

As a designated 501(c)3 nonprofit hospital, Piedmont Fayette Hospital is required by the Internal Revenue System to provide to conduct a triennial community health needs assessment (CHNA), in accordance with federal regulations. In its simplest definition, a CHNA is a measurement of the relative health or well-being of a given community. It's both the activity and the end-product of identifying and prioritizing unmet community health needs, which is accomplished by gathering and analyzing data, soliciting the feedback of the community and key stakeholders and evaluating our previous work and future opportunities. Through this assessment, we hope to better understand local health challenges, identify health trends in our community, determine gaps in the current health delivery system and craft a plan to address those gaps and the identified health needs.

Key findings

- Fayette County is in the top percentile in most all areas of health, including clinical care and health outcomes.
- People here live longer and healthier than most others in Georgia.
- This means that services for Medicare populations are crucial, and Fayette County already ranks high in access to clinical care and screening services for older adults.
- Fayette County also has higher than average incomes and adequate housing.
- Smoking and binge drinking rates were below state averages in 2015, as were deaths related to alcohol in 2016.
- Obesity is a critical issue for community members, and this is evidenced in high rates of obesity-related issues, such as diabetes and heart disease.
- Cancer is increasingly prevalent, and especially lung cancer.
- Issues related to social determinants of health are prevalent in all areas we examined.
- Mental health remains a top unmet need, evidenced by high rates of suicide and deaths from other mental issues.
- The county has high opioid prescription rates and alcohol-related incidences in the emergency department.

2020 to 2022 health priorities

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

- Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes
- Decrease deaths from all cancers, with a focus on lung and breast cancers
- Reduce instances of and deaths from heart disease
- Reduce preventable instances of diabetes and increase access to care for those living with the disease
- Reduce rates of obesity and increase access to healthy foods and recreational activities
- Support senior health and healthy aging
- Reduce opioid-related substance abuse and overdose deaths

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

Community snapshot

OUR COMMUNITY

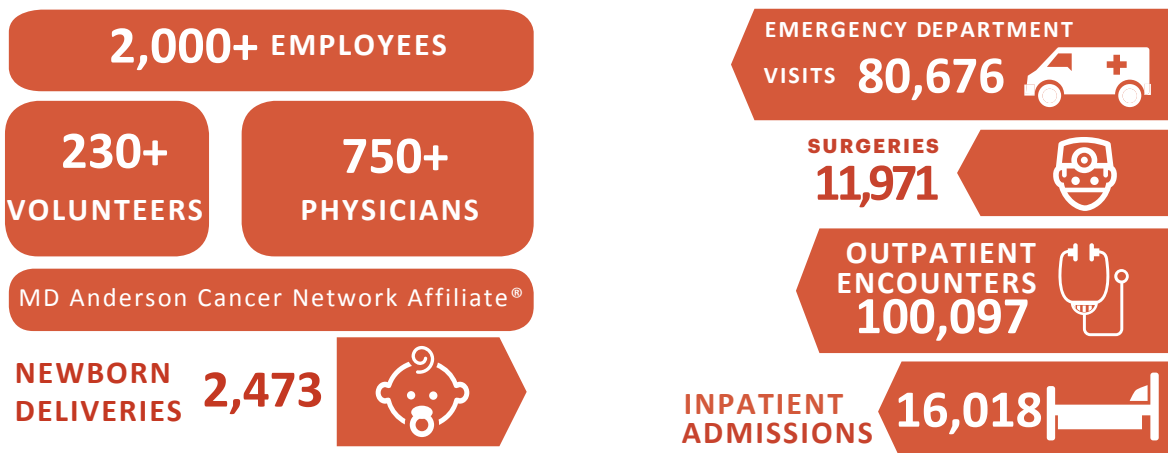
While we serve patients from many parts of Georgia, for the purposes of this CHNA, we only examined the hospital's home county of Fayette County.



- In 2017, approximately 110,306 people lived in Fayette County. The county skewed older, with a third of the county as 55+, and white, with about 70 percent of the population having self-reported as Caucasian.
- In 2017, the median household income was \$84,861, much higher than both state and national averages.
- Most people owned their own home in Fayette County, about 80 percent in 2017, a rate much higher than state and national averages.
- Of the 39,604 households in 2017, 19 percent were headed by a single parent.
- In 2017, the top industries for employed residents were, in order: transportation and warehousing, education, healthcare and social assistance, accommodation and food services, and professional/scientific/technical services.
- Three percent of adults were unemployed in 2017, a figure a percentage point better than state and national averages
- There were 10,602 veterans living in Fayette County in 2017. More than half served in the Gulf War, and about one in five lived with a disability.
- About 18 percent of the county is rural, with more limited access to community assets.

Key hospital stats

Piedmont Fayette Hospital is a 282-bed, acute care, not-for-profit, community hospital that combines clinical excellence with a focus on wellness, high-quality, and exceptional service. Serving Fayette County and surrounding communities, Piedmont Fayette offers 24-hour emergency services, medical and surgical services and obstetrics/women's services. The award-winning hospital boasts leading-edge medical technology in robotic surgery, digital imaging, diagnostics, rehabilitation, cardiovascular services, and hyperbaric medicine/wound care services and cancer center.



Community rankings

In 2018 and in comparison with the other 159 Georgia counties, the University of Wisconsin's County Health Rankings placed Fayette County:

- **4th for health outcomes**, which includes indicators for mortality and morbidity for all its community members
- **5th in length of life**, with an estimated 5,400 years of life lost by all community members due to health factors, far less than the state average of 7,500.
- **4th for quality of life**, with indicators for health, poor physical health days, poor mental health days and low birth weight rates better than state averages.
- **5th for healthy behaviors**, with better than average rates of smoking, physical inactivity, excessive drinking, motor vehicle crashes and teen births, and very low rates of sexually transmitted diseases.
- **2nd for clinical care**, with better than average uninsured rates, diabetes monitoring and preventable hospital stays.
- **3rd for social and economic factors**, with better than average rates of violent crime, children in single-parent households, unemployment and children living in poverty.
- **144th for physical environment**, with rates below the state average for long commutes and drinking water violations.

