FY25

Community Health Needs Assessment

Piedmont

Columbus Regional Midtown

Piedmont

Columbus Regional Northside

Piedmont

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Executive summary

As part of its mission as a not-for-profit hospital, Piedmont conducted a Community Health Needs Assessment (CHNA) in 2025, an IRS-required triennial process that measures the relative health or well-being of a given community. A CHNA is both the activity and the end product of prioritizing unmet community health needs. This is achieved by gathering and analyzing data, soliciting feedback from the community and key stakeholders, evaluating previous work, and assessing future opportunities.

Through this assessment, we aim to understand local health challenges better, identify health trends in our community, determine gaps in the current health delivery system, and craft a plan to address those gaps and the identified health needs. The FY25 Piedmont CHNA will serve as a foundation for developing our community benefit strategies and further strengthening our community-focused work.

Piedmont Columbus leadership established the following priorities for fiscal years 2026, 2027, and 2028. The hospital's board of directors approved the following priorities in its June 05, 2025 meeting.

Increase access to appropriate and affordable care

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

Reduce preventable instances and deaths from cancer

Reduce the impact of poor mental health

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 a broader population health goal, such as reducing obesity, and we will report on the tactic's impact on the identified population health goal.

There were also health challenges identified in the community that weren't explicitly named as a health priority, though we'll continue to address these issues to the best of our ability. These community health problems include Alzheimer's disease and maternal and child health.

About the hospitals

Piedmont Columbus Regional

Piedmont Columbus Regional dates back to 1836 and now serves as the leading healthcare provider for west Georgia and east Alabama. Piedmont Columbus includes two hospital campuses—Midtown and Northside—a children's hospital, a cancer center, and more than 35 physician practice locations. Piedmont Columbus Regional joined Piedmont Healthcare in 2018.

Midtown Campus

The Midtown Campus is a 583-bed acute-care hospital and the largest in west Georgia. It operates a regional Level II Trauma Center and houses the Bill and Olivia Amos Children's Hospital, the only children's hospital within Piedmont, and a Children's Miracle Network facility. The campus also includes a Level III Neonatal Intensive Care Unit (NICU), a Family Medicine Residency Program established in 1972, and advanced programs in cardiology, neurology, orthopedics, oncology, and maternity care. In FY24, the Midtown Campus reported 87,787 emergency department visits, 8,838 surgeries, 146,667 outpatient encounters, and 15,310 inpatient admissions. The hospital recorded 2,734 newborn deliveries and is supported by 2,000+ employees, 36 family medicine residents, and 10 pharmacy residents.

Northside Campus

The Northside Campus is a 100-bed general acute-care hospital providing medical, surgical, bariatric, gynecology, urology, and general health services. Northside is designated as a Blue Distinction Center by Blue Cross Blue Shield for its bariatric and surgical programs and is recognized as a Comprehensive Bariatrics Center and Surgical Quality Partner.

In FY24, Piedmont Columbus Regional employed 2,700+ staff members, including 90+ physicians and 150+ volunteers, and delivered more than 129,000 emergency department visits, 14,828 surgeries, 161,373 outpatient encounters, and 21,202 inpatient admissions across both campuses.

Piedmont Healthcare

Piedmont Healthcare is a private, not-for-profit organization that annually 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.

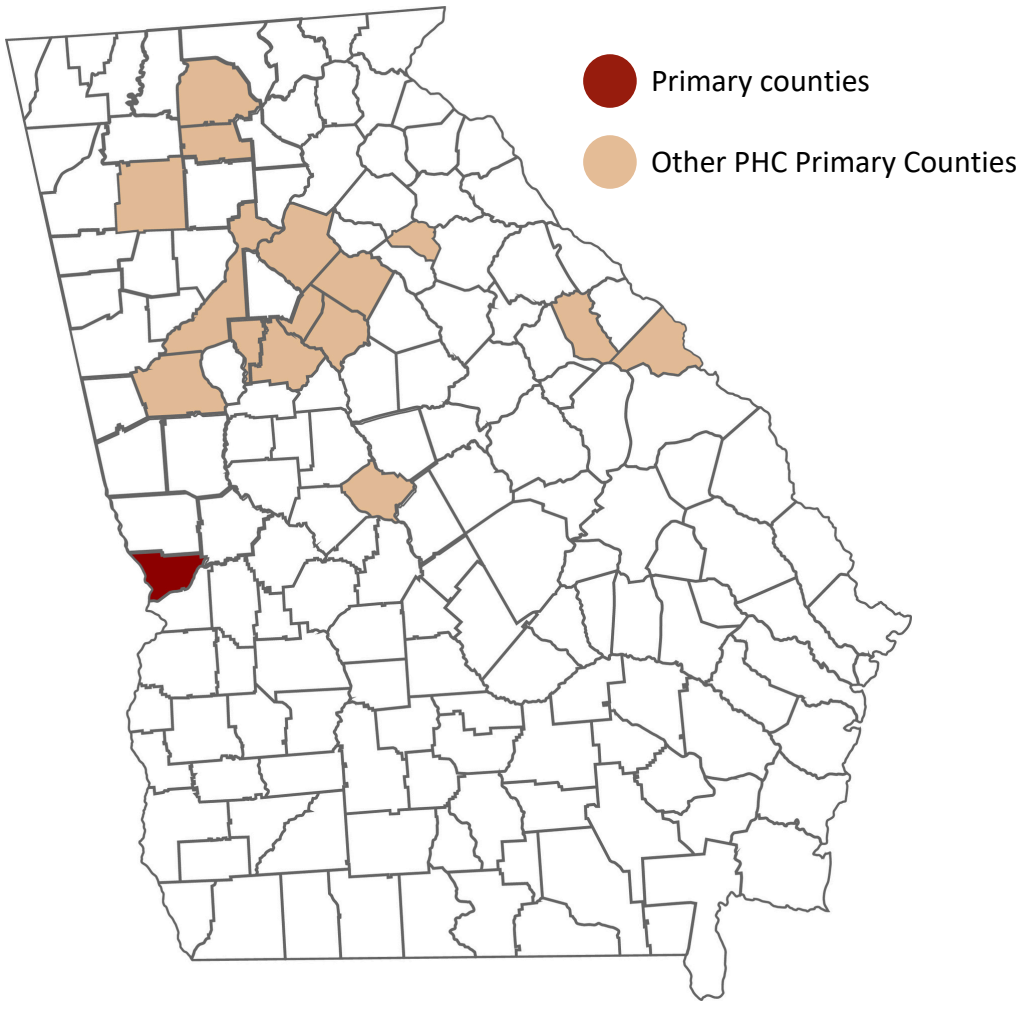
With more than 47,000 caregivers, we are the largest Georgia-based private employer of Georgians, who all came for the job, but stayed for the people. In 2024 and 2023, Piedmont earned recognition from Newsweek as one of America's Greatest Workplaces for Diversity and also as one of America's Greatest 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 FY24.

Defining our community

While Piedmont Columbus serves patients from many counties in the region, for purposes of this CHNA we consider our primary community to be our home county of Muscogee. 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 our secondary communities to be the home counties of our inpatients.

Within this CHNA, we refer to PHC Primary Counties. These are the home counties of the other hospitals within Piedmont Healthcare: Bartow, Bibb, Clarke, Coweta, Fayette, Fulton, Gwinnett, Henry, McDuffie, Newton, Pickens, Gilmer, Richmond, Rockdale, and Walton counties. Even though we use inpatients to establish our community, we look at *all* community members, regardless of whether they are a Piedmont patient. To that end, health priorities and subsequent strategies reflect support of all vulnerable populations, no matter where they receive care.

Piedmont Columbus CHNA community



CHNA methodology

The Piedmont Columbus Regional Midtown and Piedmont Columbus Regional Northside CHNA was led by the Piedmont Healthcare community benefits team and contractor Public Goods Group, with input and direction from Piedmont Hospital leadership, direct input from board members, 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. This included resources from the US Census, USDA, and the US Department of Education.

National Center for Education Statistics, Kaiser Family Foundation's State Health Facts, American Heart Association, County Health Rankings, and the Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2023, unless otherwise noted.

We conducted two community-based surveys: one targeting community leaders and another for patients and community members. Through both, local stakeholders were asked their thoughts on unmet community health needs and the hospital's role in addressing them. These stakeholders included local leaders, nonprofit representatives, elected officials, and those with unique knowledge of vulnerable populations' challenges.

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 plan.

Data analysis
Identify, gather, and analyze qualitative and quantitative data to assess unmet health needs.

Prioritize & Present
Using data, determine priorities; present to the board for approval; finalize publicly-available CHNA.

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

CHNA methodology, continued

Through this process, we evaluated the prevalence of issues within community-focused data, community survey results, stakeholder interviews, and benchmark analyses. Once data collection was complete, PHC community benefit and hospital leadership met to review results, evaluate trends, and identify any potential priorities. Hospital leadership then reviewed all information and established their proposed priorities for FY26, FY27, and FY28.

In 2025, the PHC community benefit and hospital leadership presented the CHNA data to the board of directors, who reviewed the data and approved the proposed priorities. Hospital leadership and their community leads then created implementation strategies for each priority. An implementation strategy is a plan outlining how a hospital will address the priority health needs identified. It details specific actions, planned collaborations with other organizations, the resources to be committed, and the anticipated impact of these efforts to improve community health over the next three years. The hospital's board of directors later approved the implementation strategies.

Throughout the CHNA process, we considered social drivers of poor health and health equity in both data collection and in crafting the implementation strategies.

Social Drivers of Poor Health

The conditions in which people are born, grow, work, live, and age. This includes income, education, literacy rates, employment, housing, food access, neighborhood conditions, transportation systems, and social connections.

Health equity

The state in which everyone has the opportunity to attain full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance.

Key themes

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

- The community has a high percentage of disabled populations – about 17.4% – and these populations need additional support as they are more likely to develop chronic conditions and carry more debt, including medical debt, due to higher health costs.
- Poverty rates are higher, especially for children, than the state average, and median incomes are lower. Student loan debt and any debt in collections rates are also higher than state averages.
- Stakeholders repeatedly expressed concern over potential federal cuts to social services and fear for Hispanic and/or Latino populations accessing needed healthcare services.
- Community members struggle with access to food and safe, affordable housing. Education rates lag, with most children scoring not proficient in reading and math tests, and lower than the state average rates of educational attainment.
- While uninsured rates are slightly better than the state average, they are still high, and low-income, uninsured populations demonstrate some struggles in accessing timely care.

Topic areas that surfaced in both data + community feedback	Conditions that continue to persist in our communities	Situations in the community that lead to bad health
Maternal and child health	Heart disease	High poverty rates
Access to care for minority populations	Cerebrovascular disease	High unemployment rates
Mental health care	Hypertension	High uninsured rates
Access to safe housing and food	Diabetes	Limited access to Medicaid providers
Access to green spaces and exercise opportunities	Cancer	Limited access to healthy foods
		Poor dental health

Top identified issues

We evaluated stakeholder input and available data to detect themes in the data. Below are the top 16 issues that emerged throughout both. They are not listed in order of prevalence or importance.

Accessible and affordable housing	Access to adequate and supportive community-based care
Health costs and medical debt	Knowledge of/availability of relevant resources
Mental health and wellbeing	Concern that federal actions will lead to reduced social services
Education rates, including proficiency for math and reading, and attainment	Obesity and limited physical activity
High rates of uninsurance and Medicaid enrollment	Accessible and affordable transportation
Being underinsured and the costs that come with that	Alzheimer's disease
High rates of populations with disabilities within the community	Food insecurity
Chronic conditions, and especially hypertension and diabetes	Preventative education and especially information that is culturally relevant

Generally, these issues are prominent throughout the community and Georgia, as issues facing patients and their communities tend to be similar in the South. At the time of this CHNA, there is great uncertainty as to the future of certain social and medical services, including potential cuts to Medicaid, concern over education funding, decreases in USDA-supported food programming, and other services targeting low-income and other vulnerable populations.

Primary data

Primary data, or qualitative data is descriptive information that focuses on qualities, characteristics, and concepts rather than numerical measurements. It's gathered from methods like interviews, observations, and written materials to understand behaviors, experiences, and perspectives, providing deeper insights into "why" and "how" something happens. To gain these insights, we talked to people via one-on-one interviews, and conducted two online surveys.

32

Stakeholders interviewed: Interviewees included representatives of public health, charitable clinics, food banks, homeless populations, health advocates, and other community leaders throughout the state.

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 a 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 across the state to understand what makes a healthy community, what barriers prevent health access, and what opportunities exist to best support our communities. These interviews provided a critical context for the external and internal data indicators.

Stakeholder perspectives on health and social concerns in Georgia

- **Geographic and resource disparities ("Two Georgias"):** Stakeholders emphasized that many rural counties continue to lag in health outcomes, reporting higher mortality rates from chronic diseases, lower life expectancy, and greater "years of productive life lost" compared to metropolitan counties. They noted that rural residents face persistent structural barriers—such as limited transportation options, provider shortages, long travel distances, and insufficient broadband access—that hinder access to preventive and specialty care.

- **Provider shortages and underserved areas:** Participants shared that numerous counties across Georgia are designated as Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs), with particular deficits in primary care, obstetrics, mental health, and specialty services.
    - Stakeholders also reported that counties with high diabetes prevalence frequently lack accredited Diabetes Self-Management Education and Support (DSMES) programs, restricting access to vital education and management resources.

- **Socioeconomic and structural social drivers of health**: Stakeholders described persistent challenges related to poverty, unemployment, limited educational attainment, food insecurity, housing instability, and inadequate transportation infrastructure—factors that disproportionately affect rural and low-income communities and heighten health risks.
    - The "digital divide" was identified as a significant obstacle: many Georgians lack reliable broadband or home internet, limiting opportunities for telehealth, remote patient monitoring, and health education.
    - Stakeholders also cited insurance coverage gaps as a significant barrier, noting that Georgia's partial Medicaid expansion has left many low-income adults without coverage or access to affordable care.

- **Health behaviors and risk factor clustering:** Stakeholders observed that obesity remains widespread, with many counties surpassing the state average of approximately 29.6% obesity prevalence. They highlighted that smoking, physical inactivity, poor diet, and chronic stress frequently cluster within disadvantaged communities, compounding risks for multiple chronic diseases and worsening population health outcomes.

- **High maternal mortality and morbidity in Georgia:** Stakeholders consistently expressed concern that Georgia continues to have one of the highest maternal mortality rates in the nation, and in some years, nearly twice the U.S. average.
    - Stakeholders emphasized that rural women—particularly Black rural women—face the greatest risk, noting that rural maternal mortality rates are roughly 50 % higher than those in urban areas.

One-on-one interviews

- **High maternal mortality and morbidity in Georgia, continued:** Stakeholders emphasized that mental and behavioral health conditions—including perinatal depression, anxiety, and substance use—are key contributors to poor maternal outcomes. They noted that limited behavioral health infrastructure, especially in rural areas, restricts screening and treatment options.
    - Chronic conditions such as hypertension, obesity, and diabetes were also frequently cited as drivers of maternal morbidity and mortality, with stakeholders calling for better integration of chronic disease management into prenatal and postpartum care.

- **Role of charitable and free clinics in serving uninsured Georgians:** Stakeholders highlighted that charitable and free clinics play a vital safety-net role, especially for uninsured or underinsured adults who fall outside Medicaid eligibility. These clinics often provide primary care, chronic disease management, dental, and behavioral health services at little or no cost, while reducing preventable emergency department visits.
    - Stakeholders also noted that charitable clinics rely heavily on volunteer providers, philanthropic donations, and limited grant funding, making sustainability a continuing challenge. Expanding partnerships with hospitals, public health departments, and community organizations was viewed as key to maintaining and strengthening this safety-net network.

- **Hypertension and Chronic Disease Burden:** Stakeholders emphasized that hypertension remains one of Georgia's most pervasive and undercontrolled chronic conditions, contributing to high rates of stroke, heart disease, and kidney failure across the state. They noted that limited access to consistent primary care—especially in rural and low-income areas—prevents many residents from receiving early diagnosis, medication management, and ongoing monitoring.

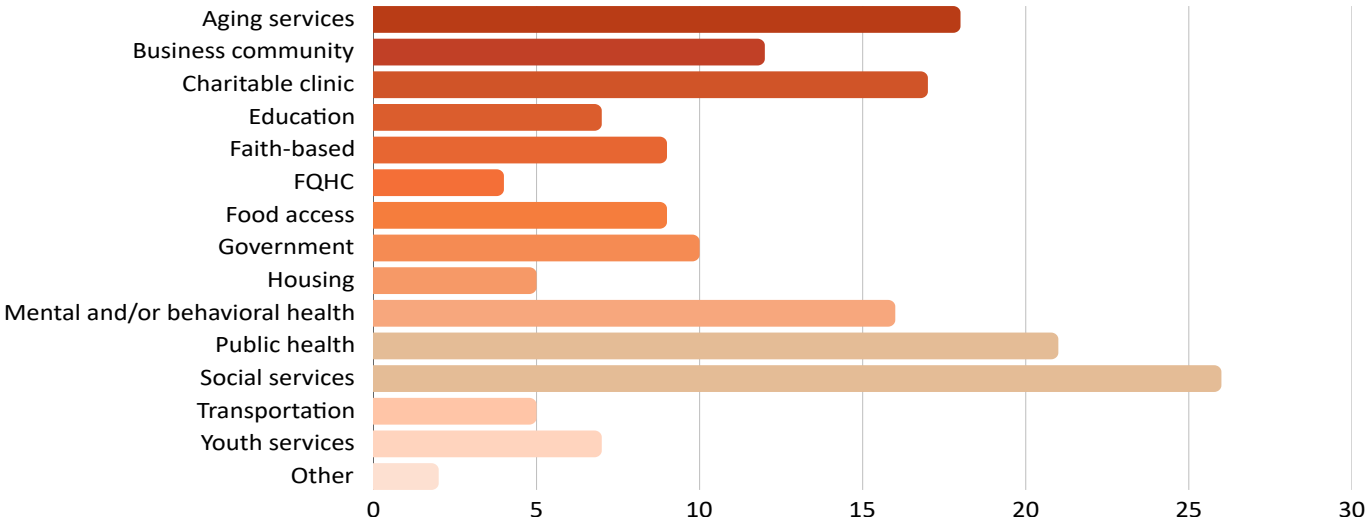
- **Not-for-profit organization uncertainty:** Stakeholders reported that fluctuations in federal funding streams and shifting policy priorities create significant uncertainty for Georgia's nonprofit organizations, particularly those providing health, housing, and social services.
    - Leaders shared that unpredictable grant renewals, delayed appropriations, and changing eligibility requirements make it difficult to plan long-term programs or retain staff.
    - Participants expressed concern that instability in federal budgets can lead to service disruptions for vulnerable populations, forcing nonprofits to scale back outreach, delay projects, or depend more heavily on private philanthropy to fill funding gaps.

> **"Each day we come to work wondering if what will change for our clients -- will we still be able to get the food they need? The medications? For now, they are okay. But tomorrow? We're not sure."**

Community leaders survey

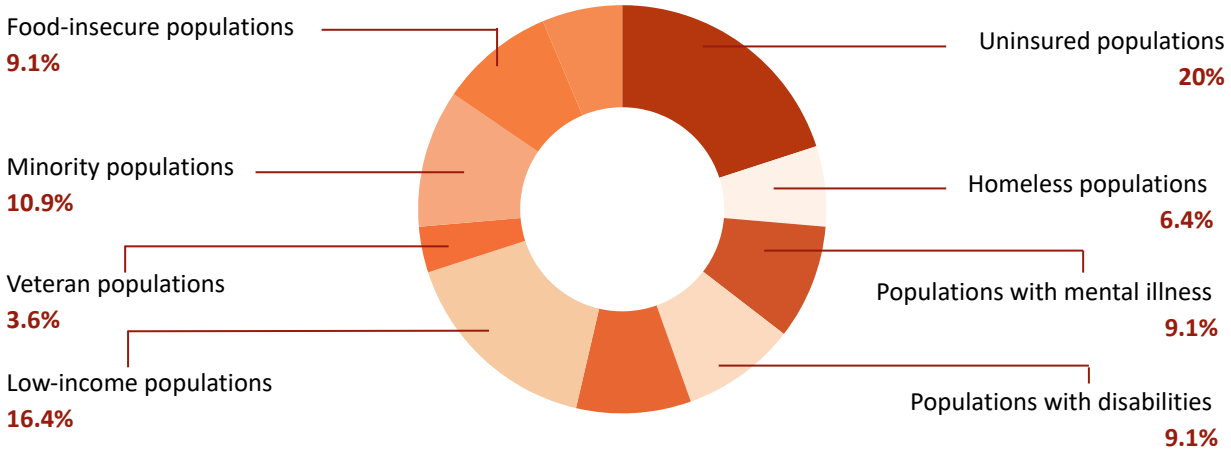
From January to March 2025, approximately 167 community leaders completed an online survey specifically tailored to their unique role within our neighborhoods and cities. The 17-question survey covered topics of community health, community resources, health equity, medical debt, and other related topics.

Survey respondents by area of work



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

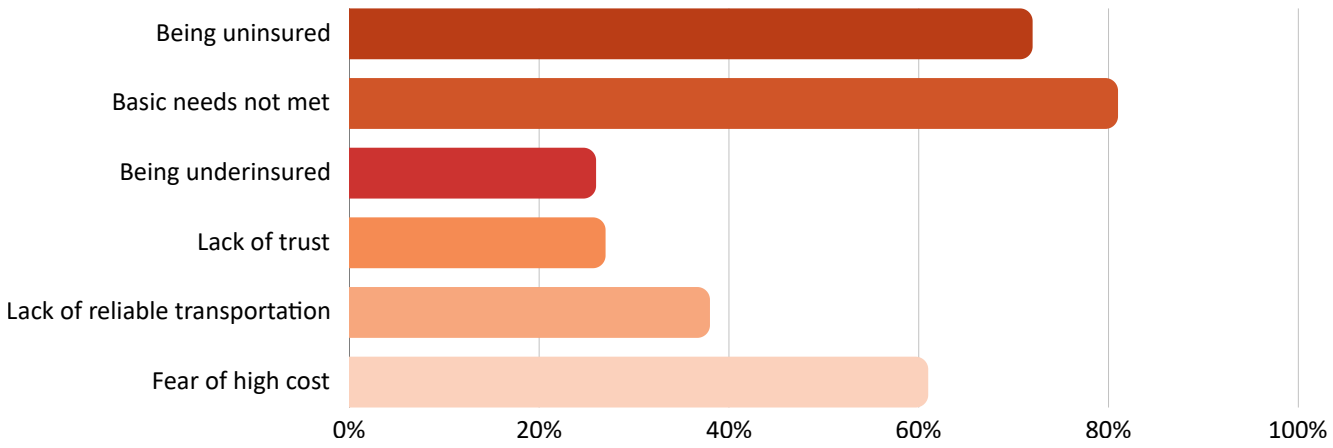
Top populations served by survey respondents



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

Community leaders survey

Top barriers to accessing care identified by respondents



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

Q: How would you define a healthy community? Some responses are below.

"Everyone has reliable access to primary care, nutritious food, and the ability to pay for essential healthcare and prescriptions."

"A healthy community is one where everyone feels seen, supported, and able to get the care they need without worrying about cost or distance."

"People in small towns shouldn't have to drive hours for a doctor or specialist — rural Georgia deserves the same access to care that folks in the cities have."

"When we have access to healthy food, stable housing, and opportunities to stay active, our whole community thrives."

"Mental health should be treated with the same importance as physical health — a healthy community is one that cares for the mind and the body."

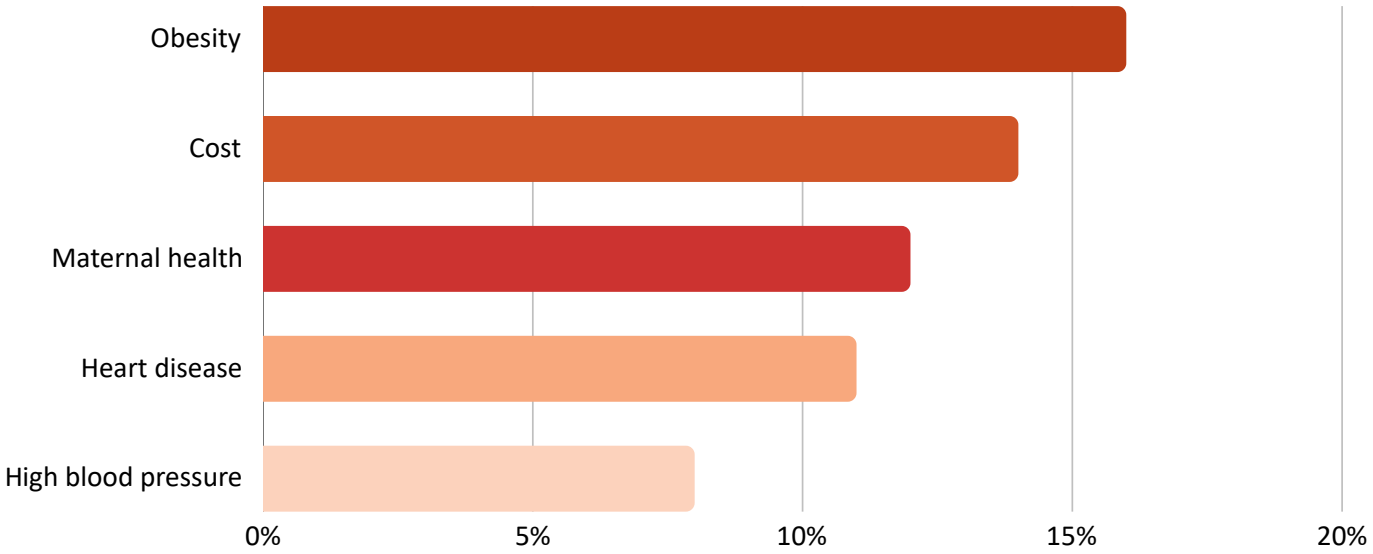
"A truly healthy community gives people hope — it's a place where resources are shared, voices are heard, and everyone has a chance to live well."

"To me, a healthy community means being able to see a doctor close to home, find fresh food nearby, and know your neighbors have your back."

"Our health is tied to our communities — when we invest in our clinics, our schools, and our people, we all grow stronger together."

Community leaders survey

What are the most pressing health concerns in the next few years? Below are the top five keywords used and some quotes.



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

"Chronic diseases like diabetes and high blood pressure keep getting worse — we've got to focus on prevention before it's too late."

"Mental health is the biggest concern now. People are struggling quietly, and we don't have enough counselors or places to go for help."

