Piedmont Augusta Hospital
Piedmont Augusta Summerville

FY25 Community Health Needs Assessment

Interim CHNA
Data and Priorities
June 2025

Overview and process

In our commitment to meaningfully and sustainably supporting our communities, Piedmont Healthcare hospitals conduct a Community Health Needs Assessment (CHNA) every three years. Required by the IRS, this triennial process measures a community's relative health or well-being, representing the activity and end-product of identifying and prioritizing unmet community health needs. This assessment is conducted by gathering and analyzing data, soliciting feedback from the community and key stakeholders, and evaluating our previous work and future opportunities.

The CHNA was led by the Piedmont Healthcare community benefits team and contractor, Public Goods Group, with input and direction from Piedmont leadership, as well as direct input from board members at board meetings and individual meetings with hospital leadership, including the hospital's chief executive officer. Additionally, key leaders from the Piedmont Healthcare system regularly provided input on the process and outcomes.

The CHNA started by defining our community. Due to the impact of our tax-exempt status, we paid particular attention to the home counties of our hospitals. Once we established our primary community, we analyzed available public health data. We conducted two community-based surveys – one targeting community leaders and another for Piedmont Advisors. Local stakeholders, including representatives of public health, were asked to share their thoughts on unmet community health needs and the hospital's role in addressing them. Finally, we conducted direct interviews with 32 state and regional stakeholders and policymakers, each representing a specific group that tends to be adversely impacted by health equity issues.

Discover
Review related CHNAs and annual reports, ask questions, and finalize the CHNA plan.

Data analysis
Identify, gather, and analyze primary and secondary data to assess unmet health needs.

Prioritize & Present
Using data, determine priorities; present to the board for approval; release interim CHNA.

Plan & Present
Create strategies for each priority; present to the board for approval; release CHNA.

Please note that this CHNA is an interim report, as it does not include progress since the last CHNA and several other components, due to the timing of federal requirements to publish our findings and priorities. This report shares key data and the identified priorities.

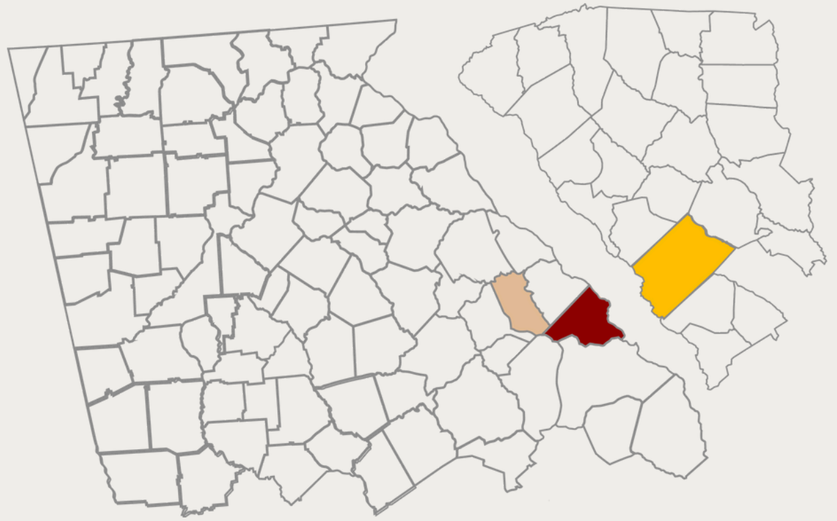
The final CHNA and the subsequent board-approved implementation strategies will be published in October 2025.

Defining our community

While the Augusta Clinical Hub serves patients from all over south Georgia and parts of South Carolina, for this CHNA, we define our primary community as the hospital's home county of Richmond County. We do this in recognition of the direct impact of our tax-exempt status on county residents, as county taxes generally comprise the highest percentage of a not-for-profit hospital's exemption.

We consider Richmond County part of the Augusta Clinical Hub, which includes McDuffie County. We present data for both in recognition of the shared community team and leadership and the opportunities for programming across both communities. We also include information about Aiken County, South Carolina, as many of Piedmont Augusta's patients come from that community. We utilized statistics for the full community based on utilization data for inpatients at Piedmont Augusta between FY22 and FY24.

Piedmont Augusta's primary and secondary communities



FY25 health priorities

Hospital leadership established the following priorities to address over fiscal years 2026, 2027, and 2028.

Increase access to appropriate and affordable care

Reduce preventable instances of chronic conditions

Prepare for the impact of reduced social services due to federal funding cuts

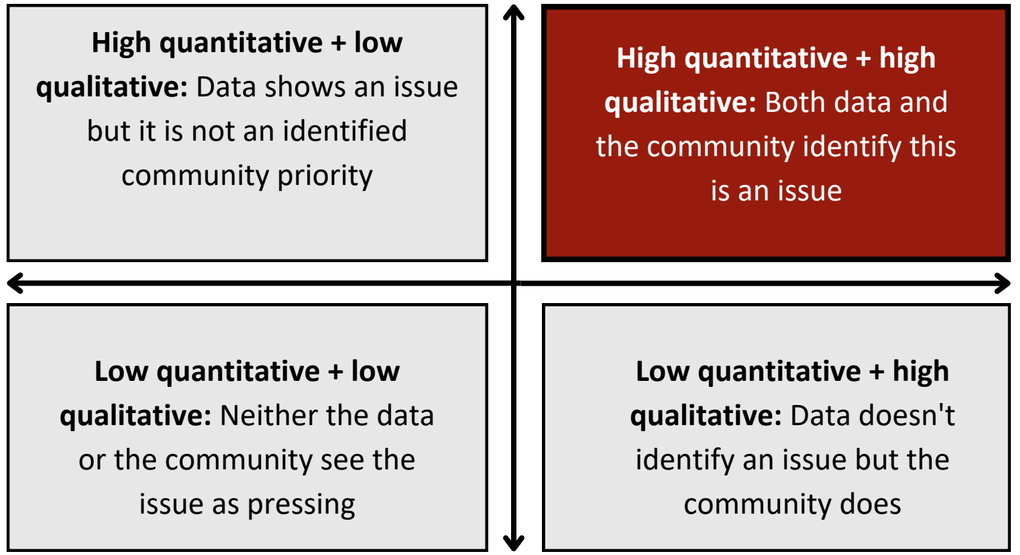
Reduce the impact of poor mental health and reduce suicide deaths

For each identified CHNA priority, we will tie its subsequent implementation strategies to defined health equity indicators with clear, measurable, and sustainable actions to be undertaken over the next three fiscal years.

How we prioritized

Over the past six months, we've evaluated:

- Prevalence of issues within public health and internal data
- How it compares to regional, state, and national averages
- The prevalence of the topic in stakeholder interviews
- What patients and employees have reported in surveys



The information was then categorized according to prevalence, as shown in the graphic. Typically, the issues landing in the top right—indicating high quantitative and qualitative significance—are the issues we considered as potential priorities for FY26, FY27, and FY28.

As we thought about these top issues, we evaluated each potential priority through the lens of three areas:

- **Root cause:** Is the issue caused by a social determinant of health or a root cause problem? Does this challenge disproportionately impact low-income, uninsured, or otherwise vulnerable populations? Would addressing this issue potentially address or impact other community issues?
- **Magnitude:** Is this a significant issue within the community? Is the problem severe and could lead to long-term disability or death?
- **Ability to impact:** Can the hospital and community address this problem? Does the community support our approach?

Summary of key themes

- Mental health is not improving, and too many people suffer from the consequences of poor mental health, including drug and alcohol use.
- Heart disease, cancer, and stroke continue to lead as top causes of death.
- High disability rates within the community mean more patients and community members with increased and nuanced needs.
- Unemployment rates are higher than state and national averages, and labor participation rates are lower, which can lead to additional challenges for these community members.
- People are worried about what comes next and what services may go away as news of funding changes on a federal level continues to top headlines.
- Community members struggle with access to food and safe, affordable housing. We heard this from stakeholders, saw it in secondary public health data, and patients searched for resources Empowering You.
- The Augusta community has higher than average rates of uninsured adults and children, as well as people on Medicaid; this creates significant challenges for many when attempting to access health care.
- Where conversations centered:
  - High rates of uninsurance, high costs of living, and debt
  - Transportation
  - Mental healthcare
  - Access to basic needs, such as safe housing and food
- What is harming us most:
  - Heart disease
  - Stroke
  - Mental health
  - Alzheimer’s disease
  - Hypertension
  - Diabetes
  - Cancer
- Situations that lead to bad health:
  - Lower than average preschool enrollment rates
  - High housing costs
  - Poverty
  - Unemployment
  - Moderate uninsured rates
  - Limited access to food
  - Stress about money
  - Bad dental care

Top issues identified by data and stakeholders

We evaluated stakeholder input + available data, running an algorithm to detect themes in the data. Below are the top 16 issues that emerged throughout both. These are not listed in order of prevalence or importance.

Accessible and affordable housing

Concern for nearby rural communities, especially since the hurricane

Mental health and wellbeing

Preventative education and especially information that is culturally relevant

High rates of uninsurance and Medicaid enrollment

Food insecurity and limited healthy foods at food pantries

Community-based providers who understand the patient

Health costs and medical debt

Concern that federal actions will lead to reduced social services

Knowledge of/availability of relevant resources

Access to adequate and supportive community-based care

Chronic conditions, especially hypertension and diabetes

Accessible and affordable transportation

Alzheimer's disease

High rates of suicide and deaths of despair among men in the community

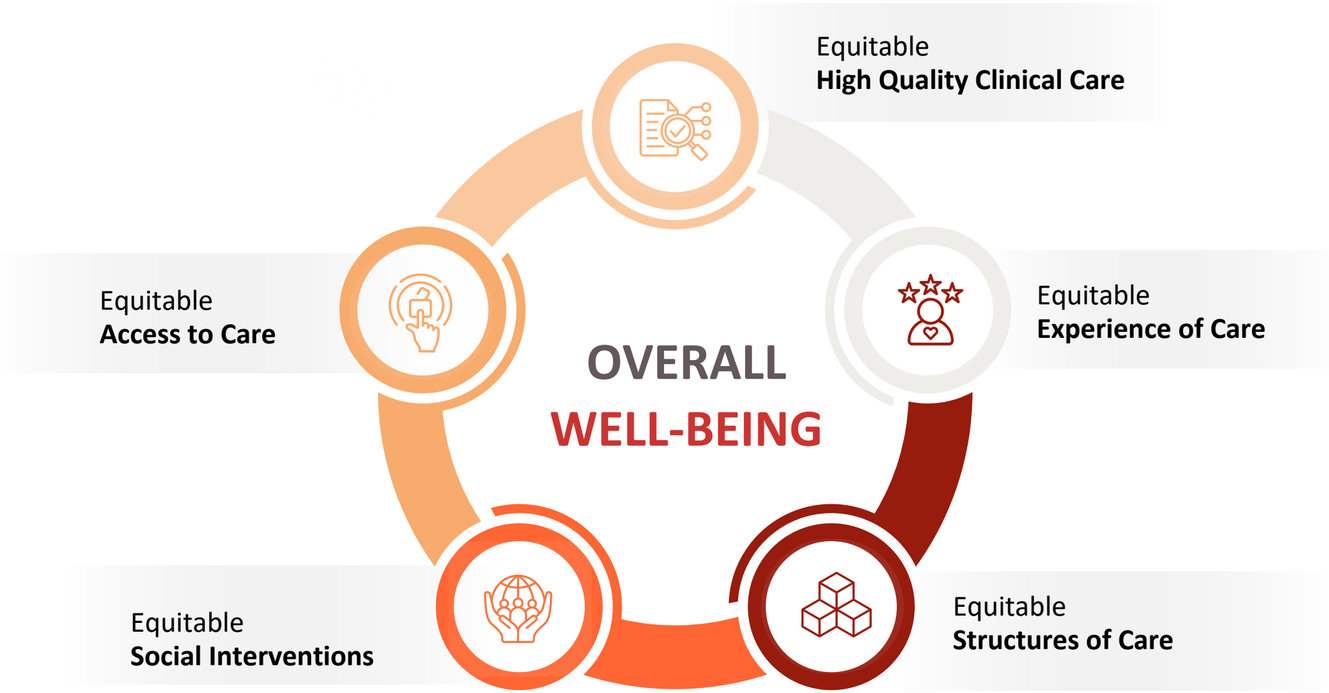
Obesity and limited physical activity

Equity as our guiding theme

For each identified CHNA priority and implementation strategy, we will tie that work to a defined health equity indicator with clear, measurable, and sustainable actions. We will continue to connect each tactic to the identified priority and we will report on the tactic's impact on the identified population health goal.

We pay particular attention to the following groups:

- Uninsured and underinsured populations
- Low-income populations
- The elderly
- Those with complex medical conditions or injury
- Those with unmanaged chronic conditions
- Veterans
- Racial and ethnic minorities
- LGBTQ+ communities
- Those living in rural communities
- Those living in substandard housing
- Those living with disabilities
- The homeless
- Those living with mental health challenges



About the hospitals

Piedmont Augusta

Piedmont Augusta (formerly University Hospital) serves the Augusta-Richmond County area and 25 counties across two states. The hospital is an 812-bed acute-care facility and part of a multi-campus system that includes three hospitals, a heart and vascular center, prompt and primary care, home health, and private physician offices. Founded in 1818 as City Hospital, Piedmont Augusta has since moved through four facilities to its present location, which opened in 1970, and includes its Summerville Campus on Wrightsboro Road.

Piedmont Augusta at Summerville Campus

Piedmont Augusta at Summerville Campus, formerly University Hospital, was founded in 1952 and joined the Piedmont family on March 1, 2022. The hospital is known for its comprehensive diagnostic services, including cardiac catheterization, magnetic resonance imaging, and osteoporosis treatment. It offers a 24-hour, 15-bed Emergency Department, a 12-bed inpatient unit and new and enhanced imaging services. Outpatient services include Wound & Hyperbaric Services, Diabetes Services, Full-service Lab, Sleep Lab, Coumadin Clinic, Primary Care and Piedmont Heart. It offers these services in the Summerville Medical Building and in the newly renovated Occupational Medicine suite.

Piedmont Healthcare

Piedmont Healthcare is a private, not-for-profit organization that cares for more than 4.5 million patients and serves communities that comprise 85 percent of Georgia’s population. This includes 26 hospitals, 108 immediate care locations, 1,875 Piedmont Clinic physician practices, and nearly 3,600 Piedmont Clinic members. Our patients conveniently engage with Piedmont online, having scheduled more than 560,000 appointments and over 120,000 virtual visits.

With more than 47,000 caregivers, we are the largest Georgia-based private employer of Georgians, who all came for the job, but stayed for the people. In 2024 and 2023, Piedmont has earned recognition from Newsweek as one of America’s Greatest Workplaces for Diversity and also as one of America's Greatest Workplaces for Women. In 2022, Forbes ranked Piedmont on its list of the Best Large Employers in the United States. Piedmont provided more than $607 million in community impact in Fiscal Year 2024.

Primary data: Community voices

The most important part of a CHNA is the community itself. We conducted one-on-one interviews and surveys to hear from key individuals and groups, including patients and the community.

32

Stakeholders interviewed

Interviewees included representatives of public health, charitable clinics, food banks, homeless populations, health advocates, and other community leaders.

167

Community leader surveys submitted

Survey respondents represented key community groups and shared insights on challenges and opportunities within Piedmont communities.

1266

Community surveys submitted

Patients and employees were surveyed through an questionnaire that asked what was working well, what wasn’t, and what barriers prevented patients from being healthy.

One-on-one interviews

From January to March 2025, we interviewed 32 key stakeholders to understand what makes a healthy community, what barriers prevent health access, and what opportunities exist to best support our communities. These interviews, which included representatives of public health, provided a critical context to the external and internal data indicators.

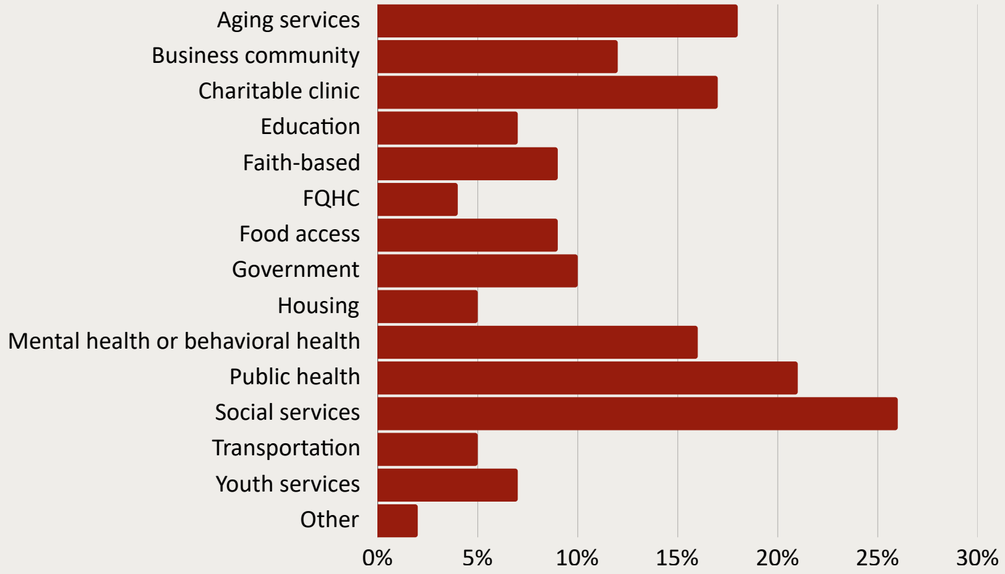
These interviews carried specific themes throughout:

- Concern for potential federal changes to social safety nets, such as Head Start programming, Meals on Wheels, free or reduced-cost school lunches, and Medicaid funding
- Concern for nearby rural communities, especially when it comes to prenatal care, food access, and health access overall
- As awareness of health equity grows, many felt there was a stronger understanding of the role government and non-profits can play in the lives of those who need help; this causes concern on the aforementioned federal cuts
- Mental health is a significant concern, with many citing concern over basic needs, social isolation, depression, alcohol and substance abuse, and the negative impacts of social media as driving factors of poor mental health
- Social media is also a concern when it comes to accessing health information, with many citing Facebook as a primary source for many populations, especially older clients
- Concern for pregnant women and especially those who are minorities, who may face particular challenges in accessing prenatal care

Community leaders survey

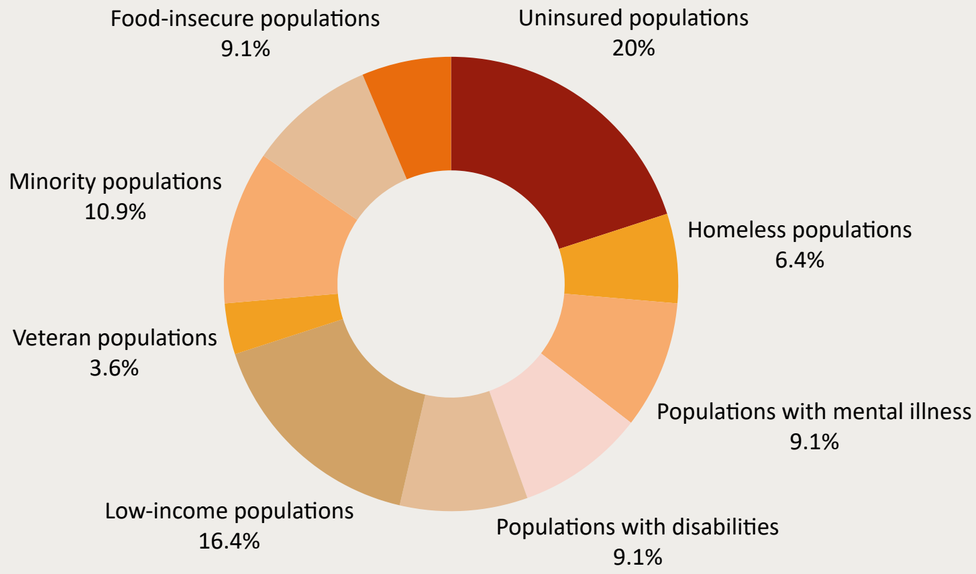
From January to March 2025, approximately 167 community leaders completed an online survey specifically tailored to their unique role within our neighborhoods and cities. The 17-question survey covered topics of community health, community resources, health equity, medical debt, and other related topics.

Survey respondents by area of work



Source: FY25 PHC CHNA Community Leaders Survey, Accessed March 2025.

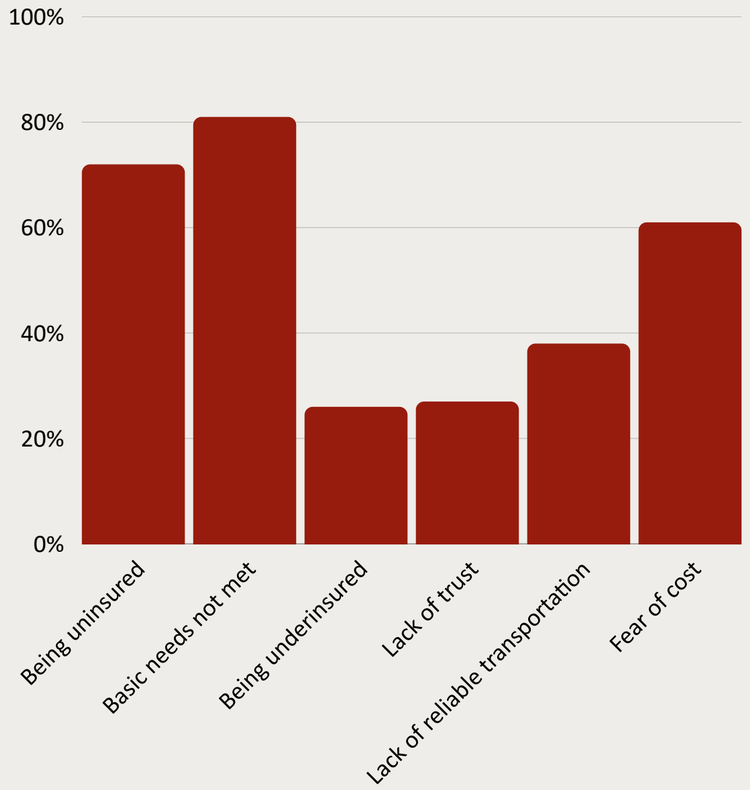
Top populations served by survey respondents



Source: FY25 PHC CHNA Community Leaders Survey, Accessed March 2025.

Community leaders survey, continued

Q: Top barriers to accessing care identified by respondents



Source: FY25 PHC CHNA Community Leaders Survey

Q: What is your vision for a healthy community?

"A community that has opportunity for everyone, regardless of your race or your income."

"Political differences don't mean that you can't talk to your neighbor anymore."

"One of safety and security, where we all feel we can access the resources we need without judgment or fear, and where our children shouldn't have to practice what to do if there's a school shooter."

> **"...a community where food deserts don't exist, where children aren't hungry, where everyone has access to health care, [and] where no public schools are failing..."**

"Cancer rates fall and people have what they need to be healthy."

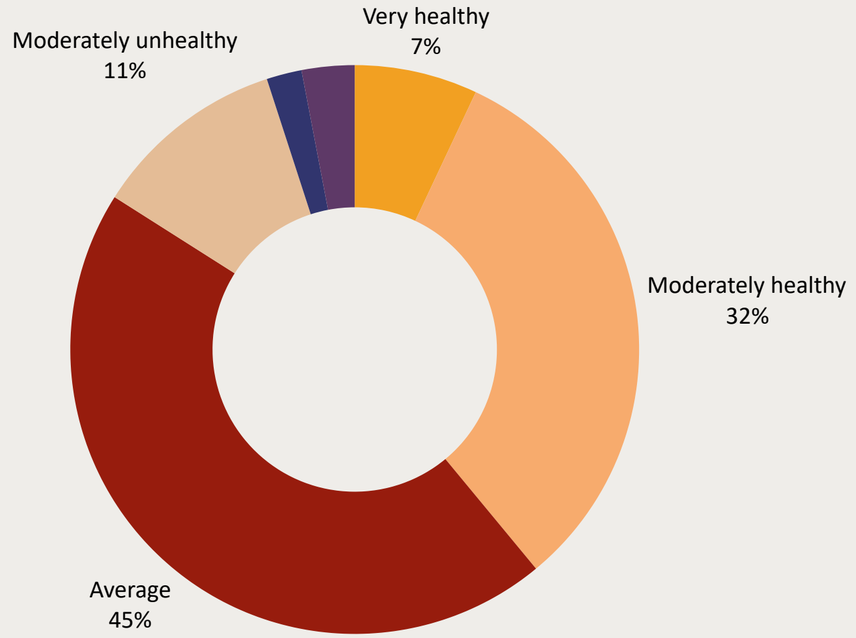
"A community where our older neighbors aren't choosing between medications and meals, where social services are secure and accessible, and everyone has the ability to get where they need to go."

