
FY22

PIEDMONT WALTON HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT



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Introduction

As a not-for-profit healthcare system, the mission of Piedmont Walton is healthcare marked by compassion and sustainable excellence in a progressive environment, guided by physicians, delivered by exceptional professionals, and inspired by the communities we serve.

In our commitment as a not-for-profit health system, Piedmont Healthcare studied the region's community health needs for its Community Health Needs Assessment (CHNA), a triennial process required by the Internal Revenue Service due to our tax-exempt status. 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 done 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. This is the fourth Piedmont CHNA, with the others having been conducted in 2013, 2016 and 2019. The 2022 Piedmont CHNA will serve as a foundation for developing our community benefit strategies and further strengthening our community-focused work.

About the hospital

Piedmont Walton Hospital is a 77-bed, not-for-profit community hospital in Monroe, Georgia and serves as the sole hospital provider for the Walton County community. With more than 400 employees and 200 physicians, Piedmont Walton offers 24-hour emergency services, with a designated level III trauma center, plus other major medical, surgical and diagnostic care.

About Piedmont Healthcare

Piedmont has more than 31,000 employees caring for 3.4 million patients across 1,400 locations and serving communities that comprise 80 percent of Georgia's population. This includes 22 hospitals, 55 Piedmont Urgent Care centers, 25 QuickCare locations, 1,875 Piedmont Clinic physician practices and more than 2,800 Piedmont Clinic members. Piedmont has provided \$1.4 billion in uncompensated care and community benefit programming to the communities we serve over the past five years.

Community benefit

Piedmont Walton is a not-for-profit hospital, meaning it is exempt from paying certain taxes. In exchange for those exemptions, federal and some state laws require that communities receive from their hospitals certain benefits, appropriately called community benefit. These programs are generally meant as programs intended to increase access to care and boost the health of the community, with a focus on low-income populations and others who face unique challenges to being healthy. Since our last CHNA, in FY20 and FY21 combined, Piedmont Walton provided \$16.4 million in community benefit.

	Combined FY20 and FY21
Care for low-income patients	\$12,017,992
Community health promotion	\$292,700
Health professions education	\$1,228,277
Bad debt	\$2,862,232

Key programs include: support for labs and prescriptions for our partner charitable clinic F.I.S.H. MD, community-focused health education, health professions education within the hospital, COVID-19 vaccination clinics, and, importantly, financial assistance for low-income patients who aren't able to afford their health care and care for those covered through the low-income state/federal public insurance program Medicaid.

Additionally, the health system provides two programs free of charge to patients, regardless of where they receive their care. Sixty Plus Services provides educational and supportive programs designed to enhance the well-being of older adults and their families, including geriatric support, dementia support, insurance guidance, the Aging Helpline, and community education and wellness. Piedmont's Cancer Wellness provides free programs such as yoga, cooking demos, expressive art classes, and counseling that are available to anyone affected by cancer at any phase in his or her journey, regardless of whether they are a Piedmont patient.

Financial assistance

Piedmont Healthcare provides financial assistance to qualifying low-income patients at or below 300 percent of the Federal Poverty Level. Patients qualify for financial assistance in one of two ways: either through presumptive eligibility, in which the patient's file is automatically scanned for certain indicators that mean he or she would qualify for financial assistance, or via manual application by the patient or his or her representative. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years.

ZIP code	No. of patients - FY20	No. of visits - FY20	No. of patients - FY21	No. of visits - FY21
30655	3,249	5,503	2,503	4,368
30656	1,081	1,685	729	1,233
30052	1,173	1,561	380	505
30025	505	757	375	564
30014	227	301	181	244
30054	210	314	113	174
30680	140	180	87	133
30620	114	155	75	102
30641	76	93	84	114
30016	82	104	41	55

Please note we provided financial assistance to patients outside of these ten ZIP codes as well.

Examining ZIP code data can help us to better target specific communities that may have unique challenges due to social determinants of health, such as having a low income, poor housing conditions, or limited access to healthy foods.

Medicaid

Piedmont provides services to patients who receive benefits through the state/federal public insurance program Medicaid, which covers the cost of care for low-income patients who: are pregnant, are a child or teenager, are 65 and older, are legally blind, have a disability, or need nursing home care. Below is a list of the top ten ZIP codes by volume of patients receiving care at the hospital as a Medicaid beneficiary during the last two fiscal years.

ZIP code	No. of patients - FY20	No. of visits - FY20	No. of patients - FY21	No. of visits - FY21
30655	9,342	20,202	9,283	20,226
30052	5,250	8,590	6,111	10,590
30656	3,746	7,492	3,885	7,781
30025	1,559	2,814	1,552	2,863
30014	820	1,285	983	1,645
30054	680	1,196	742	1,422
30620	414	649	517	802
30680	413	602	444	690
30016	301	439	391	557
30641	318	497	325	586

Please note we provided care to Medicaid beneficiaries outside of these ten ZIP codes as well.

FY22 Priorities

A key component of the CHNA is to identify the top health priorities we'll address over fiscal years 2023, 2024, and 2025. These priorities will guide our community benefit work. They are, in no order of importance:

Ensure affordable access to health, mental and dental care

We will work to ensure that all community members have access to affordable health, mental and dental care, regardless of income. This includes partnerships with community-based organizations, as well as internal programming to increase access.

Promote healthy behaviors to reduce preventable conditions, diseases and addiction

We will actively promote healthy behaviors and encourage community members to stop risky behaviors, such as smoking. This includes widespread health education and programming, and specific efforts aimed at curbing opioid use.

Reduce preventable instances of and death from cancer

We will promote both the prevention and treatment of all cancers, especially among those most vulnerable to the disease. This includes community-based screenings and the promotion of programming meant to support community members with cancer and their families.

Reduce preventable instances and death from heart disease

We will promote both the prevention and treatment of heart disease, and will emphasize early detection and healthy behaviors to help reduce risk. We will pay particular attention to populations most at risk for heart disease.

With each priority, we will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators for that priority. This means we will prioritize programming and investment in areas that directly address issues related to income and poverty and others who face particular challenges in accessing care due to disability, race, English proficiency, educational attainment, and other areas of socioeconomic status. Additionally, whenever possible, health education will be available in the languages found within the community, with special attention spent on outreach to those populations.

When possible, we will work to address other issues that arose during the CHNA, such as Alzheimer's Disease, even though those are not listed in the above priority list.

Progress since last CHNA

In the hospital's FY19 CHNA, four health priorities were identified to address over the following three years. These priorities were:

- Increase access points for appropriate and affordable health, dental and mental care for all community members, especially those who are uninsured and those with low incomes
- Decrease deaths from cancer and increase access to cancer programming for those living with the disease, with a focus on lung cancer
- Promote healthy weights and behaviors to decrease preventable instances of heart disease and diabetes
- Reduce opioid and related substance abuse and overdose deaths

It's important to note that COVID-19 had a significant impact on Piedmont Walton proactive community benefit programs, as we canceled all in-person events and classes as of early March 2020. We created programming responsive to the pandemic, including migrating vital community-based programming online.

We prioritized increasing access to appropriate and affordable health and mental care by providing funding support for a full-time nurse practitioner to treat low-income and uninsured patients. We provided funding for a full-time nurse practitioner at F.I.S.H. MD charitable clinic in Monroe. The APP's salary is \$105,000, working 36 hours per week.

In FY20 and FY21, we implemented Leadership Rounding every morning after Safety Huddle. Leaders were assigned two inpatient rooms to monitor daily, with the intention to ensure all standards of care were both met and exceed, allowing leadership to communicate any issues immediately.

We maintained our Level III trauma center designation in FY21 and our trauma and stroke coordinator tracked opportunities for improvement when reviewing charts and reported those to peer review if significant. Trauma surgeon timeliness was discussed at Trauma Peer Review every even month. Stroke Core Curriculum meetings were held twice a month for staff and emergency medical services partners.

We also were actively involved in other emergency services meetings, including the Emergency Management Committee, the Emergency Operations Center, Region 10 EMS, and the COVID-19 Task Force.

We worked to reduce opioid and related substance abuse and overdose deaths by providing meaningful leadership in the community and partnering with others in combating opioid abuse. The Walton County Sheriff's Office has a box present year-round to take back unused prescription medications, and we regularly referred patients to this box.

Progress since last CHNA, cont'd

We also helped promote the Monroe Police Department's annual Take Back Day event, which is an advertised opportunity for community members to safely dispose of any medications.

In April 2021, our pharmacy director convened 16 community leaders to discuss the local opioid and substance abuse issue, providing an opportunity for community input to ensure we are working collaboratively to combat this deadly issue. Attendees included representatives from: Walton County Chamber of Commerce, Northeast Georgia Medical Center Barrow, Uniting Hope 4 Children, Department of Community Supervision, and The Walton Tribune.

We actively provided cancer support services, having partnered with the Cancer Foundation of Northeast Georgia, and we worked to help connect community members with resources through The Cancer Foundation and The Partnership of Families, Children, and Youth. Unfortunately, our Cancer Support Group was placed on hold in FY21 due to COVID-19. There are plans to restart these meetings once a month, once it is safe to do so.

We promoted healthy weights and behaviors by working with Walton Wellness, a community collaboration within the county, to promote Food Rx, a program targeting low-income county residents who are obese, hypertensive, or diabetic to receive fresh produce and nutrition education during a six-month period. In FY21, 14 residents participated in the program.

Finally, we hosted Diabetes Support Groups, led by a dietician, who met once per month and supported five participants in FY21.

FY22

Community Health Needs Assessment

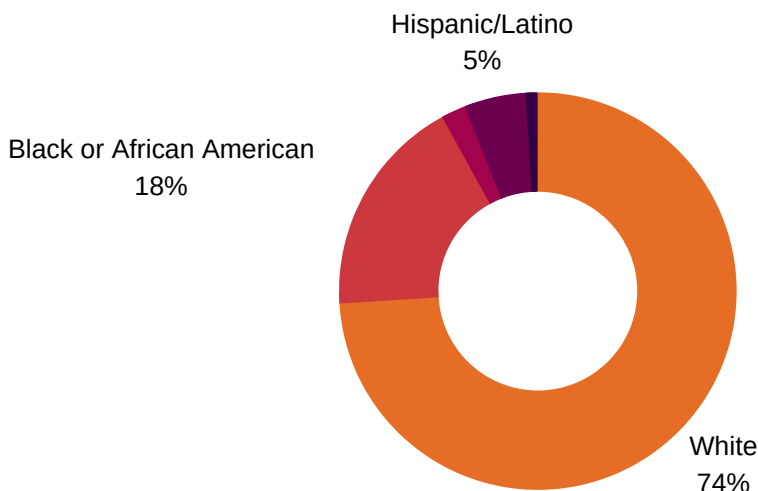
About the community

While Piedmont Walton serves patients from all over northeast Georgia, for purposes of this CHNA, we consider our community to be Walton County. We do this in recognition of the direct impact of our tax-exempt status on county residents.

