Piedmont Newnan
FY25 Community Health Needs Assessment

Interim CHNA

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 Hospital 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 communities

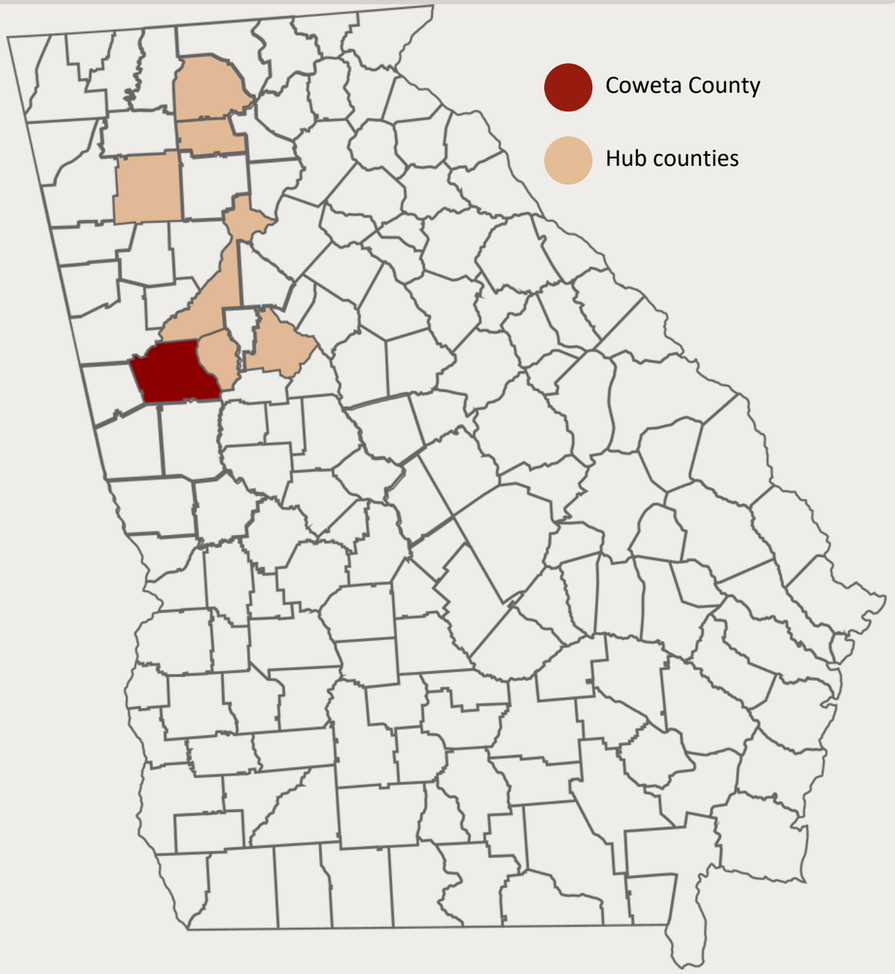
While Piedmont Newnan serves patients from all over suburban Atlanta, for purposes of this CHNA, we define our primary community to be the home county of our hospital—Coweta County. We do this in recognition of the direct impact of our tax-exempt status on county residents, as county taxes generally comprise the highest percentage of a not-for-profit hospital's exemption.

We also consider the communities within the Atlanta Clinical Hub, which includes Piedmont Atlanta (Fulton County), Piedmont Cartersville (Bartow County), Piedmont Fayette (Fayette County), Piedmont Henry (Henry County), and Piedmont Mountainside (Pickens and Gilmer Counties). This will become especially important during the implementation planning phase of the comprehensive Community Health Needs Assessment (CHNA) process.

Within this CHNA, we refer to PHC Primary Counties. These are the home counties of the other hospitals within Piedmont Healthcare:

- Piedmont Athens: Clarke County
- Piedmont Atlanta: Fulton County
- Piedmont Augusta: Richmond County
- Piedmont Cartersville: Bartow County
- Piedmont Eastside: Gwinnett County
- Piedmont Fayette: Fayette County
- Piedmont Henry: Henry County
- Piedmont McDuffie: McDuffie County
- Piedmont Macon: Bibb County
- Piedmont Mountainside: Pickens and Gilmer counties
- Piedmont Newnan: Coweta County
- Piedmont Newton: Newton County
- Piedmont Rockdale: Rockdale County
- Piedmont Walton: Walton County

Piedmont Newnan's Community



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, focusing on heart, stroke, and diabetes

Reduce preventable instances of and deaths from cancer

Reduce preventable instances of and deaths from heart disease

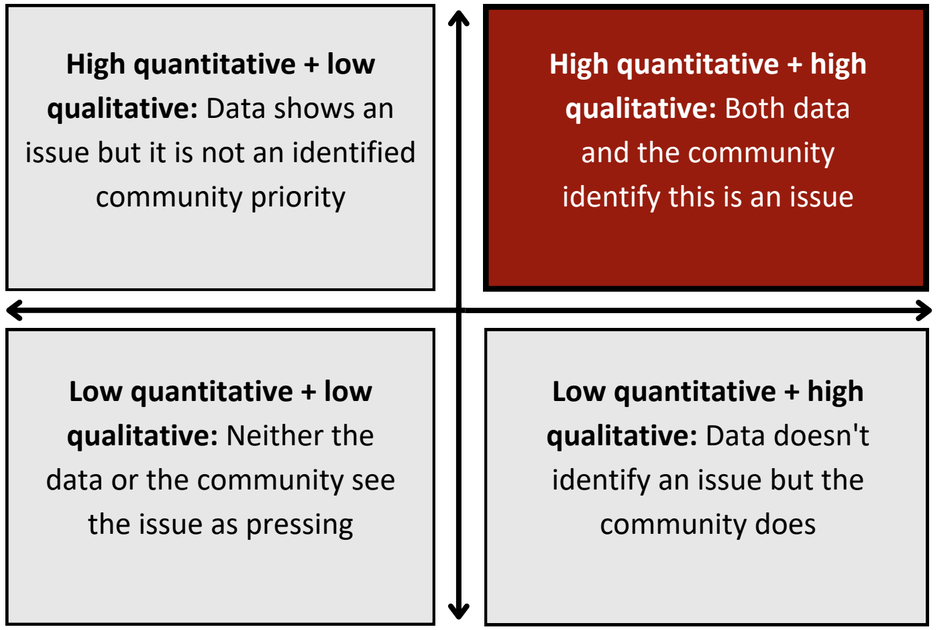
For each identified CHNA priority, we will tie its subsequent implementation strategies to defined health equity indicators with clear, measurable, and sustainable actions to be undertaken over the next three fiscal years.

How we determine priorities

Over the past year, 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'll want to consider 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?

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 issues that emerged throughout both. These are not listed in order of prevalence or importance.

- Accessible and affordable housing
- Food insecurity
- Mental health and wellbeing
- Support for patients in nearby rural communities
- High rates of uninsurance and Medicaid enrollment
- Community-based providers who understand the patient
- Health costs and medical debt
- Cancers
- Concern that federal actions will lead to reduced social services
- Need for continued attention to drug and substance abuse
- Access to adequate and supportive community-based care
- Chronic conditions, and especially hypertension and diabetes
- Accessible and affordable transportation
- Alzheimer’s disease
- Obesity and limited physical activity
- Preventative education

Summary of key themes

Throughout both stakeholder engagement and data collection, several themes emerged:

- The county has cancer incidence rates higher than the state average, with breast, colon, and rectum cancers particularly high.

- Maintaining good mental health remains a challenge, and the rate of both addiction/substance abuse providers and general mental health practitioners is lower than the state average. Community members report rates of poor mental health higher than the state average. Binge drinking rates are also high.

- Heart disease and cerebrovascular disease continue to lead as the top causes of death, as do high cholesterol, hypertension, and heart disease rates.

- Obesity rates continue to climb and were higher than the state average in 2022.

- Community members struggle with access to food, especially healthy food, and safe, secure housing. We heard this from stakeholders, in secondary public health data, and in the searches patients and community members make through Empowering You.

- Access to care remained similar to rates in the FY22 CHNA, and uninsured rates dropped slightly in most communities. Even so, some communities still show higher rates than the state average, underscoring the need for vital partnerships with community-based groups that support these populations.

- Areas where both primary and secondary data support further examination:
  - Maternal and child health
  - Rural healthcare
  - Mental, dental, and primary care providers
  - Support for mental wellbeing
  - Access to basic needs, such as safe housing and food
  - Still high levels of opioid use disorder

- Conditions that continue to persist in our communities:
  - Heart disease
  - Stroke
  - Alzheimer’s disease
  - Hypertension
  - Diabetes
  - High cancer incidence and death rates

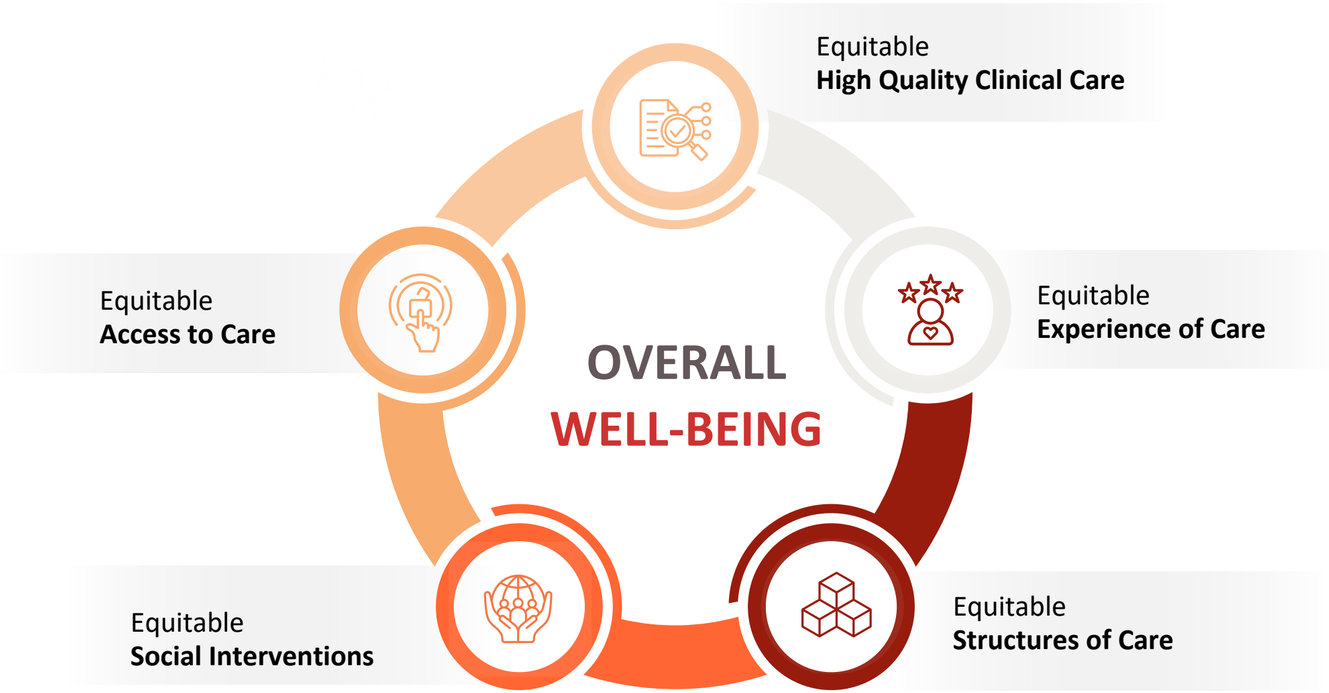
- Situations that lead to bad health:
  - High housing costs
  - Limited Head Start programming and preschool enrollment
  - High levels of public assistance income
  - More limited access to exercise opportunities
  - Limited access to preventative and necessary care for some populations

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 hospital

Piedmont Newnan Hospital

Piedmont Newnan Hospital is a 217-bed, acute-care, community hospital in Newnan, Georgia. Piedmont Newnan is a cornerstone of wellness as the only acute-care facility in Coweta County. As a not-for-profit organization, hospital earnings go directly back into maintaining and improving services and facilities, and to educational outreach.

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 respondants 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.

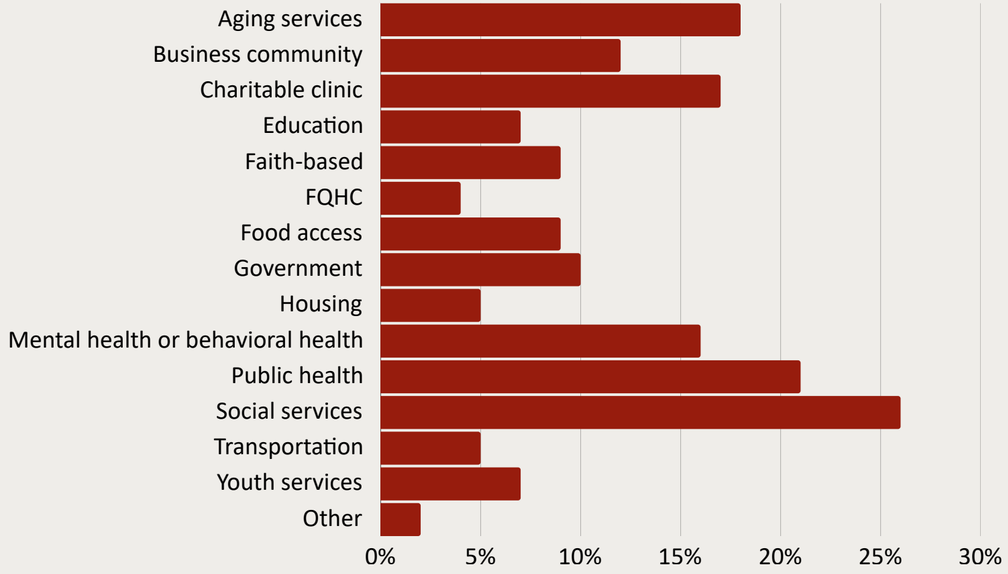
These interviews carried specific themes throughout:

- 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

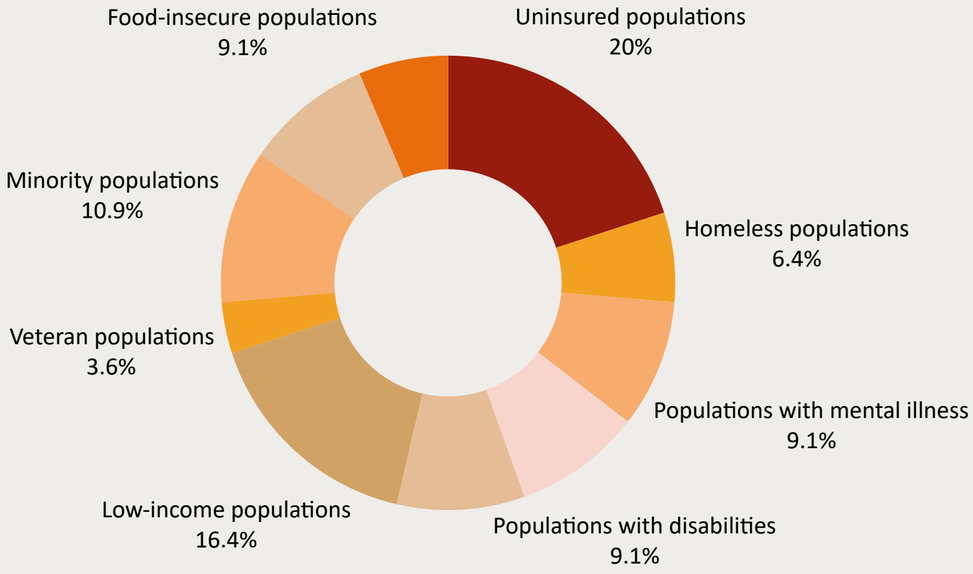
From January to March 2025, approximately 167 community leaders completed an online survey specifically tailored to their unique role within our neighborhoods and cities. The 17-question survey covered topics of community health, community resources, health equity, medical debt, and other related topics.

Survey respondents by area of work



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

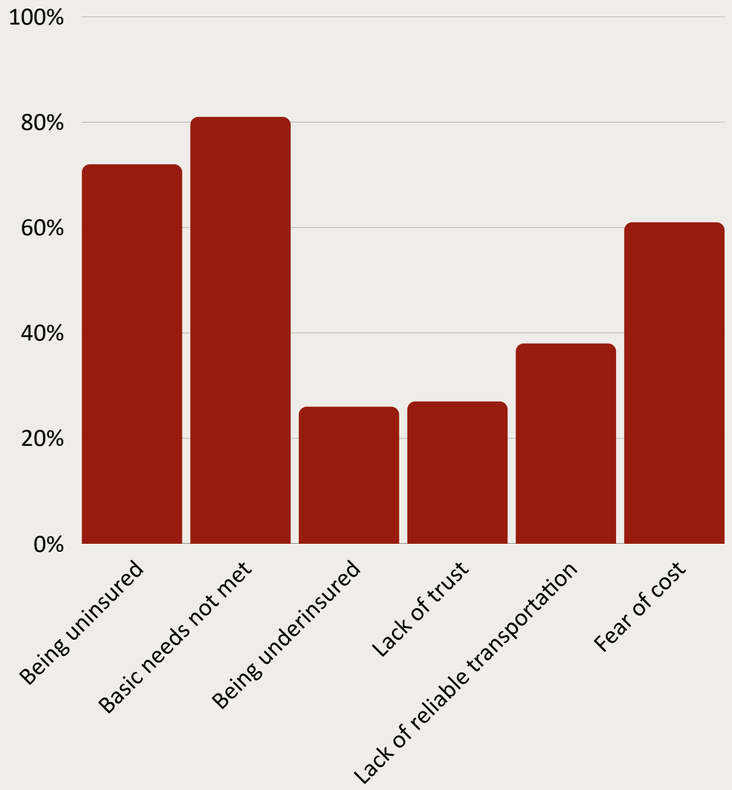
Top populations served by survey respondents



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."

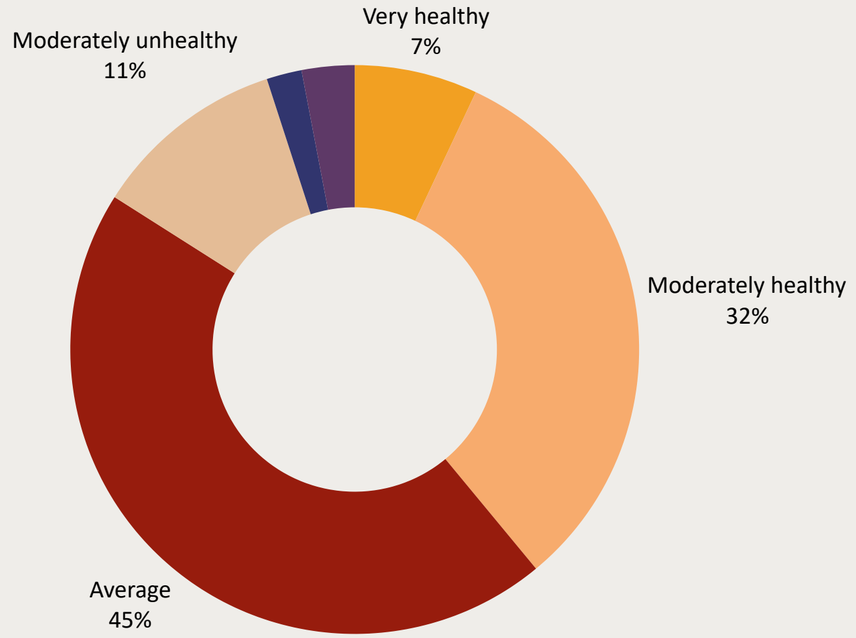
"A community where our older neighbors aren't choosing between medications and meals, where social services are secure and accessible, and everyone has the ability to get where they need to go."

Source: FY25 PHC CHNA Community Leaders Survey

Community survey

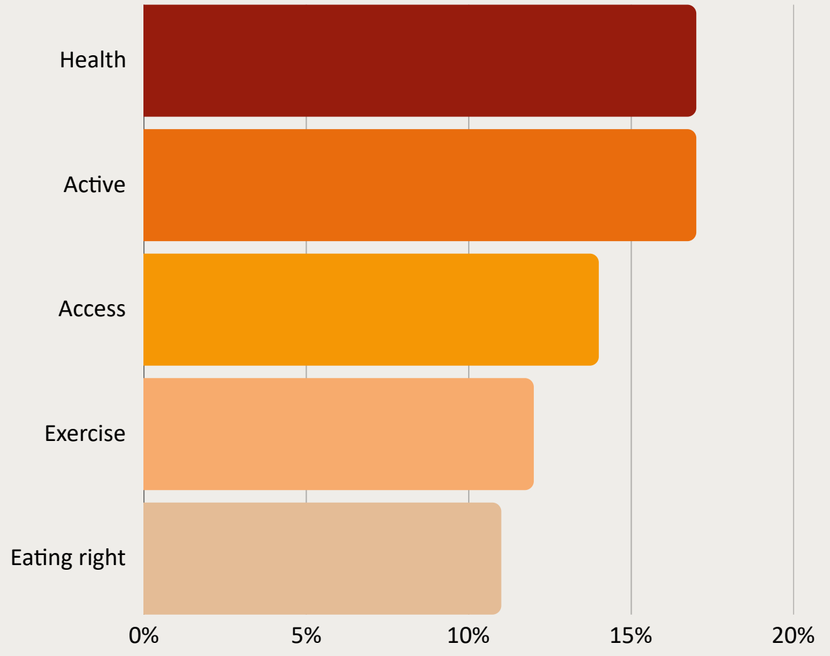
In February 2025, Piedmont launched a five-question survey among its Piedmont Advisors, a group of self-identified community members who often provides feedback to the system. These advisors live and work within Piedmont communities. Approximately 1,266 Advisors provided their insight on what makes a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

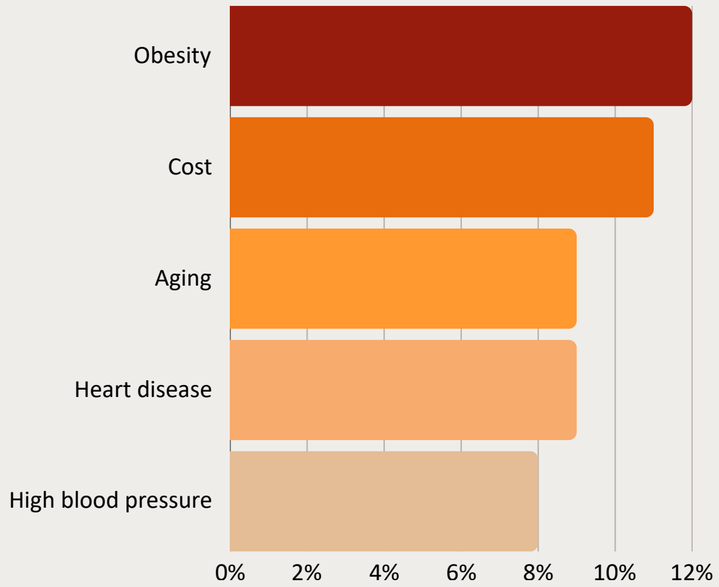
Q: When you think of a healthy community, what comes to your mind first? The top five answers are below.



