FY25

Community Health Needs Assessment

Piedmont

Fayette Hospital

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 Fayette 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 11, 2025 meeting.

Increase access to appropriate and affordable care

Reduce preventable instances and deaths from cancer

Reduce preventable instances of chronic conditions, focusing on heart, stroke and diabetes

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 report on its impact on that 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 hospital

Piedmont Fayette Hospital

Piedmont Fayette Hospital is a 310-bed acute-care community hospital located in Fayetteville, Georgia, serving Fayette County and surrounding areas. The hospital provides 24-hour emergency care, medical and surgical services, and women's health services. It offers advanced capabilities in robotic surgery, diagnostic imaging, cardiology, rehabilitation, and wound care, including hyperbaric medicine.

Clinical programs at Piedmont Fayette include cardiovascular care, stroke care, oncology, and orthopedics, supported by a comprehensive cancer center. The hospital also provides specialized imaging services such as MRI, CT, and nuclear medicine, as well as mammography and breast biopsy guided by advanced technology.

In FY24, Piedmont Fayette reported 87,746 emergency department visits, 13,220 surgeries, 133,428 outpatient encounters, and 20,501 inpatient admissions. The hospital recorded 2,761 newborn deliveries and employs approximately 2,260 staff members, including more than 900 physicians and 99 volunteers.

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.

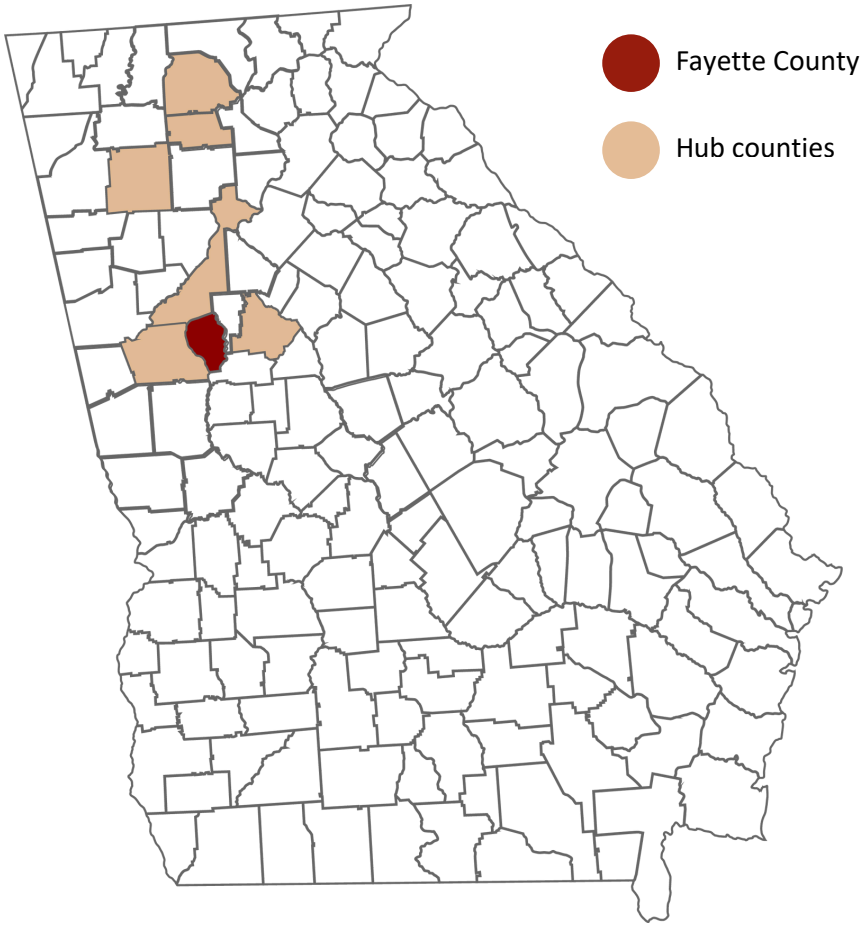
With more than 47,000 caregivers, we are the largest Georgia-based private employer of Georgians, who all came for the job, but stayed for the people. In 2024 and 2023, Piedmont earned recognition from Newsweek as one of America's Greatest Workplaces for Diversity and also as one of America's Greatest 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 Fayette serves patients from many counties in the region, for purposes of this CHNA we consider our primary community to be our home county of Fayette. 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.

We consider Fayette County part of the Atlanta Clinical Hub, which includes Piedmont Cartersville (Bartow County), Piedmont Atlanta (Fulton County), Piedmont Henry (Henry County), Piedmont Mountainside (Pickens and Gilmer counties), and Piedmont Newnan (Coweta County). This area makes up the PHC Primary Community. 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 Fayette CHNA community



CHNA methodology

The Piedmont Fayette 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 at a June 2025 board meeting, 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 and Present
Using data, determine priorities; present to the board for approval; finalize publicly-available CHNA.

Plan and 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 June 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:

- While there is strong access to care within the immediate Fayette community, this access decreases within nearby rural communities, where many community members need adequate transportation to access basic services.
- Heart disease and cerebrovascular disease continue to lead as a top cause of death.
- 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, especially healthy food, and safe, secure housing. Food access is particularly challenging in nearby rural communities. People increasingly battle with debt, and many community members have had the threat of utilities being cut off.
- Although the homeless population is still a relatively small percentage of the overall population, the numbers are still relatively high for a community Fayette's size.

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
Rural healthcare	Heart disease	High poverty rates
Concern for certain populations in the community	Cerebrovascular disease	High uninsured rates
Mental health care	Hypertension	Food and housing insecurity
Access to safe housing and food	Diabetes	Limited access to healthy foods
Access to green spaces and exercise opportunities	Cancer	Poor dental health
	Alzheimer's disease	Unhealthy behaviors
	Maternal and child 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
Support for patients in rural communities	Chronic conditions, and especially hypertension and diabetes
High rates of uninsurance and Medicaid enrollment, with potential Medicaid cuts	Accessible and affordable transportation
Shortfalls in insurance (for the patient, their family, and the provider)	Alzheimer's disease
Speciality care for low-income patients	Food insecurity, food bank food availability, and especially in nearby rural communities
Obesity and limited physical activity	Preventative education and especially information that is culturally relevant

Generally, these issues are prominent throughout Piedmont Fayette 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.

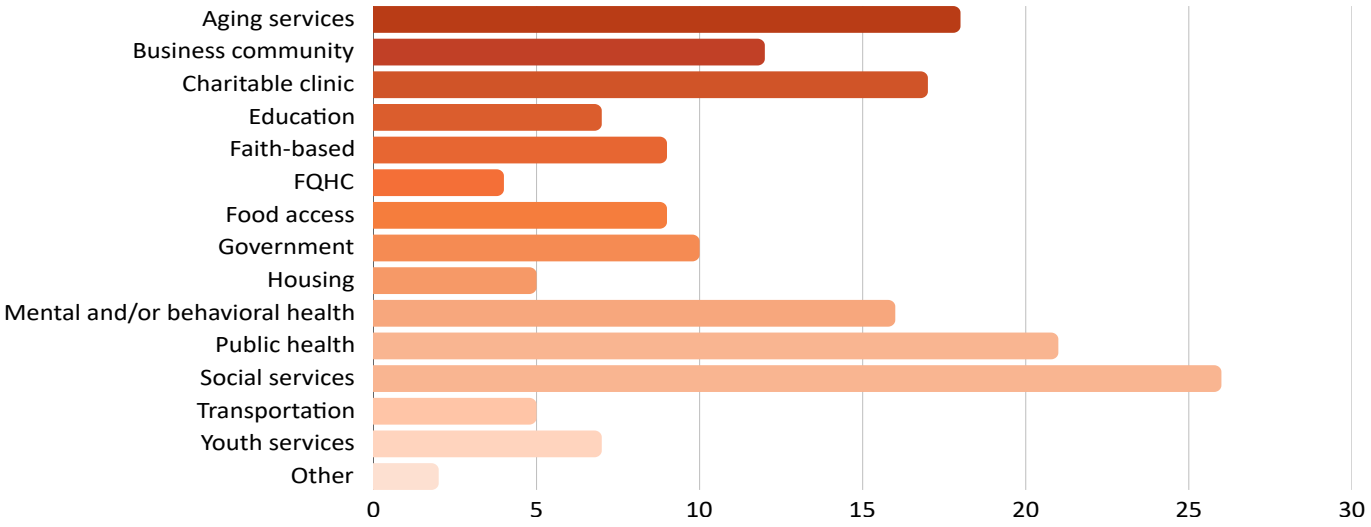
- **Not-for-profit organization uncertainty:** Stakeholders reported that fluctuations in federal funding streams and shifting policy priorities create significant uncertainty for Georgia's nonprofit organizations, particularly those providing health, housing, and social services.
    - Leaders shared 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

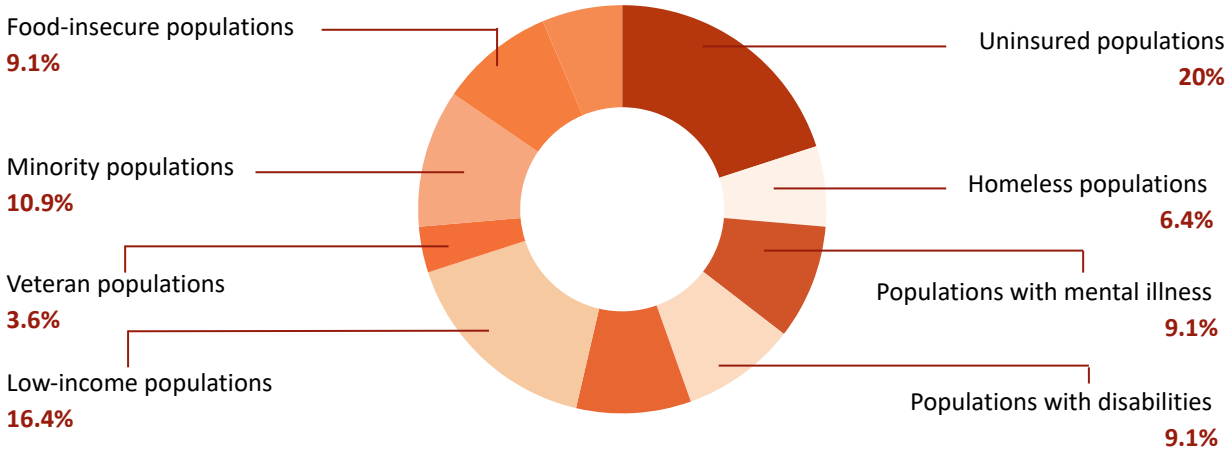
From January to March 2025, approximately 167 community leaders completed an online survey specifically tailored to their unique role within our neighborhoods and cities. The 17-question survey covered topics of community health, community resources, health equity, medical debt, and other related topics.

Survey respondents by area of work



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

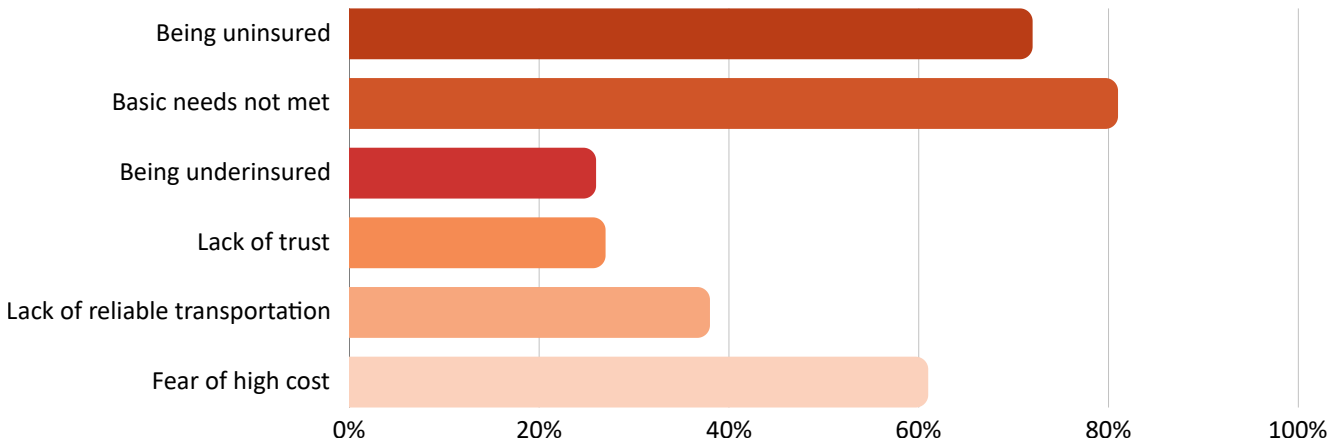
Top populations served by survey respondents



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."

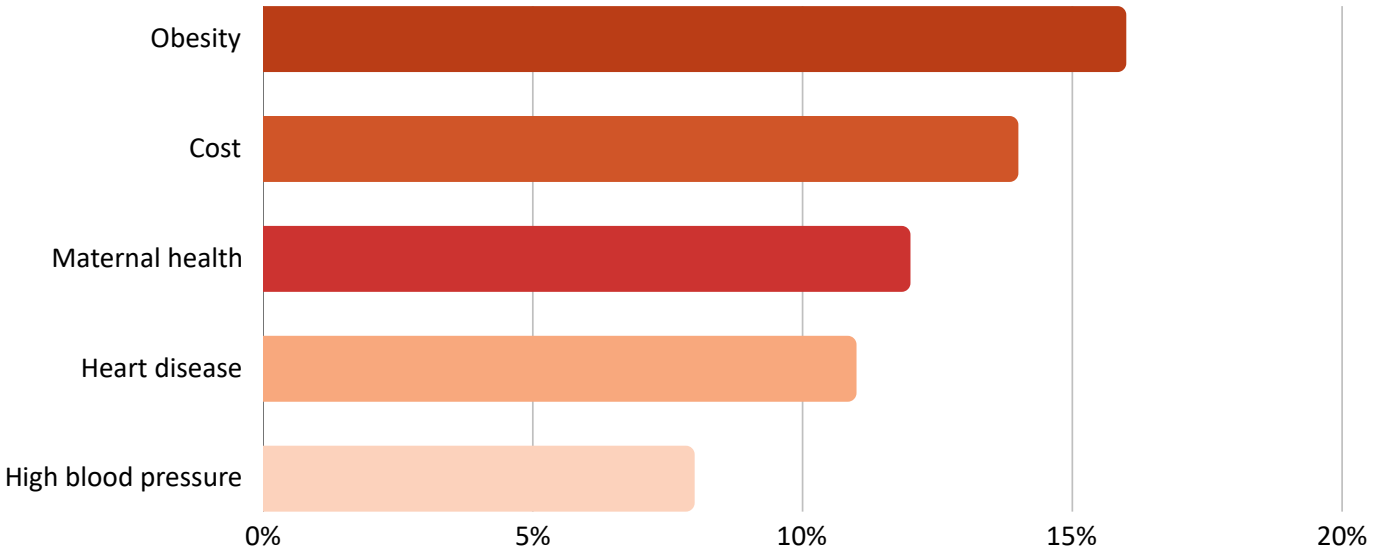
"A truly healthy community gives people hope — it's a place where resources are shared, voices are heard, and everyone has a chance to live well."

"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."

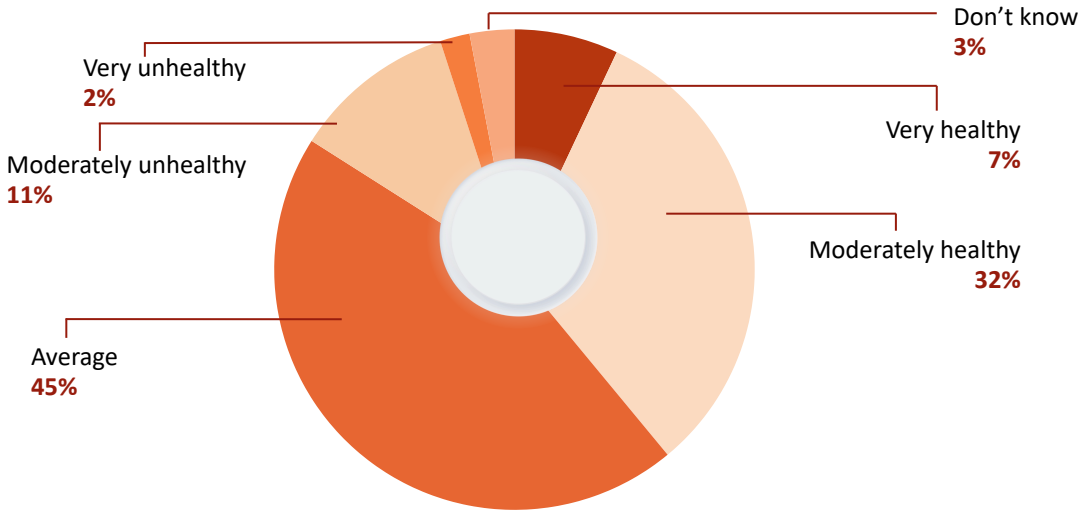
"We've got to take heart disease seriously — it's taken too many people in this community, and it's preventable with the right care."

"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

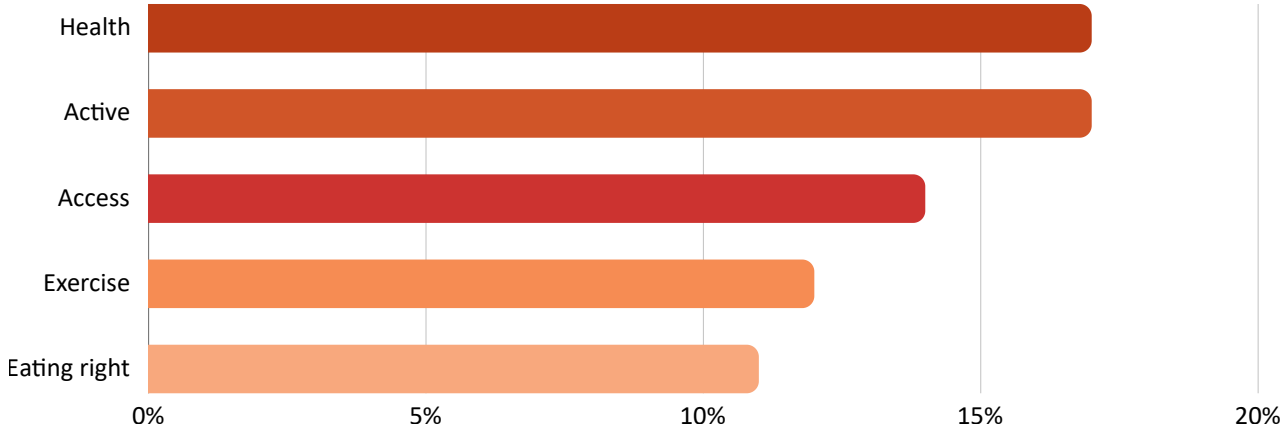
In February 2025, Piedmont launched a five-question survey among its Piedmont Advisors, a group of self-identified community members who often provide feedback to the system. These advisors live and work within Piedmont communities. Approximately 1,266 Advisors provided insight into what makes a community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

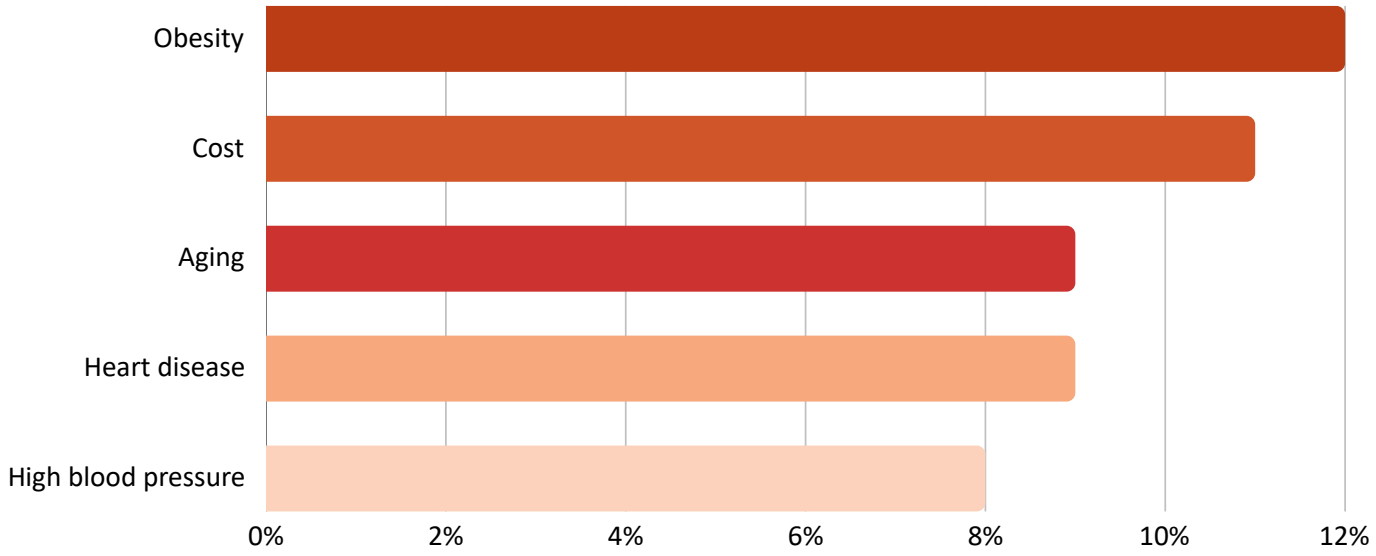
"More partnerships between hospitals, churches, and nonprofits could bring care and information right into neighborhoods that need it most."

