

Piedmont Healthcare

Community Health Needs Assessment

July 2016

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EXECUTIVE SUMMARY

As a nonprofit healthcare system, the mission of Piedmont Healthcare 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.

This report identifies and assesses community health needs in the areas served by Piedmont Healthcare hospitals in accordance with regulations put forth by the Internal Revenue Service pursuant to the 2010 Patient Protection and Affordable Care Act (ACA).

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 system then identified the top priorities it will address over the next three years.

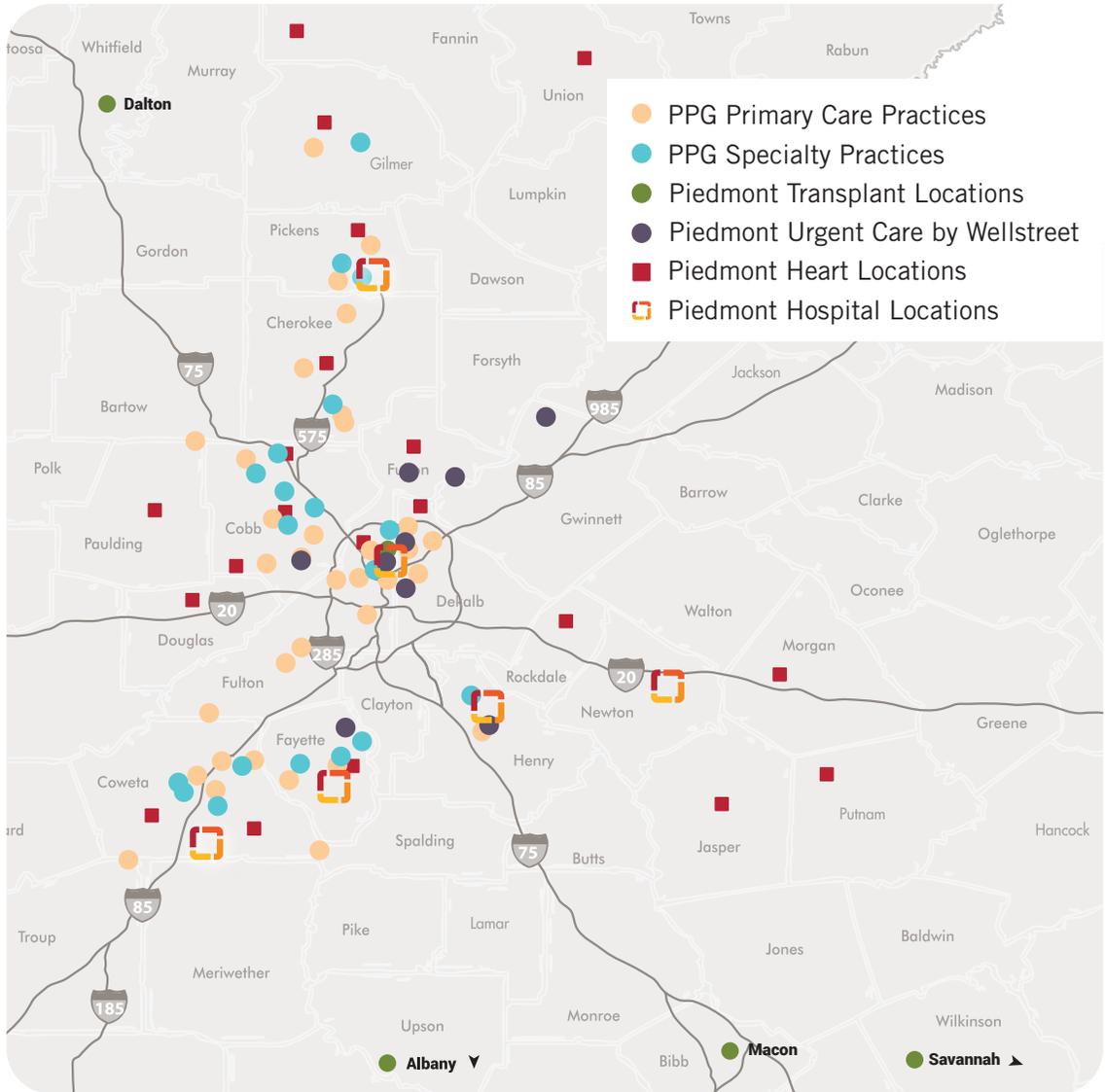
In partnership with our six primary communities, we crafted strategies to address those prioritized needs, with an end goal of bettering community health, and particularly that of those most vulnerable. Through these programs and strong partnerships between consumers, neighborhood leaders, advocates and hospitals, the hospital's communities can become stronger and healthier, both physically and fiscally. The CHNA guides this work.

This is the second set of Piedmont Healthcare hospitals' community health needs assessments (CHNAs) in response to that federal government regulation, with the first having been conducted in Fiscal Year 2013 (FY13). We completed our first CHNA and implementation plan for each Piedmont hospital community back in 2013 for use during FY14 to FY16. We repeated that process for our new Fiscal Year 2016 (FY16) CHNAs which cover a three-year time period of FY17, FY18 and FY19. The FY16 Piedmont Healthcare hospitals' CHNAs serve as a foundation for developing an implementation strategy to address those needs that (a) the hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the hospital's service area.

The question of how the hospital can best use its limited charitable resources to assist communities in need will be the subject of the hospital's implementation strategy. To answer these questions, this assessment considered multiple data sources, some primary (survey of market area residents and hospital discharge data) and some secondary (regarding demographics, health status indicators, and measures of health care access). Our CHNAs took into account input from persons representing the broad interests of the community through both a randomized mail survey of households in service area counties, and a series of mail surveys and in-person interviews with community leaders.

ABOUT PIEDMONT HEALTHCARE

As the flagship hospital of Piedmont Healthcare, Piedmont Atlanta Hospital's legacy of medical excellence began more than 110 years ago. Today it is a 529-bed facility renowned for its high quality, patient-centered healthcare. Located in Fayetteville, Piedmont Fayette Hospital is a 189-bed, acute care community hospital that combines clinical excellence with a focus on wellness, high-quality and exceptional service. Piedmont Henry Hospital is a 215-bed, acute-care, community hospital on a tobacco-free campus in Stockbridge, Georgia. Piedmont Mountainside Hospital is a private, not-for-profit, 52-bed, acute-care, community hospital located in Jasper, Georgia. Piedmont Mountainside is the sole hospital provider for Pickens County. Piedmont Newnan Hospital is a 136-bed, acute-care, community hospital in Newnan, Georgia. Piedmont Newnan is a cornerstone of wellness as the only acute-care facility in Coweta County. Piedmont Newton Hospital is a 97-bed, acute-care, community hospital in Covington, Georgia offering 24-hour emergency services, women's services and general medical/surgical services. Piedmont Newton is the newest addition to the Piedmont family, having joined the system in October 2015. Additionally, Piedmont Healthcare includes the Piedmont Heart Institute, Piedmont Transplant Institute, Piedmont Foundation and Piedmont Physicians Group.



OUR APPROACH TO COMMUNITY BENEFIT

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. 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. Among these programs include: financial assistance for low- and no-income patients, coverage for shortfalls incurred when providing care to patients receiving Medicaid, our Sixty Plus adult services program, our health professions education programs, partnerships with community-based charitable clinics and health education programs, such as nutrition programs aimed at high-risk low-income families.

FY15 PIEDMONT HEALTHCARE STATISTICS



8,625

Hospital Employees



56,485

Surgeries



10,696

Newborn Deliveries



550,099

Outpatient Encounters



328,164

Emergency Department Visits

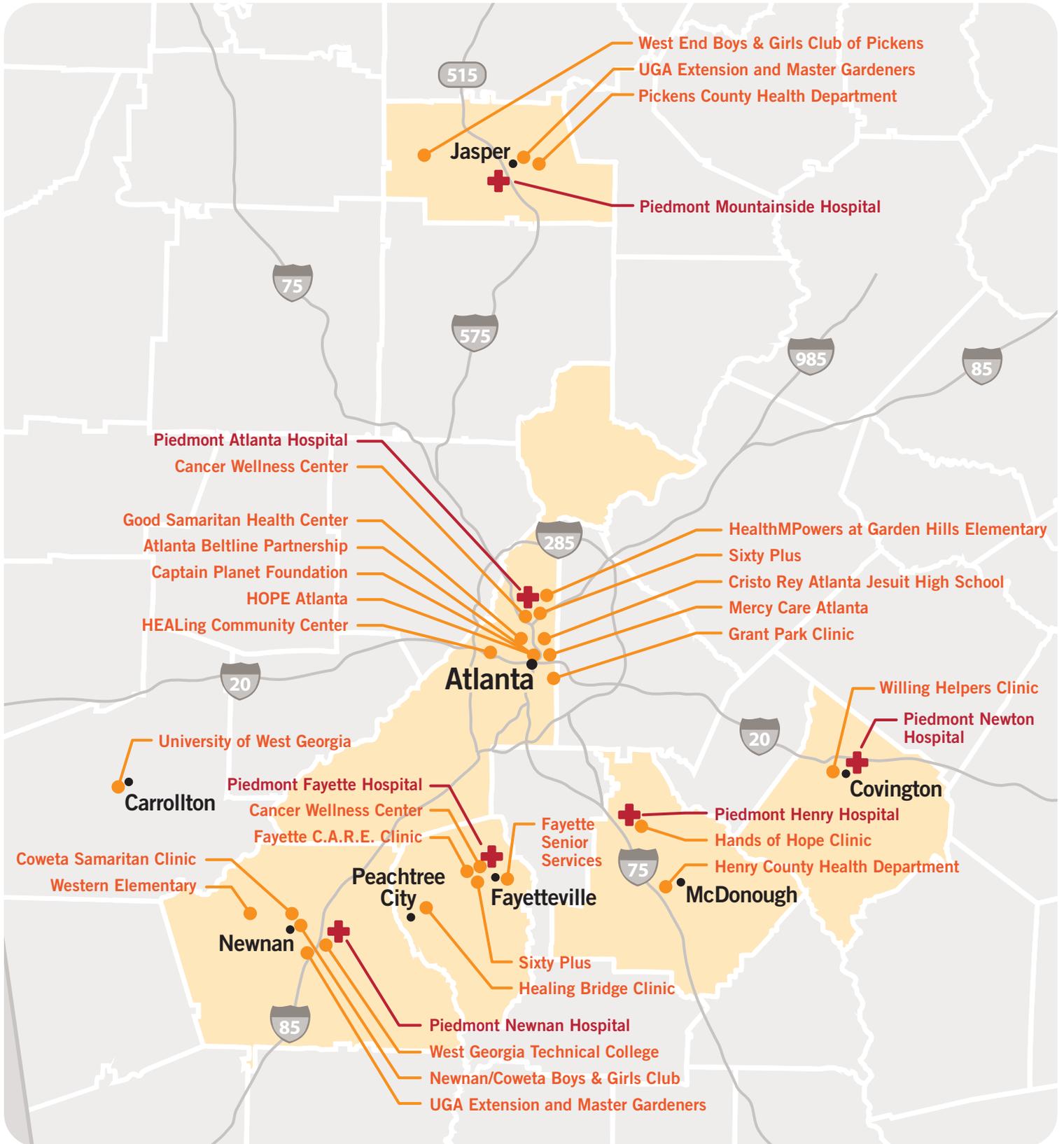


69,456

Inpatient Admissions

PIEDMONT IMPACT

This map highlights Piedmont's FY14-16 community benefit programs and partnerships throughout the larger metropolitan Atlanta area.



HOW WE CONDUCTED THE FISCAL YEAR 2016 ASSESSMENT

The Piedmont Hospital community health needs assessment was led by the Piedmont Healthcare community benefits team. We started first with an analysis of available public health data, which was done in partnership with Georgia State University's Georgia Health Policy Center (GHPC). We looked at our entire service region, which is comprised of approximately 20 counties. These counties were determined by examining internal data as to know from where the majority of our patients come. We paid particular attention to the home counties of our hospitals.

From there, and also in partnership with GHPC, 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, the faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and individuals representing our most vulnerable patients. The Piedmont Healthcare board of directors and leadership from all six hospitals were actively informed and engaged throughout this process.

An internal survey was also conducted throughout the healthcare system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Approximately 775 employees spanning the system responded.

Additionally, we conducted two focus groups comprised of primarily low-income, uninsured patients. The input provided by these focus groups indicates where Piedmont has been successful and where we still have room to grow, particularly in situations that apply to our communities' most vulnerable populations. These conversations centered on issues of health care access, as well as issues within the community. All interviews, survey, and focus group data informed the CHNA process, including the identification of key health priorities and potential implementation plan strategies.

PRIORITIES CHOSEN DURING FY16 ASSESSMENT

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.

FY17 TO FY19 PRIORITIES



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Increase access to and awareness of cancer-related programming.



Reduce preventable instances of heart disease, hypertension and stroke through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.



Reduce obesity rates and obesity-related diseases, such as Type II Diabetes, through educational awareness and promotion of healthy behaviors, including nutrition counseling and exercise.

FY17 TO FY19 PRIORITIES PER HOSPITAL

PIEDMONT ATLANTA

Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; and reduce preventable instances of heart disease, hypertension and stroke

PIEDMONT FAYETTE

Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; reduce preventable instances of heart disease and stroke; reduce obesity rates and obesity-related diseases; and address senior health issues when possible

PIEDMONT HENRY

Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; and reduce preventable instances of heart disease, hypertension and stroke

PIEDMONT MOUNTAINSIDE

Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; and reduce preventable instances of heart disease, hypertension and stroke

PIEDMONT NEWNAN

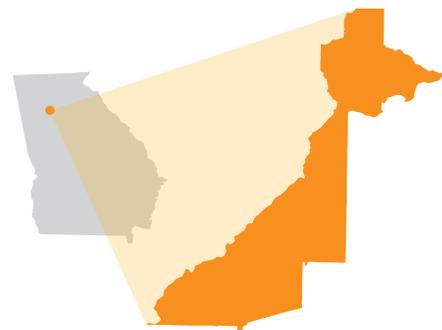
Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; reduce preventable instances of heart disease and stroke; and reduce obesity rates and obesity-related diseases

PIEDMONT NEWTON

Increase access to appropriate and affordable care; reduce preventable readmissions and emergency department re-encounters; increase access to and awareness of cancer-related programming; reduce preventable instances of heart disease and stroke; and reduce obesity rates and obesity-related diseases

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 late 1950s, when it moved to its current location. It has continually grown over the years, and currently is a 529-bed full-service tertiary facility serving the region.



PROGRESS ON PAH PRIORITIES FY14 TO FY16

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.

In Fiscal Year 2013, when we conducted our first assessment, we focused on the following priorities, which were determined through the criteria outlined above.

Increase access to appropriate and affordable care for low- and no-income patients: Develop and execute a plan to strengthen access points for low- and no-income patients, with a focus on those utilizing high-cost care settings, such as an emergency department, for their care, and continue to provide necessary care to all patients.

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (FY14-16)
- Evaluated our current financial assistance policy and billing process, and designed a new policy and process as to better serve our patients (FY16)
- Provided in-kind lab services to Good Samaritan Health Center, the Center for Black Women's Wellness and Grant Park Clinic at no charge, at an average annual value of \$200,000 (FY14-16)
- Supported clinic capacity-building workshops offered by the Georgia Charitable Care Network (FY14-16)
- Funded after-hours safety net clinics at the Center for Black Women's Wellness (FY14-16) and the Good Samaritan Health Center (FY14-15)

PROGRESS ON PAH PRIORITIES (continued)

FY14 TO FY16

- Supported increased capacity to serve homeless veterans and families through a partnership with Hope Atlanta and Cristo Rey as well as provided funding for Hope Atlanta's awareness campaign (FY15)
- Supported the FoodRX Program and Homeless Clinic at Good Samaritan Health Center through fiscal support (FY16)

Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients: Increase care coordination efforts between the hospital and community-based providers to help avoid costly readmissions and ED re-encounters.

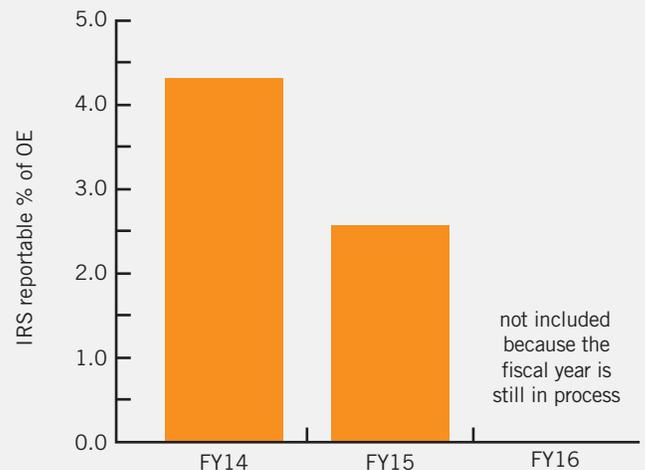
- Piloted the Walk with a Doc walking initiative (FY15-16)
- Supported HealthMPowers, which provided extensive nutrition and physical education to 625 Garden Hills Elementary school students (FY14)
- Designed and executed "What's in Store," a comprehensive nutrition and shopping program aimed at low income women (FY15-16)
- Created and distributed bi-lingual heart disease, hypertension and stroke awareness campaigns to reduce the risks of these conditions (FY16)
- Supported local school gardening programs in Fulton County by creating 2,000 recipes cards for two schools linking food grown in the school garden to cooking at home (FY15-16)
- Through funding provided by the Braves Foundation, implemented nutrition education and gardening programs in Fulton County (FY16)
- Sponsored a team of students from Douglass High School to create a PSA on healthy living through Reimagine:Atl (FY16)

Reduce instances of preventable heart disease, stroke and hypertension through the promotion of healthy behaviors: Utilize community-wide awareness campaigns and provide education that encourages community members to reduce their risks of heart disease through healthy behaviors.

- Provided extensive case management, caregiver support and other services for older adults through the Sixty Plus program (FY14-16)

- Kaiser Grant: Decreased the 60-day readmit/reencounter by 15% for low- and no income, uninsured and underinsured patients through aggressive case management and caregiver support (FY14)
- Distributed a resource guide to approximately 4,600 individuals through various Piedmont Atlanta access points and approximately 45 community benefit partners (FY16)
- Created a task force to reduce readmissions through process improvement, patient education and case management, through Piedmont Heart Institute (FY14-16)
- Supported Mercy Care's Recuperative Care Unit, which provides transitional care to homeless individuals recently discharged from the hospital, at the Gateway Center (FY15-16)

Piedmont Atlanta's community benefit spend



In aggregate, PAH's community benefit spend for FY14 and FY15 is: health professions education and other community benefit programming, including labs for three partner clinics (\$10.6m), financial assistance (\$20.3m), and shortfalls incurred from Medicaid and the provider fee (\$19.6m). The above chart represents these totals as a percentage of the hospital's operating expense, a common way to examine community benefit spends. Please note that FY16 totals are not available at this time.

PAH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts;



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming, including lung cancer screenings and low-cost mammograms to qualifying women through partnership programs.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, hypertension and stroke through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.

Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan.

- **Mental health:** We currently don't have the resources to make a meaningful impact on mental health as Piedmont Atlanta does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Violent crime:** As a health care provider, our ability to significantly impact this issue is limited as Piedmont Atlanta does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **HIV/AIDS/STDs:** While we will not focus on this priority over the next three years, we will continue to provide care and support to those with these health conditions, and will explore additional opportunities for community-based partnerships around prevention.

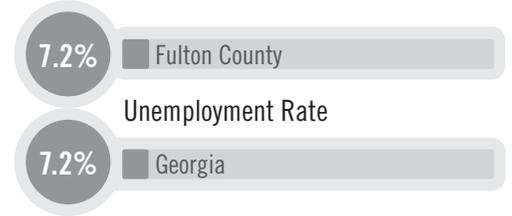
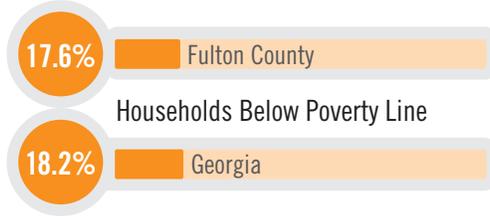
Although we will not focus on these issues during our assessment, as opportunities arise to make a positive difference on the issue, we will do so.

PAH COMMUNITY

In 2016, approximately
948,554
people live in our community



There are approximately
68 languages and cultures
found in the larger community



HEALTH FACTORS



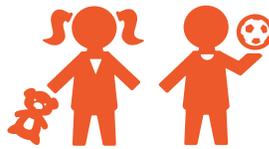
In Fulton County, **25%** of adults are uninsured.



