Piedmont Walton Hospital

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

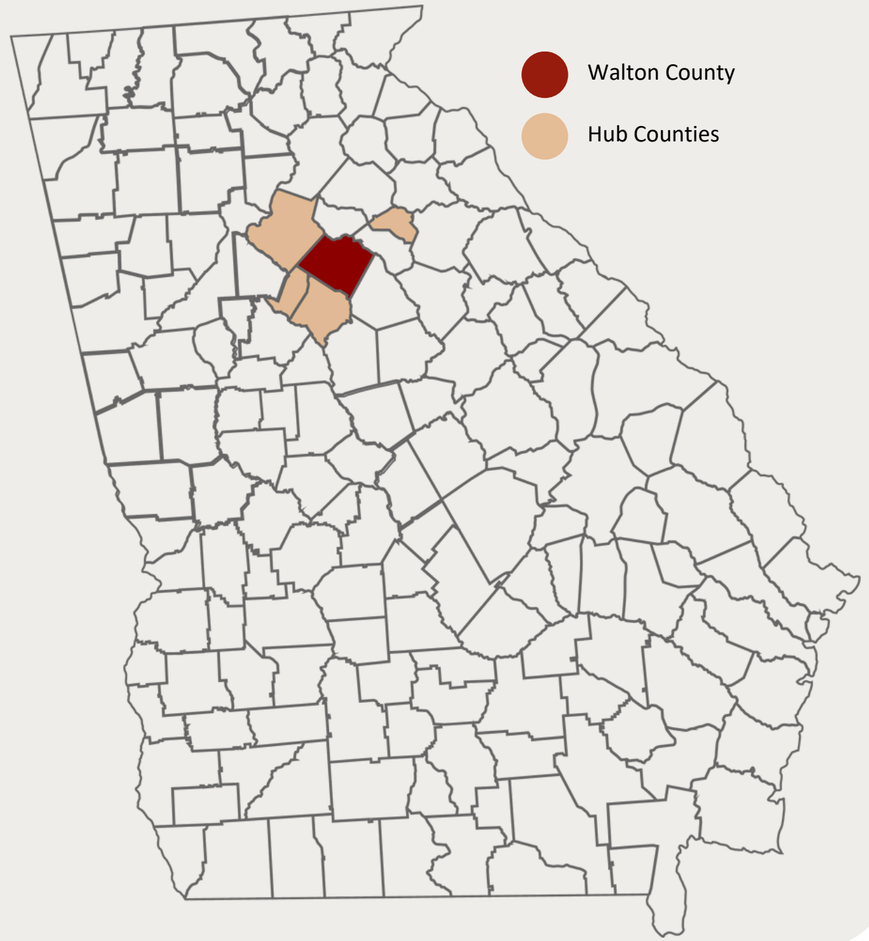
While Piedmont Walton serves patients from all over northeast Georgia, for this CHNA, we define our primary community to be the hospital's home county of Walton County. We do this in recognition of the direct impact of our tax-exempt status on county residents, as county taxes generally comprise the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

We consider Walton County part of the Athens Clinical Hub, including Piedmont Athens (Clarke County), Piedmont Eastside (Gwinnett County), Piedmont Newton (Newton County), and Piedmont Rockdale (Rockdale County). We present data for all within this presentation. The hub communities will become especially important during the implementation planning stage, as they will also need supportive programming.

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

The Piedmont Walton community



FY25 health priorities

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

Ensure affordable access to health, mental and dental care

Reduce preventable instances of and deaths from chronic conditions, with a focus on heart disease and stroke

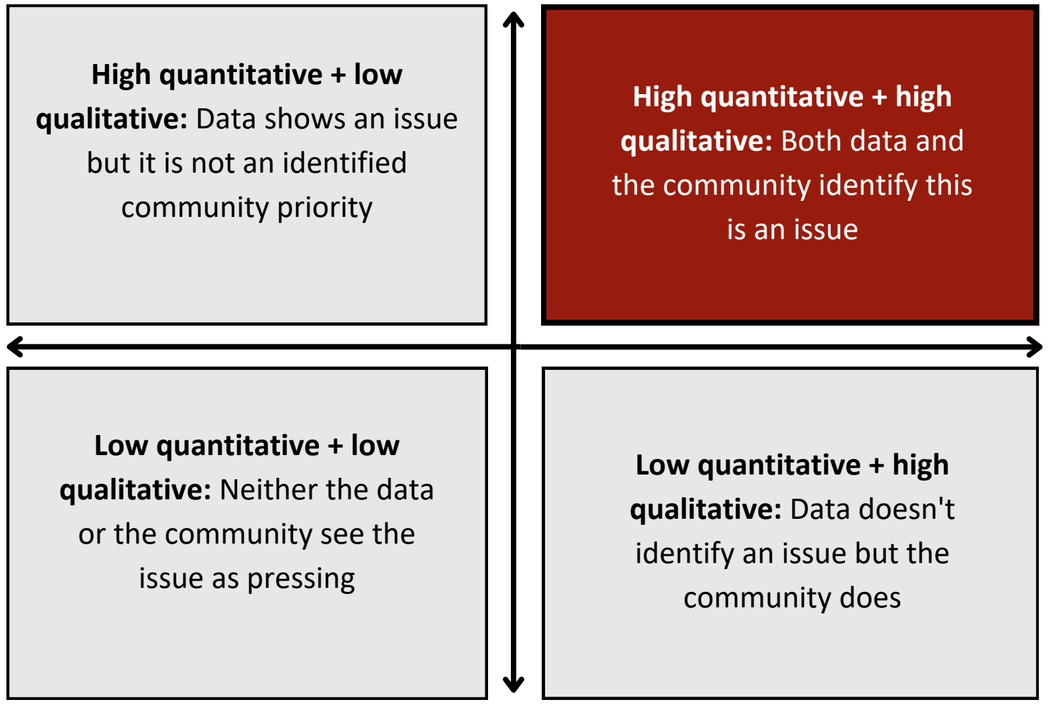
Promote healthy behaviors to reduce preventable conditions, diseases, and addictions

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 determined 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 driver 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 impact this problem? Does the community support our addressing this issue?

Top identified issues

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 rural communities

High rates of uninsurance and Medicaid enrollment

Obesity and limited physical activity

Community-based providers who understand the patient

Health costs, medical debt

Mental health concerns, including depression and substance abuse

Knowledge of/availability of relevant resources

Access to adequate and supportive community-based care

Chronic conditions, and especially hypertension and diabetes

Accessible and affordable transportation

Alzheimer's disease

Poor dental health

Access to exercise opportunities

Summary of key themes

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

- There is considerable concern about needs within nearby rural communities, especially regarding healthy lifestyles and access to basic needs.
- There are limited resources for low-income children, including access to Head Start programming.
- Obesity came up in multiple conversations and was displayed in the data, with many community members worried about the long-term effects of obesity on the overall community.
- Mental health is a top concern, which is shown in both qualitative and quantitative data, including challenges not only in accessing mental health services but also in having healthy behaviors that may support mental well-being, such as adequate rest and ample exercise.
- Heart disease and cerebrovascular disease continue to lead as the top causes of death.
- Community members struggle with access to food, especially healthy food, and safe, secure housing.

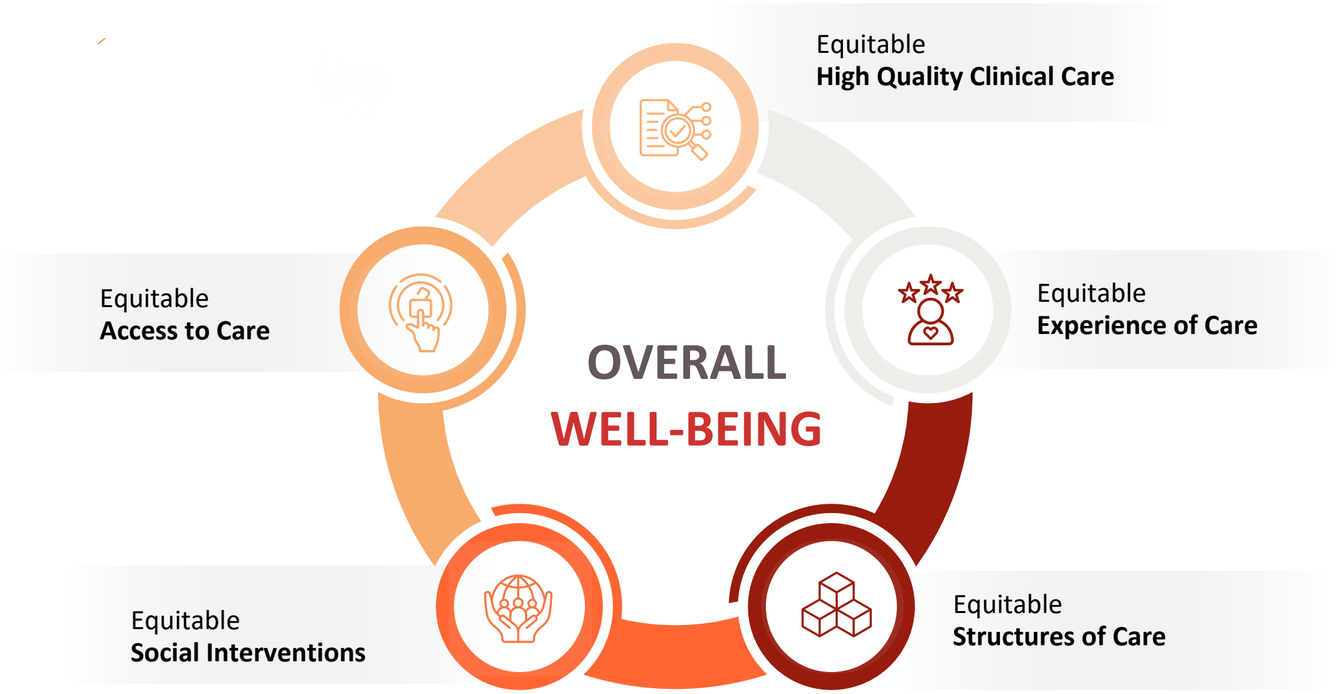
- Areas where both primary and secondary data support further examination:
  - Rural healthcare
  - Mental healthcare
  - Access to basic needs, such as safe housing and food
- Conditions that continue to persist in our communities:
  - Heart disease
  - Cerebrovascular disease
  - Hypertension
  - Diabetes
  - Cancer
- Situations that lead to bad health:
  - Increasing poverty rates
  - Obesity
  - Still high uninsured rates
  - Limited access to Medicaid providers
  - Limited access to healthy foods
  - Poor dental health

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 Walton

Piedmont Walton is a 77-bed, not-for-profit community hospital in Monroe, Georgia and serves as the sole hospital provider for the Walton County community offering 24-hour emergency services, with a designated level III trauma center, plus other major medical, surgical and diagnostic care. Piedmont Walton is known for delivering high-quality, patient-centered care closer to home, and the hospital's employees are committed to making a positive difference in every life they touch.

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.

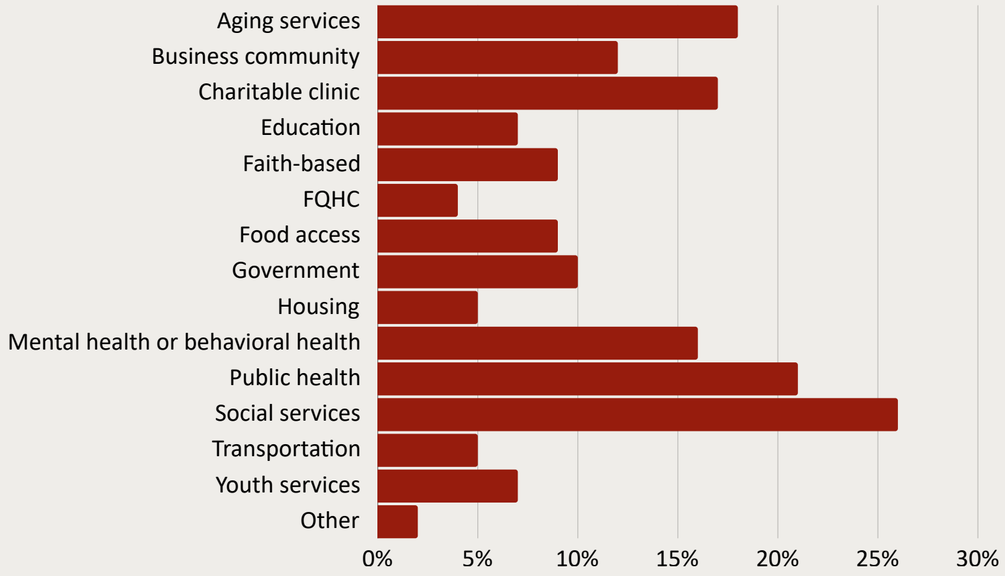
These interviews carried specific themes throughout:

- 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

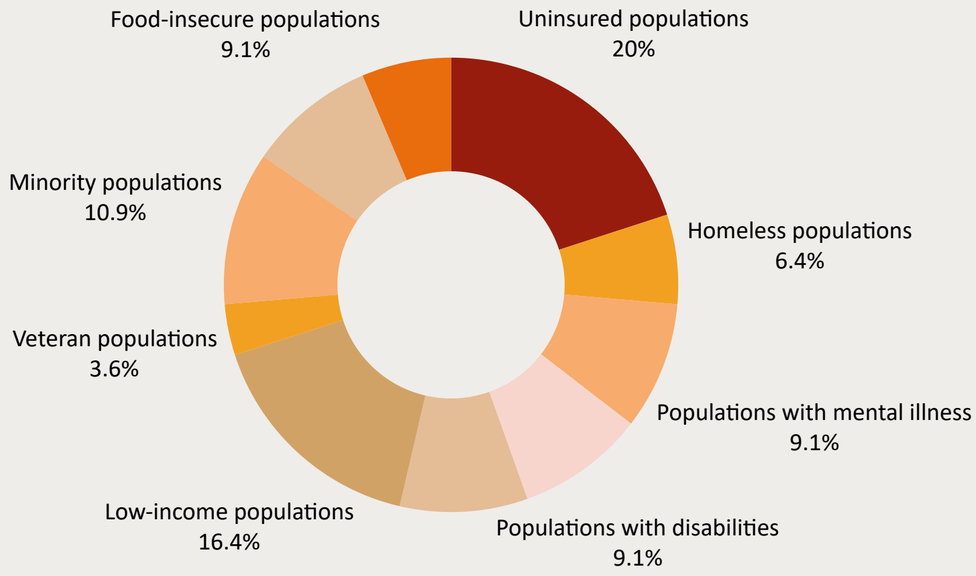
From January to March 2025, approximately 167 community leaders completed an online survey specifically tailored to their unique role within our neighborhoods and cities. The 17-question survey covered topics of community health, community resources, health equity, medical debt, and other related topics.

Survey respondents by area of work



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

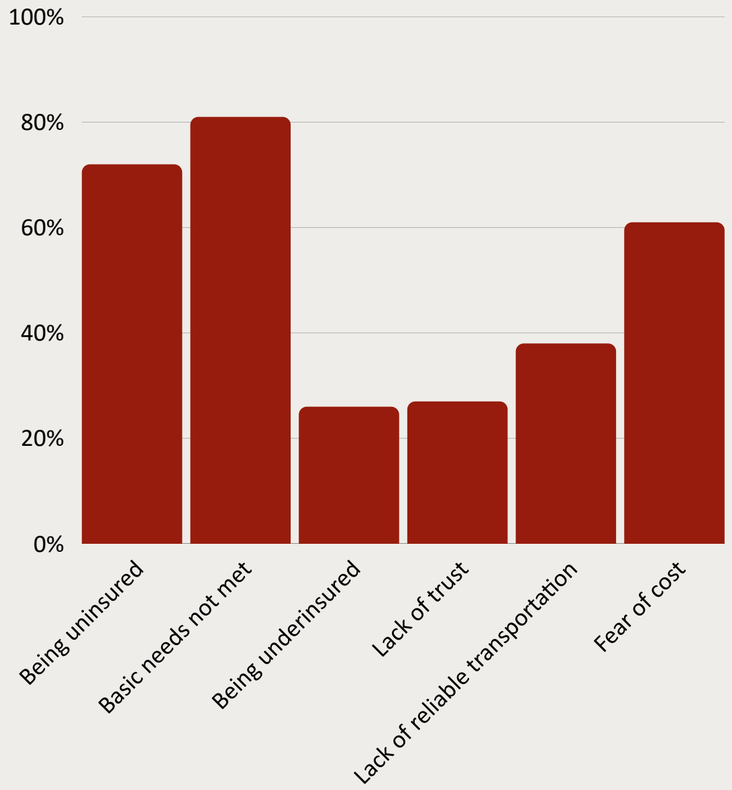
Top populations served by survey respondents



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."

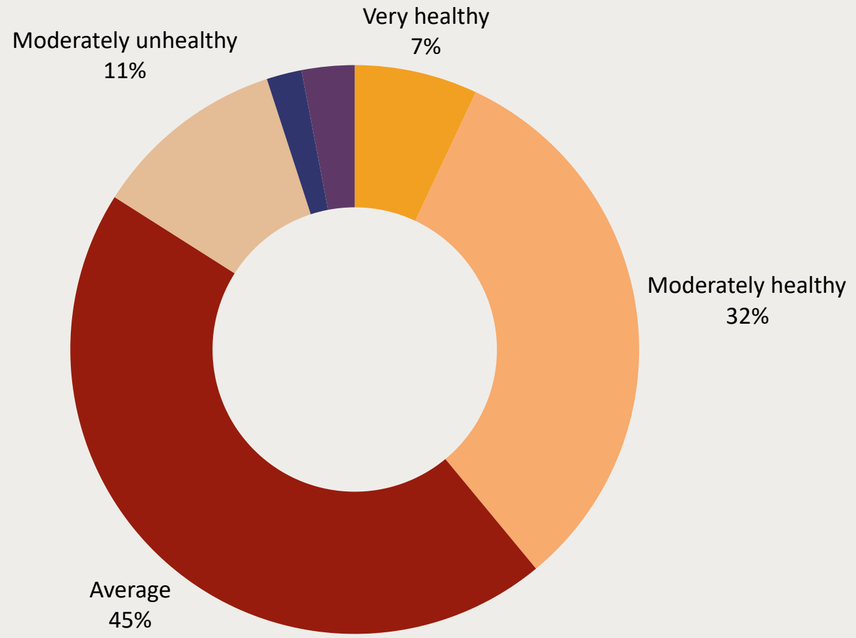
"A community where our older neighbors aren't choosing between medications and meals, where social services are secure and accessible, and everyone has the ability to get where they need to go."

Source: FY25 PHC CHNA Community Leaders Survey

Community survey

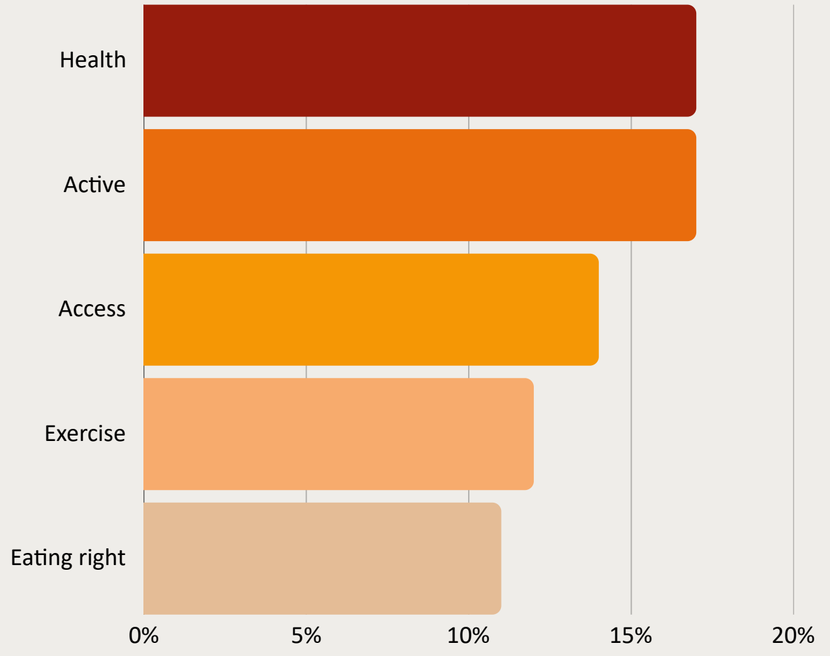
In February 2025, Piedmont launched a five-question survey among its Piedmont Advisors, a group of self-identified community members who often provides feedback to the system. These advisors live and work within Piedmont communities. Approximately 1,266 Advisors provided their insight on what makes a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

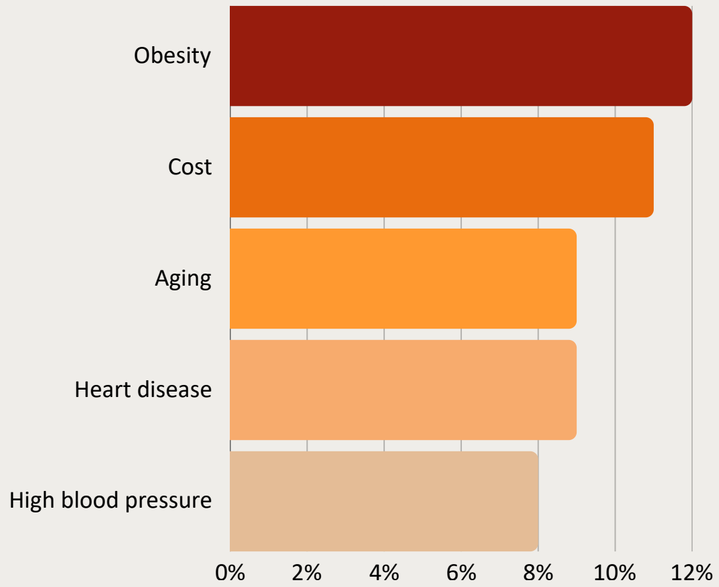
Q: When you think of a healthy community, what comes to your mind first? The top five answers are below.