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.

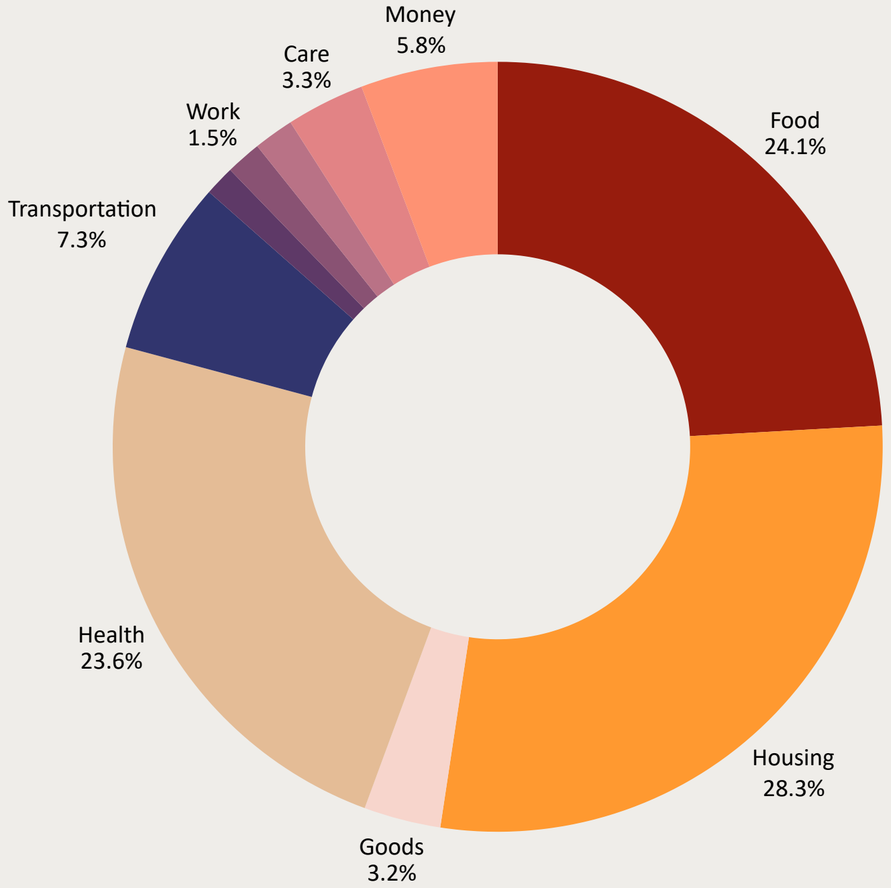
Empowering You

Beginning in January 2023, Piedmont offers to 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
Muscogee 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. This helped us understand both the patient population and the impact of potential health inequities on patient populations traditionally underserved within healthcare.

Demographics

Approximately 150,100 people lived in Coweta County annually between 2019 and 2023. This community is primarily urban -- about 55 percent.

When examining the population by age during that time, we see the majority were non-elderly adults.

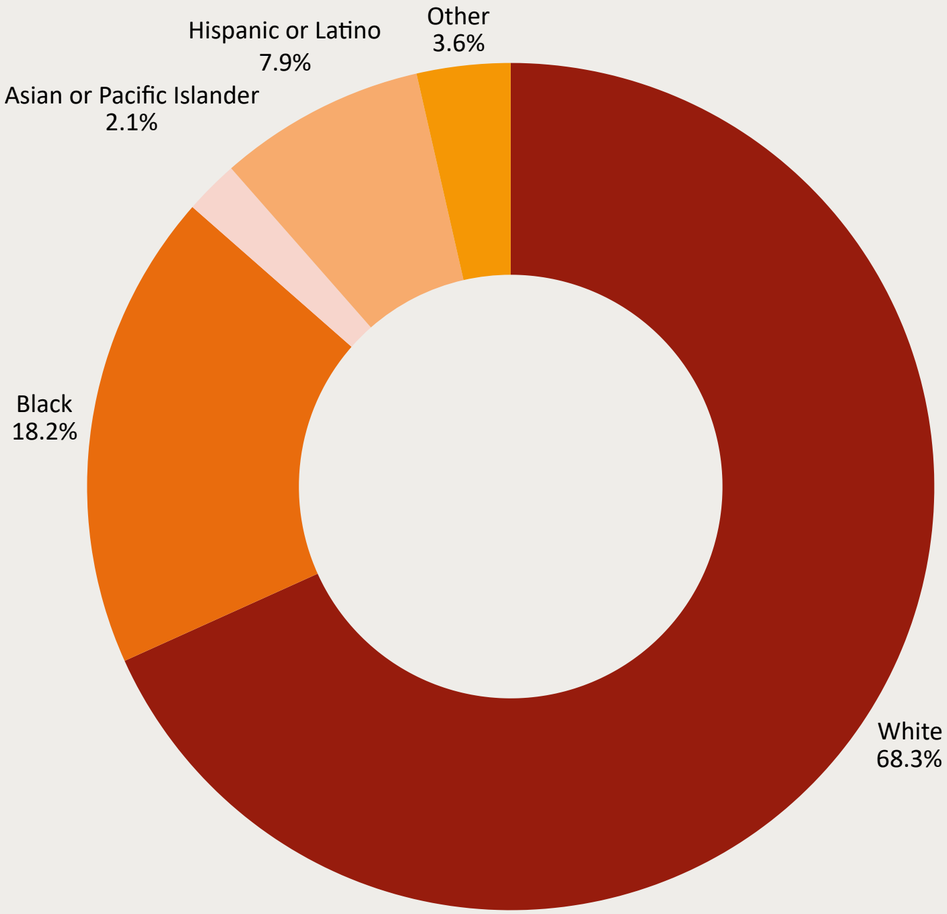
- **0-4:** 5.6%
- **5-17:** 17.8%
- **18-24:** 8.2%
- **25-34:** 12.4%
- **35-44:** 13.4%
- **45-54:** 14.3%
- **55-64:** 13.6%
- **65+:** 14.7%

61.9%

Coweta County grew between 2010 and 2020, with an increase of 14.8%. Asian and other Non-Hispanic populations led this growth.

About 1% of the community is in a limited English-speaking household, meaning most members can speak English at least fluently. That said, about 9% of households speak a language other than English at home. Of those languages, Spanish ranks the highest at 5.8% and Other Indo-European languages comes in second at 0.8%.

Percent of population by race and ethnicity, Coweta County, 2019 to 2023



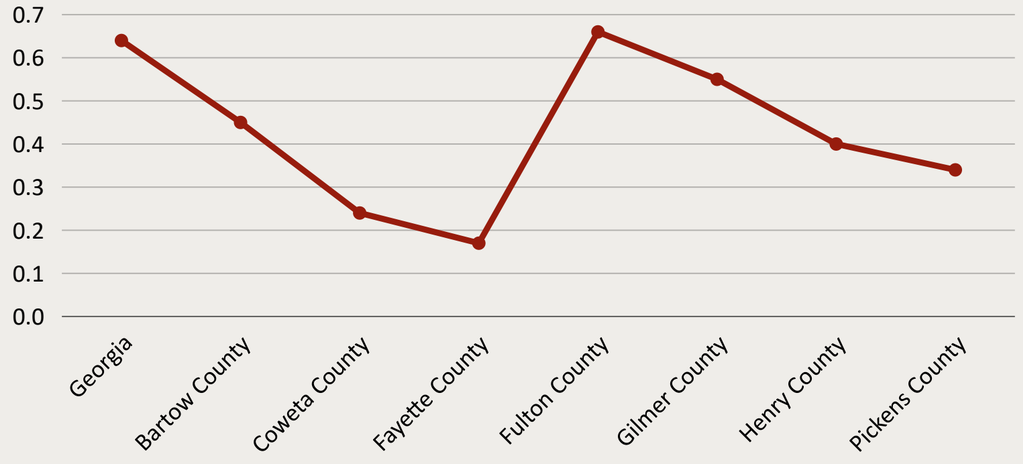
Source: US Census Bureau, American Community Survey. 2019-2023.

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.**

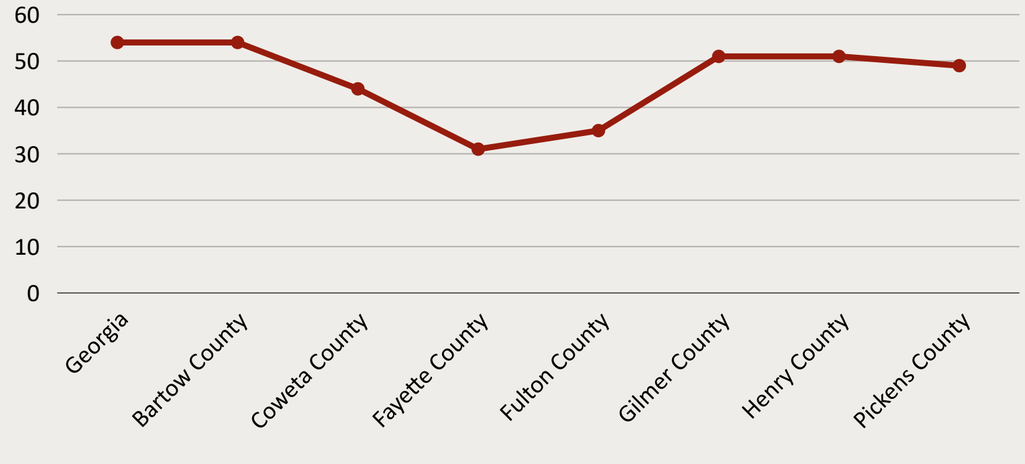
The Area Deprivation Index ranks neighborhoods and communities relative to all neighborhoods nationwide (national percentile) or relative to other neighborhoods within one state (state percentile). The ADI is calculated based on 17 measures in four primary areas: education, income and employment, housing, 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, Coweta County, 2022



Source: CDC GRASP, 2022.

ADI, state percentile, Coweta County, 2022

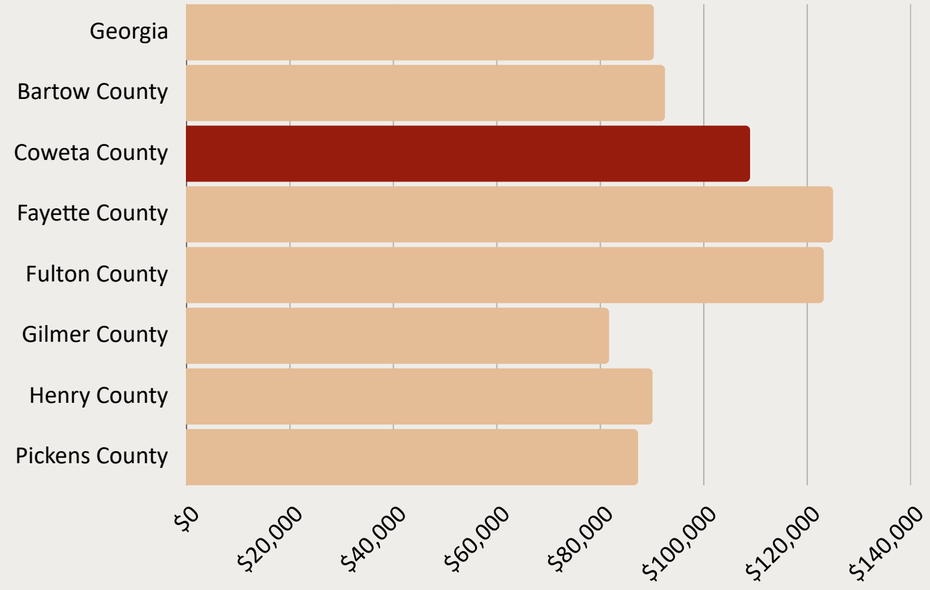


Source: University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas. 2022.

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.

Median family income, Coweta County, 2019 to 2023



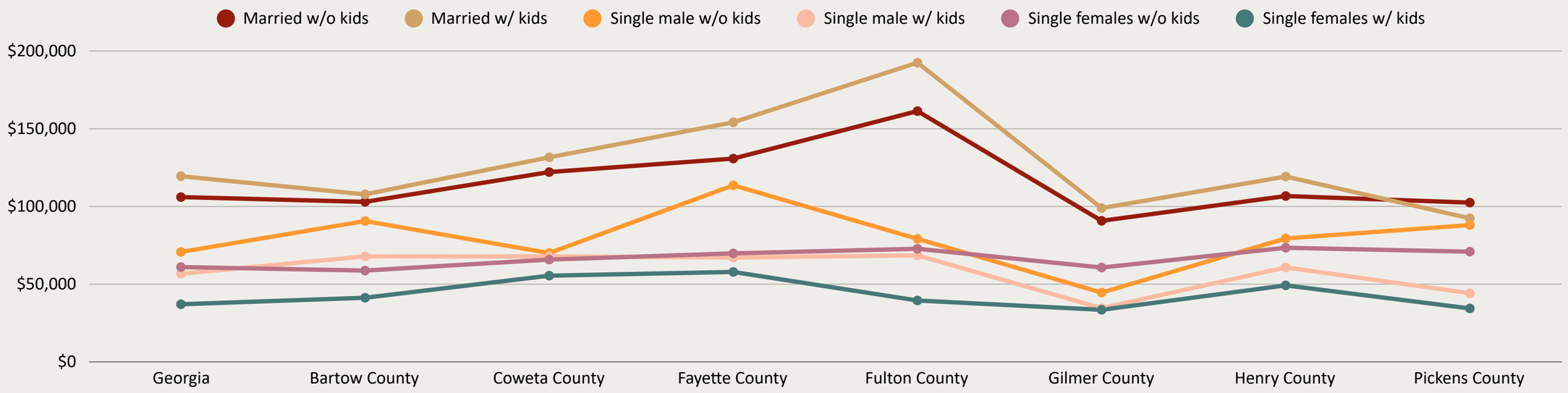
Source: US Census Bureau, American Community Survey, 2019-2023.

- 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

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, Coweta County, 2019 to 2023

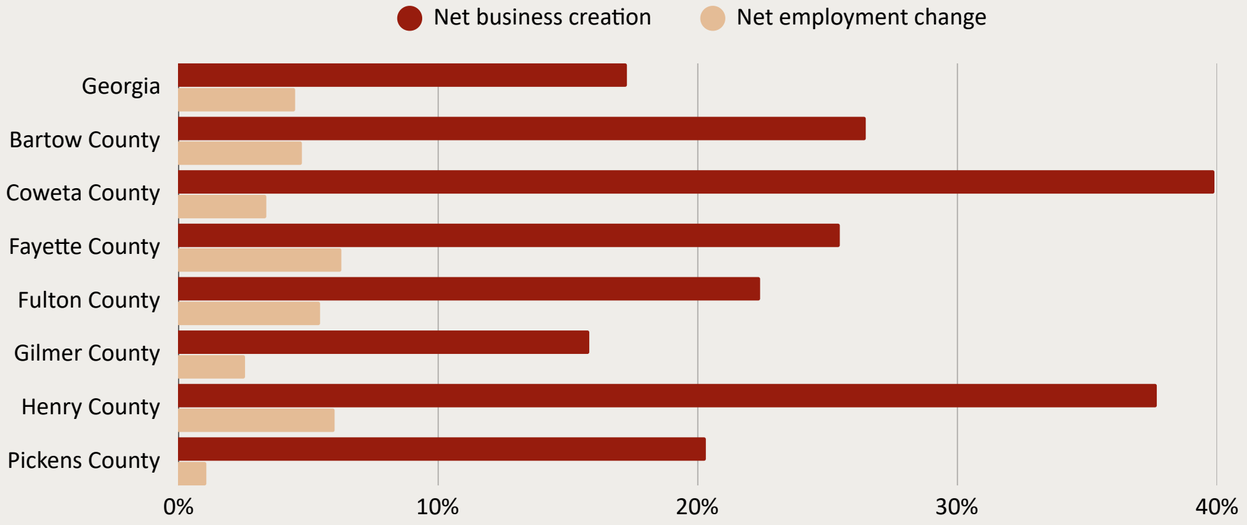


Source: US Census Bureau, American Community Survey. 2019-2023.

Employment

Between 2011 and 2021, 3,148 new businesses were created within the county. During that same time, approximately 2,409 businesses closed, resulting in a establishment net change rate of 39.9%, far above the state average of 17.3%.

Net business creation and net employment change, 2011 to 2021



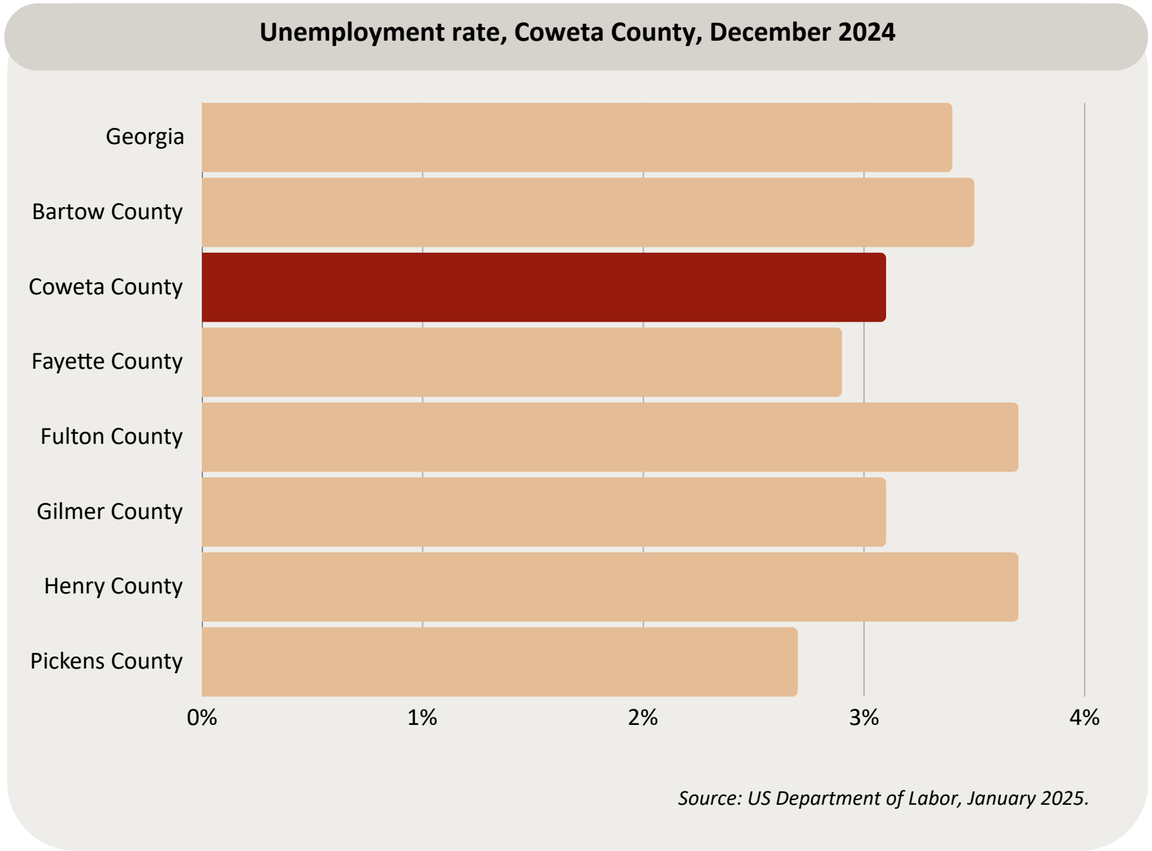
US Census Bureau, US Census Business Dynamics Statistics. 2011-2022.

Within the county, between 2019 and 2023:

- About 76.6% of those working commuted to work alone in a car or truck.
- About 11.6% of those commuted for more than an hour each way.
- 12.7% of the population worked from home.
- About 94% percent of working age adults with a disability worked, below the rate of 97.5% for non-disabled populations.

Unemployment

We examine unemployment rates, as unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute 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.

Increased stress-related illnesses: Unemployed individuals are more likely to experience stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis.

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.

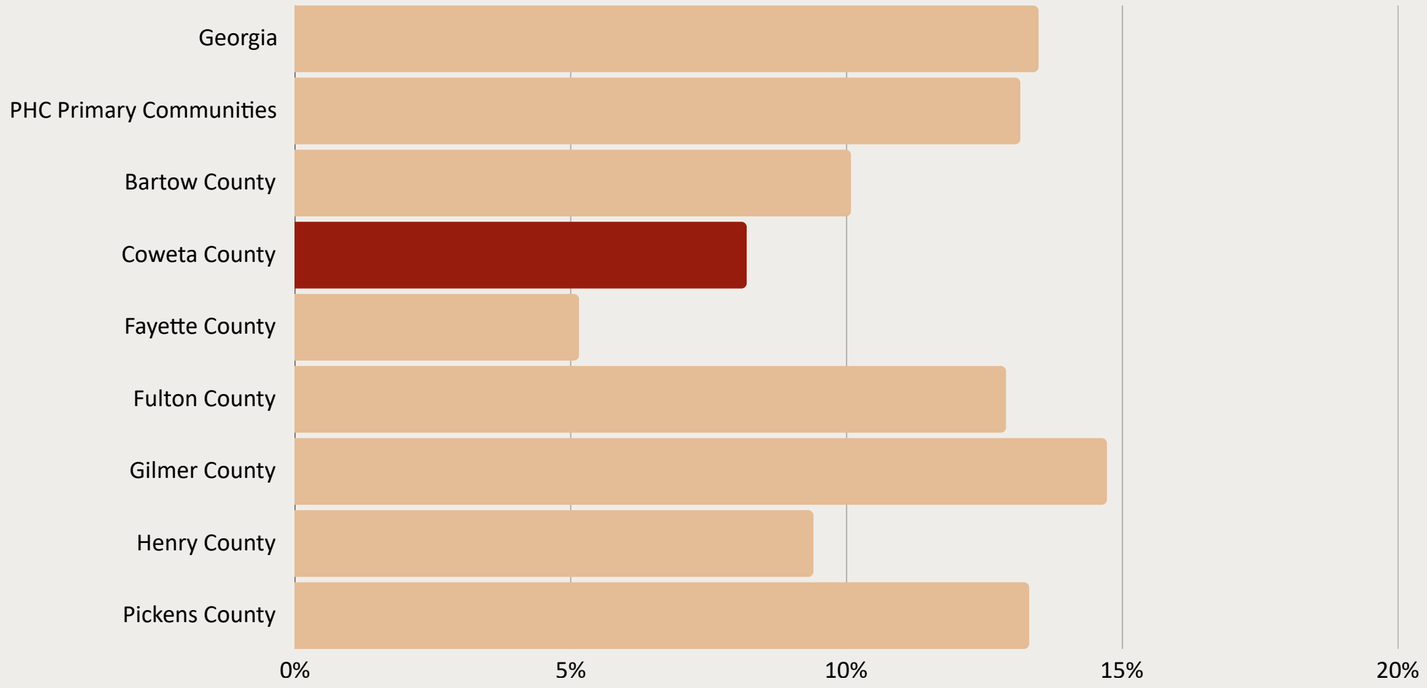
Within Coweta County, between 2019 and 2023:

- Women are generally more likely to live in poverty then men.
- Minorities are often far more likely to live in poverty than their white counterparts.