In Walton County, 93,284 people lived in the 326.82 square mile area in 2020. The population density for this area, estimated at 285 persons per square mile, is more than the national average population density of 91.93 persons per square mile.

Walton County is mostly urban, as 57 percent of lived in an urban setting in 2020, and ZIP code 30019 had the highest concentration of urban dwellers. The median age of people living within the county was 39, a little older than state and national averages. About 26 percent of the population were 18 or younger, 16 percent were over the age of 65, and the rest were between ages of 18-64. Twenty-five percent of the population identified as being born outside of the US and two percent of the total population do not possess US citizenship status.

About 7 percent of county residents were veterans in 2020, with the highest concentration living in ZIP code 30052 (Loganville). The majority were over the age of 65. About 13 percent of the county population lived with a disability in 2020, and most were over the age of 65.



The chart to the left represents a breakdown of races within the community. Minority populations have steadily grown in recent years, with Hispanic or Latino populations leading growth.

The community is growing, and about 12,900 people moved into Walton County between 2010 and 2020, representing a 15.4 percent growth. With this growth comes increased diversity, as white populations decreased and all other races and ethnicities increased. Specifically, there was a four percent increase in white populations, a 32 percent increase in black or African American populations, a 49 percent increase in Asian populations, and a 95 percent increase in Hispanic or Latino populations.

Root causes of poor health

In conducting the FY22 CHNA, we recognized two main issues that emerged that are root causes of poor health.

Poverty and health

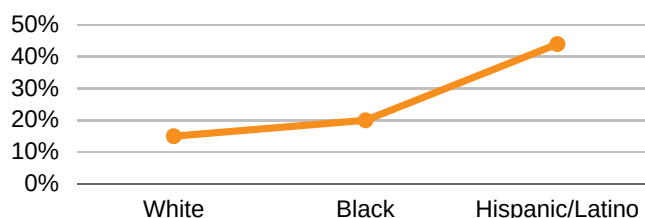
Poverty is the most significant indicator of health as, in general, poorer people are sicker than their richer counterparts. Those living at or near poverty are most likely to die from cancer, heart disease and diabetes, due to several factors that go beyond income, such as education, housing and simple geography, things commonly dubbed “social determinants of health.” This means that factors outside your immediate physical self can play a huge role in your health, even including how long you live. Life expectancy can vary as much as 30 years between the richest and poorest Georgia counties. Walton County has a low poverty rate as compared to the rest of the state, with 12.3 percent of the population living at or below the Federal Poverty Level in 2020.

Insurance status and health outcomes

In 2020, about 12 percent of the county's population was insured. Being uninsured is generally a marker of low income, and the overwhelming majority of those that are uninsured are also within certain ranges of the Federal Poverty Level (FPL). This means these populations are also likely to face the myriad of other social determinants of health (SDH), like housing and food insecurity.

No insurance can mean no access to primary and specialty care, due to cost and/or provider availability. Conditions that could have been treated affordably in a community setting are often not and, because of this, those without insurance statistically suffer worse health outcomes than their insured counterparts. Diseases like cancer are often diagnosed later, and manageable conditions such as hypertension can elevate to dangerous levels.

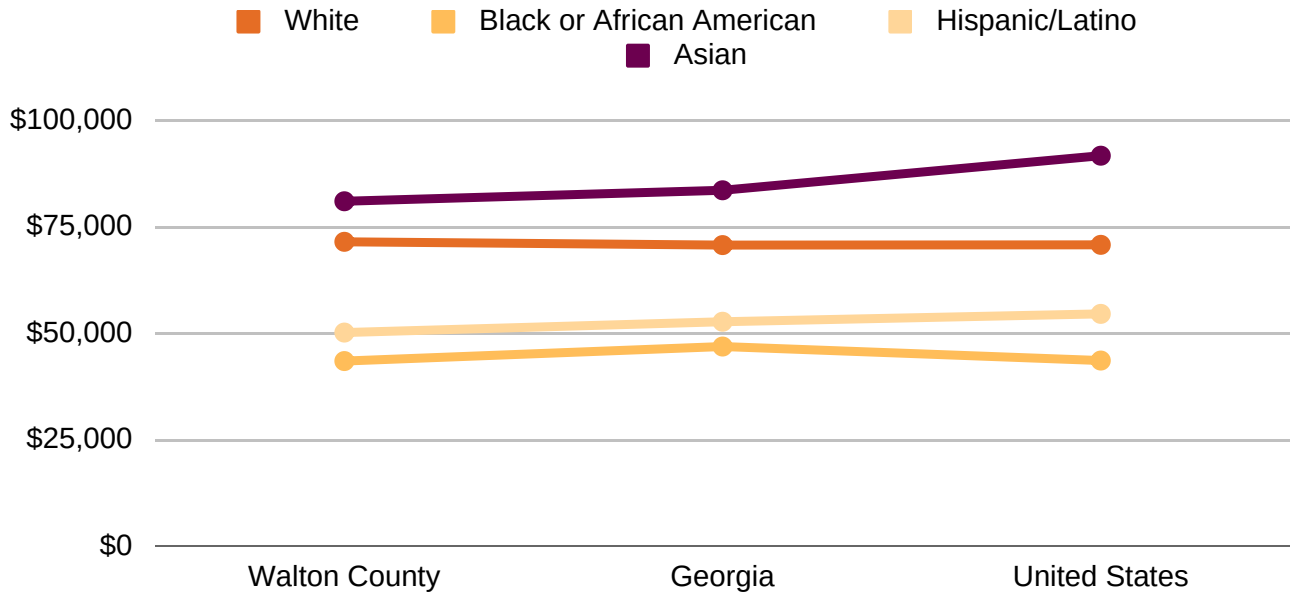
Adults aged 18 to 64 are most likely to be uninsured, and that's true in Walton County. In 2020, 18 percent of the population was uninsured. Minorities were much more likely to be uninsured.



Additionally, more than 19 percent of the county's population were covered through Medicaid, the state-federal public health insurance program for low-income children and adults. The highest concentration of Medicaid beneficiaries was in ZIP code 30655 (Monroe), where 31 percent of the population received Medicaid benefits in 2020. The majority of these recipients were low-income children.

Community and income

In 2020, the median household income was \$65,491, which is slightly higher than state and national median incomes, which are \$61,224 and \$64,994, respectively. When broken down by the four dominant races in the community, income disparities are evident.



Of employers in the community, in 2020, the largest sector by employment size was construction, which employed 4,889 people at an average wage of \$39,008. Government and government enterprises was the next largest sector, employing 4,036 people at an average wage of \$65,980. Retail trade was the third largest sector, employing 3,673 people at an average wage of \$26,856.

Unemployment and labor force participation

In 2020, of the 73,292 working age population, 45,918 were included in the labor force, and the labor force participation rate was 62.65 percent. Total unemployment in the county in March 2022 equaled 1,429, or 2.9 percent of the civilian non-institutionalized population age 16 and older.

This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status. This rate has steadily dropped since January 2021, when the unemployment rate was 3.2 percent. When looking back further, the rate is nearly four times less than the unemployment rate in 2012.

Community safety

Relatively speaking, Walton County is among the safest communities in the state. Below is a chart breaking down offenses in 2017, as reported to the Georgia Bureau of Investigation. This is the last year for which this information is publicly available.

Murder	Rape	Robbery	Assault	Burglary	Larceny	Vehicle Theft
11	14	24	149	291	1,261	125

Sexual assault

Within the county, the average annual rate for rapes (as reported by law enforcement) was 15.1 rapes per 100,000 people, significantly lower than the statewide rate of 24.60 and national rate of 38.6.

Juvenile arrests

Juvenile arrests can illustrate one aspect of the complex societies in which youth live. Juvenile arrests are the result of many factors such as policing strategies, local laws, community and family support, and individual behaviors. Youth who are arrested face disproportionately higher morbidity and mortality. Those who are arrested and incarcerated experience lower self-reported health, higher rates of infectious disease and stress-related illnesses, and higher body mass indexes. In 2018, there were a total 27 juvenile arrests, and nearly all made their way through the court process.

Firearm fatalities

Firearm fatalities are a critical public health issue as they are largely preventable. The vast majority of firearm fatalities are the result of suicides and homicides. Between 2016 and 2020, there were 76 firearm fatalities in Walton County, equaling an age-adjusted death rate of 16.2, which is above both state and national averages, which were 16.0 and 12.2, respectively.

Assault

In Walton County, the three-year total of reported assaults was 470, equaling an annual rate of 169.2 assaults per 100,000 people, significantly lower than the statewide rate of 230.20 and national rate of 261.2.

Vulnerability and Deprivation indexes

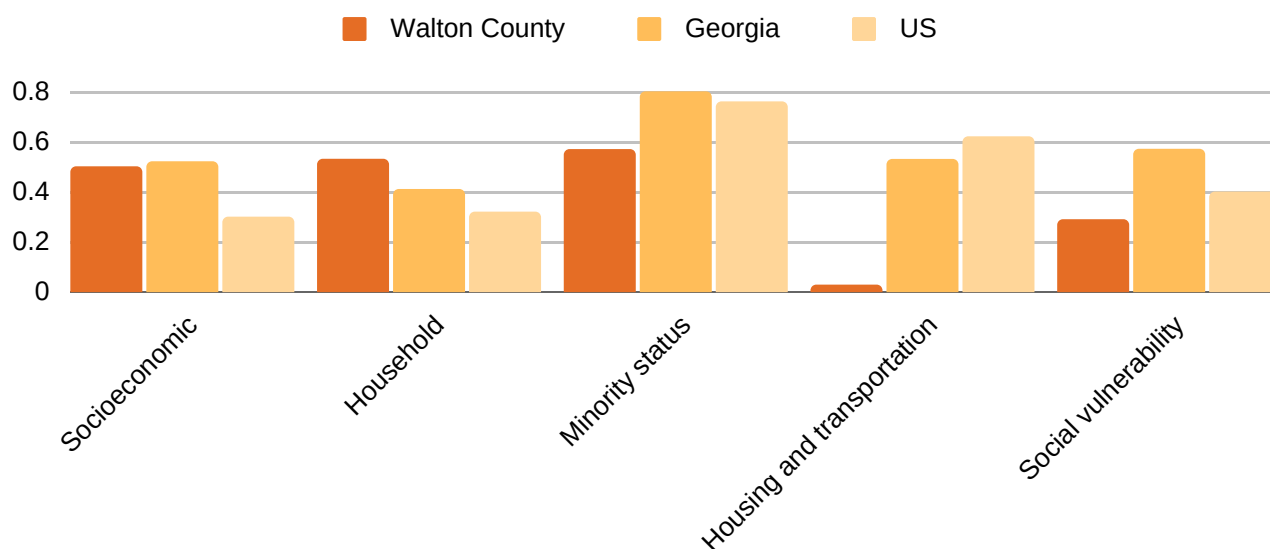
Area Deprivation Index

The Area Deprivation Index (ADI) ranks neighborhoods and communities relative to all neighborhoods across the nation and the state. ADI is calculated based on 17 measures related to four primary domains: education, income and employment, housing, and household characteristics. The overall scores are measured on a scale of 1 to 100 where 1 indicates the lowest level of deprivation (least disadvantaged) and 100 is the highest level of deprivation (most disadvantaged). Walton County ranks in the 41st percentile for Georgia and in the 52nd national percentile, both of which are relatively low figures and indicate a low level of deprivation.

