Community Health Needs Assessment and Implementation Plan

As a nonprofit hospital, Piedmont Fayette Hospital belongs to the communities and patients we serve. Our mission is healthcare marked by compassion and sustainable excellence in a progressive environment, guided by physicians, delivered by exceptional professionals, and inspired by the communities we serve. This mission is evidenced within our community benefit programs, which were created to provide quality and meaningful access to health care services to all members of our community. During Fiscal Year 2013, Piedmont Fayette Hospital conducted a community health needs assessment (CHNA) for the residents of Fayette County, Georgia, as to better understand the health and related challenges county residents face.

A CHNA is both the activity and product of identifying and prioritizing a community’s health needs, and this is accomplished through input from community stakeholders and an analysis of relevant data. Once that information was gathered, the hospital then identified the top priorities it will address over the next three years. In partnership with the community, the hospital crafted strategies to address those prioritized needs, with an end goal of bettering community health, and particularly that of those most vulnerable. Through these programs and strong partnerships between consumers, neighborhood leaders, advocates and hospitals, the hospital’s community can become stronger and healthier, both physically and fiscally. The CHNA guides this work.

About the hospital
Piedmont Fayette Hospital is a full-service facility with 172 beds, and is among the most highly-ranked and awarded hospitals in the Southeast. Located on Highway 54 in Fayetteville, the hospital was opened in 1997 as Fayette Community Hospital and became Piedmont Fayette Hospital in November 2004.

Overall approach to community benefits
Community benefits are those programs and activities offered to the community in exchange for a nonprofit hospital’s tax-exempt status, and Piedmont Fayette Hospital is a 501(c)(3) nonprofit organization. These programs should boost the health of the community the hospital serves, especially that of its more vulnerable populations. Per federal law, community benefit programs must do at least one of the following:

- Generate a low or negative margin;
- Respond to the needs of vulnerable populations;
- Supply services or programs that would likely be discontinued if the decision to offer this program was made on a purely financial basis;
- Respond to an identified public health need; and/or,
- Involve education or research that improves overall community health.

The goal of Piedmont’s community benefit programs is to improve the health status of its communities by identifying and responding to unmet community health needs, facilitating relationships to create stronger communities and serving as an example and a leader to others in community benefits. In Fiscal Year 2012, Piedmont Fayette Hospital provided:

- Approximately $4.4 million in financial assistance at cost for low-income uninsured patients
- $4.7 million in shortfalls from treating Medicaid patients
- $524,814 in community health improvement services and community benefit oversight
- $533,555 in educating future health professionals
- $74,556 in subsidized health services
• $1.15 million in cash and in-kind contributions to nonprofit community groups

Additionally, in 2012, Piedmont Healthcare formed the Georgia Center for Healthier Communities, a non-partisan research, advocacy and educational organization committed to building a healthier Georgia through community building, the promotion of pro-community policy and the formation of strategic partnerships. Though policy and advocacy, the organization will address key public health issues, such as access to care, obesity and mental health. These activities will be done in tandem with and in support of Piedmont Fayette’s community benefit activities laid out in this assessment and implementation plan.

Piedmont Fayette’s community

In 2010, approximately 106,000 people lived in Fayette County, which has been dubbed the second healthiest county in Georgia in 2013. The county seat is Fayetteville, where the majority of county residents live. The community is growing; between 2000 and 2010, the population increased by nearly 17 percent.

Demographics

Fayette is comprised of a population that was approximately 73 percent Caucasian, 19 percent African American, and 8 percent Hispanics, Asians, and other minorities, in 2010. The county skewed slightly female in 2010, with women comprising about 52 percent of the county and men at about 48 percent, according to the 2010 US Census. Children aged 5 to 17 made up a large chunk of the county’s demographic, with a reported 23,239 children living in Fayette County in 2010, comprising about 22 percent of the total population. Adults 45 to 54 comprised the second largest group, at 19,374 that year, or about 19 percent of the population. Nearly 12 percent of the population was elderly.

