WELLSTAR
Health System

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WELLSTAR Health System

2018 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

Your **Health.** Our **Mission.**

WellStar Spalding Regional Hospital | WellStar Sylvan Grove Hospital

WellStar Spalding Regional Hospital

EIN#: 81-0864789
601 S 8th St.
Griffin, GA 30224

For over a century, the wellness of our community has been our primary focus. WellStar Spalding Regional Hospital supports the medical/health needs of over 110,000 patients annually.

Fully accredited by the Joint Commission on Accreditation, our medical specialties include: Emergency Services, Cardiac Health, Primary Stroke Center, Orthopedic & Joint Health, Women's Services and Oncology. The hospital also operates several specialized outpatient facilities among four counties: Center for Rehabilitation, Center for Sleep Medicine and Center for Wound Healing and Hyperbaric Medicine. We are accredited by the American College of Radiology (ACR) in CT, mammography, MRI, nuclear medicine, and ultrasound.

WellStar Spalding Regional Hospital has received several awards and recommendations, including multiple Joint Commission accreditations, distinctions from the American Heart Association, Georgia Association of Emergency Medical Services and American College of Surgeons. The Center for Wound Healing and Hyperbaric Medicine has been named a National Center of Distinction. Our Primary Stroke Center was presented with the Gold Plus – Target: Stroke Honor Role Elite award by The American Heart/ American Stroke Association. The hospital's Emergency Medical Services was named "Best in the State" and was given the Gold Award for Cardiac Services from the prestigious American Heart Association. Recently, WellStar Spalding Regional Hospital also was bestowed with a statewide Quality and Patient Safety Award in the Infection Prevention and Control category from Partnership for Health and Accountability (PHA).

WellStar Sylvan Grove Hospital

EIN#: 81-0875069
1050 McDonough Road
Jackson, GA 30233

For more than 50 years, the wellness of our community has been top priority. WellStar Sylvan Grove Hospital supports the health/ medical needs of over 15,800 patients annually.

Fully accredited by the state of Georgia, our medical specialties at WellStar Sylvan Grove include: Emergency Services, Inpatient Center of Rehabilitation, swing-bed, and diagnostics and pulmonary evaluation programs.

WellStar Sylvan Grove Hospital offers 24-hour Emergency Services and provides inpatient programs focused around adult/pediatric occupational, physical and speech therapy. Programs are designed for recovery regarding diverse conditions, including joint replacement, various surgeries, stroke, cardiac occurrences, and resistant wounds that cannot be treated through outpatient means. The hospital also offers placement for post-acute, extended care and personalized nursing care and treatment.

WellStar Sylvan Grove Hospital is nationally recognized for patient safety and quality and locally known for its friendliness, personalized care and community involvement. Recently, the hospital was named a 2017 Top Rural Hospital by The Leapfrog Group. The Leapfrog Top Hospital award is widely acknowledged as one of the most competitive honors American hospitals can receive. Performance measurements for this award include infection rates, quality care and the hospital's capacity to prevent medication errors.

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This report serves to identify and assess the health needs of the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Submitted in fiscal year ended June 30, 2018 to comply with federal tax law requirements set forth in Internal Revenue Code Section 501(r) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in Code Section 501(c)(3).

A digital copy of this CHNA is publicly available:
www.wellstar.org/chna

Date CHNA adopted by the WellStar Board of Trustees:
June 7, 2018

Date CHNA made publicly available:
June 30, 2018

Community input is encouraged. Please address CHNA feedback to
chna@wellstar.org

Community is **Care**

BEING THE BRIDGE

Executive Summary

This report utilizes a data-driven approach to better understand, identify and prioritize the health needs of the community served by WellStar Health System's ("WellStar") WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

Griffin-based WellStar Spalding Regional Hospital is a 160-bed hospital that provides comprehensive care. Located in the adjacent town of Jackson, WellStar Sylvan Grove Hospital has 25 inpatient beds and has successfully served the medical and health needs through a 24-hour emergency department (ED). Both hospitals are designated not-for-profit hospitals under the Internal Revenue Code (IRC) Section 501(r).

Community Health Needs Assessment

The 2010 Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a Community Health Needs Assessment (CHNA) and Implementation Strategy every three years to better meet the health needs of under-resourced populations living in the communities they serve. WellStar Spalding Regional and WellStar Sylvan Grove hospitals serve the same geographical community and have chosen to complete a joint CHNA and Implementation Planning process. What follows is a comprehensive CHNA that meets industry standards including IRS final regulations of Section 501(r) titled "Additional Requirements for Charitable Hospitals."

WellStar partnered with the Georgia Health Policy Center (GHPC) to complete a comprehensive CHNA process, which includes synthesis of:

- Secondary data specific to the populations and geographic area served
- 15 individual key informant interviews with stakeholders
- One listening session with each hospital's Regional Board
- One focus group with residents
- 24 participants at a Health Summit with community and hospital leaders

The primary focus of data collection for this assessment was on under-resourced, high-need and medically underserved populations living in five zip codes concentrated in the primary service area of Butts, Pike and Spalding counties.

Priority Health Needs

WellStar Spalding Regional and WellStar Sylvan Grove hospitals worked with community and hospital leaders to identify the top community health priorities based on the data included in this CHNA.[1] The community health priorities identified for the service area include improving:

1. Wellness education
2. Access to appropriate care
3. Transportation
4. Access to behavioral healthcare
5. Birth outcomes

Key Findings

There are specific populations identified in this CHNA that experience greater barriers to being healthy and, as a result, have higher disease burden and death rates. The following populations need to be the focus of further study and targeted investment to address persistent health disparities:

- Residents living in Butts and Spalding counties
- Black, Latino and Asian residents
- Single parents
- Residents with behavioral health needs
- Residents from zip codes 30223, 30224 and 30233

In general, the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals is slightly older, less diverse and lower income earning. Among the three primary counties in the service area, Butts and Spalding counties are slightly younger, more diverse and lower-income-earning than Pike County.

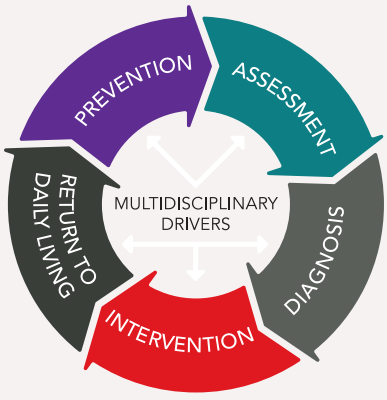
Social Determinants of Health

Social determinants of health[2] influence residents in the areas served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. In the last 10 years, the community served by both hospitals has experienced significant wage loss and low educational attainment. Spalding County residents experience the greatest socioeconomic barriers related to income, employment, insurance, housing, and education, when compared to residents of Butts and Pike counties. Butts County also experiences above average socioeconomic barriers when compared to Pike County and the state. Racial and ethnic disparities in socioeconomic status also are the greatest in Spalding County when compared to the service area and the state.

This assessment also found that many community members do not have access to the most appropriate care to meet their needs due to insurance status, number of providers, transportation, residents' ability to navigate available services, and quality of care. Residents have access to appropriate care when there is a properly functioning continuum of care available to them. See Figure 1 for one example of a care continuum. There is evidence in both the secondary and primary data of significant gaps in the care continuum throughout the service area. Often, examples of these disruptions are identified through anomalies in data that warrant further investigation to better understand and address the causes, such as:

- Health professional shortage areas
- High rates of ED visits
- High hospitalization rates for preventable issues
- High mortality rates

Figure 1 | Care Continuum



Health Outcomes

The data shows that behavioral health is a significant community health need in the service area, with higher than average rates of ED use, hospital discharge for self-harm and mortality for suicide.

There are several other undesirable health outcomes in the service area. Most of the top 10 causes of death in the service area are related to restricted access to healthcare, chronic conditions, lifestyle, and behaviors (e.g., heart disease, stroke, chronic obstructive pulmonary disease (COPD), lung cancer, diabetes, kidney disease septicemia, pneumonia, and mental and behavioral disorders). When considering county-level data, morbidity and mortality rates are high throughout the service area. Butts and Spalding counties show higher prevalence and death rates when compared to Pike County. Similarly, Black residents have the highest rates when compared to any other racial or ethnic cohort in the service area, though there is limited racial/ethnic data available for these counties.

There are several health issues prevalent throughout the service area, including high rates of:

Investments in addressing these issues would influence the health of communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

Limitations to Findings

There are several limitations to be aware of when considering the findings of this assessment:

- Most of the data included in this CHNA is available only at the county level. Where smaller pieces of data were available, they were included. County-level data is an aggregate of large populations and does not always capture or accurately reflect the nuances of community health needs.
- Secondary data is not always available. For example, Pike County often has unreportable data, meaning the sample size is too small to be validated or the data was not reported. Another example would be that there is no population measure of educational awareness in the context of healthy options, availability of resources or health literacy. In the absence of secondary data, the CHNA notes relevant anecdotal data gathered during primary data collection. It is important to note that primary data is limited by individual vocabulary, interpretation and experience.
- There is no measure of the accessibility and effectiveness of available services listed in the Community Facilities, Assets and Resources section of the Appendix, particularly for under-insured and uninsured residents.

1 *See the Primary Data and Community Input, Community Health Summit, section of the Appendix for more detailed information about the community health priorities.*

2 *According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."*

Community is **Commitment**

WE EXIST TO SERVE

Community Definition

WellStar Spalding Regional and WellStar Sylvan Grove hospitals are located approximately 20 miles away from each another in Griffin and Jackson, respectively. The hospitals serve the same geographic areas because of their proximity. For the purposes of this CHNA, the primary service area for both hospitals is defined as the five zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of patients are from Butts, Pike and Spalding counties. This geographic region shown in Map 1 is defined as the service area throughout the remainder of this report.

This CHNA considers the population of residents living in the five residential zip code areas regardless of the use of services provided by WellStar or any other provider. More specifically, this assessment focuses on residents in the service area that are medically under-resourced or at risk of poor health outcomes.

Map 1 | Primary Service Area of WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

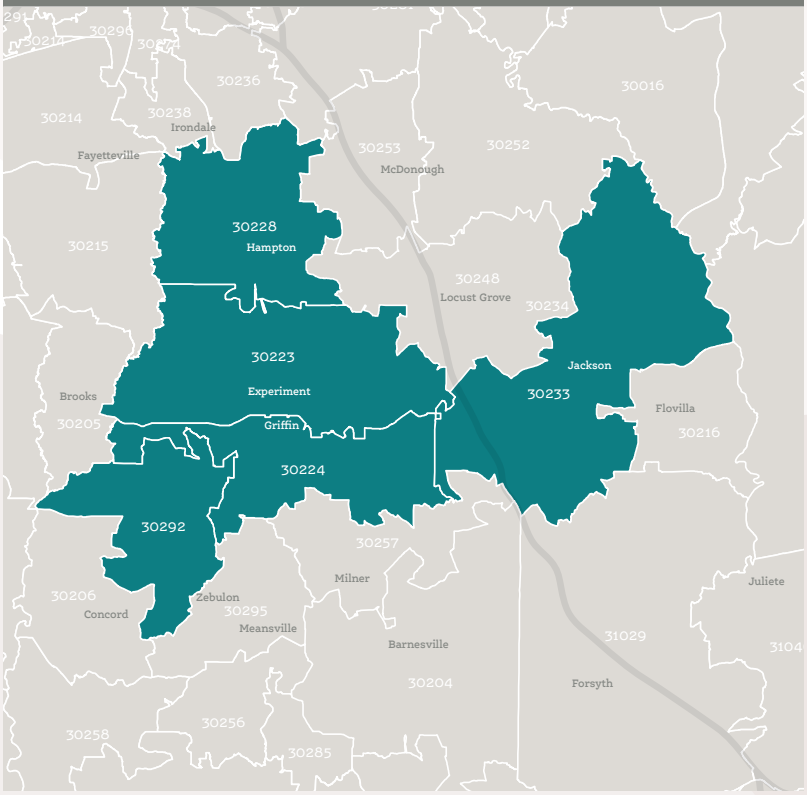


Table 1 | Primary Service Area of WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

County	Zip Codes (5)	Population (2015)
Spalding	30223, 30224	62,016
Pike	30292	5,927
Butts	30233	24,882
Henry	30228	44,331

Demographic Data

by County and State (2016)*

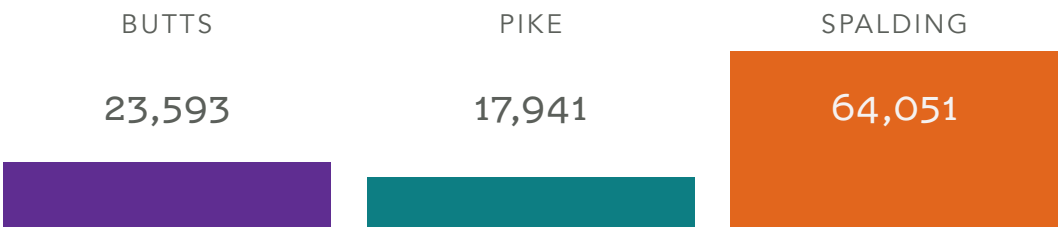
WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

The population in Georgia is one of the fastest growing in the nation. When compared to Georgia, the community served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals is slightly older, less diverse and lower-income-earning. Among the three primary counties in the service area, Butts and Spalding counties are slightly younger, more diverse and lower-income-earning than Pike County.

Total Population

GEORGIA TOTAL POPULATION

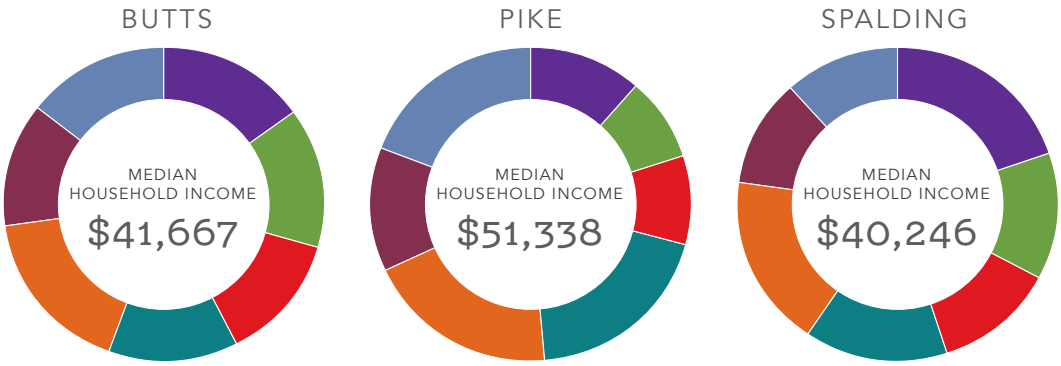
10,214,860



Income Distribution (2011-15)

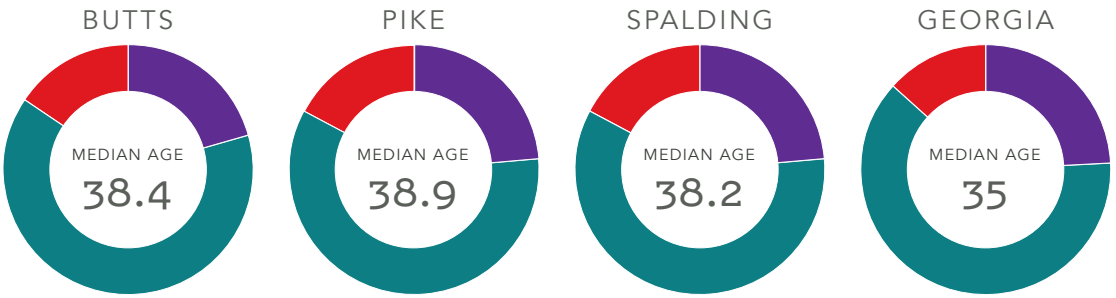
GEORGIA MEDIAN HOUSEHOLD INCOME

$53,559



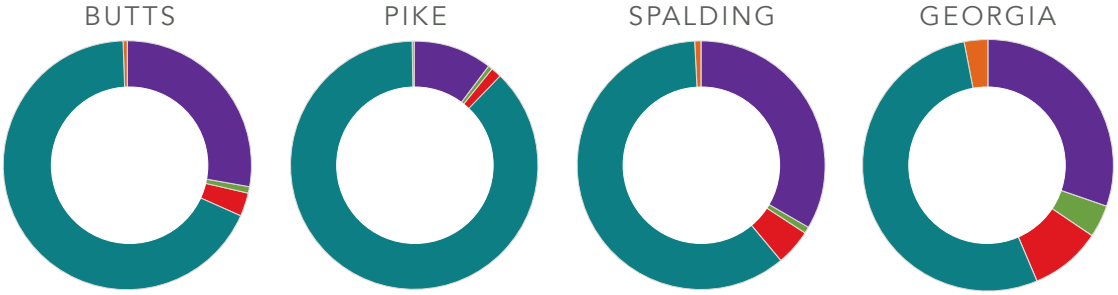
	BUTTS	PIKE	SPALDING
Less than $15,000	15.2%	11.4%	19.9%
$15,000 - $24,999	14.4%	8.8%	13.0%
$25,000 - $34,999	13.0%	9.1%	12.1%
$35,000 - $49,999	13.2%	19.4%	14.5%
$50,000 - $74,999	17.2%	19.4%	17.8%
$75,000 - $99,999	12.6%	12.9%	11.2%
Over $100,000	14.4%	19.0%	11.4%

Age Distribution



	BUTTS	PIKE	SPALDING	GEORGIA
0-17 years old	20.7%	23.6%	23.6%	24.3%
18-64 years old	63.9%	51.0%	59.2%	62.6%
65+ years old	15.4%	15.4%	17.1%	13.1%

Racial/Ethnic Distribution



	BUTTS	PIKE	SPALDING	GEORGIA
Black	27.8%	10.2%	33.1%	30.9%
Asian	0.6%	0.5%	0.9%	4.0%
Hispanic‡	3.1%	1.6%	4.5%	9.4%
Non-Hispanic White	67.1%	86.1%	59.6%	53.9%
Limited English	0.5%	0.1%	0.8%	3.0%

* *County Health Rankings and Roadmaps: countyhealthrankings.org*
Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us
Truven Health Analytics, Community Need Index
Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Community is **Contribution**

ASSESSING THE NEEDS

Data Collection

Georgia Health Policy Center (GPHC) partnered with WellStar to implement a collaborative and comprehensive CHNA process.

The secondary data included in this assessment was compiled from a variety of sources that are both reliable and representative of the communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Quantitative data sources included but were not limited to:

- Centers for Disease Control and Prevention
- Community Commons
- Community Need Index (CNI)
- County Health Rankings and Roadmaps
- Georgia Department of Public Health
- Georgia Prevention Project
- U.S. Census Bureau

Many publicly available data sources are only available at the county level and not in smaller segments. However, where possible, the data was analyzed at the zip code or census tract level to get a more comprehensive understanding of community needs. Data sources reviewed for this assessment can be found with the following data tables.

