FY22

PIEDMONT NEWNAN HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT

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Introduction

As a not-for-profit healthcare system, the mission of Piedmont Newnan 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 Newnan Hospital is a 167-bed, acute-care, community hospital in Newnan, Georgia. Piedmont Newnan is the only acute-care facility in Coweta County. Since joining Piedmont Healthcare in 2007, the hospital generated more than $1 billion in revenue for the local and state economy in the first five years, while at the same time providing nearly $44 million in uncompensated care. As a not-for-profit organization, hospital earnings go directly back into maintaining and improving services and facilities, and to educational outreach.

In FY21, Piedmont Newnan employed 1,200+ community members, 600+ physicians, and hosted 130+ volunteers. The hospital delivered 1,680 newborns, treated 55,113 patients through the emergency department, performed 8,878 surgeries, saw 86,140 outpatient encounters, and admitted 11,118 patients.

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 Newnan 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 Newnan provided $51.5 million in community benefit. Specifically, Piedmont Newnan provided:

	FY20	FY21
Care for low-income and other vulnerable patients	$18,898,928	$14,468,869
Community health promotion	$174,002	$604,997
Community health services	$130,000	$134,186
Health professions education	$2,702,701	$1,528,830
Bad debt	$5,983,124	$6,864,543

Key programs include support for labs and care coordination for our partner charitable clinic Coweta Samaritan Clinic, 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 healthcare, and care for those covered through the low-income state/federal public insurance program Medicaid.

Additionally, the hospital 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 demonstrations, expressive art classes, and counseling that are 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 the Federal Poverty Level. Patients qualify for financial assistance in one of two ways: either through presumptive eligibility, in which the patient's file is automatically scanned for certain indicators that mean he or she would qualify for financial assistance, or via manual application by the patient or his or her representative. Below is a list of the top 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 - FY20
30014	3,691	5,481	2,226	3,551
30016	3,254	4,588	1,239	1,706
30054	613	895	316	507
30025	478	673	312	424
31064	386	594	336	468
30013	252	318	168	235
30055	217	334	155	219
30012	228	291	165	210
30056	172	288	123	178
30094	199	227	94	118

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
30263	20,747	46,938	20,201	46,490
30265	10,934	22,507	11,376	24,231
30277	4,953	10,171	5,325	10,951
30276	3,284	6,513	3,584	7,227
30269	2,114	3,425	2,574	4,031
30268	2,022	4,159	2,007	4,173
30220	1,839	4,061	1,809	4,028
30230	1,639	3,462	1,566	3,486
30213	1,419	2,470	1,697	2,977
30259	1,297	2,876	1,270	2,967

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 affordable access to health, mental 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.

Reduce preventable instances of and death from cancer

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

Promote healthy behaviors to reduce preventable conditions, obesity, diseases and addiction

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

Reduce preventable instances of and death from heart disease

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

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. Also, we will work in all areas that need our assistance within our service area.

Progress since last CHNA

In our FY19 CHNA, we identified six health priorities we'd work to address over the following three years. These priorities were:

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

To address these priorities, we:

- Supported the Coweta Samaritan Clinic by processing all lab services free of charge, providing funding for a full-time licensed medical social worker, and continuing its provision of Epic EMR to the clinic at no cost.
- Continued the Piedmont community benefit grants program, offering grant opportunities to local nonprofits providing specific health-related services and programs that address unmet health needs identified in the hospital's FY19 CHNA and implementation strategy by providing $70,000 in grants to the following organizations and programs:
  - Coweta Samaritan Clinic and their program providing specialty care and advanced diagnosis coordination;
  - Meals on Wheels of Coweta, to increase their meal service;
  - Coweta Force, for their opioid awareness programming; and,
  - Drug-Free Coweta, for their work to address addiction issues within the community.
- Provided a public bilingual community resource guide, giving information on community resources and plain language details on the hospital's financial assistance programs for low-income populations.
- Continued programming for seniors through the hospital's Sixty Plus program, which provides support services aimed at older populations and their families, regardless of where the patient receives their care. These programs were impacted by COVID-19, where almost all in-person activities ceased in March 2020.
- Created and convened a Patient and Family Community Council to facilitate community feedback on critical areas of care and to provide a platform for input from patients and families, including improving their healthcare experience, safety and quality in care, and a better understanding of the healthcare system.
- Provided medical staff oversight and education to students and residents training to be health professionals at a combined cost of $4.23 million.

Progress since last CHNA, cont'd

- Provided support services to cancer patients and their families free of charge through Cancer Wellness, a program available to any community member who has been diagnosed with cancer, regardless of where they receive their healthcare. This programming was deployed via both in-person and virtual programming in FY20 and FY21, and saw an attendance increase year over year, from 63 people in July 2020 to 340 people in June 2021.
- Prioritized local opportunities for lung cancer screening through community and physician outreach, resulting in an increase of Low Dose CT Lung Screenings from 604 community members in FY20 to 726 in FY21.
- Worked to reduce cultural barriers to vital cancer prevention, education and awareness for the Latino community through community-based partnerships and provided free screening mammograms, diagnostic mammograms, and breast ultrasounds for Coweta Samaritan Clinic patients through the Mammogram Voucher Program (MVP) for uninsured women.
- Adopted opioid-sparing pain management order sets in the Emergency Department and the hospital’s Electronic Medical Records System, including the ALTO (alternatives to opiates) protocol, which decreased opioid use by 38 percent.
- Partnered with Drug-Free Coweta with a supporting grant in FY21, and the hospital’s pharmacy director served on the coalition’s leadership team.
- Hosted lead anti-opioid agency Coweta FORCE to speak to hospital leadership and emergency department staff on reducing the negative stigma around opioid addiction and providing community resources for recovery.
- Partnered with local law enforcement to host Take Back Day, in which residents were encouraged to bring in any unused prescriptions for safe disposal.
- Continued as a lead convening groups for the Coweta Substance Abuse Prevention Coalition, a multi-sector collaboration aimed at reducing substance abuse throughout the community.
- Created public service announcements to reach at-risk populations for heart disease. This included publishing an article for National Stroke Awareness Month in Winters Media's The Shopper section entitled "Piedmont Healthcare: When Treating Stroke Every Minute Counts," which details the importance of acting quickly at the first signs of a stroke.
- Recognized by the American Heart Association and American Stroke Association for the Get with The Guidelines-Stroke Gold-Plus Quality Achievement and Target: Stroke Honor Roll-Elite Plus for quality stroke and cardiac care.
- Offered virtual healthy cooking classes to Coweta and Fayette communities through the Piedmont Women's Heart Program, focusing on minority and uninsured populations at a greater risk for heart disease, collaborating with the Coweta Samaritan Clinic and health insurer Cigna.

