority of those that are uninsured are also within certain ranges of the Federal Poverty Level. This means these populations are also likely to face the myriad of other social determinants of health (SDH), like housing and food insecurity. No insurance can mean no access to primary and specialty care, due to cost and/or provider availability. Conditions that could have been treated affordably in a community setting are often not and, because of this, those without insurance statistically suffer worse health outcomes than their insured counterparts. Diseases like cancer are often diagnosed later, and manageable conditions such as hypertension can elevate to dangerous levels. Adults aged 18 to 64 are most likely to be uninsured, and that's true in Richmond County. In 2020, 17.81 percent of nonelderly adults were uninsured. In Richmond County Hispanics represent 23.08 percent, the highest percentage of uninsured adults.

**Family and children**

- 39 percent of Richmond County children live at or below the poverty level. It is significantly higher than the state average of 20.09%.
- 92.08% of children qualified for free or reduced cost lunch in the 2020-2021 school year.
- 51% of children live in single-parent homes in 2020, above the state average of 30%.

# Community and Income

In 2020 the median household income was $53,033, lower than state and national levels, which are $61,224 and $64,994 respectively. When broken down by the four dominant races in the community, income disparities are evident.



**Unemployment and Labor Force Participation**
According to the 2020 US Census 91,512 people in the community were part of the labor force, approximately 56.98 percent. Only about 3.80% were unemployed in 2022. This figure has steadily decreased; in 2020, 7.6% of the labor force was unemployed.

This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

# Community Safety

Below is a chart breaking down offenses in 2017, as reported to the Georgia Bureau of Investigation. This is the most recent year for which this information is publicly available.

| Murder | Rape | Robbery | Assault | Burglary | Larceny Theft | Vehicle Theft |
|---|---|---|---|---|---|---|
| 23 | 47 | 283 | 523 | 1615 | 6832 | 672 |

**Incarceration rate**
The Opportunity Atlas estimates the percentage of individuals born in each census tract who were incarcerated at the time of the 2020 Census. According to the Atlas data, 3.9 percent of the county population were incarcerated, higher than the state average of 2.1 percent.

**Violent crime**
Violent crime is a critical public health issue as it is often largely preventable. Between 2014 and 2016, there were a total 1,772 violent crimes within Richmond County, a figure that includes homicide, rape, robbery, domestic violence, and aggravated assault. This equates to a violent crime annual rate of 292.5 per every 100,000 people, a figure lower than the state and national rates of 373.1 and 416, respectively.

**Juvenile arrests**
Within the county, in 2018, there were 160 juvenile arrests. Juvenile arrests can illustrate one aspect of the complex societies in which youth live. Juvenile arrests are the result of many factors such as policing strategies, local laws, community and family support, and individual behaviors. Youth who are arrested face disproportionately higher morbidity and mortality. Those who are arrested and incarcerated experience lower self-reported health, higher rates of infectious disease and stress-related illnesses, and higher body mass indices.

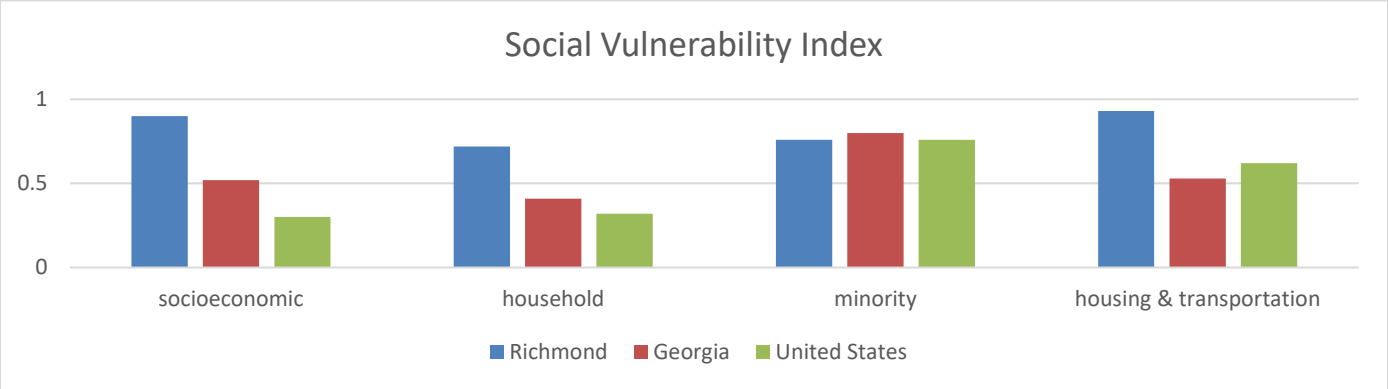
**Firearm fatalities**
Firearm fatalities are a critical public health issue as they are largely preventable. Most firearm fatalities are the result of suicides and homicides. Between 2015 and 2019, there were 220 firearm fatalities in Richmond County.

**Assault**
In Richmond County, between 2014 and 2016, there were 996 reported assaults equaling an annual rate of 164 assaults per 100,000 people, much lower than the statewide rate of 230.20.

# Vulnerability and Deprivation Indexes

**Area Deprivation Index**
The Area Deprivation Index (ADI) ranks neighborhoods and communities relative to all neighborhoods across the nation and the state. ADI is calculated based on 17 measures related to four primary domains: education, income and employment, housing, and household characteristics. The overall scores are measured on a scale of 1 to 100 where 1 indicates the lowest level of deprivation (least disadvantaged) and 100 is the highest level of deprivation (most disadvantaged). Richmond County ranks in the 72nd percentile for Georgia and 76th in the national percentile, both of which are relatively high figures.

**Social Vulnerability Index**
The Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability. The social vulnerability index is a measure of the degree of Richmond County has a social vulnerability index score of 0.93, which is higher than the state score of 0.57. Broken down by themes:




# Income and Poverty

A person's income status is directly related to their health status, and predictably the more money you have, the healthier you tend to be.

In 2020 25.5% of Richmond County's population lived in poverty, higher than the state average of 14%.

**SNAP Benefits**
The Georgia Supplemental Nutrition Assistance Program (SNAP) is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. A household may be one person living alone, a family, or several unrelated individuals cohabitating who routinely purchase and prepare meals together. SNAP enrollment and poverty rates are correlated. In Richmond County, more than 19 percent of households received SNAP benefits in December 2020. Black populations are far more likely to receive SNAP benefits than any other demographic. The ZIP codes with the highest percentage of SNAP recipients were 30901 & 30906, where more than a quarter of the population received SNAP benefits.

Households Receiving SNAP Benefits by Race/Ethnicity, Percent

| Report Area | Total Population | Non-Hispanic White | Black | Asian | American Indian or Alaska Native | Some Other Race | Multiple Race | Hispanic or Latino |
|---|---|---|---|---|---|---|---|---|
| Richmond County, GA | 19.32% | 9.59% | 26.93% | 4.90% | 36.92% | 11.46% | 16.11% | 16.86% |
| Georgia | 12.23% | 6.70% | 22.23% | 5.12% | 16.21% | 14.51% | 12.40% | 12.85% |
| United States | 11.35% | 6.86% | 24.38% | 7.10% | 23.34% | 19.65% | 16.33% | 18.53% |

# Housing

In 2020, the median rent cost for a one-bedroom in Richmond County was $908. Rising rents mean less of an ability to pay for other crucial areas of life. According to 2020 USDA data, the average adult male spends between $193 and $358 on groceries per month, and the average adult female spends between $174 and $315. As the family size grows, costs increase, and households are increasingly burdened. None of the above reflects the impact of COVID-19 on housing stock, income, and increased cost of living, meaning the situation is likely worse than before.

**Cost-burdened households**

Of the 72,526 total occupied households in Richmond County in 2020, 25,998 -- about 35.85% -- of the population live in cost burdened households, in which housing costs are 30 percent or more of total household income. This is higher than the state percentage of 29.07%. Approximately 18.15% of households had costs that exceeded 50 percent of the household income which places the household in significant financial strain. This compares to the state percentage of 13.3%.