An estimated 3.65 percent – or about 4,000 people – were identified as “linguistically isolated” in the 2010 US Census. Linguistically isolated refers to those aged 5 and older who speak a language other than English at home and do not speak English well, if at all. This percentage is relevant as the inability to speak English well creates formidable barriers to healthcare access, provider communications and health education. In Fayette County, these populations are primarily Hispanic/Latino (about 41 percent of the total). Spanish, Vietnamese and Chinese are the top requested languages for translation and interpretation services at the hospital, according to hospital officials.

Unemployment in Fayette was approximately 8.1 percent in December 2012, which is lower than the state unemployment rate, and close to the national unemployment rate of 8.3 percent during that same time. Of those employed, approximately 79 percent worked for a private firm, 16 percent worked for the government and the remaining were self-employed. Nearly 94 percent of county residents had graduated high school in 2010, and about 6.5 percent of adult residents were reported illiterate that year, according to the US Census.

Median household income is $82,216 per family, a significantly higher amount than the state average of $49,347. That said, one in five children qualify for free or reduced price lunch due to their family’s income, about 6 percent of all children live in poverty. The majority of these children are female (about 60 percent) and Caucasian (also at about 60 percent). Sixteen percent of the county’s households live at or below 200 percent of the Federal Poverty Line, and a fourth of those lived below the poverty line. For context, in 2013, the Federal Poverty Line means that a family of four would have a total income no more than $23,550. For a family of six, the income limit would be $31,590.

Key health findings

About 10 percent of non-elderly adults in Fayette County are currently uninsured. About 7.5 percent of county residents receive Medicaid, which is federal health insurance for some low-income Georgians. In Fayette County, as in Georgia, the majority of Medicaid recipients are children, as eligibility requirements are different and children qualify more easily for the program than their adult counterparts. Of the privately insured, approximately 31 percent is likely underinsured, which is when a person spends at least 10 percent
or more of their annual income on health care, including co-pays, deductibles and prescriptions.

Approximately 7 percent of the overall adult population has reported they were unable to see a doctor in 2011 due to cost. In 2013, an estimated 9 percent are in poor or fair health, a figure lower than the national benchmark of 10 percent reporting that low level of health. About 14 percent of the adult population is in poor dental health and about 17 percent of the population had not been to the dentist in the last year, when surveyed, according to the Centers for Disease Control and Prevention's 2006 to 2010 Behavioral Risk Factor Surveillance System. More than 8 percent of the total noninstitutionalized population lived with a disability in 2012, according to the US Census.

In Fayette County, the leading causes of death between 2008 and 2011 in a five-year aggregate were:

**Leading causes of age-adjusted death**

1. Ischemic heart and vascular disease
2. Cancer
3. Cerebrovascular disease
4. All other mental and behavioral disorders
5. Alzheimer’s disease

**Leading causes of premature death**

1. Ischemic heart and vascular disease
2. Motor vehicle crashes
3. Suicide
4. Cancer of the trachea, bronchus, and lung
5. Accidental poisoning

For every 100,000 people, there were about 4,384 years of potential life lost, or YPLL, which is a statistic that measures premature death and is calculated by subtracting the age of death from the 75 year benchmark. This is a relevant indicator, as it can provide a unique and comprehensive look at overall health status.

Cancer, heart disease and stroke are among the top killers in the community, as evidenced in both age-adjusted and premature death rates. Annually, about 149 Fayette County residents die from cancer, with males more often dying because of the disease than women, according to the National Cancer Institute. Annually, an average 141 women are newly diagnosed with breast cancer, and an average 202 men are diagnosed with prostate cancer. Both figures are high above both the state and national averages. About 38 Fayette County residents are diagnosed annually with either rectal or colon cancer, and an average 55 residents will be diagnosed with lung cancer. Both are statistically better than state and national averages.