"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."

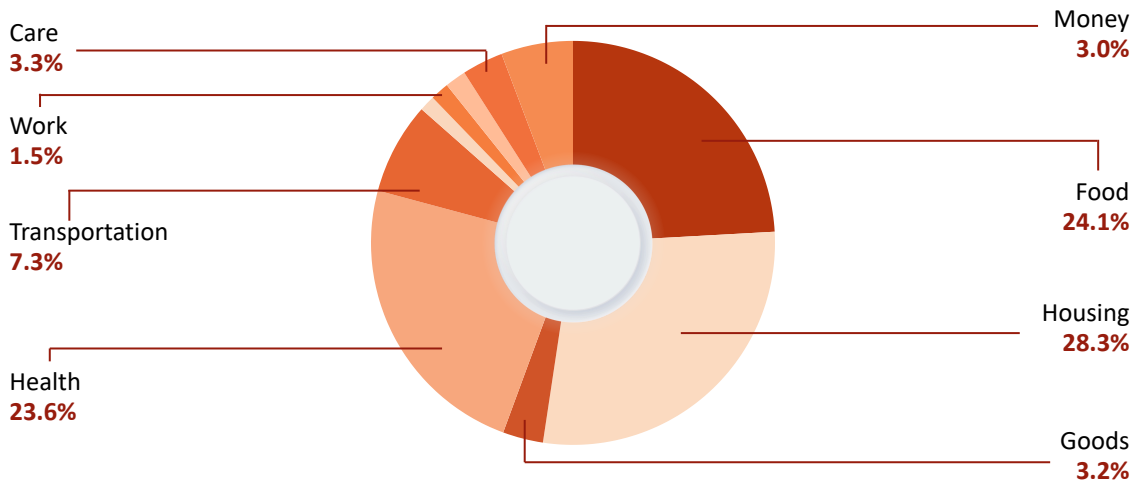
"Misinformation from the talking heads. Health needs to be depoliticized and those "non-doctors" need to remove themselves from the equation. We need to continue to stress the need for public health and others well being. Provide better information about vaccinations due to real concerns of past illnesses 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 120,700 people lived in Fayette County annually between 2019 and 2023. This community is primarily urban -- about 82%.

When we expand to include PHC Primary Communities (defined on page five) the population expands to include approximately 1.76 million people, with about 13.4% living in a rural community. Rural communities in the US face significant health disparities compared to urban areas, stemming from factors like limited access to healthcare, higher rates of certain health risks, and socioeconomic challenges. These disparities can lead to poorer health outcomes and shorter lifespans in rural populations.

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 Fayette County are English-proficient and only about 4.3% speak a language other than English at home.

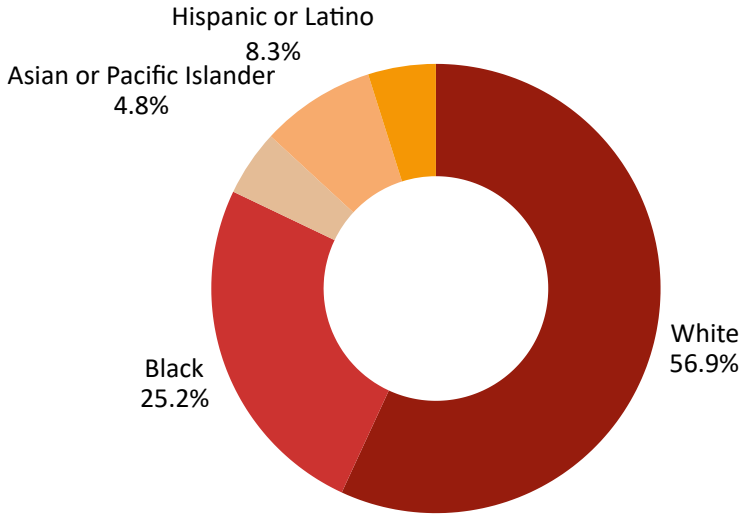
Breakdown by age, Fayette County, 2019 to 2023

57.8%

- 0-17: 22.8%
- 18-24: 8.5%
- 25-34: 8.9%
- 35-44: 12.0%
- 45-54: 13.8%
- 55-64: 14.6%

65+: 19.5%

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



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

Veterans

About 6.5% of the population are veterans, with some communities having a larger percentage, such as Gilmer County, where 11.0% of the population is a veteran.

Veteran populations by age group, Fayette County, 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	1.8%	5.3%	9.5%	12.3%	18.7%
Bartow County	2.6%	4.7%	11.8%	12.5%	18.0%
Coweta County	1.7%	7.7%	12.3%	14.6%	24.1%
Fayette County	3.8%	6.4%	14.6%	19.1%	26.5%
Fulton County	1.3%	3.8%	6.8%	10.0%	15.6%
Gilmer County	3.7%	5.2%	14.6%	13.2%	26.0%
Henry County	2.8%	10.3%	14.4%	14.2%	21.4%
Pickens County	1.1%	7.5%	5.5%	15.9%	16.8%

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.

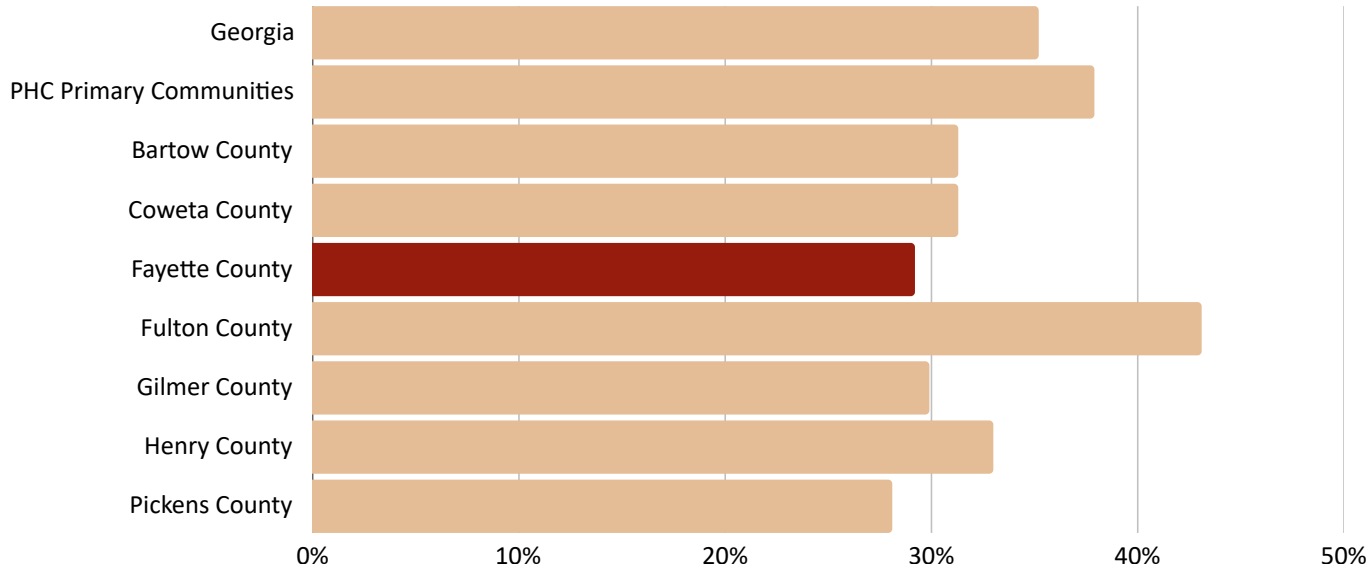
Elderly populations

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, Fayette County, 2019 to 2023

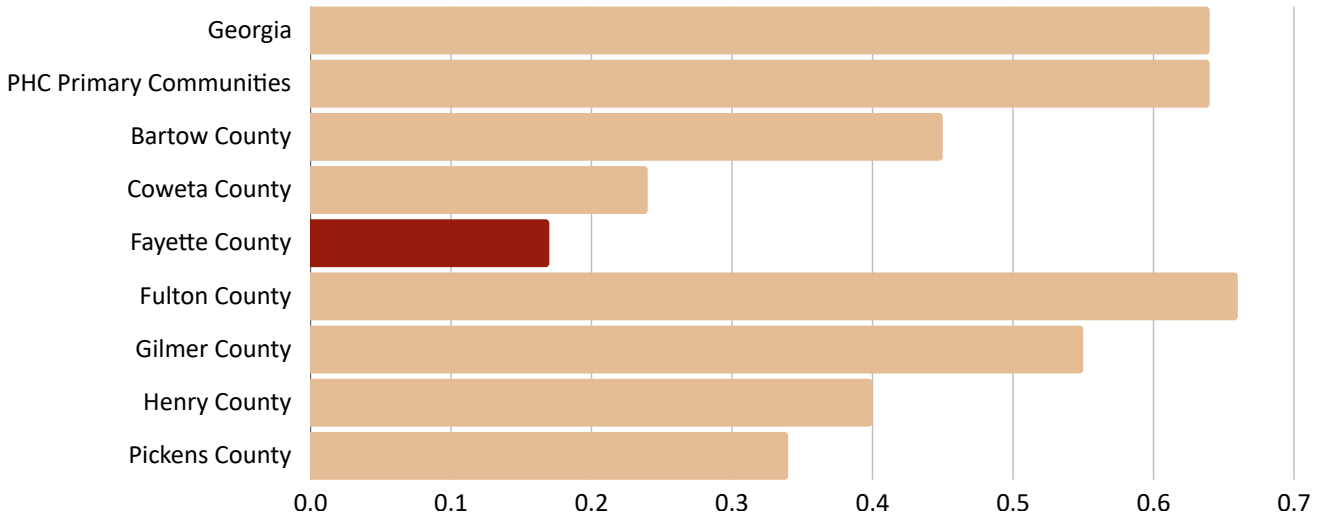


Source: US Census Bureau, American Community Survey, 2019-2023.

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.

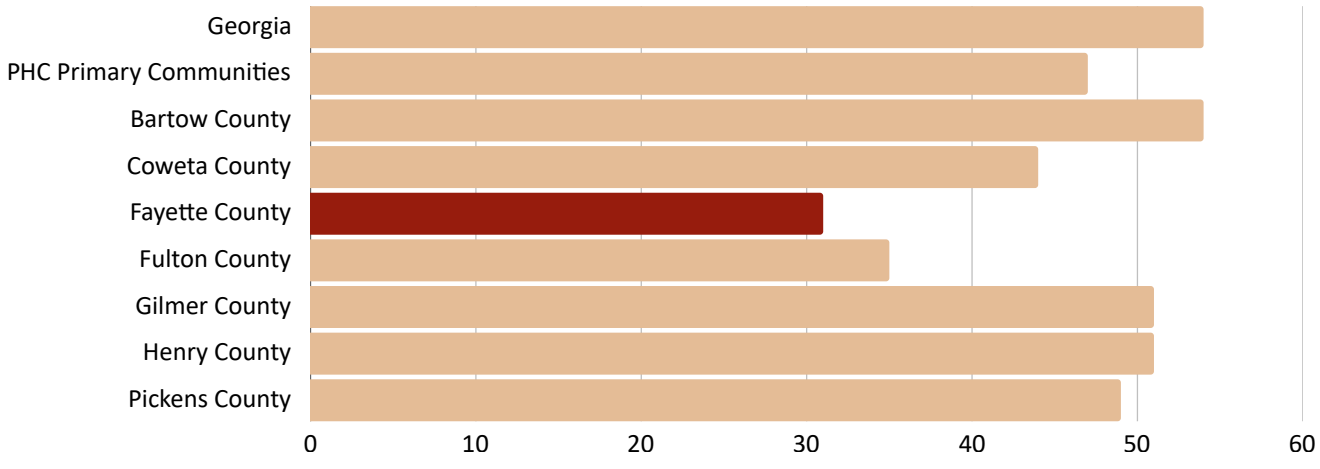
Social Vulnerability Index, Fayette County, 2022



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, Fayette County, 2022

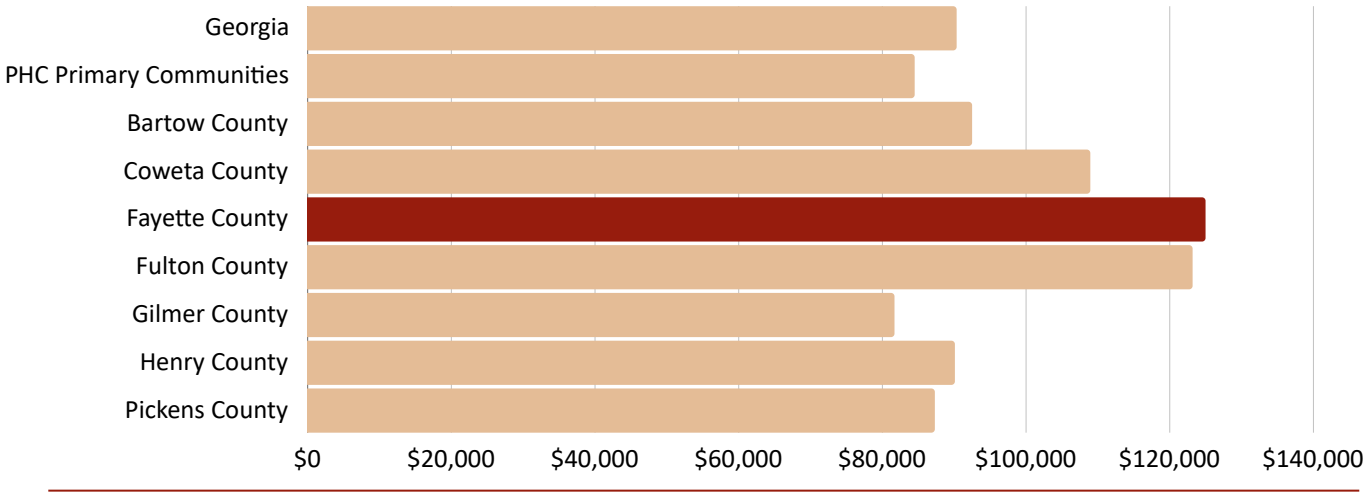


Source: University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2022.

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, Fayette County, 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, Fayette County, 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 Communities	$102,732	$108,558	$68,801	$59,252	$63,269	$38,641
Bartow County	$102,973	$107,786	$90,625	$67,911	$58,770	$41,261
Coweta County	$122,129	$131,636	$70,051	$67,891	$65,824	$55,478
Fayette County	$130,823	$154,176	$113,629	$67,129	$69,821	$57,875
Fulton County	$161,379	$192,528	$79,196	$68,558	$72,797	$39,504
Gilmer County	$90,771	$98,958	$44,583	$34,552	$60,714	$33,516
Henry County	$106,724	$119,252	$79,426	$60,805	$73,423	$49,243
Pickens County	$102,490	$92,393	$88,056	$44,196	$70,917	$34,399

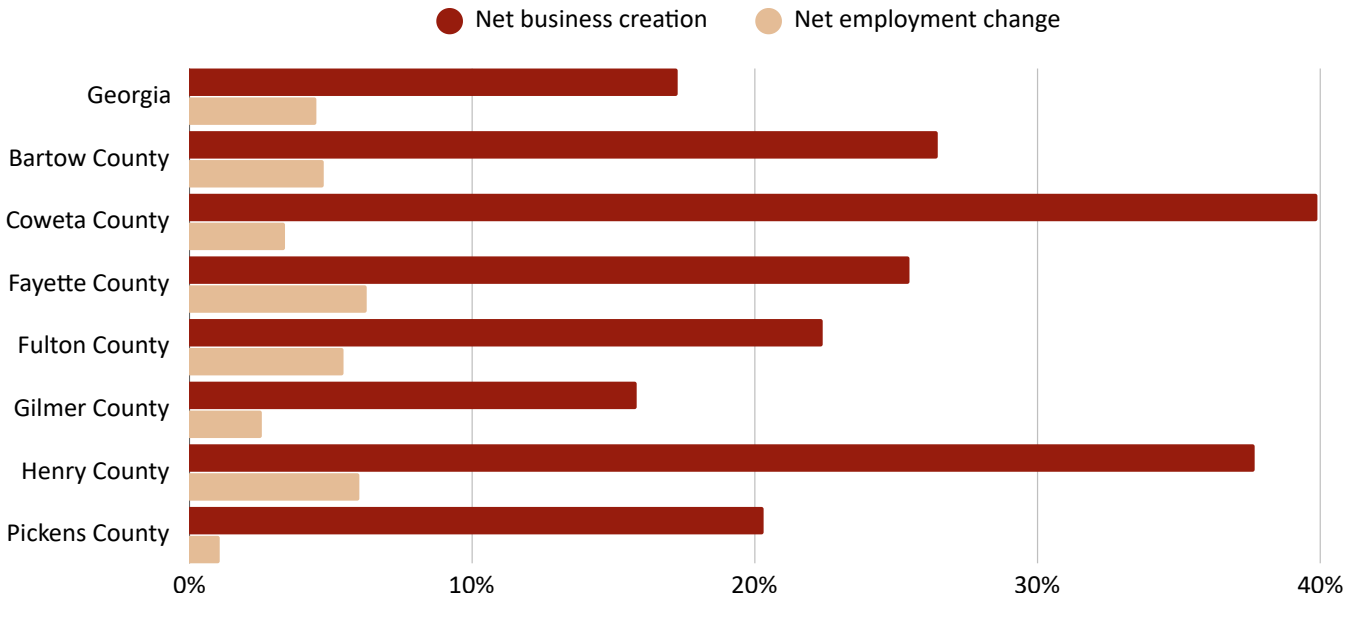
Source: US Census Bureau, American Community Survey, 2019-2023.

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 5,109 new businesses were created within the county. During that same time, 4,016 businesses closed, resulting in an establishment net change rate of 37.7%, far above the state average of 17.3%. Coweta County experienced the greatest growth, with an establishment net change rate of nearly 40%.

Net business creation and net employment change, Fayette County, 2011 to 2022



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

About 72.1% of those working commute to work alone in a car or truck, with some counties – such as Fulton and Henry counties – having the highest amount of commuters.

Gilmer County community members also had the longest commutes, with about 15.4% of workers driving at least an hour to get to work each day.

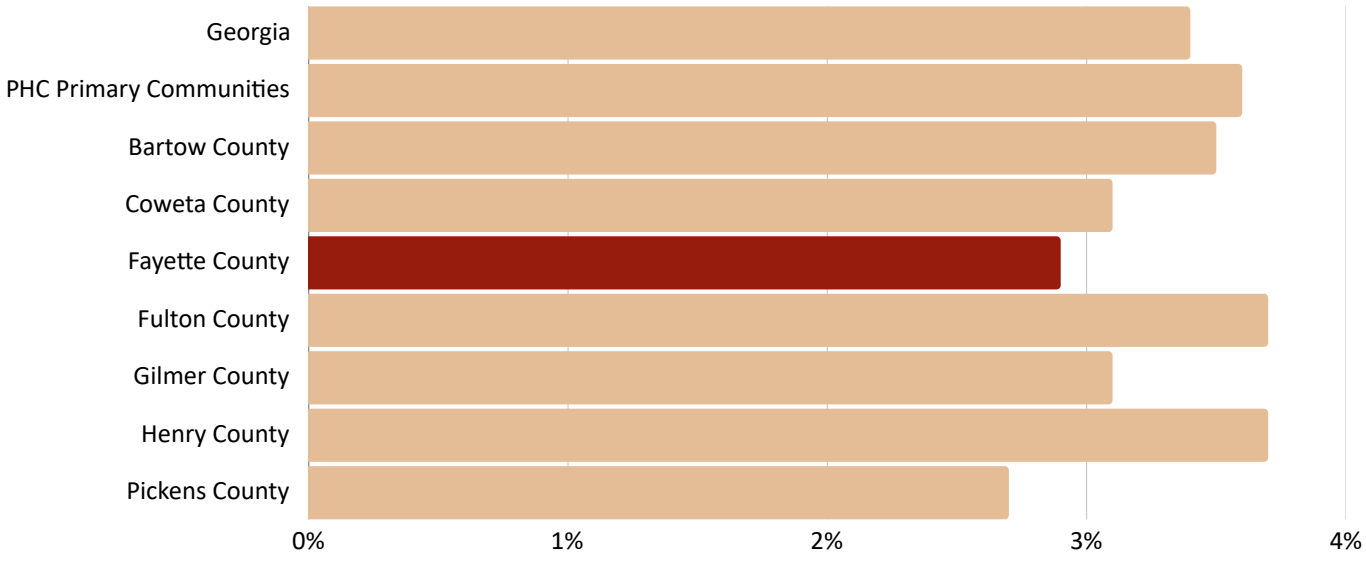
Fayette County residents are less likely to walk or bike to work – about 0.7%; a rate below the state average of 1.5%.

About 91.5% of working age adults with a disability work, a number slightly below the rate of 96.6% of non-disabled populations.

Unemployment

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

Unemployment rates, Fayette County, January 2025



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.

