Community Health Needs Assessment and Implementation Plan

As a nonprofit hospital, Piedmont Atlanta Hospital belongs to the communities and patients we serve. Our mission 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. This mission is evidenced within our community benefit programs, which were created to provide quality and meaningful access to health care services to all members of our community. During Fiscal Year 2013, Piedmont Atlanta Hospital conducted a community health needs assessment (CHNA) for the residents of Fulton County, Georgia, as to better understand the health and related challenges county residents face.

A CHNA is both the activity and product of identifying and prioritizing a community’s health needs, and this is accomplished through input from community stakeholders and an analysis of relevant data. Once that information was gathered, the hospital then identified the top priorities it will address over the next three years. In partnership with the community, the hospital crafted strategies to address those prioritized needs, with an end goal of bettering community health, and particularly that of those most vulnerable. Through these programs and strong partnerships between consumers, neighborhood leaders, advocates and hospitals, the hospital’s community can become stronger and healthier, both physically and fiscally. The CHNA guides this work.

About the hospital
Piedmont Hospital was founded in 1905 as a ten-bed sanatorium located in a fifteen-room home in downtown Atlanta. Founded by Drs. Ludwig Amster and Floyd W. McRae Sr., the sanatorium was chartered to provide the most modern medical care available in a comfortable, homelike setting. The hospital remained in this location until the late1950s, when it moved to its current location. It has continually grown over the years, and currently is a 488-bed full-service tertiary facility serving the region.

Overall approach to community benefits
Community benefits are those programs and activities offered to the community in exchange for a nonprofit hospital’s tax-exempt status, and Piedmont Atlanta Hospital is a 501(c)(3) nonprofit organization. These programs should boost the health of the community the hospital serves, especially that of its more vulnerable populations. Per federal law, community benefit programs must do at least one of the following:

- Generate a low or negative margin;
- Respond to the needs of vulnerable populations;
- Supply services or programs that would likely be discontinued if the decision to offer this program was made on a purely financial basis;
- Respond to an identified public health need; and/or,
- Involve education or research that improves overall community health.

The goal of Piedmont’s community benefit programs is to improve the health status of its communities by identifying and responding to unmet community health needs, facilitating relationships to create stronger communities and serving as an example and a leader to others in community benefits. In Fiscal Year 2012, Piedmont Atlanta Hospital provided:

- Approximately $10.5 million in financial assistance at cost for low-income uninsured patients
- $14.4 million in shortfalls from treating Medicaid patients
- $481,524 in community health improvement services and community benefit oversight
• $398,472 in educating future health professionals
• $461,635 in subsidized health services
• $2 million dedicated to relevant research activities
• $117,457 in cash and in-kind contributions to nonprofit community groups

Additionally, in 2012, Piedmont Healthcare formed the Georgia Center for Healthier Communities, a non-partisan research, advocacy and educational organization committed to building a healthier Georgia through community building, the promotion of pro-community policy and the formation of strategic partnerships. Though policy and advocacy, the organization will address key public health issues, such as access to care, obesity and mental health. These activities will be done in tandem with and in support of Piedmont Atlanta’s community benefit activities laid out in this assessment and implementation plan.

Piedmont Atlanta’s community
In 2010, approximately 1,600,000 people lived in Fulton and DeKalb counties, with the majority residing in Fulton. Both are urban communities, and together comprise the city of Atlanta. Atlanta is the county seat of Fulton County. Fulton has grown by nearly 13 percent since 2000.

Demographics
Fulton County’s population is primarily Caucasian and African American, with both groups together representing about 88 percent of the population. Asians and Hispanics make up the additional approximate 12 percent. Approximately 65 languages and cultures are found throughout the community, making it the most diverse county in the state by far. The county skews slightly female, with women comprising about 51 percent of the county and men at about 49 percent, according to the 2010 US Census. The majority of residents are between the ages of 25 and 54, and only about 9 percent of the population is elderly.

In 2010, an estimated 6.5 percent of Fulton County’s population was identified as “linguistically isolated” in the 2010 US Census. Linguistically isolated refers to those aged 5 and older who speak a language other than English at home and do not speak English well, if at all. This percentage is relevant as the inability to speak English well creates formidable barriers to healthcare access, provider communications and health education. In Fulton County, these populations are primarily Hispanic or Latino population (about 54 percent of the total), and Asian languages were a close second. Fulton County’s linguistically isolated population rate is higher than state and lower than national averages, which are 5.87 percent and 8.7 percent, respectively. Spanish, Russian, Vietnamese, Chinese Mandarin, Thai and Farsi are the top requested languages for translation and interpretation services at the hospital.

