Community Health Needs Assessment
Fiscal Year 2019

Piedmont MOUNTAINSIDE

Overview

As a designated nonprofit hospital, Piedmont Mountainside is required by the Internal Revenue System to provide to conduct a triennial community health needs assessment (CHNA), in accordance with regulations put for by the IRS following the 2010 Patient Protection and Affordable Care Act (ACA). In its simplest definition, a CHNA is a measurement of the relative health or well-being of a given community. It's both the activity and the end-product of identifying and prioritizing unmet community health needs, which is accomplished by gathering and analyzing data, soliciting the feedback of the community and key stakeholders and evaluating our previous work and future opportunities. Through this assessment, we hope to better understand local health challenges, identify health trends in our community, identify gaps in the current health delivery system and craft a plan to address those gaps and the identified health needs.

Key findings

- Rates of premature death have declined overall during the last 15 years, though they still remain higher than the state average.
- Pickens County has an incredibly high rate of food deserts, meaning many residents have limited access to healthy foods.
- The community has seen a marked improvement in overall community health over the last three years since our last CHNA.
- Pickens significantly increased access to care by opening a freestanding ED in nearby Gilmer County.
- The uninsured rate in Pickens County is high at 12 percent, which creates significant affordability issues.
- Heart disease still remains the community's biggest threat.
- Lung cancer is also a big killer in the community, with incidences rising annually.
- Rates of diabetes incidences have also continued to rise over the last ten years.
- Social determinants of health continue to be a significant issue in the community, and have a strong impact on community health.

2020, 2021 and 2022 health priorities

A key component of the CHNA is to identify the top health priorities we'll address over fiscal years 2020, 2021 and 2022. These priorities will guide our community benefit work. They are, in no order:

- Increase access to appropriate and affordable health and mental care for all community members
- Reduce opioid, substance and nicotine abuse and overdose deaths

With each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators. You can find more detail on how priorities were chosen, our overall process and our data sources beginning on page 14. You can find our implementation strategy beginning on page 16.

Community snapshot

OUR COMMUNITY

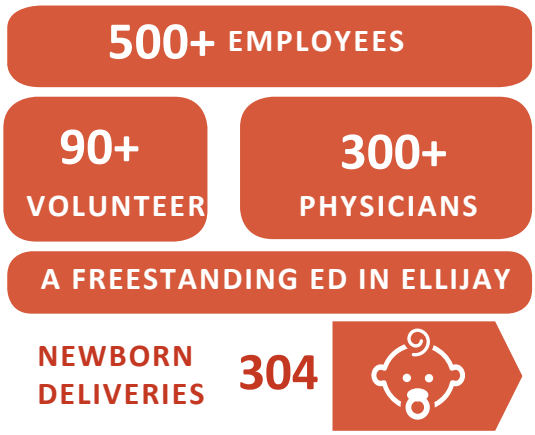
While we served patients from many parts of north Georgia, for the purposes of this CHNA, we only examined the hospital's home county of Pickens County.

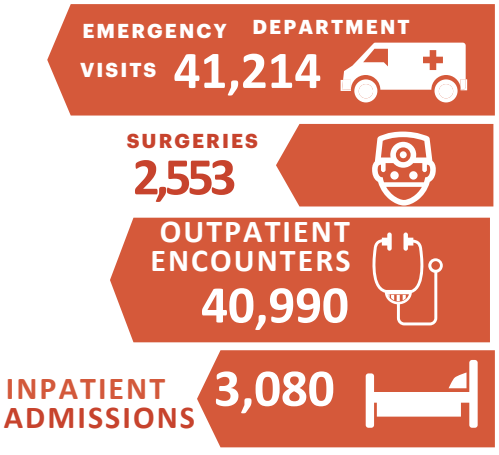
- In 2017, approximately 30,343 people lived in Pickens County and 73 percent, lived in a rural community.
- The county is overwhelmingly white -- about 96 percent, of the population self-reported as Caucasian in 2017.
- In 2017, the median household income was $61,542, higher than both state and national averages.
- That year, the median age of people living within the county was 45. A fifth of the population were 18 or younger, 21 percent, were over the age of 65 and the rest were in between. The population skewed slightly female.
- In 2017, the top industries for employed residents were, in order: retail, manufacturing, health care and social assistance, construction and professional services.
- For the 2015-2016 school year, the graduation rate was 94 percent,, much higher than the state average of 82 percent,. That said, about 16 percent, of the county's adult population does not have a high school diploma.
- There were 2,695 veterans living in Pickens County in 2017. Most served in Vietnam. About a third of all veterans are disabled, and about 10 percent, live below the poverty level.

Key hospital stats

Piedmont Mountainside Hospital is a private, not-for-profit, 52-bed, acute-care, community hospital located in Jasper, Georgia. Piedmont Mountainside is the sole hospital provider for Pickens County and provides a range of services from cardiac rehabilitation and imaging to orthopedic services and cardiac catheterization. Mountainside offers intensive care, 15-bed 24-hour emergency services.

In FY18, Piedmont Mountainside also opened its free-standing emergency department, located in nearby Ellijay, Georgia, which is an extension of the hospital ED by providing 24-hour access to emergency physicians, nurses, labs and radiology technicians.