FY22

Community Health Needs Assessment

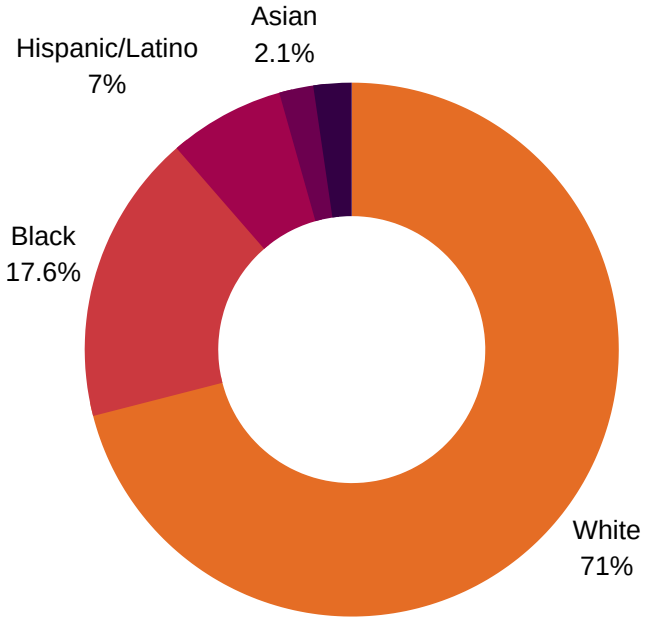
About the community

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

In Coweta County, an average 143,260 people lived in the 119.22 square mile area each year between 2015 and 2019.The population density for this area, estimated at 325 persons per square mile, is greater than the national average population density of 92 persons per square mile. The ZIP code with the highest concentration of people was 30263, where 42 percent of the county's population called home. Coweta is mostly urban, as 67 percent of community members live within an urban setting. The ZIP code with the highest concentration of rural population was 30230. Rural populations in Coweta are overwhelmingly white. Coweta County is growing, having seen a 15 percent jump in total population between 2010 and 2020.

About 9 percent of the population were veterans in 2020, and nearly half were aged 65 and older. Eleven percent of the population - about 15,732 people - lived with a disability. Most of that population was between the ages of 18 and 64.

Between 2015 to 2019, about 71 percent of all Coweta County residents were white, 17.01 percent were African American, 7.01 were Hispanic/Latino, 2.22 percent were Asian, and the remaining 4.01 percent were comprised of other races. About 25 percent of the population were 18 or younger, 13.5 percent were over the age of 65, and the remaining population were between the ages of 18-64. About six percent identified as being born outside of the US and approximately half of those do not possess US citizenship status.



The chart to the left represents a breakdown of races within the community. The community is still predominately white, though that is shifting. Minority populations have steadily grown in recent years, with Hispanic or Latino populations leading growth at 30 percent from 2010 to 2020, as compared to 13.7 percent for all other races. This is on-trend with Hispanic/Latino population growth throughout the state.

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. Coweta County has a poverty rate lower than state and national averages, with about 11 percent of the population living at or below poverty, with minorities far more likely to live in poverty. For example, 20 percent of black populations lived in poverty, on average between 2015 and 2020, versus only 9 percent of whites.

Insurance status and health outcomes

In 2020, 9.71 percent of the population had no form of insurance. Insurance status and health are inextricably linked. Being uninsured is generally a marker of low-income, as the overwhelming majority of those that are uninsured are also within certain ranges of the Federal Poverty Level. This means these populations are also likely to face the myriad of other social determinants of health (SDH), like housing and food insecurity.

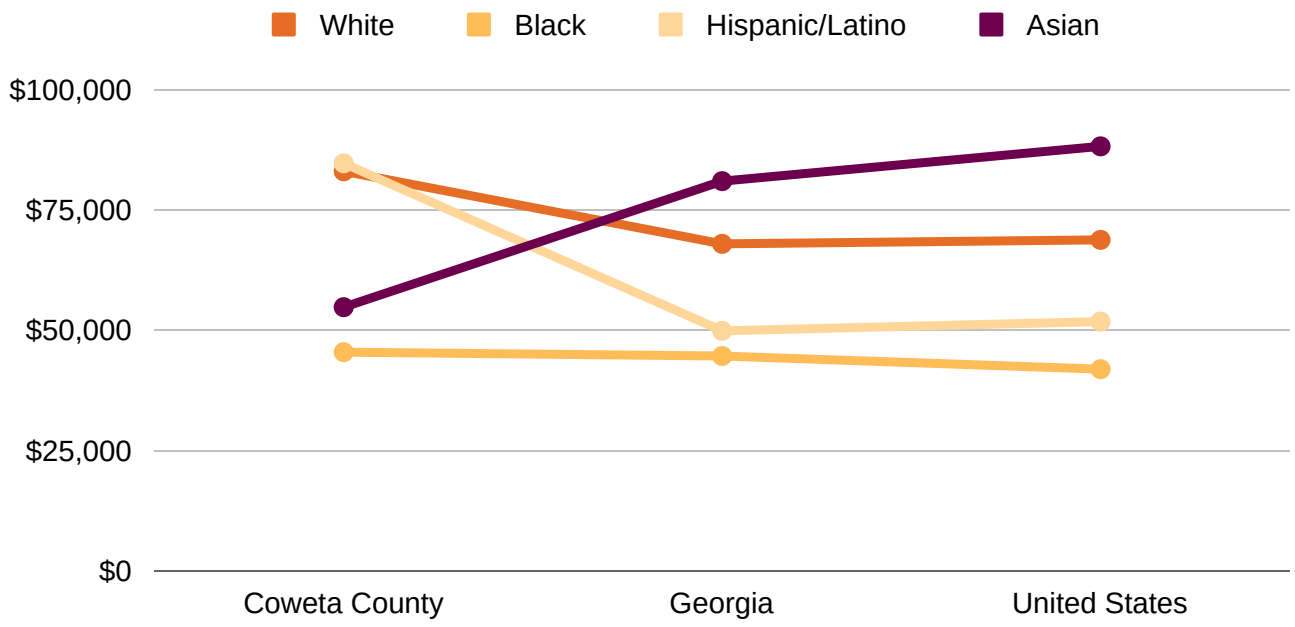
No insurance can mean no access to primary and specialty care, due to cost and/or provider availability. Conditions that could have been treated affordably in a community setting are often not and, because of this, those without insurance statistically suffer worse health outcomes than their insured counterparts. Diseases like cancer are often diagnosed later, and manageable conditions such as hypertension can elevate to dangerous levels.

Adults aged 18 to 64 are most likely to be uninsured, and that's true in Coweta County. In 2020, 86 percent of those that were uninsured were adults aged 18 to 64 in 2020. Approximately 13 percent of teens and children under age 18 were uninsured.

As with other indicators, race matters. Approximately 20 percent of Hispanic/Latino populations were uninsured, 27 percent of Asians were uninsured, 12.19 percent of blacks were uninsured, and 7.56 percent of whites were uninsured.