**Substandard housing**

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. Of all households in the county, about 35.13 % have substandard housing and 20.91% have severe substandard housing compared to the state averages of 29.52% and 17.71% respectively.

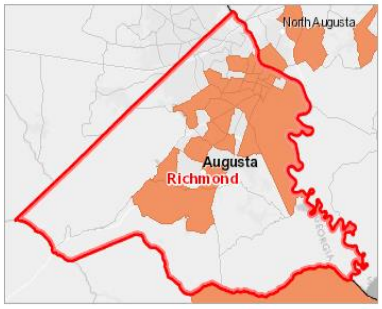
**Area Median Income and affordable housing**

This indicator reports the number and percentage of housing units at various income levels relative to Area Median Income (AMI). The AMI is the midpoint of a region's income distribution, meaning that half of households in a region earn more than the median and half earn less than the median. A household's income is calculated by its gross income, which is the total income received before taxes and other payroll deductions. Affordability is defined by assuming that housing costs should not exceed 30 percent of total household income. Income levels are expressed as a percentage of the county's AMI. About 67 percent of housing units are affordable at 100 percent AMI, which means that housing is not affordable for the remaining 33 percent of the population. This is similar to the state rate of 66.39% and slightly better than the national rate of 60.68 percent of housing units affordable at 100 percent AMI.

# Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially so if they were already low-income. As with many health indicators, minorities are much more likely than their white counterparts to experience food insecurity. Neighborhood conditions can affect physical access to food. For example, people living in some urban areas, rural areas, and low-income neighborhoods may have limited access to full-service supermarkets or grocery stores. Predominantly black and Hispanic neighborhoods tend to have fewer full-service supermarkets than predominantly white and non-Hispanic neighborhoods. Communities that lack affordable and nutritious food are commonly known as “food deserts.”

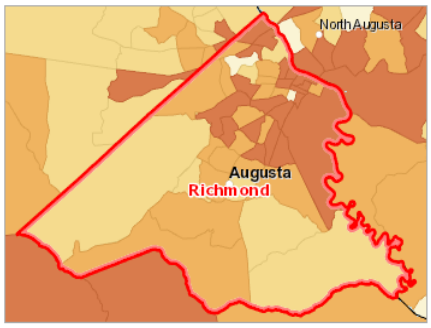
In Richmond County, in 2019, 25 of the county's census tracts were food deserts, as shown in the map below. About 88,892 people lived within these census tracts. These tracts almost directly correspond with census tracts demonstrating retailers who are authorized to take SNAP benefits. In Richmond County, like with most of the state, those retailers tend to be convenience and discount stores that carry limited, if any, healthy foods. Increasingly, discount stores like Dollar General do have some sort of produce section, but that is inconsistent among communities.




View larger map

Food Desert Census Tracts, 1 Mi. / 10 Mi. by Tract, USDA - FARA 2019

- Food Desert
- Not a Food Desert
- No Data
- Richmond County, GA




View larger map

SNAP-Authorized Retailers Access, Rate per 10,000 Population by Tract, USDA 2021

- Over 12.0
- 6.1 - 12.0
- Under 6.0
- No SNAP-Authorized Retailers
- No Population or No Data
- Richmond County, GA

**Grocery stores**

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. There are 28 grocery establishments in the county, a rate of 13.55 per 100,000 population, which is lower than the state rate of 15.7. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included, and convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

**Low food access**
Low food access is defined as living more than 0.5 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity. According to the 2021 Food Access Research Atlas database, 47.58 percent of the total population in the county have low food access, meaning more than 98,000 county residents may struggle to access healthy foods. This is much worse than the state and national rates of 30.89 percent and 22.22 percent, respectively. ZIP codes 30905 & 30912 has the worst rate of low food access at 99.72 & 99.62 percent respectively.

# Access to Care

At the crux of healthcare is access, which is determined by a few factors: availability of providers, insurance status, and ability to pay.

**Insurance**
Insurance status is directly related to a person's ability to access care, and this is particularly true for non-emergent care and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected. Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are over three times more likely than insured adults to say they have not had a visit about their own health to a doctor or other health professional’s office or clinic in the past 12 months. They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening. Part of the reason for poor access among the uninsured is that half do not have a regular place to go when they are sick or need medical advice, while most insured people do have a regular source of care.

In Richmond County, in 2020, about 13.38 percent of the population were uninsured, a figure similar to the state rate of 13.03% and the national figure of 8.73 percent. As with other indicators, these rates are much worse for minorities, and particularly Hispanic/Latino populations, which had an uninsured rate of 23.08 percent.

**Insurance coverage**
The below table demonstrates the type of insurance for those who had coverage in 2020, by percentage of the population. Note this doesn't equal 100 percent, as some community members have two types of coverage.

| Report Area | Employer or Union | Direct Purchase | TRICARE or Other Military | Medicare | Medicaid | VA Health Care |
|---|---|---|---|---|---|---|
| Richmond County, GA | 49.99% | 14.15% | 10.89% | 20.15% | 28.81% | 6.76% |
| Georgia | 62.00% | 14.71% | 4.70% | 18.28% | 19.83% | 2.88% |
| United States | 60.75% | 14.99% | 2.98% | 19.29% | 21.99% | 2.49% |

# Access to Dental and Primary Care

**Dental care and dental outcomes**
Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Within the county, in 2018, 56.50 percent of adults went to the dentist in the past 12 months. That year, 21.4 percent of the county reported having lost all natural teeth because of tooth decay or gum disease. This is an impactful measure in multiple ways:

- Research shows that losing your teeth will shorten your lifespan. Missing nine teeth for nine years or more reduces lifespan compared to a contemporary who maintains their teeth.
- The lower your income and education level, the more likely you are to lose your teeth, which results in even fewer economic opportunities, creating a poverty cycle. For example, it is difficult to gain employment if you have visible missing teeth.
- The individual will inevitably struggle with eating certain foods, limiting their options, which can be detrimental for lower-income populations already facing food insecurity.

It's important to note that there are few options for low-income patients needing dental care. Christ Community Health is one of the limited options for low-income dental care services within the county, and there are few -- if any, at a given time -- options for low cost dental services that go beyond cleaning, basic fillings, and extractions.

**Primary care and routine check-ups**
In 2019, about 79 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, a measure that is likely over-reported and is lower than both state and national averages. For Medicare recipients, this number drops to 67.73 percent of adult beneficiaries, which is below both state and national averages which are 83.81% and 80.64%, respectively. Routine check-ups are a critical component to maintaining good health and identifying conditions that can be treated affordably in a community based setting. Absent that, even simple-to-treat conditions can escalate to deeper issues, eventually requiring more intensive care, later stage diagnoses, or reduced life expectancy. As with most all other indicators, race and income play heavily into this. White populations are far more likely to receive preventative care than their white counterparts (60.92 percent among black populations compared to 72.55 percent among non-black populations), and those with insurance are also much more likely to go to the doctor for a routine check-up than those without insurance.