Social Vulnerability Index

The CDC's Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

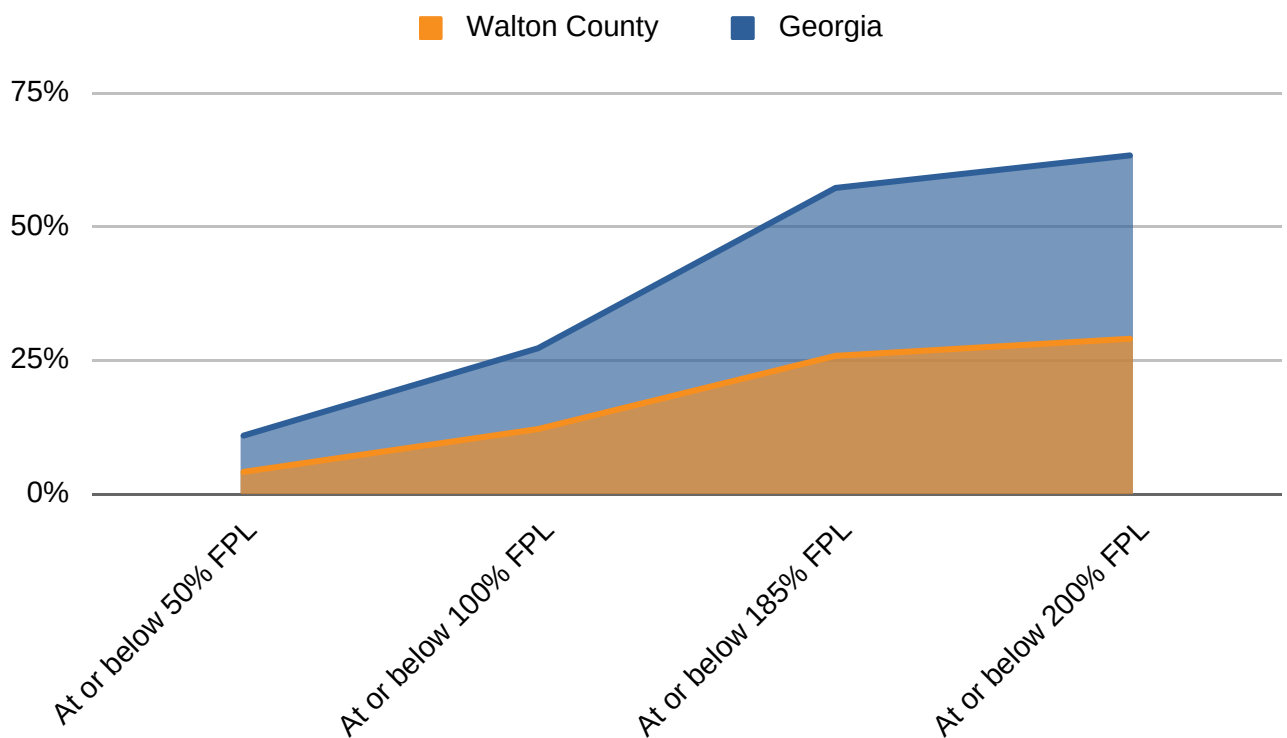
The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. Walton County has a social vulnerability index score of 0.29, which is much lower than the state score of 0.57 and the national score of 0.40. Broken down by themes:



Income and poverty

A person's income status is directly related to their health status, and predictably the more money you have, the healthier you tend to be.

The chart below demonstrates how many community members live in poverty or near-poverty. In 2022, the Federal Poverty Level (FPL) placed a family of four as having a total household income of \$27,750. Even when living at twice the FPL, families are likely unable to afford many of life's basics. The poorest zip code within Walton County is 30655, where 18.70 percent of the population lived at or below the FPL in 2020.



SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. A household may be one person living alone, a family, or several unrelated individuals cohabitating who routinely purchase and prepare meals together. SNAP enrollment and poverty rates are co-related.

In Walton County, nearly 3,580 households received SNAP benefits in December 2020, representing about 11 percent of the total population. Black populations are three times and Hispanic or Latino populations are more than twice as likely than their white counterparts to receive SNAP benefits. The median income of a household receiving SNAP benefits was \$30,898.

Housing

In 2021, the average rent for a one-bedroom apartment was \$1,058, representing a 15 percent increase from the previous year. According to 2020 USDA data, the average adult male spends between \$193 and \$358 on groceries per month, and the average adult female spends between \$174 and \$315. In Walton, in 2020, basic utilities averaged \$107 per month (though in summer, costs rise), and internet averaged \$89. None of this includes transportation, insurance, and other costs of living.

Cost-burdened households

Of the 32,094 total occupied households in Walton County, 8,311 -- about 26 percent -- of the population lived in cost burdened households in 2020, meaning their housing costs are 30 percent or more of total household income. Forty-seven percent were occupied by renters. Approximately 11 percent of households had costs that exceeded 50 percent of the household income, which places the household in significant financial strain.

Substandard housing

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. Of all households in the county, 98,478 households (26 percent of all households) have one or more substandard conditions. This is lower than the state average of 30.1 percent.

Area Median Income and affordable housing

This indicator reports the number and percentage of housing units at various income levels relative to Area Median Income (AMI). The AMI is the midpoint of a region's income distribution, meaning that half of households in a region earn more than the median and half earn less than the median. A household's income is calculated by its gross income, which is the total income received before taxes and other payroll deductions.

This indicator reports the number and percentage of housing units affordable at various income levels. Affordability is defined by assuming that housing costs should not exceed 30 percent of total household income. Income levels are expressed as a percentage of the county's AMI. About 73 percent of housing units are affordable at 100 percent AMI, which means that housing is not affordable for a significant percent of the county's population. This is higher than the state rate of 67.13 percent of housing units affordable at 100 percent AMI.

Food deserts and food insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially so if they were already low-income. As with many health indicators, minorities are much more likely than their white counterparts to experience food insecurity.

Neighborhood conditions can affect physical access to food. For example, people living in some urban areas, rural areas, and low-income neighborhoods may have limited access to full-service supermarkets or grocery stores. Predominantly black and Hispanic neighborhoods tend to have fewer full-service supermarkets than predominantly white and non-Hispanic neighborhoods. Communities that lack affordable and nutritious food are commonly known as “food deserts.” There are three food desert census tracts within the county, meaning about 20,531 people do not have ready access to healthy foods.

The county has a food insecurity rate of 11.3 percent, meaning about 10,060 people have been unsure as to how they will access adequate food at some point over the last year. Unfortunately, many of these community members are ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants and Children), free or reduced cost school meals, the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of the 4,300 food insecure children in the county, only 32 percent were eligible for public assistance programs.

Grocery stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. In 2020, there were 11 grocery establishments in the county, equaling a rate of 13.3 per 100,000 population, which is lower than the state and national rates of 17.46 and 20.66, respectively. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included, and convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

Low food access

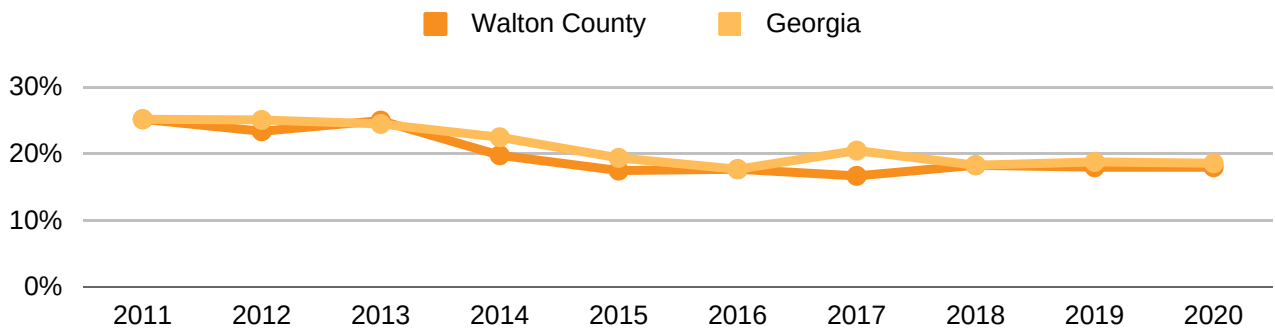
Low food access is defined as living more than 0.5 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity. According to the 2021 Food Access Research Atlas database, 33.2 percent of the total population in the county have low food access, meaning about 27,807 county residents may struggle to access healthy foods.

Access to care

Insurance

Insurance status is directly related to a person's ability to access care, and this is particularly true for non-emergent care and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected. Adults who are uninsured are more than three times more likely than insured adults to say they have not had a visit about their own health to a doctor or other health professional's office or clinic in the past 12 months.

In Walton County, in 2020, 12.07 percent of the population were uninsured, a figure between state and national rates, which were 16 percent and 8.84 percent, respectively. When looking only at adults aged 18-64, the uninsured rate jumped to more than 18 percent. Uninsured populations are statistically far less likely to have a primary care physician, receive specialty care and maintain control of chronic conditions. The chart below shows the uninsured rate for non-elderly adults.



Insurance coverage

The below table demonstrates the type of insurance for those who had coverage in 2020, by percentage of the population. Note this doesn't equal 100 percent, as some community members have two types of coverage.