Community and income

Between 2015 and 2019, the median household income was $75,913, which is much higher than state and national levels, which are $58,700 and $62,843, respectively. When broken down by the four dominant races in the community, income disparities are evident.



Of employers in the community, the largest sector by employment size is retail trade, which employed 8,394 community members at an average wage of $30,128 in 2019 according to the US Department of Commerce. Health care and social assistance is the next largest sector, employing 7,320 workers at an average wage of $64,467. The third largest job sector is government and government enterprises, with 5,812 employed at an average wage of $66,449.

Unemployment and labor force participation

According to the 2015-2019 American Community Survey, 77,991 people in the community were part of the labor force, and only 2,251 -- about 3 percent -- were unemployed as of January 2022. This figure has steadily decreased since last year, when in January 2021, 4.2 percent of the labor force was unemployed. When looking back further, the rate is nearly three times 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

Overall, Coweta County is a relatively safe community. 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
7	23	48	271	419	1,771	179

Incarceration rate

The Opportunity Atlas estimates the percentage of individuals born in each census tract who were incarcerated at the time of the 2010 Census. According to the Atlas data, 2.0 percent of the county population were incarcerated, slightly lower than the state average of 2.1 percent.

Violent crime

Violent crime is a critical public health issue as it is often largely preventable. Between 2015 and 2019, there were a total 878 violent crimes within Coweta County, a figure that includes homicide, rape, robbery, domestic violence, and aggravated assault. This equates to a violent crime annual rate of 232.7 per every 100,000 people, a figure much lower than the state and national rates of 373.1 and 416, respectively.

Sexual assault

Within the county, the three-year total of reported rapes was 205, equaling an annual rate of 15.20 rapes per 100,000 people, lower than the statewide rate of 24.60 and among the lowest in the state. Please note that this data is based on three-year aggregate reports between 2014 and 2016, the last year for which that data is available. It is important to note that this figure is notoriously underreported, and an estimated two out of every three rapes is not reported to authorities.

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 14 firearm fatalities in Coweta County.

Assault

In Coweta County, the three-year total of reported assaults was 744, equally an annual rate of 177 assaults per 100,000 people, much lower than the statewide rate of 230.20 Please note that this data is based on three-year aggregate reports between 2014 and 2016, the last year for which that data is available.

Vulnerability and Deprivation indexes

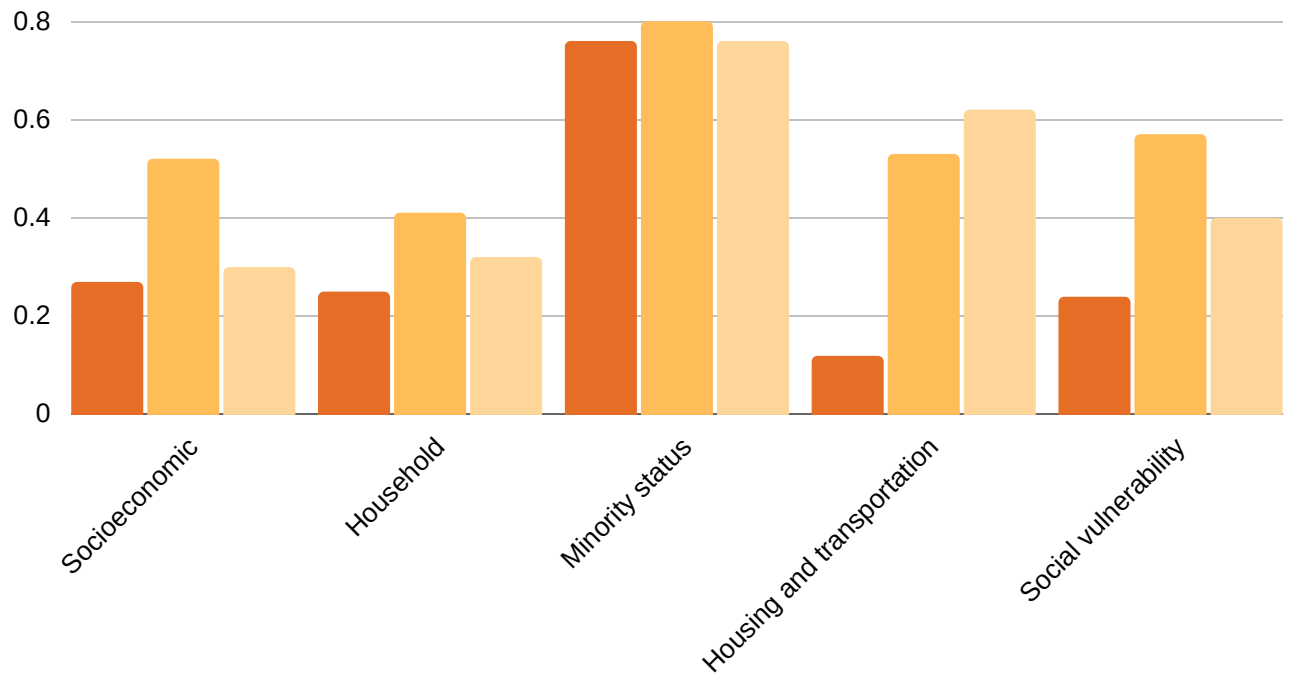
Area Deprivation Index

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). Coweta County ranks in the 33rd percentile for Georgia and 44th in the national percentile, both of which are relatively low figures.

Social Vulnerability Index

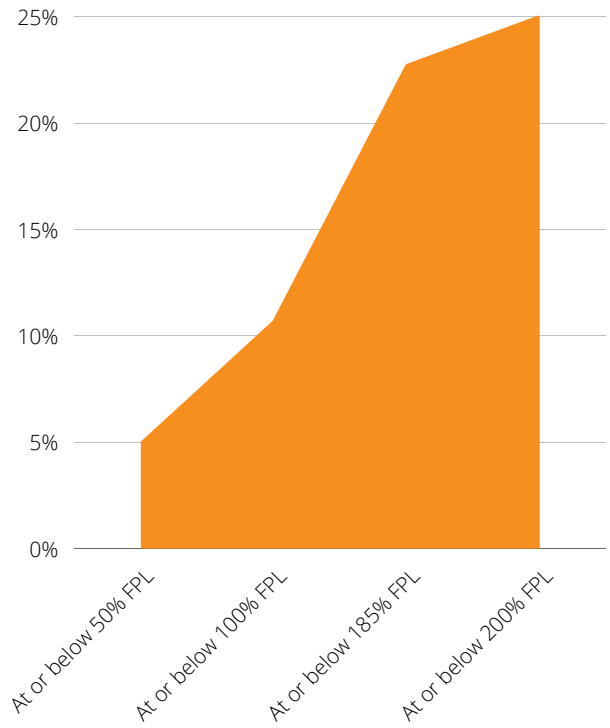
The Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods, where a **higher score indicates higher vulnerability**. Coweta County has a social vulnerability index score of 0.24, which is much lower than the state score of 0.57 and the national score of 0.40. Broken down by themes:



Income and poverty

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



The chart to the left demonstrates how many community members live in poverty or near-poverty.