# Causes of Death

In Richmond County and the state of Georgia, heart disease is the number one cause of both age-adjusted and premature death. Below are the nine leading causes of age-adjusted death from 2016 – 2020.

| Ranking | Age-adjusted death rate, in aggregate 2016 - 2020 |
|---|---|
| ***1*** | Ischemic heart and vascular disease |
| ***2*** | Primary hypertension & hypertensive renal & heart disease |
| ***3*** | Lung Cancer |
| ***4*** | All COPD except Asthma |
| ***5*** | Alzheimer's Disease |

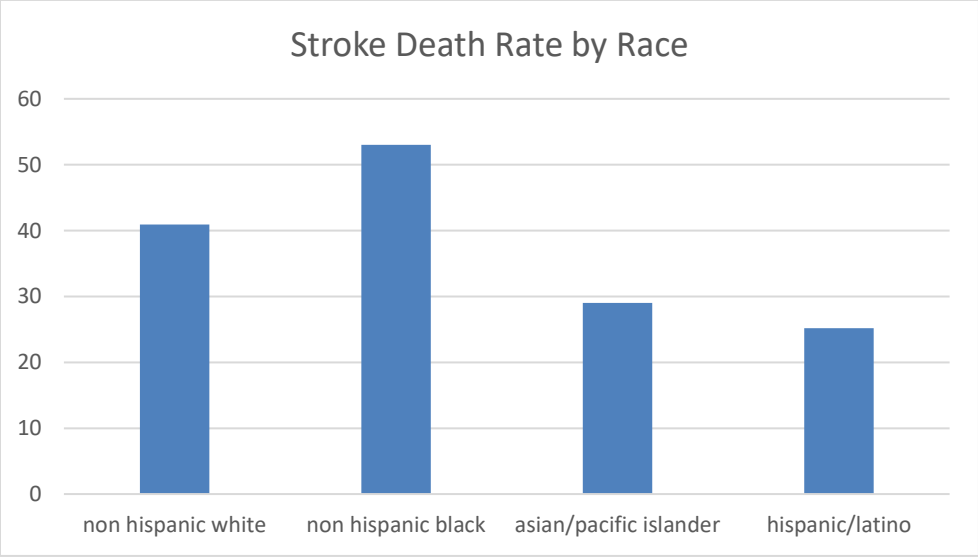
| | |
|---|---|
| ***6*** | Cerebrovascular disease |
| ***7*** | Mental and behavioral disorders |
| ***8*** | Diabetes mellitus |
| ***9*** | Accidental poisoning |

When broken down by race, the leading causes of death shift. Below is a list of the top three causes of death, by race.

- White: Ischemic heart/vascular; all COPD, Alzheimer's
- Black: Hypertension & heart disease; Ischemic Heart/vascular; Cerebrovascular
- Asian: Ischemic heart/vascular; Cerebrovascular Disease; Diabetes Mellitus

# Heart Disease and Stroke

Heart disease is a leading cause of death for both women and men in Richmond County. Between 2016 and 2020, the age-adjusted death rate was 240.7 persons for every 100,000 people, which is much higher than both state and national rates, which were 178 and 164.8 heart-related deaths per 100,000 people, respectively. Between 2016 and 2020, there were 479 deaths due to stroke, representing an age-adjusted death rate of 46.8 deaths per every 100,000 people. Men are more likely to die from stroke than women, as are black populations. Below is a chart demonstrating the state death rate broken down by race, per every 100,000 people, between 2016 and 2020.




**Hospitalizations**

The cardiovascular disease hospitalization rate in 2018 was 10.8 hospitalizations per every 1,000 Medicare beneficiaries, which is lower than the state and national rates of 12.2 and 11.8, respectively. The hospitalization rate for stroke, is below state and national rates, with 7.9 hospitalizations per every 1,000 Medicare beneficiaries, as compared to the state rate of 9.3 and the national rate of 8.4.

# Cancer

Although heart disease leads in county deaths, cancer remains a critical issue within the community. The cancer incidence rate for Richmond County each year, on average between 2014 and 2018, was 482.5 per every 100,000, which equates to a diagnosis rate of an average 1,051 new cases each year. Below is a chart showing cancer diagnoses, by site, between 2014 and 2018, the last year for which this data is available.

| Cancer Site | Incidence Rate (per 100,000 population) | New Cases (annual average) |
|---|---|---|
| Cancer incidence rate | 482.3 | 1051 |
| Breast | 131.1 | 156 |
| Prostrate | 141.8 | 148 |
| Lung & Bronchus | 72.6 | 159 |
| Colon & Rectum | 36 | 77 |
| Melanoma of the Skin | 13.5 | |

Poverty is directly related to increased incidence rates of cancer, as those with lower levels of education and lower levels of income experience higher rates of cancer diagnoses. They are also more likely to die from certain cancers – particularly lung cancer and colorectal cancer. For survivors, income and socioeconomic status are significant predictors of quality of life after cancer. Increased income allows patients to maintain a level of comfort that people with low SES might not be able to afford, meaning that even if a low-income patient survives cancer, their quality of life after will be worse than someone more well off.

# Hospitalizations and ER visits

**Emergency department visits**

In 2021, Piedmont Augusta treated patients through approximately 64,730 emergency room visits, a decrease of about 8,434 visits from 2020 and 31,424 from 2019. This is likely in part due to the impact of COVID-19 and a wariness among patients to visit a hospital.

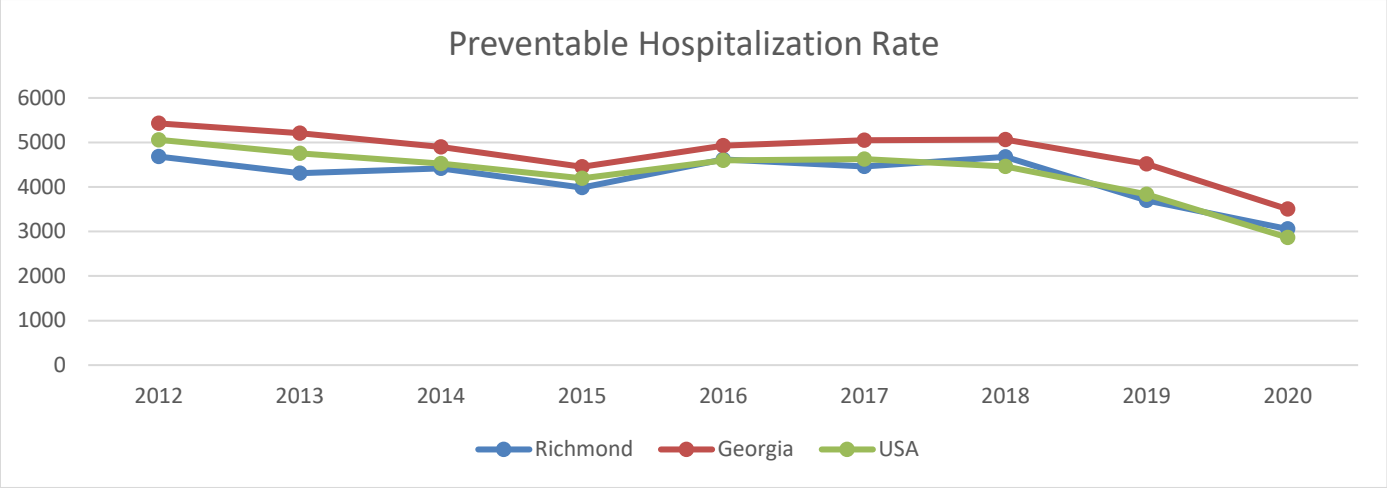
| | 2019 | 2020 | 2021 |
|---|---|---|---|
| Emergency Visits | 96154 | 73164 | 64730 |
| Inpatient Stays | 28891 | 26085 | 24204 |
| Outpatient Surgery | 35621 | 30984 | 29130 |
| Births | 3283 | 3102 | 3117 |
| Outpatient Visits | 1148263 | 1172260 | 1185351 |

**Inpatient stays**

In 2020, there were 35,525 Medicare beneficiaries in the county. Approximately 13.8 percent, had a hospital inpatient stay, and the rate of stays was 223 per every 1,000 beneficiaries. The rate of inpatient stays in the county was lower than the state rate of 230.0 during the same time.

**Preventable hospitalizations among Medicare beneficiaries**
Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infections. Rates are presented per 100,000 beneficiaries. In 2020, there were 35,525 Medicare beneficiaries in the county, and the preventable hospitalization rate was 3,057, which is better than the state rate of 3,503 during the same time. As with other health indicators, African Americans were twice as likely to experience preventable hospitalizations than other races in 2020.

The chart below demonstrates the five-year trend for preventable hospitalizations over the last eight years.




As with other health indicators, African Americans were more likely to experience preventable hospitalizations though Richmond County is below the state average. Below is a table with Preventable Hospitalization Rates by race:

| Race | Richmond County | State of Georgia |
|---|---|---|
| White | 2747 | 3279 |
| Black | 3648 | 5029 |
| Hispanic Latino | 554 | 3927 |

# Chronic Conditions

A chronic condition is a health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time. As with most health indicators, low-income households are most at risk for developing chronic diseases and for premature deaths. Such households are more vulnerable for several reasons, including their inability to cover medical expenses and diminished access to health care facilities.