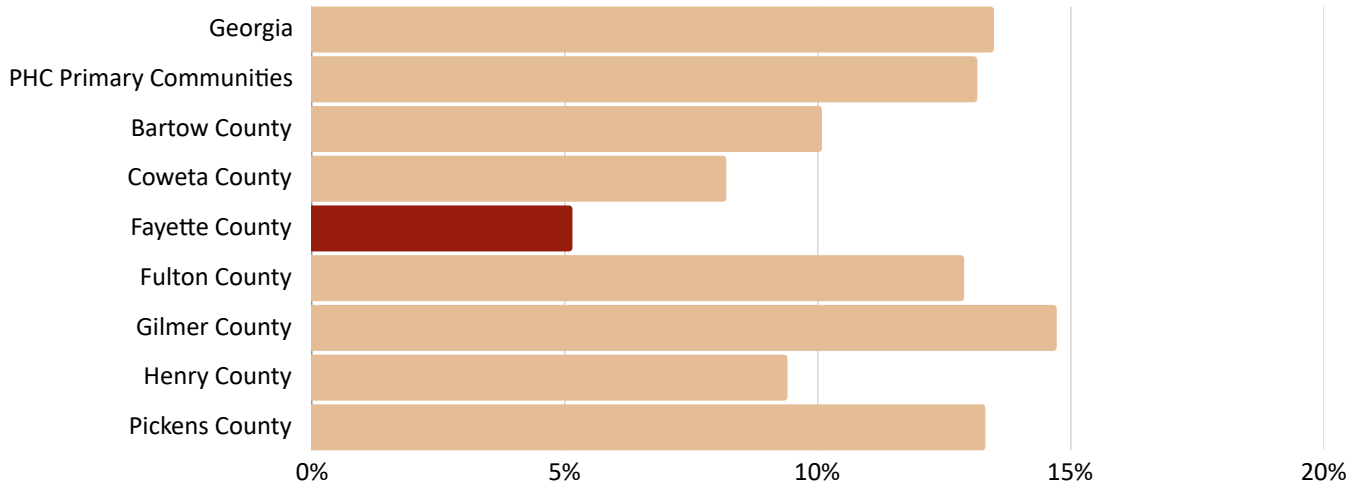
Obesity and chronic conditions: Unemployment can contribute to poor health behaviors, such as unhealthy eating habits and lack of physical activity, leading to increased obesity and chronic health conditions.

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 Fayette County, about 6.6% of women live in poverty, as compared to 4.3% of men.

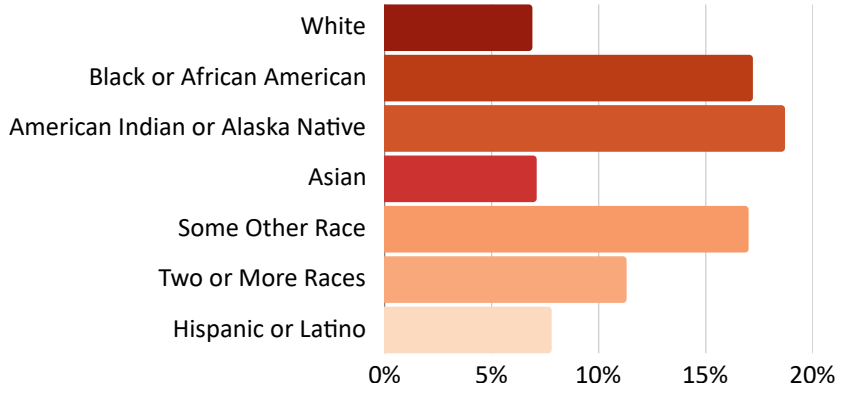
Poverty rates, annually on average, Fayette County, 2019 to 2023



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, Fayette County, 2019 to 2023



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

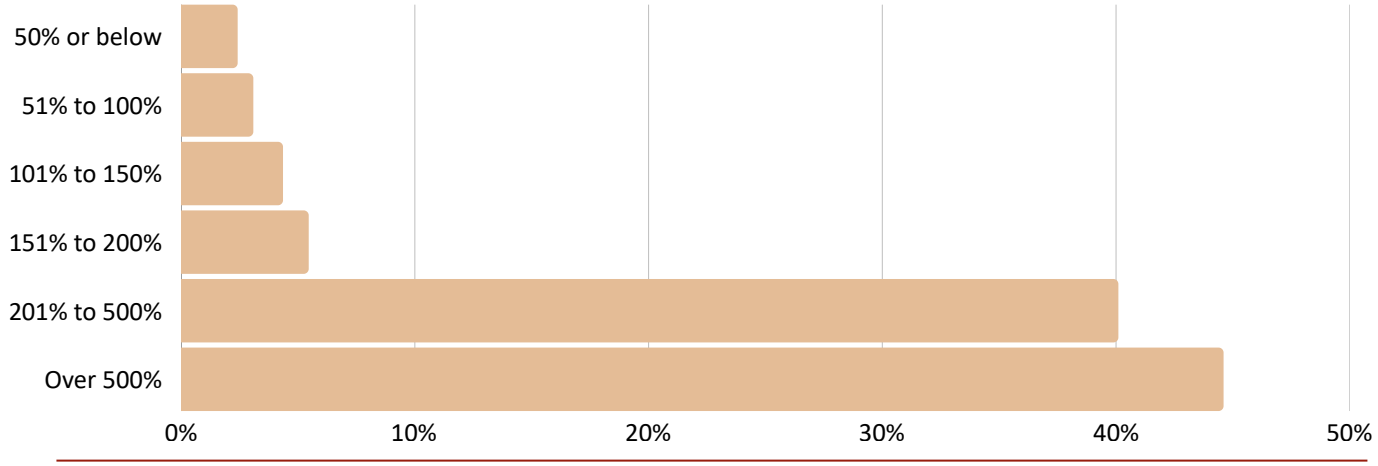
Geography matters too. People living in rural communities are more likely to experience poverty than those in urban areas. According to the USDA's Economic Research Service, poverty has consistently been higher in rural areas across all racial and ethnic groups.

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, Fayette County, 2023



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

Childcare

Annually between 2019 and 2024, childcare costs consumed about 19% of median household income - an average $20,914 annually for two children. Costs were lowest in Pickens County at $11,631. In Henry County, the childcare burden was nearly 26% of household income for two children in childcare.

Collections

Annually, between 2019 and 2024, 17.6% of Fayette County's community members had debt in collections and the median of that was $2,579. Henry County had a much higher rate – just over 33%. When broken out by race, communities of color are far more likely than their White counterparts to have debt in collections – 27.7% compared to 13.2%.

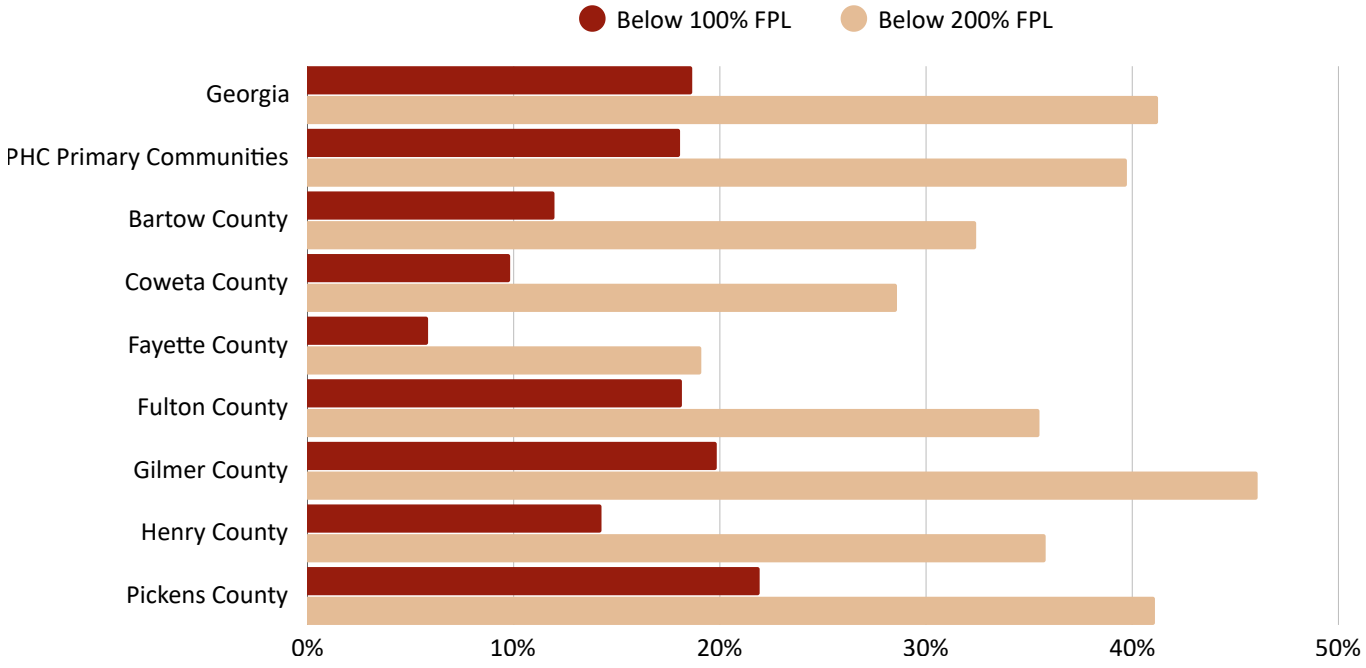
Student loan debt

Annually, between 2019 and 2024, about 19.9% of Fayette County residents had a share with any student loan debt with a median of $25,541 for those with that specific type of debt. Fulton County had the highest amount of median student loan debt – about $28,449 for those with that specific type of debt.

Children in poverty

From 2019 to 2023, more than 5,205 children in Fayette County lived in households earning less than 200% of the Federal Poverty Level. 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, Fayette County, 2019 to 2023

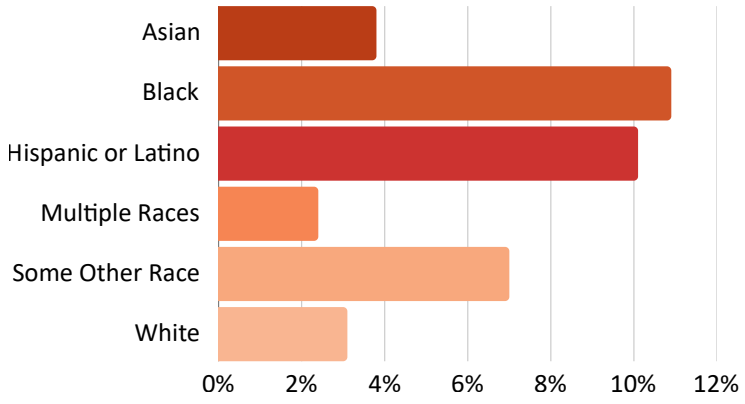


Source: US Census Bureau, American Community Survey, 2019-2023.

Within Fayette County, **27.5%** -- or about **5,600** children -- qualified for free or reduced-price lunch at their school during the 2022-2023 school year. When expanding out to the PHC Primary Community, that number increases to about **50.2%.**

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, Fayette County, 2019 to 2023

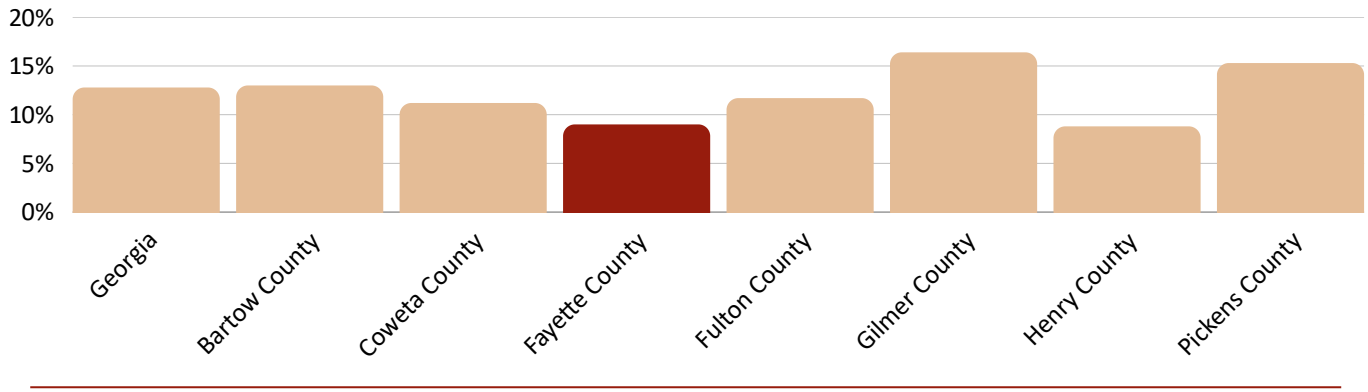


Source: US Census Bureau, American Community Survey, 2019-2023.

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, Fayette County, 2022



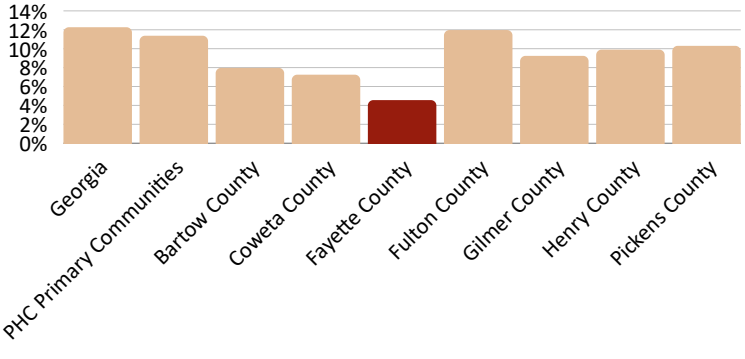
Source: Feeding America, 2022.

When examining only children, 10% of all children within Fayette County are food insecure which is lower 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 Fayette County, minority populations were far more likely to receive SNAP benefits. For example, Black populations were nearly four times more likely to receive SNAP benefits than their White counterparts. The Hispanic or Latino population was the second largest group receiving SNAP at 8.5% of the total population.

Households receiving SNAP, Fayette County, 2019 to 2023

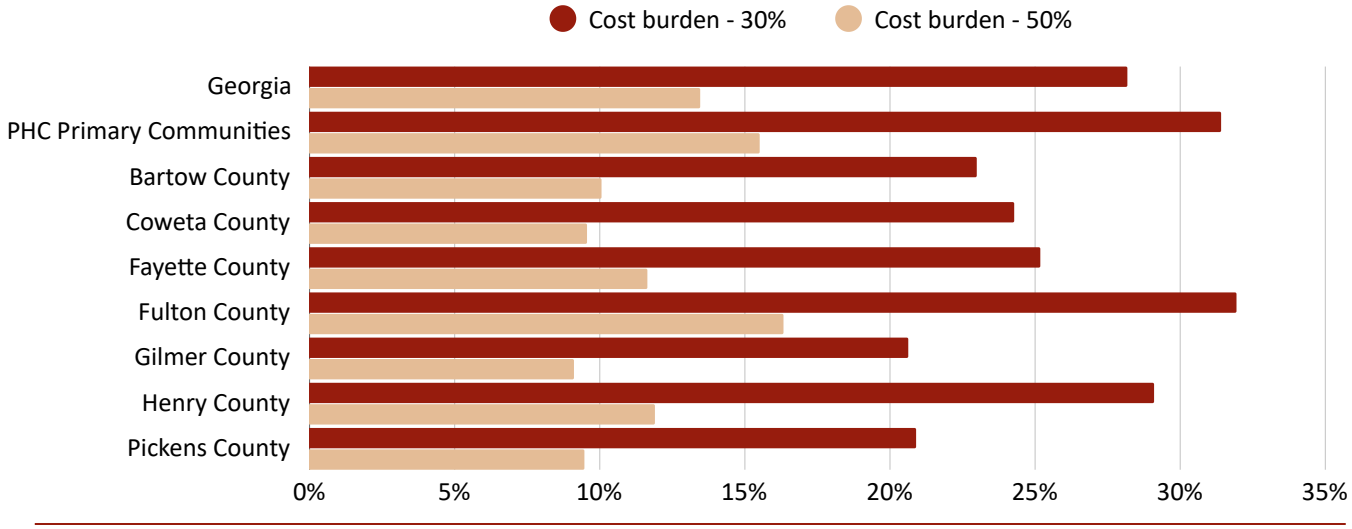


Source: US Census Bureau, American Community Survey, 2019-2023.

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, Fayette County, 2019 to 2023



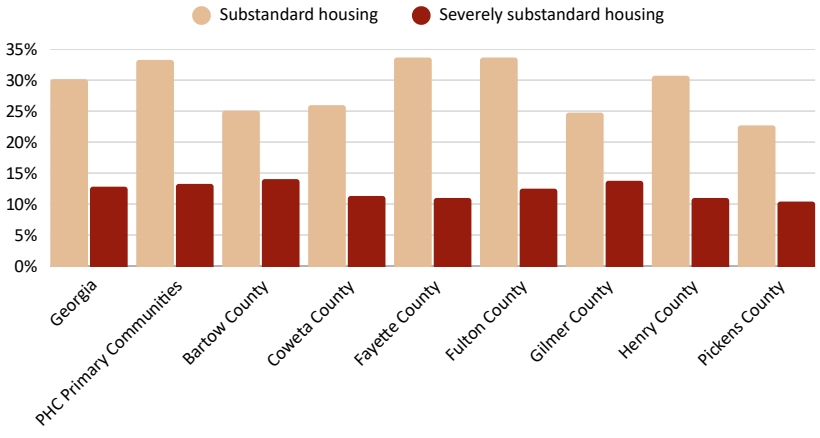
Source: US Census Bureau, American Community Survey, 2019-2023.

Housing costs take up a larger share of income for many minority households, making them more likely to be "cost-burdened." About 31.0% of Hispanic or Latino households spend more than they can comfortably afford on housing, compared to 24.8% of non-Hispanic or Latino households. The gap is even wider when looking at race: nearly 33.8% of Black households are cost-burdened, while only 21.4% 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, Fayette County, 2019 to 2023



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

Homes without plumbing and kitchens

Within Fayette County, there were many homes without complete plumbing, kitchens, or are lacking telephone service, including cell phones. For example, there were about 80 occupied homes without complete plumbing facilities annually on average between 2019 and 2023. Bartow County had the highest percentage of homes that lacked complete plumbing.

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

	Lacking complete kitchens	Lacking complete plumbing	Lacking telephone service (including cell phones)
Georgia	2.4%	0.3%	1.2%
PHC Primary Communities	3.4%	0.5%	1.4%
Bartow County	2.3%	0.7%	1.0%
Coweta County	1.5%	0.4%	1.6%
Fayette County	1.0%	0.2%	0.5%
Fulton County	1.7%	0.3%	0.8%
Gilmer County	4.5%	0.6%	2.2%
Henry County	0.9%	0.6%	1.3%
Pickens County	3.2%	0.5%	1.6%

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 Fayette County, about 91 people were homeless in January 2024, according to a point-in-time count of homeless populations conducted by the Georgia Department of Community Affairs.

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

	Sheltered	Unsheltered	Total
All populations	20	71	91
Veteran populations	0	2	2

Source: Georgia Department of Community Affairs, January 2024.

Within the Fayette County, 0.3% of students were homeless during the 2021-2022 school year, which is lower than the state rate of 2.1%.