To better understand the experience and needs of residents served by the two hospitals, several types of qualitative data were used. Qualitative data used in this assessment included a focus group with residents, one-on-one interviews with key stakeholders, listening sessions with the hospitals' Regional Health Boards, and a Health Summit with hospital and community leaders. An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community is **Connection**

YOUR STORY IS OUR STORY

Health Needs of the Community

Understanding the health of a community and what residents need to be healthier requires consideration of a variety of factors. According to the World Health Organization, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[3]

This CHNA includes a consideration of the following factors from the perspectives of community and hospital leaders, residents and secondary data:

- Social determinants of health
- Access to and use of appropriate care
- Health behaviors
- Health outcomes

Community health is measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings (CHR), a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. CHR health outcomes measures length of life and quality of life. Among the counties served by both hospitals, Butts and Spalding counties show higher rates of mortality and the poorest quality of life, while Pike County shows lower mortality rates and better quality of life. This theme is seen throughout the assessment. Butts and Spalding counties often have the poorest outcomes when compared to Pike County and the state.

Table 2 | County Health Rankings by County (2017)*†

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Butts	103	73	144	49	46	103	79	78
Pike	15	22	29	20	20	83	16	102
Spalding	140	115	129	132	83	65	138	131

* *There are 159 counties in Georgia*

† *County Health Rankings and Roadmaps: countyhealthrankings.org*

The leading causes of death in the hospital service area are similar when compared to those in the state. Death rates throughout the service area are much higher when compared to the state's rate. The top cause of death in both the service area and throughout the state is related to heart disease (i.e., coronary artery disease).[4] The remainders of the top five causes of death are COPD (except asthma), lung cancer, cerebrovascular disease (stroke), and behavioral health causes (unrelated to psychoactive substance use).[5]

3 *World Health Organization, Constitution of WHO: principles, http://www.who.int/about/mission/en/*

4 *See the Secondary Data section of the Appendix for a ranked list of causes of death in Georgia and in Butts, Pike and Spalding counties*

5 *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

Social Determinants of Health

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." Each primary data source discussed the low educational attainment, lack of stable employment options, low-wage jobs, and resulting poverty among residents. This addresses the disparities seen in the social determinants of health (e.g., income, employment, education, affordable housing, etc.) throughout the hospitals' community.

Unemployment has decreased across the area in the last 10 years. However, Butts, Pike and Spalding counties saw a decrease in median household incomes of -$10,590, -$1,875 and -$854 respectively.[6] One resident explained the shift in industry and available employment this way:

> "This was known as a mill town. And there's only like … one, maybe two mills left. And some people, like myself, cannot maintain in that field anymore. For carpal tunnel, in both my hands. I've done wore it out working with my hands. Yeah, this was like a ghost town with jobs. They're popping up stores and stuff, but that's not a career for everyone."

Another resident talked about his or her experience with temporary employment in this way:

> "Yeah, that's the quickest and most reliable way to get a job. … I was working through a temp service, they'll let you work but then … they start letting people go. When you're supposed to be hired on, 50 hours away from being hired on, they let you go."

Poverty is a pervasive challenge in Butts and Spalding counties, particularly among families with children and people of color. Table 3 shows that over the last decade, poverty in the general population has increased in Butts County at a much faster pace (8.4 percent) than in Pike and Spalding counties (1.7 percent and 1.5 percent respectively). This pattern is replicated across the service area regardless of family status.

While single-parent families experience the highest rates of poverty throughout the service area, Butts County shows a significant increase between 2006 and 2015 in the percentage of single-female-head-of-household families in poverty (17.8 percent) when compared to Pike and Spalding counties, which both saw decreases during the same period (10.7 percent and 4.1 percent respectively).

6 *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

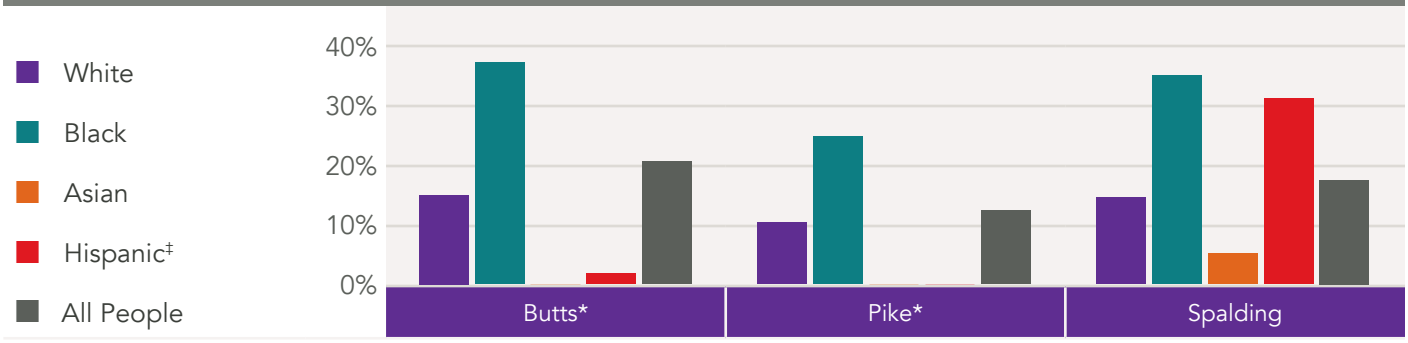
Table 3 | Population Below the Federal Poverty Level by Family Status and County (2006-2015)†

	Butts County		Pike County		Spalding County	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	7,789	7,774	5,957	6,017	23,105	22,717
All people	12.4%	20.8%	10.5%	12.2%	21.2%	22.7%
All families	9.0%	18.9%	9.4%	10.0%	17.2%	17.9%
Married couple families	5.3%	9.4%	4.7%	6.5%	4.8%	7.0%
Single female head of household families	25.9%	43.7%	33.1%	22.4%	45.8%	41.7%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

Figures 2 and 3 show that there also are disparities in the poverty and education rates of various racial and ethnic groups throughout the service area, with Black and Hispanic/Latino residents showing the highest rates of poverty and lowest rates of educational attainment when compared to the general population. Educational attainment is low throughout the service area, with one in 10 residents without a high school diploma (or equivalent).

Figure 2 | Population Below Federal Poverty Level by Race/Ethnicity and County (2011-2015)†

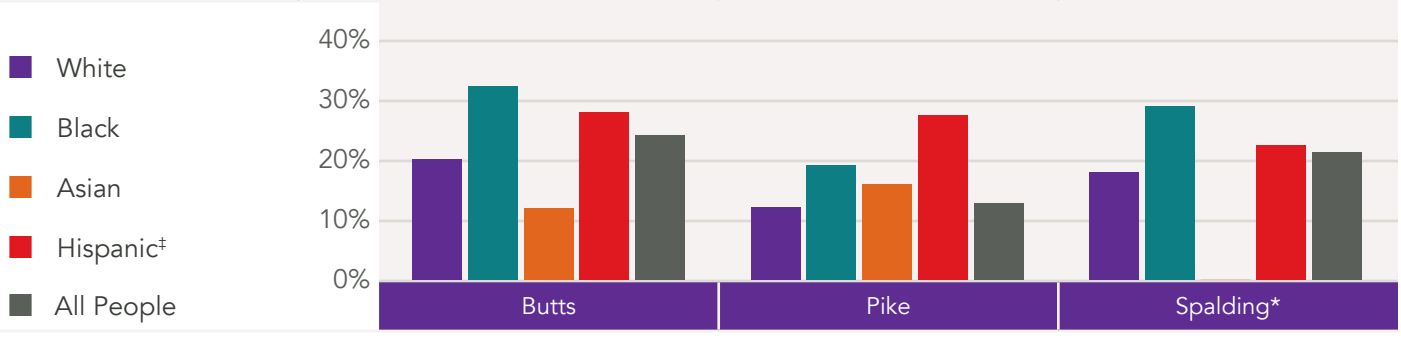


† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

* *0.00% can result from sample size and margin of error*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Figure 3 | Percentage of Population Without a High School Diploma by Race/Ethnicity and County (2011-2015)†



† *Community Commons CHNA Portal: CHNA.org*

* *0.00% can result from sample size and margin of error*

‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Housing

The quality, age, availability, and affordability of housing influence community health. Community input suggests that the housing stock is poor and becoming unaffordable for residents. During interviews, community leaders discussed the impact that unaffordable housing is having on residents' ability to afford other necessities, such as healthy food and transportation. In the last 10 years, home values and homeownership have declined in Butts and Spalding counties and increased in Pike County. In Butts and Spalding counties, home ownership is being replaced by renting. This fact alone does not indicate health challenges and likely is related to both the housing crisis and the younger median age of the service area.

As the region rebounds from the housing crisis, older homes are being replaced by newer dwellings. This, coupled with the decreasing vacancy rates, may be setting the community up for challenges related to unaffordable housing and displacement. This may be what is driving the increases in the percentage of residents paying more than 30 percent of their monthly income for rent in Butts and Spalding counties.

Table 4 | Selected Housing Indicators by County (2006-2015)†

	Butts County		Pike County		Spalding County	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	7,789	7,774	5,957	6,017	23,105	22,717
Family households	75.9%	72.5%	82.1%	79.9%	70.2%	71.0%
Nonfamily households	24.1%	27.5%	17.9%	20.0%	29.8%	29.0%
Vacant housing units	16.0%	16.3%	10.5%	11.8%	12.6%	15.6%
Homes more than 20 years old	63.1%	51.1%	55.0%	46.4%	84.0%	81.2%
Median value of homes	$142,900	$113,900	$153,300	$155,200	$124,400	$111,500
Households paying more than 30% of income for monthly mortgage	30.4%	29.7%	25.2%	26.1%	27.6%	28.6%
Households paying more than 30% of income for monthly rent	39.9%	50.8%	47.0%	39.6%	49.3%	49.9%

† *Atlanta Regional Commission, 2016 Neighborhood Nexus, County Profiles: www.neighborhoodnexus.org*

There are existing resources throughout the service area that address the social determinants of health.[7] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the social determinants of health noted in the CHNA.

7 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

8 *See the Secondary Data section of the Appendix for complete CNI data.*

Access to Appropriate Care

Having access to the right care at the right time influences health outcomes as well as healthcare-seeking behavior, according to the input provided by residents and community leaders. Community Health Summit participants identified access to appropriate care as one of the top community health needs to address. Often, there are a variety of factors associated with the access residents have to appropriate care, such as insurance status, residents' ability to navigate available services, number of providers, quality of care, and transportation.

Community residents spoke of the difficulty they experience when trying to maintain and use affordable health insurance. One group noted that affordable insurance often is not accepted by providers in their area or has such expensive copays and deductibles that they cannot afford to use the insurance benefits.

Socioeconomic Factors

The CNI ranks each zip code in the United States against all other zip codes on five socio-economic factors that are barriers to accessing healthcare: income, culture, education, insurance, and housing.[8] Each factor is rated on a scale of one to five (one indicates the lowest barrier to accessing healthcare and five indicates the most significant). A score of three is the scale median.

According to the 2015 CNI (see Map 2 and Table 5), all of the zip codes served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals have above average socioeconomic barriers to accessing healthcare.

A closer look shows:

- There are three zip codes with CNI scores of four or higher, two of which are in Spalding and one in Butts counties.
- Spalding County presents the highest socioeconomic barriers to accessing healthcare when compared to the rest of the service area.
- Pike County presents the lowest socioeconomic barriers to accessing healthcare when compared to the rest of the service area.

Map 2 | WellStar Spalding Regional and WellStar Sylvan Grove Hospitals 2015 CNI Scores by Zip Code†

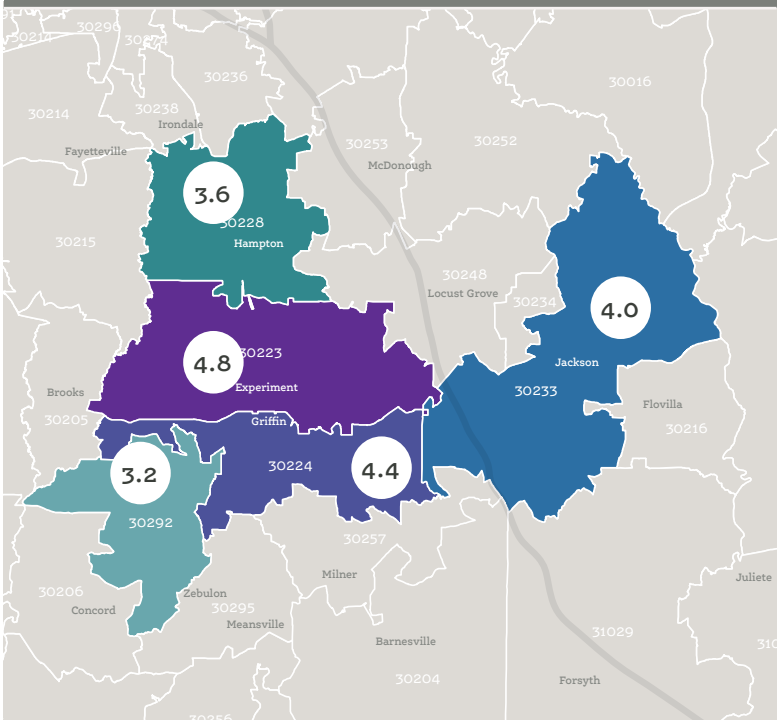


Table 5 | 2015 Community Need Index (CNI) Scores WellStar Spalding Regional and WellStar Sylvan Grove Hospitals)†

Zip	County	2015 CNI Score
30223	Spalding	4.8
30224	Spalding	4.4
30233	Butts	4.0
30228	Henry	3.6
30292	Pike	3.2

† *Dignity Health: Community Need Index*

Community input suggests that care coordination for residents seeking care in the ED is not readily available. One hospital leader noted:

> "Many people that go to our ER are better served in a primary care setting. They call 911 and we get them. Some patients aren't compliant with their discharge orders and need education – they may not know about other healthcare options before they go home."

According to the 2017 ED utilization data provided by WellStar, WellStar Spalding Regional and WellStar Sylvan Grove hospitals served 19,809 self-pay patients in the EDs. Patients are considered self-pay if they do not provide medical insurance to cover the care they receive. This is often a sign of the number of under- and uninsured patients receiving care in any hospital department. A closer look at the community's five zip codes shows:

- Butts County zip codes contain 18 percent of the total population of the service area and 16 percent of the self-pay patient population seen at both EDs.
- Pike County zip codes contain four percent of the total population of the service area and just two percent of the self-pay patient population seen at both EDs.
- Spalding County zip codes contain 44 percent of the total population of the service area and 63 percent of the self-pay patient population seen at both EDs.

Table 6 | Characteristics of Self-Pay Patients Receiving Care in the Emergency Departments at WellStar Spalding Regional and WellStar Sylvan Grove Hospitals (2017)†

County	# of Service Area Zip Codes	# of Self-Pay ED Visits to WSRH and WSGH	Percent of All Self-Pay ED Visits	Total Population	Percent of Service Area Population
Butts	1	3,120	16%	24,882	18.14%
Pike	1	397	2%	5,927	4.32%
Spalding	2	12,438	63%	60,016	43.76%
Service Area	**5**	**19,809**	**100%**	**137,156**	**100%**

† *WellStar Health System, Deidentified Emergency Department Utilization, Self-Pay (2017)*

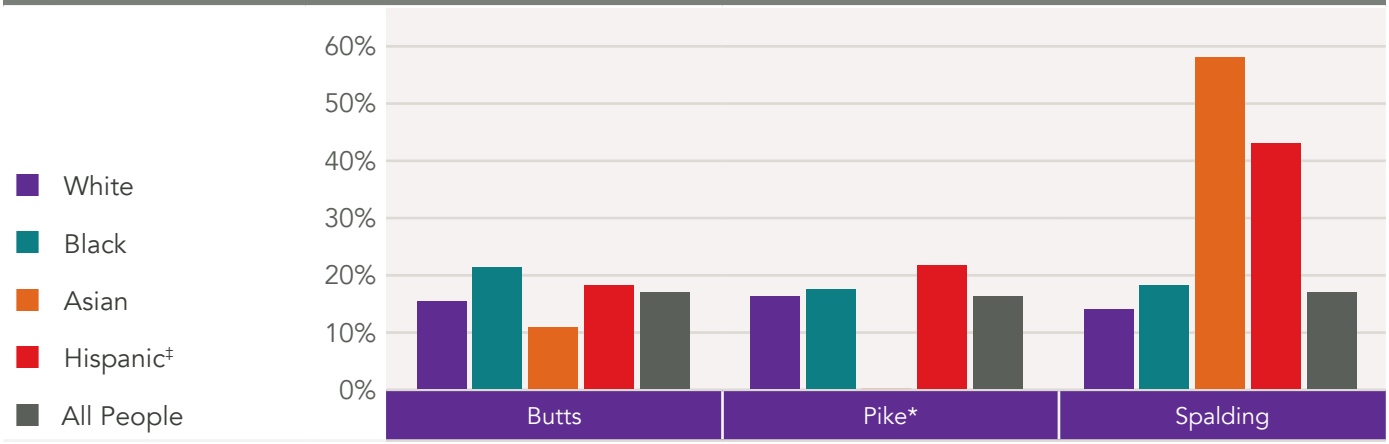
A greater percentage of Georgia residents are uninsured than the national average, due to the lack of Medicaid expansion. The percentage of uninsured residents in all three primary counties is average for the state. One resident recounted their experience trying to maintain self-paid insurance in Spalding County:

> "I've been buying insurance on my own, 'cause I'm not Medicare age yet. And my first year, I was under a certain healthcare plan being a resident of Spalding County; they dropped the whole plan. … [I] got a new plan last year; it was dropped at the end of the year. So now, I'm on the third plan in three years because they keep dropping insurance for Spalding County. Now, there's one provider I have access to. I have very little access to any doctors."

Uninsured

Figure 4 shows disparities in the rates of uninsured in Spalding County when considering the data by racial and ethnic groups, with Asian and Latino residents showing the highest rates of uninsured when compared to their White and Black counterparts. While there are slight variances by race in Butts and Pike counties, they are not significant. Asian and Latino residents in Spalding County are twice as likely to be uninsured, when compared to their White and Black counterparts.