Overall, Fayette County ranks in the very top percentile in all but one category, physical environment, and showed a marked improvement in all health-related indicators since our last CHNA in 2016.

Mortality

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

Ranking	Age-adjusted death rate, in aggregate, 2013 to 2017
1	Ischemic heart and vascular disease
2	Mental and behavioral disorders
3	Cerebrovascular disease
4	Alzheimer's Disease
5	All COPD except asthma
6	Trachea, bronchus and lung cancer
7	Primary hypertension and hypertensive renal and heart disease
8	Diabetes
9	Nephritis, nephrotic syndrome and nephrosis
10	All other diseases of the nervous system

Suicide was the top cause of premature death in Fayette County between 2013 and 2017, with a total staggering 1,838 community members that took their own lives. Heart disease was the second leading cause of premature death and accidental poisoning the third. Breast, lung and colon cancers were the sixth, seventh and tenth leading causes of death between 2013 and 2017, respectively.

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

Health factors

Access to care

- There were no designated health professional shortage areas in the community in 2016, meaning that all communities are considered to have adequate access to a physician.
- The same holds true for dental care. There were 94 dentists for every 100,000 people in 2015, a figure above average and national rates.
- It's important to note, though, that adequate providers does not necessarily mean full access to care for all community members (see sidebar).
- Throughout Georgia, more than a fifth of all women and a third of all men report having no personal doctor or health home. This was particularly true for minorities, whose rates of not having a doctor are much higher than that of their white counterparts.

Health status

- Community members have reported an average 3.2 and 3.3 poor or fair physical and mental health days, respectively, and a total 13 percent of Fayette County residents reported their health as poor or fair. All three indicators have worsened since our last CHNA.
- Statewide, race matters when it comes to poor health status. Approximately 26 percent of Hispanics reported being in poor health in 2017, as compared to their white and African-American counterparts (18 percent and 19 percent, respectively). Information on other races was not available.

Quality and length of life

- Preventable hospital stays among Medicare enrollees significantly decreased over the last few years, from 51 preventable stays per 1,000 enrollees in 2007 to 38 preventable stays in 2015.
- Medicare enrollees tend to receive proper health screenings, with overall rates above state and national averages.
- Nine percent of the population lived with at least one disability in 2017, which was lower than the state average of 12 percent. The highest concentration of disabled populations in the southern part of the county.
- The infant mortality rate in Fayette County is far less than state and national averages, at 4.8 infant deaths per every 1,000 births in 2017.
 - That year, 7 percent of all babies born were at a low birth weight, and with African American infants most likely to be born at a low birth weight.



In Fayette County, **7 percent of the total population was uninsured in 2017, and 10 percent of the adult population was uninsured that year.** People without insurance coverage have less access to care than people who are insured. Statewide, in 2017, one in five uninsured adults went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

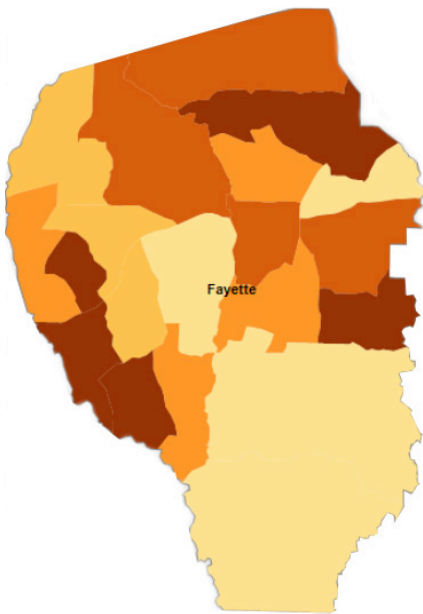
Additionally, these patients are less likely to be able to afford necessary medicine and ongoing chronic condition management. Lower-income patients are more likely to have increased health issues due to social determinants of health.

There are two charitable clinics in Fayette County: the Fayette C.A.R.E. Clinic and the Healing Bridge Clinic. Both serve low-income uninsured patients, and Piedmont Fayette actively partners with both to support their work, including the provision of free lab services and funds for programs. Piedmont and the Fayette C.A.R.E. Clinic share electronic medical records.

There is no Federally Qualified Health Center (FQHC) in Fayette County. Like charitable clinics, FQHCs are community assets that provide health care to low-income populations. FQHCs receive extra funding from the federal government to promote access to community-based care for everyone.

Heart disease

The number one cause of age-adjusted deaths and premature deaths for both men and women each year between 2013 and 2017 in Fayette County was ischemic heart and vascular disease. During that time, 1,674 people died from this disease.



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

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

Stroke

Between 2013 and 2017, 228 Fayette County community members died from stroke, making it the third leading cause of age-adjusted death. This equals a death rate of 35 people per every 100,000 people. This is higher than both state and national averages.

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

Diabetes



Approximately 11 percent of adults lived with diabetes in Fayette County in 2015, a figure relatively in line with state and national averages (11 percent and 9 percent, respectively). In 2015, 24 percent of Medicare beneficiaries lived with diabetes. The numbers may be higher for Medicare beneficiaries because that population is more likely to be tested routinely for the disease.