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

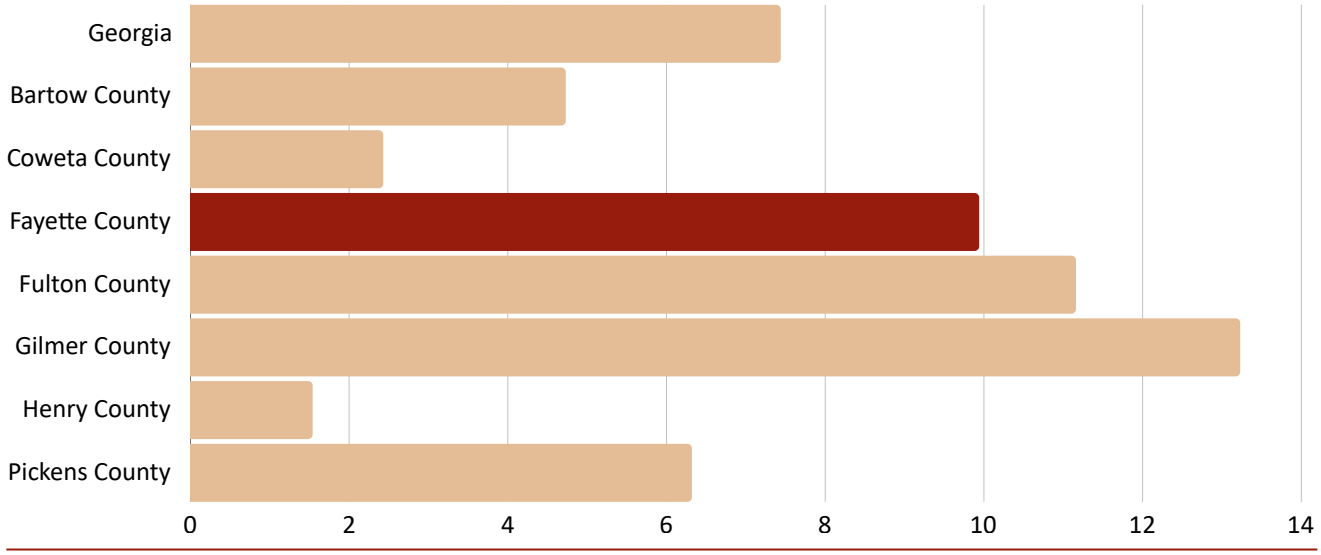
	Doubled-up	Unsheltered	Hotels or motels	Shelters and transitional housing
Bartow County	261	4	115	13
Coweta County	42	18	62	6
Fayette County	29	0	15	18
Fulton County	1,253	42	598	306
Gilmer County	52	3	5	0
Henry County	1,062	20	226	63
Pickens County	99	0	0	0

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

Head Start and preschool enrollment

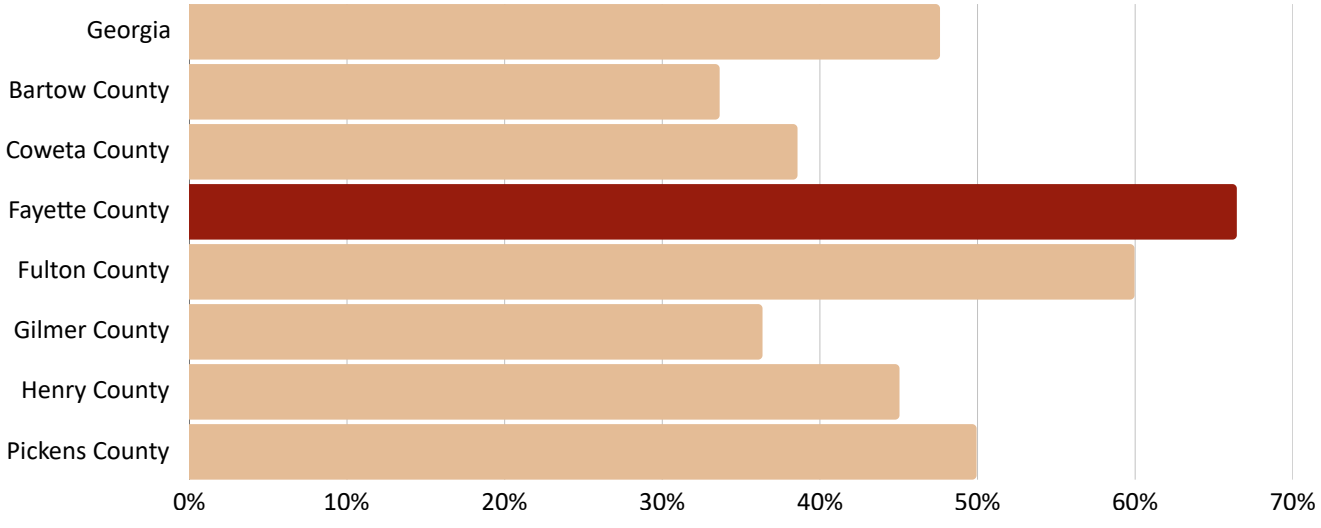
Head Start is a federal program that supports children from birth to age five in families living at or below the poverty line. Its goal is to prepare children for kindergarten by meeting essential needs such as healthcare, nutrition, and family support. Participation in Head Start and preschool enrollment 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, Fayette County, 2024



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

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

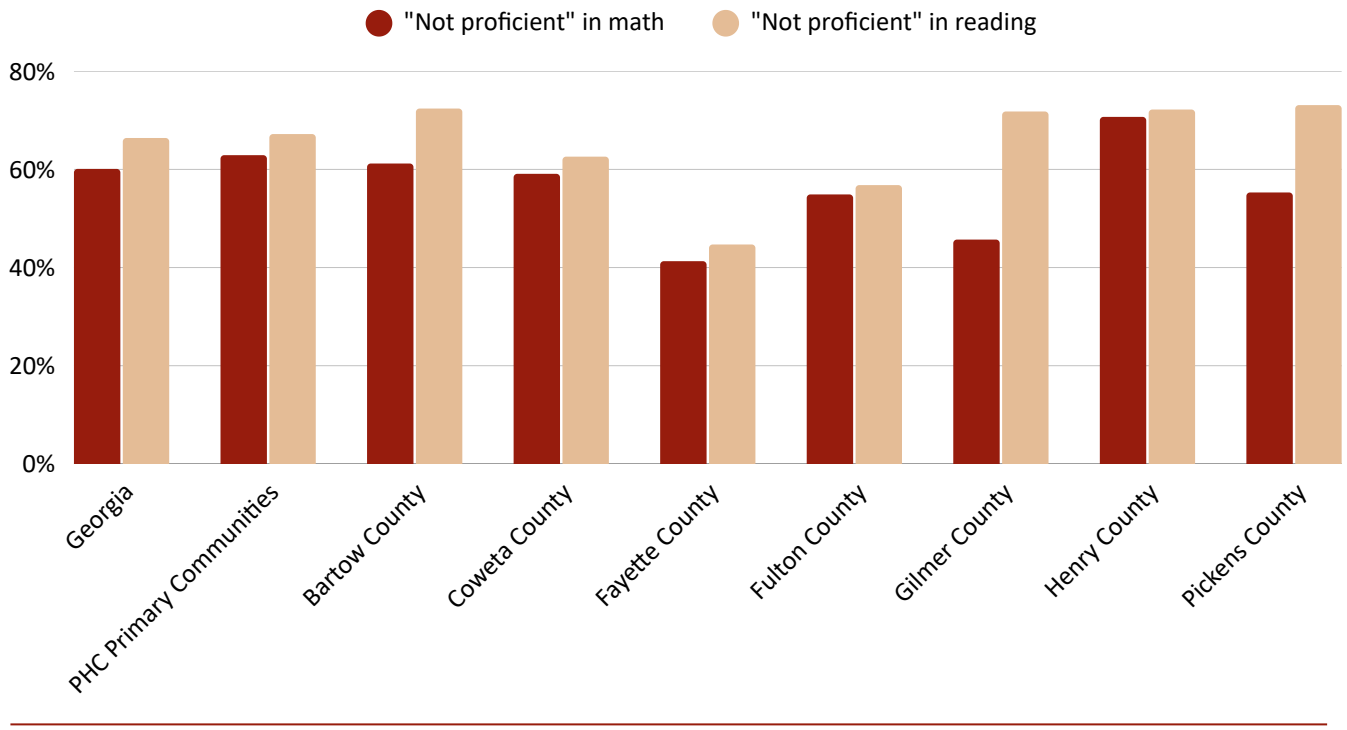


Source: US Census Bureau, American Community Survey, 2019-2023.

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, Fayette County, 2021-2022 school year



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

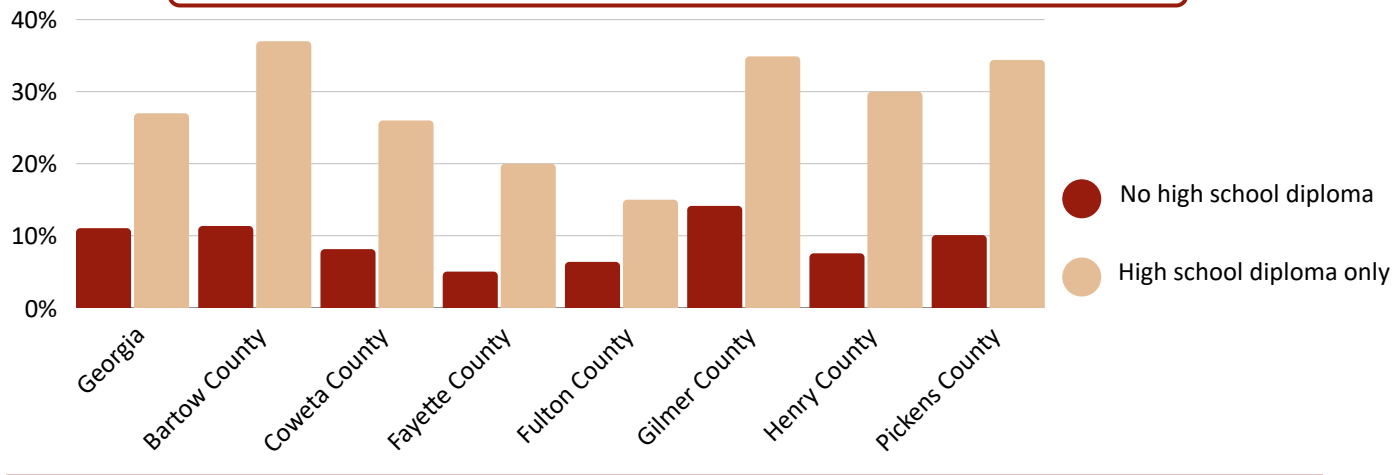
The Centers for Disease Control and Prevention notes that early childhood education (ECE) plays a vital role in shaping lifelong health and well-being. High-quality ECE programs not only strengthen children's cognitive and social-emotional skills but also encourage healthier behaviors and lower the risk 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, Fayette County, 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, Fayette County, 2019 to 2023

	Associate's degree	Bachelor's degree	Graduate or professional degree
Georgia	8.3%	20.7%	13.5%
Bartow County	8.2%	15.4%	7.5%
Coweta County	9.8%	21.9%	12.7%
Fayette County	8.4%	29.8%	18.3%
Fulton County	5.8%	33.6%	24.4%
Gilmer County	9.5%	14.7%	8.1%
Henry County	11.2%	18.4%	9.7%
Pickens County	8.3%	17.0%	7.9%

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 Fayette County, approximately 110,000 community members have health insurance coverage. Of those, 85.3% have private insurance and 30.5% have public health insurance. Insurance provides access to healthcare, including regular primary care, specialty care, and other health services that prevent poor health status.

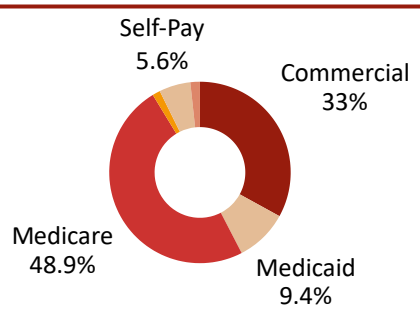
Insurance source type, annually on average, Fayette County, 2019 to 2023

	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%
Bartow County	65.6%	12.2%	5.0%	17.8%
Coweta County	69.8%	13.1%	6.0%	17.6%
Fayette County	69.6%	15.8%	11.0%	21.6%
Fulton County	67.0%	15.6%	3.7%	14.4%
Gilmer County	49.0%	19.4%	8.8%	33.8%
Henry County	66.3%	14.0%	8.9%	14.9%
Pickens County	54.8%	17.5%	5.0%	28.0%

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

Medicare represents the biggest payor mix at Piedmont Fayette, with private commercial insurance as second.

Piedmont Fayette payor mix, FY23 and FY24

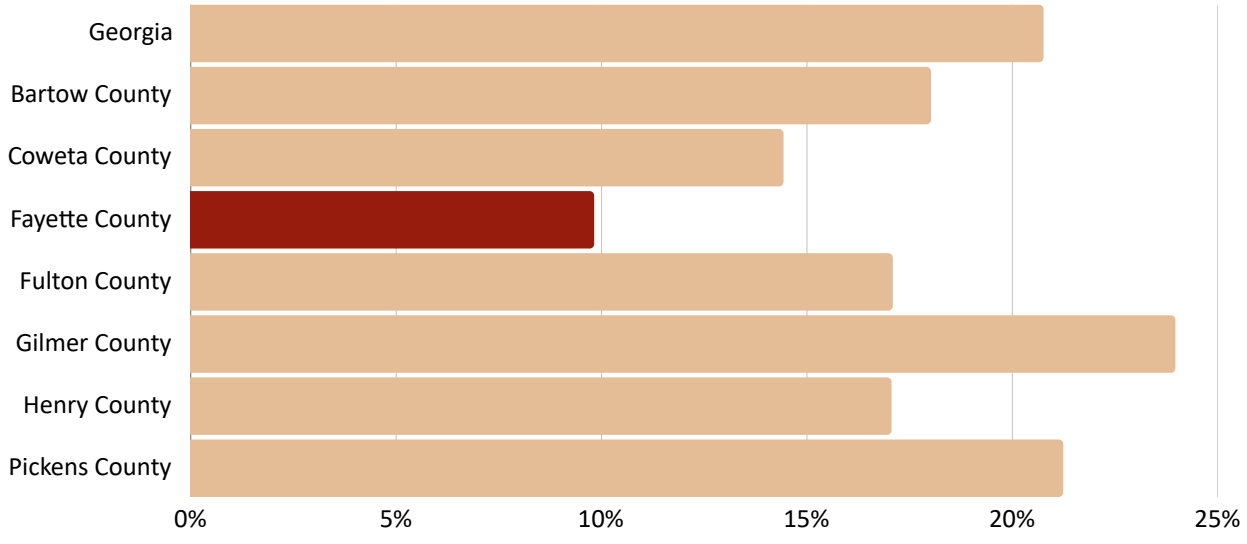


Source: Piedmont Healthcare internal data, FY23 and FY24.

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, Fayette County, 2019 to 2023



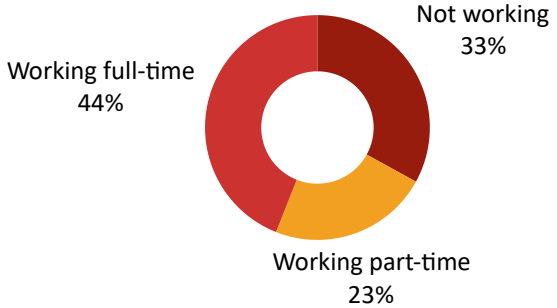
Source: US Census Bureau, American Community Survey, 2019-2023.

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

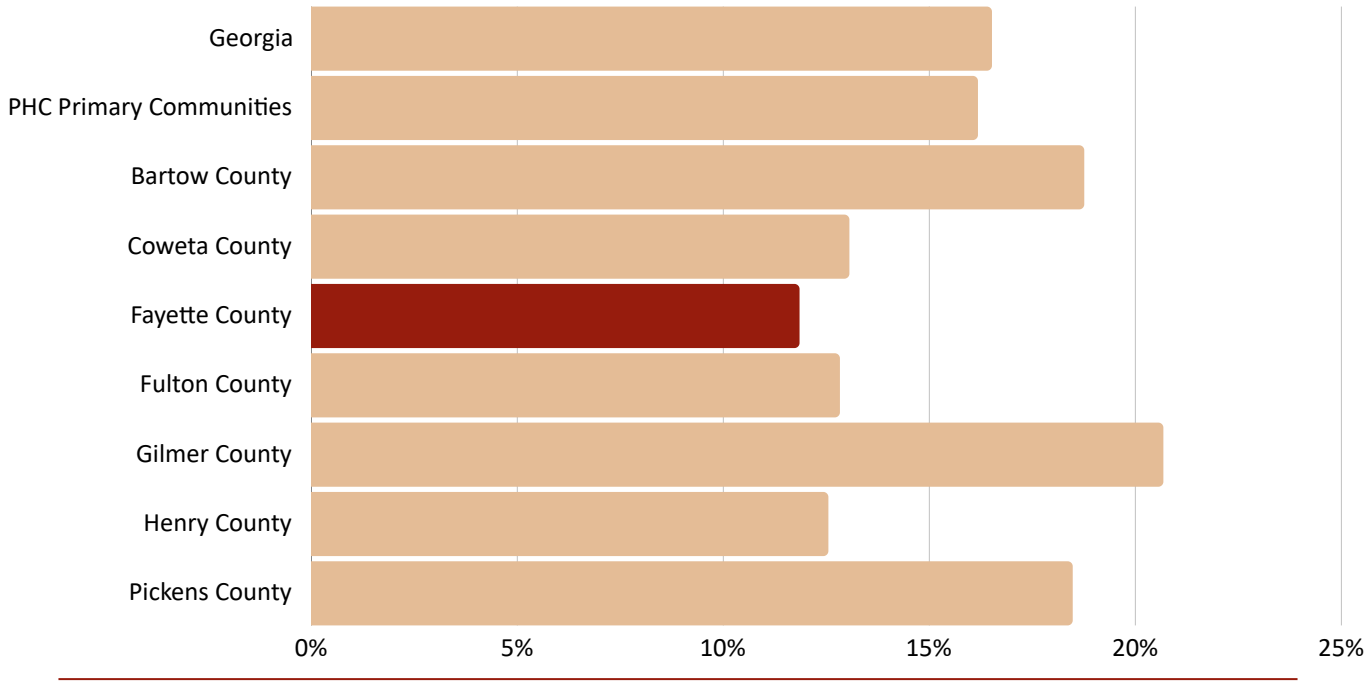


Source: Kaiser Family Foundation, Accessed 2025.

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, Fayette County, 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.

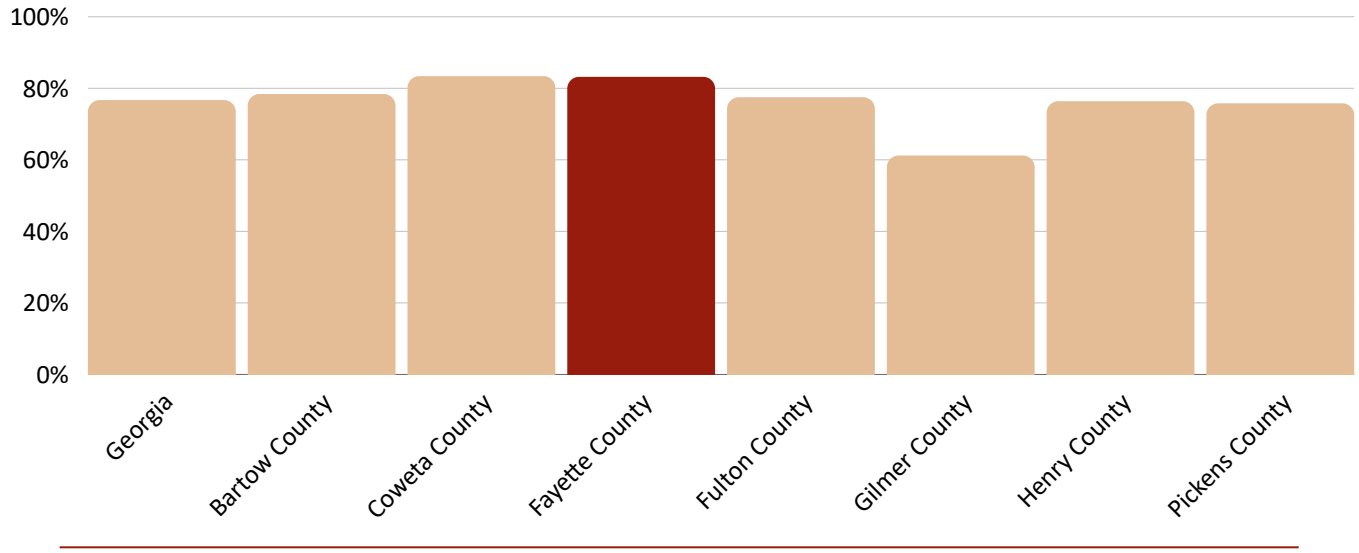
Most people without insurance are actually working: about 74% are employed full-time, 11% work part-time, and the remaining 15% are unemployed.