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.

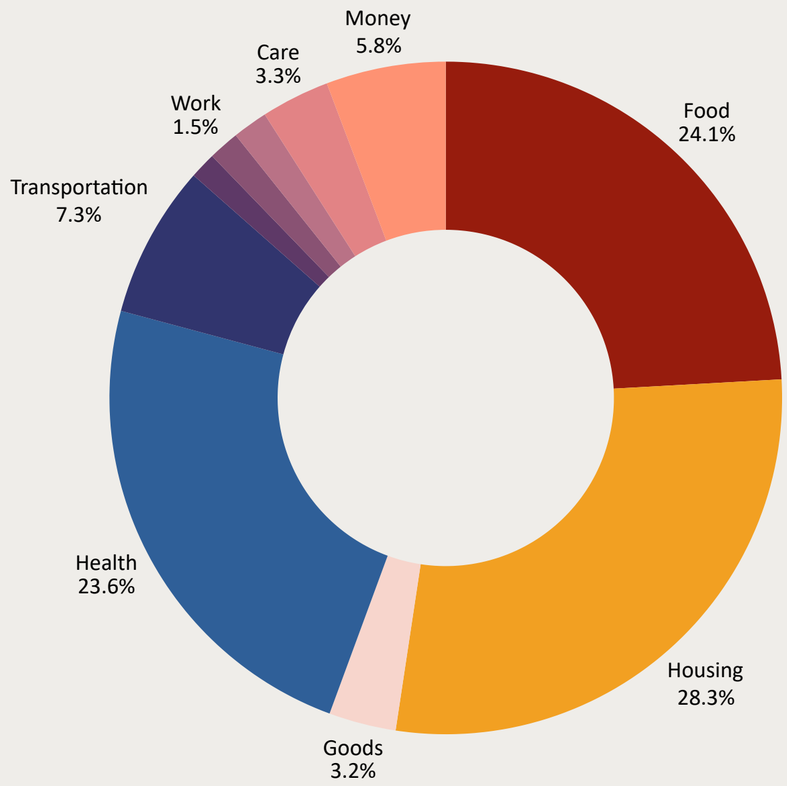
Empowering You

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. This helped us understand both the patient population and the impact of potential health inequities on patient populations traditionally underserved within healthcare.

Demographics

Approximately 100,000 people lived in Walton County annually between 2019 and 2023. These communities are primarily rural -- about 58 percent.

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

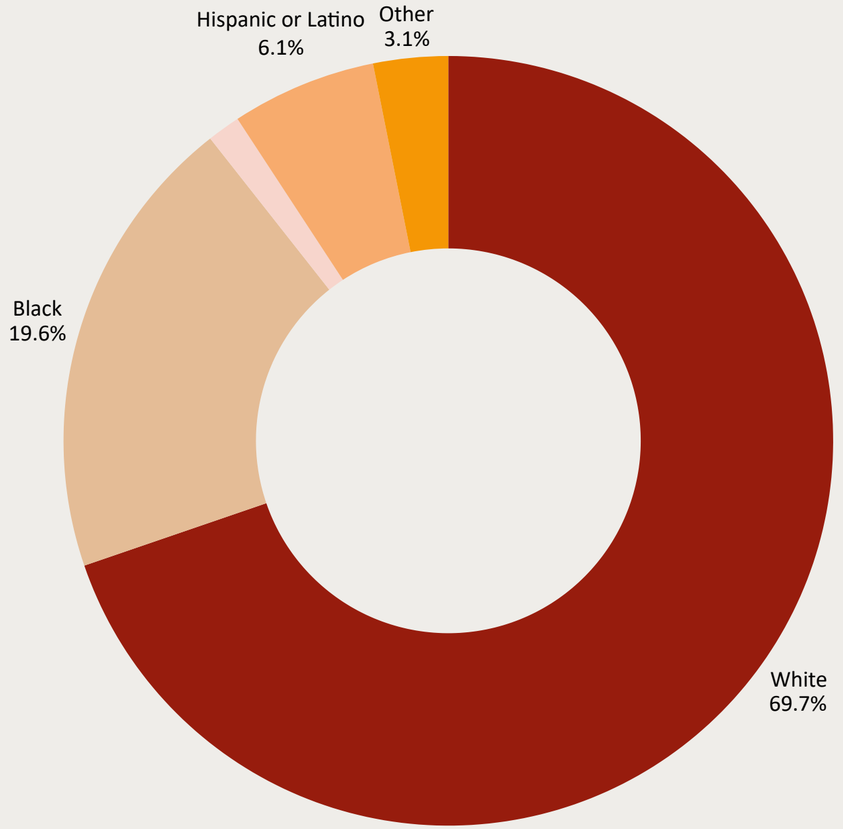
- **0 to 4:** 5.8%
- **5-17:** 18.37%
- **18-24:** 8.48%
- **25-34:** 12.02%
- **35-44:** 12.84%
- **45-54:** 13.68%
- **55-64:** 12.78%
- **65+:** 16.03%

59.8%

Walton County experienced a nearly 15% growth rate between 2010 and 2020. Non-Hispanic populations classified as other and multiple races led this growth. Less than a percent of the county's population speaks a language other than English at home.

Veterans comprise approximately 7.7% of the population, and the highest percentage of veterans were over the age of 75,

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

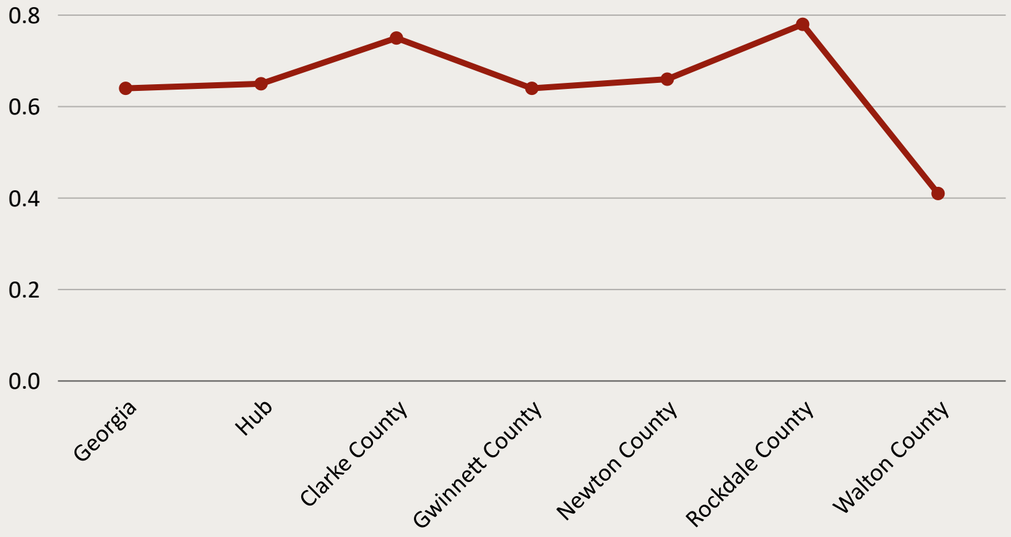


Source: US Census Bureau, American Community Survey, 2019-2023.

Social Vulnerability Index and Area Deprivation Index

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

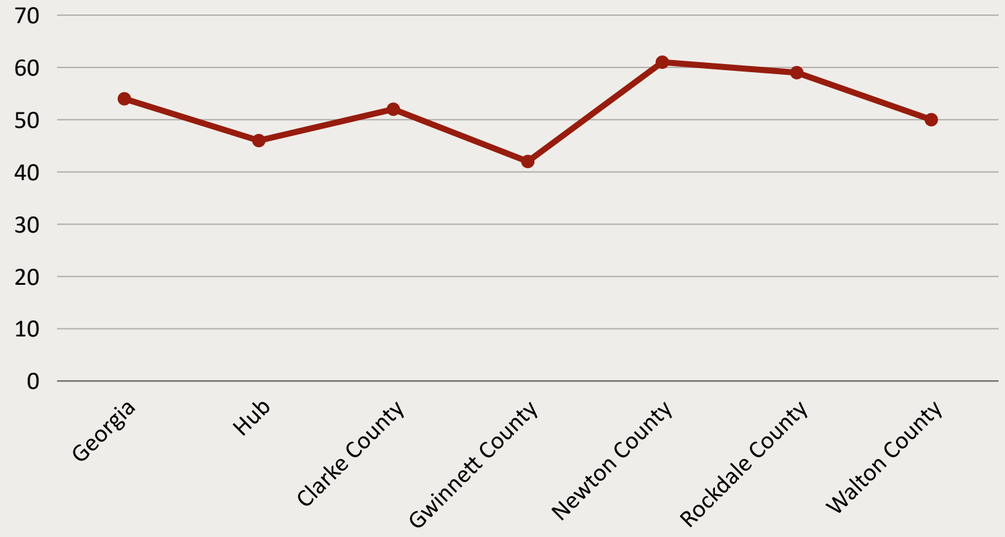
SDI, state percentile, 2022



Source: CDC GRASP, 2022

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).

ADI, state percentile, 2022

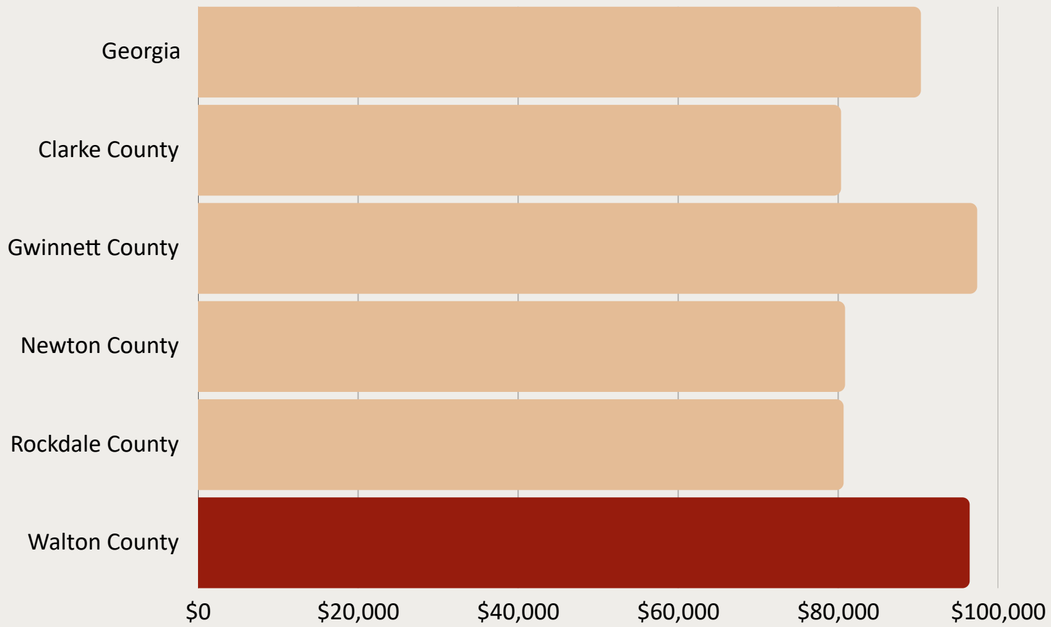


Source: University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas. 2022.

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.

Median family income, annually on average, 2019 to 2023



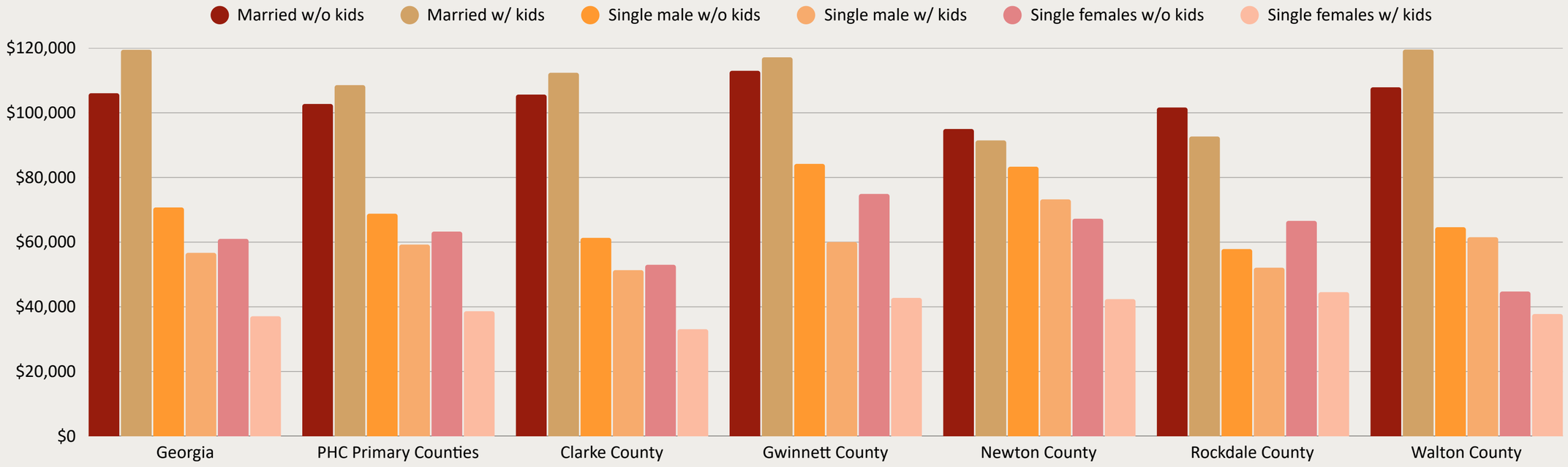
Source: US Census Bureau, American Community Survey, 2019-2023.

- 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, continued

When we break income down by household type, we see where certain structures are more likely to be poorer.

Median family income by household type, Walton County, 2019 to 2023

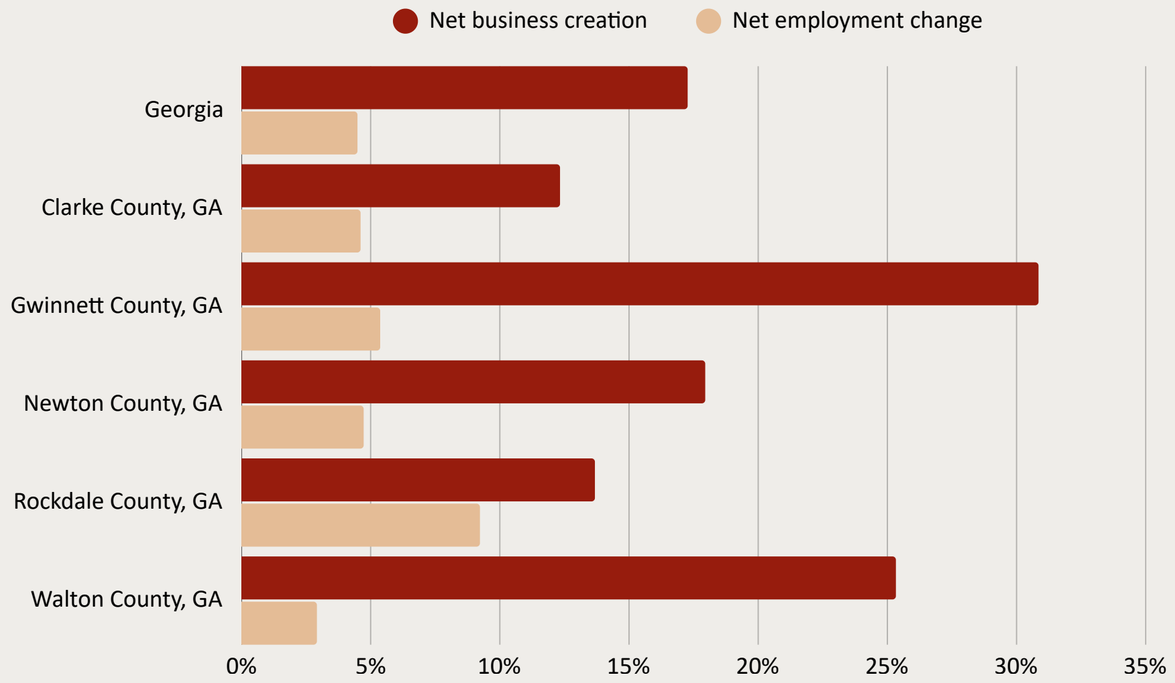


Source: US Census Bureau, American Community Survey, 2019-2023.

Employment

Between 2011 and 2021, about 2,043 new businesses were created within the county. During that same time, 1,702 businesses closed, resulting in an establishment net change rate of 25.3%, far above than the state average of 17.3%.

Net business creation and net employment change, 2011 to 2021



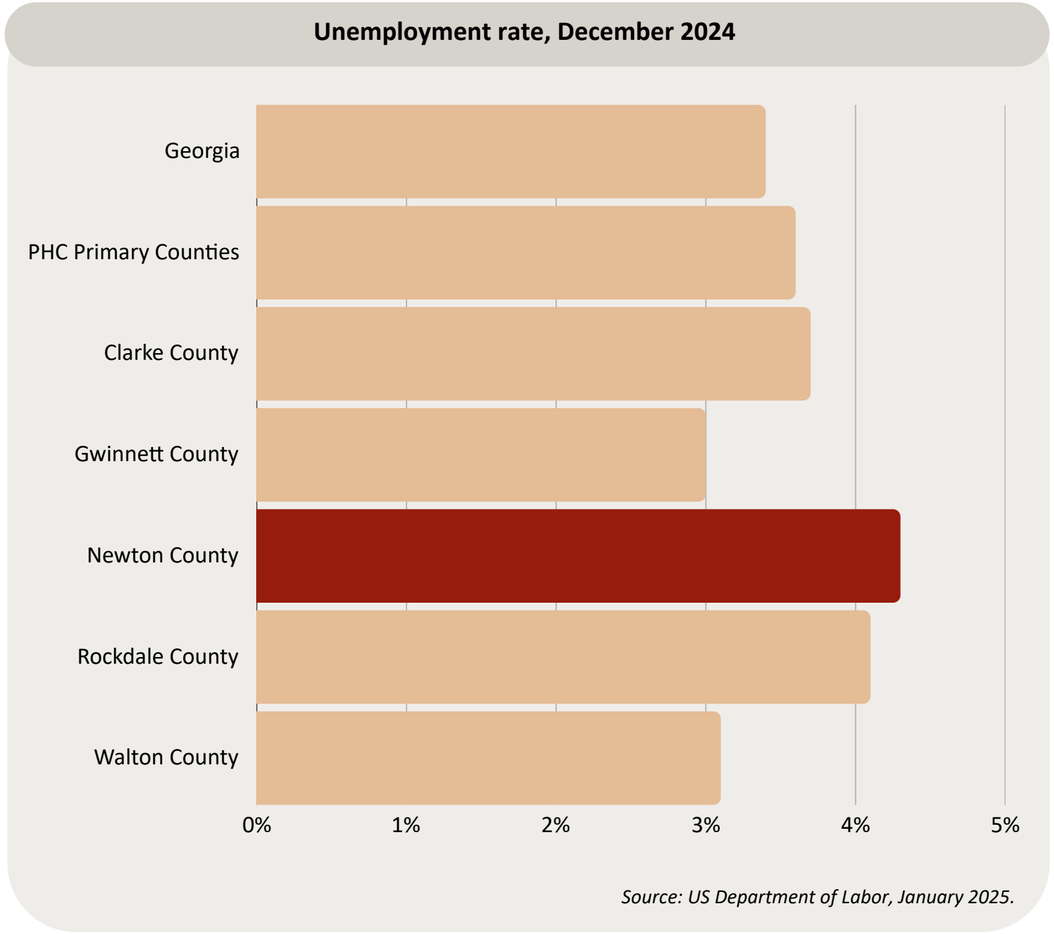
US Census Bureau, US Census Business Dynamics Statistics. 2011-2022.

Within the service area:

- About 71% of those working commute to work alone in a car or truck.
- Walton County community members had the longest commutes, with about 18% of workers driving at least an hour to get to work each day.
- Walton County residents are less likely to walk or bike to work – about 0.6% compared to the state average of 1.5%.
- About 88% percent of working age adults with a disability work, below the rate of 95% 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 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.