Figure 4 | Percentage of Uninsured Population by Race/Ethnicity and County (2011-2015)†



† *Community Commons CHNA Portal: CHNA.org*

* *0.00% can result from sample size and margin of error*

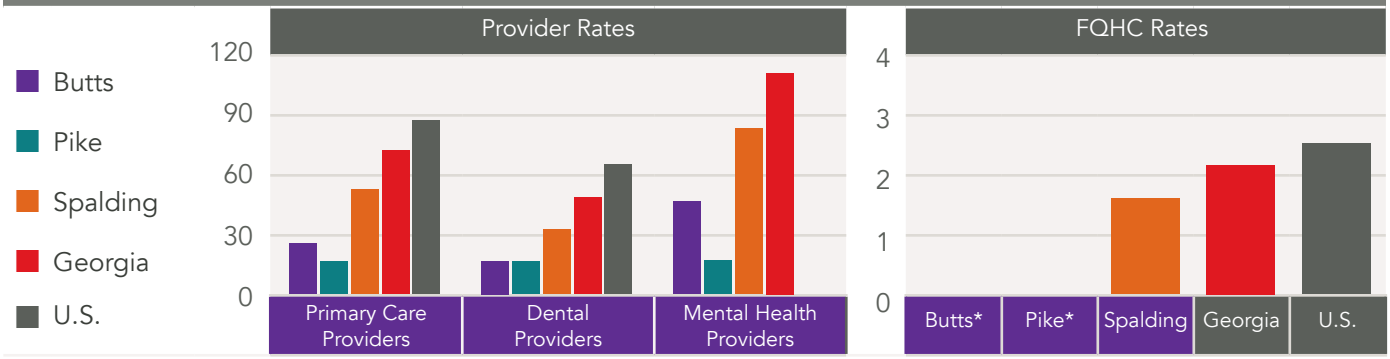
‡ *"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.*

Provider Shortage

There is a shortage of healthcare and dental providers throughout service area, particularly among safety net providers that offer free or reduced-cost healthcare based on income (see Map 3 for a geographic representation). While the entire service area has fewer providers than is average in the state and the nation, Pike County has the fewest providers in the area when compared to Butts and Spalding counties.

Community input suggests that there is a shortage of primary care providers, safety net providers, specialists, and trauma care. Residents explained that the closest specialists are at least a 45-minute drive away from their community.

Figure 5 | Provider Rates by County Per 100,000 Population (2014)†



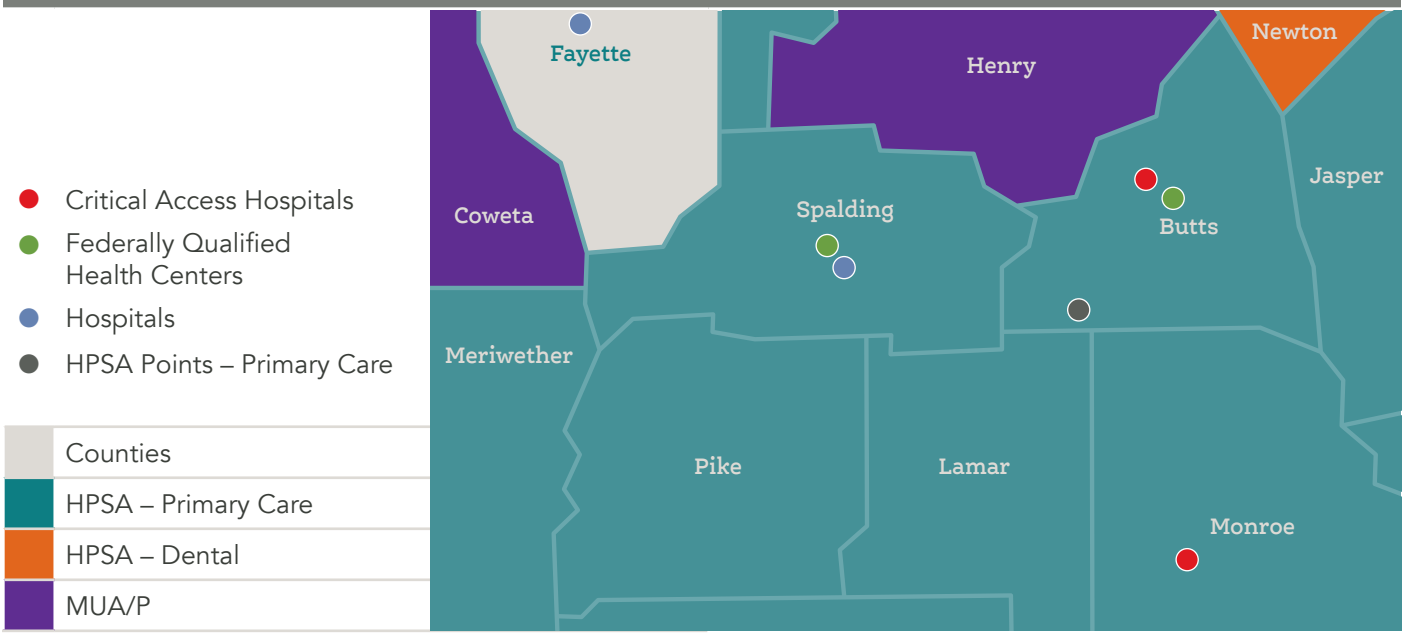
† *Community Commons CHNA Portal: CHNA.org*

* *0.00% can result from sample size and margin of error*

Map 3 shows that each county is considered a professional shortage area according to the Health Resources and Services Administration (HRSA). Additionally:

- Butts, Pike and Spalding counties are all considered Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs).
- Butts County needs three primary care providers and 12 dental care providers – the shortage impacts the care of an estimated 26,039 residents.
- Pike County needs one primary care provider and one dental care provider – the shortage impacts the care of an estimated 5,634 residents.
- Spalding County needs eight primary care providers and six dental care providers – the shortage impacts the care of an estimated 30,354 residents.
- Most safety net providers are located in the center of each county, with the exception of Pike County with no safety net providers noted.

Map 3 | Primary Care and Dental HPSA, Safety Net Providers and Hospitals†



† *U.S. Department of Health and Human Services, The HRSA Data Warehouse, Primary Dataset: Health Professional Shortage Areas (HPSAs), Secondary Dataset: Medically Underserved Areas/Populations (MUA/P)*

Health Summit participants discussed the limited transportation options that residents have as one of the most pressing priorities in the service area when coupled with the rural nature of the area. Community input suggested that the lack of transportation restricts access to employment options, health services, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of comprehensive public transportation that is reliable and the distance residents must travel to secure necessities. The limited transportation options can facilitate poor health outcomes.

There are existing resources throughout the service area that offer access to care.[9] Unfortunately, it is difficult to determine the reach and effectiveness of these collective services in addressing most of the barriers to accessing appropriate care noted in this assessment.

9 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

Health Behaviors

To better understand behaviors that impact health, it is important to consider factors influencing choices residents make that cause them to be either healthy or unhealthy. Often these choices are influenced by access to, awareness of and preference for healthy or unhealthy options. Community input noted that residents often have low awareness about healthy choices and limited access to affordable healthy options (nutrition and exercise).

One resident had this to say about the quality of food available in under-resourced areas:

> "I'm frustrated by grocery stores in low-income areas that offer unhealthy choices."

Food Insecurity

According to the U.S. Department of Agriculture (USDA), food security is access by all people at all times to enough food for an active, healthy life. It is one of several conditions necessary for a population to be healthy and well nourished. In 2016, the USDA found that 14 percent of households in Georgia experience low food security, and 5.6 percent experience very low food security.[10]

Spalding and Butts counties show signs of food insecurity and low access to grocery stores. The geographic areas with lowest access to grocery stores are closest to each hospital (see Map 3).[11] Residents in Spalding County have the lowest access to supermarkets and grocery stores when compared to Pike and Butts residents. The highest rates of low-income, food-insecure populations are in zip codes 30223, 30224 and 30233.

Table 7 | Selected Populations With Low Access to a Supermarket or Large Grocery Store by County (2010-2015)†

Healthy Eating Active Living Indicators	Butts	Pike	Spalding
Residents with low access to a supermarket	NA	NA	52.7%
Low-income residents with low access to a supermarket	NA	NA	12.5%
Children with low access to a supermarket	NA	NA	16.0%
Seniors with low access to a supermarket	NA	NA	6.1%

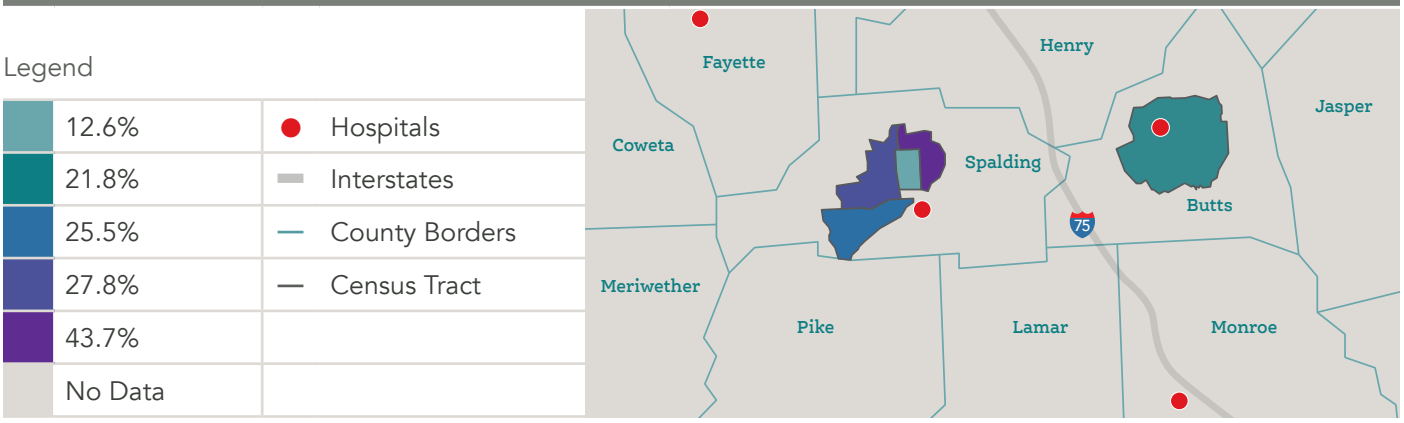
NA: Data was not available

† Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp

10 USDA Economic Research Service, Household Food Security in the United States in 2016, ERR-237

11 Spalding Regional Hospital is closest to census tracts 13255160500, 13255160400 and 13255160300, and Sylvan Grove sits in the middle of census tract 13035150200.

Map 4 | Percentage of Low-Income Population With Low Access to a Supermarket or Large Grocery Store†



† *Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015 (January 2017), Economic Information Bulletin No. (EIB-165) 21 pp*

Hospital leaders felt that high rates of obesity in the service areas are related to poor food choices, limited awareness of health outcomes and lack of access to regular opportunities to be physically active. Community input suggests that residents do not have access to healthy nutrition or facilities to be physically active. Focus group participants noted that there are very few places to exercise safely outside due to crime and the lack of infrastructure (sidewalks, parks, green space, etc.).

Long Commute Times

Table 8 shows that there is limited access to exercise facilities in Butts and Pike counties, when compared to Spalding county and the state. Additionally, more residents in all three primary counties spend more than an hour commuting, when compared to the state and national averages.

Table 8 | Selected Healthy Eating, Active Living Indicators†

	Butts	Pike	Spalding	Georgia	U.S.
Inadequate fruit and vegetable consumption	ND	ND	19.2%	75.7%	75.7%
Access to exercise facilities	40.0%	47.0%	74.0%	75.0%	NA
Adult physical inactivity	28.0%	25.7%	28.0%	23.1%	21.8%
Commute over 60 minutes	14.5%	20.3%	10.4%	9.4%	8.5%

ND: Data was unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† *Community Commons CHNA Portal: CHNA.org, County Health Rankings and Roadmaps: countyhealthrankings.org*

Health Knowledge

Health Summit participants prioritized wellness education and awareness as one of the most pressing health issues that could improve health outcomes in their community if effectively addressed. They felt residents need more effective outreach in the areas where they live, work and play. There is no measure of education and/or awareness in the context of healthy options, availability of resources or health literacy.

Health Summit participants and community leaders interviewed discussed low educational attainment coupled with a lack of outreach as barriers to health literacy in the community. Community input suggests that residents are not aware of the services that exist in the community due to challenges in effectively disseminating information throughout their rural community.

There are existing resources throughout the service area addressing health behaviors in the community.[12] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors noted in this assessment.

12 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

Health Outcomes

Most of the top 10 causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, COPD, lung cancer, diabetes, and kidney disease). When considering county-level data, morbidity and mortality rates are high throughout the service area. Butts and Spalding counties show the highest rates when compared to Pike County. Black residents show the highest disease burden when the data is considered by race, though there is limited racial/ethnic data available for these counties.

Obesity

At the time of this report, body mass index (BMI) is a health issue throughout the country, with this community as no exception. More than one in three adults is overweight and more than one in four adults is obese. Diabetes is a health concern in Butts and Spalding counties, where morbidity rates are elevated, and mortality rates are higher than in the rest of the area.

Table 9 | Selected Adult BMI and Diabetes Indicators by County and Race (2012-2016)†

	Butts	Pike	Spalding	White**	Asian**	Black**	Hispanic**‡	Georgia
Overweight	36.6%	40.7%	21.5%	ND	ND	ND	ND	35.1%
Obese	28.4%	25.6%	32.3%	ND	ND	ND	ND	29.3%
Living with diabetes	10.9%	0.3%	11.5%	ND	ND	ND	ND	10.6%
Diabetes discharge rate*	193.5	135.8	249.5	193.8	ND	301.7	ND	187.3
Diabetes mortality*	33.6	26.8	36.6	26.4	ND	41.4	ND	21.6

ND: Data was unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Age adjusted, per 100,000 population ** Three-county aggregate*

‡ "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. In Oasis, hospital discharge rates are not available for ethnic groups

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, this community reflects higher cardiovascular disease when compared to the nation and shows higher morbidity and mortality related to obstructive heart disease (where data is available). Community input suggests that it is difficult to secure cardiology services, which may be related to higher mortality rates. Residents living in Butts and Pike counties experience higher than average hospital discharge rates due to hypertensive heart disease. Spalding County residents experience higher stroke-related mortality (data is not available for Butts and Pike counties).

Table 10 | Selected Cardiovascular Condition Indicators by County and Race (2012-2016)†

	Butts	Pike	Spalding	White**	Asian**	Black**	Hispanic**	Georgia
Obstructive heart disease/heart attack discharge rate*	24.0	ND	37.6	26.4	ND	41.1	ND	21.1
Obstructive heart disease mortality*	360.0	291.9	346.4	355.1	0.0	310.9	ND	260.0
Hypertensive heart disease discharge rate*	99.0	81.3	66.6	72.2	0.0	95.3	ND	75.4
Hypertensive heart disease mortality*	23.9	0.0	10.7	10.0	16.1	0.0	ND	31.0
Stroke mortality*	ND	ND	39.6	27.6	0.0	41.7	ND	17.5

ND: Data was unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

†Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Age adjusted, per 100,000 population ** Three-county aggregate*

‡ "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. In Oasis, Hospital Discharge rates are not available for ethnic groups, only race

Cancer

Cancer rates are elevated in Georgia when compared to the national average. There are higher morbidity rates for all types of cancer throughout the service area where data is available.

Table 11 | Selected Cancer Indicators by County and Race (2012-2016)†

	Butts	Pike	Spalding	White**	Asian**	Black**	Hispanic**‡	Georgia	U.S.
Breast cancer incidence*	104.8	94.6	122.1	110.3	ND	127.9	ND	123.4	123.4
Cervical cancer incidence*	ND	ND	14.1	ND	ND	ND	ND	7.7	7.6
Colon and rectum cancer incidence*	39.0	49.5	50.6	46.2	ND	51.2	ND	41.7	40.6
Prostate cancer incidence*	161.4	156.7	173.8	146.0	ND	259.3	ND	139.8	123.4
Lung cancer incidence*	95.7	75.6	74.3	80.6	ND	73.97	ND	67.3	62.6
Cancer mortality*	230.9	224.3	197.5	199.8	ND	222.6	ND	169.3	166.3

ND: Data was unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Age adjusted, per 100,000 population ** Three-county aggregate*

‡ "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. In Oasis, Hospital Discharge rates are not available for ethnic groups, only race

Asthma

Adult residents suffer from higher morbidity rates for asthma.

Table 12 | Selected Respiratory Indicators by County and Race (2012-2016)†

	Butts	Pike	Spalding	White**	Asian**	Black**	Hispanic**‡	Georgia
Asthma discharge rate*	100.4	77.9	123.8	109.0	0.0	127.6	ND	87.8
Asthma ED visit rate*	659.9	224.2	828.2	397.6	ND	1,315.1	ND	551.6

ND: Data was unavailable due to a lack of data reporting or data suppression ND for rates: Rates based on 1-4 events are not shown

† Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Age adjusted, per 100,000 population ** Three-county aggregate*

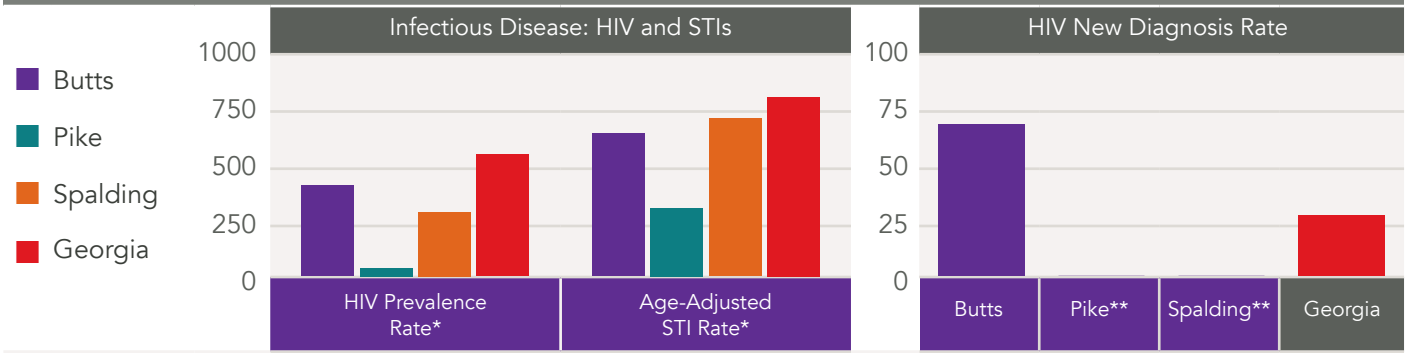
‡ "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. In Oasis, Hospital Discharge rates are not available for ethnic groups, only race

Sexually Transmitted Infections

The Metro Atlanta area has some of the highest morbidity rates for HIV and AIDS in the nation. Where data is available, Butts and Spalding counties show higher rates of HIV when compared to rates in Pike County and the state.