"Our older adults need more support. Between the cost of medicine and transportation, a lot of seniors are falling through the cracks."

"Access to affordable healthcare is still a challenge — especially for folks without insurance or who work hourly jobs."

"We're seeing more young people with anxiety, depression, and even diabetes. The next generation needs better tools to stay healthy."

"Substance use and addiction are still real issues. We need more recovery programs close to home, not just in the big cities."

"Housing and health go hand in hand — if people don't have stable, safe homes, it's hard to stay healthy or manage their conditions."

"Nutrition and food access are major concerns. Too many families rely on fast food because it's the only thing nearby or affordable."

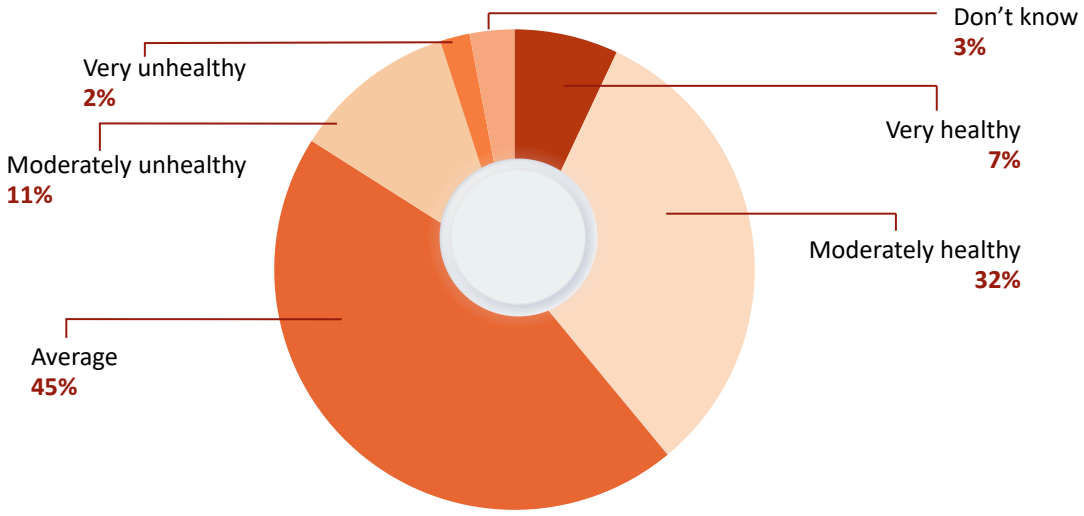
"We've got to take heart disease seriously — it's taken too many people in this community, and it's preventable with the right care."

"I worry about burnout — for healthcare workers, teachers, and families. If we don't take care of the people caring for others, everything else falls apart."

Community survey

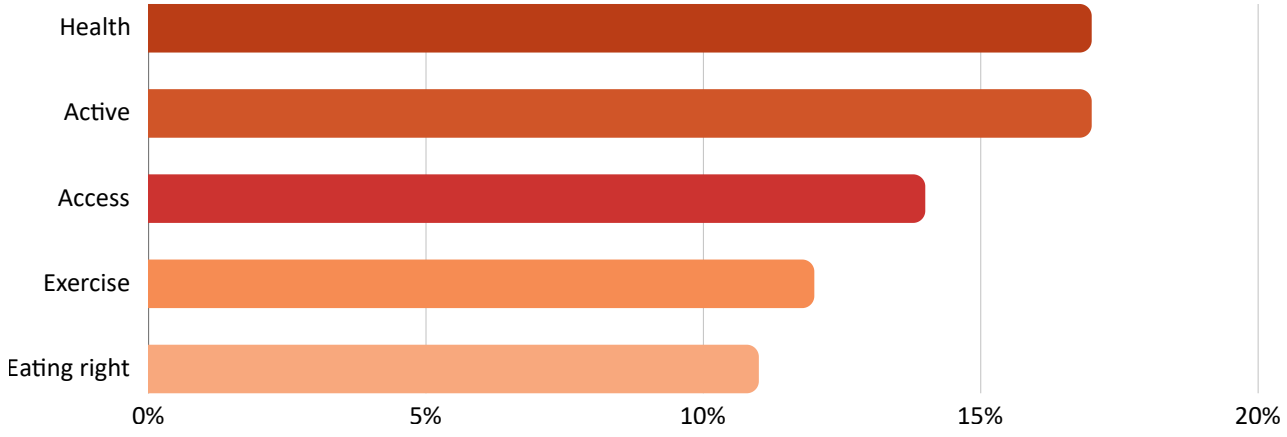
In February 2025, Piedmont launched a five-question survey among its Piedmont Advisors, a group of self-identified community members who often provide feedback to the system. These advisors live and work within Piedmont communities. Approximately 1,266 Advisors provided insight into what makes a community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

Q1: Please rate your community's health, from very healthy to very unhealthy.



Source: Piedmont Advisors Survey, February 2025.

Q2: 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

Q3: What are some positive drivers on health and quality of life in your community? Some answers are below.

"Our local clinic has been a blessing — they treat everyone with respect, whether you have insurance or not."

"The hospital staff truly cares about this community. You can feel it in how they go the extra mile for patients."

"We've got a strong sense of community here — folks check in on their neighbors and make sure people get the help they need."

"It's good to see more health fairs and screenings happening around town. They make health care feel more approachable."

"Our churches and local nonprofits work together to support people with food, medicine, and care — that's real community health."

"I appreciate that even in a small town, we've got dedicated doctors and nurses who care about keeping us healthy."

"Our community has become more open about talking about health — from mental wellness to nutrition — and that's helping everyone feel more supported and informed."

Q4: What are areas of improvement for the health and life in your community? Some answers are below.

"We need more clinics and mobile health units that come to us — not everyone can take a day off or drive an hour just to see a doctor."

"Affordable healthy food would change everything. If we had more grocery stores or farmers' markets close by, people would eat better and feel better."

"Improving mental health starts with access — more counselors in schools, workplaces, and community centers would make a big difference."

"Transportation is a big barrier. Better bus routes or community ride programs could help people get to appointments and jobs."

"Education is key — teaching families about nutrition, chronic disease prevention, and where to find local resources helps us take control of our health."

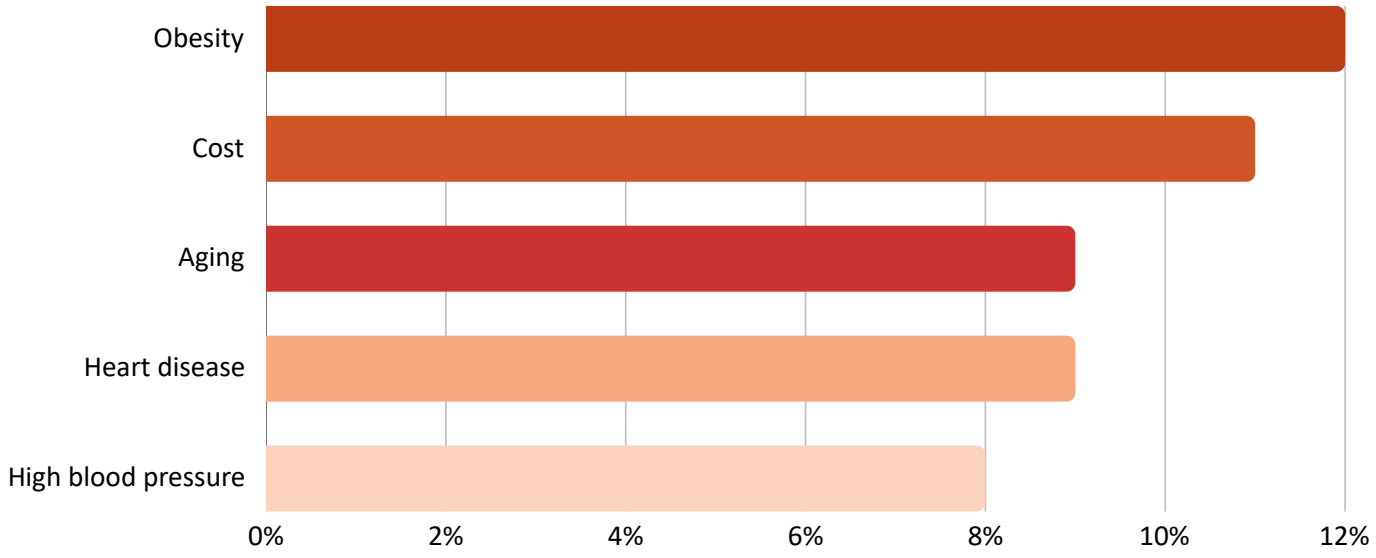
"More partnerships between hospitals, churches, and nonprofits could bring care and information right into neighborhoods that need it most."

"Health care should be affordable and easy to understand. People skip care because the system feels complicated and expensive."

"Rural communities need better internet access for telehealth. We can't use online doctor visits if we don't have reliable service."

Community survey

Q5: What do you see as the most pressing health concerns in the next few years? Below are the top five keywords used and some quotes.



Source: Piedmont Advisors Survey, February 2025.

"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."

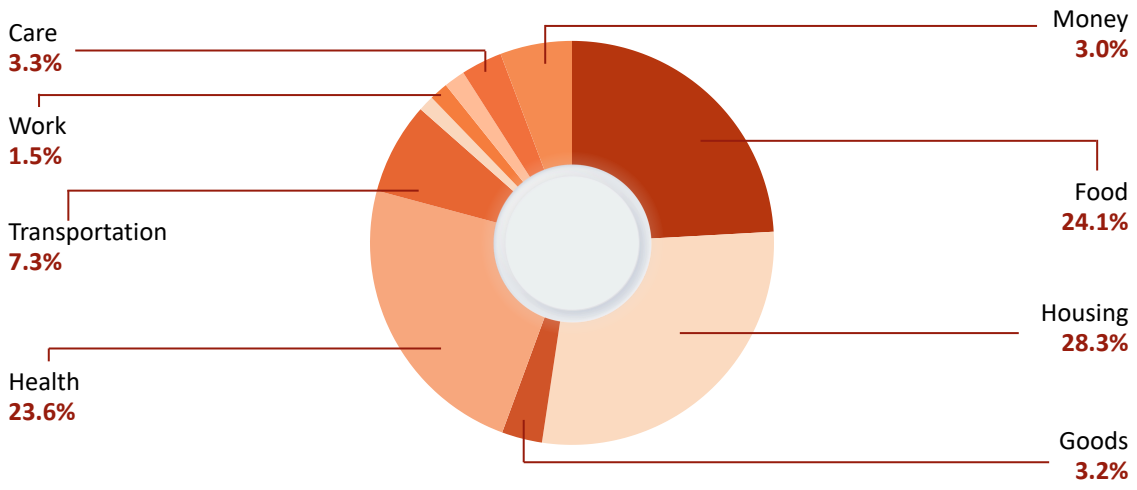
"Misinformation from the talking heads. Health needs to be depoliticized and those "non-doctors" need to remove themselves from the equation. We need to continue to stress the need for public health and others well being. Provide better information about vaccinations due to real concerns of past illnesses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

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.

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



Measurable data

Quantitative data, or measurable data, uses numbers to tell a clear, evidence-based story about what's happening. Instead of relying on opinions or assumptions, it provides measurable insights that reveal trends, patterns, and relationships. When analyzed carefully, these data points offer a grounded view of performance and progress, helping hospital and community leaders understand what's effective, where improvements can be made, and how to plan for the future with greater confidence. In this way, quantitative data turns raw numbers into a meaningful picture of growth, efficiency, and impact.

1,500

health-related quantitative data indicators analyzed from a range of sources that provide measurable information about health status, behaviors, and system performance. National databases like those from the CDC and National Center for Health Statistics collect large-scale data on topics such as chronic disease, nutrition, and healthcare access. Public health surveillance systems track infectious diseases, immunizations, and emerging health threats.

27

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

35

CHNAs from similar hospitals and facilities evaluated for potential sources of indicators and to better understand how other hospitals and systems approach their community's health

Demographics

Approximately 200,000 people lived in Muscogee County annually between 2019 and 2023. This community is primarily urban, comprising about 96% of its population. When examining the population by age during that time, we see that the majority were non-elderly adults.

Non-elderly adults comprise the largest demographic within the community. This is typical of cities; generally, urban areas, and particularly metropolitan areas, tend to have a higher concentration of non-elderly adults. This is likely due to job opportunities, educational institutions, and a wider range of amenities that attract younger populations.

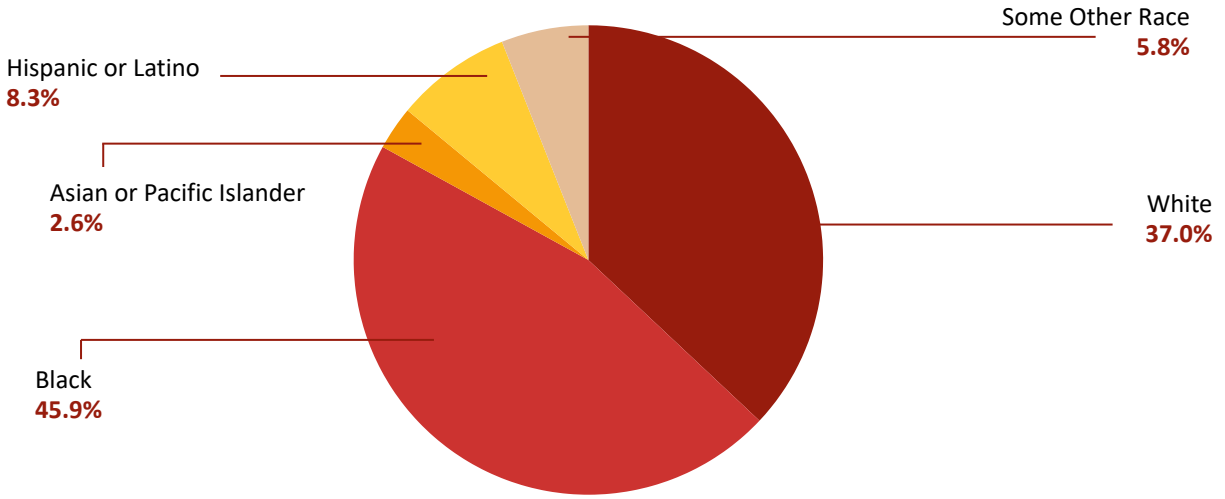
Most families within the full community are English-proficient and only about 6% speak a language other than English at home.

Breakdown by age, Muscogee County, 2019 to 2023

59.3%

- 0-17: 25.0%
- 18-24: 9.1%
- 25-34: 15.7%
- 35-44: 13.2%
- 45-54: 11.2%
- 55-64: 11.4%
- 65+: 14.14%

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



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

Veterans

About 14.3% of the population was comprised of veterans between 2019 and 2023, a figure nearly twice the state rate.

Veteran populations by age group, 2019 to 2023

	Age 18-34	Age 35-54	Age 55-64	Age 65-74	Age 75+
Georgia	2.2%	6.0%	10.0%	13.9%	19.1%
PHC Primary Communities	2.0%	5.9%	10.1%	13.7%	18.6%
Muscogee County	5.8%	14.3%	20.9%	23.8%	20.1%

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

In 2022, about 30.9% of veterans in Georgia had a disability, which is higher than the rate in the general population. This highlights that a substantial number of veterans in the state are living with service-related disabilities.

The shift from military to civilian life can be tough for many veterans. They often face challenges such as finding stable employment, accessing benefits, adjusting to civilian culture, and coping with the psychological impacts of their service. Offering the right support and resources can make a significant difference, helping them overcome these obstacles and successfully reintegrate into their communities.

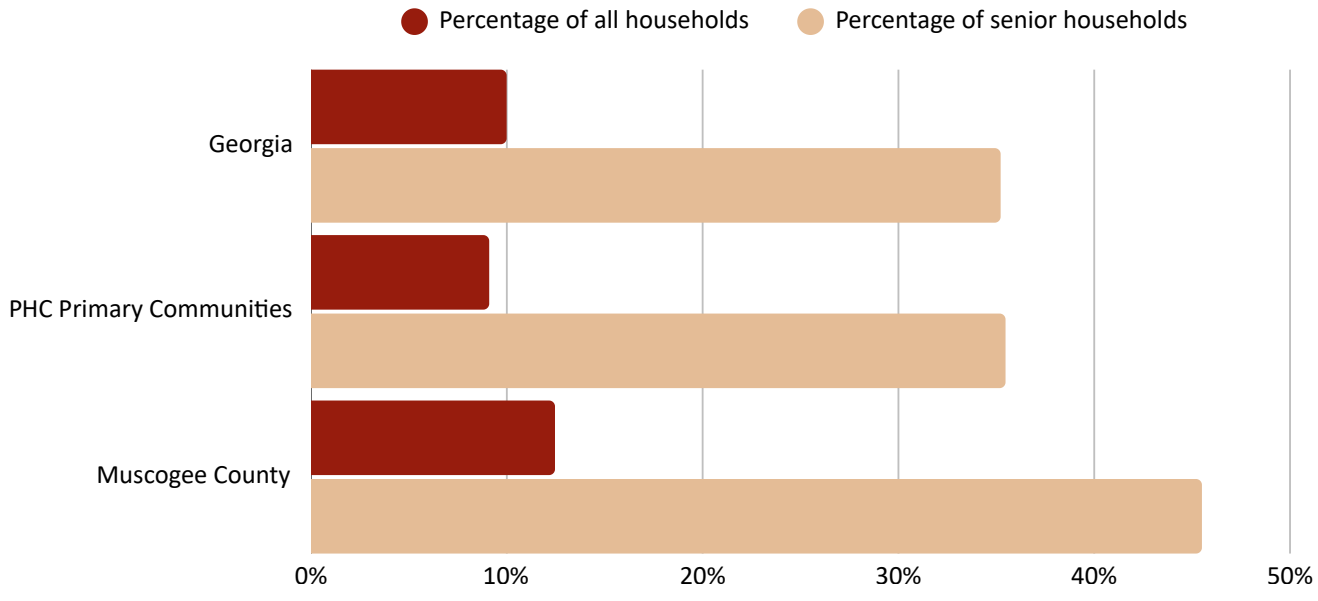
Elderly populations

Social drivers of health have a significant impact on the health and well-being of elderly populations, often worsening existing health disparities and creating additional barriers to accessing quality care. These non-medical factors, including income, housing, access to healthcare, and social support, influence health outcomes and quality of life for older adults.

- Economic factors: Lower incomes are associated with increased risks of disability, earlier onset of disability, and higher mortality rates in older adults.
- Social isolation and loneliness: Lack of social connections can negatively impact cognitive function, increasing the risk of dementia and other serious health problems.
- Health literacy: Many older adults struggle to comprehend medical information, which hinders their ability to make informed health decisions.
- Housing: Older adults living in rural areas may have lower health-related quality of life compared to those in urban areas.
- Access to healthcare: Lack of transportation, affordable care, and insurance can hinder access to timely and effective medical care.
- Social support: Strong social networks can provide emotional support, help with daily tasks, and improve overall health outcomes.

Senior populations face many challenges, and living alone creates additional barriers, particularly for those with limited mobility and high health needs.

Percentage of households where seniors live alone, 2019 to 2023

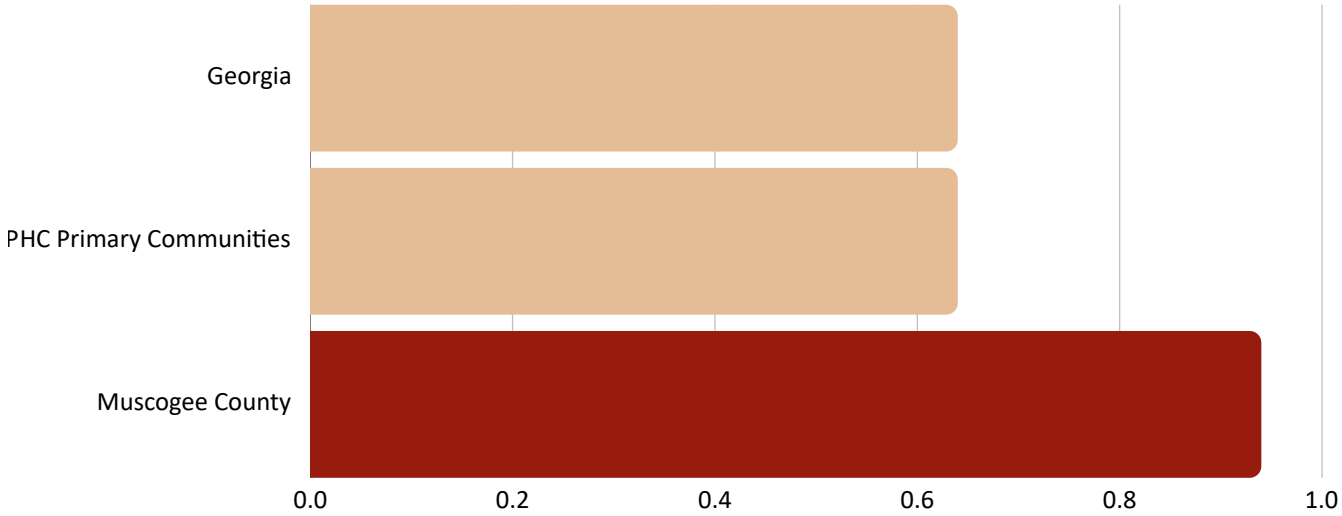


Source: US Census Bureau, American Community Survey, 2019-2023.

Social Vulnerability and Area Deprivation Indexes

The Social Vulnerability Index assesses the level of social vulnerability in counties and neighborhoods throughout the United States. A higher score indicates greater vulnerability, which can include factors like high poverty, limited access to vehicles, or overcrowded households. The higher the score, the more at-risk the community is.

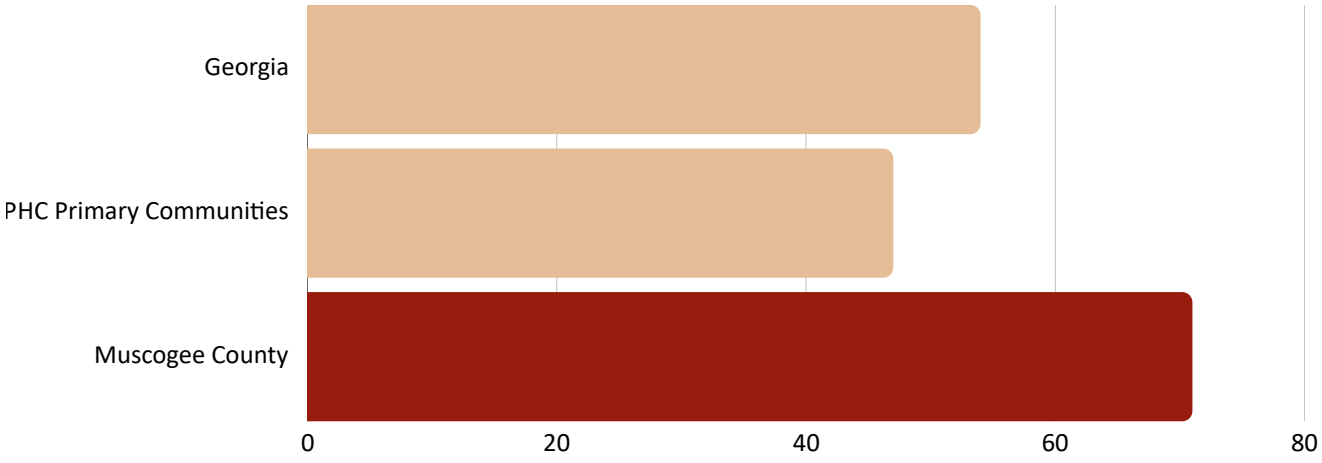
Social Vulnerability Index, 2022



Source: CDC GRASP, 2022.

The Area Deprivation Index ranks neighborhoods and communities within a state based on 17 factors related to education, income and employment, housing, and household characteristics. A score of 1 represents the lowest level of deprivation (least disadvantaged), while a score of 100 reflects the highest level of deprivation (most disadvantaged).

Area Deprivation Index, 2022

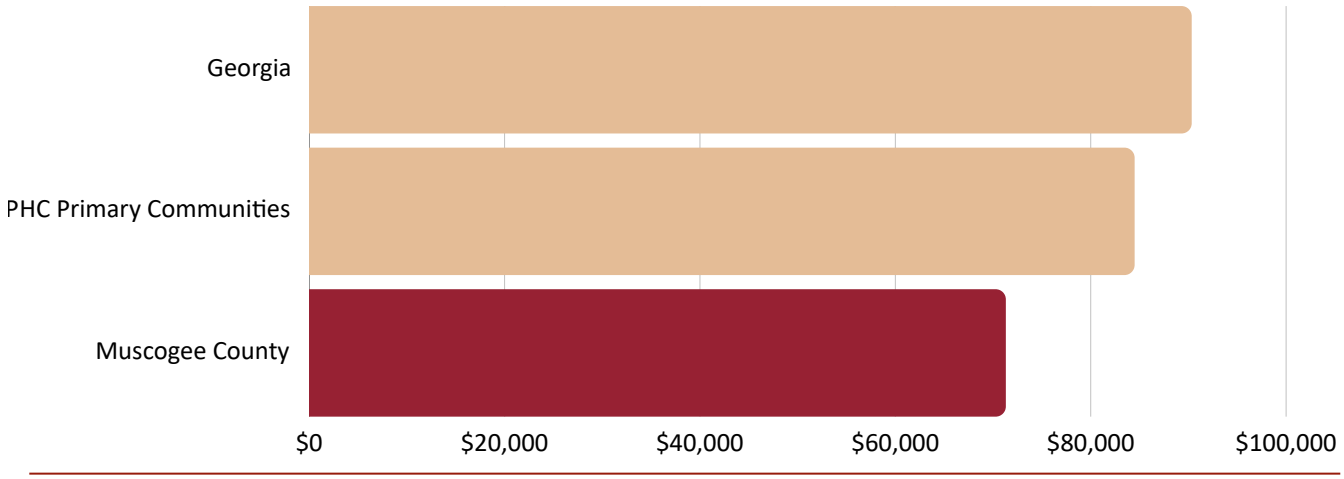


Source: University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2022.

Incomes and families

Income plays a central role in shaping community health, as it affects access to healthcare, nutritious food, stable housing, and overall quality of life. Measures like median household income and poverty rates provide insight into a community's economic stability and well-being.

Median family income, annually on average, 2019 to 2023



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

Financial stability is crucial to well-being.

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.

Longer life expectancy: Studies have shown that higher income is associated with longer life expectancy and lower mortality rates.