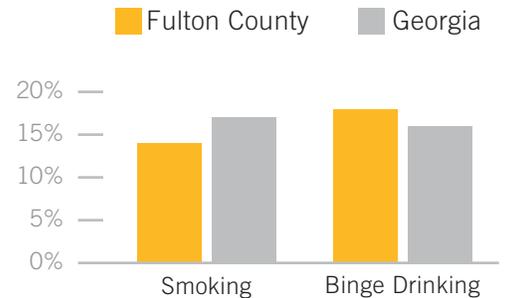
27% of Fulton County residents live in an area designated as having a **shortage of medical professionals.**

11% of adult residents are living with **diabetes.** An estimated one-third of adults who have the disease are undiagnosed.

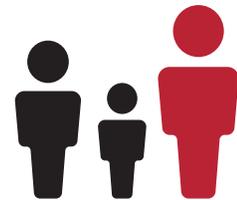
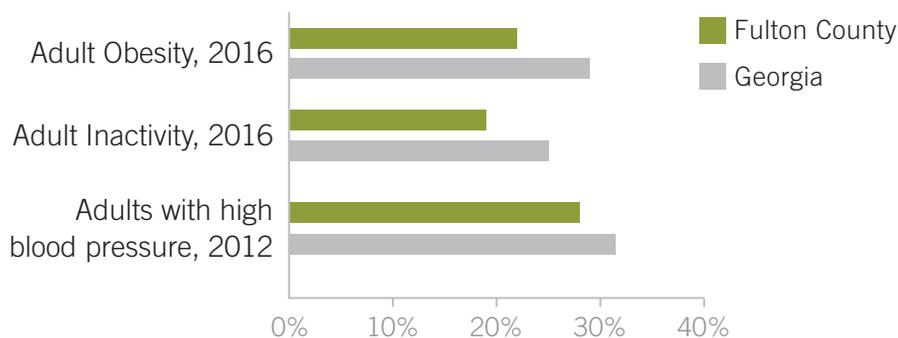
15% reported they were in poor or fair health, a **figure lower than the state benchmark of 19%.**



10% of children in Fulton County are uninsured, a figure in line with the state average.



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for hospital admissions in Fulton County in 2016.

Sources: US Census, US Health and Human Services' Community Health Status Indicators, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2016, unless otherwise noted. Health indicators are estimates provided by County Health Rankings, which is based on census data.

THE PAH COMMUNITY AT LARGE

Fulton County encompasses many different populations and development areas. Overall, the county aligns with metropolitan Atlanta region averages for many health factors and outcomes, although there are disparities concealed within these averages. Some key stats about the county:

POPULATION

- Adults under the age of 65 tend to be educated: 75.6% have attended college, though only about two-thirds of those adults complete their education.
- 43% of children live in single parent homes, which is often linked to low college graduation rates.
- More children live in poverty (25%) than the regional average (21.9%).
- One in five households have experienced food insecurity within the last year.
- While the 2016 unemployment rate was in line with the state average (7.2%), the unemployment rate for black residents (18.4%) was about three times higher than the rate for non-Hispanic white residents (6.2%). In one part of the county, women were employed at 3.8 times the rate of men in the labor force.
- Fulton County residents report the second-lowest number of days of poor physical health per month (3.5 versus 3.9), average premature death rates, and very low rates of preventable hospitalization (41 versus 55 statewide).
- County residents also report the third-lowest number of poor mental health days (3.5 versus 4.0). However, ER utilization for mental health needs is above average (1,146.2 versus 902.9).
- The county has a high rate of mental health providers (490:1) though not all residents may be able to access these services at the same rate due to insurance limitations or fiscal restraints.
- Fulton County also has elevated rates of assault-related hospitalizations (46.6 versus 33.0) and ER visits (368.6 versus 230.0).
- One in four county residents live in a health professional shortage area.

HEALTH FACTORS

- 19.1% of adults reported that they did not engage in intentional physical activity, versus 22.3% of the region. 14.2% of workers used a physically active form of commuting.
- Diabetes diagnoses were relatively low (8.6% versus 10.0% regionally), though hospitalization for this condition was above average (181.4 versus 155.4).
- Most cardiovascular diseases were average or below average, except hypertension-related conditions; Fulton residents tend to be hospitalized for hypertension-related conditions at a rate about a third higher than the region.
- Smoking rates were below average at 14% compared with 15% regionally, although asthma-related ER visits tend to remain high at hospitals throughout the county.
- Sexually transmitted infections continue to be a concern for the county as well. Chlamydia prevalence was 556.9 versus 421 region-wide, and gonorrhea was prevalent at 239.5 versus 124.
- At 1,307.3 per 100,000 residents, HIV/AIDS rates were the highest in the region, and one of the highest rates in the U.S. HIV testing rates (55.0%), were also some of the highest in the region.

It's important to keep in mind that the county is geographically large and the northern part tends to have far higher wages, lower poverty rates and better overall health.

PAH STAKEHOLDER INTERVIEWS

As a part of our process, the Georgia Health Policy Center interviewed several stakeholders, including policymakers in the Fulton community. The major themes discussed by key informants included the need for better access to healthy nutrition, the need for better access to care, and the need for behavioral health services.

Key informants discussed the impact that nutrition can have on outcomes including obesity, diabetes, and high blood pressure. They recommended that adults and children receive health education and outreach efforts that would focus on showing people how food is grown and how to cook healthy foods.

The lack of affordable and appropriate access to care for the underserved impacts emergency room utilization and increased long-term chronic health issues. Key informants suggested that increasing the number of FQHCs in communities and the use of satellite centers offering access to qualified nursing staff that could consult physicians by secure internet or telehealth technologies could improve the access residents have to care and in turn improve outcomes.

Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize behaviors that are a direct result of behavioral health diagnoses and to make appropriate referrals that offer residents the treatment they require to improve outcomes.

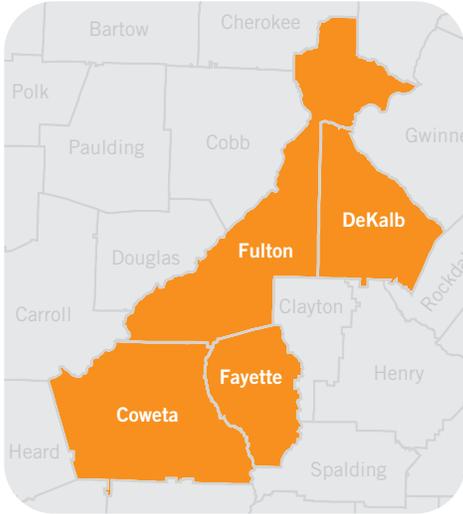
FY15 PIEDMONT ATLANTA STATISTICS

July 01, 2014 to June 30, 2015



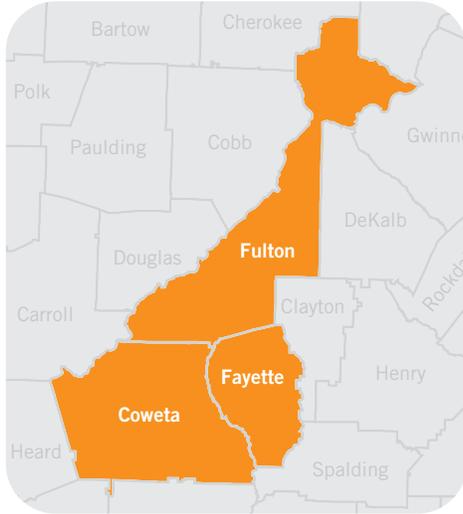
ENCOUNTERS AT PAH BY ZIP CODE

An encounter is an interaction between a patient and a healthcare provider for the purpose of providing a healthcare service or assessing the health status of a patient.



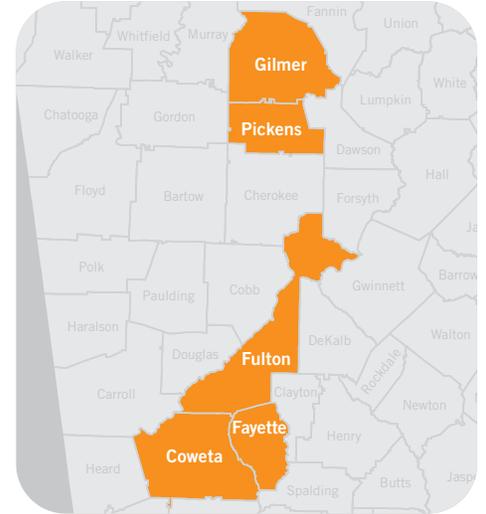
Top 10

COWETA 30263 - 22,693	FAYETTE 30214 - 13,010 30215 - 12,582 30269 - 12,176	FULTON 30305 - 24,380 30327 - 21,424 30331 - 20,138 30318 - 19,136 30309 - 17,570
DEKALB 30319 - 13,270		



Top 10 - Medicare

COWETA 30263 - 19,922 30265 - 9,565	FAYETTE 30214 - 10,441 30215 - 9,477 30269 - 9,445	FULTON 30305 - 14,546 30331 - 12,583 30327 - 12,335 30318 - 9,647 30309 - 8,372
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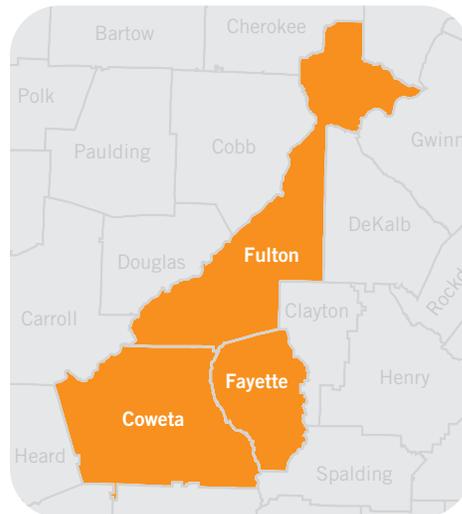
Top 10 - Medicaid

COWETA 30263 - 1,352 30265 - 353	FULTON 30318 - 1,207 30331 - 601 30309 - 524 30349 - 462 30213 - 210	GILMER 30540 - 408 PICKENS 30143 - 467
FAYETTE 30214 - 202		



Top 10 - Financial Assistance Qualified

DEKALB 30032 - 565	FULTON 30318 - 907 30310 - 903 30331 - 734 30314 - 732 30315 - 692	FULTON (cont.) 30349 - 488 30311 - 432 30344 - 299 30354 - 264
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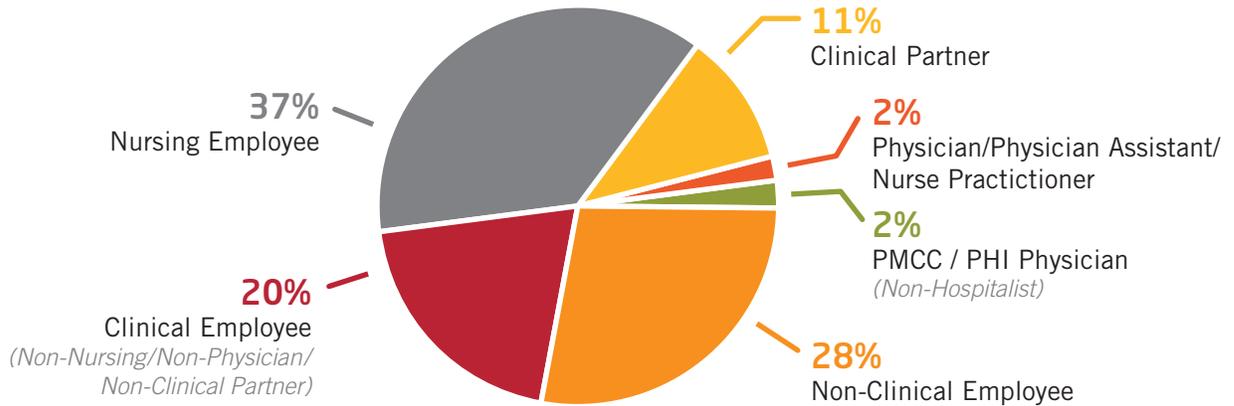
Top 10 - Other Payors

COWETA 30263 - 19,922 30265 - 9,565	FAYETTE 30214 - 10,441 30215 - 9,477 30269 - 9,445	FULTON 30305 - 14,546 30331 - 12,583 30327 - 12,335 30318 - 9,647 30309 - 8,372
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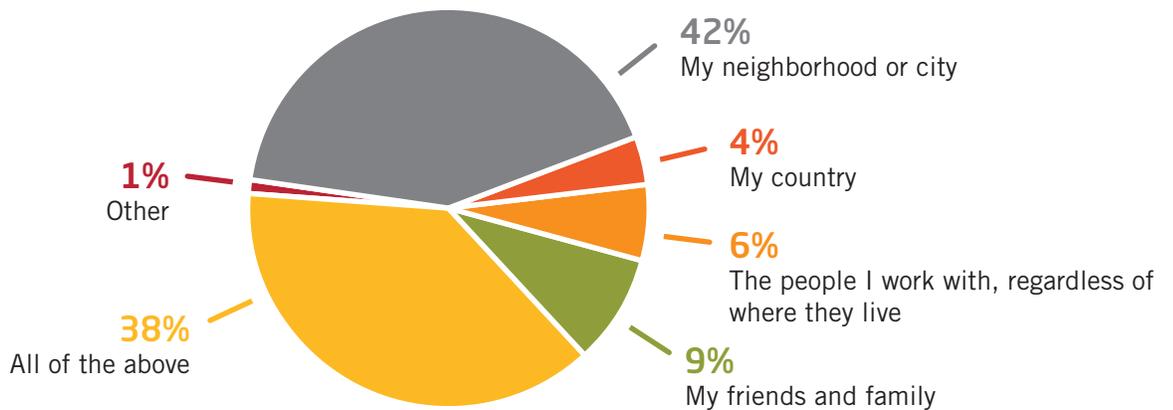
PAH EMPLOYEE SURVEY

Two hundred Piedmont Atlanta employees completed the internal CHNA survey, which focused on questions regarding community health and the hospital's role. Below are some selected questions. The full system survey is available in the addendum.

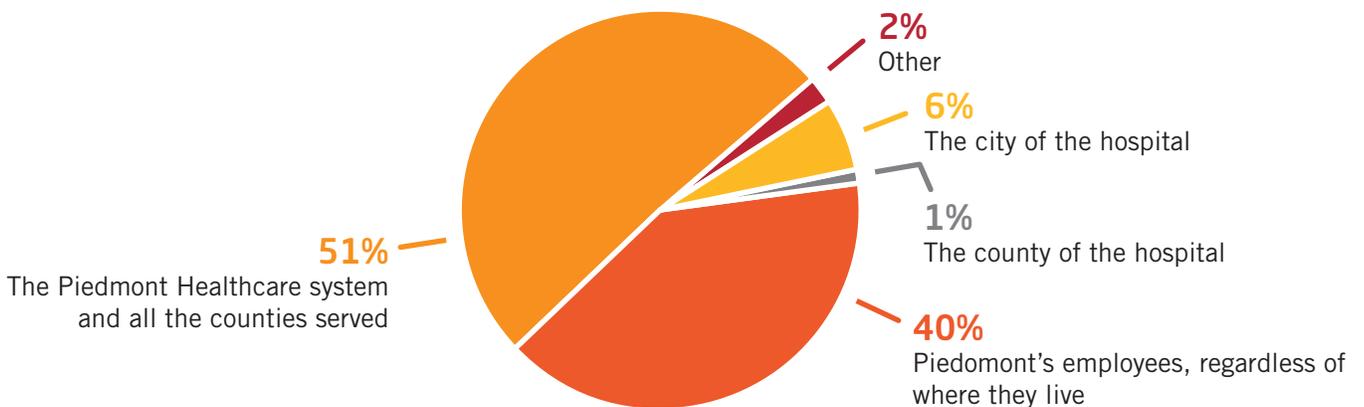
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PAH EMPLOYEE SURVEY (continued)

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

Top 5 answers highlighted in the "Important" column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	2.0%	18.8%	79.2%
Community-based health education	1.0%	9.6%	89.4%
Community-based programs around health and wellness	1.0%	10.7%	88.3%
Increased social services for patients needing additional attention	1.5%	13.8%	84.7%
Financial assistance for those who qualify	1.5%	18.2%	80.3%
Affordable healthy food	2.0%	14.8%	83.2%
Support in finding job opportunities	4.1%	26.4%	69.5%
Local outpatient mental health services	2.0%	10.2%	87.8%
Parks and recreation facilities	8.2%	34.7%	57.1%
Transportation for care	2.6%	18.9%	78.6%
Partnerships with charitable clinics	1.5%	19.3%	79.2%
Wellness services outside of the hospital	0.5%	12.8%	86.7%
Expanded access to specialty physicians	3.1%	16.3%	80.6%
Free or affordable health screenings	0.0%	8.7%	91.3%
Safe places to walk/play	5.1%	15.7%	79.2%
Substance abuse rehabilitation services	2.1%	22.1%	75.9%
Community public service projects	2.6%	29.1%	68.4%

Q To you, what does “community benefit” mean?

Common Answers:

“A healthier community produces healthier lives for everyone”

“Improving, empowering, and helping the community with their health needs”

“It means having access to affordable healthcare”

“Programs and services that will help the community thrive”

“Taking care of and considering all the healthcare needs of the patients and employees”

“Providing services, city/state influence, outreach, and direct action to ensure and promote the health, safety, and wellbeing of the community for all races and socio-economic peoples”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Better mental health collaboration
- Accept more insurance policies
- Health education
- Accessibility to non-English speaking communities
- Better access to care and financial aid
- Helping the homeless
- Transportation

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“Communication about community benefit programs and partners, more awareness”

“Partnerships with schools and churches”

“Free health education opportunities for everyone”

“More affordable care”

“Lack of Piedmont physicians accepting Medicare. Need an increase in specialty services.”

PAH NEXT STEPS

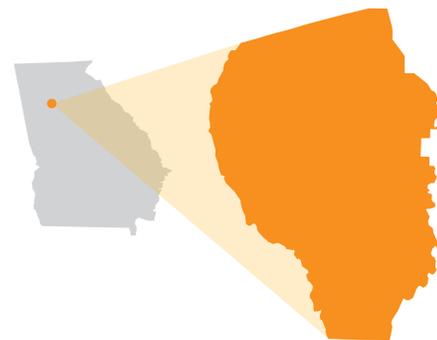
We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. This implementation plan will be 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.

APPROVAL

The Piedmont Atlanta Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 17, 2016.

ABOUT THE HOSPITAL

Piedmont Fayette Hospital is a full-service facility with 189 beds, and is among the most highly-ranked and awarded hospitals in the Southeast. Located on Highway 54 in Fayetteville, the hospital was opened in 1997 as Fayette Community Hospital and became Piedmont Fayette Hospital in November 2004. In June 2015, a 130,000 square foot expansion project launched to better meet patient needs at Piedmont Fayette. In addition to expanding the inpatient bed capacity by more than one-third, the number of emergency department exam rooms will double with the addition of 27 exam rooms, 12 observation beds, and three trauma rooms, among other expansions.



PROGRESS ON PFH PRIORITIES FY14 TO FY16

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.

In Fiscal Year 2013, when we conducted our first assessment, we focused on the following priorities, which were determined through the criteria outlined above. We started work on these priorities in FY14.

Increase access to appropriate and affordable care for low- and no-income patients: Develop and execute a plan to strengthen access points for low- and no-income patients, with a focus on those utilizing high-cost care settings, such as an emergency department, for their care, and continue to provide necessary care to all patients.

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (FY14-FY16)
- Evaluated our current financial assistance policy and billing process, and designed a new policy and process to better serve our patients (FY16)
- Provided lab services at no charge to the Fayette C.A.R.E. Clinic and its patients (FY14-16)
- Provided mammograms with appropriate follow-up care for low-income women through a Komen grant and applied for future grants to continue providing services to the Fayette community (FY14-15)

PROGRESS ON PFH PRIORITIES (continued)

FY14 TO FY16

Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients:

Increase care coordination efforts between the hospital and community-based providers to help avoid costly readmissions and ED re-encounters.