Community rankings

In 2018 and in comparison with the other 159 Georgia counties, Pickens County ranks:

- **16th for health outcomes,** which includes indicators for mortality and morbidity for all its community members.
- **45th in length of life**, with an estimated 8,030 years of life lost by all community members due to health factors.
- **6th for quality of life**, with indicators for poor or fair health, poor physical health days, poor mental health days and low birth weight rates better than state averages.
- **13th for healthy behaviors**, with relatively average rates of smoking, obesity, physical inactivity, excessive drinking, motor vehicle crashes and teen births, and very low rates of sexually transmitted diseases.
- **27th for clinical care**, with average uninsured rates, diabetes monitoring and mammography screenings, but better than average rates of preventable hospital stays.
- **17th for social and economic factors**, with better than average rates of high school graduation, violent crime, children in single-parent households, unemployment and children living in poverty.
- **30th for physical environment**, with rates on par with the state for housing problems and commutes.

Overall, Pickens County ranks in the top percentile in all categories, showing a marked improvement in health-related indicators since our last CHNA in 2016.

Mortality

In Pickens County, like with the rest of Georgia, heart disease is the number one cause of both age-adjusted and premature death, and this holds true for all races. Age-adjusted allows communities with different age structures to be compared. Premature death is when death happens before the average age for a given community.

Ranking	Age-adjusted death rate, in aggregate, 2013 to 2017
1	Ischemic heart and vascular disease
2	Lung, trachea and/or bronchus cancer
3	All COPD except asthma
4	Mental and behavioral disorders
5	Cerebrovascular disease
6	Alzheimer's Disease
7	Primary hypertension and hypertensive renal and heart disease
8	Nephritis, nephrotic syndrome and nephrosis
9	Pneumonia
10	Suicide

Suicide is the second leading cause of premature death for all races, with a staggering 893 deaths by self-harm within a four year year period. Lung cancer was the third leading causes of premature death, accidental poisoning the fourth and motor vehicle crashes the fifth.

Most indicators for premature death are related to unhealthy behaviors and mental health, and indicate a need for further community-based interventions for high-risk community members, including efforts to curb tobacco use and resources for those struggling with depression, anxiety and other mental health issues.

Health factors

Access to care

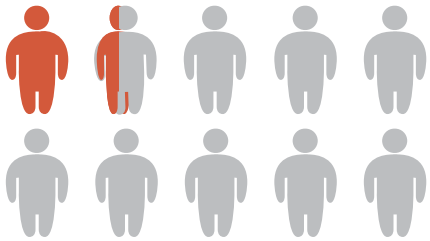
- There were three designated health professional shortage areas in the community in 2016, all of which are located just southeast of Georgia. Shortage areas were: one primary care, one mental health and one dental health.
- However, it is important to note that even if there isn't a shortage, there still can be issues of access to care.
- Throughout Georgia, more than a fifth of all women and a third of all men report having no personal doctor or health home. This was particularly true for minorities, whose rates of not having a doctor are much higher than that of their white counterparts.
- There were only 30 dentists for every 100,000 people in 2915, a figure far below state average and national rates, indicating a strong need for increased access to dental care.

Health status

- Community members have reported an average 3.4 and 3.6 poor or fair physical and mental health days. Poor or fair health days have decreased since our last CHNA in 2016, though poor or fair days have increased
- A total 13 percent, of Pickens County residents reported their health as poor or fair. This is a slight decrease since our last CHNA.
- Statewide, race matters when it comes to poor health status. Approximately 26 percent,of Hispanics reported being in poor health in 2017, as compared to their white and African-American counterparts.

Quality and length of life

- Preventable hospital stays among Medicare enrollees averaged 39.5 preventable hospital events per every 1,000 enrollees in 2015. This figure is better than state and national averages.
- Medicare enrollees tend to receive proper health screenings, with rates above state and national averages.
- 11 percent, of the population lived with at least one disability in 2017, which was lower than the state average of 12 percent,. The highest concentration of disabled populations in the western part of the county.
- The infant mortality rate in Pickens County is far less than state and national averages. During that same time, 7 percent, of all babies born were at a low birth weight, with African American children more likely to be born at a low birth weight than their white, Asian and Hispanic or Latino counterparts.



In Pickens County, **12 percent, of adults were uninsured in 2017**, and minorities comprise 90 percent,.

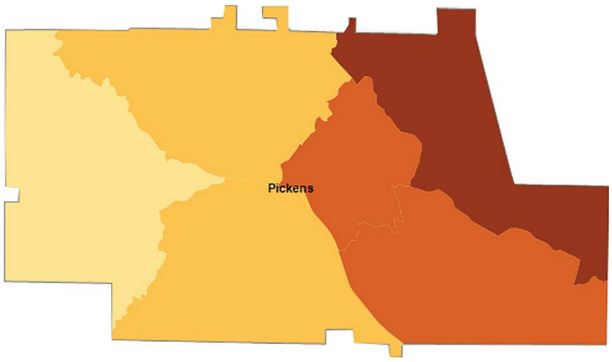
People without insurance coverage have worse access to care than people who are insured. Statewide, one in five uninsured adults in 2017 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

There is only one Federally Qualified Health Center in Pickens County -- the Good Samaritan Health and Wellness Clinic. FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved. There are no charitable clinics in the community.

Access to community-based care is important for all populations, and this is especially true for low income patients, as these populations tend to have additional health issues brought on by social determinants of health, such as food and housing instability, and tend to suffer worse health outcomes.

Heart disease

The number one cause of overall deaths and premature deaths for both men and women each year between 2013 and 2017 in Pickens County is ischemic heart and vascular disease.



To the left is a breakdown of premature deaths related to ischemic heart and vascular disease by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue. This allows us to see exactly where we have the most instances so we can more directly target interventions to this community in the future.

The prevalence of heart disease in the United States is expected to rise 10 percent, between 2010 and 2030. This change in the trajectory of cardiovascular burden is the result not only of an aging population but also of a dramatic rise over the past 25 years in obesity, diabetes and physical inactivity that accompany weight gain. Extensive research from the American Heart Association has also demonstrated a strong correlation between social determinants of health (SDHs) and heart disease. Issues related to SDHs include higher rates of smoking, obesity, lack of physical activity and poor diets, all key contributors to heart disease.