Educational opportunities: Income plays a significant role in accessing quality education, leading to better job opportunities and improved health outcomes later in life.

Income by household type

When income is broken down by household type, it becomes clear that some family structures are more likely to experience poverty. Please note that in the chart below, data were not available for all family structures within a given community.

Median family income by household type, 2019 to 2023

	Married w/o kids	Married w/ kids	Single male w/o kids	Single male w/ kids	Single females w/o kids	Single females w/ kids
Georgia	$106,049	$119,486	$70,732	$56,694	$61,013	$37,085
PHC Primary Counties	$102,732	$108,558	$68,801	$59,252	$63,269	$38,641
Muscogee County	$93,639	$97,734	$67,550	$58,454	$54,551	$32,884

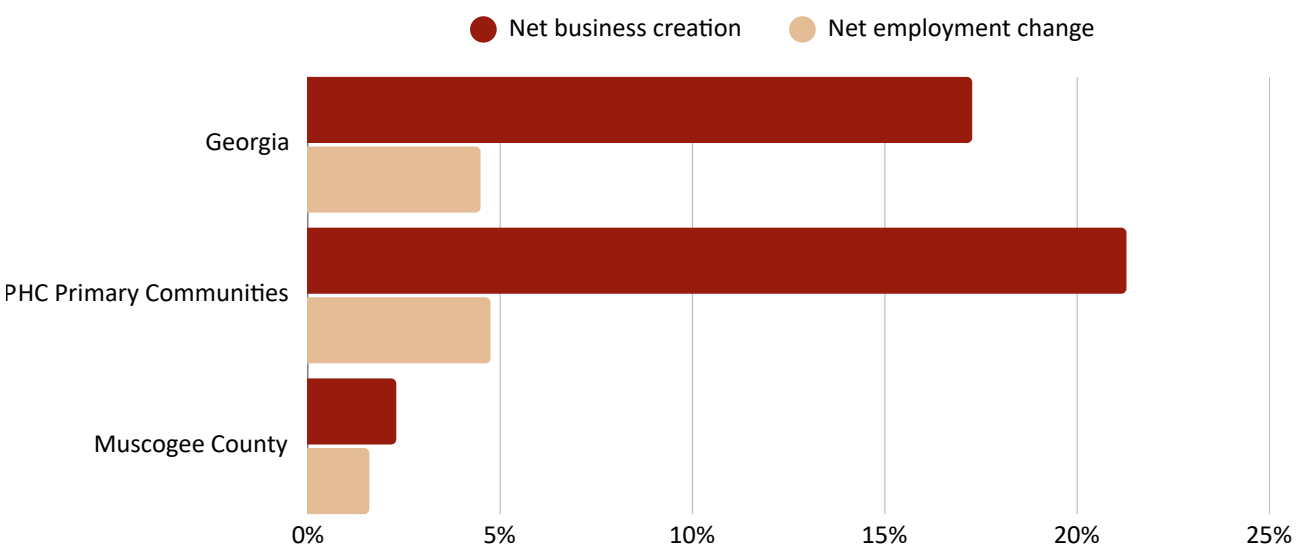
Source: US Census Bureau, American Community Survey, 2019-2023.

Certain household types are more vulnerable to poverty because of differences in income sources, caregiving responsibilities, and access to opportunities. For example, single-parent households often rely on just one income while also managing childcare, which makes it harder to cover basic expenses. Larger families may struggle because the cost of food, housing, and healthcare grows with each additional child. Households with older adults or people with disabilities may face limits on earning potential, while also having higher medical expenses. Young households (like those just starting out) may not yet have stable jobs, savings, or assets to fall back on. All of these factors can create financial strain, making certain households more likely to experience poverty.

Employment

Between 2011 and 2021, about 4,171 new businesses were created within Muscogee County. During that same time, 4,076 businesses closed, resulting in an establishment net change rate of 2.3%, far less than the state average of 17.3%. During the same time, the county saw a net employment change of 1.2% in growth, which is also less than the state rate of 4.5%.

Net business creation and net employment change, 2011 to 2022



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

About 76.6% of those working commuted to work alone in a car or truck between 2019 and 2023, a rate higher than the state average of 72.3%.

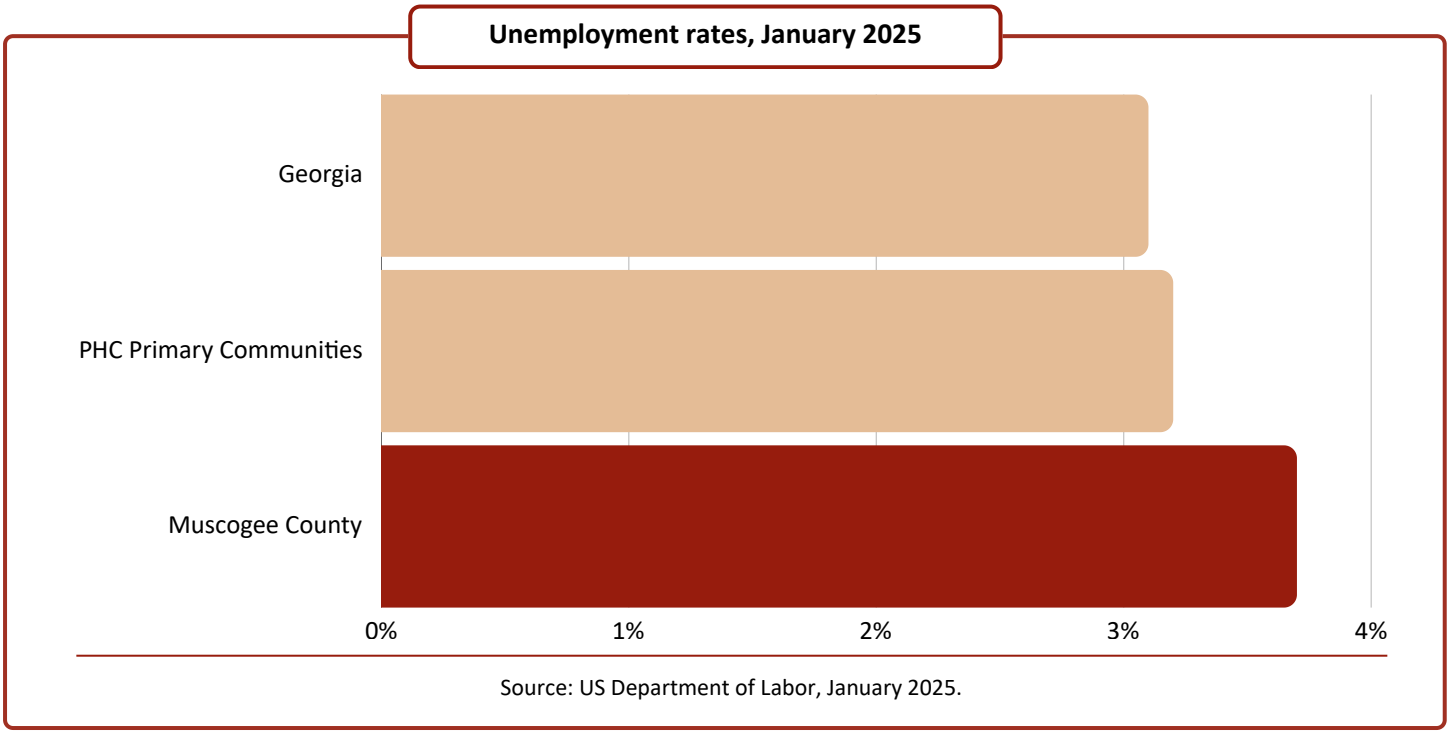
Residents had a shorter commute than the state average, with only 3.8% of those 16 and older commuting more than 60 minutes or more to work each direction.

About 9.4% of working county members worked from home.

About 87.5% of working age adults with a disability work, a figure slightly less than the state average of 89.3%.

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.



Source: US Department of Labor, January 2025.

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. Unemployment can lead to:

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.

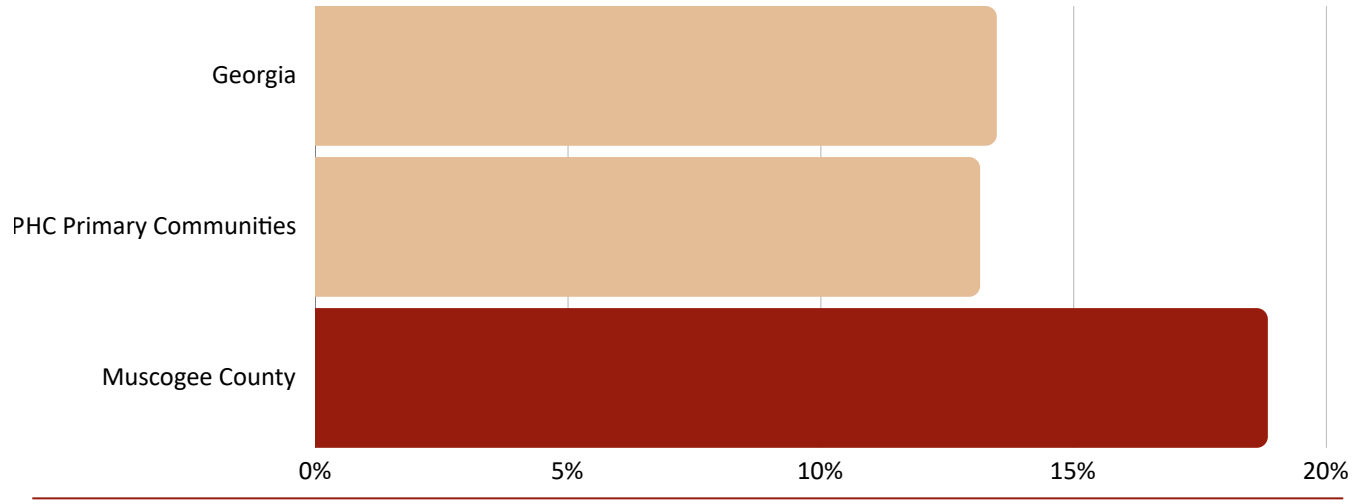
Obesity and chronic conditions: Unemployment can contribute to poor health behaviors, such as unhealthy eating habits and lack of physical activity, leading to increased obesity and chronic health conditions.

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 rates

Poverty is a major factor that contributes to poor health outcomes for individuals in low-income communities. It creates significant obstacles to accessing essential resources like healthcare, nutritious food, and other necessities that are crucial for maintaining good health. In 2023, a family of four with an annual gross income of $30,000 or less was considered to be living at 100% of the Federal Poverty Level (FPL). Women are generally more likely to live in poverty than men; in Muscogee County, nearly 20% of all females lived in poverty, as compared to 17.8% of all males.

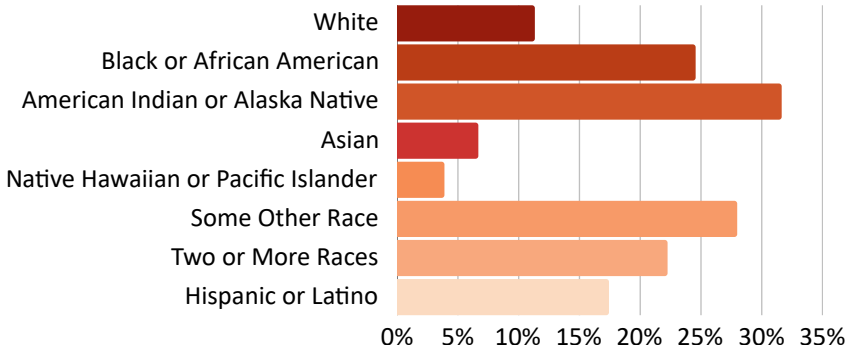
Poverty rates, annually on average, 2019 to 2023



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

Poverty doesn't affect all groups equally, and race and ethnicity play an important role. Across the state, racial and ethnic minorities often face higher poverty rates than White populations, reflecting the lasting impact of unequal access to education, jobs, and other opportunities in many communities.

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



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

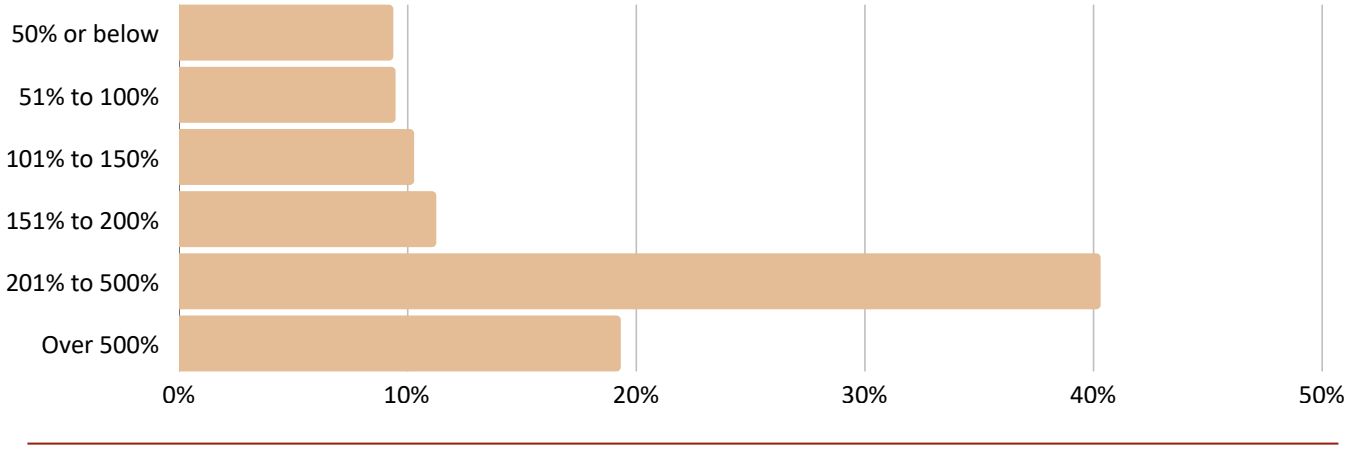
Geography matters too. People living in rural communities are more likely to experience poverty than those in urban areas. According to the USDA's Economic Research Service, poverty has consistently been higher in rural areas across all racial and ethnic groups.

People with disabilities are also disproportionately affected by poverty. Many face barriers to stable employment, housing, and other essential resources, making it harder to achieve financial security.

Poverty at different rates

Many people in the region live at 201% to 500% of the FPL, meaning they had pre-tax incomes ranging from $60,000 to $150,000 for a family of four. It's important to remember the costs that come with life, including dwindling income reserves.

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



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

Childcare

Annually, between 2019 and 2023, childcare costs consumed about 28% of median household income – about $14,862 annually for two children. This percentage is higher than the state rate of 23%, though the average amount is lower than the state rate as incomes in Muscogee are generally lower.

Collections

Between 2019 and 2024, 40% of the county's community members had debt in collections, with a median amount of just over $2,000. The percentage of community members with debt in collections is much higher than the state average of 29.6%. People of color are far more likely to have debt in collections than their White counterparts; approximately half of all people of color held a debt in collections, as compared to less than a third of the White population.

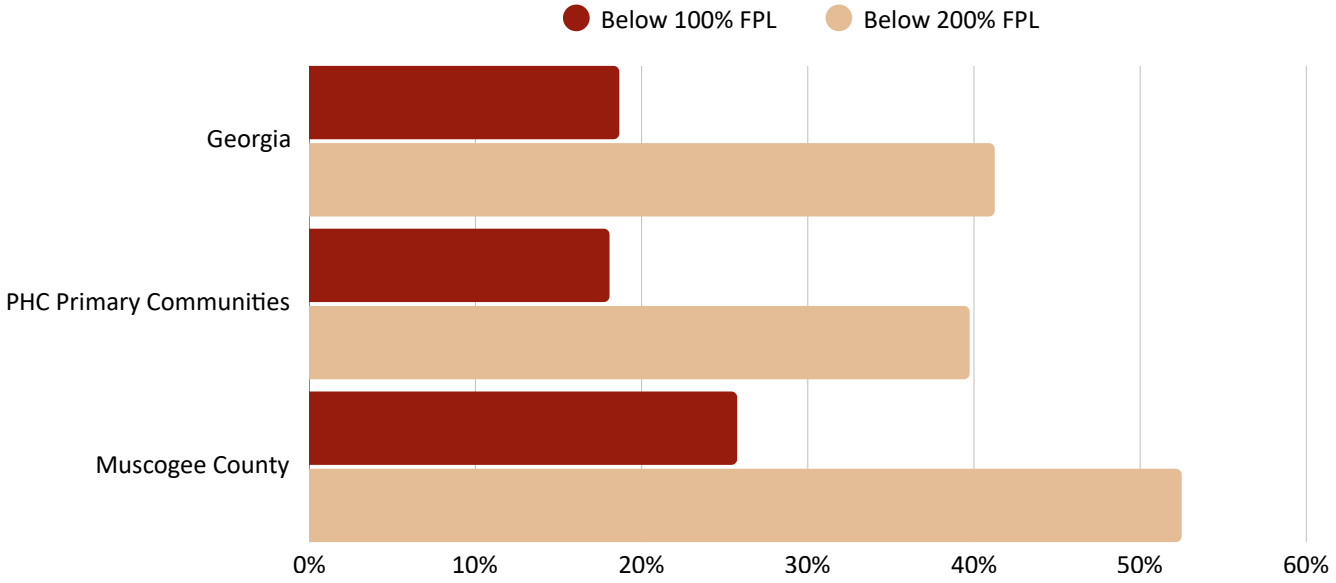
Student loan debt

Between 2019 and 2024, 20% of the county's community members held student loan debt, with a median debt amount of $24,278, higher than the state average of 17.9%.

Children in poverty

In Muscogee County, over 26,000 children lived in households with income below 200% of the Federal Poverty Level between 2019 and 2023. Living in poverty can limit access to healthcare, nutritious food, and other necessities, all of which are closely tied to a child's health and future well-being.

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

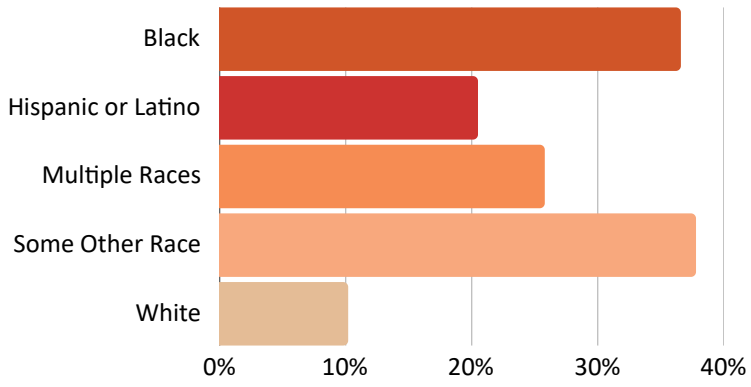


Source: US Census Bureau, American Community Survey, 2019-2023.

Within Muscogee County, about **80%** -- or about **23,770** children -- qualified for free or reduced-price lunch at their school during the 2022-2023 school year.

In the U.S., free and reduced-price school lunches are available to students in households with incomes at or below 130% of the federal poverty level are eligible for free meals, while those between 130% and 185% can receive reduced-price lunches. The National School Lunch Program (NSLP) provides these federally assisted meals.

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

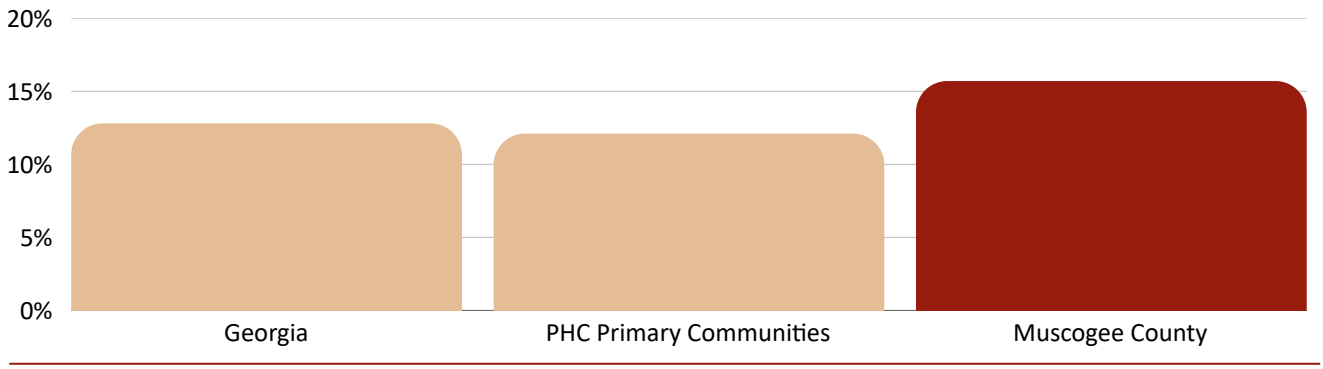


Source: US Census Bureau, American Community Survey, 2019-2023.

Food insecurity

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

Percentage of population facing food insecurity, 2022



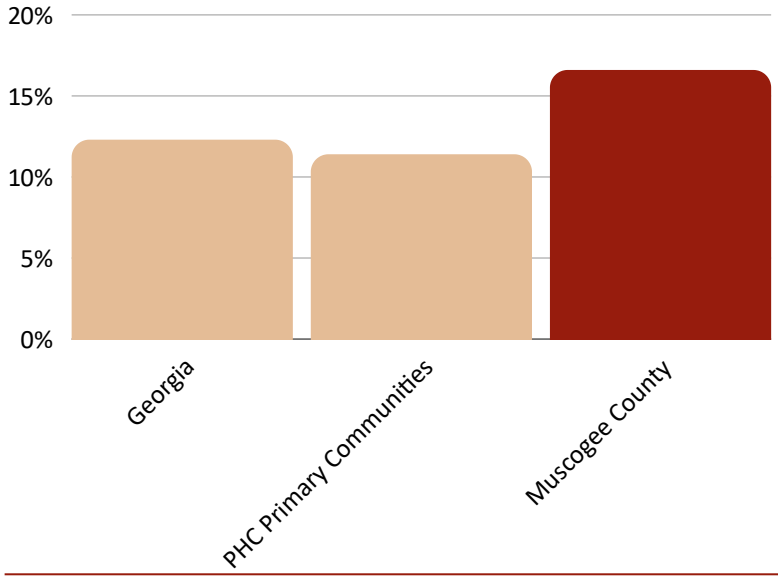
Source: Feeding America, 2022.

When looking only at children, that rate jumps to **28%** of all children within Muscogee County, much higher than the state and national rates of **18.3%** and **18.0%**, respectively. Active-duty military personnel also experience high rates of food insecurity. According to Feeding America, approximately one in nine working-age veterans are food insecure, and nearly one-quarter of all active duty service members were food insecure in 2020.

The Supplemental Nutrition Assistance Program (SNAP), commonly known as food stamps, provides monthly assistance to help families buy groceries. SNAP participation is an important indicator because it highlights vulnerable populations that often face multiple challenges related to health access, health status, and social support.

Within Muscogee County, minority populations were far more likely to receive SNAP benefits. For example, Black populations were over three times more likely to receive SNAP benefits than their White counterparts.

Households receiving SNAP, 2019 to 2023

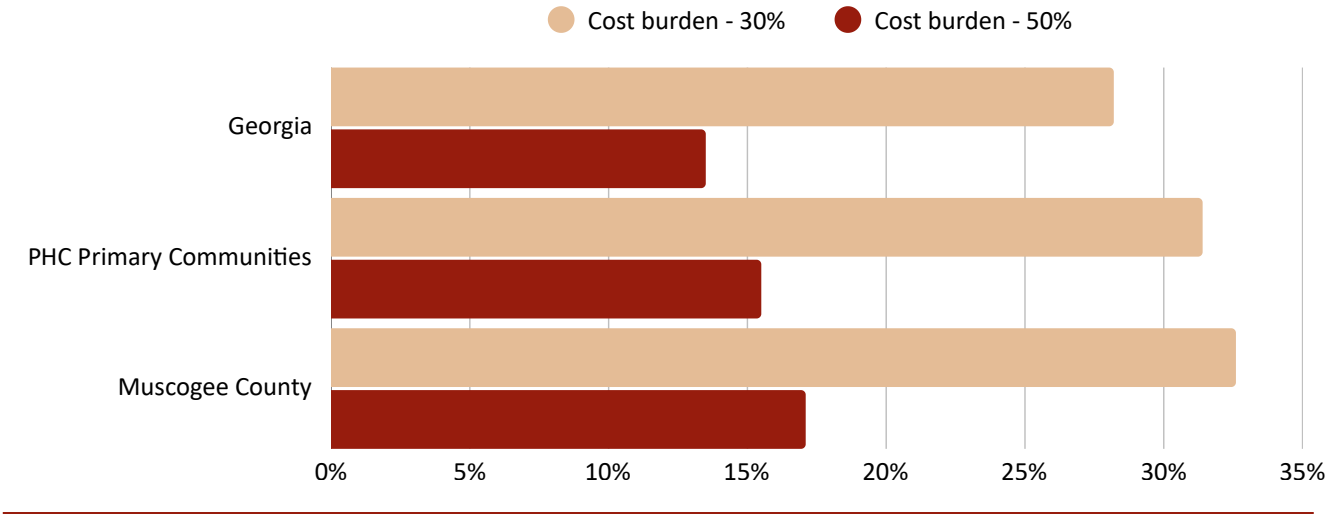


Source: US Census Bureau, American Community Survey, 2019-2023.

Cost-burdened households

Housing is a critical component of well-being, as a stable home indicates both economic ability and ability to stay healthy. The cost of housing is a key component of that, as affordable housing is often out of reach for many community members, creating additional burdens.

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



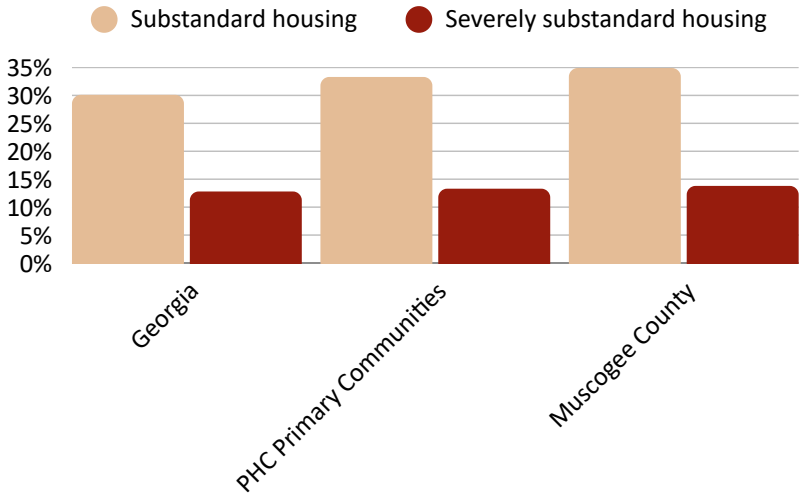
Source: US Census Bureau, American Community Survey, 2019-2023.