Generally, 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, Coweta County, 2019 to 2023



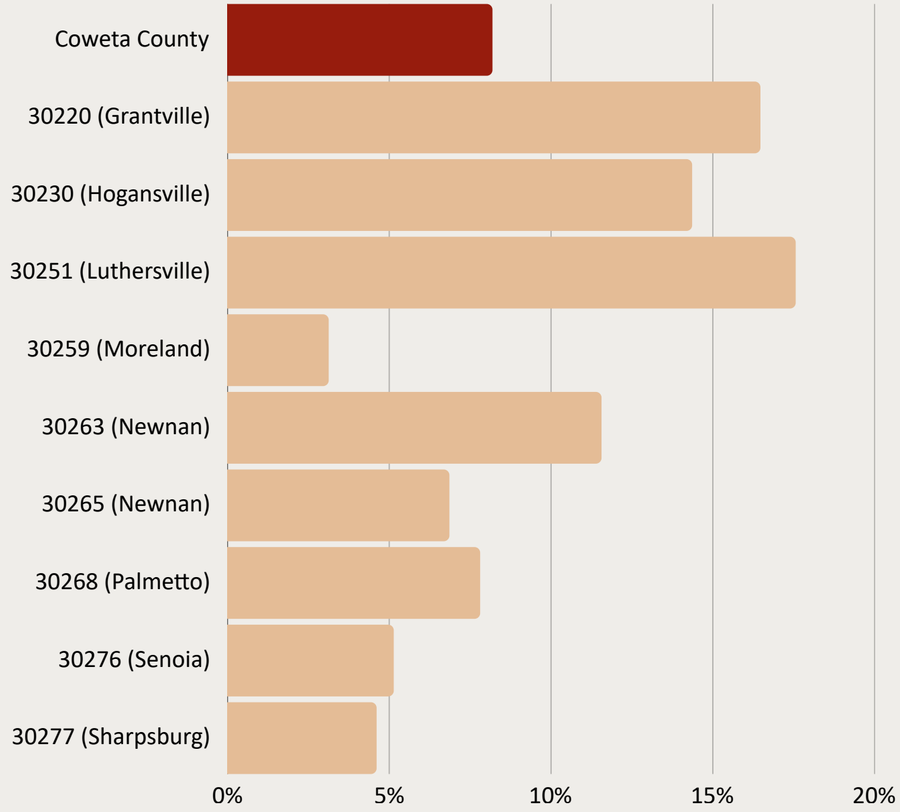
Source: US Census Bureau, American Community Survey, 2019-23.

Poverty and geography

Poverty tends to cluster within geographic areas, with some neighborhoods experiencing higher rates of poverty than others. Like most of the country, income levels tend to be segregated within Richmond County, with some neighborhoods experiencing higher poverty rates than others.

- Poor health outcomes: These neighborhoods may have higher crime rates, exposure to environmental hazards, and limited access to healthy food options, leading to poorer physical and mental health outcomes.
- Reduced educational attainment: Children in these neighborhoods may attend under-resourced schools with higher dropout rates, which can impact their educational attainment and prospects.
- Weakened job-seeking networks: Residents may have weaker social networks, making it harder to find employment and advance their careers.
- Financial insecurity: High-poverty neighborhoods are often characterized by higher financial instability and limited access to economic resources.
- Intergenerational poverty: The cycle of poverty can be perpetuated as children growing up in these neighborhoods face challenges that limit their opportunities and future outcomes.

Poverty rates by ZIP code, Coweta County, 2019 to 2023



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

Percent of population at varying poverty rates

As demonstrated in the chart to the right, most people in the region 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.

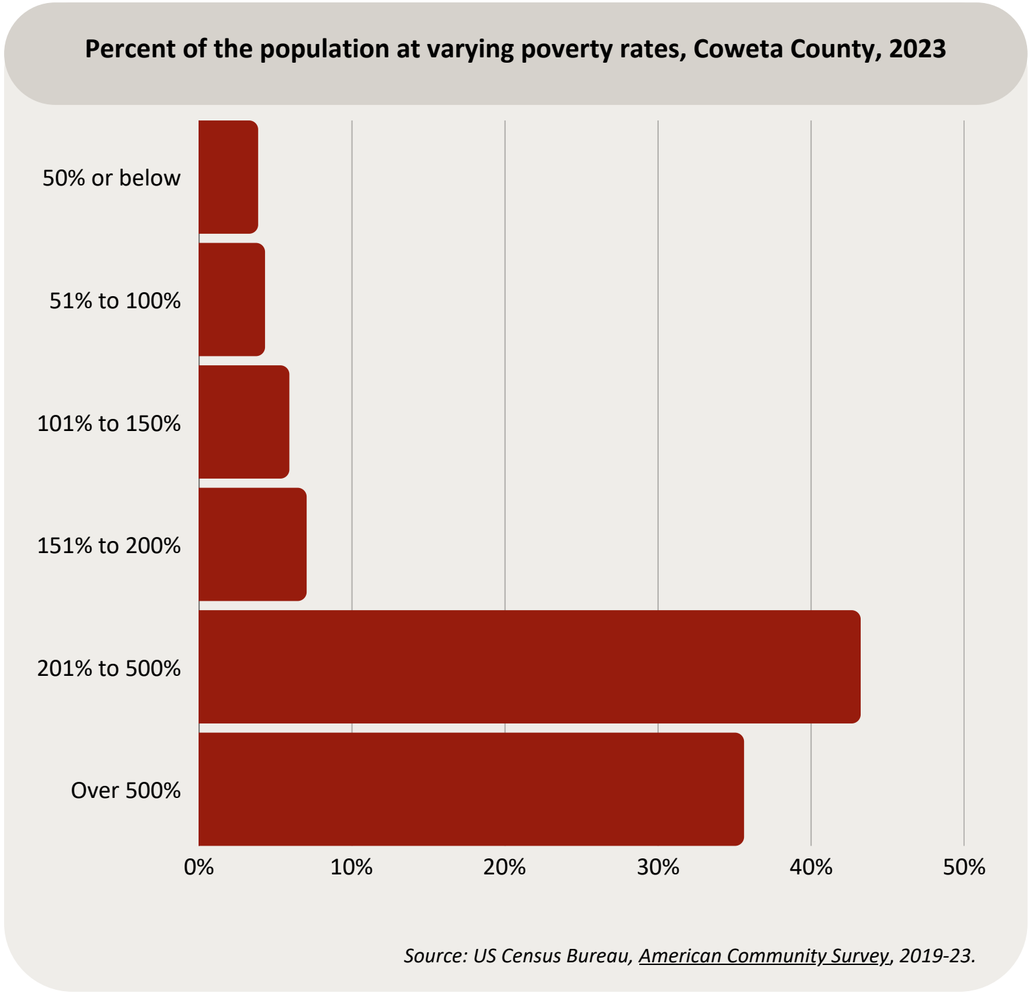
Even so, there are costs that drive down disposable income.

Childcare
Annually between 2019 and 2023, childcare costs consumed about 17% of median household income.

Collections
Between 2019 and 2023, 29% of Coweta County members had debt in collections, and the median of that amount was about $1,700.

Student loan debt: According to the Urban Institute, about 17% of Coweta County had student loan debt between 2019 and 2024. The median amount owed was $20,390.

Utility services threat: In 2022, about 7% of Coweta County community members reported nearly having their utilities cut due to nonpayment.

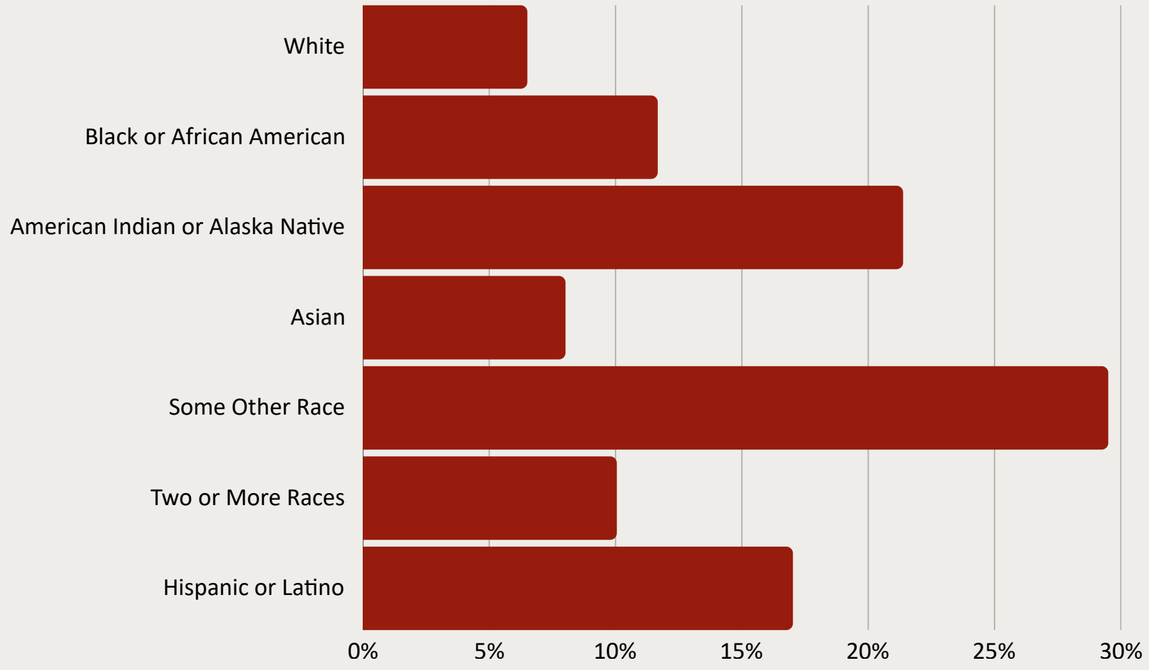


Poverty by race and ethnicity

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

- 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.

Poverty rates by race and ethnicity, Coweta County, 2019 to 2023

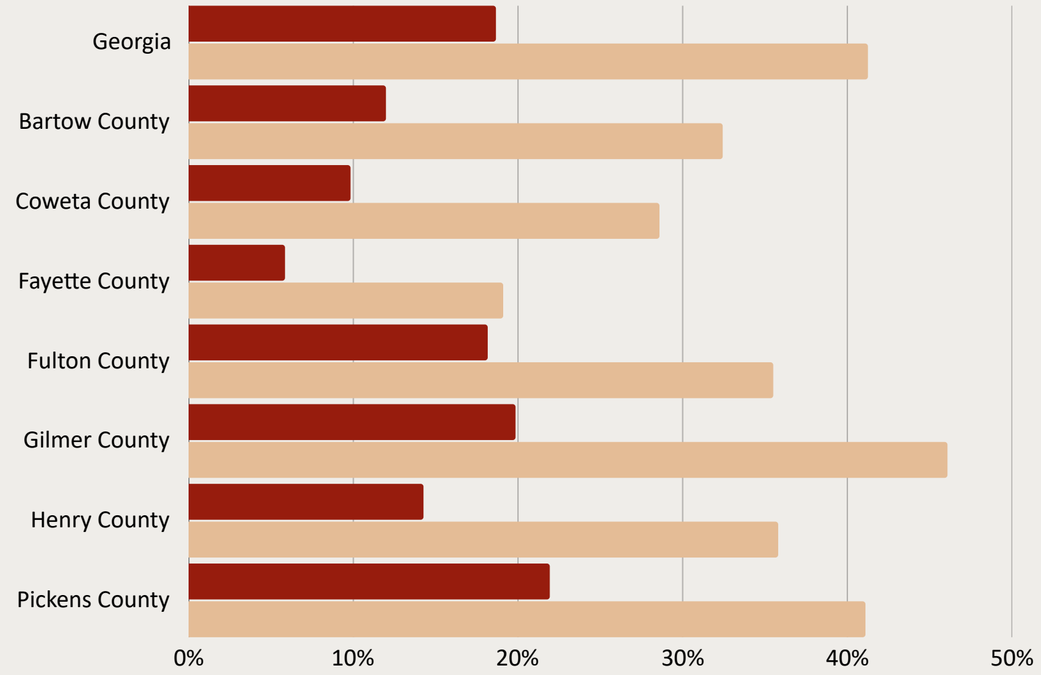


Source: US Census Bureau, American Community Survey, 2019-2023.

Children in poverty

In Coweta County, nearly 10,000 children lived in households with income below 200% of the Federal Poverty Level between 2019 and 2023. Child poverty is more than just low income; it encompasses the lack of access to essential resources and opportunities. Childhood poverty can lead to long-term adverse outcomes, including poor health, reduced educational attainment, and limited economic opportunities.

Percent of children living at or below 100% and 200% FPL, Coweta County, 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.

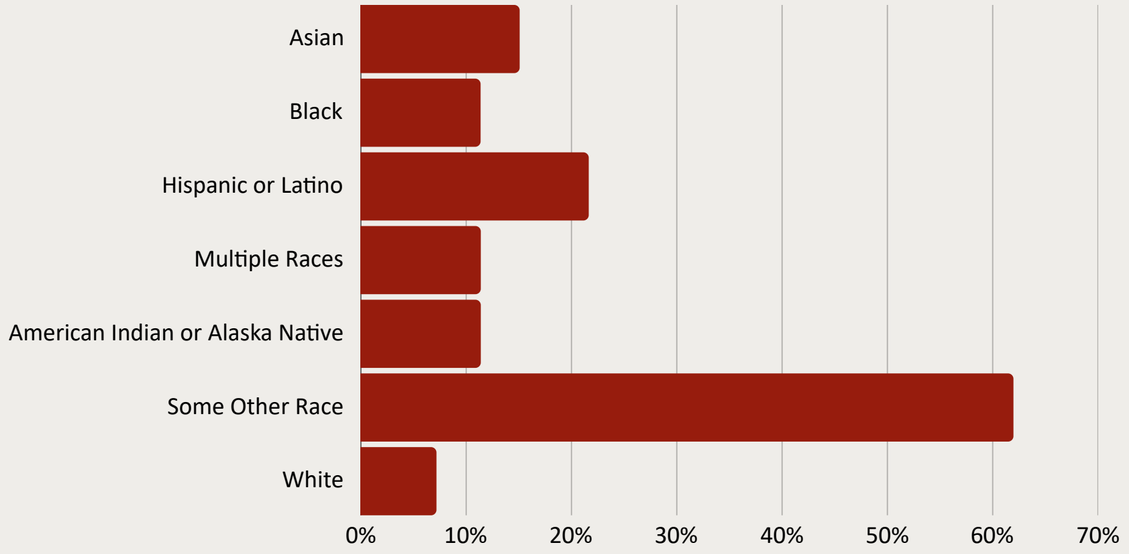
Mental health: Children living in poverty are at higher risk of experiencing poor mental health and psychological distress.

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), child care subsidies, and changes in the federal minimum wage can help reduce child poverty.

Children in poverty, continued

Racism and discrimination have historically led to unequal access to education, housing, employment, and healthcare, which are all crucial for economic mobility and upward social movement. These disparities create a situation where certain racial groups are more likely to experience poverty and its associated challenges. Low-income children of color may attend under-resourced schools, live in neighborhoods with limited opportunities, and face systemic barriers to accessing quality healthcare and social services. These factors can negatively impact their educational attainment, health outcomes, and life chances.

Percent of children living at or below 100% FPL by race, Coweta County, 2019 to 2023



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

Racial segregation and economic mobility: Children who grow up in more racially segregated metropolitan areas experience less economic mobility than those in less segregated ones. More racially and economically segregated regions tend to have lower incomes and educational attainment and higher homicide rates.

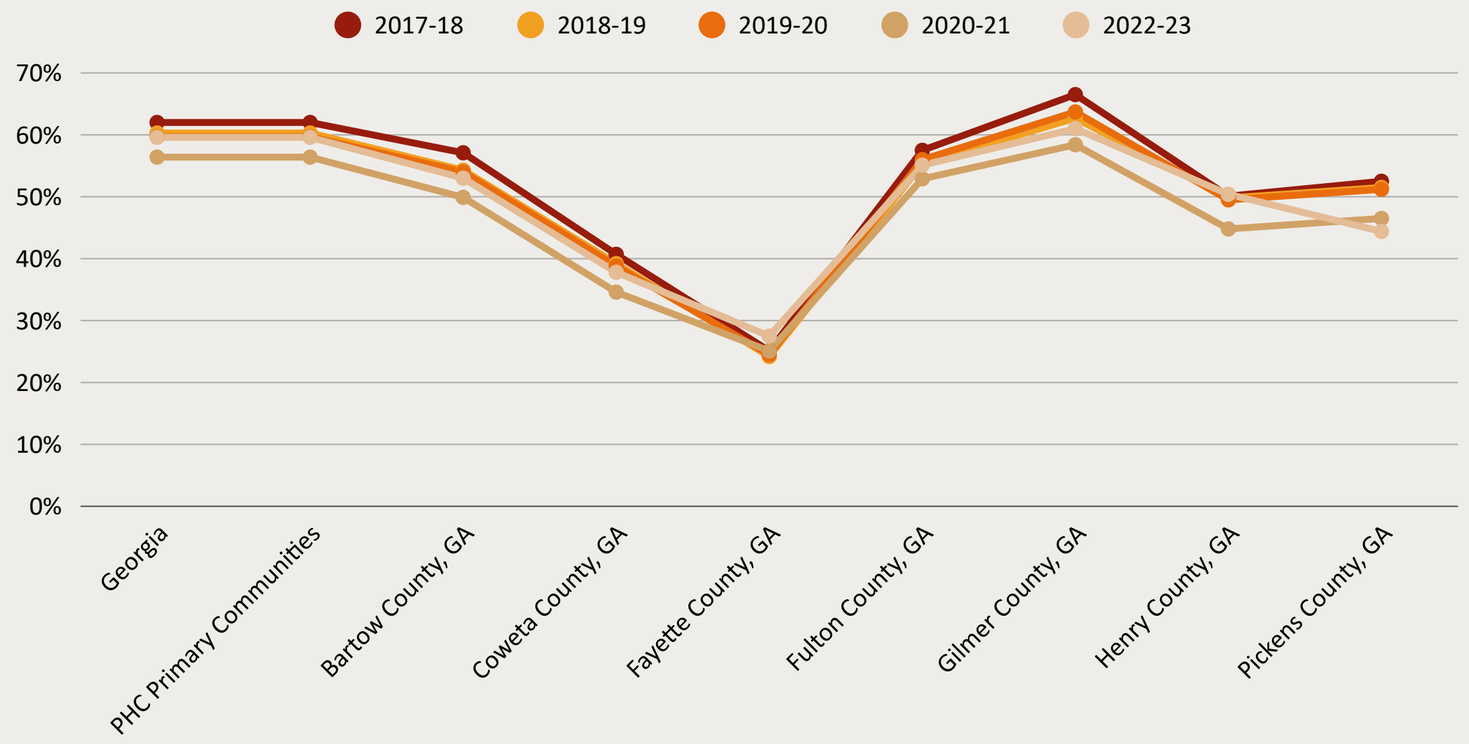
Impact on health and well-being: Poverty among children of color can lead to adverse childhood experiences (ACEs), which are linked to adverse health and social outcomes. Children of color are disproportionately exposed to ACEs, which can undermine their development and well-being.

Intergenerational cycles of poverty: The combination of poverty and racism can create intergenerational cycles of disadvantage, where low-income children of color are more likely to face similar challenges as their parents and grandparents, which can make it difficult for them to escape poverty and achieve their full potential.

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. Please note there was no data available for the 2021-2022 school year.

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



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

In Coweta County, 37.8% of children—or about 9,200 children—qualified for free or reduced-price lunch at their school during the 2022-2023 school year. Within the county, during that school year, the ZIP code with the highest rates of qualifying children was tied to Griffin (97.4%).

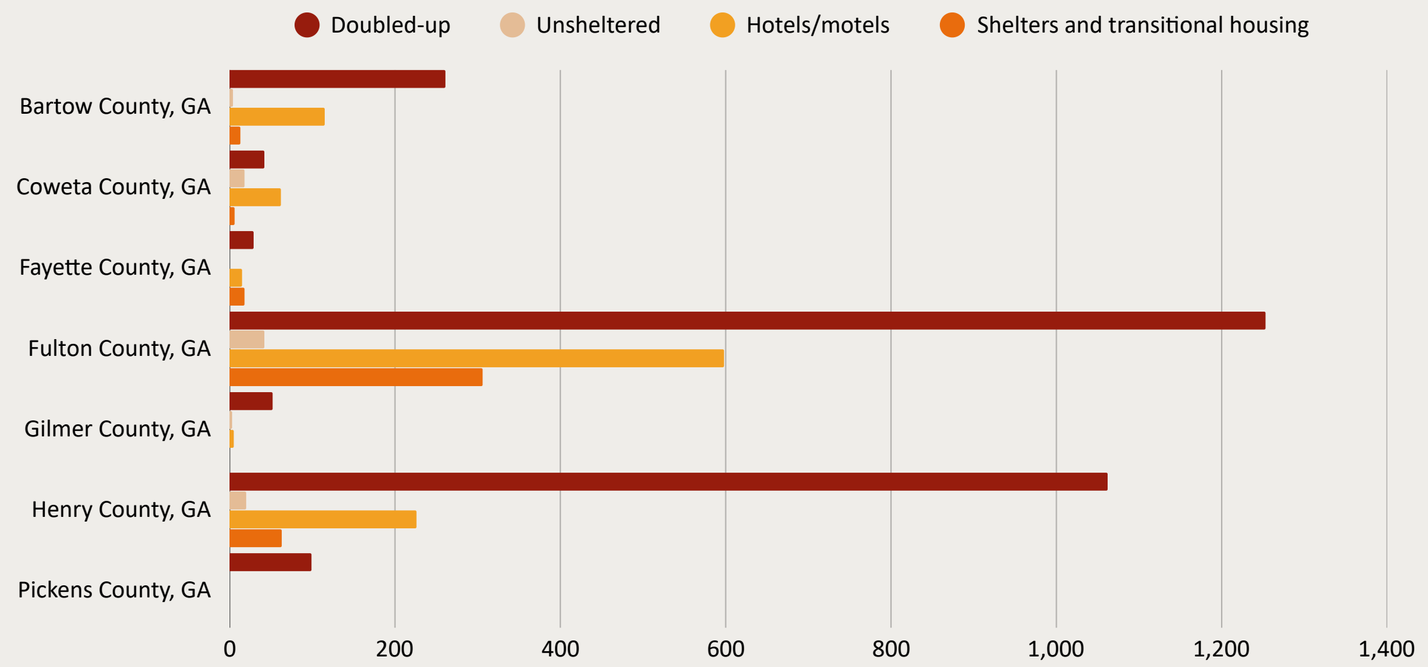
Free and reduced-price school lunch programs directly address food insecurity, a major social driver of poor health. These programs ensure students have access to healthy, nutritious meals, reducing the risk of hunger and its associated negative consequences.

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 children

Homelessness significantly impacts children's health, development, and education, with long-lasting consequences. Children experiencing homelessness face higher rates of developmental delays, health problems, and mental health challenges. They also experience increased stress, trauma, and instability, which can affect their ability to learn and form healthy relationships.

Students experiencing homelessness by primary nighttime residence, 2021-2022 school year



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.