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

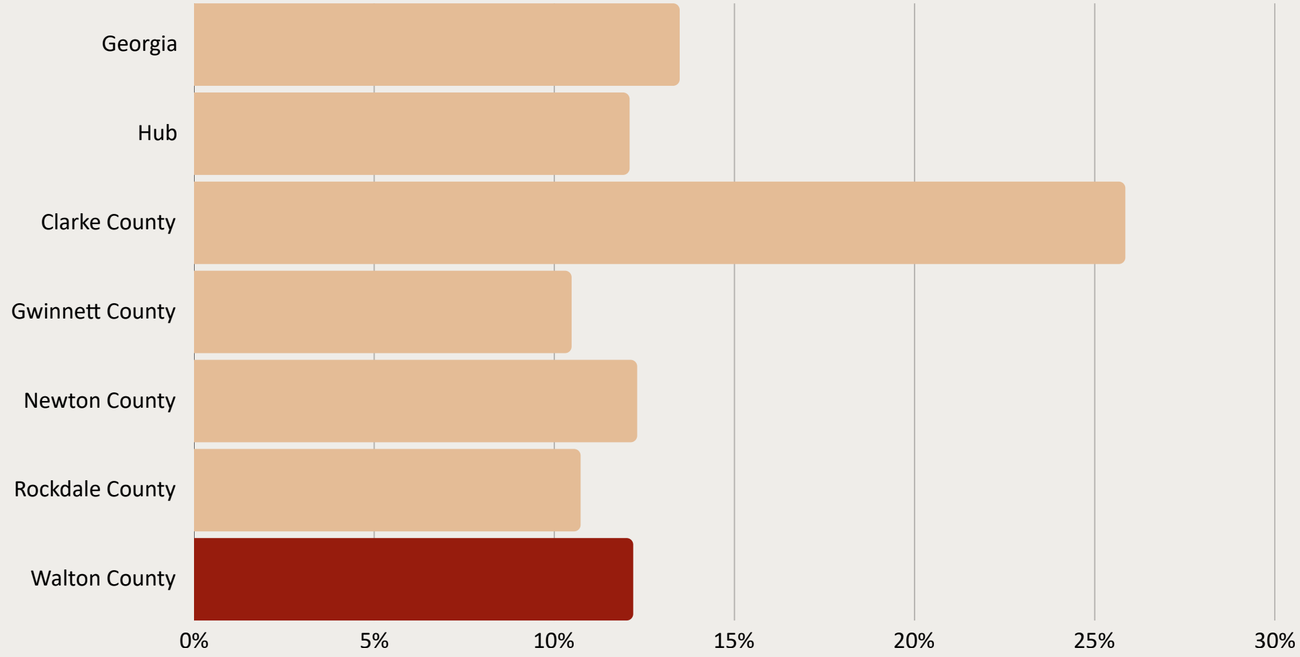
Living in poverty is the driving force of poor health for lower-income community members. Poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

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

Within Walton County, 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

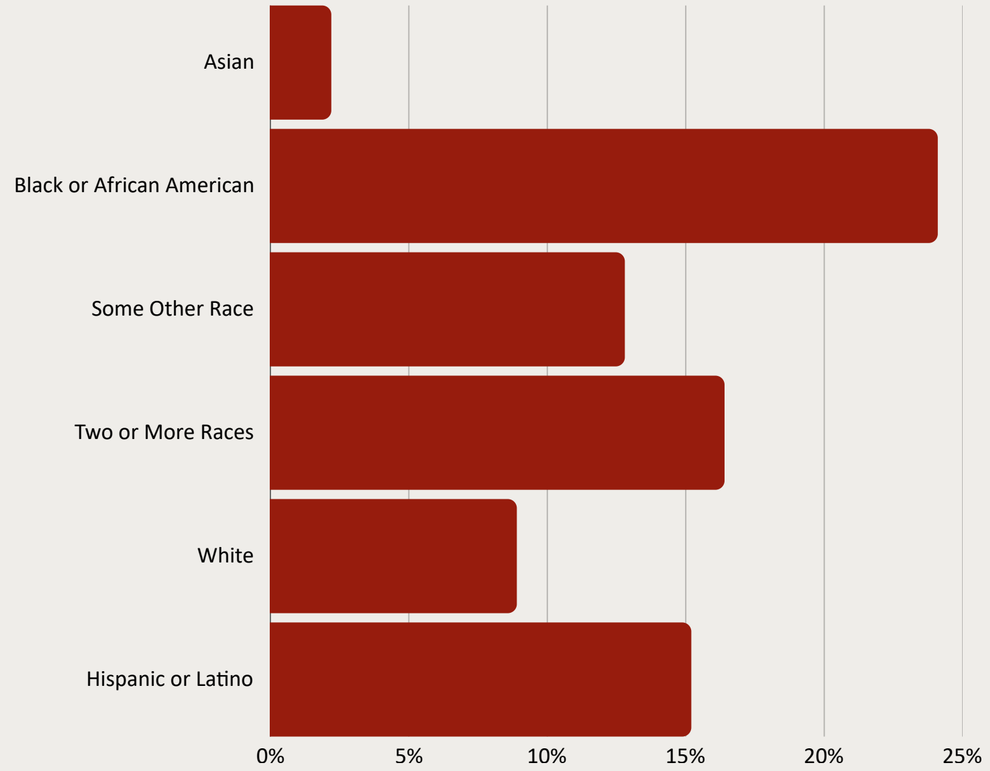


Source: US Census Bureau, American Community Survey, 2019-2023.

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, Walton County, 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 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 incomes ranging from $55,500 to $138,750 for a family of four.

Childcare

Annually between 2019 and 2023, childcare costs consumed about 18% of median household income for Walton County parents.

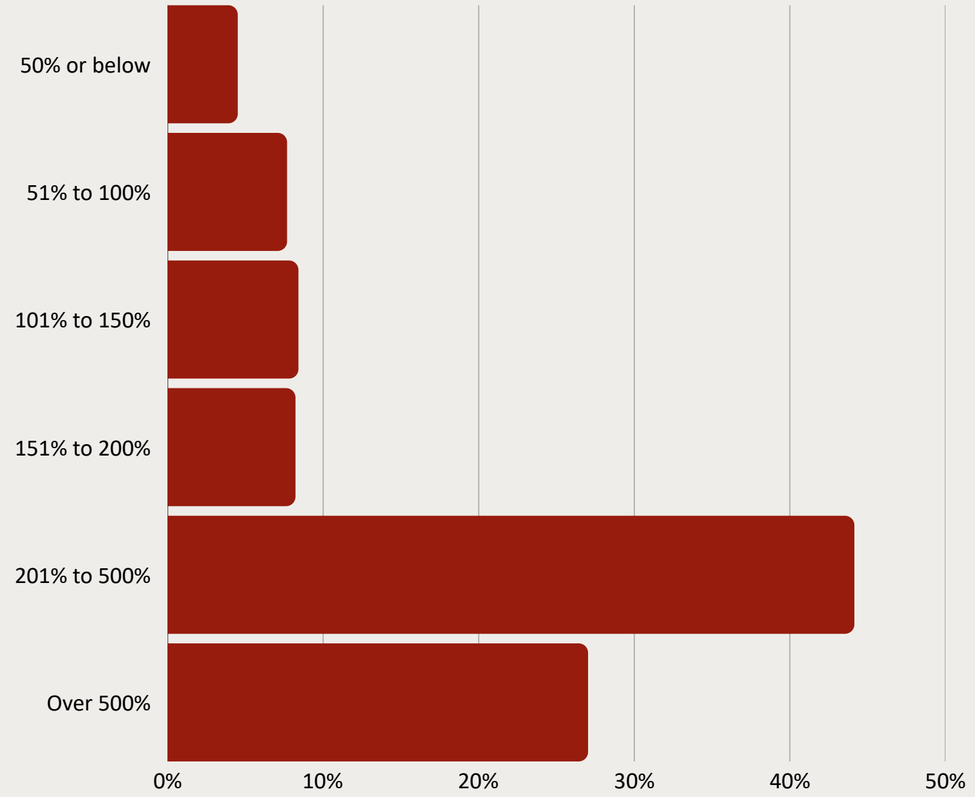
Collections

Between 2019 and 2023, 25% of Walton County's community members had debt in collections.

Additionally, poverty tends to cluster within geographic areas, with some neighborhoods experiencing higher rates of poverty than others. Like with most of the country, income levels tend to be segregated within Walton County, with some neighborhoods experiencing higher poverty rates than others. Within Walton County, the following ZIP codes had the highest rates of poverty:

30655 (Monroe): 20.82%
30641 (Good Hope): 11.67%
30052 (Loganville): 6.52%

Percent of the population at varying poverty rates, Walton County, 2023

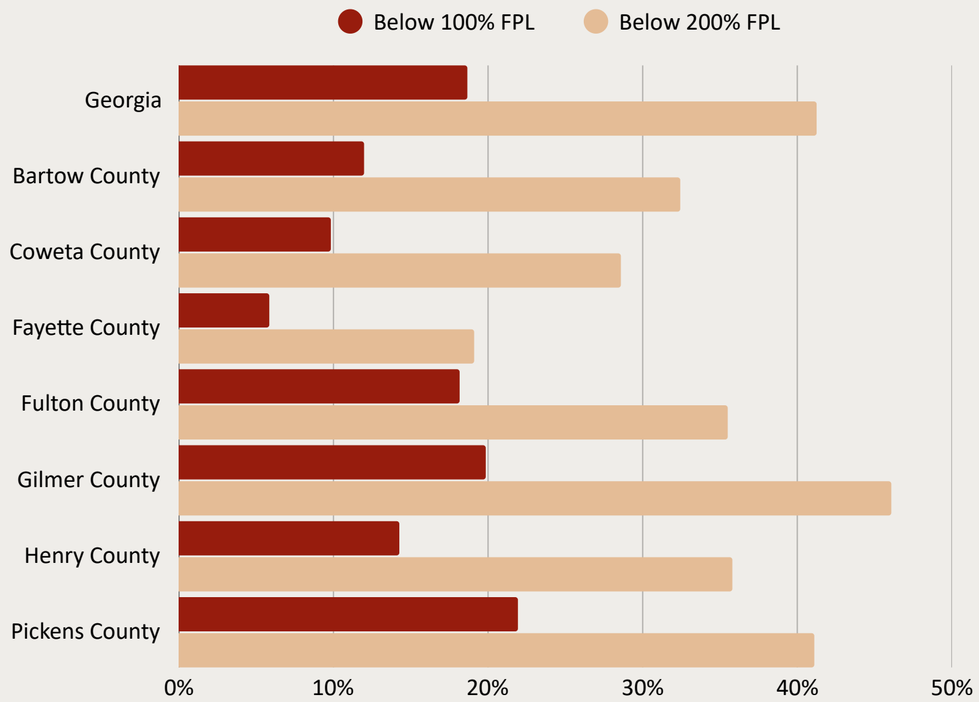


Source: US Census Bureau, American Community Survey, 2019-2023.

Children in poverty

In Walton County, nearly 8,900 children lived in households with income below 200% of the Federal Poverty Level between 2019 and 2023. Poverty creates barriers to access including health services, healthy food, and other necessities that contribute 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.

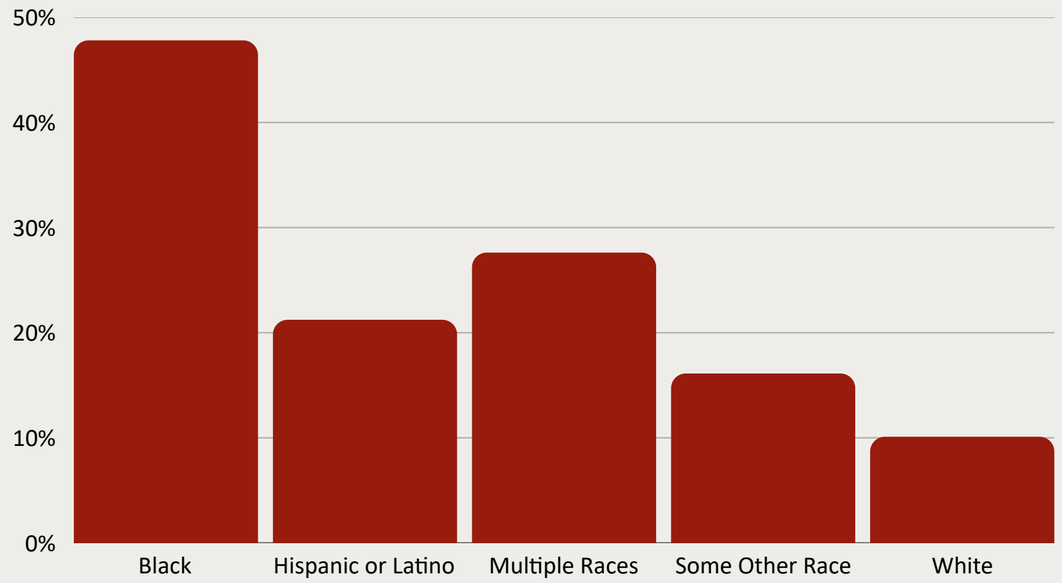
Mental health: Children living in poverty are at higher risk of experiencing poor mental health and psychological distress.

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 or ethnicity

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, Walton 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 communities 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.

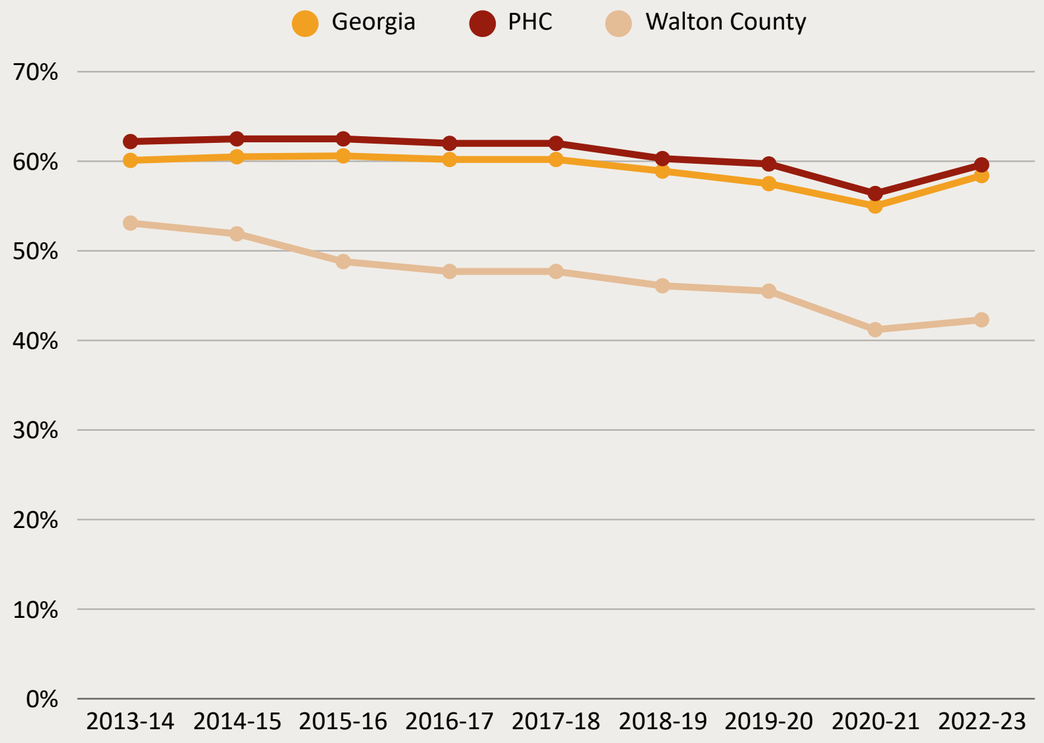
Impact on health and well-being: Poverty among children of color can lead to adverse childhood experiences (ACEs), which are linked to adverse health and social outcomes. Children of color are disproportionately exposed to ACEs, which can undermine their development and well-being.

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.

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



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

In Walton County, 42% of children—or about 6,978—qualified for free or reduced-price lunch at their school during the 2022-2023 school year.

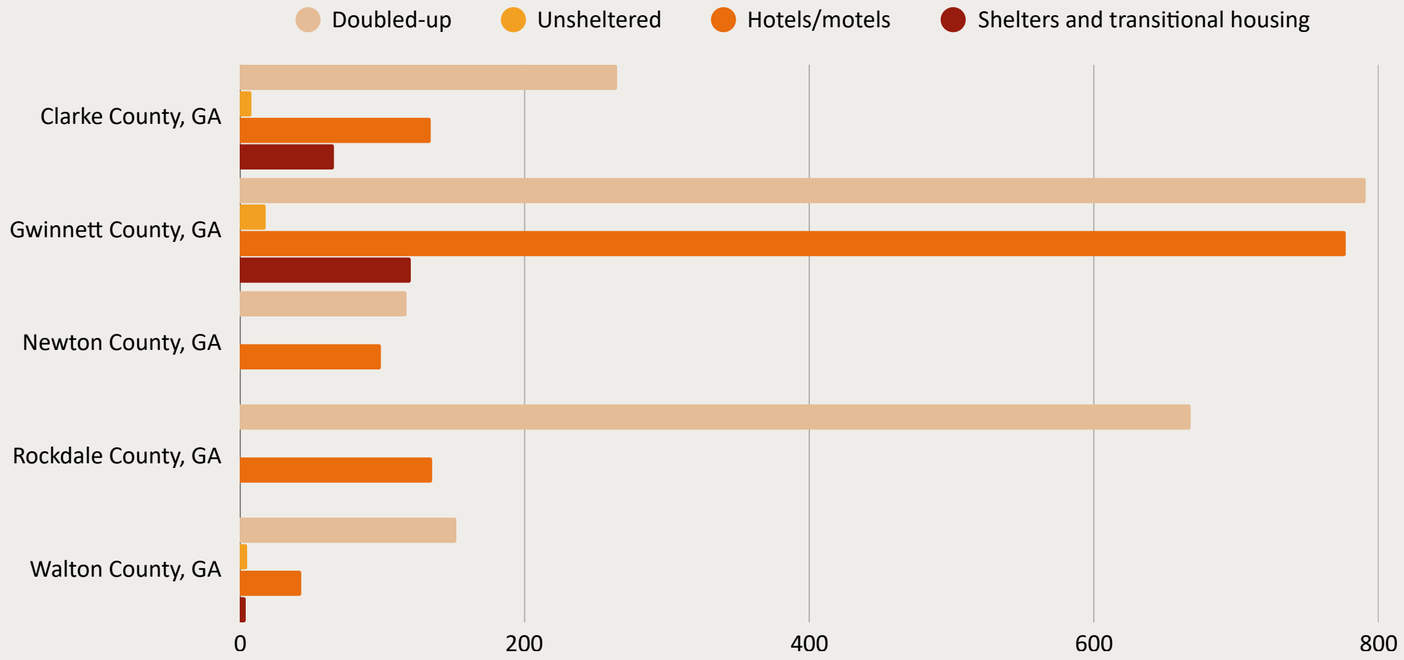
Free and reduced-price school lunch programs directly address food insecurity, a major social driver of poor health. These programs ensure students have access to healthy, nutritious meals, reducing the risk of hunger and its associated negative consequences.

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

Within these counties, 1.4% of students were homeless during the 2021-2022 school year. Rockdale County had the highest rates in the service area with 5.4% of children experiencing homelessness when looking at primary nighttime residence. The state rate was 2.1%

Students experiencing homelessness by primary nighttime residence, 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.

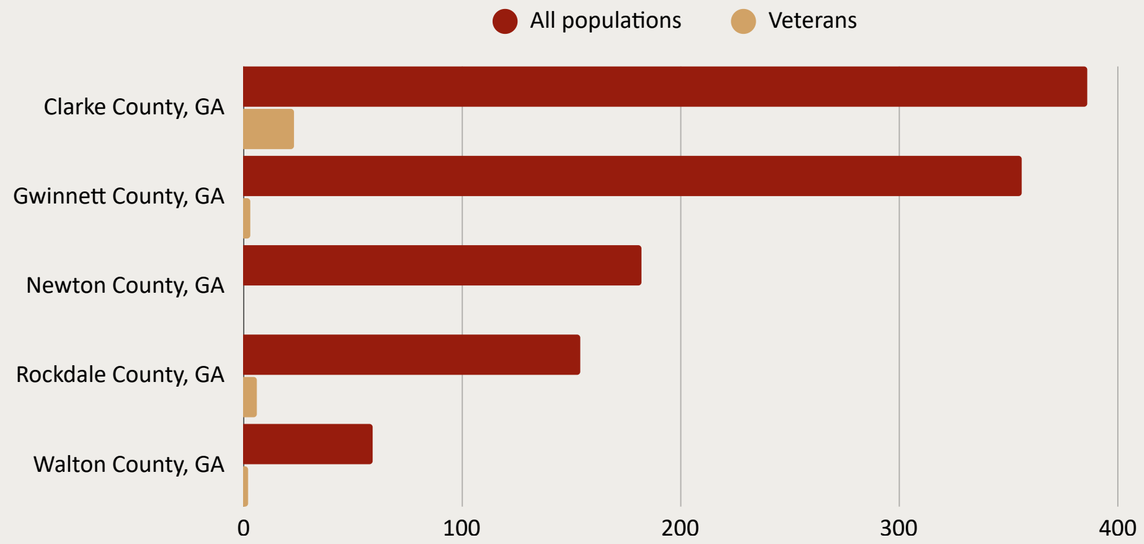
Hotels/motels: As indicated by the name, refers to stays in hotels or motels.

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. Note that data was not available for all counties and categories.

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.