Stroke

Between 2013 and 2017, 74 Pickens County community members died from stroke, making it the fifth leading cause of age-adjusted death. This equals to a death rate of 32 people per every 100,000 people. This is higher than both state and national averages.

Stroke can be caused from several reasons, including a blocked artery, high blood pressure, diabetes, high cholesterol, certain heart conditions, obesity and unhealthy lifestyle choices. While stroke impacts all patients, like with most health measures, the lower income and less educated a person is, the more likely he or she is to experience more severe repercussions, such as death, for several reasons, including limited health literacy, difficulty affording care and necessary prescriptions and unhealthy behaviors.

Diabetes

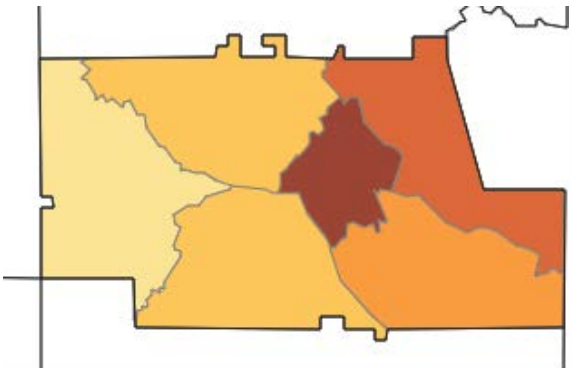
Approximately 12 percent, of adults lived with diabetes in Pickens County in 2015, a figure higher than state and national averages (11 percent, and 9 percent,, respectively). In 2015, 22 percent, of Medicare beneficiaries lived with diabetes. The numbers may be higher for Medicare beneficiaries because that population is more likely to be tested routinely for the disease.

In Georgia, the less educated you are, the more likely you are to have diabetes. In 2017, Georgians who did not graduate high school were more than twice as likely to be diagnosed with the disease than Georgians with a college diploma. The same holds true for lower incomes versus higher incomes. According to the CDC, in 2017, the highest percentage of Georgians with diabetes had not graduated high school and earned less than $25,000.

Cancer

Cancer continues to have a devastating impact in Pickens County. Lung cancer was the 2nd leading cause of age-adjusted death, and 122 people died from the disease between 2013 and 2017.

To the right is a map of lung cancer deaths by census tract between 2013 and 2017. The darker the color, the more deaths that occurred in that area of the county. This helps us focus our efforts on prevention and screening for patients at high-risk for lung cancer. Because lung cancer is so closely tied to behaviors, with tobacco use at the top, programs that support smoking cessation targeted to the southeast part of Pickens County could have a big impact.



There are increasing incidences of colon, rectum and anal cancers, which ranked 13th in age-adjusted deaths between 2013 and 2017. Breast cancer death rates have declined over the last several years, but so has prevention. In 2015, only 56 percent, of Medicare enrollees said they had a mammogram sometime within the previous two years, a figure significantly down from 68 percent, in 2009.

Cancer and health equity

Both nationally and statewide, the gap in the cancer rates widens between racial and socioeconomic groups, particularly in preventable cancers.

For example:

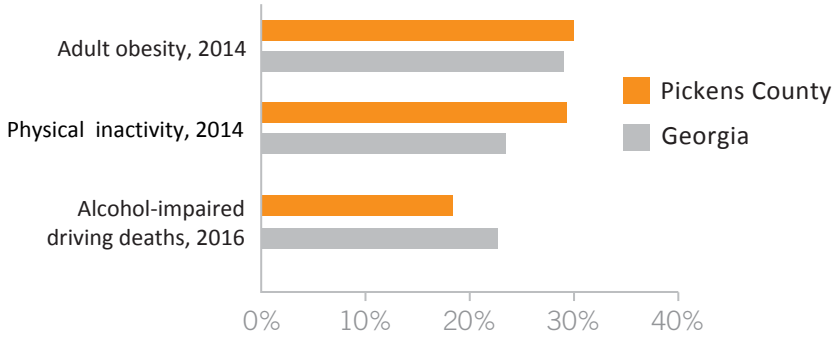
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 percent, higher in poor men compared to affluent men.
- White females in Georgia are 8 percent, more likely than black females to be diagnosed with cancer.
- Black males in Georgia are 8 percent, more likely than white males to be diagnosed with cancer, and black males are 25 percent, more likely than white males to die from cancer.
- Cancer survivors carry greater financial burdens related to medical debt payments and bills vs patients without a cancer history, and younger survivors face the greatest hardships.

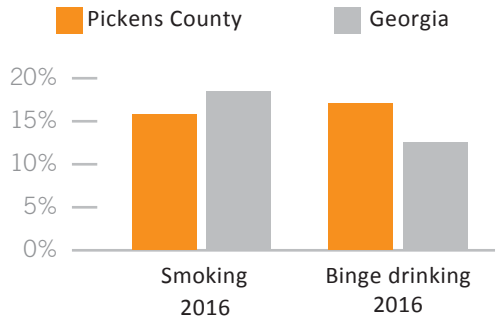
Unhealthy behaviors, such as tobacco use, poor diet, physical inactivity and obesity, continue to heavily contribute to cancer rates and tend to disproportionately impact low-income populations. For example, although overall smoking rates have decline statewide, high rates still persist among lower educated, lower income populations. Also, low income populations tend to have less access to healthy foods.