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, Fayette County, 2020-2022



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

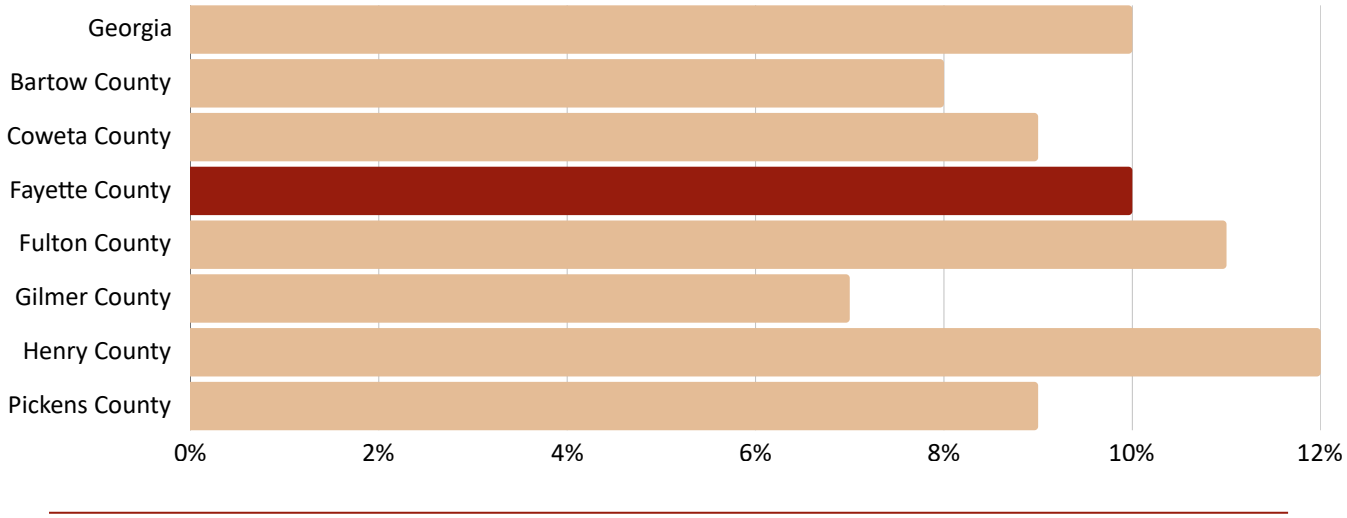
Unfortunately, not all communities have the same access or quality of prenatal care. Black women, in particular, face significant disparities, which contribute to poorer outcomes for both mothers and infants. Accessing prenatal care can be a real challenge for many low-income and minority women in Georgia. 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, Fayette County, 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, Fayette County, 2022

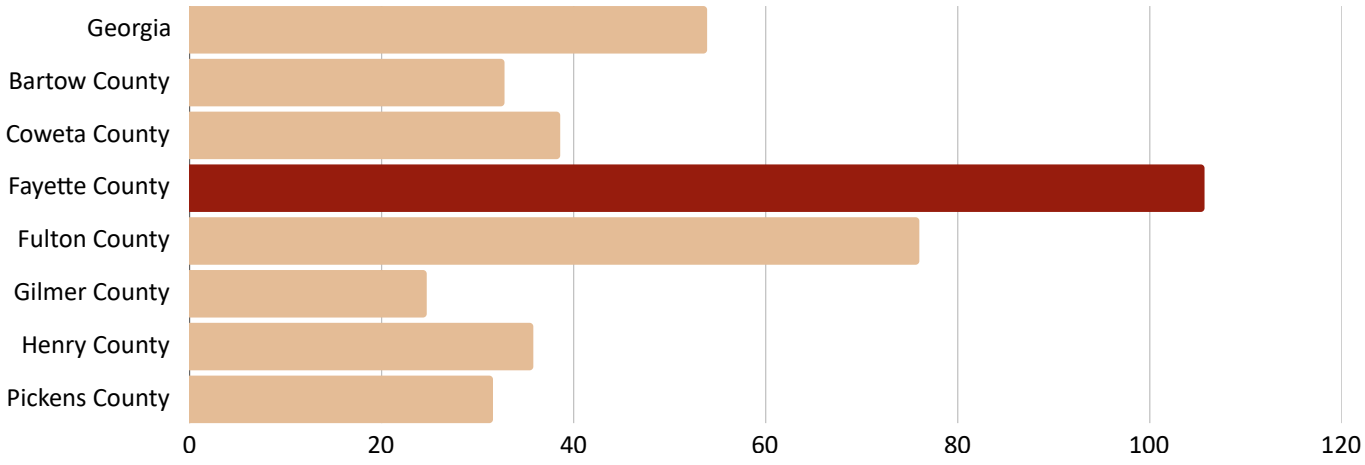
	Mammogram screenings, Medicare beneficiaries	Mammogram screenings, adult women	Cervical cancer screenings, adult women
Georgia	34.0%	75.8%	82.3%
Bartow County	31.0%	75.1%	80.1%
Coweta County	34.0%	75.0%	83.3%
Fayette County	38.0%	79.8%	84.6%
Fulton County	32.0%	79.1%	84.9%
Gilmer County	32.0%	73.9%	79.5%
Henry County	36.0%	78.1%	83.9%
Pickens County	32.0%	72.8%	81.3%

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, Fayette County had 100 dentists for every 100,000 people—higher than the state average of 54 per 100,000. Still, limited access to dental care is often linked to poorer oral health overall.

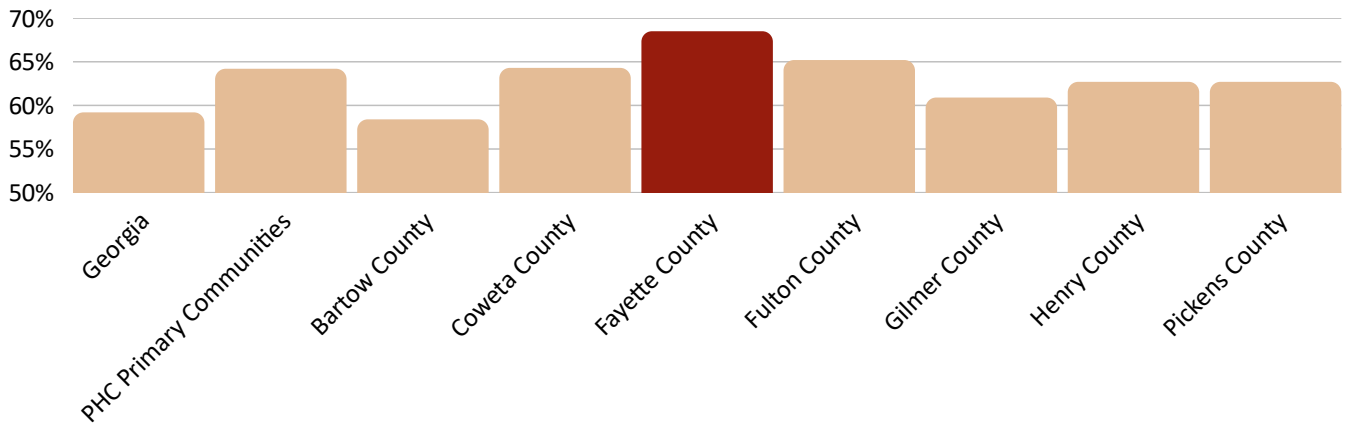
Rate of dentists per every 100,000 people, Fayette County, 2022



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

In 2022, approximately 6.7% of Fayette County residents aged 65 and older have lost all of their natural teeth. This figure often correlates to adults having had a recent dental visit.

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

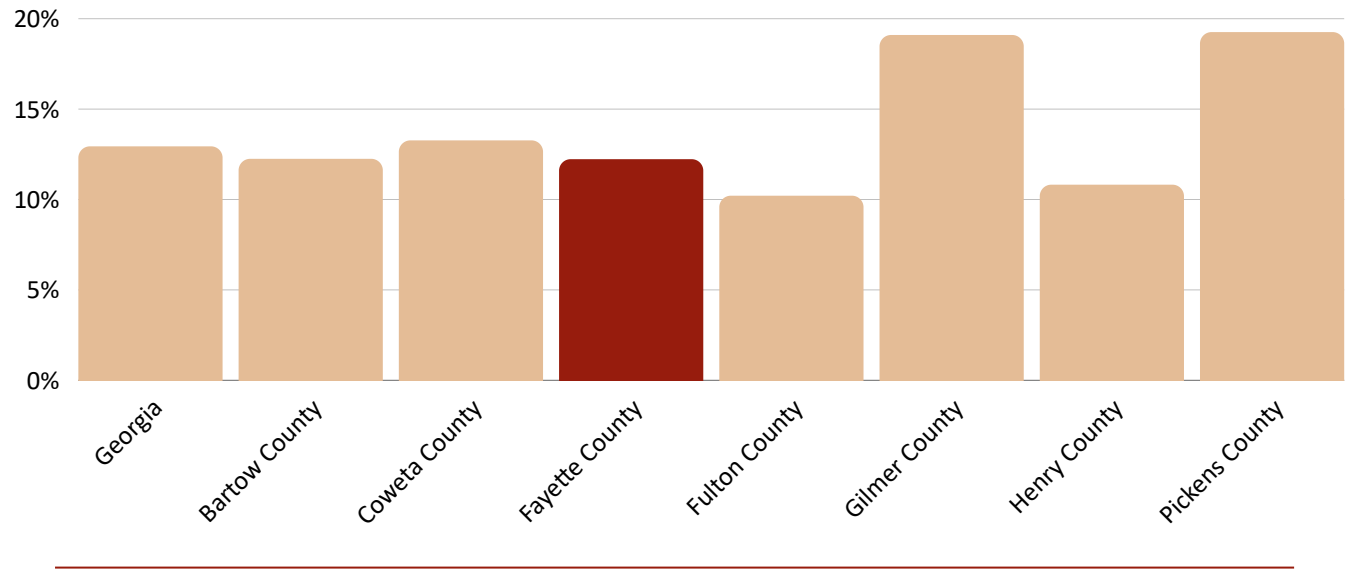


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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, Fayette County, 2019 to 2023

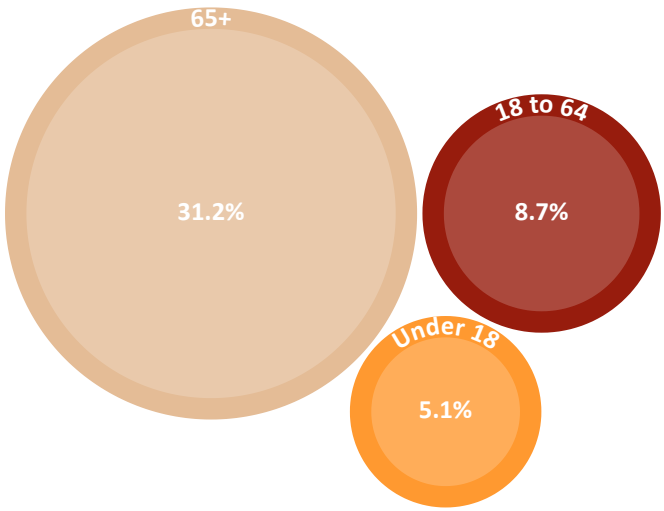


Source: US Census Bureau, American Community Survey, 2019-2023.

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

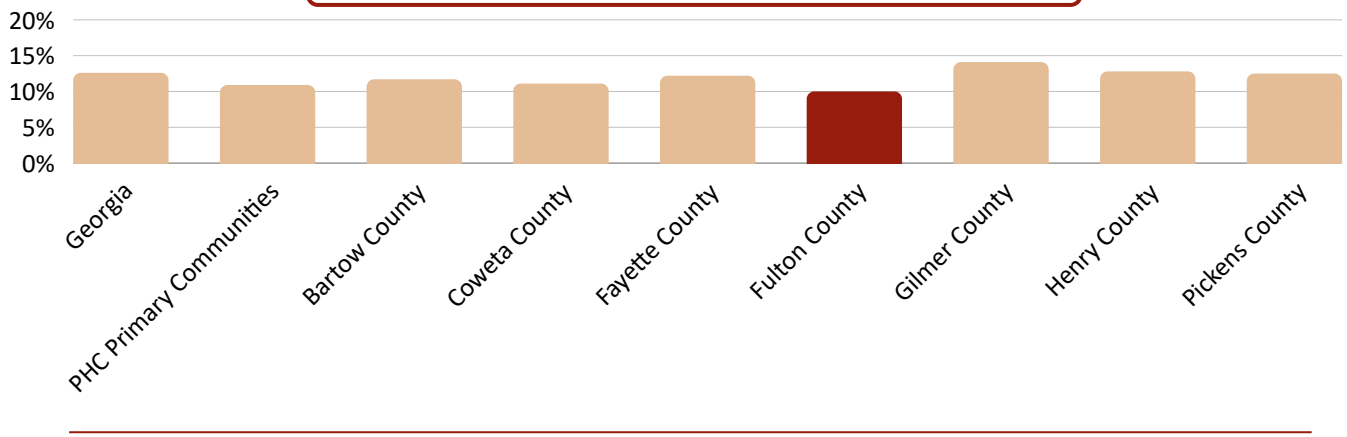


Source: US Census Bureau, American Community Survey, 2019-2023.

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, Fayette County, 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.

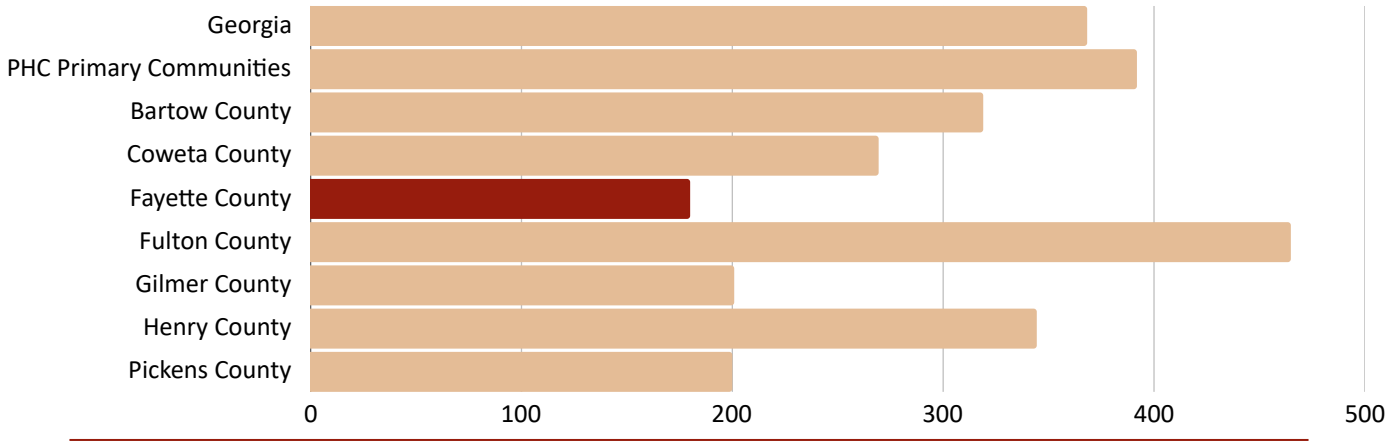
Type 2 diabetes can also increase the risk of developing dementia, including Alzheimer's and vascular dementia. Being diagnosed at a younger age—especially before 50—or having obesity can further raise this risk.

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 Fayette County, about 3.4% 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, Fayette County, 2023



Source: Georgia OASIS, accessed April 2025.

About 10% of adults had asthma in 2022 in Fayette County. Adult asthma rates have steadily increased over the years. **Among adults 18 and older, about 6% had COPD in 2022 in Fayette County.** When looking at Medicare beneficiaries only, that number jumps to 8%.

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 Fayette County 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, Fayette County, 2020 to 2022

	2020	2021	2022
Georgia	6.6%	5.9%	6.4%
PHC Primary Communities	5.7%	5.0%	5.4%
Bartow County	7.1%	6.3%	6.8%
Coweta County	6.5%	5.7%	6.1%
Fayette County	6.4%	5.9%	6.4%
Fulton County	5.1%	4.5%	4.8%
Gilmer County	10.2%	9.0%	9.6%
Henry County	5.8%	5.0%	5.4%
Pickens County	8.7%	7.8%	8.0%

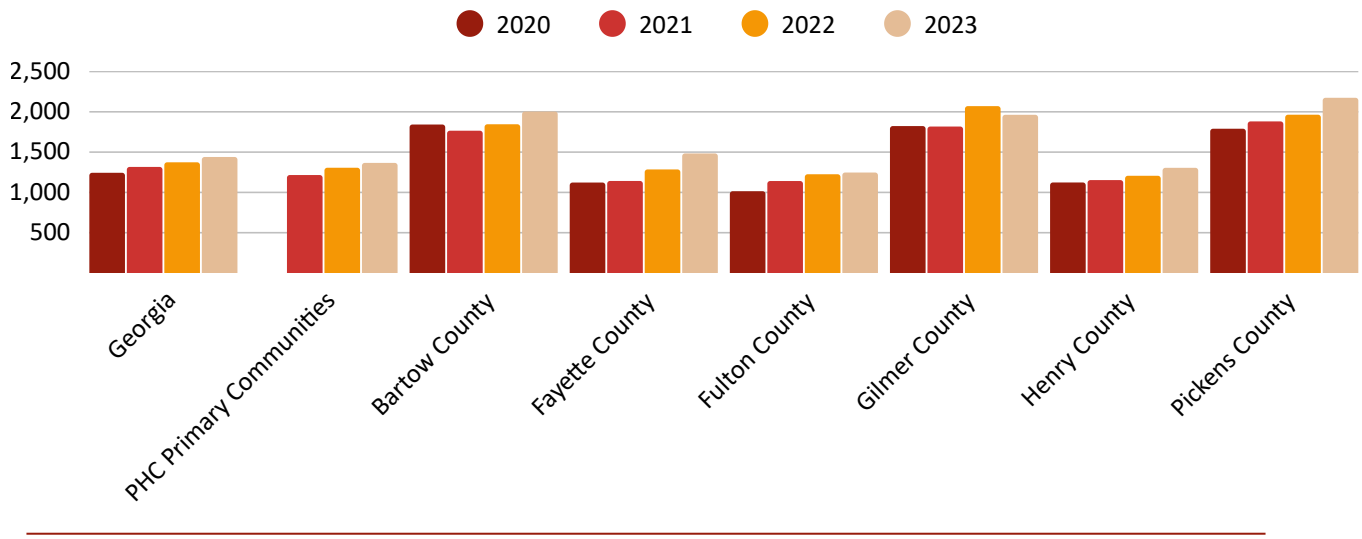
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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 Fulton 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, Fayette County, 2023



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

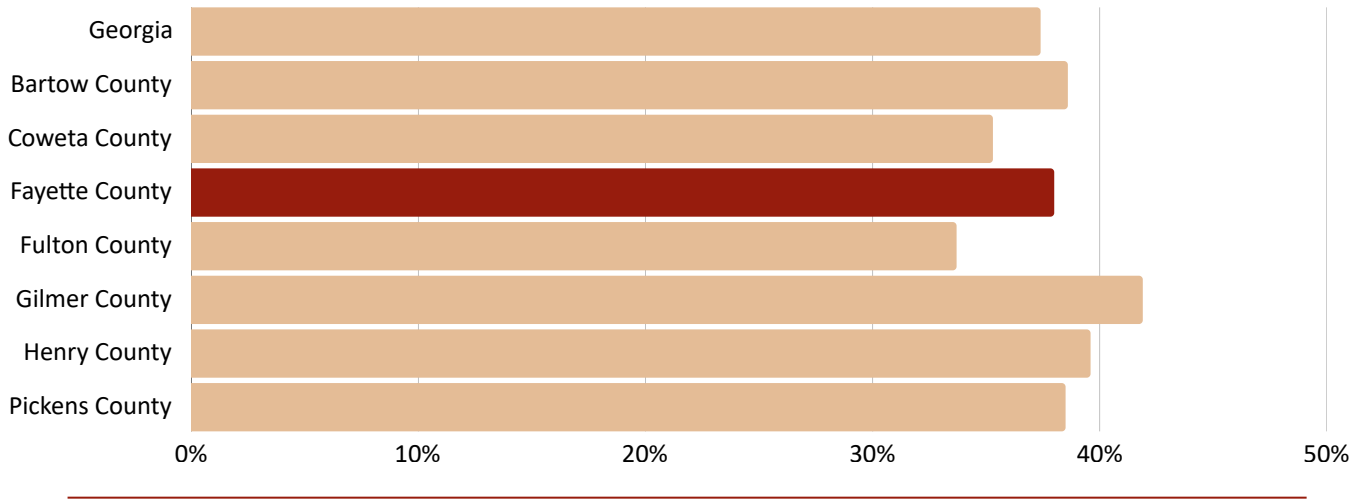
Rural areas in the US experience higher rates of heart disease and related deaths compared to urban areas, which show up at the hospital, with disparities seen in both heart failure risk and mortality. This is linked to factors like the availability of specialists within a given community and issues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

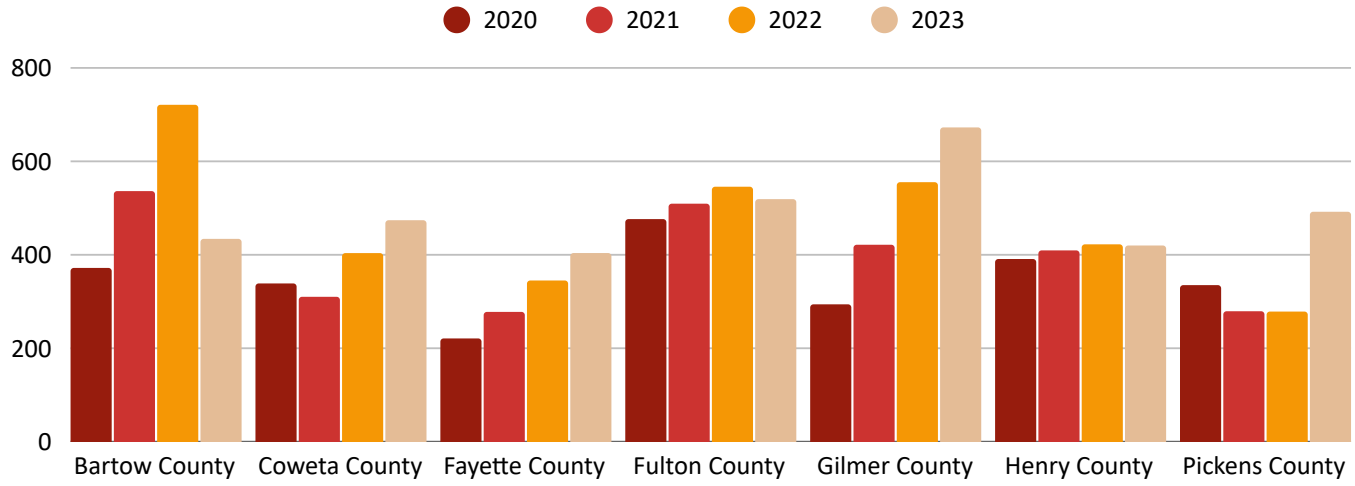
Hypertension is often tied to income, with lower-income individuals facing more challenges in managing the condition. Limited education can make it harder to recognize hypertension, follow treatment plans, and access health insurance.

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.