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

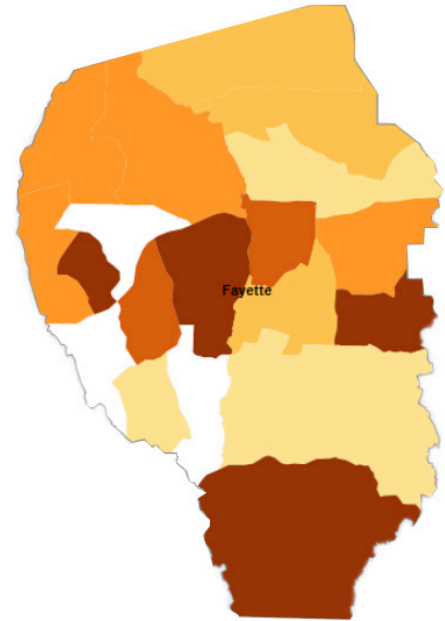
Cancer

Cancer continues to have a devastating impact in Fayette County. In 2017 alone, 162 people died from cancer. Of those, lung cancer kills the most Fayette County members.

To the right is a map of lung cancer deaths by census tract between 2013 and 2017. The darker the color, the more deaths that occurred in that area of the county.

Breast cancer ranked 11th in age-adjusted death, and colon, rectum and anal cancers ranked 13th between 2013 and 2017. Overall, breast cancer death rates have declined over the last several years, but so has prevention. In 2015, only 69 percent of Medicare enrollees said they had a mammogram sometime within the previous two years, a figure down by about 10 percent from three years previous.

Rates of new breast cancer diagnoses rates are high at 143.6 per every 100,000 residents, a figure high above the state and national average of 125 per every 100,000 residents. African Americans are more likely to be diagnosed with the disease than whites.



Cancer and health equity

Both in the U.S. and throughout Georgia, the gap in the cancer rates widens between racial and socioeconomic groups, particularly in preventable cancers. For example, according to the American Cancer Society:

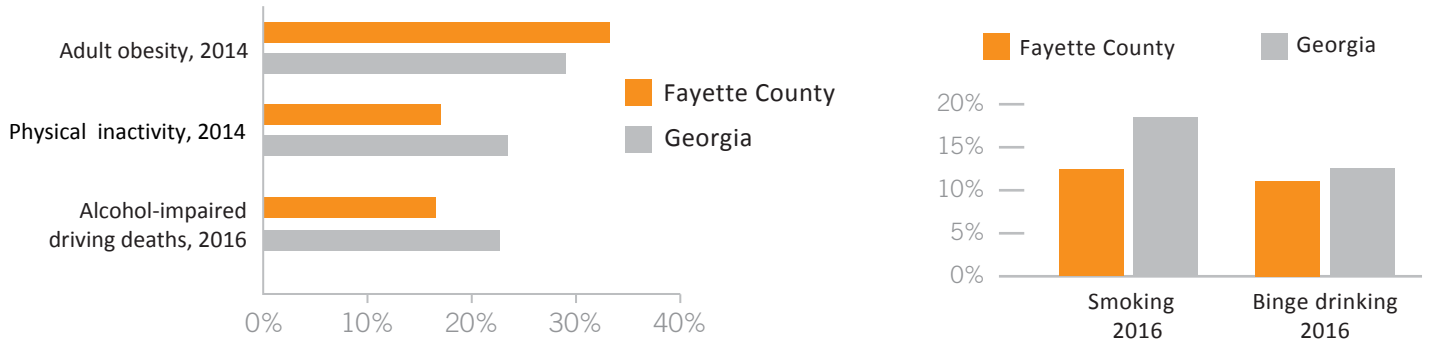
- Deaths from some cancers, mostly related to obesity and tobacco use, continue to rise among low-income populations.
- Poor women have twice as many deaths from cervical cancer than affluent women.
- Lung and liver cancer mortality is more than 40 percent higher in poor men compared to affluent men.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

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

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

Healthy behaviors

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



- **Chronic obstructive pulmonary disease was the fifth leading cause of age-adjusted death between 2013 and 2017.** The most common cause of the disease is smoking.
- **Obesity rates are higher than state and national averages in Fayette County,** and contributes to a number of diseases, including heart disease, stroke and diabetes.
- Smoking rates are much lower than the state average, as is binge drinking.
- **Long commutes are also higher in Fayette County than in the rest of the state - 13 percent drove more than 30 minutes to work in 2016, and most drive alone.** A 2017 study showed that those with long commutes tend to be more depressed, have more work-related stress, get less sleep and are more likely to be obese.
- The violent crime rate was 80.1 per every 100,000 county residents, a figure significantly less than the state average of 378 and 380 per every 100,000 residents.

Mental health

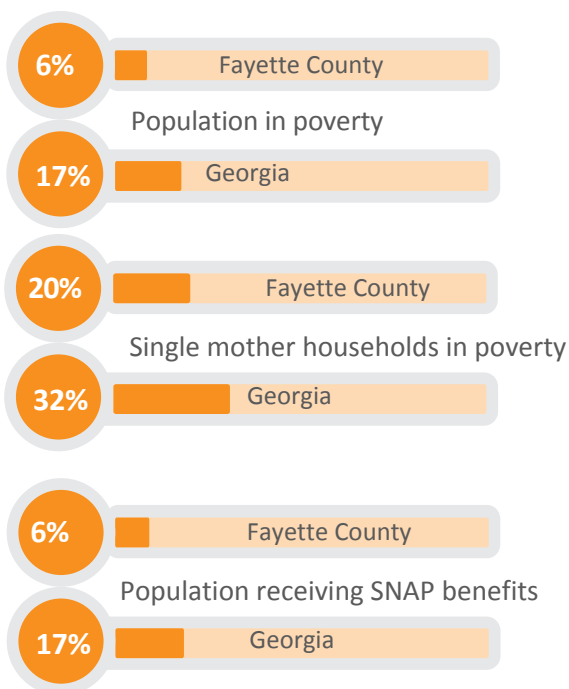
- **Mental health and behavioral disorders was the second leading cause of death for all county residents between 2013 and 2017.**
- **Suicide was the top cause of premature deaths for whites between 2013 and 2017.** It was most common among males aged 25 to 34 years of age.
- There was one mental health providers for every 634 residents in the county in 2017, a rate better than the state and national averages of one provider for every 813 and 493 residents, respectively.

