FY22

PIEDMONT MOUNTAINSIDE HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT

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Introduction

As a not-for-profit healthcare system, the mission of Piedmont Mountainside is healthcare marked by compassion and sustainable excellence in a progressive environment, guided by physicians, delivered by exceptional professionals, and inspired by the communities we serve.

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 Mountainside is a not-for-profit, acute-care community hospital located in the foothills of the North Georgia Mountains. The hospital provides an integrated range of services including cardiac rehabilitation and imaging, cardiac catheterization, orthopedic services and general surgery. Additionally, Piedmont Mountainside offers access to intensive care and 24-hour emergency services.

Piedmont Mountainside's free-standing emergency department in Ellijay, Georgia, operates as an extension of the emergency department, providing 24-hour access to emergency physicians, nurses, labs and radiology technicians. Patients can receive similar services to a hospital-based emergency department, like moderate-complexity blood testing and advanced imaging and care for most emergency illnesses such as heart attack, stroke and minor trauma.

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 career and community benefit programming to the communities we serve over the past five years.

Community benefit

Piedmont Mountainside 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 Mountainside provided $22.5 million in community benefit. Specifically, Piedmont Mountainside provided:

	FY20	FY21
Care for low-income and other vulnerable patients	$10,188,726	$7,027,069
Community health promotion	$161,822	$116,002
Health professions education	$518,714	$484,820
Bad debt	$1,680,744	$2,296,366

Key programs include community-focused health education, health professions education within the hospital, COVID-19 vaccination clinics, and, importantly, financial assistance for low-income patients who can't afford their health care, and care for those covered through the low-income state/federal public insurance program Medicaid.

Additionally, the health system provides two programs free of charge to patients, regardless of where they receive their care. The Sixty Plus Services provides educational and supportive programs designed to enhance the well-being of older adults and their families, including geriatric support, dementia support, insurance guidance, the Aging Helpline, and community education and wellness. Piedmont's Cancer Wellness provides free programs such as yoga, cooking demos, expressive art classes, and counseling 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 Healthcare provides financial assistance to qualifying low-income patients at or below 300 percent of the Federal Poverty Level (FPL). 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 ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years.

ZIP code	No. of patients - FY20	No. of visits - FY20	No. of patients - FY21	No. of visits - FY21
30540	2,394	4,094	2,232	3,738
30143	1,777	3,025	1,388	2,413
30536	704	1,178	605	1,018
30175	743	1,284	487	757
30107	450	700	301	465
30513	255	396	241	365
30114	258	355	181	226
30139	150	235	129	193
30539	105	196	105	188
30734	121	223	98	152

Please note we provided financial assistance to patients 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.

Medicaid

Piedmont 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 ten ZIP codes by volume of patients receiving care at the hospital as a Medicaid beneficiary during the last two fiscal years.

ZIP code	No. of patients - FY20	No. of visits - FY20	No. of patients - FY21	No. of visits - FY20
30143	8,199	18,849	8,123	18,497
30540	7,928	18,588	7,837	18,728
30536	2,800	6,647	2,865	6,693
30175	2,426	5,421	2,312	5,157
30114	1,601	2,798	1,811	3,155
30107	1,565	3,125	1,511	3,052
30513	1,314	2,551	1,397	2,791
30115	1,065	1,796	1,180	1,921
30188	493	698	577	899
30183	408	878	488	932

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.

FY22 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 access to affordable and appropriate health and dental care

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

Promote healthy behaviors to reduce preventable instances of chronic conditions

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

Promote mental well-being

We will work with the community to decrease substance abuse and addiction, as well as promote mental wellbeing for all community members, with a particular focus on children and youth.

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.

Additionally, whenever possible, health education will be available in the languages found within the community, with special attention spent on outreach to those populations. When possible, we will work to address other issues that arose during the CHNA, such as Alzheimer's Disease, even though those are not listed in the above priority list. Additionally, when possible, we will weigh in on issues of growth and traffic, though those are outside the realm of us being able to directly impact those issues.

Progress since last CHNA

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

- Increase access to appropriate and affordable health and mental care for all community members
- Reduce opioid, substance and nicotine abuse and overdose deaths

n FY20 and FY21, through the guidance of our Implementation Strategy, the hospital addressed these issues in the following ways. To start, in FY20, the hospital continued its community benefit grants program, which offered grant opportunities to local nonprofit organizations providing specific health-related services and programs that address the unmet health needs identified in its FY19 CHNA and implementation strategy. The hospital provided $50,000 in grants funding for five organizations: Gilmer County EMS (opioid-related work), Good Samaritan Clinic, Highland Rivers, Pickens County Council on Child Abuse, and the Pickens County Sheriff's Department.

Additionally, Piedmont Mountainside Hospital financially supported its local Federally Qualified Health System Good Samaritan Health and Wellness Clinic and the Pickens County Sheriff's Department with one-time donations to support two programs. One is JumpStart, an eight-week community health initiative and wellness program designed to improve cardiovascular health-and more specifically, reducing blood pressure, which is offered free of charge to the public, and the program combines exercise, nutrition, and clinical education in a weekly two-hour class format. In addition to the financial support, PMH has a leadership member who participates on the Good Samaritan Board of Directors and additional leaders provide support by volunteering at the clinic.

The hospital created a managed care program for low-income patients that utilizes a licensed medical social worker to work with high-risk, low-income income patients who have presented at the emergency department with the condition that will need ongoing care. The hospital staffed an LMSW in the emergency department, who evaluated high-risk and low-income patients' need for services, assisted patients with referrals to community resources, and was available for post-discharge from the emergency department. The hospital continued to work with Good Samaritan Health and Wellness, a local Federally Qualified Health Center that provides vital health services to low-income community members.

The hospital also partnered with Pickens County Sheriff's Department with its "Project Lifesaver" program. The program helps to locate individuals with cognitive disorders such as Alzheimer's, dementia, autism, and other special needs groups who are prone to the life-threatening behavior of wandering.

Progress since last CHNA, cont'd

The hospital worked to reduce opioid, nicotine, and related substance abuse and overdose deaths by providing meaningful leadership in its community and partnering with others to combat opioid abuse. The hospital created and deployed a PSA campaign on e-cigarette use among teens and adults. The hospital distributed and displayed the campaign via community partners throughout the hospital and community. The hospital actively supported messaging and efforts of Pickens County Sheriff's Department to address illegal e-vaping among underage teens. The hospital also convened a local task force comprised of community stakeholders, the school system, law enforcement, and parents to develop effective strategies to reduce e-cigarette use.

As part of a Piedmont Healthcare systemwide effort, Piedmont Mountainside was an active participant in anti-opioid work, which included: active participation on the systemwide task force, tracking opioid prescriptions within the hospital and by providers, utilizing Epic EMR tools to monitor opioid use, offering patients and the community ways to safely dispose of unused medication, and providing ongoing education on opioid prescribing. The advent of COVID-19 precluded local take-back day activities, in which the hospital usually partnered with local law enforcement to host an event in which residents were encouraged to bring in any unused prescriptions for safe disposal.

At the beginning of the COVID pandemic, hospital leadership recognized the lack of effective communication between key stakeholders in the communities it serves. Hospital staff initiated virtual meetings that included hospital leadership, state, county, and city government officials, Georgia Department of Public Health representatives, law enforcement officials, county school board officials, court system officials, and community members. Calls were held daily, bi-weekly and weekly dependent on the state of the pandemic.

During the COVID-19 pandemic, the hospital worked with the Gilmer County Health Department by utilizing the Community Building to hold COVID-19 vaccine clinics for the community. The hospital also sent a team of leaders to assist Pickens County schools with conducting a risk assessment on the individual schools and the infection control processes they implemented before bringing students back to in-person education. Hospital staff members participated in community COVID-19 vaccine clinics. The hospital also started a Bamlanivimab clinic at the hospital and provided the much-needed monoclonal antibody treatment to community members close to home while eliminating the need to travel to Atlanta for treatments.