Each year, heart disease claims the lives of about 74 Fayette County residents, and men are far more likely than their female counterparts to succumb to heart disease. An estimated 2.5 percent of the population -- about 2,000 people -- currently lives with heart disease, according to the American Heart Association. Fayette County’s stroke mortality rate is also high, annually averaging about 37 deaths each year, according to the National Center for Health Statistics’ Underlying Causes of Death report for 2006 through 2010.

About 10 percent of the county’s adults are living with diabetes in 2013, according to the University of Wisconsin’s County Health Rankings. Of those living with diabetes, men are more affected by women in Fayette, and nearly 11 percent of all men currently have a diabetes diagnosis. In aggregate between 2008 and 2011, diabetes was the 13th leading cause of a hospital discharge.

**Unhealthy behaviors**

Of the top five causes of Fayette County deaths identified, all are conditions commonly associated with unhealthy lifestyles such as the use of tobacco, high fat diets and a lack of exercise. For example, 15 percent of the county’s adult population reports that tobacco use, a figure slightly lower than the state average of 19 percent and higher than the national average of 14 percent. The motor vehicle crash rate is the same as the state average at 17 percent. Approximately 18 percent of the county reports heavy and/or binge drinking, according to the University of Wisconsin’s County Health Rankings.
One in five adults are notably physically inactive, and nearly 24 percent of adults are obese (with a Body Mass Index of more than 30) and 37 percent are overweight (with a Body Mass Index between 25 and 30). Access to healthy foods is not a major obstacle for the majority of the population; only about 6 percent of the population does not live within close proximity of a grocery store that sells fresh fruit and vegetables. Data shows that contributors to the obesity and inactivity rates could be influenced by the fact that four in ten restaurants in the area serve fast food, and a marked lack of recreation facility access in the area, only seven facilities per 100,000 residents.

Teen birth
The teen birth rate in Fayette County is extremely low at 15 births per 1,000 teenaged women, as compared to a state average of 54 births per 1,000 and still significantly lower than the national average of 21 births per 1,000 women. The majority of the births are to Hispanic/Latino teens, who are more than twice as likely than their other ethnic and racial counterparts to become pregnant in their teens. Generally speaking, pregnant teens have a higher risk of having high blood pressure – called pregnancy-induced hypertension – than pregnant women in their 20s or 30s. They also have a higher risk of preeclampsia, a dangerous medical condition that combines high blood pressure with excess protein in the urine, swelling of a mother’s hands and face, and organ damage. Teens are also at higher risk of having low birthweight babies.

Additionally, there is a strong connection between teen birth and low incomes, and generational poverty can play heavily into that. For example, females born to a teen mother are a third more likely to become a teen mother themselves, according to national statistics. Other socioeconomic issues exist as well. Sons born to teen mothers are 2.7 times more likely to be incarcerated than sons born to women at least 20 years of age. Children born to unmarried teen mothers are ten times more likely to live in poverty the majority of their life. Children of teen parents are about 50 percent more likely to repeat a grade and are less likely than children born to adult parents to graduate high school.

Mental health
Throughout 2013, Fayette County adults will have a reported 2.6 poor mental health days each month, according to the University of Wisconsin’s County Health Rankings. This figure is lower than the state average of 3.4 average days each month. Over the last five years, mental and behavioral disorders were the sixth leading cause of emergency department visits, in aggregate, and this does not include the ramifications of violent outbursts, such as assault. In 2010, about 581 mental health related visits were made to the hospital’s emergency department, a figure that has steadily grown over the last few years. About a fourth of those came from self-pay patients, who are often uninsured.

Instances of mental health issues are generally most prevalent in low-income communities, as the link between poverty and mental illness is significant. According to a March 2011 article in the Archives of Psychiatry, the affect of poverty on mental illness – and vice versa – is repeatedly demonstrated. For example, persons dropping from a higher income level to poverty will often face mental illness in the form of anxiety, depression and mood disorders. Conversely, those living in poverty for an extended period of time may suffer from mental illness for other reasons. Their depression and mood disorders may stem from a lack of optimism for the future. Additionally, those in poverty often do not have access to, or knowledge about, medical help and therapy that would help diagnose and treat their mental illness. Lack of nutrition, lack of education and a feeling of living day to day can contribute to mental instability.