Additionally, this population is far less likely than the rest of the community to have a primary care physician, receive annual testing and preventative care, including cancer screenings. They are statistically more likely to be diagnosed due to hospitalization or an emergency department visit once the disease has progressed, meaning their condition is generally far more advanced and will require significant intervention. When dealing with cancer, this could translate to a diagnosis at a later stage and a worse prognosis. In other words, it could mean life or death for the patient.

Healthy behaviors

While poor health and chronic conditions are caused by a number of factors, a key contributor is healthy behaviors. All years below are for the latest time frame for which data was available.

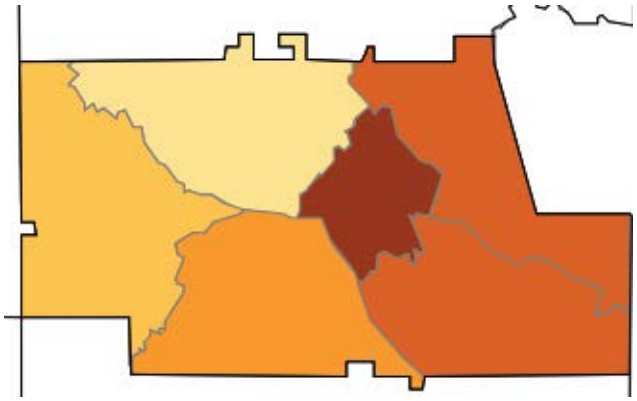




- Chronic obstructive pulmonary disease is the third leading cause of age-adjusted death and is caused almost exclusively from smoking.
- Firearm fatalities are an issue in Pickens County with a rate above the state average and more than twice the national average in 2017.
- Patients presenting at Piedmont Mountainside with diagnoses related to alcohol abuse jumped by 400 percent between FY16 and FY18.

Mental health

- Mental health and behavioral disorders was the fourth leading cause of death for all county residents between 2013 and 2017.
- We see this particularly in premature death. Suicide was the 2nd leading cause of premature deaths for whites between 2013 and 2017. It is most common among males aged 25 to 34 years of age.
- There was only one mental health providers for every 1,468 residents in the county in 2017, a rate significantly lower than the state and national averages of one provider for every 813 and 493 residents, respectively.
- Portions of Pickens County are federally-designated as mental health professions shortage areas, meaning there is a serious lack of resources for mental services.



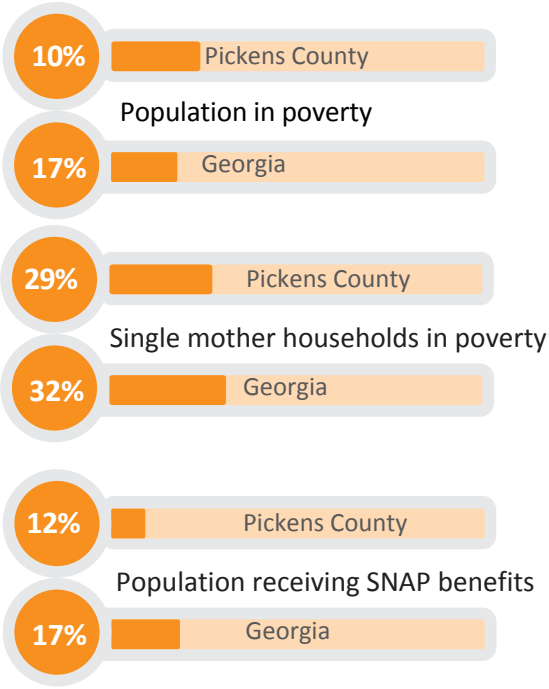
Above is a breakdown of premature deaths related to mental health or behavioral disorders by census tract within the county between 2013 and 2017. The darker the color, the more prevalent the issue.

Opioid Use

- Opioid prescriptions are a significant issue in the Pickens County community, with a total 111.5 opioids prescriptions written per very 100 people in 2017. Please note we aren't able to tell how many prescriptions are going to a single person, just the overall figure, meaning a single person could have several prescriptions.
- This figure is down from 2007, when there were 132.6 retail opioid prescriptions dispensed per every 100 persons.
- Even so, in 2017, Pickens remained nearly twice the national average of 58.7 prescriptions per every 100 people. The Georgia state average was 70.9 prescriptions per every 100 people.

Social determinants of health

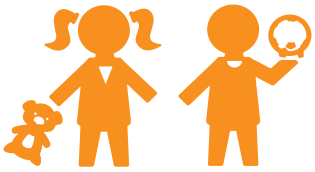
As defined by the World Health Organization, social determinants of health (SDHs) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Included among these is economic stability, housing stability, food security, adequate income to pay for core services such as utilities, literacy, access to healthy food, access to safe recreational spaces, access to health care and access to services in languages the person understands. SDHs often carry negative health impacts, including increased risk of mortality, poor health, and increased cardiovascular disease risks.



- 3 percent, of adults were unemployed in 2017, a figure a percentage point better than state and national averages
- 36 percent, of those living in poverty in the county did not graduate high school in the 2015-2016 school year
- In 2016, 34 percent, of the population had limited access to healthy foods and 15 percent, have no access to healthy foods. These patients live in what's called a food desert, meaning there is no food outlet within a given census area.
- 17 percent, reported having extended periods when they aren't sure how they or their families will eat.
  There were 19 fast food restaurants in Pickens County in 2019, a figure that's much better, per capita, than state and national averages.
- 26 percent, of households had housing costs that exceeded more than 30 percent, of total household income in 2017, indicating a cost burdened household more likely to face overall financial difficulty.