FY22

Community Health Needs Assessment

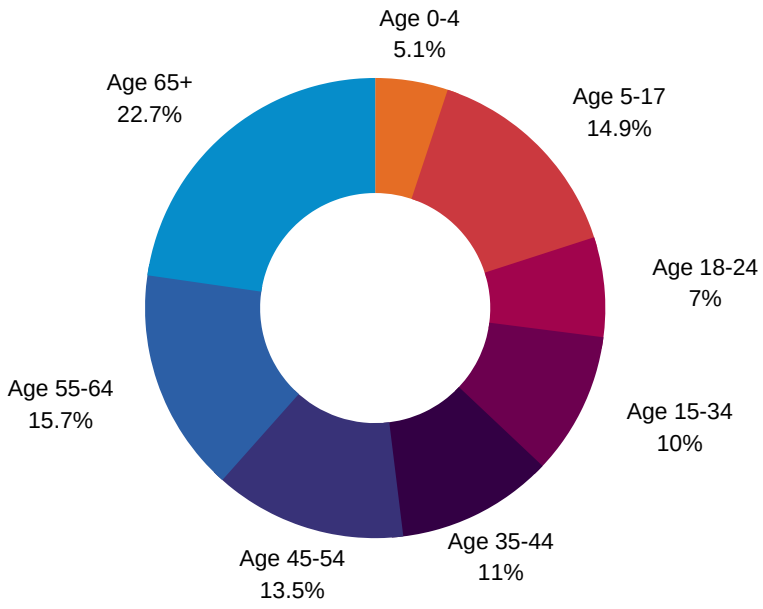
About the community

While Piedmont Mountainside serves patients from all over northeast Georgia, however, for purposes of this CHNA, we consider our community to be Pickens and Gilmer counties. We do this in recognition of the direct impact of our tax-exempt status on county residents.

In both counties, an average 61,801 people lived in the 658.27 square mile area each year between 2015 and 2019.The population density for this area, estimated at 94 persons per square mile, is much less than the state average population density of 181 people per square mile and is on par with the national average population density of 92 persons per square mile. The ZIP code with the highest population is 30534, which is Dawsonville and is home to nearly half the total population for both counties combined. The two counties are mostly rural, with 80 percent of the population living in a designated rural area. as 69 percent of community members live within an urban setting. Like in most of Georgia, these rural populations are mostly white and between the ages of 18 and 64. Both counties are growing, and saw a population jump of 12 percent between the 2010 and 2020 Census.

About 11 percent of the population were veterans in 2020, and the most common age range was between 65 and 74. Nearly 20 percent of the population - about 12,000 people - lived with a disability, and most of that population was over the age of 65.

Between 2015 to 2019, about 86 percent of Gilmer and Pickens residents were white, less than a percent were African American, less than a percent were Asian, and 7 percent were Hispanic/Latino. About 5 percent of the population were born outside of the US and 3 percent of those do not have citizenship status. Nearly 2 percent of households do not speak English at home.



The chart to the left represents a breakdown of ages within the community. Generally speaking, both counties tend to skew older in age, though younger populations are growing.

Root causes of poor health

In conducting the FY22 CHNA, we recognized two main issues that emerged that are 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. Life expectancy can vary as much as 30 years between the richest and poorest Georgia counties. Combined, Gilmer and Pickens counties have a poverty rate of 13.44 percent. This figure jumps to 34 percent when looking at 200 percent of the Federal Poverty Level (FPL), which is known as near-poverty, and still is considered to be a low enough income to require additional social service assistance. About 20,935 people lived in near poverty in 2020.

Insurance status and health outcomes

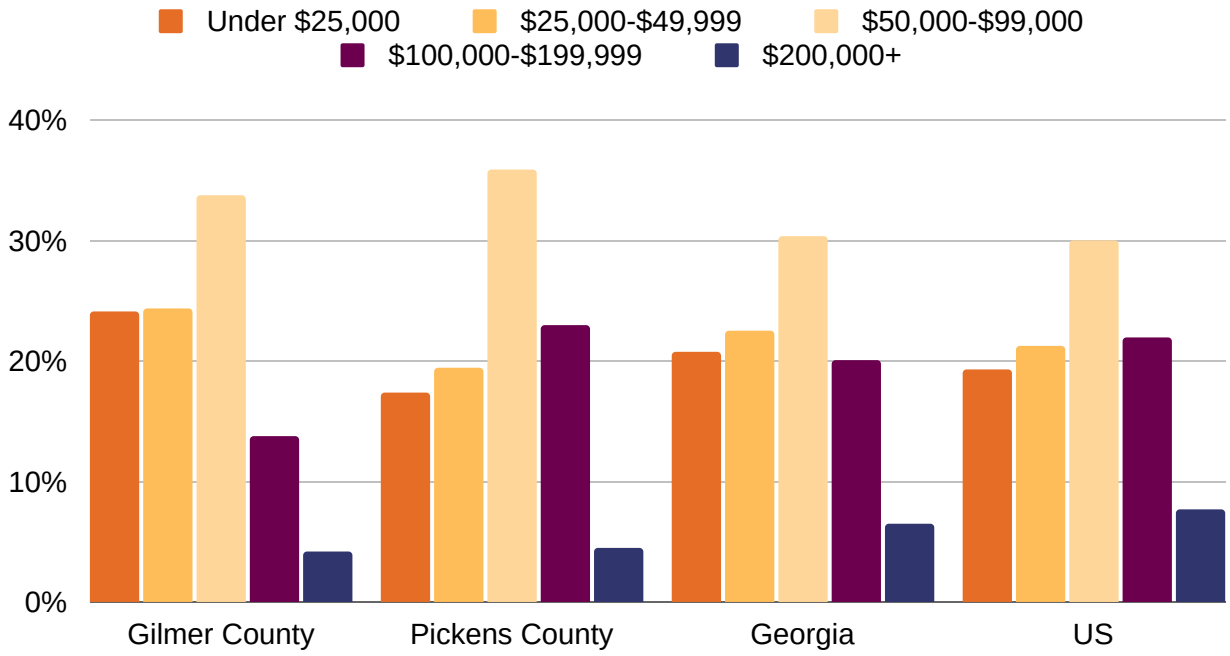
In 2020, approximately 15.21 percent -- about 9,323 community members -- had no form of insurance. Insurance status and health are inextricably linked. Being uninsured is generally a marker of low-income, as the overwhelming majority of those that are uninsured are also within certain ranges of the FPL. 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.

Throughout Georgia, adults aged 18 to 64 are most likely to be uninsured, and that's true in both Gilmer and Pickens counties. In 2020, 22 percent of non-elderly adults were uninsured, a rate higher than the state and national averages of 19 percent and 13 percent, respectively. The highest concentration of uninsured populations was in Cherry Log and Ellijay, where the percent of uninsured adults jumps to a quarter of the population.

Community and income

Between 2015 and 2019, the median household income in Gilmer County was $52,625 and the median household income in Pickens County was $67,631. The chart below is a breakdown of median household incomes, as compared to state and national averages.



Of employers in the community, the largest sector by employment size in 2019 was retail trade, which employed 3,168 community members at an average wage of $27,792, according to the US Department of Commerce. Manufacturing was the second largest sector, with 2,507 people employed at an average wage of $50,792. Construction was the third largest sector, with 2,442 people employed at an average wage of $16,167.

Unemployment and labor force participation

According to the US Department of Labor, in February 2022, 28,426 people in the community were part of the labor force, and only 821 -- about 2.9 percent -- were unemployed. This figure has steadily decreased since last year, when in January 2021, 3.2 percent of the labor force was unemployed. When looking back further, the rate is nearly three time less than the unemployment rate in 2012.

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

Pickens and Gilmer counties are relatively safe communities, with lower-than-average crime rates, except when looking at violent crime. Below is a chart breaking down offenses in 2017, as reported to the Georgia Bureau of Investigation. This is the last year for which this information is publicly available.

	Murder	Rape	Robbery	Assault	Burglary	Larceny	Vehicle Theft
Gilmer	1	0	0	2	100	51	3
Pickens	0	8	4	67	103	508	46

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, 1.4 percent of Pickens and Gilmer residents were incarcerated, which is lower than the state average of 2.1 percent. Pickens incarceration rate was twice that of Gilmer: 2 percent versus 0.9 percent.

Incarceration impacts more than just the person in jail or prison. Children whose parents are involved in the criminal justice system, in particular, face a host of challenges and difficulties: psychological strain, antisocial behavior, suspension or expulsion from school, economic hardship, and their own criminal activity. Additionally, incarceration can lead to poverty, if the family is not already there. A recent study found that, nationally, a family's income was 22 percent lower during the incarceration period and 15 percent lower after the parent's re-entry.

Violent crime

Violent crime is a critical public health issue as it is often largely preventable. Between 2015 and 2019, there were a total 459 violent crimes in both counties, a figure that includes homicide, rape, robbery, domestic violence, and aggravated assault. This equates to a violent crime annual rate of 251.8 per every 100,000 people, a figure much lower than the state and national rates of 373.1 and 416, respectively.

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 18 firearm fatalities in Pickens County and 26 in Gilmer County, and all of these were suicide.