**Diabetes**
In 2019, 22,007 of adults aged 20 and older had diabetes, equaling 14 per cent of the county's population, which is higher than the state rate of 9.8 percent. Diabetes is a prevalent problem in the US, often indicating an unhealthy lifestyle and puts individuals at risk for further health issues.

**Kidney Disease**
Chronic kidney disease, also called chronic kidney failure, involves a gradual loss of kidney function. Your kidneys filter wastes and excess fluids from your blood, which are then removed in your urine. Advanced chronic kidney disease can cause dangerous levels of fluid, electrolytes and wastes to build up in your body. In 2019, 3.9 percent of the county's population had a diagnosis of kidney disease, a rate higher than the state and national percentages of 3.22 percent and 3.1 percent, respectively.

**High cholesterol**
In 2019, 31.40 percent of adults 18 and older reported having high cholesterol of the total population, just below the state rate of 32.3%. Too much cholesterol puts you at risk for heart disease and stroke, two of the main causes of death within the county.

**High blood pressure**
In 2019, 40.7 percent of adults 18 and older had a diagnosis of high blood pressure, this is higher than the state percentage of 35.5. High blood pressure can damage your arteries by making them less elastic, which decreases the flow of blood and oxygen to your heart and leads to heart disease.

**Multiple chronic conditions among Medicare populations**
This indicator reports the number and percentage of the Medicare fee-for-service population with multiple (more than one) chronic conditions. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Within the county, there were 11,120 beneficiaries with multiple chronic conditions based on administrative claims data in the latest report year, representing 59.8 percent of the total Medicare fee-for-service beneficiaries. Of these with multiple chronic conditions 4,760 or 42.8% have six or more chronic conditions.

# Infectious diseases

**HIV/AIDS**
HIV (human immunodeficiency virus) is a virus that attacks the body’s immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). While there is no cure for HIV/AIDS, if treated, most can live a relatively healthy life. In Richmond County in 2018, there were 834.4 confirmed cases of HIV/AIDS for every 100,000 people. This is significantly higher than the state rate of 624.90 confirmed cases per every 100,000 people.

**Chlamydia**
Chlamydia is a common STD that can cause infection among both men and women. It can cause permanent damage to a woman's reproductive system. This can make it difficult or impossible to get pregnant later. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb). In Richmond County, in 2018, there were 2,580 confirmed cases of chlamydia, resulting in a rate of about 1278.49 infections per every 100,000 people. This is significantly higher than the state rate of 632.2 confirmed cases per every 100,000 people.

**Gonorrhea**
Gonorrhea is an STD that can cause infection in the genitals, rectum, and throat. It is very common, especially among young people ages 15-24 years. Untreated gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea can spread into the uterus or fallopian tubes and

cause pelvic inflammatory disease (PID). In Richmond County, in 2018, there were 623 confirmed cases of gonorrhea for every 100,000 people. This is higher than the state rate of 200.10 confirmed cases per every 100,000 people.

**Influenza and pneumonia**
Within the county, between 2016 and 2020, there were a total 150 deaths due to influenza and pneumonia, representing an age-adjusted death rate of 14.4 per every 100,000 people, which is higher than the state and national rates of 13.6 and 13.6, respectively.

# COVID-19

COVID-19 has been one of the most impactful health events to happen within the local community and around the world. As of July 14, 2022, Richmond County had a total 51,410 confirmed COVID-19 cases and 898 COVID-19 related deaths.

Approximately 60 percent of the county was fully vaccinated as of July 20, 2022, and the county had a COVID-19 vaccine coverage index (CVAC) of 0.72, which is a score of how challenging vaccine rollout may be in some communities compared to others, with values ranging from 0 (least challenging) to 1 (most challenging). CVAC ranks states and counties on barriers to coverage through 28 indicators across five themes:

- Historic under-vaccination
- Sociodemographic barriers
- Resource-constrained health system
- Health care accessibility barriers
- Irregular care-seeking behaviors

The CVAC can help contextualize progress to widespread COVID-19 vaccine coverage, identifying underlying community-level factors that could be driving low vaccine rates.

# Community resilience

The US Census's Community Resilience Estimates (CRE) provide a metric for how at-risk every neighborhood in the United States is to the impacts of disasters, including COVID- 19. The more risk factors you have, the less likely you are to recover from the impacts of COVID-19 in several ways, such as physically, economically, and psychologically. According to these estimates, as of July 2022, within McD County:

- 31 percent of the population had no risk factors
- 45.1 percent of the population had one to two risk factors
- 23.9 percent of the population had three or more risk factors

These risk factors include:

- Poverty rates
- Single or zero caregiver household
- Crowding
- Communication barriers
- Households without full-time, year-round employment
- Households with disabilities
- No health insurance
- Age 65+ living alone
- No vehicle access
- No broadband internet access

# Children

In Richmond County in 2020, 22.86% of the population was under the age of 18. Approximately 2.1 percent of students were homeless in 2020 -- about 629 kids.

Of all children, 61.97% lived at or below 200 percent of the Federal Poverty Level (FPL), which was $55,500 gross household income for a family of four in 2022. This is higher than the state percentage of 43.27%.

Additionally, 92.08 percent of county children qualified for free or reduced-price lunch in the 2020- 2021 school year, a figure far above state and national rates of 56 percent and 42 percent, respectively. Free or reduced-price lunches are served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the US FPL as part of the federal National School Lunch Program (NSLP).

**Access - Head Start and preschool enrollment**
Head Start is a program designed to help children from birth to age five who come from families at or below poverty level. This helps these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. Richmond County has 15 Head Start programs, with a rate of 10.1 per 10,000 children under 5 years old in 2019. This rate is far above state rates and on par with the national rates of 6.83 and 10.53, respectively. Approximately 39.64 percent of all children aged 3 to 4 were enrolled in preschool in 2020, a rate lower than state figure of 49.05 percent.

**Single-parent households**
In 2020, 51 percent of children lived in households where only one parent is present, and the majority of those were led by a single woman. Statistically, compared to married parents, single parents tend to be poorer (because there is not a second earner in the family) and less well-educated (in part because early childbearing interrupts or discourages education, and single parent households tend to be led by younger parents).

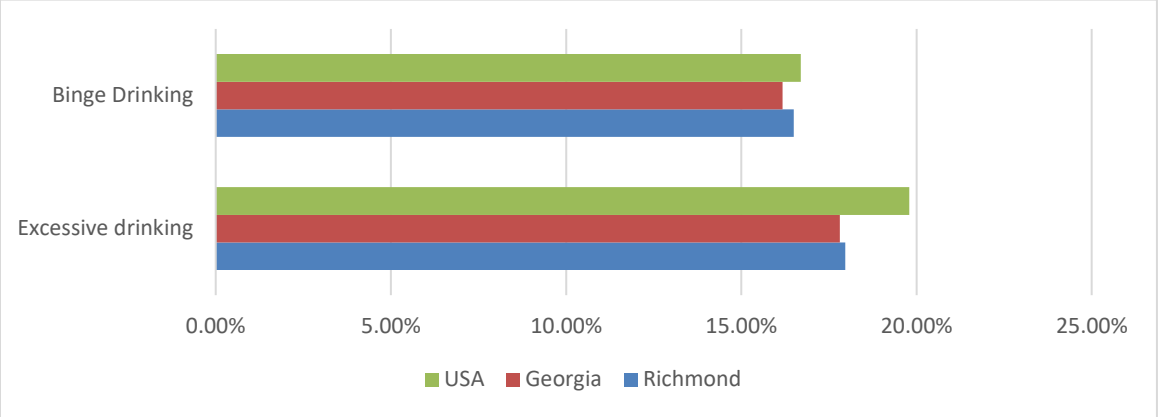
**English and math 4$^{th}$ grade proficiency**
Of 10,170 students tested, 78.30 percent of 4th graders tested below the "proficient" level in the English Language Arts portion of state standardized tests in the 2018-2019 school year, which is worse than the state rate of 60.7 percent and the national rate of 53.8 percent. Reading proficiency is key; up until 4th grade, students are learning to read. After that, they are reading to learn. For the math portion of the test, of 10,145 students tested, 72.4 percent of 4th graders tested below the "proficient" level, according to the latest data. Students in the county tested worse than the statewide rate of 53.9 percent.