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
64.60%	12.86%	2.71%	19.87%	19.21%	2.52%

Access to care, cont'd

Health professions shortages and provider ratios

In Walton County, as of May 2022, there were four designated health professions shortage areas: one primary care, one dental health, and two mental health shortage areas. Physician to patient ratios within those three areas are as follows:

- Primary care: There was one primary care physician for every 26 county residents, which is nearly three times less than state and national rates.
- Mental health: There was one mental health provider for every 76 people within the county.
- Dental care: There was one dentist for every 31 people, a figure better than the state rate of one provider for every 49 and the national rate of one provider for every 66 people.

Charitable care

There is one charitable clinic in Walton County that serve low-income, uninsured county residents: F.I.S.H. MD, located in Monroe. The clinic provides both primary care and dental services. Piedmont actively partners with this clinic.

Low-cost and charitable clinics are vital to the community's health, as they are generally the only access point for those without insurance.

Primary care and routine check-ups

In 2019, 76 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, a measure that is on par with both state and national averages. For Medicare recipients, this number jumps to 86 percent of adult beneficiaries, which is above both state and national averages. Routine check-ups are a critical component to maintaining good health and identifying conditions that can be treated affordably in a community-based setting. Absent that, even simple-to-treat conditions can escalate to deeper issues, eventually requiring more intensive care, later stage diagnoses, or reduced life expectancy.

As with most all other indicators, race and income play heavily into this. White populations are far more likely to receive preventative care than their black counterparts (78 percent among black populations compared to 87 percent among white populations), and those with insurance are also much more likely to go to the doctor for a routine check-up than those without insurance.

In 2018, about 30 percent of men and 34 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services.

Access to dental and primary care

Dental care and dental outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Within the county, in 2018, 63 percent of adults went to the dentist in the past 12 months. That year, 16 percent of the county reported having lost all natural teeth because of tooth decay or gum disease. This is an impactful measure in multiple ways:

- Research shows that losing your teeth will shorten your lifespan. Missing nine teeth for nine years or more reduces lifespan compared to a contemporary who maintains their teeth.
- The lower your income and education level, the more likely you are to lose your teeth, which results in even fewer economic opportunities, creating a poverty cycle. For example, it is difficult to gain employment if you have visible missing teeth.
- The individual will inevitably struggle with eating certain foods, limiting their options, which can be detrimental for lower-income populations already facing food insecurity.

It's important to note that there are few options for low-income patients needing dental care. While most dental services for children enrolled in the low-income public health insurance program PeachCare are covered, for adults covered by Medicaid, only emergency dental care is provided. There are limited options for low-income dental care services within the county, and there are few -- if any, at a given time -- options for low-cost dental services that go beyond cleaning, basic fillings, and extractions. For example, if you have lost even one tooth, you have few, if any, options for implants that aren't at full retail cost. In Georgia, the cost to replace a single tooth can range from \$3,000 to \$4,500, out of pocket.

Causes of death

Below are the eight leading causes of age-adjusted death, in total between 2016 and 2020. The dials indicate how severe the rate is, as compared to the rest of the state. The further to the right the dial is, the more severe that issue is within the county, as compared to Georgia overall.



Ischemic heart and vascular disease - 1



All COPD except Asthma - 2



Trachea, bronchus and lung cancer - 3



Cerebrovascular disease - 4



All other mental and behavioral disorders (usually dementia) - 5



Alzheimer's disease - 6



Essential hypertension and hypertensive renal and heart disease - 7



All other diseases of the nervous system - 8

When looking at the premature death rate, causes shift. Between 2016 and 2019, the leading causes of premature death were:

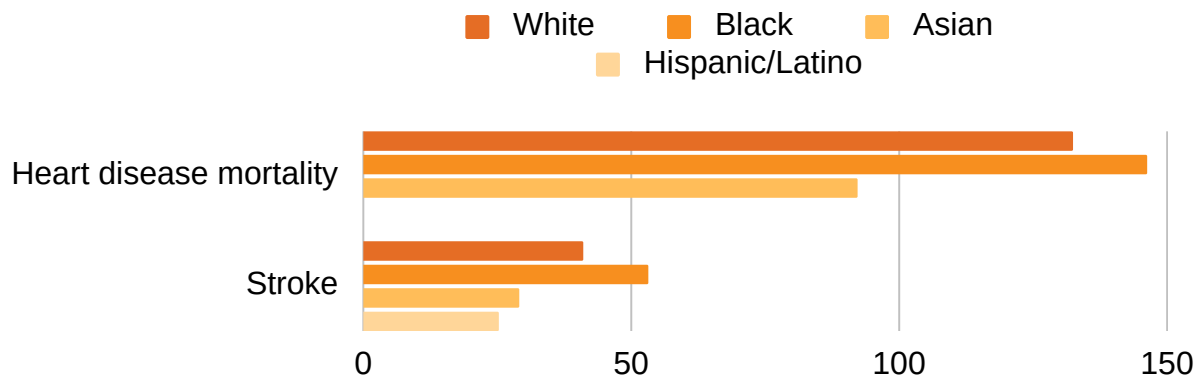
1. Ischemic heart and vascular disease
2. Accidental poisoning and exposure to noxious substances
3. Motor vehicle crashes
4. Suicide
5. Trachea, bronchus, and/or lung cancer
6. Essential hypertension and hypertensive renal and heart disease
7. Certain conditions originating in the perinatal period
8. Cerebrovascular disease
9. Homicide
10. All COP except asthma
11. Colon, rectum, or anal cancer
12. All other diseases of the nervous system

Heart disease and stroke

Heart disease is the leading cause of death in Walton County. Between 2016 and 2020, the age-adjusted death rate was 207.1 deaths for every 100,000 people, which is worse than both state and national averages, though it is a rate that has steadily decreased over the last ten years. Broken down by ZIP code, we see higher death rates in ZIP codes 30641, 30650, 30655, and 30656, which could indicate higher rates of poverty and higher rates of uninsurance.

We see similar trends with stroke deaths. Between 2016 and 2020, there were 249 deaths due to stroke, resulting in an age-adjusted death rate of 49.1 deaths per every 100,000 people. This is worse than the state and national rates of 43.2 and 37.6 deaths, respectively. Like with heart disease, we see higher rates of stroke death in community members living in ZIP codes 30550, 30544, and 30656.

When looking at race, there is a disparity in death rates between races. Note there was no data for Hispanic/Latino populations for heart disease deaths in 2020.



There are several potential reasons for this, including a higher poverty rate among black populations, which impacts all areas of life, including access to primary health care and healthy foods. Hypertension and other related chronic conditions also tend to be higher among black populations, as do obesity and diabetes, all of which tend to occur at a younger age than they do for their white counterparts. Finally, neighborhoods matter. In Walton County, minority populations tend to live in communities with lower walkability rates and more limited access to healthy foods.

Hospitalizations

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years, though they are still high. The cardiovascular disease hospitalization rate in 2018 was 12.4 hospitalizations per every 1,000 Medicare beneficiaries, which is worse than the state and national rates of 12.2 and 11.8, respectively. The hospitalization rate for stroke is also above state and national rates, at 10.2 hospitalizations per every 1,000 Medicare beneficiaries, versus the state rate of 9.3 and the national rate of 8.4.

Cancer

Although heart disease leads in county deaths, cancer remains a critical issue within the community. Below is a chart showing cancer diagnoses, by site, between 2014 and 2018, the last years for which this data is available.

Cancer Site	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Population)
1 - Lung and Bronchus	74	68.1
2 - Breast	67	124
3 - Prostate	64	122.4
4 - Colon & Rectum	41	40.2
5 - Melanoma	36	26

When comparing to state and national averages, Walton County is on par with state rates in terms of overall diagnosis. This means one of two things: there are either fewer incidence rates of cancer within the community or there are fewer screenings for all members of the community, therefore resulting in fewer diagnoses.

When broken down by race, Hispanic/Latino populations are more likely to be diagnosed with cancer than any other race, with a cancer incidence rate of 539.5 diagnoses per every 100,000 people, as compared to an incidence rate of 498.7 and 476.3 per every 100,000 people for white and black populations, respectively.

Poverty is directly related to increased incidence rates of cancer, as those with lower levels of education and lower levels of income experience higher rates of cancer diagnoses. They are also more likely to die from certain cancers – particularly lung cancer and colorectal cancer. For survivors, income and socioeconomic status are significant predictors of quality of life after cancer. Increased income allows patients to maintain a level of comfort that people with low SES might not be able to afford – so even if a low-income patient survives cancer, their quality of life after will be worse than someone more well off.

Hospitalizations and ER visits

Emergency department visits

In Fiscal Year 2021, Piedmont Walton treated patients through approximately 33,580 total emergency room visits for all patients, regardless of payor. In Calendar Year 2020, Medicare beneficiaries visited the emergency department 5,072 times, resulting in an ER visit rate of 588.0 visits per every 1,000 beneficiaries, which is higher than state and national rates.

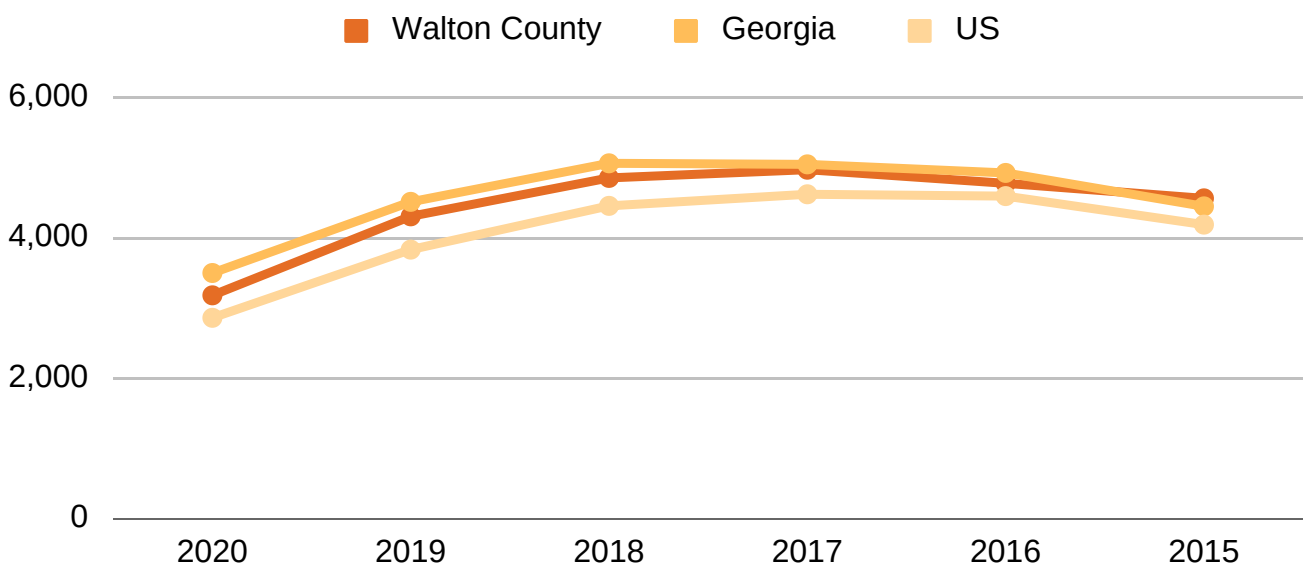
Inpatient stays

In 2020, there were 17,044 Part A and Part B Medicare beneficiaries in the county and approximately 1,267 total beneficiaries, or 14.7 percent, had at least one hospital inpatient stay. This resulted in a rate of 226 stays per every 1,000 beneficiaries. This is lower than the state rate of 230.0 inpatient stays during the same time.