Source: FY25 PHC CHNA Community Leaders Survey

Community survey

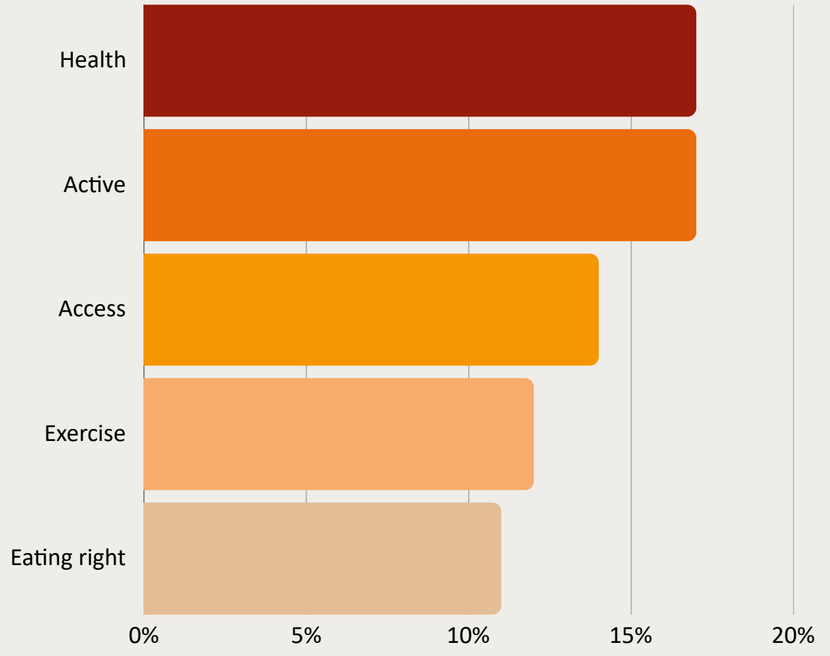
In February 2025, Piedmont launched a five-question survey among its Piedmont Advisors, a group of self-identified community members who often provides feedback to the system. These advisors live and work within Piedmont communities. Approximately 1,266 Advisors provided their insight on what makes a community healthy, their biggest concerns for their communities, and what opportunities they feel exist.

Q: Please rate your community's health, from very healthy to very unhealthy.



Source: Piedmont Advisors Survey, February 2025.

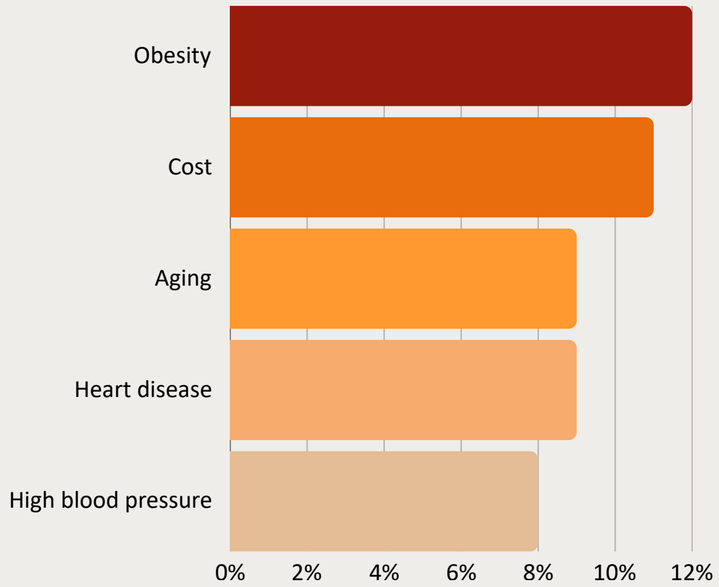
Q: When you think of a healthy community, what comes to your mind first? The top five answers are below.



Source: Piedmont Advisors Survey, February 2025.

Community survey, continued

Q: What do you see as the most pressing health concerns in the next few years? Below are the top five key words used and some quotes.



"Poor nutrition, lack of exercise, and unhealthy work-life balance has led to high levels of obesity, hypertension, and diabetes, which then leads to cascading additional health problems throughout the life cycle."

"Shortage of nurses and doctors."

"The population is aging quickly, and I don't think we have affordable elder care options for most people"

"Obesity, mental health conditions, decline in sociability"

"Misinformation from the talking heads. Health needs to be depoliticized and those "non-doctors" need to remove themselves from the equation. We need to continue to stress the need for public health and others well being. Provide better information about vaccinations due to real concerns of past illnesses making a return."

Source: Piedmont Advisors Survey, February 2025.

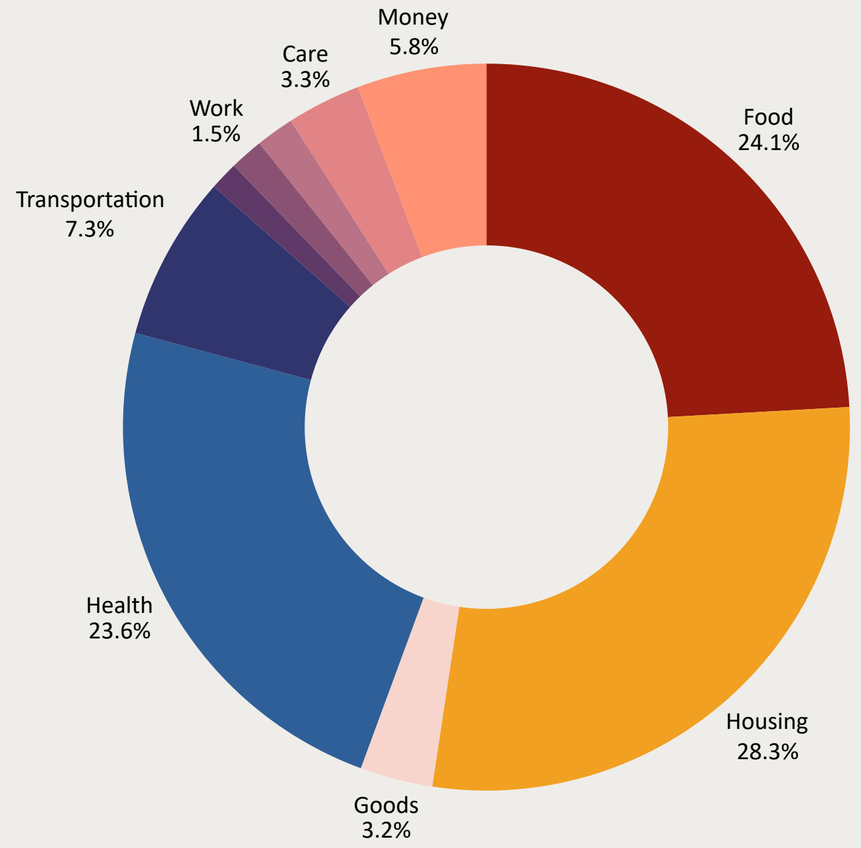
Empowering You

Beginning in January 2023, Piedmont offers its community the Empowering You portal through FIndHelp.org. Through this web-based platform, community members can use search terms to find support within their communities for common resources generally aimed at addressing social drivers of poor health.

Between January 2023 and March 13, 2025, Piedmont community members searched Empowering You approximately 196,000 times. Below are the top ten origin counties + number of searches.

County	No. of searches
Fulton County	26,752
Henry County	12,551
Clayton County	12,519
Coweta County	10,890
Bibb County	10,389
Newton County	10,210
DeKalb County	9,425
Fayette County	8,758
Clarke County	7,473
Rockdale County	7,381

Top searches, by topic, across the Piedmont system, January 2023 to March 2025



Secondary data: The numbers

For our quantitative data, we've examined about 1,500 indicators from approximately 80 sources, including:

- Georgia Department of Public Health
- US Department of Health and Human Services, Center for Medicare and Medicaid Services
- US Department of Health & Human Services, Health Resources and Services Administration
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System
- University of Wisconsin Population Health Institute, County Health Rankings
- Centers for Disease Control and Prevention
- National Center for Health Statistics
- US Census Bureau
- US Department of Agriculture
- US Department of Labor

We also conducted extensive literature reviews of CHNAs from similar hospitals and facilities to evaluate potential sources.

Finally, we reviewed multiple studies and journals for potentially relevant data, helping us understand both the patient population and the impact of potential health inequities on patient populations traditionally underserved within healthcare.

Demographics

Approximately 206,000 people lived in Richmond County annually between 2019 and 2023. When we expand to include Aiken County, that number grows to about 378,000. About 92 percent of the combined community is 78% urban, and most residents are between 18 and 64.

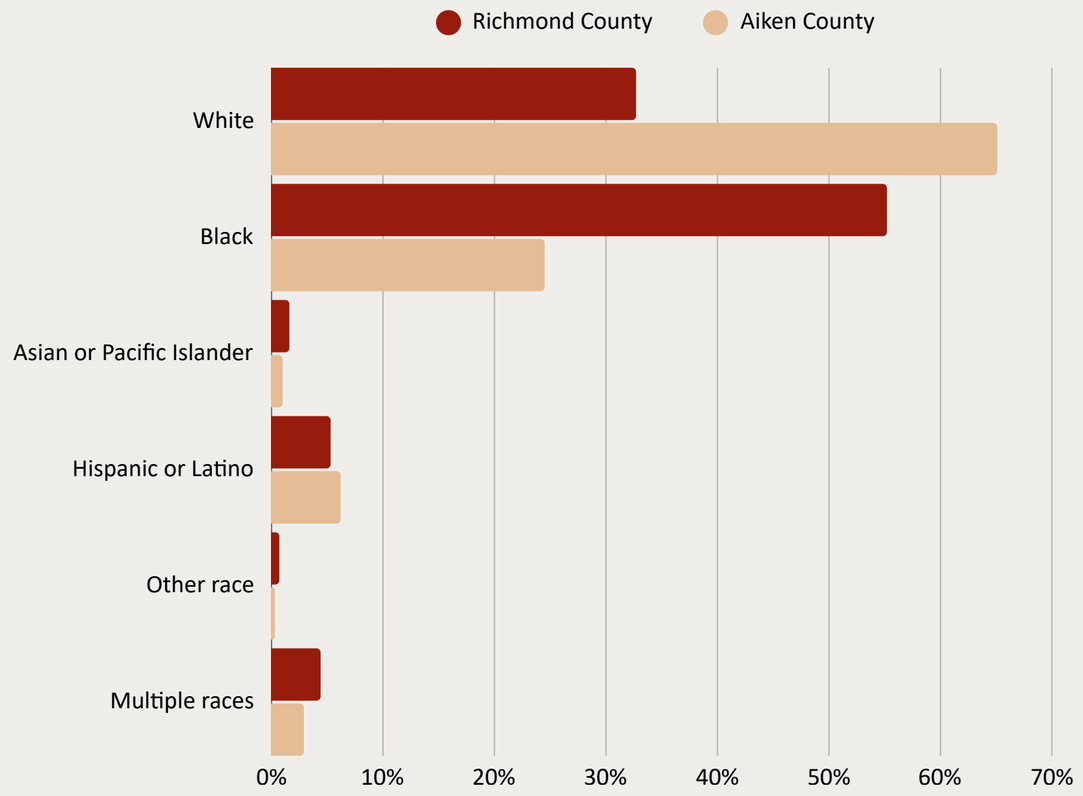
- **0 to 4:** 6.1%
- **5-17:** 16.2%
- **18-24:** 9.4%
- **25-34:** 14.5%
- **35-44:** 12.1%
- **45-54:** 11.2%
- **55-64:** 13.1%
- **65+:** 17.4%

60.3%

Richmond County grew by 3.0% between 2010 and 2020, led by the Asian and Hispanic or Latino populations. Aiken County grew by 5.5%, also largely led by Hispanic or Latino populations.

Less than 0.1% of the combined community is in a limited English-speaking household, meaning most members can speak English at least fluently. That said, about 6.5% of households speak a language other than English at home. Of those languages, Spanish ranks the highest at 4%.

Percent of population by race and ethnicity, Richmond and Aiken counties, 2019 to 2023



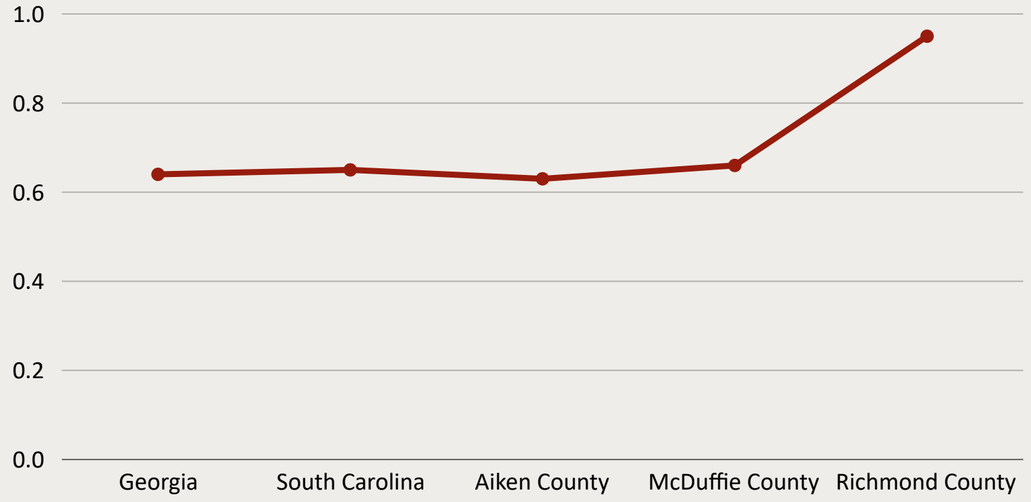
Source: US Census Bureau, American Community Survey, 2019-2023.

Social Vulnerability Index and Area Deprivation Index

The Social Vulnerability Index (SVI) is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, which collectively describe a community's social vulnerability. The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods across the US, where a higher score indicates higher vulnerability. **The higher the score, the more vulnerable the community.**

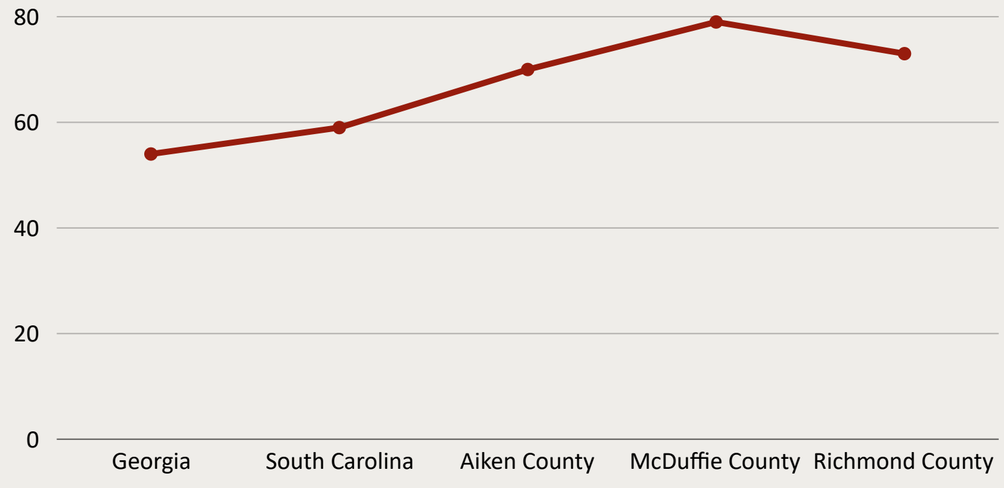
The Area Deprivation Index ranks neighborhoods and communities relative to all neighborhoods relative to other neighborhoods within one state (state percentile). The ADI is calculated based on 17 measures in four primary areas: education, income and employment, housing, and household characteristics. The scores are measured on a scale of 1 to 100 where **1 indicates the lowest level of deprivation** (least disadvantaged) and **100 is the highest level** (most disadvantaged).

SVI, state percentile, 2022



Source: CDC GRASP, 2022.

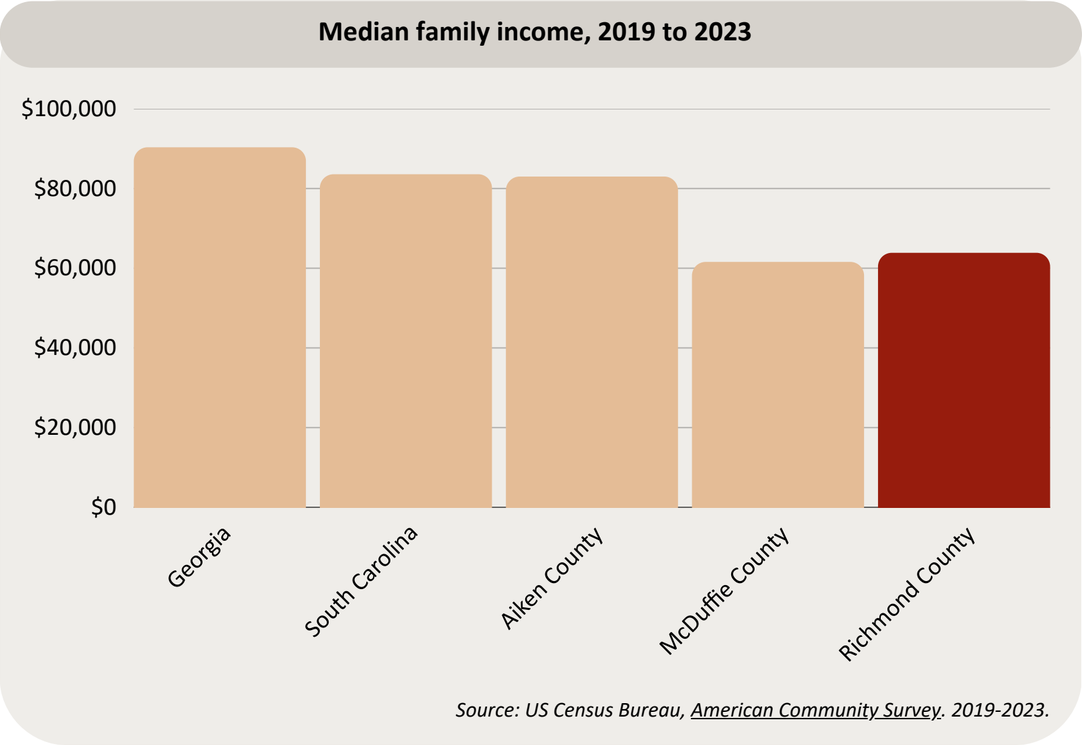
ADI, state percentile, 2022



Source: University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2022.

Income

Income is a key determinant of community health, influencing access to healthcare, healthy food, housing stability, and overall quality of life. Indicators such as median household income and poverty rates reflect a community's economic well-being.



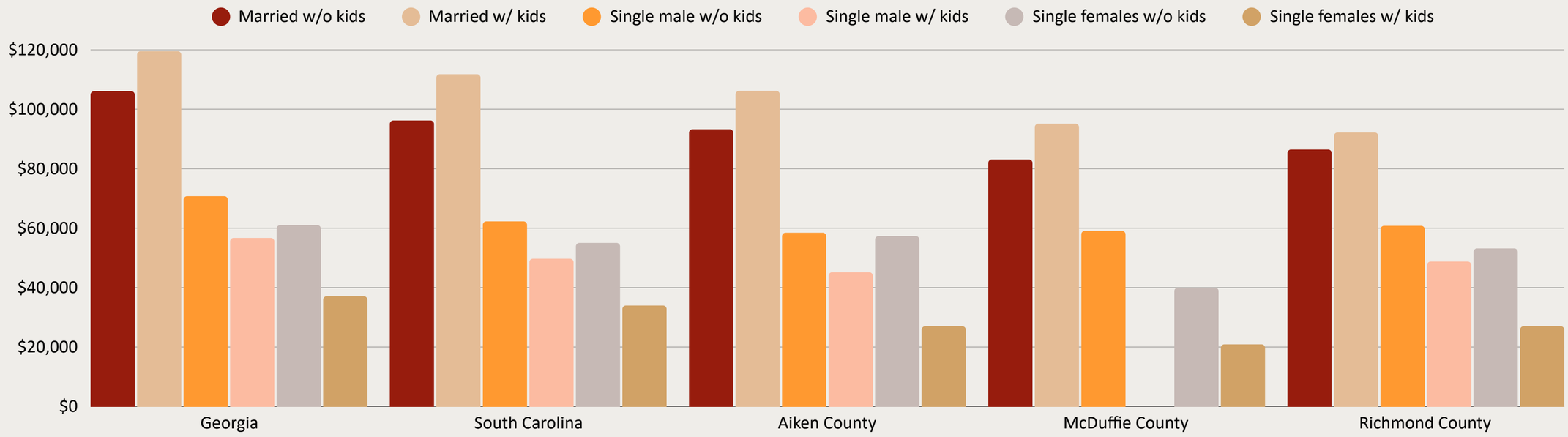
Source: US Census Bureau, American Community Survey. 2019-2023.

- Access to care: Income allows individuals and families to afford health insurance, medical care, and necessary medications, all vital for preventing and treating illnesses.
- Reduced stress and financial strain: Financial stability can reduce the stress of managing debt, housing insecurity, and job instability.
- Access to safe and healthy environments: Income can influence where people live, affecting access to safe neighborhoods, clean air and water, and nutritious food options.
- Educational opportunities: Income plays a significant role in accessing quality education, leading to better job opportunities and improved health outcomes later in life.
- Longer life expectancy: Studies have shown that higher income is associated with longer life expectancy and lower mortality rates.

Income by household type

When we break income down by household type, we see where certain family structures tend to be poorer. In Georgia and the Augusta area, the poorest household tends to be led by a single mother, who traditionally experience higher rates of poverty and food insecurity, which directly impacts their health and the health of their children. Limited financial resources can lead to inadequate housing, healthcare, and nutrition, impacting overall well-being. The constant struggle to make ends meet can lead to increased stress, depression, and other mental health issues.

Median family income by household type, 2019 to 2023

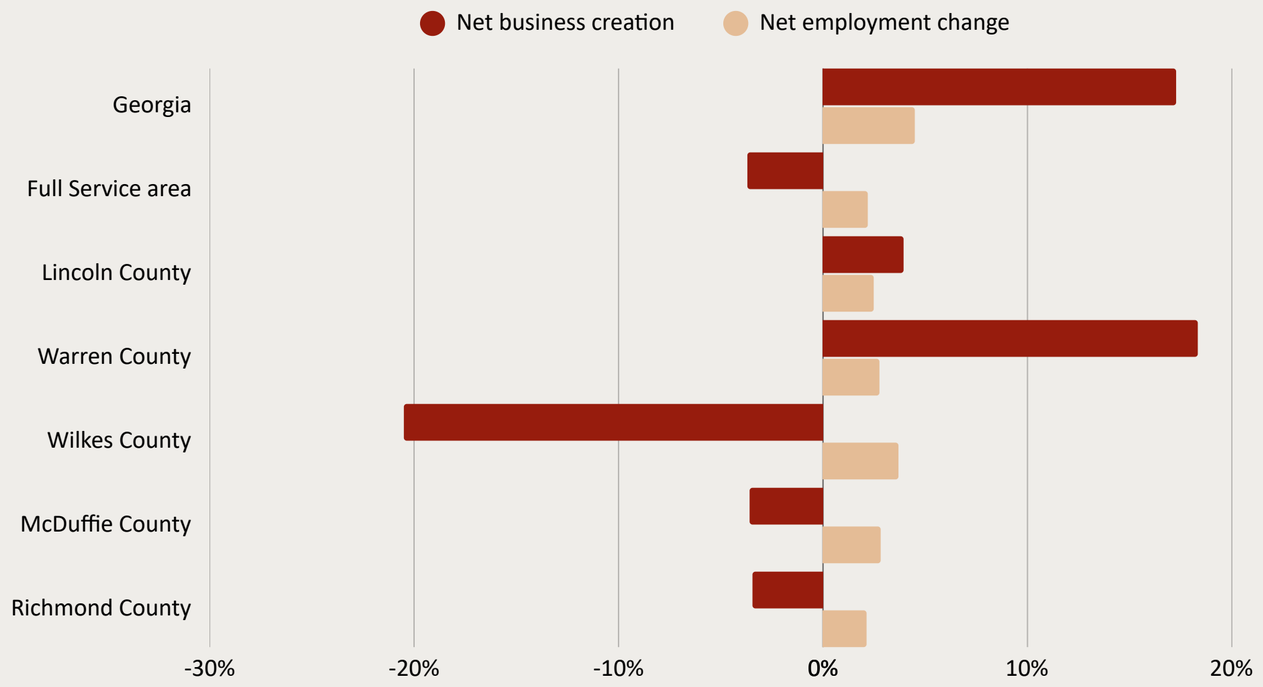


Source: US Census Bureau, American Community Survey. 2019-2023.

Employment

Between 2011 and 2021, about 4,450 new businesses were created within the full service area. During that same time, 4,630 businesses closed, resulting in an establishment net change rate of -3.7%, far less than the state average of 17.3%. Wilkes County saw the greatest decline in businesses, with a rate of -20.5%. Warren County experienced the greatest growth, with an establishment net change rate of nearly 21%.