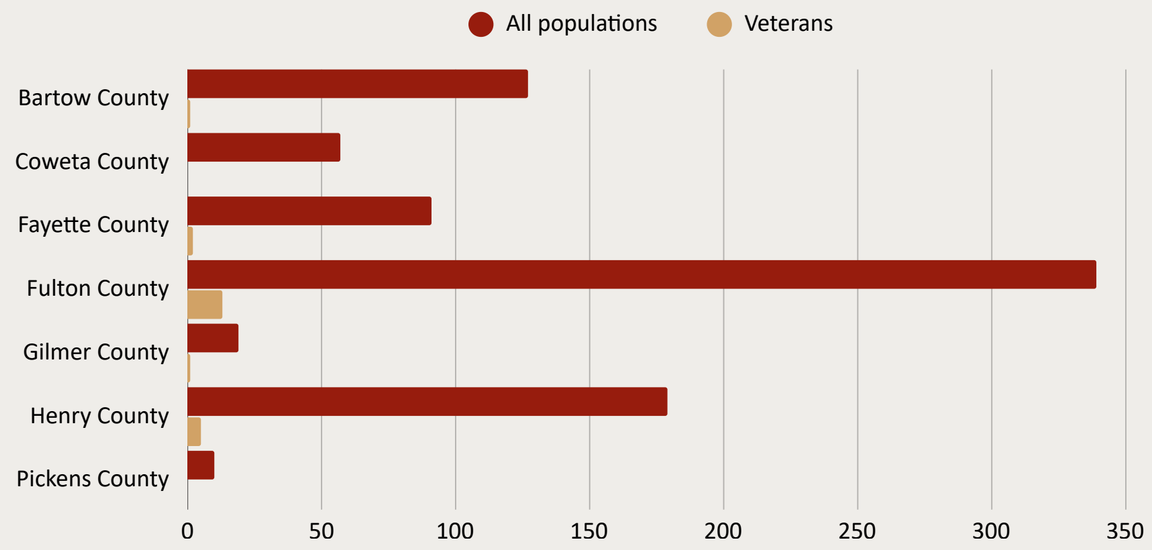
Hotels/motels: As indicated by the name, refers to stays in hotels or motels.

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 2024



Source: Georgia Department of Community Affairs, January 2024.

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

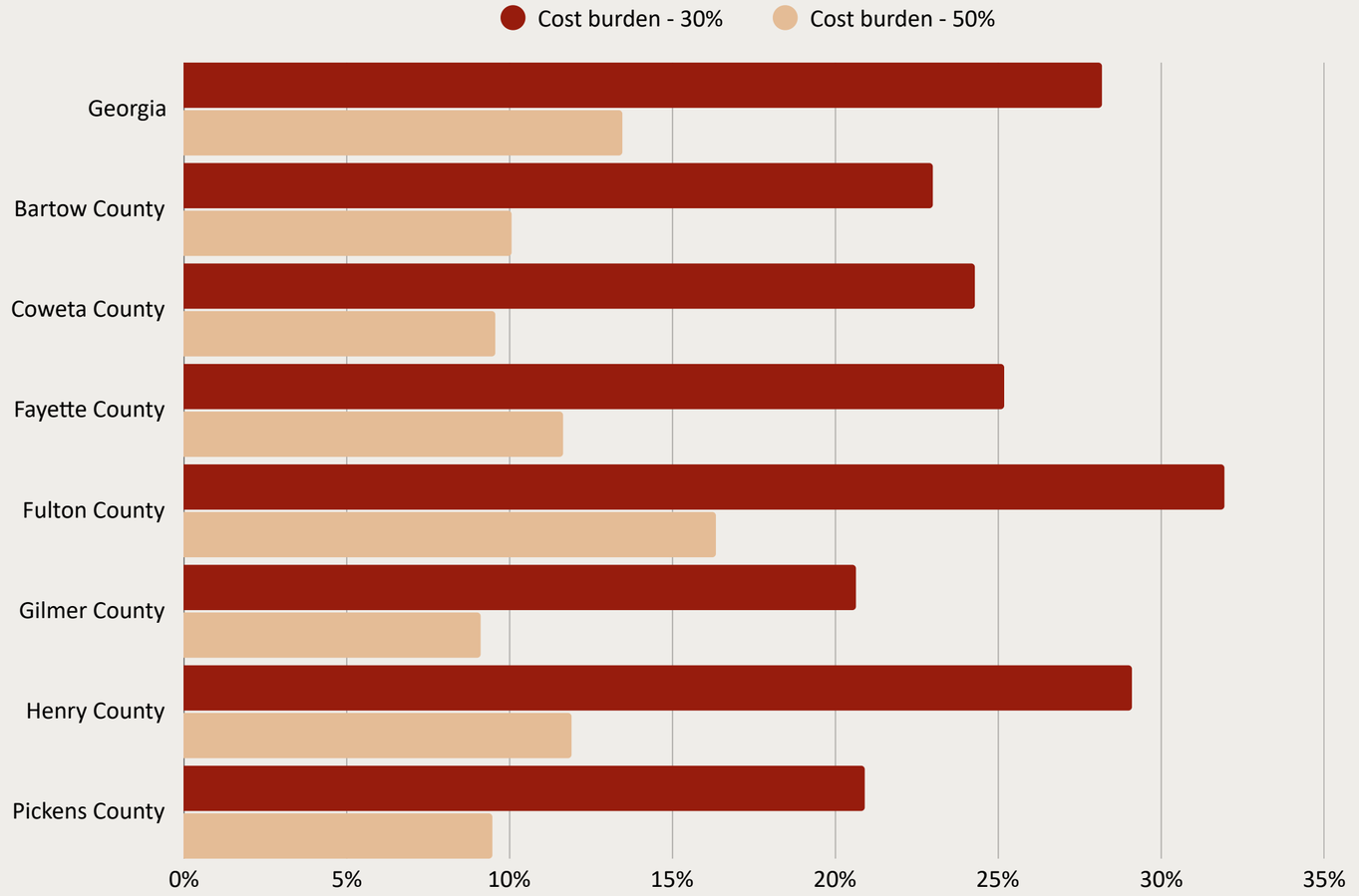
Housing is a critical component of wellbeing, as a stable home is an indicator of both economic ability and ability to stay healthy.

Some key statistics on housing within Coweta County:

In total, most homes within Coweta County are not overcrowded, however, some ZIP codes carry rates higher than the state average of 1.9% of households:

- 30268 (Palmetto): 3.1%
- 30220 (Grantville): 3.1%
- 30263 (Newnan): 2.5%
- 30230 (Hogansville): 2.1%

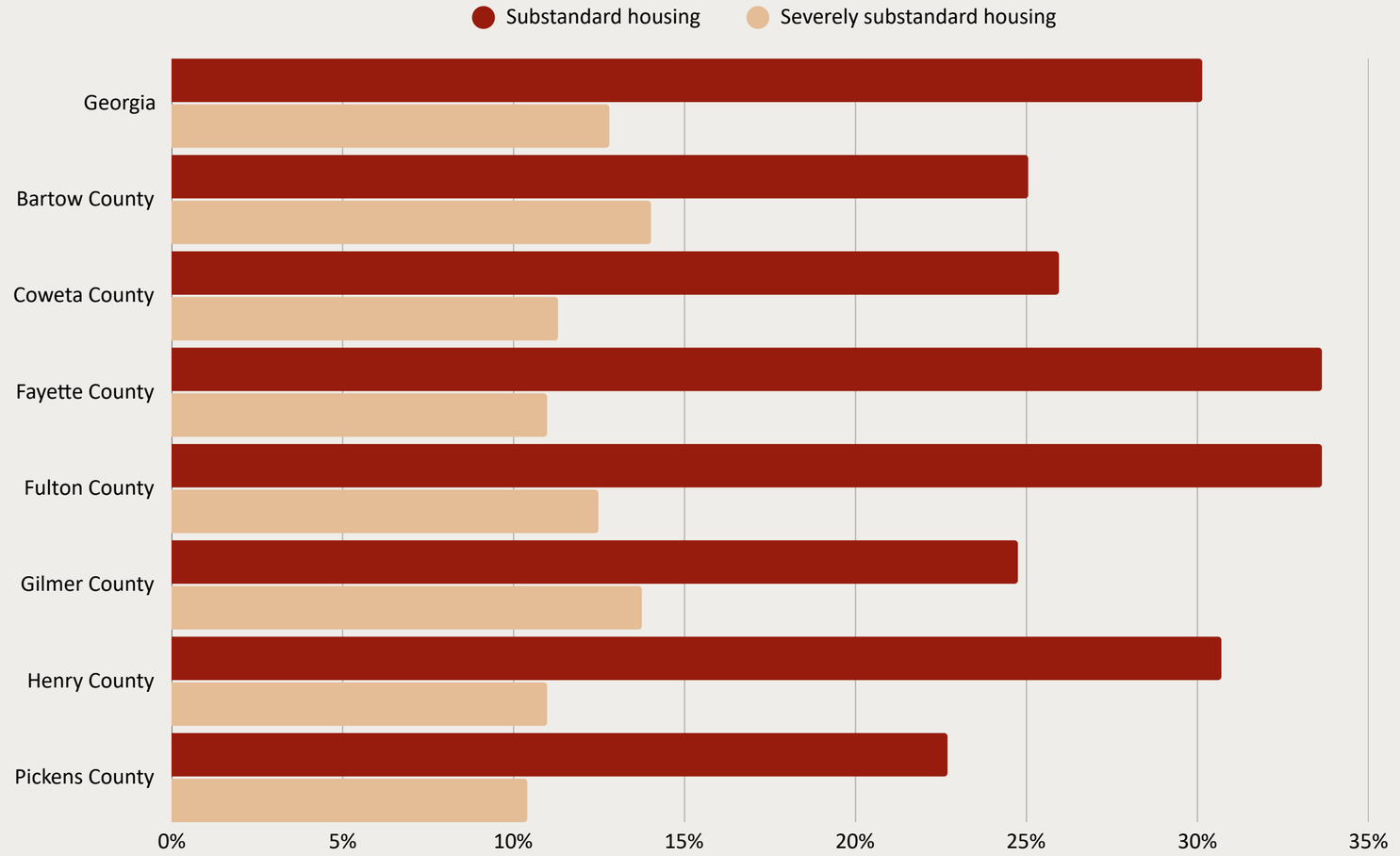
Housing cost burden as percentage of household income, Coweta County, 2019 to 2023



Source: US Census Bureau, American Community Survey, 2019-23.

Substandard housing

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



Source: US Dept. of Housing and Urban Developmemt, 2019-23.

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

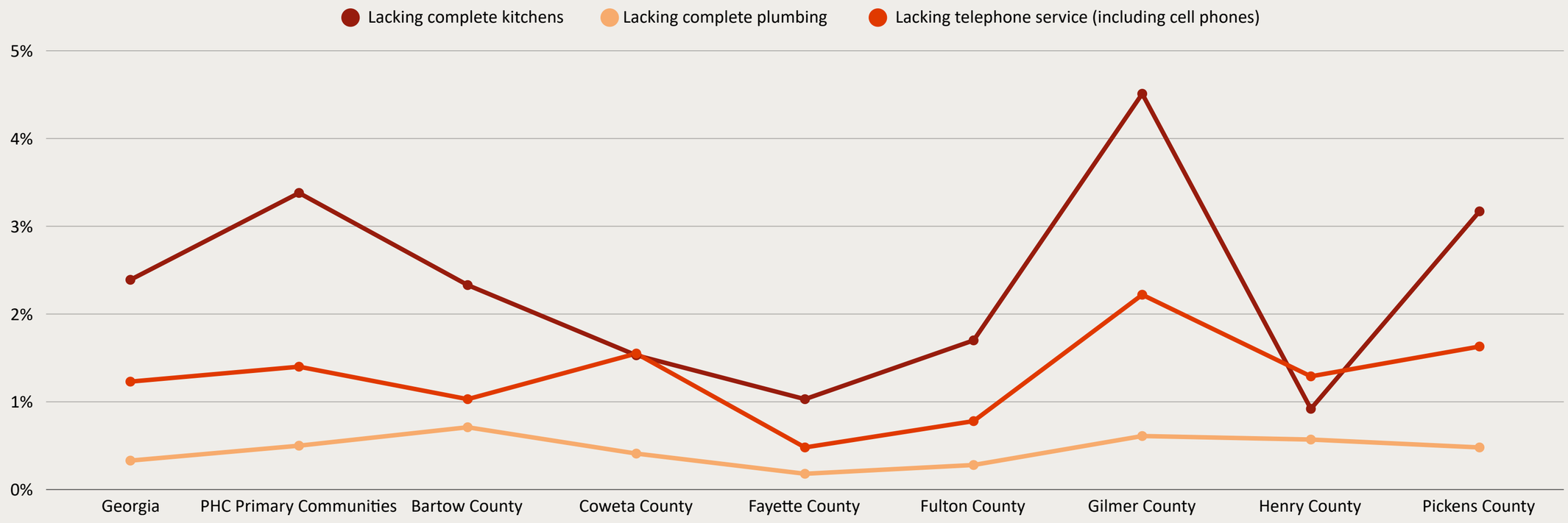
1. Lacking complete plumbing facilities
2. Lacking complete kitchen facilities
3. With on or more occupants per room
4. Selected monthly owner costs as a percentage of household income greater than 30%
5. Gross rent as a percentage of household income greater than 30%

Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Housing without complete plumbing and kitchens or phone service

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 800 occupied homes without complete plumbing facilities annually on average between 2019 and 2023. Houston County had the highest amount of these homes – nearly half of all homes in the service area without complete plumbing.

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

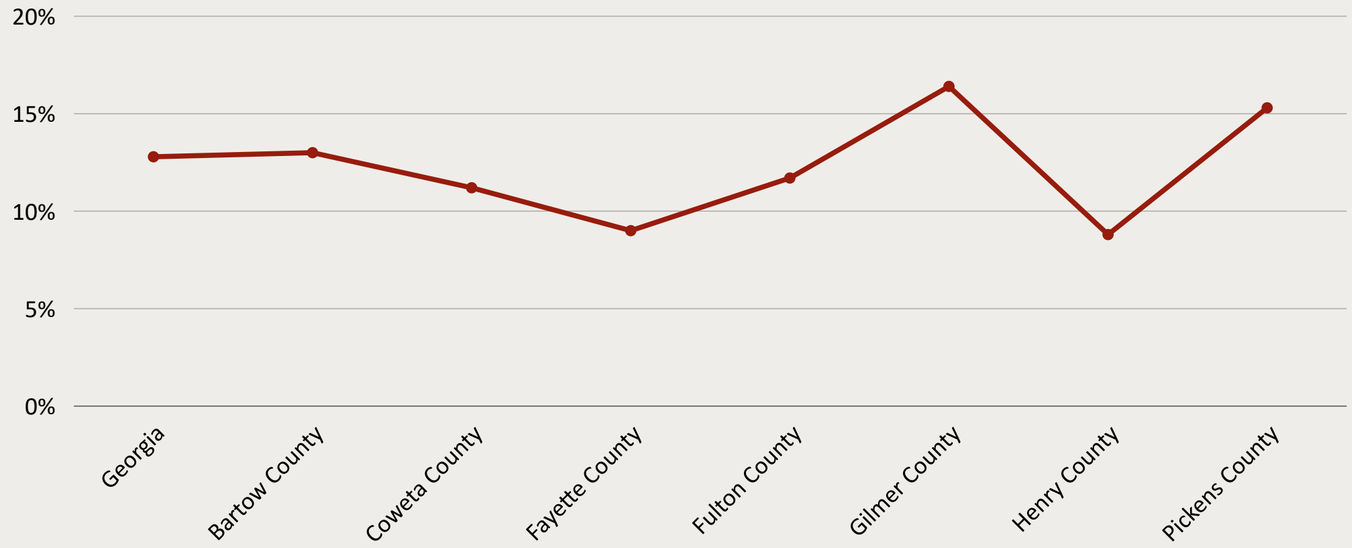


Source: US Dept. of Housing and Urban Development, 2019-2023.

Food insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen 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, Coweta County, 2022



Source: *Feeding America, 2022.*

When looking only at children, that rate jumps to 12% of all children within Coweta County.

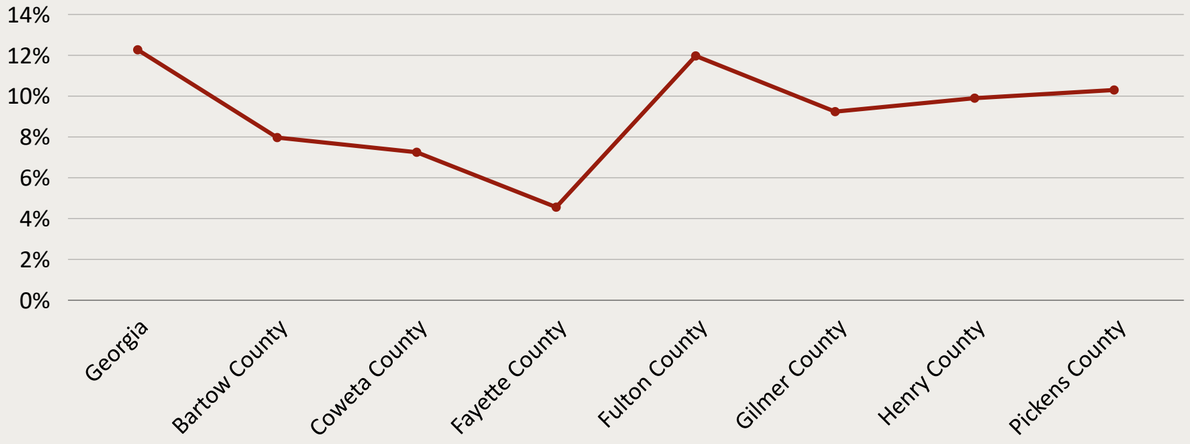
Of those children, 30% are ineligible for SNAP assistance due to income restrictions.

Both figures have dipped over the years, though most communities saw a spike in food insecurity in 2022.

SNAP benefits

In Coweta County, an estimate of 4,000 or 7.3% households receive Supplemental Nutrition Assistance Program (SNAP) benefits. The value for the report area is less than the national average of 11.8%. This indicator is relevant because it assesses vulnerable populations which are 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.

Households receiving SNAP, Coweta County, 2019 to 2023



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

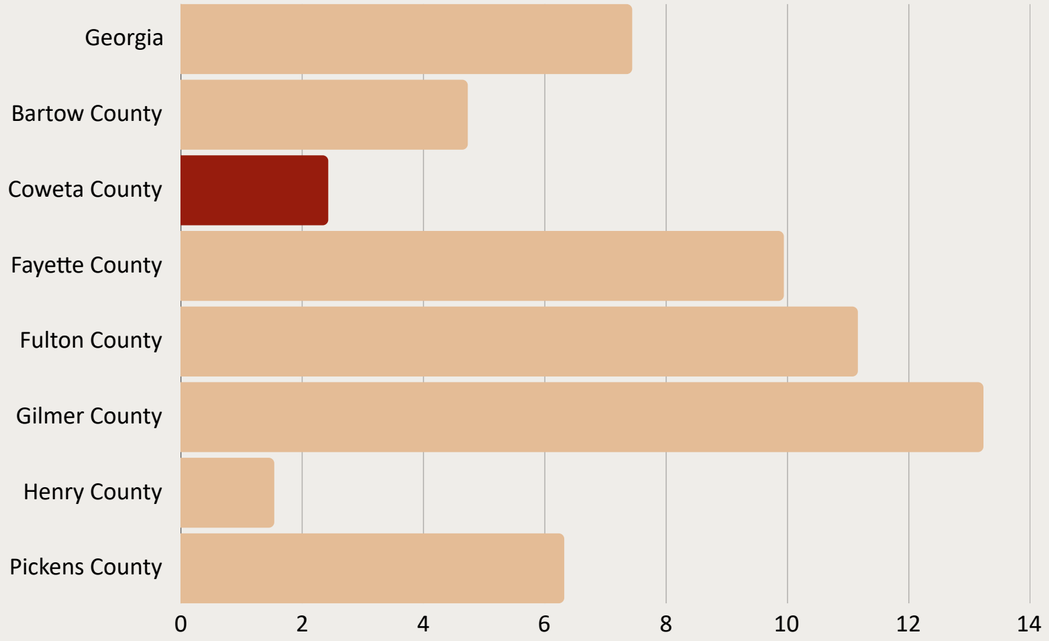
Within Coweta County, minority populations were far more likely to receive SNAP benefits than their white counterparts:

- White: 4.5%
- Black: 19.7%
- Asian: 5.3%
- America Indian or Alaska Native: 0%
- Some other race: 6.5%
- Multiple race: 5.6%
- Hispanic or Latino: 5.9%

Head Start programming

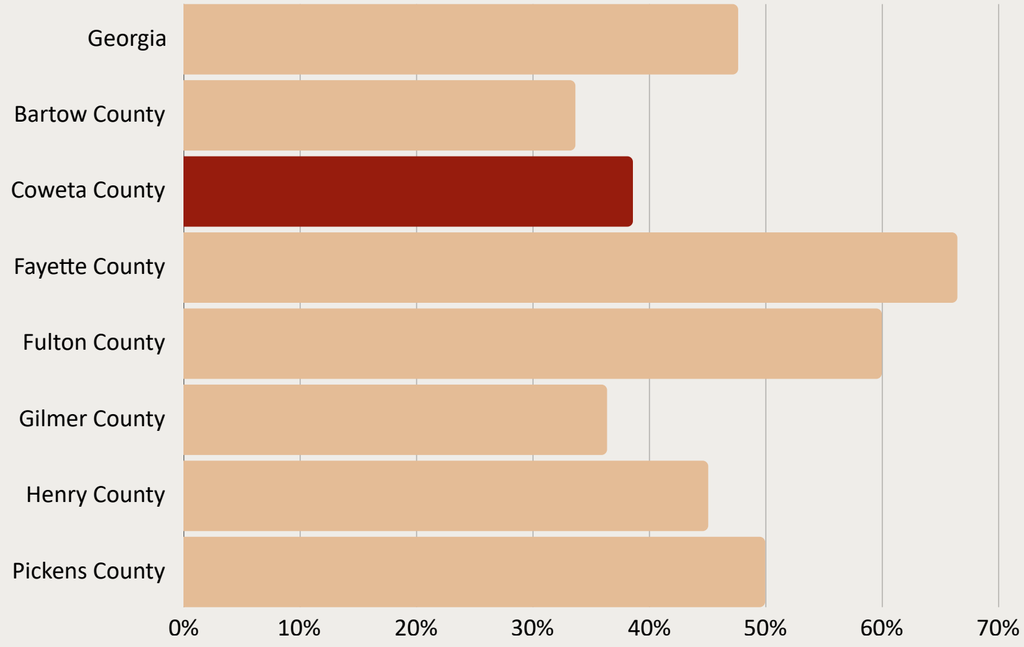
Head Start is a program designed to help children from birth to age five who come from families at or below poverty level. The program's goal is to help children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. This indicator reports the number and rate of Head Start program facilities per 10,000 children under age 5.