Opioid and substance abuse

- **Opioid prescriptions are a significant issue in the Fayette County community,** with a total 79.2 opioid prescriptions written per every 100 people in 2017. **Fayette is above both state and national averages of 70.9 and 58.7 per every 100 people, respectively.** Please note we aren't able to tell how many prescriptions were written to a single person. We only know the overall figure, meaning a single person could have several prescriptions.
- **Statewide, the age-adjusted opioid death rate was 9.7 per every 100,000 people,** a 10 percent change in rate from 2016. This shows the issue is only continuing to worsen.
- **There were 14 total deaths from all drug overdoses in Fayette County,** which is a 50 percent increase from 2007.

Social determinants of health

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



- **26 percent of those living in poverty in the county did not graduate high school in the 2015-2016 school year.**
- For the 2015-2016 school year, the graduation rate was 94 percent, much higher than the state average of 82 percent. That said, **about 16 percent of the county's adult population does not have a high school diploma, a significant figure.**
- In 2016, **38 percent of the population had limited access to healthy foods and a 17 percent have no access to healthy foods.** These patients live in what's called a food desert, meaning there is no food outlet with healthy food options, such as produce, within a reasonably short travel time.
- **There were 102 fast food restaurants in Fayette County in 2019,** a figure that's much higher, per capita, than state and national averages.
- **25 percent of households had housing costs that exceeded more than 30 percent of total household income in 2017,** indicating a cost burdened household more likely to face overall financial difficulty.

Families and children

- 56 percent of children read at a proficient level in 4th grade testing, a statistic better than state and national averages.
- **26 percent of children qualified for free or reduced cost lunch in the 2015-2016 school year,** a statistic that represents poverty and food instability. Fayette County is less than half of the 2017 state average of 62 percent.
- **For every 1,000 teen girls aged 15 to 18 in Fayette County, 12 gave birth to a child** on average each year between 2010 and 2016. Children born to teen mothers are statistically much more likely to experience adverse health and socioeconomic issues as they grow older. Additionally, this impacts minorities more than their white counterparts. In Fayette, African American and Hispanic or Latina teen birth rates were 15.2 and 35.8 teen births per every 1,000 teen women, respectively.

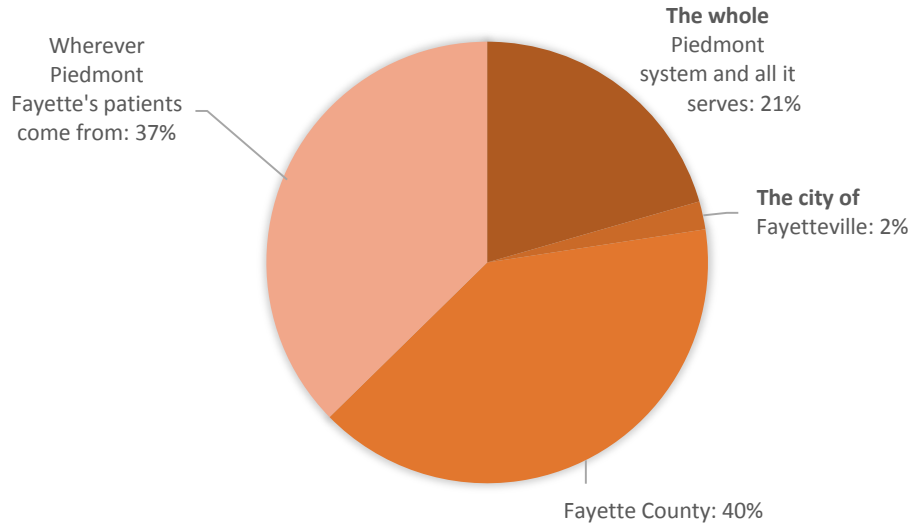


8 percent of children in Fayette County lived in poverty in 2017, a figure that has steadily gotten worse over the last ten years. Poor children are statistically less likely to graduate high school or complete college. They are nearly twice as likely to become poor adults and, should they have children,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

PFH stakeholder survey

In December 2018 and December 2019, 41 key stakeholders within the Piedmont Fayette community provided their thoughts on community health, community assets and the role of the hospital in addressing unmet community health needs via a web survey. Below are the results of that survey.

How would you best define Piedmont Fayette's community?



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

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

1. Cost of health care
2. Mental health
3. Ability to pay for care
4. Lack of health insurance
5. Drug abuse - prescription medications
6. Lack of transportation to health care services
7. Cancer
8. Access to health care services
9. Heart disease
10. Dementia/Alzheimer's disease

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

Top ten answers:

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

PFH stakeholder survey (continued)

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

Top 10 answers ranked "most important":

1. Access to health care services
2. Access to low-cost mental health services
3. Access to dental care services
4. Access to local inpatient behavioral health facilities
5. Additional access points to affordable care within the community
6. Local outpatient mental health services
7. Free or affordable health screenings
8. Expanded access to specialty physicians
9. Safe plays to walk/play
10. Affordable healthy foods



What is your vision for a healthy community?