In 2022, the Federal Poverty Level (FPL) placed a family of four as having a total household income of $27,750. Even when living at twice the FPL, families are likely unable to afford many of life's basics.

By far, the poorest ZIP code within Coweta County is 30289, where 21.15 percent of the population lived in poverty in 2020.

In Coweta County, like most of the state, minorities are far more likely to live in poverty - at least twice as likely to live in poverty. For example, in 2020, 20 percent of blacks in Coweta County were living at or below poverty, as compared to 8.6 percent of whites.

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 Coweta County, nearly 8.8 people received SNAP benefits in December 2020, representing about 4,576 households. Black populations are far more likely to receive SNAP benefits than any other demographic --- nearly a fourth of all SNAP recipients are black, as compared to 5.1 percent of white recipients and 13.8 percent of Hispanic or Latino populations.

Housing

In 2019, the median rent cost for a one-bedroom was $1,152 within the county, with some differences between living within urban and rural settings. This figure has steadily grown over the last few years, and rent is now, on average, about 11.2 percent more than it was three years ago. 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 Newnan, in 2020, basic utilities average $103 per month, and internet averaged $59. Added together, the monthly costs for a single person are, at the very lowest end, $1,507, not including transportation, 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

Of the 52,035 total occupied households in Coweta County, 13,080 -- about 25 percent -- of the population live in cost burdened households, in which housing costs are 30 percent or more of total household income. Eighty percent of these households were occupied by renters. Approximately 10.44 percent of 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) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. Of all households in the county, 13,159 (about 25.29 percent) have one or more substandard conditions. This is better 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.

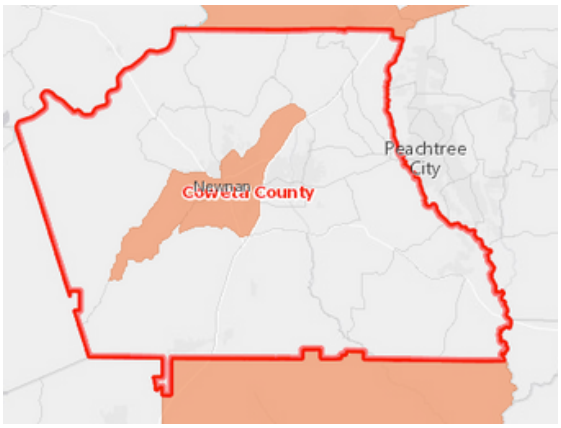
Affordability is defined by assuming that housing costs should not exceed 30 percent of total household income. Income levels are expressed as a percentage of the county's AMI. About 71 percent of housing units are affordable at 100 percent AMI, which means that housing is not affordable for the remaining 30 percent of the population. This is slightly better than the state rate of 67.13 percent of housing units affordable at 100 percent AMI.

Food deserts and food insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially so if they were already low-income. As with many health indicators, minorities are much more likely than their white counterparts to experience food insecurity.

Neighborhood conditions can affect physical access to food. For example, people living in some urban areas, rural areas, and low-income neighborhoods may have limited access to full-service supermarkets or grocery stores. Predominantly black and Hispanic neighborhoods tend to have fewer full-service supermarkets than predominantly white and non-Hispanic neighborhoods. Communities that lack affordable and nutritious food are commonly known as “food deserts.”

In Coweta County, in 2019, only three of the county's 20 census tracts were food deserts. About 23,969 people lived within these census tracts. These tracts almost directly correspond with census tracts demonstrating retailers who are authorized to take SNAP benefits. In Coweta County, like with most of the state, those retailers tend to be convenience and discount stores that carry limited, if any, healthy foods. Increasingly, discount stores like Dollar General do have some sort of produce section, but that is inconsistent among communities.



Grocery stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. There are 25 grocery establishments in the county, a rate of 19.64 per 100,000 population, which is better than the state and national rates of 17.46 and 20.66, respectively. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included, and convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

Low food access

Low food access is defined as living more than 0.5 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity. According to the 2021 Food Access Research Atlas database, 45 percent of the total population in the county have low food access, meaning about 57,146 county residents may struggle to access healthy foods. This is much worse than the state and national rates of 30.89 percent and 22.22 percent, respectively. ZIP code 30277 has the worst rate of low food access at 70.34 percent.

Access to care

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

Insurance

Insurance status is directly related to a person's ability to access care, and this is particularly true for non-emergent care and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are over three times more likely than insured adults to say they have not had a visit about their own health to a doctor or other health professional’s office or clinic in the past 12 months. They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening. Part of the reason for poor access among the uninsured is that half do not have a regular place to go when they are sick or need medical advice, while most insured people do have a regular source of care.

In Coweta County, in 2020, about 9.71 percent of the population were uninsured, a figure lower than the state rate 16 percent and the national figure of 8.84 percent. When looking only at adults, the uninsured rate jumps to 15.23 percent. Rates, though, have steadily declined. In 2011, approximately 21 percent of all adults were uninsured. Location matters in Coweta for insurance rates. In ZIP codes 30289 and 30275, uninsurance rates for adults were 42.31 percent and 35.71 percent, respectively.

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
69.91%	12.52%	3.35%	16.5%	14.16%	2.83%

Access to dental and primary care

Dental care and dental outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Within the county, in 2018, 65 percent of adults went to the dentist in the past 12 months. That year, 13.5 percent of the county reported having lost all natural teeth because of tooth decay or gum disease. This is an impactful measure in multiple ways:

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

It's important to note that there are few options for low-income patients needing dental care. 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.

Primary care and routine check-ups

In 2019, only 77.2 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 85.49 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.

As with most all other indicators, race and income play heavily into this. White populations are far more likely to receive preventative care than their white counterparts (76.5 percent among black populations compared to 86.49 percent among white populations), and those with insurance are also much more likely to go to the doctor for a routine check-up than those without insurance.

Causes of death

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.