Net business creation and net employment change, 2011 to 2021



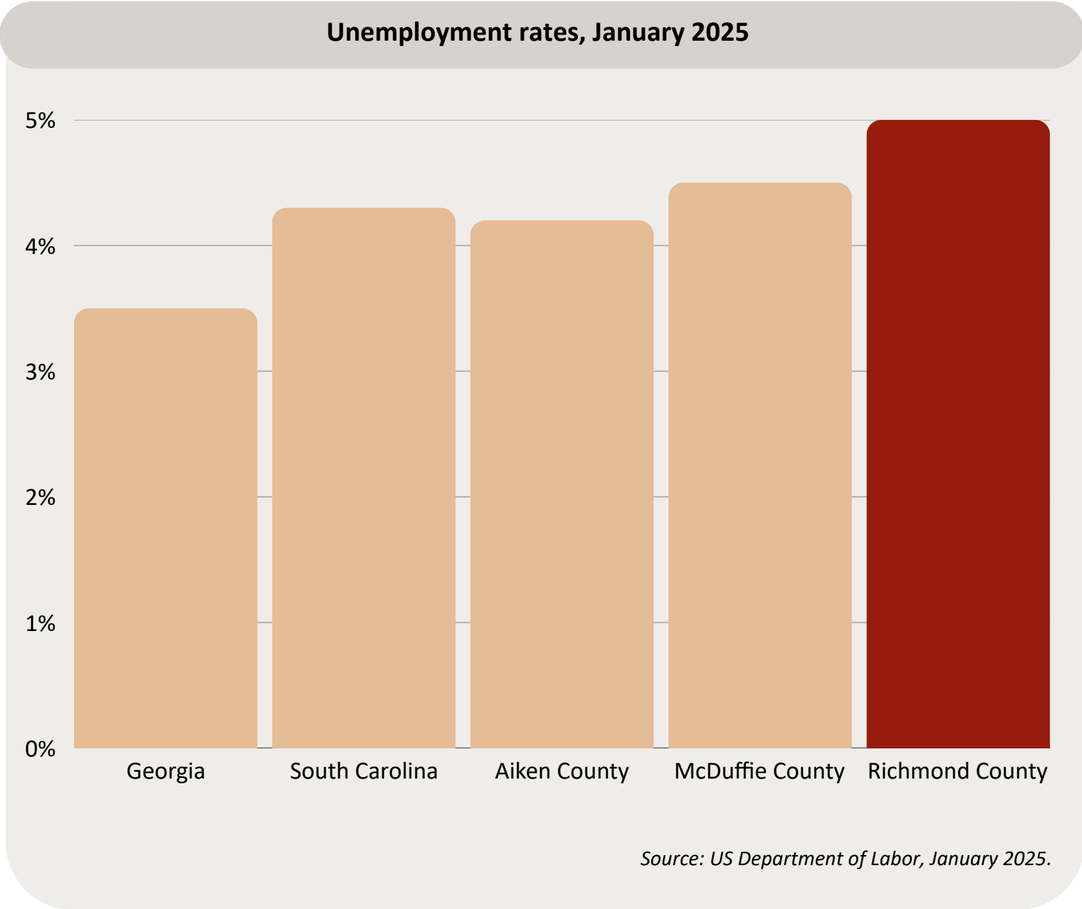
US Census Bureau, US Census Business Dynamics Statistics. 2011-2022.

Within the service area:

- About 77% of those working commute to work alone in a car or truck, with Richmond County having the most amount of commuters.
- Warren County community members had the longest commutes, with about 19% of workers driving at least an hour to get to work each day.
- Richmond County residents are more likely to walk or bike to work – about 2.4%, a rate above the state average of 1.5%.
- About 91% percent of working age adults with a disability work, a number not far from the rate of 93% of non-disabled populations.

Unemployment

Unemployment creates financial instability and barriers to access including, insurance coverage, health services, healthy food, and other necessities contributing to poor health status.



Unemployment significantly impacts health, leading to poorer mental and physical well-being, increased stress, and higher rates of chronic diseases, including mental health issues like depression and anxiety, as well as physical conditions like heart disease.

Mental health impacts: Studies consistently show that unemployment is associated with higher rates of depression, anxiety, and other mental health issues.

Increased risk of suicide: Research indicates that unemployment is linked to an increased risk of suicidal thoughts and attempts, particularly among men.

Obesity and chronic conditions: Unemployment can contribute to poor health behaviors, such as unhealthy eating habits and lack of physical activity, leading to increased obesity and chronic health conditions.

Reduced access to healthcare: Unemployment can lead to financial difficulties, making it harder for individuals to afford healthcare, medications, and preventative care, further impacting their health.

Poverty

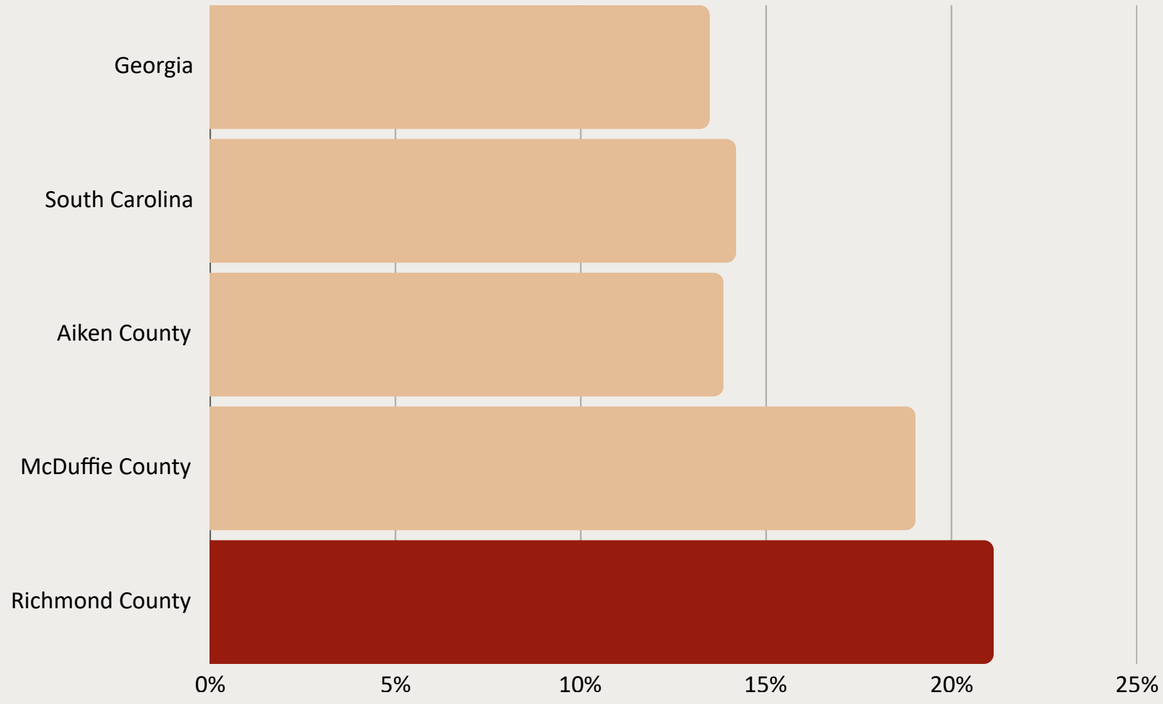
Living in poverty is the driving force of poor health for lower-income community members. Poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status.

In 2023, a family of four living at 100% of the FPL had an annual gross income of $30,000 or below.

Within the combined community, between 2019 and 2023, we see that:

- Women are generally more likely to live in poverty than men.
- Minorities are often far more likely to live in poverty than their White counterparts.
- Low-income individuals and families often have higher rates of heart disease, stroke, diabetes, and other chronic conditions compared to those with higher incomes.
- These populations are more likely to smoke, participate in other risky behaviors (such as driving ATVs without helmets), and have higher rates of teen pregnancy.

Poverty rates, annually on average, 2019 to 2023

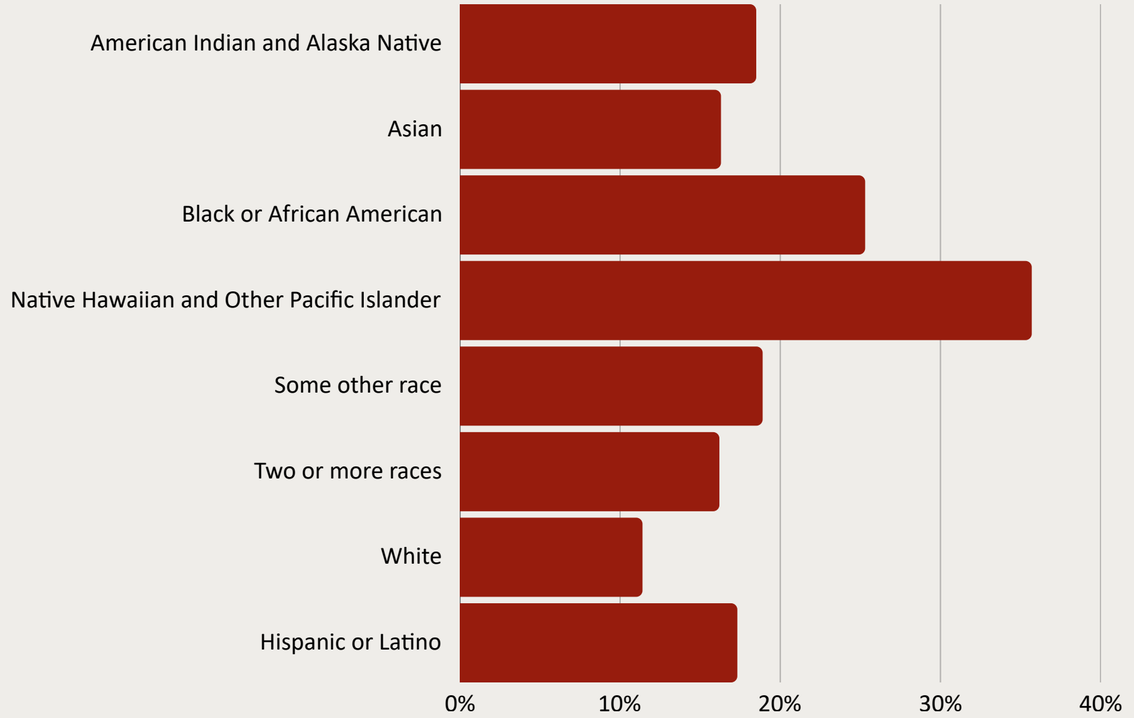


Source: US Census Bureau, American Community Survey. 2019-2023.

Poverty by race and ethnicity

Poverty often shifts between races and ethnicities, with white and Asian populations traditionally the two least likely to live in poverty.

Poverty rates by race and ethnicity, Richmond and Aiken counties, 2019 to 2023



Source: US Census Bureau, American Community Survey. 2019-2023.

- Multigenerational poverty: The effects of poverty can extend across generations, with Black Americans being disproportionately affected by multigenerational poverty.
- Wealth disparities: Racial wealth gaps persist, with White households having significantly more wealth than Black households.
- Employment: Communities of color are statistically likelier to be unemployed or in low-paid jobs.
- Education: Children in high-poverty neighborhoods may attend schools with fewer resources, impacting their educational outcomes.
- Housing: People of color are likelier to be extremely low-income and struggle to pay rent.
- Health: Poverty and racial discrimination can lead to disparities in health outcomes, including lower life expectancy and increased exposure to violence.

Percent of the population at varying poverty rates

As demonstrated in the chart to the right, most people in Richmond and Aiken counties live at 201% to 500% of the FPL, meaning they had pre-tax incomes ranging from $55,500 to $138,750 for a family of four.

Even so, there are costs that drive down useable income.

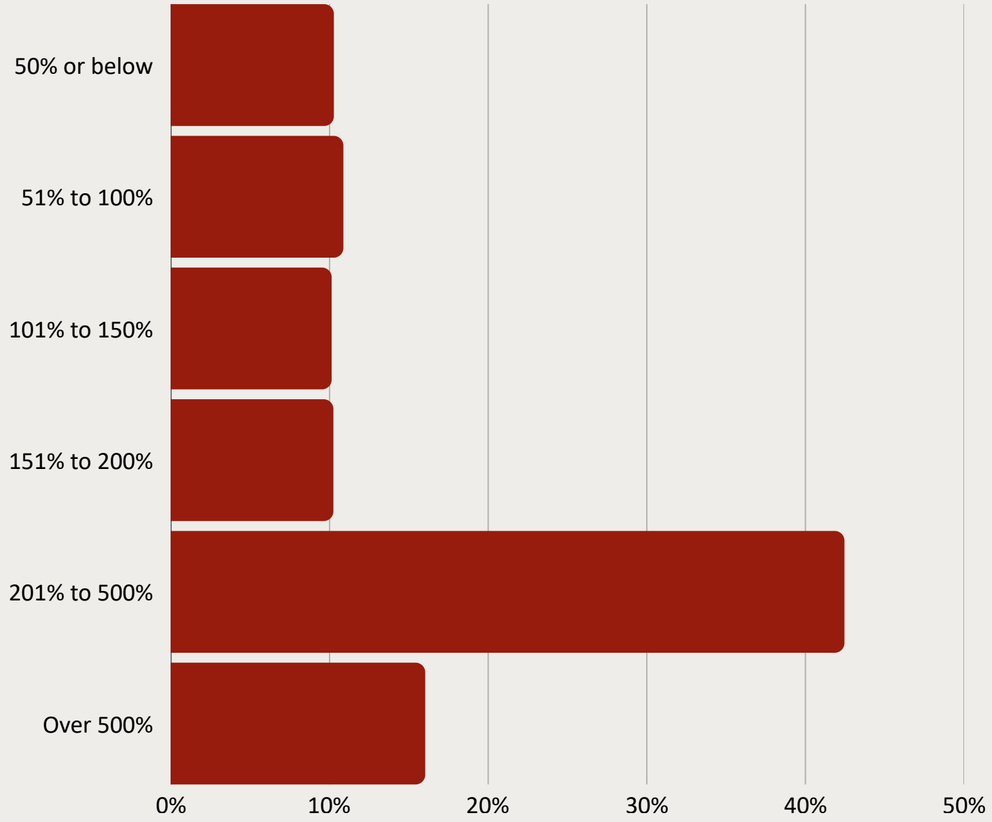
Childcare: Between 2019 and 2023, **childcare costs consumed about 30% of the median household income for parents in Richmond and Aiken counties.** Overall, childcare costs were more expensive in Aiken than in Richmond.

Collections: In the combined communities, about **37.3% of residents had debt in collections**, with significant differences between the two communities. About 445 of Richmond County residents and about 30% of Aiken County residents had debt in collections. Approximately 33% of White populations had any debt in collections, compared to communities of color, of which 40% had debt in collections in the combined communities.

Student loan debt: According to the Urban Institute, **about 20% of Richmond County and 15.1% of Aiken County residents had student loan debt** between 2019 and 2024. The median amount owed was $24,565 and $23,062 for Richmond and Aiken residents, respectively.

Utility services threat: In 2022, about 11.7% of Richmond County and 8% of Aiken County community members reported nearly having their utilities cut due to nonpayment.

Percent of the population at varying poverty rates, Richmond and Aiken counties, 2019 to 2023

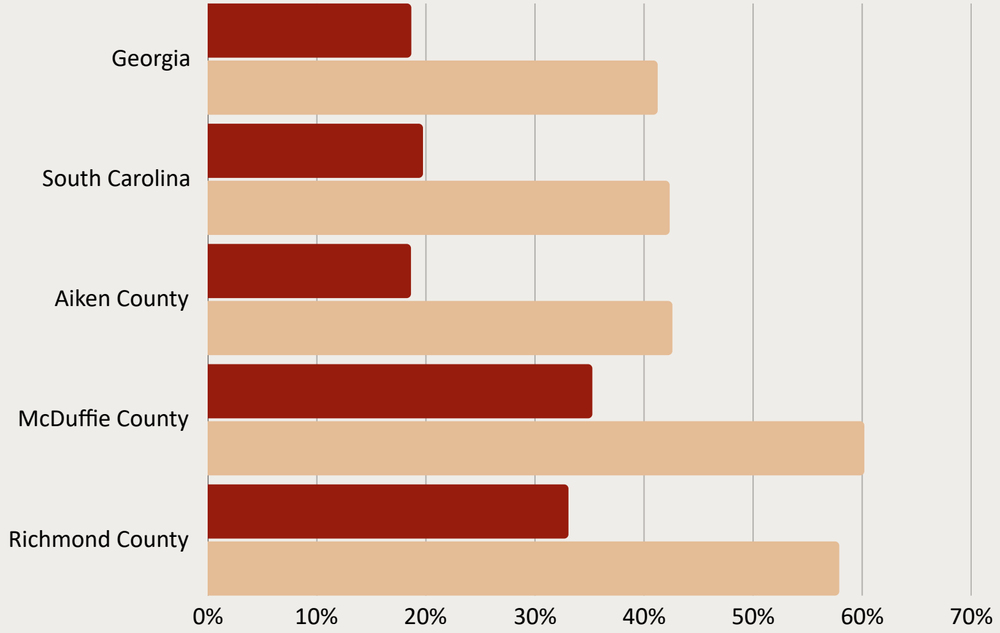


Source: US Census Bureau, American Community Survey, 2019-2023.

Children in poverty

In Richmond County, nearly 27,000 children lived in households with income below 200% of the Federal Poverty Level between 2019 and 2023. When expanded to include Aiken County, that number grows to 42,515 children in poverty. This is relevant because poverty creates barriers to access including, health services, healthy food, and other necessities contributing to poor health status.

Percent of children living at or below 100% and 200% FPL, 2019 to 2023



Source: US Census Bureau, American Community Survey. 2019-2023.

What creates child poverty: Economic factors (lack of job opportunities, low wages), social issues (gender, ethnicity, race), and inadequate social safety nets contribute to child poverty.

Intergenerational poverty: Children raised in poverty are at higher risk of remaining poor in adulthood, creating a cycle of poverty.

Impact on development: Poverty affects a child's development even before birth, increasing the risk of low birth weight, poor health, and developmental delays.

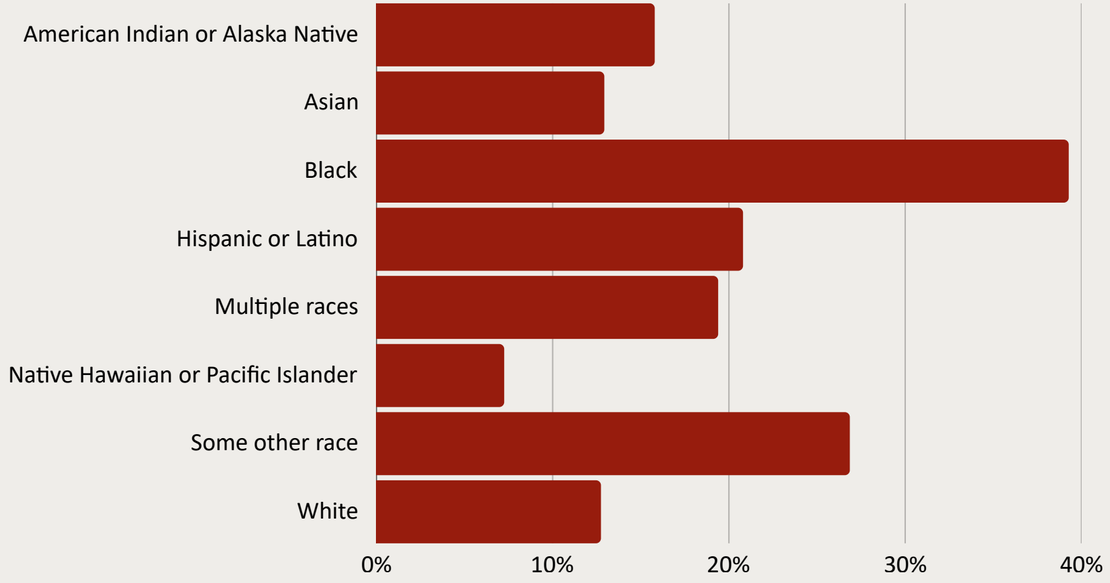
Mental health: Children living in poverty are at higher risk of experiencing poor mental health and psychological distress.

Solutions: Addressing child poverty requires comprehensive strategies, including access to quality education, stable employment opportunities, and supportive community resources. Policies like modifications to the Earned Income Tax Credit (EITC), childcare subsidies, and changes in the federal minimum wage can help reduce child poverty.

Children in poverty by race and/or ethnicity

As with many indicators, communities of colors tend to be disproportionately impacted by social determinants of health.

Percent of children living at or below 100% FPL, by race, Richmond and Aiken counties, 2019 to 2023



Source: US Census Bureau, American Community Survey, 2019-2023.

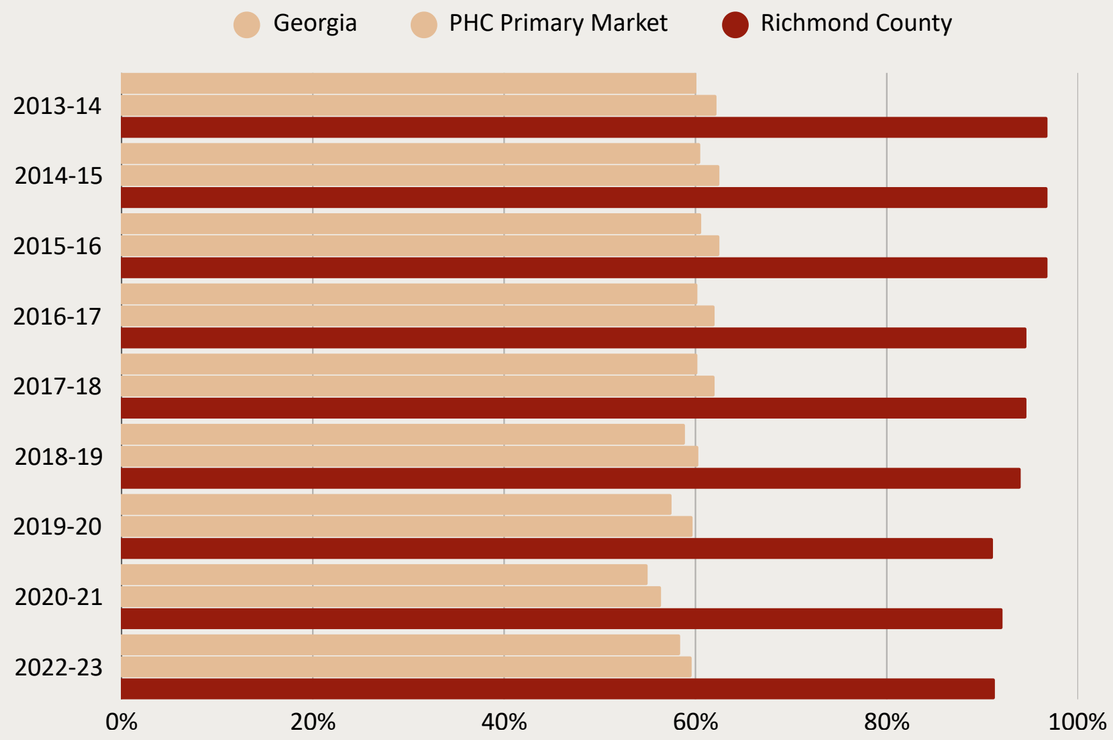
Children of color are disproportionately more likely to live in poverty due to a complex interplay of historical and ongoing systemic factors, including racial discrimination, residential segregation, and unequal access to resources and opportunities. These factors contribute to lower income levels, limited access to quality education and healthcare, and increased vulnerability to poverty for families of color.

- Single-parent households: Children of color are more likely to live in single-parent households, which often face greater economic hardship.
- Neighborhood effects: Living in high-poverty neighborhoods can expose children to violence, crime, and limited access to healthy food and recreational opportunities.

Children qualifying for free or reduced cost lunch

Children qualifying for free/reduced lunch programs often face significant barriers to healthcare access, consistent medical treatment, and educational achievement, with these socioeconomic challenges frequently resulting in higher absenteeism, learning gaps, and reduced academic performance.

Children eligible for free or reduced-cost lunch, Richmond County, 2013 to 2023



Source: National Center for Education Statistics, NCES - Common Core of Data, 2022-2023.

In Richmond and Aiken counties, 80% -- or about 44,000 children -- qualified for free or reduced-price lunch at their school during the 2022-2023 school year. Looking just at Richmond County, that figure jumps to 91.3%.

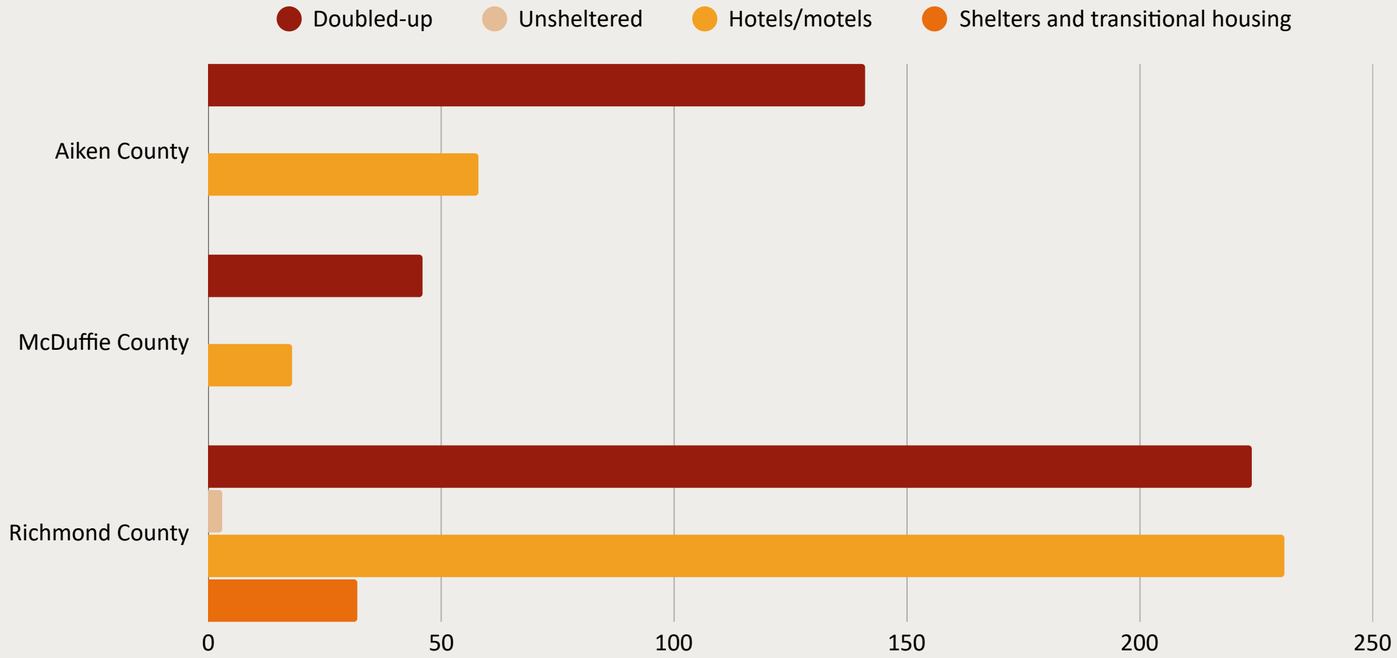
Free and reduced-price school lunch programs directly address food insecurity, a major social driver of poor health. These programs ensure students have access to healthy, nutritious meals, reducing the risk of hunger and its associated negative consequences.