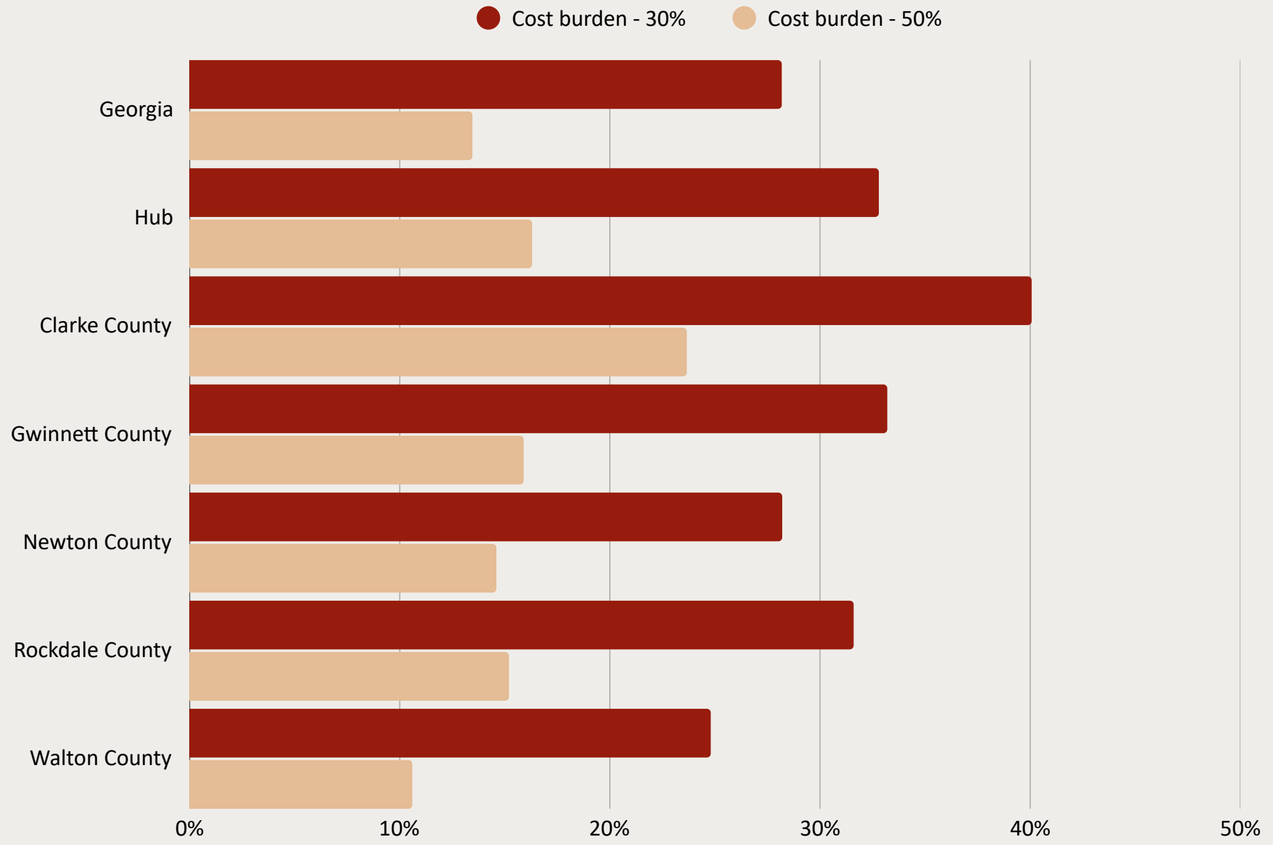
Some key statistics on housing within Walton County:

In total, most homes within the combined service area are not overcrowded.

Walton County had an overcrowded rate of 2.4% which was slightly higher than the 2.3% state average. ZIP codes with the highest rates of overcrowded housing units are:

- 30655 (Monroe): 4.99%
- 30656 (Monroe): 1.32%

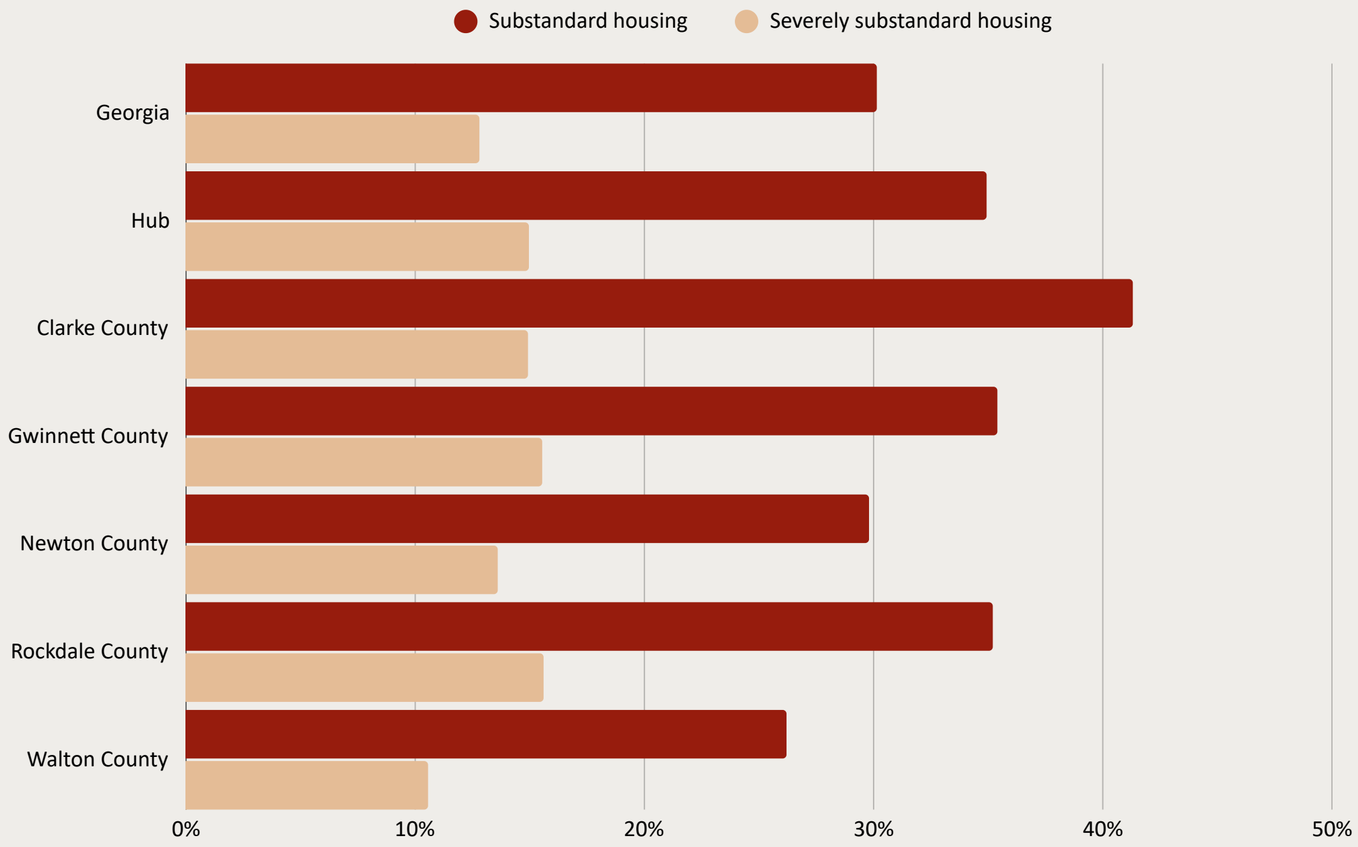
Housing cost burden as percentage of household income, Walton County, 2019 to 2023



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

Substandard housing

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



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

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

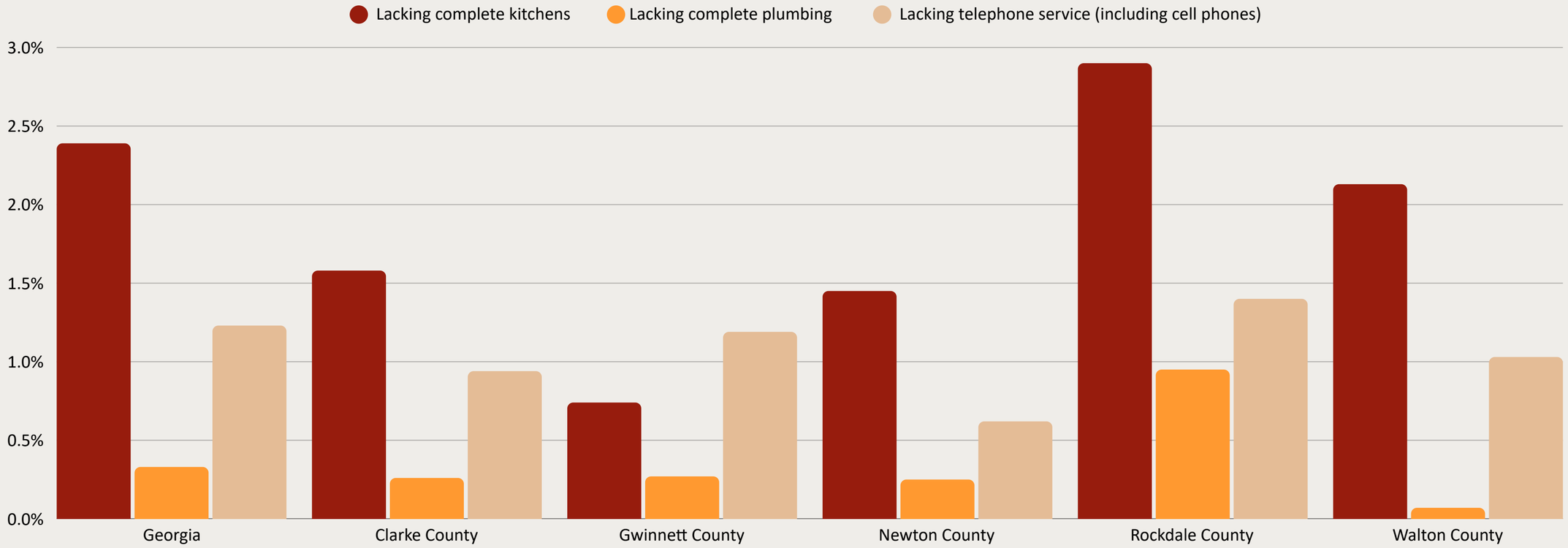
1. Lacking complete plumbing facilities
2. Lacking complete kitchen facilities
3. With one or more occupants per room
4. Selected monthly owner costs as a percentage of household income greater than 30%
5. Gross rent as a percentage of household income greater than 30%

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 county, there were many homes without complete plumbing, kitchens, or are lacking telephone service, including cell phones. This chart looks at the annual average rate of each measure between 2019 and 2023.

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

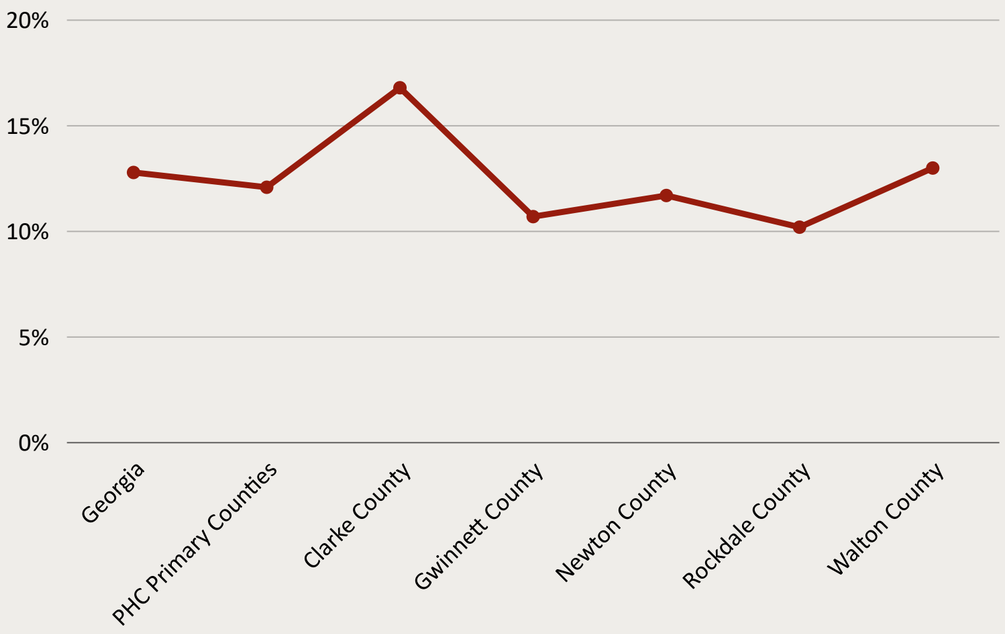


Source: US Dept. of Housing and Urban Development, 2019-2023.

Food insecurity

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

Percentage of population facing food insecurity, Walton County, 2022



Source: Feeding America, 2022.

Within Walton County, nearly 16% of children are food insecure. Of these children, nearly 40% 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.

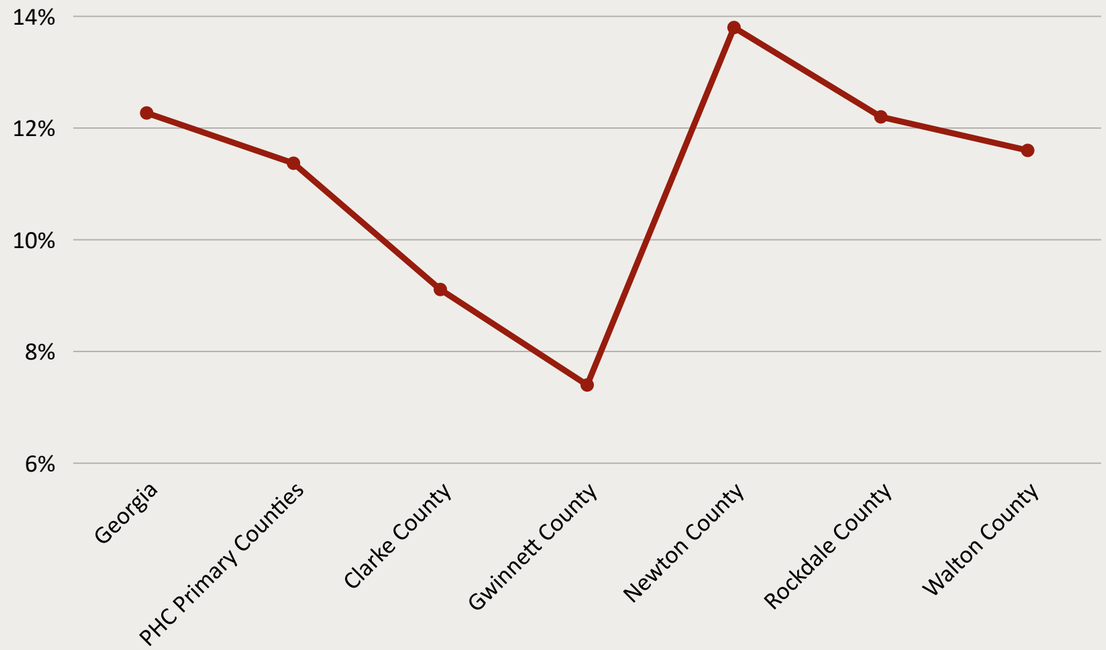
According to the academic journal *Health Affairs,* food-insecure children are at least twice as likely to report being in fair or poor health and at least 1.4 times more likely to have asthma, compared to food-secure children; and food-insecure seniors have limitations in activities of daily living comparable to those of food-secure seniors fourteen years older.

Food insecurity is linked to increased risks of developing chronic diseases like type 2 diabetes, high blood pressure, heart disease, and obesity. Individuals experiencing food insecurity may consume less nutritious foods, leading to deficiencies in essential vitamins and minerals.

SNAP benefits

In Walton County, nearly 4,000 or 11.62% households receive Supplemental Nutrition Assistance Program (SNAP) benefits. This is slightly below the national average of 11.77%. 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, Walton County, 2019 to 2023



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

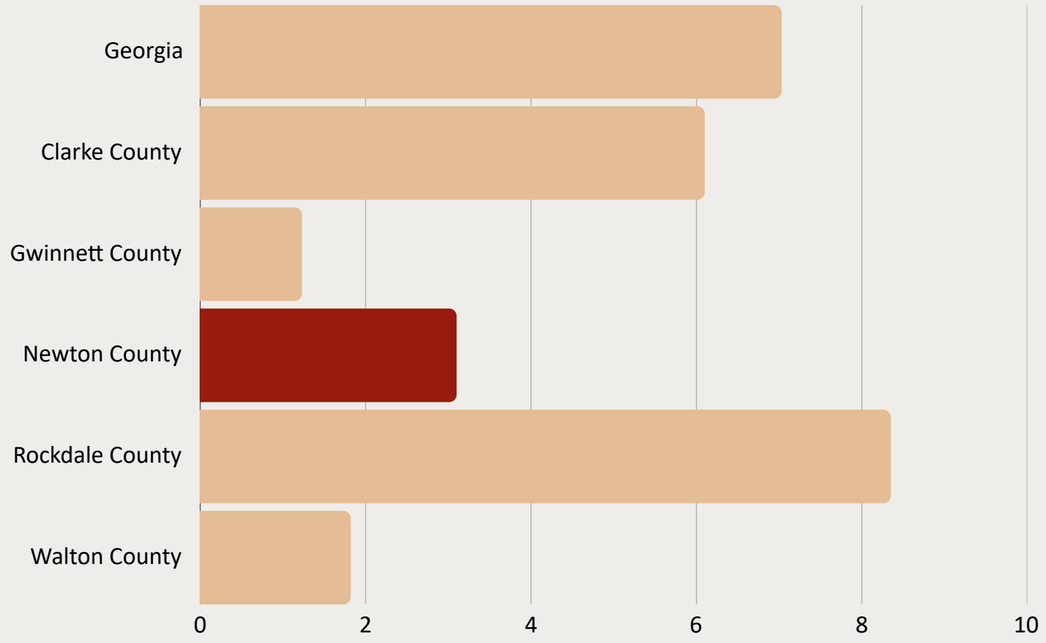
Within Walton County, minority populations were far more likely to receive SNAP benefits than their white counterparts. For example, for all communities combined and when broken down by race, as a percentage of all households within that racial or ethnic group, the following were enrolled in SNAP:

- White: 8.47%
- Black: 23.98%
- Asian: 7.03%
- Some other race: 14.98%
- Multiple race: 19.32%
- Hispanic or Latino: 9.91%

Head Start programming

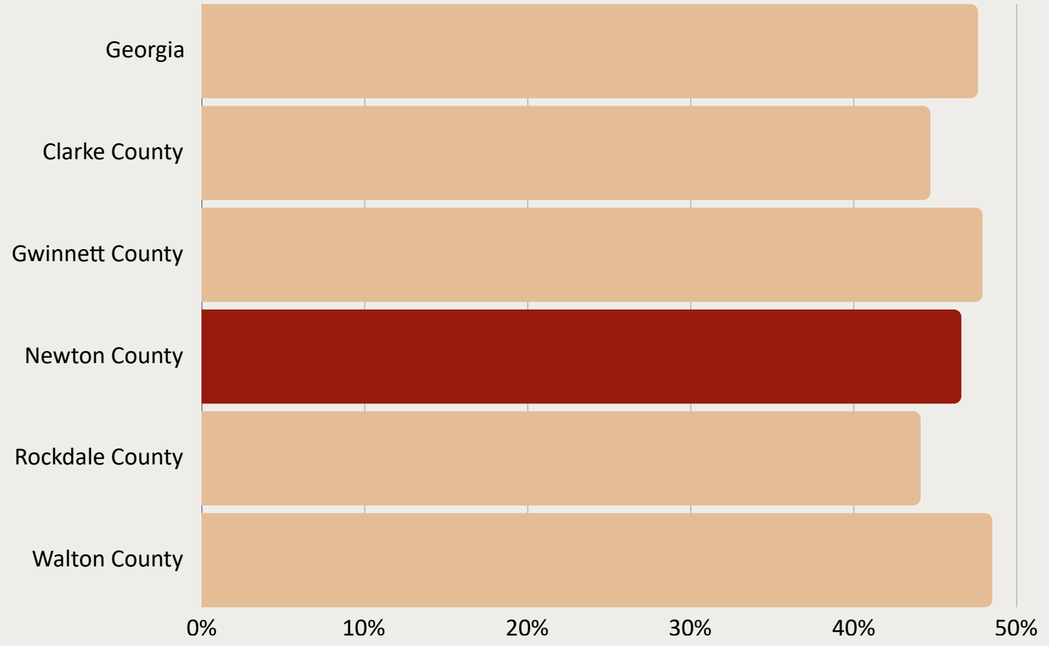
Head Start is a program designed to help children from birth to age five who come from families at or below poverty level. The program's goal is to help children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. This indicator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

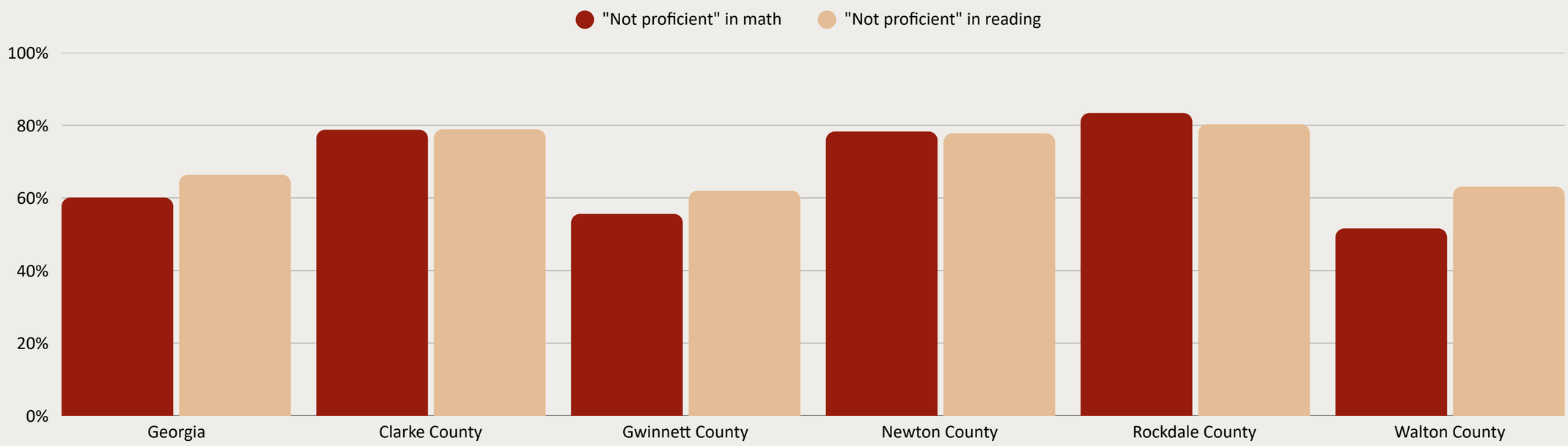


Source: US Census Bureau, American Community Survey, 2019-2023.