Some answers:

- "Ensuring that every member of the community has equal access to healthcare and that all healthcare is equally helpful"
- "More free clinics for preventive medicine"
- "Increased local access to specialty services, focus on healthy food and physical exercise"
- "Expand access to those who need it most, poor community, low wage families"
- "Having information on problems/issues affecting our community and an ability to address those problems when they arise"
- "A community that insures access to medical services for those facing transportation and financial barriers to the services"
- "Developing a transportation system that will meet the rural needs"
- "Lots of walk/play opportunities"
- "Continued expansion of hospital based services"



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

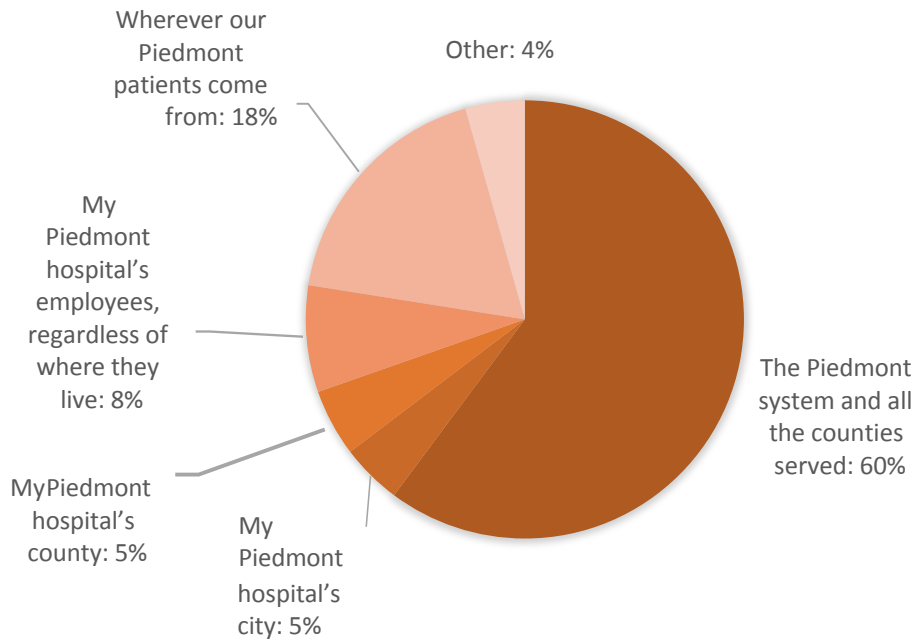
Some answers:

- "Transportation for seniors to medical appointments"
- "Health care cost"
- "Lack of affordable access to mental health services"
- "Access to affordable health care and resources necessary to address issues related to maintaining ongoing relationships with health care providers"
- "Opioid addiction"
- "Obesity"
- "Cost of insurance for young adults"
- "Developing a one stop shop that will provide the basis services and be the gate referral point to other services"
- "Lack forums to bring awareness to the community"
- "Obtaining health insurance"
- "Drug and alcohol misuse"

PHC EMPLOYEE SURVEY

Sixty-three Piedmont Fayette employees completed the internal survey for this assessment. Questions focused on issues facing community members and the hospital's role in addressing those issues. Below are the results from all who answered the surveyed throughout the system, which had a total 897 responses.

How would you best define Piedmont's community?



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

Top ten answers:

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

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

Top ten answers:

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

PHC EMPLOYEE SURVEY (continued)

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

Top 20 answers ranked most important:

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



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

Answers centered on the following themes:

- Health education
- Financial assistance program
- Support for local charitable services and community partnerships
- The Cancer Wellness Program
- Continued growth with beds and services
- The Walk with a Doc program
- Sixty Plus Program
- Giving Epic to local clinics
- Care coordination services
- Breast feeding training for new moms



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

Answers centered on the following themes:

- More Piedmont-sponsored low-cost clinics
- More visible community involvement, especially with minorities
- More outreach and free services for preventative care
- Increased access to specialty physicians
- More attention to mental health
- More attention to opioid and substance abuse
- Screenings that are free for community members, especially for cancers
- A better system for referring patients to the services they need that are outside the hospital

PHC stakeholder interviews

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

Affordability and access

- Health insurance coverage was identified among almost every interviewee as a key pressing health need, and 84 percent of interviewees felt the hospitals could play a larger role in promoting public policies that could expand coverage (such as Medicaid eligibility expansion) or in promoting local activities to encourage enrollment in existing programs.
- Some interviewees suggested programs such as expanded scope of service for nurse practitioners and physician assistants could broaden access to affordable care, as well as the expanded use of telehealth.
- Each interviewee cited the role that Federally Qualified Health Centers (FQHCs) and low-cost clinics currently play in addressing the needs of uninsured patients, and all encouraged further investment in these organizations through the provision of free labs and imagery and shared Electronic Medical Records (EMRs).
 - This is an area where Piedmont has already made significant gains, as most all hospitals currently have a clinic partner and, as of this report, two have full access to our EMRs and a third has read-only rights. This is an area to continue to explore.
- Several interviewees noted the need for increased access to follow up and specialty care for all patients. One patient advocate interviewee stated she fielded questions daily from publicly insured patients who didn't understand how their network worked and uninsured patients who were directed to follow up with a specialist but didn't know who would take them.
- Affordability is a barrier, as many private physicians do not provide financial assistance. As one interviewee stated: **"The patient then just decides they can't get to that specialist and, most likely, their condition gets worse and they are back in the emergency department, sicker and needing even more care now."**
- Almost every interviewee noted transportation issues as a key barrier to access, particularly for older adults and those who are disabled.

Local investment and care coordination

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

Mental and behavioral health

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

PHC stakeholder interviews (continued)

Social determinants and root causes of poor health

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

CHNA approval

This community health needs assessment was unanimously approved by the Piedmont Fayette Hospital Board of Directors on May 08, 2019. The CHNA implementation strategy was approved November 13, 2019.

Methodology

The Piedmont Fayette CHNA was led by the Piedmont Healthcare community benefits team, with significant input and direction from Piedmont Fayette leadership, including the Executive Director of Patient Services, and the Piedmont Fayette Board of Directors, who provided input on the assessment at their March 13, 2019, board meeting.

Process

The CHNA started first with a definition of our community. We looked at our entire Piedmont Healthcare service region, which spans the majority of the state. We paid particular attention to the home counties of our hospitals, which is reflected in the individual hospital CHNAs, including this one, due to the impact of our tax-exempt status. Generally, nonprofit hospitals do not pay four types of taxes: property, state and local income, sales and use, and bond financing. Of these, property taxes make up the largest segment of a hospital's tax exemption – about one-quarter. Because of this, we want to ensure that we are providing commiserate benefit to our local community. Additionally, we take into consideration patient origin, and especially that of our lower-income patients, such as those who qualify for financial assistance or receive insurance coverage through Medicaid. While this report focuses on Fayette County, we will consider other communities -- including nearby Clayton County -- when determining our strategies.