Additionally, consistent access to nutritious meals can improve overall health and well-being, particularly for children from low-income families who may otherwise face food insecurity.

Homeless students

Within the service area, 1.5% of students were homeless during the 2021-2022 school year.

Students experiencing homelessness by primary nighttime residence, Richmond County, 2021 to 2022 school year



Source: US Department of Education, ED Data Express. Additional data analysis by CARES, 2021-2022.

A brief description of each column is provided below:

Doubled-up: Refers to doubled-up or shared housing due to loss of housing, economic hardship, or similar reasons.

Unsheltered: Includes situations such as living in cars, parks, campgrounds, temporary trailers (including FEMA trailers), or abandoned buildings. This is the most uncommon scenario in the service area.

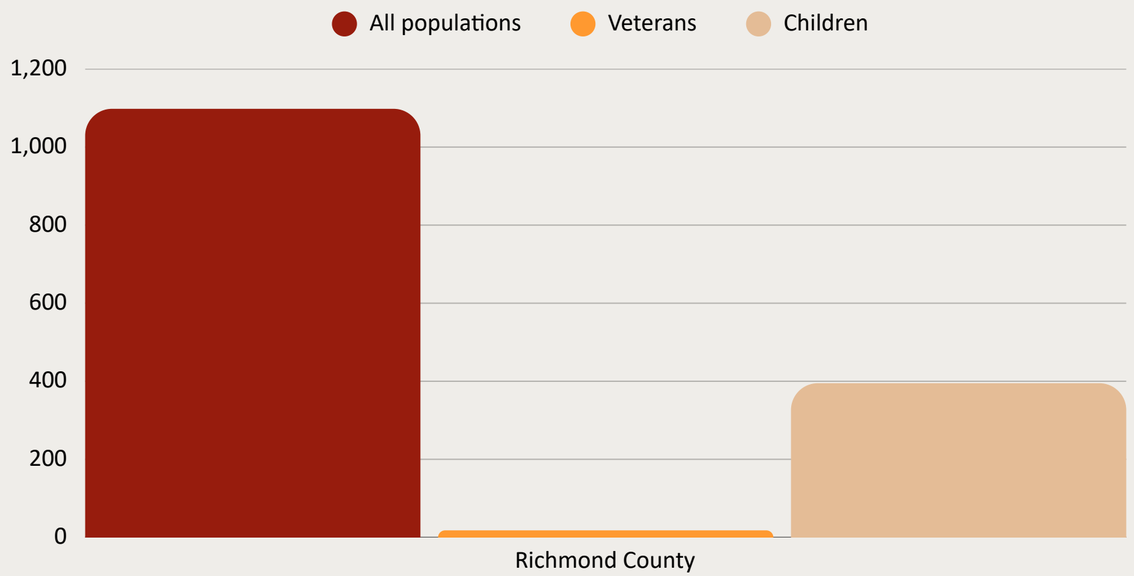
Hotels/motels: As indicated by the name, refers to stays in hotels or motels.

Shelters and transitional housing: Refers to stays in shelters or transitional housing programs, as indicated.

Homeless populations

Homelessness significantly impacts both physical and mental health. It's a complex issue with intertwined causes and effects. People experiencing homelessness are at higher risk for infectious diseases like Viral Hepatitis (especially Hepatitis C), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and COVID-19, often due to crowded living conditions in shelters and limited access to sanitary facilities. They also face a higher prevalence of chronic conditions like diabetes, heart disease, and lung disease.

Point-in-time count of homeless populations, January 2025



Source: Georgia Department of Community Affairs, 2024 Point in Time Homeless Count, 2025.

Factors contributing to homelessness:

- Lack of affordable housing: A shortage of affordable housing is a major factor contributing to homelessness.
- Low wages: Low wages that don't keep pace with rising housing costs can lead to financial instability and homelessness.
- Untreated mental illness: Serious mental illness and substance use disorders, if left untreated, can make it difficult for individuals to maintain housing and social support networks.

Veterans and homelessness

Veteran homelessness is a significant issue, with veterans experiencing homelessness at a higher rate than the general population. While the number of homeless veterans has decreased since 2010, there was a recent increase in 2023, and veterans still represent a disproportionate share of the overall homeless population. Various factors contribute to this, including poverty, lack of support networks, and mental health issues. However, there are also numerous programs and resources available to help homeless veterans find housing and support services.

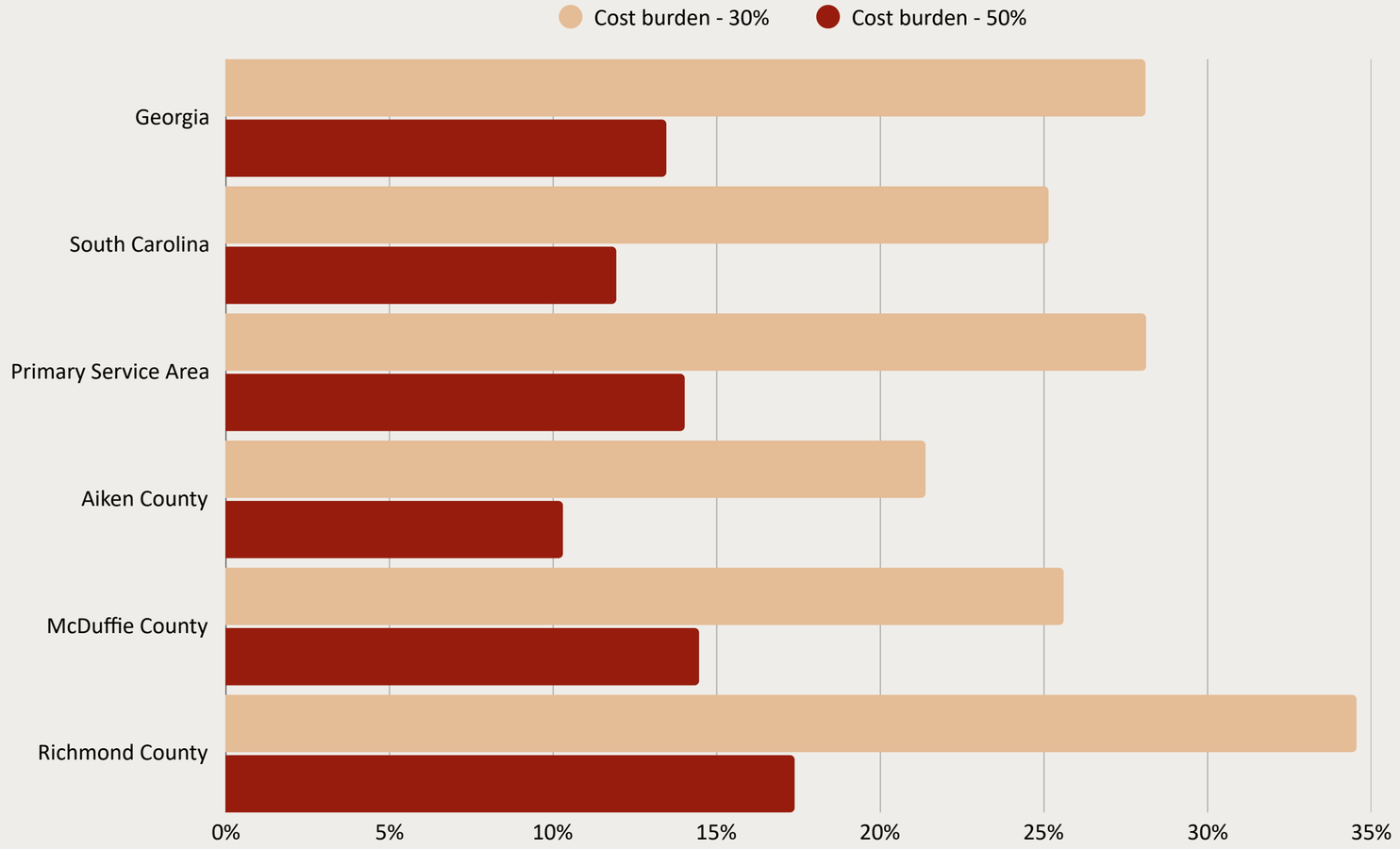
Cost-burdened households

Housing is a critical component of well-being, as a stable home indicates both economic ability and ability to stay healthy.

Minority populations are most likely to live in a cost-burdened household. For example, when looking at ethnicity, approximately 35% of Hispanic or Latino populations lived in a cost-burdened household, as compared to 28% of non-Hispanic or Latino populations.

When looking at race only, **nearly 38% of Black populations live in a cost-burdened household, as compared to only 20% of White households.** In most communities, 100% of Native Hawaiian or Pacific Islander populations live in a cost-burdened household.

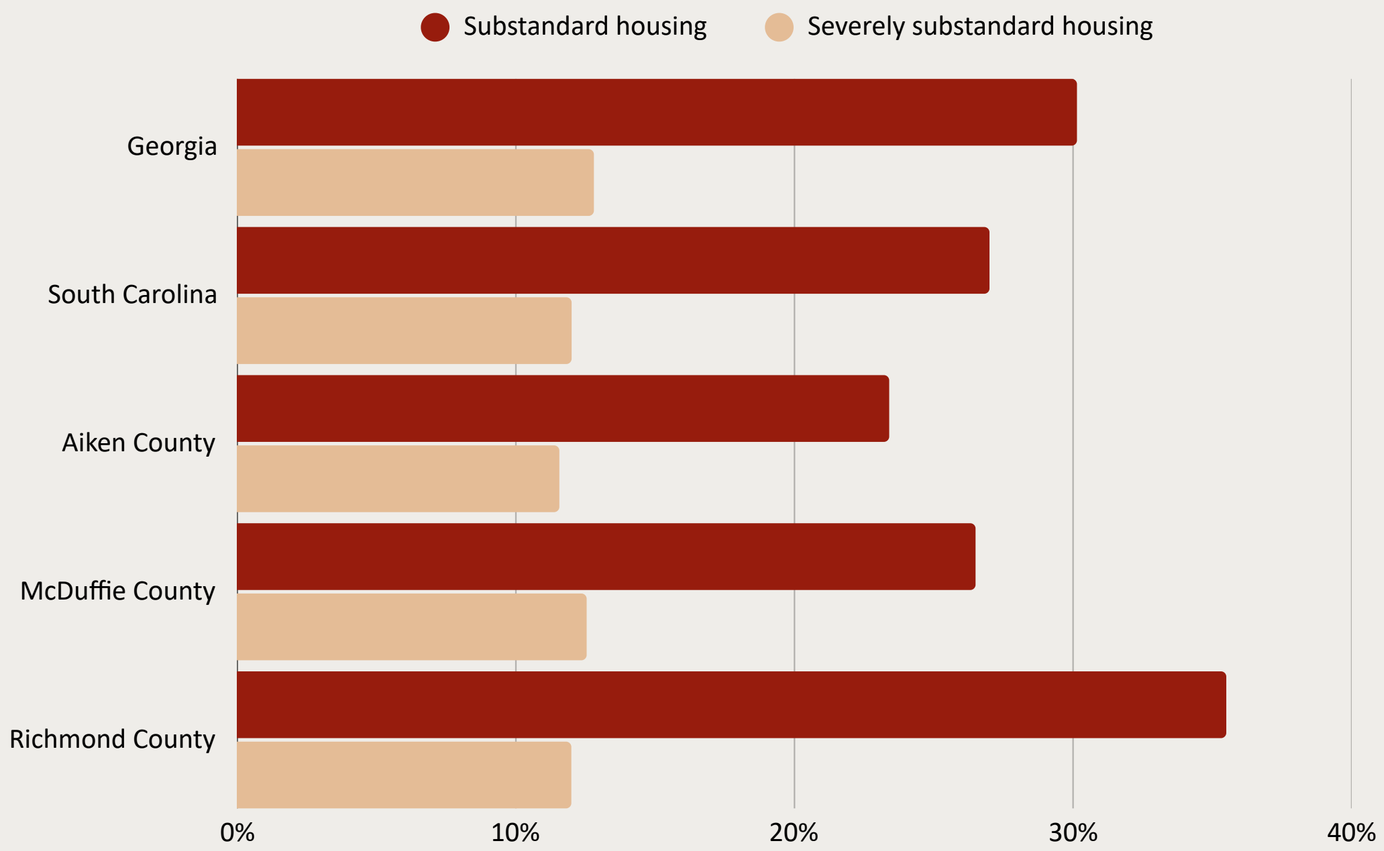
Housing cost burden as percentage of household income, Richmond County, 2019 to 2023



Source: US Census Bureau, American Community Survey. 2019-2023.

Substandard housing

Substandard and severely substandard housing, Richmond County, 2019 to 2023



Source: US Census Bureau, American Community Survey, 2019-2023.

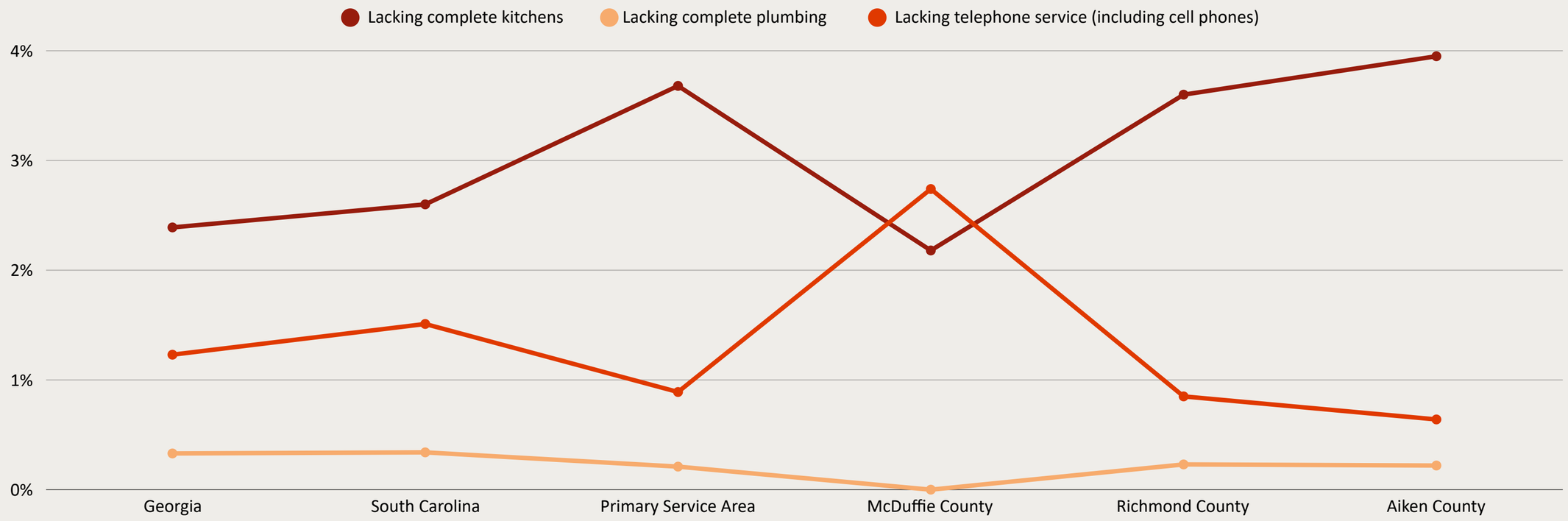
This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions:

1. Lacking complete plumbing facilities
2. Lacking complete kitchen facilities
3. With more than one occupant per room
4. Selected monthly owner costs as a percentage of household income greater than 30%
5. Gross rent as a percentage of household income greater than 30%

Housing without complete plumbing and kitchens

Within the overall service area, there were many homes without complete plumbing, kitchens, or are lacking telephone service, including cell phones. For example, there were nearly 6,700 occupied homes without complete kitchens annually on average between 2019 and 2023. Richmond County had the highest amount of these homes – more than half of all homes in the service area without complete kitchens.

Occupied housing units missing key components, as a percent of total occupied homes, Richmond County, 2019 to 2023

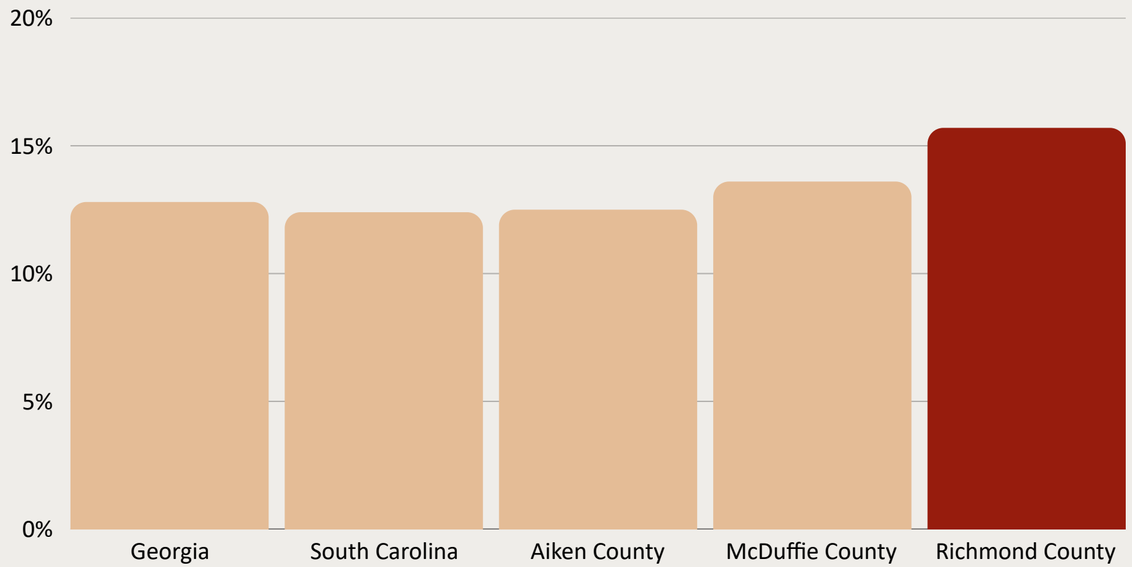


Source: US Dept. of Housing and Urban Development, 2019-2023.

Food insecurity

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

Percentage of population facing food insecurity, Richmond County, 2022



Source: Feeding America, 2022.

Within Richmond and Aiken counties, more than 21,670 – about 26% – of children were food insecure. This issue was worse in Richmond County, with 32% of the county's children as having uncertain access to adequate food.

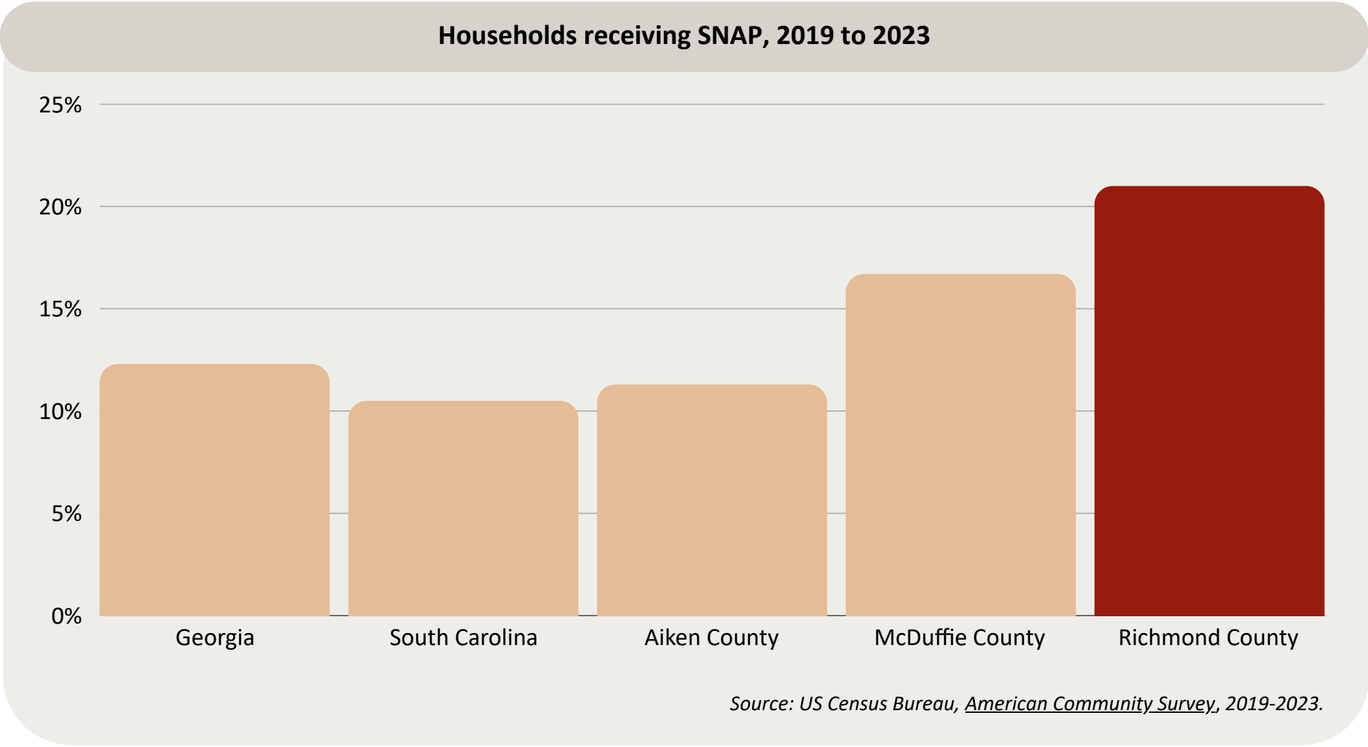
Of those children in the combined communities, 23% are ineligible for SNAP assistance due to income restrictions.

Food insecurity, or limited or uncertain access to adequate food, is strongly linked to negative health outcomes across all age groups and socioeconomic statuses. Individuals experiencing food insecurity are at higher risk of developing chronic diseases, poorer mental health, and other health problems.

Food insecurity is associated with increased risk of diabetes, heart disease, high blood pressure, obesity, and certain types of cancer.

SNAP benefits

SNAP benefits are relevant because it assesses vulnerable populations more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.



In both counties, minority populations were far more likely to receive SNAP benefits than their white counterparts. For example, for all communities combined and when broken down by race, as a percentage of all households within that racial or ethnic group, the following were enrolled in SNAP:

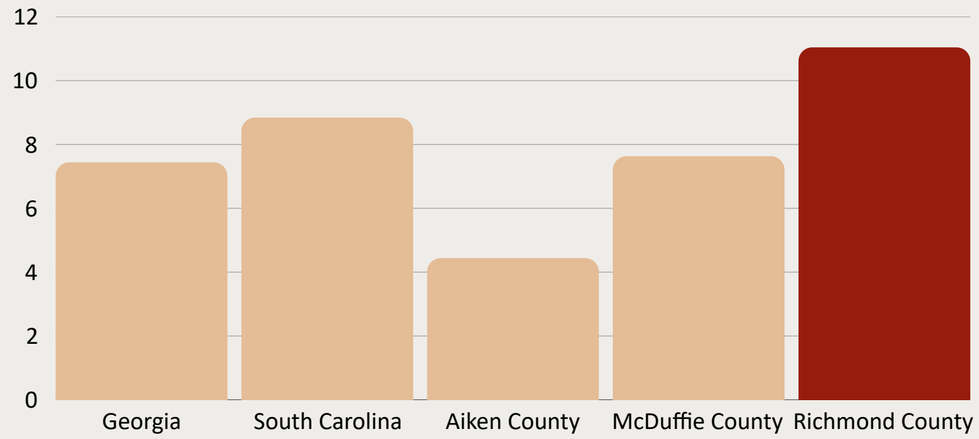
- White: 8.3%
- Black: 27.2%
- Asian: 4.8%
- America Indian or Alaska Native: 9.7%
- Some other race: 5.4%
- Multiple races: 16.6%
- Hispanic or Latino: 15.6%

Within both communities, there were about 12 SNAP-authorized food retailers for every 10,000 people. This includes grocery stores, supercenters, speciality food stores, and convenience stores.

Head Start programming and preschool enrollment

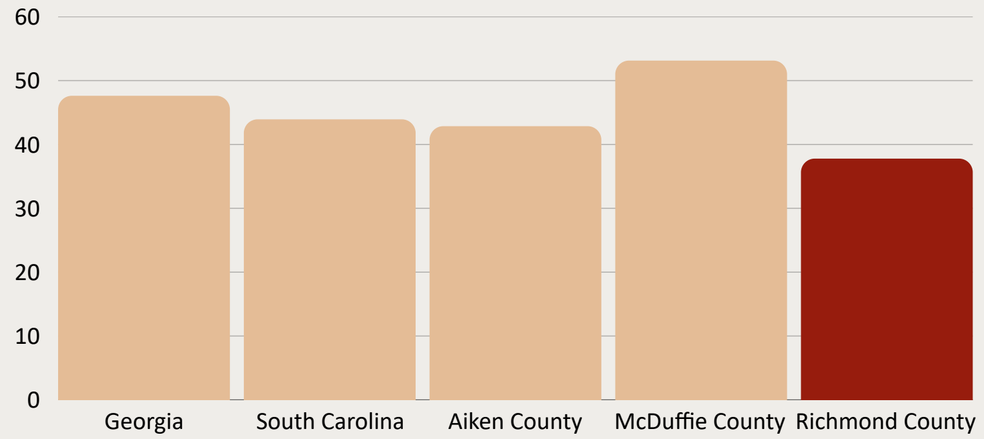
Head Start is a program designed to help children from birth to age five from families at or below the poverty level. The program's goal is to help children prepare for kindergarten while also providing the needed requirements to thrive, including health care and food support. The chart below provides the number and rate of Head Start program facilities per 10,000 children under age 5 in 2024, as well as the percentage of children aged three to four enrolled in preschool between 2019 and 2023.