Vulnerability and Deprivation indexes

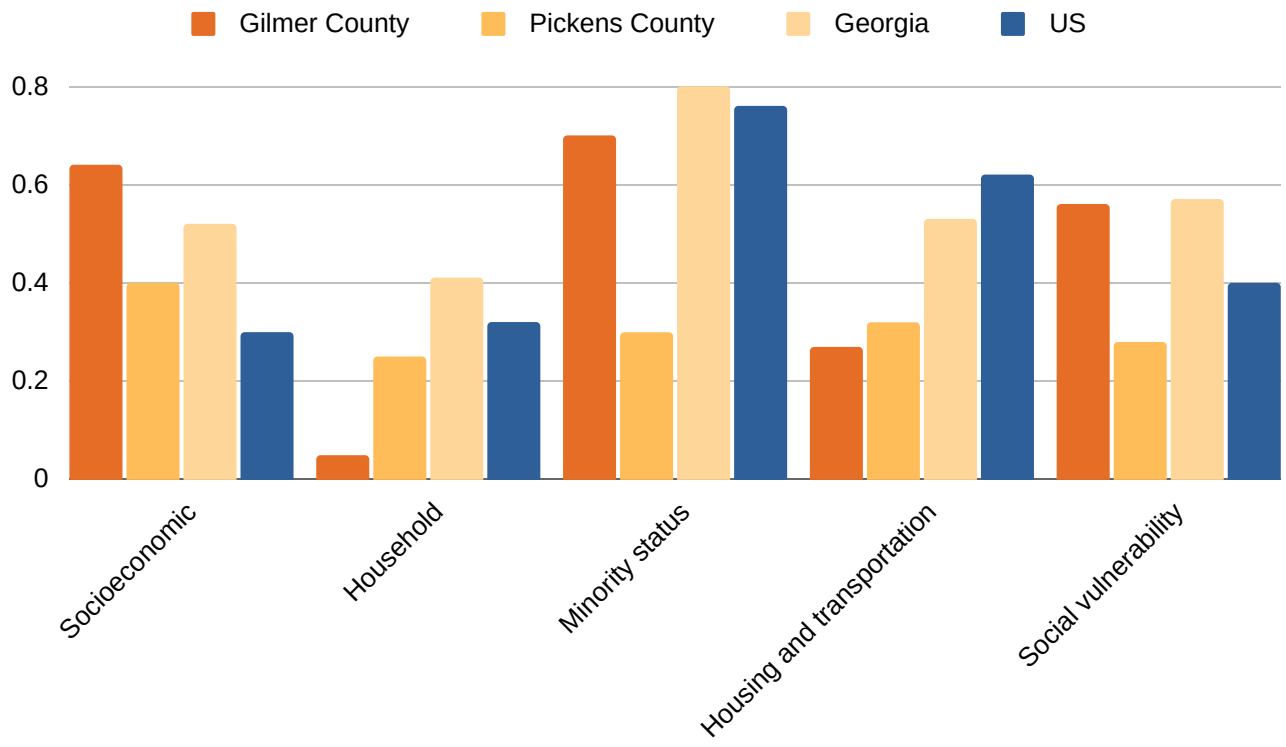
Area Deprivation Index

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). Gilmer County ranks in the 48th percentile for Georgia and 58th in the national percentile. Pickens County ranks in the 38th percentile for Georgia and 48th in the national percentile, placing it somewhat better than Gilmer.

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.

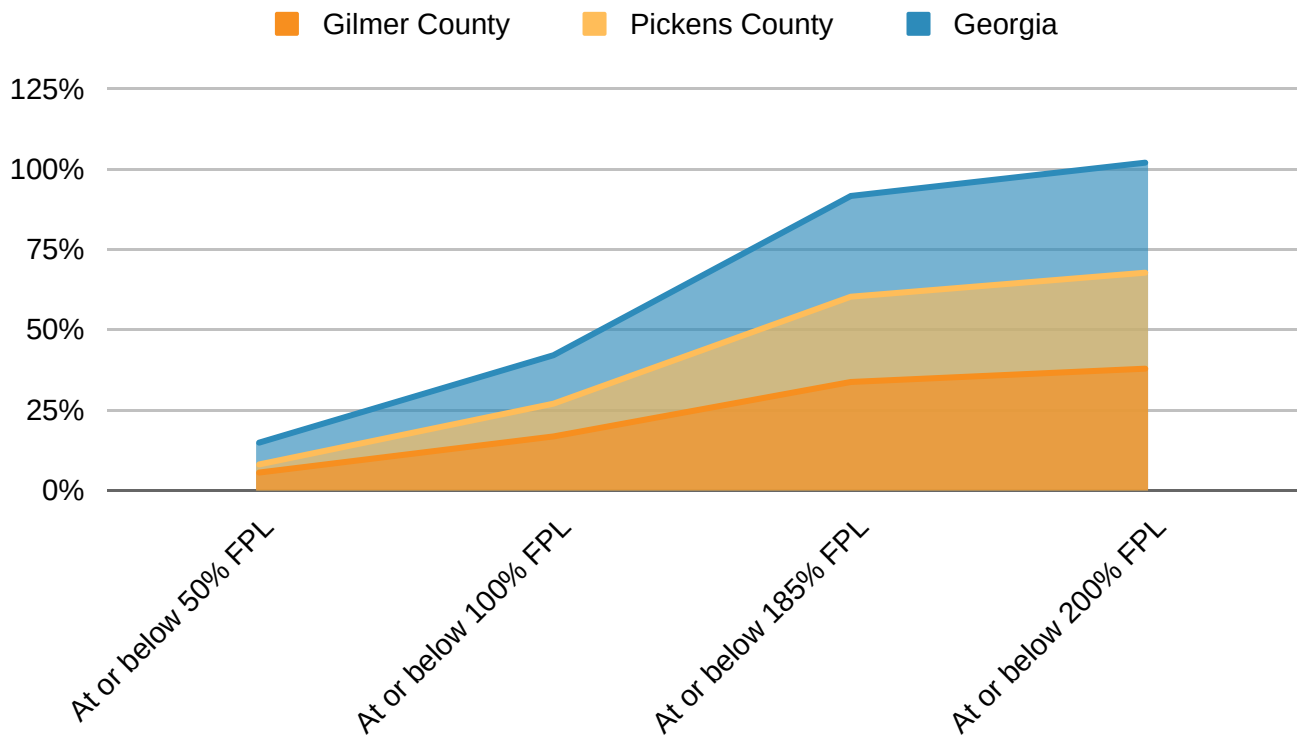
The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods, where a **higher score indicates higher vulnerability**. Combined, the two counties have a social vulnerability index score of 0.42, which is better than the state score of 0.57. Broken down by county and 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.

The chart below demonstrates how many community members live in poverty or near-poverty. In 2020, 13.44 percent of the two counties' population lived at or below 100 percent of the Federal Poverty Level (FPL). In 2022, a family of four with a total household income of $27,750 or less lived at or below the FPL. As shown, Gilmer families tend to live in more poverty than those in Pickens County.



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 co-related.

In both counties combined, 111 percent of households received SNAP benefits in December 2021, representing about 2,608 households. As SNAP goes hand-in-hand with poverty, more people living in Gilmer County received SNAP benefits, as compared to Pickens. Both, though, are below the state average.

Housing

In 2020, the median rent for a house in both Gilmer and Pickens counties was $1,248, up about 9 percent over the previous three years. 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. In both counties, in 2020, basic utilities average $101 per month, and internet averaged $59. None of these costs include car payments, childcare, insurance, and other costs of living. 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

In 2020, the 23,889 total occupied households in both counties, about 5,500 -- 23 percent -- of live in cost burdened households, in which housing costs are 30 percent or more of total household income. Households in Gilmer were slightly more likely to be cost burdened than Pickens. Approximately ten percent of combined county households had costs that exceeded 50 percent of the household income, which places the household in significant financial strain.

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) one 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 both counties, nearly a quarter have one or more substandard conditions. This is better, though, than the state average of 30.1 percent.

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.

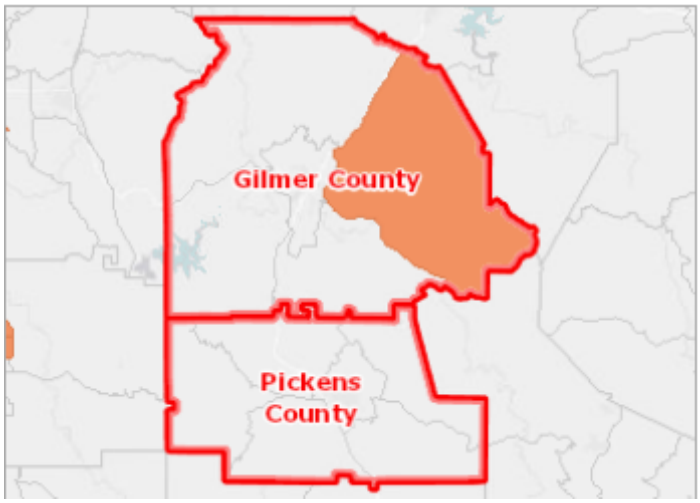
Affordability is defined by assuming that housing costs should not exceed 30 percent of total household income. Income levels are expressed as a percentage of the county's AMI. About 62 percent of homes units in Gilmer County and 59 percent of homes in Pickens County are affordable at 100 percent AMI, which means that housing is not affordable for the remaining 38 and 41 percent of the population, respectively.