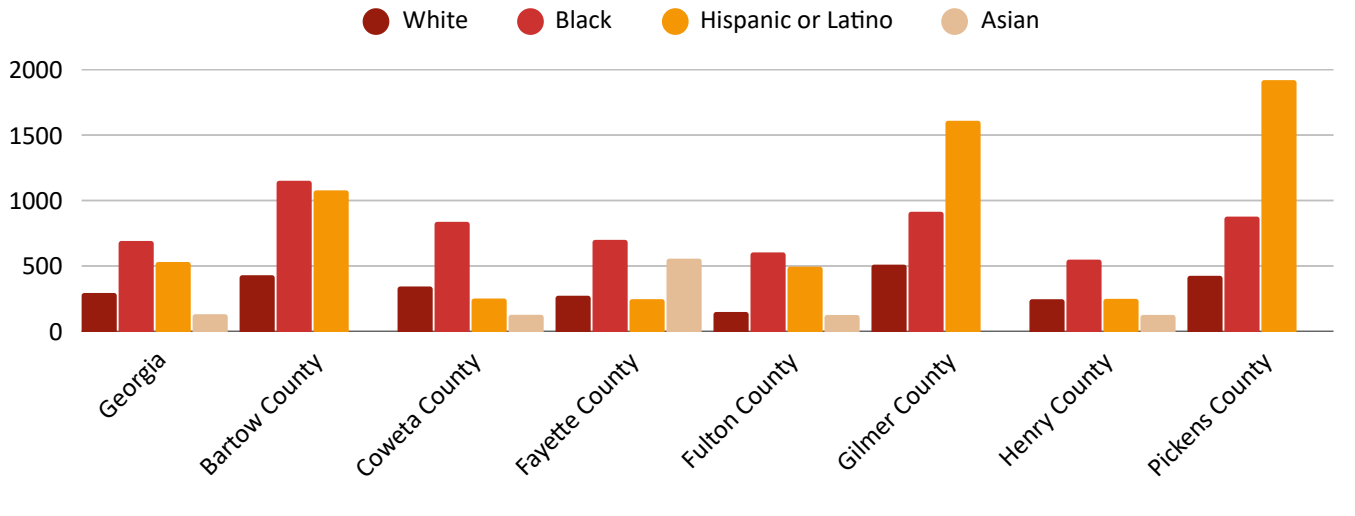
Emergency room discharge rate by patient county origin, per every 100,000, with a primary diagnosis code of hypertension, Fayette County, 2020 to 2023



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, per every 100,000, by race, Fayette County, 2023



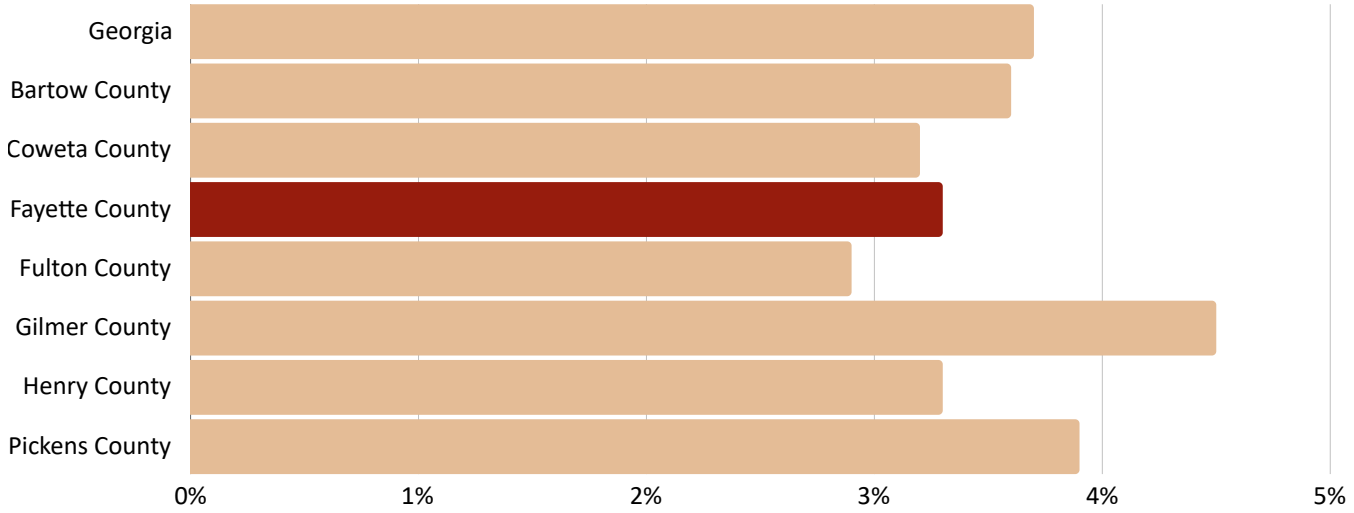
Source: Georgia Online Analytical Statistical Information System, Accessed February 2025.

Stroke

Stroke, also known as cerebrovascular disease, is one of the leading causes of death in Georgia and across Fayette County. 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+, Fayette County, 2022

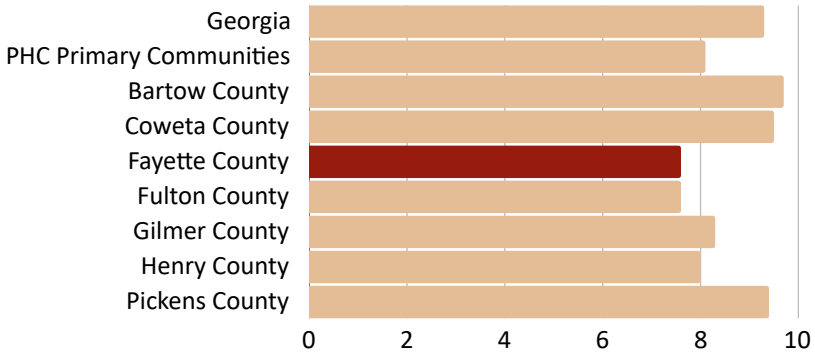


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2022.

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.

Within the county, approximately 93% of patients presenting at the hospital with stroke symptoms received medicine to break up a blood clot within three hours after symptoms started, a rate better than the state average of 90.7%.

Hospitalizations due to stroke, Fayette County, 2018-2020

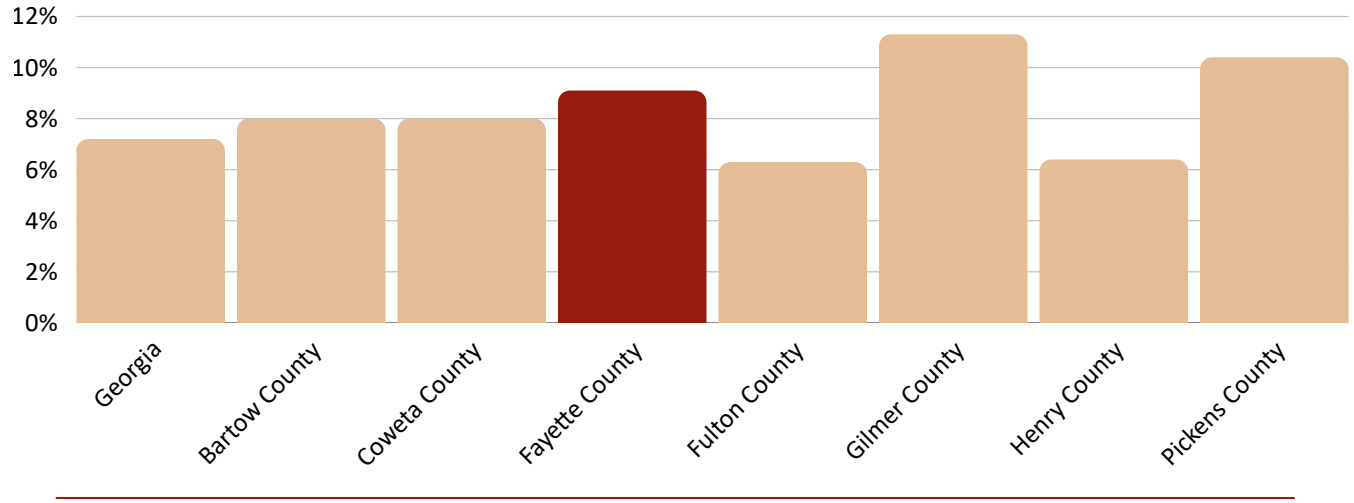


Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2018-2020.

Cancer prevalence rates

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

Cancer prevalence rates among adults 18+, Fayette County, 2022



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, Fayette County, 2017-2021

	Breast	Lung and bronchus	Prostate	Colon and rectum
Georgia	132.6	56.8	138.3	39.4
Bartow County	120.1	76.9	111.4	42.9
Coweta County	142.4	54.7	113.5	41.8
Fayette County	143.9	36.2	143.9	37.9
Fulton County	137.4	47	156.7	36.8
Gilmer County	110.6	62.8	128	No data
Henry County	134.3	50.8	161.3	40.2
Pickens County	144.4	75.5	132.9	No data

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

Clinicians diagnosed approximately 474 new cancer cases each year, annually on average between 2017 and 2021. Within the community, Pickens County, Gilmer County, and Bartow County had the highest rates, in order of incidence. Fayette County, Fulton County, and Coweta County had the lowest rates.

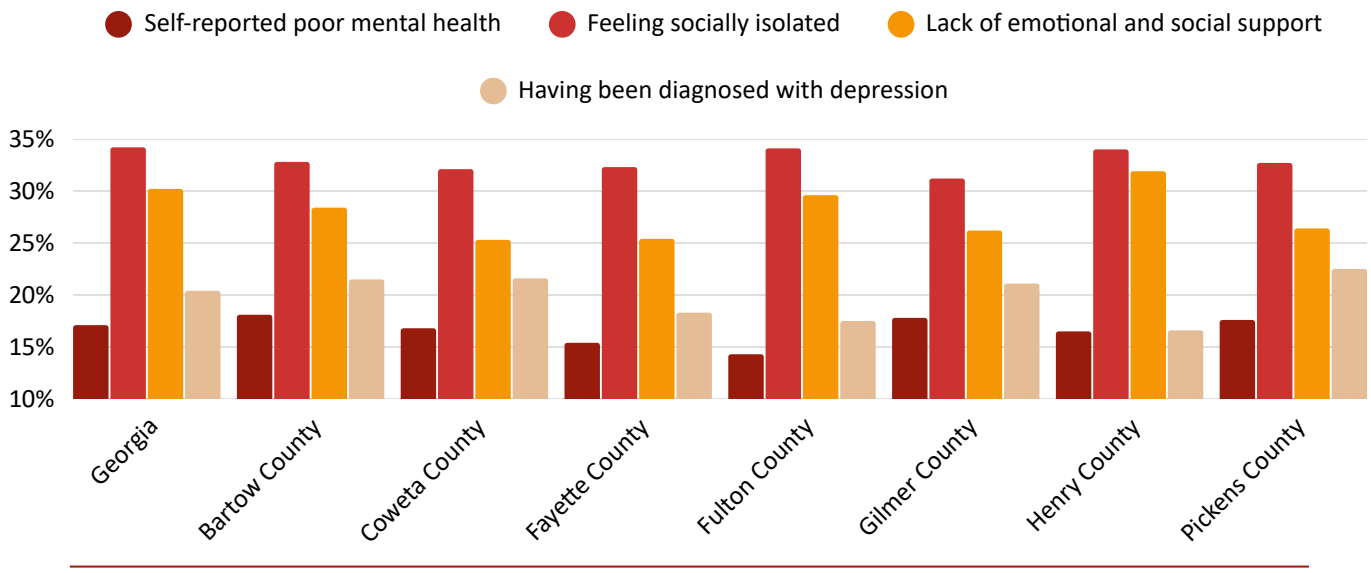
Cancer rates in Georgia are shaped by a mix of personal choices, environmental exposures, and social factors. Lifestyle habits—such as smoking, poor diet, lack of physical activity, and too much sun exposure—play a big role. For instance, melanoma rates in Georgia are higher than the national average, 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, Fayette County, 2022



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

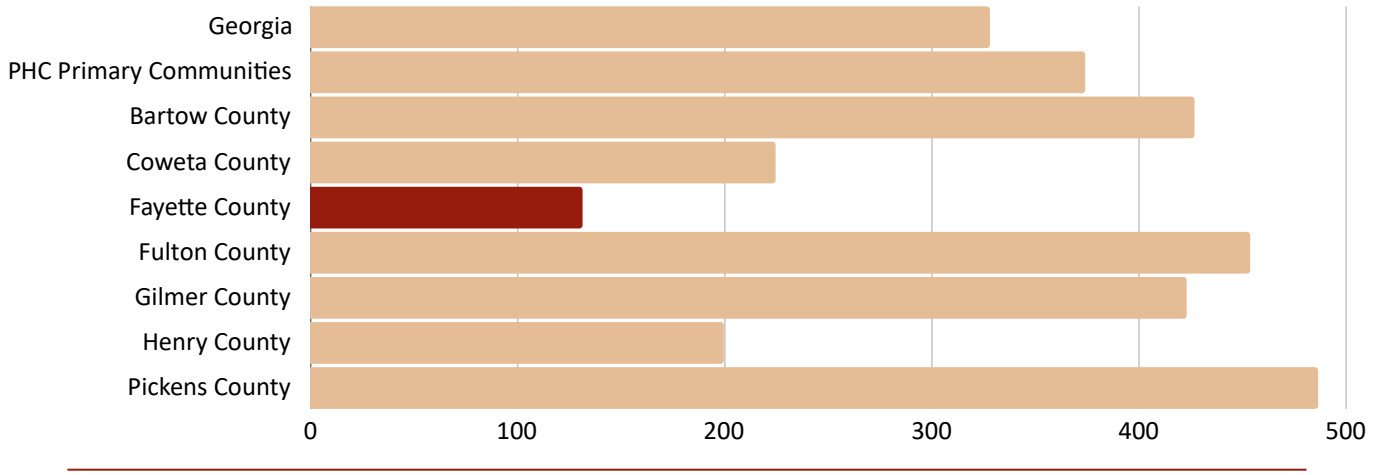
People living in low-income communities often face higher rates of mental health challenges, yet they also encounter the greatest barriers to getting the care they need. Poverty itself can fuel stress, anxiety, and depression—and, in turn, mental health struggles can make it even harder to break free 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, Fayette County, 2023



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

Within Fayette County 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 194 visits for Hispanic and/or Latino populations.

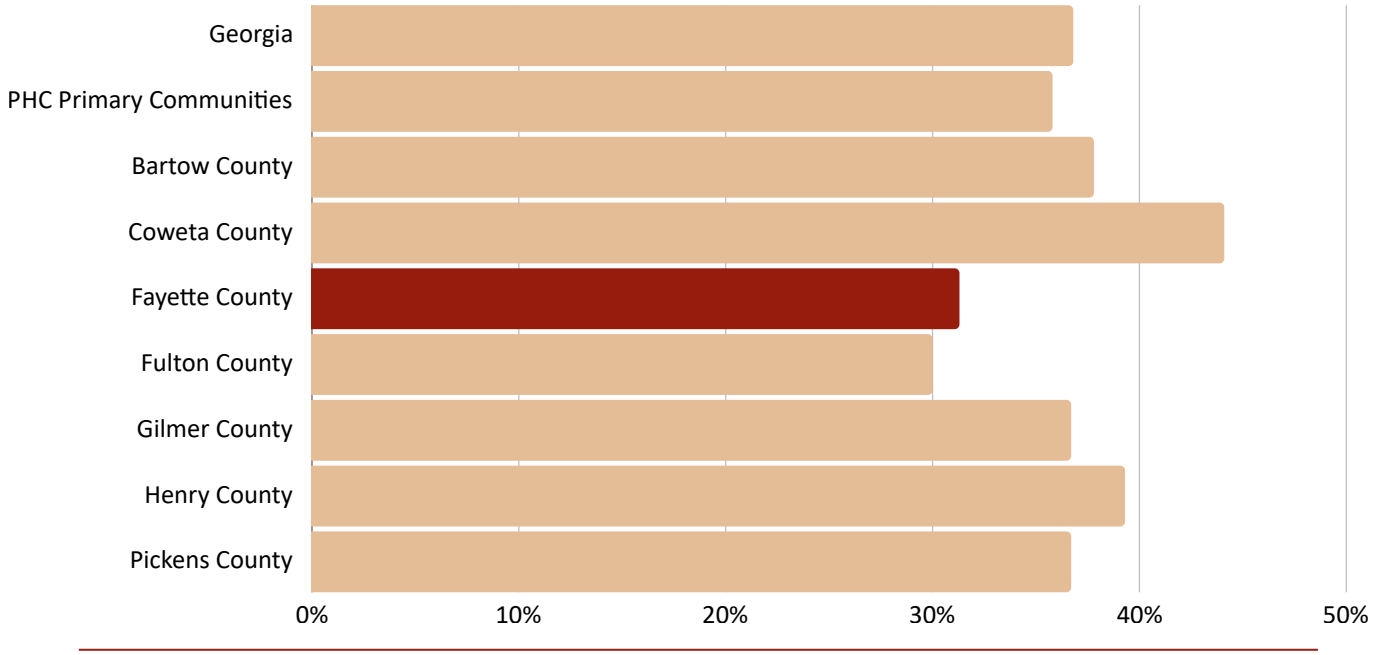
Socioeconomic factors, such as poverty and a lack of opportunities, also play a role. Racial and ethnic minorities may enter treatment later and have negative experiences. Black Americans are less likely to complete SUD treatment, and treatment systems may not be adequately equipped to meet the needs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

Adult obesity rates, Fayette County, 2022



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, Fayette County, 2022

	Binge drinking	Insufficient sleep	Current smokers
Georgia	15.8%	38.9%	14.7%
PHC Primary Communities	15.6%	39.1%	13.2%
Bartow County	16.9%	37.1%	15.4%
Coweta County	17.3%	37.0%	13.8%
Fayette County	15.7%	34.8%	10.7%
Fulton County	17.0%	39.8%	10.7%
Gilmer County	16.9%	34.6%	14.8%
Henry County	14.0%	40.1%	13.0%
Pickens County	17.6%	34.3%	14.0%

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

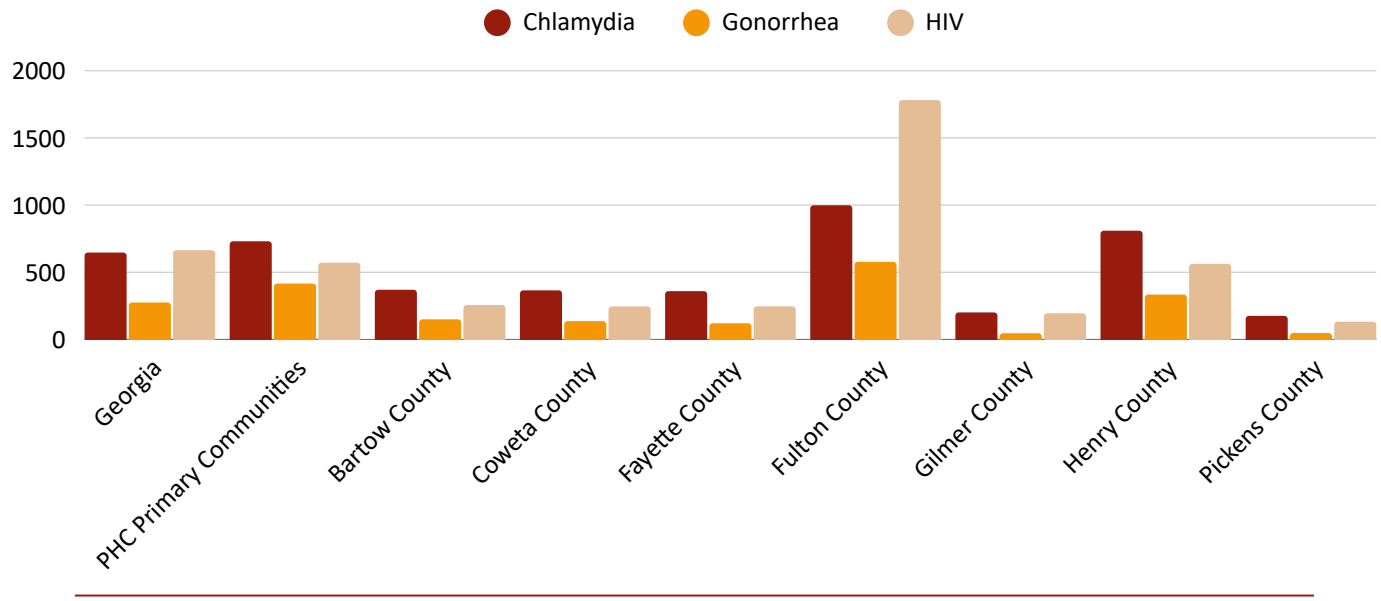
Healthy behaviors—such as maintaining a balanced diet, engaging in regular physical activity, and obtaining sufficient sleep—are essential for overall health and well-being. However, disparities in both access to and adoption of these behaviors persist across populations. Socioeconomic status, food insecurity, 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, Fayette County, 2023



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2023.

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.