HIV screening rates are low in Butts and Pike counties, where residents report never being screened for HIV at a rate of 81.7 percent and 100 percent respectively. Residents in Butts County have higher diagnostic and prevalence rates of HIV than residents in any other county in the service area.

Figure 6 | Prevalence and Diagnoses Rates for HIV and All Other STIs†



† *Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STI, and TB Prevention (NCHHSTP): www.cdc.gov/NCHHSTP/Atlas/*

* *Per 100,000 population* ** *0.00% can result from sample size and margin of error*

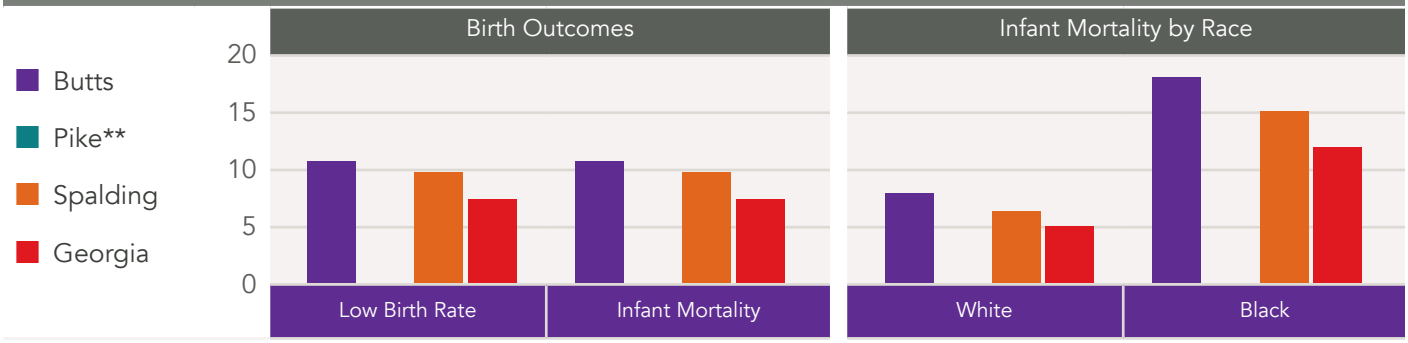
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birth-weight infants and infant mortality, among other issues.[13]

Health Summit participants prioritized birth outcomes as one of the most pressing issues in their community. Also, access to and appropriate use of prenatal care and birthing services was identified as a pressing health need during the hospitals' Regional Health Board listening sessions and the Health Summit. In interviews, community leaders discussed the lack of health education as a facilitating factor for risky sexual behaviors, which leads to teen pregnancy and a cycle of economic hardships. Input gathered from residents during a focus group also cited the limited education offered to youth about risky sexual behaviors and lack of adult supervision of youth as driving forces behind poor birth outcomes and higher rates of STIs.

Figure 7 shows Butts and Spalding counties have higher rates of infant mortality and LBW births than the state. Data was not available for Pike County.

Figure 7 | Infant Mortality and Low Birth Weight by County†*



† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *Rates based on 1-4 events are not shown* ** *0.00% can result from sample size and margin of error*

13 *Healthy Mothers, Health Babies Coalition of Georgia, 2016 State of the State of Maternal and Infant Health in Georgia https://drive.google.com/file/d/0BxndQpkPFFfySm5aNmdkYXZYQm8/view*

Table 13 shows that injury and assault rates are higher than average in Butts and Spalding counties. Residents discussed high crime rates as one reason residents do not feel safe exercising outside.

Table 13 | Selected Injury Indicators (2012-2016)†

	Butts	Pike	Spalding	Georgia
Assault discharge rate*	33.1	ND	22.5	19.9
Motor vehicle crash ER visit rate*	1,494.7	1,137.0	1,816.2	1,168.3
Percent traffic deaths involving alcohol	14.5%	20.3%	10.4%	23.0%

ND for rates: Rates based on 1-4 events are not shown

† Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Age adjusted, per 100,000 population*

Behavioral Health

The need for behavioral health resources, particularly for under-insured and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. Summit participants discussed the prevalence of adverse childhood experiences (ACEs), lack of behavioral health providers and lack of family support as root causes for poor behavioral health outcomes.

Additionally, community leaders noted that residents with undiagnosed behavioral health issues often end up incarcerated due to limited resources. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia hospitals for mental health issues in 2016.[14] The data show that behavioral health is a significant community health need in the service area, with higher than average rates of ED use, hospital discharge for self-harm and suicide mortality.

Table 14 shows low behavioral health provider rates and higher than average ED rates in all three counties. Pike County has the fewest providers and Spalding County shows the highest ED use. Input from community residents related to behavioral health suggested that residents may resist seeking care due to stigma, lack of insurance, unaffordable cost of care, and the location of providers too far away from home.

Table 14 | Selected Characteristics Health Professional Shortage Areas by County (2016)†

	Butts	Pike	Spalding	Georgia
Mental health providers*	47.0	17.0	84.0	112.0
Poor mental health days	3.7	3.6	3.9	3.8
Mental health ER rate*	1,272.2	1,109.2	2,026.0	1,083.3
Self-harm age-adjusted discharge rate*	59.2	31.8	43.1	33.8

† Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us

** Per 100,000 population*

14 Overwhelmed In The ER: Georgia's Mental Health Crisis (Feb 28, 2018), Elly Yu, https://www.wabe.org/overwhelmed-er-georgias-mental-health-crisis/

Substance Abuse

In the last decade, substance abuse has become an increasing concern in many parts of the United States, specifically related to opioid abuse and overdose. According to a white paper written and presented to the state Senate by the Georgia Prevention Project's Substance Abuse Research Alliance:

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses including heroin.
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014.
- Overdose deaths tripled between 1999 and 2013 in Georgia.[15]

Figure 8 shows the increase of substance abuse overdoses in Butts, Pike and Spalding counties since 1999. Butts and Spalding counties show the highest rates when compared Pike County and the state. Each primary data source talked about substance abuse in the community, noting that methamphetamine is the most common drug used. Health Summit participants noted that opioid abuse is a present and growing challenge in their community, but not yet the sizeable challenge that it has become in surrounding areas.

Over the past 10 years the rate of opioid-related overdoses in Butts and Spalding counties has been much higher than in Pike County and the state.

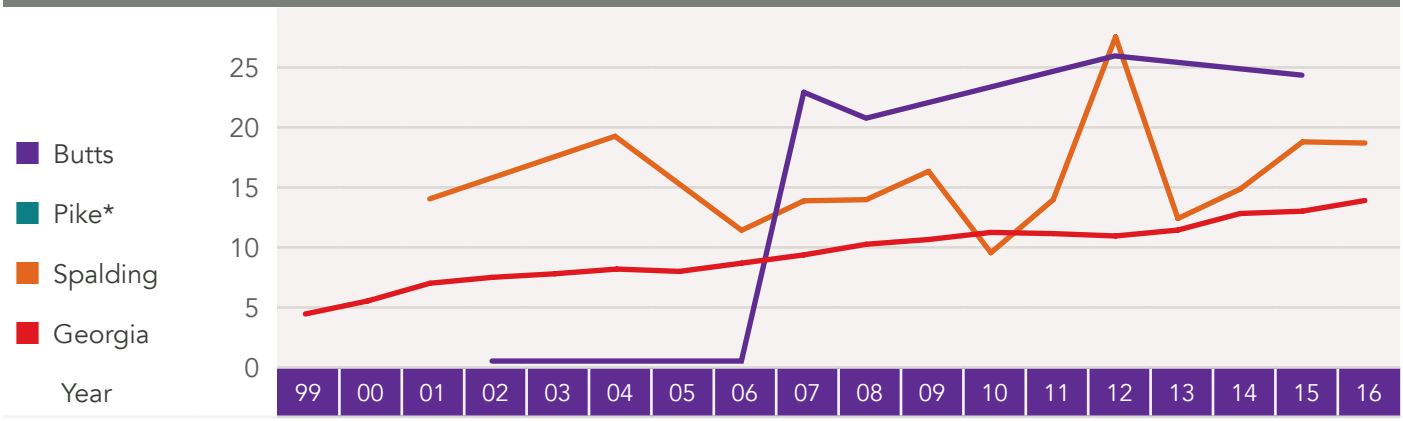
Table 15 | Age-Adjusted Death Rate, Drug Overdoses (2006-2016)†

	Butts	Pike	Spalding	Georgia
Opioid Overdoses (2006-2016)*	11.9	2.3	10.2	6.4

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

** Age-adjusted discharge rate, per 100,000 population*

Figure 8 | Age-Adjusted Death Rate per 100,000 population Drug Overdoses (1999-2016)†



† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*

* *0.00% can result from sample size and margin of error*

There are existing resources throughout the service area that addresses the common health outcomes noted in this section.[16] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the health issues noted in this assessment.

15 *Georgia Prevention Project: Substance Abuse Research Alliance, Prescription Opioids and Heroin Epidemic in Georgia (2017), http://www.senate.ga.gov/sro/Documents/StudyCommRpts/OpioidsAppendix.pdf*

16 *See the Community Facilities, Assets and Resources section of the Appendix for a list of resources.*

Community is **Compassion**

RALLYING PEOPLE AND RESOURCES

Community Input

This assessment engaged residents and leaders from the communities and leaders of hospitals that provide services in the communities served by WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital. An in-depth description of the participants, methods used and collection period for each qualitative process is located in the Primary Data and Community Input section of the Appendix.

Listening sessions were conducted with each hospital's Regional Health Board and individual key informant interviews were conducted with 15 community leaders. Hospital and community leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including public health, community health, epidemiology, social services, and health disparities. The listening session and interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the CHNA.

One focus group was conducted to gather input from more than 10 residents living and working in the communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Focus group participants were asked to discuss their opinions related to the health status and outcomes; context, facilitating and blocking factors of health; and what is needed to be healthier in their community. The follow page is a summary of the community input gathered during this assessment process.

Summary of CHNA Community Input

WellStar Spalding Regional and WellStar Sylvan Grove Hospitals

Commonly Discussed Health Issues

Overutilization of the ED	**Chronic conditions:**				
Substance abuse (marijuana, methamphetamine, cocaine)	Cardiovascular (i.e., hypertension and congestive heart failure)		Diabetes (unmanaged and undiagnosed)		
Medication noncompliance	Obesity (adult and child)	Cancer	COPD	STIs	Teen pregnancy

Commonly Discussed Causes

Geographic location of health services coupled with limited transportation options, with no formal public transportation (e.g., babies born in ED at Sylvan Grove)	**Low health literacy/awareness of:**		
	Available services	Healthy practices	Prevention
	Appropriate use of health services		Medication management

Limited services available for:			**Restricted insurance options that change from year to year**
Primary and specialty providers	Walk-in/same-day appointments	Behavioral health (psychiatric and crisis)	
After-hours urgent care	Substance abuse (in- and outpatient medical stabilization)	Engaging residents (education and prevention)	**Lack of safety** (high crime rates, gang activity and poor infrastructure)
Care coordination for residents seeking primary care in the ED		Prenatal care	
		Trauma care	**Poverty**

Unaffordable cost:	**Poor access to:**	**Poor employment options** (temp agencies)	**Lack of appropriate supervision/risky behavior of youth**	**Unhealthy cultural preferences and traditions**
Prescriptions	Healthy nutrition			
Uninsured care	Physical activity	**Low educational attainment**	**Substandard/unaffordable housing**	

Common Recommendations

Engage community partners to:

- Better understand health needs
- Improve health literacy
- Expand community engagement

Disseminate educational material about healthy habits to youth (i.e., sex, nutrition, behavioral health awareness, physical education, and drug education)

Conduct health seminars that will promote health education

Develop a local homeless shelter to address drug abuse and family welfare

Improve the readability of educational materials by decreasing the reading level and translating into most common languages spoken in the service area

Increase transportation options

Increase the use of mobile programs to:

Teach healthy habits to youth and their families

Offer remote services (i.e., mobile medical centers, paramedic outreach)

Offer a hotline for residents that find navigating services problematic

Advocate for policies that improve health (payment reform, etc.)

Increase access to care:

- Increase the number of providers (i.e., safety net clinics, primary care, dental, etc.)
- After-hours care

Community is **Collaboration**

STRONGER TOGETHER

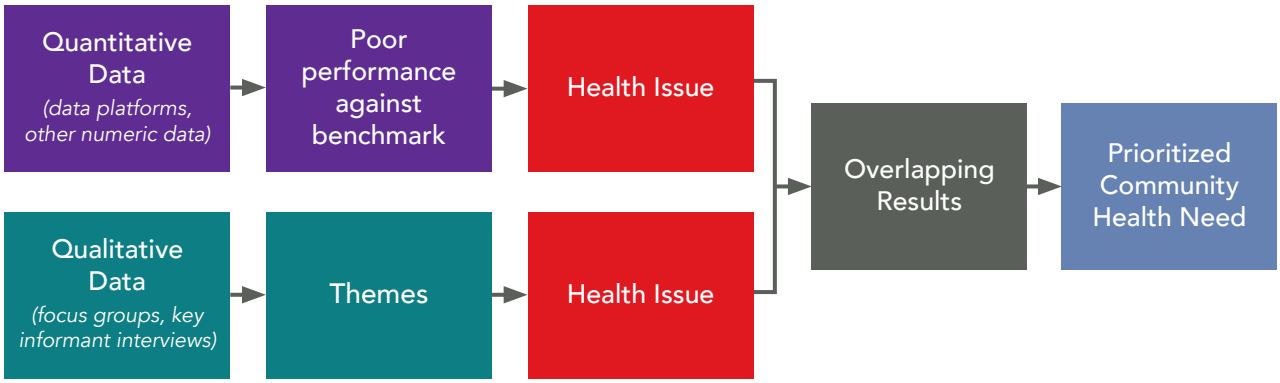
Community Health Priorities

WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital engaged 24 community and hospital leaders to help establish the community priorities for the areas served by both hospitals during a community Health Summit held on March 1, 2018 at the Griffin Regional Welcome Center.

Community stakeholders represented organizations serving residents in the WellStar Spalding Regional and WellStar Sylvan Grove hospitals' community. An in-depth summary of the results along with a description of the participants, methods used and collection period is located in the Primary Data and Community Input Section of the Appendix.

GHPC presented to community leaders findings from the CHNA generated from analysis of secondary data, key informant interviews, focus groups, and listening sessions (see Figure 9).

Figure 9 | Process Used to Identify the Most Pressing Health Needs



The most pressing health needs presented during the Health Summit included:

- Uninsured
- Poverty
- Educational attainment
- Provider rates
- Hospital utilization rates
- HIV and STI
- Cardiovascular disease
- Birth outcomes
- Cancer
- Obesity/BMI
- Diabetes
- Healthy eating, active living indicators
- Behavioral health
- Substance use

Community leaders were then asked to discuss the health needs of the community they serve and encouraged to add any needs that may have been absent from the data presented. Grouped by self-selected tables, participants were asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the under-resourced populations. Needs that were identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface the community health priorities, listed in the order they were prioritized.

1 Wellness education

Health Summit participants considered education to be the most pressing health issue within the hospitals' community. Some concerns discussed were related to low levels of health literacy, language barriers, poor reading comprehension, limited information dissemination, and lack of awareness.

2 Access to appropriate care

Health Summit participants discussed the limited access that residents have to appropriate care when and where it is needed. Several of the concerns discussed were access to safety net providers, number of providers in the community (safety net, primary care, dental, etc.) and access to and affordability of insurance options.

3 Transportation

Participants discussed the limited transportation options that residents have, coupled with the rural nature of the area restricting access to employment options, healthcare, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of comprehensive public transportation that is reliable and the distance residents must travel to secure necessities.

4 Access to behavioral healthcare

Health Summit participants prioritized behavioral health as one of the most pressing issues in their communities. Poor behavioral health in this service area was attributed to the limited number of behavioral health professionals in the area, the number of ACEs, limited family supports, substance abuse, and stigma.

5 Birth outcomes

Lastly, poor birth outcomes were attributed to the limited number of providers (e.g., OB/GYN and planned parenting), lack of affordable insurance options available to women before becoming pregnant and lack of awareness about healthy practices.

Appendix

Consultant Qualifications

Georgia Health Policy Center (GHPC), housed within Georgia State's Andrew Young School of Policy Studies, provides evidence-based research, program development and policy guidance locally, statewide and nationally to improve communities' health status. With more than 21 years of service, the GHPC focuses on solutions to the toughest issues facing health care today, including insurance coverage, long-term care, children's health, and the development of rural and urban health systems.

The GHPC draws on more than a decade of combined learnings from its experience with 100+ projects supported by 75 diverse funders. The studies span the layers of the socioecological model and include individual, multi-site and meta-level assessments of communities, programmatic activities and provision of technical assistance.

The GHPC has guided a national expert team in the design of the Federal Office of Rural Health Policy's Network and Outreach Program evaluations, been commissioned by communities as external evaluators and conducted assessments and community engagements that include the following:

- GHPC conducted a regional community health needs assessment process to meet the IRS regulations of Schedule H, which included 29 Georgia counties and Metro-Atlanta between 2015 and 2016. Partners included Grady Health System, Piedmont Healthcare, WellStar Health System, Mercy Care, and Kaiser Foundation Health Plan of Georgia (KFHPGA). The regional assessment project served as the foundation for the community health improvement planning process employed by GHPC to generate the implementation plan in partnership with Grady Health System and KFHPGA. GHPC has conducted similar assessments and plans to address needs for Grady Health System and KFHPGA in 2009 and 2013.
- GHPC managed the community engagement and conducted the county-level CHNA for which the results will serve as the foundation for Clayton County Board of Health's application to the Public Health Accreditation Board (PHAB) for accreditation. GHPC remains engaged as Clayton County prepares for the next stages of accreditation.
- GHPC evaluated seven metro-Atlanta counties to measure the demand on and capacity of the urban health care "safety net." The study addresses the issue of shrinking access for those who face most significant barriers to health care and examines the health needs and safety net services in Fulton, DeKalb, Cobb, Forsyth, Gwinnett, Fulton and Henry counties. The project is funded by a grant from the KFHPGA through the Community Foundation of Greater Atlanta.
- GHPC conducted an assessment of Georgia's public health system to: more clearly define public health's "core business" related to the broader system of health and health care in the state; gain an accurate understanding of the public's perception of the role of public health; examine the areas of existing service overlap; and investigate opportunities for increased collaboration with various health care providers and stakeholders.