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

Methodology (continued)

From there, we interviewed key stakeholders who have a particular expertise or knowledge of our communities. Specifically, we interviewed representatives of local and regional public health entities, minority populations, faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and individuals representing our most vulnerable patients. The Piedmont Healthcare board of directors and leadership from all 11 hospitals were actively informed and engaged throughout this process.

An internal survey was also conducted throughout the healthcare system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Nearly 900 employees spanning the system responded. Additionally, we conducted a community-based survey in which local stakeholders were asked their thoughts on unmet community health needs and the hospital's role in addressing those needs. These stakeholders included local leaders, nonprofit representatives, elected officials and those with a unique knowledge of the challenges vulnerable populations face. Finally, we conducted direct interviews with 31 state and regional stakeholders and policymakers, with each representing a specific group that tends to be adversely impacted by issues of health equity. These groups included but are not limited to: Georgians for a Healthy Future, Georgia Watch, ConsiderHealth, the Community Foundation for Greater Atlanta, the Georgia Charitable Care Network, the Medical Association of Georgia and Healthy Mothers, Healthy Babies.

How we determined our priorities

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

- The number of persons affected;
- The seriousness of the issue;
- Whether the health need particularly affected persons living in poverty or reflected health disparities; and,
- Availability of community and/or hospital resources to address the need.

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

About community benefit

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

CHNA Implementation Strategy – Fiscal Years 2020, 2021 and 2022

On November 13, 2019, Piedmont Fayette’s board of directors approved the hospital's community health needs assessment, which measured the relative health and well-being of our community. Through this process, we identified key health priorities we’ll address over the next three fiscal years. This below strategy was developed to address those identified priorities.

Priority: Increase access to appropriate and affordable health and mental care for all community members, and especially those who are uninsured and those with low incomes			
Vision	Goal	Tactics	How to measure
Low- and no-income patients receive assistance for necessary care	Eligible low- and no-income patients are enrolled in Medicaid or hospital-based financial assistance program	<ul style="list-style-type: none"> • Financial assistance is available for eligible low- and no-income populations • Patients are adequately alerted that financial assistance is available • Patients are given tools, resources and ample opportunity to apply for assistance • Eligibility threshold of 300% Federal Poverty Level for financial assistance is maintained throughout all Piedmont hospitals • Actively screen all potential patients for Medicaid coverage 	<ul style="list-style-type: none"> • Annual review of policy, guidelines, PLS and languages served, updated to reflect any changes • Consistent policy administered throughout PHC
Low- and no-income patients receive necessary laboratory tests	Ensure that patients at partner not-for-profit charitable clinics have access to the care needed to get – and stay – healthy	<ul style="list-style-type: none"> • Continue to partner with local charitable clinic through the provisions of certain services, including pro bono lab services and Epic EMR licensure (Fayette C.A.R.E. Clinic) 	Clinic to provide a quarterly report on how many patients received labs, how many labs were processed, the top twenty labs utilized, and relevant trends in patient care

Local efforts to increase access to care are strengthened and grown	Provide funding to support specific programs of not-for-profit organizations who provide direct physical and/or mental health services to low-income patients	<ul style="list-style-type: none"> • Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients through direct service • Areas can include primary and specialty care, transportation to and from physical and mental health appointments and the provision of mental health care 	<ul style="list-style-type: none"> • Goals of funded programs are to be determined by the individual organizations and approved by PHC and PFH • Progress evaluated by PHC and PFH every six months
Future health workers are trained	Provide health professions education to students as to further build the health workforce	<ul style="list-style-type: none"> • Continue to provide health education opportunities within the hospital, growing the program when possible and appropriate 	Regularly monitor program by compiling monthly data on students and residents that is then used to evaluate program effectiveness, opportunities for growth
Patients and their families have meaningful input in their care	Regularly convene the Patient Family Advisory Council to provide meaningful input on key areas of care	<ul style="list-style-type: none"> • Regularly convene approximately 10 to 15 advisors comprised of patients, their families and other caregivers, as well as staff, who apply firsthand knowledge to improving the experiences of other patients and caregivers • Set specific scope and goal of council, which could include internal initiatives to improve patient care and quality 	Evaluation tactics to be determined by specific goals of council
Patients have an increased awareness of local resources	Provide resource guide of state and local health-related services and other relevant information to vulnerable community members	<ul style="list-style-type: none"> • Update guide annually • Publish online and in print • Distribute widely throughout hospital and community 	Annual distribution number of guides 10% year over year increase for FY20 to FY22 (approximately 1.5K distributed throughout the Fayetteville community in FY19)
Promote mental well-being among all community members	Reduce barriers to improve access to mental health and substance use screening and assessment	Activities could include partnering with stakeholders to support education, prevention, intervention, treatment services and recovery by partnering with local non-profit mental health	Regularly monitor partnerships, evaluating effectiveness and opportunities to increase collaboration

		providers to raise awareness for community mental health resources to those in need	
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Priority: Reduce opioid and related substance abuse and overdose deaths