Head Start programs per 10,000 children under age 5, 2024



Source: US Department of Health & Human Services, HRSA - Administration for Children and Families, 2024.

Percent of children aged 3 to 4 enrolled in preschool, 2019 to 2023

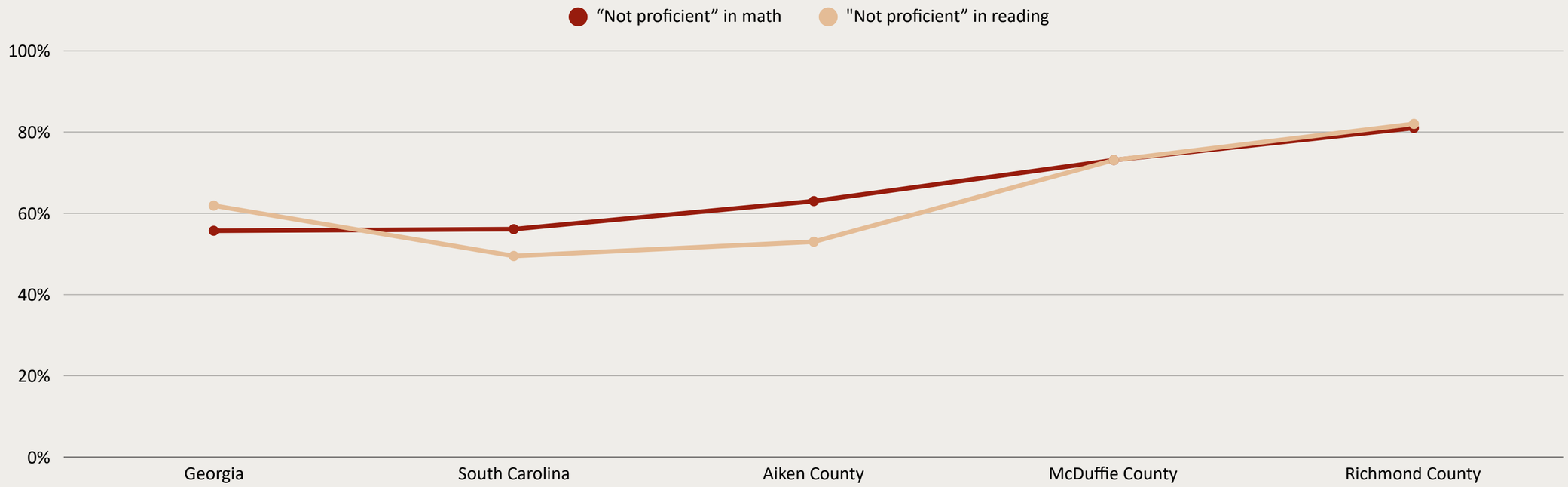


Source: US Census Bureau, American Community Survey, 2019-2023.

Fourth-grade math and reading proficiency

Math and reading proficiency scores measure the percentage of fourth-grade students who meet or exceed established standards in reading and mathematics. By fourth grade, students should be reading to learn, not learning to read. If not, they will likely continue to fall behind in school. The same holds for math.

Student fourth grade math and reading proficiency with a score of "Not Proficient," 2020-21 school year

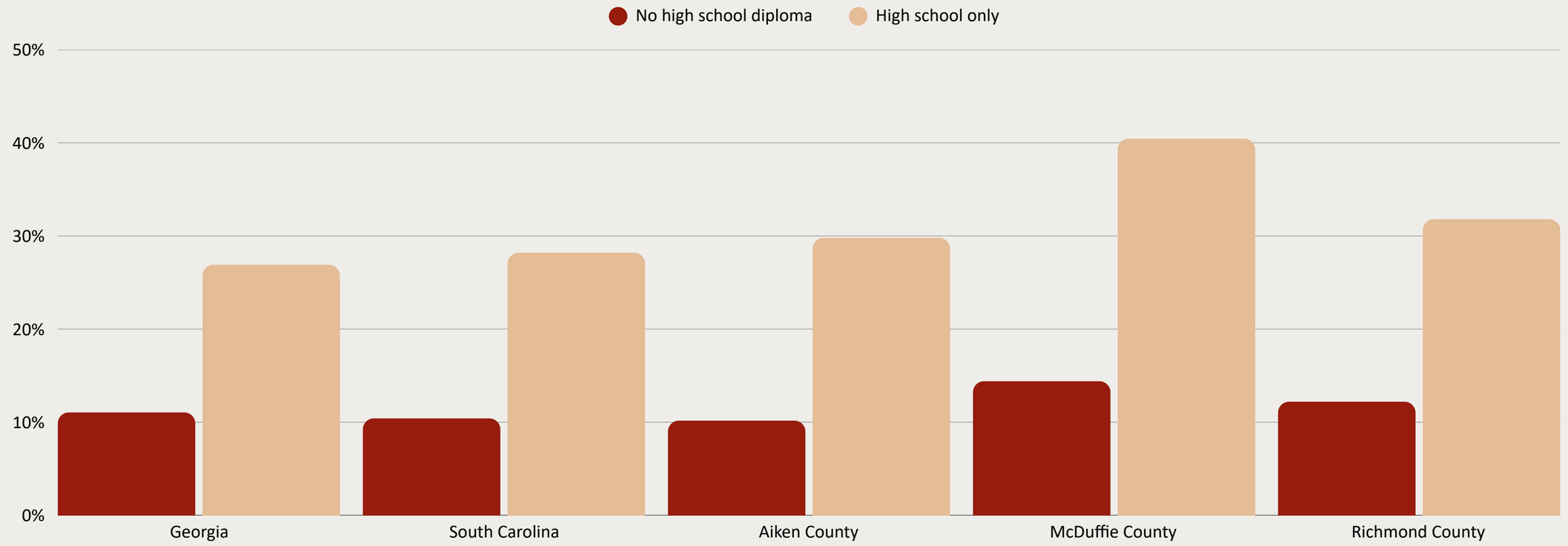


Source: US Department of Education, EDFacts, 2020-2021.

High school diploma attainment

Examining educational attainment helps us understand the needs of adults, including potential hospital- or community-based workforce training that may help those without a college degree attain the skills needed for a career. The chart below reflects adults 25 and older.

High school diploma attainment, 2019 to 2023

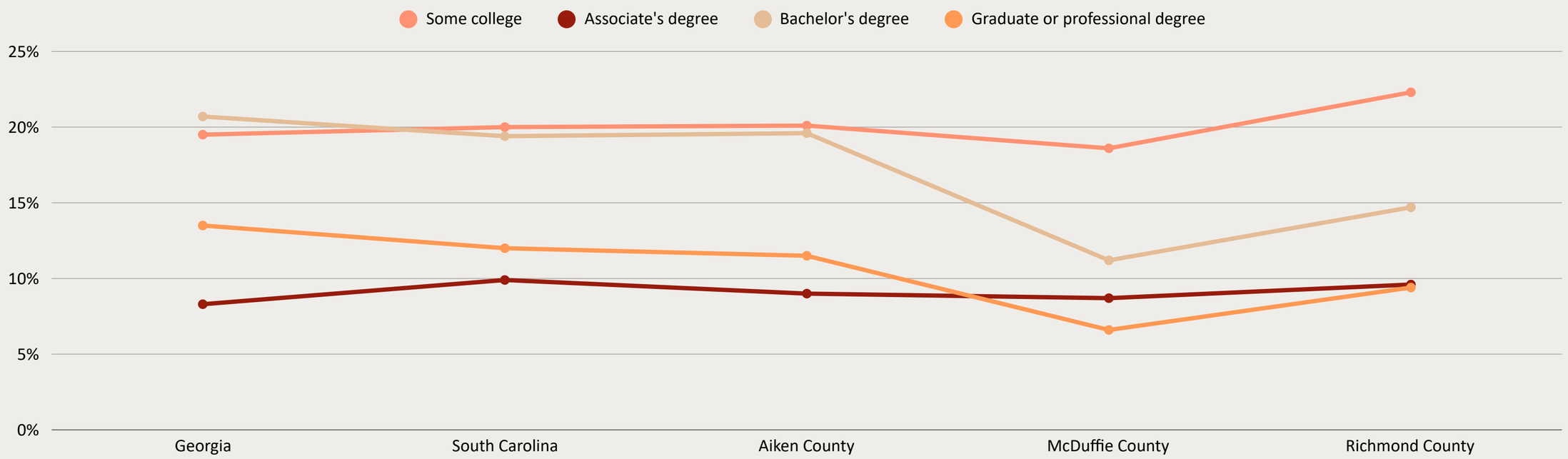


Source: US Census Bureau, American Community Survey, 2019-2023.

Educational attainment

Educational attainment shows the distribution of the highest level of education achieved in the community and helps us understand the needs of adults, whether it be workforce training or the ability to develop science, technology, engineering, and mathematics opportunities. We calculate this for people over 25 years old.

Educational attainment, annually on average, 2019 to 2023

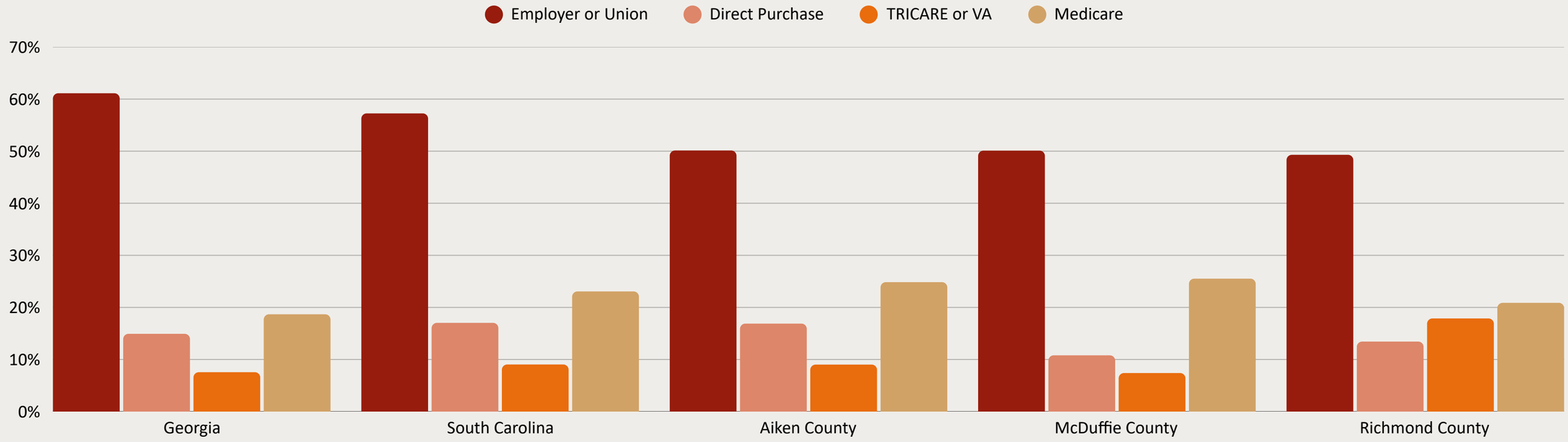


Source: US Census Bureau, American Community Survey, 2019-2023.

Access to care: Insurance

In Richmond County, between 2019 and 2023, approximately 172,000 community members had health insurance coverage. Of those, 66.5% have private insurance and 49.3% have public health insurance. Many on Medicare have both private and public insurance. This indicator is relevant because insurance provides access to healthcare, including regular primary care, specialty care, and other health services that prevent poor health status.

Insurance source type, annually on average, Richmond County, 2019 to 2023

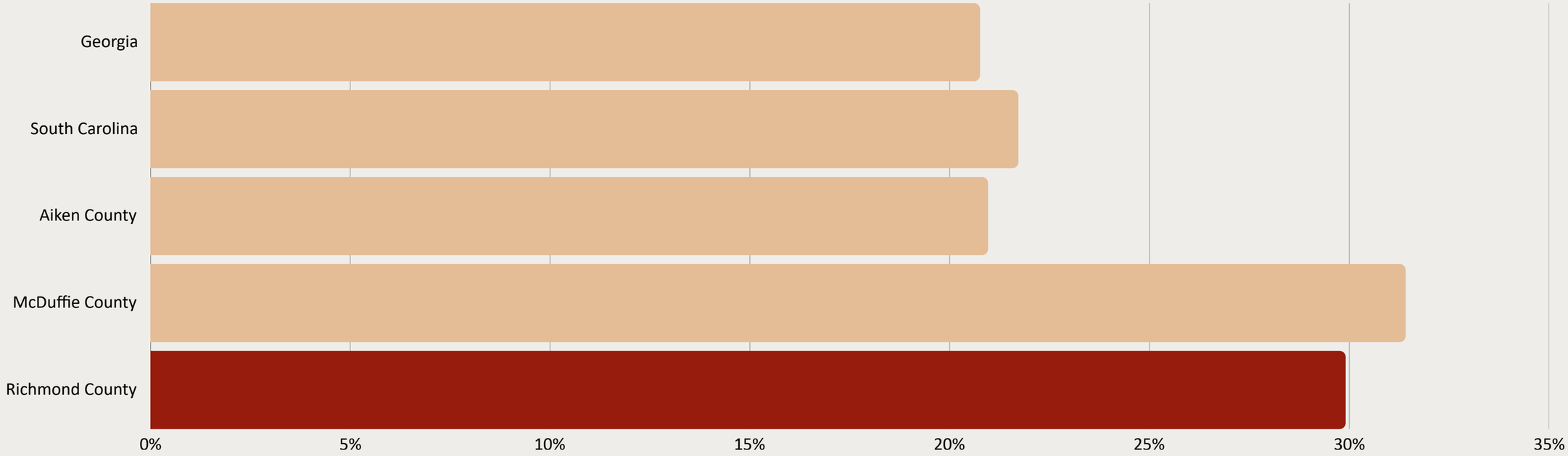


Source: US Census Bureau, American Community Survey, 2019-2023.

Access to care: Medicaid

Medicaid is the means-tested program that provides health insurance coverage for low-income populations. Access to providers accepting Medicaid can be a challenge in some communities, and being on Medicaid usually means a lower income, which presents additional barriers to good health. We call out Medicaid specifically as coverage through this program can be limited in Georgia.

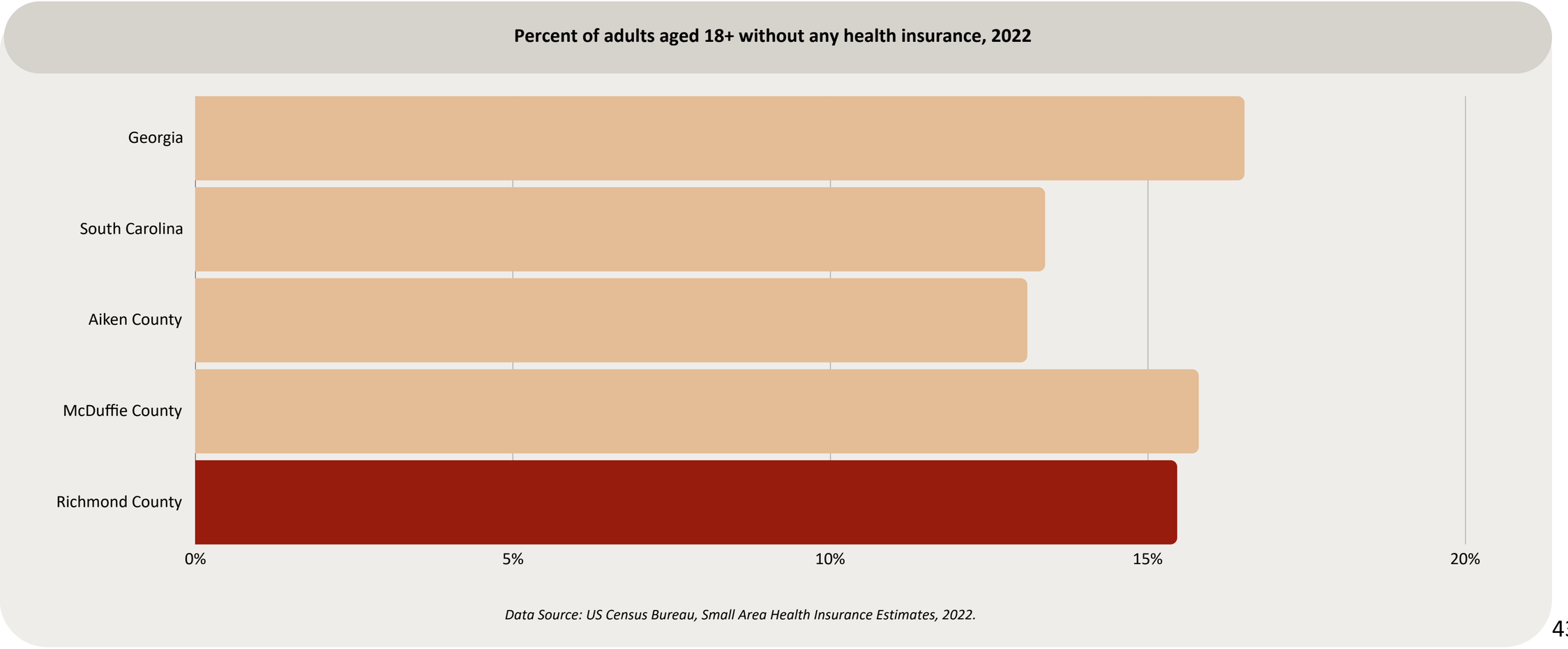
Percent of population covered through Medicaid, 2019 to 2023



Source: US Census Bureau, American Community Survey, 2019-2023.

Access to care: Uninsured adults

Access to care encompasses barriers community members may face, including lack of providers, transportation, and limited services for low-income populations. Often, the primary indicator is insurance status, as those without insurance face significant barriers to care.

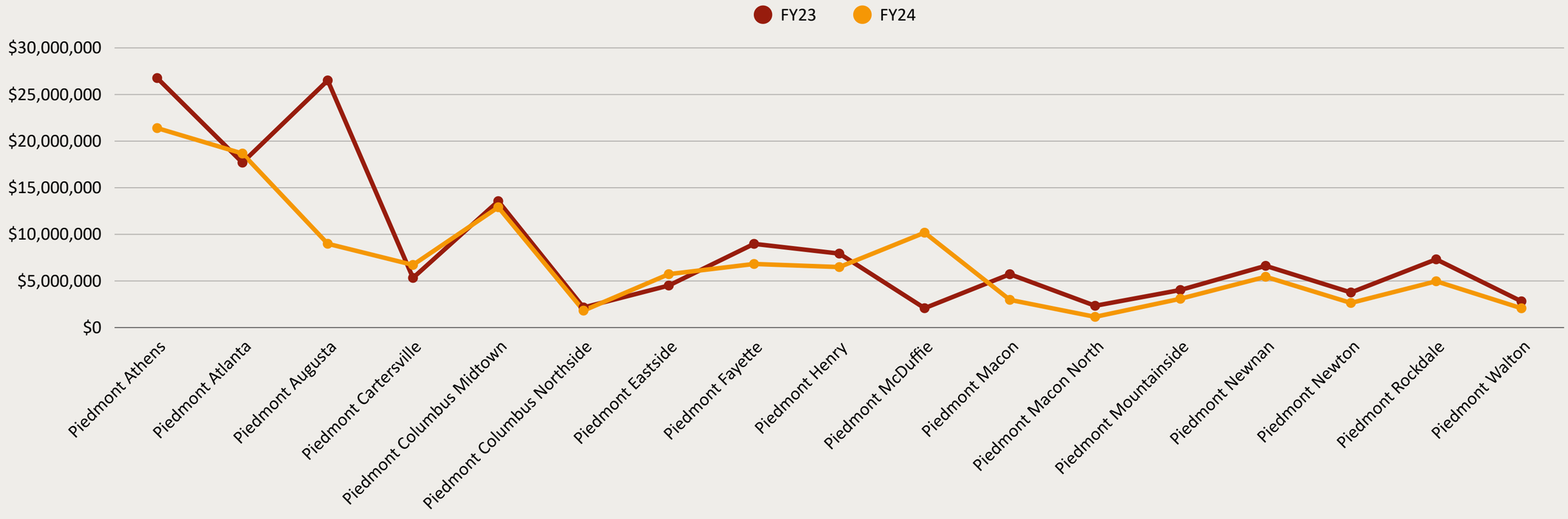


Data Source: US Census Bureau, Small Area Health Insurance Estimates, 2022.

Access to care: Financial assistance at Piedmont hospitals

In FY23 and FY24, Piedmont hospitals provided nearly $300 million combined in financial assistance for patients who lived at or below 300 percent of the Federal Poverty Level.

Financial assistance (in dollars) by hospital provided in FY23 and FY24

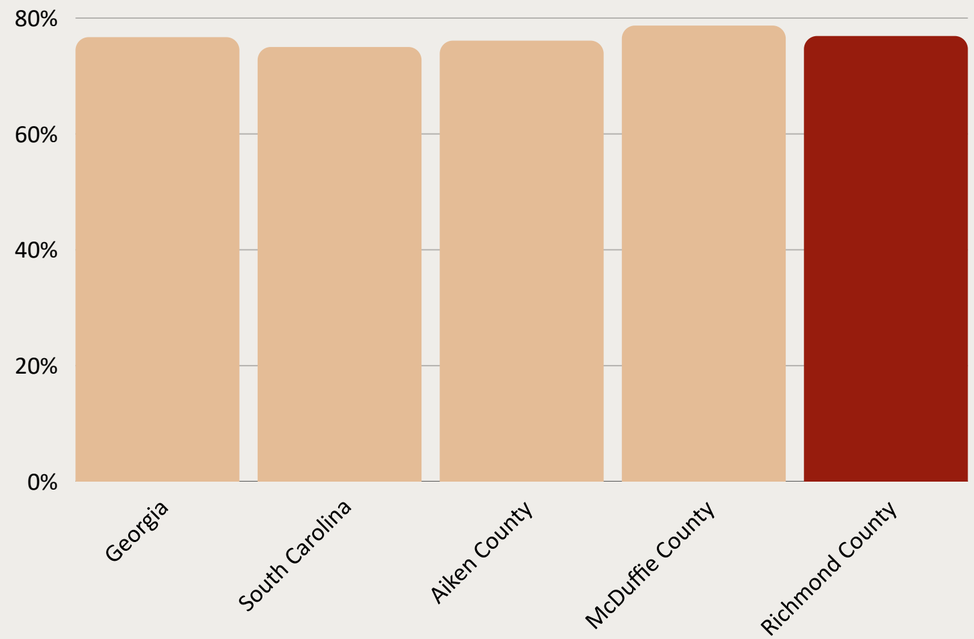


Source: PHC Internal Data

Prenatal care

A lack of access to care presents barriers to good health. Supply of facilities and physicians, the uninsurance rates, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access. Prenatal care in the first trimester is crucial for establishing a healthy pregnancy because it allows for early detection and management of potential risks, ensures proper fetal development, and provides an opportunity to address health-related needs and make lifestyle changes.

Prenatal care in the first trimester, 2020-2022



Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Significant racial and ethnic disparities exist in prenatal care access and quality, leading to poorer maternal and infant health outcomes, particularly for Black, women. These disparities stem from various factors, including socioeconomic status.

Lower rates of early prenatal care: Black, American Indian, and Native Hawaiian and Pacific Islander women are less likely to initiate prenatal care in the first trimester compared to White women.

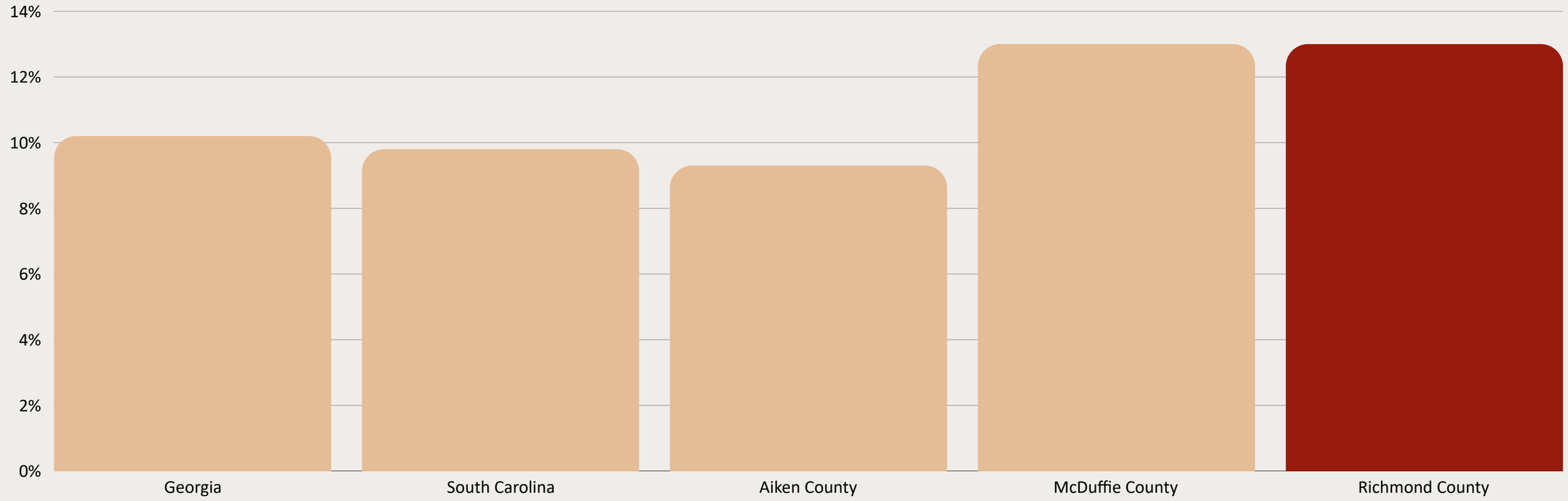
Late or no prenatal care: A higher percentage of Black, American Indian, and Native Hawaiian and Pacific Islander women receive late or no prenatal care, which increases the risk of adverse pregnancy outcomes.