Preventable hospitalizations among Medicare beneficiaries

Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries. In 2020, there were 16,337 Medicare beneficiaries in the county, and the preventable hospitalization rate was 3,185 preventable hospitalizations per every 100,000 people, which was lower than the state rate of 3,503. This number has steadily decreased over the years.

The below chart demonstrates the five-year trend for preventable hospitalizations over the last five years.



Chronic conditions

A chronic condition is a health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time. As with most health indicators, low-income households are most at risk for developing chronic diseases and for premature deaths. Such households are more vulnerable for several reasons, including their inability to cover medical expenses and diminished access to health care facilities.

Diabetes

In 2019, 7,341 of adults aged 20 and older had diabetes, equaling 9.2 percent of the county's population, which was lower than the state rate of 9.8 percent. Diabetes is a prevalent problem in the US, often indicating an unhealthy lifestyle and puts individuals at risk for further health issues. This figure has steadily increased year over year.

Kidney disease

Chronic kidney disease, also called chronic kidney failure, involves a gradual loss of kidney function. Kidneys filter wastes and excess fluids from your blood, which are then removed in your urine. Advanced chronic kidney disease can cause dangerous levels of fluid, electrolytes, and wastes to build up in your body. In 2019, 3.2 percent of the county's population had a diagnosis of kidney disease, a rate on par with the state and national percentages of 3.22 percent and 3.1 percent, respectively.

High cholesterol

In 2019, 35 percent of adults 18 and older reported having high cholesterol of the total population. Too much cholesterol puts you at risk for heart disease and stroke, two of the main causes of death within the county.

High blood pressure

In 2019, 36.6 percent of adults 18 and older had a diagnosis of high blood pressure. High blood pressure can damage your arteries by making them less elastic, which decreases the flow of blood and oxygen to your heart and leads to heart disease.

Multiple chronic conditions among Medicare populations

This indicator reports the number and percentage of the Medicare fee-for-service population with multiple (more than one) chronic conditions. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Within the county, there were 6,611 beneficiaries with multiple chronic conditions based on administrative claims data in 2018, representing 75 percent of all Medicare fee-for-service beneficiaries. Nineteen percent of beneficiaries have six or more chronic conditions.

Infectious diseases

Infectious diseases are an issue in Walton County, as with most communities. Most infectious diseases have only minor complications. But some infections — such as pneumonia, AIDS and meningitis — can become life-threatening. A few types of infections have been linked to a long-term increased risk of cancer. For example, human papillomavirus is linked to cervical cancer.

HIV/AIDS

HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). While there is no cure for HIV/AIDS, if treated, most can live a relatively healthy life. In Walton County, in 2018, there were 290.1 confirmed cases of HIV/AIDS for every 100,000 people. This is much lower than the state rate of 624.90 confirmed cases per every 100,000 people.

Chlamydia

Chlamydia is a common STD that can cause infection among both men and women. It can cause permanent damage to a woman's reproductive system. This can make it difficult or impossible to get pregnant later. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb). In Walton County, in 2018, there were 320.96 confirmed cases of chlamydia for every 100,000 people. This is much lower than the state rate of 632.2 confirmed cases per every 100,000 people.

Gonorrhea

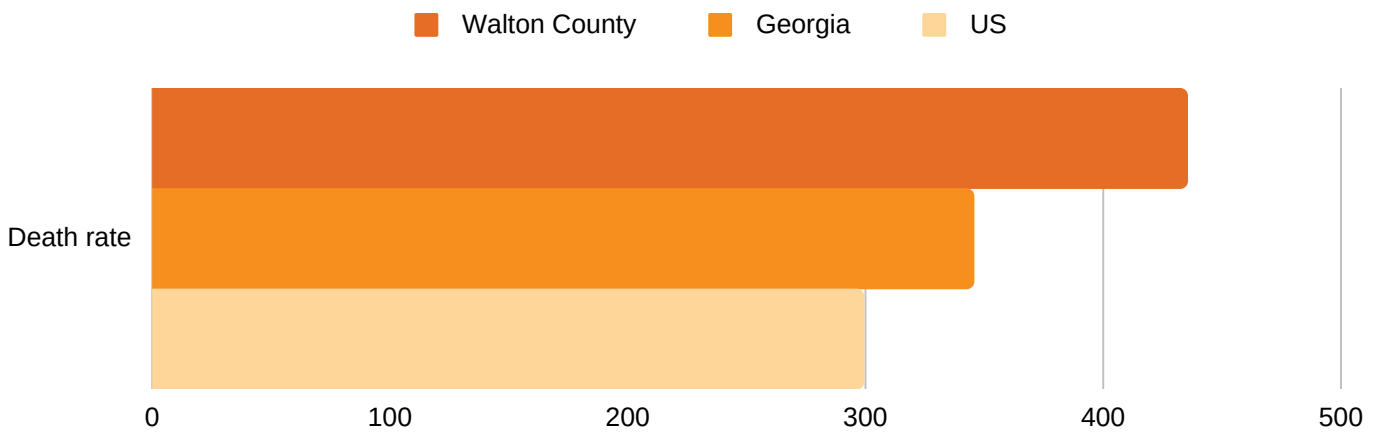
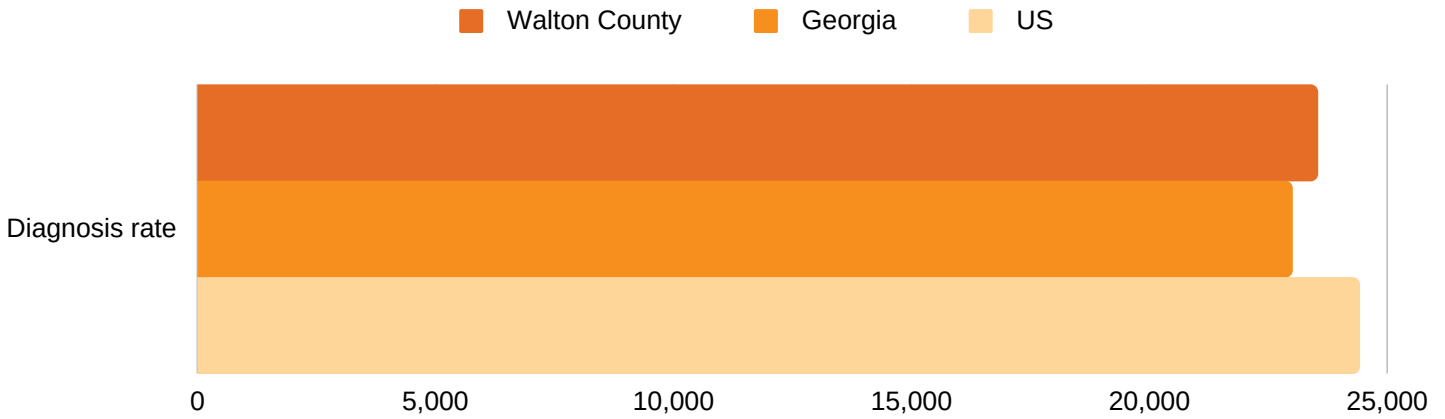
Gonorrhea is an STD that can cause infection in the genitals, rectum, and throat. It is very common, especially among young people ages 15-24 years. Untreated gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). In Walton County, in 2018, there were 56 confirmed cases of gonorrhea, resulting in a rate of 61.1 infections for every 100,000 people. This is much lower than the state rate of 200.10 confirmed cases per every 100,000 people.

Influenza and pneumonia

Within the county between 2016 and 2020, there were 88 deaths due to influenza and pneumonia, representing an age-adjusted death rate of 16.7 per every 100,000 total population, worse than the state and national rates of 13.6 and 13.6, respectively. In Walton County, men are nearly twice as likely to die from influenza or pneumonia than women, and white men are especially susceptible.

COVID-19

Without a doubt, COVID-19 is easily one of the most impactful health events to happen within both the community and the world. As of May 03, 2022, the diagnosis rate and death rates were as follows:



Approximately 51 percent of the county was fully vaccinated as of May 26, 2022, with an estimated 15.88 percent of adults hesitant about receiving the vaccination. The county had a COVID-19 vaccine coverage index (CVAC) of 0.62, which is a score of how challenging vaccine rollout may be in some communities compared to others, with values ranging from 0 (least challenging) to 1 (most challenging). CVAC ranks states and counties on barriers to coverage through 28 indicators across five themes:

- Historic undervaccination
- Sociodemographic barriers
- Resource-constrained health system
- Health care accessibility barriers
- Irregular care-seeking behaviors.

The CVAC can help contextualize progress to widespread COVID-19 vaccine coverage, identifying underlying community-level factors that could be driving low vaccine rates.

Youth and young adults

There were approximately 23,000 children and youth in Walton County in 2020, representing a quarter of the population. The ZIP code with the highest number of children was 30019, and 30656 had the lowest number of children, according to the Census Bureau. Approximately 1.5 percent of children were homeless in 2020, meaning 247 children had no stable home.

Of all children, 37 percent lived at or below 200 percent of the Federal Poverty Level (FPL), which was \$55,500 gross household income for a family of four in 2022. The highest percentage of poor children was in the 30012 ZIP code, where 59 percent of children lived in poverty in 2020.

Approximately 41 percent of county children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure far less than state and national rates of 60 percent and 50 percent, respectively. Free or reduced-price lunches are served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the US FPL as part of the federal National School Lunch Program (NSLP).

Access - Head Start and preschool enrollment

Head Start is a program designed to help children from birth to age five who come from families at or below poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. Walton County had only one Head Start program in 2019, resulting in a rate of 1.72 programs per 10,000 children under 5 years old in 2020. This is far below state and national rates of 6.83 and 10.53, respectively. Approximately 55 percent of all children aged 3 to 4 were enrolled in preschool in 2020, a rate on par with state and national averages.