- Created and deployed the Sams Care Coordination program to reduce preventable, low-acuity ED visits among limited-income, high-risk patients by increasing staff capacity at the Fayette C.A.R.E Clinic, streamlining communication through the provision of electronic medical records, and eliminating socioeconomic barriers to care through licensed medical social workers (FY14-16)
- Provided extensive case management, caregiver support and other services for older adults through the Sixty Plus program (FY14-FY16)
- Created a task force to reduce readmissions through process improvement, patient education and case management, through Piedmont Heart Institute (FY14-FY16)
- Designed and distributed a resource guide to approximately 1,700 individuals through various Piedmont Fayette access points and approximately 10 community benefit partners (FY15-16)

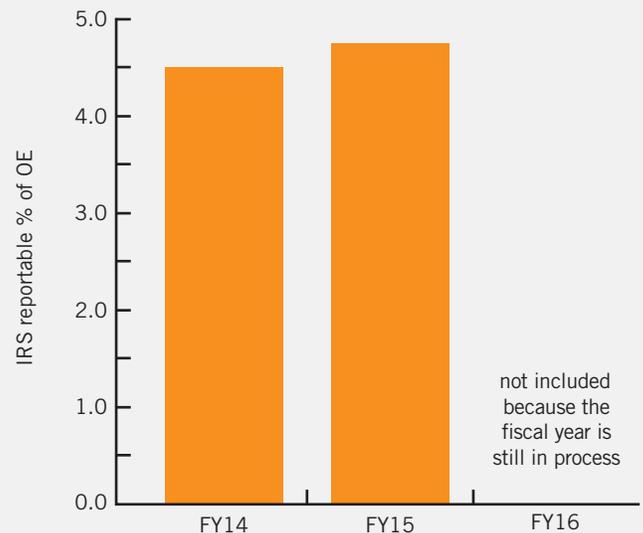
Reduce instances of preventable heart disease, stroke and hypertension through the promotion of healthy behaviors:

Utilize community-wide awareness campaigns and provide education that encourages community members to reduce their risks of heart disease through healthy behaviors.

- Launched the Live Better program, which helps to foster community collaboration around shared health concerns through community-based partnerships and programs (FY14-16)
- Created the Walk with a Doc initiative, with 654 miles walked by 376 community members (FY14-FY16)
- Created heart disease, hypertension and stroke awareness educational materials in English and in Spanish to reduce risks through healthy lifestyle changes aimed at reaching high-risk community members (FY15)

- Created and implemented the “Catch Me Clean” Hygiene Campaign to raise awareness about hand washing and to help decrease the spread of infections and seasonal flu; project done in partnership with Fayette County Board of Education, and is in 26 Fayette County schools, three libraries and community centers (FY15-16)
- Supported the creation of a learning garden at Spring Hill Elementary, a school with a high percentage of low-income students, in partnership with the Fayette UGA Extension Office (FY16)

Piedmont Fayette’s community benefit spend



In aggregate, PFH’s community benefit spend for FY14 and FY15 is: health professions education and other community benefit programming, including labs for three partner clinics (\$5.1 million), financial assistance (\$10.2 million), and shortfalls incurred from Medicaid and the provider fee (\$6.6 million). The above chart represents these totals as a percentage of the hospital’s operating expense, a common way to examine community benefit spends. Please note that FY16 YTD totals are not available at this time.

PFH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts.



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients,

including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming,

including low-cost mammograms to qualifying women through partnership programs.



Maintain and, when possible, grow efforts around senior health.



Reduce preventable readmissions and emergency department re-encounters,

particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, obesity and stroke

through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.



Beginning in 2014, PFH provided funding to the Fayette CARE Clinic that enabled them to hire several new staff members, implement an electronic medical records system, double their office hours and significantly increase the number of patients they are able to serve.

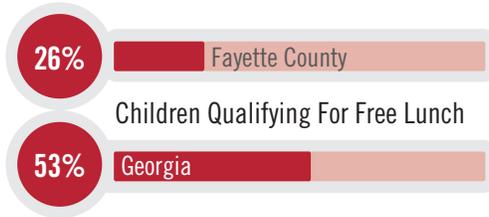
Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan that we will not focus on during the next three-year community benefit cycle:

- **Mental health:** We don't have the resources to make a meaningful impact on mental health as Piedmont Fayette does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them.
- **Chronic Obstructive Pulmonary Disease:** We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts.

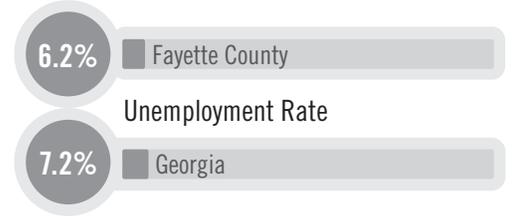
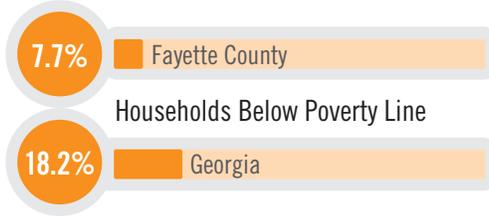
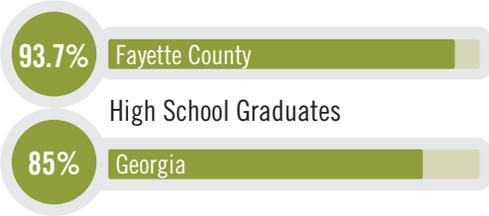
Although we will not focus on these issues during our assessment, if the opportunity arises to make a positive difference on the issue, we will do so.

PFH COMMUNITY

In 2016, approximately
107,105
people live in our community



Approximately **1 in 7**
adults reports having **poor dental health.**



HEALTH FACTORS



In Fayette County, **16%**
of adults are uninsured.

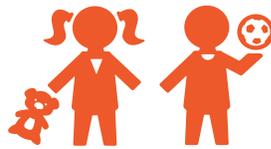


There are **910:1**
patients to primary care
physicians in Fayette County
vs. **1,540:1** across Georgia.

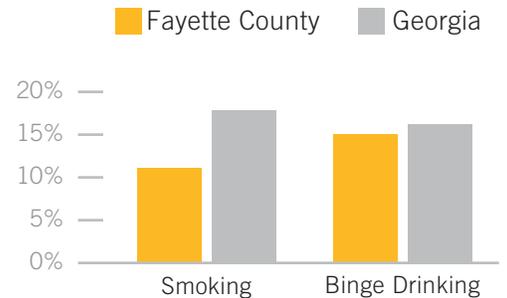
This shows a shortage of medical professionals.

11% of adult residents are
living with **diabetes.**
An estimated one-third of adults who
have the disease are undiagnosed.

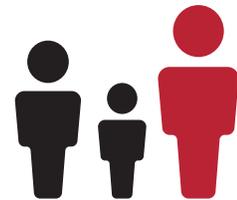
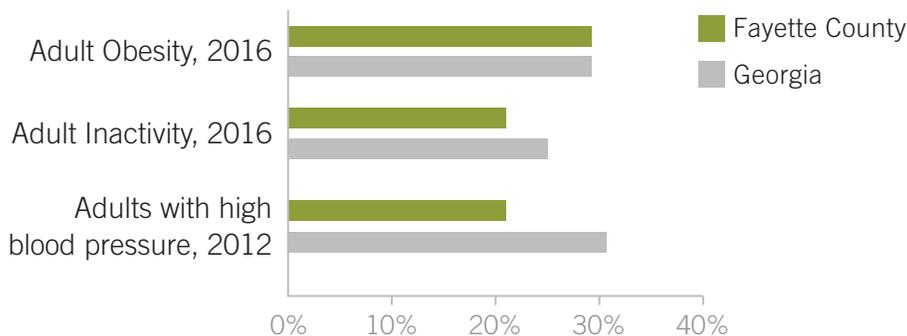
12% reported they
were in poor or
fair health, a figure lower than
the state benchmark of **19%.**



9% of children in Fayette County
are uninsured, a figure below the
state average of 10.0%.



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for
hospital admissions in Fayette County in 2016.

Sources: US Census, US Health and Human Services' Community Health Status Indicators, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2016, unless otherwise noted. Health indicators are estimates provided by County Health Rankings, which is based on census data.

THE PFH COMMUNITY AT LARGE

While a portion of Fayette County is within pockets of affluence, there are some significant health concerns that need to be addressed in the overall community, particularly among lower-income adults and elderly. Some key statistics about the county:

POPULATION

- Fayette County has a larger than average population aged 65 and over, making up more than 14% of the overall population.
- Almost three in four county residents are white.
- Adults in the county are fairly well-educated: just one in fifteen adults lack a high school diploma or equivalent and more than three in four adults have attended college.
- Fayette has a low percentage of single-parent homes in the service region, at 22% versus 37% regionally.
- Fayette also has the highest rate of participation in civic or social associations at 14% of adults among the service region.

HEALTH FACTORS

- Suicide rates are about average, accounting for approximately 30 deaths per 100,000 individuals versus 33 average deaths across the service region.
- Fayette County has the highest rate of dental providers in the service region (90.4 versus 49.7 on average), but county residents reported similar rates of poor dental health as compared to the rest of the region.
- At least one in ten workers who live in the county spend more than an hour commuting each way to work each day.
- At least one in ten households experienced food insecurity in the last year.

MEDICAL FACTORS

- Fayette County residents report fewer poor physical health days per month at 3.0 than the state rate of 3.9, as well as fewer poor mental health days per month at 3.3 versus the state rate of 4.0.
- Fayette County residents are also less likely to die prematurely than those in other parts of the region.
- Most disease rates are lower than average, including most heart and respiratory diseases, injuries, and other chronic disease. However, a higher percentage of adults (17%) have been told they have asthma relative to the service region (14%).
- Hospital utilization for heart disease and stroke is slightly lower than average, although residents are marginally more likely to visit the ER for heart attack or obstructive heart disease emergencies and for stroke than across the state.

PFH STAKEHOLDER INTERVIEWS

As a part of our process, the Georgia Health Policy Center interviewed several key stakeholders including local policy makers and community leaders in the Fayette community. Interviewees noted that Fayette is overall a fairly healthy county, particularly compared to other Georgia counties, but still has community health issues. Among the many issues mentioned, they emphasized that Fayette has a large aging population that requires special resources. Health issues for an aging population can include dementia, physical health and mobility issues, and heart health. Other notable health issues frequently discussed were mental health and obesity.

Key informants discussed mental health and substance abuse as major factors that impact community health in Fayette County. One informant stated, “I think a lot of the mental health issue is tied back into socioeconomics and the struggles or pressure families face.” They recommended developing stronger partnerships among community stakeholders and a better referral system, as well as addressing socioeconomic factors.

Numerous interviewees also felt that addressing the obesity issue in Fayette County could help to reduce health outcomes related to heart attack, stroke and diabetes. Recommendations included increasing free health education opportunities and awareness campaigns for the community.

FY15 PIEDMONT FAYETTE STATISTICS

July 01, 2014 to June 30, 2015



1,660

Employees



11,100

Surgeries



2,571

Newborn Deliveries



95,711

Outpatient Encounters



67,555

Emergency Department Visits

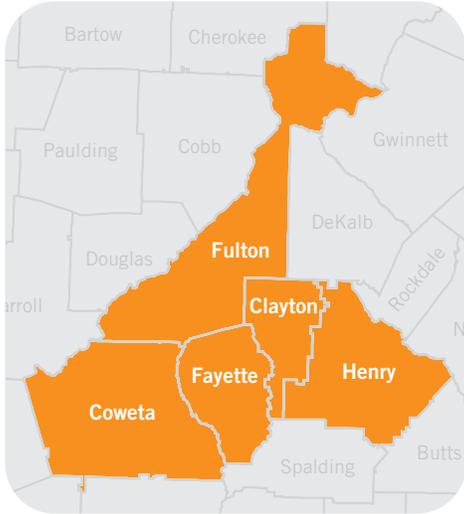


13,171

Inpatient Admissions

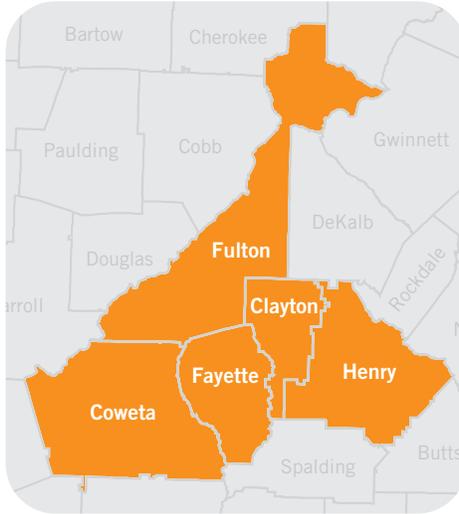
ENCOUNTERS AT PFH BY ZIP CODE

An encounter is an interaction between a patient and a healthcare provider for the purpose of providing a healthcare service or assessing the health status of a patient.



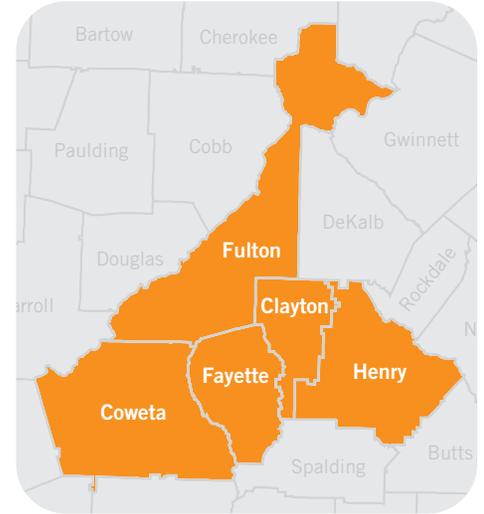
Top 10

CLAYTON 30238 - 17,444	FAYETTE 30215 - 42,453 30214 - 41,972 30269 - 36,941	FULTON 30213 - 18,502 30349 - 12,193
COWETA 30277 - 10,173 30276 - 10,088 30263 - 10,015	HENRY 30228 - 13,875	



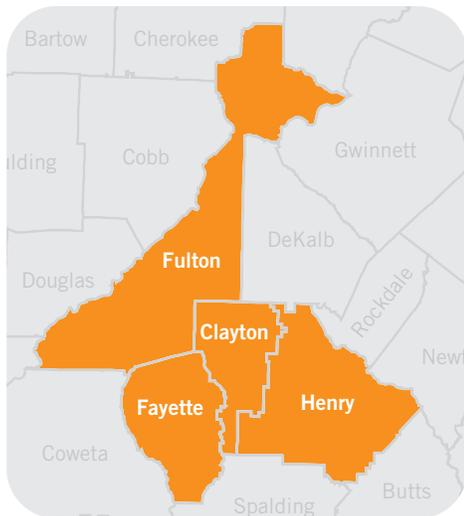
Top 10 - Medicare

CLAYTON 30238 - 10,714 30236 - 4,602	FAYETTE 30214 - 26,159 30215 - 21,412 30269 - 18,640	FULTON 30213 - 10,669 30349 - 6,809
COWETA 30263 - 5,270 30277 - 4,572	HENRY 30228 - 7,557	



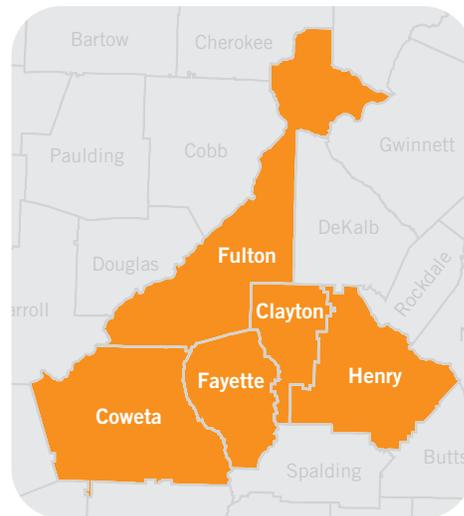
Top 10 - Medicaid

CLAYTON 30238 - 4,053 30236 - 1,331	FAYETTE 30214 - 4,077 30215 - 2,686 30269 - 1,838	FULTON 30213 - 3,452 30349 - 2,072
COWETA 30263 - 1,239 30276 - 895	HENRY 30228 - 2,290	



Top 10 - Financial Assistance Qualified

CLAYTON 30238 - 1,598 30274 - 825 30296 - 746	FAYETTE 30214 - 1,151 30269 - 784 30215 - 687	FULTON 30213 - 1,412 30349 - 810 30291 - 771
HENRY 30228 - 1,022		



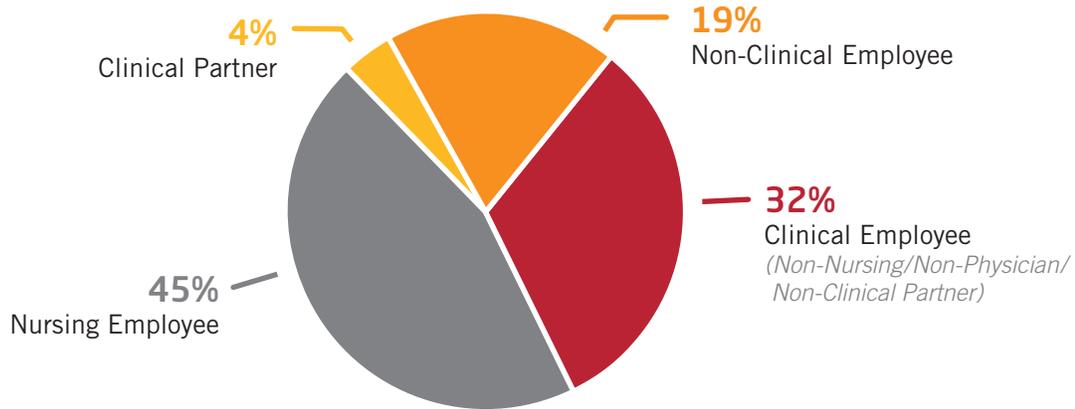
Top 10 - Other Payors

CLAYTON 30238 - 10,714 30236 - 4,602	FAYETTE 30214 - 26,159 30215 - 21,412 30269 - 18,640	FULTON 30213 - 10,669 30349 - 6,809
COWETA 30263 - 5,270 30277 - 4,572	HENRY 30228 - 7,557	

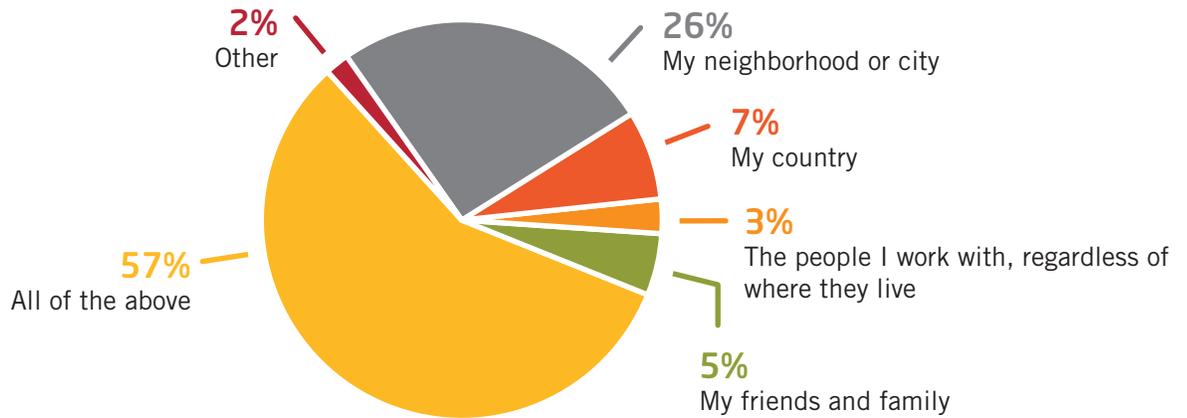
PFH EMPLOYEE SURVEY

Ninety-five Piedmont Fayette employees completed the internal CHNA survey, which focused on questions regarding community health and the hospital's role. Below are some selected questions. The full system survey is available in the addendum.