Housing costs take up a larger share of income for many minority households, making them more likely to be "cost-burdened." About 35% of Hispanic or Latino households spend more than they can comfortably afford on housing, compared to 28% of non-Hispanic or Latino households. The gap is even wider when looking at race: nearly 38% of Black households are cost-burdened, while only 20% of White households face the same challenge.

Substandard housing examines the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions:

- Lacking complete plumbing facilities
- Lacking complete kitchen facilities
- Selected monthly owner costs as a percentage of household income greater than 30%
- Gross rent as a percentage of household income is greater than 30%

Substandard and severely substandard housing, 2019 to 2023



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

Homes without plumbing and kitchens

Within the Muscogee County there were many homes without complete plumbing, kitchens, or are lacking telephone service, including cell phones. For example, there were approximately 215 occupied homes without complete plumbing facilities between 2019 and 2023.

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

	Lacking complete kitchens	Lacking complete plumbing	Lacking telephone service (including cell phones)
Georgia	2.4%	0.3%	0.8%
PHC Primary Communities	2.0%	0.3%	0.7%
Muscogee County	4.3%	0.3%	0.9%

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

Homes that lack these key components are often indicators of socioeconomic status, meaning the household likely has a lower income than households that have complete kitchens, plumbing, and telephone services. These households are more likely to struggle with access to healthy foods, health costs, and other costs of living.

Populations that are homeless

Within the community, about 880 people were homeless in January 2024, according to a point-in-time count of homeless populations conducted by the Georgia Department of Community Affairs. Of those, 62 were veterans.

Point-in-time count of homeless populations, January 2024

	Emergency shelter	Transitional Housing	Unsheltered
All populations	189	186	307
Veteran populations	1	32	13

Source: Georgia Department of Community Affairs, January 2024.

Within Muscogee County, 3% of students were homeless during the 2021-2022 school year.

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

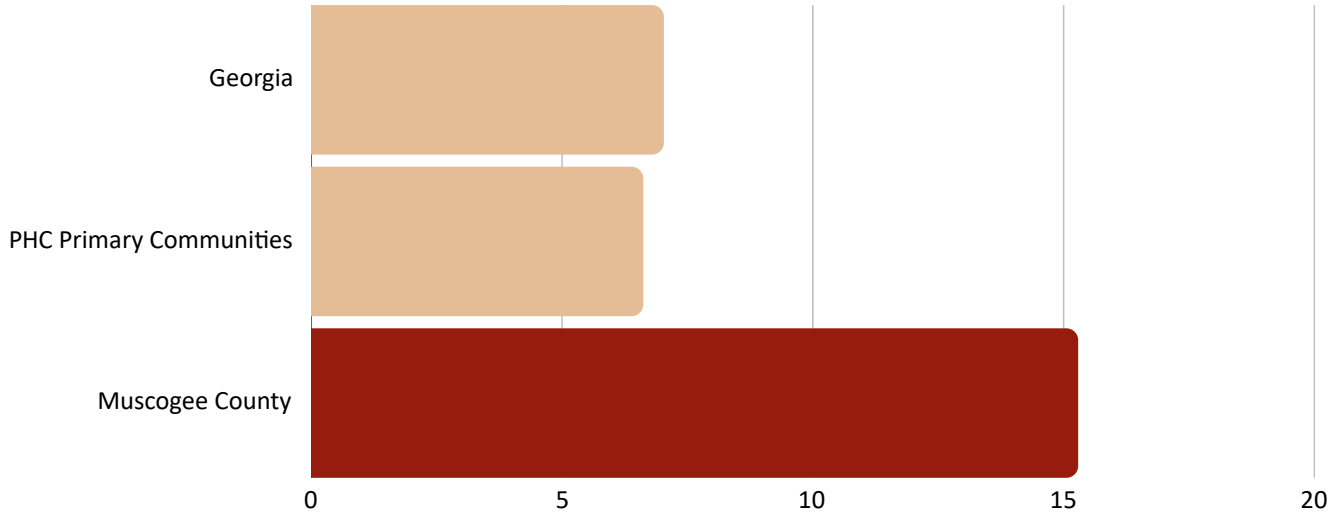
	Doubled-up	Unsheltered	Hotels or motels	Shelters and transitional housing
Muscogee County	708	6	147	51

Source: US Department of Education, ED Data Express, 2021-2022.

Head Start and preschool enrollment

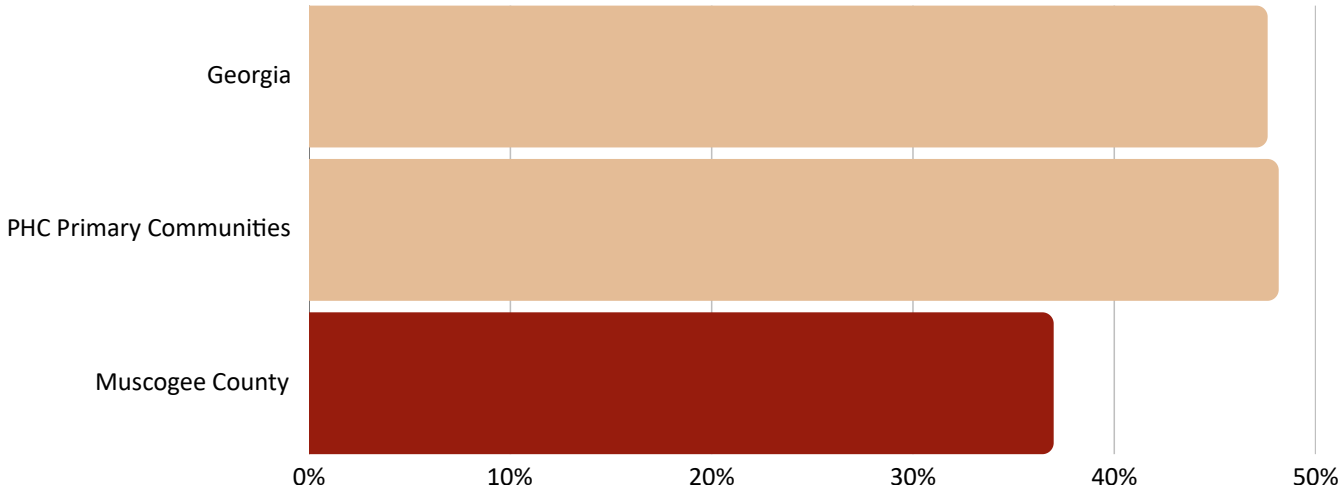
Head Start is a federal program that supports children from birth to age five in families living at or below the poverty line. Its goal is to prepare children for kindergarten by meeting essential needs such as healthcare, nutrition, and family support. Participation in Head Start and preschool enrollment are important indicators of a child's readiness to succeed in reading, writing, and math in elementary school.

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.

Preschool enrollment, by percent of children aged 3 to 4, 2019-2023

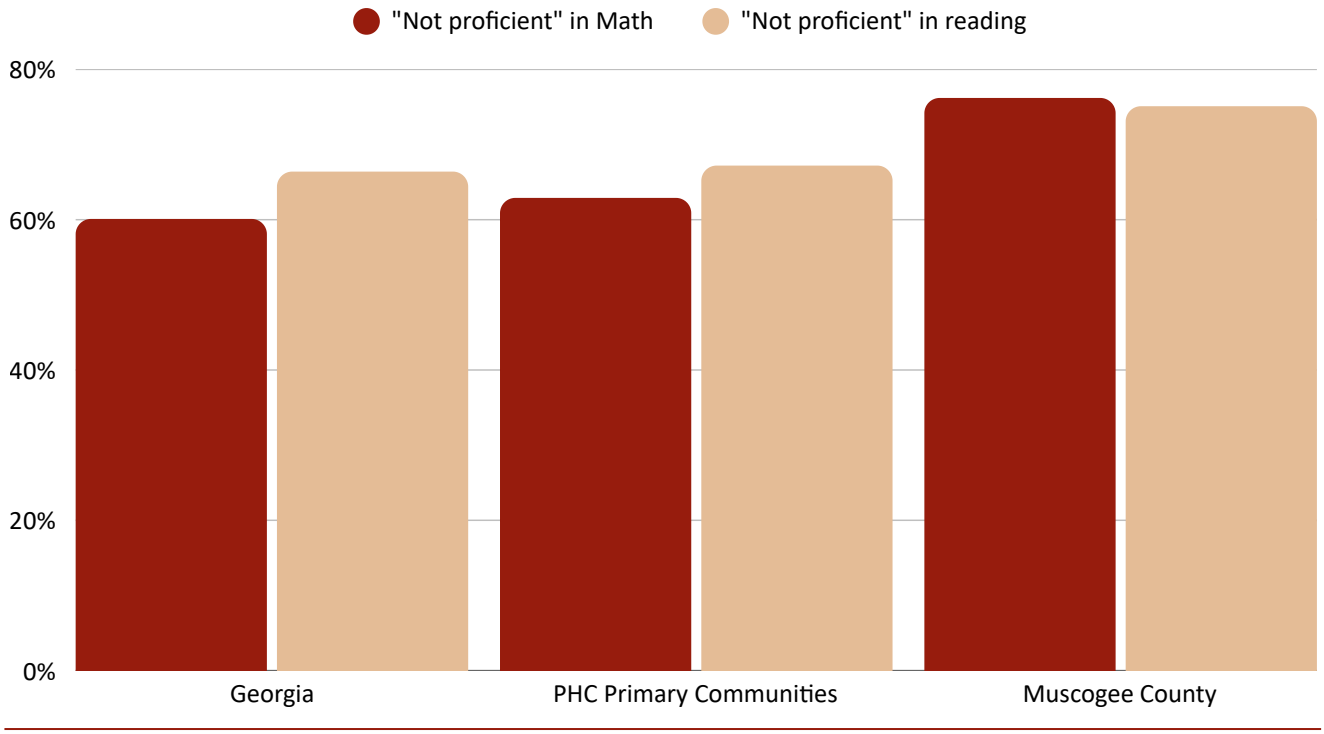


Source: US Census Bureau, American Community Survey, 2019-2023.

Math and reading proficiency

By fourth grade, children are expected to make a big transition—using their reading skills to explore and learn about the world around them. If they haven't reached this stage, it can be harder to keep up with classmates, and the gap often widens over time. The same is true for math, where early struggles can make future learning more difficult. Supporting kids at this stage helps set them up for confidence and success in school and beyond.

Percent of students scoring "Not Proficient" or worse in fourth grade math and reading standardized tests, 2021-2022 school year



Source: US Department of Education, EDFacts, 2021-2022.

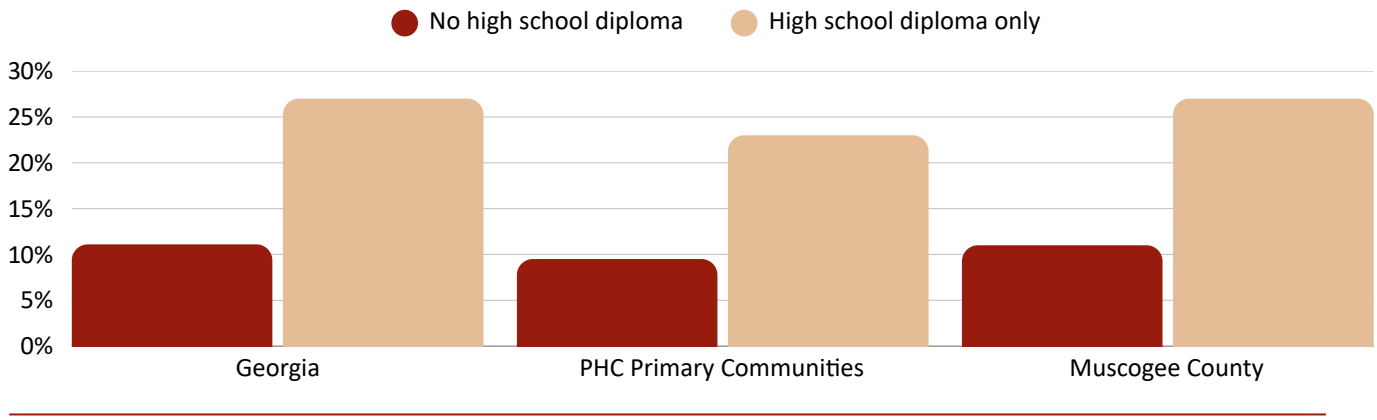
The Centers for Disease Control and Prevention notes that early childhood education (ECE) plays a vital role in shaping lifelong health and well-being. High-quality ECE programs not only strengthen children's cognitive and social-emotional skills but also encourage healthier behaviors and lower the risk of chronic disease later in life. These programs can also benefit parents by reducing stress and providing support, which in turn positively influences children's health.

When children fall behind in reading or math, the effects can ripple far beyond academics. Struggles in the classroom may lead to stalled progress, lower self-confidence, and challenges with future learning and job opportunities. Over time, these setbacks can make it harder for children to stay on pace with their peers, leaving them vulnerable to feelings of frustration and isolation.

High school graduation rates

Understanding how many adults have earned a high school diploma helps us see where the community might need extra support. For example, local hospitals or community programs can offer training to help adults without a college degree gain the skills they need for good careers. The chart below shows this information for adults age 25 and older.

High school diplomas attainment rate, annually on average, 2019 to 2023



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

There's a strong connection between a family's socioeconomic status and whether a student finishes high school. Kids from lower-income families often face more challenges and are more likely to drop out than those from higher-income families. This gap can affect their future job opportunities, earnings, and overall well-being—and it often becomes a cycle, where the children of adults without a diploma are less likely to finish school themselves.

Finishing high school also has a big impact on health. Adults with a diploma tend to live longer, have a lower risk of chronic conditions like heart disease, high blood pressure, and diabetes, and report better mental health overall. Supporting students in completing high school helps set them—and future generations—up for both better opportunities and healthier lives.

Secondary attainment rates

Looking at how many people in a community have completed high school or attended college helps us understand its overall potential. People with some college education often earn more, are more likely to have health insurance, and are less likely to engage in risky behaviors like smoking.

Educational attainment, annually, 2019 to 2023

	Some college	Associate's degree	Bachelor's degree	Graduate or professional degree
Georgia	19.5%	8.3%	20.7%	13.5%
PHC Primary Communities	18.5%	8.2%	24.4%	16.0%
Muscogee County	22.8%	9.6%	17.6%	12.2%

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

Completing secondary education can have a significant impact on a person's life. It often opens the door to better job opportunities and higher income, which can help reduce poverty and support overall health. Higher-paying jobs also make it more likely that individuals have access to health insurance, ensuring they can receive timely and quality healthcare. Beyond these benefits, education can empower people to make healthier choices, such as quitting smoking, eating a balanced diet, and staying physically active, all of which contribute to long-term well-being.

Insurance rates

In Muscogee County, approximately 173,000 community members have health insurance coverage. Of those, 71.6% have private insurance and 45.5% have public health insurance. Insurance provides access to healthcare, including regular primary care, specialty care, and other health services that prevent poor health status.

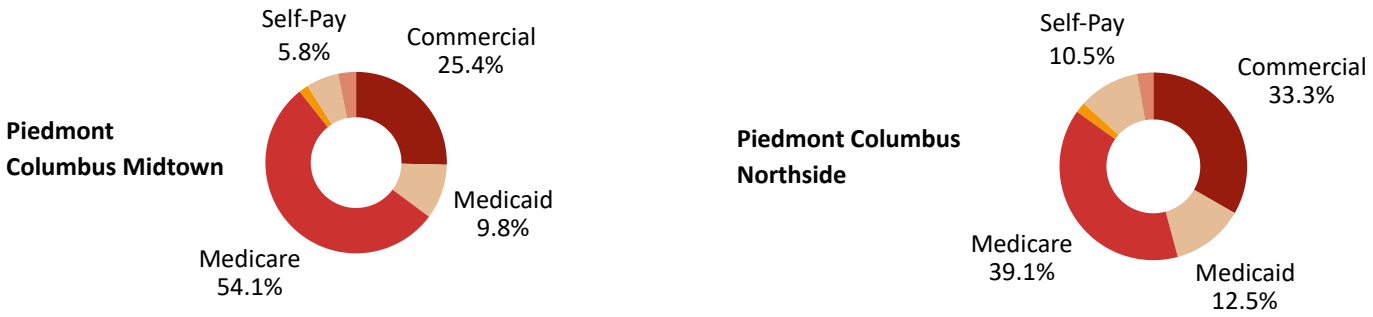
Insurance source type, annually on average, 2019 to 2023

	Employer or Union	Direct Purchase	TRICARE or VA	Medicare
Georgia	61.1%	14.9%	7.6%	18.7%
PHC Primary Communities	62.8%	15.4%	6.9%	16.3%
Muscogee County	51.2%	12.6%	25.0%	19.9%

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

Medicare represents the biggest payor mix at both Piedmont Columbus Regional Midtown and Piedmont Columbus Regional Northside, with private commercial insurance as second.

Piedmont Columbus Midtown and Piedmont Columbus Northside payor mix, FY23 and FY24

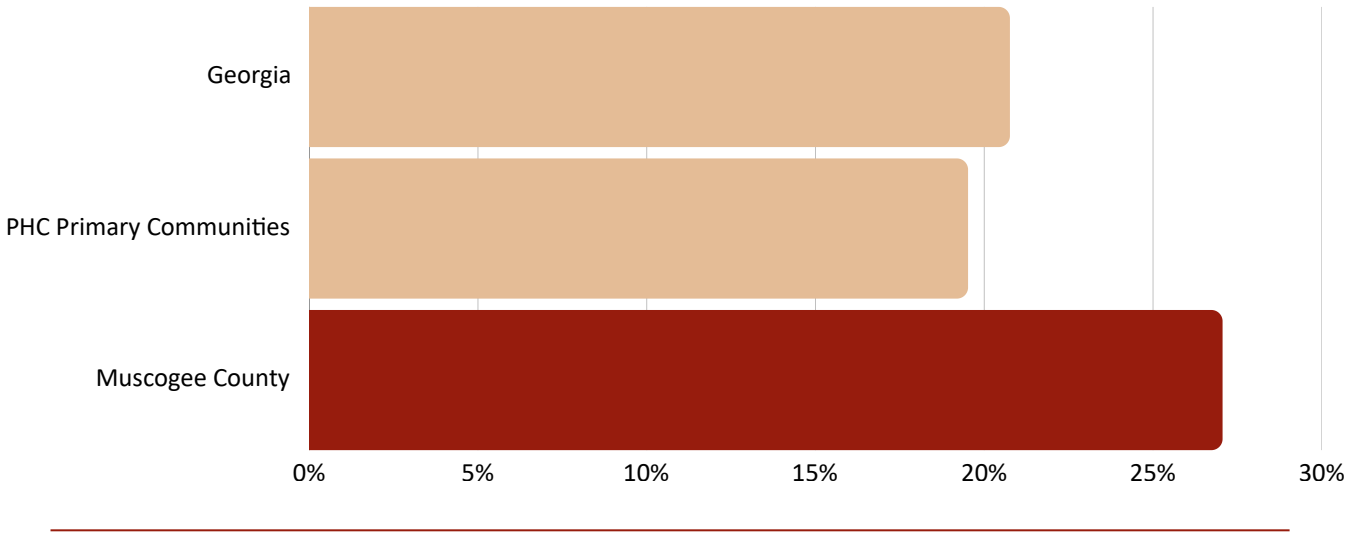


Source: Piedmont Healthcare internal data, FY23 and FY24.

Populations enrolled in Medicaid

Medicaid is a program that helps provide health insurance for people with low incomes. In some communities, it can be hard to find providers who accept Medicaid, and being on the program often goes hand-in-hand with lower income, which can create extra barriers to staying healthy. We highlight Medicaid here because coverage through this program can be limited in Georgia, especially when it comes to getting access to primary care.

Percent of population covered through Medicaid, 2019 to 2023



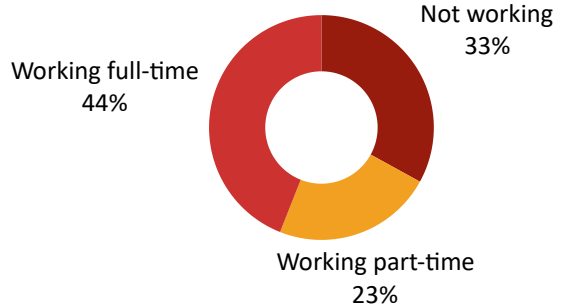
Source: US Census Bureau, American Community Survey, 2019-2023.

Georgia is one of the more restrictive states when it comes to qualifying for Medicaid. Income limits differ depending on the program and personal circumstances. For instance, under Georgia Pathways to Coverage, a single person can qualify with an income up to 100% of the Federal Poverty Level (FPL)—$15,650 per year in 2025—while a family of three can earn up to $26,650. Traditional Medicaid eligibility can also depend on factors like age, disability, and whether someone meets the work or education requirements set by Georgia Pathways.

According to the Kaiser Family Foundation, in 2024, over three-quarters of Georgia's Medicaid recipients were working. About one in five lived in rural areas, three out of five were children, and roughly one in seven had three or more chronic health conditions.

Across the state, Medicaid provided coverage for 31% of adults with disabilities and supported 45% of all births.

Medicaid recipients and employment, 2024

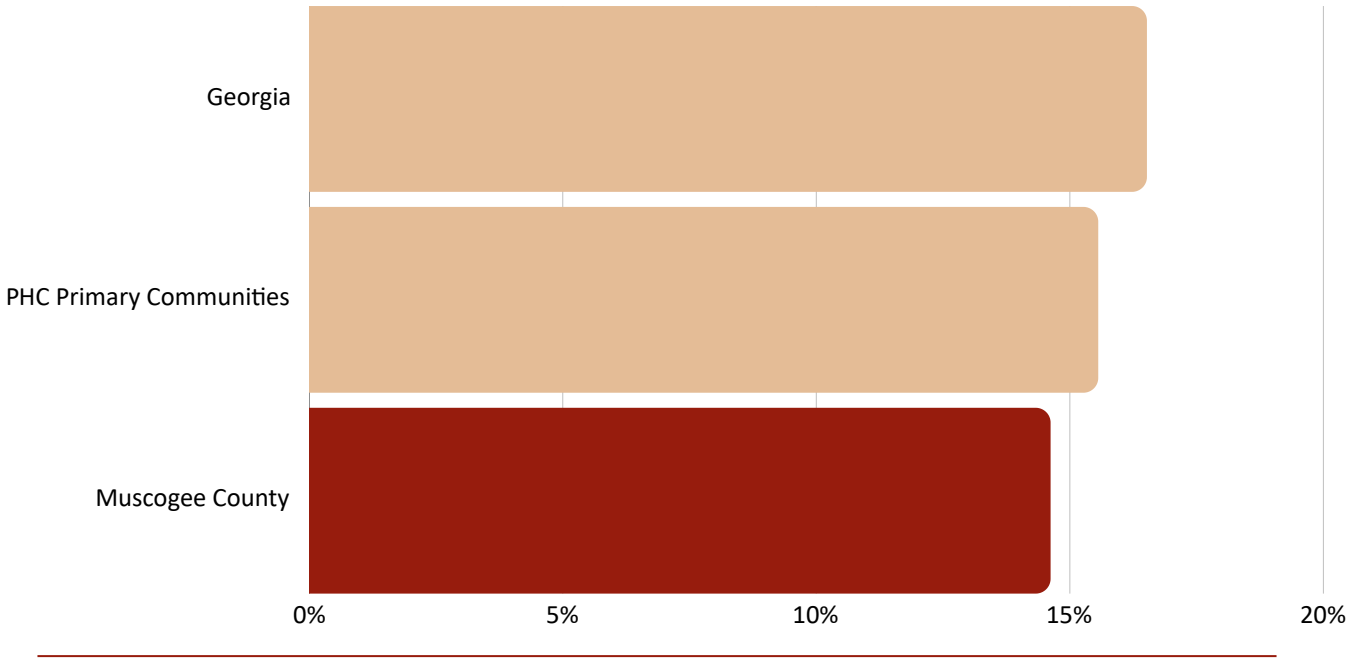


Source: Kaiser Family Foundation, Accessed 2025.

Populations without insurance

Access to care covers the challenges people might face, like not having enough providers nearby, limited transportation, or fewer services available for low-income communities. One of the biggest factors affecting health is whether a person has health insurance. The Institute of Medicine estimates that not having insurance contributes to about 18,000 deaths each year—making it the sixth leading cause of death for adults ages 25 to 64, right after cancer, heart disease, injuries, suicide, and strokes, but ahead of HIV/AIDS and diabetes.

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



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

According to the Kaiser Family Foundation, the main reason most people are uninsured is cost. In 2023, 63% of adults ages 18–64 without coverage said insurance was too expensive.

Many uninsured people don't have access to coverage through their jobs, and some—especially low-income adults in states like Georgia that haven't expanded Medicaid—aren't eligible for financial help. Even though more than half of uninsured individuals could qualify for Medicaid or Marketplace subsidies, many aren't aware of these options or face challenges enrolling. And for some, even with subsidies, Marketplace coverage can still feel out of reach.

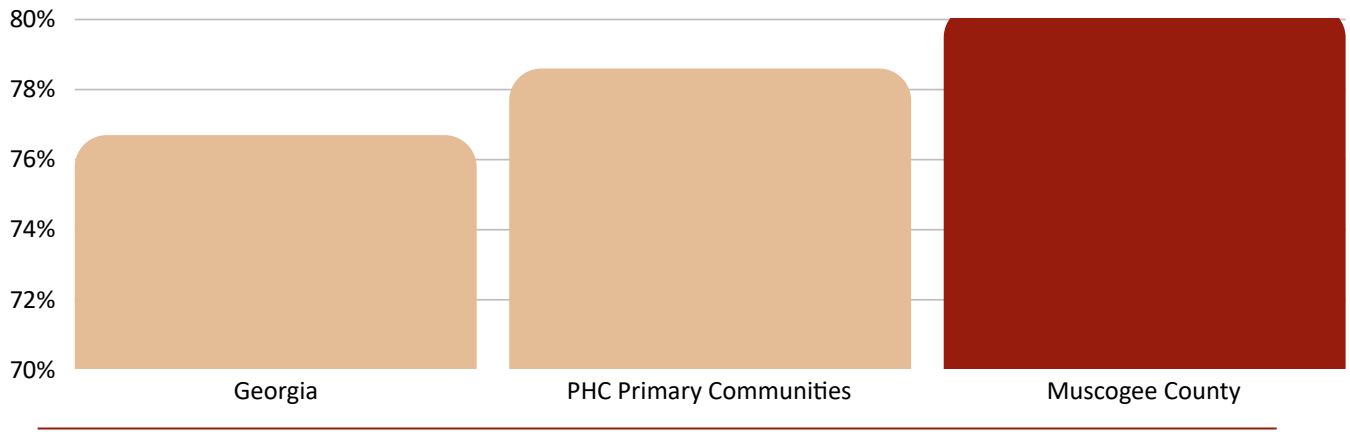
Most people without insurance are actually working: about 74% are employed full-time, 11% work part-time, and the remaining 15% are unemployed.