Ischemic heart and vascular disease - 1

All COPD except asthma - 2

Trachea, bronchus and lung cancer - 3

Essential hypertension and hypertensive renal and heart disease - 4

Alzheimer's Disease - 5

Cerebrovascular disease - 6

All other diseases of the nervous system - 7

All other mental and behavioral disorders - 8

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

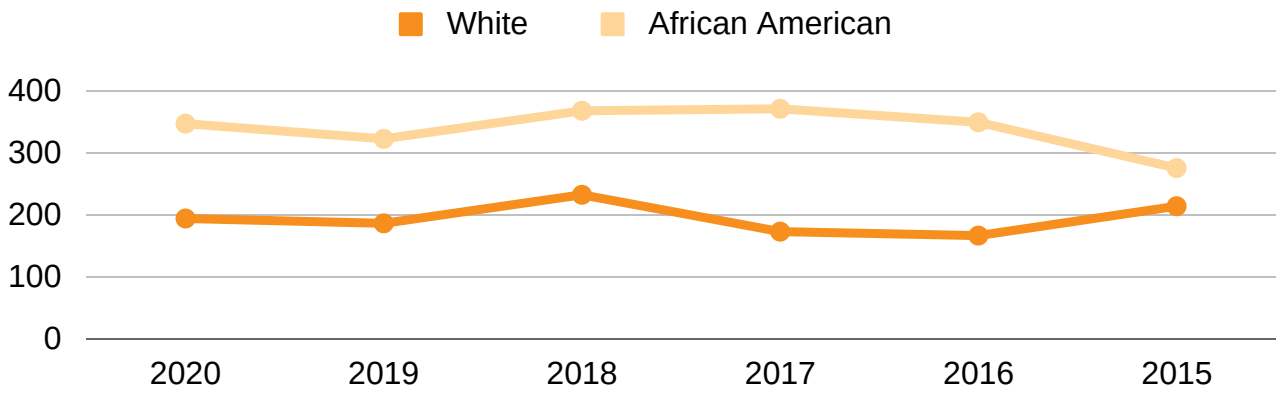
- White: Ischemic heart disease and vascular disease; all COPD except asthma; Alzheimer's disease
- Black or African American: Ischemic heart disease and vascular disease; essential hypertension and hypertensive renal and heart disease; malignant neoplasms of the trachea, bronchus and lung
- Asian: Cerebrovascular disease (the remaining numbers were too small to report)
- Hispanic/Latino: Ischemic heart disease and vascular disease; diabetes; essential hypertension and hypertensive renal and heart disease

All other races had numbers too small to report.

Heart disease and stroke

Heart disease is the leading cause of death for both women and men in Coweta County, with a disproportionate impact on black populations. In 2020, the age-adjusted death rate was 233.6 persons for every 100,000 people, an increase since our last CHNA, when the data rate was 221.4 per every 100,000 people. When looking at race, there is a stark difference between African American and white populations.

The below chart demonstrates the death rate for major cardiovascular disease per every 100,000 people for the two populations over the last five years for which data is available. Deaths among other populations were nominal, and not reflected below.



There are similar disparities when looking at other areas of heart and cerebrovascular disease deaths. For example, in 2020, the death rate for stroke for African Americans was 87.3 per every 100,000 people, as compared to the death rate for whites, which was 33.8 per every 100,000 people.

There are several potential reasons for this, including a higher poverty rate among black populations, which impacts all areas of life, including access to primary health care and healthy foods. Hypertension and other related chronic conditions also tend to be higher among black populations, as does obesity and diabetes, all of which tend to occur at a younger age than it does for their white counterparts. Finally, neighborhoods matter. In Coweta County, black populations tend to live in communities with lower walkability rates and more limited access to healthy foods.

Hospitalizations

The hospitalization rate for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 11.7 hospitalizations per every 1,000 Medicare beneficiaries, which is below the state and national rates of 12.2 and 11.8, respectively. The hospitalization rate for stroke, though, is between state and national rates, with 8.9 hospitalizations per every 1,000 Medicare beneficiaries versus the state rate of 9.3 and the US rate of 8.4.

Cancer

Although heart disease leads in county deaths, cancer remains a critical issue within the community. The cancer incidence rate for Coweta County each year, on average between 2014 and 2018, was 477.2 per every 100,000, which equates to a diagnosis rate of an average 731 new cases each year. Below is a chart showing cancer diagnoses, by site, between 2014 and 2018, the last year for which this data is available.

Cancer Site	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Population)
1 - Breast (All Stages)	110	133.5
2 - Lung & Bronchus (All Stages), 2014-2018	93	61.3
3 - Prostate	87	111.1
4 - Colon & Rectum (All Stages)	67	43.3
5 - Melanoma of the skin (All Stages)	38	24.7

When comparing to state and national average, though, Coweta County does 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.

When broken down by cancer site, though, the breast cancer incidence rate is much higher than state and national rates, which are 128.4 and 126.8 diagnoses per every 100,000 people, on average each year. Other diagnosed cancer sites are below state and national averages.

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

Hospitalizations and ER visits

Emergency department visits

In FY21, Coweta County treated patients through approximately 55,113 emergency room visits, an increase of about 48,159 visits from 2019. 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 46,000 total visits each year.

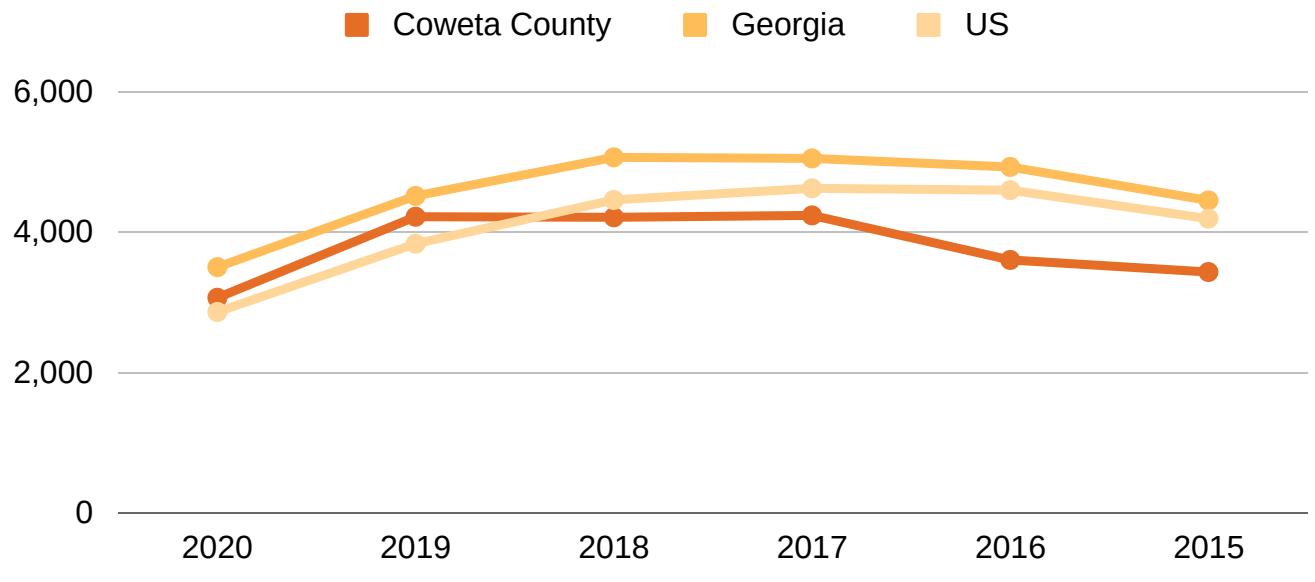
Inpatient stays

In 2020, there were 23,262 Medicare beneficiaries in the county. Approximately 1,784 total beneficiaries, or 14.6 percent, had a hospital inpatient stay, and the rate of stays per 1,000 beneficiaries was 221.0. The rate of inpatient stays in the county was lower than the state rate of 230.0 during the same time.