Teen births

In 2019, the teen birth rate was 24.8 births per every 1,000 females aged 15 to 19, a statistic which is higher than state and national rates of 24.2 and 20.9, respectively. Teen mothers face unique challenges and are statistically more likely to dropout of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. They also tend to have additional children, who are themselves statistically more likely to have children at a young age.

English and math 4th grade proficiency

Of 4,353 students tested, 52.2 percent of 4th graders tested below the "proficient" level in the reading portion of state standardized tests in the 2018-2019 school year. This is worse than the statewide rate of 39.2 percent. Up until 4th grade, students are learning to read. After 4th grade, they are reading to learn, making these statistics key for future success. For the math portion, of students tested, 43.9 percent of 4th graders tested below the "proficient" level, according to the latest data, which is better than the statewide rate of 46.1 percent.

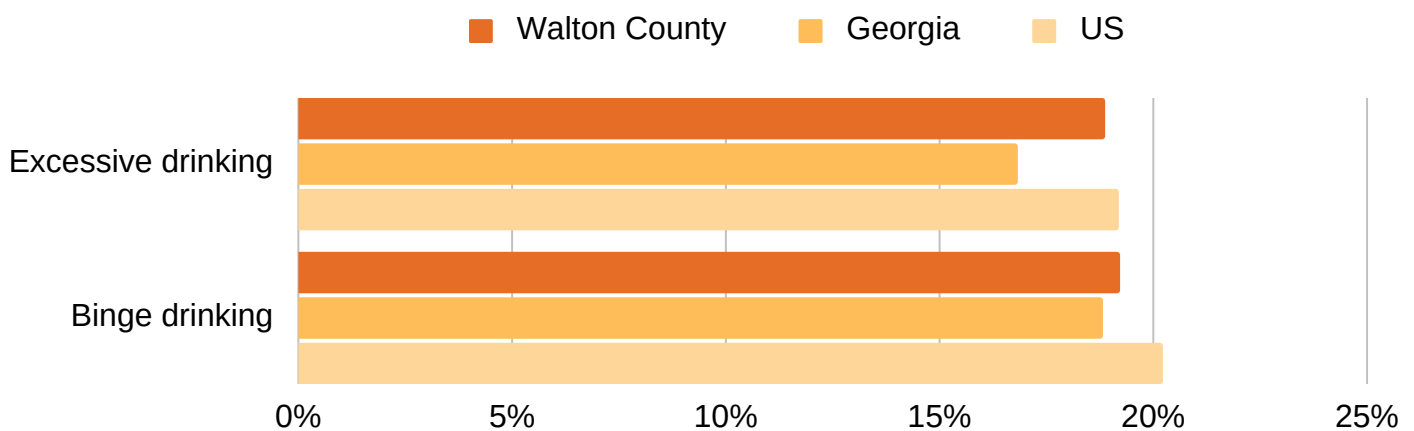
Risky behaviors

Behaviors are directly related to health outcomes, leading to increased risks of cardiovascular disease, cancer, liver diseases, hepatitis, and sexually transmitted diseases.

Alcohol use

Excessive alcohol use can lead to a myriad of health issues, including liver disease, depression, injuries, violence, and cancer. In Walton County, 14,987, or 16 percent of adults self-report excessive drinking in the last 30 days, which is slightly better than the state rate of 16.81 percent. Data for this indicator were based on survey responses to the 2018 Behavioral Risk Factor Surveillance System (BRFSS) annual survey, the last year for which data is available. Based on preliminary national data, these rates likely increased during 2020, in which alcohol use increased during COVID-19 quarantine periods.

The below chart shows self-reported excessive and binge drinking rates in 2018. Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Excessive drinking is when binge drinking episodes occurred multiple times within the last 30 days.



Tobacco use

Within the county in 2019, a fifth of all adults reported being a current smoker. Smoking is directly related to a myriad of health issues, the most serious of which is cancer.

Insufficient sleep

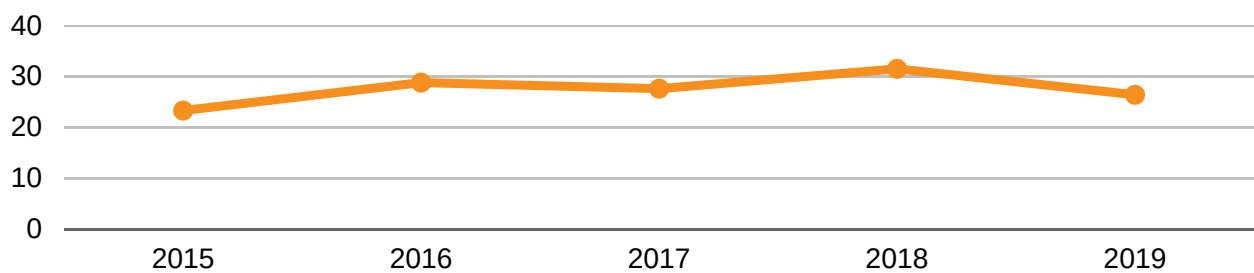
Approximately 36.2 percent of county residents reported regularly sleeping less than seven hours most nights, on average, in 2019. Sleep is an essential function that allows your body and mind to recharge, leaving you refreshed and alert when you wake up. Healthy sleep also helps the body remain healthy, fight diseases and maintain good mental health. Without enough sleep, the brain cannot function properly.

Health factors

Certain health factors have a strong impact on overall health, including obesity and physical inactivity.

Obesity

In 2019, 26.4 percent of county residents aged 20 and older were obese, meaning they had a body mass index of 30 percent or more. Obesity rates have generally increased over the last ten years. Obesity is directly linked to a number of health issues, including diabetes and heart disease.



In Walton County, as throughout the state and nation, the poorer you are, the more likely you are to be obese. Additionally, Hispanic/Latino and black populations are much more likely to be obese than their white counterparts.

Physical inactivity

Within the county in 2019, 25.6 percent of adults aged 20 and older self-report no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Walking or biking to work

Integrating walking or biking into daily routines, such as commuting to work, provide a significant health benefit and can indicate a healthier lifestyle if commuting by walking is by choice. In 2019, about 1.4 percent of the county's population walked or biked to work. Certain ZIP codes saw higher physical commutes, such as 30656, where about 210 people walked or biked to work in 2019.

Soda expenditures

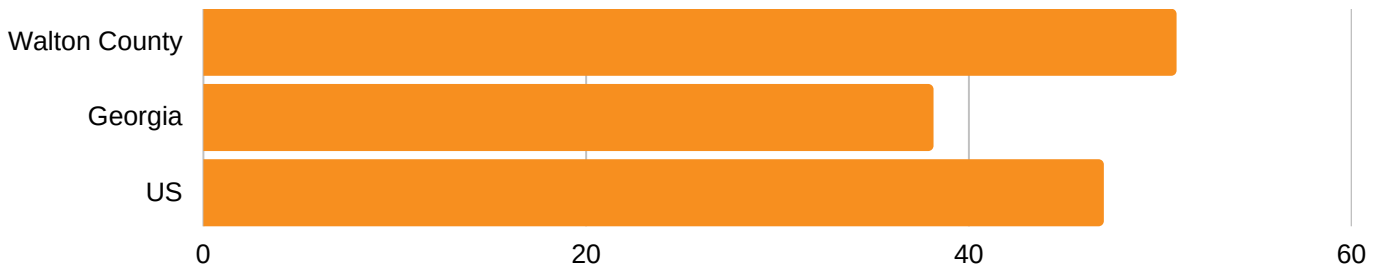
This indicator reports soft drink consumption by census tract by estimating expenditures for carbonated beverages, as a percentage of total food-at-home expenditures. Soda is directly related to obesity and poor dental health. In Walton County, households spent an average 4.02 percent of their food budget on sodas in 2019, which is lower than average state and national expenditures, which were 4.11 percent and 4.18 percent, respectively.

Mental health

Mental health is a critical driver of overall health, as being in a good mental state can keep you healthy and help prevent serious health conditions. A study found that positive psychological well-being can reduce the risks of heart attacks and strokes. On the other hand, poor mental health can lead to poor physical health or harmful behaviors.

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the Centers for Disease Control and Prevention (CDC). The below chart demonstrates these rates, as occurring for every 100,000 people each year, on average, between 2016 and 2020.

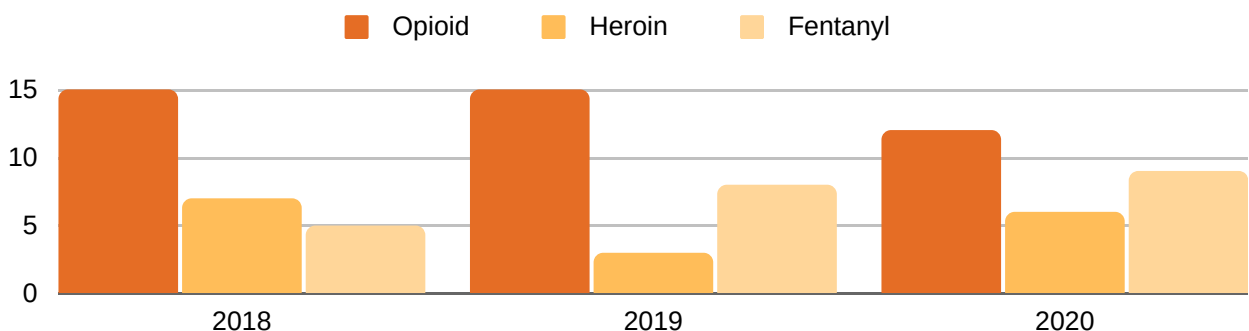


Poor mental health days

In 2018, the last year for which data is available, county residents reported an average 4.4 poor mental health days over the last 30 days, which is slightly higher than the state average of 4.2 poor mental health days. This is a statistic that likely sharply increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community. Additionally, in 2018, 17 percent of adults reported being in frequent mental distress, which is 14 or more poor mental health days within a 30-day period. This statistic also likely increased during 2020 and 2021.