Prenatal care

Prenatal care is a clear example of why access matters. Receiving care in the first trimester gives mothers and babies the best chance at a healthy start. Early visits help identify potential risks, support healthy fetal development, and give providers the opportunity to guide families on important health and lifestyle decisions.

When mothers don't receive timely prenatal care, the risks for both maternal and infant health increase. Limited use of prenatal services often signals deeper issues—like lack of access to preventive care, limited health knowledge, minimal provider outreach, or social and economic barriers.

Prenatal care in the first trimester, 2020-2022



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

Unfortunately, not all communities have the same access or quality of prenatal care. Black women, in particular, face significant disparities, which contribute to poorer outcomes for both mothers and infants.

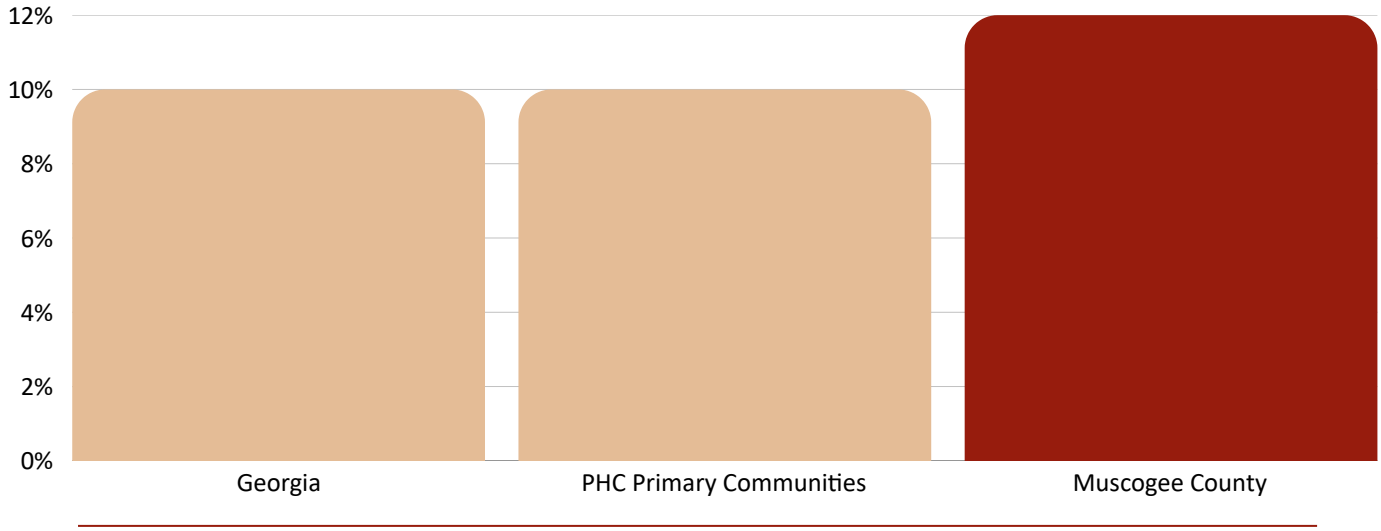
Accessing prenatal care can be a real challenge for many low-income and minority women in Georgia. Nearly half of the state's counties are considered "maternity care deserts," meaning they don't have hospitals, birth centers, or obstetric providers nearby. Women in these areas often have to travel much farther for care, and these gaps are most common in rural and predominantly Black communities.

The March of Dimes' 2024 Report Card gives Georgia a preterm birth rate of 11.8%, among the highest in the nation, and highlights significant racial disparities—Black birthing people experience infant mortality rates roughly 1.4 times higher than the state average. The Georgia Department of Public Health's Maternal Mortality Review Committee has also found that a majority of pregnancy-related deaths are preventable, underscoring the need for improved access to quality prenatal care, postpartum support, and mental health services.

Low birth weight babies

Newborns, infants, and their mothers are especially vulnerable during the early stages of life. The following indicators highlight key measures of infant health, including low birth weight (LBW), which is defined as weighing 5 pounds, 8 ounces or less at birth.

Percentage of low birth weight babies, 2016-2022



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

In Georgia, low birth weight remains a significant concern, particularly among Black infants. Between 2021 and 2023, Black infants in Georgia experienced a LBW rate of 15.5%, nearly double that of White infants, who had a rate of 7.5%, according to the March of Dimes This disparity underscores the ongoing challenges in achieving equitable maternal and infant health outcomes.

Low income is strongly associated with an increased risk of LBW. Studies consistently demonstrate a link between lower income and higher rates of LBW, particularly in low-income communities. This is often attributed to various factors like limited access to prenatal care, nutritional deficiencies, and increased exposure to stressors.

Cancer screenings

Regular health screenings play a crucial role in maintaining good health. They help detect diseases and conditions early, before they become serious, allowing for timely treatment and better outcomes. Screenings also identify risk factors for chronic conditions like heart disease, diabetes, and cancer, giving individuals the chance to address these risks early. Overall, early detection and intervention through regular screenings can lead to improved health, fewer complications, reduced hospitalizations, and lower mortality rates.

Cancer screening data is crucial because it helps catch cancers early, when treatment is more likely to be successful. It also lets public health officials track trends, see which communities are being screened, and identify areas where people might not have enough access to care. This information helps healthcare systems target resources more effectively, improve programs, and reduce disparities so everyone has a better chance at staying healthy. In short, screening data is a powerful tool for preventing advanced disease and improving overall community health.

Cancer screenings for women, 2022

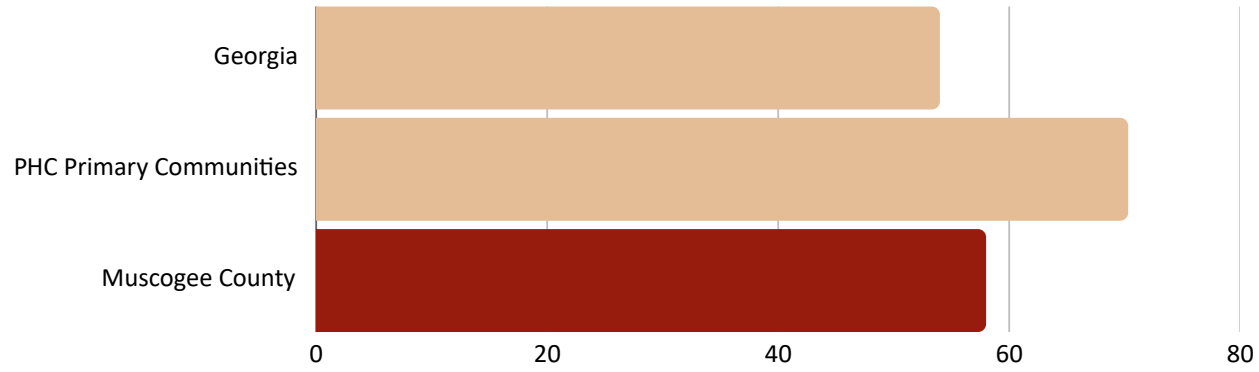
	Mammogram screenings, Medicare beneficiaries	Mammogram screenings, adult women	Cervical cancer screenings, adult women
Georgia	36.0%	75.8%	82.3%
PHC Primary Communities	35.0%	76.4%	82.7%
Muscogee County	37.0%	76.5%	81.0%

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

Dental care

Good dental care is important for overall health. It helps prevent tooth decay and gum disease, which can lead to serious issues like heart disease, stroke, and even dementia, while also affecting the ability to eat, speak, and smile confidently. In 2022, there were 58 dentists for every 100,000 people within Muscogee County, higher than the state rate of 54 dentists for every 100,000 people. Limited access to dental care is often linked to poorer oral health overall.

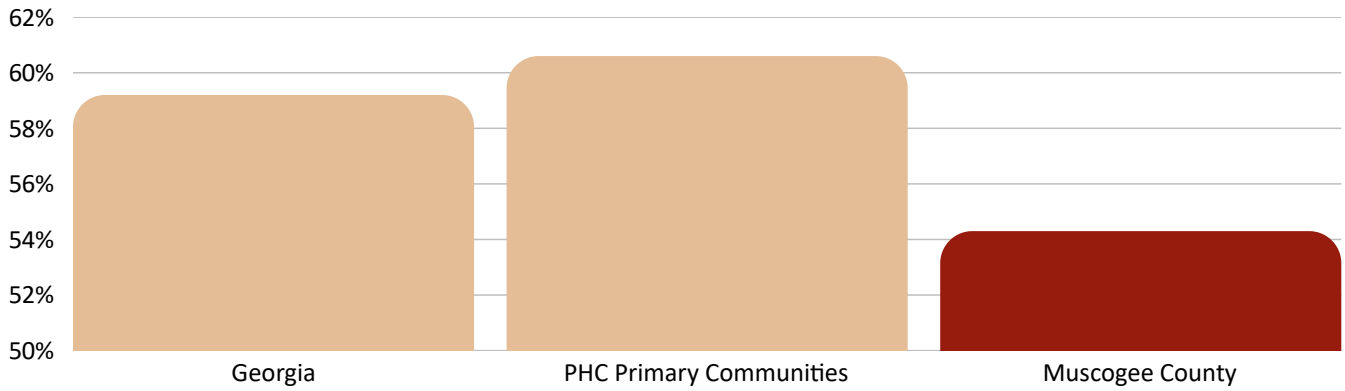
Rate of dentists per every 100,000 people, 2022



Source: US Department of Health and Human Services, Health Resources and Services Administration, 2022.

In 2022, and in the PHC primary community, approximately 18.0% of adults 65 and older have lost all of their natural teeth. this number jumps to 18.7% in Muscogee County. This figure often correlates to adults having had a recent dental visit.

Adults 18+ with recent dental visit, 2022

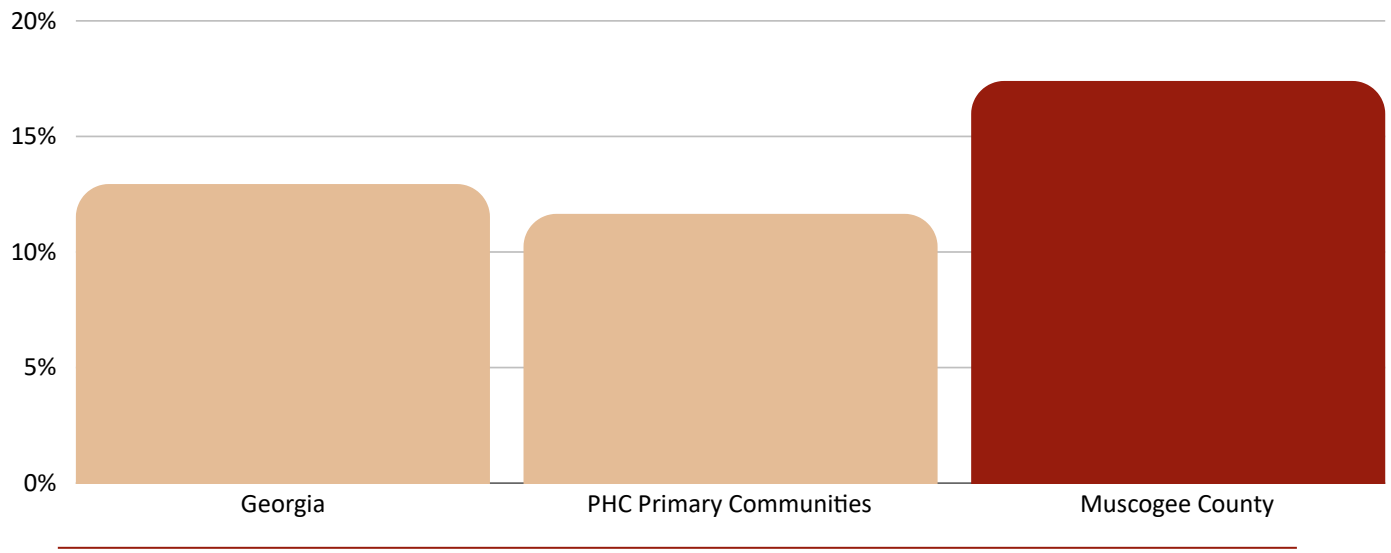


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Populations with disabilities

Of the total population, about 16% have some form of disability between 2019 and 2023, according to the US Census Bureau's American Community Survey, including both developmental and physical disabilities.

Percent of population with a disability, 2019 to 2023

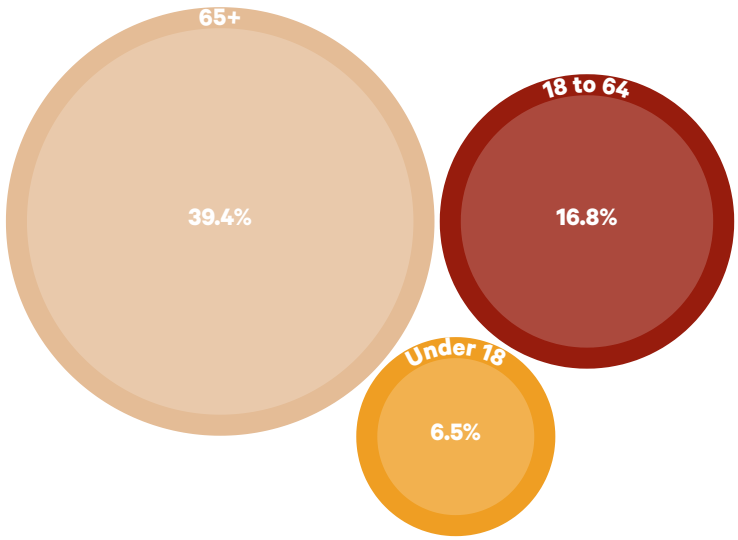


Source: US Census Bureau, American Community Survey, 2019-2023.

It's expected that older adults make up the largest share of people with disabilities. For adults between 18 and 64, disabilities often stem from musculoskeletal issues like arthritis or back problems, as well as mental health conditions such as depression and anxiety. Mobility and cognitive challenges are also fairly common in this age group, according to the Centers for Disease Control and Prevention.

In addition, chronic illnesses like heart disease or kidney disease, along with injuries such as spinal cord or traumatic brain injuries, can lead to disability at any age.

Percent of population with a disability by age, 2019 to 2023

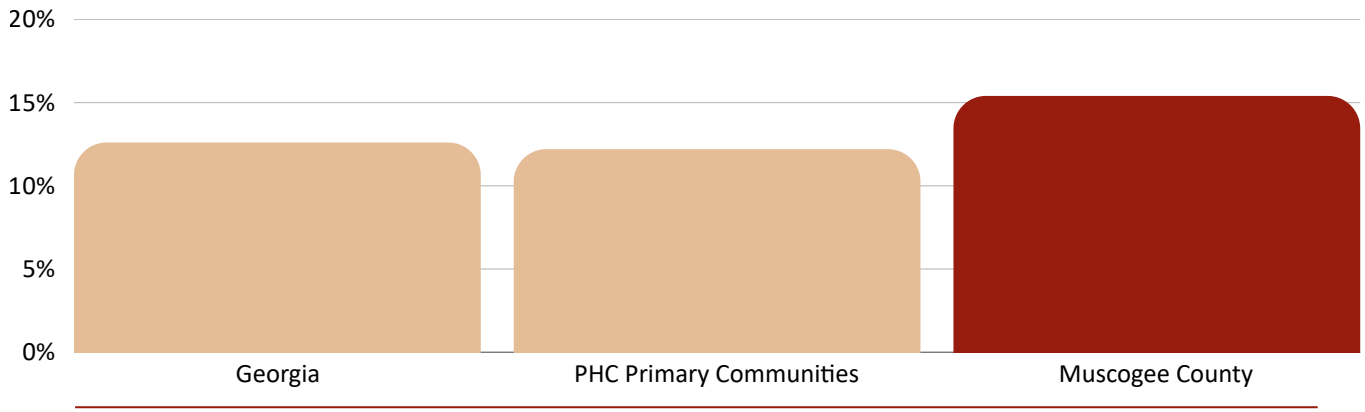


Source: US Census Bureau, American Community Survey, 2019-2023.

Diabetes and kidney disease

Chronic diseases are long-term health conditions that can affect daily life and usually require ongoing medical care. Some common examples are diabetes, heart disease, and chronic lung conditions. Tracking how many people in a community have these conditions helps identify health trends and make sure resources are directed where they're needed most.

Percentage of adults with diabetes, 2022



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

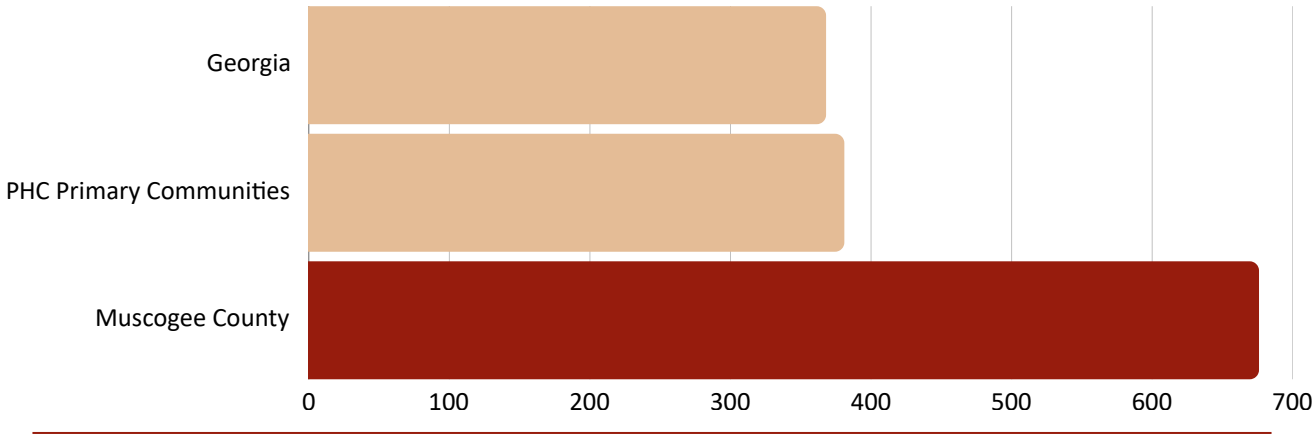
Diabetes is much more common in low-income communities, and the gap between income groups has been widening over time. This heavier burden is often linked to challenges like food insecurity, limited access to healthcare and healthy foods, and differences in health habits.
Type 2 diabetes can also increase the risk of developing dementia, including Alzheimer's and vascular dementia. Being diagnosed at a younger age—especially before 50—or having obesity can further raise this risk.

Diabetes is the leading cause of kidney disease because it can reduce the kidneys' ability to filter waste, sometimes leading to chronic kidney disease. In the community, about 3.6% of the population had kidney disease in 2021, which is higher than the state average for Georgia.

Asthma and COPD

Although both affect breathing, asthma and chronic obstructive pulmonary disease (COPD) are not the same. Asthma is a chronic inflammatory condition that makes the airways swell and narrow, while COPD is a progressive lung disease where airflow becomes increasingly obstructed over time. Both can cause similar symptoms—like coughing, shortness of breath, and wheezing—but they differ in their causes, how they progress, and how they are treated.

Annual ER visit rate with asthma as the primary diagnosis, per every 100,000 people, 2023



Source: Georgia OASIS, accessed April 2025.

Among adults 18 and older, about 8% had chronic obstructive pulmonary disease (COPD) in 2022 in the county, a rate higher than both the average rate among PHC primary service counties and the state, at 6.2% and 7.2%, respectively. White males were more likely to have COPD by a slight margin. About 10% of adults in the county had asthma in 2022, which was on par with the state average. Adult asthma rates have steadily increased over the years, though not by much. In 2018, about 9.2% of adults had asthma.

Asthma and COPD are strongly influenced by the conditions in which people live and work. Poor housing, air pollution, and exposure to smoke or allergens are more common in lower-income communities, increasing the risk and severity of respiratory illness. Limited access to healthcare and affordable medications makes managing these diseases even harder, often leading to more hospital visits and missed opportunities for prevention.

Social and economic challenges—like unstable employment, low health literacy, and chronic stress—also play a role in how people manage asthma and COPD. These factors can make it difficult to follow treatment plans or maintain healthy environments. In this way, asthma and COPD reflect not only medical conditions but also the broader social and environmental inequities that shape health outcomes.

Heart disease

Heart disease is very common in the community and remains the leading cause of death among adults. In 2022, nearly 8% of adults reported being diagnosed with heart disease, making it one of the top chronic health conditions in the community.

Heart disease prevalence, 2020 to 2022

	2020	2021	2022
Georgia	6.6%	5.9%	6.4%
PHC Primary Communities	0.6%	0.5%	0.6%
Muscogee County	0.7%	0.6%	0.7%

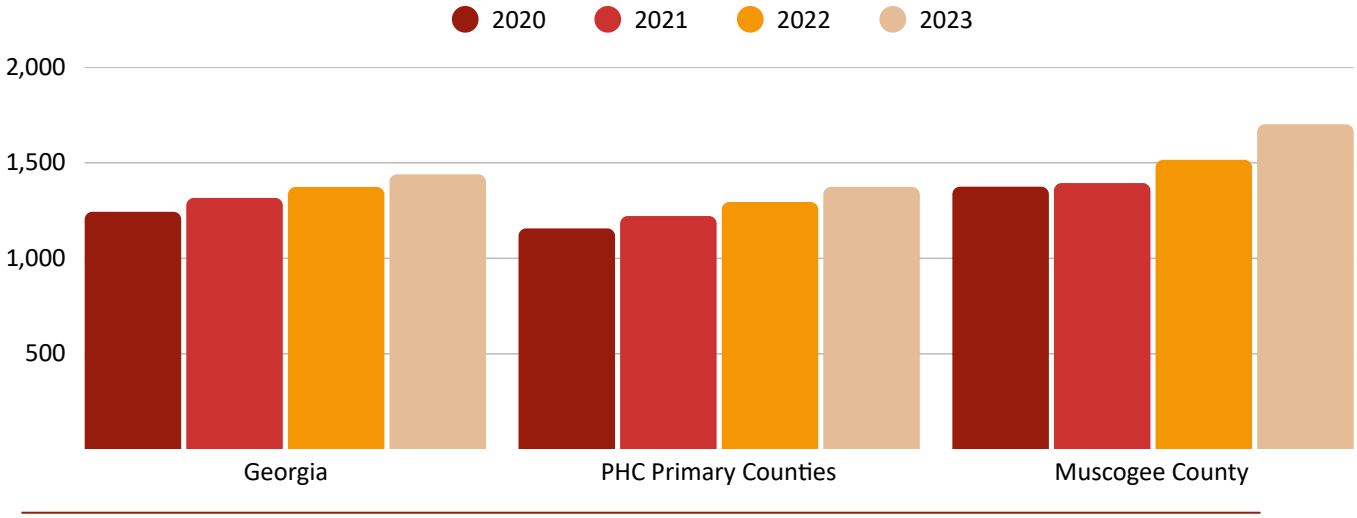
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

Heart disease is a major health concern in the South, where mortality rates are higher and declines have been slower than in other parts of the country. This is linked to higher rates of risk factors such as obesity, high blood pressure, diabetes, and smoking, along with diets that are often high in unhealthy fats and fried foods. In Muscogee County and across Georgia, heart disease continues to pose a serious threat, reflecting the prevalence of chronic conditions, lifestyle habits like poor diet, smoking, and binge drinking, and lower rates of preventive care and chronic disease management.

Heart disease at the hospital

For many community members, heart disease will, at some point, bring them to the hospital.

Hospital discharges due to cardiovascular disease by patient county of origin, for every 100,000 people, 2023



Source: Georgia Online Analytical Statistical Information System, accessed April 2025.

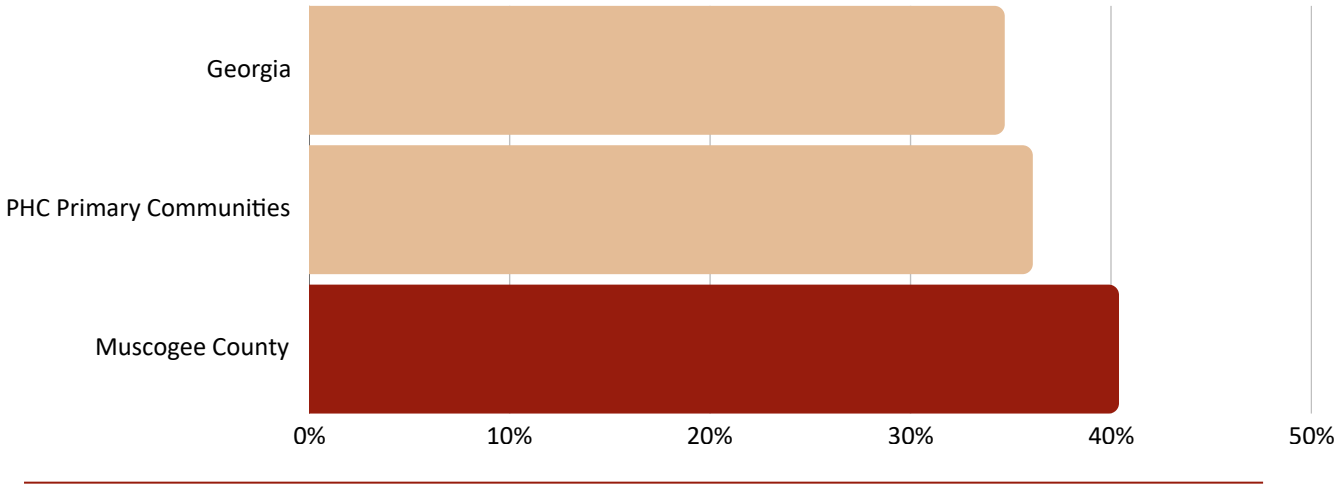
Rural areas in the US experience higher rates of heart disease and related deaths compared to urban areas, which show up at the hospital, with disparities seen in both heart failure risk and mortality. This is linked to factors like the availability of specialists within a given community and issues related to transportation and access to a cardiology appointment.