Head Start programs per 10,000 children under age 5, Coweta County, 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, Coweta County, 2019 to 2023

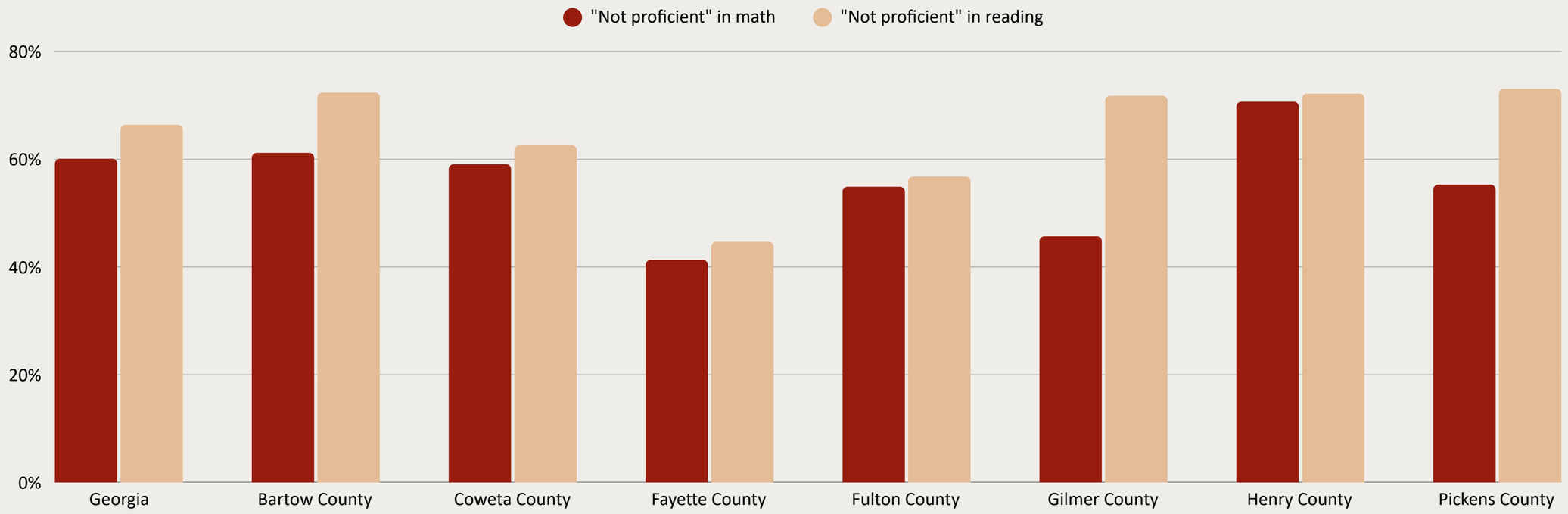


Source: US Census Bureau, American Community Survey, 2019-2023.

Math and reading proficiency

Math and reading proficiency scores measure the percentage of 4th-grade students who meet or exceed established standards in reading and mathematics. By 4th 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 true for math. In Coweta County, only 41% of students score ‘proficient’ or better on the math assessments, and 37% on the reading assessments.

Student 4th grade math and reading proficiency with a score of “Not Proficient,” Coweta County, 2020 to 2021

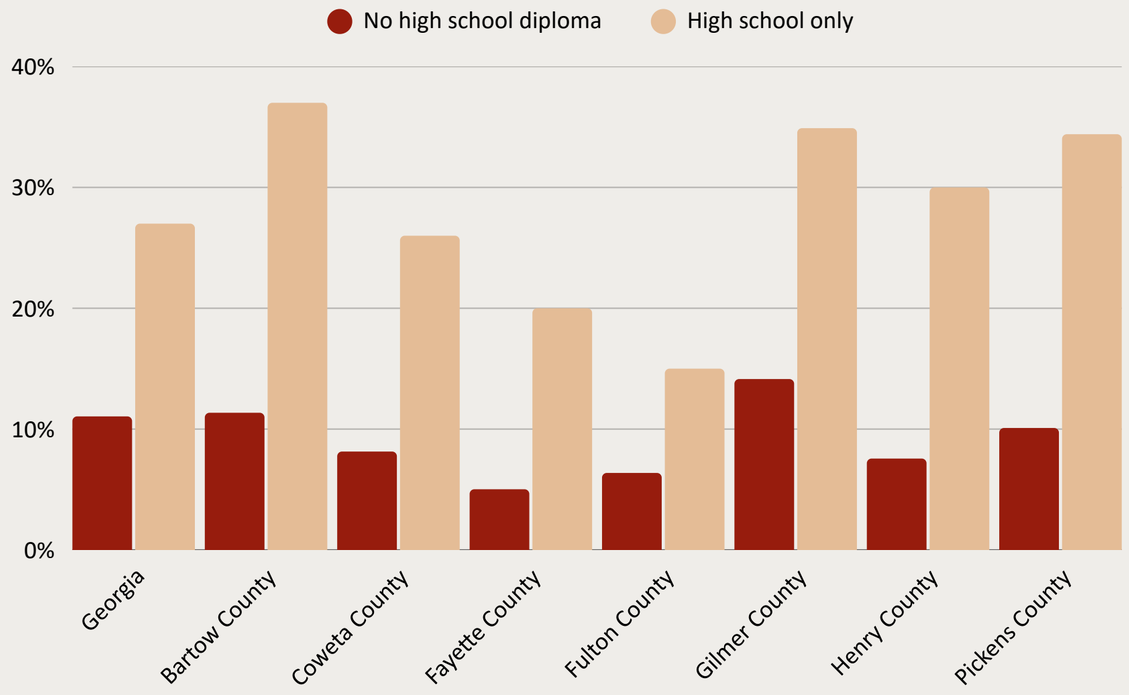


Source: US Department of Education, EDFacts. Additional data analysis by CARES, 2020-21.

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 below reflects adults 25 and older.

High school diploma attainment, Coweta County, 2019 to 2023

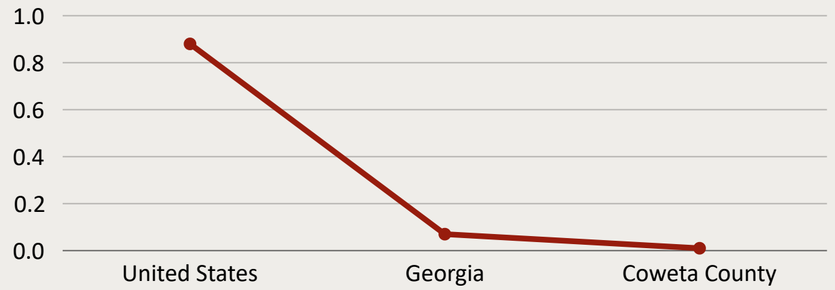


Source: US Census Bureau, American Community Survey, 2019-2023.

In the 2022 to 2023 school year, **Coweta County students were chronically absent at a rate lower than the state average**—23% of students missed 10% or more of classes, compared to the state rate of 25.5% of students. There was a higher absenteeism rate among Black and Hispanic/Latino students than their White counterparts.

Students also reported lower rates of bullying than the state average, with two reported incidents.

School bullying, Coweta County, 2020-2021 school year

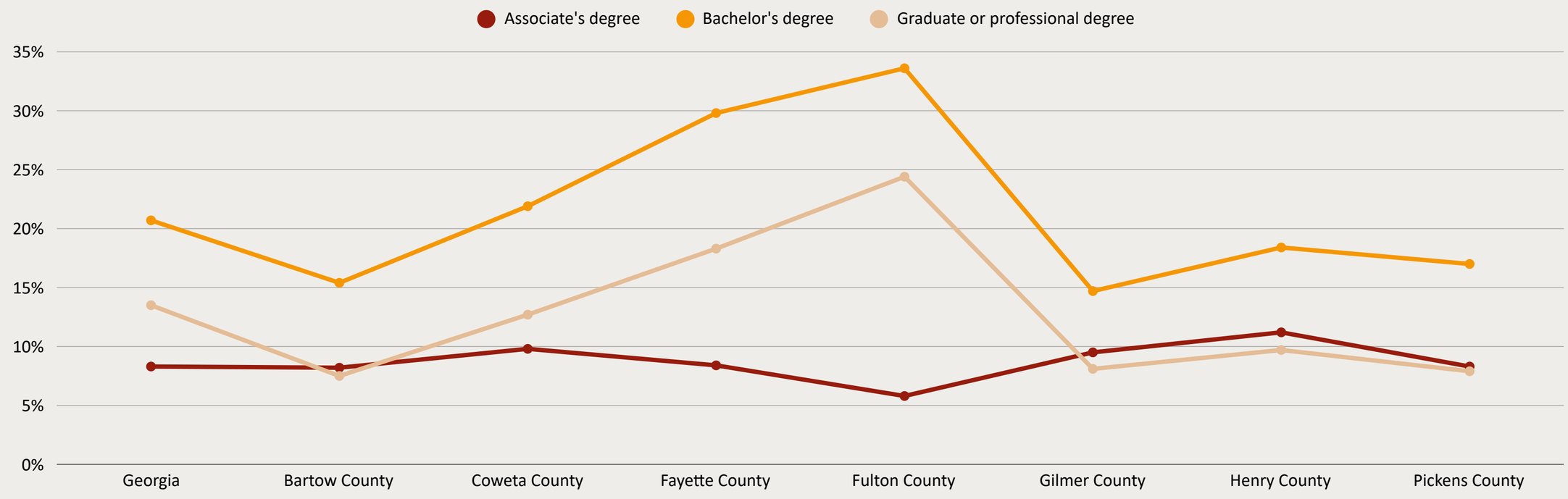


Source: U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2020-2021.

Attainment overview

Educational attainment shows the distribution of the highest level of education achieved in the report area, 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, Coweta County, 2019 to 2023

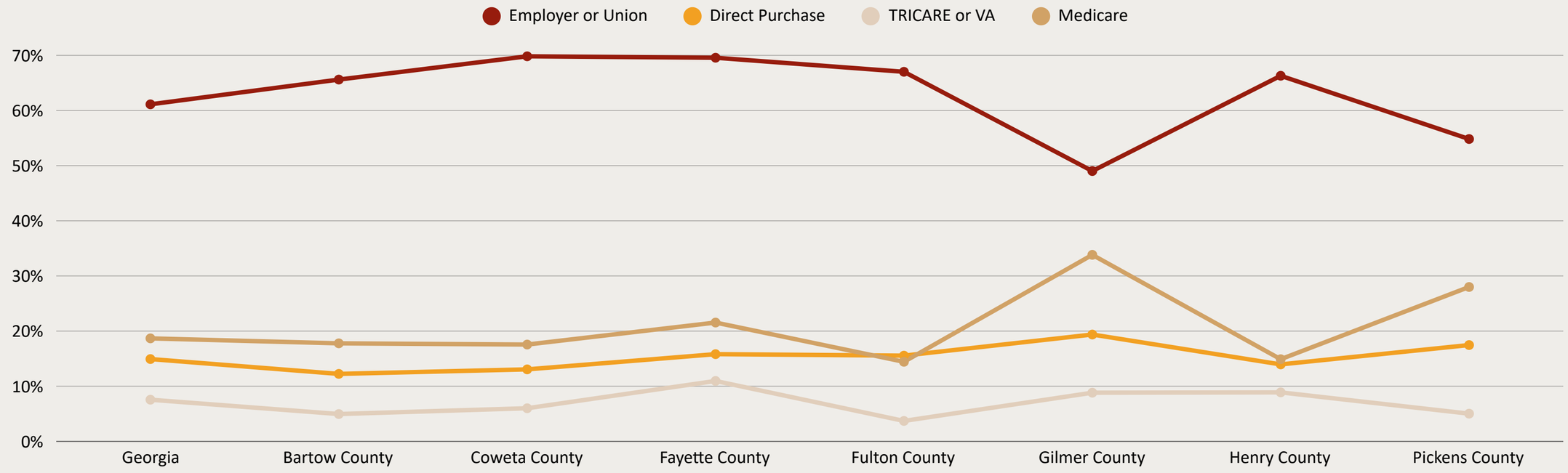


Source: US Census Bureau, American Community Survey, 2019-23.

Access to care: Insurance overview

In Coweta County, approximately 221,000 community members have some form of health insurance coverage. Of those, 80% have private insurance and 32% have public health insurance, including those with Medicare who also has an Advantage plan. 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, Coweta County, 2019 to 2023

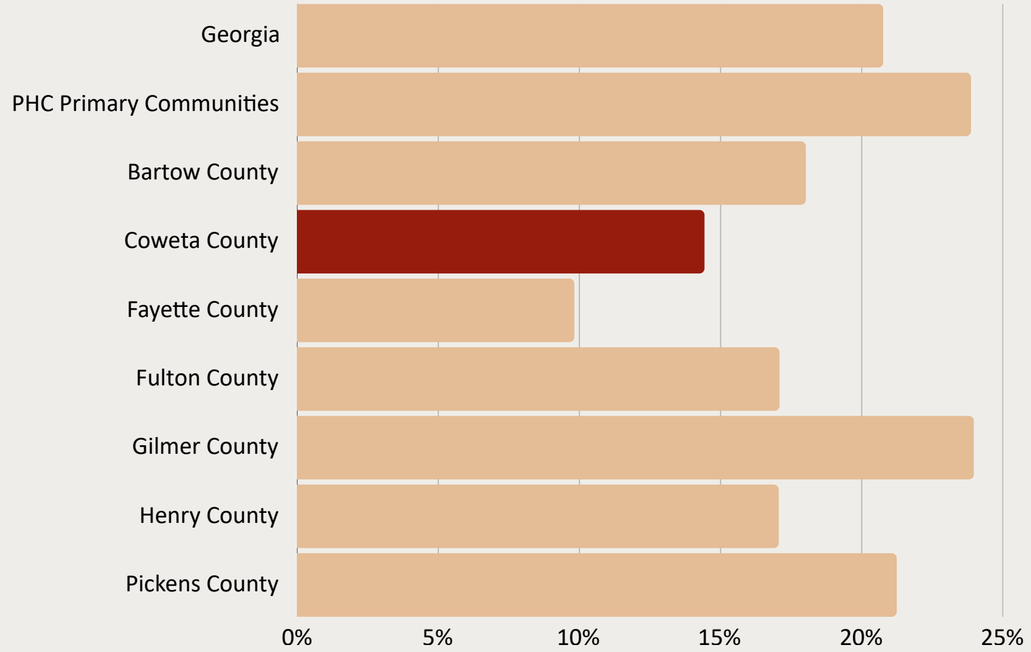


Source: US Census Bureau, American Community Survey, 2019-2023.

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. Georgia has one of the more restrictive programs in the country, and often community-based providers will limit the number of Medicaid patients they serve.

Percent of population covered through Medicaid, Coweta County, 2019 to 2023



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

In Georgia, Medicaid eligibility is generally for people with low income who fit into specific categories, such as:

- Pregnant women
- Children and teenagers under 19
- Adults aged 65 or older
- Individuals who are legally blind
- Individuals with disabilities
- Those requiring nursing home care
- Individuals with breast or cervical cancer

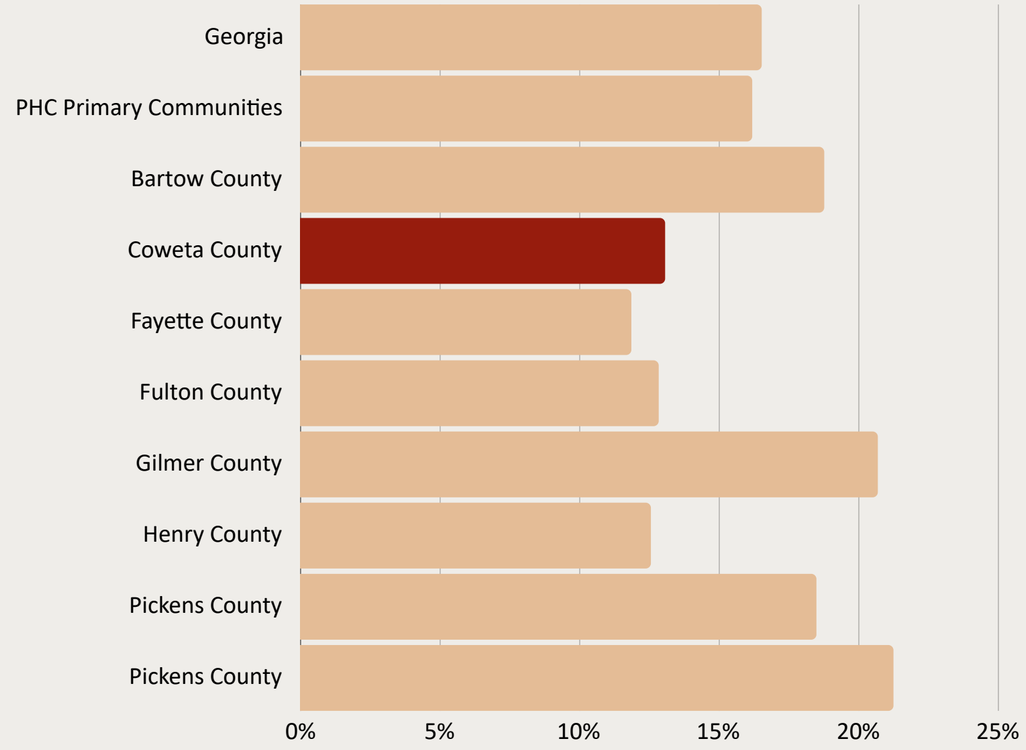
Georgia has not fully expanded Medicaid under the Affordable Care Act (ACA), but offers the Georgia Pathways to Coverage program as a partial expansion for some low-income adults.

Medicaid is a primary source of health coverage for many individuals who might otherwise be uninsured or face significant financial barriers to accessing healthcare. This increased coverage is linked to improved access to care, including preventive services, and reductions in delayed or forgone care due to cost.

Uninsured populations

Insurance status is a key indicator of health and those without insurance are far more likely to suffer adverse health events than their insured counterparts.

Percent of adults aged 18+ without any health insurance, Coweta County, 2022



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

Uninsured individuals often face significant health disparities due to limited or no access to healthcare services. This lack of access can lead to delayed or forgone care, resulting in poorer health outcomes and increased mortality rates, particularly for certain racial and ethnic groups.

Limited access to care: Uninsured individuals are more likely to postpone or forgo necessary medical care due to cost concerns, leading to delayed diagnoses and treatments.

Poorer health outcomes: This lack of access can result in more frequent hospitalizations, emergency room visits, and higher mortality rates, especially for preventable or manageable conditions.

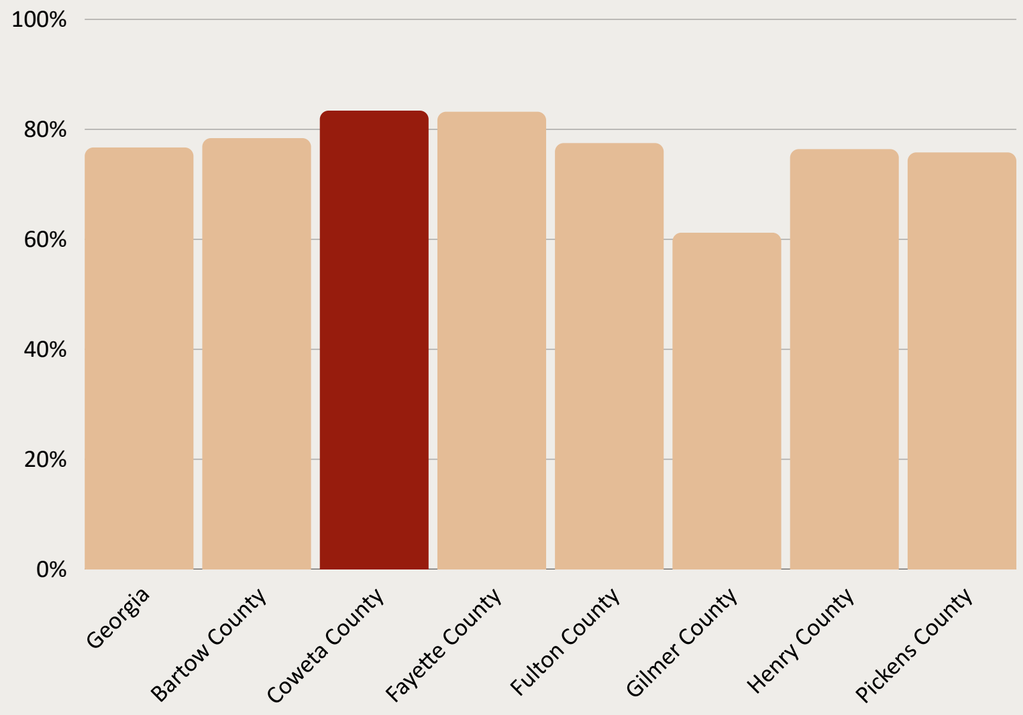
Racial and ethnic disparities: Certain racial and ethnic groups, such as Black, Hispanic, and American Indian/Alaska Native individuals, experience higher uninsured rates and worse health outcomes, exacerbating existing health disparities.

Cost burden: Uninsured individuals often face high out-of-pocket medical expenses, leading to financial hardship and further limiting their ability to access care.

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, Coweta County, 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.

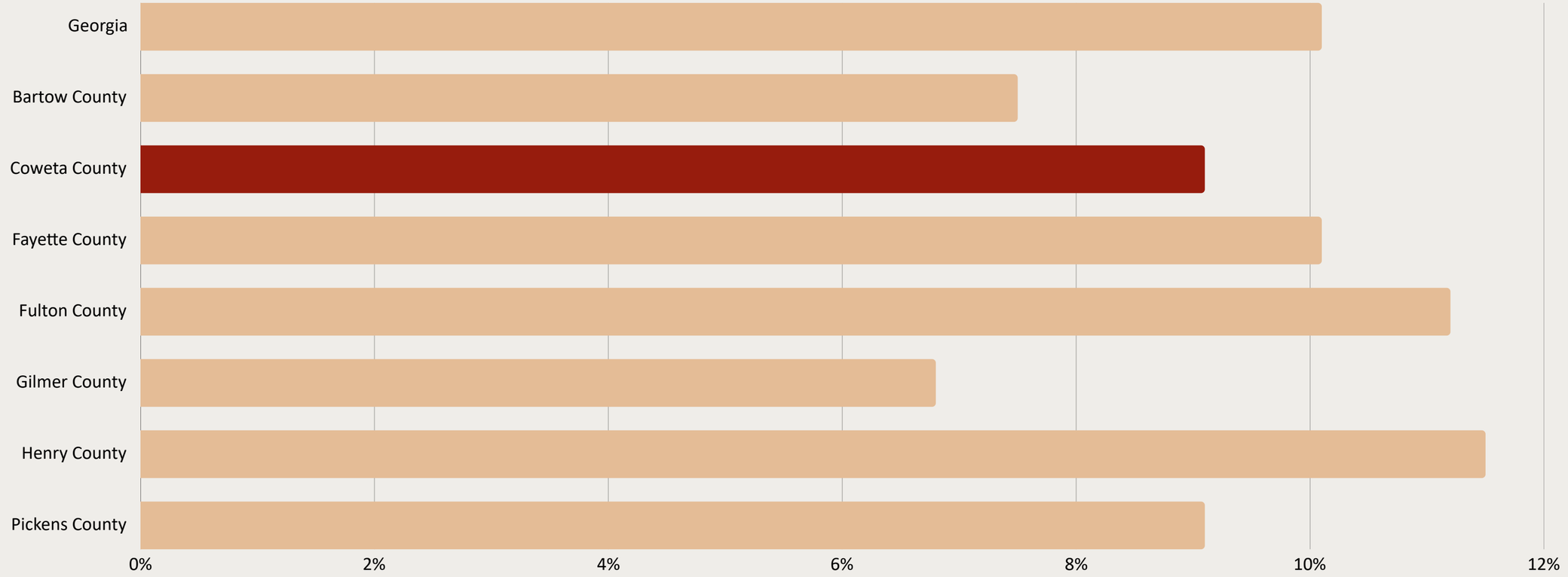
Late or no prenatal care: A higher percentage of Black, American Indian, and Native Hawaiian and Pacific Islander women receive late or no prenatal care, which increases the risk of adverse pregnancy outcomes.