Secondary Data

(November 2017–February 2018)

County Health Rankings (2016)	
Butts	103
Pike	15
Spalding	24

Age Distribution	Butts	Pike	Spalding
0-17 yrs.	20.7%	23.6%	23.6%
18-64 yrs.	63.9%	61.0%	59.2%
65+ yrs.	15.4%	15.4%	17.1%

Racial Distribution	Butts	Pike	Spalding
Black	27.8%	10.2%	33.1%
Hispanic	3.1%	1.6%	4.5%
White	67.1%	86.1%	59.6%

Socioeconomic (per 100,000 pop.)	Butts	Pike	Spalding	CHNA	Georgia	U.S.
Poverty Rate (< 100% FPL) (2011-15)	20.8%	12.2%	22.8%	20.5%	18.4%	15.5%
High School Graduation Rate (2014-15)	86.1%	84.1%	69.0%	76.0%	81.5%	85.0%
Students Eligible for Free / Reduced Lunch (2014-15)	77.3%	41.2%	76.6%	69.8%	62.4%	52.1%
Unemployment Rate (2017)	6.0	5.7	7.5	6.8	5.7	5.2
Uninsured Population (2011-15)	17.0%	16.4%	16.7%	16.7%	17.1%	13.0%
Health Care Access (per 100,000 pop.)	Butts	Pike	Spalding	CHNA	Georgia	U.S.
Primary Care Providers (2014)	25.68	16.87	53.13	40.9	72.9	87.8
Dental Providers (2015)	16.95	16.72	32.79	26.5	49.2	65.6
Mental Health Providers (2016)	47.0	17.0	84.0	NA	112.0	
% of Adults with No Regular Doctor (2011-2012)	35.7%	7.37%	25.1	25.2%	26.1%	22.1%
Federally Qualified Health Centers (2016)	0	0	1.56	0.95	2.1	2.5
% Population in Health Professional Shortage Area (2016)	100.0%	100.0%	100.0%	10.00%	37.9%	33.1%
Health Determinants	Butts	Pike	Spalding	CHNA	Georgia	U.S.
Tobacco Use – Cigarette Smokers (2006-12)	ND	ND	19.2%	19.2%	17.8%	18.1%
Inadequate Fruit & Vegetable Consumption (2005-09)	ND	ND	ND	NA	75.7%	75.7%
Access to Exercise Facilities (2010/2014)	40.0%	47.0%	74.0%	NA	75.0%	
Commute over 60 Minutes (2011-2015)	14.5%	20.3%	10.4%	NA	9.4%	8.5%
% Traffic Deaths Involving Alcohol (2011-15)	14.5%	20.3%	10.4%	NA	9.4%	

ND: Data was unavailable due to a lack of data reporting or data suppression *ND for rates: Rates based on 1-4 events are not shown*
NA: Data was not available

Clinical Care & Prevention	Butts	Pike	Spalding	CHNA	Georgia	U.S.
% Population Receiving SNAP (2014)	24.3%	15.9%	25.0%	23.2%	18.6	14.9%
Adults Never Screened for HIV / AIDS (2011-12)	81.7%	100.0%	61.8%	73.4%	55.1%	62.8%
Physical Inactivity – 18+ yrs. (2013)	28.0%	25.7%	28.0%	27.6%	23.1%	21.8%
Preventable Hospitalization (2014)	66.6	59.1	59.1	60.9	51.8	49.9
Teen Birth Rate (15-19) (2008-14)	62	32	64	NA	39.0	
Other Health Indicators (per 100,000 pop.)	Butts	Pike	Spalding	CHNA	Georgia	U.S.
Poor physical health days (2015)	4.0	3.6	4.5	NA	3.7	
Poor mental health days (2015)	3.7	3.6	3.9	NA	3.8	
% Reporting poor dental health (2006-10)	0.00%	0.00%	18.70%	NA	16.7%	15.7%
Years of Potential Life Lost (YPLL75) (2016)	2,228.0	1,311.0	7,569.5	NA	767,308.0	
Mental health ER rate (2016)	1,272.0	1,109.2	2,026.0	NA	1,083.3	
Self-harm age adjusted discharge rate (2012-16)	59.2	31.8	43.1	NA	33.8	
Age adjusted Opioid Overdoses (2006-2016)	11.9	2.3	10.2	NA	6.4	
Assault age adjusted discharge rate (2012-16)	33.1	ND	22.5	NA	19.9	
% Diabetes Prevalence (2016)	10.9%	0.26%	11.5%	NA	10.6%	9.2%
Diabetes age adjusted discharge rate (2016)				NA	187.3	NA
Diabetes Hospitalization (2016)	193.5	135.8	249.5	NA		
Diabetes age adjusted Mortality rate (2016)	30.9	20.3	24.9	NA	21.8	NA
% Adults Overweight (2016)	36.6%	40.7%	21.5%	NA	35.1%	35.8%
% Adults Obese (2016)	28.4%	25.6%	32.3%	NA	29.3%	27.5%
Obs. Heart Disease/Heart Attack age adjusted discharge rate (2012-16)	386.4	359.0	399.3	NA	276.2	
Hypertensive Heart Disease age adjusted discharge rate (2012-16)	7.3	4.4	7.9	NA	14.2	
Asthma ER visit rate (2016)	600.4	206.2	790.1	NA	538.8	
Motor Vehicle Crash ER visit rate (2016)	1,494.7	1,137.0	1,816.2	NA	1,168.3	

Other Health Indicators (continued)	Butts	Pike	Spalding	CHNA	Georgia	U.S.
HIV prevalence rate (2013)	429	40	303	NA	564.0	
HIV new diagnosis (2015)	70	–	–	NA	28.0	
Age-Adjusted STI rate Except Congenital Syphilis (2016)	672.7	322.1	742.9	NA	833.0	
Low birth weight (< 2500g) per 1,000 births (2012-16)	10.8	ND	9.8	NA	7.4	
Infant mortality (Total) (2012-16)	10.8	ND	9.8	NA	7.4	
Infant mortality (White) (2012-16)	7.9	ND	6.3	NA	5.2	
Infant mortality (Black) (2012-16)	18.2	ND	15.2	NA	12.0	

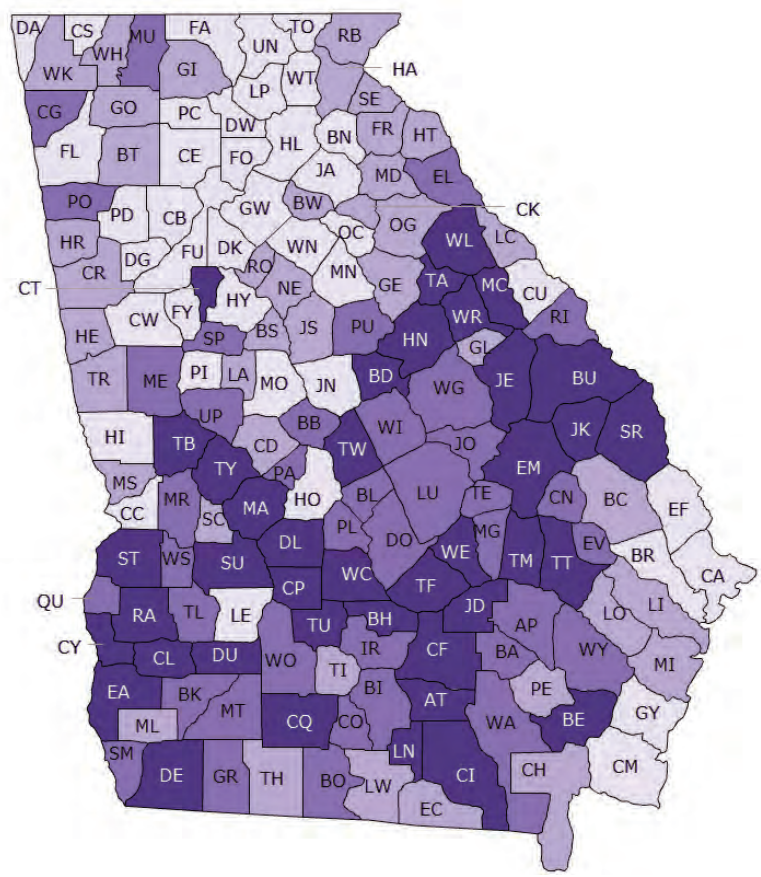
Racial/Ethnic Disparities (per 100,000 pop.)	Butts	Pike	Spalding	White	Asian	Black	Hispanic	Georgia	U.S.
% Uninsured Population	17.0%	16.4%	16.7%	ND	18.4%	45.6%	37.1%	17.1%	13.0%
Stroke Mortality, Age-Adjusted Death Rate	46.3	62.3	47.6	49.5	53.0	0.0	ND	42.9	37.3
Breast Cancer Mortality, Age-Adjusted Death Rate	104.8	94.6	122.1	110.3	127.9	ND	ND	123.4	123.4
Cancer Mortality, Age-Adjusted Death Rate	214.9	194.9	198.5	199.8	0	199.8	ND	169.3	166.3
Annual Cervical Cancer Incidence Rate	39.0	49.5	50.6	46.2	51.2	ND	ND	7.7	7.6
Annual Colon and Rectum Cancer Incidence Rate	161.4	156.7	173.8	146.0	259.3	ND	ND	41.7	40.6
Annual Prostate Cancer Incidence Rate	95.7	75.6	74.3	80.6	74.0	ND	ND	139.8	123.4
Annual Lung Cancer Incidence Rate	104.8	94.6	122.1	110.3	127.9	ND	ND	67.3	62.7
% Population Below 100% FPL	20.8%	12.2%	22.8%	20.8%	35.6%	4.0%	24.8%	18.4%	15.5%
% Children Below 100% FPL	35.6%	15.9%	33.0%	35.6%	52.2%	0.0%	25.3%	26.0%	21.7%
% Population With Less than High School Diploma (or Equivalent)	23.9%	13.1%	21.1%	23.9%	29.1%	3.7%	23.9	14.6%	13.4%
% Population with Any Disability	14.7%	12.8%	16.9%	14.7%	15.2%	27.1%	0.5%	12.2%	12.4%

Ranked Causes: Age Related Death Rate, State and County Comparison (2012–2016)				
	Butts	Pike	Spalding	Georgia
#1	Ischemic Heart and Vascular Disease (123)	Ischemic Heart and Vascular Disease (69)	Ischemic Heart and Vascular Disease (383)	Ischemic Heart and Vascular Disease (40,546)
#2	All COPD Except Asthma (96)	Cerebrovascular Disease (57)	All COPD Except Asthma (263)	Malignant Neoplasms of the Trachea, Bronchus and Lung (22,516)
#3	Malignant Neoplasms of the Trachea, Bronchus and Lung (95)	All COPD Except Asthma (55)	Malignant Neoplasms of the Trachea, Bronchus and Lung (200)	ALL COPD Except Asthma (21,173)
#4	Cerebrovascular Disease (63)	Malignant Neoplasms of the Trachea, Bronchus and Lung (53)	Cerebrovascular Disease (190)	Cerebrovascular Disease (19,602)
#5	All Other Mental and Behavioral Disorders (54)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (49)	Diabetes Mellitus (137)	All other Mental and Behavioral Disorders (18,972)
#6	Alzheimer's Disease (54)	Alzheimer's Disease (42)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (135)	Alzheimer's Disease (14,356)
#7	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (51)	All Other Mental and Behavioral Disorders (32)	Alzheimer's Disease (128)	Essential Hypertension and Hypertensive Renal, and Heart Disease (14,042)
#8	Diabetes Mellitus (45)	Diabetes Mellitus (25)	Pneumonia (127)	Diabetes Mellitus (10,849)
#9	Pneumonia (34)	Pneumonia (23)	All Other Mental and Behavioral Disorders (125)	Nephritis, Nephrotic Syndrome and Nephrosis (8,638)
#10	Nephritis, Nephrotic Syndrome and Nephrosis (33)	All Other Diseases of the Nervous System (20)	Septicemia (98)	Malignant Neoplasms of Colon, Rectum and Anus (7,604)
Not Top Ten but Significantly High	Malignant Neoplasm of the Breast (29)	Intentional Self-Harm (Suicide) (16)	Motor Vehicle Crashes (64)	
	Malignant Neoplasm of Pancreas (24)	Malignant Neoplasm of Pancreas (14)	Malignant Neoplasm of the Breast (61)	

Maps

Health Outcomes

The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

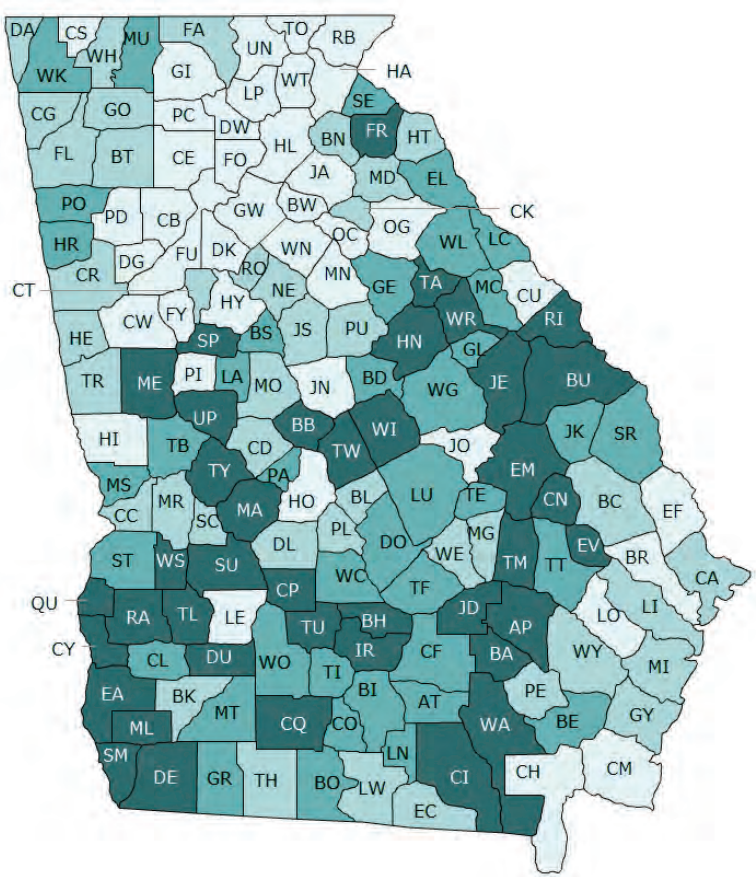


Rank
1-40
41-80
81-119
129-159

http://www.countyhealthrankings.org/app/georgia/2018/overview

Health Factors

The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.



Rank
1-40
41-80
81-119
129-159

Primary Data and Community Input

Regional Health Board Listening Sessions, Community Health Summit, Key Informant Interviews, and Focus Groups

CHNA Collaborators

Collaborator	Areas of Service
Beck, Owen, Murray Stephanie Windham, *Attorney / Spalding Regional Health Board Chair*	Listening Session
Bush Farms, LLC Andy Bush, *Poultry and Cattle Farmer / Spalding Regional Health Board Member*	Listening Session
Butts Collaborative	Key Informant
Butts County Michael Brewer, *Director, Government Relations / Sylvan Grove Regional Health Board Chair*	Listening Session
Butts County Fire Department Mike Wilson, *Chief and EMS Director / Sylvan Grove Regional Health Board Member*	Listening Session
Butts County Hospital Authority Jean Dodson, *Former Administrator/ Board Member*	Key Informant Summit Participant
Butts County Pregnancy Center Cheryl Kish, *Executive Director & Nurse Manager / Sylvan Grove Regional Health Board Member*	Listening Session
Butts County School Board Mamie Crawford, *Retired Teacher and School Board Member / Sylvan Grove Regional Health Board Member*	Listening Session
Jerry Carter, *Sylvan Grove Regional Health Board Vice Chair*	Listening Session
City of Barnesville Peter Banks, *Retired Mayor / Spalding Regional Health Board Member*	Listening Session

Collaborator	Areas of Service
City of Jackson Mayor Kay Pippin Don Cook, *City Council*	Summit Participant Key Informant
Clay Davis, *Spalding Regional Health Board Member*	Listening Session
Coldwell Banker – Bullard Realty Loy Hutcheson, *Associate Broker / Sylvan Grove Regional Health Board Member*	Listening Session
Delta Air Lines, Inc. Joseph Grubbs, *Retired / Spalding Regional Health Board Member*	Listening Session
Eagle's Way Church & Board of Education Will Doss, *Pastor & Chairman / Spalding Regional Health Board Member*	Listening Session
1st National Bank Dick Brooks, *Retired Senior Vice President / Spalding Regional Health Board Member*	Listening Session
Georgia Association for Positive Behavior Support Jason Byars, *President/District Coordinator*	Key Informant
Georgia Department of Public Health	Key Informant
Griffin Housing Authority	Summit Participant
Griffin-Spalding Chamber of Commerce Bonnie Pfrogner, *Retired / Spalding Regional Health Board Member*	Listening Session
Griffin-Spalding County Board of Education Zach Holmes, *Chairman*	Key Informant
Griffin-Spalding County Health Department Cynthia Tidwell, *Nursing Director*	Key Informant

Collaborator	Areas of Service
Griffin-Spalding County School System Anna Burns, *Public Speaker and Published Author / Spalding Regional Health Board Member*	Listening Session
Haisten & Johnston, P.C. Rae Johnston, *CPA & Partner and Sylvan Grove Health Board Member*	Listening Session
Jackson Police Department Chief James Morgan	Key Informant
Jackson United Methodist Church Pastor Chris Shurtz	Key Informant
Lamar and Upson County Health Departments Sherry Farr, *County Nurse Manager*	Summit Participant Key Informant
NAACP	Summit Participant
Oxford Associates Cal Oxford, *Owner / Spalding Regional Health Board Member*	Listening Session
Personnel Options, Inc. Allen Edwards, *President / Spalding Regional Health Board Member*	Listening Session
Project AWARE	Key Informant
Rock Springs Clinic Bobbi Riley, *Administrative Director*	Key Informant
Southern Realty Group April English, *Realtor / Spalding Regional Health Board Member*	Listening Session
Southside Medical Center Katherine Lovell, *Corporate Editor/ Grants Management* Carl Henry, *Practice Administrator*	Summit Participant Key Informant
Spalding Collaborative Regina Abbott, *Executive Director*	Key Informant
Spalding County Rita Johnson, *Commissioner / Spalding Regional Health Board Member* William Wilson, *Manager / Spalding Regional Health Board Member*	Listening Session
Spalding County Fire Department Glenn Polk, *Deputy Chief-Administration*	Key Informant

Collaborator	Areas of Service
State Farm Insurance Tim Broyles, *Agent*	Summit Participant
The Emergency Preparedness Group Sandra Hone, *President*	Summit Participant
United Way Denise Quick, *Executive Director*	Summit Participant Key Informant
University of Georgia Archway Partnership Kristen Miller, *Archway Professional*	Summit Participant
WellStar Health System, WellStar Spalding Regional and WellStar Sylvan Grove Kristin Caudell, *Director, Community Education & Outreach* Geraldine Chandler, *Operations Manager-Food Services* Clay Davis, *Board Member* Jean Dodson, *Retired Director of Nursing / Sylvan Grove Regional Health Board Member* Stacey Hancock, *Vice President – Human Resources* Sherry Henson, *Navigator* David Hitson, *M.D. / Spalding Regional Health Board Member* Tamara Ison, *SVP, Hospital President* Kem Mullins, *Executive Vice President / Sylvan Grove Regional Health Board Member* Philip Osehobo, *CMO/VPMA* Cecelia Patellis, *Assistant Vice President, Community Education & Outreach* Bonnie Pfrogner, *Regional Health Board Member* Carrie Plietz, *Executive Vice President & Chief Operating Officer / Spalding Regional Health Board Member* Kim Stephens, *Community Education and Outreach* Sandy Stovall, *Community Paramedic* Shara Wesley, *Director, Community Benefit*	Listening Session and/or Summit Participant
Community-At-Large Lucy Cawthon Turner Duffey	Summit Participant

WellStar Spalding Regional and WellStar Sylvan Grove Hospitals'

Community Health Summit

The following is a summary of the WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital Health Summit held on March 1, 2018, at Griffin Regional Welcome Center. The Health Summit was facilitated by Georgia Health Policy Center (GHPC) in partnership with WellStar Health System and lasted approximately three hours. The 24 participants included employees of WellStar and community stakeholders. Community stakeholders represented organizations serving residents in the primary service areas of WellStar Spalding Regional and WellStar Sylvan Grove hospitals.