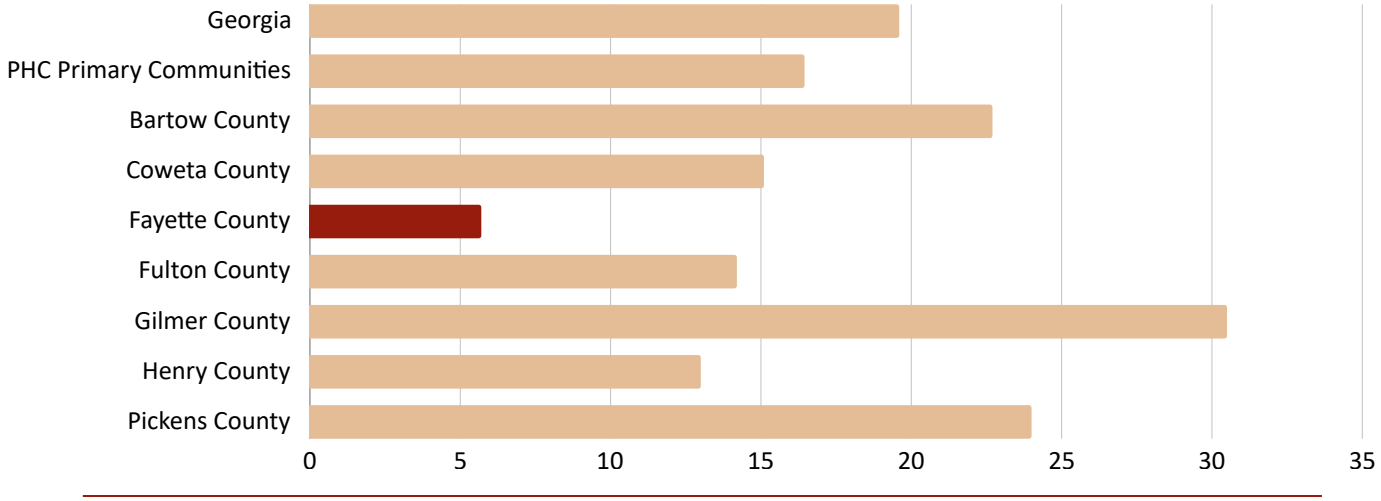
Communities with concentrated poverty and limited resources often face disproportionately high rates of HIV, syphilis, herpes simplex virus, chlamydia, and hepatitis B. These disparities reflect inequitable access to healthcare and broader gaps in resource allocation. Individuals with a history of incarceration 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, Fayette County, 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.

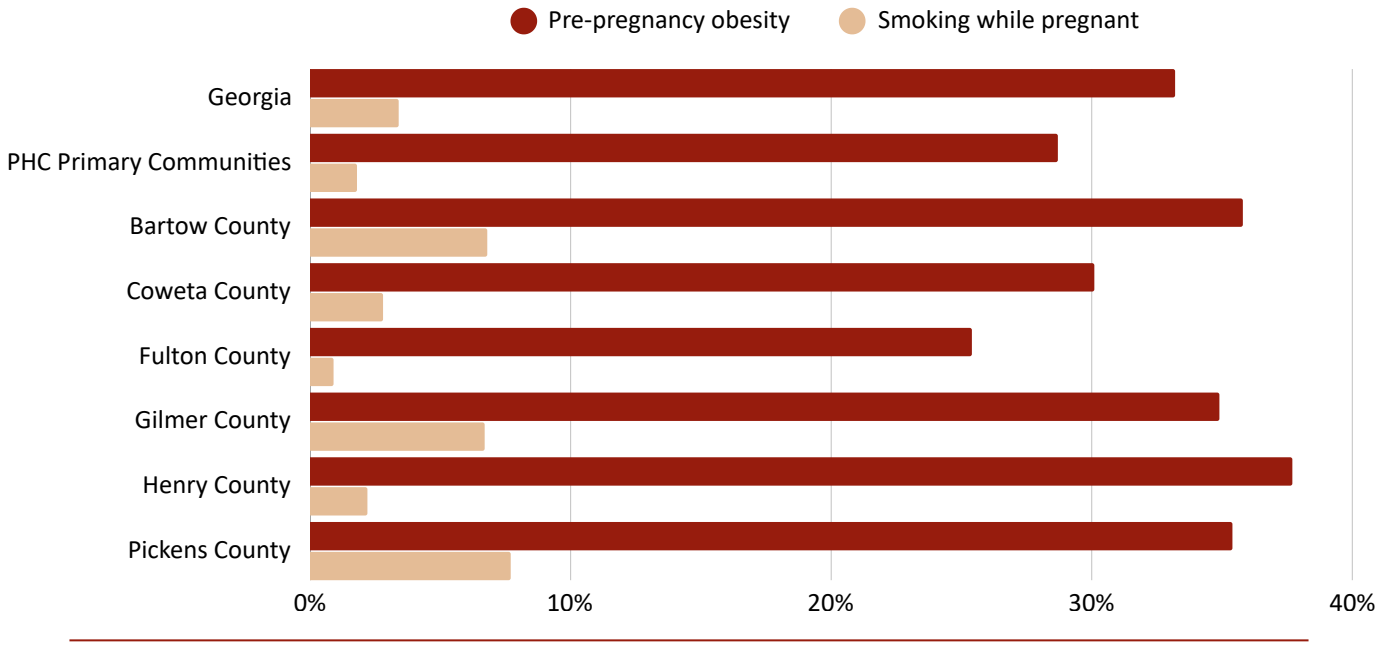
Teen mothers are at a higher risk of mental health problems, including postpartum depression and suicidal ideation.

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, Fayette County, 2020-2022



Source: Health Resources and 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.

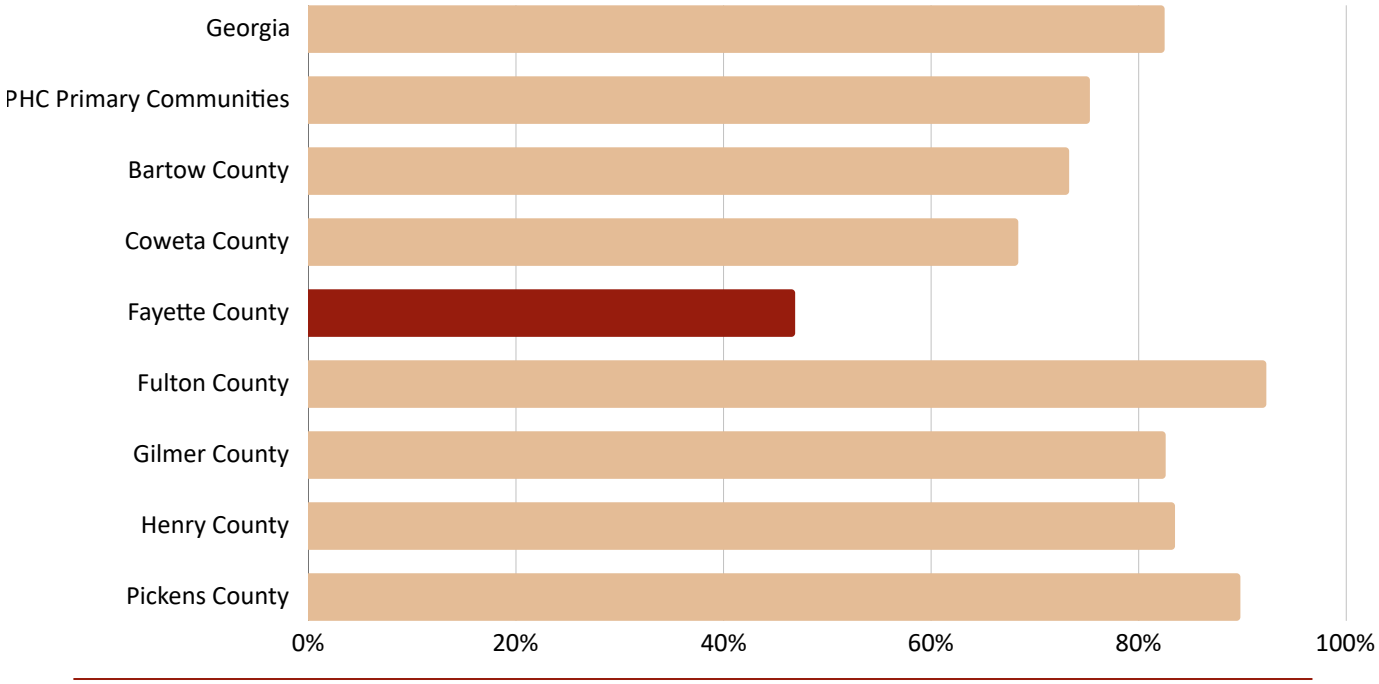
The timing of care also reflects these inequities. Black women are nearly twice as likely as White women to have births with late or no prenatal care, while non-Hispanic Pacific Islander women are four times more likely than White women to delay care until the third trimester or to forgo it entirely.

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, Fayette County, 2020-2022



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

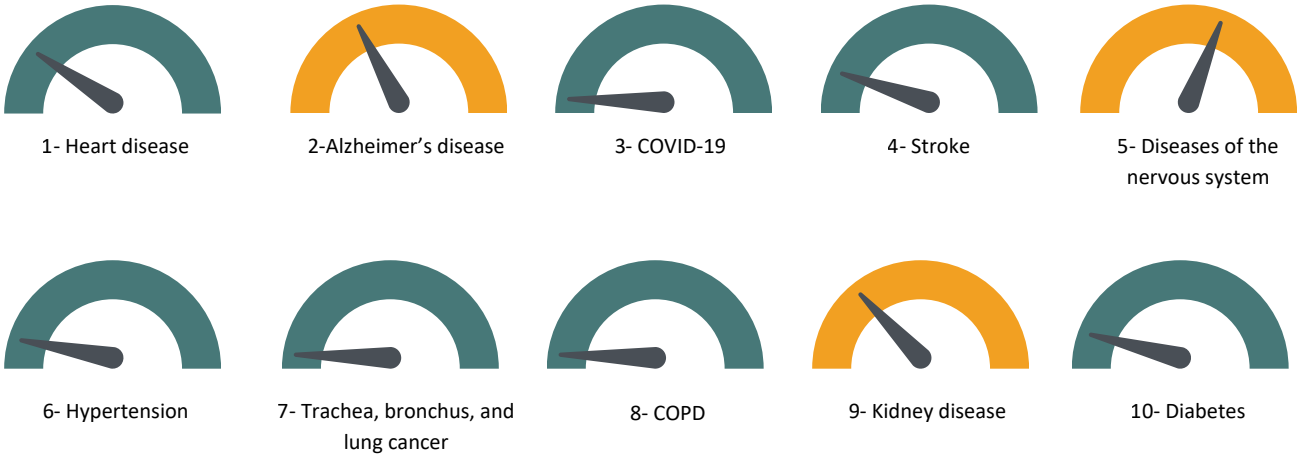
Despite its benefits, structural and social barriers disproportionately affect low-income mothers. Limited access to paid parental leave and inflexible workplace policies often force mothers to return to work shortly after giving birth, making it difficult to establish or sustain breastfeeding. Many 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 Fayette 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 Fayette County, as compared to Georgia overall.

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



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

When broken down by age, the leading causes of death shift, as seen in the list below that shows the top causes of death by age group.

Top cause of death by age, Fayette County, 2019 to 2023

<1	1-4	5-9	10-24
Certain conditions originating in the perinatal period	Certain conditions originating in the perinatal period	Septicemia	Motor Vehicle crashes
25-44	**45-54**	**55-74**	**75+**
Accidental poisoning	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 Fayette 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.

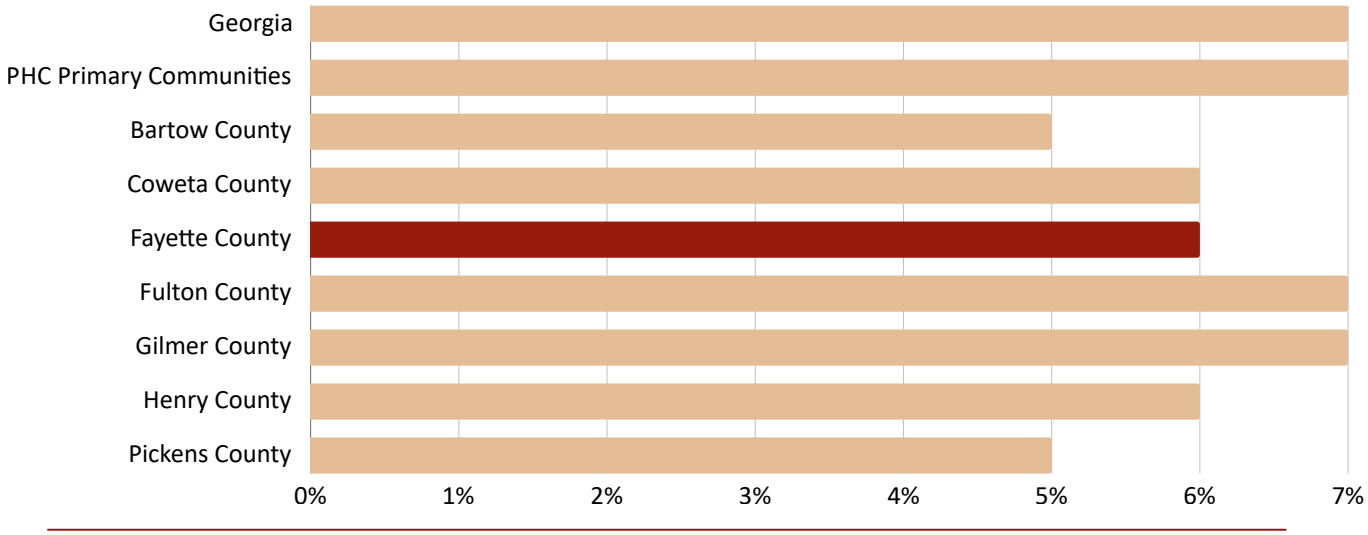
Ranking	Georgia women	All women (Fayette County)	Black women (Fayette County)	White women (Fayette County)
1	Heart disease	Alzheimer's disease	Diseases of the nervous system	Alzheimer's disease
2	Alzheimer's disease	Heart disease	Heart disease	Stroke
3	COVID-19	Stroke	Breast cancer	Heart disease
4	COVID-19	Diseases of the nervous system	Alzheimer's disease	COVID-19
5	Stroke	COVID-19	Stroke	Breast cancer

Ranking	Georgia men	All men (Fayette County)	Black men (Fayette County)	White men (Fayette County)
1	Heart disease	Heart disease	Homicide	COVID-19
2	COVID-19	COVID-19	COVID-19	Number too small to report
3	Hypertension	Hypertension	Diseases of the nervous system	Number too small to report
4	Trachea, bronchus and lung cancer	Diseases of the nervous system	Stroke	Number too small to report
5	Stroke	Kidney disease	Trachea, bronchus and lung cancer	Number too small to report

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, Fayette County, 2020 to 2022



Source: Health Resources and 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.

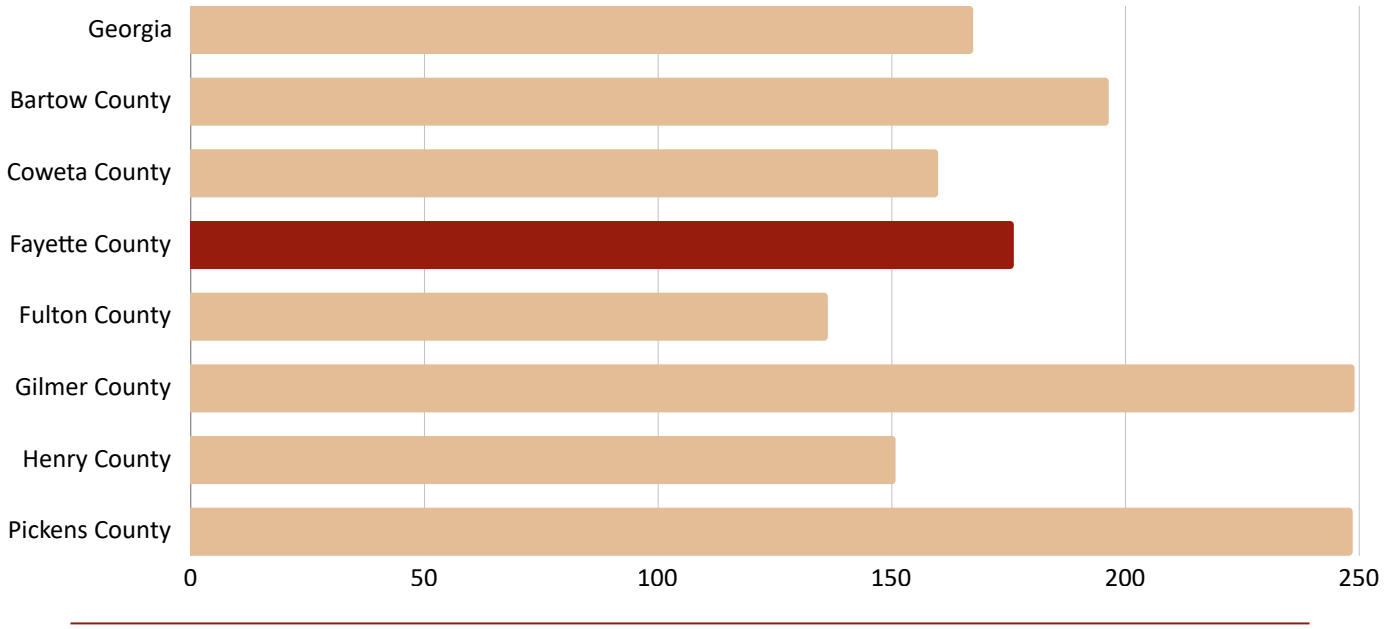
In Georgia, these national trends are clearly reflected. Black infants in the state have an infant mortality rate of about 9.6 deaths per 1,000 live births—nearly double that of other groups. By comparison, the rate is 5.1 for Hispanic infants, 5.0 for White infants, and 3.5 for Asian and Pacific Islander 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 1,050 community members died from cancer, resulting in a rate of 176.1 deaths for every 100,000 people, worse than the state rate of 167.4. The cancer death rate in Gilmer County is the highest at 249.0 deaths for every 100,000 people.

Cancer death rate, per every 100,000 people, Fayette County, 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 182 men per 100,000 people, compared with 171 women. Within Fayette County, White populations experienced the highest cancer mortality rates—220 deaths per 100,000—compared with 147 among Black populations and 52 among Hispanic/Latino populations.

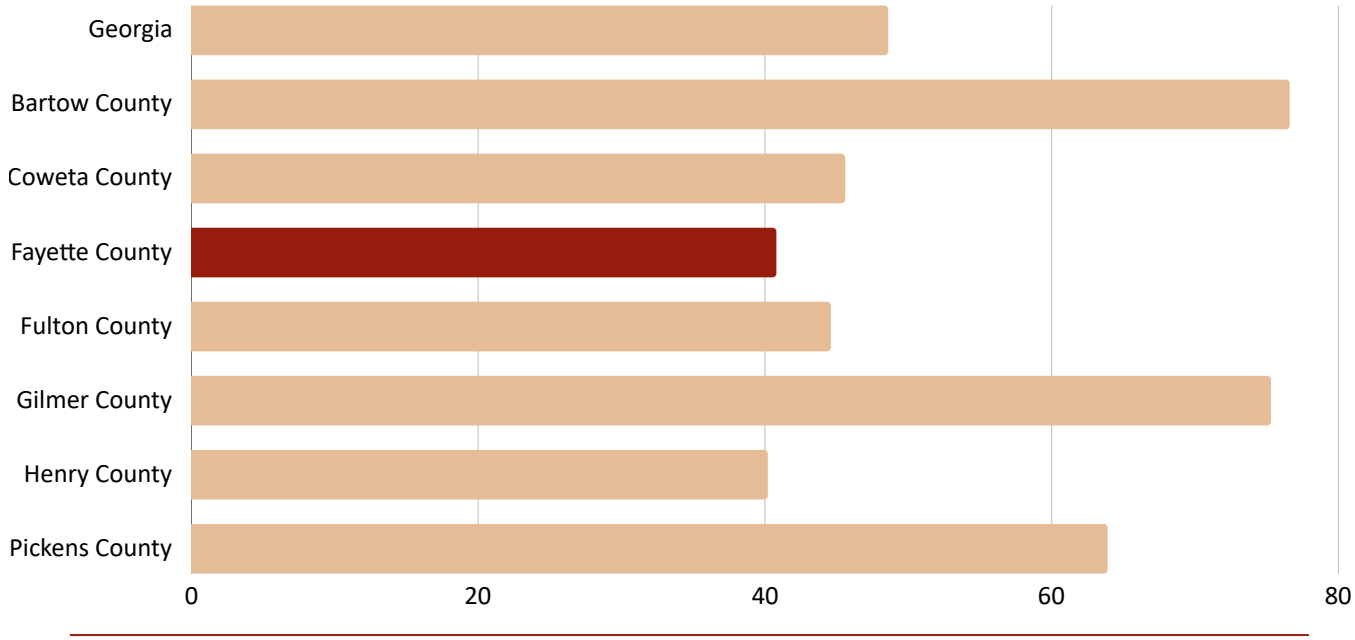
Cancer outcomes are closely tied to income and socioeconomic status, which influence diagnosis, treatment, and survival. Individuals with lower incomes are more likely to face financial hardship, experience higher healthcare costs, and encounter delays or gaps in care. These barriers often lead to worse 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. Between 2019 and 2023, approximately 243 people in Fayette County lost their lives to deaths of despair.