Preventable hospitalizations among Medicare beneficiaries

Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries. In 2020, there were 22,216 Medicare beneficiaries in the county, and the preventable hospitalization rate was 3,067, which is better than the state rate of 3,503 during the same time. As with other health indicators, African Americans were twice as likely to experience preventable hospitalizations than other races in 2020.

The 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, 10,377 of adults aged 20 and older had diabetes, equaling 8.4 percent of the county's population, which is lower 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 figure has remained somewhat steady over the last decade.

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, 2.9 percent of the county's population had a diagnosis of kidney disease, a rate better than the state and national percentages of 3.22 percent and 3.1 percent, respectively.

High cholesterol

In 2019, 27.30 percent of adults 18 and older reported having high cholesterol of the total population. Too much cholesterol puts you at risk for heart disease and stroke, two of the main causes of death within the county.

High blood pressure

In 2019, 33.3 percent of adults 18 and older had a diagnosis of high blood pressure. High blood pressure can damage your arteries by making them less elastic, which decreases the flow of blood and oxygen to your heart and leads to heart disease.

Multiple chronic conditions among Medicare populations

This indicator reports the number and percentage of the Medicare fee-for-service population with multiple (more than one) chronic conditions. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program, Within the county, there were 6,898 beneficiaries with multiple chronic conditions based on administrative claims data in the latest report year, representing 67.8 percent of the total Medicare fee-for-service beneficiaries. Twenty-eight percent of these beneficiaries have six or more chronic conditions.

Infectious diseases

Infectious diseases are an issue in Coweta County, 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.

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 Coweta County, in 2018, there were 209.8 confirmed cases of HIV/AIDS 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 Coweta County, in 2018, there were 328.41 confirmed cases of chlamydia for 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 Coweta County, in 2018, there were 76.2 confirmed cases of gonorrhea for every 100,000 people. This is 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 86 deaths due to influenza and pneumonia, representing an age-adjusted death rate of 12.5 per every 100,000 total population, which is better than the state and national rates of 13.6 and 13.6, respectively. In Coweta County, men are nearly twice as likely to die from influenza or pneumonia than women, and white men are especially susceptible.

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 09, 2022, Coweta County had a total 32,899 confirmed COVID-19 cases and 478 COVID-19 related deaths.

Approximately 54 percent of the county was fully vaccinated as of March 2022, and the county had a COVID-19 vaccine coverage index (CVAC) of 0.70, 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.

Community resilience

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

- 41.5 percent of the population had no risk factors
- 42.2 percent of the population had one to two risk factors
- 16.4 percent of the population had three or more risk factors

These risk factors include:

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

Children

There were approximately 35,540 children in Coweta County in 2020, representing 24.81 percent of the population. The ZIP code with the highest number of children was 30220, and 30289 and 30275 had the lowest number of children, according to the Census Bureau. Approximately 1 percent of students were homeless in 2020 -- about 178 kids.

Of these children. 32.6 percent lived at or below 200 percent of the Federal Poverty Level (FPL), which was $55,500 gross household income for a family of four in 2022. The highest percentage of poor children was in the 30220 ZIP code, where 53 percent of children lived in poverty in 2020.

Additionally, 34.6 percent of county children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure far 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 US FPL as part of the federal National School Lunch Program (NSLP).

Access - Head Start and preschool enrollment

Head Start is a program designed to help children from birth to age five who come from families at or below poverty level. This helps these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. Coweta County has only four Head Start programs, with a rate of 4.31 per 10,000 children under 5 years old in 2020. This rate is far below state and national rates of 6.83 and 10.53, respectively. Approximately 47.55 percent of all children aged 3 to 4 were enrolled in preschool in 2020, a rate slightly lower than state and national averages.

Single-parent households

In 2019, 23 percent of children lived in households where only one parent is present. Statistically, compared to married parents, single parents tend to be poorer (because there is not a second earner in the family) and less well-educated (in part because early childbearing interrupts or discourages education, and single parent households tend to be led by younger parents).

English and math 4th grade proficiency

Of 45,835 students tested, 54.6 percent of 4th graders performed at or above the "proficient" level, and 65.8 percent tested below the "proficient" level in the English Language Arts portion of state standardized tests in the 2018-2019 school year. Students in the county tested better than the statewide rate of 39.2 percent. For the math portion, of 4,787 students tested, 47 percent of 4th graders performed at or above the "proficient" level, and 61.5 percent tested below the "proficient" level, according to the latest data. Students in the county tested better than the statewide rate of 46.1 percent.

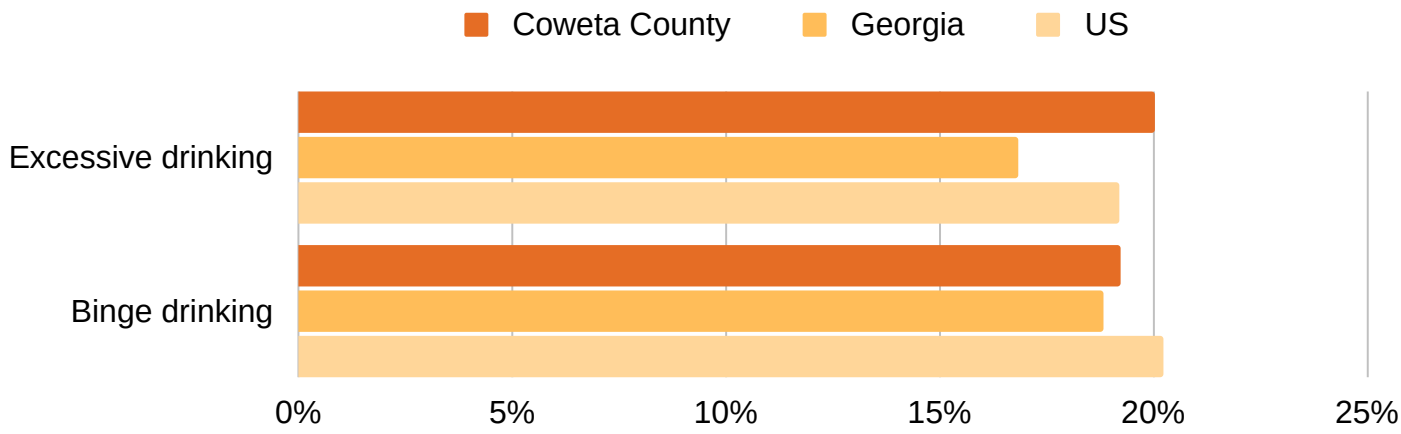
Risky behaviors

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

Alcohol use

Excessive alcohol use can lead to a myriad of health issues, including liver disease, depression, injuries, violence, and cancer. In Coweta County, in 2018, about 20 percent of adults self-reported excessive drinking in the last 30 days, which was worse 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

Within the county in 2019, 17 percent adults reported being a current smoker. Smoking is directly related to a myriad of health issues, the most serious of which is cancer.