# Risky Behaviors

Behaviors are directly related to health outcomes, leading to increased risks of cardiovascular disease, cancer, liver diseases, hepatitis, and sexually transmitted diseases.

**Alcohol use**
Excessive alcohol use can lead to a myriad of health issues, including liver disease, depression, injuries, violence, and cancer. In Richmond County, in 2019, 17.97 percent of adults self-reported excessive drinking in the last 30 days, which was more than the state rate of 17.81 percent. Data for this indicator were based on survey responses to the 2019 Behavioral Risk Factor Surveillance System (BRFSS) annual survey, the last year for which data is available. Based on preliminary national data, these rates likely increased during 2020, in which alcohol use increased during COVID-19 quarantine periods.

The below chart shows self-reported excessive and binge drinking rates in 2019. Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Excessive drinking is when binge drinking episodes occurred multiple times within the last 30 days.




**Tobacco use**
Within the county in 2019, 21 percent of adults reported being a current smoker. Smoking is directly related to a myriad of health issues, the most serious of which is cancer.

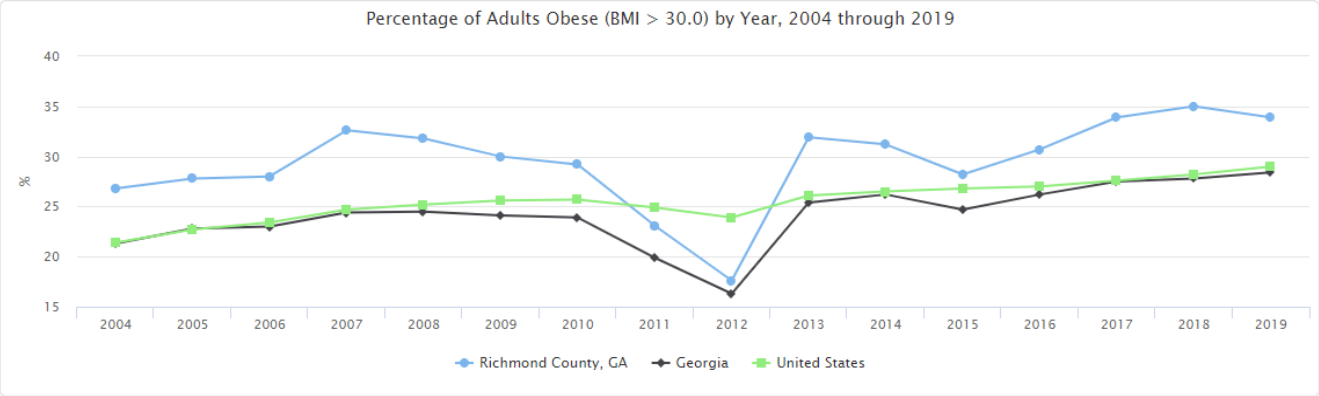
**Insufficient sleep**
Approximately 43 percent of county residents reported regularly sleeping less than 7 hours most nights, on average, in 2018. Sleep is an essential function that allows your body and mind to recharge, leaving you refreshed and alert when you wake up. Healthy sleep also helps the body remain healthy, fight diseases, and maintain good mental health. Without enough sleep, the brain cannot function properly.

# Health Factors

Certain health factors have a strong impact on overall health including obesity and physical inactivity.

**Obesity**
In 2019, 33.9 percent of county residents aged 20 and older were obese, meaning they had a body mass index of 30 percent or more. This is higher than the state and national percentages which are 28.4 and 27.6%, respectively.

In Richmond County this health risk affects 31.5% of males and 36% of females.  Obesity is directly linked to several health issues, including diabetes and heart disease.




**Physical inactivity**
Within the county in 2019, 29.2 percent of adults aged 20 and older self-report no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

One reason may be the lack of available public places for physical activity. For example, only 1.27% of county residents live within a half mile of a park, a figure much lower than state and national rates of 17.42 percent and 38.01 percent, respectively. Additionally, there were only 14 recreation and fitness places within the county in 2019, resulting in a rate of 6.78 facilities per every 100,000 people, another number below state and national averages which were 10.8 and 11.94, respectively.

# Mental Health

Mental health is a critical driver of overall health, as being in a good mental state can keep you healthy and help prevent serious health conditions. A study available in the National Library of Medicine found that positive psychological well-being can reduce the risks of heart attacks and strokes. On the other hand, poor mental health can lead to poor physical health or harmful behaviors.

**Deaths of Despair**
Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the Centers for Disease Control and Prevention (CDC). In Richmond County, between 2016 and 2020 the average rate of death due despair was 53.2 people per every 100,000. This is significantly higher than the state rate of 38.1.

**Poor mental health days**
In 2019, the last year for which data is available, county members reported an average 5.5 poor mental health days over the last 30 days, which is higher than the state average of 4.8 poor mental health days. This is a statistic that likely sharply increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community. Additionally, in 2019, 18 percent of adults reported being in frequent mental distress, which is 14 or more poor mental health days within a 30-day period. This statistic also likely increased during 2020 and 2021.

**Opioid and substance use**

In Richmond County in 2019 there were 1,621,149 prescription drug claims from Medicare beneficiaries. Of those drug claims 68,802 or 4.2 percent were opioid drug claims. This is lower than the state and national percentages of 4.40 and 5.30 percent, respectively.

Between 2016 and 2020 there were 13 deaths from opioid overdose representing a death rate (per 100,000 population) of 16.9. This rate is higher than the state and national rates of 9.6 and 15.7, respectively.

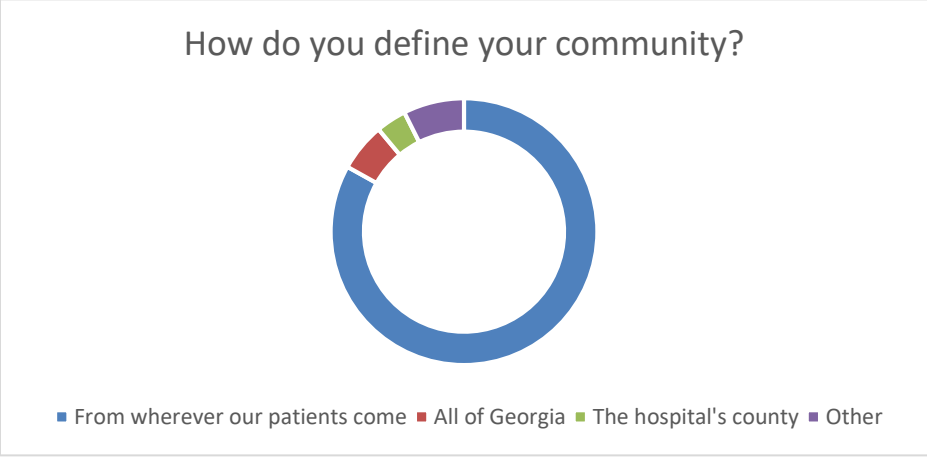
# Employee Survey

In July 2022 we launched an online employee survey to solicit community input on key health issues. More than 320 Piedmont Augusta employees responded. Below are the results of that survey. The survey questions can be found in the appendix.

The employees who responded worked in:

| Department | Responses |
|---|---|
| Administrative | 27.78% - 90 |
| Clinical | 51.85% - 168 |
| Other | 20.37% - 66 |
| TOTAL | 324 |

**Q:** How do you define the community you serve in your role?




**Q:** In the following list, what do you think are the five most important factors for a healthy community? We consider this to be those factors which most improve the quality of life in a community.