The organizations that took part in the Health Summit included:

- WellStar Spalding EMS
- Lamar and Upson County Health Departments
- WellStar Spalding Regional and WellStar Sylvan Grove Hospitals
- Southside Medical Center at Hope Health Clinic
- University of Georgia Archway Partnership
- State Farm Insurance
- Griffin-Spalding Board of Education
- Griffin-Spalding County United Way
- The Emergency Preparedness Group
- City of Jackson

GHPC presented to community leaders the findings from the CHNA generated from analysis of secondary data, key informant interviews, focus groups, and listening sessions. Community leaders were then asked to discuss the health needs of the community they serve and encouraged to add any needs that may have been absent from the data presented. Participants were then asked to identify the top five health needs that they believed, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the most under-resourced populations. The needs identified by individual groups were consolidated into mutually exclusive health priorities and voted upon to surface community health priorities.

Group Recommendations and Problem Identification

During the Health Summit, participants prioritized five community health needs of residents within the primary service area served by both hospitals: wellness education, access to appropriate care, transportation, access to behavioral healthcare, and birth outcomes. The following is a summary of the input participants offered when asked about contributing factors, potential solutions and community resources to address the health priorities.

Wellness Education

Health Summit participants considered education to be the most pressing health issue within the WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital community. Some concerns that Health Summit participants discussed were related to low levels of health literacy, language barriers, poor reading comprehension, limited information dissemination, and lack of awareness.

Contributing Factors:

- Health literacy is low among youth and adults, and there are limited efforts to address this issue in the public setting (e.g., public schools, etc.).
- Residents in community served by both hospitals are not always aware of how to be healthy (e.g., services available in the community, healthy behaviors, preventive practices, etc.).
- Residents could benefit from having more resources that offer educational information in the places they normally go (e.g., church, grocery stores, work, school, etc.). Recommended topics included family planning, HIV prevention, healthy eating, active living, insurance options, financial stability, and other topics residents might value if asked.
- It is difficult to reach residents in rural areas due to limited access to methods and outlets that can and will effectively disseminate health information to broader audiences.
- Health information can be difficult to comprehend for some residents that have limited reading, vocabularies or English-speaking skills.

Recommendations:

- Develop partnerships among medical schools, residents, local schools, faith-based organizations, and senior centers to better disseminate health knowledge, improve health literacy and understand ongoing health needs.
- Integrate health education into all school settings (primary to tertiary) to educate students and their parents. Several topics mentioned were related to overall wellness (nutritional education and chronic diseases), substance abuse, HIV/STIs, healthy coping mechanisms and life skills.
- Develop a marketing strategy to address the consequences of poor diet, lack of exercise, premarital sex, substance abuse, etc.
- Both hospitals could work to increase residents' awareness of local resources.
- All reading materials should be translated to an eighth-grade reading level, and into languages that are most commonly spoken, to broaden their application and effectiveness.
- Expand the use of mobile methods to reach residents with education and prevention efforts (e.g., mobile medical units, paramedic outreach, etc.).
- Coordinate community volunteers to educate residents in their areas of expertise (i.e., healthcare professionals, nutritionists, insurers, financial advisors, physical fitness trainers, etc.).
- Integrate health education into the workplace as a benefit offering to employees through workplace wellness programs and mobile health services.
- Increase the level of hospital participation in community seminars and health fairs that focus on health issues affecting residents in the area.

Access to Appropriate Care

Health Summit participants discussed the limited access that residents have to appropriate care when and where it is needed. Several of the concerns discussed were access to safety net providers, number of providers in the community (safety net, primary care, dental, etc.) and access to and affordability of insurance options.

Contributing Factors:

- The number of providers is low in the region, which either means residents must travel to secure care (i.e., specialty care — OB/GYN, cardiology, endocrinology, etc.) or wait long periods of time to secure appointments in the area (if available). Care coordination is challenging when residents are seeking care at the ED and/or outside of the area.
- Uninsured residents have limited care options with few Federally Qualified Health Centers (FQHCs) and safety net clinics in the region.
- There are very few local walk-in care options that offer residents access to convenient and affordable care for non-emergent issues after hours.
- Insurance options are limited and may be unaffordable for residents who are not able to secure full-time employment with medical benefits.
- Residents are using the ED to address non-emergency issues (i.e., primary care, behavioral health, dental, etc.).

Recommendations:

- Develop a long-term plan to recruit and retain more providers and specialists to the service area.
- Increase the number of safety net clinics in the community to give under- and uninsured residents access to more affordable care.
- Increase the number of primary and urgent (walk-in and after-hours) care clinics.
- Provide care to residents in their current locations by offering services like mobile clinics equipped with Advanced Practice Providers, telehealth and paramedic outreach programs.
- Explore and try different approaches to educate people on available resources and how to access appropriate services and providers, including tapping into the network of leaders in local communities.
- Increase partnerships with existing providers to better meet the needs of the community.
- Advocate for tort reform at the state level to lower the overall cost of healthcare in the long run.

Transportation

Health Summit participants discussed the limited transportation options that residents have, coupled with the rural nature of the area restricting access to employment options, healthcare, education, etc. Several of the concerns discussed were the lack of affordable transportation options (personal vehicles, ride sharing, etc.) for low-income residents, the lack of a comprehensive public transportation that is reliable and the distance residents must travel to secure basic necessities.

Contributing Factors:

- Many families with limited incomes do not have access to reliable private transportation options (e.g., personal vehicles, ride sharing, etc.).
- The local transit system is not comprehensive or reliable enough for residents to get to and from the places they need to go (i.e., medical appointments, work, grocery store, etc.).
- The rural nature of the region presents health challenges to residents who do not have ready access to comprehensive and reliable methods of transportation due to the distance they must travel.

Recommendations:

- Hospitals could collaborate with community providers and resources to provide mobile clinics to serve low-income areas.
- Collaboratively develop a transportation resource that uses a variety of community resources (e.g., hospitals, community businesses, faith-based organizations, Three Rivers Regional Commission, ride-sharing programs and others with the capacity to address transportation).
- WellStar hospitals could work with companies (i.e., Uber, Lyft, or local taxis, Three Rivers Regional Commission) to provide transportation to and from medical appointments.
- Offer incentives to small businesses to encourage offering transportation to community residents.

Access to Behavioral Healthcare

Participants prioritized behavioral health as one of the most pressing issues in the community. Poor behavioral health in this service area was attributed to the limited number of behavioral health professionals in the area, the number adverse childhood experiences (ACEs), limited family supports, substance abuse, and stigma.

Contributing Factors:

- There are a limited number of behavioral health providers and facilities in the service area, which leads to lengthy waits for appointments and the need to leave the area for care.
- Residents that have undiagnosed or untreated behavioral health issues often end up in the penal system.
- Many children in the area have experienced ACEs, which can be an indication of increased use of healthcare resources among adults.
- Families are not always able to offer the protection and support needed to prevent behavioral health issues that may result from life experience.
- Substance abuse is widespread in the region and methamphetamines are the primary substance. Participants indicated the opioid abuse is a present and growing challenge in their community, but not yet the sizeable challenge that it has become in surrounding areas.

Recommendations:

- Integrate behavioral health services into healthcare and school settings.
- Advocate insurance coverage of behavioral health services among insurers.
- Increase access to and use of WellStar behavioral health services through greater partnership with community organizations.
- Expand the use of telepsych services and paramedic outreach programs where possible to further meet behavioral health needs.
- Increase resident awareness of behavioral health, prevention, symptoms, and local treatment options.
- Collaborate with local for-profit behavioral health providers to offer "enhancement opportunities" to their available services that could effectively build upon existing resources.

Birth Outcomes

Health Summit participants prioritized birth outcomes as one of the most pressing issues in their communities. Poor birth outcomes in this service area were attributed to the limited number of providers (e.g., OB/GYN and planned parenting), lack of affordable insurance options available to women before becoming pregnant and lack of awareness about healthy practices.

Contributing Factors:

- There are limited providers (e.g., OB/GYN and planned parenting) in the area. This causes residents to seek prenatal and other types of maternal, along with child health services, outside of the area.
- Uninsured women of childbearing age do not have access to insurance (Medicaid) before becoming pregnant, which often translates into undiagnosed and untreated health issues that cause poor birth outcomes.
- Residents are not always aware of what is required along the continuum of preconception, prenatal, postnatal, and inter-conception to give birth to a healthy baby.

Recommendations:

- Offer community-based health classes that raise awareness about prenatal, postnatal, inter-conception health, sex education, and life skills that will lead to healthy birth outcomes.
- Partner with local institutions and agencies (e.g., the local schools system, Division of Family and Children Services (DFCS) and local neighborhood programs) to integrate sex education in the curriculum and educate youth and their parents early about healthy choices.
- Increase the number and availability of specialists focused on birth outcomes (e.g., OB/GYN) offering care to under- and uninsured residents.
- Ensure access to prenatal, postnatal and inter-conception services through local safety net clinics and FQHCs.
- Increase the number of local pregnancy centers to provide services and programs to those seeking prenatal care.

Listening Sessions

WellStar Spalding Regional Health Board (February 2018)

1. In your opinion, what are the most serious health problems/needs in our community? What are some of the causes?

- Diabetes – both unmanaged and undiagnosed. The biggest problem surrounding this problem is the lack of education. We are raising a population who are prone to diabetes because of improper nutrition. Many are untreated and/or noncompliant, and the population with diabetes is growing because of lack of education.
- This is related to high rates of obesity – poor food habits – and it also boils down to education. The community does have access to parks and playgrounds for recreational activities.
- We need resources for the school system – middle school partnerships. We know we must change the behavior, not just educate.
- I'm frustrated by grocery stores in low-income areas that offer unhealthy choices. Relates to food insecurity.
- We could have a meaningful impact on community health by helping people manage their medications. They don't understand how to be compliant with their meds, especially if they are on multiple medications. It causes confusion in the chronically ill and elderly who use the ED as their primary care. They also don't understand how to properly take medications.
- Spalding has a community paramedic program. They identify patients who are high-risk at readmissions and they educate at home. Currently, only 10 patients are in the program post discharge. There is an opportunity to expand.
- There are two resources in the community that are underutilized:

  1) Health clinic – Southside. They close doors at 6 p.m.; then patients come to the Spalding ED.

  2) Sun City has approximately 3,000 homes and a classroom in community for health education events.

- King Food – a food pantry-type program at the next level where people buy their food at a discounted rate. Residents have to be qualified to access the food pantry.

2. Who are the community leaders and partners WellStar could collaborate with to help reach under-resourced people with preventive care and education and to improve overall community health?

- School nurses/clinics: Butts County has two schools that have telemedicine.
- Southside: Butts County Medical Center, 176 Lyons St., Jackson, Ga.

  http://www.jacksonprogress-argus.com/news/local/butts-county-medical-center-expands-services/article_57350522-301f-50d4-8397-f3f3105fc0f1.html

  Article excerpt: "The Butts County Medical Center has served Butts County since March 1, 2014. It recently added pediatrics and teen care, HIV testing and a discount prescription program to its offerings, Southside Medical Center Director of Marketing Keisha Williams said.

  There is also a new lab on-site and the clinic now has buses that can provide free, non-emergency medical transportation to and from appointments. The clinic continues to provide family medicine, senior care, behavioral counseling, and women's health services.

- Spalding is an Archway community – UGA partnership. Has a health issue work group that currently needs an initiative that everyone can rally around. http://www.archwaypartnership.uga.edu/communities/spalding-county/
- Spalding Collaborative – http://spalding.gafcp.org/.
- Southside partners with McIntosh Trail for mental health/Dr. Hitson, WellStar IM doc is the medical director for the NPs at Southside – http://www.mctrail.org/spalding.html.
- Pine Woods Mental Health is also utilized – Pine Woods Behavioral Health Crisis Center, 1209 Greenbelt Drive, Griffin, GA 30223. 770-358-8338
- Local churches have counseling. First Baptist, First Assembly – have a counseling program with certified psychologists.
- The hospital has a social worker.

WellStar Sylvan Grove Hospital
(February 2018)

1. In your opinion, what are the most serious health problems/needs in our community?

- Overuse of ED **–** Education regarding options and resources
- Access to affordable care
- Better access to medication
- Transportation
- Many people that go to our ER are better served in a primary care setting. They call 911 and we get them (for lack of transportation). Some patients aren't compliant with their discharge orders and need education – they may not know about other healthcare options before they go home.
- We have a relationship with a clinic – Butts County Medical Center (formerly Southside). We use a flyer referral – nothing formalized.
- Transportation is an issue – there's no public transport – bus, cabs available. Uber is available but not consistent. There are babies born in the ED at Sylvan Grove that were supposed to be born at Spalding, but no transport or gas.

2. Who are the community leaders and partners WellStar could collaborate with to help reach under-resourced people with preventive care and education and to improve overall community health?

- We have many one-off partnerships to try and engage the community – special events, health fairs. Jackson Alive – a medication take-back day, Jackson High School Career Fair, Butts County Counseling Center.
- Worked with Butts County fire, police, health departments, Butts County Life Enrichment Team (LET). http://butts.gafcp.org/files/Butts-Co-Resources_4-14-16.pdf (part of Georgia Family Connection, region 4).
- We need something between ED and doctor's office where people can go to get healthcare without a trip to the ED, such as Urgent Care.
- Would be great if physicians did home visits.
- We need an opportunity to better communicate to the community the value WellStar adds to the community. Many people aren't aware of the services we have and the "give back" to the community. An example: Butts County residents pay a 1 percent tax: "What are we getting out of it?" We have an opportunity there.
- "How can we do that more? We're open to speaking in the community more."

Key Informant Summary

(December 2017–January 2018)

GHPC conducted interviews with community leaders. Leaders who participated in the interview process encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health-related data and (3) representatives of underserved populations. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the CHNA.

Methodology

The following qualitative data were gathered during individual interviews with 12 stakeholders in communities served by WellStar Spalding Regional and WellStar Sylvan Grove hospitals. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents, as well as ways to address those concerns.

There was a diverse representation of community-based organizations and agencies among the 12 stakeholders interviewed. The organizations represented included:

- Griffin-Spalding County Health Department
- Georgia Department of Public Health*
- Spalding Collaborative
- Rock Springs Clinic
- Spalding County Fire Department
- Griffin-Spalding County Board of Education
- United Way*
- Butts Collaborative
- Jackson Police Department
- City of Jackson
- Jackson United Methodist Church
- Butts County Hospital Authority*
- Georgia Association for Positive Behavior Support
- Project AWARE
- Griffin-Spalding County School System
- Southside Medical Center*

** Denotes organizational participation in key informant interview and WellStar Health Summit*

Major Health Challenges:

- STIs
- Mental Health
- Diabetes
- Cancer
- Obesity
- Cardiovascular disease/ congestive heart failure
- COPD
- Hypertension
- Teen pregnancy
- Substance abuse (meth, marijuana)
- Respiratory illnesses

Context and Drivers:

- Low health literacy
- Poor community outreach
- Transportation
- Low educational attainment
- Access to healthy foods (affordability, distance, cultural preference)
- Economic instability (under- and unemployment, disenfranchised community, inadequate job market, poverty affects housing and insurance opportunities, diluted job market)
- Access to care (affordability for under- and uninsured, limited primary and specialty providers, distance/transportation, extended wait times)
- Limited specialty care (prenatal care, OB/GYN)
- Risky sexual behaviors (teens and adults, lack of parental oversight)
- Inadequate housing

Recommendations:

- As a collaborative effect, improve education dissemination (sex education and job skills) by increasing resource marketing across various media
- Increase the prevalence of primary, specialty (esp. women's services) and behavioral health providers/facilities in the community
- Develop a comprehensive transportation method to assist residents with accessing appropriate care
- Advance in payment reform by assisting residents with medical costs
- Design a confidential hotline for residents that find navigating services problematic
- Involve affected residents in healthcare plans and strategies
- Develop a local homeless shelter to address drug abuse and family welfare
- Offer under-resourced populations mobile services

Resident Focus Group Summaries

(January 9, 2018)

Target Population:
Butts, Pike and Spalding Residents

Location:
Griffin, Georgia

Number of Participants:
13

Major Health Challenges:

- Heart disease
- Cancer
- Mental health
- Substance abuse (meth, cocaine)
- Obesity
- High blood pressure
- Dental health

Context and Drivers:

- Economic instability (low income, under- or unemployed)
- Diluted workforce (lack of jobs, no job security, employers hire mostly temp positions, undereducated, underskilled, underexperienced)
- Access to healthy foods (dense fast food market)
- Disenfranchised community (used for film industry, dumping ground)
- Access to care (limited primary and specialty providers, distance, local referrals to prestigious specialist, forced to use out-of-network providers, poor hospital quality, no trauma care)
- Insurance (gap in certain demographics, restricted choices, barriers with acceptance)
- Limited resources for youth (gangs, crime, drugs, poor parental oversight)

Recommendations:

- Develop a youth-based program that ensures local children have access to a centralized, productive environment (i.e., YMCA and Boys & Girls Club). This improves parental oversight and creates a platform for mentorship and resource dissemination.
- Encourage a system that supplies resources, similar to the Supplemental Nutrition Assistance Program, to residents that don't currently fit criteria for benefits.

Primary Data Collection Tools

Key Informant Questionnaire

(2018–2019)

Before we begin, please remember not to use any names or identifying information about yourself or other people.

Context

In your opinion, over the past three years, has health and quality of life in your county:
(Circle or highlight your selection.)