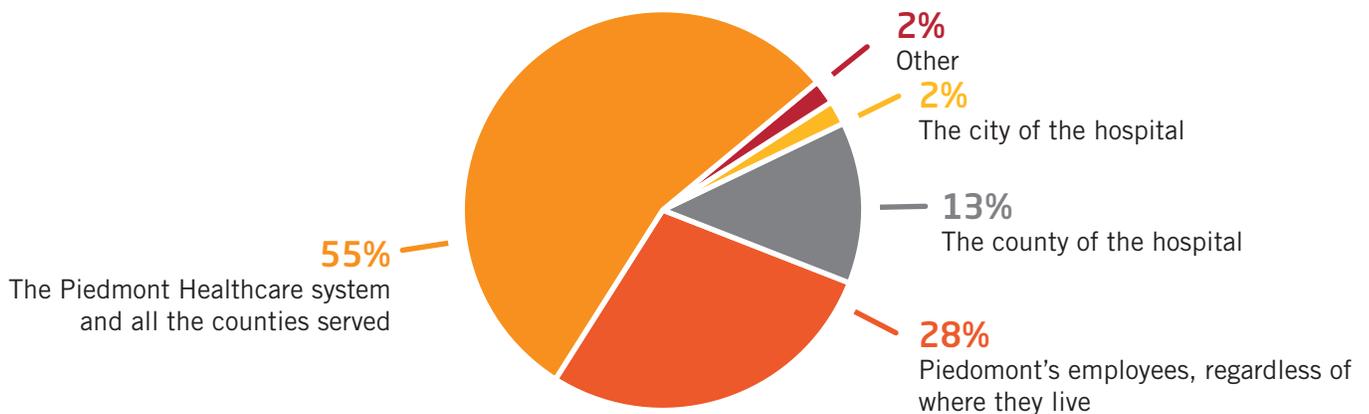
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PFH EMPLOYEE SURVEY (continued)

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

Top 5 answers highlighted in the "Important" column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	2.1%	13.7%	84.2%
Community-based health education	0.0%	6.3%	93.7%
Community-based programs around health and wellness	0.0%	7.4%	92.6%
Increased social services for patients needing additional attention	0.0%	7.4%	92.6%
Financial assistance for those who qualify	0.0%	14.7%	85.3%
Affordable healthy food	0.0%	6.3%	93.7%
Support in finding job opportunities	2.1%	20.2%	77.7%
Local outpatient mental health services	1.1%	5.3%	93.7%
Parks and recreation facilities	3.2%	15.8%	81.1%
Transportation for care	1.1%	12.6%	86.3%
Partnerships with charitable clinics	0.0%	15.8%	84.2%
Wellness services outside of the hospital	0.0%	8.4%	91.6%
Expanded access to specialty physicians	1.1%	12.6%	86.3%
Free or affordable health screenings	0.0%	12.8%	87.2%
Safe places to walk/play	1.1%	15.1%	83.9%
Substance abuse rehabilitation services	1.1%	18.5%	80.4%
Community public service projects	2.1%	23.4%	74.5%

Q To you, what does “community benefit” mean?

Common Answers:

“Resources that are accessible to everyone in the community”

“The good things that come from being part of a community”

“Things that can help and make the community grow”

“To me it is something that empowers or helps the greater good. Not just the lowly or high up but reaches from end to end to have a better way of life”

“What we do to improve access to healthcare and education for all staff and patients will benefit the entire community”

“Benefiting our community by being accessible, safe, caring, present, and meeting community needs”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Transportation
- Health education
- Mental health services and partnerships
- Access to affordable care and follow up care, including assistance with costly medications
- Food assistance programs
- More primary care providers for vulnerable populations

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“More advertising and communication about community benefit programs and partnerships”

“Access to affordable healthcare resources”

“Mental health services need to be expanded across all communities”

“Transportation for patients to get to the hospital”

“Community education and making it aware to people in community”

“Piedmont needs to branch further out into more rural areas, where healthcare is not as easily accessible”

PFH NEXT STEPS

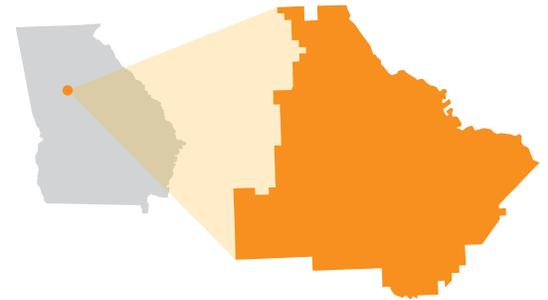
We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. This implementation plan will be 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.

APPROVAL

The Piedmont Fayette Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 11, 2016.

ABOUT THE HOSPITAL

Piedmont Henry Hospital is a full-service facility with 215 beds, and is the only hospital within the county. The hospital was founded in 1979 as Henry General Hospital. In 1995, the name was changed to Henry Medical Center, and remained that until the hospital joined the Piedmont Healthcare family of community hospitals on January 01, 2012, thus becoming Piedmont Henry Hospital.



PROGRESS ON PHH PRIORITIES FY14 TO FY16

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.

In Fiscal Year 2013, when we conducted our first assessment, we focused on the following priorities, which were determined through the criteria outlined above. We started work on these priorities in FY14.

Increase access to appropriate and affordable care for low- and no-income patients: Develop and execute a plan to strengthen access points for low- and no-income patients, with a focus on those utilizing high-cost care settings, such as an emergency department, for their care, and continue to provide necessary care to all patients.

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (FY14-16)
- Evaluated our current financial assistance policy and billing process, and designed a new policy and process to better serve our patients (FY16)
- Provided in-kind lab services to Hands of Hope at no charge to the clinic or its patients (FY14-16), and provided clinical space and utility support for Hands of Hope and the Henry County Health Department (FY14-16)
- Provided free screening mammograms with referrals to follow-up care when necessary for qualifying women through the Breast Health Connection program in partnership with the Henry County Health Department (FY15)

PROGRESS ON PHH PRIORITIES (continued)

FY14 TO FY16

Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients: Increase care coordination efforts between the hospital and community-based providers to help avoid costly readmissions and ED re-encounters.

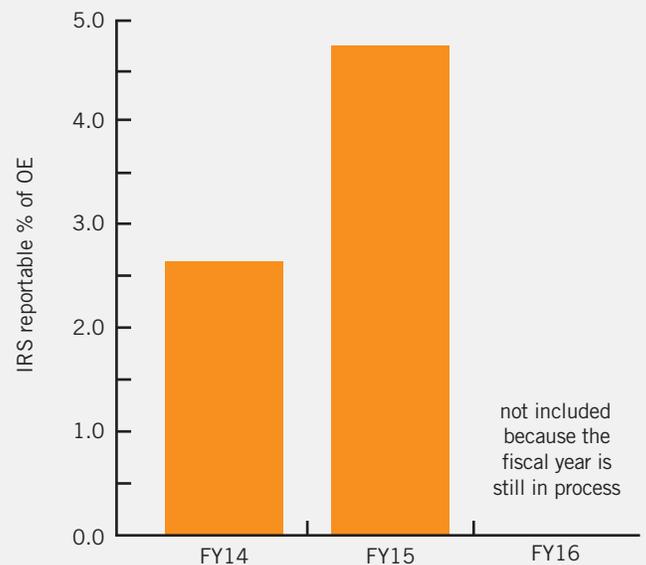
- Created and deployed the Sams Care Coordination program to reduce preventable, low-acuity ED visits among limited-income high-risk patients by increasing staff capacity at the Hands of Hope Clinic, streamlining communication through access to patients' electronic medical records, and eliminating socioeconomic barriers to care through a licensed medical social worker (FY14-16)
- Created a task force to reduce readmissions through process improvement, patient education and case management, through Piedmont Heart Institute (FY14-16)
- Distributed a resource guide to approximately 2,790 individuals through various Piedmont Henry access points and approximately nine community benefit partners, which outlines federal and local organizations that offer programming for limited-income individuals and how to apply for assistance in English and in Spanish (FY16)

Reduce instances of preventable heart disease, stroke and hypertension through the promotion of healthy behaviors: Utilize community-wide awareness campaigns and provide education that encourages community members to reduce their risks of heart disease through healthy behaviors.

- Created the Live Better program, which works to foster community collaboration around shared health concerns (FY14-16)
- Piloted and continued the Walk with a Doc walking initiative, with about 265 miles walked by more than 158 community members (FY14-16)
- Created and distributed stroke awareness educational materials in English and Spanish in partnerships with the stroke accreditation teams aimed at high-risk community members (FY15-16)
- Sponsored a learning garden at Red Oak Elementary, in partnership with Community Gardens of Henry County (FY16)

Other community benefit programs included health professions education, in which approximately 65,942 hours of service was provided by medical professions students at a cost of \$1.9 million.

Piedmont Henry's community benefit spend



In aggregate, PHH's community benefit spend for FY14 and FY15 is: health professions education and other community benefit programming, including labs for three partner clinics (\$2.0 million), financial assistance (\$10.4 million), and shortfalls incurred from Medicaid and the provider fee (\$483 thousand). The above chart represents these totals as a percentage of the hospital's operating expense, a common way to examine community benefit spends. Note that care provided to low-income patients through financial assistance or Medicaid may not be reflected in the FY16 YTD figures. Please note that FY16 totals are not available at this time.

PHH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts.



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming, including low-cost mammograms to qualifying women through partnership programs.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, hypertension and stroke through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.



Beginning summer 2015, PHH provided funding to the Hands of Hope Clinic that enabled them to hire several new staff members, double their office hours and significantly increase the number of patients they are able to serve. PHH has also provided the clinic with another office suite, which represents a 50% increase in space.

Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan:

- **Mental health:** We currently don't have the resources to make a meaningful impact on mental health as Piedmont Henry does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Chronic Obstructive Pulmonary Disease:** Although we will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts.
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them.

Although we will not focus on these issues during our assessment, if the opportunity arises to make a positive difference on the issue, we will do so.

PHH COMMUNITY

In 2016, approximately
206,349
people live in our community

40.9% Henry County

Children Qualifying For Free Lunch

51.2% Georgia

Approximately **1 in 6**
adults reports having **poor dental health.**

89.6% Henry County

High School Graduates

11.2% Henry County

Households Below Poverty Line

18.2% Georgia

7.3% Henry County

Unemployment Rate

7.2% Georgia



In Henry County, **22%**
of adults are uninsured.

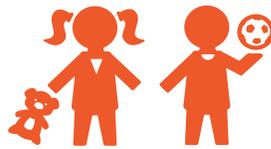


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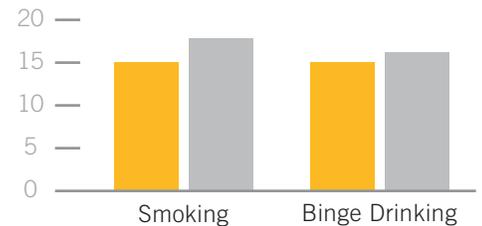
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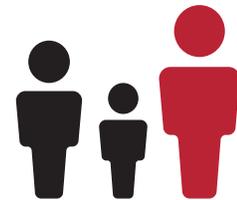
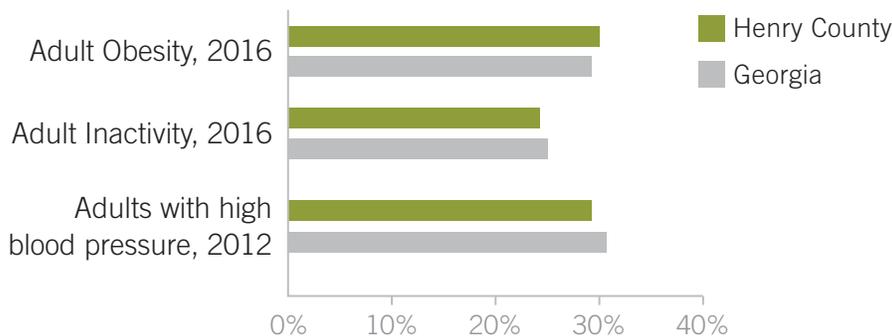


10% of children in Henry County
are uninsured, a figure in line with the
state average of 10%.

Henry County Georgia



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for
hospital admissions in Henry County in 2016.

THE PHH COMMUNITY AT LARGE

Like other communities in Georgia, Henry County residents experience some common health issues, such as high rates of obesity, type 2 diabetes and hypertension. The county carries high rates of uninsured populations, and there are pockets of physician shortages as well. Some key statistics about Henry County:

POPULATION

- About half of all Henry County residents are white, 39% are African American and about 6% are Hispanic.
- More than 28% of the population is under the age of 18, which is higher than the regional average.
- About 11% of residents live in poverty, and nearly 22% of adults are uninsured.
- About 76% of Henry County high school students graduated in four years, as compared to the service region average of 70%.

MEDICAL FACTORS

- Approximately 32% of adults did not have a regular doctor, which was one of the highest rates in the service region.
- There are 2,030 patients to every primary care provider, where the Georgia average is 1,540 patients to every primary care provider.
- There are 810 patients to every mental health provider in comparison to the Georgia rate of 850 patients to every mental health provider.
- The average teen birth rate for Henry County is below average at 30 births per 1,000 females ages 15-19 as compared to the state average of 40 teen births.
- The number of poor physical health days is similar to the regional average at 3.5 average number of poor physical health days reported in the last 30 days in Henry County, as compared to the regional average 3.5 poor physical health days.

HEALTH FACTORS

- The premature mortality rate is also similar to the regional average with 7,300 years of potential life lost per every 100,000 Henry County residents as compared to 7,000 years of life lost.
- Significant mortality concerns include hypertensive and kidney diseases. Primary contributors to excess premature mortality include traffic crashes, breast cancer and cancers in children, kidney failure, injury and drug overdose.
- Obese residents in Henry County have higher rates of heart disease, more visits to the ER for stroke and hypertension, increased risk of hospitalization for obstructive heart disease and increased risk for diabetes.
- Traffic crashes also produce ER usage at a rate of 1,047.7 per 100,000 individuals, versus 973.7 per 100,000 regionally.
- The county appears to have an unusual increase in children with cancer of the brain or central nervous system, although the number of children affected is relatively small.
- Henry County adults had below average fruit and vegetable consumption, which often indicates pockets of what is called a food desert, which means there is limited access to fresh fruits and vegetables.
- Approximately 15% of Henry County residents smoke as compared to a regional average of 15%.
- 82% of county residents drive alone to work, and 14% travel over an hour each way.

PHH STAKEHOLDER INTERVIEWS

As a part of our process, the Georgia State Health Policy Center interviewed several stakeholders, including community leaders from education, law enforcement, healthcare and pastoral services in the Henry community. The major themes discussed by key informants representing Henry County included the need for improved education and resources that reduce chronic disease, primarily through healthy lifestyle behaviors; the need for better access to care, specifically for underserved populations; and the need for behavioral health services.

Key informants discussed the impact that nutrition and physical activity can have on outcomes including obesity, diabetes, and high blood pressure. They recommended that adults and children receive health education and outreach efforts that would focus on showing people how make healthy lifestyle choices, especially in underserved populations.

A common theme among interviews included the lack of affordable and appropriate access to care for the underserved which impacts emergency room utilization and exacerbates long-term chronic health issues, particularly as the number of high risk persons in Henry County grows due to increases in transience and homelessness. Key informants suggested that increasing resources that aid in navigating the healthcare system and current assistance programs, as well as increasing the capacity of local FQHCs and clinics could improve the access residents have to care and in turn improve outcomes.

Key informants also noted that a lack of access to behavioral health services for both the insured and uninsured populations of Henry County has a huge impact on community health. Despite having a few great mental health resources in the county, there are not enough services available to meet the needs of the community. Recommendations included expanding the capacity and resources of current mental health facilities to make them more accessible, as well as including more mental and primary health resources in the school system to help address the needs of the high volume of transient, homeless or underserved youth as a means to improve outcomes.

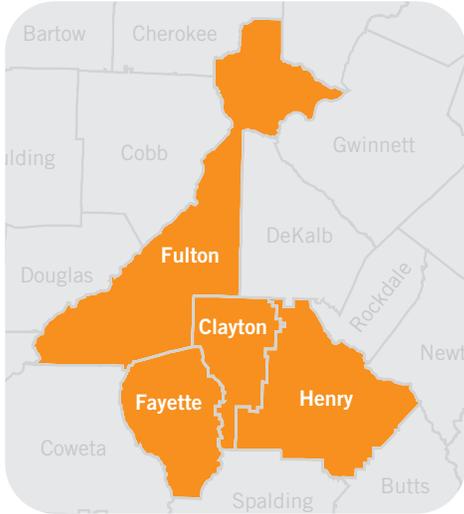
FY15 PIEDMONT HENRY STATISTICS

July 01, 2014 to June 30, 2015



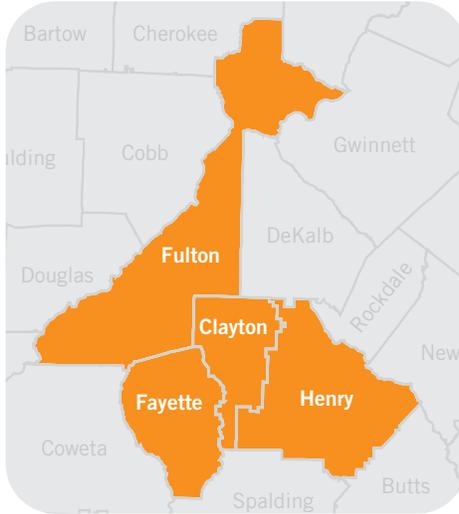
ENCOUNTERS AT PHH BY ZIP CODE

An encounter is an interaction between a patient and a healthcare provider for the purpose of providing a healthcare service or assessing the health status of a patient.



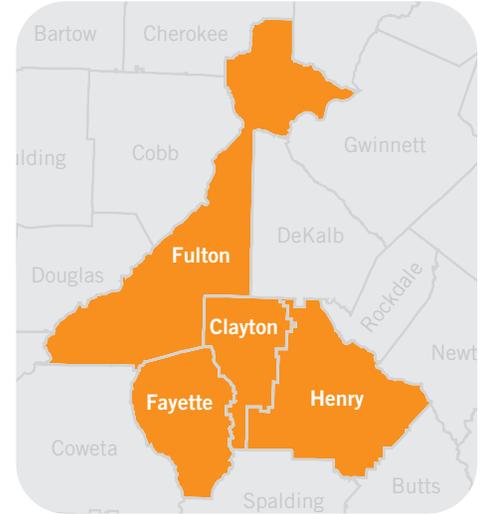
Top 10

CLAYTON	HENRY
30236 - 17,813	30281 - 58,525
30238 - 6,299	30253 - 55,002
	30252 - 30,648
FAYETTE	30228 - 20,286
30215 - 720	30248 - 18,373
	30294 - 13,625
FULTON	
30349 - 1,746	



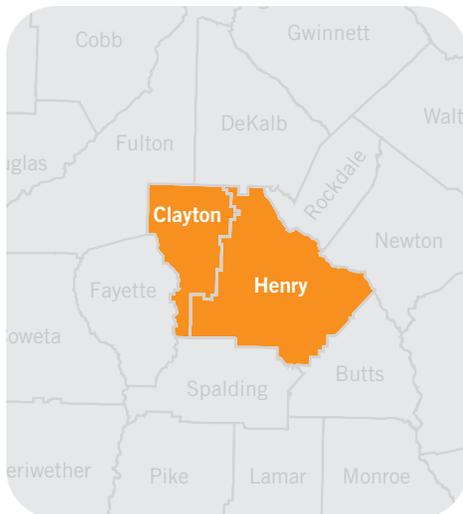
Top 10 - Medicare

CLAYTON	HENRY
30236 - 11,477	30281 - 36,949
30238 - 4,339	30253 - 32,382
	30252 - 15,046
FAYETTE	30228 - 11,904
30214 - 448	30248 - 10,300
	30294 - 8,395
FULTON	
30349 - 1,121	



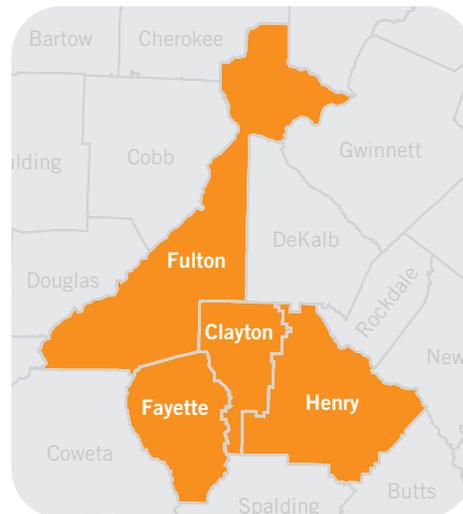
Top 10 - Medicaid

CLAYTON	HENRY
30236 - 3,557	30281 - 12,146
30238 - 1,779	30253 - 11,016
	30252 - 4,360
FAYETTE	30228 - 4,197
30214 - 147	30294 - 3,213
	30248 - 3,173
FULTON	
30349 - 403	



Top 10 - Financial Assistance Qualified

CLAYTON	HENRY
30236 - 1,472	30281 - 6,133
30260 - 1,088	30253 - 4,718
30273 - 936	30252 - 1,814
30297 - 730	30228 - 1,777
	30248 - 1,413
	30294 - 1,166



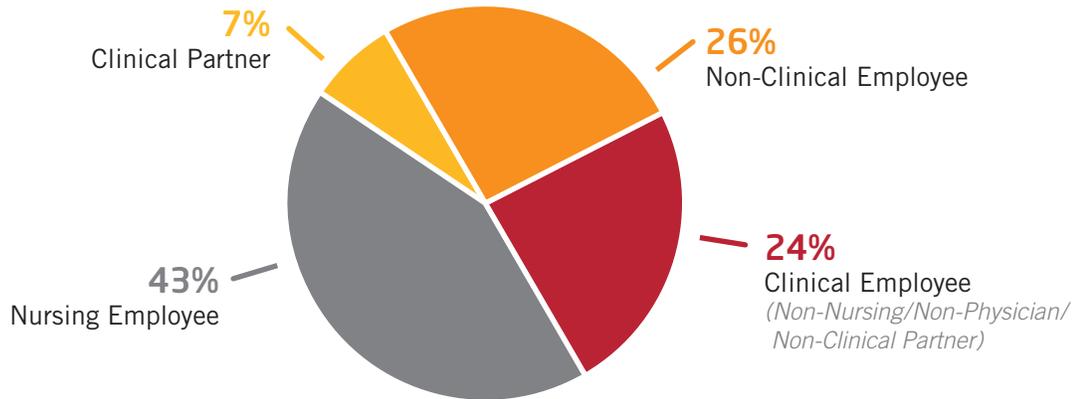
Top 10 - Other Payors

CLAYTON	HENRY
30236 - 11,477	30281 - 36,949
30238 - 4,339	30253 - 32,382
	30252 - 15,046
FAYETTE	30228 - 11,904
30214 - 448	30248 - 10,300
	30294 - 8,395
FULTON	
30349 - 1,121	

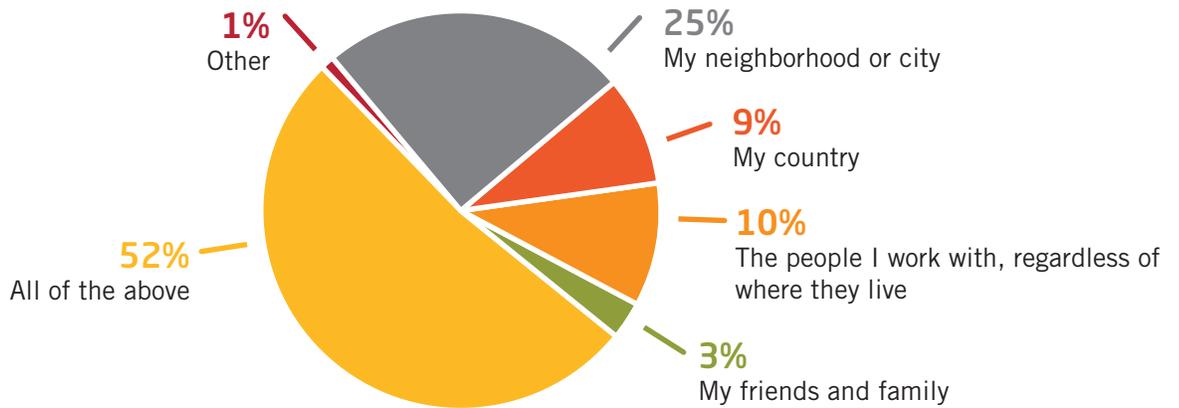
PHH EMPLOYEE SURVEY

Sixty-eight Piedmont Henry employees completed the internal CHNA survey, which focused on questions regarding community health and the hospital's role. Below are some selected questions. The full system survey is available in the addendum.