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. Below are several key indicators for infant mortality and low birth weight babies. 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 with infant mortality and low birth rates.

Percentage of low birth weight babies, Coweta County, 2016-2022



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

Screenings

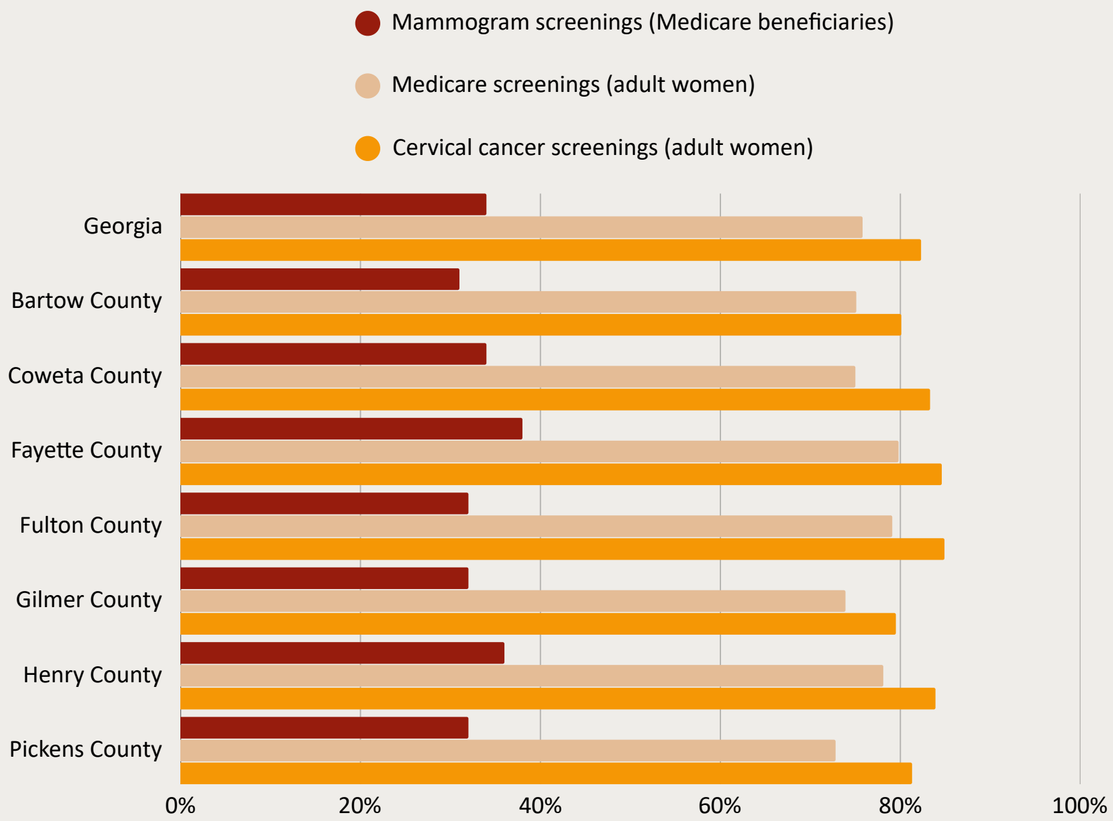
Health screenings are crucial in maintaining and improving overall health and well-being. Here are the key reasons why health screenings are essential:

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, Coweta County, 2022



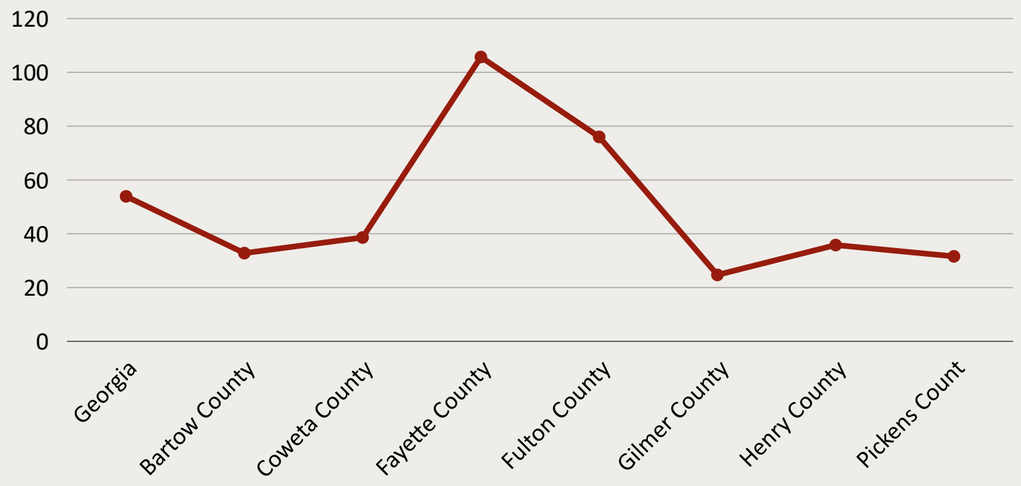
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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 43 dentists for every 100,000 people within Coweta County, a number far less than the state rate of 54 dentists for every 100,000 people and the Atlanta hub average of 65 dentists for every 100,000 people.

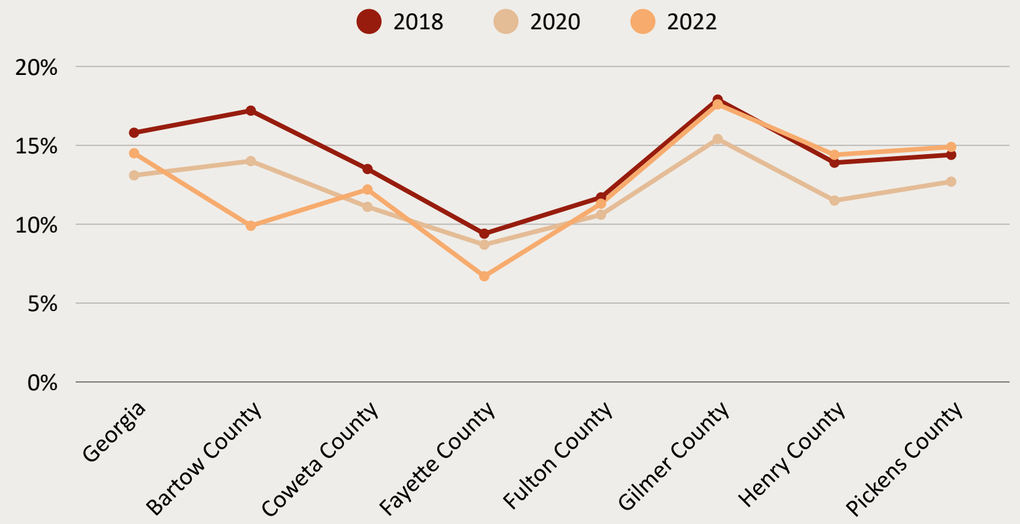
Rate of dentists per every 100,000 people, Coweta County, 2022



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

In 2022, approximately 10% of Coweta County aged 65 and older reported having lost most of all or their natural teeth. This figure is lower than the state average of 15%. This figures has generally decreased over the years.

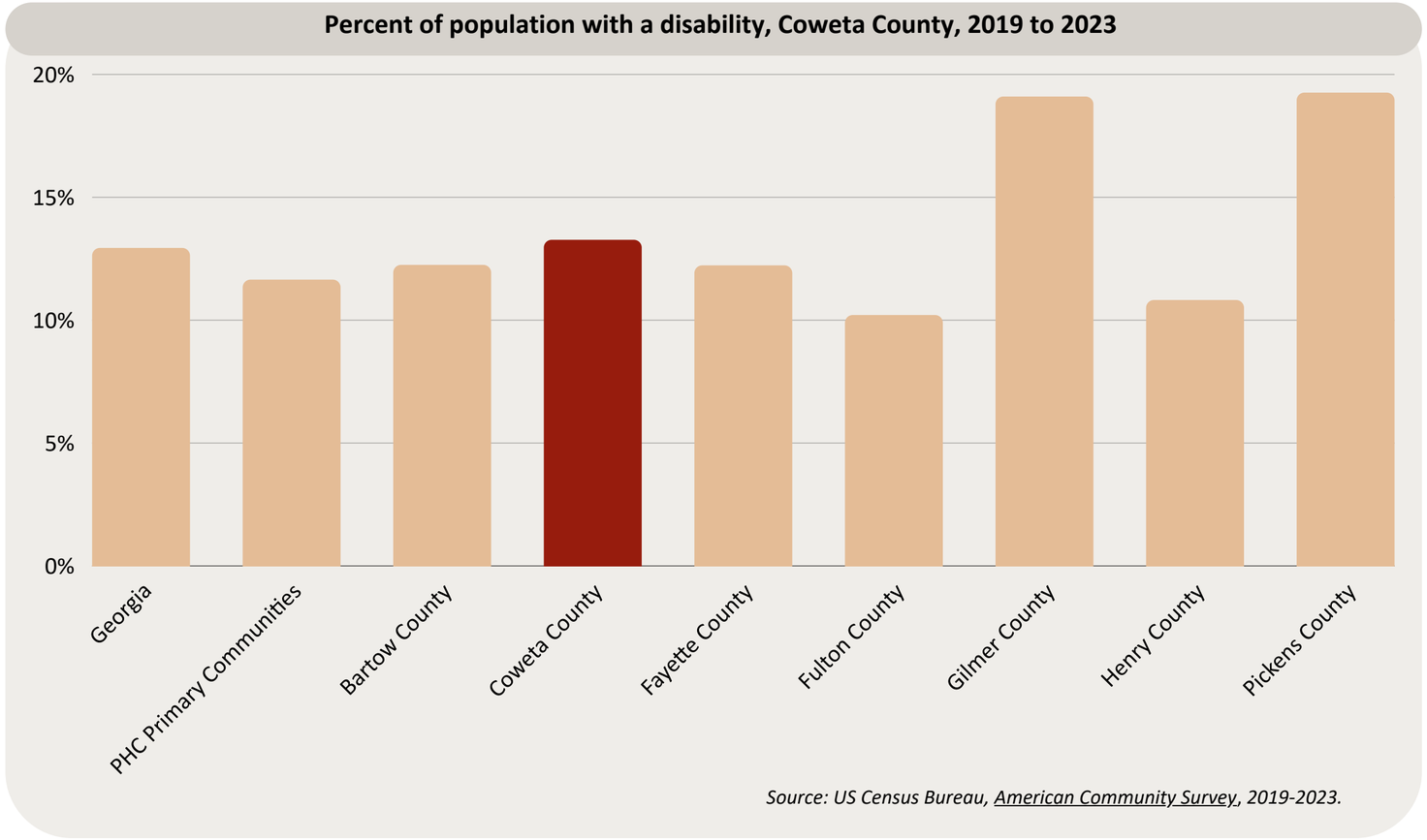
Percent of people having lost most or all natural teeth, Coweta County, 2018-2022



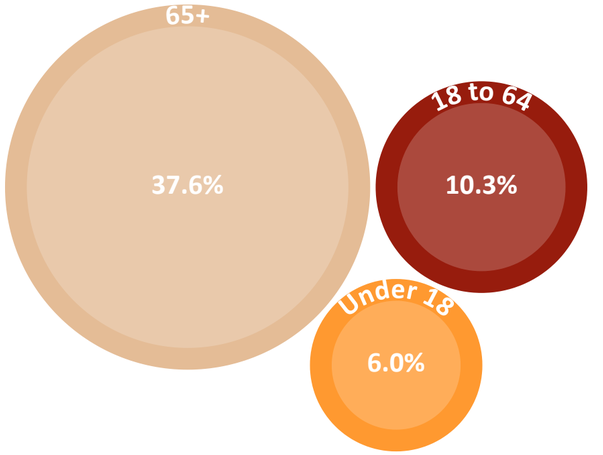
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Disability

Of the total population for which disability status has been determined, about 13 percent have some form of disability, according to the US Census Bureau's American Community Survey, 2019 to 2023.



- **Men and women in Coweta County experience a disability at nearly the same rate:** 13.3% for men and 13.1% for women.
- **The age group with the highest percentages of disabled populations are those 65 and older.** The differences in age breakdown as a percentage of the total population can be seen below.



Chronic conditions and those with disabilities

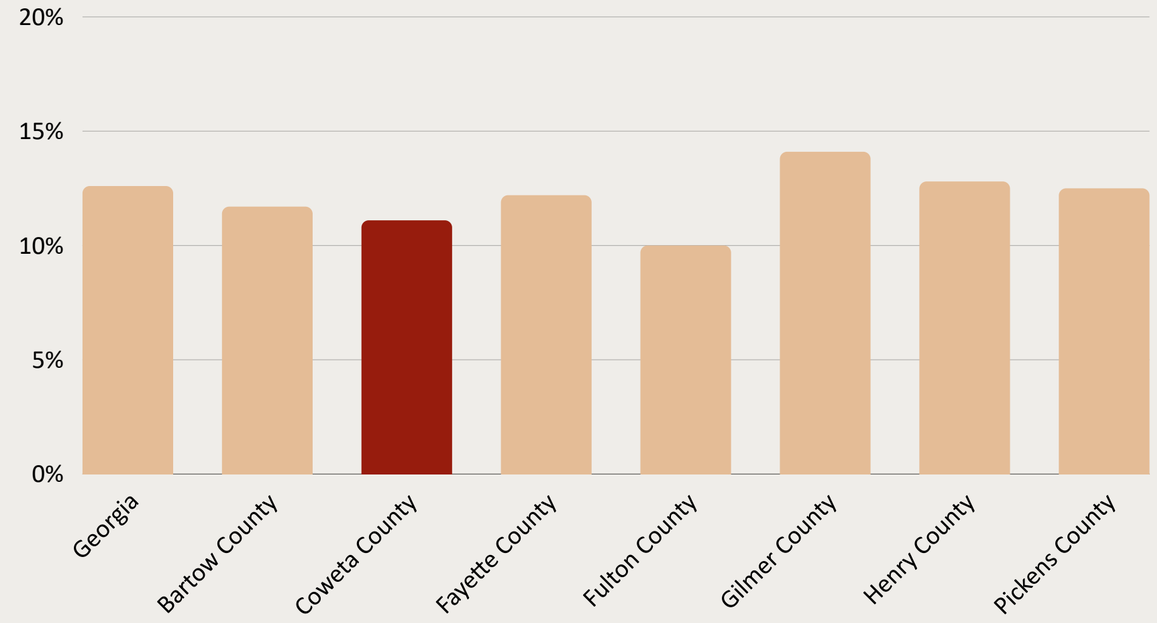
Between 2018 and 2022, the last year for which data is available, we saw the following trends in chronic conditions among those living with a disability:

- **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, though it is steadily increasing among the non-disabled population.
- **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 identify community health trends and target resources effectively.

Percentage of adults with diabetes, Coweta County, 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 the two counties, in 2022, **about 3.1% of the population had kidney disease, which was below the Georgia average of 3.3%.**

Asthma and COPD

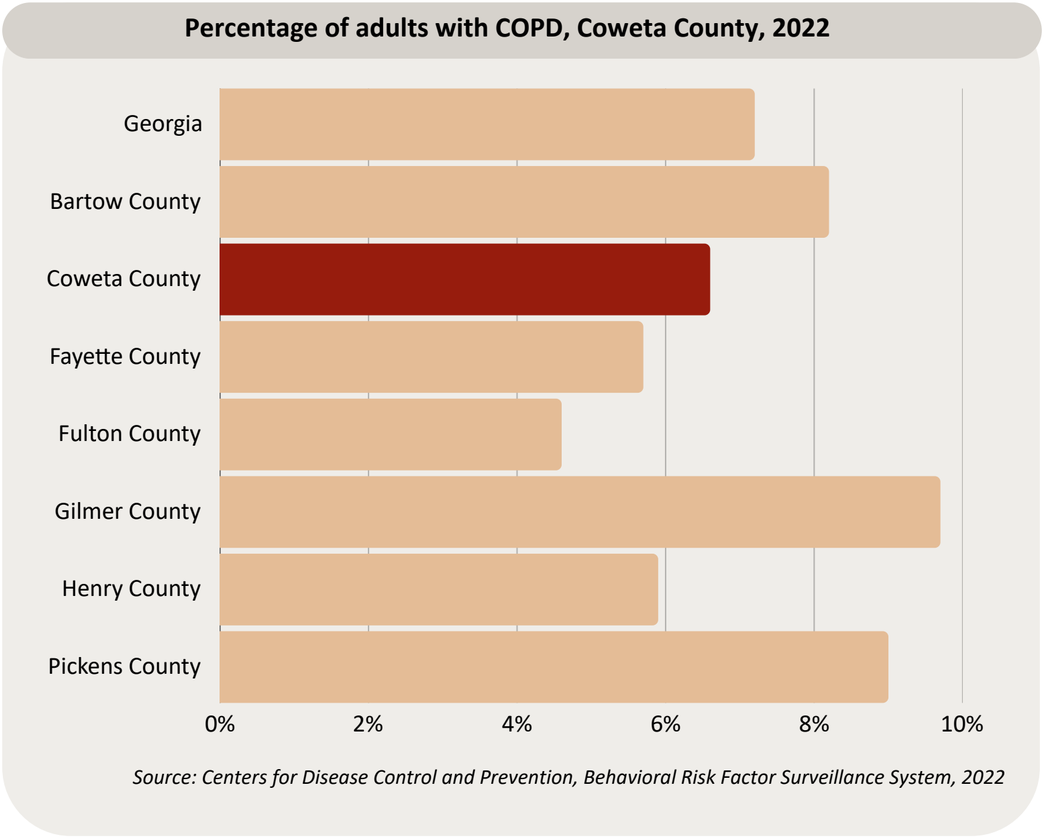
Though they both cause problems with breathing, asthma and COPD are not the same.

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 significantly. COPD is also often a leading cause of death.

Managing COPD is crucial because it helps improve quality of life, reduces the risk of complications, and can slow disease progression. Proper management can significantly impact a patient's ability to function in daily life, minimize hospitalizations, and potentially increase their lifespan.

Among adults 18 and older, **about 6.6% had chronic obstructive pulmonary disease (COPD) in 2022 in the county,** which is below the state average of 7.2% and above the hub average of 5.4%

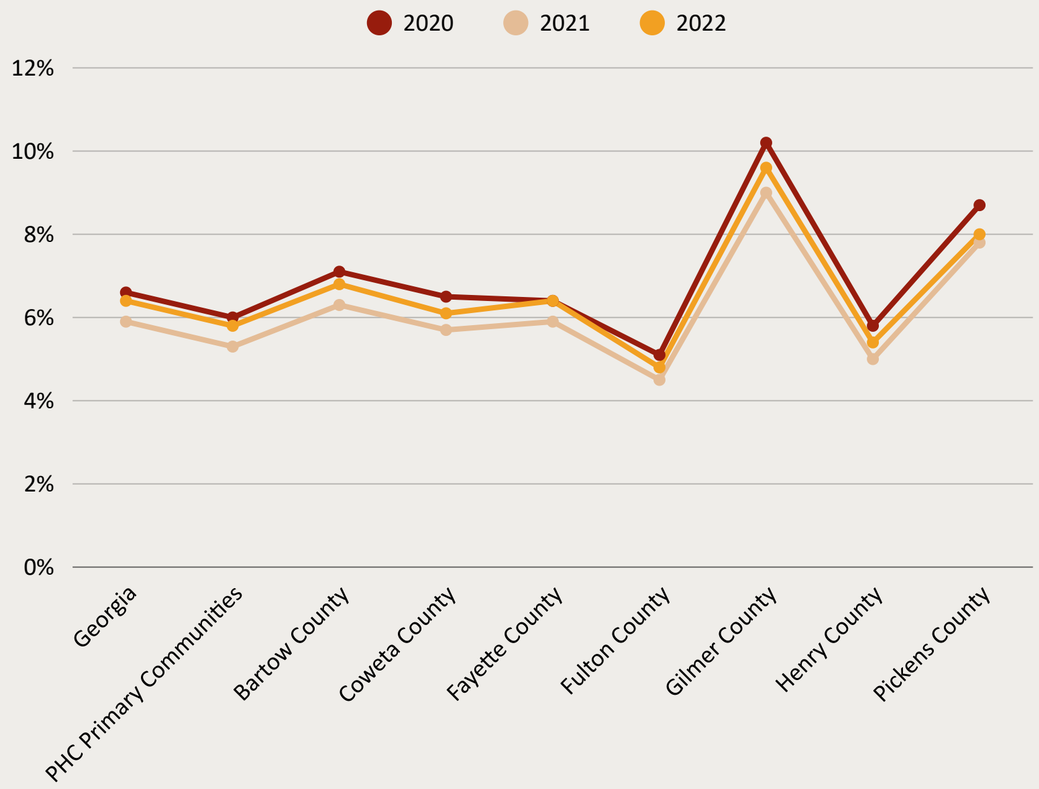
About 9.9% of adults had asthma in 2022 in the county, below both state and national averages.



Heart disease and hypertension

Heart disease remains one of the top challenges within the community and can lead to serious health outcomes, including heart failure, heart attack, stroke, and sudden cardiac arrest, impacting quality of life and potentially leading to disability or death.

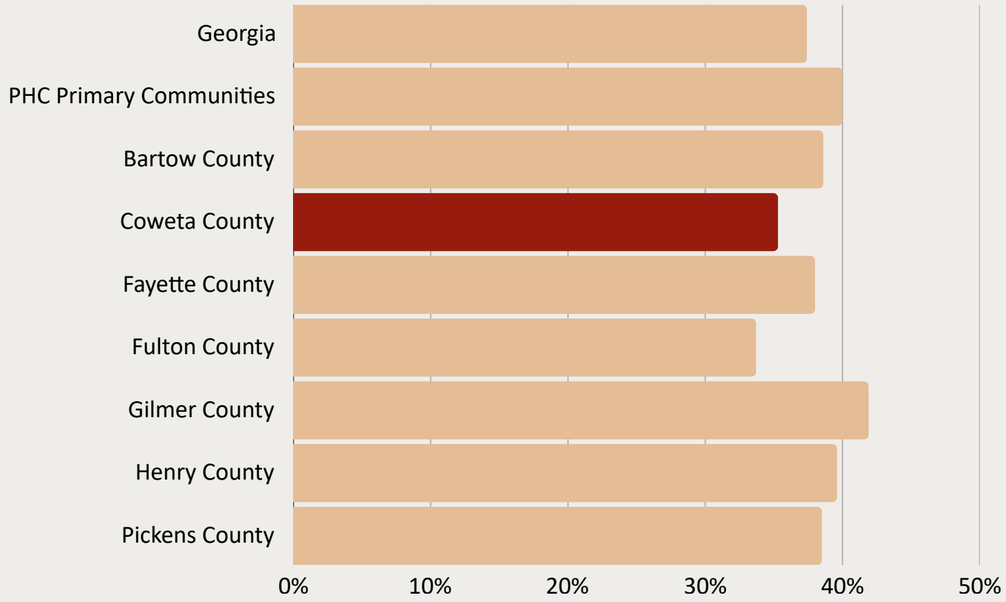
Heart disease prevalence, Coweta County, 2018 to 2022



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

High blood pressure, also known as hypertension, is a condition where the force of blood pushing against the artery walls is consistently too high. This can lead to various health problems if left untreated, as it puts extra strain on the heart and blood vessels.