Vision	Goal	Tactics	How to measure
Hospital-based prescriptions for opioids and related drugs are reduced	Patients are at low risk of misusing opioids	<ul style="list-style-type: none"> Track opioid prescribing by hospital and physician Use Epic EMR to provide caregivers with tools to monitor opioid use Offer patients ways to safely dispose of unused medication Provide ongoing education on opioid prescribing 	Regularly monitor and increase program and activities, comparing with a FY19 baseline of participation, opioid prescriptions and educational outreach
Patients are supported in recovery from their opioid addiction	All hospital patients with opioid use disorders are provided support in receiving effective treatment leading to recovery	<ul style="list-style-type: none"> Develop relationships with community resources to which patients can be transitioned Make these community resources known and available to our caregivers 	Regularly monitor and increase percentage of PHC patients, identified with an opioid use disorder, who are referred to treatment or support are increased, measured by program participation and qualitative measures
Opioid addiction is viewed as a disease	All hospital employees and medical staff members view opioid use disorders as a medical condition, free of negative stigma	<ul style="list-style-type: none"> Use Teachable Moments to engage employees on reducing stigma associated with opioid addiction 	Regularly monitor percentage of PHC employees who report that they view opioid use disorders as a medical condition, free of stigma are increased, measured by qualitative mechanisms

		<ul style="list-style-type: none"> Regularly look for opportunities to engage staff in internal opioid-awareness activities and opportunities 	
Hospital-based prescriptions for opioids and related drugs are reduced	PHC adopts and uses appropriate non-opioid pain management strategies	<ul style="list-style-type: none"> Implement Enhanced Recovery After Surgery (ERAS) throughout Piedmont Offer multi-modal pain module to caregivers to provide options for opioid in treating pain Create support for exploring other non-opioid pain management therapies (e.g., cryotherapy) 	Regularly monitor non-opioid pain management strategies throughout the hospital, charting increases in non-opioid pain protocols and therapies
Community-based efforts to curb opioid addiction and overdose deaths are increased	PFH provides meaningful leadership in its community by partnering with others in combating opioid abuse	<ul style="list-style-type: none"> Serve as leaders in community-based programs to address opioid abuse and addiction Support community-based strategies to combat opioid abuse through partnerships and task forces 	<ul style="list-style-type: none"> Measure general community awareness of opioid use by charting what resources and partnerships are active now, with a goal to increase those year over year
Local efforts to decrease opioid abuse and overdose deaths are increased	Provide funding to community-based non-profit organizations that work to increase access to care for vulnerable patients	<ul style="list-style-type: none"> Issue of a notice of available funding to all communities soliciting grant applications to curb opioid addiction and overdose deaths Award annual funding based on merit of application and group's ability to positively impact issue Monitor grant progress 	<ul style="list-style-type: none"> Goals of funded programs are to be determined by the individual organizations and approved by PHC and PFH Progress evaluated by PHC and PFH every six months

Community members are more familiar with identifying addiction and local resources to help support recovery	Create and widely distribute an opioid-centric Georgia-based resource guide	<ul style="list-style-type: none"> • Develop an eight- to ten-page guide to address issues of opioid use and prevention • Print and distribute guide throughout Piedmont communities and to patients 	Aim for initial communitywide distribution of 1,500 copies locally, to be increased 15% year over year
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Priority: Decrease deaths from all cancers, with a focus on lung and breast cancer

Vision	Goal	Tactics	How to measure
Patients receive tools necessary for healthy recovery from cancer	Increase promotion of PHC Cancer Wellness to community via non-profits, faith-based community and others	<ul style="list-style-type: none"> • Provide services that include, but aren't limited to: nutrition counseling, cooking demos, personal strength coaching, mindfulness, exercise, music and art therapy, financial counseling and psychosocial support services 	<ul style="list-style-type: none"> • Measure current participation in programs; aim for an annual increase in participation • Utilize client feedback and other qualitative measures to evaluate programming and effectiveness
Cancer prevention and screenings to the Hispanic/Latino community is increased	Reduce cultural barriers to cancer prevention and education for Hispanic/Latino community	<ul style="list-style-type: none"> • Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Engage staff to identify cultural barriers • Work with utilize best practices for engaging the Hispanic/Latino • Identify community agencies/organizations that work with the Latino communities • Coordinate with community stakeholders/ partners on promotional health fairs and 	<ul style="list-style-type: none"> • Establish baseline of current activities • Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

		cultural events with a focus on screening, early detection and education	
More community members are screened for cancer	Overcome challenges of barriers to screenings and Increase cancer screening awareness through community-based partnerships	<ul style="list-style-type: none"> Identify community partners who can help provide necessary outreach and messaging Provide cancer education programs, information booth, and screening kits at events with community partners who are serving uninsured and high-risk individuals Establish a mechanism for screening referrals Establish a mechanism for appropriate follow-up care that takes insurance status, income and other barriers, such as transportation, into consideration 	<ul style="list-style-type: none"> Establish baseline of current activities and partnerships Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys

Priority: Reduce preventable instances of and deaths from heart disease

Vision	Goal	Tactics	How to measure
Community-based heart survival rates are increased	Provide Early Heart Attack Care (EHAC)/Hands-only CPR to community	<ul style="list-style-type: none"> Utilizing data from CHNA, determine priority areas for free CPR training to nonprofit partners Deploy programming, in partnership with community-based groups and emergency medical services 	Monitor participation, with aim to increase year over year

<p>Public is alerted to risks and ways to reduce harm from heart disease, hypertension and stroke</p>	<p>Create public service announcements aimed at reaching at-risk populations on various health topics</p>	<ul style="list-style-type: none"> • Utilizing evidenced-based messaging, create and deploy local public service announcements aimed at high-risk populations and the general public, in appropriate languages • Distribute via social media, community partners, Piedmont.org website, community events • Ensure all programming and relevant materials are bilingual and are accessible to populations with limited health literacy 	<ul style="list-style-type: none"> • Establish baseline of current messaging • Measure participation, outreach and engagement for current and new work, aiming for a significant increase year over year
<p>Women have the necessary information to prevent or survive heart disease</p>	<p>Educate women on preventing and managing heart disease through multimodal traditional and complimentary/alternative education; focus efforts on African American Women and uninsured women</p>	<p>Continue to look for opportunities for community outreach, connect with physicians for referrals to coaching, host community education sessions (lectures, cooking classes, farmers market tours, etc.), involve a vast array of stakeholders and building on work already in place</p>	<p>Will monitor and track education results through readiness to change surveys, screening results and coaching results</p>