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 both counties combined, in 2019, only one of the county's 11 census tracts were food deserts, as shown in the map to the right. About 4,223 people lived within this census tract, which is in Gilmer County. Within both counties, about 9.5 percent of the population were not sure they had enough food to eat at some point during 2019, a status that likely increased during COVID-19. When broken down by county, 10.6 percent of Gilmer County residents and 8.4 percent of Pickens County residents were food insecure.



Grocery stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. Combined within the two counties, there were only ten grocery stores in 2019, resulting in a rate of 17.32 stores per 100,000 population, which is relatively on par than the state rates of 17.46. 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.

Low food access

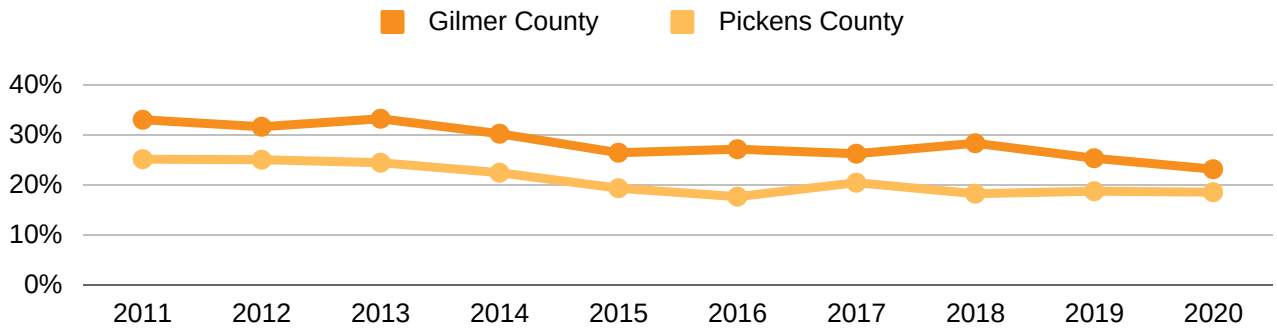
Low food access is defined as living more than 0.5 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity. According to the 2021 Food Access Research Atlas database, a combined 18 percent of both counties' population have low food access, meaning about 10,000 community members may struggle to access healthy foods. This is better than the state and national rates of 30.89 percent and 22.22 percent, respectively.

Access to care

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. 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.

In 2020, approximately 15.21 percent -- about 9,323 community members -- had no form of insurance, and 22 percent of adults aged 18 to 64 went uncovered. ZIP codes 30522 (Cherry Log), 30513 (Blue Ridge), and 30540 (Ellijay) had the highest number of uninsured adults. Collectively, these rates have declined over the last few years, as demonstrated below:



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.

	Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
Gilmer County	47.5%	18.8%	4.98%	35.47%	22.19%	4.55%
Pickens County	55.81%	20.07%	4.08%	26.98%	19.35%	2.41%

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 both counties, in 2018, 60.6 percent of adults went to the dentist in the past 12 months, which is less than both state and national averages. That year, 16 percent of combined county residents 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. While most dental services for children enrolled in the low-income public health insurance program PeachCare are covered, for adults covered by Medicaid, only emergency dental care is provided. There are 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. For example, if you have lost even one tooth, you have few, if any, options for implants that aren't at full retail cost. In Georgia, the cost to replace a single tooth can range from $3,000 to $4,500, out of pocket.

As of April 2022, dental health comprises two health professions shortage areas for low-income populations in both in Gilmer and in Pickens, as designated by the Health Resource and Service Administration (HRSA).

Primary care and routine check-ups

In 2019, in both counties combined, 78 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 jumps to 88.12 percent of adult beneficiaries, which is above both state and national averages. 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.

Both Gilmer and Pickens counties have HRSA-designated primary care health professions shortage areas, and both for low-income populations. There are about 30 primary care physicians within both counties, resulting in a primary care physician rate of 47.77, which is far below the state and national rates of 66.3 and 75.81, respectively.

Causes of death

Below are the eight leading causes of age-adjusted death, in total between 2016 and 2020. The dials indicate how severe the rate is, as compared to the rest of the state. The further to the right the dial is, the more severe that issue is within the county, as compared to Georgia overall.

Pickens County

Ischemic heart and vascular disease - 1

Trachea, bronchus and lung cancer - 2

All COPD except asthma - 3

Alzheimer's Disease - 4

Cerebrovascular disease - 5

All other mental and behavioral disorders - 6

Nephritis, nephrotic syndrome, and nephrosis - 7

Suicide - 8

Gilmer County

Ischemic heart and vascular disease - 1

All COPD except asthma - 2

Essential hypertension and hypertensive renal and heart disease - 3

Alzheimer's Disease - 4

Trachea, bronchus and lung cancer - 5

Cerebrovascular disease - 6

Suicide - 7

All other mental and behavioral disorders - 8

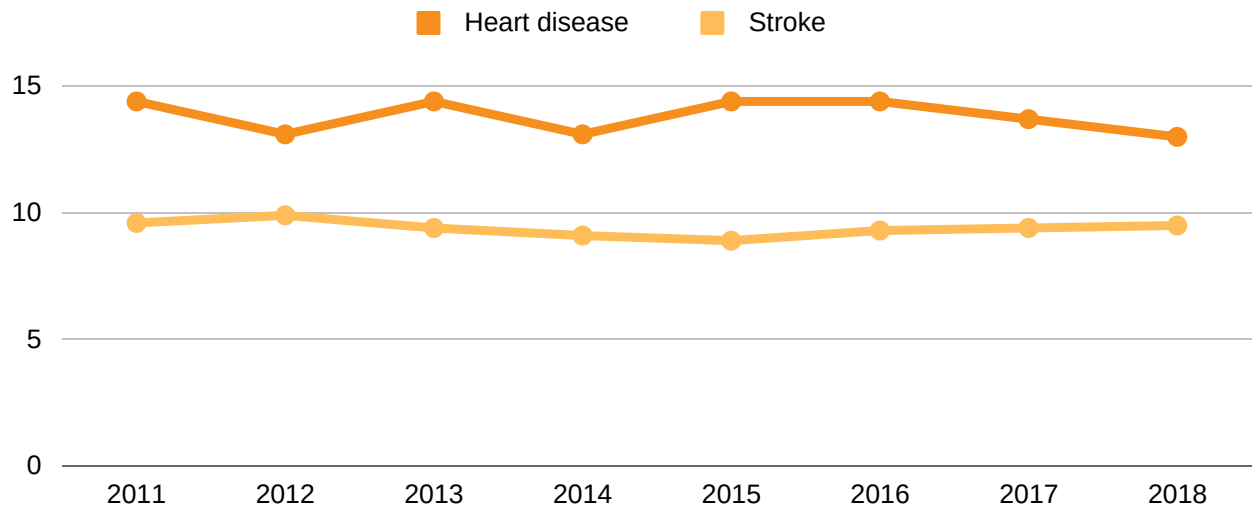
Heart disease and stroke

Heart disease is a leading cause of death for in both Gilmer and Pickens counties. In 2020, the age-adjusted rate was 190.9 deaths for every 100,000 people, which is higher than both state and national rates, which were 178 and 164.8 heart-related deaths per 100,000 people, respectively. When adjusting for gender, we see that men are far more likely to die from heart disease than women, at a rate of 228.2 male deaths per every 100,000 people, as opposed to a rate of 157.5 deaths for women.

Between 2016 and 2020, there were 177 deaths due to stroke, representing an age-adjusted death rate of 37.5 deaths per every 100,000 people, combined for both counties. Like with heart disease, men are more likely to die from stroke than women, as are minority populations.

Hospitalizations

The hospitalization rate for heart disease and stroke among Medicare recipients have generally decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 13 hospitalizations per every 1,000 Medicare beneficiaries, combined for both counties. This is higher than the state and national rates of 12.2 and 11.8, respectively. The hospitalization rate for stroke is also slightly above state and national rates, with 9.5 hospitalizations per every 1,000 Medicare beneficiaries, as compared to the state rate of 9.3 and the national rate of 8.4. The below chart shows hospital rates among Medicare beneficiaries.



Between 2015 and 2018, the average 30-day readmission rate for heart failure patients was 19.30, which is slightly better than state and national averages. The readmission rate for heart attack patients was 15.3, which is also slightly better than state and national averages. Readmission measures are estimates of the rate of unplanned readmission to an acute care hospital in the 30 days after discharge from a hospitalization due to heart failure or attack.