1. Access to health care (e.g., family doctor)
2. Access to healthy food
3. Healthy behaviors and lifestyles
4. Low crime/safe neighborhoods
5. Quality of care

**Q:** In the following list, what do you think are the five most important health problems in our community? Please check five.

1. Heart disease and stroke
2. Diabetes
3. Mental health problems
4. High blood pressure
5. Cancers

**Q:** How would you rate the overall health of our community?

| ANSWER CHOICES | RESPONSES |
|---|---|
| *Very unhealthy (most have three or more chronic conditions such as heart disease or diabetes)* | *11.15% - 36* |
| *Unhealthy (most have one or two chronic conditions such as heart disease or diabetes)* | *39.94% - 129* |
| *Somewhat unhealthy* | *33.13% - 107* |
| *Somewhat healthy* | *14.55% - 47* |
| *Healthy* | *1.24% - 4* |
| *Very healthy (most have no chronic conditions such as heart disease or diabetes)* | *0.00% - 0* |
| *TOTAL* | *323* |

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

- No insurance
- Unable to pay co-pays and deductibles
- Language barriers
- Lack of access to transportation
- Unable to use technology to find doctors, schedule appointments, manage online care
- Fear (e.g., not ready to face or discuss health problem)
- Don't understand the need to see a doctor
- Don't know how to find doctors
- Cultural/religious beliefs
- Lack of availability of doctors

**Q:** Of the following, what do you think are the top five things most important in improving the health of community members living in our communities?

1. Access to health care services
2. Free or affordable health screenings
3. Access to local outpatient mental health services
4. Access to low-cost mental health services
5. Access to local inpatient mental health services

**Q:** What are the five most important health problems in our community? (Top 10 answers)

1. Heart disease and stroke
2. Diabetes
3. Mental health problems
4. High blood pressure

5. Cancers
6. Poverty
7. Health illiteracy
8. Aging problems (e.g., arthritis, hearing/vision loss, etc.)
9. Child abuse / neglect
10. COVID-19

**Q:** What do you think are the top five things most important in improving the health of community members living in our communities?

1. Access to health care services
2. Free or affordable health screenings
3. Access to low-cost mental health services
4. Access to local outpatient mental health services
5. Access to local inpatient mental health services

**The following questions called for open-ended responses. The most common responses are noted here:**

| | |
|---|---|
| :**Q:** What is your vision for a healthy community? | • Decrease in preventable diseases<br>• Educating the public<br>• Safe and healthy homes for children and elderly<br>• Easy access to affordable healthcare<br>• Access to outdoor spaces<br>• Expanded care locations in rural areas<br>• Access to everyone for health care, including mental health issues<br>• Affordable housing<br>• Nutrition that prevents disease<br>• More focus on preventative care<br>• More mental health professionals |
| **Q:** What is the single most pressing issue you feel our patients face? | • Access to health care in rural areas<br>• Cost of medication<br>• Lack of health education<br>• Poverty<br>• Lack of access due to transportation or money<br>• Lack of mental health providers or facilities<br>• High cost of care<br>• Lifestyle changes to achieve better health |
| **Q:** What are one or two things we can do better to serve our patients/our community? | • Access to mental health services so there is a plan at discharge<br>• Proper patient to staff ration in ER<br>• Outreach. Reach out to community to address education and prevention.<br>• Diabetes education<br>• Disease prevention programs<br>• Education in low income areas<br>• More health care workers<br>• Expand healthcare clinics to rural areas |

# Community Stakeholders

A Community Listening Session was held in Richmond County; individuals from various health and social service agencies from Richmond, Columbia and Aiken were invited to attend.

Those agencies that participated in the sessions are: Rape Crisis and Sexual Assault Services, I Am My Brother's Keeper Ministry, Long Term Liaisons, City of Grovetown, United Way of the CSRA, Safe Homes, Richmond County School System, Harrisburg Family Healthcare.

These agencies represent the homeless, the elderly, and individuals living in poverty, as well as those facing food insecurity, mental health issues, or addiction.

Those who were invited but did not attend were from the following organizations: Augusta Housing & Community Development, Augusta Partnership for Children, Augusta Rescue Mission, Christ Community Health, Coordinated Health Services, Inc., CSRA Area Agency on Aging, Family Promise of Augusta, Gap Ministries, Garden City Rescue Mission, Georgia Department of Public Health, East Central Health District IV, Richmond County Health Department, Golden Harvest Food Bank, Hope for Augusta, Hope House, Lamar Medical Center, Mercy Ministries, Senior Citizen Council, Turn Back the Block, Walton Options for Independent Living, Columbia County, City of Harlem, Columbia County Community, Columbia County Health Department, United Way of Aiken County, Community Ministry of North Augusta, Aiken Senior Life Services, Aiken County Help Line, Inc., ACTS- Area Churches Together Serving, Community Medical Clinic of Aiken County, Jackson First Alert Rescue Squad, Lower Savannah COG, Rural Health Services, Inc. - Family Health Care, Aiken County Health Department.

Representatives from these organizations were sent an email with the list of questions from the listening session and invited to provide feedback.

These agencies represent the homeless, the elderly, and individuals living in poverty, as well as those facing food insecurity, mental health issues, or addiction.

Representatives from Piedmont Augusta facilitated the listening session, following questions and guidelines provided by the CHNA Steering Committee. These questions and guidelines were based on the North Carolina Department of Health and Human Services, North Carolina Division of Public Health's Community Health Assessment Guide, revised June 2014.

Taking notes for the session were Rebecca Sylvester, Piedmont Augusta Director of Corporate Communications; Christine McDowell, Piedmont Augusta Community Relations Specialist; Sean Bayer, Piedmont Augusta Process Improvement Engineer.

The session length was one and one-half hours. The following chart is a summary of the questions and feedback received. Questions and answers may have been combined or changed slightly to accommodate repeated and/or similar responses or themes. The order of feedback as it appears in the chart is not significant.

| | |
|---|---|
| **Q:** What do people in this community do to stay healthy? | • Bike on the greenway<br>• Gyms<br>• Walking<br>• Farmers' market<br>• Kayaking<br>• Depends on the county – parks & trails, basketball, sports<br>• On the most basic level some people, the homeless for example, can only try to get basic hygiene and medications<br>• Staying healthy mentally can include grief counseling, meditation |
| **Q:** What are the major health problems in our community? | • Access to mental health programs<br>• Hypertension<br>• Diabetes<br>• High cholesterol<br>• COPD<br>• Asthma (seeing more in kids due to environmental factors)<br>• Heart disease<br>• Stroke<br>• Weight management<br>• Substance abuse<br>• Obesity<br>• HIV<br>• STDs<br>• Low literacy levels affect the ability to best patient education and follow up<br>• More students are overweight (RCBOE nurse)<br>• More students are having seizures due to parents not being educated to address signs or issues earlier<br>• COVID & effects: mental health issues, stress on parents and households, delayed care<br>• Addiction, substance abuse<br>• Domestic violence<br>• Lack of oral/dental health leads to decline in quality of life including speech and self-confidence. |
| **Q:** What are the causes of these problems? Also: What keeps people from being healthy? | • Income<br>• Education<br>• Complexity of system<br>• Mental health issues<br>• Transportation<br>• Health literacy<br>• Shortage of healthcare providers<br>• Train lay people (non-clinical) to bridge the gap and relay information so the patient can understand.<br>• Trauma is often the cause of mental illness<br>• Lack of mental health resources<br>• Need more mental health beds<br>• Healthcare workers don't take time with the patient to educate them on their condition |

| | |
|---|---|
| | • Mental health stigma keeps people from seeking help<br>• Diet due to living in a food desert<br>• No availability of fresh fruits and vegetables<br>• Lack of transportation to get healthier food<br>• Local planning & development<br>• Lack of knowledge of resources<br>• Non-compliance w/meds and follow up |
| **Q:** What can be done/is being done to solve these problems? | • United Way can provide Lyft rides to doctors' offices and clinics<br>• The community needs to work together more to collaborate and maximize our resources and capabilities<br>• RCBOE: Success Center wrap around services, meal packets, telehealth for mental health, social workers and crisis intervention.<br>• Holistic counseling<br>• Collaborate/involve law enforcement in community discussions<br>• Health education & outreach by city/municipalities<br>• Know partners in the community<br>• Cross organization collaboration<br>• Local fresh markets & food education<br>• Directory of local resources<br>• Health education to parents<br>• Healthcare model transformation |

# Methodology

Our process included studying assessments conducted by peer hospitals as well as processes used for our previous CHNAs. We made every effort to adhere to the final IRS rules regarding community health need assessments. We formed an internal team comprised of staff from Corporate Communications, Community Relations and Systems Engineering to conduct the assessment.