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 true for math. In Walton County, only 48.4% of students score ‘proficient’ or better on the math assessments, and 36.9% on the reading assessments.

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

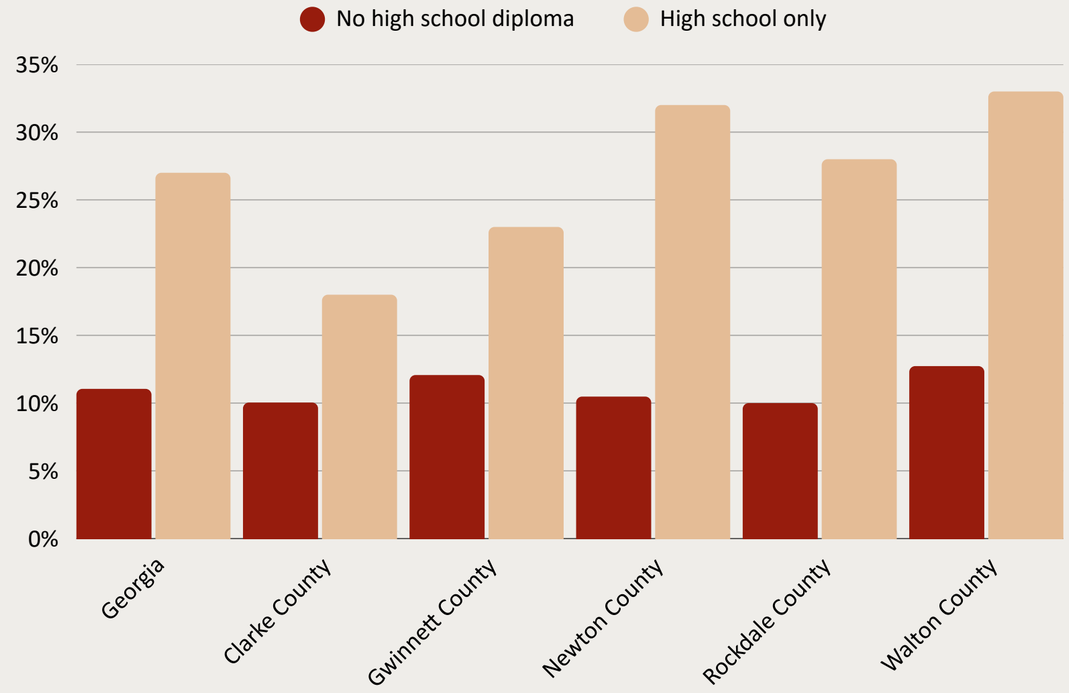


Source: US Department of Education, EDFacts, 2020-2021.

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 below reflects adults 25 and older.

High school diplomas, 2019 to 2023

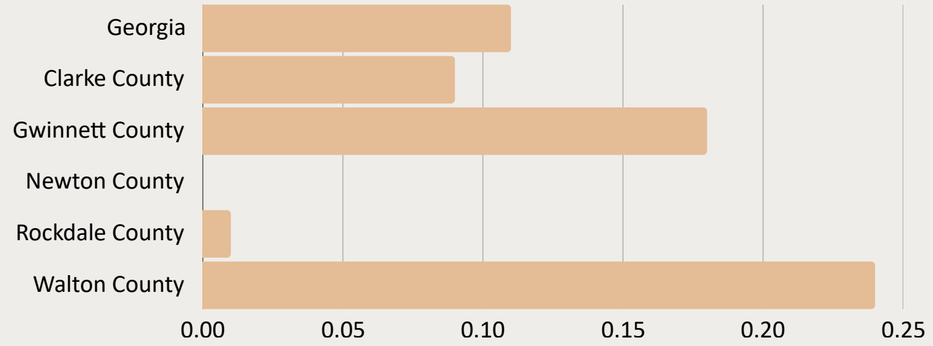


Source: US Census Bureau, American Community Survey, 2019-2023.

In the 2022-2023 school year, **county students were chronically absent at a rate lower than the state average**—23.8% 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.

There were 38 reported allegations of school bullying in the 2020-2021 school year, resulting in a rate much higher than that of the state.

School bullying, 2020-2021 school year

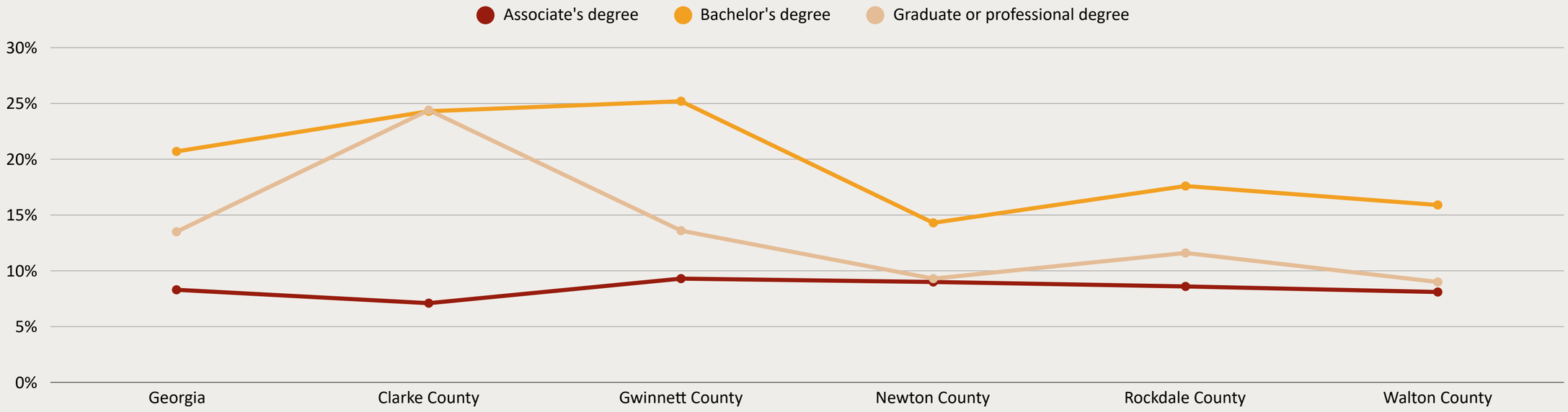


Source: U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2020-2021.

Attainment overview

Educational attainment shows the distribution of the highest level of education achieved, 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, 2019 to 2023

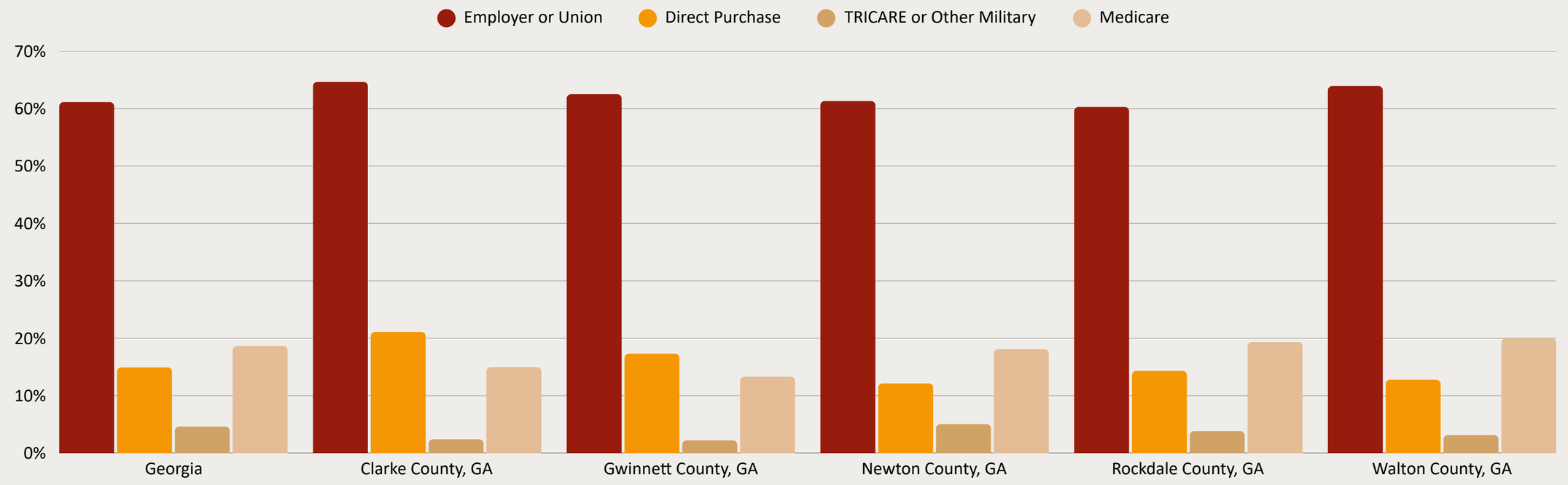


Source: US Census Bureau, American Community Survey, 2019-2023.

Access to care: Insurance overview

In Walton County, approximately 88,000 community members have some form of health insurance coverage. Of those, 76.20% have private health insurance and 37.09% have public health 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.

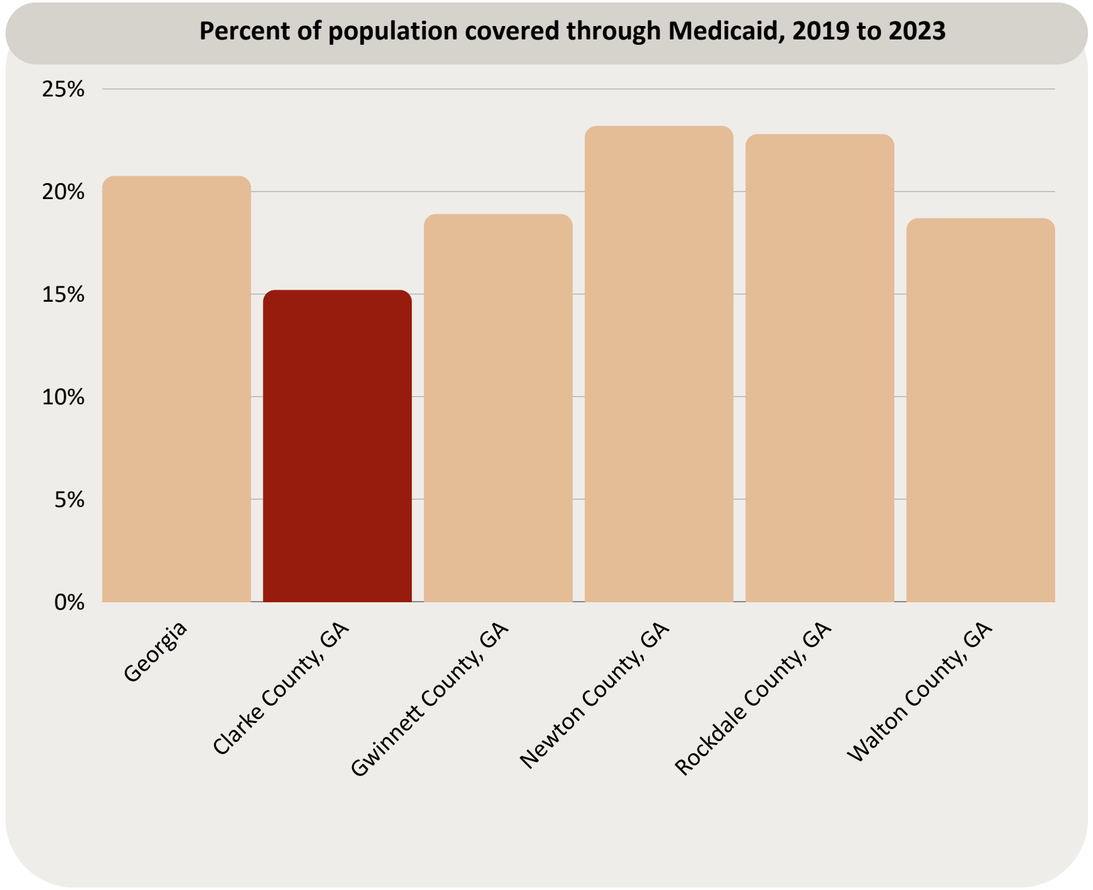
Insurance source type, annually on average, 2019 to 2023



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.



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

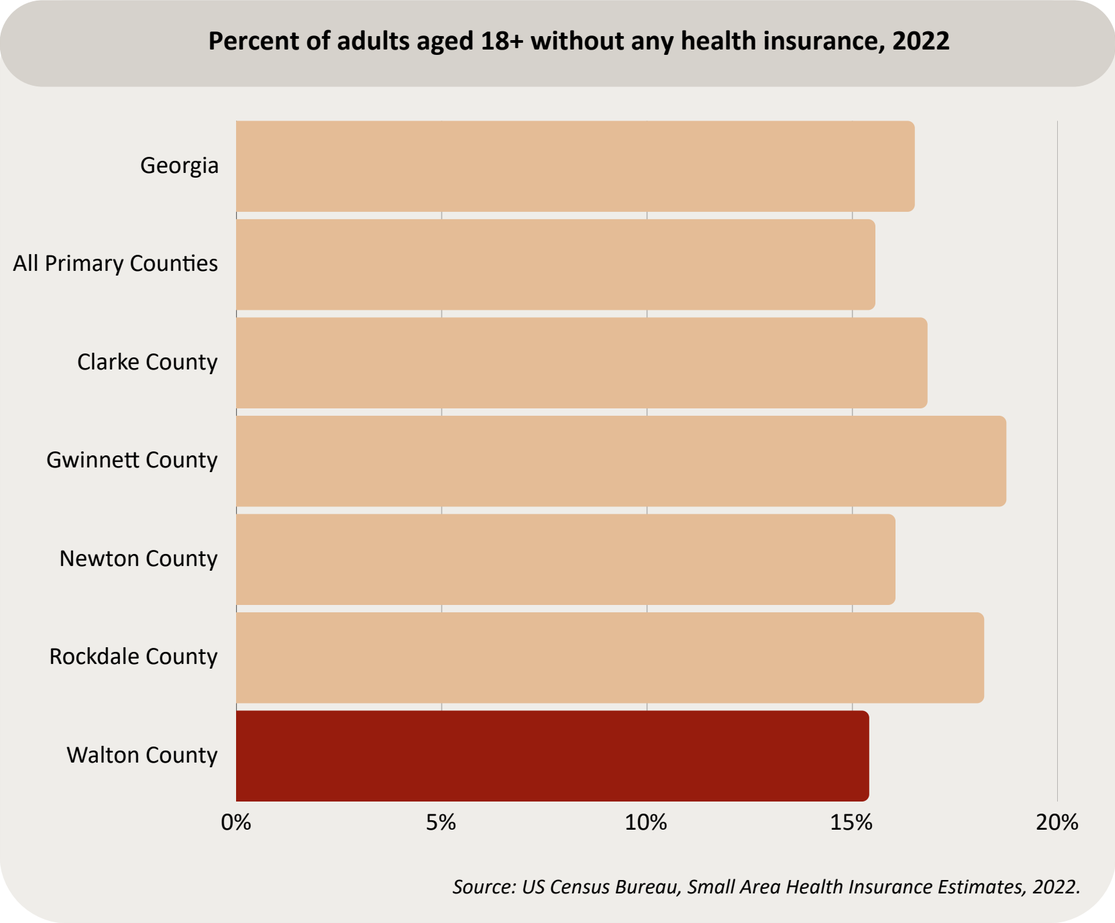
Georgia has not fully expanded Medicaid under the Affordable Care Act (ACA), but offers the Georgia Pathways to Coverage program as a partial expansion for some low-income adults.

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.

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

Populations that are uninsured

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.



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.

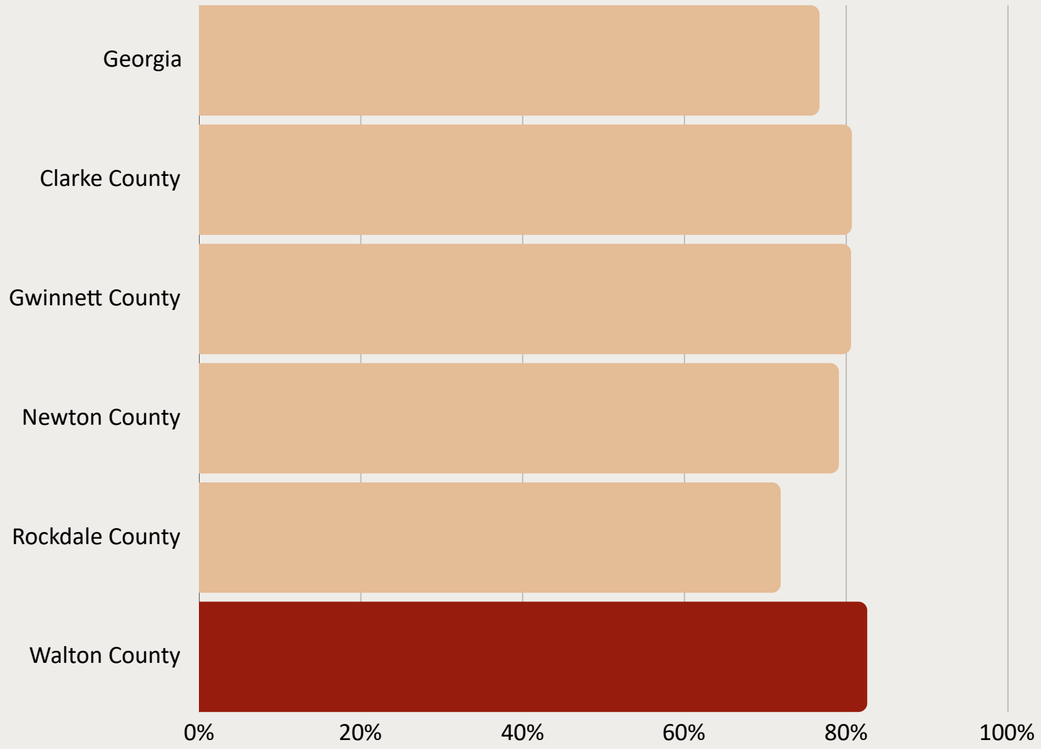
Racial and ethnic disparities: Certain racial and ethnic groups, such as Black, Hispanic, and American Indian/Alaska Native individuals, experience higher uninsured rates and worse health outcomes, exacerbating existing health disparities.

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.

Percentage of pregnant women receiving prenatal care in the first trimester, 2016-2022



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.