Insufficient sleep

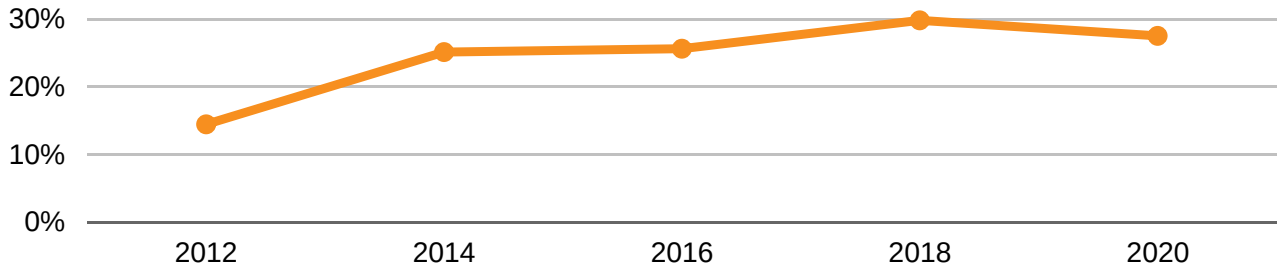
Approximately 36 percent of county residents reported regularly sleeping less than 7 hours most nights, on average, in 2019. Sleep is an essential function that allows your body and mind to recharge, leaving you refreshed and alert when you wake up. Healthy sleep also helps the body remain healthy, fight 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, 27.5 percent of county residents aged 20 and older were obese, meaning they had a body mass index of 30 percent or more. Obesity rates have steadily risen in Coweta County, where ten years ago, only 14 percent of the population were considered obese. There was a dip in 2020, which provides some hope. Obesity is directly linked to several health issues, including diabetes and heart disease.



In Coweta County, as throughout the state and nation, the poorer you are, the more likely you are to be obese. Additionally, Hispanic/Latino and black populations are much more likely to be obese than their white counterparts.

Physical inactivity

Within the county in 2019, 25.2 percent of adults aged 20 and older self-report no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

One reason may be the lack of available public places for physical activity. For example, only 9.44 percent of county residents live within a half mile of a park, a figure much lower than state and national rates of 17.42 percent and 38.01 percent, respectively. Additionally, there were only 13 recreation and fitness places within the county in 2019, resulting in a rate of 10.21 facilities per every 100,000 people, another number below state and national averages.

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 Coweta County, households spent an average 4.05 percent of their food budget on sodas in 2019, which is relatively on par with average state and national expenditures, which were 4.18 percent and 4.02 percent, respectively. Some ZIP codes spent more on soda, such as 30259 and 30220, which had rates much higher than other ZIP codes.

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). In Coweta County, the average rate of death due despair was 37.4 people every 100,000 people in 2020, a number that has steadily risen since 2010, when it was 29.5 people per every 100,000 people. This is most common among white adults with four-year degrees.

Specifically, suicide rates in the county continue to climb, and are among leading causes of death for middle-age white men.

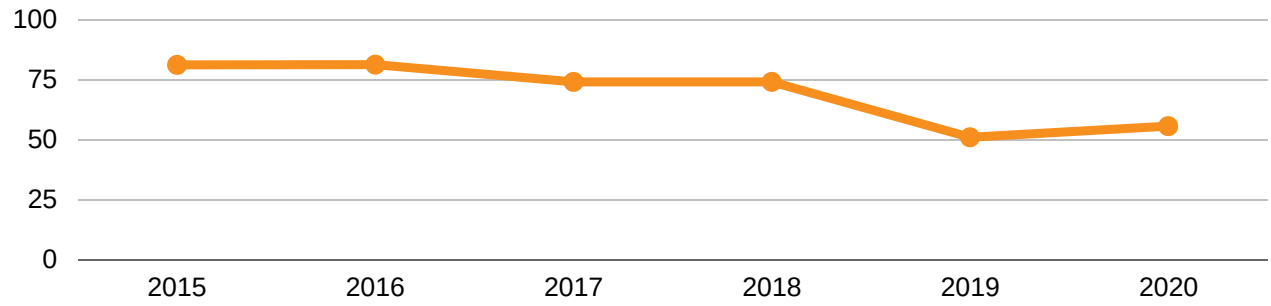
Poor mental health days

In 2018, the last year for which data is available, county members reported an average 4 poor mental health days over the last 30 days, which is lower 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, 13 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

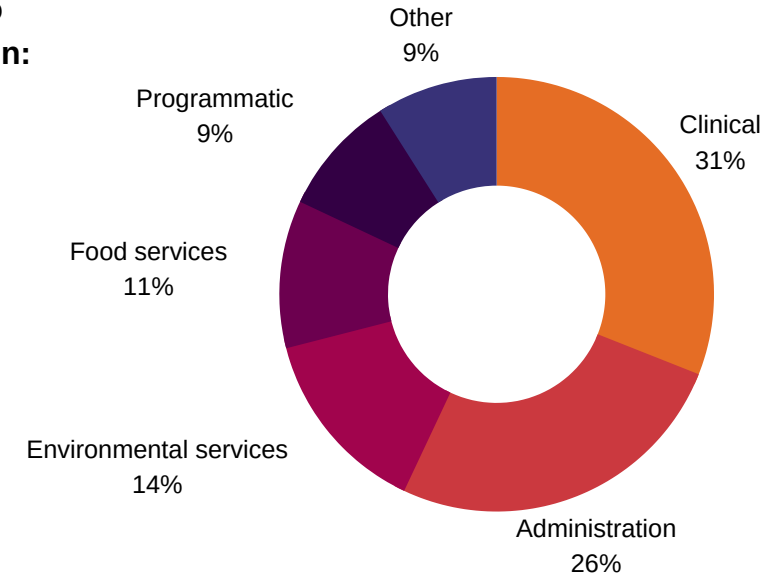
Providers in Coweta County prescribed 55.645 prescriptions per every 100 people in 2020, the last year for which data is available. While it's a slight increase over 2019, this number has steadily declined, likely thanks to local efforts.