Opioid and substance use

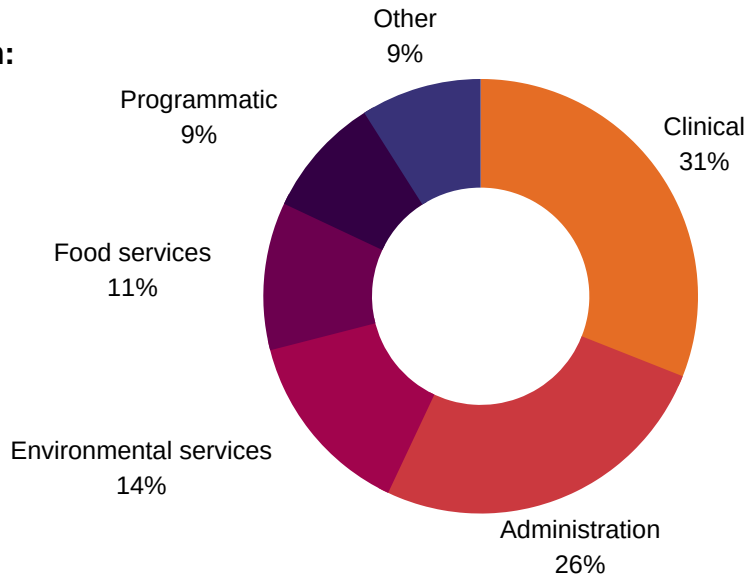
In 2020, providers in Walton County prescribed 22.273 opioid prescriptions per every 100 people, which is a figure steadily decreasing each year. That said, deaths related to all opioids have risen, particularly for heroin and fentanyl. The below chart is for years 2018, 2019, and 2020, by drug type.



Employee survey

In March 2022, we launched an online employee survey to solicit community input on key health issues. A total of 1,053 system employees responded, including 63 Piedmont Walton employees. Below are the results of that survey.

The employees who responded worked in:



They worked at:

- Piedmont Athens: 13.12%
- Piedmont Atlanta: 9%
- Piedmont Cartersville: 2.98%
- Piedmont Columbus: 8.93%
- Piedmont Eastside: 4.31%
- Piedmont Fayette: 7.69%
- Piedmont Healthcare: 4.29%
- Piedmont Henry: 5%
- Piedmont Macon: 4.4%
- Piedmont Mountainside: 5.83%
- Piedmont Newnan: 7.38%
- Piedmont Newton: 3.33%
- Piedmont Physicians: 4.4%
- Piedmont Rockdale: 4.64%
- Piedmont Walton: 3.45%
- Multiple locations: 5.98%
- Other: 5.36%

Q: What do you think are the five most important factors for a healthy community? The top five answers were:

1. Access to health care
2. Access to healthy foods
3. Economic opportunity for everyone
4. Healthy behaviors and lifestyle
5. Good place to raise children

Q: What do you think are the five most important health problems in your community? The top five answers were:

1. Aging problems
2. Poverty
3. Mental health problems
4. COVID-19
5. Heart disease and stroke

Employee survey, cont'd

Q: What do you think are the five riskiest behaviors in your community?

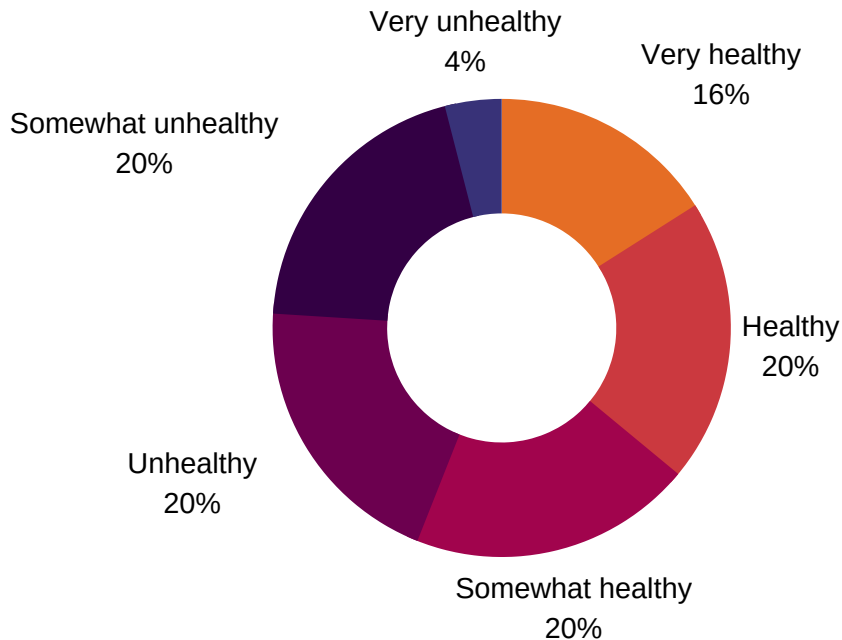
The top five answers were:

1. Not getting vaccinations to prevent disease, including COVID-19
2. Poor diet
3. Alcohol abuse
4. Tobacco use
5. Lack of exercise

Q: What issues do you think may prevent community members from accessing care? The top five answers were:

1. Unable to pay co-pays and deductibles
2. No insurance
3. Lack of access to transportation
4. Fear (e.g., not ready to face or discuss health problem)
5. Don't understand the need to see a doctor

Q: How would you rate the overall health of your community?



Employee survey, cont'd

Q: What do you think are the top five most important actions in improving the health of community members living within Piedmont communities? The top five answers were:

1. Access to low-cost mental health services
2. Financial assistance to those who qualify
3. Access to dental care services
4. Community-based programs for health
5. Expanded access to specialty physicians

Q: What is your vision for a healthy community? Some answers were:

A healthy community includes access to affordable healthcare, healthy food, safe housing, quality education, and stable jobs.

A place where people are healthy enough to move about and enjoy life.

One that is educated, with access to health services both financially and geographically.

Families and individuals who care for each other.

A community who has access to services, I have been an ER nurse for nearly a decade and the mental health population continues to grow. There are not many resources for these patients; Advantage is great but it would be wonderful to have a local Piedmont facility to help with these patients.

Affordable housing that is safe.

More community care clinics where underserved communities can have access to "affordable" healthcare.

Using healthcare for prevention instead of trying to treat most problems after onset.

Free little food pantries on different blocks in towns, with healthy food choices.

A healthy community to me would be a place where social and financial factors do not stop a person for asking for help when in need. If everyone was able to get healthcare assistance, the community would be a healthy place as a whole.

Employee survey, cont'd

Q: What is the single most pressing issue that you believe our patients face? Most answers centered around cost, with some health factors. Among the answers:

Barriers to accessing health care including lack of health insurance and poor socioeconomic status.

Medical bills.

Affordable, really affordable, health care for everyone.

Financial insecurity (including but not limited to people living at or below poverty lines).

Mental health.

Drug use, obesity, and heart failure are things that could probably be helped if they had the access to the right facilities.

Uninsured and underinsured people are so underserved. There are so many people who don't access care until they are falling apart and end up hospitalized simply because they couldn't afford to see a doctor and pay out of pocket rates.

Low healthcare literacy.

Q: What are one or two things we can do better to serve our patients/our community? Some answers were:

Include better discharge instructions on how to stay well at home. Also have a health hotline to triage calls before heading to emergency room.

Participate in community clinics that offer reduced cost preventative services (wellness, vaccines, chronic illness management) in challenged communities.

Get more involved in schools, as healthy behaviors start early.

Make non-emergent care more viable for uninsured and underinsured populations.

Help lower income patients with housing and food issues and provide discharge instructions that are viable for these patients.

Push the Governor to accept federal funding to fully expand Medicaid under the ACA.

Community stakeholders

As part of our process, we interviewed nearly 245 stakeholders, policy makers, and lawmakers representing public health, low-income populations, minorities, chronic conditions, older adults, and our communities. These included 13 stakeholders within the county, whose voices are reflected below.

Mental Health and Substance Use

Without a doubt, mental health and substance abuse were cited as top concerns for most stakeholders, who felt that there were not enough resources to address the unique mental health needs of both children and adults. Some stated there needed to be more providers within the community, and others noted that having more providers likely would not solve the affordability problem, as those with lower incomes often have higher levels of stress and addiction without the resources to adequately address either.

Since the onset of the COVID 19 pandemic, multiple stakeholders report seeing an increase in deaths of despair (suicide and substance use) due to more people going without treatment and an uptick in abuse cases, including physical, mental, and elder abuse. Mental health resources are scarce for Medicaid patients, resulting in people having to travel outside of the community for the mental care services needed, particularly for the pediatric population.

Access to Care

Almost all stakeholders noted a growing need for increased access to health services, including primary care, mental care, and dental care, all of which are identified health professions shortage areas by the federal government. Added to that is the issue that not enough providers accept Medicaid, as one stakeholder stated.

There was a sense among stakeholders that many in the community are unhealthy due to their choices, such as what they eat and how much they exercise. Some felt, though, there weren't enough good options for people, especially those without adequate transportation to a grocery store or the money for a monthly gym membership.

Transportation was an often-cited issue among stakeholders, with many stating that older adults in the more rural parts of the community faced particular challenges in physically accessing their care. There was some concern for older adults overall, and some stakeholders cited isolation, depression, and lack of funds for necessary medicine as significant barriers to staying healthy for the older populations.

Methodology

The Piedmont Walton CHNA was led by the Piedmont Healthcare community benefits team and consulting organization Public Goods Group, with significant input and direction from Piedmont Walton's leadership and Piedmont Healthcare's Department of External Affairs.

The CHNA started first with an analysis of available public health data. We looked at our Piedmont service region, which spans the northeast section of the state. We paid particular attention to the home county of our hospital, which is reflected in this CHNA. We focused on the home counties in the individual CHNAs due to the local impact of our tax-exempt status.

Once our community was established, 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.

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. Approximately 1,053 employees spanning the system responded. Additionally, we conducted a community-based survey that was widely advertised to the community.

Once both qualitative and quantitative data was gathered, we authored the preliminary report. Several key community health needs emerged during the assessment process. The chosen priorities were recommended by the community benefit department with sign-off from hospital and board leadership. The following criteria were used to establish the priorities:

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

While the priorities reflect clinical access and certain conditions, all priorities are viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race. 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. Once priorities were chosen, we then authored the CHNA and presented our findings and recommendations to the hospital's board of directors for their input and approval.

Approval

Hospital leadership then reviewed the CHNA and provided input. We incorporated their input into the final CHNA report, which is this report. We then presented our findings and recommended priorities to the hospital board of directors.

Once we established our priorities, we presented the CHNA to the Piedmont Walton board of directors for approval on June 09, 2022.

Appendices

Appendix one: Federal Poverty Levels

Data on the poverty threshold is created by the US Census Bureau, which uses pre-tax income as a yardstick to measure poverty. The statistical report on the poverty threshold is then used by the HHS to determine the federal poverty level (FPL). Below are the rates for 2022.