Unemployment rates in Fulton have steadily climbed since 2001, peaking in 2009, and remaining somewhat steady since then at about 10 percent. Median household income in Fulton County is higher than the state average at $56,709 per family, about $7,000 more than the state average. That said, half of the children in Fulton County qualify for free lunch, and about 15 percent, respectively, of the county’s households live below the poverty line. About 80 percent of the county’s residents have graduated high school, and about 13 percent of adults in Fulton County are illiterate.

Key health findings
About 27 percent of non-elderly adults in Fulton County are currently uninsured. About 13 percent of county residents receive Medicaid, which is federal health insurance for some low-income Georgians. In Fulton County, as in Georgia, the majority of Medicaid recipients are children, as eligibility requirements are different and children qualify more easily for the program than their adult counterparts. Of the privately insured, an estimated one-third is likely underinsured, which is when a person spends at least 10 percent or more of their annual income on health care, including co-pays, deductibles and prescriptions.
Approximately 14 percent of the overall adult population reported they were unable to see a doctor in 2011 due to cost. In 2013, an estimated 13 percent are in poor or fair health, a figure higher than the national benchmark of 10 percent reporting that low level of health. About 15 percent of the adult population is in poor dental health, according to the Centers for Disease Control and Prevention's 2006 to 2010 Behavioral Risk Factor Surveillance System. Nearly 9 percent of the total noninstitutionalized population lived with a disability in 2012, according to the US Census. About 8 percent of the county's adults are living with diabetes in 2013, according to the University of Wisconsin's County Health Rankings, a figure low in comparison to state and national averages.

In Fulton County, the leading causes of death between 2008 and 2011 in a five-year aggregate were:

<table>
<thead>
<tr>
<th>Leading causes of age-adjusted death</th>
<th>Leading causes of premature death</th>
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<tbody>
<tr>
<td>1. Ischemic heart and vascular disease</td>
<td>1. Assault (homicide)</td>
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<tr>
<td>2. Cerebrovascular disease</td>
<td>2. HIV</td>
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<tr>
<td>3. Mental and behavioral disorders</td>
<td>3. Ischemic heart and vascular disease</td>
</tr>
<tr>
<td>4. Hypertension and hypertensive heart disease</td>
<td>4. Conditions starting in the perinatal period</td>
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<tr>
<td>5. Cancer of the trachea, bronchus, and lung</td>
<td>5. Motor vehicle crashes</td>
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For every 100,000 people, there were about 7,493 years of potential life lost, or YPLL, which is a statistic that measures premature death and is calculated by subtracting the age of death from the 75 year benchmark. This is a relevant indicator, as it can provide a unique and comprehensive look at overall health status. Cancer, heart disease and stroke are among the top killers in the community, as evidenced in both age-adjusted and premature death rates. Annually, about 1,236 Fulton County residents die from cancer. African-American men are disproportionately affected by the disease; for every 100,000 black men, an average 214 die each year, a figures much higher than their other racial and gender counterparts.

Each year, heart disease claims the lives of nearly 800 Fulton County residents, and an estimated 2.44 percent of the population currently lives with heart disease, according to the American Heart Association. In Fulton County, men are almost twice as likely as women to die from heart disease, and African-Americans are also more likely to die. Fulton County’s stroke mortality rate is also high, annually averaging about 331 per year, according to the National Center for Health Statistics’ Underlying Causes of Death report for 2006 through 2010. In 2010, nearly 10 percent of the population over age 18 was not taking their blood pressure medication when needed, a relevant indicator that often means limited access to preventative care and/or access to prescription services.

HIV prevalence is much higher than both state and national averages. In 2009, for every 100,000 Fulton County residents, 1,228 have been diagnosed with HIV, as compared a prevalence rate of 443 in Georgia and 309 nationally. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Unhealthy behaviors

Of the top five causes of Fulton County deaths identified, most are conditions commonly associated with unhealthy lifestyles such as the use of tobacco, high fat diets and a lack of exercise. For example, 15 percent of the county’s adult population reports that tobacco use, a figure slightly lower than the state average of 19 percent and higher than the national average of 14 percent. The motor vehicle crash rate is on par with the state average at 17 percent. Approximately 17 percent of the county reports heavy and/or binge drinking, according to the University of Wisconsin's County Health Rankings.

One in five adults are notably physically inactive, and nearly 25 percent of adults are obese (with a Body
Mass Index of more than 30) and 37 percent are overweight (with a Body Mass Index between 25 and 30). Access to healthy foods is an issue; about 7 percent of the population lives in a food desert, which means that part of the community has little or no access to large grocery stores that offer fresh and affordable foods needed to maintain a healthy diet. Instead of such stores, these districts often contain many fast food restaurants and convenience stores. This is true in Fulton County, as more than half of the restaurants in the county primarily serve fast food.