Our first step was to define our community using data from our medical record system. We examined the counties from which our ER patients live. Having defined our community, we sought to understand their health needs by collecting information from public health data and community leaders.

With public health data, we sought to answer several questions. First, which issues are affecting the highest number of people in our community and in the most significant ways? Second, how does each county in our community compare to others in our community, and to the general population of Georgia, South Carolina, and the United States? Third, is the incidence rate of the health problem, symptom, or factor increasing? And finally, do minority groups experience higher incidence rates or more severe outcomes than the general population?

We also sought the feedback of community leaders, inviting them to a listening session in which a moderator posed several questions about their communities' health problems and causes. We have described the format of the listening sessions, the leaders, and the feedback they provided, both regarding the community's current needs and regarding our 2019 CHNA and ISG. Equipped with these sources of

information, our steering committee prioritized the health needs of our community using a nominal group method.

# Approval

Hospital leadership then reviewed the CHNA and provided input. We incorporated their input into the final CHNA report, which is this report. We then presented our findings and recommended priorities to the hospital board of directors. Once we established our priorities, we presented the CHNA to the board of directors for approval on October 27, 2022.

### Piedmont Augusta Board of Directors

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- Eugene F. McManus, Vice Chairman*
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*Hospital Authority Member

### Richmond County Hospital Authority

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- Brandon Garrett (County Commission)
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- Rabbi David Sirull
- Edward Tarver+
- Anne D. Trotter
- Atoya Jones, Recording Secretary

+Board of Directors Trustee

**Next steps**

Upon approval of the CHNA and Implementation Strategy, the Piedmont Healthcare Community Benefits team will work with hospital leadership to follow through on the strategies to address the identified priorities. This plan includes both internal and external strategies to positively impact our communities and boost the health of all, with a special focus on those most vulnerable due to income, race, insurance status, age and geography. This plan will be board approved and will serve as our blueprint for community benefit activities over the next three years.

# Appendices

**Appendix one: Federal Poverty Levels**

Data on the poverty threshold is created by the US Census Bureau, which uses pre-tax income as a yardstick to measure poverty. The statistical report on the poverty threshold is then used by the HHS to determine the federal poverty level (FPL). Below are the rates for 2022.

| Family size | 100% | 150% | 200% | 300% | 400% |
|---|---|---|---|---|---|
| 1 | $13,590 | $20,385 | $27,180 | $40,770 | $54,360 |
| 2 | $18,310 | $27,465 | $36,620 | $54,930 | $73,240 |
| 3 | $23,030 | $34,545 | $46,060 | $69,090 | $92,120 |
| 4 | $27,750 | $41,625 | $55,500 | $83,250 | $111,000 |
| 5 | $32,470 | $48,705 | $64,940 | $97,410 | $129,880 |
| 6 | $37,190 | $55,785 | $74,380 | $111,570 | $148,760 |
| 7 | $41,910 | $62,865 | $83,820 | $125,730 | $167,640 |
| 8 | $46,630 | $69,945 | $93,260 | $139,890 | $186,520 |

**Appendix two: Stakeholders interviewed**

In May 2022, we conducted a community listening session and heard from 8 community members from Richmond, Columbia, and Aiken counties to better understand their perspectives on community health through the lens of their role within the community. These stakeholders were: Isiah Lineberry (Harrisburg Family Clinic), Dr. Ebony Whisenant (Harrisburg Family Clinic), Tina Wisniewski (Richmond County School System), Hannah Meagher (Safe Homes), Angela Collins (United Way of CSRA), Lakesha Armstrong (I Am My Brother's Keeper), Ceretta Smith (City of Grovetown), Amy Hane (Long Term Liaisons), Dee Dee Poccia, RN (Piedmont Augusta Rape Crisis and Sexual Assault Services).

**Appendix three: Sources for data**

We utilized numerous data sources throughout the CHNA process. Due to the high volume in this report, we did not individually cite each statistic. That said, we provide a list of all data sources below. Please contact the Piedmont Healthcare community benefit department at communityprograms@piedmont.org for questions on specific data points.

| Category | Data Source |
|---|---|
| Demographics | US Census Bureau, Decennial Census, 2020. |
| Demographics | US Census Bureau, American Community Survey, 2015-19. |
| Demographics | University of Wisconsin Net Migration Patterns for US Counties, 2010-20. |
| Income and Economics | US Census Bureau, American Community Survey, 2015-19. |
| Income and Economics | US Census Bureau, Business Dynamics Statistics, 2018-19. |
| Income and Economics | US Department of Commerce, US Bureau of Economic Analysis, 2019. |
| Income and Economics | US Department of Commerce, US Bureau of Economic Analysis, 2019. |
| Income and Economics | US Department of Labor, Bureau of Labor Statistics, Jan. 2022. |
| Income and Economics | IRS - Statistics of Income, 2018. |

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|---|---|
| Income and Economics | US Census Bureau, American Community Survey, 2015-19. |
| Income and Economics | US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11. |
| Income and Economics | US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017. |
| Income and Economics | US Department of Commerce, US Bureau of Economic Analysis, 2016. |
| Income and Economics | National Center for Education Statistics, NCES - Common Core of Data, 2020-21. |
| Income and Economics | US Census Bureau, Small Area Income and Poverty Estimates, 2020. |
| Education | US Department of Health & Human Services, HRSA - Administration for Children and Families, 2019. |
| Education | US Census Bureau, American Community Survey, 2015-19. |
| Education | National Center for Education Statistics, NCES - Common Core of Data, 2020-21. |
| Education | US Department of Education, EDFacts, 2018-19. |
| Education | US Census Bureau, American Community Survey, 2014-18. |
| Education | U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18. |
| Housing and Families | US Census Bureau, American Community Survey, 2015-19. |
| Housing and Families | US Department of Housing and Urban Development, 2019. |
| Housing and Families | US Department of Housing and Urban Development, US Census Bureau, American Community Survey, 2019. |
| Housing and Families | Eviction Lab, 2016. |
| Housing and Families | US Census Bureau, American Community Survey, 2011-15. |
| Housing and Families | Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014. |
| Housing and Families | US Census Bureau, Decennial Census, US Census Bureau, American Community Survey, 2015-19. |
| Housing and Families | US Department of Housing and Urban Development, 2014. |
| Housing and Families | US Census Bureau, Census Population Estimates, 2019. |
| Housing and Families | US Department of Housing and Urban Development, 2020-Q4. |
| Other Social & Economic Factors | University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2021. |
| Other Social & Economic Factors | Feeding America, 2017. |
| Other Social & Economic Factors | US Department of Education, EDFacts, 2019-20. |
| Other Social & Economic Factors | US Census Bureau, American Community Survey, 2015-19. |