Families and children

- 24 percent, of children lived in single-parent homes in 2017, a statistic often linked to lower graduation rates.
- 53 percent, of children qualified for free or reduced cost lunch in the 2015-2016 school year, a statistic that represents poverty and food instability. This is an increase from our FY16 CHNA, when about 46 percent, of children qualified for free or reduced cost lunch. Pickens County is also high above the 2017 state average of 62 percent,.
- For every 1,000 teen girls aged 15 to 18 in Pickens County, 52 birth gave birth to a child on average each year between 2010 and 2016. Children born to teen are statistically much more likely to experience adverse health and socioeconomic issues as they grow older.

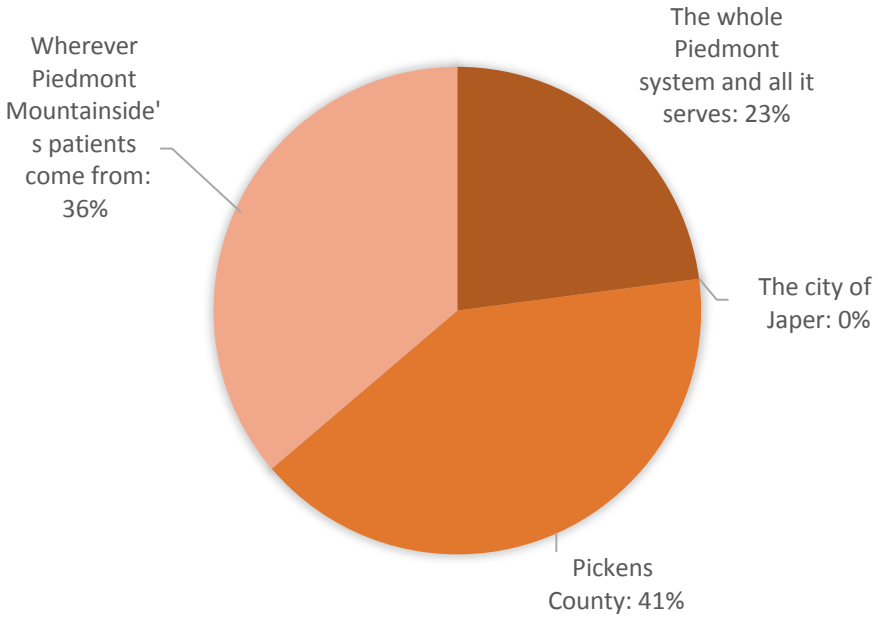


11 percent, of children in Pickens County lived in poverty in 2017, a figure that has steadily gotten worse over the last ten years. Poor children are statistically less likely to graduate high school or complete college. They are nearly twice as likely to become poor adults and. These children are also more likely to experience dental issues, anxiety problems and higher rates of accidental injury.

PMH stakeholder survey

In December 2018 and December 2019, 22 key stakeholders within the Piedmont Mountainside community provided their thoughts on community health, community assets and the role of the hospital in addressing unmet community health needs via a web survey. Below are the results of that survey.

How would you best define Piedmont Mountainside's community?



What do you think are the most pressing health problems in Piedmont Mountainside's community?

Top ten answers for "very important," out of 25 potential interventions:

1. Ability to pay for care
2. Lack of health insurance
3. Cost of health care
4. Mental health
5. Lack of transportation to health care services
6. Cancer
7. Obesity in adults
8. Diabetes
9. Drug abuse prescription medication
10. Prescription medication too expensive

What issues do you think may prevent community members from accessing care?

Top ten answers:

1. Drug abuse - illegal substances
2. Cost of health care
3. Lack of health insurance
4. Ability to pay for care
5. Mental health
6. Drug abuse - prescription medications
7. Obesity in adults
8. Tobacco use/smoking among teenagers
9. Lack of transportation
10. Lack of dental care

PMH stakeholder survey (continued)

How important are the following actions in improving the health of Piedmont Mountainside's communities?

Top 10 answers ranked most important:

1. Free or affordable health screenings
2. Access to health care services
3. Financial assistance for those who qualify
4. Partnerships with local charitable clinics
5. Access to local inpatient behavioral health facilities
6. Access to low-cost mental health services
7. Additional access points to affordable care within the community
8. Affordable healthy food
9. Local outpatient mental health services
10. Substance abuse rehabilitation services

Q What is your vision for a healthy community?

Some answers:

"Access to all healthcare and affordable prescriptions."

"Reduced child neglect and substance abuse"

"Healthy children ready to learn."

"A community that has resources that include a direct linkage to ALL services - a comprehensive coordinated entry system that will connect a client based upon their individual need to needed services at the point of system entry. Housing and affordable medical care are a top priority for a healthy community."

"A place where residents feel safe and have what they need to be healthy."

"Doctors who listen to their patients and work with them rather than feeling that what they say and think are the only options. "

"Educating people where ever they are. Especially in ER , physicians, pharmacy waiting rooms."

"Working together to promote healthy lifestyle choices through diet, exercise, and reducing risky behaviors."

Q What is the single most pressing issue you feel our patients face?