**Teen birth**

The teen birth rate in Fulton is 44 births per 1,000 teenaged women, which is below Georgia’s average but above the national average. The majority of the births are to Hispanic/Latino teens, which are more than twice more likely than their other ethnic and racial counterparts to become pregnant in their teens. Generally speaking, pregnant teens have a higher risk of having high blood pressure—called pregnancy-induced hypertension—than pregnant women in their 20s or 30s. They also have a higher risk of preeclampsia, a dangerous medical condition that combines high blood pressure with excess protein in the urine, swelling of a mother’s hands and face, and organ damage. Teens are also at higher risk of having low birthweight babies.

Additionally, there is a strong connection between teen birth and low incomes, and generational poverty can play heavily into that. For example, females born to a teen mother are a third more likely to become a teen mother themselves, according to national statistics. Other socioeconomic issues exist as well. Sons born to teen mothers are 2.7 times more likely to be incarcerated than sons born to women at least 20 years of age. Children born to unmarried teen mothers are ten times more likely to live in poverty the majority of their life. Children of teen parents are about 50 percent more likely to repeat a grade and are less likely than children born to adult parents to graduate high school.

**Mental health**

Throughout 2013, Fulton County adults will have a reported 2.8 poor mental health days each month, according to the University of Wisconsin's County Health Rankings. Over the last five years, mental and behavioral disorders were the sixth leading cause of Fulton County emergency department visits, in aggregate, and this does not include the ramifications of violent outbursts, such as assault.

Violence is a significant issue in both Fulton and DeKalb counties, with rates that that soar above both state and national benchmarks. In Fulton County, there were 953 violent crime incidents per every 100,000 residents in 2010, a figure more than double the state average and more than 13 times the national average. In aggregate between 2008 and 2012, suicide was top cause of premature death for Caucasians. Suicide was the fifteenth leading cause of premature death for African-Americans. It should be noted that the leading cause of premature death for African-Americans is homicide, and children aged 1 to 4 and 15 to 34 most often die because of this level of assault.

Instances of mental health issues are generally most prevalent in low-income communities, as the link between poverty and mental illness is significant. According to a March 2011 article in the Archives of Psychiatry, the affect of poverty on mental illness – and vice versa – is repeatedly demonstrated. For example, persons dropping from a higher income level to poverty will often face mental illness in the form of anxiety, depression and mood disorders. Conversely, those living in poverty for an extended period of time may suffer from mental illness for other reasons. Their depression and mood disorders may stem from a lack of optimism for the future. Additionally, those in poverty often do not have access to, or knowledge about, medical help and therapy that would help diagnose and treat their mental illness. Lack of nutrition, lack of education and a feeling of living day to day can contribute to mental instability.

**Identification of unmet community health needs**

Several key community health needs emerged during the assessment process. The initial list of priorities to
be addressed was determined by the community benefits department and the strategic planning department. The following criteria were used to establish the initial list of 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.

Through this process, the hospital identified three priority issues for the community:

1. Increased access to necessary and appropriate care for uninsured and underinsured patients
2. Reduced preventable readmissions and emergency department re-encounters
3. Reduced instances of preventable heart disease and hypertension

Piedmont Atlanta aims to address those priorities as follows:

**Increased access to necessary and appropriate care for uninsured and underinsured patients**

Piedmont Atlanta Hospital is committed to helping low-income community members access necessary and appropriate care in the right setting. Over the next three years, we will do this through a multi-faceted approach:

- Further develop our current emergency department care coordination program that targets preventable encounters, including those led by underlying mental health issues and ambulatory care sensitive conditions, and further define and develop our partnership with the local community clinics primarily treating uninsured patients, as well as Federally Qualified Health Centers
- Continue to provide laboratory services to the Center for Black Women's Wellness, the Grant Park Clinic and the Good Samaritan Health Center
- Utilize our safety net clinics with the Center for Black Women's Wellness and the Good Samaritan Health Center to address underlying mental health needs of vulnerable populations, particularly as they relate to depression, violent behavior, domestic violence and substance abuse
- Further develop community-based partnerships to better address underlying mental health needs of our patients and the overall community, including clinically-based groups specializing in mental health
- Undertake an internal awareness campaign aimed at helping clinicians identify potential underlying mental health conditions
- Create a resource guide of mental health resources along with information to help community members self-identify potential mental health issues, such as depression and substance abuse
- Work to eliminate certain socioeconomic barriers to accessing appropriate care, including transportation, through the strengthening of current community-based partnerships and the development of other relevant partners
- Continue to provide financial assistance to qualifying low-income, uninsured patients
- Translate relevant materials, including information about financial assistance, into appropriate languages