Nationally, adults in rural areas have a 19% higher risk of developing heart failure compared to urban residents. Increasing access to quality healthcare, including specialists such as cardiologists and heart failure specialists, is crucial. Additionally, support for healthy behaviors is vital, as rural populations tend to make unhealthy choices at a higher rate than their urban counterparts.

Hypertension

Hypertension, commonly called high blood pressure, occurs when blood pushes too hard against the walls of your arteries. If left uncontrolled, it can lead to serious heart problems, including heart attacks and strokes, though it can often be managed with proper care.

Percent of adults with high blood pressure, 2021



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021.

Numerous factors can lead to hypertension, such as genetics, unhealthy diets (and especially those with high salt counts), smoking, drinking, a lack of physical activity, stress, certain medications, plaque buildup in the arteries, age, race, and income.

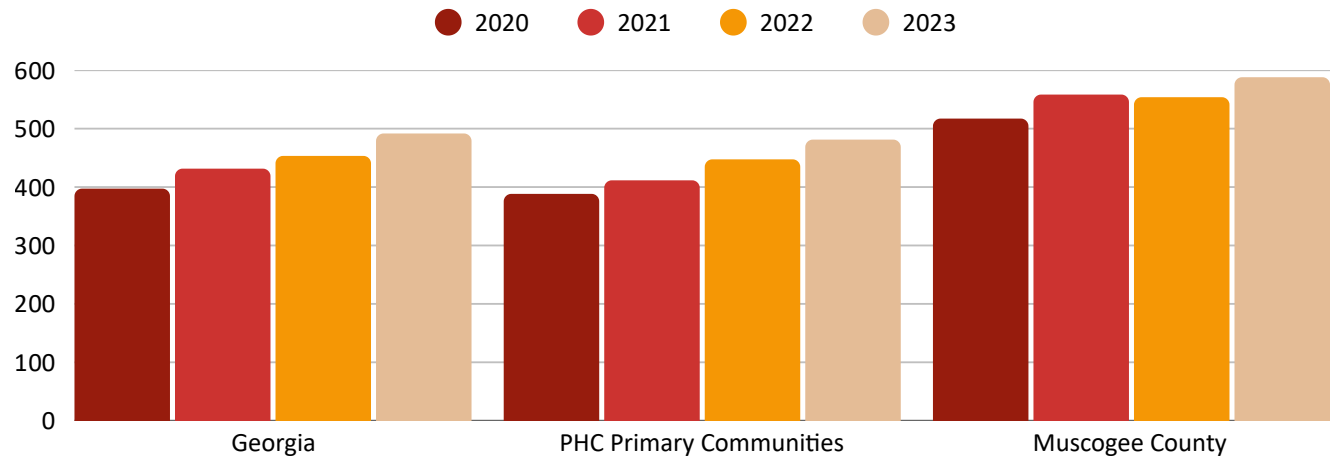
Hypertension is often tied to income, with lower-income individuals facing more challenges in managing the condition. Limited education can make it harder to recognize hypertension, follow treatment plans, and access health insurance.

Access to healthcare also plays a big role—without preventive care or specialized treatment, hypertension may go unmanaged. On top of that, living in high-poverty neighborhoods, areas with limited healthy food options, or places lacking safe spaces for exercise can increase stress and promote unhealthy habits, all of which raise the risk for high blood pressure.

Hypertension and the emergency room

Uncontrolled hypertension often shows up in the emergency department.

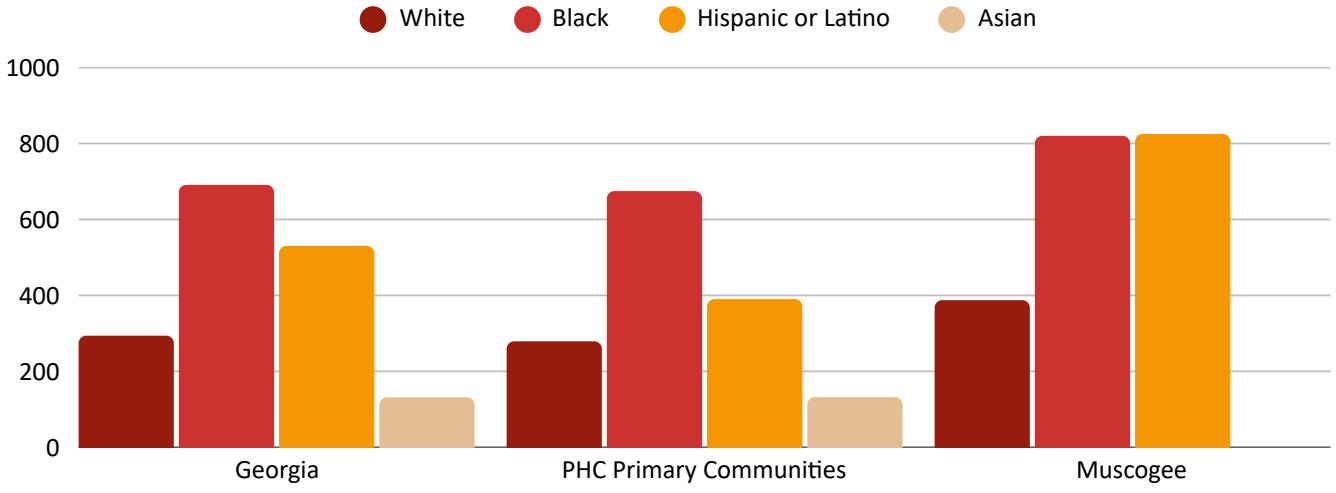
Emergency room discharge rate by patient county origin, per every 100,000, with a primary diagnosis code of hypertension, 2020 to 2023



Source: Georgia Online Analytical Statistical Information System, Accessed February 2025.

When broken down by race, clear disparities exist with Black and Hispanic or Latino populations having much higher rates than their White or Asian counterparts. Please note that information about certain racial groups was not available.

Emergency room discharge rate by patient county origin, with a primary diagnosis code of hypertension, per every 100,000, by race, 2023



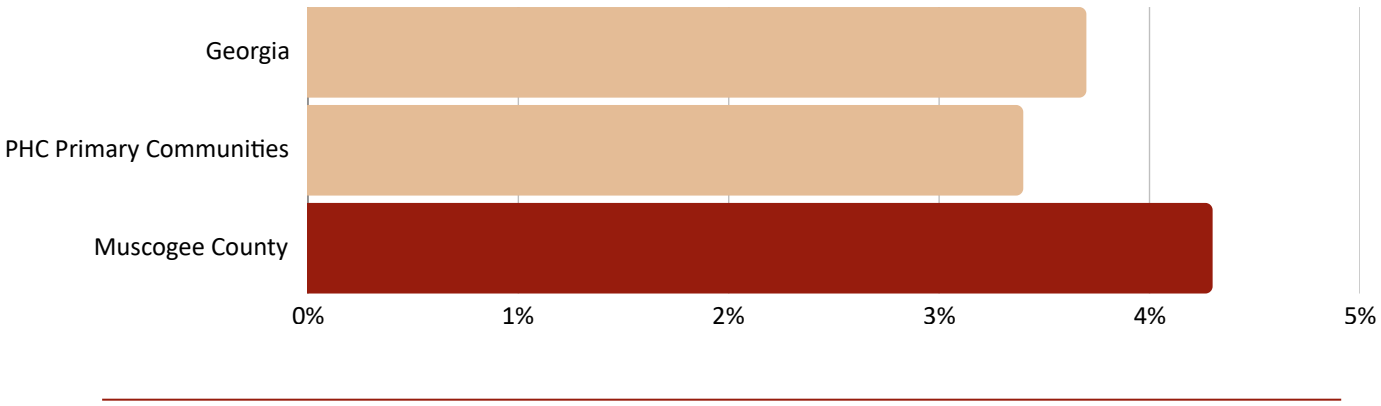
Source: Georgia Online Analytical Statistical Information System, Accessed February 2025.

Stroke

Stroke, also known as cerebrovascular disease, is one of the leading causes of death in Georgia and across the community. The Centers for Disease Control and Prevention reports that in the United States, someone experiences a stroke every 40 seconds, and every 3 minutes and 11 seconds, someone dies from one.

Risk is not the same for everyone. Non-Hispanic Black adults are nearly twice as likely as White adults to have a first stroke, and both Non-Hispanic Black and Pacific Islander adults face the highest death rates from stroke. Socioeconomic factors also play a major role. People with lower incomes are more likely to suffer a stroke, often experience more severe effects, and are less likely to receive timely, evidence-based care—leading to poorer outcomes overall.

Stroke prevalence among adults age 18+, 2022



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

Yes — there is evidence that certain populations in Muscogee County are more likely to suffer from strokes, reflecting broader patterns of disparity in Georgia and across the U.S. According to the Georgia Department of Community Health, stroke mortality rates are higher among Black residents compared to White residents in the county.

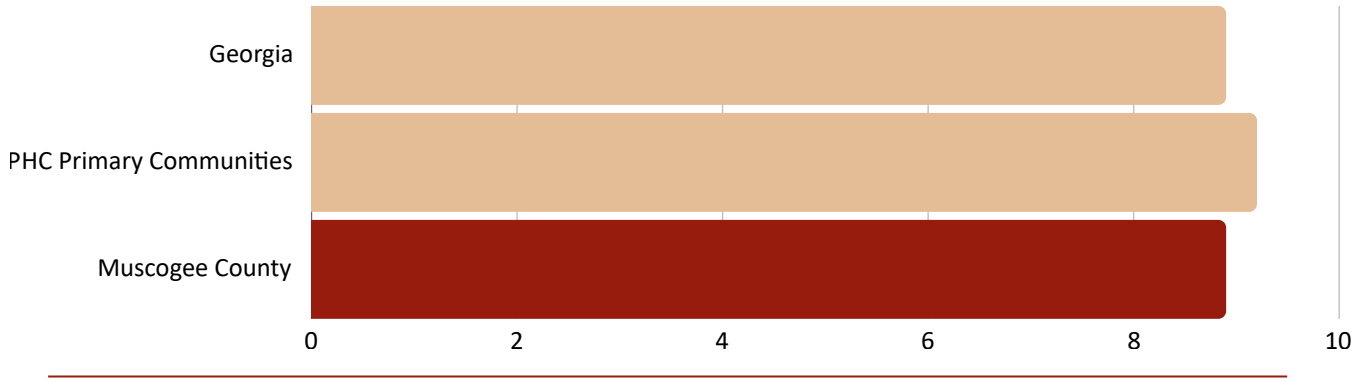
These local disparities align with national and state trends: Black Americans generally face a higher risk of stroke and worse outcomes, due in part to disproportionate burdens of hypertension, diabetes, and limited access to high-quality care. (Sources: AHA “Improving Stroke Risk Factor Management” review; Georgia stroke reports) In short, race and geography (as reflected in Muscogee County) correlate with elevated stroke risk, especially when combined with social determinants like access to care, socioeconomic status, and chronic disease prevalence.

Stroke and hospital care

A stroke in progress is generally diagnosed at the hospital, and timely hospital care is key to stroke recovery. Timely stroke care is critical because every minute counts when a stroke occurs. Brain cells begin dying rapidly when blood flow is disrupted, and the longer the delay in treatment, the greater the potential for long-term disability and even death. Immediate intervention, including clot-dissolving medications like tPA, can help minimize brain damage and improve recovery.

Within Muscogee County, approximately 94% of patients presenting at the hospital with stroke symptoms received medicine to break up a blood clot within 3 hours after symptoms started, a rate about 3% higher than the state average.

Hospitalizations due to stroke, 2018-2020

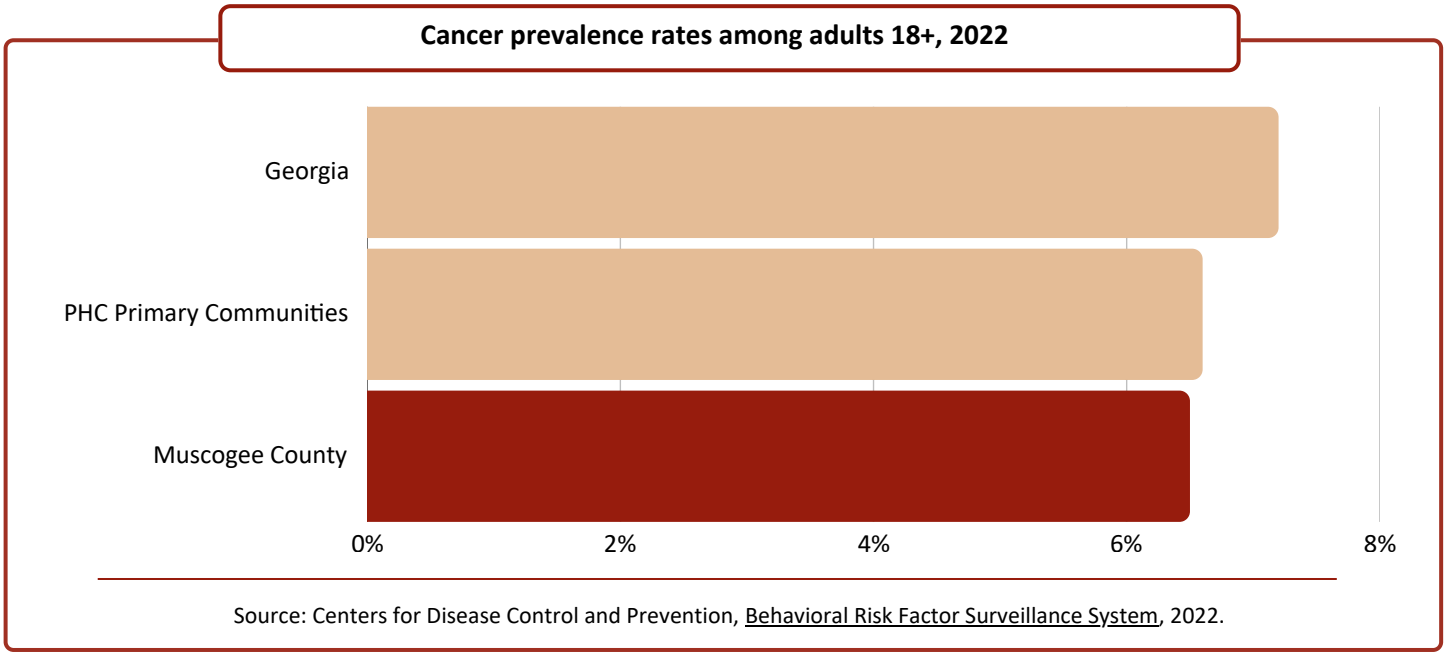


Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2018-2020.

Hospitalizations due to stroke refer to instances where a patient is admitted to a hospital because they have experienced a stroke due to a blockage in an artery that reduces blood flow to the brain (ischemic stroke) or bleeding in or around the brain caused by a ruptured blood vessel (hemorrhagic stroke). These admissions are also used as a key indicator of community health, as high rates can reflect underlying risk factors such as high blood pressure, diabetes, smoking, and limited access to preventive care.

Cancer prevalence rates

Cancer continues to be a leading cause of death in our communities, with some areas in the service region showing prevalence rates even higher than the state average.



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

Social drivers of health—like income, education, housing, access to healthcare, and environmental exposures—play a powerful role in cancer outcomes. In Georgia, these factors affect everything from when cancer is diagnosed to the treatment received and the chances of survival.

For instance, cancer incidence and death rates vary significantly across the state. In 2023, Georgia saw an estimated 61,170 new cancer cases and about 18,510 cancer deaths. Meanwhile, Black residents in Georgia experience notably worse outcomes: Black men are 19% more likely to die from cancer than White men, and Black women are 9% more likely to die than White women.

When it comes to lung cancer—which remains a leading cause of cancer death—Black Georgians face additional disadvantages. Only 22.8% of lung cancers in Black patients are caught early, compared to 27.2% in White patients. Moreover, just 16.5% of Black Georgians with lung cancer receive surgery—a key treatment—compared to 19% of White patients. Alarmingly, 23.7% of Black patients receive no treatment at all, higher than the 21.5% rate among White patients.

Further deepening these disparities, research highlights that African Americans in Georgia are often diagnosed at later cancer stages, face less access to essential treatments, and endure worse survival outcomes across nearly all cancer types. A contributing factor is insurance coverage: non-African American cancer patients are over 4 times more likely to have full coverage for cancer treatment than African American patients. Additionally, counties with higher proportions of Black residents, lower income levels, and rural settings consistently show higher cancer mortality rates.

Cancer incidence rates

Cancer incidence rates describe how often new cases of cancer are diagnosed in a population during a specific period of time.

Cancer incidence rates by site, for every 100,000 people, 2017-2021

	Breast	Lung and bronchus	Prostate	Colon and rectum
Georgia	133	57	138	39
PHC Primary Communities	134	52	148	38
Muscogee County	131	63	150	42

Source: National Cancer Institute, State Cancer Profiles, 2017-2021.

In Muscogee County, clinicians diagnosed approximately 475 new cancer cases each year, annually, on average between 2017 and 2021.

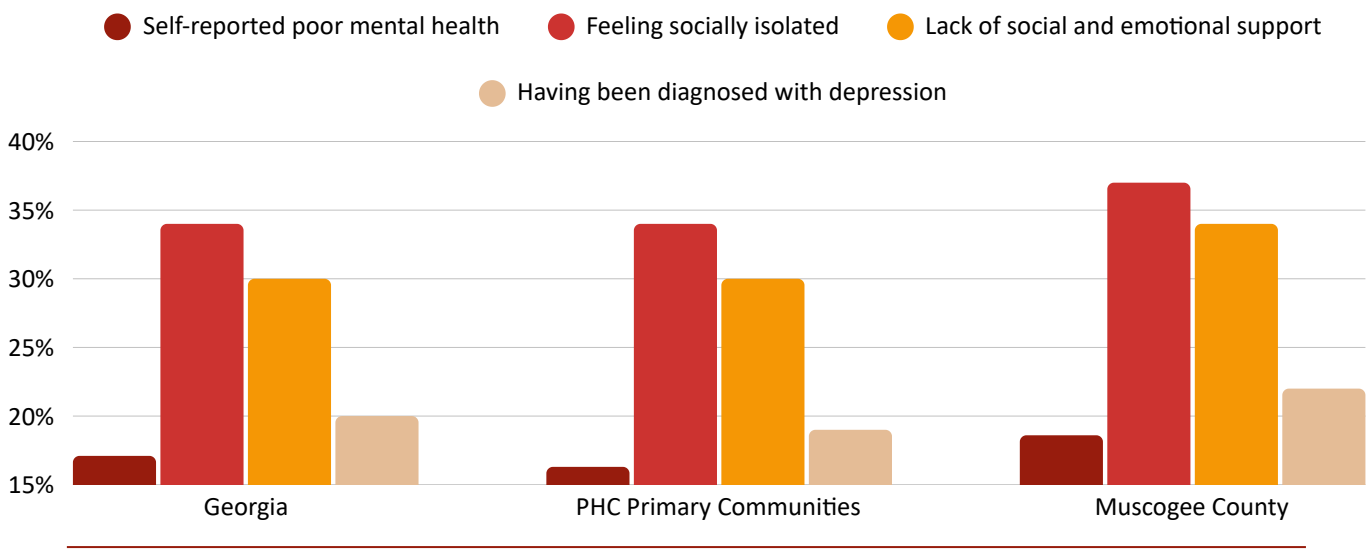
Cancer rates in Georgia are shaped by a mix of personal choices, environmental exposures, and social factors. Lifestyle habits—such as smoking, poor diet, lack of physical activity, and too much sun exposure—play a big role. For instance, melanoma rates in Georgia are higher than the national average, reflecting the impact of frequent sunburns and limited sun protection.

Beyond individual behavior, the environment also contributes. Communities located near refineries or manufacturing plants face greater exposure to pollutants like benzene, which has been linked to certain cancers, including Non-Hodgkin's lymphoma. These risks are compounded in rural areas, where healthcare is harder to access. Fewer screening facilities, long travel times, and financial barriers mean many residents are diagnosed later, when treatment is less effective.

Mental health

Mental health shapes how we think, feel, and interact with the world around us—it's at the core of our emotional, psychological, and social well-being. When our mental health suffers, it can take a serious toll on daily life, lowering our quality of living, reducing productivity, and even increasing the risk of long-term health problems.

Adults 18+ and mental health, 2022



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

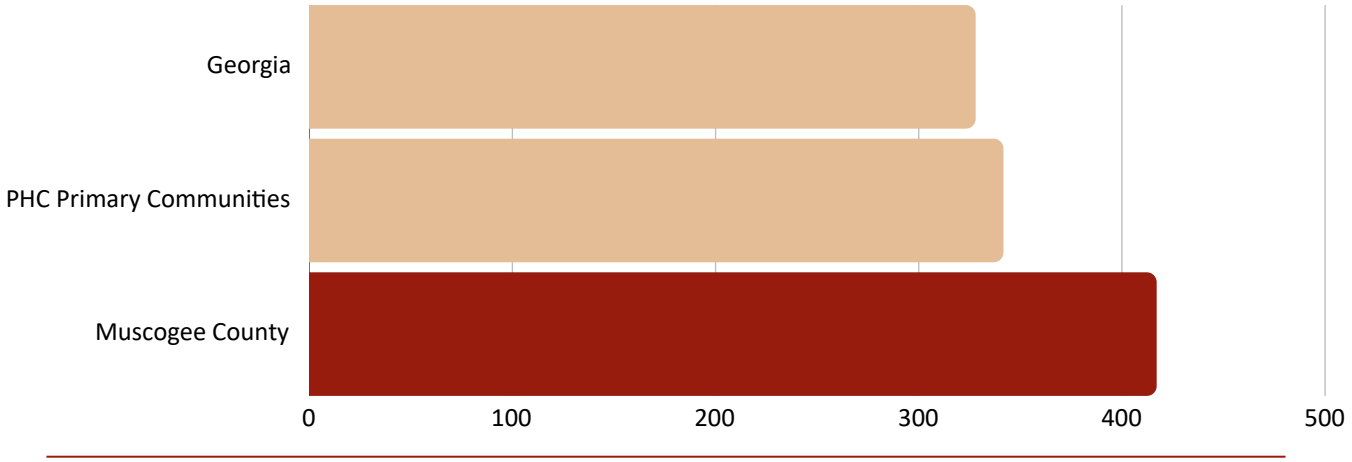
People living in low-income communities often face higher rates of mental health challenges, yet they also encounter the greatest barriers to getting the care they need. Poverty itself can fuel stress, anxiety, and depression—and, in turn, mental health struggles can make it even harder to break free from financial hardship.

When money is tight, worries about food, housing, and steady income create ongoing stress that takes a toll on both mind and body. On top of that, these communities often have fewer resources—like access to quality schools, safe housing, and reliable healthcare—which can further strain mental well-being.

Drug use

Drug use negatively impacts the health, productivity, and well-being of the community across all age groups, contributing to chronic disease, mental health disorders, and reduced quality of life. It strains families, workplaces, and communities through increased healthcare costs, crime, and social instability. Prevention, education, and access to addiction treatment are critical for supporting a healthier population.

Rate of ED visits due to drug use, by patient home county, 2023



Source: Georgia Online Analytical Statistical Information System, Accessed February 2025.

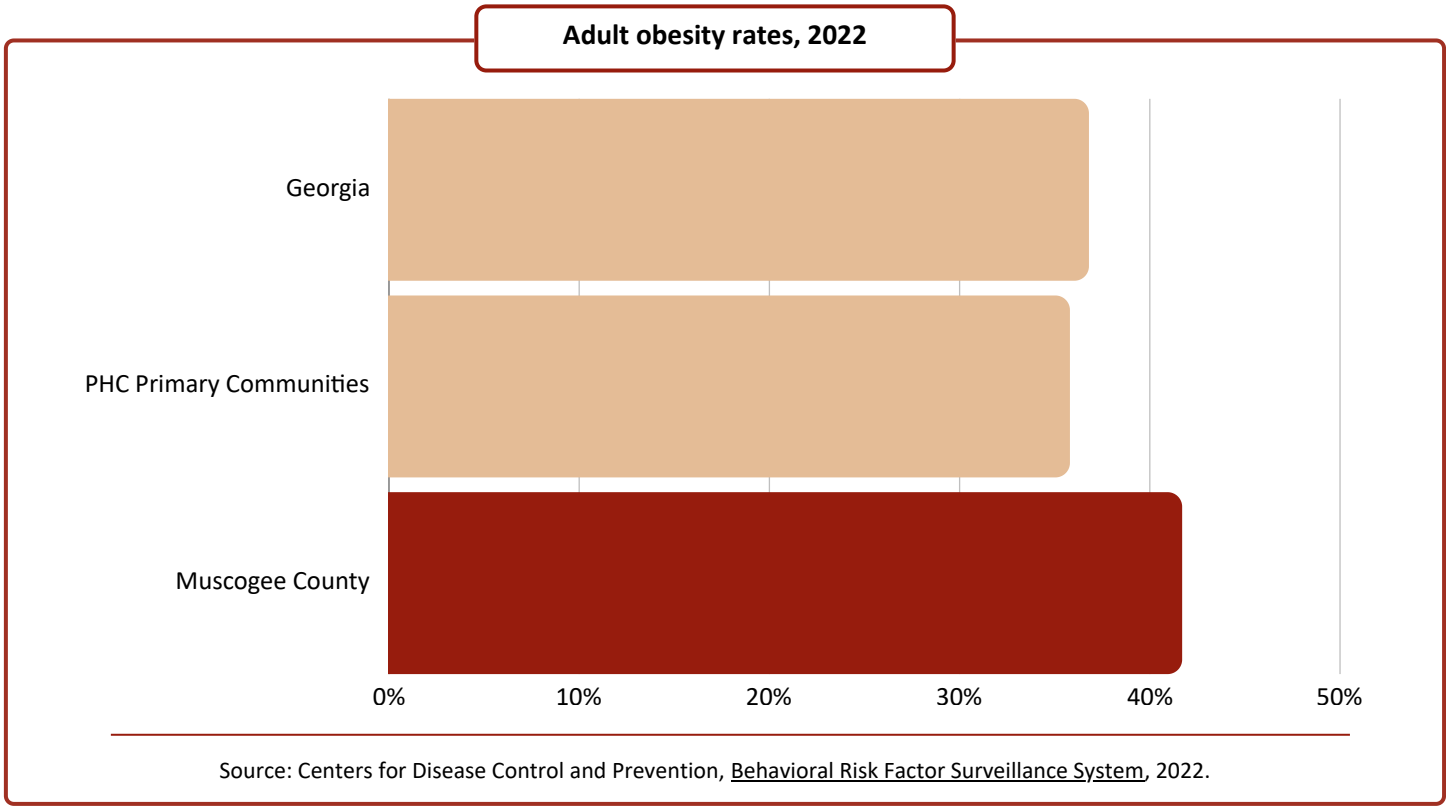
Within the community and in Georgia, racial differences persist in emergency department visits. In 2023, Black populations came to the emergency department for a drug-related issue at a rate of 372 visits, as compared to 300 visits for White populations and 196 visits for Hispanic and/or Latino populations.