Some answers:

"Lack of insurance for the working class"

"Cost of healthcare"

"Unable to prioritize proactive, healthy living"

"Cost of drugs is too high"

"Lack of resources in regards to safe affordable housing, which has an effect on the client's total well-being"

"Mental health"

"Lack of knowledge of prevention and control methods for chronic disease"

"Unable to prioritize proactive, healthy living"

"Obesity, heart related problems, and not having health insurance"

"Drug usage"

"Financial burden"

"Affordable healthcare and housing"

"Transportation to and from care"

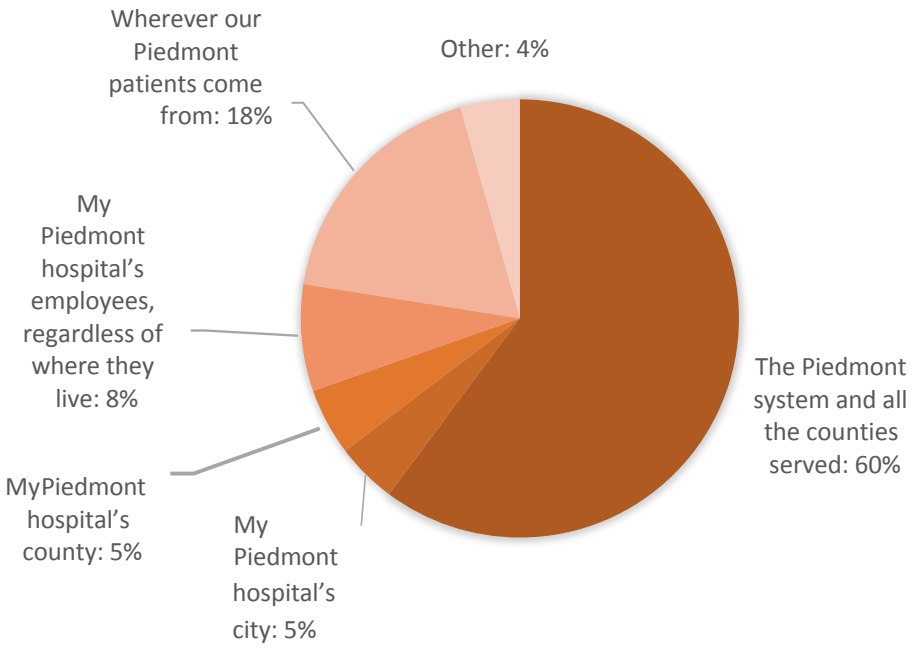
"Healthcare for the needy"

"Resources to stay healthy"

PHC employee survey

Twenty-two Piedmont Mountainside employees completed an internal system-wide staff survey for this assessment. Questions focused on health and access issues our employees felt community members faced and what they felt the hospital could do to address those issues. Below are the results from all who answered the survey throughout the system, which had a total 897 responses.

How would you best define Piedmont's community?



What do you think are the most pressing health problems in Piedmont's community?

Top ten answers:

1. Ability to pay for care
2. Lack of health insurance
3. Cost of health care
4. Mental health
5. Prescription medicine too expensive
6. Lack of transportation to health care services
7. Drug abuse - prescription medications
8. Cancer
9. Obesity in adults
10. Lack of supportive services for patients

What issues do you think may prevent community members from accessing care?

Top ten answers:

1. No insurance and unable to pay for the care
2. Unable to pay co-pays/deductibles
3. Transportation
4. Fear (e.g., not ready to face/discuss health problem)
5. Don't understand the need to see a doctor
6. Unable to use technology to help schedule appointments, find the doctor, etc.
7. Don't know how to find doctors
8. Language barriers
9. Lack of availability of doctors
10. Cultural/religious beliefs

PHC employee survey (continued)

How important are the following actions in improving the health of Piedmont's communities?

Top 20 answers ranked most important:

1. Access to low-cost mental health services
2. Access to local inpatient behavioral health facilities
3. Free or affordable health screenings
4. Local outpatient mental health services
5. Additional access points to affordable care within the community
6. Financial assistance for those who qualify
7. Expanded access to specialty physicians
8. Affordable healthy food
9. Services to help physically or developmentally disabled children and adults
10. Safe places to walk/play
11. Community-based health education
12. Community-based programs for health and wellness
13. Cancer awareness and prevention campaigns
14. Increased social services for patients needing additional attention
15. Opioid awareness and prevention campaigns
16. Transportation for care
17. Substance abuse rehabilitation services
18. Programs and resources to address joblessness, homelessness and other social determinants of health
19. Access to dental care services
20. Partnerships with local charitable clinics

Q What do you think works well in how Piedmont supports the community?

Answers centered on the following themes:

Health education

Financial assistance program

Support for local charitable services and community partnerships

The Cancer Wellness Program Continued growth with beds and services The Walk with a Doc program

Sixty Plus Program

Giving Epic to local clinics

Care coordination services

Breast feeding training for new moms

Q What do you think is missing in how Piedmont works with the community?

Answers centered on the following themes:

More Piedmont-sponsored low-cost clinics

More visible community involvement, especially with minorities

More outreach and free services for preventative care

Increased access to specialty physicians

More attention to mental health

More attention to opioid and substance abuse

Screenings that are free for community members, especially for cancers

A better system for referring patients to the services they need that are outside the hospital

PHC stakeholder interviews

As a part of our process, we interviewed 31 statewide key stakeholders and policy makers that represent public health, low-income populations, minorities, chronic conditions, older adults and lawmakers. These interviews were conducted for people representing the entire region, including Pickens County. Answers carried certain themes. Below is a summary of comments.

Affordability and access

- Health insurance coverage was identified among almost every interviewee as a key pressing health need, and 84 percent of interviewees felt the hospitals could play a larger role in promoting public policies that could expand coverage (such as Medicaid eligibility expansion) or in promoting local activities to encourage enrollment in existing programs. As one interviewee stated: **"Hospitals tend to wait until the patient shows up sick to consider how that patient can afford their care or if he or she can get coverage. If they supported more outreach for getting coverage, the patient would probably have been able to get care before they were so sick they needed hospital care."**
- Some interviewees suggested programs such as expanded scope of service for nurse practitioners and physician assistants could broaden access to affordable care, as well as the expanded use of telehealth. Each interviewee cited the role that Federally Qualified Health Centers (FQHCs) and low-cost clinics currently play in addressing the needs of uninsured patients, and all encouraged further investment in these organizations through the provision of free labs and imagery and shared EMRs.
- Several interviewees noted the need for increased access to follow up and specialty care for all patients. One patient advocate interviewee stated she fielded questions daily from publicly insured patients who didn't understand how their network worked and uninsured patients who were directed to follow up with a specialist but didn't know who would take them.
- Affordability is a barrier, as many private physicians do not provide financial assistance. As one interviewee stated: **"The patient then just decides they can't get to that specialist and, most likely, their condition gets worse and they are back in the emergency department, sicker and needing even more care now."**
- Almost every interviewee noted transportation issues as a key barrier to access, particularly for older adults and those who are disabled.