Improved Stayed the same Declined Don't know

Please explain why you think the health and quality of life in the county has improved, stayed the same, or declined and any factors informing your answer.

- What in your opinion are the district's/county's biggest health issues or challenges that need to be addressed? Gaps? Strengths?
- In your opinion, who are the people or groups of people in your county whose health or quality of life may not be as good as others? Why? Please note any zips/areas where there are health disparities/pockets of poverty.
- What do you think are some of the root causes for these challenges? What are the barriers to improving health and quality of life?
- How important an issue to the district/county is the reduction/elimination of health disparities? What is your perception of current disparities?
- What specific programs and local resources have been used in the past to address health improvement/disparity reduction? (To what extent is healthcare accessible to members of your community? Might cite examples of programs by disease state, life stage, or otherwise)

Community Capacity

- Which community-based organizations are best positioned to help improve the community's health?
- Do you see any emerging community health needs, especially among under-resourced populations, that were not mentioned previously? (Please be as specific as possible.) (How does this impact the health of residents?)

Moving the Needle

- If you could only pick three of these health issues, which are the most important ones to address either now (short term) or later (long term)? What should be the focus of intervention by county/district/community?
- Supportive network to help residents in a one-stop place. How do we address these issues in a comprehensive way using existing resources and stitching together a safety net for residents most at risk?
- Why did you pick these?
- What interventions do you think will make a difference? Probe for different types of interventions.
- Do you have any other recommendations that you would make as they develop intervention strategies?

Wrap Up

- Is there anything we left out of this survey that we need to know about the most pressing health needs of the community you serve?

Focus Group Discussion Guide

Community Health Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

Facilitator introduces self and thanks those in attendance for participating

Facilitator explains purposes of discussion:
The project is being undertaken by WellStar Health System. They are seeking ways to improve the health of residents in your community. They would like to hear from people who live in these counties. They are particularly interested in your feelings about the health and health needs of the community, how the health-related challenges might be addressed and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of new initiatives or opportunities.

Explain about focus groups:

- Give-and-take conversation
- I have questions I want to ask, but you will do most of the talking
- There are no right or wrong answers
- You are not expected to be an expert on healthcare, we just want your opinion and your perspective as a member of this community
- You don't have to answer any questions you are uncomfortable answering
- It is important to speak one at a time because we are recording this conversation
- Your names will not be used when the tapes are transcribed, just male or female will appear on any transcript
- I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to "hold on a minute" while I hear from someone else, so don't take offense
- Please remember that what people say in this group is confidential. I ask that you do not share what you heard from others outside of this group.
- You will be asked to talk about yourself, your family and your friends today. Please do not use anyone's name in your comments.
- Here is an informed consent form for you to read along with me and then sign if you decide to participate today. It is important for you to know that your participation today is completely voluntary. You can stop your participation now, or at any time. *(Read informed consent, collect signatures)*

Participant Introductions

Please go around the table and introduce yourself and tell us how long you have lived in [this county/community].

I am going to ask you all a series of questions about your own family's health first, and then some questions about what you see happening in your larger community related to health and well-being.

Health Concerns for Your Family

1. What does the term "healthy lifestyle" mean to you?
2. Do you think you and your family have healthy lifestyles? Why or why not? What affects your ability to be healthy? What prevents you from being as healthy as you would like to be?

I want to go a bit deeper in a few areas related to your and your family's health.

3. Let's start with healthy eating. Most of the time, do you and your family eat as healthily as you would like? What prevents you from eating healthily? (Probe for cultural issues, access to healthy food.)
4. What do you think would make you change your eating habits? What could make it easier for you and your family to eat healthier?

Focus Group Discussion Guide (continued)

5. Now let's talk about physical activity. What kinds of physical activity do you and your family engage in? Do you think you get enough physical activity to be healthy?
6. What keeps you and your family from being as physically active as you would like to be? What would help you and your family get more exercise? What could be done in your community to help you and your family to become more physically active?
7. How about tobacco use? How prevalent is tobacco use among your family and friends? Do you think most people are aware of the risks related to tobacco use? Knowing those risks, why do you think people continue to use tobacco products? What do you think it would take to change people's habits when it comes to tobacco use?
8. Are drug and alcohol abuse a problem in your community? What contributes to this problem? What could be done to address the problem?
9. Another health issue of concern is risky sexual behavior among teens. Do you see this as prevalent in your community? Are there support services to help teens deal with this type of issue? What more could be done?
10. When you think about the health concerns we have discussed – healthy eating, physical activity, tobacco use, drug and alcohol use, and risky sexual behavior – do you know of any resources/programs/services in your community that help with these issues? Are the services that are available adequate to meet the need? Are there different types of services that would be more appropriate or effective?
11. Do you and your family have somewhere or someone that you go to for routine medical care? When you go there, does anyone ever talk to you or provide you with information about the health issues we have been discussing – weight, exercise, healthy eating, tobacco, drug and alcohol use, sexual behavior? Do you think your primary care provider should ask you about these issues? Provide you with information? Help you to change your habits?

Health Concerns in the Community

12. Now let's talk about your community. Please tell me about the strengths/positives in your community.
13. Do you think that most people in your community are healthy? Do you know many people that have chronic diseases such as diabetes, high blood pressure, heart disease?
14. Do you think that there is something about your community that contributes to people having these types of issues?
15. Do you think that people with chronic illnesses have access to the health services they need in order to control their diseases? Why or why not? What services are needed in your community to support those with chronic disease?
16. What do you see as the role of the hospital or health system to address these issues?

Facilitator: Present community-appropriate data summary to participants.

17. What is your reaction to this information? Does it ring true to what you know about your community? Is there anything missing from these data that you believe to be true about your community?
18. What do you think is the best/most effective way to begin to address these issues?
19. Considering the information that I just presented to you, along with your own experience with critical health needs here, which one or two of these health issues should be the priorities for addressing over the next three years?
20. What suggestions do you have for making specific changes in your neighborhood or community? This is another opportunity to make suggestions about needed programs, changes in the community, educational campaigns, etc. that would best meet the needs of this particular community.
21. In communities, people often talk about community leaders – these are organizations or individuals that everyone knows, places/people that you seek out when you need information that is trusted.

    Do you know of these types of organizations or people who are concerned about health issues and serve as leaders in trying to improve health in your community? Who are they – what are they doing? Are their efforts successful? Why or why not?
22. Would these organizations or people be good leaders for addressing other health issues in the community? If not them, then who?
23. What should be done to ensure that children in your community finish their education and can find jobs?

Closing

24. How would you like your community to be different in five years in order to be a healthier place for you and your family to live? If you could make two or three changes that would promote better health, what would they be?

Community Facilities, Assets and Resources

Not an all-inclusive list (January–March 2018)

Health Departments	
Butts County Health Department 463 Ernest Biles Dr., Ste. A Jackson, GA 30233 770-504-2230	The Georgia Department of Public Health (DPH) funds and collaborates with eighteen separate public health districts throughout the state. District 4 Public Health is comprised of 12 counties in west Georgia: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson.
Spalding County Health Department 1007 Memorial Drive Griffin, GA 30224 770-467-4740	Mission is to protect and improve the health of our communities through the prevention of disease, the promotion of healthy behaviors, access to quality services, strong community partnerships, and disaster preparedness.
Pike County Health Department and Environmental Health Office 541 Griffin Street Zebulon, GA 30295 770-567-8972	

Primary Care: Safety Net Clinics & Federally Qualified Health Centers	
Southside Medical Center Butts County Medical Center 176 Lyons Street Jackson, GA 30233 404-688-1350 http://www.southsidemedical.net	Southside Medical Center is a leader in organizing, providing and supporting affordable health care and related services to the public through diversified business activities. Services offered at Butts County Medical Center: Primary Care Dental Care Pediatrics
Rock Springs Clinic 211 Rock Springs Road Milner, GA 678-688-1950 http://www.rsclinic.org/index	The Rock Springs Clinic is a non-profit community faith-based health clinic that provides a comprehensive range of services for individuals without insurance or the means to afford such care. Located in Milner, Georgia, the clinic serves those in 34 counties and 31 cities throughout the middle Georgia area. The clinic is staffed with a team of professional medical and clerical volunteers and provides services free of charge.
Griffin-Spalding County United Way Mailing Address: P.O Box 83 Griffin, GA 30224 770-229-4212 E-mail: united_way@bellsouth.net	United Way understands that you really want to make a difference right here in Griffin and Spalding County. We want to help you do that. Our experience tell us that the best way to help the most people is to focus on the underlying causes of the most serious problems. Here in Griffin and Spalding County, we're focused on critical issues like healthcare, education for adults and children, and the rising number of working people living on the edge of poverty.

Primary Care: Safety Net Clinics & Federally Qualified Health Centers (continued)

Southside Medical Center at Hope Health Clinic
409 W. Solomon Street
Griffin, GA 30223 678-688-8700
www.hopehealthclinic.com

Hope Health Clinic is a medical clinic for Spalding County residents who DO NOT qualify for Medicaid or Medicare and do not have any other type of health insurance. Fees are based on income. Contributions from patients and the community are encouraged.

The services provided include the following:

- Complete medical exams and follow up exams as needed
- Routine/General medical care
- Medical laboratory testing
- Treatment of infectious disease
- Provision of medications for clinic patients
- Referrals to specialists as needed
- Diabetic screening, testing and treatment
- Hypertension screening, testing, treatment counseling and education
- Blood pressure monitors
- Cholesterol screening testing, treatment, counseling and education
- Medical records management for disability claims
- Non-emergent medical treatment for Spalding County Diversion Center
- Depression screening and therapy
- Weight loss clinic

Transportation

Non-Emergency Medical Transportation (NEMT)

Schedule Transportation:
Logisticare:
1-888-224-7981 (Central)
1-888-224-7985 (Southwest)
1-888-224-7988 (East)

Medicaid Member Call Center:
866-211-0950

The Non-Emergency Medical Transportation (NEMT) program provides eligible members transportation needed to get to their medical appointments. To be eligible for these services, members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program.

Non-Emergency Medical Transportation

Logisticare:
1-800-486-7647
or 770-907-7596
http://www.logisticare.com/transportation/

Drivers pick members up at their homes, take them to their appointments and bring them home in a timely manner.

Members, families, social workers, and health care professionals all book rides via our online reservation portals or call centers.

Three Rivers Regional Commission Transportation Service

Call 706-883-1670 to schedule a trip 24 hours in advance
http://www.threeriversrc.com/transportation-services.php

The regional public transportation program provides public transportation for residents of Butts, Lamar, Meriwether, Pike, Spalding, and Upson counties, and has operated in the region since 1999. The regional public transportation program is administered by the Three Rivers Regional Commission on behalf of its participating governments. The regional public transportation program operates under a "demand response" model which means that there are no fixed routes, bus stops, or pick up times. With a demand response model residents call in and order a trip 24 hours in advance, and daily routes are generated based on the destinations requested.

Behavioral Health

McIntosh Trail CSB
MTCSB Administrative Office
1435 North Expressway, Suite 301
Griffin, GA 30223

Locations in Butts, Spalding and Pike County

Call Center 770-358-5252

The McIntosh Trail Community Service Board is a public entity created by the Georgia legislature in 1993 to provide mental health, developmental disability and addictive disease services. Services are available to residents of Butts, Fayette, Henry, Lamar, Pike, Spalding and Upson counties.

Services:

- Addictive Diseases
- Developmental Disabilities
- Mental Health
- Specialty

Pathways Centers
244 O'Dell Road, Suite 3
Griffin, GA 30223
770-229-3407
www.pathwayscsb.org

Pathways Center provides mental health, developmental disabilities and addictive disease services in the west central Georgia region to include the following counties – Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, and Upson.

Services include:

- Outpatient Services
- Community Support
- Peer Support
- Psychosocial Rehabilitation
- Supportive Living
- Developmental Disabilities
- Crisis Stabilization Programs
  – Second Seasons
  – HOPE'S Corner
- Mobile Crisis Services

Georgia Project AWARE
205 Jesse Hill Jr. Drive SE
Atlanta, GA 30334

Rebecca Blanton
Project Coordinator
404-463-0712
Fax: 404-651-6457
Email: rblanton@doe.k12.ga.us

Georgia Project AWARE Goals:

Goal 1: Increase participation of the community (including families and youth) and mental health providers (including school-based and community-based providers) in efforts to identify the mental health resources available to meet the needs of the students and families in each LEA.

Goal 2: Increase awareness and identification of mental health and behavior concerns, and student and family access to mental health providers through the PBIS framework in GPA schools.

Goal 3: Increase the percentage of Georgia youth and families receiving needed mental health services through collaboration between LEAs and community mental health providers.

Goal 4: Train educators, first responders and parents to respond to mental health needs of youth.

HIV

AID Atlanta-Haven of Hope
770 Garrison Trail Suite H
Newnan, GA 30263
770-252-5418
https://www.aidatlanta.org/aid-atlanta/services/clinical-care/haven-of-hope

AID Atlanta's Haven of Hope Healthcare Center, which is located in Newnan, Georgia, specializes in providing comprehensive primary care services specifically for patients with HIV.

Services at our Newnan clinic include:

- Primary Medical Care for HIV-Positive Patients
- Medication and Insurance Co-Pay Assistance
- On-Site Pharmacy
- Laboratory Services
- Medical Case Management

Employment

Work Source-Three Rivers
1210 Greenbelt Dr.
Griffin, GA 30224
Local: (770) 229-9799
http://www.threeriversrc.com/workforce.php

Local One Stop Career Centers help individuals prepare themselves to meet job requirements and help employers identify suitable job applicants. The Career Connections places additional emphasis on assisting youth and veterans.

Serving Spalding, Butts and Pike
Residents can call 770-229-9799 or TOLL-FREE: 1-877-633-9799
For location serving their area.

Youth Programs

Summer Food Service Program:
Seamless Summer

Contact:
Georgia Department of Education
205 Jesse Hill Jr. Drive S.E.
1662 Twin Towers East
Atlanta, GA 30334
404-651-9443

School Food Authorities (SFAs) participating in the NSLP or SBP are eligible to apply for the Seamless Summer Option. Once approved through their governing state agency, SFAs serve meals free of charge to children 18 years and under from low-income areas.

Implementation Strategy

Building a Culture of Health

This joint Implementation Strategy for WellStar Spalding Hospital and WellStar Sylvan Grove Hospital has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a Community Health Needs Assessment at least once every three years and adopt an Implementation Strategy to meet the community health needs identified through the CHNA written reports per hospital facility. This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in proposed regulations.

Background

After an analysis of primary and secondary data gathered for the 2018 WellStar Spalding Regional and WellStar Sylvan Grove hospitals' Community Health Needs Assessment (CHNA), priority health needs were identified at a Community Health Summit. This Summit was comprised of a broad spectrum of hospital leaders and community stakeholders. Using current assets / capacity measures[1] as key indicators to improve community health, the Summit participants answered this overriding question reflecting the patient-centered Triple Aim[2] framework: *Which health needs, when collaboratively addressed, will make the greatest difference in care access, care quality and costs to improve the health of the community, especially the under-resourced?*

To deliver more comprehensive, collaborative and value-based community benefit initiatives, services, education, and events, a task force, the WellStar Community Health Collaborative (WCHC), was created in the fall of 2016 at the System level to address Legacy WellStar's priority health needs.

The WCHC is now expanding beyond Legacy WellStar to encompass all WellStar hospital communities/ strategic markets after the April 2016 acquisition of six hospitals in Georgia, five of whom were converted to not-for-profit in 2017, including WellStar Spalding Regional and WellStar Sylvan Grove hospitals.[3] With the involvement of community partners and stakeholders, the task force enables WellStar to better implement community benefit initiatives and measure outcomes of collaborative efforts to improve community health.

1 *Other considerations: (1) The burden, scope, severity, and urgency of the need. (2) The estimated feasibility and effectiveness of possible interventions. (3) Health disparities associated with the need or the importance the community places on addressing the need.*

2 *The Institute of Healthcare Improvement's (IHI) "Triple Aim" framework to optimize a health system's performance: (1) Improve the patient care experience. (2) Improve the health of a population. (3) Reduce healthcare costs.*

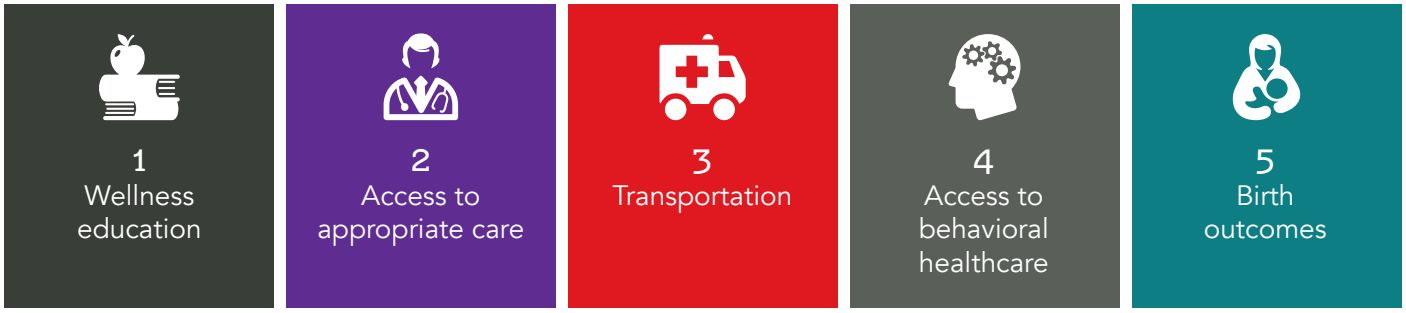
3 *Legacy WellStar is defined as the four-county community where WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, WellStar Paulding Hospital, and WellStar Windy Hill Hospital are located. Legacy WellStar is the entity prior to the acquisition of WellStar West Georgia Medical Center and former Tenet hospitals – WellStar Atlanta Medical Center and Atlanta Medical Center South, WellStar North Fulton Hospital, WellStar Spalding Regional Hospital and WellStar Sylvan Grove Hospital.*

Pairing WellStar Health System experts in a specific health need arena with WellStar Population Health and Community Education & Outreach team members, the WCHC's community benefit programs are designed to:

- Provide organization, framework and leadership to the delivery of community benefit services which enables us to more effectively evaluate and measure the impact on community health, especially among the under-resourced.
- Strengthen WellStar's strategic community partnerships in public and private sectors through formalized engagement as "Partners in Health" leveraging their expertise, resources and services to help build capacity, bridge intervention gaps and address health disparities.
- Boost WellStar's ability to replicate and deliver community benefit services across an expanding health system footprint.
- Maximize the investment in WellStar's safety net clinic/non-profit partners by better aligning our services and resources to address priority health needs.
- Improve overall community health, especially among the under-resourced community members.