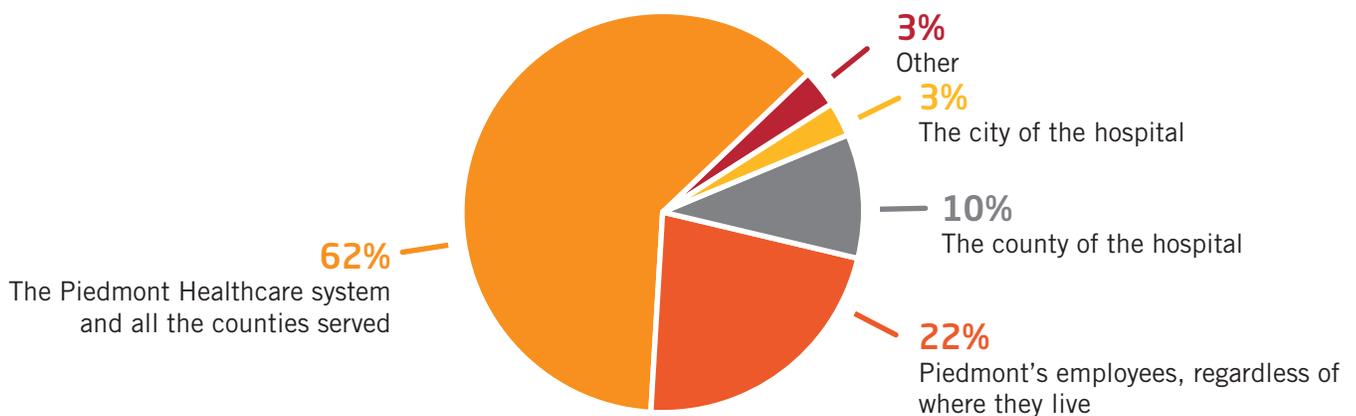
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PHH EMPLOYEE SURVEY (continued)

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

Top 5 answers highlighted in the “Important” column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	0.0%	15.9%	84.1%
Community-based health education	1.4%	8.7%	89.9%
Community-based programs around health and wellness	1.4%	7.2%	91.3%
Increased social services for patients needing additional attention	2.9%	5.8%	91.3%
Financial assistance for those who qualify	4.3%	14.5%	81.2%
Affordable healthy food	2.9%	10.1%	87.0%
Support in finding job opportunities	5.8%	21.7%	72.5%
Local outpatient mental health services	1.4%	7.2%	91.3%
Parks and recreation facilities	2.9%	18.8%	78.3%
Transportation for care	2.9%	10.1%	87.0%
Partnerships with charitable clinics	0.0%	14.5%	85.5%
Wellness services outside of the hospital	2.9%	7.2%	89.9%
Expanded access to specialty physicians	1.5%	5.9%	92.6%
Free or affordable health screenings	0.0%	7.2%	92.8%
Safe places to walk/play	1.4%	8.7%	89.9%
Substance abuse rehabilitation services	1.5%	13.2%	85.3%
Community public service projects	2.9%	18.8%	78.3%

Q To you, what does “community benefit” mean?

Common Answers:

“Health care and education for the community”

“Services that help improve the community that we serve”

“Support systems in place to help ensure the physical, mental, social and spiritual wellbeing of our community”

“A program that people living in the community are informed of, invited to participate in, and where the information provided will add to one's life or knowledge in a beneficial way”

“A community that is educated, healthy, and active”

“Being part of Piedmont Healthcare and helping our patients and future patients”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Access to care for low income or fixed-income patients
- Community education
- High costs for healthy foods
- Lack of knowledge of how to manage disease
- Being more diverse
- Transportation

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“Helping patients to find clinics that their insurance cover and any resources they may need”

“Dedicated professionals who can empathize and relate to those who suffer from chronic health problems especially those who have to contend with common barriers to healthcare such as finances, transportation, or knowledge of their illness”

“Piedmont Hospital is missing in local communities and local faith-based organization within all ethnic groups”

“Piedmont seems detached from the community. To attach the name to a sporting event or other events does not work. Piedmont needs to be visible as a good neighbor to regular individuals”

“There are not many visible events/projects in the high-risk populations, just the affluent and insured”

PHH NEXT STEPS

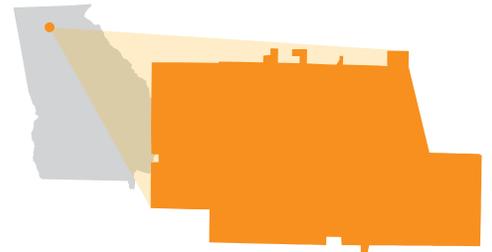
We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. This implementation plan will be 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.

APPROVAL

The Piedmont Henry Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 2, 2016.

ABOUT THE HOSPITAL

Once called Mountainside Medical Center, the 52-bed hospital was renamed Piedmont Mountainside Hospital in June 2004 and is located along Georgia 515 near Jasper, which is the city seat of Pickens County, a rural mountain community located in Georgia's north central region. Piedmont Mountainside is the sole hospital provider for Pickens County and provides a range of services.



PROGRESS ON PMH PRIORITIES FY14 TO FY16

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.

In Fiscal Year 2013, when we conducted our first assessment, we focused on the following priorities, which were determined through the criteria outlined above. We started work on these priorities in FY14.

Increase access to appropriate and affordable care for low- and no-income patients: Develop and execute a plan to strengthen access points for low- and no-income patients, with a focus on those utilizing high-cost care settings, such as an emergency department, for their care, and continue to provide necessary care to all patients.

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (FY14-16)
- Evaluated our current financial assistance policy and billing process, and designed a new policy and process as to better serve our patients (FY16)
- With support from the U.S. Health Resources and Services Agency, Piedmont is a lead convener of the Pickens County Rural Health Network, in partnership with the Pickens County Health Department and the Good Samaritan Health and Wellness Center. The Network has several public health and safety goals, including efforts to reduce costly and avoidable emergency department encounters by increasing access to care in community-based settings. We applied for additional funding to implement the Network's goals in 2015 (FY15-16)
- Provided free mammograms with referrals to follow-up care for qualifying women at Piedmont Mountainside Hospital (FY14-16)

PROGRESS ON PMH PRIORITIES (continued)

FY14 TO FY16

Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients:

Increase care coordination efforts between the hospital and community-based providers to help avoid costly readmissions and ED re-encounters.

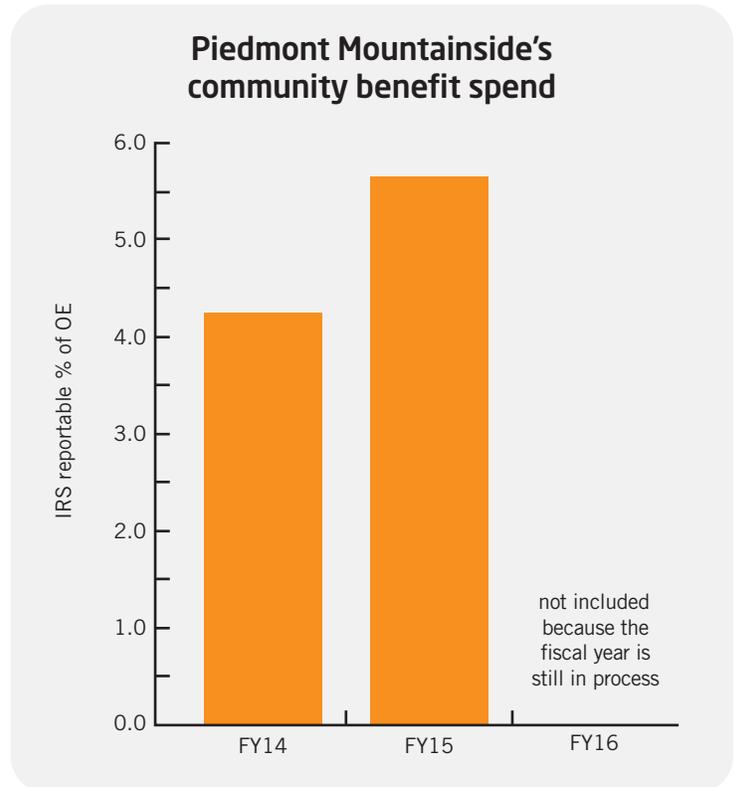
- Created a task force at Piedmont Mountainside Hospital to reduce readmissions through process improvement, and strong patient education and case management, through leadership of Piedmont Heart Institute (FY14-16)
- Provided extensive case management, caregiver support and other services for older adults through the Sixty Plus program (FY14-16)
- Piedmont Mountainside also offers a special grant-funded Sixty Plus position that does home visits after patients are discharged from the hospital to help seniors overcome barriers to successful recovery, including medication reconciliation and nutrition counseling (FY16)
- Distributed a limited-income resource guide to approximately 1,080 individuals through various Piedmont Mountainside access points and approximately 10 community benefit partners (FY16)

Reduce instances of preventable heart disease, stroke and hypertension through the promotion of healthy behaviors:

Utilize community-wide awareness campaigns and provide education that encourages community members to reduce their risks of heart disease through healthy behaviors.

- Created the Live Better program, which works to foster community collaboration around shared health concerns (FY15-16)
- Created the Walk with a Doc walking initiative that connects doctors and individuals in the community to exercise and discuss health (FY15-16)
- Offered “What’s in Store,” a comprehensive cooking and shopping education program aimed at reaching low-income women in partnership with the Good Samaritan Clinic and the Pickens County Health Department (FY15-16)

- Created and distributed heart disease and hypertension awareness educational materials to reduce the risks through healthy lifestyle changes aimed at reaching high-risk community members in English and in Spanish (FY15-16)
- Built a learning garden in partnership with the Pickens County Extension Master Gardeners and the West End Boys & Girls Club focused on heart-healthy activities for underserved children (FY14-15)



In aggregate, PMH’s community benefit spend for FY14 and FY15 is: health professions education and other community benefit programming (\$801 thousand), financial assistance (\$4.8 million), and shortfalls incurred from Medicaid and the provider fee (\$382 thousand). The above chart represents these totals as a percentage of the hospital’s operating expense, a common way to examine community benefit spends. Please note that FY16 YTD totals are not available at this time.

PMH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts;



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming, including low-cost mammograms to qualifying women through partnership programs.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, hypertension and stroke through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.

Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan.

- **Chronic Obstructive Pulmonary Disease:** Although we will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts.
- **Mental health:** We currently don't have the resources to make a meaningful impact on mental health as Piedmont Mountainside does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue
- **Motor vehicle accidents:** While we will not focus on this particular area during the next three years, we will continue to support policies that works to reduce motor vehicle accidents in Pickens.

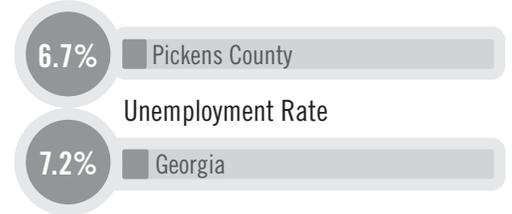
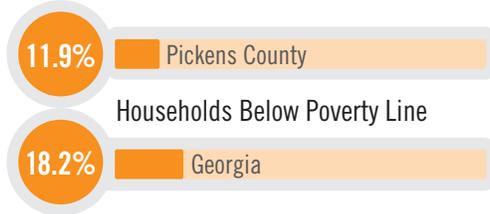
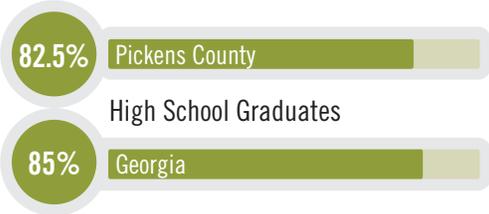
Although we will not focus on these issues during our assessment, if the opportunity arises to make a positive difference on the issue, we will do so.

PMH COMMUNITY

In 2016, approximately
29,486
people live in our community



In 2015, approximately
22% of children
lived in
single-parent homes.



HEALTH FACTORS



In Pickens County, **24%**
of adults are uninsured.

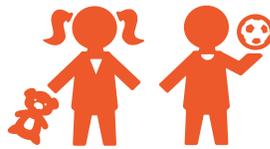


There are **2,470:1**
patients to primary care
physicians in Pickens County
vs. **1,540:1** across Georgia.

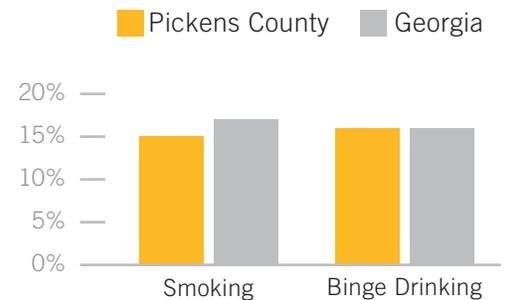
This shows a shortage of medical professionals.

11% of adult residents are
living with **diabetes.**
An estimated one-third of adults who
have the disease are undiagnosed.

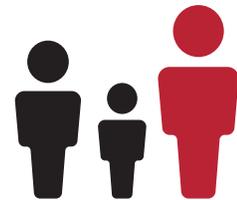
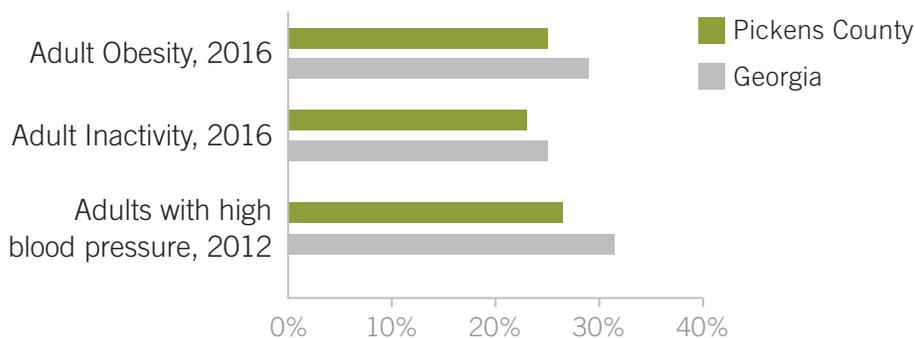
14% reported they
were in poor or
fair health, a figure lower than
the state benchmark of **19%.**



11% of children in Pickens County
are uninsured, a figure slightly above
the state average of 10.0%.



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for
hospital admissions in Pickens County in 2016.

Sources: US Census, US Health and Human Services' Community Health Status Indicators, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2016, unless otherwise noted. Health indicators are estimates provided by County Health Rankings, which is based on census data.

THE PMH COMMUNITY AT LARGE

The indication ‘primary’ refers to those counties where a Piedmont hospital is located. ‘Secondary’ refers to counties that are close in proximity to primary counties and ‘service region’ refers to both service areas together as a whole. Pickens County suffers from some of the relatively poorest physical health outcomes of the Piedmont Healthcare service region as a whole. Some key statistics include:

POPULATION

- About one-fifth of the population was under 18 in 2015, which is one of the lowest percentages in the Piedmont service region; about 18% of county residents are over 65, which is high above the regional average of 10.4%.
- The county population was predominantly white (93.6%) and 15% of county residents reported having a disability.
- One in five residents are uninsured, which is higher than the regional average of 18%.
- Poverty rates were low: approximately 12 percent of the county’s population lived in poverty in 2015, as compared to a state average of 18%.
- Residents reported less poor physical health days (3.6 versus 3.9 per month) but the premature death rate is higher in Pickens versus the rest of the state.

MEDICAL FACTORS

- Major factors influencing the premature mortality rates are heart disease and stroke; lung cancer, COPD, and other tobacco-related cancers; injury from self-harm, assault, traffic injuries, poisoning, and falls; cervical and uterine cancer; nervous system disorders including cancers; pneumonia; and liver disease. However, with such a relatively small population, these rates can be significantly influenced by even a few cases.
- Residents of Pickens County had above average hospital usage for obstructive heart diseases and stroke, as compared to state rates.

- Residents also sought hospital services for mental health needs at a slightly elevated rate than that of state and regional rates.
- Other leading causes of excess hospital utilization included many disorders associated with advanced age, likely due to a large percentage of older adults in the community, self-harm and unintentional injuries, many of which also affect older adults.

HEALTH FACTORS

- The county had an above average percentage of alcohol-related traffic crashes (27.8% versus 24% statewide).
- Infant mortality was low and the overall birth rate was low but the teen birth rate was slightly above average (13.2 versus 12.0) compared to state rates.
- One in six people smoke, a figure high above state and regional averages. Pickens County smokers were also less likely to attempt to quit smoking, at 54.5% versus 64.5% in the Piedmont service region.
- Relatively few households experienced food insecurity (13% versus 19% in GA), and there was a statistically high number of stores that accepted the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) relative to the population. That said, access to fresh fruit and vegetables is limited to several pockets of the community, and exercise rates are slightly below the state average. Even so, obesity was below the state average (25% versus 29%).

PMH STAKEHOLDER INTERVIEWS

As a part of our process, the Georgia Health Policy Center interviewed several stakeholders, including policymakers and healthcare leaders in the Pickens community. Among the many issues mentioned, notable health issues that emerged included reducing the number of motor vehicle accidents, the need for behavioral health services and the need for better access to affordable care for the underserved.

Key informants felt that the lack of affordable and appropriate access to care for the underserved greatly impacts emergency room utilization and increased long-term chronic health issues. Key informants suggested that increasing access to medical specialists, specifically for underserved populations would be beneficial to the community, as Pickens is primarily rural and patients typically have to travel to Atlanta or Chattanooga for specialty care. Additionally, interviewees noted that there is a relatively low perception of health disparities in the county, meaning there is ample opportunity to address unmet health disparities, including those due to income or insurance status, within the community.

Lack of access to behavioral health services also has a huge impact on community health. Currently, there are not enough mental health providers in Pickens County, and many seek treatment for their behavioral health needs in the emergency department or with primary care providers. In addition to increasing access to mental health providers, key informants recommended training a cross-section of professionals to recognize behaviors that are a direct result of behavioral health diagnoses and to make appropriate referrals that offer residents the treatment they require to improve outcomes.