Local investment and care coordination

- Most interviewees stated a need for stronger hospital intervention and investment in local communities. While most acknowledged the positive role Piedmont hospitals currently play in the community, some were critical of how Piedmont handles patients and programs that don't pay well.
- Several interviewees noted the need for Piedmont hospitals, including Piedmont Mountainside, to better coordinate with surrounding rural communities, including the expansion of primary and specialty care physicians into underserved areas, perhaps through the use of telehealth.

Mental and behavioral health

- Lack of access to behavioral health services also has a huge impact on community health. Key informants recommended training a cross-section of professionals to recognize the role of behavioral health in diagnoses and make appropriate referrals.
- Interviewees also stated a need for hospital investment in substance abuse, addiction and prevention services, including its own approach to issues like opioid prescriptions, due to the health impacts addiction have on patients.

PHC stakeholder interviews (continued)

Social determinants and root causes of poor health

- All interviewees discussed the role of social determinants of health (SDHs) as a critical issue Piedmont is well-positioned to address. As one interviewee stated: **"Piedmont is... in a great position to create programs and referral systems to help address the underlying issues that many patients face. Piedmont could lead all hospitals in this space."**
- Some interviews noted that SDHs are issues that impact everyone, and are a key cost driver due to the role SDHs play in preventing people from staying well.
- Most interviewees felt that the issues facing our community members were not just solely the responsibility of the hospital, but all acknowledged the outsized role hospitals can play in triggering and sustaining long-term positive change, particularly when working in partnerships with others in the community.

CHNA approval

This community health needs assessment was unanimously approved by the Piedmont Mountainside Hospital board of directors on May 17, 2019. The implementation strategy was unanimously approved August 23, 2019.

Methodology

The Piedmont Newton CHNA was led by the Piedmont Healthcare community benefits team, with input and direction from Piedmont Mountainside leadership.

Process

The CHNA started first with a definition of our community. We looked at our entire Piedmont Healthcare service region, which spans the majority of the state. We paid particular attention to the home counties of our hospitals, which is reflected in the individual hospital CHNAs, including this one, due to the impact of our tax-exempt status.

Generally, nonprofit hospitals do not pay four types of taxes: property, state and local income, sales and use, and bond financing. Of these, property taxes make up the largest segment of a hospital's tax exemption – about one-quarter. Because of this, we want to ensure that we are providing equal benefit to our local community. Additionally, we take into consideration patient origin, and especially that of our lower-income patients, such as those who qualify for financial assistance or receive insurance coverage through Medicaid.

Once we established our primary community, we then conducted an analysis of available public health data. This included resources from: US Census, US Health and Human Services' Community Health Status Indicators, US Department of Agriculture, Economic Research Service, National Center for Education Statistics, Kaiser Family Foundation's State Health Facts, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures are for 2017, unless otherwise noted. Health indicators are estimates provided by County Health Rankings and hospital data was provided by the hospital.

Methodology (continued)

An internal survey was also conducted throughout the healthcare system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Nearly 900 employees spanning the system responded. Additionally, we conducted a community-based survey in which local stakeholders were asked their thoughts on unmet community health needs and the hospital's role in addressing those needs. These stakeholders included local leaders, nonprofit representatives, elected officials and those with a unique knowledge of the challenges vulnerable populations face.

Finally, we conducted direct interviews with 31 state and regional stakeholders and policymakers, with each representing a specific group that tends to be adversely impacted by issues of health equity. These groups included but are not limited to: Georgians for a Healthy Future, Georgia Watch, ConsiderHealth, the Community Foundation for Greater Atlanta, the Georgia Charitable Care Network, the Medical Association of Georgia and Healthy Mothers, Healthy Babies.

How we determined our priorities

Several key community health needs emerged during the assessment process. The chosen priorities were recommended by the community benefit department with sign-off from hospital and board leadership. The following criteria were used to establish the 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.

The priorities we chose reflected a collective agreement on what hospital leadership, staff and the community felt was most important and within our ability to positively impact the issue. While the priorities reflect clinical access and certain conditions, all priorities will be viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race.

About community benefit

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. These programs increase access to health care and improve community health, with a focus on vulnerable populations, such as those that are low-income, uninsured, underinsured, those with chronic conditions, the disabled, the elderly and any others who face additional barriers and health inequity. By federal mandate, community benefit programs must:

- 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 CHNA guides Piedmont's community benefit work.

Piedmont Mountainside Hospital
CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022

On August 23, 2019, Piedmont Mountainside's board of directors approved the hospital's community health needs assessment, which measured the relative health and well-being of our community. Through this process, we identified key health priorities we'll address over the next three fiscal years. This below strategy was developed to address those identified priorities.