Socioeconomic factors, such as poverty and a lack of opportunities, also play a role. Racial and ethnic minorities may enter treatment later and have negative experiences. Black Americans are less likely to complete SUD treatment, and treatment systems may not be adequately equipped to meet the needs of people of color.

Healthy behaviors

Health behaviors are the choices people make that influence their well-being. Some behaviors—like eating nutritious foods and staying active—promote better health, while others—such as smoking, drinking too much alcohol, or engaging in risky sexual activity—can increase the chance of disease.

One key measure of health is obesity, which reflects the impact of daily habits. The chart below shows the percentage of adults age 18 and older who are considered obese. Obesity is defined as having a body mass index (BMI) of 30 or higher, a calculation based on height and weight that helps estimate body fat. Because this information is self-reported, obesity rates are often undercounted.



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

People with lower incomes, less education, and certain occupations often face higher rates of obesity. A big part of this comes down to access—whether or not someone has nearby grocery stores with fresh produce, safe places to exercise, or neighborhoods designed with sidewalks and parks instead of only fast-food options.

Stress, discrimination, and social isolation can also play a role, pushing people toward unhealthy coping behaviors that lead to weight gain.

In communities known as "food deserts," where affordable, nutritious food is scarce, obesity rates tend to be higher. Likewise, areas without safe walking paths, bike lanes, or parks make it harder for people to stay active, which can contribute to weight gain over time.

Across Georgia, nearly 2 million residents—including about 500,000 children—live in food deserts, areas that lack affordable, healthy food access. This is especially true in rural communities.

Excessive drinking, limited sleep, and smoking

Everyday habits have a big impact on health. Behaviors like heavy drinking, smoking, not getting enough sleep, and being physically inactive all increase the risk of serious health problems. The data below shows the percentage of adults who report engaging in these behaviors. Heavy alcohol use and smoking are closely linked to chronic illnesses and preventable diseases. Likewise, too little sleep and low levels of physical activity raise the risk of obesity, heart disease, diabetes, mental health challenges, and even a weakened immune system.

Adults reporting excessive drinking, insufficient sleep, and tobacco use, 2022

	Binge drinking	Insufficient sleep	Current smokers
Georgia	15.8%	38.9%	14.7%
PHC Primary Communities	15.6%	39.1%	13.2%
Muscogee County	14.3%	44.2%	17.0%

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

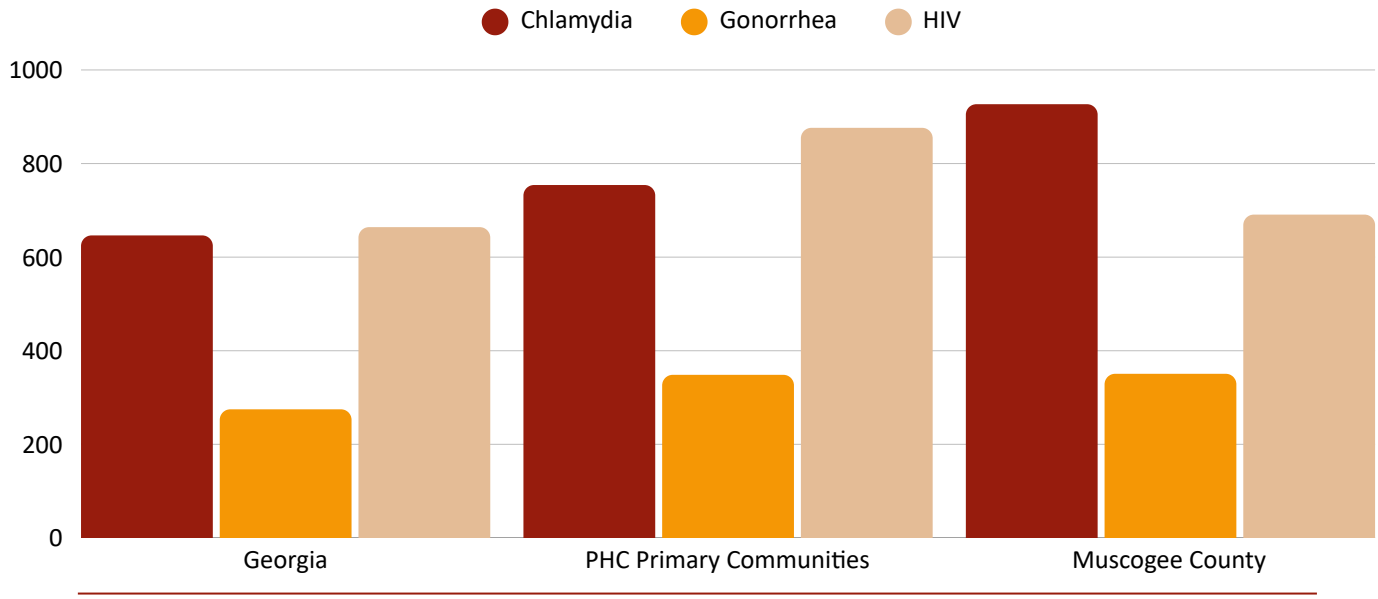
Healthy behaviors—such as maintaining a balanced diet, engaging in regular physical activity, and obtaining sufficient sleep—are essential for overall health and well-being. However, disparities in both access to and adoption of these behaviors persist across populations. Socioeconomic status, food insecurity, and limited healthcare resources are key factors that contribute to these inequities.

Racial and ethnic disparities are also evident in health behaviors, with measurable differences in obesity rates, levels of physical activity, and dietary patterns. In addition, variations in cultural practices, including diet and alcohol consumption, further influence these outcomes. These disparities are largely shaped by broader social determinants of health, including socioeconomic conditions, resource availability, and cultural context.

Sexually transmitted diseases

Keeping track of sexually transmitted diseases (STDs) is an important part of protecting community health. Monitoring helps us see trends over time, spot outbreaks quickly, and understand whether prevention and treatment efforts are working. Because many STDs don't cause obvious symptoms, regular testing is key. Early detection and treatment not only prevent serious health complications but also reduce the risk of passing infections to others. In short, monitoring and testing are essential tools for keeping individuals—and entire communities—healthy.

Rate of infection by disease, 2023



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

Sexually transmitted infections (STIs) are shaped by social and structural determinants of health. Lower socioeconomic status—including low income, unemployment, and unstable housing—is strongly associated with increased risk and higher rates of STIs. Limited access to quality healthcare and the absence of health insurance further hinder opportunities for early detection, timely treatment, and effective prevention.

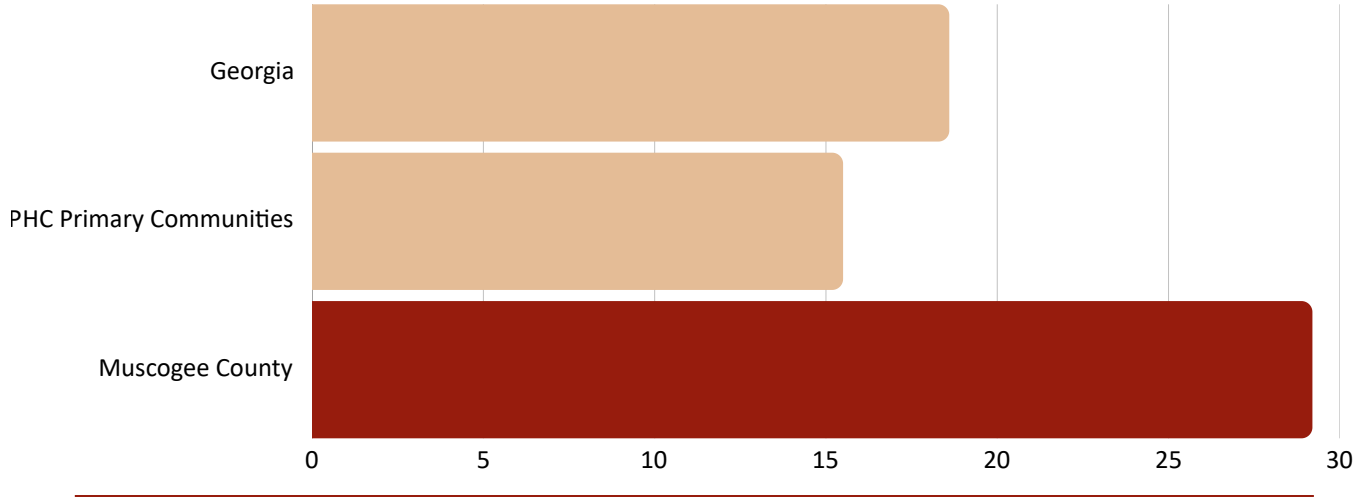
Communities with concentrated poverty and limited resources often face disproportionately high rates of HIV, syphilis, herpes simplex virus, chlamydia, and hepatitis B. These disparities reflect inequitable access to healthcare and broader gaps in resource allocation. Individuals with a history of incarceration are also at elevated risk of STIs, influenced by factors such as crowded living environments, and reduced access to medical care during and after incarceration.

At the same time, protective factors matter. Strong social networks and supportive community connections can help reduce vulnerability by fostering healthier behaviors and decreasing the risk of both acquiring and transmitting STIs.

Teen births

Studying teen births is important because they are linked to serious social, health, and financial challenges that affect not only the teen mothers but also their families and communities. Young mothers are at greater risk for pregnancy and childbirth complications, including eclampsia, puerperal endometritis, and systemic infections. This measure focuses on births to mothers ages 15 to 19.

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



Source: Centers for Disease Control and Prevention, National Vital Statistics System, 2017-2023.

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, often 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.

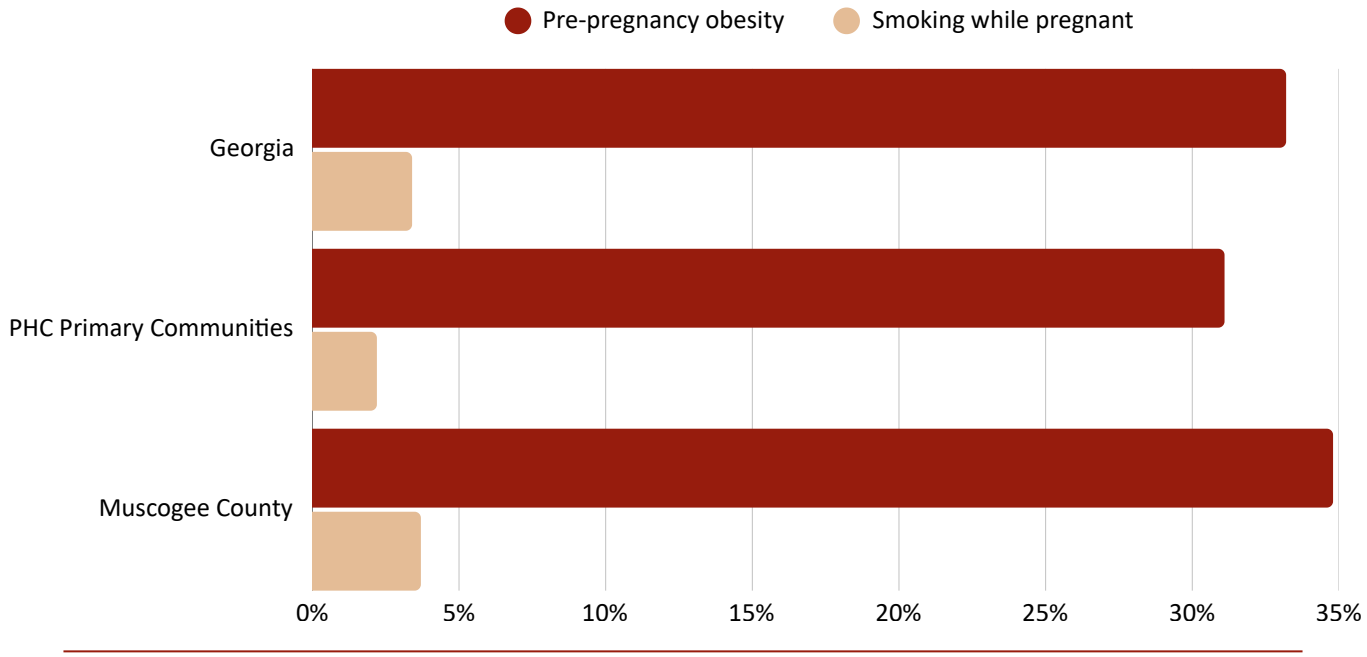
Teen mothers are at a higher risk of mental health problems, including postpartum depression and suicidal ideation.

Pregnancy and healthy behaviors

The choices a woman makes before and during pregnancy can have a powerful influence on the health of both mother and baby. For instance, entering pregnancy with obesity raises the risk of serious complications such as gestational diabetes, preeclampsia, and delivery challenges, while also increasing the likelihood of long-term health issues for the child.

Smoking during pregnancy poses additional dangers, doubling the risk of abnormal bleeding and heightening the chances of complications such as premature rupture of membranes, placenta previa, placental abruption, and ectopic pregnancy—all of which can be life-threatening for both mother and baby.

Pregnancy and behaviors, 2020-2022



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

Significant racial disparities exist in prenatal care, with Black women and other women of color facing persistent inequities in both access and quality compared to White women. These disparities contribute to poorer health outcomes for mothers and infants. Nationally, White women are the most likely to begin prenatal care early: from 2021 to 2023, 82.7% initiated care in the first trimester, compared with 70.6% of Hispanic women, 67.9% of Black women, and 65.0% of American Indian/Alaska Native women, according to final natality data from the March of Dimes and the National Center for Health Statistics.

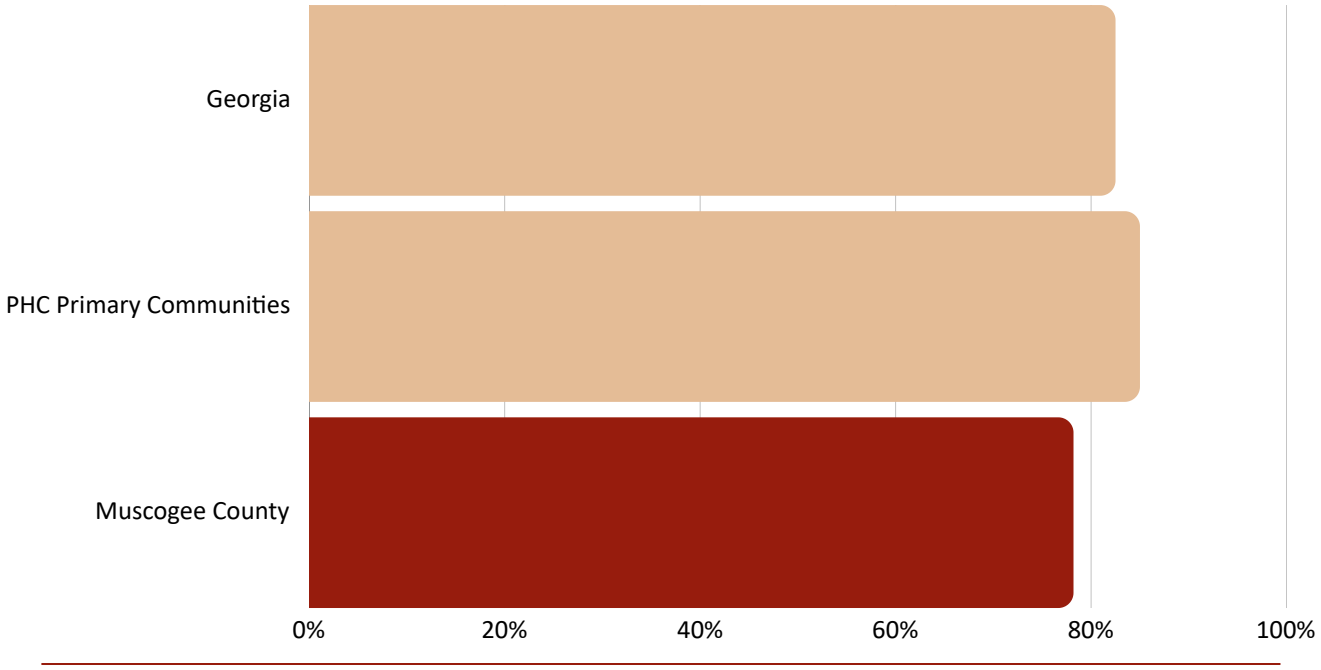
The timing of care also reflects these inequities. Black women are nearly twice as likely as White women to have births with late or no prenatal care, while non-Hispanic Pacific Islander women are four times more likely than White women to delay care until the third trimester or to forgo it entirely.

Breastfeeding

Breastfeeding is one of the best ways to support the health of both babies and mothers. It gives babies a stronger immune system and helps protect them from illnesses now and in the future. Breastfed babies are less likely to develop asthma, obesity, type 1 diabetes, or experience sudden infant death syndrome (SIDS).

For mothers, breastfeeding lowers the risk of breast and ovarian cancer and supports better mental health and overall well-being. It can also bring peace of mind by reducing the high costs of formula and lowering long-term health expenses. In short, breastfeeding nourishes babies, strengthens mothers, and benefits families as a whole.

Breastfed infants, 2020-2022



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

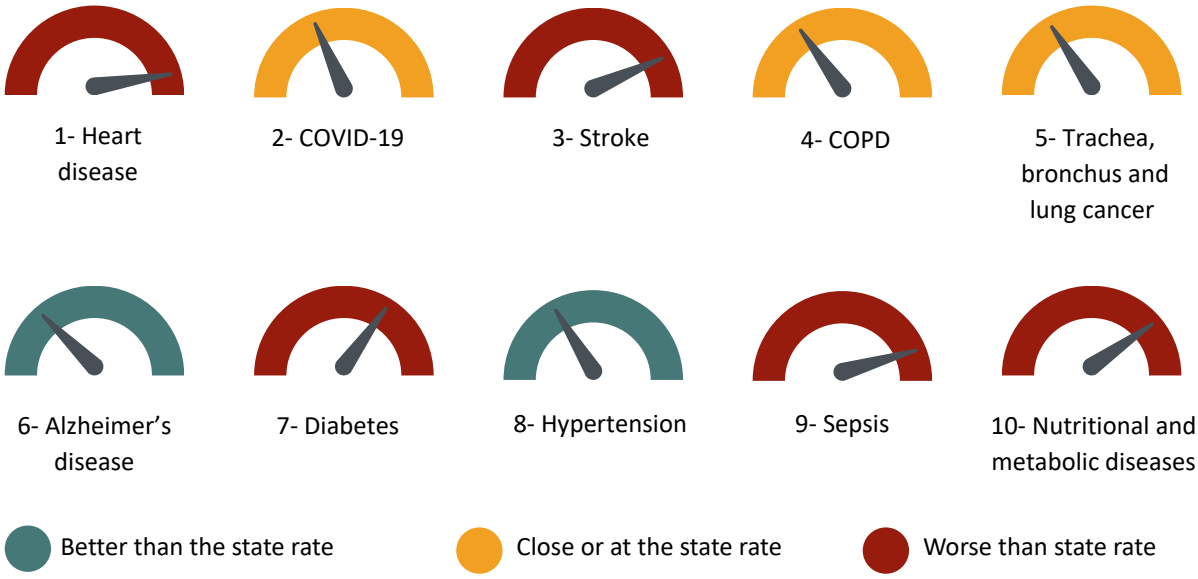
Despite its benefits, structural and social barriers disproportionately affect low-income mothers. Limited access to paid parental leave and inflexible workplace policies often force mothers to return to work shortly after giving birth, making it difficult to establish or sustain breastfeeding. Many workplaces lack private, supportive environments for pumping. Access to lactation consultants, peer counseling, and breastfeeding education is also limited for families with fewer resources. In addition, cultural norms, lack of social support, and stigma can further discourage breastfeeding.

Public health programs play a critical role in addressing these disparities. The Women, Infants, and Children (WIC) program provides breastfeeding education, counseling, and supplies, while hospital-based initiatives and community programs offer additional support. Policies that expand paid leave and require lactation accommodations in the workplace also improve breastfeeding rates among low-income women.

Causes of death

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

Top ten causes of death, 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, as seen in the list below that shows the top causes of death by age group.

Top cause of death by age, community, 2019 to 2023

<1	1-4	5-9	10-19
Certain conditions originating in the perinatal period	Homicide	Diseases of the nervous system	Homicide
20-34	**35-44**	**55-74**	**75+**
Homicide	Heart disease	Heart disease	Heart disease

Source: Online Analytical Statistical Information System (OASIS), Georgia DPH, 2025.

Causes of death by sex and race

Below are the five leading causes of death, by sex and race, in Muscogee County 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. Please note that mental and behavioral disorders do not include suicide.

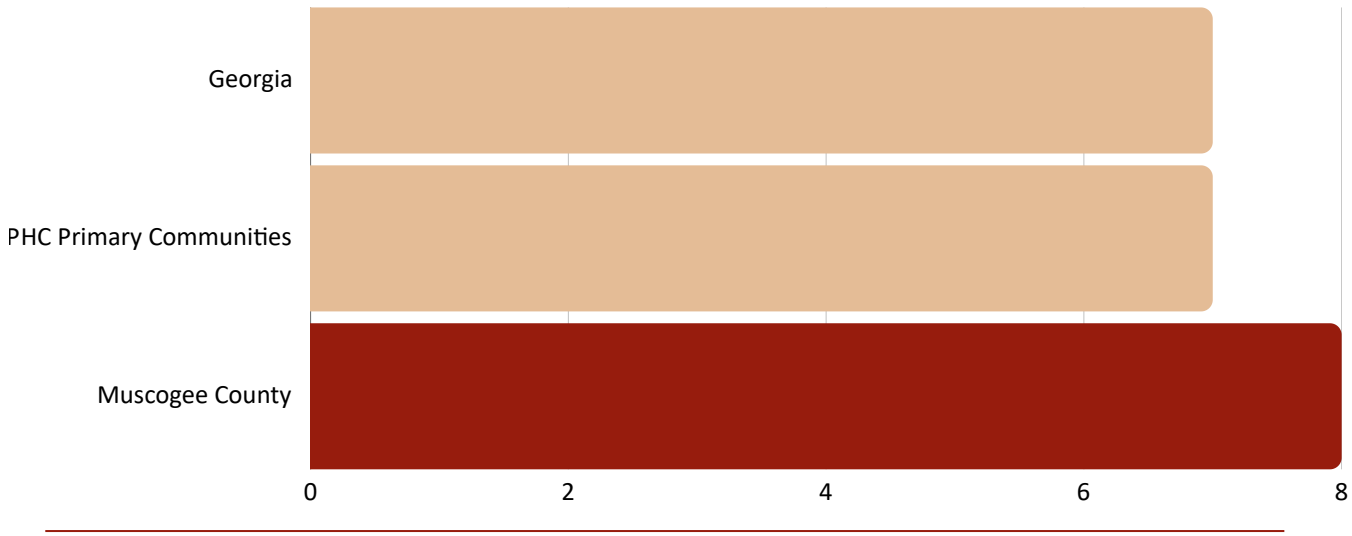
Ranking	Georgia women	All women (Muscogee County)	Black women (Muscogee County)	White women (Muscogee County)
1	Heart disease	Heart disease	Heart disease	Heart disease
2	Alzheimer's disease	COVID-19	COVID-19	COVID-19
3	COVID-19	Stroke	Stroke	Alzheimer's disease
4	Stroke	Alzheimer's disease	Diabetes	COVID-19
5	COPD	COPD	Hypertension	Stroke

Ranking	Georgia men	All men (Muscogee County)	Black men (Muscogee County)	White men (Muscogee County)
1	Heart disease	Heart disease	Homicide	Heart disease
2	COVID-19	COVID-19	Homicide	COVID-19
3	Hypertension	Stroke	COVID-19	COPD
4	Trachea, bronchus and lung cancer	Trachea, bronchus and lung cancer	Stroke	Trachea, bronchus and lung cancer
5	Stroke	COPD	Diabetes	Stroke

Infant mortality

Infant mortality refers to the death of a baby before their first birthday. It's often measured as the number of infant deaths per 1,000 live births. The leading causes include birth defects, premature birth, low birth weight, sudden infant death syndrome (SIDS), unintentional injuries, and complications during pregnancy.
These challenges are often made worse by factors like poverty, poor nutrition, limited access to healthcare, lack of prenatal care, and substance use such as smoking, drinking, or drugs during pregnancy.

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



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

Racial and ethnic disparities

Infant mortality rates in the United States reveal deep disparities across racial and ethnic groups. Black infants are especially at risk, with a mortality rate 2.4 times higher than that of White infants. American Indian or Alaska Native infants, as well as Native Hawaiian or other Pacific Islander infants, also face higher rates of infant death.