Cancer

Although heart disease leads in county deaths, cancer remains a critical issue within the community. Below is a chart showing cancer diagnoses, by site, between 2014 and 2018, the last year for which this data is available. New cases show the annual average of new diagnoses each year, and the rate is also averaged over those years.

Cancer Site	New Cases - Gilmer	Cancer Incidence Rate - Gilmer	New Cases - Pickens	Cancer Incidence Rate - Pickens
Breast	31	129.2	32	145
Lung and bronchus	32	63	41	83
Prostate	30	112.5	35	137.1
Colon and rectum	21	45.1	23	52
Melanoma of the skin	14	34.2	26	56.6

When comparing to state and national average, though, both counties generally fare better in terms of overall diagnosis. This means one of two things: there are either fewer incidence rates of cancer within the community or there are fewer screenings for all members of the community, therefore resulting in fewer diagnoses.

Breast screening rates have remained relatively steady over the last few years and, in 2018, the last year for which data is available, 72.3 percent of all women aged 50-74 reported having had a mammogram within the two previous years. This is below the state and national averages of 77.1 percent and 74.8 percent, respectively. Approximately 65 percent of community members had a colonoscopy at some point in their lives, and 84 percent of women aged 21 to 25 had a pap smear within the last two years.

It's important to note that screenings are less prevalent among uninsured populations and, given the high rate of uninsurance within both communities, there is a probability that those populations are missing these regular exams.

Hospitalizations and ER visits

Emergency department visits

In 2020, there were a combined 24,778 emergency visits in Gilmer and Pickens, a rate that is that is down from the year before, when the emergency departments treated approximately 32,000 patients. This is likely in part due to the impact of COVID-19 and a wariness among patients to visit a hospital. In previous years, the rate remained steady, usually around 32,000 total visits each year. Medicare beneficiaries specifically totaled 5,927 visits, resulting in a rate of 543.7 per every 1,000 beneficiaries.

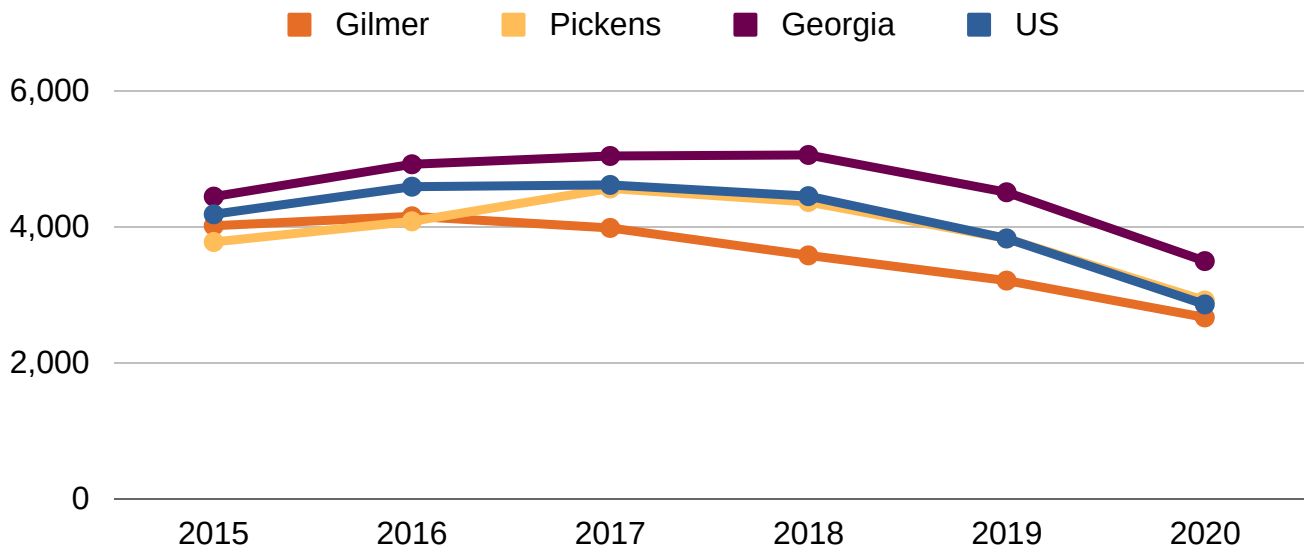
Inpatient stays

In 2020, there were 17,814 Medicare beneficiaries in both counties, and 1,447 beneficiaries, or 13.3 percent had a hospital inpatient stay. This makes the rate of stays 200 per every 1,000 beneficiaries, which is 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 17,106 Medicare beneficiaries in both counties, and the preventable hospitalization rate was 2,801 hospitalizations per every 100,000 beneficiaries, which is better than the state rate of 3,503 during the same time. This rate has steadily declined over the years.

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



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, 6,157 of adults aged 20 and older had diabetes, equaling 9.3 percent of the combined counties' population. This 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. This is an increase from the two years previous, when the rate was 8.5 percent in 2017 and 2018.

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, 3.6 percent of the combined counties' population had a diagnosis of kidney disease, a rate slightly higher than the state and national percentages of 3.22 percent and 3.1 percent, respectively.

High cholesterol

In 2019, one-third of adults 18 and older reported having high cholesterol, combined for both counties. Too much cholesterol puts you at risk for heart disease and stroke, two of the main causes of death within the community.

High blood pressure

In 2019, 38.3 percent of adults 18 and older had a diagnosis of high blood pressure, combined for both counties. 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 two counties, 72.2 percent of the total Medicare fee-for-service beneficiaries had at least two chronic conditions, and a fourth had six or more chronic conditions.

Infectious diseases

Infectious diseases are an issue in both counties, as with most communities. Most infectious diseases have only minor complications. But some infections — such as pneumonia, AIDS, and meningitis — can become life-threatening. A few types of infections have been linked to a long-term increased risk of cancer. For example, human papillomavirus is linked to cervical cancer.

One note is there has been a sharp increase nationwide in STDs during COVID, and the below data does not reflect those potential increases.

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 both counties combined, in 2018, there were 74 confirmed cases of HIV/AIDS, resulting in a rate of 136.65 cases for every 100,000 people. This is significantly lower 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 both counties combined, in 2018, there were 128 confirmed cases of chlamydia, resulting in a rate of about 205.58 infections per every 100,000 people. This is much lower than the state rate of 632.2 confirmed cases per every 100,000 people.

Gonorrhea

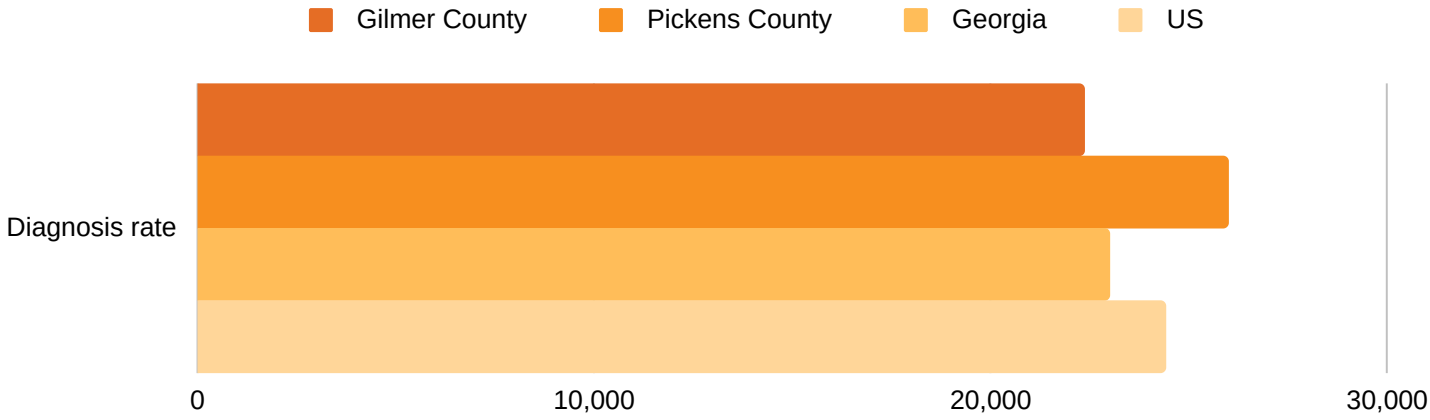
Gonorrhea is an STD that can cause infection in the genitals, rectum, and throat. It is very common, especially among young people ages 15-24 years. Untreated gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). In both counties combined, in 2018, there were 27 confirmed cases of gonorrhea, resulting in a rate of 43.4 cases for every 100,000 people. This is considerably lower than the state rate of 200.10 confirmed cases per every 100,000 people.