Percentage of adults with high blood pressure, Coweta County, 2021

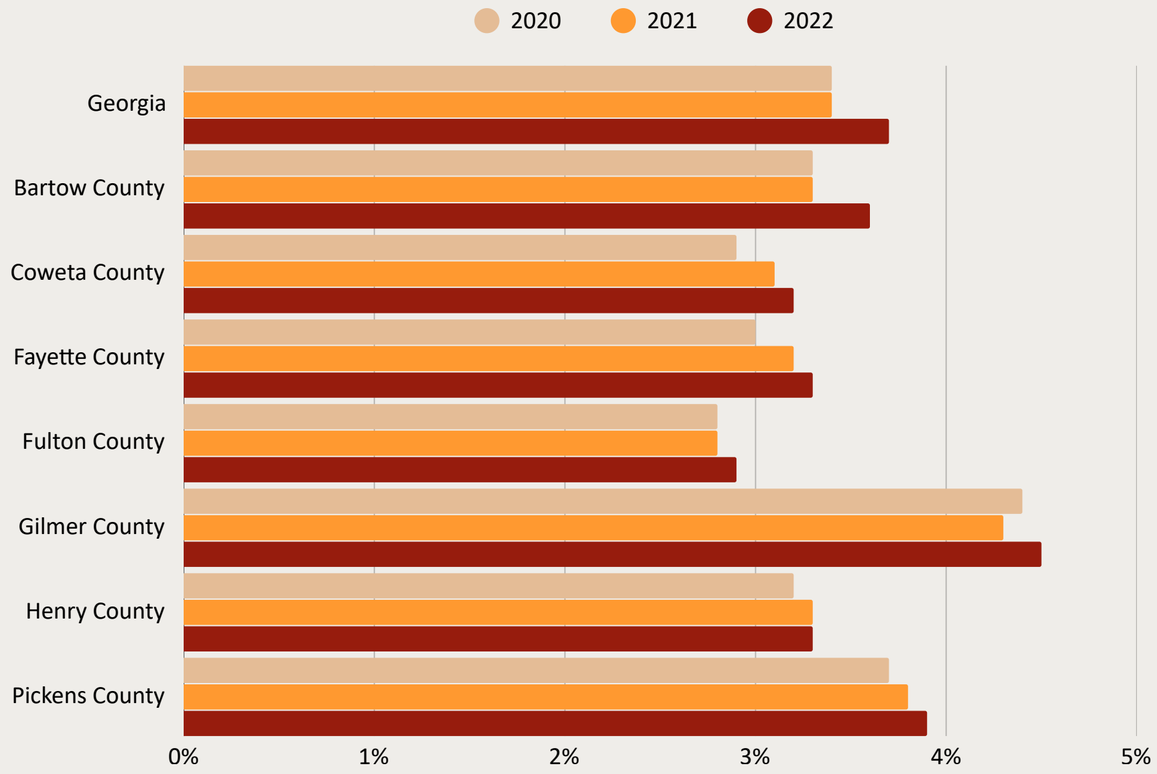


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Stroke

A stroke, also known as a cerebrovascular accident (CVA), occurs when blood flow to the brain is interrupted, causing brain cells to die. This is either caused by a blockage or rupture of a blood vessel within the brain.

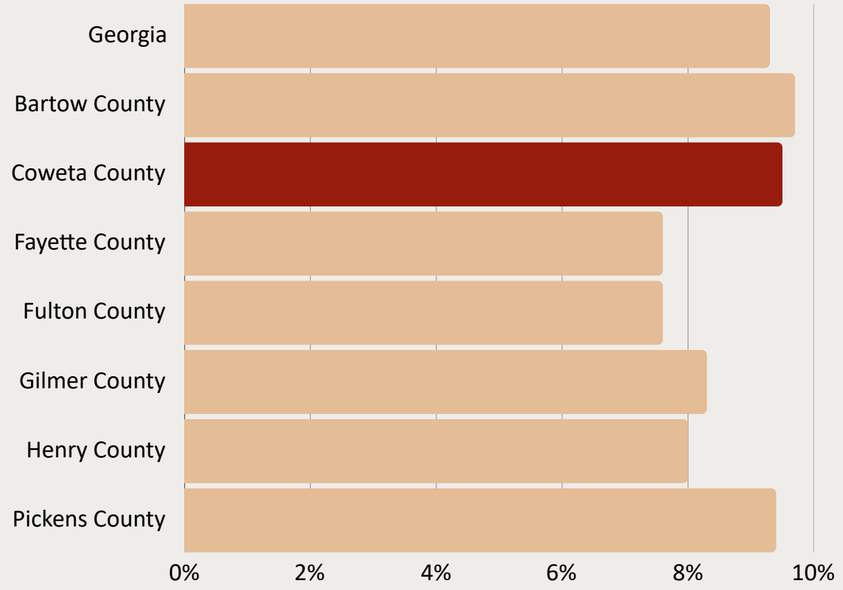
Stroke prevalence among adults age 18+, Coweta County, 2020 to 2022



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

The chart below reports the hospitalization rate for Ischemic stroke among Medicare beneficiaries age 65 and older for hospital stays occurring between 2018 and 2021.

Hospitalizations due to stroke, Coweta County, 2018-2021

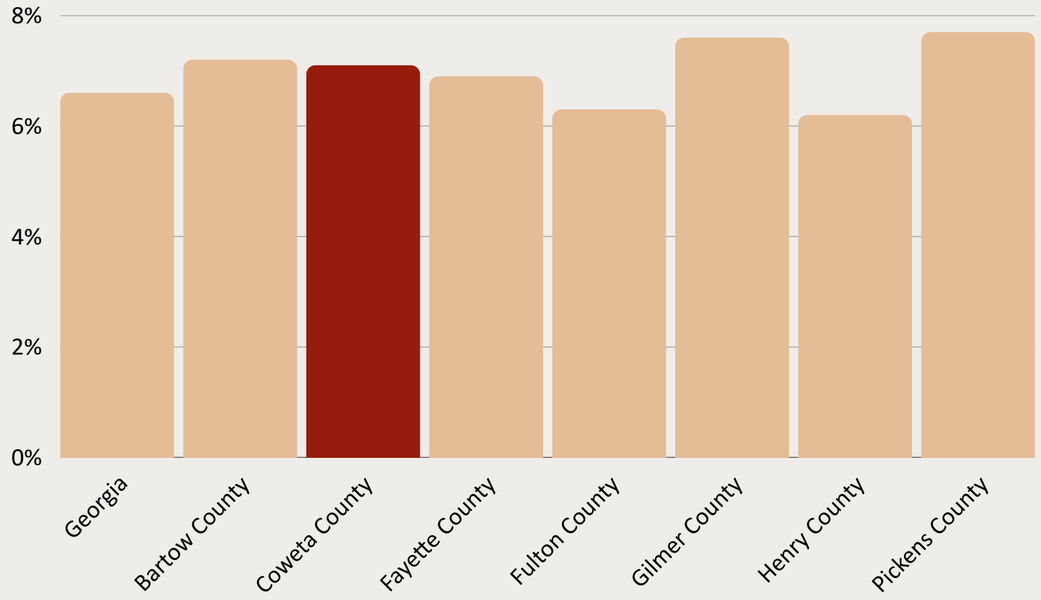


Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2018-2021.

Cancer prevalence

Cancer remains a top killer within our communities, and cancer incidence rates within the PHC community often rank below state and national averages.

Cancer prevalence rates among adults 18+, per 100,000 people, Coweta County, 2022



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

Social determinants of health (SDOH) significantly impact cancer outcomes, influencing everything from cancer risk and prevention to diagnosis, treatment, and survivorship. These factors, which encompass social, economic, and environmental conditions, can create disparities in cancer care and outcomes, particularly for marginalized populations.

Lower income populations statistically have higher cancer incidence and mortality rates. Individuals with lower incomes may have limited access to healthy food, safe housing, and quality healthcare, and may also face higher rates of smoking and obesity, all of which increase cancer risk.

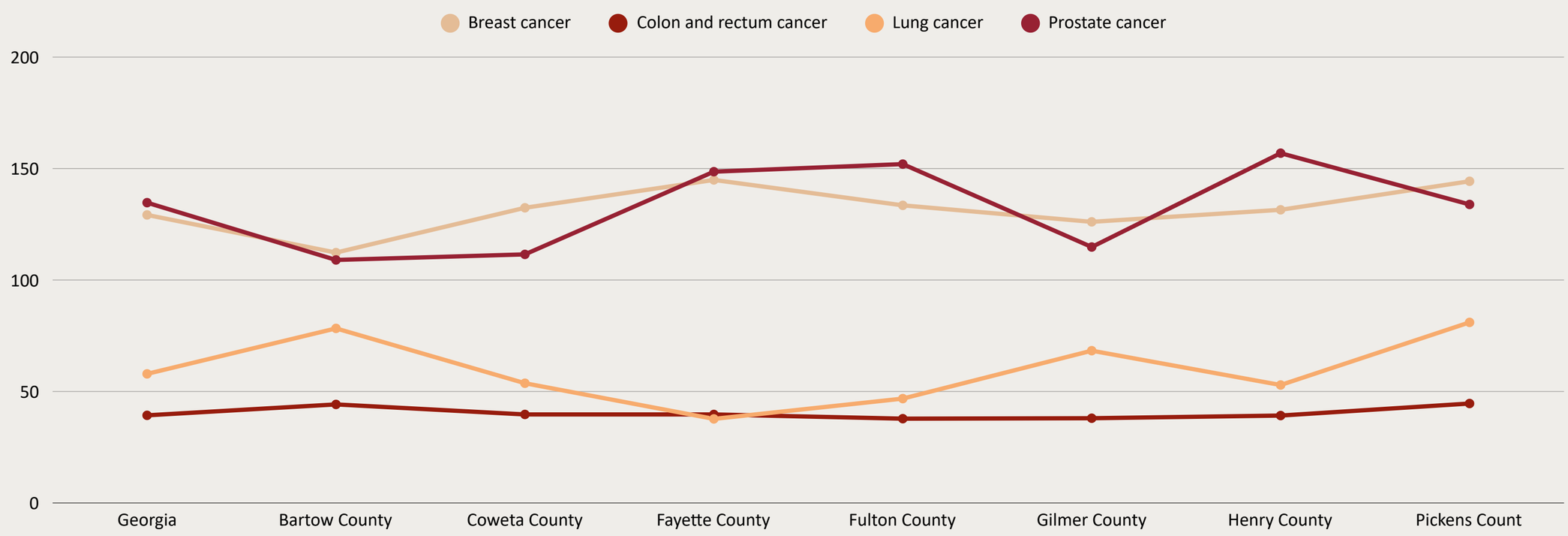
Lower levels of education are associated with higher cancer incidence and mortality rates. Education can influence health behaviors, access to healthcare, and occupational exposures, all of which can impact cancer risk and outcomes.

Racial and ethnic minorities often face disparities in cancer outcomes, with higher incidence and mortality rates compared to non-Hispanic whites. These disparities are often rooted in social determinants of health, such as poverty, lack of education, and limited access to healthcare.

Cancer incidence by site

Below are the specific incidence rates for certain cancers.

Cancer incidence rates for every 100,000 adults 18+, 2016-2020

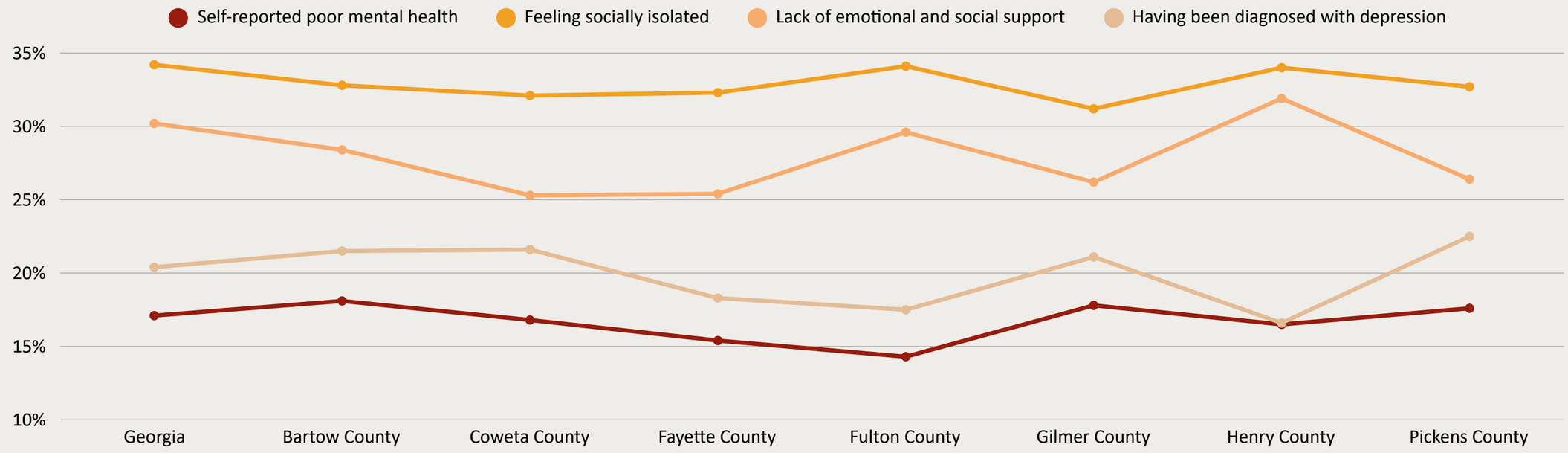


Source: State Cancer Profiles. 2016-2020.

Mental and behavioral bealth

Mental health encompasses our emotional, psychological, and social well-being, profoundly impacting how we think, feel, and behave throughout our lives. Poor mental health can significantly diminish quality of life, productivity, and overall well-being, and it often correlates with increased risk of chronic illnesses. As of December 2024, there were 98 mental health providers for every 100,000 people in the Coweta County. This is less than the state's rate of 179 providers for every 100,000 people, and below the national rate of 312.

Adults 18+ and key mental health indicators, 2022



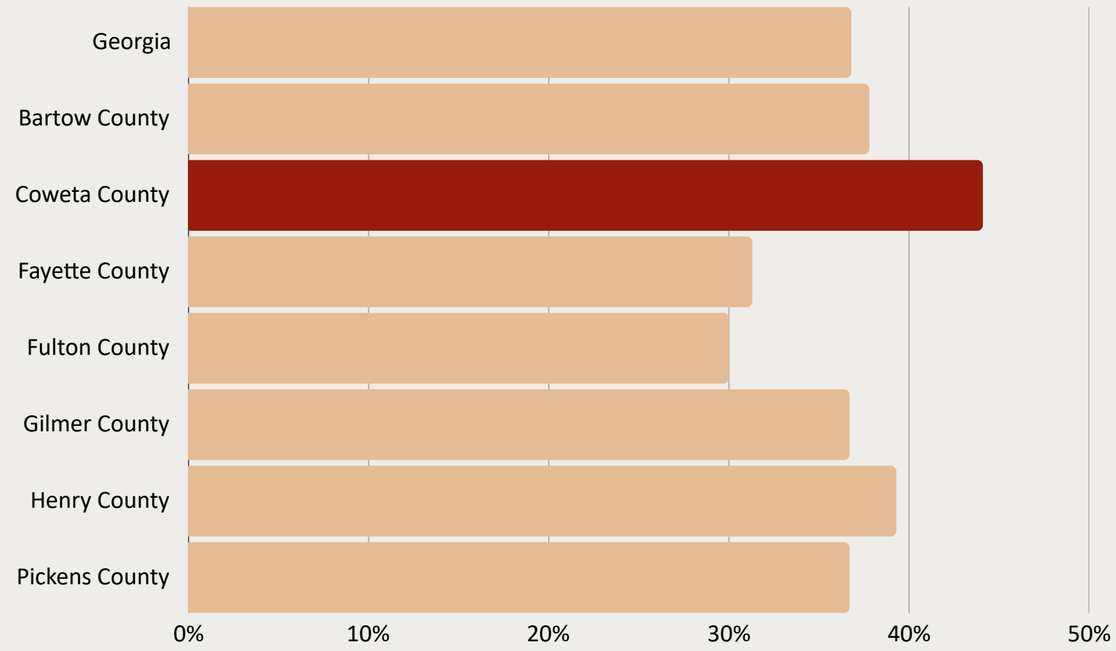
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Obesity and healthy behaviors

Health behaviors are actions individuals take that affect their health. This includes 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 below chart 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.

Adult obesity rates, Coweta County, 2022



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

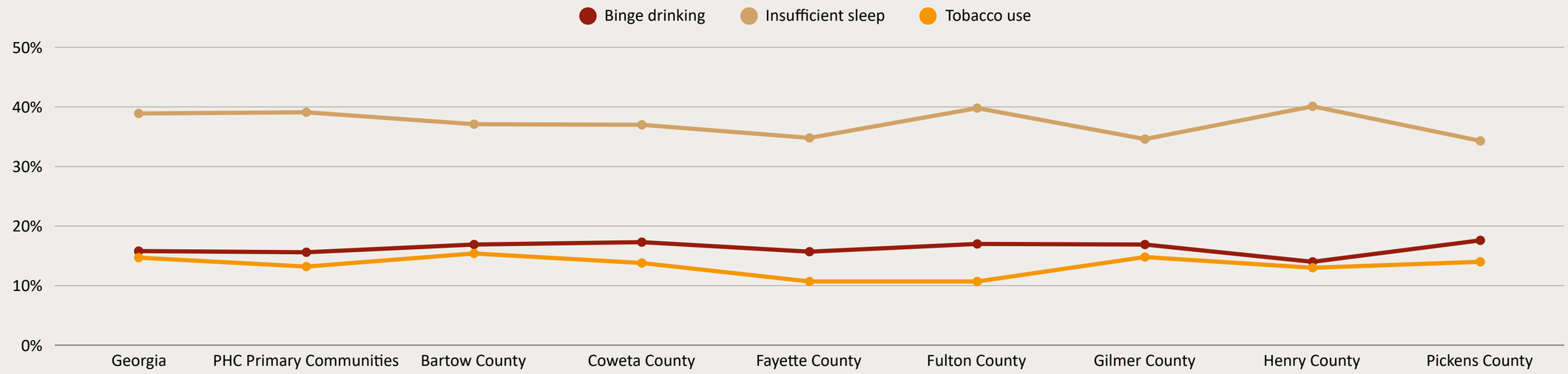
How social drivers contribute to obesity:

- 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.

Excessive drinking, insufficient sleep, and tobacco use

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 each of these behaviors. Heavy alcohol consumption and tobacco use directly contribute to chronic health conditions and preventable illnesses, while 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, Coweta County, 2022

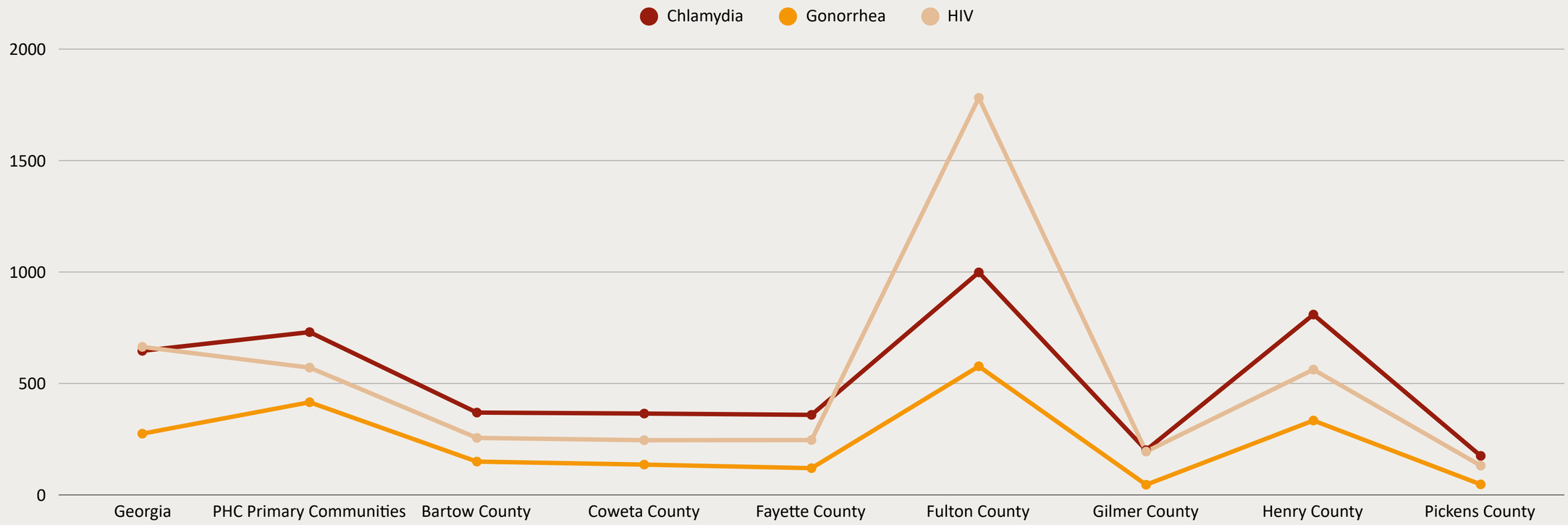


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Sexually transmitted diseases

Monitoring STDs is crucial for public health as it helps track trends, identify outbreaks, and assess the effectiveness of prevention and treatment efforts. Early detection and treatment of STDs are essential to prevent complications and transmission to others. Many STDs are asymptomatic, making regular testing and monitoring vital for identifying and managing infections before they cause significant health problems.