Identification of unmet community health needs
Several key community health needs emerged during the assessment process. The initial list of priorities to be addressed was determined by the community benefits department and the strategic planning department. The following criteria were used to establish the initial list of priorities:
The number of persons affected;
The seriousness of the issue;
Whether the health need particularly affected persons living in poverty or reflected health disparities; and,
Availability of community and/or hospital resources to address the need.

Through this process, the following four priority community health issues were identified:

1. Increased access to necessary and appropriate care for uninsured and underinsured patients
2. Reduced preventable readmissions and emergency department re-encounters
3. Reduced instances of preventable heart disease
4. Reduced rates of obesity and obesity-related diseases, including diabetes

Piedmont Fayette aims to address these priorities as follows:

**Increased access to necessary and appropriate care for uninsured and underinsured patients**
Piedmont Fayette Hospital is committed to helping low-income community members access necessary and appropriate care in the right setting. Over the next three years, we will do this through a multi-faceted approach:

- Develop an emergency department care coordination program targeting preventable encounters, including those led by underlying mental health issues and ambulatory care sensitive conditions, in partnership with the Fayette Care Clinic and the Healing Bridge Clinic
- Provide support for an expansion of Fayette Care Clinic's capacity through the provision of Community Connect electronic medical records, and continue providing laboratory services at no cost to clinic patients
- Develop community-based partnerships to better address underlying mental health needs of our patients and the overall community
- Create a resource guide of mental health resources along with information to help community members self-identify potential mental health issues, such as depression and substance abuse
- Work to eliminate certain socioeconomic barriers to accessing appropriate care, including transportation, through the strengthening of current community-based partnerships
- Continue to provide financial assistance to qualifying low-income, uninsured patients
- Translate relevant materials, including information about financial assistance, into appropriate languages

**Reduced preventable readmissions and emergency department re-encounters**
Piedmont Fayette Hospital is committed to reducing preventable readmissions and emergency department re-encounters, as to ensure community members have the necessary tools and education to better self-manage their health and to stay out of the hospital unnecessarily. Over the next three years, we will do this through a multi-faceted approach:

- Utilize the emergency department care coordination program to help curb preventable emergency department reencounters, particularly around ambulatory-care sensitive conditions
- Develop a patient care self-management program that focuses on three primary areas:
  - Emergency department and admission discharge planning, including special consideration for those with limited health literacy
  - Medication management, including the connection of patients to appropriate prescription assistance programs and the provisions of relevant durable medical equipment, such as glucose monitors
• Post-emergency department or admission follow-up to ensure continued good health
• Create a gatekeeper program, which will allow the hospital to provide health-specific information to those who come in contact with members of more vulnerable communities, including volunteers delivering meals to elderly populations
• Translate relevant educational materials into appropriate languages

Reduced incidences of preventable heart disease
Piedmont Fayette Hospital is committed to helping community members achieve and maintain a healthy weight. Over the next three years, we will do this through a multi-faceted approach:

• Create and regularly convene the Healthy Fayette program as to foster independent, healthy lifestyles in families that live in high risk areas of Fayette County. The hospital will act as lead convener of a group of relevant community groups. The program is composed of four components: assessment, nutrition, exercise and monitoring. Our primary focus will be on the cultivation of community gardens to achieve relevant end goals.
• Create and execute relevant public service announcements and health education aimed at the general population
• Provide in-hospital education efforts targeted at high-risk populations
• Continue community-based health screenings aimed at identifying at-risk and diagnosable heart disease and stroke risk factors with appropriate follow-up care
• Translate relevant educational materials into appropriate languages

Reduced rates of obesity and obesity-related diseases
Piedmont Fayette is committed to helping community members achieve and maintain a healthy weight, and to avoid obesity-related diseases, including diabetes. Over the next three years, we’ll do this through a multi-faceted approach.