Family size	100%	150%	200%	300%	400%
1	\$13,590	\$20,385	\$27,180	\$40,770	\$54,360
2	\$18,310	\$27,465	\$36,620	\$54,930	\$73,240
3	\$23,030	\$34,545	\$46,060	\$69,090	\$92,120
4	\$27,750	\$41,625	\$55,500	\$83,250	\$111,000
5	\$32,470	\$48,705	\$64,940	\$97,410	\$129,880
6	\$37,190	\$55,785	\$74,380	\$111,570	\$148,760
7	\$41,910	\$62,865	\$83,820	\$125,730	\$167,640
8	\$46,630	\$69,945	\$93,260	\$139,890	\$186,520

Appendix two: Sources for data

We utilized numerous data sources throughout the CHNA process. Due to the high volume of sources in this report, we did not individually cite each statistic. That said, we provide a list of all data sources below. Please contact the Piedmont Healthcare community benefit department at communityprograms@piedmont.org for questions on specific data points.

Category	Data Source
Demographics	US Census Bureau, Decennial Census, 2020.
Demographics	US Census Bureau, American Community Survey, 2015-19.
Demographics	University of Wisconsin Net Migration Patterns for US Counties, 2010-20.
Income and Economics	US Census Bureau, American Community Survey, 2015-19.
Income and Economics	US Census Bureau, Business Dynamics Statistics, 2018-19.
Income and Economics	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Income and Economics	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Income and Economics	US Department of Labor, Bureau of Labor Statistics, Jan. 2022.
Income and Economics	IRS - Statistics of Income, 2018.
Income and Economics	US Census Bureau, American Community Survey, 2015-19.

Category	Data Source
Income and Economics	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income and Economics	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income and Economics	US Department of Commerce, US Bureau of Economic Analysis, 2016.
Income and Economics	National Center for Education Statistics, NCES - Common Core of Data, 2020-21.
Income and Economics	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Education	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2019.
Education	US Census Bureau, American Community Survey, 2015-19.
Education	National Center for Education Statistics, NCES - Common Core of Data, 2020-21.
Education	US Department of Education, EDFacts, 2018-19.
Education	US Census Bureau, American Community Survey, 2014-18.
Education	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.
Housing and Families	US Census Bureau, American Community Survey, 2015-19.

Category	Data Source
Housing and Families	US Department of Housing and Urban Development, 2019.
Housing and Families	US Department of Housing and Urban Development, US Census Bureau, American Community Survey, 2019.
Housing and Families	Eviction Lab, 2016.
Housing and Families	US Census Bureau, American Community Survey, 2011-15.
Housing and Families	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.
Housing and Families	US Census Bureau, Decennial Census, US Census Bureau, American Community Survey, 2015-19.
Housing and Families	US Department of Housing and Urban Development, 2014.
Housing and Families	US Census Bureau, Census Population Estimates, 2019.
Housing and Families	US Department of Housing and Urban Development, 2020-Q4.
Other Social & Economic Factors	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2021.
Other Social & Economic Factors	Feeding America, 2017.
Other Social & Economic Factors	US Department of Education, ED Facts, 2019-20.

Category	Data Source
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
Other Social & Economic Factors	Opportunity Insights, 2018.
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
Other Social & Economic Factors	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2020.
Other Social & Economic Factors	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Other Social & Economic Factors	Opportunity Nation, 2019.
Other Social & Economic Factors	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020.
Other Social & Economic Factors	US Census Bureau, Small Area Income and Poverty Estimates, 2019.
Other Social & Economic Factors	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Other Social & Economic Factors	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2018.
Other Social & Economic Factors	Debt in America, The Urban Institute, 2021.

Category	Data Source
Other Social & Economic Factors	Centers for Disease Control and Prevention, National Vital Statistics System, 2013-19.
Other Social & Economic Factors	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Other Social & Economic Factors	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Other Social & Economic Factors	Townhall.com Election Results, 2016.
Physical Environment	US Environmental Protection Agency, 2018-19.
Physical Environment	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Physical Environment	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2016.
Physical Environment	EPA - National Air Toxics Assessment, 2014.
Physical Environment	US Environmental Protection Agency, 2019.
Physical Environment	US Census Bureau, County Business Patterns, 2019.
Physical Environment	National Broadband Map, Dec. 2020.
Physical Environment	US Census Bureau, American Community Survey, 2015-19.

Category	Data Source
Physical Environment	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-20.
Physical Environment	Climate Impact Lab, 2018.
Physical Environment	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Physical Environment	Federal Emergency Management Agency, National Flood Hazard Layer, 2019.
Physical Environment	Center for Disease Control and Prevention, CDC National Environmental Public Health Tracking, 2017-19.
Physical Environment	Federal Emergency Management Agency, National Risk Index, 2020.
Physical Environment	US Census Bureau, Decennial Census, ESRI Map Gallery, 2013.
Physical Environment	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Physical Environment	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Physical Environment	Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011.
Physical Environment	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2021.

Category	Data Source
Physical Environment	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.
Physical Environment	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Clinical Care and Prevention	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Clinical Care and Prevention	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Clinical Care and Prevention	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke, 2016-18.
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2020.
Clinical Care and Prevention	Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019.
Clinical Care and Prevention	Centers for Disease Control and Prevention, CDC - FluVaxView, 2019-20.
Clinical Care and Prevention	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.

Category	Data Source
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2015-18.
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2018-19.
Clinical Care and Prevention	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2015-16.
Health Behaviors	University of Wisconsin Population Health Institute, County Health Rankings, 2018.
Health Behaviors	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Health Behaviors	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Health Behaviors	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
Health Behaviors	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Health Behaviors	US Census Bureau, American Community Survey, 2015-19.
Health Outcomes	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File, 2018.
Health Outcomes	State Cancer Profiles, 2014-18.

Category	Data Source
Health Outcomes	State Cancer Profiles, 2014-18.
Health Outcomes	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Health Outcomes	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Health Outcomes	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Health Outcomes	Centers for Medicare and Medicaid Services, 2018.
Health Outcomes	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-20.
Health Outcomes	University of Wisconsin Population Health Institute, County Health Rankings, 2013-19.
Health Outcomes	Institute for Health Metrics and Evaluation, 2017.
Health Outcomes	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15.
Health Outcomes	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-19.
Health Outcomes	University of Wisconsin Population Health Institute, County Health Rankings, 2017-19.

Category	Data Source
Health Outcomes	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Health Outcomes	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Healthcare Workforce	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May 2021.
Healthcare Workforce	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Feb. 2022.
Healthcare Workforce	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2015.
Healthcare Workforce	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Healthcare Workforce	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2020.
Healthcare Workforce	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2017.
Healthcare Workforce	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, Sept. 2020.
Healthcare Workforce	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019.

Category	Data Source
Healthcare Workforce	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
COVID-19	Johns Hopkins University, 2022.
COVID-19	Google Mobility Reports, Feb 01, 2022.
COVID-19	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022.

Appendix three: Employee survey

From March 01 to March 31, 2022, the hospital placed online an employee survey meant to capture employees' thoughts on challenges within our communities and suggestions on how the hospital can improve its community's health. Below are the survey questions these employees answered.

In our commitment as a not-for-profit health system, Piedmont is currently studying the region's community health needs for its Community Health Needs Assessment. As a member of our community, we invite you to take this 15-minute survey so that your feedback can be heard and included in identifying health priorities which we'll address over the next three years.

Thank you for your time and input.

1. What type of role do you have?

- Administrative
- Clinical
- Environmental Services
- Food Services
- Programmatic
- Other: Please describe

2. Are you an employee or are you a contract employee?

3. What is your home zip code?

4. How do you define the community you serve in your role?

- From wherever our patients come
- All of Georgia
- The hospital's county
- Other: Please describe

5. In the following list, what do you think are the five most important factors for a healthy community? We consider this to be those factors which most improve the quality of life in a community.

- Access to health care (e.g., family doctor)
- Access to healthy food
- Arts and cultural events
- Civic participation
- Clean environment
- Ethnic and cultural diversity
- Financial assistance for health care at the hospital
- Healthy behaviors and lifestyles
- High retirement rates
- Emergency preparedness
- Good place to raise children
- Low adult death and disease rate
- Low crime/safe neighborhoods
- Low infant deaths
- Low level of child abuse
- Parks and recreation
- Low- and no-cost options for health care within the community
- Quality of care
- Quality of housing or housing availability
- Religious or spiritual values
- Social cohesion
- Strong family life
- Strong school district
- Transportation and walkability
- Other: Please describe

6. In the following list, what do you think are the five most important health problems in our community? Please check five.

- Aging problems (e.g., arthritis, hearing/vision loss, etc.)
- Cancers
- Child abuse / neglect
- COVID-19
- Dental problems
- Diabetes
- Domestic violence
- Firearm-related injuries
- Heart disease and stroke
- High blood pressure
- HIV/AIDS
- Homicide
- Infant death
- Infectious diseases
- Mental health problems
- Motor vehicle crash injuries
- Poverty
- Rape/sexual assault
- Respiratory/lung disease
- Sexually transmitted diseases (STDs)
- Social isolation
- Suicide
- Teenage pregnancy
- Terrorist activities
- Health illiteracy
- Built environment
- Housing insecurity
- Neighborhood environmental risk (e.g., pollution, high lead exposure)
- Other: Please describe

7. How would you rate the overall health of our community?

- Very unhealthy (most have three or more chronic conditions such as heart disease or diabetes)
- Unhealthy (most have one or two chronic conditions such as heart disease or diabetes)
- Somewhat unhealthy
- Somewhat healthy
- Healthy
- Very healthy (most have no chronic conditions such as heart disease or diabetes)

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

- No insurance
- Unable to pay co-pays and deductibles
- Language barriers
- Lack of access to transportation
- Unable to use technology to find doctors, schedule appointments, manage online care
- Fear (e.g., not ready to face or discuss health problem)
- Don't understand the need to see a doctor
- Don't know how to find doctors
- Cultural/religious beliefs
- Lack of availability of doctors

9. Of the following, what do you think are the top five things most important in improving the health of community members living in our communities?

- Access to local inpatient mental health services
- Access to local outpatient mental health services
- Access to low-cost mental health services
- Access to health care services
- Access to dental care services
- Additional access points to affordable care within the community
- Cancer awareness and prevention
- Community-based health education
- Community-based programs for health
- Curbing tobacco use, such as banning indoor smoking
- Expanded access to specialty physicians
- Financial assistance for those who qualify
- Free or affordable health screenings
- Increased social services
- More options for paying for care
- Opioid awareness and prevention campaigns
- Partnerships with local charitable clinics
- Programs that address issues of housing
- Programs that address food insecurity
- Safe places to walk and play
- Substance abuse rehabilitation services
- Other: Please describe

10. What is your vision for a healthy community?
11. What is the single most pressing issue you feel our patients face?
12. What are one or two things we can do better to serve our patients/our community?
13. Do you have questions about this survey or community health in general?