Geographical barriers: Limited access to healthcare facilities, particularly in marginalized communities, can hinder access to prenatal care.

Low birth weight babies

Newborns, infants, and their mothers can be especially vulnerable. Low birth weight is defined at being at or below 5 lbs., 8 oz. at birth. As with many indicators, Black populations are twice as likely as any other race or ethnicity to have babies born at low birth weights.

Percentage of low birth weight babies, 2016-2022



Source: University of Wisconsin Population Health Institute, County Health Rankings, 2016-2022.

Screenings

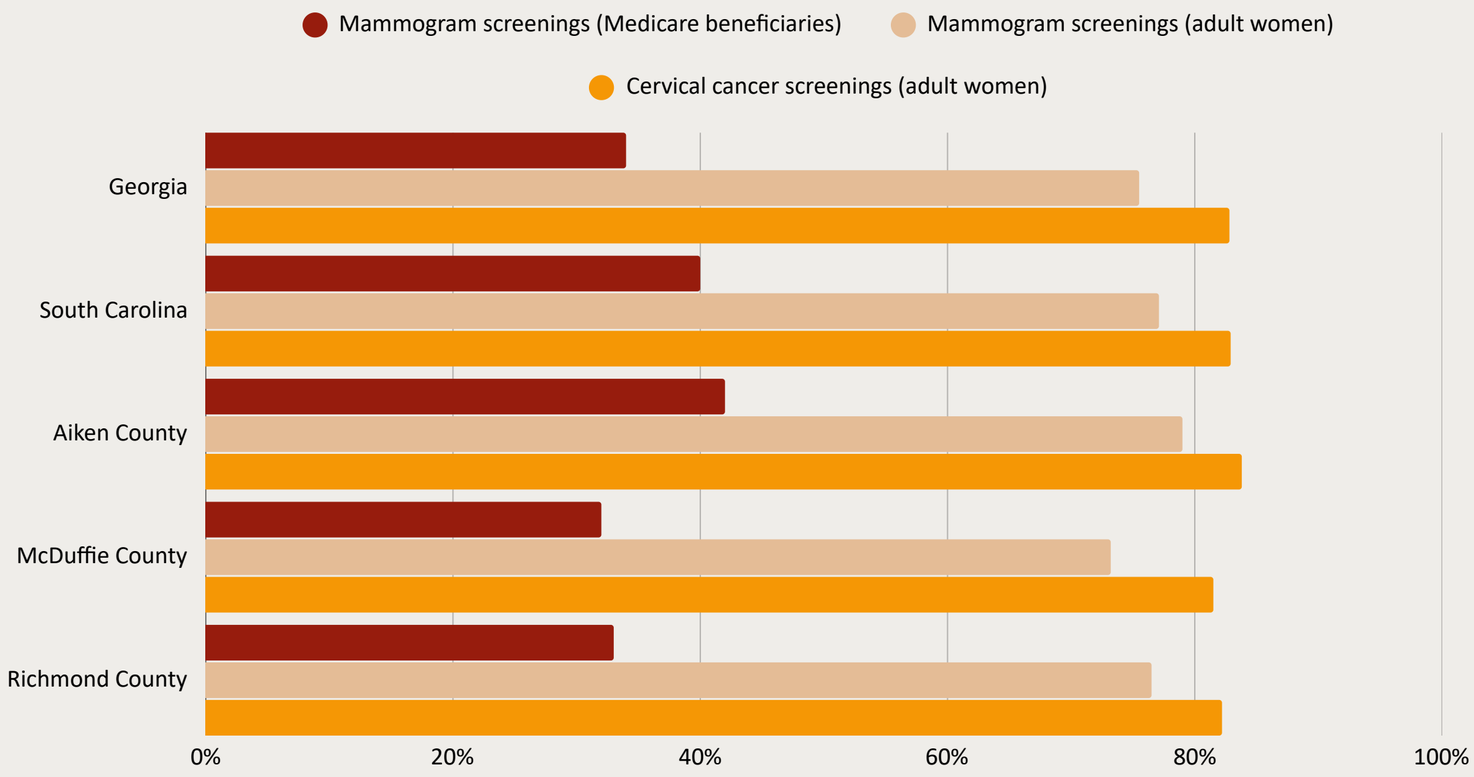
Health screenings are crucial in maintaining and improving overall health and well-being. Here are the key reasons why health screenings are essential:

Early detection of diseases: Health screenings allow for the early detection of diseases and health conditions before they develop into serious problems. This enables timely intervention and treatment, improving the chances of successful outcomes.

Prevention of chronic diseases: Regular screenings can help identify risk factors for chronic diseases, such as heart disease, cancer, and diabetes. By addressing these risk factors early on, individuals can reduce their chances of developing these conditions.

Improved health outcomes: Early detection and treatment through health screenings lead to better health outcomes, including reduced hospitalizations, complications, and mortality rates.

Cancer screenings for women, Richmond County, 2022



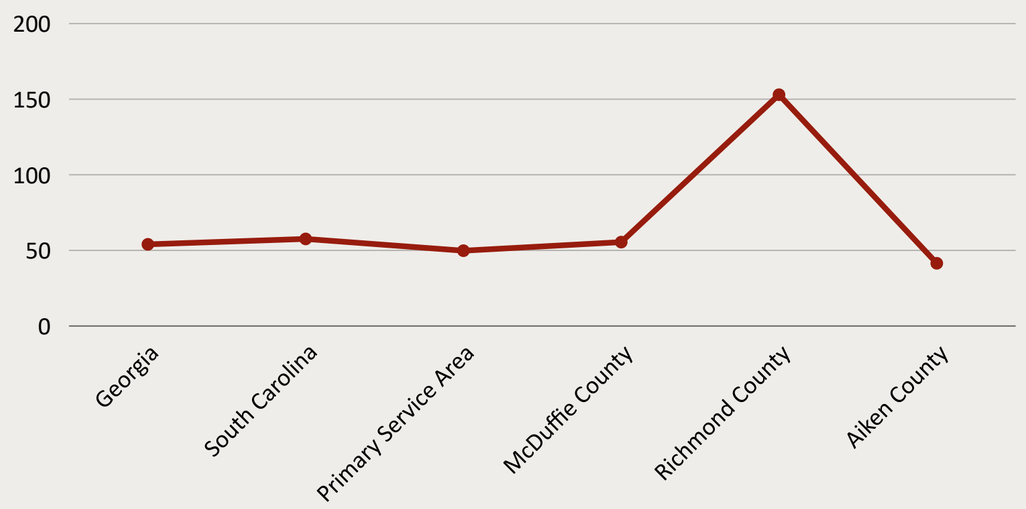
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Dental care

Good dental care is crucial for overall health, preventing tooth decay and gum disease, which can lead to serious health complications like heart disease, stroke, and even dementia, while also impacting your ability to eat, speak, and smile with confidence.

In 2022, there were 153 dentists for every 100,000 people within Richmond County, higher than the state rate of 54 dentists for every 100,000 people.

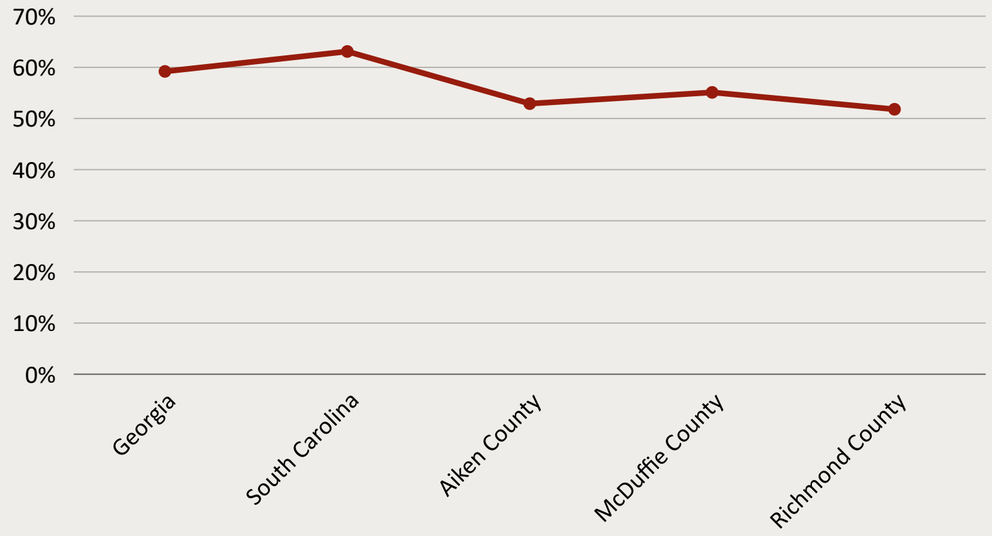
Rate of dentists per every 100,000 people, Richmond County, 2022



Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2022.

In 2022, and in the full service area, approximately 19% of adults 65 and older have lost all of their natural teeth. This number jumps to 21% in Richmond County. This figure often correlates to adults having had a recent dental visit.

Adults 18+ with recent dental visit, Richmond County, 2022

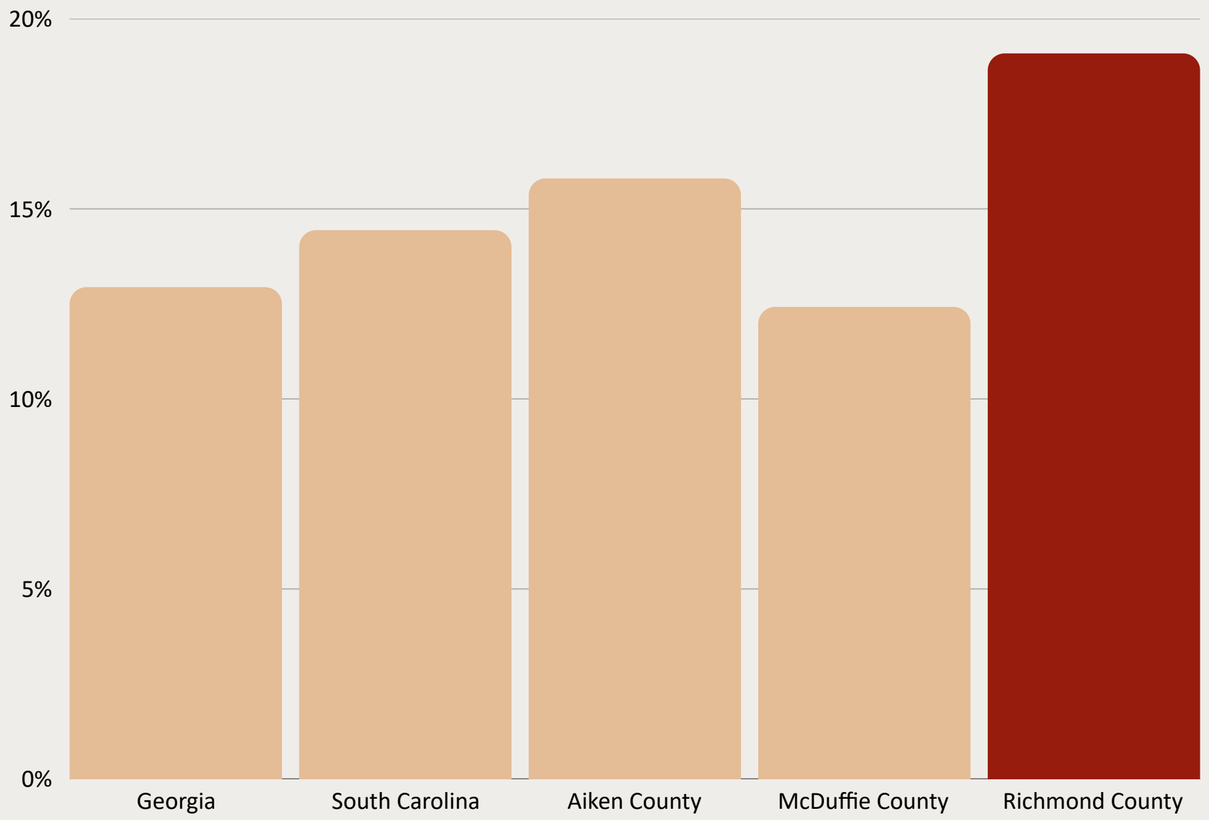


Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2022.

Disability

Of the total population, about 18 percent have some form of disability, according to the US Census Bureau's American Community Survey, 2019 to 2023. This includes both developmental and physical disabilities.

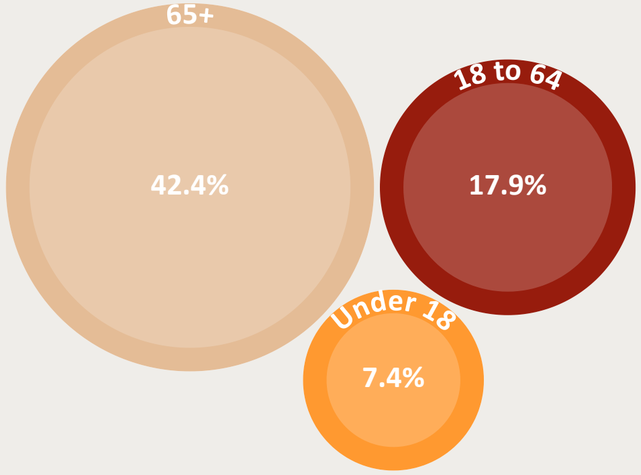
Percent of population with a disability, Richmond County, 2019 to 2023



Source: US Census Bureau, American Community Survey. 2019-2023.

- Women are slightly more likely than men to be disabled: 18% of women are disabled as compared to 17% of men within the full service area.
- Those 65 and older make up the age group with the highest percentages of disabled populations, as shown in the graph below.

Percent of age groups with a disability, Richmond County, 2019 to 2023



Source: US Census Bureau, American Community Survey. 2019-2023.

Chronic conditions and those with disabilities

Between 2018 and 2022, the last year for which data is available, we saw the following trends in chronic conditions among those living with a disability:

- **Disabled Georgians are twice as likely to have diabetes**, on average, for those with disabilities across the nation than for those without disabilities. Diabetes is consistently decreasing among the disabled population in both the US and Georgia. However, it is steadily increasing among the non-disabled population, meaning this gap will close at some point in the future.

- **People with disabilities are 1.4 times more likely to be obese** in Georgia and across the US.

- **Georgians with disabilities are 3.3 times more likely to have heart disease,** a statistic that decreases to 2.8 times more likely nationally.

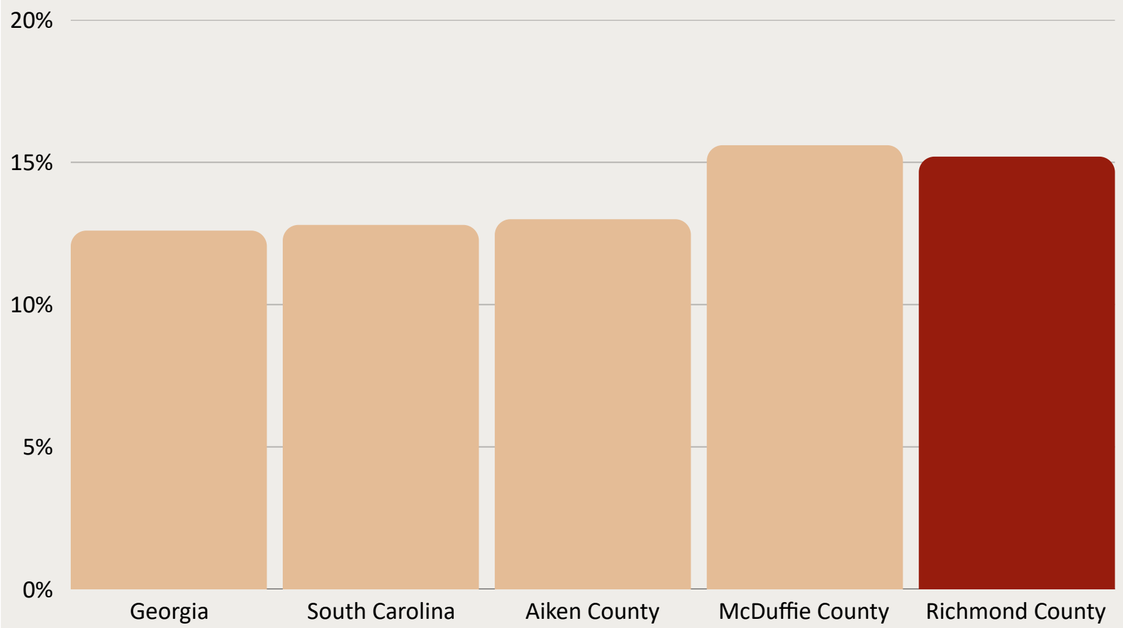
- Statewide, the **percentage of adults who have had a stroke is 5.1 times higher for adults with a disability than those without a disability**. That figure drops to 4.3 times higher for disabled populations.

- In Georgia, **adults with disabilities are 3.9 times more likely to have ever had depression** than those without disabilities; nationally, that drops to 3.4 times that of a person without a disability.

Diabetes and kidney disease

Chronic diseases are long-term health conditions that require ongoing medical attention or limit daily activities. Examples include diabetes, heart disease, and chronic respiratory conditions. Monitoring chronic disease prevalence—such as diabetes, heart disease, or COPD—helps effectively identify community health trends and target resources.

Percentage of adults with diabetes, 2022



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Diabetes prevalence is significantly higher in low-income communities, with income-related disparities widening over time; this disproportionate burden is linked to factors like food insecurity, limited access to healthcare and healthy foods, and differences in health behaviors.

Diabetes, particularly type 2, is associated with an increased risk of developing dementia, including Alzheimer's disease and vascular dementia. Early onset of diabetes, especially before age 50, and obesity may further increase dementia risk.

Diabetes is the leading cause of kidney disease. Over time, high blood sugar from diabetes can damage blood vessels in the kidneys and nephrons. Many people with diabetes also develop high blood pressure, which can damage kidneys too. Diabetes can reduce how well kidneys filter waste, leading to chronic kidney disease.

Within Richmond and Aiken counties, in 2021, **about 3.8% and 3.5% of the population, respectively, had kidney disease, rates above state averages for both South Carolina and Georgia.**

Chronic conditions: Asthma and COPD

Though they both cause problems with breathing, asthma and COPD are not the same.

Asthma is a chronic inflammatory condition that affects the airways, causing them to narrow and swell, while COPD is a progressive lung disease characterized by airflow obstruction that worsens over time. While both can cause similar symptoms like coughing, shortness of breath, and wheezing, their causes, progression, and treatment differ significant

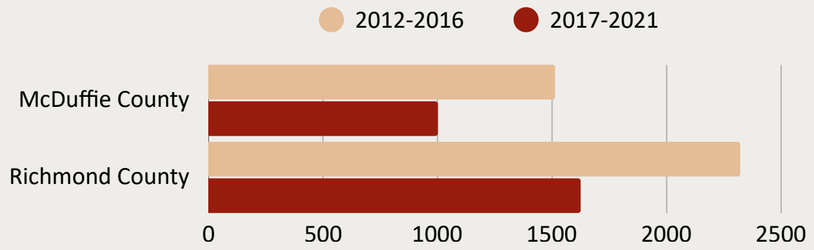
Among Medicare beneficiaries, **about 12 percent had chronic obstructive pulmonary disease (COPD) in 2022**, which is among the top ten causes of death within the county, according to CMS's Mapping Medicare Disparities Tool.

- Men and women have COPD at similar rates within the community.
- White populations were nearly twice as likely as Black populations to have COPD — an average 15% for White populations, as compared to 8% of Black populations.
- Asian populations had the disease at a rate of 4% of the total Asian population in 2022, and Hispanic or Latino populations carried higher rates at 11% of that subset of the population.

Among adults age 18 and older, **about 11 percent had asthma in 2022**.

- Richmond County had the highest rates of adult asthma – about 12 percent of the county's adult residents.
- Adult asthma rates have steadily increased over the years; childhood asthma rates, though, have decreased some over the last years, though the region remains among top in the state for the condition.

Annual ER visits for children age 0-17 per every 100,000, comparison

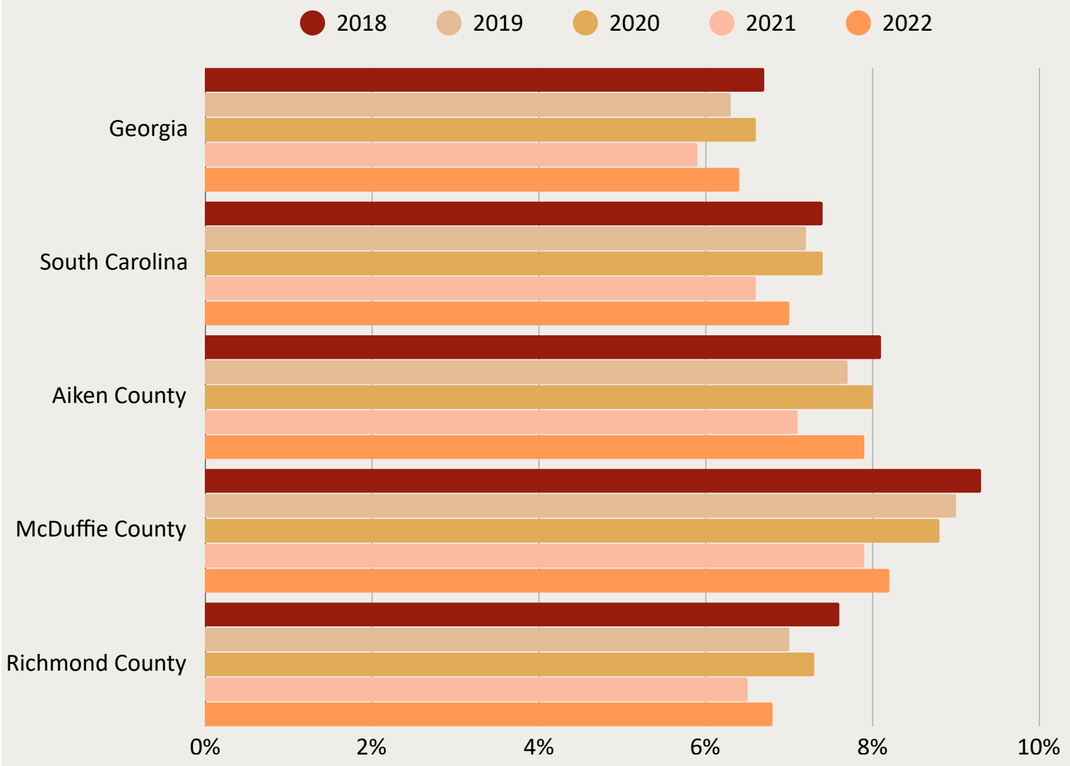


Source: ArcGIS, Maternal Health & Child Asthma (by County) 2021, Accessed April 2025.

Heart disease prevalence and high blood pressure

Heart disease is the top cause of death year-over-year in the Augusta community.

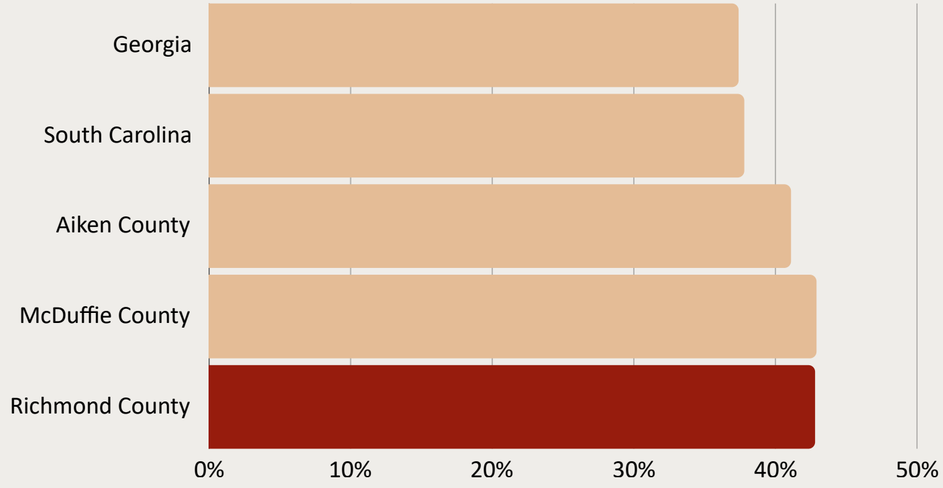
Heart disease prevalence, 2018 to 2022



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022..

High blood pressure (hypertension) is a major risk factor for heart disease, and prolonged, uncontrolled high blood pressure can lead to various forms of heart disease, including coronary artery disease, heart failure, and atrial fibrillation. High blood pressure puts extra strain on the heart and blood vessels, damaging them over time and increasing the risk of heart-related complications.