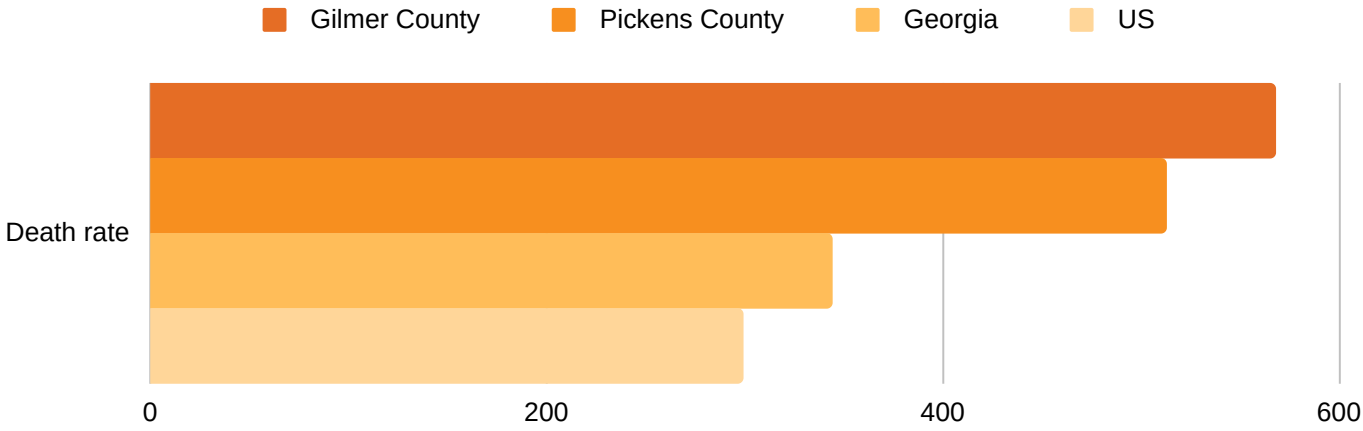
Influenza and pneumonia

Within the county, between 2016 and 2018, there were a total 63 deaths due to influenza and pneumonia, representing an age-adjusted death rate of 14.6 per every 100,000 total population, which is higher than the state and national rates of 13.6 and 13.6, respectively. In both counties, men are more likely to die from influenza or pneumonia than women.

COVID-19

Without a doubt, COVID-19 is easily one of the most impactful health events to happen within both the community and the world. As of April 27, 2022, the diagnosis rate and death rates were as follows:





Approximately 51.4 percent of the county was fully vaccinated as of April 27, 2022, with an estimated 17 percent of adults hesitant about receiving the vaccination, and the county had a COVID-19 vaccine coverage index (CVAC) of 0.58, 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 undervaccination
- 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.

Youth and young adults

There were approximately 12,312 youth under the age of 18 combined in each county in 2020, representing about 20 percent of the population. Approximately 2.7 percent of students were homeless in 2020 -- about 227 school-age kids. This problem is more prevalent in Pickens County, where 3.1 percent of students are homeless, a statistic higher than both state and national averages.

Of all children in both counties, 45 percent lived at or below 200 percent of the FPL, which was $55,500 gross household income for a family of four in 2022. The highest percentage of poor children were in the 30148 ZIP code, where all percent of children lived at or below 200 percent of the poverty line in 2020. Overall, in both communities, minority children were three times more likely to live in poverty than white children.

Additionally, 62 percent of county children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure above state and national rates of 60 percent and 50 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 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. Combined, the counties have three Head Start programs, with a rate of 8.79 per 10,000 children under 5 years old in 2020. This rate is in the middle of state and national rates, which were 6.83 and 10.53, respectively. Approximately 28 percent of all children aged 3 to 4 were enrolled in preschool in 2020, a rate much lower than state and national figures of 50.26 percent and 48.32 percent, respectively.

Teen births

In 2019, the two counties saw a combined teen birth rate of 36.6 teen births per every 1,000 females aged 15 to 19, a statistic higher than state and national rates of 24.2 and 20.9, respectively. Teen women in Gilmer were more likely to have a child and had a rate of 41.5 births per every 1,000 teen women, as compared to 32 births in Pickens County.

English and math 4th grade proficiency

In the two counties combined, 42 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 better than the state rate of 60.8 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, in both counties combined, 43 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 46.1 percent of students testing below proficient levels.

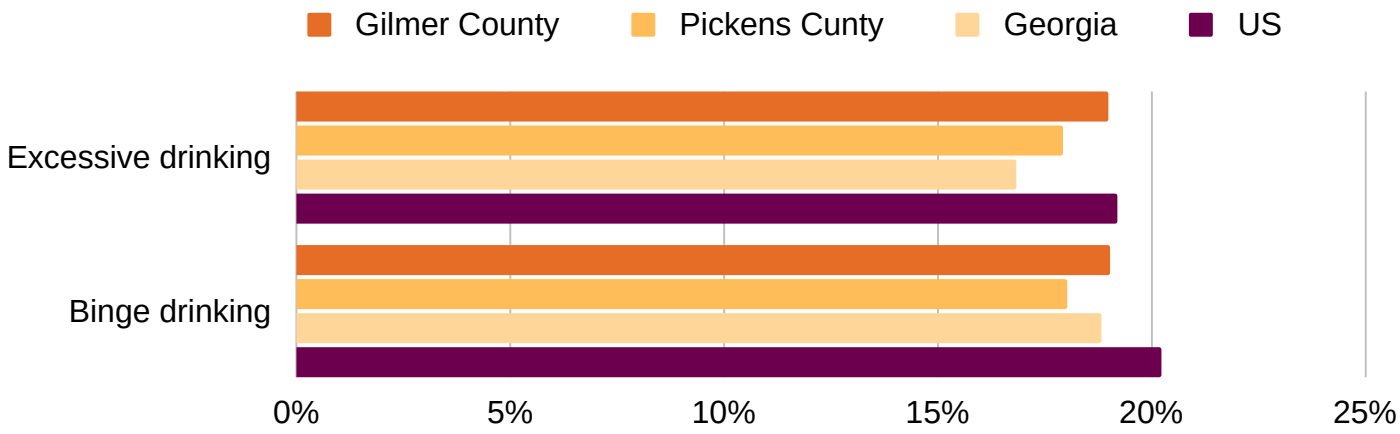
Risky behaviors

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 both counties, in 2018, an average 17 percent of adults self-reported excessive drinking in the last 30 days, which was less than the state rate of 16.81 percent. Data for this indicator were based on survey responses to the 2018 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 2018. 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

In 2019, 21 percent adults within both counties reported being a current smoker. Smoking is directly related to a myriad of health issues, the most serious of which is cancer.

Insufficient sleep

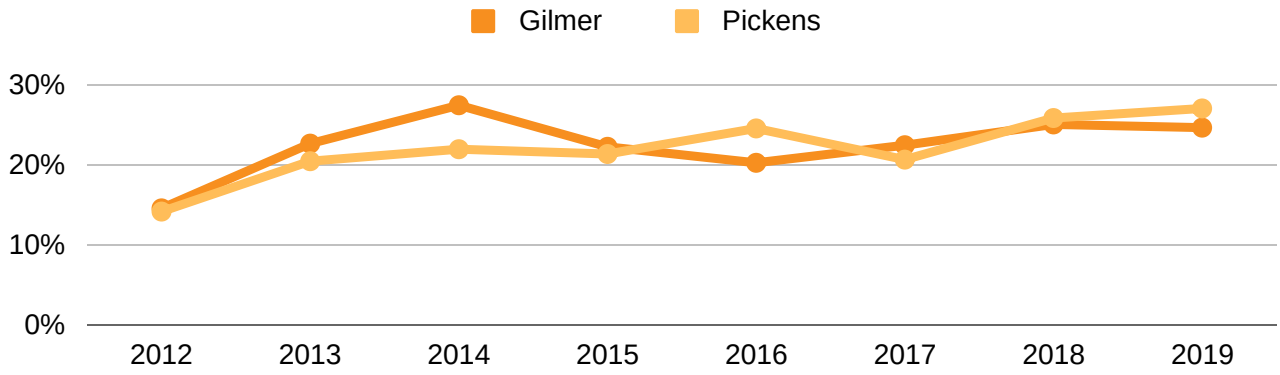
Approximately 34 percent of Gilmer and Pickens residents reported regularly sleeping less than 7 hours most nights, on average, in 2019. Sleep is an essential function that allows your body and mind to recharge, leaving you refreshed and alert when you wake up. Healthy sleep also helps the body remain 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, 26 percent of Pickens and Gilmer residents aged 20 and older were obese, meaning they had a body mass index of 30 percent or more. Obesity rates have steadily risen over the years and, ten years ago, only 14.4 percent of the population were considered obese. Obesity is directly linked to several health issues, including diabetes and heart disease.



Physical inactivity

Within the two counties in 2019, 20 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 a fifth of Pickens and Gilmer residents live within a half mile of a park. Additionally, there were only seven recreation and fitness places within the county in 2019, resulting in a rate of 12.13 facilities per every 100,000 people.