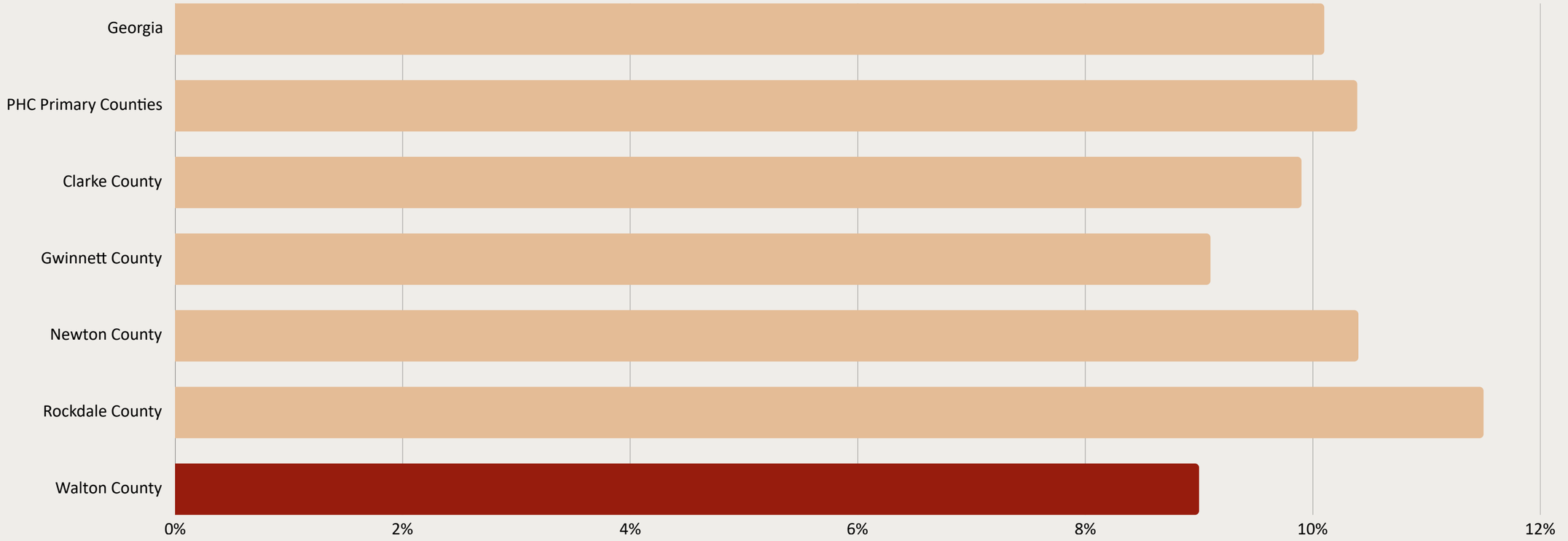
Late or no prenatal care: A higher percentage of Black, American Indian, and Native Hawaiian and Pacific Islander women receive late or no prenatal care, which increases the risk of adverse pregnancy outcomes.

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, Walton County, 2016-2022



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

Screenings

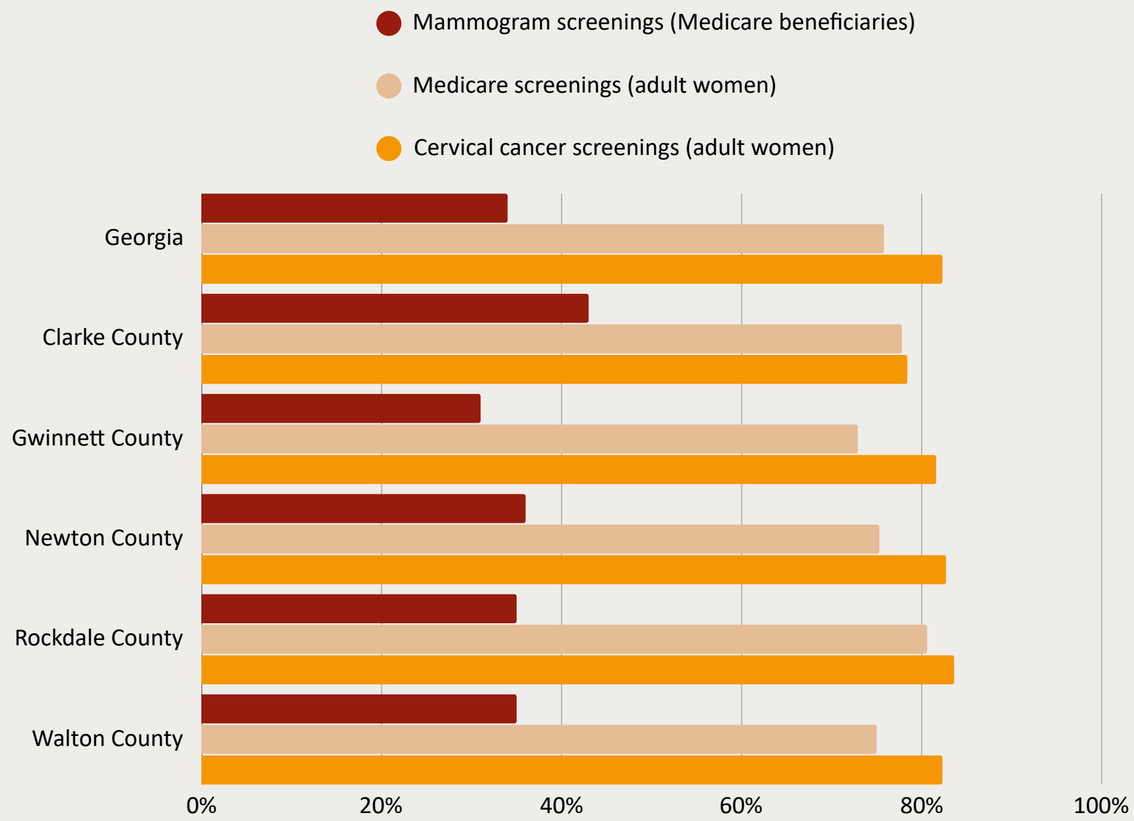
Health screenings are crucial in maintaining and improving overall health and well-being. Here are the key reasons why health screenings are essential:

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, 2022



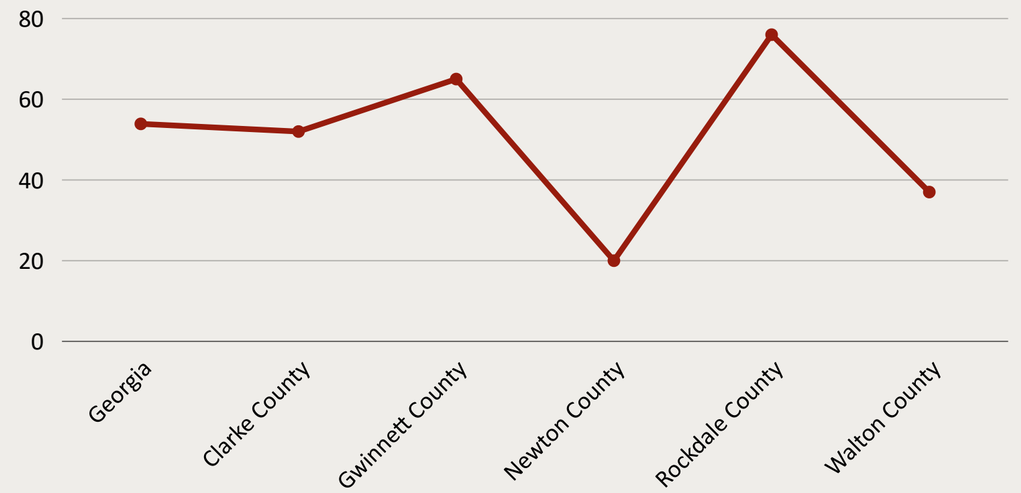
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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 37 dentists for every 100,000 people within the county, a number significantly less than the state rate of 54 dentists for every 100,000 people and the Athens hub average of 59 dentists for every 100,000 people.

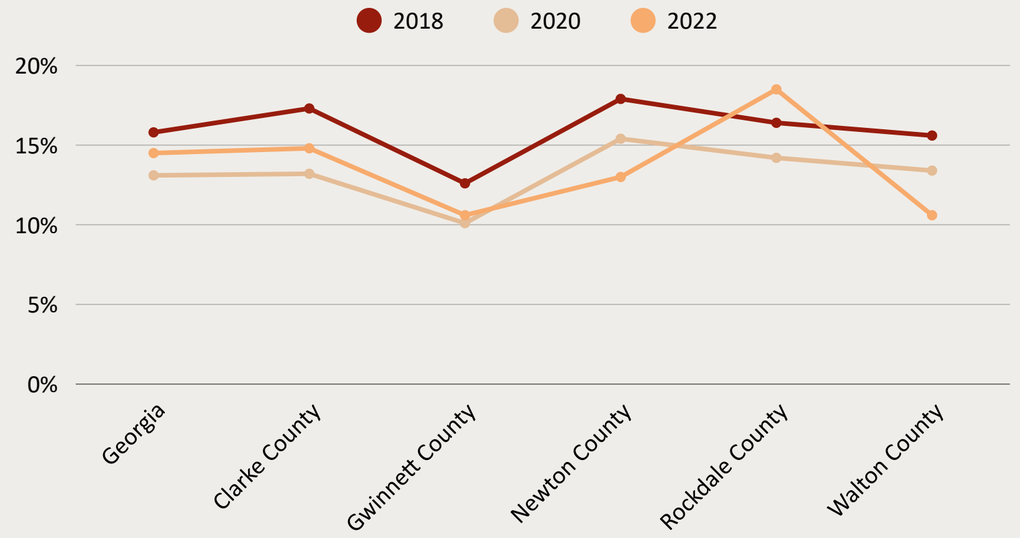
Rate of dentists per every 100,000 people, 2022



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

In 2022, approximately 57.3% of county residents had been to the dentist within the last 12 months. This indicator is often directly tied to dental health, including tooth loss.

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

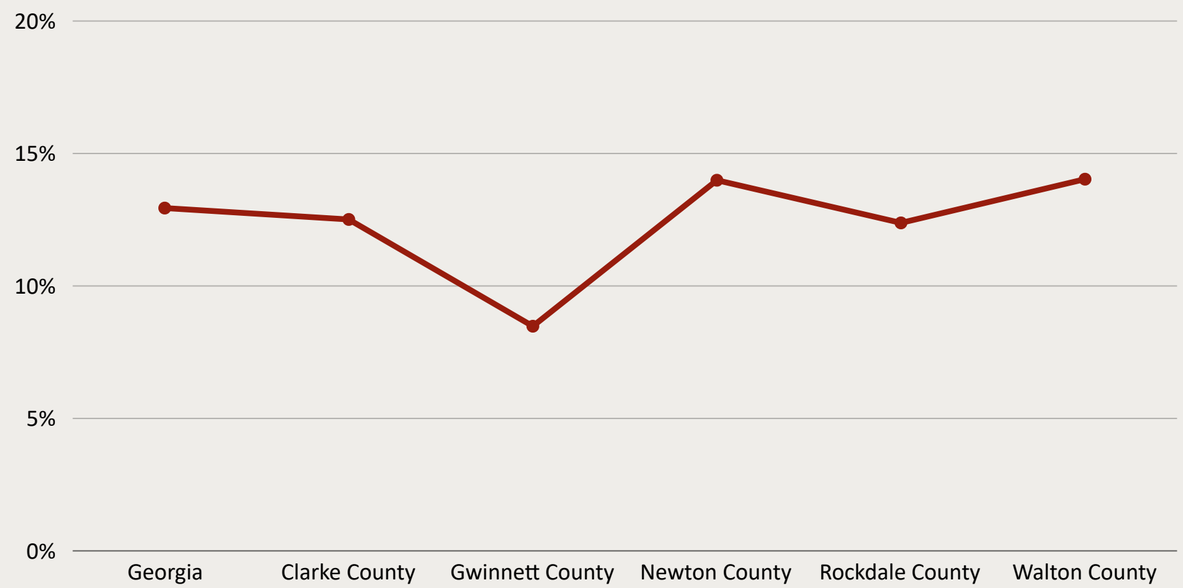


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Disability

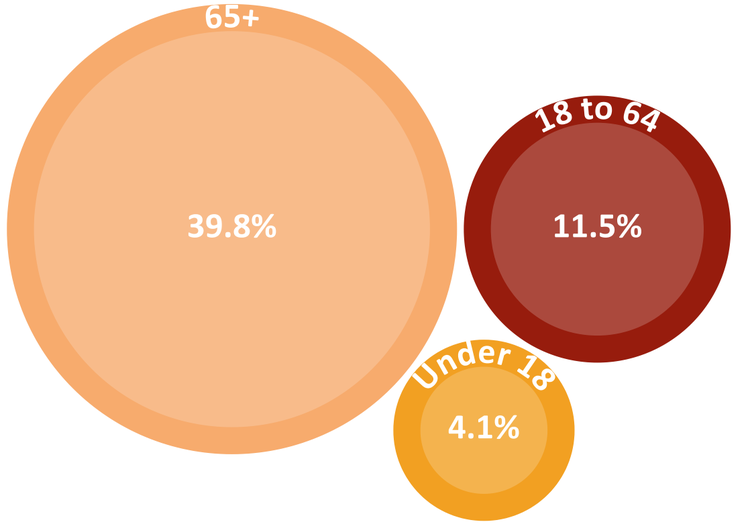
In Walton County, between 2019 and 2023, about 14 percent have some form of disability, according to the US Census Bureau's American Community Survey, including physical and developmental disabilities.

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



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

- **Men and women are fairly close in numbers overall** (13.4% versus 14.6%, respectively).
- **The age group with the highest percentages of disabled populations are those 65 and older**. For Walton County, for example, we see the differences in age breakdown are:



Chronic conditions and those with disabilities

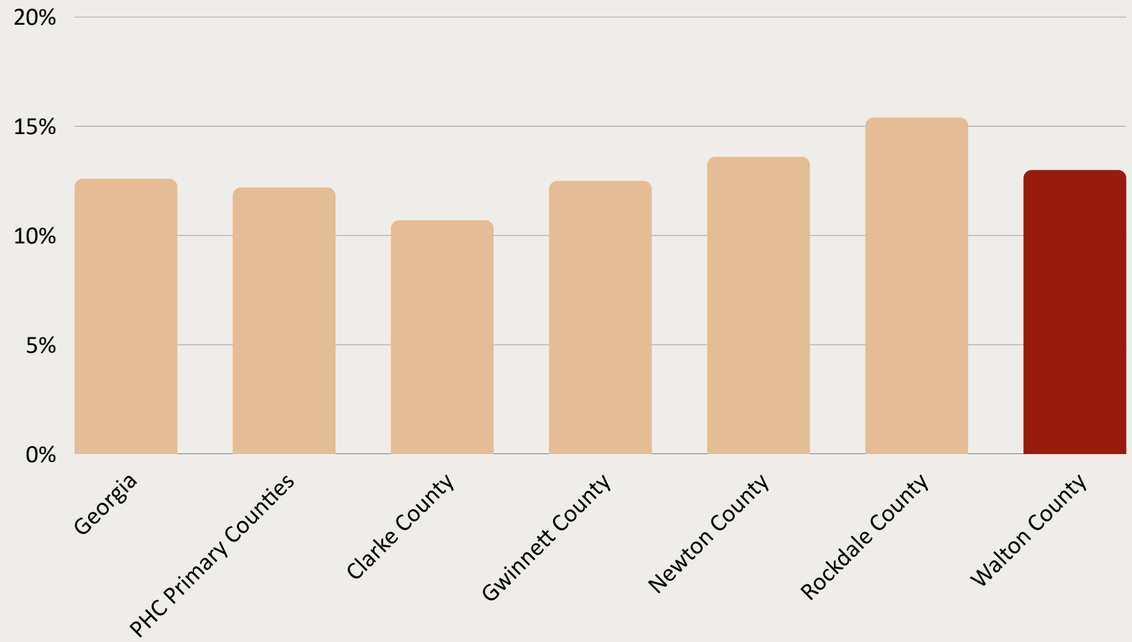
Between 2018 and 2022, the last year for which data is available, we saw the following trends in chronic conditions among those living with a disability:

- **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, 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 county, in 2022, **about 3.3% of the population had kidney disease, which was on par with the Georgia average of 3.3%.**

Asthma and COPD

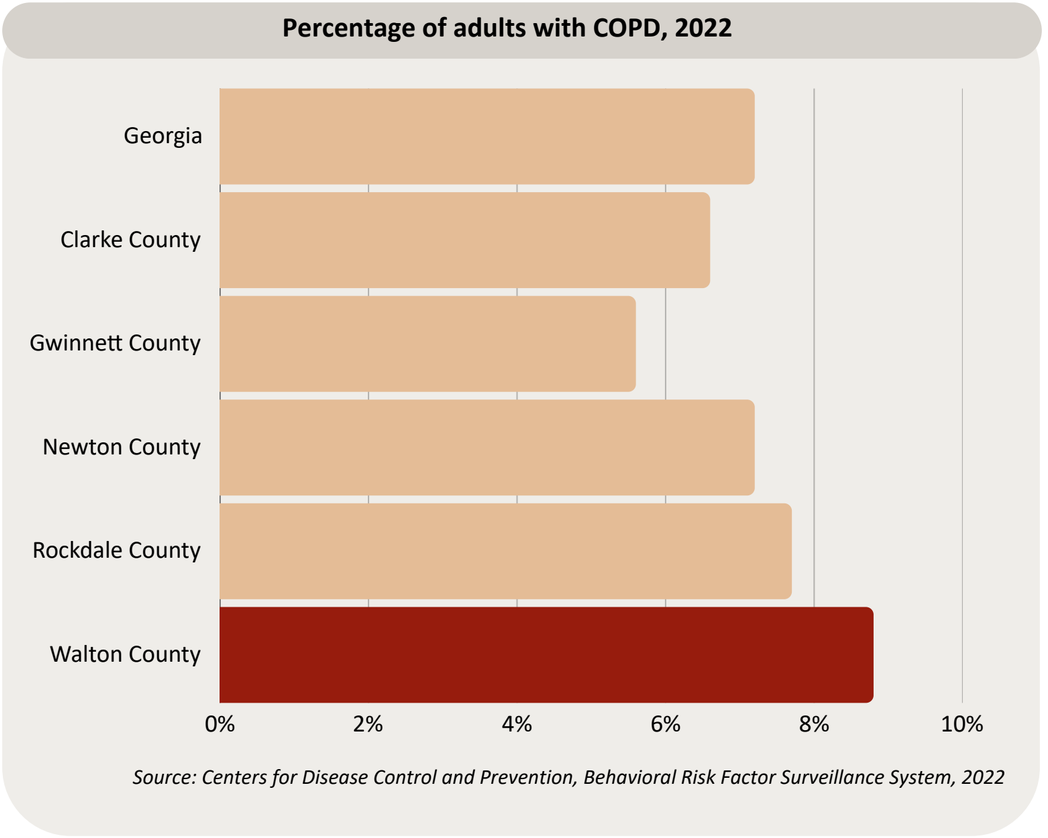
Though they both cause problems with breathing, asthma and COPD are not the same.

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 8.8% had chronic obstructive pulmonary disease (COPD) in 2022 in the county,** which is above the state average of 7.2%.

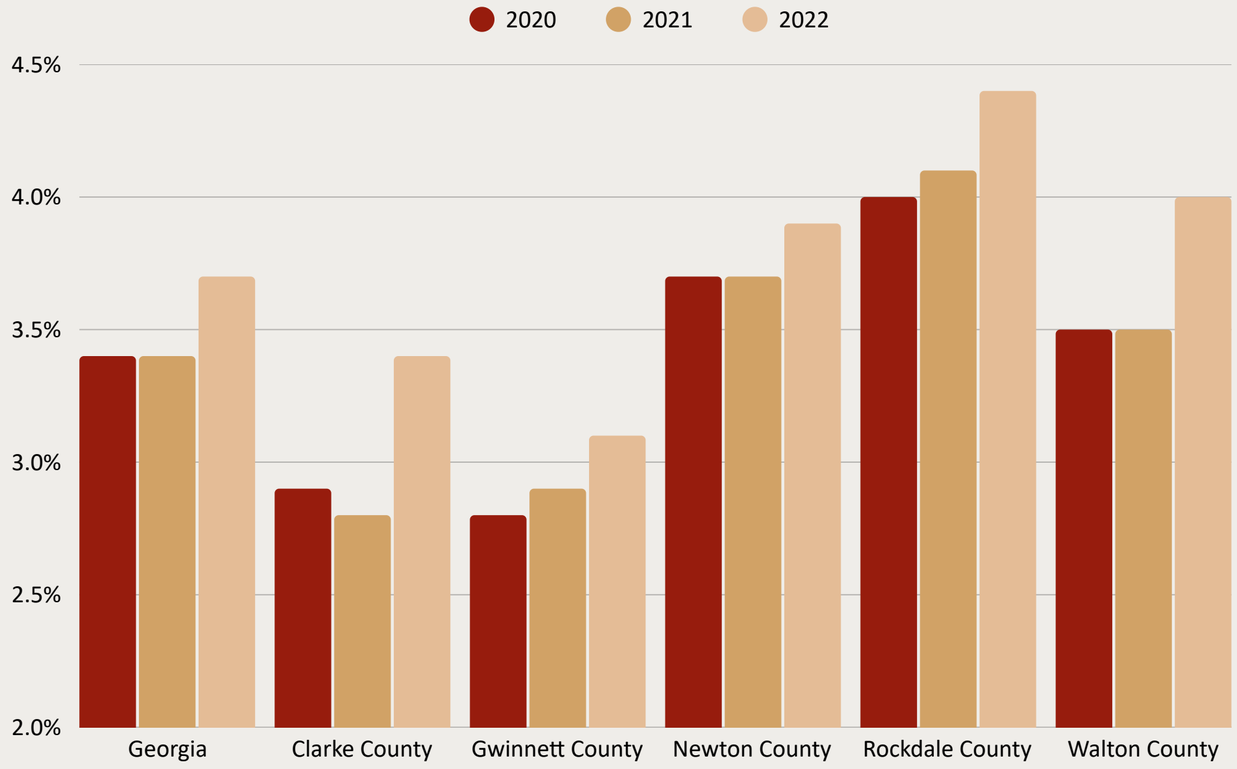
About 10.8% of adults had asthma in 2022 in the county, above both state and national averages.



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.