Employee survey

In March 2022, we launched an online employee survey to solicit community input on key health issues. A total of 1,053 system employees responded, including 94 Piedmont Newnan 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

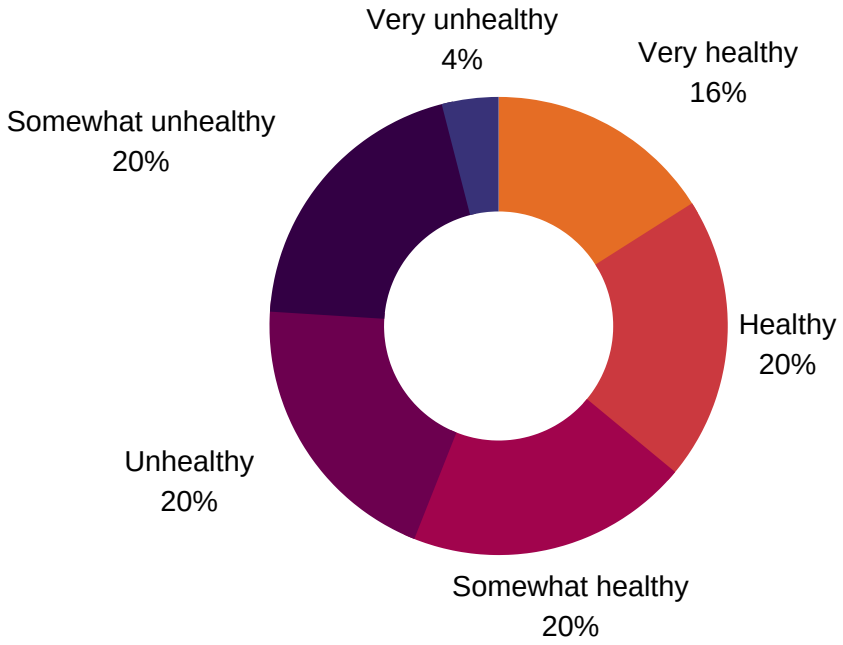
Q: What do you think are the five riskiest behaviors in your community? The top five answers were:

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 where 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 twelve respondents within the Coweta County community.

Overall, local stakeholders felt resources and finances are strong in Coweta County, and that was instrumental in the area rebuilding after a devastating EF-4 tornado struck in late March 2021. Many felt Newnan was “months ahead” in tornado recovery, compared to other similar towns that have been hit by similar natural disasters. The thriving economy promotes growth, and despite being close to Atlanta’s airport, there is still a small-town character. People know each other in these good family towns. The people are “special and have a strong sense of community.” There is a sense that the county is at “a watershed moment to make choices about how we look for the next ten to 30 years.”

Generally, stakeholders felt there are plenty of resources to address community issues, but there is sometimes duplication of efforts. The Coweta Cares program was an often-cited example of partnering and networking.

Growth is a top concern and driving force for transportation and traffic issue. Some stakeholders stated residents want growth managed in a balanced way, with a healthy mix of industries and sectors. The challenge is how to stay “quaint and special,” while allowing for some change. Additionally, several stakeholders cited race issues within the community, something that continues to grow in prominence as the community becomes more diverse.

There is a lack of affordable housing; a multi-year wait list is in place for low-income housing, stakeholders stated. Added to this is the lack of shelters for homeless populations within the community, a problem laid bare after the tornado, in which numerous community members were left with damaged or destroyed homes. Additionally, while stakeholders cited there were jobs available, “living wages are hard to find.”

Access to care

Among most stakeholders, access to care is a top issue. There seems to be an increasing lack of insurance benefits, either due to job structure (in particular, independent contractors), income level, or procedures and prescriptions that aren’t covered under certain insurance plans. To stakeholders, this is creating an increased demand on services for these community members, with only one option for primary care for uninsured patients in the community (the Coweta Samaritan Clinic).

Additionally, multiple stakeholders mentioned the cumbersome financial assistance application process, which requires reapplication for every incidence of care, creating a burden on low-income patients that is proving to be a significant in accessing necessary services, which in turn

Community stakeholders, cont'd.

creates potentially deadly delays in care, especially when the provider reschedules services, at which point the patient must re-apply for financial assistance again.

To most stakeholders, up-front payment requirements for non-emergent health services are prohibitive, and often, treatment options are not made clearly known. And prospective patients aren't aware of available facilities, or the facilities are full. The county lacks an "advocate" to assist people with insurance processes.

Dental care is also considered as a significant need within the community, as there are limited resources for services at a subsidized cost. For those needing more extensive services, stakeholders felt low-income patients (and the ones most likely to need these services) have few options. This, in turn, impacts their health, putting them at an even higher risk.

Mental health was predominantly named, particularly in the wake of the pandemic. There are worries about how connected people feel to others. Many people, especially kids, are feeling disconnected from their community, despite having access to more information than ever before, which is proving to be unhealthy. One stakeholder stated that some older residents struggle with accessing mental health services through their private insurance options, due to excluded services, high deductibles, and/or high co-pay costs, placing a burden on those living on a fixed income. When choosing between a therapist or needed medicines, the tendency is naturally to choose the prescription.

The recreation and parks department encourage people to get out and move, which stimulates mental health. Pathways is providing some mental health care. But there must come a point where we stop talking about it and doing something about it, especially among veterans. One stakeholder stated the Veterans Administration needs more funding and better resources to fully address the unique issues veterans face.

Stakeholders strongly felt Coweta Force is doing a great job addressing substance abuse, and that Coweta County has become a model for how a community can address opioid and substance abuse. Even though there will always still be work to do on this issue, there have been considerable gains in the last few years, and Coweta Force is often cited as the key reason for this.

Finally, several stakeholders named transportation as a key issue for many community members, as there are limited options for those without a car. To at least one stakeholder, while Coweta Transit (Dial-A-Ride) is useful for many, the requirements of being scheduled well in advance is prohibitive to many. Additionally, there is no public transportation service that operates outside of an 8:00 to 5:00 schedule, which isn't helpful for night-shift workers or others who need transportation assistance outside of those hours.

Methodology

The Piedmont Newnan CHNA was led by the Piedmont Healthcare community benefits team and consulting organization Public Goods Group, with significant input and direction from Piedmont Newnan'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. Nearly 900 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 June 29, 2022.

Board of Directors

Michael Robertson, CEO, Chair
Timothy Baker, MD
Douwe Bergsma
Kay Crosby, M.D.
Cynthia Jenkins
Dr. Shankar Kandaswamy
Eric Mitchell, M.D.
Diana Santiago, M.D.
Christopher Stephens
Tonya Whitlock, PhD

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, Coweta County stakeholders provided critical insights to local health and community issues. These were: the leadership team of the Coweta Samaritan Clinic (Dr. Kay Crosby, Kelly Hines, Amy Kelly, Peggie Lawson, and Ginny Lyles), Hank Arnold (Coweta Force), Candace Boothby (Newnan-Coweta Chamber of Commerce), Heather Creech (Newnan Service Center), Rebekah Dingler (Pathways Center), Jimmy Ellison (Newnan City Church/Nest Shelter), Marie Swope (St. Vincent de Paul), Gina Weathersby (Newnan Utilities), and Kelli Yeager Nelson (Bridging the Gap). We appreciate their time and insights, which were invaluable in the authorship of this report.

Appendix three: Sources for data

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

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

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 you have questions about this survey or community health in general?