<p>Heart disease education and outreach to the Hispanic/Latino community is increased</p>	<p>Reduce cultural barriers to heart disease prevention and education for Hispanic/Latino community</p>	<ul style="list-style-type: none"> • Assess effectiveness of current services and identify opportunities to improve/enhance delivery methods • Work with utilize best practices for engaging the Hispanic/Latino community • Identify community agencies/organizations that work with the Latino communities • Coordinate with community stakeholders/ partners on promotional health fairs and cultural events with a focus on screening, early detection and education • Utilize website, social media, community partners to distribute information 	<ul style="list-style-type: none"> • Establish baseline of current activities • Monitor output of activities and measure participation, outreach and engagement, aiming for a significant increase year over year • Monitor partnership and outreach effectiveness through qualitative methods, including interviews and surveys
<p>Maintain Chest Pain Center Accreditation through the American College of Cardiology by educating the community at large to reduce preventable instances of heart disease</p>	<p>Provide ongoing resources and education to community members as to maintain high level of chest pain care at hospital</p>	<ul style="list-style-type: none"> • Provide quarterly cardiovascular disease screenings to those community populations identified at risk for heart disease. • Offer an Early Heart Attack Care (EHAC) and Hands Only CPR course at least twice a year to the community-at-large • Collaborate with our local EMS agency at least annually to jointly offer an Early Heart Attack Care (EHAC) and Hands-Only CPR course to the community at large 	<p>Conduct yearly review to ensure we are maintaining CPCA designation Opportunities to engage and work with the community are regularly evaluated and implemented</p>

Priority: Reduce rates of obesity and increase access to healthy foods and recreational activities

Vision	Goal	Tactics	How to measure
<p>Low-income community members know how to shop for and prepare healthy foods on limited budgets</p>	<p>Create a Cooking Matters program in partnership with charitable clinics, FQHCs and/or other community-based groups who regularly work with low-income populations, as to combat obesity and promote healthy eating</p>	<ul style="list-style-type: none"> • Using current blueprint, design and execute programming for healthy eating and shopping for families utilizing food stamps or have limited food budgets, and in consideration of conditions such as heart disease, diabetes and obesity • Recruit patients for a four-week, four-session hour-long program that includes a trip to a convenient and affordable grocery store to learn how to best shop and read labels to encourage healthy eating • Potentially partner with local food banks to ensure ongoing access to healthy foods 	<ul style="list-style-type: none"> • Monitor participation through attendance logs • Monitor effectiveness through qualitative surveys and participant interviews • Continually seek out ways to improve programming
<p>Promote healthy weights through walking and exercise</p>	<p>Continue the Walk with a Doc program</p>	<ul style="list-style-type: none"> • Each month, participants walk 2.2 miles with physicians and can ask health-related questions • Walk is held at local farmers market to encourage healthy eating choices 	<p>Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement</p>

Priority: Reduce preventable instances of diabetes and increase access to care for those living with the disease

Vision	Goal	Tactics	How to measure
<p>Community members are able to self-manage their diabetes</p>	<p>Conduct group diabetic education sessions and one-on-one counseling to help patients learn about diabetes and how to manage the disease</p>	<ul style="list-style-type: none"> • Provide ongoing diabetes education includes information on diabetes management, physical activity, medication usage, complication prevention and how to cope with this chronic disease • Provide nutrition education that focuses on food choices and improving blood sugar control. • Provide education to reduce negative impact of diabetes reduce heart disease risk factors and improve weight management • Provide diabetes-during-pregnancy education through individualized instruction and intensive diabetes self-management instruction on insulin therapy 	<p>Regularly monitor effectiveness through qualitative surveys and participant interviews and continually seek out ways to improve programming</p>
<p>Reduce preventable instances of diabetes and diagnosis the disease among high-risk populations</p>	<p>Provide information on diabetes prevention and set up regular screening activities at a local food bank (or allow referrals for screening, either at the hospital or with a partner)</p>	<ul style="list-style-type: none"> • In partnership with relevant community-based groups, determine scope of programming, eligibility requirements • Design program • Deploy initial programming 	<p>Will develop ongoing, specific measurement tactics with partners to ensure program effectiveness and evaluate opportunities for growth and improvement</p>

Priority: Support senior health and healthy aging

Vision	Goal	Tactics	How to measure
<p>Promote mental health well-being among seniors</p>	<p>Address isolation and loneliness issues among senior population</p>	<ul style="list-style-type: none"> • Partner with Fayette Senior Services to increase wellness checks for homebound seniors through the Meals on Wheels program and maintain support for program • Partner with Real Life Center to support their older adult congregate meal program to reduce isolation and maintain support for program services • Maintain PFH Legacy Program for older adult volunteers who no longer serve PFH <ul style="list-style-type: none"> ○ Regular phone check-ins and ○ Quarterly luncheons to ensure ○ Monthly newsletters and program speakers provide health education • Identify greater needs of seniors upon discharge to connect them with valued resources such as senior centers with congregate meal programs, transportation to church, food banks, and community activities 	<ul style="list-style-type: none"> • Regularly monitor effectiveness through outcomes measurement and continually seek out ways to improve programming • Measure current participation in programs and aim for an annual increase in participation

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

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

- Chronic Obstructive Pulmonary Disease: We will not focus primarily on COPD in our upcoming community benefit work, we will continue our current clinical support and pulmonary rehabilitation program for those suffering from this condition and continue to look for ways to positively impact prevention efforts, including our overall efforts to curb smoking within the community.
- Alzheimer's disease: Alzheimer's disease continues to be a leading cause of death in the community. Although this is not a stated priority of the hospital during the FY20 to FY22 community benefit cycle, the hospital will actively support services aimed at patients and families suffering from the disease, and particularly those services offered through our Sixty Plus program and our efforts to support senior health and healthy aging.