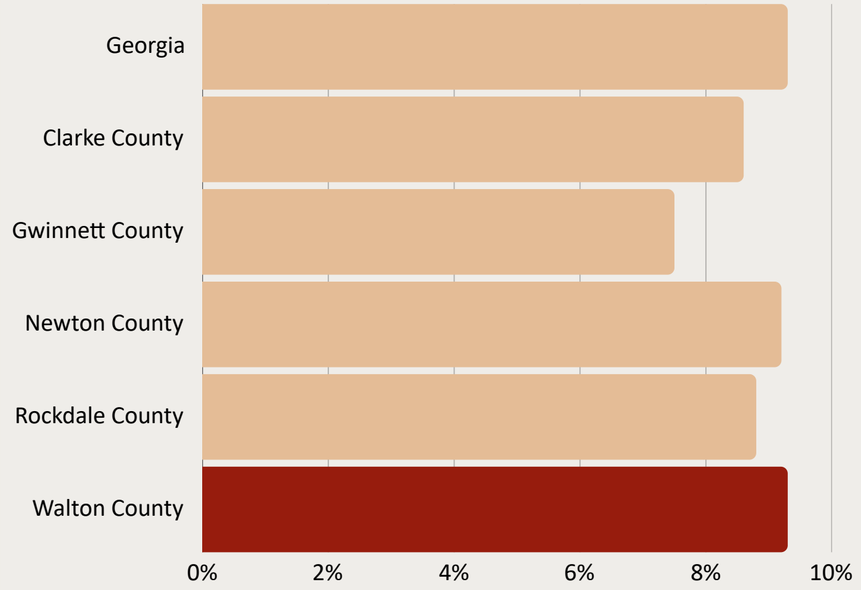
Stroke prevalence among adults age 18+, 2018 to 2022



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, 2018-2021

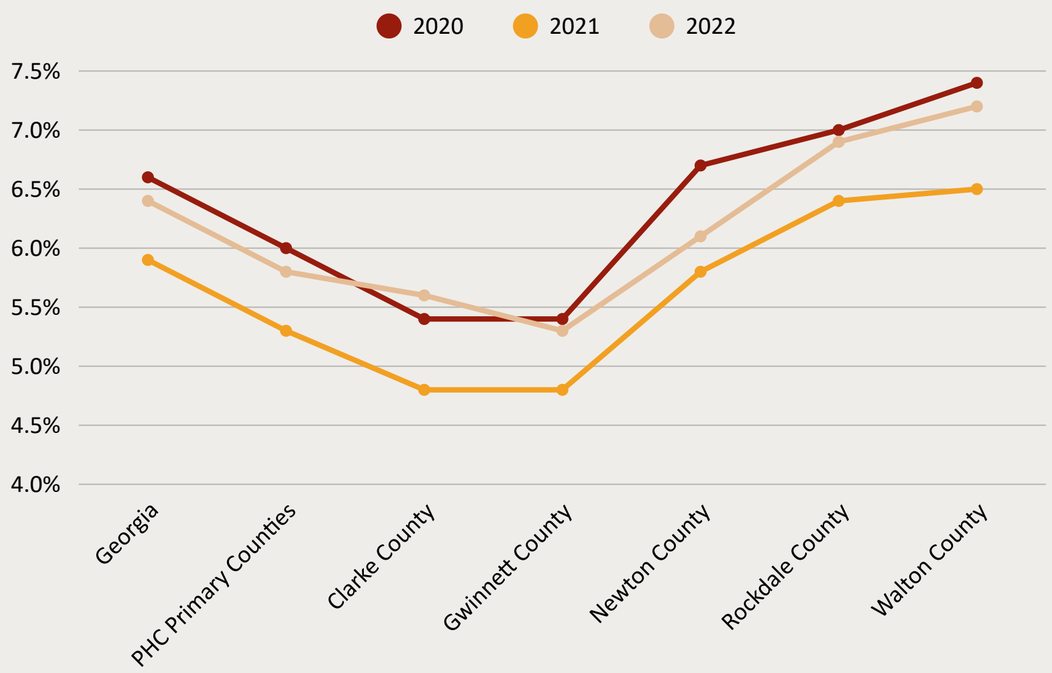


Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2018-2021.

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.

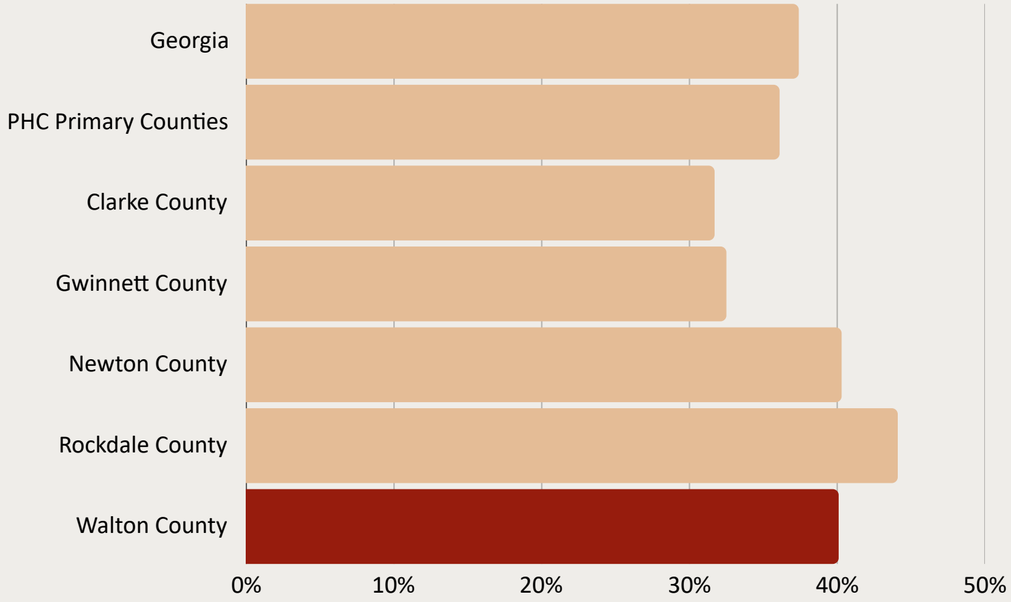
Heart disease prevalence, 2018 to 2022



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, 2021

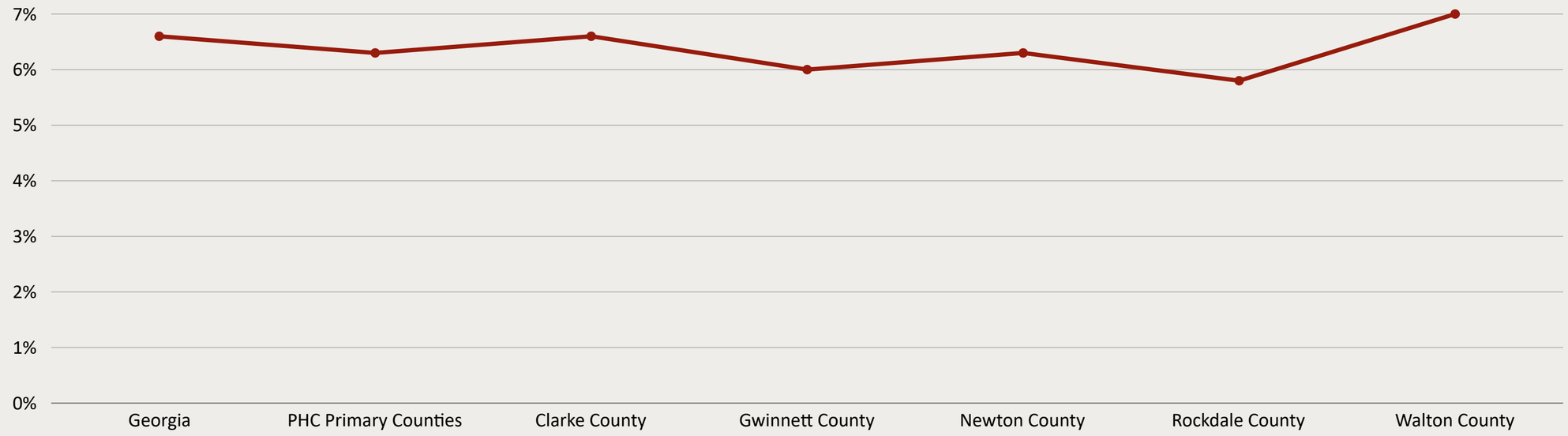


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Cancer prevalence

Cancer remains a top killer within our communities, and age-adjusted cancer prevalence rates for Walton County are slightly higher than state and national averages.

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

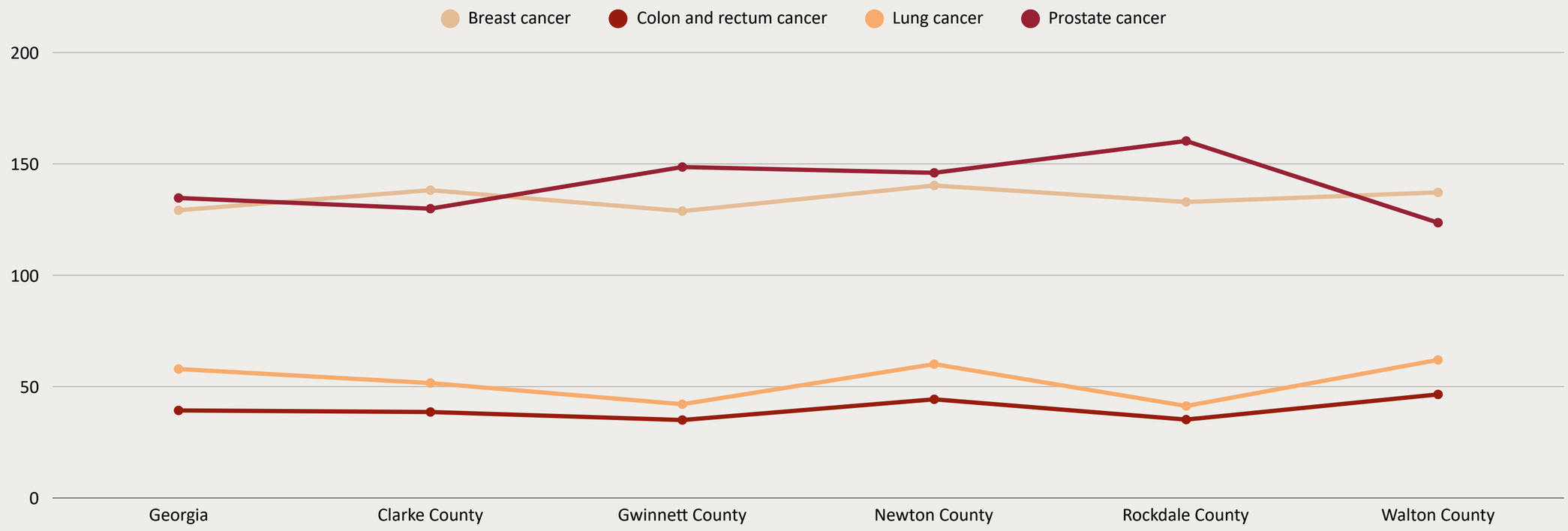


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Cancer incidence by site

Below are the specific incidence rates for certain cancers.

Cancer incidence rates for every 100,000 adults 18+, 2017-2021

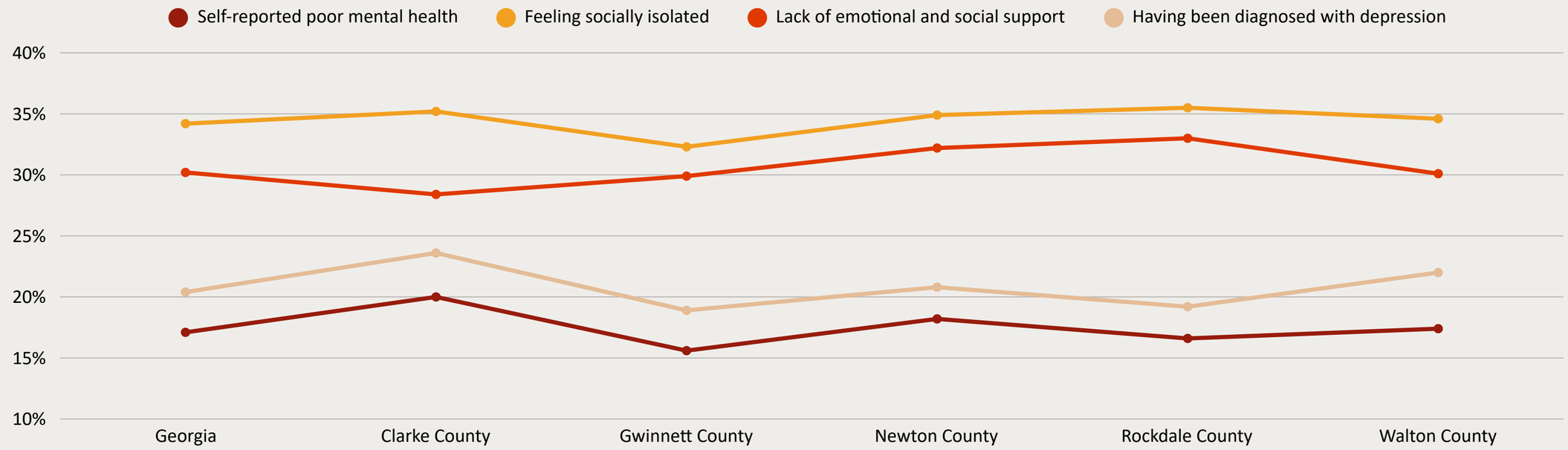


Source: State Cancer Profiles, 2017-2021.

Mental and behavioral health

Mental health encompasses our emotional, psychological, and social well-being, profoundly impacting how we think, feel, and behave 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.

Key mental health indicators for adults 18+, 2022



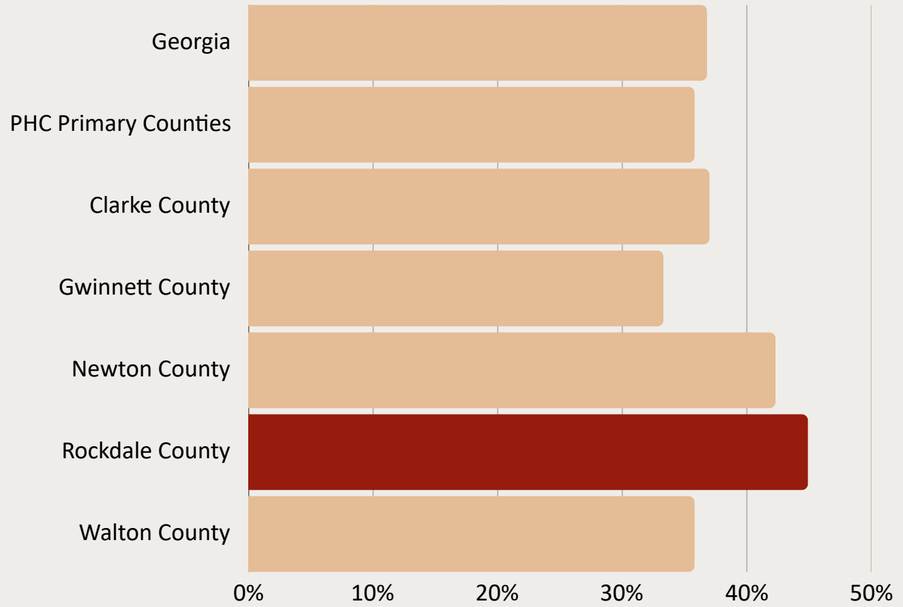
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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, Walton County, 2022



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

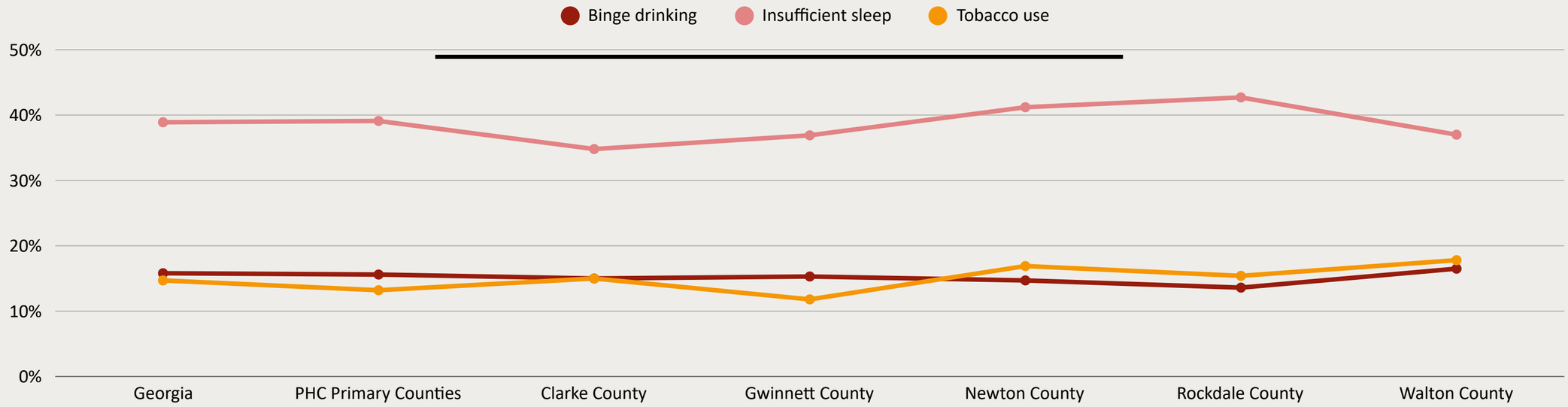
How social drivers contribute to obesity:

- 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.
- Racial and ethnic minorities often experience higher rates of obesity due to systemic inequalities in social drivers of poor health, such as housing, employment, and access to healthcare.

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, 2022

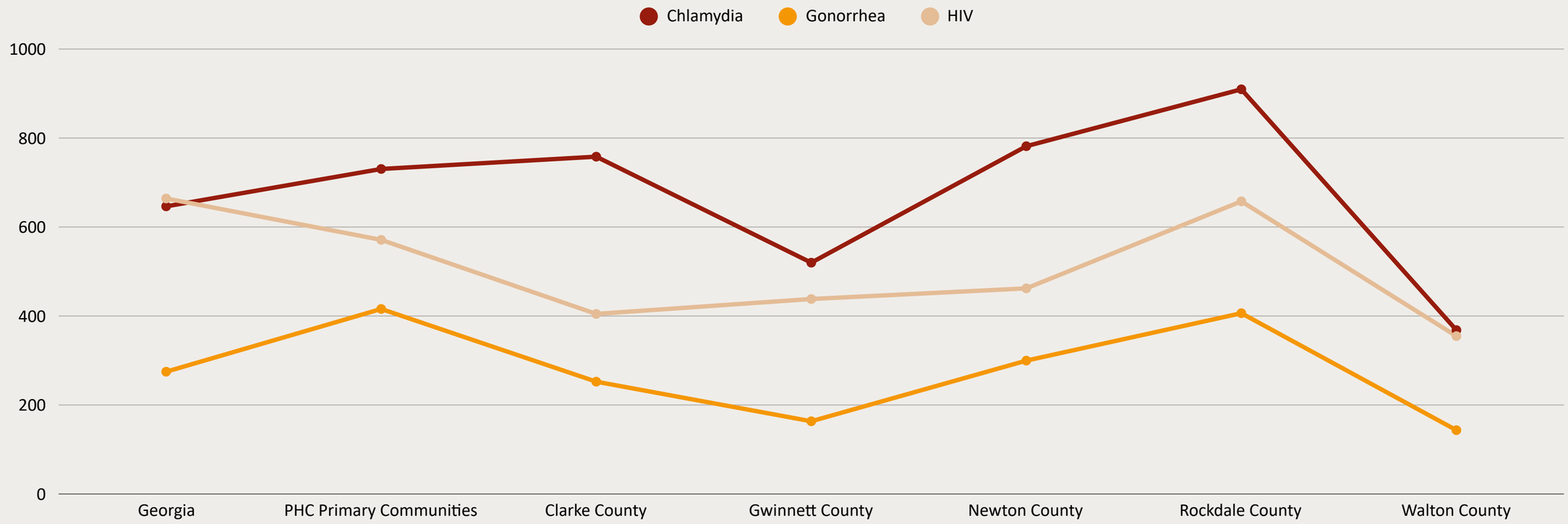


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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