Soda expenditures

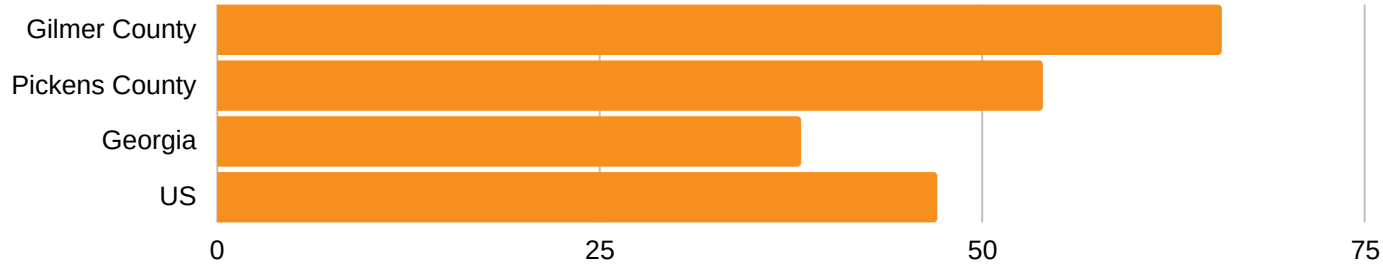
This indicator reports soft drink consumption by census tract by estimating expenditures for carbonated beverages, as a percentage of total food-at-home expenditures. Soda is directly related to obesity and poor dental health. In the two counties combined, households spent an average 4.31 percent of their food budget on sodas in 2019, which is higher than the average state and national expenditures, which were 4.18 percent and 4.02 percent, 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 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). The below chart demonstrates these rates, as occurring for every 100,000 people.

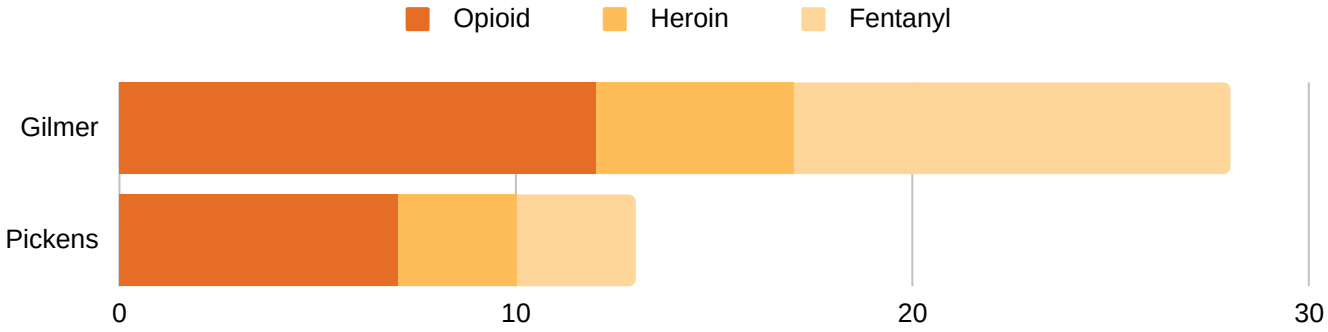


Poor mental health days

In 2018, the last year for which data is available, Pickens and Gilmer residents reported an average 4.5 poor mental health days over the last 30 days, which is higher than the state average of 4.2 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 2018, 19 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

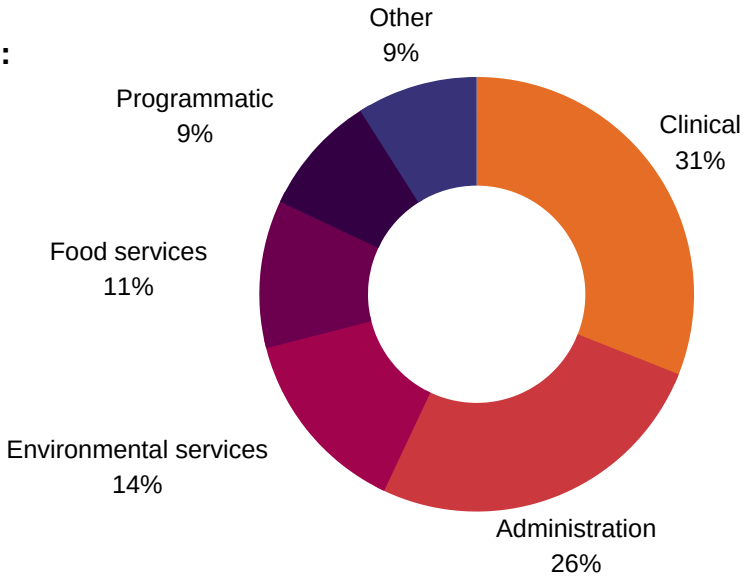
In 2020, providers in Pickens County prescribed 32.84 prescriptions per every 100 people and providers in Gilmer County prescribed 50.464 prescriptions per every 100 people. This number has somewhat declined over the last few years, likely thanks to local efforts. Deaths, though, continue to rise. The below chart is for years 2018, 2019, and 2020 combined.



Employee survey

In March 2022, we launched an online employee survey to solicit community input on key health issues. A total 1,053 system employees responded, including 61 Piedmont Mountainside employees. Below are the results of that survey. You can find all survey questions in the appendix.

The employees who responded worked in:



They worked at:

- Piedmont Athens: 13.12%
- Piedmont Atlanta: 9%
- Piedmont Cartersville: 2.98%
- Piedmont Columbus: 8.93%
- Piedmont Eastside: 4.31%
- Piedmont Fayette: 7.69%
- Piedmont Healthcare: 4.29%
- Piedmont Henry: 5%
- Piedmont Macon: 4.4%
- Piedmont Mountainside: 5.83%
- Piedmont Newnan: 7.38%
- Piedmont Newton: 3.33%
- Piedmont Physicians: 4.4%
- Piedmont Rockdale: 4.64%
- Piedmont Walton: 3.45%
- Multiple locations: 5.98%
- Other: 5.36%

Q: What do you think are the five most important factors for a healthy community? The top five answers were:

1. Access to health care
2. Access to healthy foods
3. Economic opportunity for everyone
4. Healthy behaviors and lifestyle
5. Good place to raise children

Q: What do you think are the five most important health problems in your community? The top five answers were:

1. Aging problems
2. Poverty
3. Mental health problems
4. COVID-19
5. Heart disease and stroke

Employee survey, cont'd

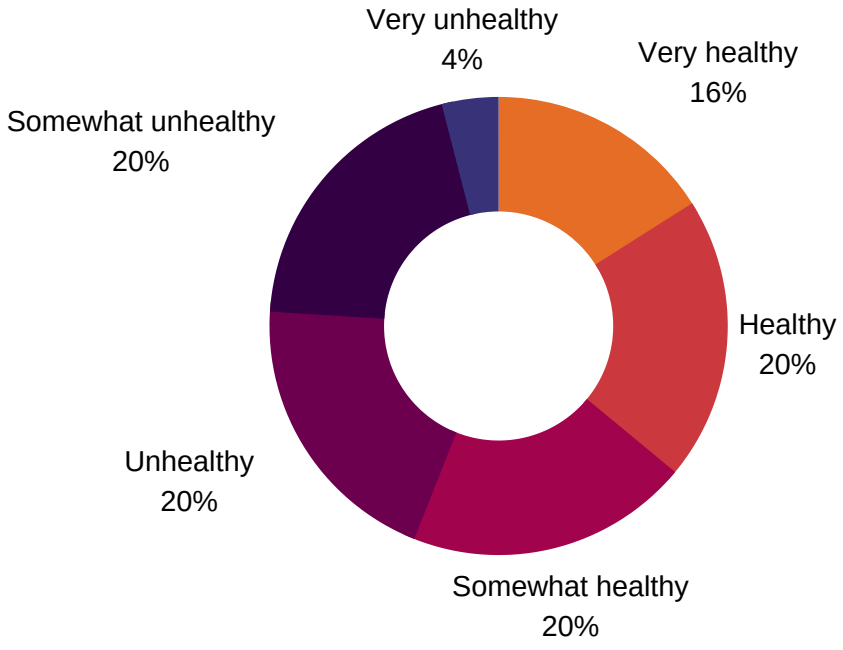
Q: What do you think are the five riskiest behaviors in your community? The top five answers were:

1. Not getting vaccinations to prevent disease, including COVID-19
2. Poor diet
3. Alcohol abuse
4. Tobacco use
5. Lack of exercise

Q: What issues do you think may prevent community members from accessing care? The top five answers were:

1. Unable to pay co-pays and deductibles
2. No insurance
3. Lack of access to transportation
4. Fear (e.g., not ready to face or discuss health problem)
5. Don't understand the need to see a doctor

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



Employee survey, cont'd

Q: What do you think are the top five most important actions in improving the health of community members living within Piedmont communities? The top five answers were:

1. Access to low-cost mental health services
2. Financial assistance to those who qualify
3. Access to dental care services
4. Community-based programs for health
5. Expanded access to specialty physicians

Q: What is your vision for a healthy community? Some answers were:

A healthy community includes access to affordable healthcare, healthy food, safe housing, quality education, and stable jobs.