Pickens County has one of the highest rates of motor vehicle collisions in the state, for both ATV and cars. Motor vehicle crashes were a leading cause of premature death and had ties to increased alcohol consumption when compared the to the rest of the state. Key informants recommended stricter enforcement of motor vehicle safety laws and increased education regarding seatbelt safety and driving under the influence.

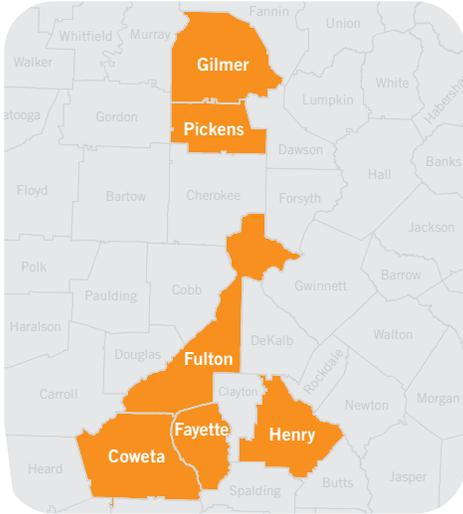
FY15 PIEDMONT MOUNTAINSIDE STATISTICS

July 01, 2014 to June 30, 2015



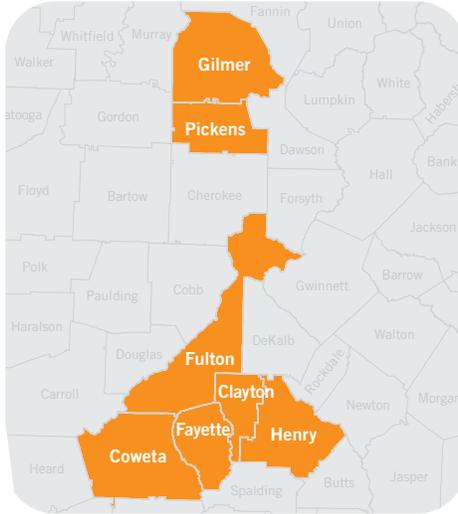
ENCOUNTERS AT PMH BY ZIP CODE

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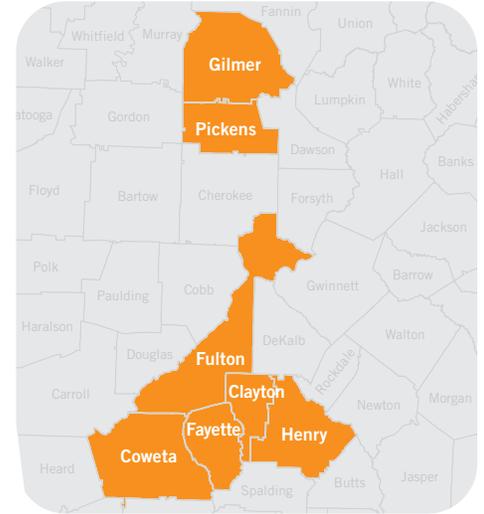
Top 10

COWETA 30263 - 16 30265 - 13	FULTON 30319 - 36 30327 - 14 30309 - 12	HENRY 30252 - 32 30281 - 22
FAYETTE 30269 - 15	GILMER 30540 - 20,042	PICKENS 30143 - 40,750



Top 10 - Medicare

CLAYTON 30236 - 6	FAYETTE 30269 - 10	GILMER 30540 - 14,864
COWETA 30265 - 9 30263 - 7	FULTON 30309 - 8 30319 - 8 30327 - 7	HENRY 30281 - 15
	PICKENS 30143 - 29,432	



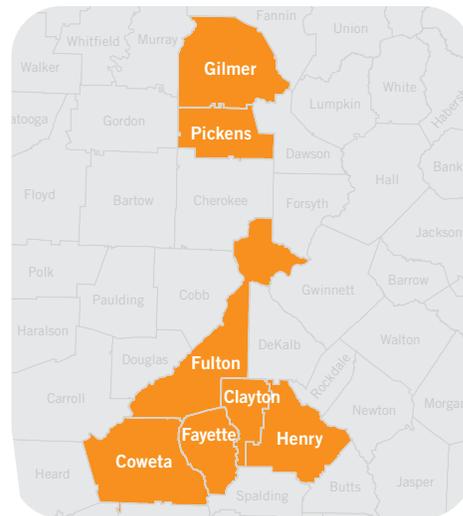
Top 10 - Medicaid

CLAYTON 30236 - 6	FAYETTE 30269 - 10	GILMER 30540 - 14,864
COWETA 30265 - 9 30263 - 7	FULTON 30309 - 8 30319 - 8 30327 - 7	HENRY 30281 - 15
	PICKENS 30143 - 29,432	



Top 10 - Financial Assistance Qualified

CHEROKEE 30107 - 605 30114 - 338 30183 - 174 30115 - 172	GILMER 30540 - 1,115 30536 - 284	PICKENS 30143 - 2,746 30175 - 840
	GORDON 30139 - 171 30734 - 113	



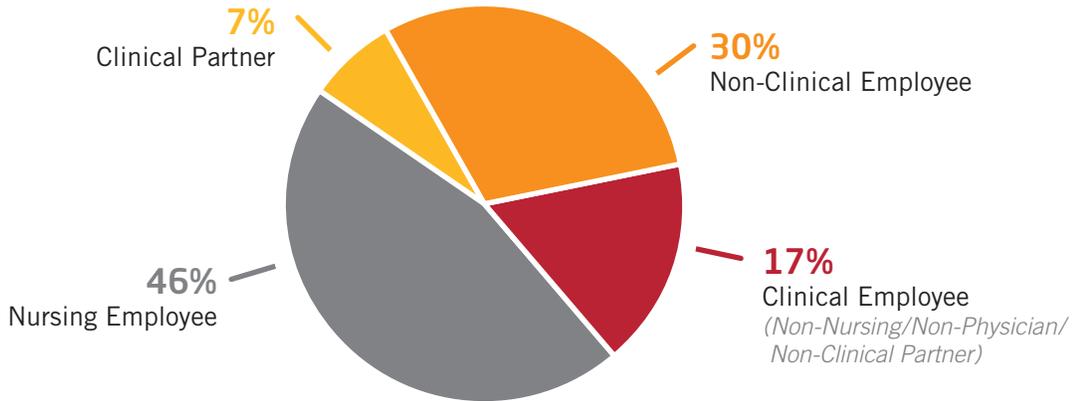
Top 10 - Other Payors

CLAYTON 30236 - 6	FAYETTE 30269 - 10	GILMER 30540 - 14,864
COWETA 30265 - 9 30263 - 7	FULTON 30309 - 8 30319 - 8 30327 - 7	HENRY 30281 - 15
	PICKENS 30143 - 29,432	

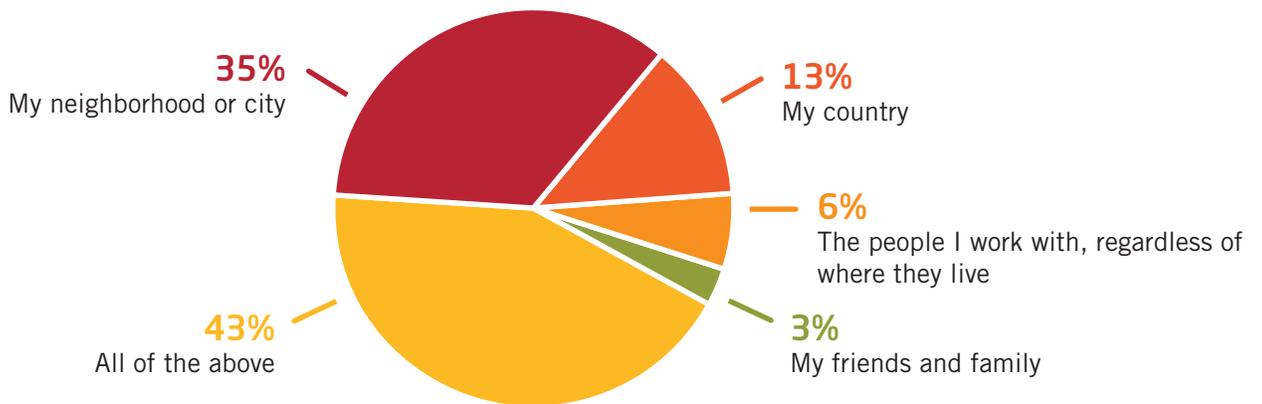
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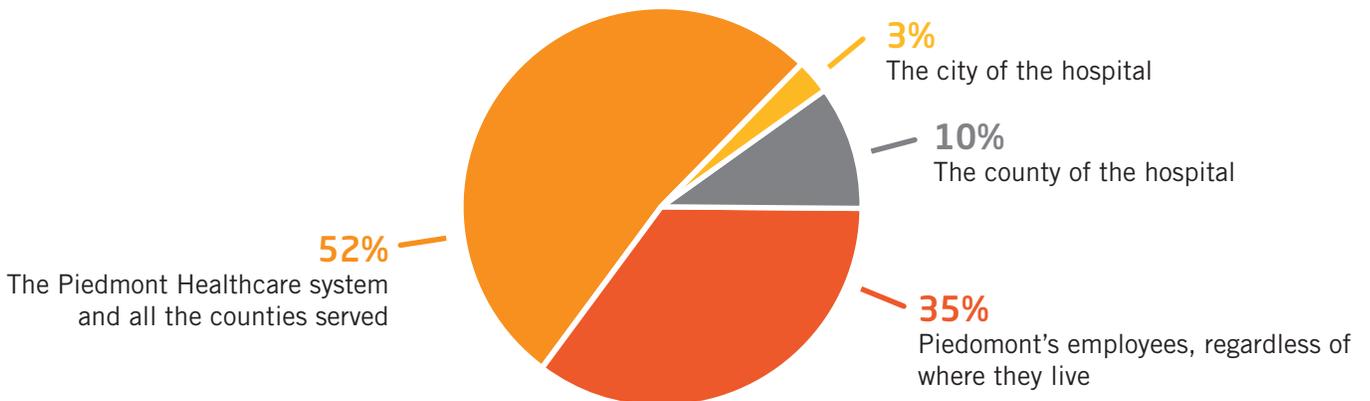
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PMH EMPLOYEE SURVEY (continued)

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

Top 4 answers highlighted in the "Important" column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	3.2%	9.7%	87.1%
Community-based health education	3.3%	3.3%	93.3%
Community-based programs around health and wellness	3.3%	3.3%	93.3%
Increased social services for patients needing additional attention	0.0%	9.7%	90.3%
Financial assistance for those who qualify	0.0%	9.7%	90.3%
Affordable healthy food	3.2%	6.5%	90.3%
Support in finding job opportunities	0.0%	16.1%	83.9%
Local outpatient mental health services	0.0%	6.5%	93.5%
Parks and recreation facilities	3.2%	19.4%	77.4%
Transportation for care	3.2%	6.5%	90.3%
Partnerships with charitable clinics	0.0%	9.7%	90.3%
Wellness services outside of the hospital	3.3%	10.0%	86.7%
Expanded access to specialty physicians	3.2%	3.2%	93.5%
Free or affordable health screenings	0.0%	9.7%	90.3%
Safe places to walk/play	3.2%	6.5%	90.3%
Substance abuse rehabilitation services	0.0%	12.9%	87.1%
Community public service projects	3.2%	9.7%	87.1%

Q To you, what does “community benefit” mean?

Common Answers:

“Anything that can make a measurable, positive improvement to a community”

“Getting the help and education needed to be as healthy as possible”

“When people are healthy and happy, the whole community benefits from a better environment in which to live”

“Community benefit means everyone regardless of age, gender or race could benefit in some way”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Access to affordable care in Pickens and in Gilmer
- Education
- Transportation
- Financial assistance
- More specialty doctors and specialty services

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“Accepting the exchange plans at PMH”

“Increased public awareness of the programs offered”

“Affordability”

“Lacking presence in the intramural, high school, middle school and parks and recreation activities designed to get people moving and engaged”

“More access to specialists in rural areas”

“Helping the community understand their care options, not matter what their situation is”

PMH NEXT STEPS

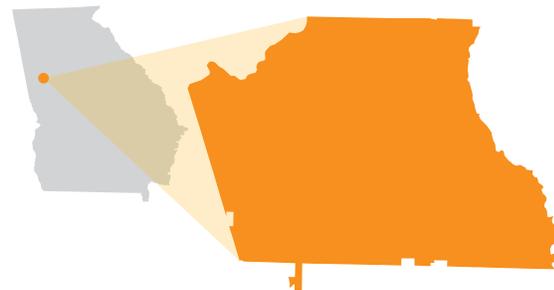
We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. This implementation plan will be 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.

APPROVAL

The Piedmont Mountainside Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 13, 2016.

ABOUT THE HOSPITAL

Piedmont Newnan Hospital is a 136-bed, acute-care, community hospital in Newnan, Georgia. The hospital has a long history of serving the community. Originally called Newnan Hospital, it opened in 1925 and the hospital remained one of the only sources of acute care in the county for decades. It remained under other owners until 2007, when it joined the Piedmont Healthcare family of community hospitals, thus becoming Piedmont Newnan Hospital.



PROGRESS ON PNH PRIORITIES FY14 TO FY16

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.

In Fiscal Year 2013, when we conducted our first assessment, we focused on the following priorities, which were determined through the criteria outlined above. We started work on these priorities in FY14.

Increase access to appropriate and affordable care for low- and no-income patients: Develop and execute a plan to strengthen access points for low- and no-income patients, with a focus on those utilizing high-cost care settings, such as an emergency department, for their care, and continue to provide necessary care to all patients.

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (FY14-16)
- Evaluated our current financial assistance policy and billing process, and designed a new policy and process as to better serve our patients (FY16)
- Provided lab services at no charge to the Coweta Samaritan Clinic and its patients (FY14-16)
- Provided mammograms with appropriate follow-up care for low-income women through grants funded by the Komen Foundation and It's the Journey (FY14-16)

PROGRESS ON PNH PRIORITIES (continued)

FY14 TO FY16

Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients:

Increase care coordination efforts between the hospital and community-based providers to help avoid costly readmissions and ED re-encounters.

- Created and deployed the Sams Care Coordination program to reduce preventable, low-acuity ED visits among limited-income high-risk patients by increasing staff capacity at the Coweta Samaritan Clinic, streamlining communication through the provision of electronic medical records, and eliminating socioeconomic barriers to care through a licensed medical social worker (FY14-16)
- Created a task force to reduce readmissions through process improvement, patient education and case management, through Piedmont Heart Institute (FY14-16)
- Created bylaws requiring that patients discharged from ED must have follow-up care by a provider with hospital ambulatory privileges (FY15-16)
- Continued to provide extensive case management, caregiver support and other services for older adults through the Sixty Plus program (FY14-16)
- Distributed a resource guide to 1,560 individuals through the Piedmont hospitals and nine community benefit partners, outlining federal and local organizations that offer programming for limited-income individuals and how to apply for assistance in English and in Spanish (FY16)

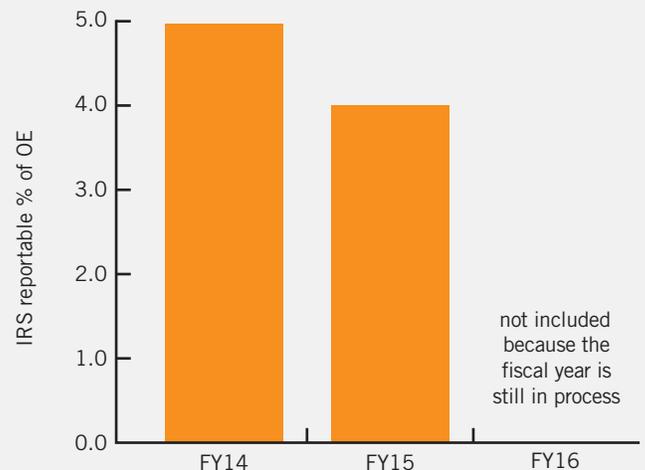
Reduce instances of preventable heart disease, stroke and hypertension through the promotion of healthy behaviors:

Utilize community-wide awareness campaigns and provide education that encourages community members to reduce their risks of heart disease through healthy behaviors.

- Created the Live Better program, which helps to foster community collaboration around shared health concerns through community-based partnerships and programs (FY14-16)
- Created the Walk with a Doc walking initiative, with about 430 miles walked by more than 285 community members (FY14-16)

- Created the Live Better Garden and related STEM programming at Western Elementary in Coweta County, which has a high percentage of students in poverty (FY14)
- Created and continued to support the Live Better Garden at the Newnan /Coweta Boys & Girls Club, which teaches gardening skills and nutrition education to club members, in partnership with the Coweta County UGA Extension (FY14-16)
- Offer heart disease and hypertension awareness educational materials in English and Spanish to reduce the risks of heart disease and high blood pressure through healthy lifestyle changes and advice from a doctor aimed at reaching high-risk community members (FY15-16)

Piedmont Newnan's community benefit spend



In aggregate, PNH's community benefit spend for FY14 and FY15 is: health professions education and other community benefit programming, including labs for three partner clinics (\$3.4 million), financial assistance (\$6.1 million), and shortfalls incurred from Medicaid and the provider fee (\$3.7 million). The above chart represents these totals as a percentage of the hospital's operating expense, a common way to examine community benefit spends. Please note that FY16 totals are not available at this time.

PNH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts;



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming, including low-cost mammograms to qualifying women through partnership programs.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, obesity and stroke through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.



Beginning in 2014, PNH provided funding to the Coweta Samaritan Clinic that enabled them to hire several new staff members, implement an electronic medical records system, double their office hours and significantly increase the number of patients they are able to serve.

Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan.

- **Chronic Obstructive Pulmonary Disease:** Although we will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts.
- **Mental health:** We currently don't have the resources to make a meaningful impact on mental health as Piedmont Newnan does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue
- **Transportation:** Due to limited resources, we cannot address transportation issues in-house, however we will support community-based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them.

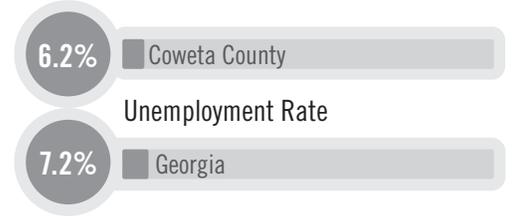
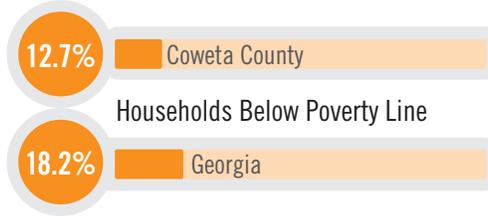
Although we will not focus on these issues during our assessment, if the opportunity arises to make a positive difference on the issue, we will do so.

PNH COMMUNITY

In 2016, approximately
129,397
people live in our community



Approximately **1 in 4**
adults reports having **poor dental health.**



HEALTH FACTORS



In Coweta County, **20%**
of adults are uninsured.

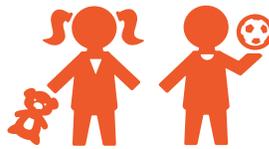


There are **2,220:1**
patients to primary care
physicians in Coweta County
vs. **1,540:1** across Georgia.

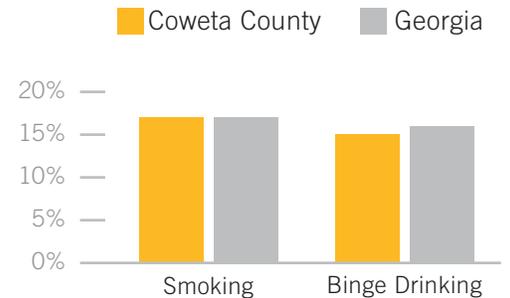
This shows a shortage of medical professionals.

10% of adult residents are
living with **diabetes.**
An estimated one-third of adults who
have the disease are undiagnosed.