• Utilization of the Healthy Fayette program to combat obesity and identify at-risk community members either living with diabetes or at risk of developing diabetes
• Create and execute relevant public service announcements and health education aimed at the general population
• Provide in-hospital education efforts targeted at high-risk populations
• Continue community-based health screenings targeting those at-risk for diabetes, and all those screened will receive appropriate follow-up care and relevant health education
• Translate relevant educational materials into appropriate languages

Next steps for priorities
For each of the priority areas listed above, Piedmont Fayette Hospital will work with community partners to:

• Build a community-based coalition to help execute activities
• Identify any related activities being conducted by others in the community that could be built upon
• Align relevant budgets with implementation plan end goals, and seek grant funding, when possible
• Develop measurable goals and objectives so that the effectiveness of their efforts can be measured
• Sync work with system initiatives, as to ensure consistent messaging and to utilize system resources
• Build support for the initiatives within the community and among other health care providers
• Develop detailed work plans

Additionally, we will continue to support our core community benefit programs, including the provision of financial assistance for low-income, uninsured patients; breast cancer screenings and education; health professions education, including nursing students and physicians; health and safety education conducted
in community settings; the Sixty Plus program; the Cancer Wellness program; referrals to community services; workforce development; lactation counseling; smoking cessation classes and assistance; community-based health education programs and health screenings; and, prescription assistance.

Implementation, oversight and execution
Piedmont Fayette Hospital has initiated the development of implementation strategies for each health priority identified by the community health needs assessment conducted in Fiscal Year 2013. This implementation plan will be executed over the next three fiscal years, and will contain measures to monitor and evaluate program effects in order to ensure that our programs are making a difference in our community.

Additionally, a community benefit oversight committee (CBOC) will be formed to guide and champion this community benefit work. This committee will be comprised of key community stakeholders from Piedmont Healthcare’s five primary communities, and will include representatives from the Fayette community. This committee will convene quarterly, though members will be kept updated of relevant community benefit-related work throughout the year. We will also form a task force specific to Piedmont Fayette Hospital to help execute activities. This task force will convene monthly.

How the assessment was conducted
The CHNA was led by the Piedmont Healthcare community benefits team, in partnership with Piedmont Fayette staff. The internal team was assisted by the Hayslett Group (for data collection) and Community Health Advisors (for stakeholder interviews). The assessment began with a review of publicly available health and socioeconomic data. Our primary sources were: US Census, US Health and Human Services’ Community Health Status Indicators, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). We then interviewed a variety of stakeholders, including elected officials, public safety officials, public health representatives, representatives from social service agencies and other community leaders. In August 2012, we conducted a focus group of low-income and uninsured patients who were receiving care at the Fayette CARE Clinic. From these patients, we were able to gain a greater perspective of the challenges accessing care in Fayette County without insurance.

Throughout the CHNA process, the Piedmont Fayette Hospital board of directors and executive leadership has been actively informed, and executive leadership played a significant role in community meetings. Community members were continually engaged and, in January 2013, Piedmont Fayette held a meeting where community stakeholders were invited to brainstorm ideas on how to address the identified priorities. Topics discussed in the meeting included elements of access to care including, transportation and mental care, obesity and heart disease. For each topic, community stakeholders shared their personal experiences and suggested program ideas and partnerships that could help to address that topic in the community.

In February 2013, Piedmont Fayette held a public meeting at the Fayette Chamber of Commerce in Fayetteville for community members to convene and discuss community health topics. The meeting was an open discussion around addressing the identified priorities in the community. Topics discussed in the meeting included issues around obesity and access to health services. Some common themes emerged from the community benefits town hall discussion, including the need for community-based partnerships as to share resources and the need for the creation of health education programs for children and for seniors. Community members indicated a great interest in community gardens and cooking classes. The group also wanted to utilize technology to share health messages with the community. This conversation was used to develop programs for the community’s implementation plan.

Approval
The Piedmont Fayette Hospital Board of Directors approved this community health needs assessment and implementation plan through a unanimous board vote on May 08, 2013.