A place where people are healthy enough to move about and enjoy life.

One that is educated, with access to health services both financially and geographically.

Families and individuals who care for each other.

A community who has access to services, I have been an ER nurse for nearly a decade and the mental health population continues to grow. There are not many resources for these patients; Advantage is great but it would be wonderful to have a local Piedmont facility to help with these patients.

Affordable housing that is safe.

More community care clinics were underserved communities can have access to "affordable" healthcare.

Using healthcare for prevention instead of trying to treat most problems after onset.

Free little food pantries on different blocks in towns, with healthy food choices.

A healthy community to me would be a place where social and financial factors do not stop a person for asking for help when in need. If everyone was able to get healthcare assistance, the community would be a healthy place as a whole.

Employee survey, cont'd

Q: What is the single most pressing issue that you believe our patients face? Most answers centered around cost, with some health factors. Among the answers:

Barriers to accessing health care including lack of health insurance and poor socioeconomic status.

Medical bills.

Affordable, really affordable, health care for everyone.

Financial insecurity (including but not limited to people living at or below poverty lines).

Mental health.

Drug use, obesity, and heart failure are things that could probably be helped if they had the access to the right facilities.

Uninsured and underinsured people are so underserved. There are so many people who don't access care until they are falling apart and end up hospitalized simply because they couldn't afford to see a doctor and pay out of pocket rates.

Low healthcare literacy.

Q: What are one or two things we can do better to serve our patients/our community? Some answers were:

Include better discharge instructions on how to stay well at home. Also have a health hotline to triage calls before heading to emergency room.

Participate in community clinics that offer reduced cost preventative services (wellness, vaccines, chronic illness management) in challenged communities.

Get more involved in schools, as healthy behaviors start early.

Make non-emergent care more viable for uninsured and underinsured populations.

Help lower income patients with housing and food issues and provide discharge instructions that are viable for these patients.

Push the Governor to accept federal funding to fully expand Medicaid under the ACA.

Community stakeholders

As part of our process, we interviewed nearly 245 stakeholders, policy makers, and lawmakers representing public health, low-income populations, minorities, chronic conditions, older adults, and our communities. These included eight stakeholders within the Pickens and Gilmer communities, whose voices are reflected below.

Overall, community stakeholders boasted a location that gives you the "best of both worlds," given its proximity to Atlanta, and a community that is filled with natural beauty, friendly and strong relationships, and connection and collaboration.

Like many Georgia communities, many feel that growth is happening too fast, and the housing market now has demand that pushing prices up, leaving too many unable to afford rent or mortgages. For many, the rural nature of both counties is an asset in some ways, but a barrier in others, and that includes a lack of widespread WIFI and broadband for many. Stakeholders stressed that telemedicine should be an asset in rural communities, but individuals can still not access telemedicine and certain times there is not even a way to contact emergency services or a physician.

While the transition of the Good Samaritan Health and Wellness Center to a Federally Qualified Health Center has brought more affordable care for low-income patients, many felt there were still many gains to be had in this area, and particularly so with hospital services. The hospital's financial assistance policy was mentioned as being prohibitive for many patients, who may not have the literacy or resources to fill it out in a timely and accurate manner.

Additionally, some stakeholders stressed the need for increased mental health services, both inpatient and outpatient, at rates that are in scale to income. This includes addiction services, which some feel is still desperately needed, as local resources can't keep up with demand. One stakeholder cited the need for solutions outside jail time, as incarceration can, in turn, lead to household poverty, which creates a cycle that needs to be broken. Additionally, and as one stakeholder said, "Jail is currently the only placement for a mental health crisis."

There is a bit of concern for children overall, with at least one stakeholder stating that lower income children are at a particular disadvantage due to their parents not being able to afford antibiotics and routine care. Additionally, these parents may work odd hours and are unable to support the child in their learning, leading to lower test scores, lower learned skills, and poor graduation rates.

Children are also impacted by substandard housing, one stakeholder said, leading to preventable asthma that has long-standing health implications. Finally, several felt there needs to be mental and behavioral health resources specifically for children with anxiety and stress. As one

Community stakeholders, cont'd.

stakeholder said, "COVID-19 has intensified the situation; children have been impacted by a lack of connection and hardships."

Obesity and diabetes were also cited as health concerns, which many noted was linked directly to a very sedentary lifestyle. One stakeholder noted that many community members are just “outright unhealthy."

Another issue some felt was on the horizon is the impact the aging population and retirement population will have on what some feel is an already-taxed health system. While most cited the hospital as a considerable community asset, some felt that more growth is needed, and particularly so for primary and specialty physicians that not just in Jasper and Ellijay but also in the more outlying areas, where older populations can more easily access their physicians.

Transportation was regularly cited as a significant health barrier, and that there are limited (and to at least one stakeholder) no good options for getting to your doctor or job without a family member or friend helping. This can also translate into barriers in accessing healthy foods, and particularly so for older populations.

Several noted that inequalities are continuing to grow, and particularly so among socioeconomic inequalities. The poor are staying poor and the gap between those low-income populations and their wealthier counterparts continues to widen. These populations are not at the table in community discussions, one stakeholder said, and often have someone who is not living in poverty represent their voice. This presents a challenge to creating solutions that actually work, the stakeholder said.

Methodology

The Piedmont Mountainside CHNA was led by the Piedmont Healthcare community benefits team and consulting organization Public Goods Group, with significant input and direction from Piedmont Mountainside's leadership and Piedmont Healthcare's Department of External Affairs.

The CHNA started with an analysis of available public health data. We looked at our Piedmont service region, which spans the northeast section of the state. We paid particular attention to the home counties of our hospitals, which is reflected in this CHNA. We focused on the home counties in the individual CHNAs due to the local impact of our tax-exempt status.

Once our community was established, we interviewed key stakeholders who have a particular expertise or knowledge of our communities. Specifically, we interviewed representatives of local and regional public health entities, minority populations, faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and individuals representing our most vulnerable patients.

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. Approximately 1,053 employees spanning the system responded. Additionally, we conducted a community-based survey that was widely advertised to the community.

Once both qualitative and quantitative data was gathered, we authored the preliminary report. 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.

While the priorities reflect clinical access and certain conditions, all priorities are viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race. 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. Once priorities were chosen, we then authored the CHNA and presented our findings and recommendations to the hospital's board of directors for their input and approval.

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 May 20, 2022.

Board of Directors

Denise Ray (Chair)
Richard B. Hubbard, III
Paul Nealey
Jason Smith
Rosemarie Spillane, MD
John Schnars, MD
Leigh Hamby, MD
Gregory A. Hurst

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 February and March 2022, we interviewed several Pickens and Gilmer community members to better understand their perspectives on community health through the lens of their role within the community. These stakeholders were: Jennifer Grimmer (Gilmer Chamber of Commerce), Ken Sanford (Greater Gilmer), Sheriff Stacy Nicholson (Gilmer County), Charlie Paris (Gilmer County Board of Commissioners), Kim Cagle (Gilmer County Schools), Tammi Sorrels (Good Samaritan Health and Wellness), and Gail Smith (Pickens County School System).

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, 2022.
Income and Economics	IRS - Statistics of Income, 2018.
Income and Economics	US Census Bureau, American Community Survey, 2015-19.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
Other Social & Economic Factors	Opportunity Insights, 2018.
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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.

Appendix three: Sources for data, cont'd

Category	Data Source
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

From March 01 to March 31, 2022, the hospital placed online an employee survey meant to capture employees' thoughts challenges within our communities and suggestions on how the hospital can improve its community's health. Below are the survey questions these employees answered.

In our commitment as a not-for-profit health system, Piedmont is currently studying the region’s community health needs for its Community Health Needs Assessment. As a member of our community, we invite you to take this 15-minute survey so that your feedback can be heard and included in identifying health priorities which we’ll address over the next three years.

Thank you for your time and input.

1. What type of role do you have?
- Administrative
- Clinical
- Environmental Services
- Food Services
- Programmatic
- Other: Please describe

2. Are you an employee or are you a contract employee?

Appendix four: Employee survey, cont'd.

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

Appendix four: Employee survey, cont'd.

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
- Somewhat healthy
- Healthy
- Very healthy (most have no chronic conditions such as heart disease or diabetes)

Appendix four: Employee survey, cont'd.

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 services
- 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

Appendix four: Employee survey, cont'd.

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?