Percent of adults with high blood pressure, 2022

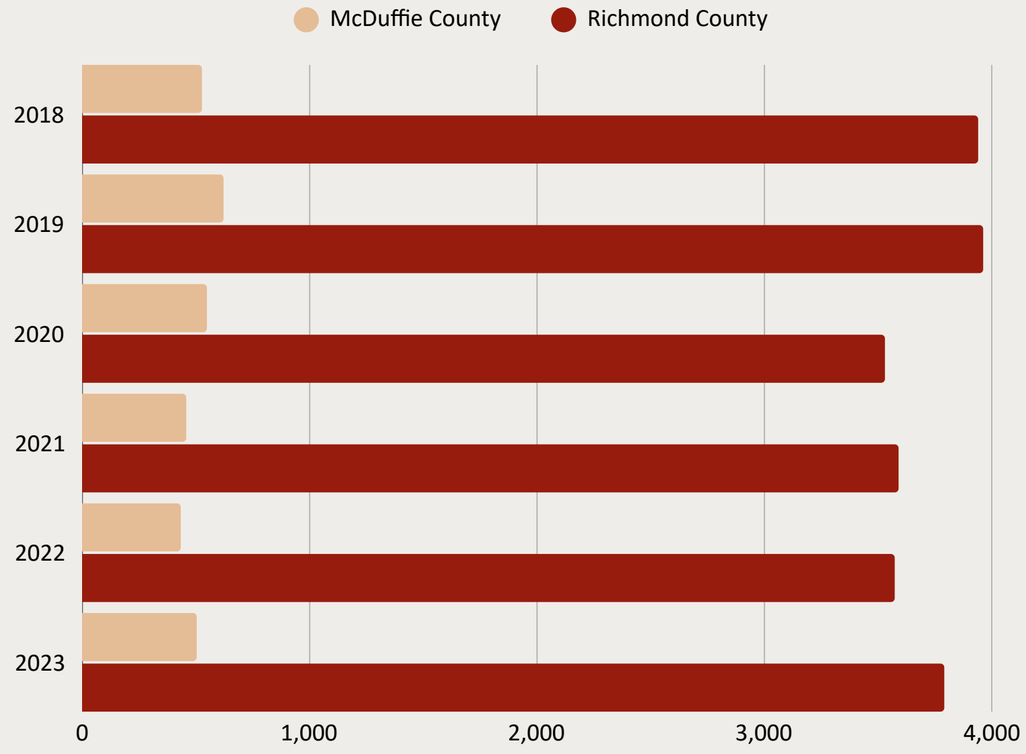


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Heart disease hospitalizations and discharges

Heart disease hospitalization rates remain relatively high within the community, as shown in the chart below.

Discharges due to cardiovascular disease, Richmond and McDuffie counties, 2018 to 2023



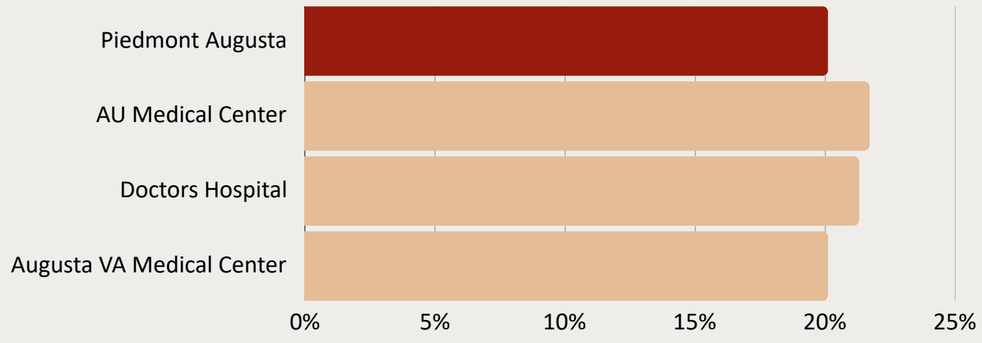
Source: Georgia OASIS, accessed March 2025.

Black or African American community members are much more likely to be hospitalized due to cardiovascular disease. For example, **in 2023, Black populations made up 64% of all discharges due to cardiovascular disease.**

About a third of patients were covered through Medicare, the highest percentage for a single-payer mix.

Between 2020 and 2023, the 30-day readmission rate for heart failure was 20.4%, slightly worse than the state average of 19.7%.

Heart failure readmissions, Richmond County, 2020 to 2022

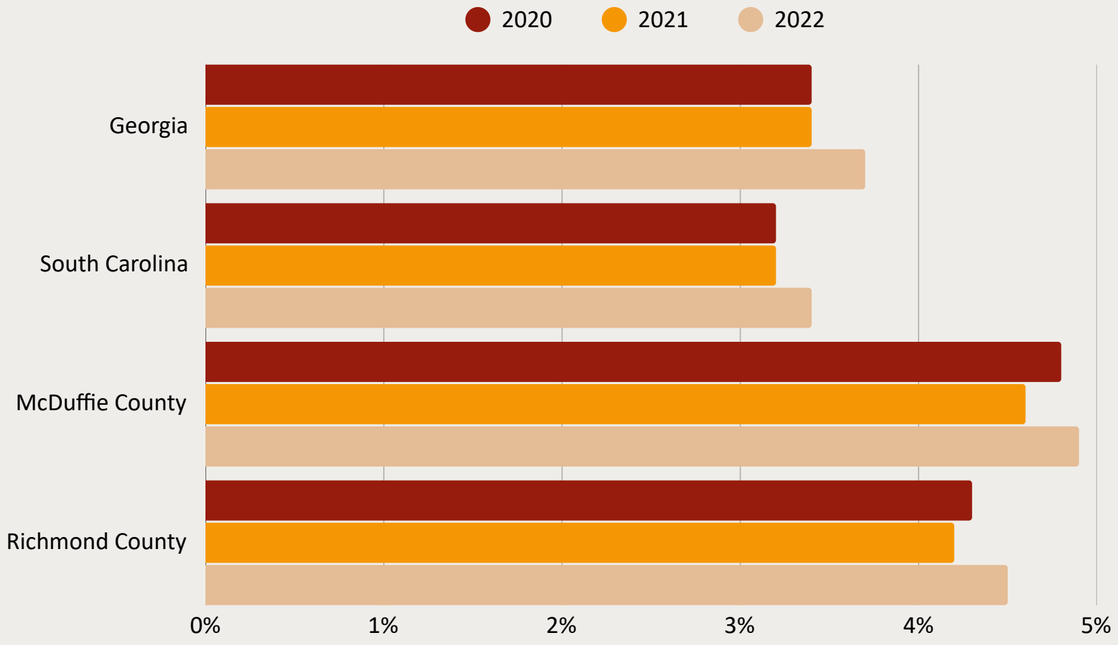


Source: Centers for Medicare and Medicaid Services, Geographic Variation Public Use File, 2020-2023.

Stroke

This indicator reports the number and percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have had a stroke. Within Richmond County, there were 4.5% of adults 18 and older who reported having a stroke of the total population age 18 and older.

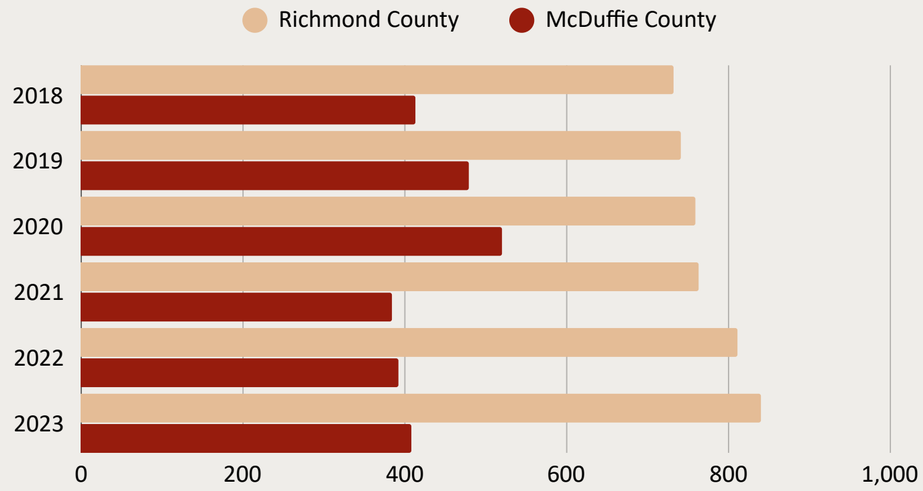
Stroke prevalence among adults age 18+, 2018 to 2022



Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

In 2023, 840 Richmond County community members were discharged from a hospital following a stroke, a small increase from previous years. In McDuffie County, the number of discharges due to stroke has decreased.

Discharges due to stroke, 2018 to 2023

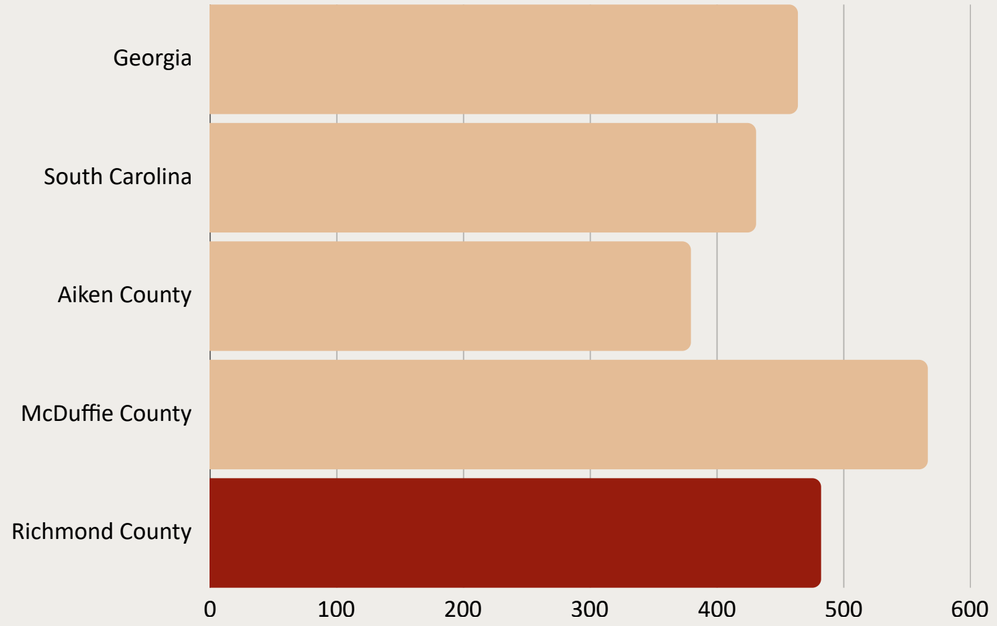


Source: Georgia OASIS, accessed March 2025.

Cancer prevalence

Cancer continues to be a significant issue for our community members, with some communities experiencing higher incidence rates than others.

Cancer incidence rates among adults 18+, per every 100,000 people, 2022



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022 .

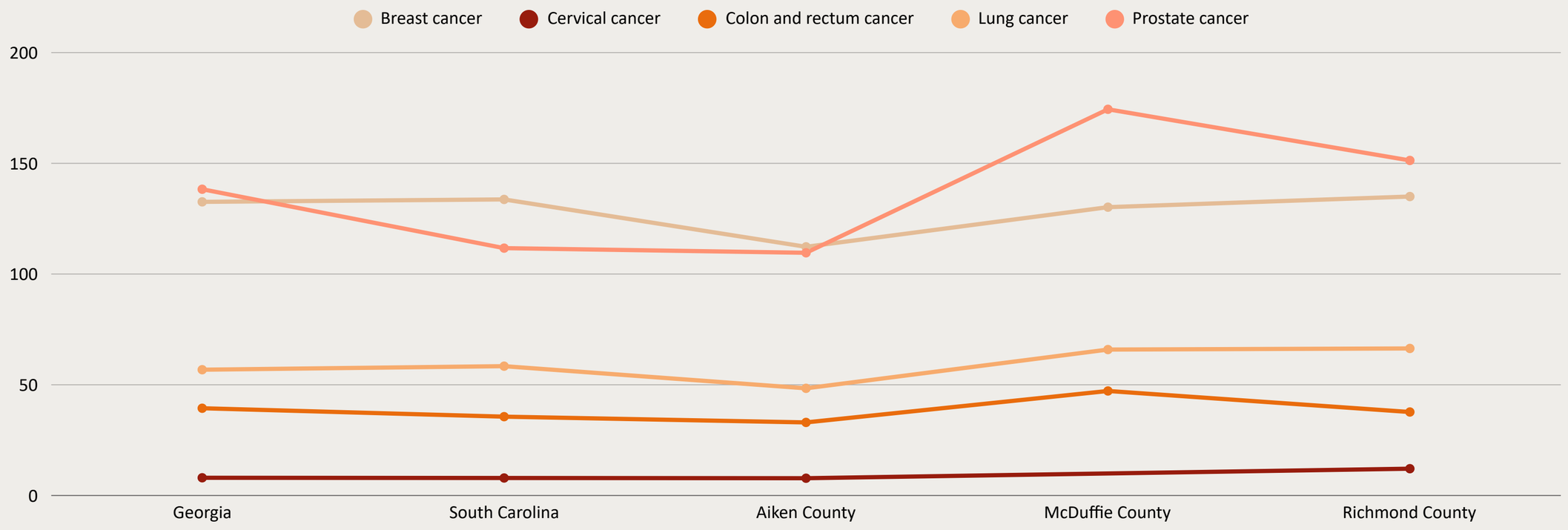
Social drivers of health (SDOH) significantly impact cancer prevalence and outcomes, influencing everything from cancer risk to access to care and survival rates. These non-medical factors, like socioeconomic status, education, and access to resources, create barriers to early detection, treatment, and support, leading to disparities in cancer incidence and mortality.

- SDOH can indirectly influence cancer risk through behaviors like smoking and diet, which are more prevalent in certain socioeconomically disadvantaged groups.
- Factors like lack of insurance, transportation issues, and low health literacy can hinder access to cancer screenings, leading to later-stage diagnoses.
- Financial constraints, lack of support networks, and geographical barriers can impact access to timely and effective cancer treatment.
- Studies have shown that individuals with multiple SDOH challenges, such as low income, lack of insurance, and housing instability, experience higher cancer mortality rates.

Cancer incidence by site

Below are the specific incidence rates for certain cancers.

Cancer incidence rates by type, per 100,000 people, 2017-2021

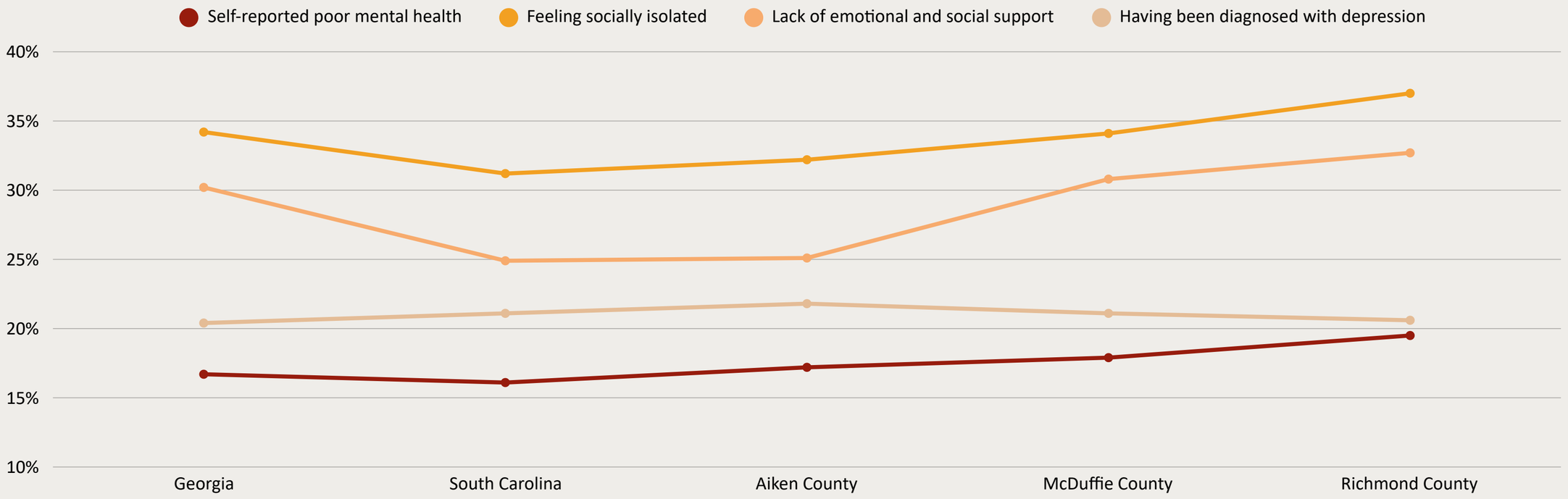


Source: State Cancer Profiles, 2017-2021.

Mental and behavioral health

Mental health encompasses our emotional, psychological, and social well-being, profoundly impacting how we think, feel, and behave. Poor mental health can significantly diminish the quality of life, productivity, and overall well-being, and it often correlates with an increased risk of chronic illnesses. The CDC's Behavioral Risk Factor Surveillance System measures poor mental health through several questions that aim to understand a person's state of mind.

Adults 18+ reporting poor mental health, 2022

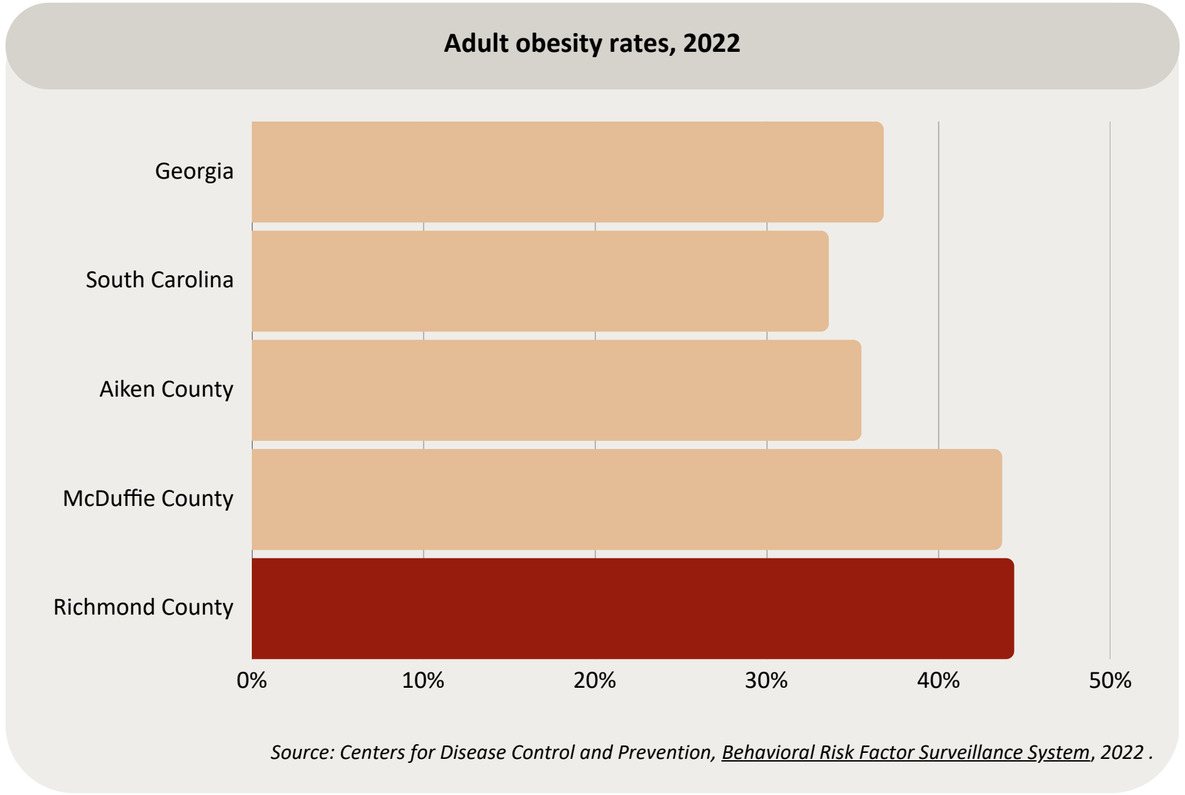


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Healthy behaviors

Health behaviors are actions individuals take that affect their health, including actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior.

Obesity is a key indicator of health and healthy behaviors. The chart below reports the percentage of adults 18 and older who are obese, which is defined as having a body mass index (BMI) of 30.0 kg/m2, which is calculated from self-reported weight and height. Because it is self-reported, this indicator is often underreported.



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022 .

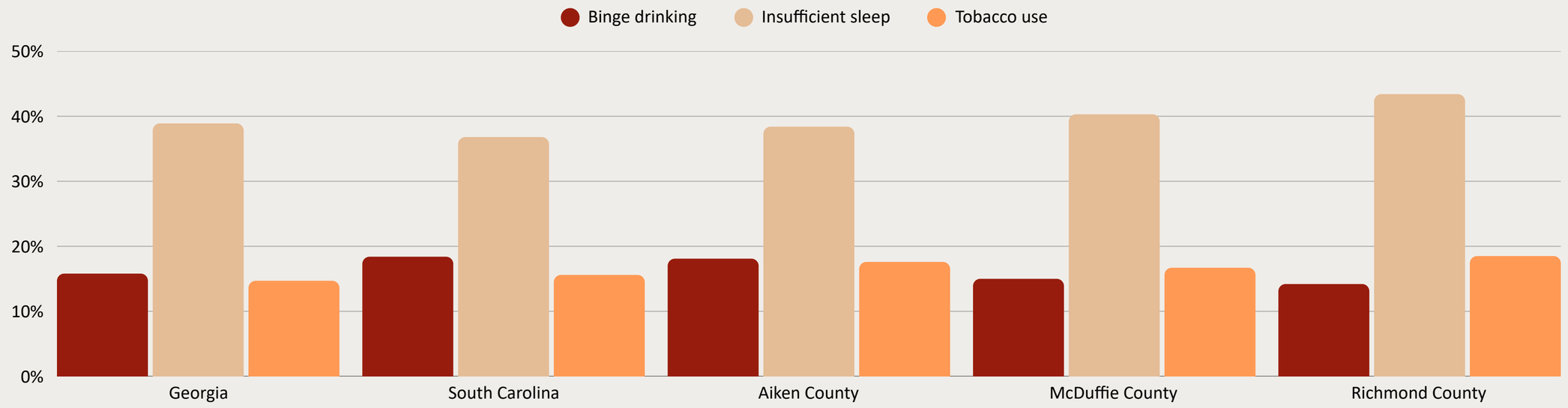
How social drivers contribute to obesity:

- Lower socioeconomic status, including income, education, and occupation, are often associated with higher obesity rates.
- Access to healthy food, safe places for physical activity, and the quality of the built environment (e.g., the presence of grocery stores vs. fast-food restaurants) significantly influence obesity.
- Stress, discrimination, and social isolation can contribute to unhealthy behaviors and weight gain.
- Communities with limited access to affordable, healthy food options (food deserts) often have higher rates of obesity.
- Areas lacking parks, sidewalks, and safe routes for walking or biking contribute to lower levels of physical activity, which can lead to weight gain.

Healthy behaviors: Excessive drinking, insufficient sleep, smoking

Heavy alcohol consumption, tobacco usage, insufficient sleep, and physical inactivity are key indicators of health-related behaviors that significantly influence overall health outcomes and disease risk. The data presented below highlights the percentage of adults engaging in these behaviors. Heavy alcohol consumption and tobacco use directly contribute to chronic health conditions and preventable illnesses. At the same time, insufficient sleep and physical inactivity are linked to increased risk of obesity, cardiovascular disease, diabetes, mental health disorders, and impaired immune function.

Percent of adults reporting excessive drinking, insufficient sleep, and tobacco use, 2022



Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

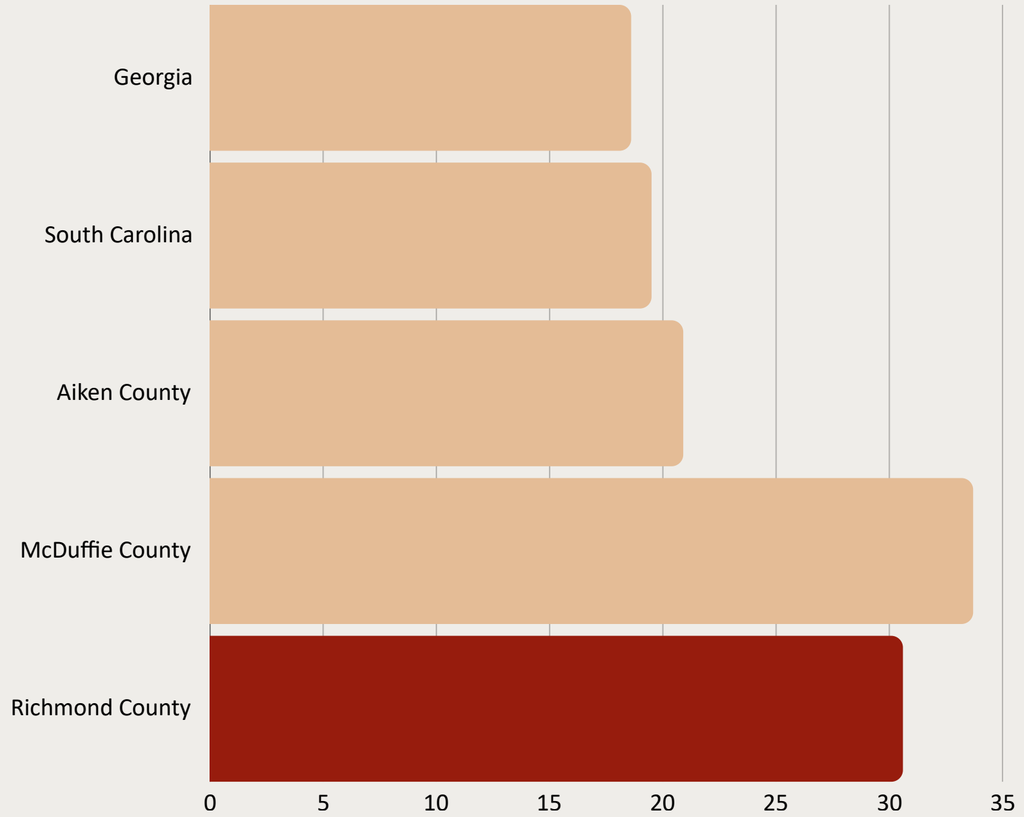
Teen births

Teen births are important to study and understand because they are associated with significant social, health, and financial risks for teens, their families, and their communities. Teen mothers face a higher risk of complications during pregnancy and childbirth, including eclampsia, puerperal endometritis, and systemic infections. Babies of adolescent mothers are at a higher risk of low birth weight, preterm birth, and severe neonatal conditions. For this, we look at mothers aged 15 to 19.