**Reduced preventable readmissions and emergency department re-encounters**

Piedmont Atlanta Hospital is committed to reducing preventable readmissions and emergency department re-encounters, as to ensure community members have the necessary tools and education to better self-manage their health and to stay out of the hospital unnecessarily. Over the next three years, we will do this through a multi-faceted approach:
• Utilize the emergency department care coordination program to help curb preventable emergency department reencounters, particularly around ambulatory-care sensitive conditions, with a focus on helping patients transition from the hospital to their home
• Develop a patient care self-management program that focuses on three primary areas:
  • Emergency department and admission discharge planning, including special consideration for those with limited health literacy
  • Medication management, including the connection of patients to appropriate prescription assistance programs and the provisions of relevant durable medical equipment, such as glucose monitors
  • Post-emergency department or admission follow-up to ensure continued good health
• Create a gatekeeper program, as to provide health-specific information coming in contact with members of more vulnerable communities
• Translate relevant educational materials into appropriate languages

Reduced incidences of preventable heart disease and hypertension
Piedmont Atlanta Hospital is committed to helping reduce preventable heart disease, as heart disease is one of the leading causes of death within our community. Over the next three years, we will do this through a multi-faceted approach:

• Utilize existing clinical partnerships to target at-risk patients with appropriate screenings and health education, with a particular focus on those disproportionately at risk due to race and/or socioeconomic factors
• Create and execute relevant public service announcements and health education targeting at-risk populations
• Provide in-hospital education efforts targeted at high-risk populations
• Translate relevant educational materials into appropriate languages

Next steps for priorities
For each of the priority areas listed above, Piedmont Atlanta Hospital will work with community partners to:

• Build a community-based coalition and a hospital-based task force to execute activities
• Identify any related activities being conducted by others in the community that could be built upon
• Align relevant budgets with implementation plan end goals, and seek grant funding, when possible
• Develop measurable goals and objectives so that the effectiveness of their efforts can be measured
• Sync work with system initiatives, as to ensure consistent messaging and to utilize system resources
• Build support for the initiatives within the community and among other health care providers
• Develop detailed work plans

We will also support our core community benefit programs, including the provision of financial assistance for low-income, uninsured patients; breast cancer screenings and education; health professions education, including nursing students and physicians; health and safety education conducted in community settings; the Sixty Plus program; Cancer Wellness; referrals to community services; workforce development; lactation counseling; smoking cessation classes and assistance; community-based health education programs and health screenings; and, prescription assistance.

Implementation, oversight and execution
Piedmont Atlanta Hospital has initiated the development of implementation strategies for each health priority identified by the community health needs assessment conducted in Fiscal Year 2013. This implementation plan will be executed over the next three fiscal years, and will contain measures to monitor and evaluate program effects in order to ensure that our programs are making a sustainable difference in our
community. Additionally, a community benefit oversight committee (CBOC) will be formed to guide and champion this community benefit work. This committee will be comprised of key community stakeholders from Piedmont Healthcare’s five primary communities, and will include representatives from the Atlanta community. This committee will convene quarterly, though members will be kept updated of relevant community benefit-related work throughout the year. We will also form a task force specific to Piedmont Atlanta Hospital to help execute activities. This task force will convene monthly.

How the assessment was conducted
The Piedmont Atlanta Hospital community health needs assessment began with a review of publicly available health and socioeconomic data. Our primary sources were: US Census, US Health and Human Services’ Community Health Status Indicators, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). The data was compiled and analyzed by the Hayslett Group, the lead convener of Georgia’s Partner Up for Public Health campaign. The Piedmont Atlanta board of directors and hospital leadership has been actively informed and engaged throughout this process. The overall health needs assessment effort was led by the Piedmont Healthcare community benefits team, and assisted by Community Health Advisors (for stakeholder interviews). Stakeholders were continually engaged during this process, with a particular focus on those groups, organizations and individuals representing those most vulnerable among us. Specifically, we interviewed representatives of local and regional public health entities, minority populations, the faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and other relevant stakeholders. Additionally, we conducted two focus groups: one comprised of 12 low-income and uninsured patients and another comprised of nine consumer and patient advocates representing a variety of vulnerable patients.

In March 2013, Piedmont Atlanta hosted a public meeting at the Helene S. Mills Multipurpose Facility in Atlanta to solicit feedback on certain health topics from community members. The meeting was an open discussion around addressing the identified priorities in the community. Topics discussed in the meeting included: access to care, socioeconomic determinants of health, and obesity and other obesity-related disorders. Some common themes emerged from the community benefits town hall discussion. Themes included the need for increased communication around available health resources in the community, the need for creating partnerships in the community to share resources, the need for the creation of health education programs for children and for the general community, and cultural and linguistic access to programs within the community. All interviews, focus groups and meetings informed the CHNA process, including the identification of key health priorities and potential implementation plan strategies.

Approval
The Piedmont Atlanta Hospital Board of Directors approved this community health needs assessment and implementation plan to address identified health issues on May 21, 2013.