Priority: Increase access points for appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes			
Vision	**Goal**	**Tactics**	**How to measure**
Low- and no-income patients receive assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	• Financial assistance is available for eligible low- and no-income populations • Patients are adequately alerted that financial assistance is available • Patients are given tools, resources and ample opportunity to apply for assistance • Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals • All potential patients for Medicaid coverage are adequately screened	• Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC and PMH
Local efforts to increase access to care are strengthened and grown	Provide funding to support specific programs of not-for-profit organizations who provide direct physical and/or mental health services to low-income patients	• Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service	• Goals of funded programs are to be determined by the individual organizations and approved by PHC and PMH • Progress evaluated by PHC and PMH every six months

Future health workers are trained	Provide health professions education to students as to further build the health workforce	• Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate	Regularly monitor program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth
Patients and their families have meaningful input in their care	Create a patient and family advisory council to provide meaningful input on key areas of care	• Create a council of approximately 10 to 15 advisors comprised of patients, their families and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers • Convene first meeting setting specific scope and goal of council, which could include internal initiatives to improve patient care and quality	• Yes/no on creation • Other evaluation tactics to be determined by specific goals of council
Patients have an increased awareness of local resources	Provide resource guide of state and local health-related services and other relevant information to vulnerable community members	• Update guide annually • Publish online and in print • Distribute widely throughout hospital and community	Annual distribution number of guides 10% year over year increase for FY20 to FY22 (approximately 3.5K distributed throughout Mountainside community in FY19)
Older adults have increased access to care and community-based resources	Collaborate with community partners in order to provide improved access to, and better coordination among, existing community resources for the aging.	• Develop and explore concept of a principal case worker to coordinate services for elders will be explored. If endorsed, PMH will lead or collaborate in the creation of a business plan as agreed by the collaborators. Additionally, PMH will also explore the capacity of existing programs to meet the needs of vulnerable older adults.	• Specific metrics to be developed with partners and collaborators • Regularly monitor program for efficacy and opportunities to improve
Low-income populations have better access to specialty care	Create a managed care program for low-income patients that utilizes a licensed	• Using Tableau, identify high-risk, low-income patients who have been recently discharged and have a health need that will be ongoing;	

	medical social worker to work with high-risk, low-income income patients who have presented at the ED with a condition that will need ongoing care	• Address issues with patient, including placement in an appropriate care setting • Will be done in partnership with community-based providers and with local FQHC	

Priority: Reduce opioid, nicotine and related substance abuse and overdose deaths			
Vision	**Goal**	**Tactics**	**How to measure**
Hospital-based prescriptions for opioids and related drugs are reduced	Patients are at low risk of misusing opioids	• Track opioid prescribing by hospital and physician • Use Epic EMR to provide caregivers with tools to monitor opioid use • Offer patients ways to safely dispose of unused medication • Provide ongoing education on opioid prescribing	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach
Patients are supported in recovery from their opioid addiction	All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery	• Develop relationships with community resources to which patients can be transitioned • Make these community resources known and available to our caregivers	Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are increased, measured by program participation and qualitative measures

Opioid addiction is viewed as a disease	All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma	• Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction • Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities	Regularly monitor percentage of PHC and PMH employees who report that they view opioid use disorders as a medical condition, free of stigma are increased, measured by qualitative mechanisms
Hospital-based prescriptions for opioids and related drugs are reduced	PHC adopts and uses appropriate non-opioid pain management strategies	• Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont • Offer multi-modal pain module to caregivers to provide options for opioid in treating pain • Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy)	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PMH provides meaningful leadership in its community by partnering with others in combating opioid abuse	• Promote local prescription take-back day activities, in partnership with local law enforcement • Serve as leaders in community-based programs to address opioid abuse and addiction • Support community-based strategies to combat opioid abuse through partnerships and task forces	• Monitor attendance for take-back day with an aim to increase participation year over year • Measure general community awareness of opioid use by charting what resources and partnerships are active now, with a goal to increase those year over year

Local efforts to decrease opioid abuse and overdose deaths are increased	Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients	• Issue of a notice of available funding to all communities soliciting grant applications to curb opioid addiction and overdose deaths • Award annual funding based on merit of application and group's ability to positively impact issue • Monitor grant progress	• Goals of funded programs are to be determined by the individual organizations and approved by PHC • Progress evaluated by PHC every six months
Community members are more familiar with identifying addiction and local resources to help support recovery	Create and widely distribute an opioid-centric Georgia-based resource guide	• Develop an eight- to ten-page guide to address issues of opioid use and prevention • Print and distribute guide throughout Piedmont communities and to patients	Aim for initial communitywide distribution of 1,000 copies, to be increased 15% year over year
Reduce use of e-cigarettes among teens and adults	• Support peer-to-peer social support to teens and young adults • Actively support messaging and efforts of Pickens County Sheriff's Department to address illegal e-vaping among underage teens • Create and deploy a PSA campaign on e-cigarette use among teens and adults, to be distributed and on display throughout the hospital and community, via community partners	Program activities are dependent on scope and community partners	Program goals to be developed with partners

	• Convene a local task force comprised of community stakeholders, the school system, law enforcement and parents to develop effective strategies to reduce e-cigarette use		

Health issues we will not actively address as a top identified priority:

Other key health issues emerged during the FY17 to FY19 implementation strategy that we will not focus on during the next three-year community benefit cycle. These include:

- Transportation: Due to limited resources, we cannot address transportation issues in-house, however we will support community- based transportation efforts, when possible and appropriate, and make sure patients know what resources are available to them. We will also continue to solicit applications to our community benefit grants program from nonprofits that actively address issues of transportation within the Mountainside community.
- Chronic Obstructive Pulmonary Disease: We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition and continue to look for ways to positively impact prevention efforts, including our efforts to curb smoking within the community.
- Alzheimer's disease: Alzheimer's disease continues to be a leading cause of death in the community. Although this is not a stated priority of the hospital during the FY20 to FY22 community benefit cycle, the hospital will actively support services aimed at patients and families suffering from the disease, and particularly those services offered through our Sixty Plus program.