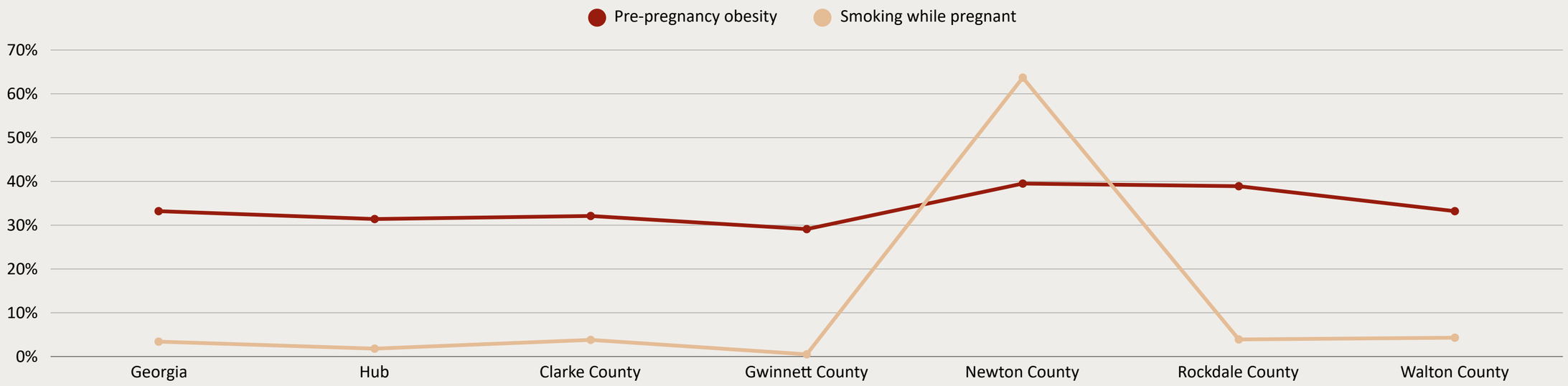


Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2023

Pregnancy 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, 2020-2022

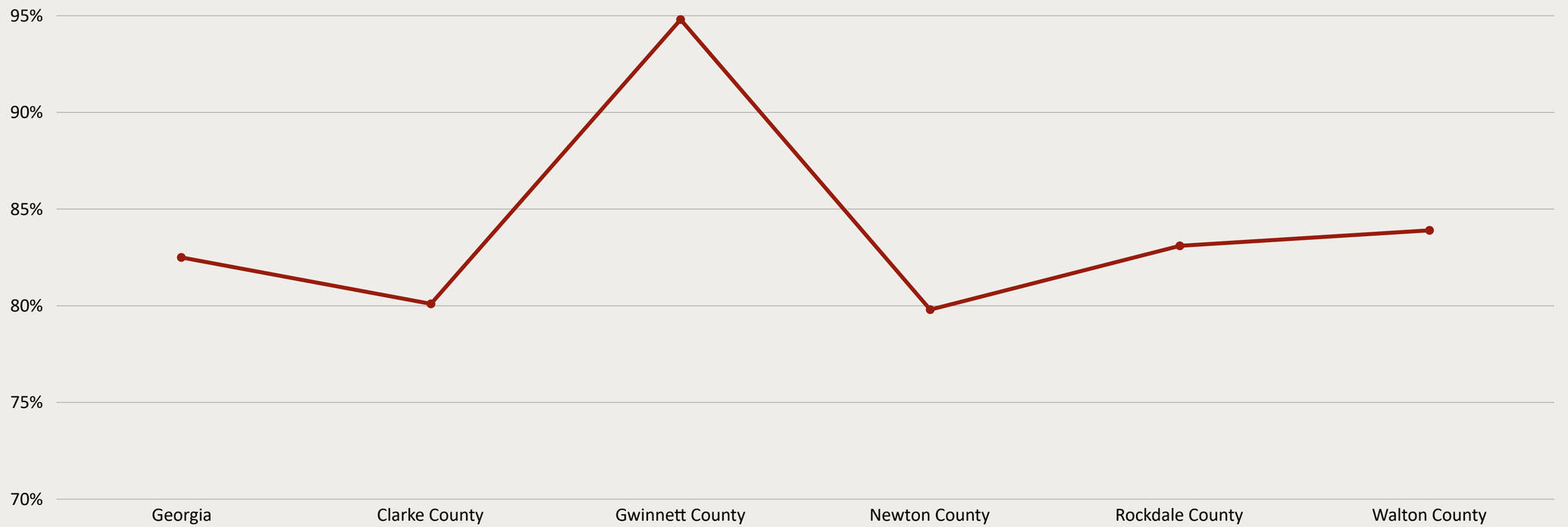


Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Breastfeeding

Breastfeeding is vital for both 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.

Breastfed infants, 2020-2022



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

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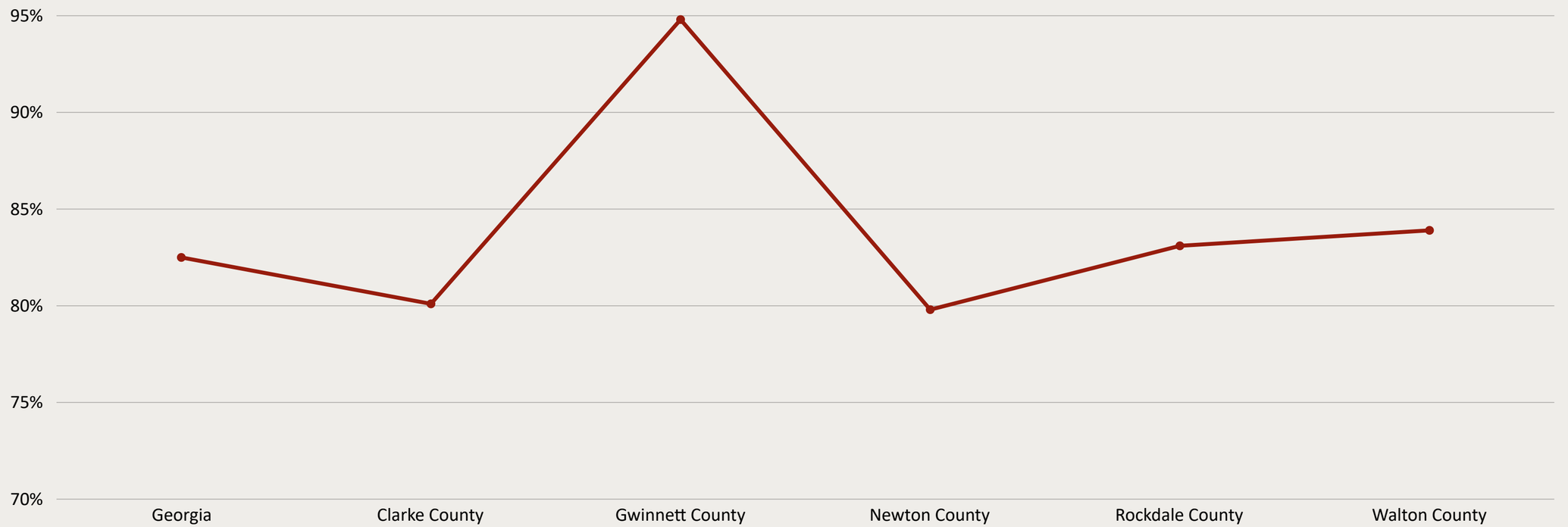
Breastfed infants, 2020-2022

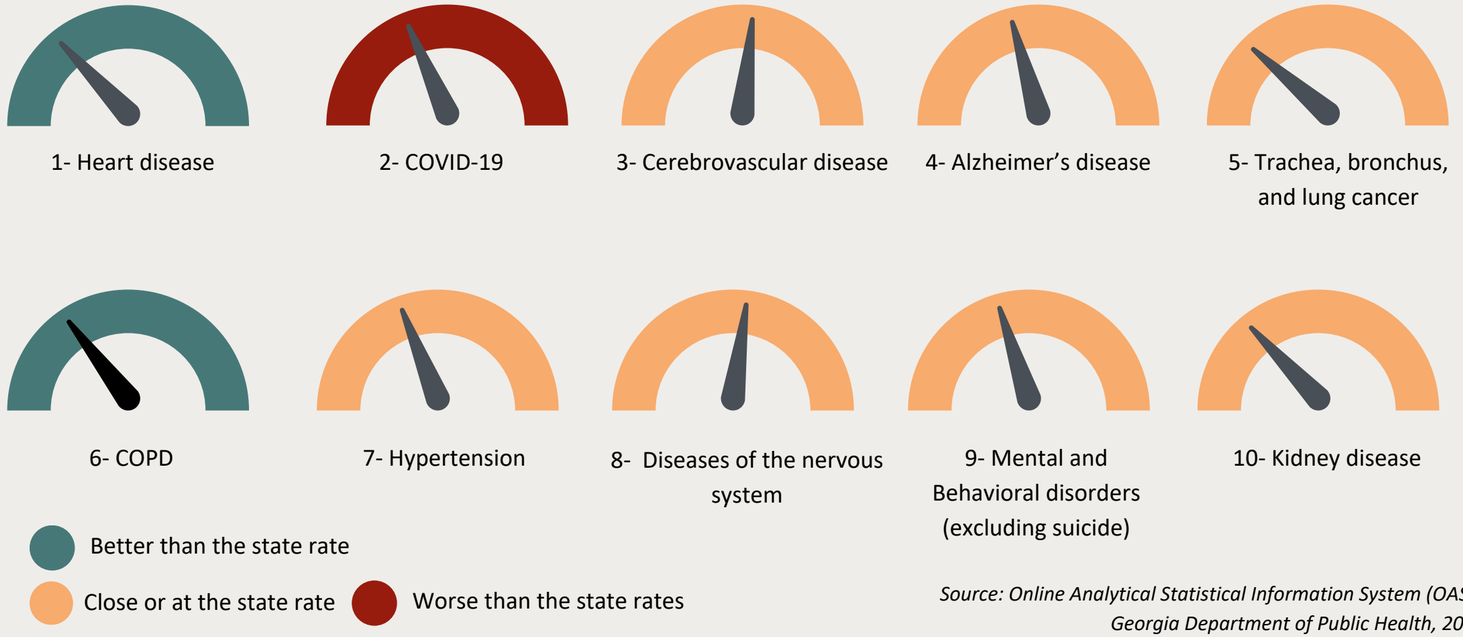


Source: Health Resources & Services Administration, HRSA - Maternal and Child Health Bureau, 2020-2022.

Causes of death

Below are the ten leading causes of age-adjusted death, in total between 2019 and 2023 for Walton 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 by PHC primary service counties, 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: Pneumonia
5-9: Leukemia
10-14: Nervous system diseases
15-24: Motor vehicle crashes
25-44: Accidental poisoning
45-74: Heart disease
75+: Alzheimer's disease

Causes of death by sex and race

Below are the five leading causes of death, by sex and race, in total between 2019 and 2023. Please note information about other races was not available, including a breakdown of top causes of death for Hispanic or Latino populations.

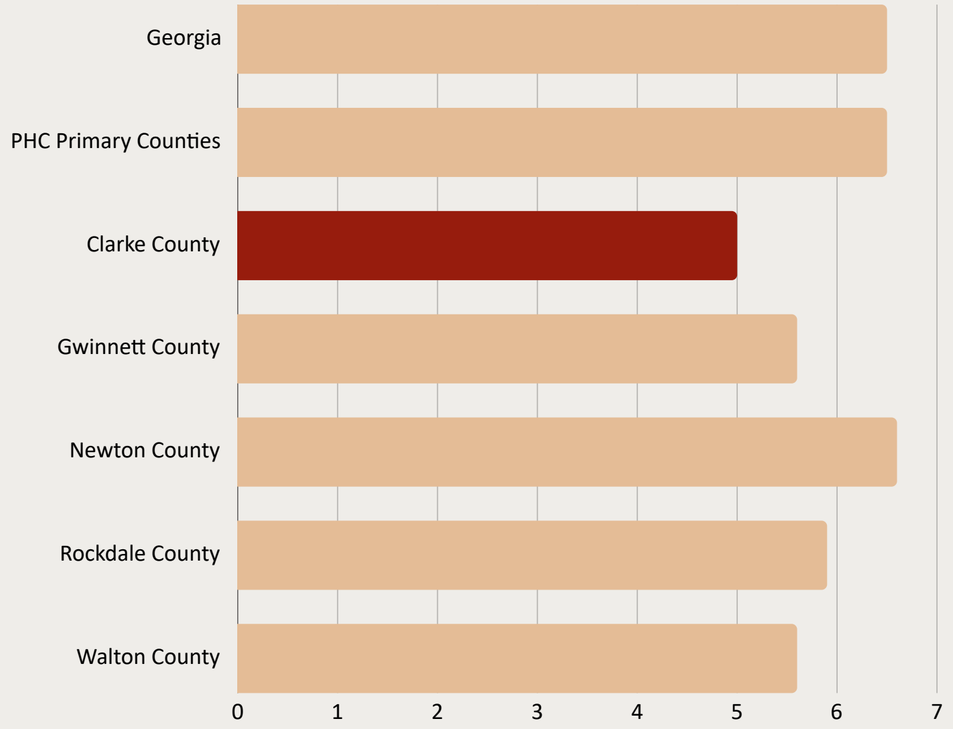
Ranking	Georgia Women	All Women (County)	Black Women (County)	White Women (County)
1	Heart disease	COVID-19	COVID-19	COVID-19
2	Alzheimer's disease	Alzheimer's disease	Hypertension	Alzheimer's disease
3	COVID-19	Stroke	Alzheimer's disease	Stroke
4	Stroke	Hypertension	Heart disease	Heart disease
5	COPD	Mental and behavioral disorders (excluding suicide)	Stroke	Mental and behavioral disorders (excluding suicide)

Ranking	Georgia Men	All Men (County)	Black Men (County)	White Men (County)
1	Heart disease	Heart disease	Heart disease	Heart disease
2	COVID-19	COVID-19	COVID-19	COVID-19
3	Hypertension	Trachea, bronchus and lung cancer	Hypertension	Trachea, bronchus and lung cancer
4	Trachea, bronchus and lung cancer	Stroke	Diseases of the nervous system	COPD
5	Stroke	Hypertension	Stroke	Stroke

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 at being at or below 5 lbs., 8 oz. at birth. Overall, Black populations are at higher risk to have low birth weight babies compared to White or Hispanic or Latino populations.

Infant mortality rate per every 1,000 live births, 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.

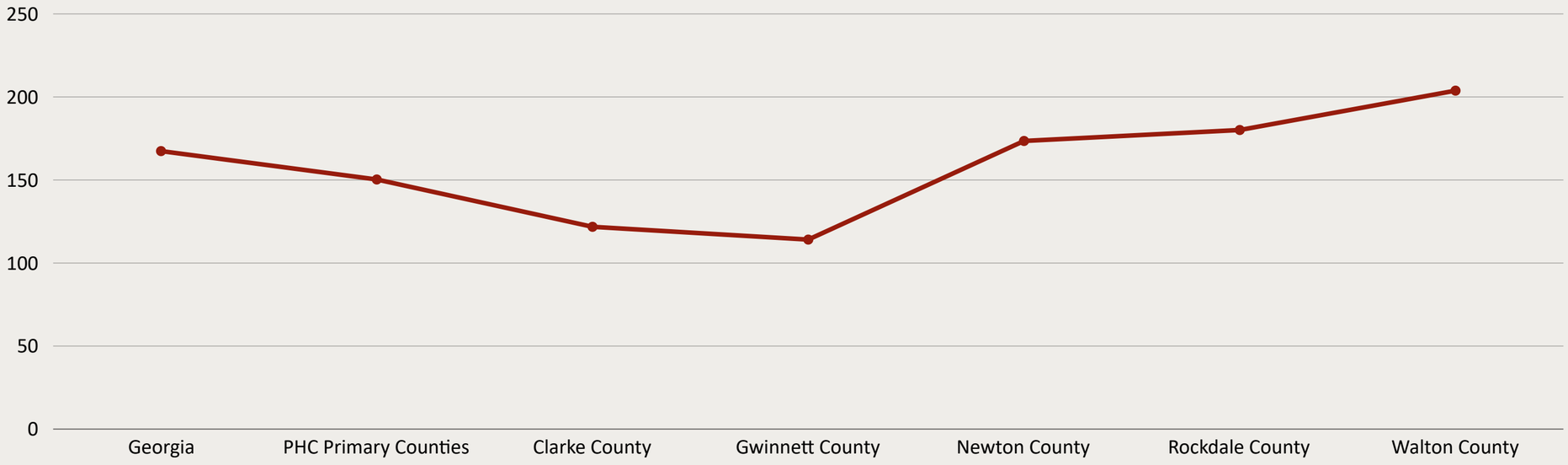
Racial and ethnic disparities

- 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 1,021 Walton County community members died from cancer, resulting in a rate of 203.8 deaths for every 100,000 people.

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

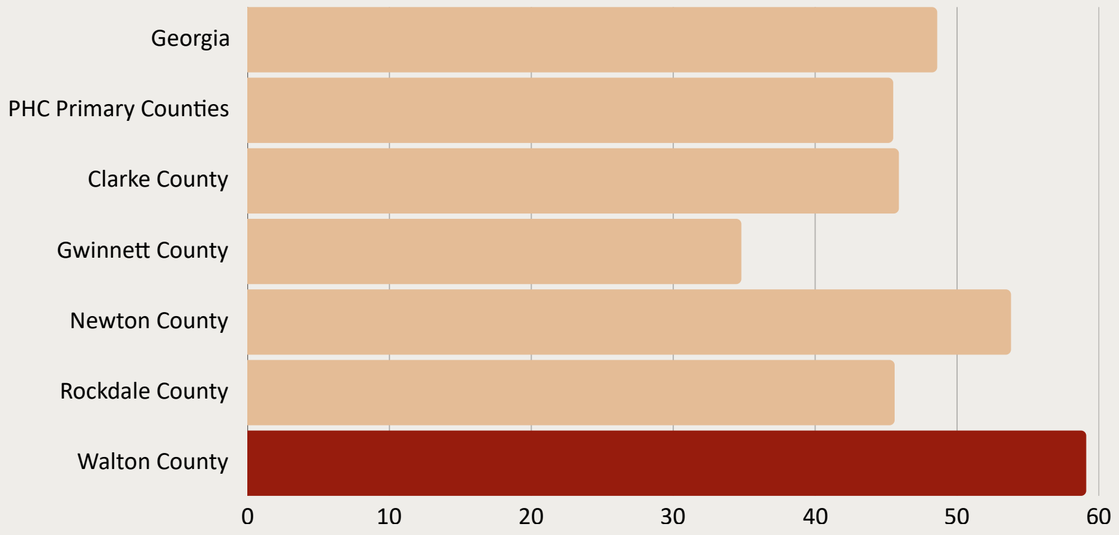


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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, 296 Walton County community members died a death of despair. Of these, over 80% were men and over 70% were white.

Deaths of despair rate, 2019 to 2023



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

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.

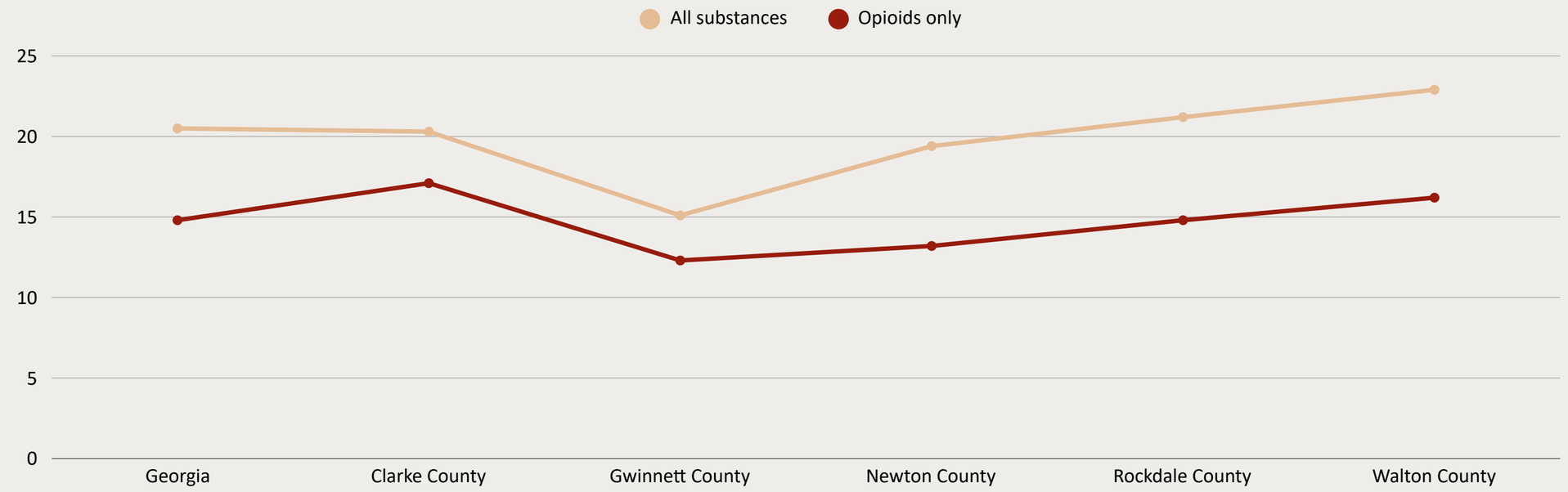
Suicide death rates are highest among people aged 25-44 years old. White individuals have the highest rates of suicide death, followed by Black or African American, Asian, and multiracial individuals.

Some Georgia counties show stark contrasts in "deaths of despair," with certain areas experiencing higher rates than others. That said, usually, the highest suicide rates occur among residents of rural Georgia counties. According to an article published in the *American Journal of Preventative Medicine,* these deaths often happen in clusters, with one of the nation's most significant clusters occurring in north Georgia.

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 Walton County, approximately 115 people died from a drug overdose between 2019 and 2023, a figure slightly higher than the state average and much lower than the national average (20.5 and 29.1 deaths for every 100,000 people, respectively).

Drug overdose death rate, Walton County, 2019 to 2023



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

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