Deaths of despair for every 100,000 county residents, Fayette County, 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.

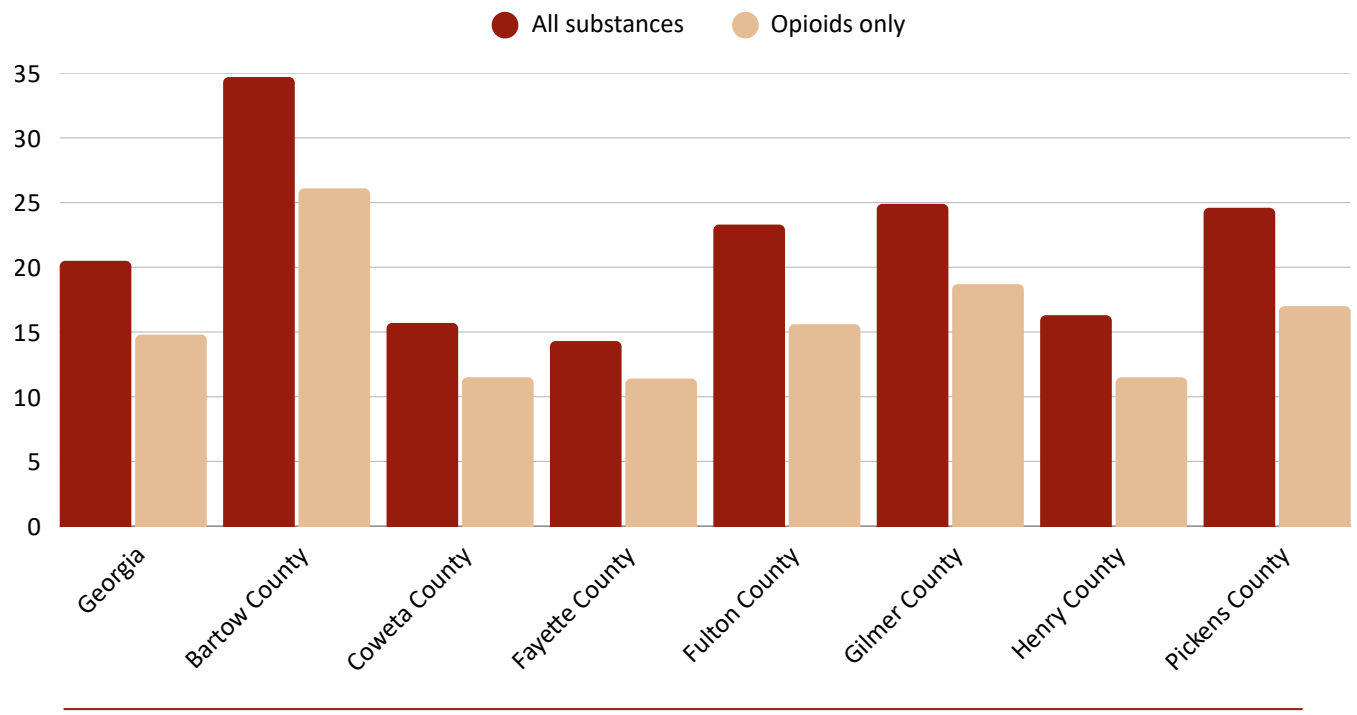
Men are more likely to die by suicide, although women report attempting suicide more often. Firearms are the most common method, followed by suffocation, drug poisoning, and other means.

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 now one of the leading causes of injury-related deaths in the United States, and the numbers have risen sharply in recent years. In Fayette County, about 85 people lost their lives to drug overdoses between 2019 and 2023, which represents a rate of 14.3 deaths for every 100,000 people. This 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, Fayette County, 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 Fayette established the following strategies to address its identified health needs. These strategies were approved by the board of directors on September 10, 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
Provide primary care for under and uninsured	Support Fayette CARE Clinic as it provides primary, specialty, and pharmacy services regardless of income or insurance status
Provide primary care for under and uninsured	Support Healing Bridge Clinic as it provides primary, specialty, and pharmacy services regardless of income or insurance status
Provide primary care for under and uninsured	Community relations will identify specific charity care clinics in South Fulton, Griffin/Spalding and Clayton Counties, establish relationships, explore opportunities
Reach vulnerable populations with health screenings and referral to care sources	Serve clients of community partners with health screenings and referral to health and social service resources
Provide transportation services for low-income, uninsured patients	Secure and cover transportation costs for discharge transportation for uninsured patients if unable to secure on their own
Provide transportation services for low-income patients and senior citizens	Sponsor transportation services at Fayette Senior Services for transport of patients for medical appointments

FY26 to FY28 Implementation Strategy

Increase access to appropriate and affordable care, continued

Goal	Tactics/Activities/Strategies
Provide services and programs to support healthy aging, dementia and Alzheimer's resources	Sixty Plus services to provide support groups for seniors and their caregivers regardless of income or insurance status
Provide educational and experiential opportunities through partnerships with relevant educational institutions	Build future healthcare workforce through high school career academies and CTAE programs, Fayette Works, shadowing and volunteer programs, school Career Days. Provide college, graduate, nursing and medical students with experiential education opportunities. Provide medical residents with clinical experience
Community leaders will receive health education and will have fuller understanding of hospital resources to inform their leadership role in the community	Leadership groups in Fayette, South Fulton, Griffin-Spalding and Clayton counties will connect with hospital through health education events and hospital tours
Improve patient and caregiver experiences through a Patient Advisory Council	Implement Patient Advisory Council comprised of patients, caregivers and staff to improve patient experience
Increase the number of local agencies listed in Empowering You and usage by PFH patients, staff, and community members	Partner with PFH Case Management, System Health Equity and local nonprofits to encourage participation and usage of Empowering You

FY26 to FY28 Implementation Strategy

Reduce preventable instances and deaths from cancer

Goal	Tactics/Activities/Strategies
Reach vulnerable populations to provide prevention education and disease management skills	Provide prevention, risk, early screening and cancer awareness education to clients of community partners serving vulnerable populations
Provide free nicotine cessation support for patients and community members in Piedmont system	Provide free, virtual nicotine cessation classes and individual coaching to support patients in making a detailed, personalized quit plan
Reach community-at-large and vulnerable populations with cancer prevention information, cancer management skills, and caregiver support	Provide free wellness programs, support therapies, education about trusted resources and treatment options, grief and illness-adjustment counseling through Piedmont Fayette Cancer Wellness, and education and resource awareness at community events
Reach community-at-large and vulnerable populations with breast cancer education	Provide education on breast cancer prevention and treatment options
Provide after-hours screening mammograms to employees of local employers	Provide reserved screening mammogram appointments at Women's Imaging Center
Reach community-at-large and vulnerable populations with lung cancer education	Provide lung cancer education and access to phone screenings to low-income populations and connect to nicotine cessation support resources
Reach community-at-large and vulnerable populations with gynecological cancer education	Provide education on gynecological cancer prevention and treatment options
Reach community-at-large and vulnerable populations with prostate cancer education	Provide prostate cancer education, access to screenings, and connect to prostate cancer support resources to uninsured community members through targeted events with community partners, faith community and charitable clinics

FY26 to FY28 Implementation Strategy

Reduce preventable instances of chronic conditions, focusing on heart disease, stroke, and diabetes

Goal	Tactics/Activities/Strategies
Reach vulnerable populations to provide prevention education and disease management skills	Provide prevention and chronic disease management education to clients of community partners serving vulnerable populations
Reach community-at-large and vulnerable populations with knowledge and education to positively manage hypertension	Provide hypertension education and access to blood pressure checks to clients of community partners serving vulnerable populations
Reach community-at-large and vulnerable populations with knowledge and skills to assist during cardiac emergencies	Provide free hands-only CPR courses to community-at-large and to staff of community partners who serve vulnerable populations
Reach community-at-large and vulnerable populations with knowledge and skills to assist during cardiac emergencies	Maintain DNV Chest Pain Center certification
Reach community-at-large and vulnerable populations with knowledge and skills to assist during stroke emergencies	Provide stroke education classes to clients of community partners serving vulnerable populations
Reach community-at-large and vulnerable populations with knowledge and skills to assist during stroke emergencies	Maintain Primary Stroke Center certification through DNV
Reach community-at-large and vulnerable populations with knowledge and skills to assist during stroke emergencies	Maintain Get With The Guidelines (GWTG) Gold+ recognition

FY26 to FY28 Implementation Strategy

Reduce preventable instances of chronic conditions, focusing on heart disease, stroke, and diabetes, continued

Goal	Tactics/Activities/Strategies
Reach community-at-large and vulnerable populations with knowledge and skills to assist preventing, managing diabetes	Provide diabetes prevention, management, nutrition education opportunities to clients of community partners serving vulnerable populations
Provide health and safety education to school-aged children and families	Healthy behavior programs in school programs and Safe Kids programming with community partners including various local sheriff and police departments
Reach community-at-large and vulnerable populations with opportunity to participate in healthy activities	Partner with local recreation departments and community partners to provide Walk with a Doc events in communities and promote healthy lifestyle
Support breastfeeding for new mothers	Provide breastfeeding classes and educational opportunities for new mothers

FY26 to FY28 Implementation Strategy

Reduce the impact of poor mental health

Goal	Tactics/Activities/Strategies
Increased access and mental health treatment provided to patients receiving care at community charitable care clinics and community partner organizations	Continue partnership with Fayette CARE Clinic and Healing Bridge Clinic to provide mental health referrals
Increased access and mental health treatment provided to patients receiving care at community charitable care clinics and community partner organizations	Continue partnership with Fayette FACTOR to support Fayette Youth Behavioral Health Alliance mission
Increased access and mental health treatment provided to patients receiving care at community charitable care clinics and community partner organizations	Identify and strengthen partnerships with clinics and organizations providing mental health resources in South Fulton, Clayton, and Griffin/Spalding counties
Quality behavioral health services provided to Piedmont Fayette patients in a timely and efficient manner	Continue partnership with McIntosh Trail Community Service Board to provide mental health care coordination
Build mental health and substance abuse awareness and reduce stigma through education and outreach	Partner with Fayette FACTOR, local nonprofit organizations and local law enforcement to support and promote mental health programming, suicide prevention and awareness, Drug Take Back Days, and safe disposal of medicines to reduce substance misuse
Build mental health and substance abuse awareness and reduce stigma through education and outreach	Collaborate with local media, faith organizations, and schools to normalize seeking mental health support
Equip frontline providers and caregivers with tools to respond to mental health needs	Communicate opportunities for Mental Health First Aid education for hospital staff, teachers, and faith leaders

FY26 to FY28 Implementation Strategy

Reduce the impact of poor mental health, continued

Goal	Tactics/Activities/Strategies
Equip frontline providers and caregivers with tools to respond to mental health needs	Partner with peer recovery and mental health organizations to connect with patients and educate about resources and support options
Equip frontline providers and caregivers with tools to respond to mental health needs	Engage chaplains and pastoral care teams to offer spiritual and emotional support in clinical and community settings

FY22 CHNA - Implementation Strategy Progress Report

In FY23, FY24, and FY25, Piedmont Fayette demonstrated a sustained commitment to improving community health, expanding access to care, and promoting equity across the Fayette 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 Fayette's board of directors approved the following community health needs:

- Ensure affordable access to health, mental, and dental care
- Reduce preventable instances of and deaths from cancer
- Reduce preventable instances of diabetes and increase access to care for those living with the disease
- Reduce rates of obesity and increase access to healthy foods and recreational activities
- Support senior health, healthy aging, and good mental health
- Reduce preventable instances of and deaths from heart disease

Progress on health priorities

Piedmont Fayette remained deeply committed to ensuring that low- and no-income patients had access to the care they needed to get well and stay healthy. Through long-standing partnerships with local charitable clinics such as the Fayette C.A.R.E. Clinic and the Healing Bridge Clinic, the hospital provided essential support that strengthened community access to healthcare.

At the Fayette C.A.R.E. Clinic, Piedmont awarded annual grants of $10,000 in FY23 and FY24 and delivered pro-bono laboratory services valued at $879,000 over three years. These services supported more than 500 unique patients each year, ensuring that vital diagnostic testing was available to those who could not otherwise afford it. The hospital also donated 100 flu shots annually, extended access to its Epic Community Connect platform to streamline records and continuity of care, contributed $1,600 each year in sponsorship support, and maintained leadership representation on the clinic's board to reinforce the partnership's long-term impact.

The Healing Bridge Clinic benefited from a similar collaboration. Piedmont provided $10,000 grants in scal years 2023 and 2024, donated 50 flu shots in 2023 and 2024 and 100 in 2025, and increased sponsorship support from $1,500 in each of the first two years to $5,000 in FY25—reflecting an ongoing investment in access to care for uninsured and underinsured residents.

Piedmont Fayette also played an active role in developing the future healthcare workforce. The hospital participated in 23 career fairs across primary and secondary schools each year, introduced students to healthcare careers, and in FY25 supported "Fayette Works," a three-day, hands-on career event for

all county eighth graders. Across the year, the hospital hosted 15 high-school work-based learning students, 50 allied-health students, and 20 clinical department shadowing participants. It supported 335 nursing preceptor students annually from regional colleges and universities, operated a Dedicated Education Unit focused on fundamentals and clinical practicums, and hosted a three-day Nurse Camp each summer for 15 high-school students exploring healthcare pathways.

To strengthen patient-centered care, Piedmont Fayette worked to reestablish its Patient and Family Advisory Council, which had been paused during the pandemic. Discussions in FY25 focused on updating the council's goals and scope. At the same time, the Quality, Safety, and Service teams, along with the Patient Experience team, continued to monitor and report on care to identify opportunities for improvement.

The hospital also advanced community mental-health prevention and education. It supported Drug Take Back Days, distributed medication lock boxes and Deterra drug-neutralization packets, and participated in overdose-awareness events and other public programs addressing substance misuse. Hospital leaders served on the boards of Fayette FACTOR and Drug Free Fayette. In 2024, the hospital hosted a community meeting advocating for zoning changes to allow a new detoxification facility to open in Fayette County, expanding access to treatment and recovery resources.

Piedmont Fayette's commitment to wellness extended to older adults. Through the Sixty Plus Program, the hospital offered ongoing education and resources that promoted healthy aging and supported family caregivers. Between FY23 and FY25, it hosted 115 wellness-education sessions across senior centers in Fayette, Spalding, South Fulton, and Clayton counties on topics such as heart health, nutrition, urology, orthopedics, oncology, gynecology, and overall wellness. The hospital sponsored transportation services for Fayette Senior Services with annual contributions of $5,000 and maintained leadership roles within the organization to ensure seniors could access vital care and programming.

Together, these efforts reflected Piedmont Fayette's sustained investment in improving access to care, supporting the healthcare workforce pipeline, and fostering a healthier, more resilient community for all.

Piedmont Fayette's Cancer Wellness program extended its reach by collaborating with nonprofits, faith-based organizations, and other local partners to support patients and caregivers—regardless of where they received clinical care. The program offered a holistic range of services that improved physical and emotional well-being, including nutrition counseling, cooking demonstrations, strength coaching, mindfulness sessions, exercise, and creative therapies such as music and art. Patients and families also received financial counseling, psychosocial support, and education on symptom management and lifestyle changes that promoted healing, recovery, and long-term survivorship. Outcomes and impacts were documented in the 2023 Donor Outcomes Report and the FY24 Fayette Cancer Wellness Programming Encounters.

To reduce cultural and socioeconomic barriers to prevention and early detection, the hospital coordinated closely with community partners to improve access to screening and education for low- and no-income residents and for minority populations at higher risk. Staff evaluated programs, addressed cultural barriers, and tailored messaging to resonate with diverse audiences. In FY23 and FY24, the hospital hosted 28 cancer-awareness education sessions that included mammogram screening appointments reserved for employees of CIGNA employer partners. It participated in a Hispanic health fair that offered Spanish-language materials on heart health, diabetes, and cancer screening; translators assisted more than 100 community members with physician connections and referrals. The hospital also supported nine health fairs across South Fulton County, providing education to more than 850 at-risk residents.

In FY24, Piedmont Fayette again delivered 28 cancer-awareness sessions, including screening appointments for 25 employees of a CIGNA-insured employer, with one follow-up scan completed. Three gynecologic cancer Lunch and Learn sessions produced a 93% increase in participant knowledge. The hospital also provided lung cancer education for low-wage government employees and offered verbal screening to determine eligibility for low-dose CT scans. Three individuals were screened, and while none met the criteria, all left with actionable prevention information. Through these efforts, the hospital strengthened its role as a trusted partner—bridging gaps in access, promoting early intervention, and empowering individuals and families to take charge of their health.

Piedmont Fayette upheld its Primary Stroke Center designation and kept community members informed about heart and stroke risks while delivering timely, evidence-based care. The hospital distributed educational materials, offered free blood-pressure screenings at community events, and provided ongoing stroke education for EMS personnel, paramedics, nursing students, and residents. Over three years, it hosted 30 community education sessions on recognizing stroke symptoms, which resulted in a 97% increase in public knowledge and awareness. Stroke-arrival data showed gradual improvement: EMS transport rose from 41% in FY23 to 49% in FY24 and held at 48% in FY25, indicating more residents recognized urgent symptoms and sought professional help promptly.

To broaden prevention, the hospital developed public-service announcements for at-risk populations and shared bilingual, evidence-based materials across its website, social media, and community events. More than 45 heart-health fairs and education events were supported in partnership with organizations throughout Fayette, South Fulton, Spalding, and Clayton counties, reaching over 750 community members. Spanish-language materials produced through the Close the Gap grant helped reduce cultural barriers and reach Hispanic and Latino residents.

Piedmont Fayette also strengthened lifesaving skills through Early Heart Attack Care and hands-only CPR programs. Guided by community-needs assessment data, it offered free CPR training to nonprofits, civic groups, and the public; provided Baby CPR classes for new and expectant parents; and taught CPR skills to high-school students attending Nurse Camp. Women's heart health remained a priority, particularly for

uninsured women and women of color. In partnership with the Women's Heart Support Network, the hospital hosted education, coaching, and practical workshops—such as cooking demonstrations and farmers-market tours—and delivered eight dedicated sessions in recent years. Spanish-language heart-health materials were distributed widely, and partnerships with local clinics and faith communities expanded reach. Quarterly cardiovascular-disease screenings continued for at-risk populations, and the $99 Women's Heart Screening remained a cornerstone of prevention.

Piedmont Fayette addressed isolation and loneliness among seniors through strong partnerships and targeted programs. The hospital worked with Fayette Senior Services to enhance wellness checks for homebound seniors through Meals on Wheels. At the same time, employee volunteer participation paused in October 2023, and financial support continued to sustain operations. Annual contributions of $5,000 to the Fayette Senior Services Transportation Program helped older adults travel to medical appointments and hospital visits. Through Sixty Plus Services, the hospital supported a monthly Dementia Support Group that served more than 150 patients and caregivers each year. It also partnered with the Real Life Center, contributing $2,500 annually to sustain a congregate-meal program that reduced isolation and strengthened community connections.

The Case Management team identified seniors' needs at discharge and referred them to community resources, including senior centers, meal programs, transportation, and faith-based organizations. The Empowering You program equipped clinical staff with tools and training to make timely referrals, ensuring comprehensive care extended beyond the hospital. Piedmont sponsored the Piedmont Wellness Series, offering five to ten sessions each year on topics like heart health, nutrition, exercise, and fall prevention. It expanded reach through partnerships with senior-service agencies across the region and with multiple senior-living communities.

Piedmont Fayette encouraged healthy living through engagement and wellness initiatives that made physical activity accessible and enjoyable. The Walk with a Doc program offered monthly 2.5-mile walks that paired exercise with informal conversations with healthcare providers. The series ran for six months in FY23 and three months in 2024, drawing more than 150 unique participants. Although it did not operate in 2025, it remained a valued component of community wellness programming. Across education and outreach, the hospital emphasized modifiable risk factors—physical activity, nutrition, and stress management—and worked with community partners to extend these messages to diverse populations. To support patients managing chronic illness or recovering from treatment, Piedmont referred individuals to MyFitRx and EVOLVE through Cancer Wellness and Piedmont Wellness. Enrollment in MyFitRx grew from 567 participants in 2023 to 637 by 2024, reflecting the community's enthusiasm for medically supported fitness.

Piedmont Fayette supported individuals living with diabetes through education, counseling, and partnerships that promoted disease management and prevention. Educational sessions covered glucose control, medication use, physical activity, complication prevention, and coping strategies. Nutrition education emphasized balanced choices and weight management, and specialized instruction supported patients managing diabetes in pregnancy. Across FY23 and FY24, the hospital hosted 16 diabetes and nutrition education

events; support groups met six times in 2023 and once in 2024 before pausing, and daily one-on-one counseling continued despite high no-show rates. As part of a systemwide restructuring, the diabetes-education service line at Piedmont Fayette was discontinued inFU25. Even so, the hospital sustained prevention and education by partnering with the Fayette C.A.R.E. Clinic and the Healing Bridge Clinic, providing financial support and resources that expanded diabetes education and screening opportunities for patients most in need.

Taken together, these initiatives showed how Piedmont Fayette consistently invested in access, prevention, education, and partnership—strengthening care for vulnerable residents, developing future clinicians, and advancing the health and resilience of the community.

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

Piedmont