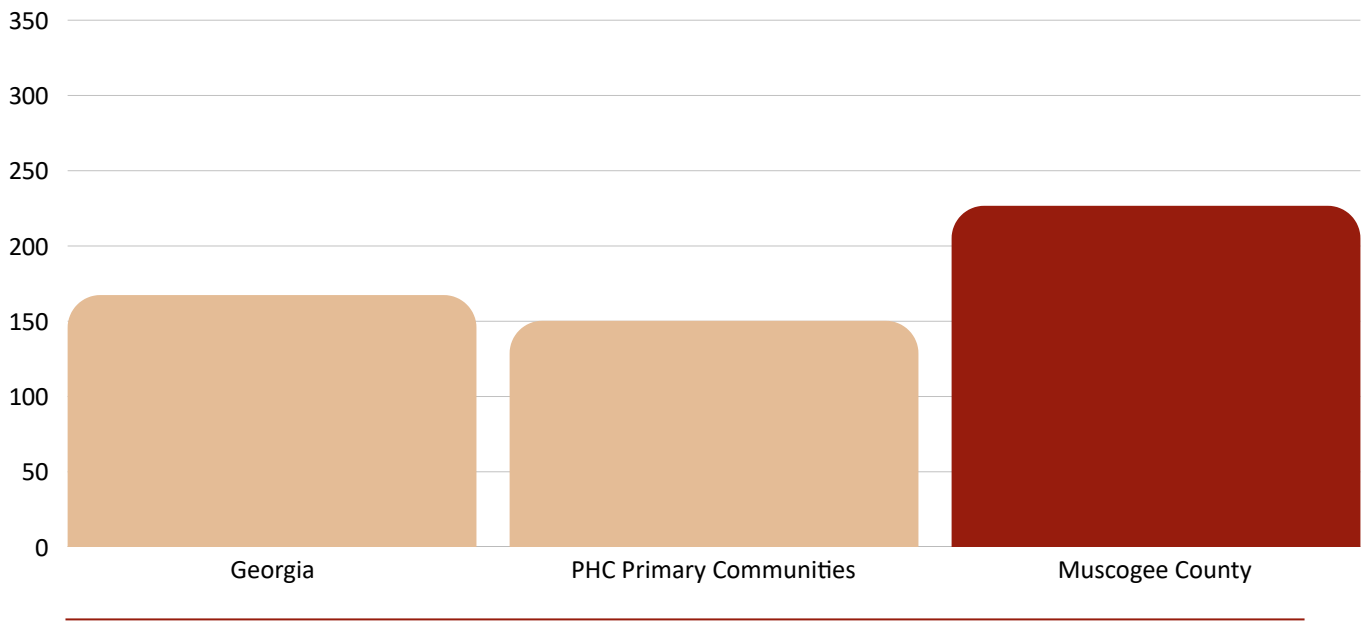
In Georgia, these national trends are clearly reflected. Black infants in the state have an infant mortality rate of about 9.6 deaths per 1,000 live births—nearly double that of other groups. By comparison, the rate is 5.1 for Hispanic infants, 5.0 for White infants, and 3.5 for Asian and Pacific Islander infants.

These disparities are closely tied to the broader challenges that Black families face. Higher rates of poverty can limit access to nutritious food, safe housing, and quality healthcare. Socioeconomic barriers also make it harder to receive consistent prenatal care or maintain healthy lifestyles during pregnancy. On top of that, where families live, whether they have reliable transportation, and whether they face food insecurity all play a role in shaping infant health outcomes.

Deaths due to cancer

Between 2019 and 2023, approximately 1,893 community members died from cancer, resulting in a rate of 188.9 deaths for every 100,000 people, higher than the state rate of 167.4.

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



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

Men are more likely than women to die from cancer. Between 2019 and 2023, cancer claimed the lives of about 207 men per 100,000 people, compared with 165 women. Within the community, White populations experienced the highest cancer mortality rates—234 deaths per 100,000—compared with 155.3 among Black populations and 36.4 among Hispanic/Latino populations.

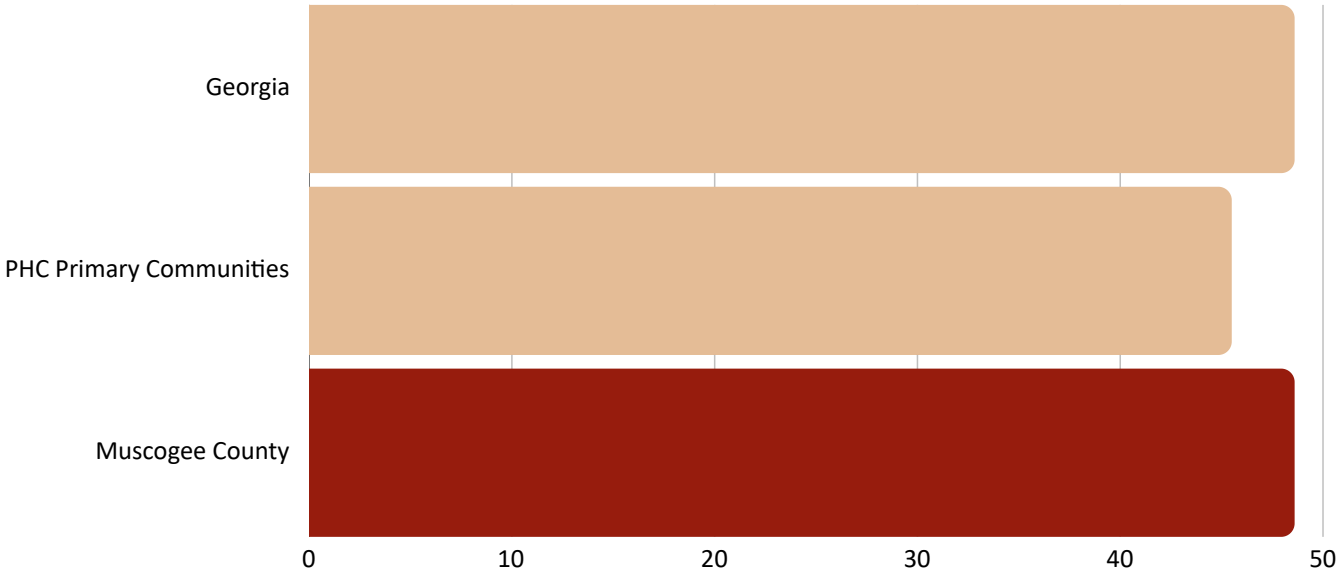
Cancer outcomes are closely tied to income and socioeconomic status, which influence diagnosis, treatment, and survival. Individuals with lower incomes are more likely to face financial hardship, experience higher healthcare costs, and encounter delays or gaps in care. These barriers often lead to worse outcomes compared to those with greater financial resources.

Geography also plays a role. Rural communities tend to have higher cancer death rates than urban areas, even though they may see fewer new cases. This disparity is linked to reduced access to prevention programs, routine screening, and timely treatment. It is particularly evident in cancers such as lung, colorectal, and cervical cancer—conditions that are often preventable or more easily treated when detected early.

Deaths of despair

"Deaths of despair" refer to fatalities caused by suicide, alcohol-related disease, and drug overdose—conditions often closely linked to mental health challenges.

Deaths of despair for every 100,000 county residents, 2019 to 2023



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

Suicide is one of the leading causes of injury-related death in Georgia. In 2022 alone, the state recorded 1,626 suicide deaths.

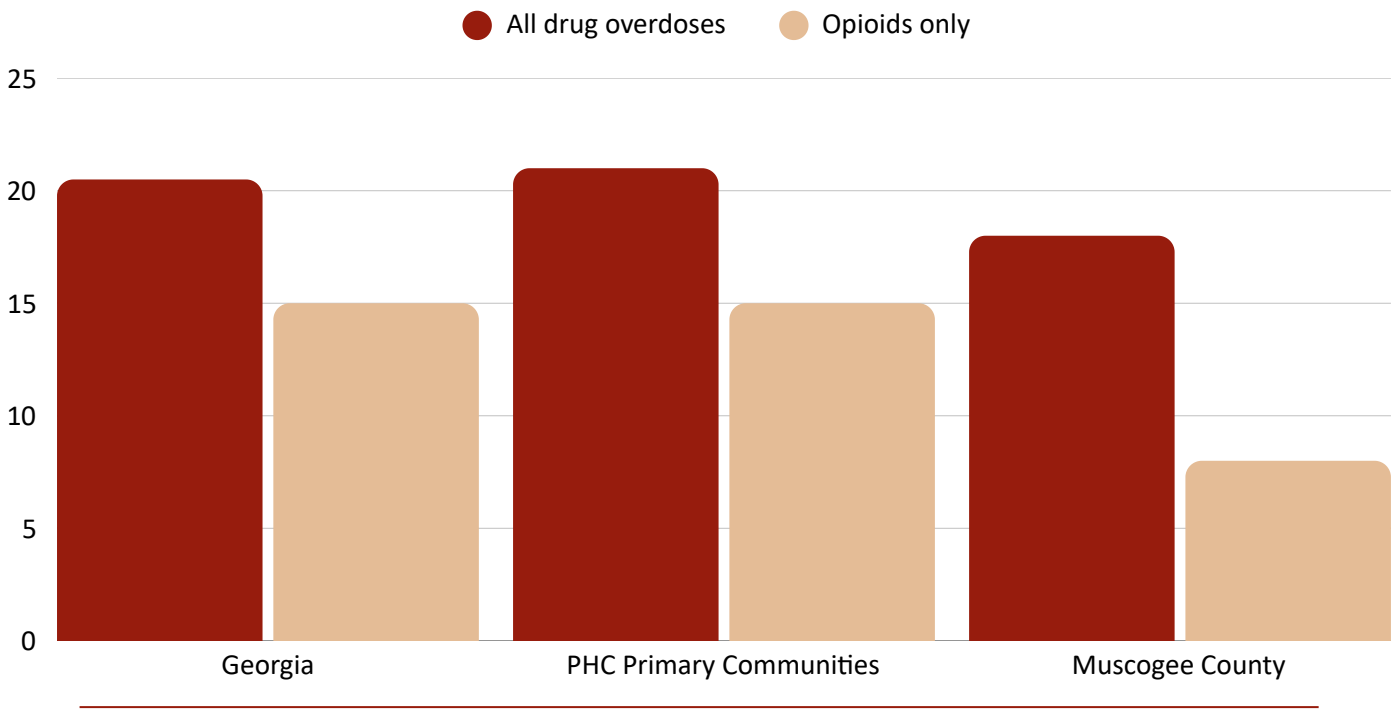
Men are more likely to die by suicide, although women report attempting suicide more often. Firearms are the most common method, followed by suffocation, drug poisoning, and other means.

Suicide rates are highest among adults ages 25 to 44. By race, White individuals experience the highest suicide death rates, followed by Black or African American, Asian, and multiracial populations.

Overdose deaths

Drug overdoses are among the leading causes of injury deaths in the United States, and they have increased dramatically in recent years. In Muscogee County, approximately 180 people died from a drug overdose between 2019 and 2023, which represents a rate of 17.9 deaths for every 100,000 people. This figure is 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, 2019 to 2023



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

The National Institutes of Health (NIH) has found a strong link between drug overdoses and low socioeconomic status, particularly low income. A 2024 NIH study showed that overdose deaths—including those tied to specific substances—are higher in counties with greater income inequality. Much of this is driven by social factors such as poverty, unemployment, and limited access to resources.

Why does this happen? Poverty often brings added stress, hopelessness, and mental health challenges, which can lead some individuals to turn to substances as a way to cope. People with lower incomes may also have less access to healthcare, mental health support, and treatment for substance use disorders, making prevention and recovery more difficult. On top of that, communities with high poverty levels often face higher rates of drug use and sales, increasing both exposure and risk.

Implementation Plans

A CHNA Implementation Plan is a strategic framework designed to address the health needs identified in a community. It follows a detailed process where community health data is gathered, analyzed, and interpreted to pinpoint key health challenges and opportunities. Once those needs are recognized, the implementation plan outlines specific actions, programs, or interventions that healthcare providers, organizations, or government agencies will take to improve health outcomes in the community.

Like a CHNA, an implementation plan should focus on the whole community and its more vulnerable members, not only the patients the hospital sees or programs available only to hospital patients. These should focus first on low-income, uninsured/underinsured, the elderly, minority populations, those living with disabilities, those who don't speak English well or at all, veterans, LGBTQ+ communities, those living in rural areas, shift workers, and other groups that may face a particular barrier when attempting to access health services to get – and stay – healthy.

We also report on the progress we've made towards our identified priorities in our last CHNA, which was conducted in FY22.

FY26 to FY28 Implementation Strategy

Piedmont Columbus established the following strategies to address its identified health needs. These strategies were approved by the board of directors on October 02, 2025.

Increase access to appropriate and affordable care

Goal	Tactics/Activities/Strategies
Eligible low- and no-income patients are enrolled in appropriate financial assistance programs and are connected with community resources	Ensure financial assistance is available for eligible low- and no-income populations; adequately alert patients to this assistance; provide patients with the tools, resources, and ample opportunity to apply; and actively screen all potentially eligible patients for Medicaid
Patients at partner not-for-profit charitable clinics have access to the care needed to get – and stay – healthy	Provide mobile medical clinics at no charge to targeted patient populations identified in CHNA and refer them to other charitable clinics if needed
Students have access to health professions education as to further build the health workforce	Continue to provide health education opportunities within the hospital for nurses, doctors, and other relevant health services fields, growing the program when possible and appropriate
High school students with leadership training and skills to pursue health careers	In partnership with nonprofit organization 21st Century Leaders, continue to provide focused leadership development training on-site at the hospital to area high school students; program participants are generally 80 percent minority students, 60 percent female, and about 33 percent low-income
Referrals between the hospital and community based charitable clinics and FQHCs are streamlined	With clinical community partner(s), evaluate potential referral process to refer to the clinics low-income patients with certain chronic conditions

FY26 to FY28 Implementation Strategy

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

Goal	Tactics/Activities/Strategies
Increased public recognition of stroke warning signs and urgency of calling 911	Launch annual BEFAST education campaigns (Teddy Bear Clinics, Youth Ambassadors, bilingual flyers, social media)
Increased detection of hypertension in the community	Conduct monthly free BP screenings in high-risk zip codes with direct referral pathways
All discharged stroke patients receive follow-up referral	Use stroke nurse navigators to help with phone follow-up, disseminating educational packets, and tracking the status of referrals
Women's Heart Program expands to reach 200 women annually	Six-session wellness coaching, peer support groups, social media campaigns
Access to affordable, healthy food for food-insecure adults is increased	Launch Columbus Heart Health Collaborative Mobile Market serving adults 35–59 (>50% food insecurity)
Recognition of B.E.F.A.S.T. and reduce pre-hospital delay is increased	Establish youth Stroke Ambassador program across the Chattahoochee Valley
ED admissions and mortality from cardiovascular disease are lowered	Expand Mosaic-partnered risk screening and rapid referral pathways
Detection and control of high blood pressure is improved	Provide regular BP checks and linkage to primary care via Mosaic; achieve 80% linkage

FY26 to FY28 Implementation Strategy

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

Goal	Tactics/Activities/Strategies
Increased awareness and community participation in diabetes prevention and outpatient diabetes self-management education initiatives	Increase marketing and outreach, through traditional communication modes and social media outlets, to include local and regional medical practices, community health departments, faith-based organizations, and others
Inpatients and the community receive diabetes and diabetes prevention education	Provide prediabetes, diabetes, and cardiovascular disease risk reduction education with an emphasis on lifestyle modification through improved nutrition practices, physical activity, appropriate medication usage, stress management, and coping with chronic disease
Diabetes management clinical rotations are increased	Through our health professions education program, provide precepting opportunities and clinical rotations with glycemic management services to expose preceptees to key concepts related to treatment, management strategies, care transition practices, and risk reduction for both acute and chronic complications associated with prediabetes, diabetes, obesity, and dyslipidemia
Care coordination is strengthened for diabetic patients	Coordinate care using multidisciplinary teams and glycemic management services that assist with safe transition and risk reduction, e.g., antiglycemic medications, care coordination, etc

FY26 to FY28 Implementation Strategy

Reduce preventable instances and deaths from cancer

Goal	Tactics/Activities/Strategies
Cancer patients receive needed comprehensive services for their recovery	Provide services to any cancer patient, regardless of where they receive care; services include cancer education, nutrition workshops and demos, support group, psychological counseling, and exercise classes, among other programs; continue to explore opportunities to expand offerings and services
High-risk community members receive lung cancer screenings	Increase CT scans for CMS-defined heavy smokers. Increase early identification of suspicious nodules and thereby increase early cancer detection utilizing new technology that identifies nodules often missed; identify populations that are more likely to smoke, explore potential mechanisms for referrals for CT scans heavy smokers from partner clinics
More community members are screened for cancer	Identify community partners who can help provide necessary outreach and messaging. Follow-up care that takes insurance status, income, and other barriers, such as transportation, into consideration

Reduce the impact of poor mental health

More information on goals and tactics will be published as soon as possible.

FY22 CHNA - Implementation Strategy Progress Report

In FY23, FY24, and FY25, Piedmont Columbus demonstrated a sustained commitment to improving community health, expanding access to care, and promoting equity across the Columbus community. Through hospital-community partnerships, educational programs, charitable collaborations, and clinical innovation, Piedmont continued to focus on meeting the needs of all residents, and particularly those who are uninsured, low-income, or face barriers to care, all in accordance with its FY22 CHNA and subsequent implementation strategy, which was approved by the hospital's board of directors in FY23.

In FY22, Piedmont Columbus's board of directors approved the following community health needs:

- Ensure affordable access to health, mental, and dental care for all community members, and espeically those that are low income and/or uninsured
- Decrease preventable instances of diabetes and decrease the number of patients with uncontrolled diabetes
- Decrease the impact of and deaths from stroke
- Reduce rates of obesity and increase access to healthy foods and recreational activities

Progress on health priorities

Piedmont Columbus continued its commitment to improving healthcare access by expanding community outreach and education through its mobile health unit. The mobile unit operated on a monthly rotation, offering blood pressure checks and educational programming focused on stroke, diabetes, cancer prevention, and vaping awareness. It served a wide range of community locations, including schools, faith-based organizations, and residential areas.

In FY23, the program conducted 1,969 blood pressure clinics and participated in 1,261 special events—a 77% increase from the previous year. Activity continued to grow in FY24, with 2,157 blood pressure clinics and 1,836 special events, reflecting a 23% increase. Although mechanical issues caused a minor dip in FY25, the team still managed 2,149 blood pressure clinics and supported 941 additional special events, including first aid stations that served nearly 6,800 attendees. Across FY23 to FY25, these combined efforts reached an impressive total of 9,870 individuals, highlighting the hospital's strong presence in local preventive health outreach.

The mobile clinic team, which included a family practice resident, also expanded its clinical reach by providing direct medical care to homeless populations through weekly visits at Safe House and Valley. Clinic volume grew by 38% in FY23 with 407 visits, then slightly decreased to 394 in FY24 due to two canceled sessions. In FY25, the team recorded 328 clinics year-to-date, marking a 16.8% decrease from the prior year, yet still a meaningful continuation of consistent service delivery to some of the community's most vulnerable residents.

In addition, a pharmacy resident and registered nurse began conducting weekly clinics, replacing the former monthly model to manage chronic conditions better and reduce emergency admissions. These efforts were supported by partnerships with on-site case workers and a licensed clinical social worker (LCSW) who helped and recruit patients for the new Safe House Victory clinic. Participation at this site steadily grew—averaging eight patients per session by FY25, up from zero at program launch. The clinic conducted 93 sessions in FY23, 104 in FY24, and 68 to date in FY25.

Piedmont also advanced its mission to strengthen the healthcare workforce through the Piedmont Futures Program. This work-based learning initiative partners with Muscogee County Career Technical and Agricultural Education programs. The program provides high school students with opportunities to explore healthcare careers by working 5–15 hours per week during the school year. Students rotated through multiple departments, including Dietary Services, Environmental Services, Imaging, Information Technology, Nursing, Patient Services, Pharmacy, and Respiratory Therapy.

The program launched in FY22 with 15 pilot students who shadowed staff across departments for two days. In FY23, 10 students participated, with three hired full-time after graduation. Participation doubled in FY24 with 20 students, and continued at that level into FY25, where seven graduates transitioned into full-time roles.

Together, these efforts—spanning mobile health outreach, community-based clinics, and workforce development—illustrated Piedmont's ongoing dedication to reducing healthcare disparities, improving preventive care access, and inspiring the next generation of healthcare professionals.

Piedmont Columbus Regional expanded its efforts to increase awareness and community engagement in diabetes prevention and self-management education throughout 2025. The hospital launched a targeted marketing and outreach campaign that used both traditional communication methods and social media to reach local and regional medical practices, community health departments, and faith-based organizations. These efforts culminated in the Outpatient Diabetes Education Class, "Building Blocks to Diabetes Management," which ran from January through July 2025 and engaged 48 participants in structured, evidence-based learning sessions.

The hospital also provided comprehensive education for inpatients transitioning to outpatient care, focusing on diabetes, prediabetes, and cardiovascular risk reduction. Education emphasized sustainable lifestyle modifications through improved nutrition, increased physical activity, appropriate medication adherence, stress management, and coping strategies for chronic disease. Between January and July 2025, there were 745 documented patient encounters in which staff provided individualized education and transition support, ensuring that patients left the hospital with the tools necessary to manage their health more effectively.

FY22 CHNA - Implementation Strategy Progress Report

As part of its commitment to training the next generation of healthcare professionals, Piedmont incorporated glycemic and diabetes management clinical rotations into its health professions education program. Medical, nursing, dietetic, and pharmacy residents participated in precepted experiences that introduced them to diabetes care best practices, medication management, and risk-reduction strategies. These rotations also addressed both acute and chronic complications associated with diabetes, prediabetes, obesity, and dyslipidemia. Post-class evaluations from 2025 showed overwhelmingly positive feedback from participants, including dietetic interns, pharmacy residents, and youth student volunteers who also contributed to community education events such as the Diabetes Education Class and Diabetes University.

In addition, the Inpatient Glycemic Management and Diabetes Services program continued to provide multidisciplinary care coordination to improve outcomes for patients with diabetes. Between January and July 2025, staff completed 745 inpatient encounters that focused on safe medication management, hyperglycemia prevention, and post-discharge care transitions. Medical residents enhanced this initiative by delivering educational presentations on diabetes care and glycemic management, reinforcing the hospital's ongoing commitment to excellence in both patient care and professional education.

Together, these programs strengthened the continuum of diabetes care at Piedmont Columbus Regional—empowering patients, training clinicians, and fostering collaboration across inpatient, outpatient, and community settings to reduce the burden of diabetes and improve long-term health outcomes.

Piedmont continued to strengthen its community partnerships to improve access to nutritious food for low-income children and families. The Farm to School Program and Truth Spring Breakfast Program both played central roles in addressing food insecurity and teaching sustainable nutrition practices.

In FY23, the Farm to School Program operated across four Muscogee County schools, reaching 700 students with hands-on learning about agriculture and healthy eating. The Truth Spring Breakfast Program provided approximately 15,000 wholesome breakfasts annually—feeding about 80 students each school day.

By FY24, the Truth Spring Breakfast Program expanded, again delivering 15,000 nourishing meals to 80 students daily while incorporating classroom and garden-based nutrition education. That year, 1,745 students participated, engaging in 805 lessons totaling nearly 700 teaching hours. Students also spent 379 hours in the garden and 195 hours in the cafeteria, learning about food production and preparation. Nineteen volunteers contributed over 60 hours of service to support the program's growing reach.

The program's success continued in FY25, with 95 students on track to receive 17,100 breakfast meals over the school year. The Farm to School initiative grew to include eight Muscogee County schools, engaging more than 1,700 students in lessons on gardening, cooking, and nutrition. The mobile market, which had been integrated into the initiative, began visiting all eight schools at least once per month—some twice monthly—

Piedmont also focused on promoting healthy eating for high-risk community members through its Mobile Market initiative. Between July and December 2022, the market distributed 2,000 pounds of locally grown produce and delivered 200,000 pounds of food from Feeding the Valley, 60% of which was fresh produce. These efforts served 1,732 households and 4,607 individuals.

In FY24, the Mobile Market's reach expanded significantly. A total of 250,000 pounds of food—more than 60% fresh produce—was distributed to 2,148 households, benefiting over 5,600 individuals and providing 305 SNAP discounts to help families stretch their food budgets.

By FY25, the market distributed 400,000 pounds of food, nearly doubling the total from 2023, a reflection of both the program's success and the rising demand for food assistance in the community. The number of households and individuals served was also on track to double from the previous year, further demonstrating Piedmont's ongoing commitment to addressing food insecurity and supporting nutrition equity for vulnerable populations.

Piedmont continued to make significant progress in improving stroke care and community awareness around early stroke recognition and treatment. The hospital emphasized education on the B.E. F.A.S.T. acronym—an important reminder for the public to act quickly when a stroke is suspected.

In FY23, the thrombolytic treatment rate reached 25%, surpassing the 10% goal, with a total stroke volume of 1,023 patients. The success continued into FY24, maintaining a 24% thrombolytic treatment rate with 1,143 stroke cases. By FY25 year-to-date, the hospital sustained the 24% treatment rate with an increased stroke volume of 1,240 patients. These outcomes demonstrated Piedmont's ability to deliver timely, effective care for patients arriving within the treatment window for acute stroke therapy.

Community outreach also played a key role in advancing stroke education and prevention. Through events such as Diabetes Stroke Alert Day and the Teddy Bear Clinic in FY23, Spinning with Stroke and the Teddy Bear Clinic in FY24, and Walk in the Brain combined with the Teddy Bear Clinic in FY25, Piedmont reached residents across diverse age groups and backgrounds. At the Teddy Bear Clinic, participants' baseline stroke knowledge improved dramatically—from just 4.5% before participation to 73% afterward—demonstrating the effectiveness of interactive, hands-on education in raising awareness.

To further strengthen regional stroke care, Piedmont expanded its partnerships with hospitals and EMS agencies across 17 surrounding counties. This outreach helped increase referrals and transfers to Piedmont Columbus for advanced stroke treatment. In FY23, 32 patients were transferred for higher-level stroke care, increasing to 57 in FY24 and 136 year-to-date in FY25. Additionally, thrombectomy cases rose by 27.5%, underscoring both the hospital's enhanced capabilities and its growing reputation as a regional leader in stroke intervention.

Appendices

Appendix one: About the report author

Public Goods Group (PGG) is a mission-driven consulting company that develops sustainable solutions, enabling health systems and companies to work more effectively with their communities. The group provides services related to community assessments, health equity, and returns in advancement through programs for underserved populations. Their clients include hospitals, health systems, think tanks, governments, and private corporations. PGG works primarily in North America.

PGG has extensive experience in community benefits and the federal regulations that govern them, with its CEO having served on the working committee to establish the components of the Patient Protection and Affordable Care Act that regard not-for-profit hospitals. PGG has authored more than 70 CHNAs in various markets and has worked on numerous related projects, including creating a nationally recognized model for best practices in conducting a CHNA through a health equity lens in partnership with the national consumer advocacy group Community Catalyst.

Appendix two: Federal Poverty Levels

Data on the poverty threshold is created by the US Census Bureau, which uses pre-tax income as a yardstick to measure poverty. U.S. Health and Human Services then uses the statistical report on the poverty threshold to determine the federal poverty level (FPL). Below are the rates for 2025.

Family size	100%	150%	200%	300%	400%
1	$15,650	$23,475	$31,300	$46,950	$62,600
2	$21,150	$31,725	$42,300	$63,450	$84,600
3	$26,650	$39,975	$53,300	$79,950	$106,600
4	$32,150	$48,225	$64,300	$96,450	$128,600
5	$37,650	$56,475	$75,300	$112,950	$150,600
6	$43,150	$64,725	$86,300	$129,450	$172,600

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