Rate of infection by disease, 2023



Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2023

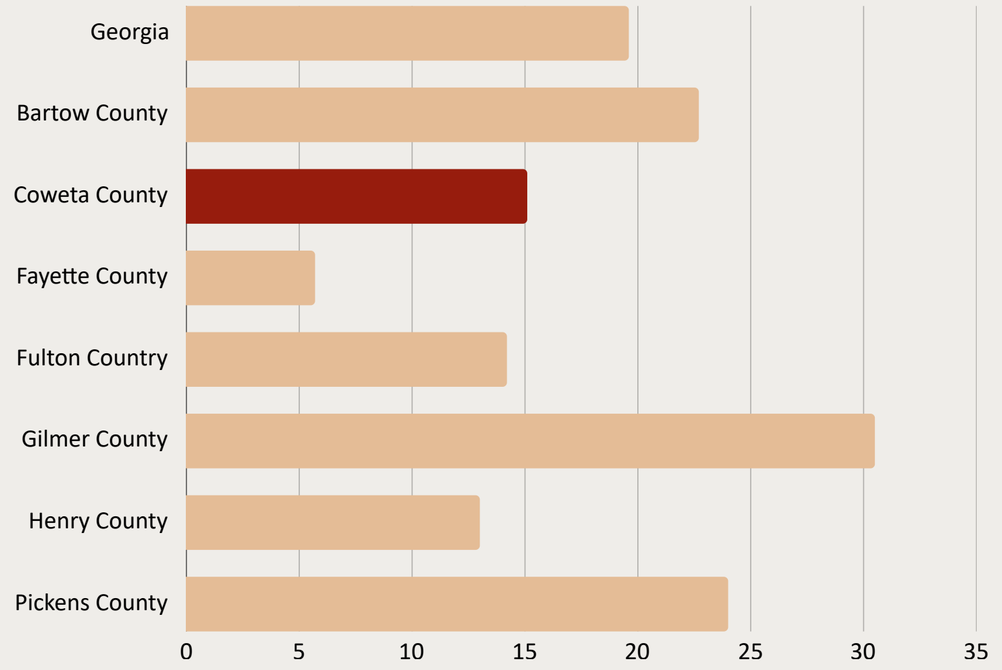
Teen births

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, Coweta County, 2016 to 2022

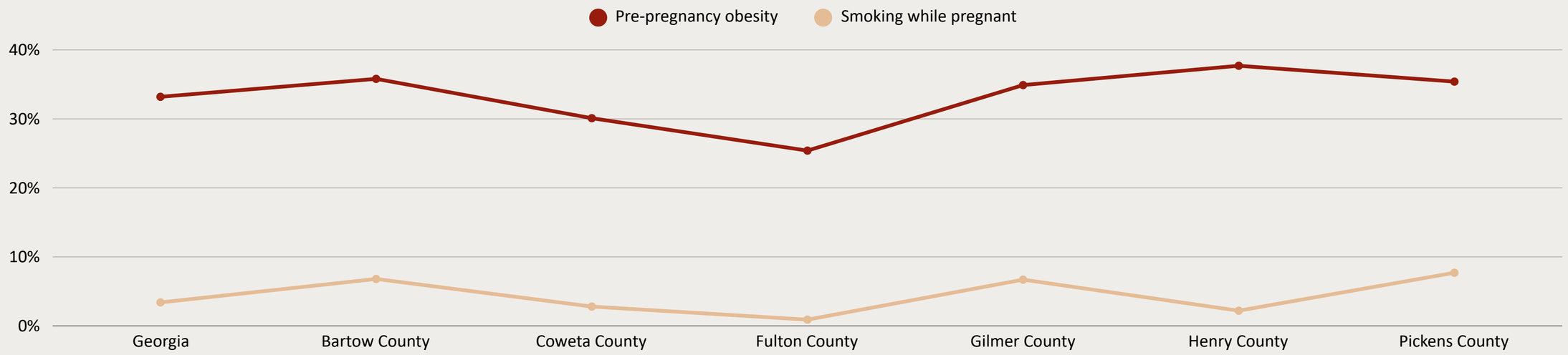


Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via County Health Rankings, 2016-2022.

Pregancy and healthy 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.

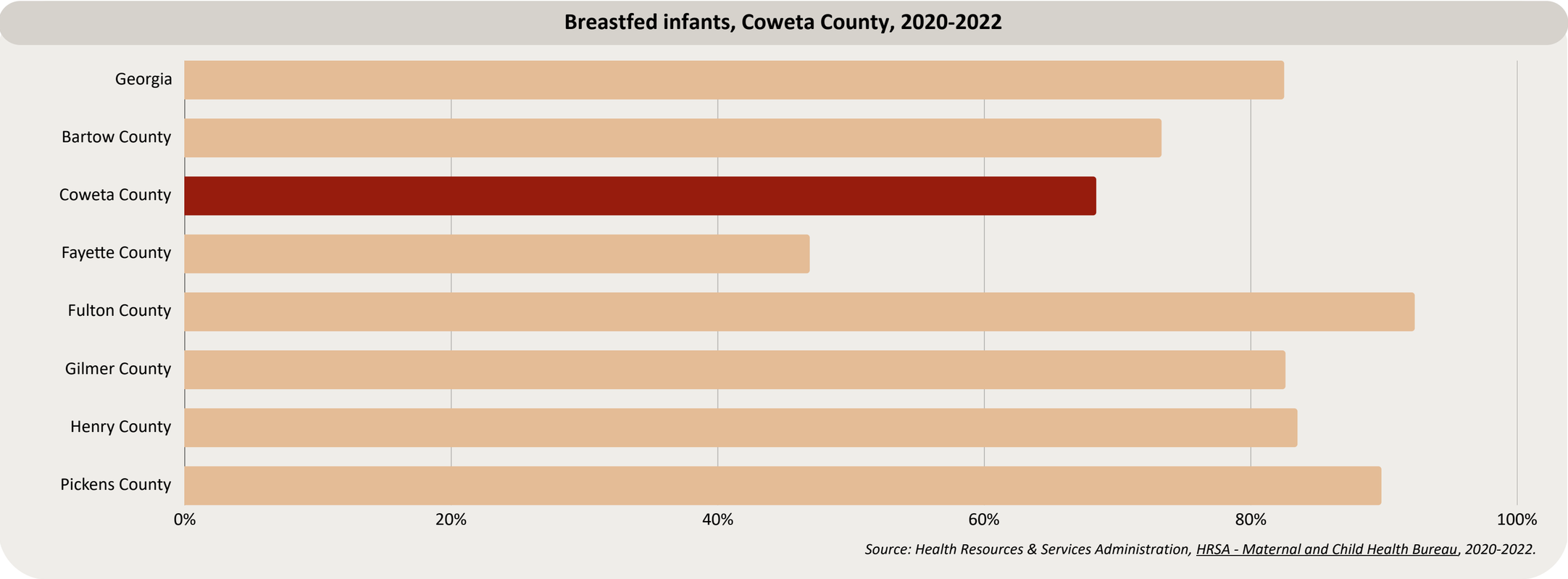
Pregnancy and behaviors, Coweta County, 2020-2022



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

Breastfeeding

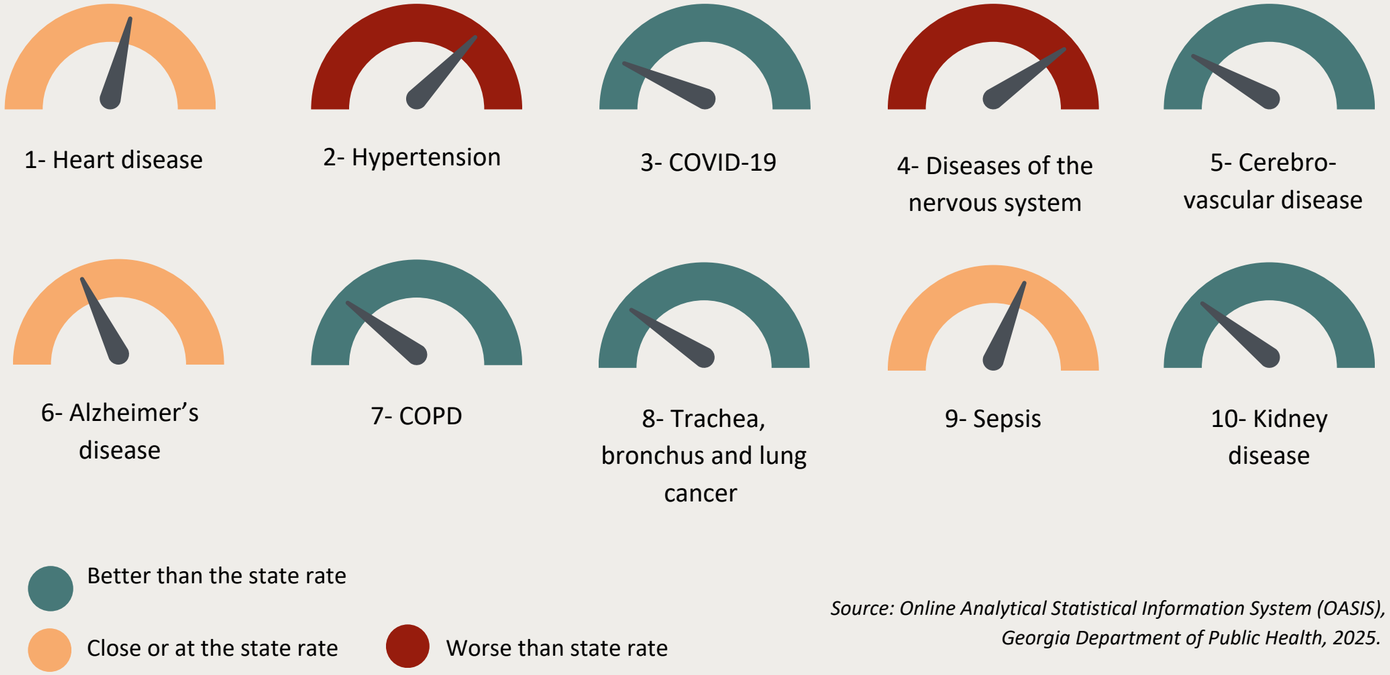
Breastfeeding is vital for babies and mothers, offering numerous health benefits, including a stronger immune system for babies, reduced risk of certain diseases, and improved maternal health outcomes. Breastfed babies have a lower risk of developing conditions like asthma, obesity, type 1 diabetes, 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.



Causes of death

Below are the ten leading causes of age-adjusted death, in total between 2019 and 2023, for Coweta 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, Coweta 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: Skin cancer
5-9: Nervous system diseases
10-14: Congenital Malformations, Deformations and Chromosomal Abnormalities
15-24: Motor vehicle crashes
25-44: Accidental poisoning
45-64: Hypertension
65-75+: Heart 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.

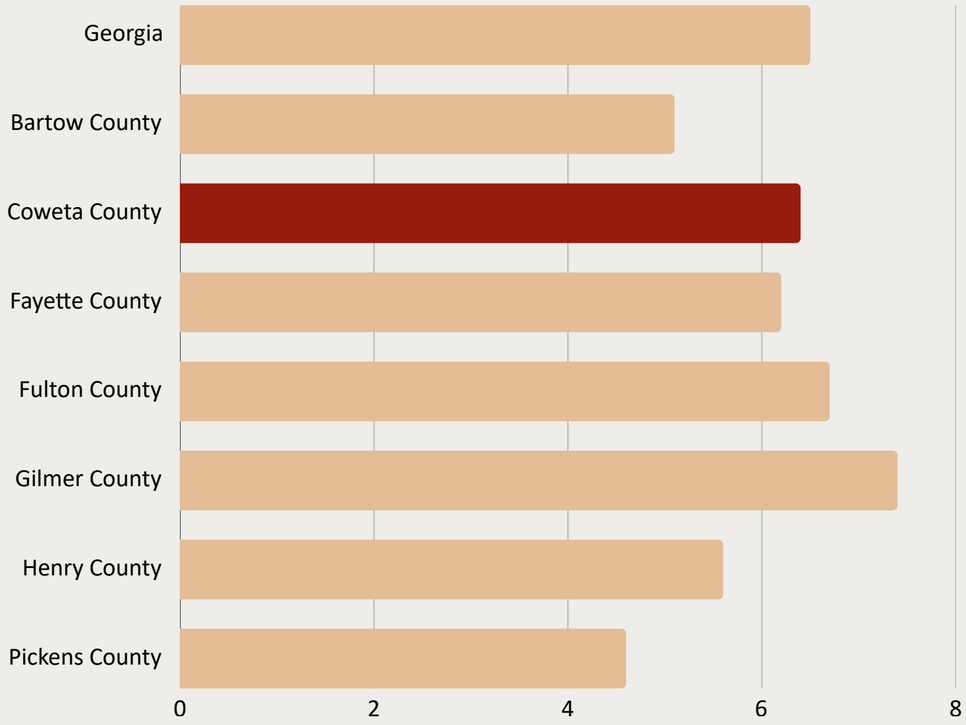
Ranking	Georgia Women	All Women (County)	Black Women (County)	White Women (County)
1	Heart disease	Heart disease	Hypertension	Heart disease
2	Alzheimer's disease	Nervous system diseases	Heart disease	Nervous system diseases
3	COPD	Hypertension	COVID-19	Alzheimer's disease
4	COVID-19	Alzheimer's disease	Nervous system diseases	COPD
5	Cerebrovascular disease	COVID-19	Cerebrovascular disease	Hypertension

Ranking	Georgia Men	All Men (County)	Black Men (County)	White Men (County)
1	Heart disease	Heart disease	Hypertension	Heart disease
2	COVID-19	Hypertension	Heart disease	COVID-19
3	Hypertension	COVID-19	Cerebrovascular disease	Hypertension
4	Trachea, bronchus, and lung cancer	Trachea, bronchus, and lung cancer	COVID-19	Trachea, bronchus, and lung cancer
5	Cerebrovascular disease	COPD	Trachea, bronchus, and lung cancer	COPD

Infants

Infant mortality refers to the death of an infant before his or her first birthday, and the infant mortality rate is measured as the number of deaths per 1,000 live births. The leading causes of infant mortality are birth defects, prematurity, low birth weight, Sudden Infant Death Syndrome, unintentional injuries, and complications during pregnancy. These issues can be caused or complicated by poverty, malnutrition, poor access to care, lack of prenatal care, or smoking, drinking, or doing drugs during pregnancy.

Infant mortality rate per every 1,000 live births, Coweta County, 2000 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.

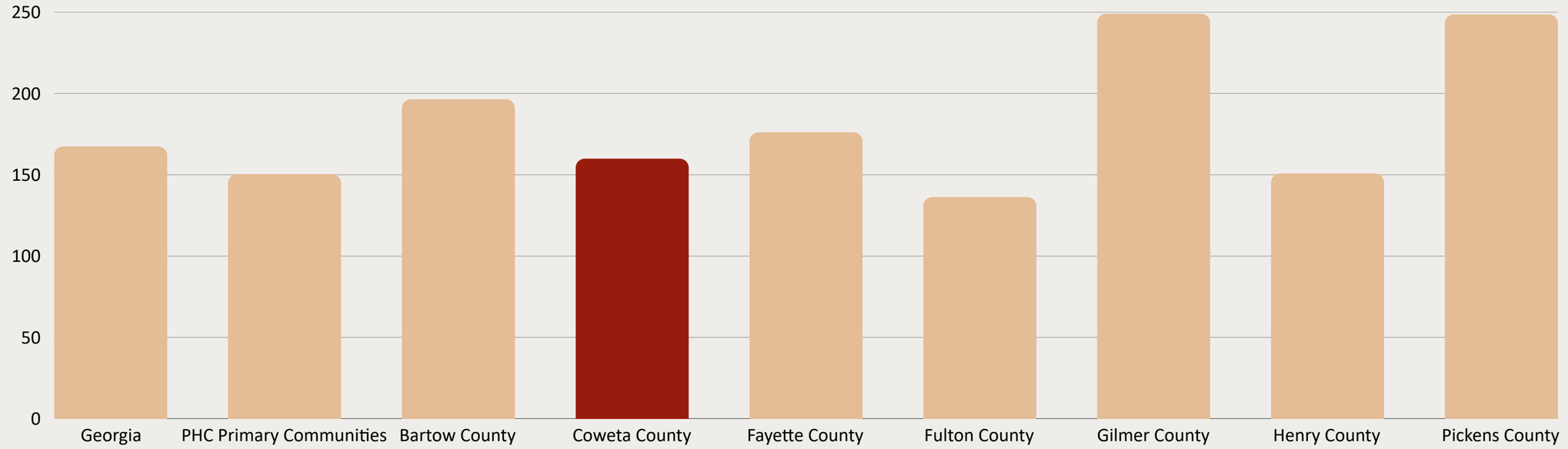
Racial and ethnic disparities

- 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

This indicator reports the 2019-2023 five-year average rate of death due to cancer per 100,000 population. Between 2019 and 2023, approximately 1,200 Coweta County members died from cancer, resulting in a rate of 159.9 deaths for every 100,000 people.

Cancer death rate, per every 100,000 people, Coweta County, 2019 to 2023

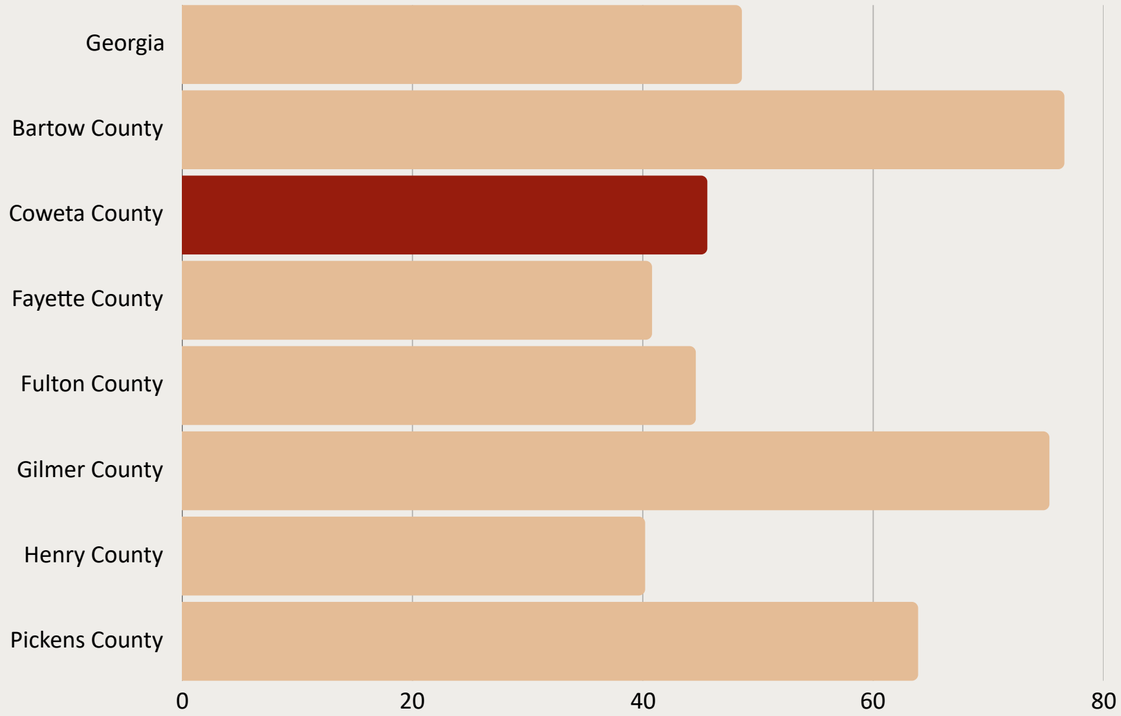


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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, a little more than 240 community members died a death of despair, resulting in a rate of 40.8 deaths for every 100,000 people. Of these, two thirds were men and one half were white.

Deaths of despair rate, Coweta County, 2019 to 2023



Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER, 2019-2023.

Suicide is a leading cause of injury-related deaths in Georgia; in 2022, there were 1,626 suicide-related deaths in Georgia.

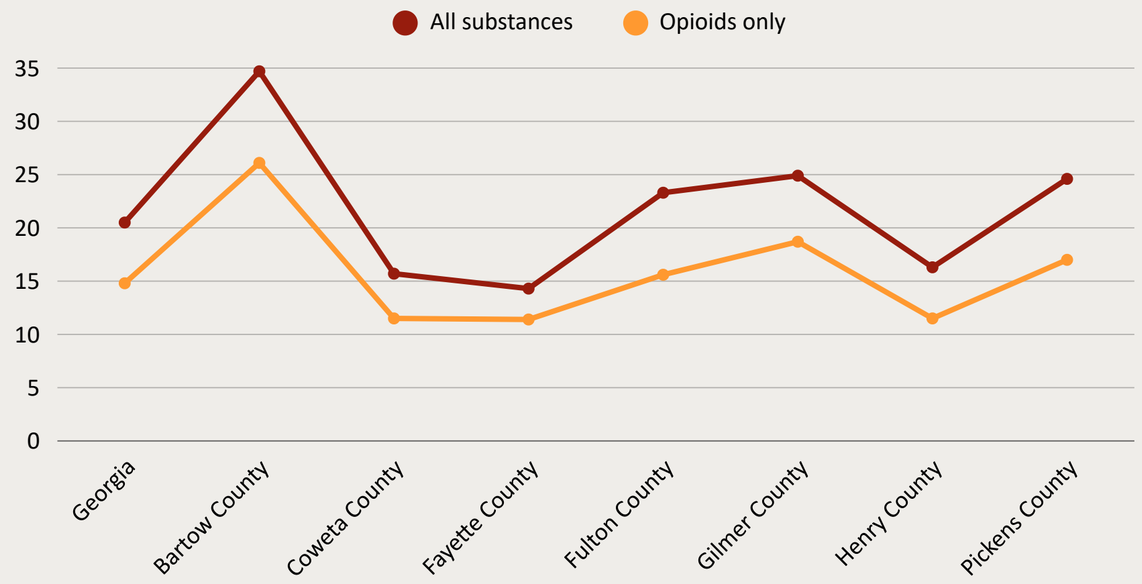
Males are more likely to die by suicide, though females attempt suicide more frequently. Firearms are the most common means of suicide death, followed by suffocation, drug poisoning, and other means.

Suicide death rates are highest among people aged 25-44 years old. White individuals have the highest rates of suicide death, followed by Black or African American, Asian, and multiracial individuals.

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 Coweta County, 119 people died from a drug overdose between 2019 and 2023, a figure lower than the state average and the national average (20.5 and 29.1 deaths for every 100,000 people, respectively).

Drug overdose death rate, Coweta County, 2019 to 2023



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

According to the Centers for Disease Control and Prevention's State Unintentional Drug Overdose Reporting System (SUDORS), illegally-made fentanyls that contained no other opioids or stimulants were the leading cause of opioid-related deaths in Georgia in 2023.

Males overdosed at more than twice the rate of females and Whites led by race. The majority were between 35 and 44. An estimated 55% of opioid-related overdoses happened with a potential bystander present.

In 2023, March saw the most amount of opioid-related deaths; October saw the least.

What’s next

Now that Piedmont hospitals have established their health priorities for the next three fiscal years, each hospital will establish the subsequent implementation strategies. A CHNA implementation strategy is a written plan that outlines how a hospital will address the identified community health needs, based on the CHNA findings. It's a crucial step in demonstrating a hospital's commitment to community health improvement and is approved by the hospital’s board of directors.

These strategies will include the relevant CHNA priority, target populations (with a focus on those most impacted by health inequities, both broad and specific goals, tactics/activities/strategies, the anticipated impact of the action, the metrics used to demonstrate success, sources for those metrics, and community partners needed for the specific tactic or strategy.

All strategies will be finalized and approved no later than October 15, 2025. Once all strategies are approved, they will 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