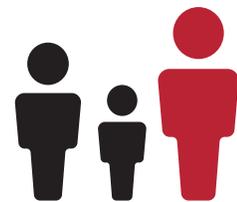
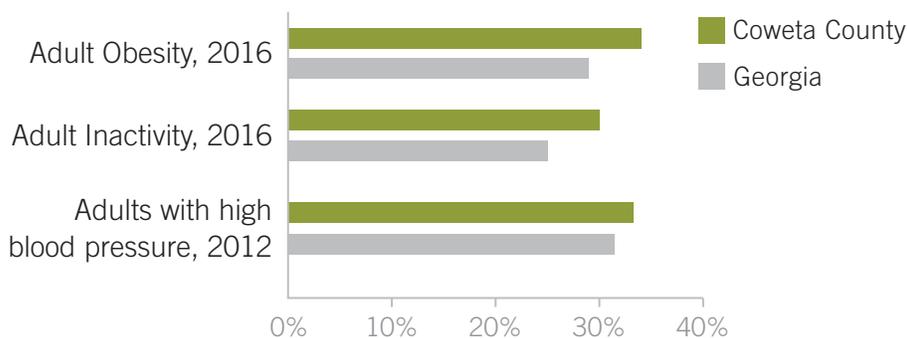
14% reported they
were in poor or
fair health, a figure lower than
the state benchmark of **19%.**



9% of children in Coweta County
are uninsured, a figure lower than
the state average of 10.0%.



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for
hospital admissions in Coweta County in 2016.

Sources: US Census, US Health and Human Services' Community Health Status Indicators, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2016, unless otherwise noted. Health indicators are estimates provided by County Health Rankings, which is based on census data.

THE PNH COMMUNITY AT LARGE

The indication 'primary' refers to those counties where a Piedmont hospital is located. 'Secondary' refers to counties that are close in proximity to primary counties and 'service region' refers to both service areas together as a whole. Coweta County represents a relatively healthy semi-urban county:

POPULATION

- More than two-thirds of Coweta County residents are white, with African American and Hispanic populations making up the remaining third.
- Approximately 70% of the population is between 18 and 64 years of age, and about one-fifth of the population is under the age of 18.
- Approximately 60% of residents have attended college, and 80% of students graduate from high school in four years.
- Unemployment rates are relatively low, and data shows that the unemployment rate for black residents (14%) was double the rate for white residents (7%), and 50% higher for Hispanic members of the labor force (11%).
- Approximately one in ten families live below the poverty level.
- One in four adults are uninsured and nearly one in ten children are uninsured in Coweta County.

HEALTH FACTORS

- There is a significant dental issue among Coweta County residents; one in four county residents report poor dental health relative to the regional average, which is roughly one in ten.
- Smoking rates are average and three-fourths of smokers have attempted to quit in the year before they were surveyed.
- More than one in five adults had been told they had asthma, versus just one in ten statewide.
- Approximately 18% of residents weren't sure where their next meal would come from at some point during the last year.
- One in every three county residents say they don't regularly engage in physical activity.

MEDICAL FACTORS

- Coweta has higher rates of diseases related to advanced age, such as septicemia, obstructive heart disease/heart attack, and Parkinson's disease, than other counties in the region.
- Premature deaths are generally related to suicide, hypertensive and metabolic conditions, smoke- and fire-related injuries, infant mortality and cancer.

PNH STAKEHOLDER INTERVIEWS

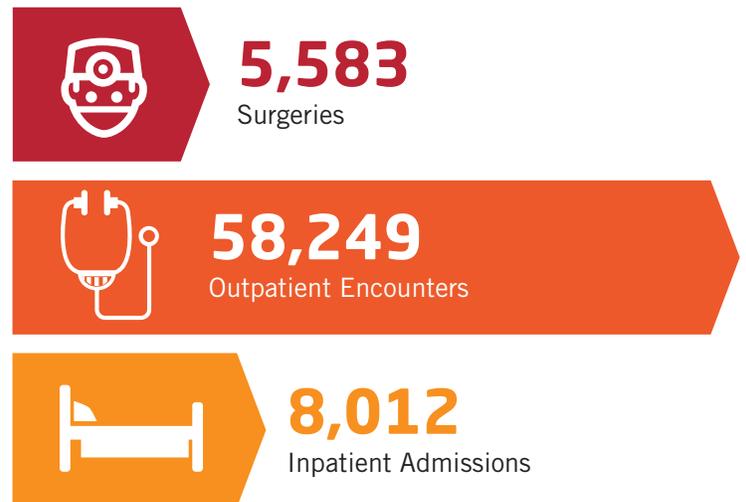
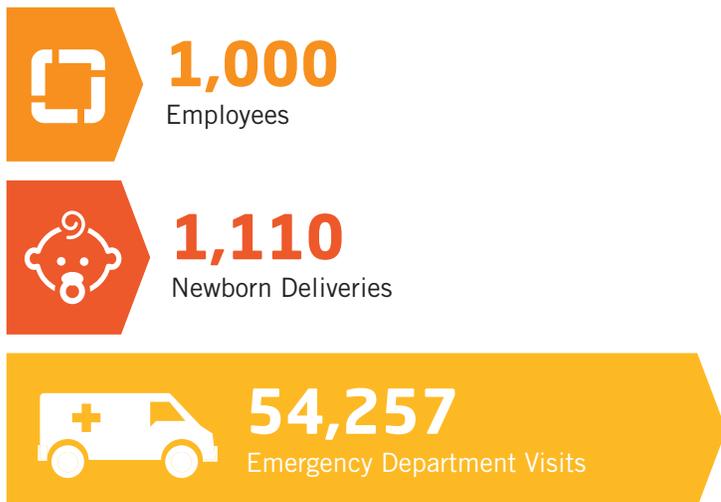
As a part of our process, the Georgia Health Policy Center interviewed several stakeholders, including local healthcare and education leadership in the Coweta community. The major themes discussed by key informants representing Coweta County included the need for better access to care for underserved populations and better access to healthy nutrition and physical activity programs.

The consensus opinion of informants agreed that the lack of affordable and appropriate access to care for the underserved impacts emergency room utilization and increased long-term chronic health issues. Key informants noted that community clinics are at capacity and local providers are not taking any additional Medicaid patients. It was suggested that increasing clinic support could expand capacity to improve access to underserved individuals.

Key informants also discussed the impact that nutrition can have on outcomes including obesity, diabetes, heart disease and high blood pressure. They recommended that adults and children receive health education and outreach efforts that would focus on showing people how food is grown and how to cook healthy foods as well as providing education on existing resources for healthy lifestyle behaviors.

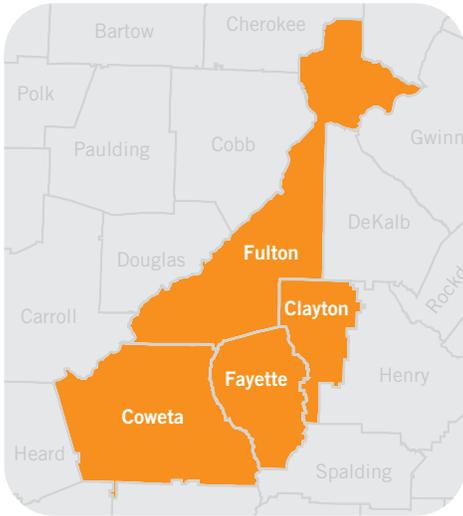
FY15 PIEDMONT NEWNAN STATISTICS

July 01, 2014 to June 30, 2015



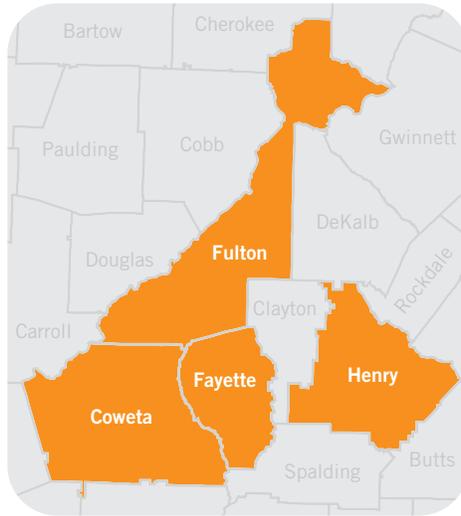
ENCOUNTERS AT PNH BY ZIP CODE

An encounter is an interaction between a patient and a healthcare provider for the purpose of providing a healthcare service or assessing the health status of a patient.



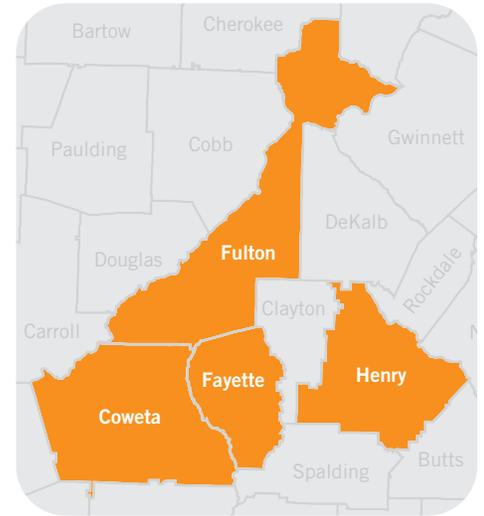
Top 10

CLAYTON 30238 - 357	FAYETTE 30269 - 4,059 30214 - 1,498 30215 - 1,479
COWETA 30263 - 87,475 30265 - 35,200 30277 - 16,274 30276 - 9,612	FULTON 30213 - 2,461 30349 - 791



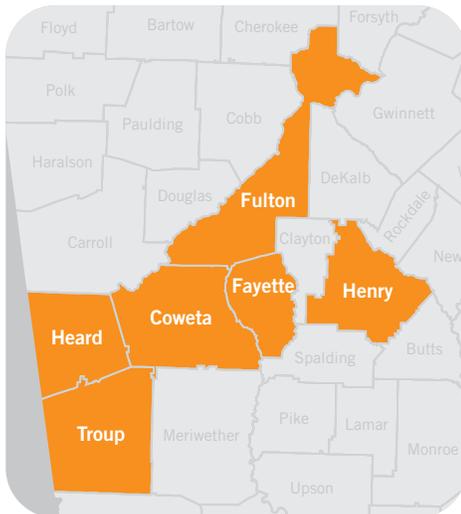
Top 10 - Medicare

COWETA 30263 - 25,675 30265 - 10,532 30277 - 5,502 30276 - 2,763	FAYETTE 30269 - 1,738 30214 - 576 30215 - 518	FULTON 30213 - 812 30349 - 276	HENRY 30228 - 812
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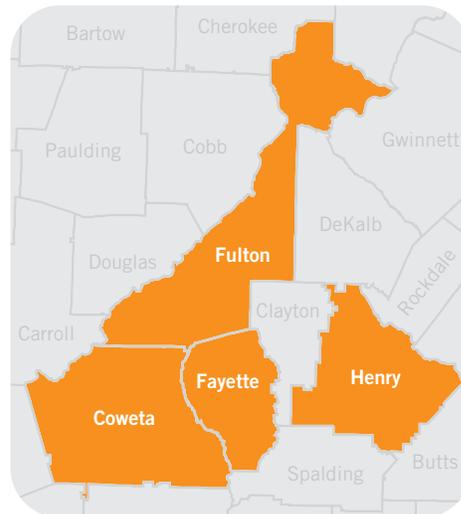
Top 10 - Medicaid

COWETA 30263 - 18,829 30265 - 4,215 30277 - 1,530 30276 - 1,494	FAYETTE 30269 - 276 30214 - 235 30215 - 122	FULTON 30213 - 319 30349 - 127	HENRY 30228 - 57
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Top 10 - Financial Assistance Qualified

COWETA 30263 - 3,970 30220 - 1,561 30265 - 607 30276 - 432 30277 - 292 30259 - 200	FAYETTE 30215 - 756	HEARD 30217 - 217	FULTON 30268 - 282	TROUP 30230 - 920
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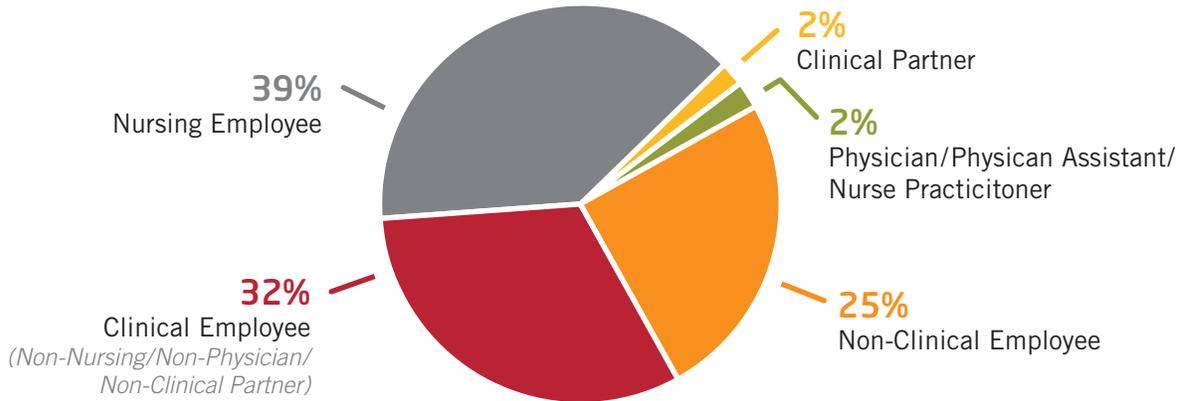
Top 10 - Other Payors

COWETA 30263 - 57,014 30265 - 17,420 30277 - 8,151 30276 - 5,391	FAYETTE 30269 - 2,242 30214 - 946 30215 - 709	FULTON 30213 - 1,382 30349 - 506	HENRY 30228 - 206
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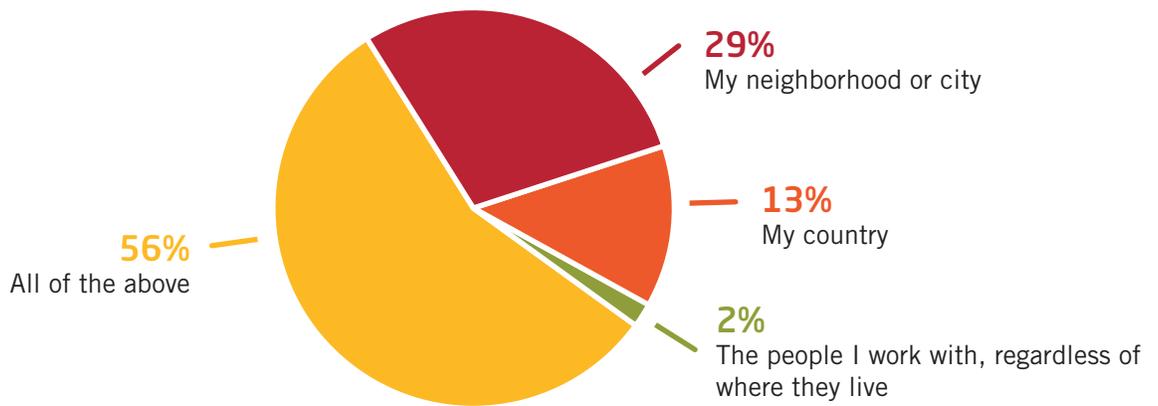
PNH EMPLOYEE SURVEY

Sixty-three Piedmont Newnan employees completed the internal CHNA survey, which focused on questions regarding community health and the hospital's role. Below are some selected questions. The full system survey is available in the addendum.

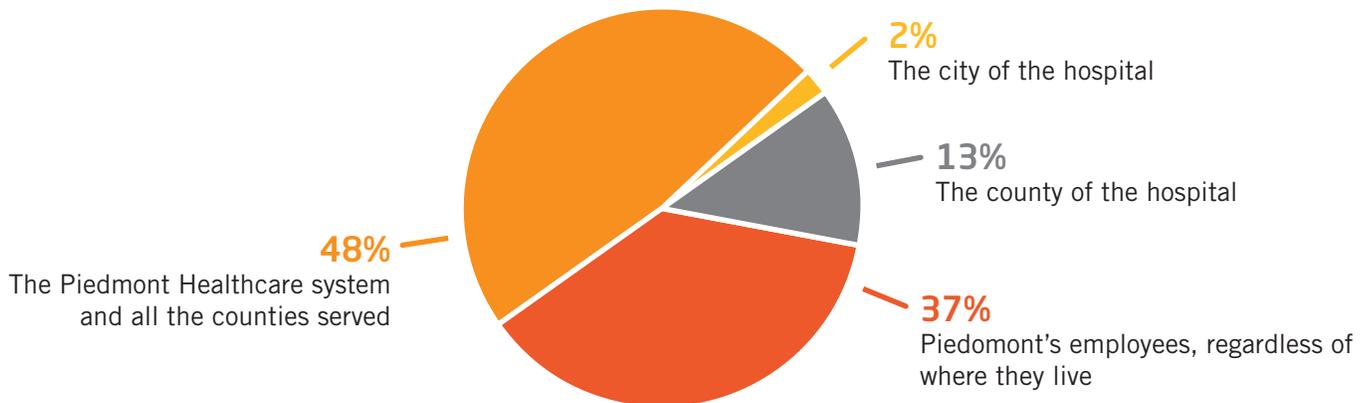
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PNH EMPLOYEE SURVEY (continued)

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

Top 5 answers highlighted in the “Important” column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	3.3%	21.3%	75.4%
Community-based health education	0.0%	6.3%	93.7%
Community-based programs around health and wellness	0.0%	1.6%	98.4%
Increased social services for patients needing additional attention	0.0%	14.3%	85.7%
Financial assistance for those who qualify	1.6%	19.0%	79.4%
Affordable healthy food	0.0%	19.0%	81.0%
Support in finding job opportunities	1.6%	14.3%	84.1%
Local outpatient mental health services	1.6%	6.3%	92.1%
Parks and recreation facilities	3.2%	28.6%	68.3%
Transportation for care	3.2%	22.2%	74.6%
Partnerships with charitable clinics	0.0%	15.9%	84.1%
Wellness services outside of the hospital	1.6%	11.3%	87.1%
Expanded access to specialty physicians	0.0%	19.0%	81.0%
Free or affordable health screenings	1.6%	12.7%	85.7%
Safe places to walk/play	1.6%	21.0%	77.4%
Substance abuse rehabilitation services	1.6%	11.1%	87.3%
Community public service projects	1.6%	27.4%	71.0%

Q To you, what does “community benefit” mean?

Common Answers:

“Access to quality healthcare and other services in your community”

“To let the community know what types of resources are out there to assist them when in need”

“The entire community has something to gain from good health care”

“When all people of the community can be educated and utilize available health resources in the county”

“Supporting the community with resources, having a positive presence, educating the community in ways that will help develop healthy lifestyles”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Access to primary care doctors and access to doctors that will see uninsured/low income families
- Health education and nutrition counseling
- Transportation
- Mental health and drug abuse programs
- Financial assistance
- Diabetes

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“Accepting all types of insurances”

“Increased behavioral health programs”

“Access to assist those unable to pay”

“I find that most patients, family members and even staff members are unaware of what services are available, who qualifies for them and how to access them. There needs to be an access point to find all of that information”

“I think what is missing in how Piedmont works in our community is the support from leadership to help make it easier for more employees to participate in events, instead of the same people. We need to have a greater number of employees encouraged by their leadership to participate”

PNH NEXT STEPS

We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. 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.

APPROVAL

The Piedmont Newnan Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 12, 2016.

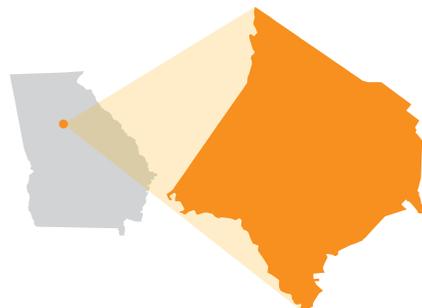
ABOUT THE HOSPITAL

In October 2015, Newton Medical Center joined Piedmont Healthcare as Piedmont Newton, a 97-bed not-for-profit community hospital located in Covington, Georgia. Serving Newton County and surrounding communities for over 60 years, Piedmont Newton Hospital offers high-quality, patient-centered care. Piedmont Newton Hospital stands out for its leading edge Nurse Navigation Program which is part of the Certified Quality Breast Center.

In 2015, we initiated Piedmont Newton's second community health needs assessment (CHNA) to identify, prioritize and address the health needs of our newest community.

OUR COMMUNITY

While we have served patients from most every one of Georgia's counties and many states, for the purposes of this CHNA, we primarily examined Newton County.



PROGRESS ON PNTH PRIORITIES 2013 TO 2015

Increase access to care for the underserved:

- Provided financial assistance to eligible patients and covered shortfalls for low-income patients enrolled in government programs (2013-2015)
- Provided lab services at no cost to the Willing Helpers Medical Clinic and its patients (2013-2015)
- Formed the Newton Medical Center Family Practice, which accepts patients regardless of insurance status at a reduced rate per visit. This service is offered primarily as ED follow-up visits for individuals without a designated medical home (2013-2015)
- Offered nurse navigation services for cancer patients that included assistance with scheduling, arranging follow-up care, coordinating insurance paperwork and linking patients with local support resources (2014-2015)

PROGRESS ON PNTH PRIORITIES (continued)

2013 TO 2015

Increased awareness of and access to prevention education for respiratory disease, heart disease, stroke, obesity and diabetes:

- Offered stroke awareness educational materials and blood pressure screenings at health fairs and community events while pursuing a Stroke Certification by the Joint Commission (2014-2015)
- Offered smoking cessation education programs to community members through employee volunteers at Willing Helpers Medical Clinic (2013-2015)
- Offered the Diabetes Self-Management Education program, diabetes support groups and glucose screenings at community health fairs (2013-2015)
- Coordinated activities for the Healthy Body Weight for Children program throughout Newton, with a dietitian teaching healthy eating habits to adults and children (2013-2015)
- Created and distributed a community resource guide to increase knowledge of available health and wellness resources in the Newton community (2013-2015)

Other community benefit programs included:

- Provided services through the Women's Diagnostic Center including navigation services, support groups, the Hope Boutique, educational programming, and breast cancer awareness and prevention events in the Newton community (2013-2015)
- Through the Reach Out and Read Program, distributed approximately 25,000 books through Newton County pediatricians' offices for children in need (2013-2015)
- Provided new mothers with educational information, car seat distribution and inspections, family community resource guide, and support after discharge through The First Steps Program at Newton (2013-2015)
- Offered lactation support groups and consultations free of charge (2013-2015)



In 2014, PNTH joined the Georgia Regional Academic Community Health Information Exchange, which provides health information in a secure, electronic format allowing healthcare professionals to appropriately access and securely share patient health information.

PNTH PRIORITIES AND SELECTION

FY17 TO FY19

Using criteria developed during our FY13 assessment, we have determined the following priorities to be the focus of our FY17 to FY19 efforts;



Maintain and, when possible, increase access to appropriate and affordable care for low- and no-income patients, including increased efforts at eliminating health disparities.



Increase access to and awareness of cancer-related programming, including low-cost mammograms to qualifying women through partnership programs.



Reduce preventable readmissions and emergency department re-encounters, particularly among high-risk patients with a focus on chronic disease management.



Reduce preventable instances of heart disease, stroke and obesity through educational awareness and promotion of healthy behaviors, including efforts to reduce tobacco use.

Other key health issues emerged that we will not focus on during the FY17 to FY19 implementation plan:

- **Mental health:** We currently don't have the resources to make a meaningful impact on mental health as Piedmont Newton does not provide these services in-house, but we will continue to support awareness and explore community-based partnerships around the issue.
- **Chronic Obstructive Pulmonary Disease:** Although we will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition, and continue to look for ways to positively impact prevention efforts.
- **HIV/AIDS/STDs:** While we will not focus on this priority over the next three years, we will continue to provide care and support to those with these health conditions, and will explore additional opportunities for community-based partnerships around prevention.
- **Motor vehicle accidents:** While we will not focus on this particular area during the next three years, we will continue to support policies that works to reduce motor vehicle accidents in Newton.

Although we will not focus on these issues during our assessment, if the opportunity arises to make a positive difference on the issue, we will do so.

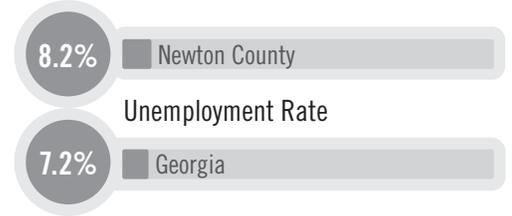
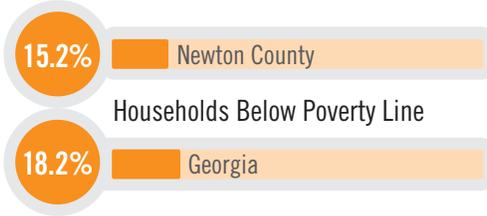
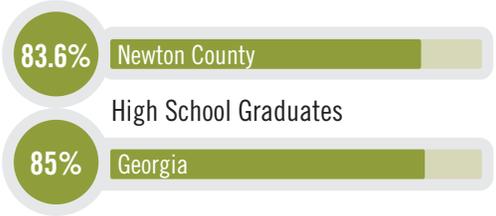
**Better health.
Better
communities.**

PNTH COMMUNITY

In 2016, approximately
100,808
people live in our community



Approximately **1 in 7**
adults reports having **poor dental health.**



HEALTH FACTORS



In Newton County, **26%**
of adults are uninsured.

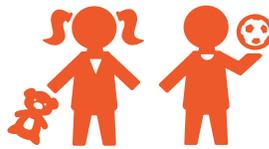


There are **2,930:1**
patients to primary care
physicians in Newton County
vs. **1,540:1** across Georgia.

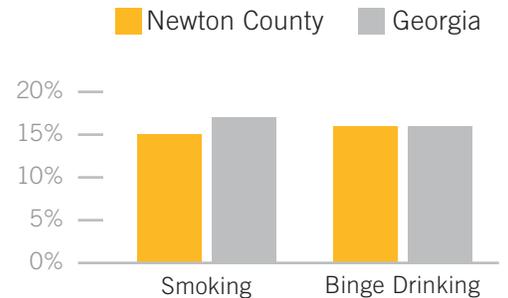
This shows a shortage of medical professionals.

12% of adult residents are
living with **diabetes.**
An estimated one-third of adults who
have the disease are undiagnosed.

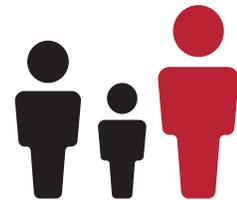
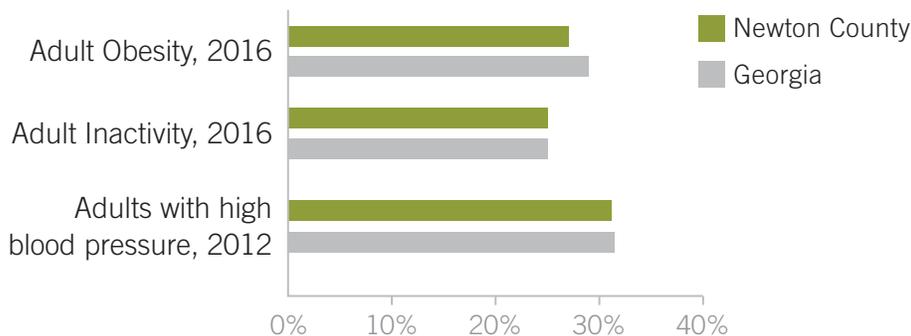
18% reported they
were in poor or
fair health, a **figure lower than**
the state benchmark of **19%.**



9% of children in Newton County
are uninsured, a figure below the
state average of 10.0%.



OBESITY, HIGH BLOOD PRESSURE & HEART DISEASE



Heart disease remained a primary cause for
hospital admissions in Newton County in 2016.

Sources: US Census, US Health and Human Services' Community Health Status Indicators, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2016, unless otherwise noted. Health indicators are estimates provided by County Health Rankings, which is based on census data.

THE PNTH COMMUNITY AT LARGE

Newton County has relatively more significant health challenges and poorer health outcomes than other counties in Georgia. The burden of poor health is disproportionately shared by low-income Hispanics and African Americans, particularly as it relates to chronic diseases.

POPULATION

- About half of all Newton County residents are white, 40% are African American and about 5% are Hispanic.
- The county has a high percentage of both children and senior citizens living in the county, resulting in a lower share of working-age adults, relative to state percentages.
- Most socioeconomic indicators, such as poverty and a lack of health insurance, were average, although there are pockets of the community where higher rates of those with lower incomes tend to live.
- 29% of children live in single-parent homes, which is often linked to lower graduation rates.

HEALTH FACTORS

- About 13% of the population lives with at least one disability, which is significantly higher than the regional average.
- People tend to die prematurely in Newton County, with the leading causes being traffic crashes, stroke, hypertension, nervous system disorders, breast and cervical cancers, and SIDS were the most significant.
- Quality of life indicators show that approximately 14% of Newton residents reported their health as poor or fair.
- Newton has slightly higher hospitalization rates by cause for many health conditions including chronic, infectious and genetic disorders as well as injuries, especially when adjusted for age.

MEDICAL FACTORS

- Traffic crashes result in over 50% more ER utilization compared to regional rates.
- The emergency department also saw increased utilization for mental health, asthma, hypertension, assault, and stroke than that of other hospitals in the region.
- Approximately 21% of adults smoke as compared to an average of 15% regionally.

PNTH STAKEHOLDER INTERVIEWS

As a part of our process, the Georgia Health Policy Center interviewed several key stakeholders and policy makers in the Newton community. The major themes discussed by key informants representing Newton County included the need for better access to healthy nutrition and physical activity opportunities; the need for better access to care; and the need for behavioral health services.

Key informants discussed the impact that nutrition and physical activity can have on health outcomes including obesity, diabetes, and high blood pressure. They recommended that adults and children receive health education and outreach efforts that would focus on showing people how food is grown, how to cook healthy foods and encouraging healthy lifestyle activities.

The lack of affordable and appropriate access to care for the underserved impacts emergency room utilization and increased long-term chronic health issues. Key informants suggested that increasing the number of FQHCs or clinics in communities and the use of satellite centers offering access to qualified nursing staff that could consult physicians by secure internet or telehealth technologies could improve the access residents have to care and in turn improve outcomes. Additionally, key informants expressed the need for transportation in their community, as it is currently a barrier in access to healthcare and activities of daily living.

Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize behaviors that are a direct result of behavioral health diagnoses and make appropriate referrals that offer residents the treatment they require and improve outcomes.

FY14 PIEDMONT NEWTON STATISTICS

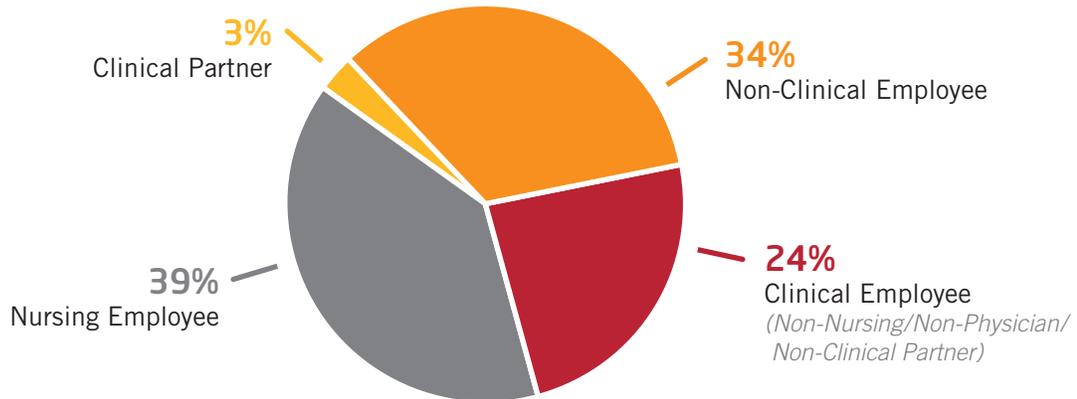
January 01, 2014 to December 31, 2014



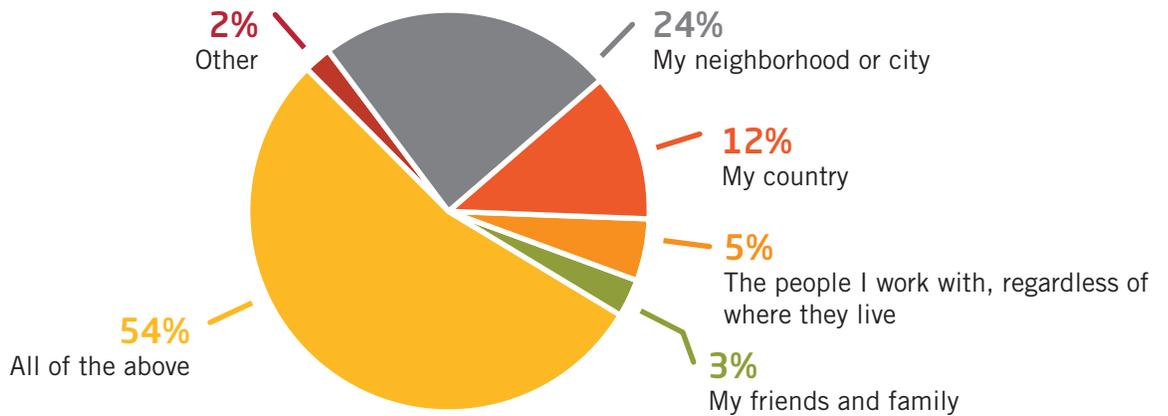
PNTH EMPLOYEE SURVEY

Fifty-eight Piedmont Newton employees completed the internal CHNA survey, which focused on questions regarding community health and the hospital's role. Below are some selected questions. The full system survey is available in the addendum.

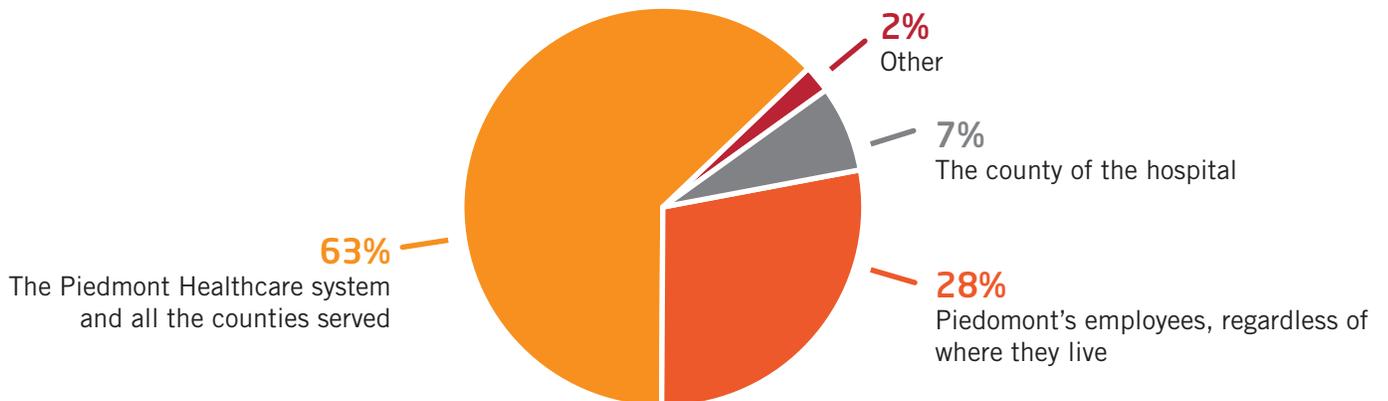
Survey participant breakdown



How would you best define your community?



How would you best define Piedmont's community?



PNTH EMPLOYEE SURVEY (continued)

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

Top 6 answers highlighted in the “Important” column:

	NOT IMPORTANT	NEUTRAL	IMPORTANT
More access points within the community	0.0%	15.5%	84.5%
Community-based health education	0.0%	3.5%	96.5%
Community-based programs around health and wellness	0.0%	3.4%	96.6%
Increased social services for patients needing additional attention	0.0%	6.9%	93.1%
Financial assistance for those who qualify	0.0%	6.9%	93.1%
Affordable healthy food	1.8%	8.8%	89.5%
Support in finding job opportunities	1.8%	33.9%	64.3%
Local outpatient mental health services	0.0%	8.6%	91.4%
Parks and recreation facilities	3.4%	31.0%	65.5%
Transportation for care	0.0%	15.5%	84.5%
Partnerships with charitable clinics	0.0%	17.5%	82.5%
Wellness services outside of the hospital	0.0%	8.8%	91.2%
Expanded access to specialty physicians	0.0%	6.9%	93.1%
Free or affordable health screenings	0.0%	1.8%	98.2%
Safe places to walk/play	3.5%	14.0%	82.5%
Substance abuse rehabilitation services	3.4%	19.0%	77.6%
Community public service projects	1.7%	29.3%	69.0%

Q To you, what does “community benefit” mean?

Common Answers:

“Anything that makes it easier for our patients to maintain good quality of life”

“Easy access to medical care”

“Programs that impact the health and wellness of a community”

“That we all have access to medical care if we have a way to pay or not”

“Those things, both tangible and intangible, that can help make our lives better”

“The services Piedmont offers inside and outside the hospital to benefit the people of that hospital location's local community”

Q What problems do you see in your communities that you feel Piedmont could better impact?

Common Answers:

- Access to affordable, primary care
- Mental health services
- Programs for seniors
- Health education programs
- An urgent care clinic in the community
- Make the hospital smoke-free

Q What do you think is missing in how Piedmont works with the community?

Common Answers:

“Access to more physicians”

“At Piedmont Newton more involvement in the community is needed”

“Letting the community know what programs are available and how to access them”

“Not enough specialty physicians in outlying areas”

“Services and programs for older adults”

PNTH NEXT STEPS

We will develop an implementation plan for our priorities that will outline our tactics to address those identified health issues. The implementation plan will then be reviewed and adopted by the hospital's board of directors, and subsequently released to the public. 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.

APPROVAL

The Piedmont Newton Hospital Board of Directors approved this community health needs assessment to address identified health issues on May 19, 2016.

Appendix 1

Community Health Needs Assessment Piedmont Employee Survey Questions

Question 1

How would you best define your community? (Check one)

- My neighborhood or city
- My county
- The people I work with, regardless of where they live
- My family and friends
- All of the above
- Other: _____

Question 2

How would you best define Piedmont's community? (Check one)

- The city of the hospital
- The county of the hospital
- Piedmont's employees and patients, regardless of where they live
- The Piedmont Healthcare system and all counties served
- Other: _____

Question 3

How important are the following actions in improving the health of Piedmont communities?
Please rate each action as Not Important, Somewhat Important, Important, or Very Important.

	Not Important	Neutral	Important
More access points within the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community-based health education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community-based programs around health and wellness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased social services for patients needing additional attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial assistance for those who qualify	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Affordable healthy food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support in finding job opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Local outpatient mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parks and recreation facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation for care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partnerships with charitable clinics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wellness services outside of the hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Expanded access to specialty physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Free or affordable health screenings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safe places to walk/play	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse rehabilitation services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community public service projects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

APPENDIX 1 (continued)

Question 4

Which of the following Piedmont programs are you familiar with? (Check all that apply)

- Financial assistance
- Cancer Wellness
- Sixty Plus
- Sams Care Coordination Program
- Health professions education
- Live Better community education programs
- Community benefit
- Partnerships with community clinics
- Community resource guide
- Student education programs
- None of the above

Question 5

To you, what does "access to care" mean? (Check all that apply)

- Consideration of cultural/religious beliefs
- Ensuring interpretation services are available
- Assisting patients in finding doctors that take their insurance or will see uninsured patients
- Eliminating fear (e.g., not ready to face/discuss health problem)
- Affording health care
- Helping secure transportation to appointments
- Other: _____

Question 6

To you, what does "community benefit" mean?

Question 7

What do you think is missing in how Piedmont works with the community?

Question 8

What problems do you see in your communities that you feel Piedmont could better impact?

Question 9

What groups/organizations do you feel Piedmont should partner with to better serve the community?

Question 10

What Piedmont entity do you work for?

- PAH
- PFH
- PHH
- PMH
- PNH
- PNTH
- PHI
- PHC
- PMCC
- Other: _____

Question 11

What is your role at Piedmont?

- Non-Clinical Employee
- Clinical Employee (Non-Nursing / Non-Physician / Non-Clinical Partner)
- Nursing Employee
- Clinical Partner
- Physician / Physician Assistant / Nurse Practitioner
- PMCC / PHI Physician (Non-Hospitalist)

Appendix 2

Community Health Needs Assessment Resources

Piedmont’s community health needs assessment process included interviews and surveys with key informants including, board members, community members, patients, and employees to gain perceptions on the needs of the community. A total of 46 key informant interviews were conducted among Piedmont’s six services counties, including five interviews conducted with state or organizational leaders, 12 interviews conducted with public health leaders, and 29 interviews conducted with stakeholder partners. Approximately 14 interviews were conducted among board members at Piedmont Healthcare hospitals. Focus groups were held at two partner clinics, with 18 total participants – five patients at the Hands of Hope Clinic (Stockbridge) and 13 patients at the Coweta Samaritan Clinic (Newnan). The community benefit department created an online survey that was completed by 785 employees. In total, 917 individuals participated in Piedmont’s community health needs assessment process.

Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

www.cdc.gov/NCHHSTP/Atlas

Community Commons CHNA Portal

www.CHNA.org

County Health Rankings and Roadmaps

www.countyhealthrankings.org

Georgia Department of Public Health Online Analytical Statistical Information System

www.oasis.state.ga.us

Georgia Health Policy Center’s Piedmont CHNA Report

<http://ghpc.gsu.edu>

US Census Bureau, American Community Survey 5-Year Dataset

www.census.gov