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|---|---|
| Other Social & Economic Factors | Opportunity Insights, 2018. |
| Other Social & Economic Factors | US Census Bureau, American Community Survey, 2015-2019. |
| Other Social & Economic Factors | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2020. |
| Other Social & Economic Factors | US Census Bureau, Small Area Health Insurance Estimates, 2019. |
| Other Social & Economic Factors | Opportunity Nation, 2018. |
| Other Social & Economic Factors | US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020. |
| Other Social & Economic Factors | US Census Bureau, Small Area Income and Poverty Estimates, 2019. |
| Other Social & Economic Factors | Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014. |
| Other Social & Economic Factors | Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2018. |
| Other Social & Economic Factors | Debt in America, The Urban Institute, 2021. |
| Other Social & Economic Factors | Centers for Disease Control and Prevention, National Vital Statistics System, 2013-19. |
| Other Social & Economic Factors | Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016. |
| Other Social & Economic Factors | Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016. |
| Other Social & Economic Factors | Townhall.com Election Results, 2016. |
| Physical Environment | US Environmental Protection Agency, 2018-19. |
| Physical Environment | Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015. |
| Physical Environment | Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2016. |
| Physical Environment | EPA - National Air Toxics Assessment, 2014. |
| Physical Environment | US Environmental Protection Agency, 2019. |
| Physical Environment | US Census Bureau, County Business Patterns, 2019. |
| Physical Environment | National Broadband Map, Dec 2020. |
| Physical Environment | US Census Bureau, American Community Survey, 2015-19. |
| Physical Environment | US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-20. |
| Physical Environment | Climate Impact Lab, 2018. |

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|---|---|
| Physical Environment | Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016. |
| Physical Environment | Federal Emergency Management Agency, National Flood Hazard Layer, 2019. |
| Physical Environment | Center for Disease Control and Prevention, CDC National Environmental Public Health Tracking, 2017-19. |
| Physical Environment | Federal Emergency Management Agency, National Risk Index, 2020. |
| Physical Environment | US Census Bureau, Decennial Census, ESRI Map Gallery, 2013. |
| Physical Environment | US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019. |
| Physical Environment | US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017. |
| Physical Environment | Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011. |
| Physical Environment | US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2021. |
| Physical Environment | US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012. |
| Physical Environment | US Fish and Wildlife Service, Environmental Conservation Online System, 2019. |
| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019. |
| Clinical Care and Prevention | Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018. |
| Clinical Care and Prevention | Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019. |
| Clinical Care and Prevention | Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2016-18. |
| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020. |
| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2020. |
| Clinical Care and Prevention | Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019. |
| Clinical Care and Prevention | Centers for Disease Control and Prevention, CDC - FluVaxView, 2019-20. |
| Clinical Care and Prevention | Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019 |

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| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2015-18. |
| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2018-19. |
| Clinical Care and Prevention | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2015-16. |
| Health Behaviors | University of Wisconsin Population Health Institute, County Health Rankings, 2018. |
| Health Behaviors | Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018. |
| Health Behaviors | Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019. |
| Health Behaviors | Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018. |
| Health Behaviors | Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018. |
| Health Behaviors | US Census Bureau, American Community Survey, 2015-19. |
| Health Outcomes | Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2018. |
| Health Outcomes | State Cancer Profiles, 2014-18. |
| Health Outcomes | State Cancer Profiles, 2014-18. |
| Health Outcomes | Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019. |
| Health Outcomes | Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019. |
| Health Outcomes | Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018. |
| Health Outcomes | Centers for Medicare and Medicaid Services, 2018. |
| Health Outcomes | Centers for Disease Control and Prevention, National Vital Statistics System, 2016-20. |
| Health Outcomes | University of Wisconsin Population Health Institute, County Health Rankings, 2013-19. |
| Health Outcomes | Institute for Health Metrics and Evaluation, 2017. |
| Health Outcomes | Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15. |

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|---|---|
| Health Outcomes | US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-19. |
| Health Outcomes | University of Wisconsin Population Health Institute, County Health Rankings, 2017-19 |
| Health Outcomes | Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018. |
| Health Outcomes | Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019. |
| Healthcare Workforce | Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021. |
| Healthcare Workforce | US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Feb. 2022. |
| Healthcare Workforce | US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2015. |
| Healthcare Workforce | Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021. |
| Healthcare Workforce | Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2020. |
| Healthcare Workforce | US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2017. |
| Healthcare Workforce | US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, Sept. 2020. |
| Healthcare Workforce | US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019. |
| Healthcare Workforce | US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021. |
| COVID-19 | Johns Hopkins University, 2022. |
| COVID-19 | Google Mobility Reports, Feb. 01, 2022. |
| COVID-19 | Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022 |

**Appendix four: Employee survey**

In August 2022, the hospital surveyed its employees regarding their opinions on challenges within our communities, and suggestions on how the hospital can improve its community's health. The survey is shown here.

1. What type of role do you have?
   - Administrative
   - Clerical
   - Environmental Services
   - Food Services
   - Programmatic
   - Other: Please describe
2. Are you an employee or are you a contract employee?
3. What is your home zip code?
4. How do you define the community you serve in your role?
   - From wherever our patients come
   - All of Georgia
   - The hospital's county
   - Other: Please describe
5. In the following list, what do you think are the five most important factors for a healthy community? We consider this to be those factors which most improve the quality of life in a community.
   - Access to health care (e.g., family doctor
   - Access to healthy food
   - Arts and cultural events
   - Civic participation
   - Clean environment
   - Ethnic and cultural diversity
   - Financial assistance for health care at the hospital
   - Healthy behaviors and lifestyles
   - High retirement rates
   - Emergency preparedness
   - Good place to raise children
   - Low adult death and disease rate
   - Low crime/safe neighborhoods
   - Low infant deaths
   - Low level of child abuse
   - Parks and recreation
   - Low- and no-cost options for health care within the community
   - Quality of care
   - Quality of housing or housing availability
   - Religious or spiritual values
   - Social cohesion
   - Strong family life
   - Strong school district
   - Transportation and walkability
   - Other: Please describe

6. In the following list, what do you think are the five most important health problems in our community? Please check five:
   - Aging problems (e.g., arthritis, hearing/vision loss, etc.)
   - Cancers
   - Child abuse / neglect
   - COVID-19
   - Dental problems
   - Diabetes
   - Domestic violence
   - Firearm-related injuries
   - Heart disease and stroke
   - High blood pressure
   - HIV/AIDS
   - Homicide
   - Infant death
   - Infectious diseases
   - Mental health problems
   - Motor vehicle crash injuries
   - Poverty
   - Rape/sexual assault
   - Respiratory/lung disease
   - Sexually transmitted diseases (STDs)
   - Social isolation
   - Suicide
   - Teenage pregnancy
   - Terrorist activities
   - Health illiteracy
   - Built environment
   - Housing insecurity
   - Neighborhood environmental risk (e.g., pollution, high lead exposure)
   - Other: Please describe

7. How would you rate the overall health of our community?
   - Very unhealthy (most have three or more chronic conditions such as heart disease or diabetes)
   - Unhealthy (most have one or two chronic conditions such as heart disease or diabetes)
   - Somewhat unhealthy
   - Healthy
   - Very healthy (most have no chronic conditions such as heart disease or diabetes)

8. What issues do you think may prevent community members from accessing care?
   - No insurance
   - Unable to pay co-pays and deductibles
   - Language barriers
   - Lack of access to transportation
   - Unable to use technology to find doctors, schedule appointments, manage online care
   - Fear (e.g., not ready to face or discuss health problem)
   - Don’t understand the need to see a doctor
   - Don’t know how to find doctors
   - Cultural/religious beliefs
   - Lack of availability of doctors

9. Of the following, what do you think are the top five things most important in improving the health of community members living in our communities?
    - Access to local inpatient mental health services
    - Access to local outpatient mental health services
    - Access to low-cost mental health services
    - Access to health care service
    - Access to dental care services
    - Additional access points to affordable care within the community
    - Cancer awareness and prevention
    - Community-based health education
    - Community-based programs for health
    - Curbing tobacco use, such as banning indoor smoking
    - Expanded access to specialty physicians
    - Financial assistance for those who qualify
    - Free or affordable health screenings
    - Increased social services
    - More options for paying for care
    - Opioid awareness and prevention campaigns
    - Partnerships with local charitable clinics
    - Programs that address issues of housing
    - Programs that address food insecurity
    - Safe places to walk and play  Substance abuse rehabilitation services Other: Please describe

10. What is your vision for a healthy community?

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

12. What are one or two things we can do better to serve our patients/our community?

13. Do have questions about this survey or community health in general?