Additionally:

- Teen mothers are less likely to complete high school and have fewer opportunities for higher education and employment.
- Many teenage parents and their children rely on public assistance programs, leading to long-term economic dependence.
- Teenage pregnancy can perpetuate a cycle of poverty as it can limit educational and economic opportunities for both the mother and her children.
- Teen mothers are at a higher risk of mental health problems, including postpartum depression and suicidal ideation.

Teen birth rate per every 1,000 teens, 2017 to 2023

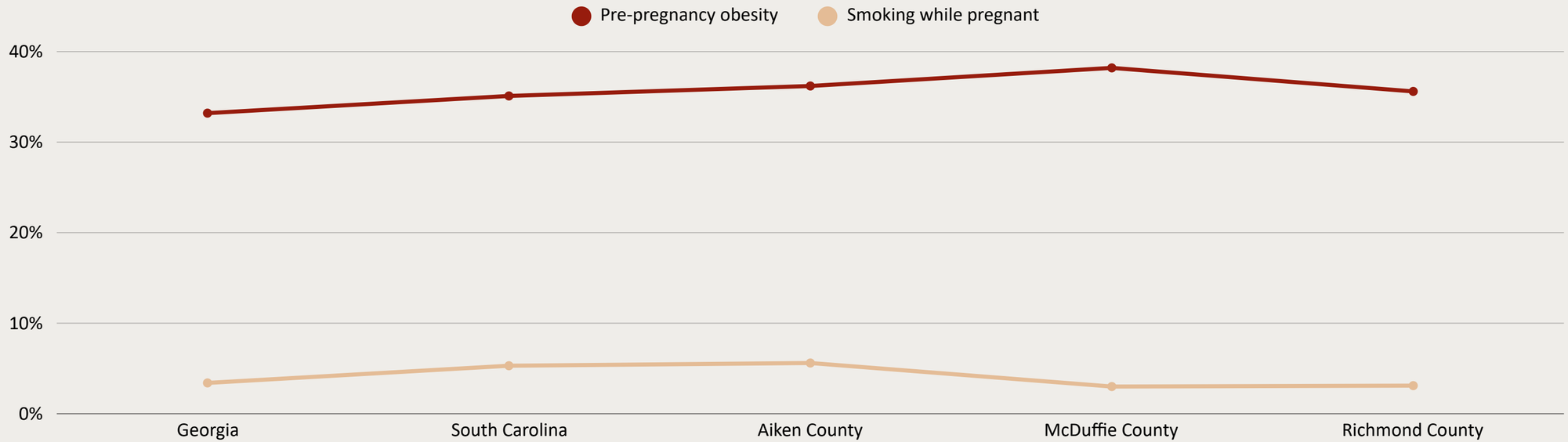


Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via County Health Rankings, 2017-2023.

Pregnancy and health behaviors

Actions just before and during pregnancy can significantly impact outcomes for both the mother and baby. For example, pre-pregnancy obesity is important because it increases the risk of adverse health outcomes for both the mother and the baby, including gestational diabetes, preeclampsia, and complications during delivery, as well as potentially impacting long-term health risks for the child. Smoking doubles the risk of abnormal bleeding during pregnancy and delivery. This is dangerous for the pregnant woman and her baby. Other complications include the premature rupture of membranes, placenta previa, placental abruption, and ectopic pregnancy.

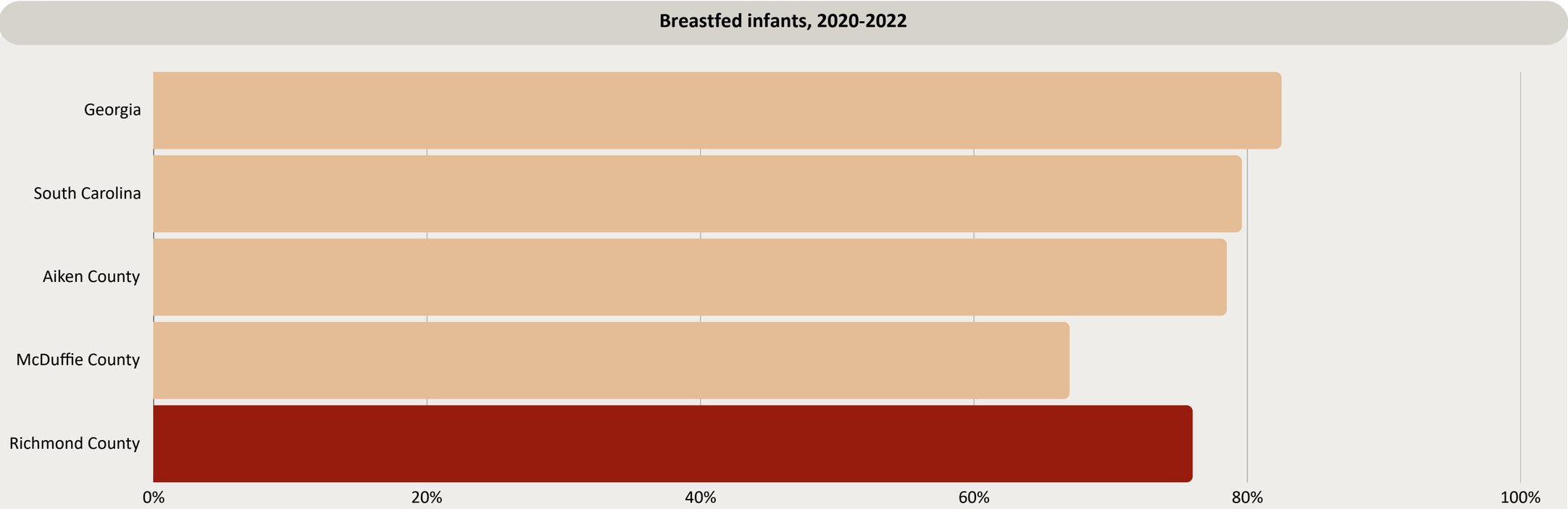
Pregnancy and behaviors, 2020-2022



Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Breastfeeding

Breastfeeding is vital for babies and mothers, offering numerous health benefits, including a stronger immune system for babies, reduced risk of certain diseases, and improved maternal health outcomes. Breastfed babies have a lower risk of developing conditions like asthma, obesity, type 1 diabetes, and sudden infant death syndrome (SIDS) in the long term. Breastfeeding can also lower a mother's risk of developing breast and ovarian cancer. Finally, breastfeeding has a demonstrated impact on a mother’s mental health and well-being.

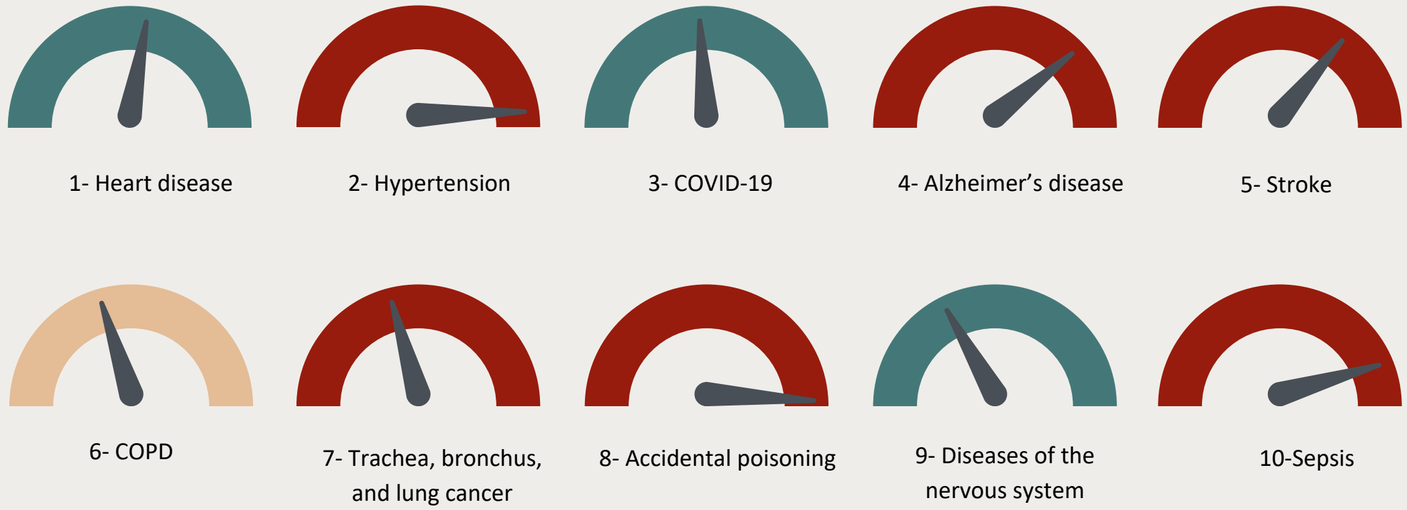


Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Causes of death

Below are the ten leading causes of age-adjusted death, in total, between 2019 and 2023 for Richmond County. The dials indicate how severe the rate is, as compared to the rest of the state. The further to the right the dial is, the more severe that issue is within the combined service area, as compared to Georgia overall.

Top ten causes of death, Richmond County, 2019 to 2023



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2025.

When broken down by age, the leading causes of death shift. Below is a list of the top cause of death, by age group.

>1: Certain conditions originating in the perinatal period
1-4: Accidental drowning
5-9: Nutritional and metabolic diseases
10-24: Homicide
25-54: Accidental poisoning
55-74: Heart disease
75+: Alzheimer's disease

Causes of death by sex and race

When broken down by sex and race, the causes shift. Please note that causes of death for races other than the ones listed were not available through the Georgia Online Analytical Statistical Information System, which is the source of cause of death data.

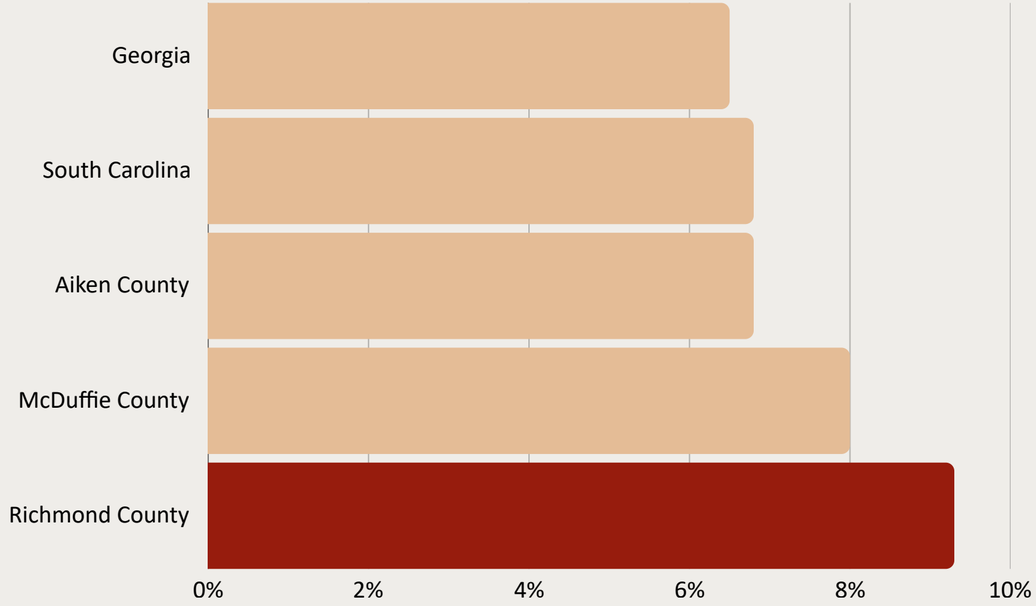
Ranking	Georgia females	All females (county)	Black females (county)	White females (county)	Hispanic or Latino females (county)
1	Heart disease	Hypertension	Hypertension	Alzheimer's disease	Stroke
2	Alzheimer's disease	Heart disease	COVID-19	COPD	Alzheimer's disease
3	COPD	Alzheimer's disease	Heart disease	Heart disease	COPD
4	COVID-19	COVID-19	Alzheimer's disease	Hypertension	Heart disease
5	Stroke	Stroke	Stroke	COVID-19	COVID-19

Ranking	Georgia males	All males (county)	Black males (county)	White males (county	Hispanic or Latino males (county)
1	Heart disease	Heart disease	Hypertension	Heart disease	COVID-19
2	COVID-19	Hypertension	Heart disease	COPD	Heart disease
3	Hypertension	COVID-19	COVID-19	COVID-19	Stroke
4	Trachea, bronchus, and lung cancer	Trachea, bronchus, and lung cancer	Accidental Poisoning	Hypertension	Kidney disease
5	Stroke	Accidental Poisoning	Stroke	Trachea, bronchus, and lung cancer	Accidental poisoning

Infant mortality

Newborns, infants, and their mothers can be especially vulnerable. Below are several key indicators for infant mortality and low birth weight babies. Low birth weight is defined as being at or below 5 lbs., 8 oz. at birth. Within Richmond County, Black populations have higher infant mortality and higher rates of low birth weight babies compared to white populations.

Infant mortality rate per every 1,000 live births, 2020 to 2022



Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Infant mortality rates show significant disparities across racial and ethnic groups in the US, with Black infants experiencing a mortality rate nearly three times higher than that of White infants, often linked to factors like low birth weight, prematurity, and SUID.

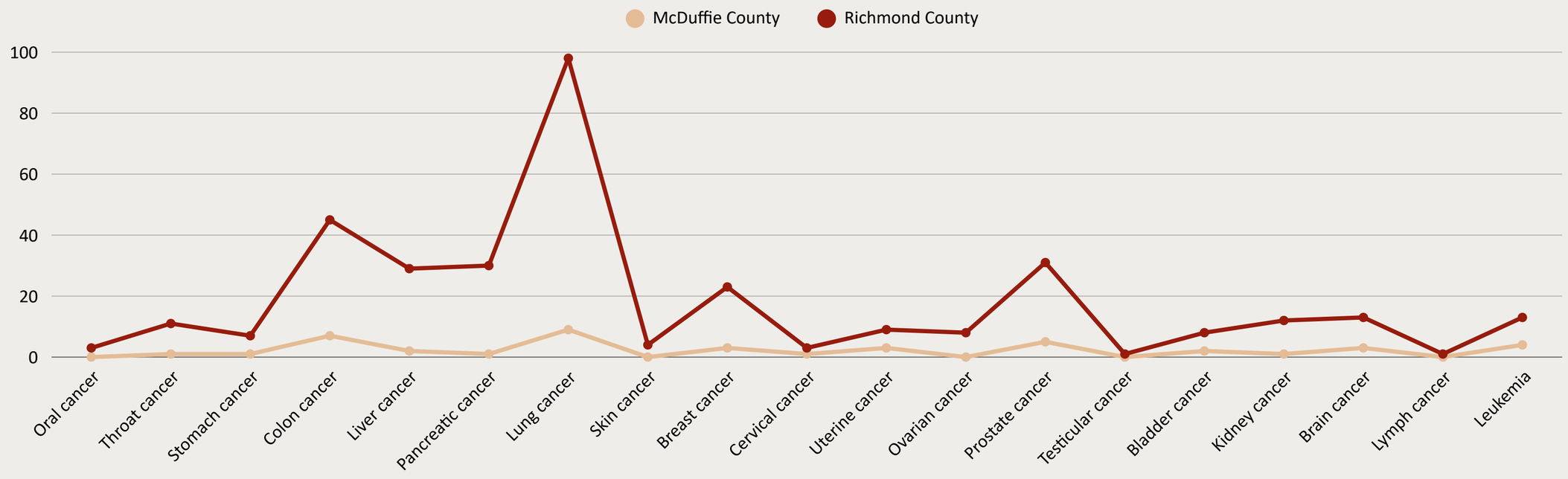
Racial and ethnic disparities

- Black infants: have the highest infant mortality rates compared to other racial and ethnic groups in the US.
- In 2022, the infant mortality rate for non-Hispanic Black or African Americans was 2.4 times the rate for non-Hispanic whites.
- Other groups: with higher rates include American Indian or Alaska Native and Native Hawaiian or other Pacific Islander infants.
- Non-Hispanic White and Asian populations: have the lowest infant mortality rates.

Cancer mortality by type

This indicator reports the 2019-2023 five-year average rate of death due to cancer per 100,000 population. Between 2019 and 2023, approximately 2,104 Richmond County community members died from cancer, resulting in a rate of 205.8 deaths for every 100,000 people. Due to the source of the information, data was only available for Richmond and McDuffie counties.

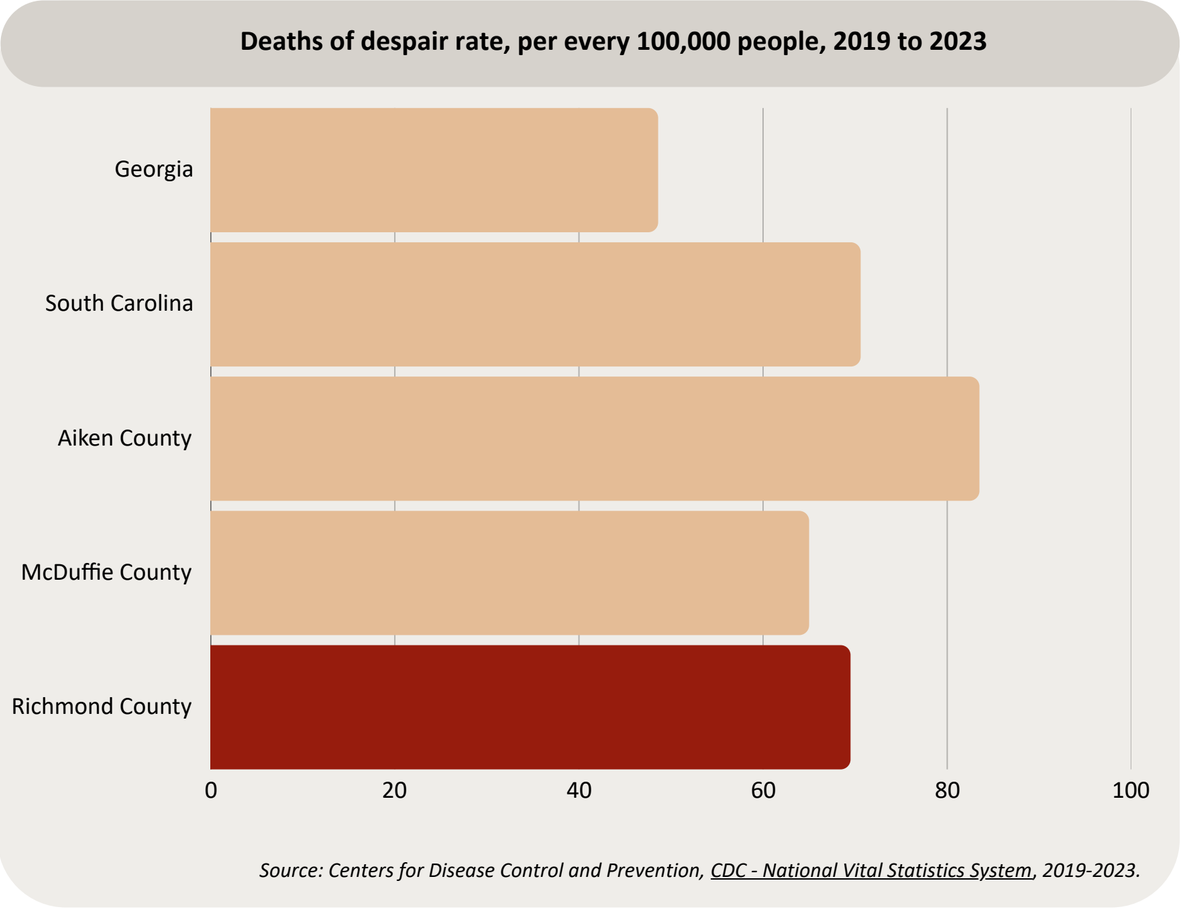
Cancer deaths by type, 2023



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2025.

Deaths of despair

Deaths of despair are those due to intentional self-harm (suicide), alcohol-related disease, and drug overdose. These are generally tied directly to mental health. Between 2019 and 2023, about 710 community members died a death of despair, resulting in rate of 69.5 deaths for every 100,000 people. Of these, over two-thirds were men and two-thirds were white.



Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2019-2023.

When looking at suicide only, the death rate for Richmond County was 16.3 suicides for every 100,000 people, which is higher than the state rate of 14.9 deaths.

As with deaths of despair overall, men are far more likely than women to commit suicide – about three times more likely.

White populations are far more likely than any other demographic; White populations take their own lives about 2.5 times more often than their Black counterparts.

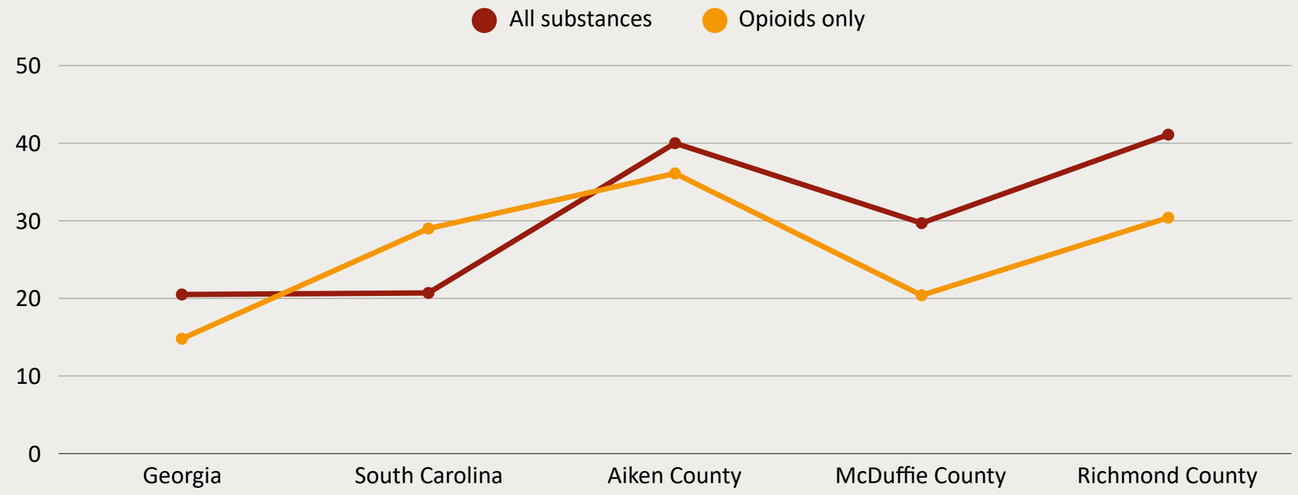
Generally speaking, any death related to mental and behavioral disorders disproportionately impacts white men far more than any demographic.

For example, in 2023, in Richmond County, white men died from mental and behavioral disorders at a rate of 26.1 deaths for every 100,000 people, as compared to Black men, who held a rate of 9.0. Data was not available for other races.

Drug overdoses

Drug overdoses are among the leading cause of injury deaths in the United States, and they have increased dramatically in recent years. In Richmond County, approximately 420 people died from a drug overdose between 2019 and 2023, a figure significantly higher than the state and national average (20.5 and 29.1 deaths for every 100,000 people, respectively).

Drug overdose death rate, all substances and opioids only, per 100,000 people, 2019 to 2023



Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2019-2023.

Overwhelmingly, White populations are more likely to die from a drug overdose than people of color. Between 2019 and 2023, White people died from an overdose rate of 60,1, as compared to 33.4 people of color for every 100,000 people.

When looking at opioids only, the same holds. In that same time frame, the death rate for the White population was 47.6, as compared to only 24.2 deaths for people of color.

Men are far more likely than women to die from an overdose. Between 2019 and 2023, the death rate for males was 55.3, as compared to 27.2 for females. When looking at opioids only, the death rate for males is 40.6 versus 20.9 for females, per every 100,000 people.

What’s next

Now that Piedmont has established its health priorities for the next three fiscal years, the hospital will create an implementation strategy, which is a written plan that outlines how the hospital will address the identified community health needs, based on the findings of the CHNA. It's a crucial step in demonstrating the hospital's commitment to community health improvement. This strategy will include the relevant CHNA priority, target populations, broad and specific goals, a targeted action, the anticipated impact of the action, the metrics used to demonstrate success, sources for those metrics, and any community partners needed for the specific tactic or strategy. The hospital’s board of directors approves the strategies.

All strategies will be finalized and approved no later than October 15, 2025. They will then be incorporated into a final CHNA report that will be widely distributed throughout the community and published at piedmont.org. The final CHNA will also include progress on the priorities and subsequent implementation strategies identified during the last CHNA, a list of engaged stakeholders, detailed results from one-on-one interviews, all survey questions, and a list of all sources used in the CHNA.

Any questions? Please reach out to us at communityprograms@piedmont.org.

Real change lives here