Review of Priority Health Needs

Leaders of Georgia State University's Georgia Health Policy Center helped guide WellStar Spalding Regional and WellStar Sylvan Grove hospitals through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research conducted, the following health needs were valuated as priority for the community the hospitals serve:



Implementation strategies for each need were recommended during group exercises. The strategies were later reviewed by the WellStar Population Health and Community Education & Outreach team and vetted by the WellStar Health System's Community Advocacy and Engagement Committee and the WCHC task force, the conduits for Systemwide delivery of community health improvement services and education.

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar Spalding Regional and WellStar Sylvan Grove hospitals play a vital role:[4,5]

Socioeconomic Factors: Interventions that address social determinants of health, such as income, education, occupation, class, or social support. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age. These determinants contribute to a wide range of health, functioning and quality of life outcomes.

Physical Environment: Interventions addressing structural and environmental conditions that have an impact on health, including the built environment, as well as the community environment. This category includes policy changes that support individuals in making healthy choices.

4 *Centers for Disease Control and Prevention, Community Health Improvement Navigator tool. http://wwwn.cdc.gov/chidatabase*

5 *The hospitals' greatest influence to address priority health needs identified in the CHNA is in the intervention areas of health behaviors and clinical care, but have a collaborative role all determinants of health.*

Health Behaviors: Interventions that promote and reinforce positive individual health behaviors, and seek to enable people to increase control over their health and its determinants. They include actions that address the knowledge, barriers and facilitators that can affect behavior.

Clinical Care: Innovative interventions focused on clinical approaches to health improvement that go beyond traditional one-on-one patient care. These activities are upstream or systems-based, and include examples of clinical providers working in teams or providing direct care in a non-traditional setting.

The scope of WellStar's healthcare footprint and its commitment to its mission makes WellStar Spalding Regional and WellStar Sylvan Grove hospitals linchpins and integrators in the community for delivering care, interventions and education to improve overall population health and health equity in the community we serve. This involves providing community benefit programming to address priority health needs via collaborative partners who provide care access, services and resources to under-resourced populations.

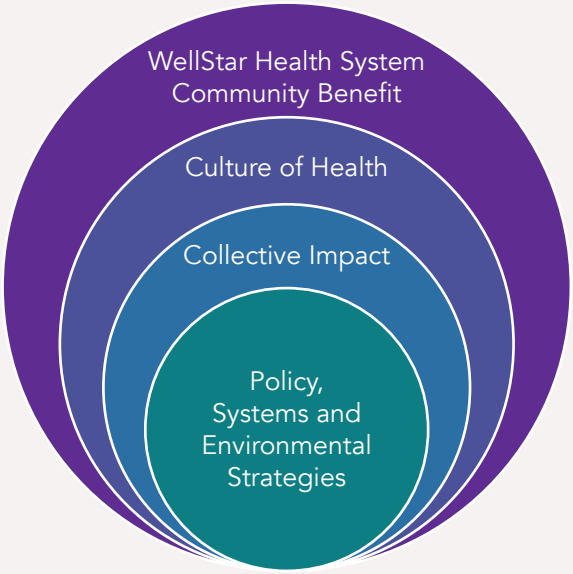
Implementation Strategy Framework and Guiding Principles

To address the priority health needs of the 2018 CHNA, WellStar Spalding Regional and WellStar Sylvan Grove hospitals are initiating and adapting components of the Robert Wood Johnson Culture of Health Framework[6] with influence from the Collective Impact Approach and Policy, Systems, and Environmental (PSE) Change Strategies. The aim is to proactively transform data-driven CHNA results into actionable and measurable community benefit programs and services to optimize patient outcomes and improve overall community health.

These efforts flow from the WellStar mission and vision and to meet the requirements of federal government (Affordable Care Act Section 9007) of Systemwide oversight and guidance regarding tracking community benefit activities, assessing community health needs and developing strategic plans that prioritize the delivery of community benefit.

The Robert Wood Johnson Culture of Health Framework is informed by rigorous research on the multiple factors which affect health. It recognizes the many ways to build a Culture of Health[7] and provides numerous entry points for all types of organizations to become collaborative Partners in Health.

Framework and Guiding Principles



To achieve better health for all, the Culture of Health framework leverages the interconnection of health and social issues; the link between population well-being and life expectancy and collaboration across many different sectors.

6 *https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html*

7 *A critical aspect of a Culture of Health is health equity, which in essence means we all have the basics to be as healthy as possible. Yet at present, for too many, prospects for good health are limited by where we live, how much money we make or discrimination we face.*

There are four Action Areas with ten underlying principles for the Culture of Health framework:

Action Area 1: Making Health a Shared Value: How can individuals, families and communities work to achieve and maintain health?		
Underlying Principles:		
Mindset and Expectations: Prioritizing and promoting health and well-being	**Civic Engagement:** Participating in activities that advance the public good	**Sense of Community:** Cultivating social connections that help us thrive

Action Area 2: Fostering Cross-Sector Collaboration: How can we encourage cooperation across all sectors?		
Underlying Principles:		
Quality of Partnerships: Organizations working together and seeing successful outcomes	**Investment in Collaboration:** Adequate financial support to enable more successful partnerships	**Policies that Support Collaboration:** Creating incentives and methods to encourage ongoing coordination

Action Area 3: Creating Healthier, More Equitable Communities: How can we develop safe environments that nurture children, support aging adults and offer equitable access to healthy choices?		
Underlying Principles:		
Built Environment: Creating safe, affordable environments that support our well-being	**Social and Economic Environment:** Providing improved public resources and economic opportunity for everyone	**Policy and Governance:** Establishing policies to create healthy environments through collaboration

Action Area 4: Strengthening Integration of Health Services and Systems: How can healthcare providers work with institutional partners to address the realities of patients' lives?		
Underlying Principles:		
Access to Care: Making comprehensive, continuous care and healthy choices available to all	**Balance and Integration:** Improving care when public health, social services and healthcare systems work together	**Consumer Experience:** Providing safe, equitable, accessible, efficient, and timely care

A Culture of Health will not be achieved by focusing on each action area alone, but by recognizing the interdependence of each area. Implementing the framework will take time and involve collaboration across multiple sectors beyond the traditional public health field.

Adopting this Culture of Health framework, with health equity at the center, will inform every aspect of community benefit at WellStar Spalding Regional and WellStar Sylvan Grove hospitals – from our safety net clinic partnerships and community grant focus areas to the types of initiatives funded and how we assess the effectiveness of programs and services addressing priority health needs. An equity-focused system of health offers everyone an opportunity to have a healthy life regardless of race, gender or income.

Collective Impact Approach

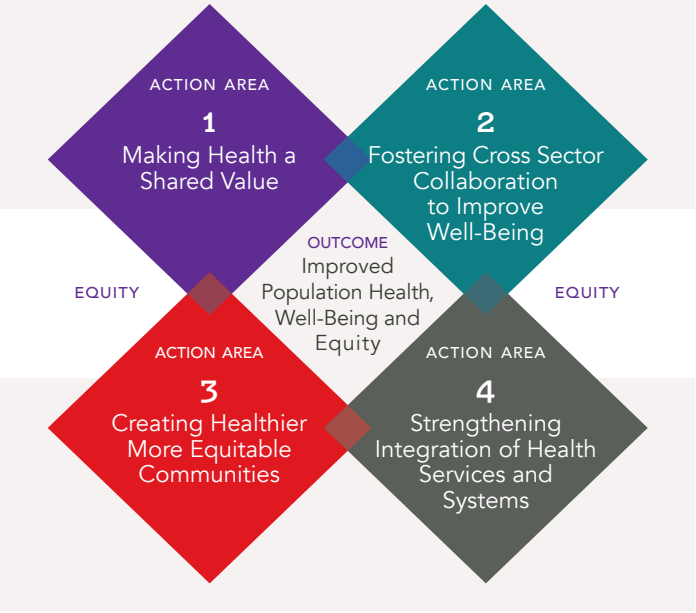
Collective Impact is an approach to tackle deeply entrenched and complex social problems like social determinants of health. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.

The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to adopt a common agenda, shared measurement and alignment of effort.

Policy, Systems and Environmental Change Strategies

Policy, systems and environmental (PSE) change is a way of modifying the environment to make healthy choices practical and available to all community members. PSE changes in communities, schools, workplaces, parks, transportation systems, faith-based organizations, and healthcare settings can significantly shape lives and health. Access to affordable fruits and vegetables, design of sidewalks and bike lanes within communities and smoke-free policies in workplaces and businesses directly increase the likelihood that people can eat healthy and nutritious food, walk to school or work and avoid exposure to second-hand smoke.[8]

Culture of Health Action Framework



Building a Culture of Health
https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html

Collective Impact Approach

8 *Centers for Disease Control and Prevention. (2011). Policy, Systems, and Environmental Change. Retrieved from http:// www.cdc.gov/communitiesputtingpreventiontowork/policy/ index.htm#strategies.*

PSE changes in communities that make healthy choices easy, safe and affordable can have a positive impact on the way people live, learn, work, and play. Cross-sector partnerships with community leaders in education, government, transportation, and business are essential in creating sustainable change to reduce the burden of chronic disease. PSE change is instrumental in creating and encouraging healthy behaviors in the community that WellStar Spalding Regional and WellStar Sylvan Grove hospitals serves.

Defining Policy, Systems and Environmental Change†	
Type of Change	Definition
Policy	Interventions that create or amend laws, ordinances, resolutions, mandates, regulations, or rules
Systems	Interventions that impact all elements of an organization, institution, or system
Environmental	Interventions that involve physical or material changes to the economic, social, or physical environment

† *National Association of County and City Health Officials*

Implementation Strategy to Address Priority Health Needs

WellStar Spalding Regional and WellStar Sylvan Grove hospitals are dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework; the Implementation Strategy focuses on two key focus areas.

Two-Prong Approach

1. **Community-Driven Solutions:** Partnering with communities to drive locally determined solutions and policies that influence systems, services and practices to create equitable conditions that improve well-being. Improving these conditions promotes health equity among people in low-income neighborhoods and fosters health for the hospitals' community.
2. **Sustainable Infrastructure:** Building community benefit capacity and competency within WellStar Spalding Regional and WellStar Sylvan Grove hospitals to streamline business practices and reporting.

Community-Driven Solutions:

Live Well

To address the priority health needs identified in the CHNA, WellStar Community Education & Outreach (CE&O) plays an integral role in the Implementation Strategy through leadership of the Live Well collaborative community program focused on health lifestyle interventions. The goal of the Live Well team is to deliver targeted preventive services, education and outreach to promote wellness and early detection of chronic disease in targeted, under-resourced populations within WellStar hospital communities.

Live Well works collaboratively with both internal and external community partners, such as community safety net clinics, congregations and other community-based organizations and companies serving under-resourced populations, to address priority health needs. For WellStar Spalding Regional and WellStar Sylvan Grove hospitals, a Live Well priority is delivering community-based wellness education and awareness focused on improving birth outcomes, behavioral health and prevention and management of obesity-related chronic diseases.

Productivity Measurement
Number of innovative, evidence-based health education classes related to health promotion and disease prevention to enhance health
Number of participants in innovative, evidence-based health education classes related to health promotion and disease prevention to enhance health
Work with WellStar Hospital leadership to identify two-targeted areas (i.e. diabetes, obesity, behavioral health, etc.)
Identify key community-based organizations to collaborate and coordinate grantmaking pursuits

Impact Measurement
Percentage of participants that recommend future community education activities and classes to others
Percentage of participants that comprehend concepts related to health promotion and disease prevention to enhance health
Percentage of participants that demonstrate the ability to access valid information, products and services to enhance health
Percentage of participants that demonstrate the ability to use decision-making skills to enhance health
Percentage of participants that demonstrate the ability to use goal-setting skills to enhance health
Percentage of participants that demonstrate the ability to practice health-enhancing behaviors
Percentage of participants that have improved health screening results
Percentage of participants that demonstrate changes in their health behaviors

WellStar Opioid Stewardship

Currently, progress is being made Systemwide to address the opioid epidemic. WellStar's Opioid Steering Committee is planning and implementing an ongoing comprehensive and collaborative response to the public health emergency by leading and collaborating with WellStar providers, patients and communities to help reduce opioid misuse, abuse and addiction. Three physician-led work groups committed to prevention, treatment and recovery – three pillars of the July 2016 Federal Comprehensive Addiction and Recovery Act – champion the Steering Committee's efforts. The result will be a transformational preventive healthcare model that is System-wide, patient-centered, equitable, efficient, and measurable to achieve better care and outcomes.

Work groups target various populations internally (team-based) and externally (community-based): 1) Provider and Patient Education, (2) Clinical Initiatives and (3) Community Awareness and Engagement. Live Well outreach relating to opioid misuse/addiction and other behavioral health issues will be implemented in partnership with the Community Awareness and Engagement work group. Instrumental in increasing community awareness is Community Education & Outreach's expanding Medication Take Back program and strengthening partnerships with community organizations/resources, government, law enforcement, and first responders.

The following Community Awareness and Engagement goals and objectives align with the Georgia Department of Public Health's goals:

GOAL #1: Increase community awareness on substance misuse, prevention and the opioid epidemic with key collaborative partners.
Reduce Supply Objective # 1.1: Build an internal and external opioid-free culture by increasing the number of Community Education & Outreach Medication Take Back Events and expand the program to new strategic markets to safely empty medicine cabinets of unused opioids and other medications.[9]
Prevention Objective # 1.2: Collaborate with community resources and strategic partnerships to provide primary prevention-based education in WellStar communities on the risks of opioid use, with a focus on teens and parents.
Treatment Objective # 1.3: Promote available treatment and recovery options and resources to help end the stigma and discrimination related to addictive diseases.

9 *Aligns with Comprehensive Addiction & Recovery Act (2016) strategy to "expand disposal sites for unwanted prescription medication to keep them out of the hands of children and adolescents."*

GOAL #2: Improve collaboration and communication between the WellStar team and law enforcement. (State goal)
Objective # 2.1: Increase access to naloxone to first responders, educators and parents and provide training on how to administer the opioid overdose reversal drug to help save lives.
Objective # 2.2: Assist GDPH's efforts to reduce the supply of opioids in WellStar strategic markets.
Objective # 2.3: Improve training and education of law enforcement and first responders about HIPAA (what information can and cannot be shared).
GOAL #3: Help shape opioid public policy at local, state and federal levels.
Objective # 3.1: Promote public policies that help prevent opioid misuse.
Objective # 3.2: Help ensure government supports the prevention / treatment services and recovery programs that make the most impact on community health as it relates to opioid misuse.
Objective # 3.3: Provide timely updates to WellStar leadership and team regarding new opioid regulations and/or community resource deficiencies.

Community-Driven Solutions:

Community Transformation Grants

The Community Transformation Grants Program will be a new community benefit initiative. This annual, competitive grant program allows WellStar Spalding Regional and WellStar Sylvan Grove hospitals to further the mission by addressing critical health issues in the community served.

WellStar will achieve this by partnering with community-based agencies that are successfully improving and measuring health outcomes through initiatives that address PSE – policy, systems and environmental – change.

Productivity Measurement
Create small and large grant opportunities for eligible organizations to develop and offer innovative programs supporting the mission of improving health outcomes in the WellStar Spalding Regional and WellStar Sylvan Grove hospitals' community
Facilitate cross-sector partnerships and connections to achieve a Culture of Health by addressing social determinants of health
Evaluate and disseminate the impact of health initiatives, programs and investments

Impact Measurement
Intervention population demonstrates reduction and/or management of preventable chronic conditions like obesity-related diseases such as diabetes and heart disease
Intervention population has increased access to the support services that they need to address preventable chronic conditions and behavioral health issues

Building a Sustainable Infrastructure:

Community Benefit Capacity Building

Although the majority of WellStar's community benefit services are delivered Systemwide, each of WellStar's 11 not-for-profit hospitals play a role in addressing the priority health needs identified from its CHNA. Hospital presidents and community benefit liaisons are vital to tracking and assisting in the implementation of WellStar's community benefit programs, most notably for the clinical engagement and care coordination needed to optimize community partnerships and identifying populations for Live Well community-based preventive education and screenings.

To accomplish this, WellStar Spalding Regional and WellStar Sylvan Grove hospitals will build a sustainable and outcomes-driven community benefit program that demonstrates commitment to community health improvement and health equity. Through dedicated leadership, accountability, collaborative partnerships, and stewardship of fiscal and human resources, we will create a more healthy community through outreach, education and advocacy focused on priority health needs.

Productivity Measurement
Identify a Community Benefit Liaison for each hospital
Track and report community benefit activities in the Community Benefit Inventory for Social Accountability (CBISA – community benefit software) and via Community Benefit 101 training
Create and promote an inventory of hospital services, activities and resources that are currently addressing social determinants of health
Assist with government-sponsored health insurance enrollment and applications for WellStar's Financial Assistance Policy and promote awareness on-site at the hospital

Impact Measurement
Increased patient referrals to community resources that address social determinants of health
Increased CBISA utilization to more accurately report Community Benefit investment
Increased primary care access through care coordination with community health clinics

Health Needs Not Addressed

As outlined in the joint 2018 CHNA, health needs not identified as priority to the hospitals fall into one of three categories:

1. Beyond the scope of WellStar services
2. Needs further intervention, but no plans for expanding current community benefit services at this time
3. Relying on community partners to lead efforts with expertise in these areas with WellStar in a supportive role

Evaluation of Action

Baseline data provides a measure the outputs and outcomes of the WellStar Live Well and Transformative Grant programs to meet objectives of priority health needs and track progress. Success is measured by the hospitals' ability to:[10]

- Reduce health disparities by increasing care access and support services to under-resourced, at-risk community members
- Strengthen community capacity and collaboration for shared responsibility to address the priority health needs of the community the hospitals serves

In addition, did the program:

- Improve the overall health of the community[11] through improved access to care and a reduction of the incidence and prevalence of chronic disease?
- Serve and advocate for the medically underserved and under-resourced populations with the goal of providing "the right care at the right place"?
- Improve the delivery and reporting of community benefit services to better demonstrate WellStar Spalding Regional and WellStar Sylvan Grove hospitals' commitment to improve overall community health?
- Implement improved financial assistance, billing and collection policies that protect patients and reduce the number of patients relying on charity care?
- Collaborate with multi-sector community partners to relieve or reduce the burden of government?

Next Steps[12]

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnership and create new health need-focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs
11. Share results at WellStar Community Health Collaborative task force meetings and, as needed, with the community

10 Public Health Institute, Kevin Barnett. Quality and Stewardship in Community Benefit, March 11, 2010.

11 WellStar uses a broad definition of community that allows for measurable opportunities to address population-health issues, while being focused enough to address health disparities.

12 County Health Rankings and Roadmaps/Evaluate Actions. http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions