WELLSTAR
Health System

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WELLSTAR Health System

2018 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

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

WellStar North Fulton Hospital

WellStar North Fulton Hospital

EIN#: 81-0851756
3000 Hospital Blvd
Roswell, GA 30076

WellStar North Fulton Hospital is a 202-bed facility located in Roswell, Georgia. North Fulton is recognized for its Accredited Cancer Program and Primary Stroke Center designations, and for being one of only three state-designated Level II Trauma Centers in metro Atlanta. North Fulton Hospital is known for providing a continuum of services through its centers and programs, including neurosciences, pain management, cardiology, women's services, rehabilitation, surgical services and oncology. With this combination of commitment and expertise, North Fulton caters services to the unique healthcare needs of all patients in the North Fulton area.

North Fulton is a proud member of WellStar Health System. WellStar, the largest health system in Georgia, is known nationally for its innovative care models, and is focused on improved quality and access to healthcare. WellStar is dedicated to reinvesting back into the community with innovative treatments, state-of-the-art technology and facilities. Its vision is to deliver world-class healthcare.

Table of Contents

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

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

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

Date CHNA made publicly available:
June 30, 2018

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

Community is **Care**

BEING THE BRIDGE

Executive Summary

This report utilizes a data-driven approach to better understand, identify and prioritize the health needs of the community served by WellStar North Fulton Hospital, a not-for-profit hospital under the Internal Revenue Code (IRC) section 501(r). WellStar North Fulton Hospital is a 202-bed facility recognized for its Accredited Cancer Program and Primary Stroke Center designations and for being one of only three state-designated Level II Trauma Centers in Metro Atlanta. Known for providing a continuum of services through its centers and programs, including neurosciences, pain management, cardiology, women's services, rehabilitation, surgical services and oncology, the hospital caters its services to the unique healthcare needs of all patients in the North Fulton area.

WellStar North Fulton Hospital is a proud member of WellStar Health System, the largest integrated health system in Georgia nationally known for its innovative care models. Focused on improved quality and access to healthcare, WellStar is dedicated to reinvesting back into the community with the latest treatments and state-of-the-art technology and facilities. Its vision is to deliver world-class healthcare.

Community Health Needs Assessment

The 2010 Affordable Care Act (ACA) requires all not-for-profit hospitals to complete a Community Health Needs Assessment (CHNA) and Implementation Strategy every three years to better meet the health needs of under-resourced populations living in the communities they serve. What follows is a comprehensive CHNA that meets industry standards including Internal Revenue Service regulations set forth in the Additional Requirements for Charitable Hospitals section of IRC 501(r).

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

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

The primary focus of data collection for this assessment was on medically under-resourced populations living in 20 zip codes concentrated in the primary service area of Cherokee, Cobb and Fulton counties.

Priority Health Needs

WellStar North Fulton Hospital worked with community and hospital leaders to identify the top community health priorities based on the data included in this assessment.[1] The community health priorities identified for the service area include improving:

1. Behavioral healthcare
2. Parental education and support
3. Access to appropriate care
4. Overuse and abuse of opioids

Key Findings

There are specific populations identified in this assessment that experience greater barriers to being healthy along with higher disease burden and death. This assessment has identified the following populations as the focus of further study and targeted investment to address persistent disparities:

- Black and Latino residents
- Single parents
- People without legal immigration status
- Residents from zip codes 30093 and 30096

In general, the community served by WellStar North Fulton Hospital are of average age, higher-income-earning and more diverse than is average for the state. Cherokee and Cobb counties have a larger population of Hispanic residents, while Cobb and Fulton counties have larger populations of Asian and Black residents. Among the three counties served by WellStar North Fulton Hospital, Cobb County has a slightly elevated population of residents with limited English-speaking skills.

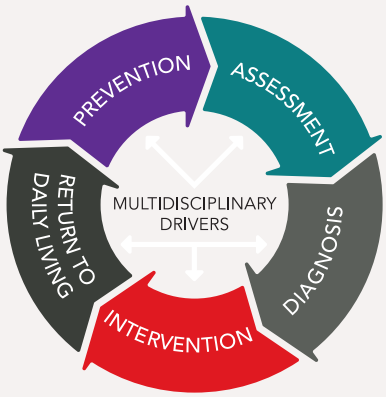
Social Determinants of Health

At first glance, the community served by WellStar North Fulton Hospital appear to have few health needs related to social determinants of health.[2] However, a closer look at the data by race, ethnicity and income shows evidence of pockets where the burden of social determinants of health are higher than in the rest of the service area. An example of this is seen in the rate of poverty among single-parent families. While single-parent families experience the highest rates of poverty throughout the service area, Cherokee County shows the starkest contrast between single-parent poverty when compared to all other types of families (see Table 3 - ARC Income table). Another example is seen in Figure 2, where Latino/Hispanic residents are three times more likely, and Black residents are nearly twice as likely, to be in poverty when compared to their White and Asian counterparts.

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

- Health professional shortage areas
- Higher than average rates of emergency department visits
- Hospitalization for preventable issues
- Higher than average mortality rates

Figure 1 | Care Continuum



These anomalies warrant further investigation to better understand and address the cause.

Health Outcomes

There are several undesirable health outcomes in the service area. Most of the top 10 causes of death in the service area are related to chronic conditions, lifestyle, behaviors (i.e., heart disease, stroke, chronic obstructive pulmonary disease, lung cancer, and diabetes), or behavioral health and substance abuse issues. The disease burden and death rates of the general population are not exceptional in the areas served by WellStar North Fulton Hospital. However, Black and Latino residents have the highest rates of poor health outcomes (often higher than state rates) when compared to any other racial or ethnic cohort in the service area. These health disparities are most notable among the following conditions:

Health Issues

There are several health issues that are prevalent regardless of race or ethnicity throughout the service area. These include:

Investments in addressing these issues would improve the health of the community served by WellStar North Fulton Hospital.

Data Limitations

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

- Most of the data included in this assessment is available only at the county level. County-level data is an aggregate of large populations and does not always capture or accurately reflect the nuances of health needs. This is particularly important for WellStar North Fulton Hospital, because the service area includes North Fulton County, which data shows has higher socioeconomic status, as well as much lower morbidity and mortality rates than the central or southern regions of Fulton County. Where smaller data points were available (i.e., for Census tracts or zip codes), they were included.
- Secondary data is not always available. For example, there is no secondary data source that offers a valid measure of educational awareness in the context of healthy options and availability of resources. In absence of secondary data, this assessment has noted relevant anecdotal data gathered from residents and stakeholders with lived experience during primary data collection. It is important to note that primary data is limited by individual vocabulary, interpretation and experience.
- There is no measure of the accessibility and effectiveness of available services listed in the Community Facilities, Assets and Resources section of the Appendix, particularly for under- and uninsured residents.

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

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

Community is **Commitment**

WE EXIST TO SERVE

Community Definition

WellStar North Fulton Hospital is located in Roswell, Ga., approximately 30 miles north of Atlanta. For the purposes of the CHNA, the primary service area for the hospital is defined as the 20 zip codes from which 75 percent of discharged inpatients originated during the previous year. The bulk of the zip codes are from Cherokee, Cobb and Fulton counties.

The CHNA considers the population of residents living in the 20 residential zip code area regardless of the use of services provided by WellStar or any other provider. More specifically, this assessment focuses on residents in the service area who are medically under-resourced or at risk of poor health outcomes.

Map 1 | Primary Service Area of WellStar North Fulton Hospital

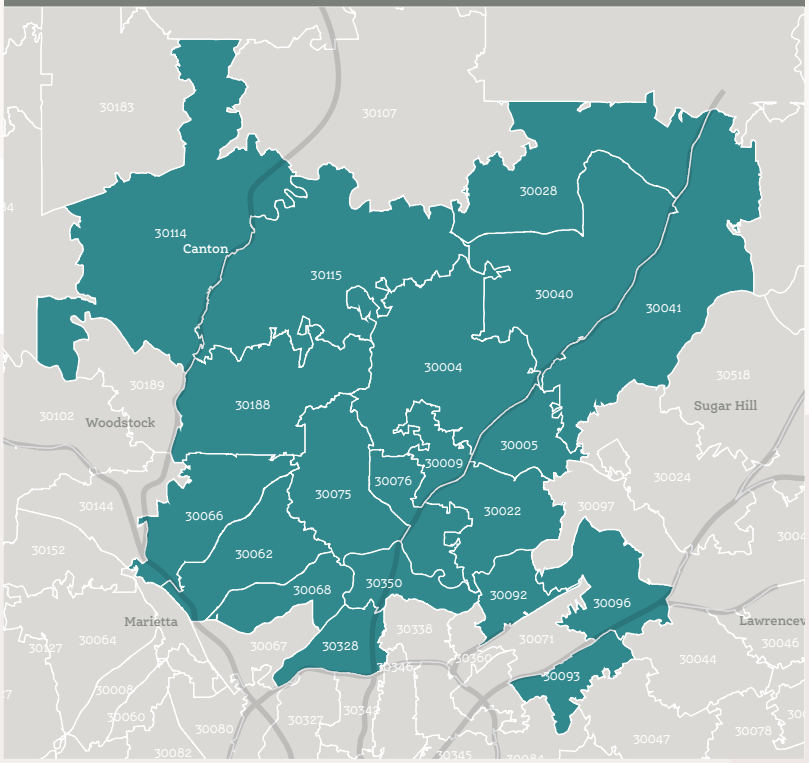


Table 1 | Primary Service Area of WellStar North Fulton Hospital

County	Zip Codes (20)	Population (2015)
Fulton	30004, 30005, 30009, 30022, 30075, 30076, 30328, 30350	351,504
Cobb	30062, 30066, 30068	151,920
Cherokee	30114, 30115, 30188	159,855
Gwinnett	30092, 30093, 30096	155,235
Forsyth	30028, 30041, 30040	165,045

Demographic Data

by County and State (2016)*

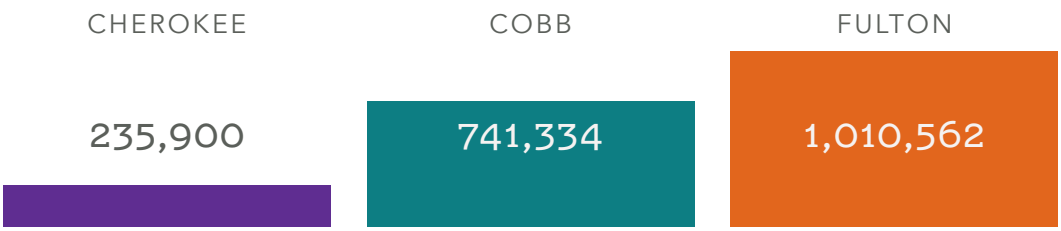
WellStar North Fulton Hospital

When compared to Georgia, the community served by WellStar North Fulton Hospital is of average age, higher-income-earning and more diverse. Cherokee and Cobb counties have a larger population of Hispanic residents, while Cobb and Fulton counties have larger populations of Asian and Black residents. Among the three counties served by WellStar North Fulton Hospital, Cobb County has a slightly elevated population of residents with limited English-speaking skills.

Total Population

GEORGIA TOTAL POPULATION

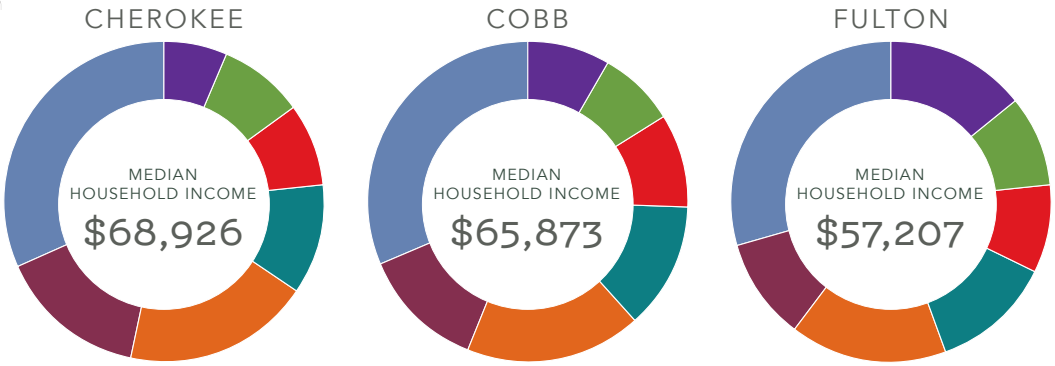
10,214,860



Income Distribution (2011-15)

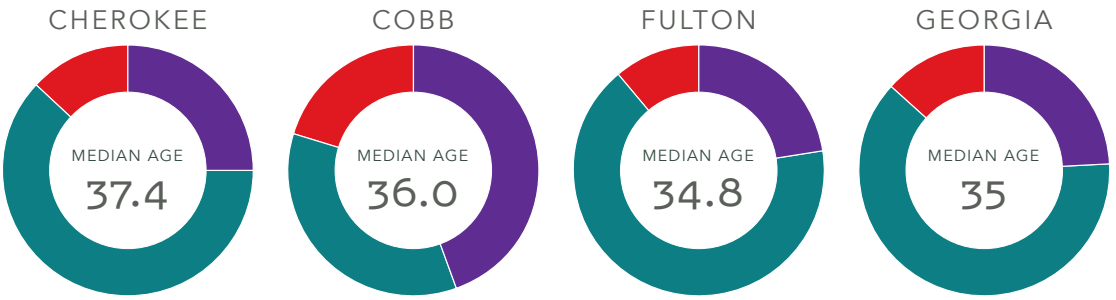
GEORGIA MEDIAN HOUSEHOLD INCOME

$53,559



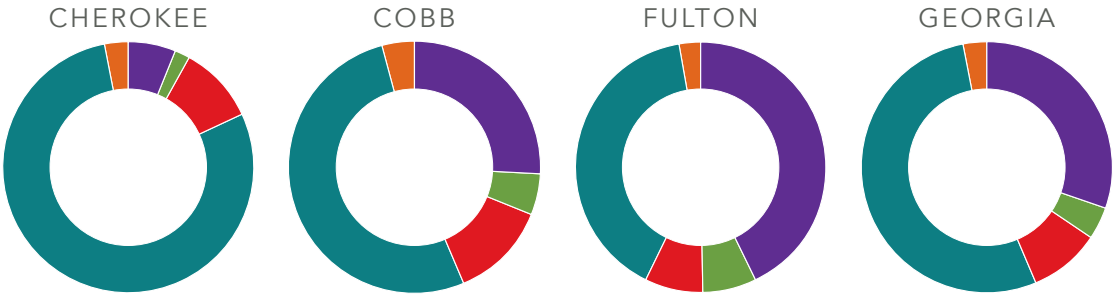
	CHEROKEE	COBB	FULTON
Less than $15,000	6.5%	8.4%	14.2%
$15,000 - $24,999	8.6%	8.0%	9.3%
$25,000 - $34,999	8.3%	9.3%	8.9%
$35,000 - $49,999	11.3%	12.8%	12.1%
$50,000 - $74,999	18.9%	17.7%	16.1%
$75,000 - $99,999	14.9%	12.7%	10.2%
Over $100,000	31.5%	31.2%	29.3%

Age Distribution



	CHEROKEE	COBB	FULTON	GEORGIA
0-17 years old	25.1%	25.3%	22.6%	24.3%
18-64 years old	61.9%	20.0%	66.4%	62.6%
65+ years old	13.0%	11.4%	11.1%	13.1%

Racial/Ethnic Distribution



	CHEROKEE	COBB	FULTON	GEORGIA
Black	6.2%	26.6%	43.3%	30.9%
Asian	2.0%	5.3%	6.9%	4.0%
Hispanic‡	10.1%	12.8%	7.5%	9.4%
Non-Hispanic White	79.8%	53.1%	40.3%	53.9%
Limited English	3.0%	4.2%	2.6%	3.0%

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

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

Community is **Contribution**

ASSESSING THE NEEDS

Data Collection

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

The secondary data included in this assessment are from a variety of sources that are both reliable and representative of the community served by WellStar North Fulton Hospital. Data sources include, but are not limited to:

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

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

To better understand the experience and needs of the residents living in the areas served by the hospital, several types of qualitative data were used including focus groups with residents, one-on-one interviews with key stakeholders, a listening session with the WellStar North Fulton Regional Health Board, and a health summit with hospital and community leaders. An in-depth description of the participants, methods used and collection period for each qualitative process is in the Primary Data and Community Input section of the Appendix.

Community is **Connection**

YOUR STORY IS OUR STORY

Health Needs of the Community

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

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

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

Community health can be measured in many ways. Understanding how residents feel (morbidity) and what is causing death (mortality) in a community is often a good place to begin when assessing the health of a community. The County Health Rankings (CHR), a popular annual measure of county-level health indicators, offers a measure of health outcomes by county. CHR health outcomes measures length of life and quality of life. Among the counties served by WellStar North Fulton Hospital, Fulton County shows the poorest rankings, with the exception of clinical care. It is important to note that the three primary counties included in this assessment have county health rankings in the top quartile, which represents the best mortality and morbidity measures, when compared to counties throughout the rest of the state.

Table 2 | County Health Rankings by County (2018)*†

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Cherokee	3	6	4	3	6	28	5	148
Cobb	7	5	6	11	2	22	8	82
Fulton	14	19	19	19	10	3	66	95

* *There are 159 counties in Georgia*

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

The leading causes of death in the hospital service area are similar when compared to those in the state. The top cause of death in both the service area and throughout the state is coronary artery disease.[4] The remainder of the top five causes of death are behavioral health causes (unrelated to psychoactive substance use), cerebrovascular disease (stroke), lung cancer, and chronic obstructive pulmonary disease (COPD).[5]

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

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

5 *See the Secondary Data section of the Appendix for a ranked list of causes of death in Georgia and in Cherokee, Cobb and Fulton counties*

Social Determinants of Health

According to Healthy People 2020, "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." While poverty is not pervasive in the service area, this assessment offers evidence of populations with high socioeconomic barriers to being healthy.

During key informant interviews, community leaders noted areas where families do not have legal immigration status and where there are high rates for unemployment, poverty and uninsured, specifically in Cherokee County (30114, 30115 and 30188) and South Cobb County. Additionally, secondary data shows high socioeconomic barriers to being healthy in the Gwinnett County zip code areas (30093, 30096 and 30092). Community input cited a lack of economic security in some areas, poor employment options and homelessness as existing health needs in the WellStar North Fulton Hospital community. One focus group participant noted:

> "Some people choose to live in certain areas based on affordability and what their finances allow but, you know, their job and the job market and where they're able to find employment is impacted as well."

Unemployment has decreased across the area in the last 10 years. During the same period, the household incomes in Cherokee County increased $2,606 and remained stagnant in Cobb and Fulton counties, rising only $351 and $498 respectively.[6]

Over the last decade, poverty in the general population has increased only slightly in Cherokee, Cobb and Fulton counties (3.4 percent, 1.8 percent and 2.2 percent respectively). This pattern is replicated across the service area regardless of family status, except in the case of single-parent families. Single-parent families have experienced the highest rates of poverty. This trend also is found in zip code-level data (see Table 5). Single-parent families in Cherokee County saw the greatest increase in poverty during the last 10 years, when compared to Cobb and Fulton counties (0.9 percent and 1.4 percent respectively).

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

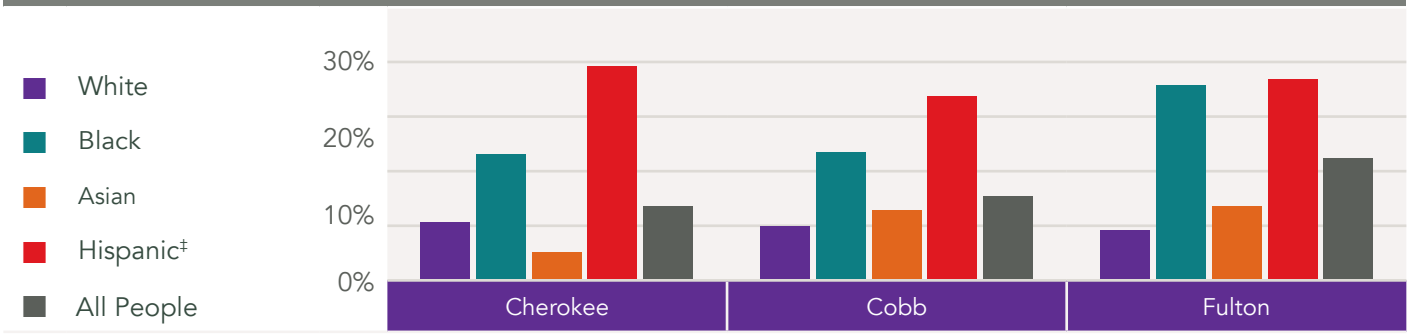
	Cherokee County		Cobb County		Fulton County	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	74,339	79,133	256,741	268,616	357,463	379,957
All people	7.4%	10.8%	10.6%	12.4%	15.3%	17.6%
All families	5.5%	8.5%	7.6%	9.4%	12.0%	13.0%
Married couple families	3.8%	5.1%	3.5%	5.2%	3.6%	4.4%
Single female head of household families	15.8%	24.9%	22.1%	23.0%	31.8%	33.2%

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

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

Figures 2 and 3 below show the disparities in the poverty and education rates of various racial and ethnic communities throughout the service area, with Latino and Black residents showing the highest rates of poverty and lowest rates of educational attainment when compared to their White and Asian counterparts. Latino/Hispanic residents are three times more likely, and Black residents are nearly twice as likely, to be in poverty, when compared to their White and Asian counterparts. Latino/Hispanic residents are more than four times more likely not to have a high school diploma when compared to their White and Asian counterparts. Black residents in Fulton County are twice as likely not to have a high school diploma; whereas, disparities related to educational attainment in Cherokee and Cobb counties are not as drastic for Black residents.

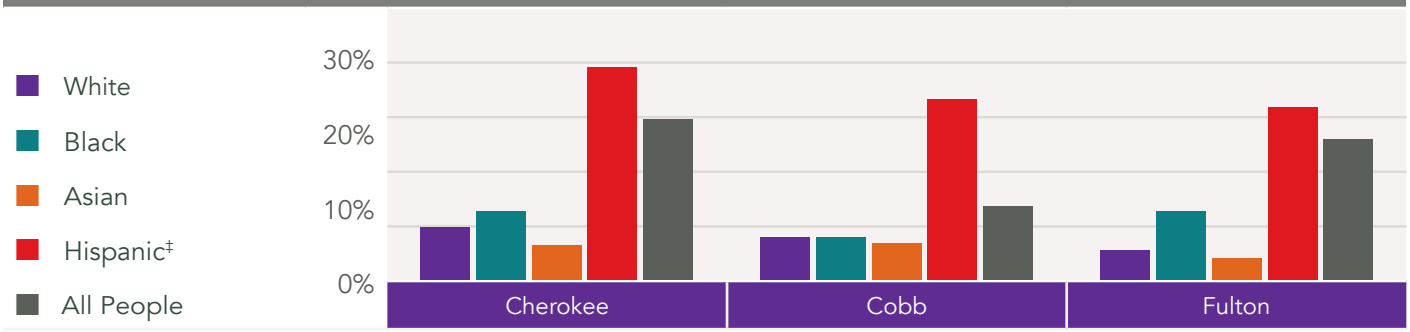
Figure 2 | Population Below Federal Poverty Level by Race/Ethnicity and County (2011-2015)†



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

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

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



† *Community Commons CHNA Portal: CHNA.org*

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

Housing

The quality, age, availability, and affordability of housing influence the health of residents in the community. One focus group participant said:

> "It just depends on what area you're in as to what the prices are. And, when you get to the areas inside the perimeter, where you have the big pockets of the lower economic status, you're gonna find substandard apartments (and) substandard facilities."

In the last 10 years, home values and homeownership have declined with home ownership replaced by renting. This fact alone does not indicate health challenges and is likely related to both the housing crisis and the younger median age of the service area.

As the Atlanta metropolitan area rebounds from the housing crisis, older homes are replaced by newer dwellings, much of which are larger apartment units. This, coupled with the population growth and decreasing vacancy rates, may be setting the community up for challenges related to unaffordable housing and displacement. Input provided by community leaders during the Health Summit noted homelessness as a growing concern in the community.

Table 4 shows that approximately 40 percent of residents throughout the service area spend more than 30 percent of their income on housing each month.

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

	Cherokee County		Cobb County		Fulton County	
	2006-10	2011-15	2006-10	2011-15	2006-10	2011-15
Total households	74,339	79,133	256,741	268,616	357,463	379,957
Family households	76.8%	74.8%	67.8%	68.2%	56.0%	54.6%
Nonfamily households	23.2%	25.2%	32.2%	31.8%	44.0%	45.4%
Vacant housing units	7.3%	6.5%	9.3%	7.7%	16.9%	14.6%
Homes more than 20 years old	36.6%	34.5%	59.1%	57.4%	61.4%	55.8%
Median value of homes	$201,900	$190,500	$211,000	$197,400	$253,100	$241,300
Households paying more than 30% of income for monthly mortgage	10.7%	6.8%	25.0%	20.2%	28.2%	24.5%
Households paying more than 30% of income for monthly rent	40.5%	38.5%	40.2%	40.1%	41.6%	41.8%

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

Zip code-level data shows that most of the zip codes served by WellStar North Fulton have below average socioeconomic barriers (see Table 6 for Community Need Index (CNI) data in selected zip code areas). A closer look at the data shows a geographic pocket in Gwinnett County where educational attainment and language skills are lower and unemployment and poverty are high, specifically in zip codes 30092, 30093 and 30096:

- Poverty is high, with more than one in three single-parent families in poverty
- Approximately one in 10 residents has limited English-speaking skills
- Unemployment rates are higher than average with more than one in 10 residents being unemployed
- Almost one-third of residents have no high school diploma in 30093

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

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

Access to Appropriate Care

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

Input from community residents noted several safety net providers have closed recently and, as a result, there are not adequate safety net services and the services that are available are not culturally and linguistically relevant to meet the needs of all residents. One example is the limited access the residents without legal immigration status have to any form of healthcare.

Socioeconomic Factors

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

Map 2 and Table 5 depict the 2015 CNI scores for the WellStar North Fulton Hospital service area. According to the 2015 CNI, most of the zip codes served by the hospital have below average socioeconomic barriers to accessing healthcare. A closer look shows:

- In general, there are lower barriers to accessing healthcare in the northern parts of the service area and higher barriers in the southern parts
- Barriers are increasing in the southern region of the service area (indicated in bold on the map)

Map 2 | WellStar North Fulton Hospital 2015 CNI Scores by Zip Code†

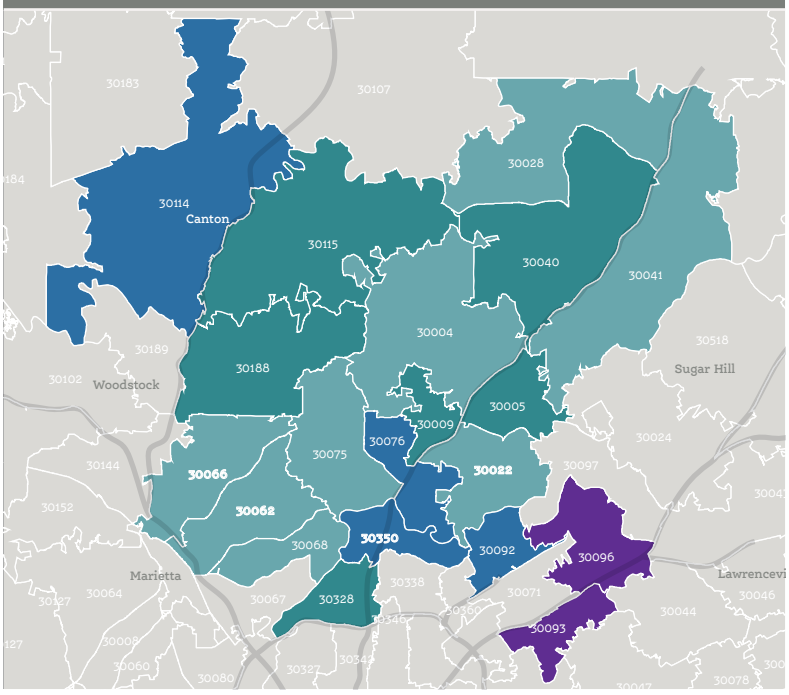


Table 5 | 2015 Community Need Index (CNI) Scores WellStar North Fulton Hospital†

Zip	County	2015 CNI Score
30093, 30096	Gwinnett	3.5
30350, 30076, 30092, 30114	Cherokee	2.8
30328, 30009, 30005, 30040, 30188, 30115	Fulton	3.7
30066, 30062, 30068, 30075, 30004, 30041, 30028	Cobb	3.4

† *Dignity Health: Community Need Index*

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

- There are six zip code areas with above average socioeconomic barriers (one in Cherokee, two in Fulton and three in Gwinnett counties)
- Two of the three primary counties covered in this assessment showed increases in barriers, Cobb (0.2) and Fulton (0.1)[9]
- Four zip codes showed increases in the barriers to accessing healthcare between 2014 and 2015[10]
- There were no decreases in the barriers to accessing healthcare between 2014 and 2015
- Two zip codes areas have higher rates of uninsured than the state (17.1 percent)

Table 5 | 2015 Community Need Index (CNI): 4 Highest Barrier vs. 5 Lowest Barrier Zip Codes†

Geography		Scores		Income			Culture		Education	Insurance		Housing
Zip	County	Change (2014-15)	2015 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/Kids	English as a Second Language	Minority	No High School Diploma	Unemployed	Uninsured	Renting
4 Areas With the Highest CNI Scores												
30093	Gwinnett	0.0	4.8	9%	38%	49%	23%	90%	30%	11%	22%	65%
30096	Gwinnett	0.0	4.2	11%	23%	34%	10%	69%	10%	12%	17%	53%
30092	Gwinnett	0.0	3.8	8%	17%	39%	7%	50%	9%	9%	14%	43%
30350	Fulton	0.2	3.4	8%	15%	35%	4%	53%	6%	8%	14%	65%
5 Areas With the Lowest CNI Scores												
30004	Fulton	0.0	2.4	7%	7%	27%	2%	34%	4%	6%	6%	22%
30068	Cobb	0.0	2.2	4%	9%	10%	2%	22%	2%	8%	9%	18%
30075	Fulton	0.0	2.2	6%	6%	21%	3%	22%	4%	8%	8%	19%
30028	Forsyth	NA	2.0									
30041	Forsyth	NA	2.0									
	Cobb Total	**0.2**	**3.4**	**7%**	**17%**	**34%**	**4%**	**47%**	**9%**	**10%**	**12%**	**32%**
	Fulton Total	**0.1**	**3.7**	**14%**	**21%**	**37%**	**3%**	**60%**	**10%**	**12%**	**18%**	**45%**
	Gwinnett Total	**0.0**	**3.5**	**9%**	**17%**	**32%**	**7%**	**59%**	**12%**	**10%**	**12%**	**29%**

† *Truven Health Analytics, Community Needs Index (2015)*

9 Detailed CNI data was not available for Cherokee or Forsyth counties.

10 Increases in CNI scores between 2014-15: Cobb (30062 and 30066) and Fulton (30022 and 30350).

Input from community residents pointed to a lack of care continuity among providers, specifically when receiving care at the emergency department (ED). According to the 2017 ED utilization data provided by WellStar, WellStar North Fulton Hospital saw a total of 10,105 self-pay patients in their ED. A patient is considered self-pay if they do not provide medical insurance to cover the care they receive. This is often a sign of the number of under- and uninsured patients receiving care in any hospital department. A closer look at the 20 zip codes included in this assessment shows:

- Cherokee County zip codes contain 16.25 percent of the total population of the service area and one-tenth (10 percent) of the self-pay patient population seen at the ED
- Cobb County zip codes contain 15.45 percent of the total population of the service area and three percent of the self-pay patient population seen at the ED
- Fulton County zip codes contain 35.74 percent of the total population of the service area and 70 percent of the self-pay patient population seen at the ED

Table 6 | Characteristics of Self-Pay Patients Receiving Care in the Emergency Departments at WellStar North Fulton Hospital (2017)†

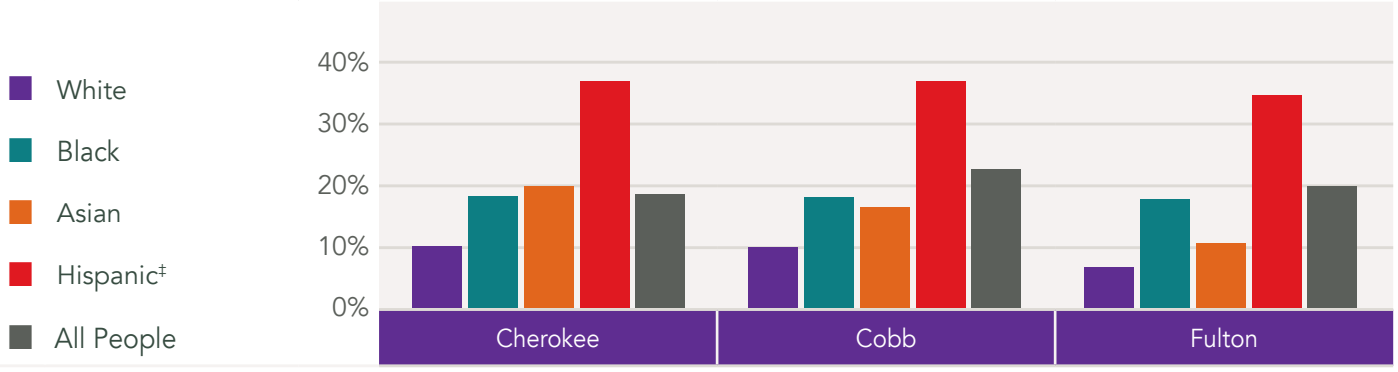
County	# of Service Area Zip Codes	# of Self-Pay ED Visits to WSRH and WSGH	Percent of All Self-Pay ED Visits	Total Population	Percent of Service Area Population
Cherokee	3	984	10%	159,855	16.25%
Cobb	3	271	3%	151,920	15.45%
Fulton	8	7,075	70%	351,504	35.74%
Service Area	**20**	**10,105**	**100%**	**983,559**	**100%**

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

Uninsured

A greater percentage of Georgia residents are uninsured than the national average due to the lack of Medicaid expansion. The percentage of uninsured residents in Cherokee, Cobb and Fulton counties is average for the state when considering the general population. Figure 4 shows the disparities in the rates of uninsured when considering the data by racial and ethnic groups throughout the service area, with Latino and Black residents showing the highest rates of uninsured when compared to their White and Asian counterparts. Latino/Hispanic residents are four times more likely to be uninsured, while Black and Asian residents are more than twice as likely when compared to their White counterparts.

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



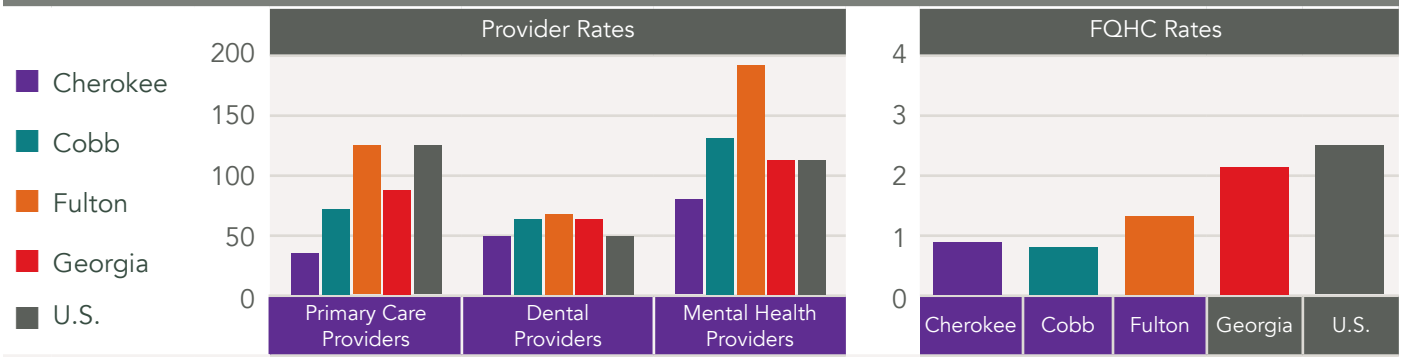
† *Community Commons CHNA Portal: CHNA.org*

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

Provider Shortage

There is a shortage of healthcare and dental providers throughout the community, particularly among safety net providers offering free or reduced care based on income (see Map 3 for a geographic representation). Cherokee County has the fewest primary care and dental care providers in the service area. Community stakeholders discussed the need to increase adult and pediatric services, particularly for under- and uninsured residents. While Fulton and Cobb counties have higher rates of primary care and dental care providers when compared to Cherokee County and the state, there are fewer Federally Qualified Health Centers (FQHCs) in all three counties when compared to the state and national rates.

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

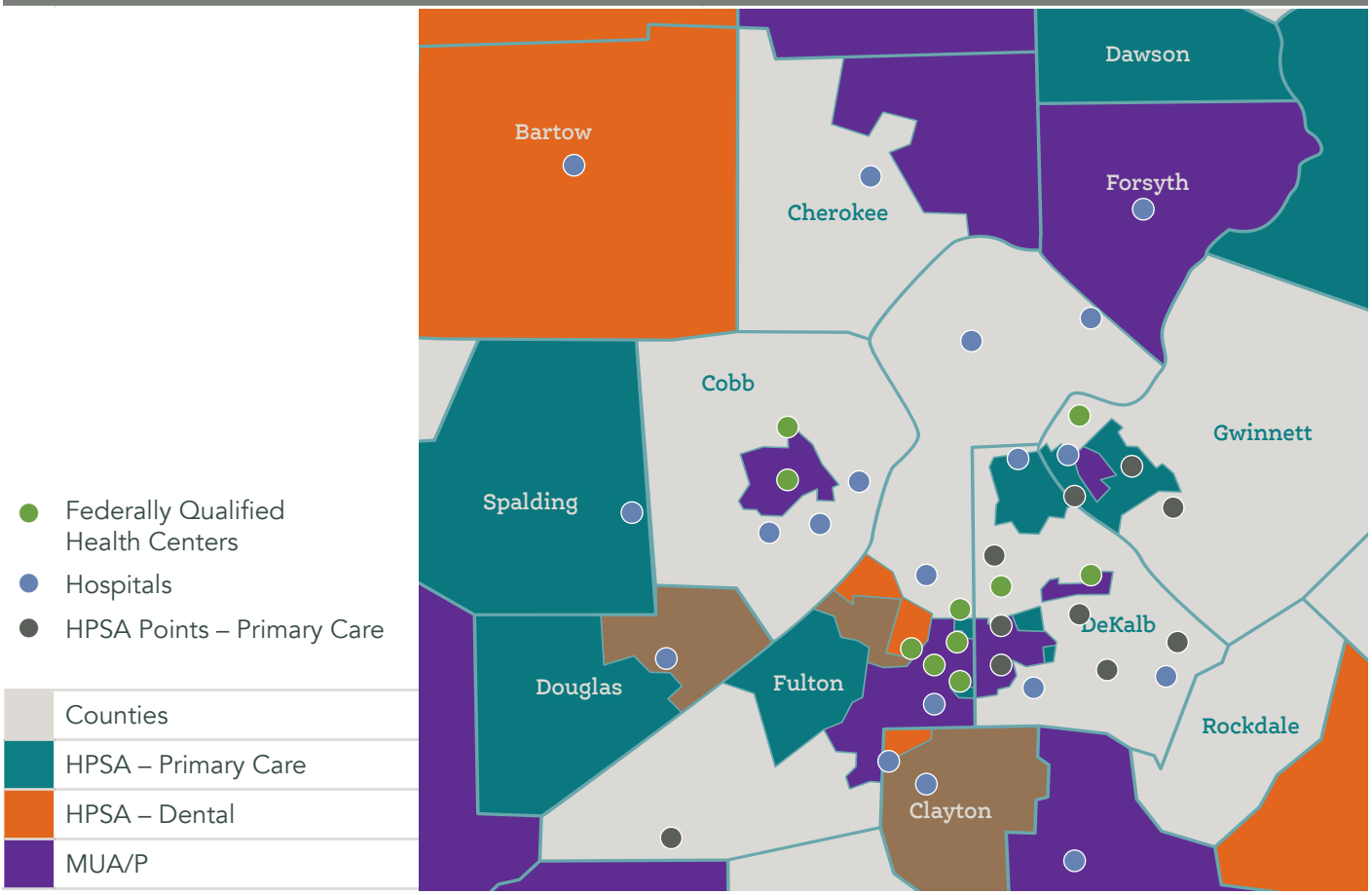


† *Community Commons CHNA Portal: CHNA.org*

According to the Health Resources and Services Administration (HRSA):

- Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) exist in Cherokee, Cobb and Fulton counties
- Cherokee County needs 17 primary care providers, which impacts the care of an estimated 170,143 residents
- Central Cobb County is designated as a geographically MUA
- Fulton County needs seven primary care providers and 13 dental care providers, which impacts the care of an estimated 19,278 residents
- Most safety net providers are located in the downtown area of Atlanta and central Cobb County, leaving few safety net providers to serve the northern and southern regions of the service area

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



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

Health Behaviors

To better understand behaviors impacting health, it is important to consider factors influencing the choices residents make that cause them to be either healthy or unhealthy. Often these choices are influenced by access to, awareness of and preference for healthy or unhealthy options.

Food Insecurity

According to the U.S. Department of Agriculture (USDA), food security is access by all people at all times to enough food for an active, healthy life, which is one of several conditions necessary for a population to be healthy and well-nourished. In 2016, the USDA found that 14 percent of households in Georgia experience low food security and 5.6 percent experience very low food security.[11]

Table 7 shows that all counties included in this CHNA show signs of food insecurity and low access to grocery stores. Residents in Fulton County have the lowest access to supermarkets and grocery stores when compared to Cherokee and Cobb counties. The percentage of low-income residents with low access to grocery stores in Fulton County is nearly six times that of Cherokee County, with Cobb County more than double. The geographic areas where low-income populations have the lowest access to grocery stores is central to the service area and Downtown Atlanta (see Map 4). A closer look at the data shows areas included in the hospital services area where low-income residents have low access to a supermarket are in Cherokee County (30188) and Gwinnett County (30093).[12]

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

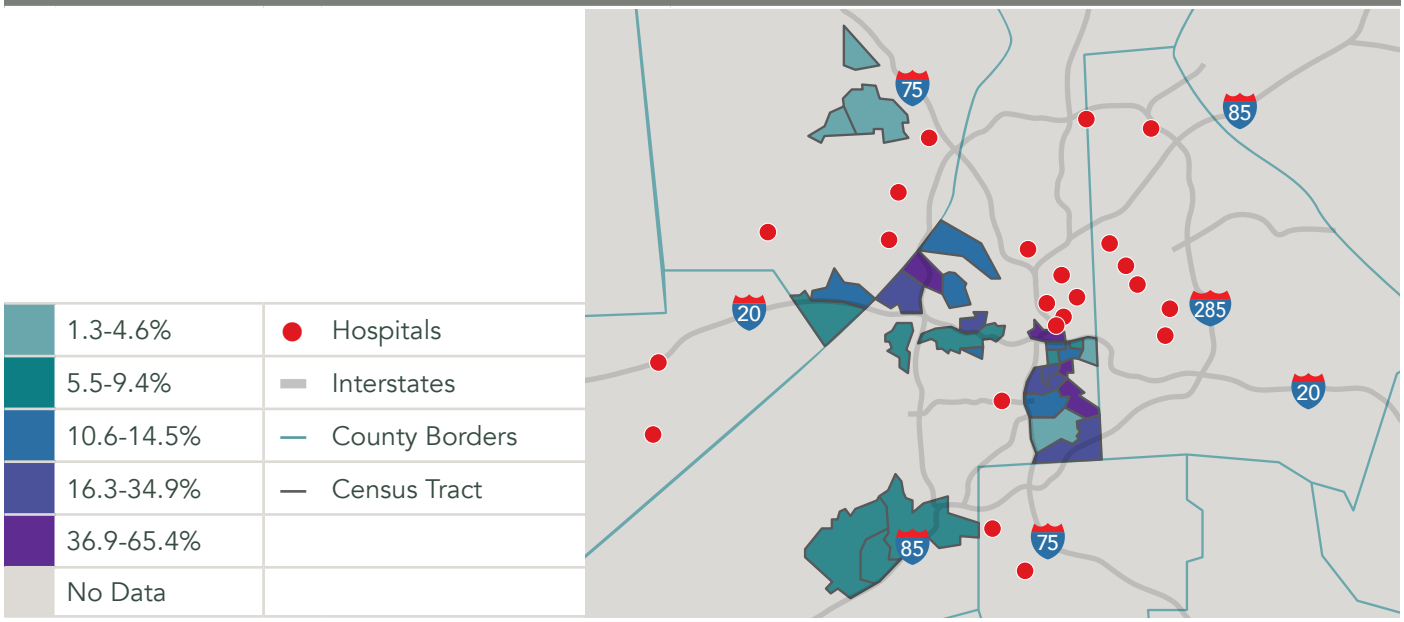
Healthy Eating Active Living Indicators	Cherokee	Cobb	Fulton
Residents with low access to a supermarket	37.5%	41.4%	57.8%
Low-income residents with low access to a supermarket	2.3%	6.8%	17.1%
Children with low access to a supermarket	9.6%	11.8%	18.2%
Seniors with low access to a supermarket	3.7%	1.9%	4.1%

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

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

12 Census Tracts 13057091001, 13135050418, 13135050421

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



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

Most of the primary data sources discussed obesity, healthy nutrition or physical activity as community health needs. Their input suggests that residents do not have time to shop and prepare meals or exercise in a healthy way. Residents discussed lengthy commutes and traffic as the primary reason they did not shop and prepare healthy meals or exercise in a healthy way.

Long Commute Times

The data in Table 8 shows more people than is average are spending over an hour during their commute in Cherokee and Cobb counties. One focus group participant said:

> "So the lack of time many times — It's trying to beat time in work, etc. It doesn't allow one — It's a barrier to feed oneself properly."

Table 8 | Selected Healthy Eating, Active Living Indicators†

	Cherokee	Cobb	Fulton	Georgia	U.S.
Inadequate fruit and vegetable consumption	74.5%	70.6%	74.1%	75.7%	75.7%
Access to exercise facilities	80.0%	89.0%	90.0%	75.0%	ND
Adult physical inactivity	19.7%	18.4%	18.0%	23.1%	21.8%
Commute over 60 minutes	15.9%	11.2%	8.8%	9.4%	8.5%

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

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

Health Knowledge

Health Summit participants prioritized educational awareness, specifically among parents, as one of the most pressing health issues that could improve health outcomes in the community if effectively addressed. One resident spoke about the importance of teaching children healthy habits at a young age by saying:

> "I think that it's easier to educate a child on healthy habits. Especially, when you think about Georgia and the obesity of children in Georgia. I think that, you know, if you start to teach better habits as young adults, it's easier to teach it as a child than it is to break old habits as a grown person. I think if you teach an education at a younger age versus somebody that's forced to get it because a life event happened, an there's a difference."

While there is no measure of educational awareness in the context of healthy options, parental awareness or family support, key informants discussed a lack of awareness of available services and poor health literacy related to healthy behaviors. One resident spoke about the need for parents to have correct information to make healthy decisions:

> "It's all about education – giving them the right information so the person can make sound decisions. Don't guess, get education."

Another resident described the need to communicate what is available by saying this:

> "The parents start teaching the kids how to be respectful and loving and eat healthy, but if we don't send information to Mrs. Maria, who is very busy, how is Mrs. Maria going to know what is going on around the community?"

There are existing resources throughout the service area that address healthy behaviors, parent education, and family support.[13] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the barriers to healthy behaviors, parent education and family support noted in this assessment.

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

Health Outcomes

Most of the top 10 causes of death in the service area are related to chronic conditions, lifestyle and behaviors (i.e., heart disease, stroke, COPD, lung cancer, drugs, and diabetes). When considering county-level data, Fulton County shows the greatest morbidity (disease burden) when compared to Cherokee and Cobb. Black residents throughout the service area show the highest disease burden when the data are considered by race. While data for Latino residents are limited, there is anecdotal evidence Latino residents experience high rates of morbidity and mortality related to chronic conditions as well.

Obesity

At the time of this CHNA, body mass index (BMI) is a health issue throughout the country, with this community as no exception. More than one in three adults is overweight and nearly one in four adults is obese. Diabetes does not appear to be high among the general population, though Black residents show higher rates of hospital discharge and death than any other race.

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

	Cherokee	Cobb	Fulton	White	Asian	Black	Hispanic‡	Georgia
Overweight	36.0%	41.0%	33.3%	ND	ND	ND	ND	35.1%
Obese	26.5%	22.6%	23.8%	ND	ND	ND	ND	29.3%
Living with diabetes	8.3%	6.8%	9.2%	ND	ND	ND	ND	10.6%
Diabetes discharge rate*	97.1	157.7	186.1	92.5	29.0	308.9	ND	187.3
Diabetes mortality*	7.1	14.5	17.3	11.0	10.0	27.4	ND	21.6

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

* *Age adjusted, per 100,000 population*

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

Heart Disease

The southeast region of the United States has higher morbidity and mortality rates related to cardiovascular conditions (i.e., cerebrovascular obstructive and hypertensive heart disease). As a result, this geographic area reflects slightly elevated cardiovascular disease when compared to the national average. When compared to the state rates for heart disease, Fulton County residents and Black residents show higher rates of hypertensive heart disease morbidity and mortality.

Table 10 | Selected Cardiovascular Condition Indicators by County and Race (2012-2016)†								
	Cherokee	Cobb	Fulton	White	Asian	Black	Hispanic‡	Georgia
Obstructive heart disease/ heart attack discharge rate*	203.8	161.4	206.9	164.6	124.9	230.6	ND	260.0
Obstructive heart disease mortality*	58.6	53.4	52.5	51.6	16.8	65.7	ND	75.4
Hypertensive heart disease discharge rate*	17.6	20.7	43.8	16.3	ND	67.9	ND	31.0
Hypertensive heart disease mortality*	19.8	9.2	27.3	13.2	6.5	37.1	ND	17.5
Stroke mortality*	37.5	56.5	37.5	40.9	53.2	39.7	ND	44.0
Adults who have had a stroke	ND	2.3%	3.8%	ND	ND	ND	ND	ND

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

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

** Age adjusted, per 100,000 population*

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

Cancer

Cancer rates are also elevated in Georgia when compared to the national average. There are higher morbidity rates for breast and prostate cancers across the service area. Cherokee County shows higher morbidity rates for lung cancer.

Table 11 | Selected Cancer Indicators by County and Race (2012-2016)†									
	Cherokee	Cobb	Fulton	White**	Asian**	Black**	Hispanic**‡	Georgia	U.S.
Breast cancer incidence*	126.9	132.8	135.3	137.63	82.19	128.87	98.6	123.4	123.4
Cervical cancer incidence*	6.8	6.1	6.9	6.0	ND	8.9	ND	7.7	7.6
Colon and rectum cancer incidence*	34.8	39.0	39.7	35.7	21.6	47.7	32.7	41.7	40.6
Prostate cancer incidence*	138.6	142.4	170.4	134.9	55.7	227.3	116.8	139.8	123.4
Lung cancer incidence*	73.2	60.3	54.5	59.2	23.8	60.9	41.2	67.3	62.6
Cancer mortality*	153.2	151.9	163.7	135.4	84.8	168.4	ND	163.0	166.3

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

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

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

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

Asthma

Asthma is common in densely populated urban areas for a variety of reasons. Residents living in Fulton County also suffer from higher morbidity rates for asthma, while residents from Cherokee and Cobb counties show less hospitalization and ED visits for asthma.

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

	Cherokee	Cobb	Fulton	White**	Asian**	Black**	Hispanic**‡	Georgia
Asthma discharge rate*	53.8	83.8	105.9	59.9	17.1	161.4	ND	87.8
Asthma ED visit rate*	227.6	504.0	621.9	234.6	65.4	1,181.9	ND	538.8

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

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

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

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

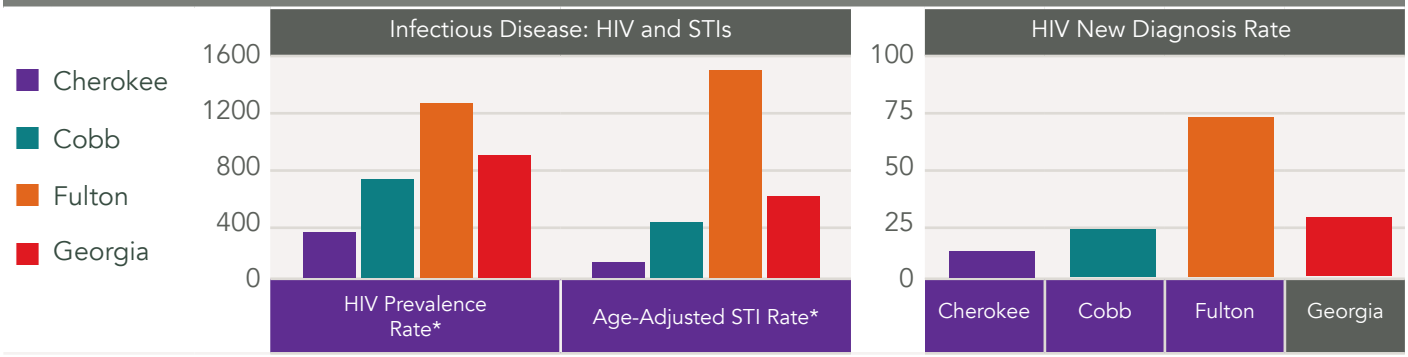
Sexually Transmitted Infections (STIs)

The Atlanta metropolitan area has some of the highest morbidity rates for human immunodeficiency virus (HIV) and AIDS in the nation. Fulton County shows higher rates of HIV when compared to the state. A closer look at zip code-level data shows a more complex picture of HIV in this region.[14, 15]

While HIV screening rates are high in the service area, annual diagnostic rates remain high among certain populations, according to a database called AIDSVu, managed by the Rollins School of Public Health at Emory University. Specifically, in the service area:

- The highest rates of prevalence and new cases are among the Fulton and Gwinnett County zip code areas
- Five zip codes have rates higher prevalence rates than the state (564 per 100,000 population)[16]
- Eight zip codes have higher rates of new cases than the state (28 per 100,000 population)[17]
- Black men are being diagnosed with HIV at a much higher rate than any other racial or ethnic group[18]

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



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

* *Per 100,000 population*

14 *HIV data is not available at the zip code level for 30114 and 30028.*

15 *See the Secondary Data section of the appendix for zip code–level data on HIV prevalence and new cases.*

16 *30350, 30093, 30092, 30328, and 30096*

17 *30350, 30093, 30096, 30092, 30328, 30076, 30062, 30066*

18 *AIDSVu. Emory University, Rollins School of Public Health. Atlanta, GA (www.aidsvu.org)*

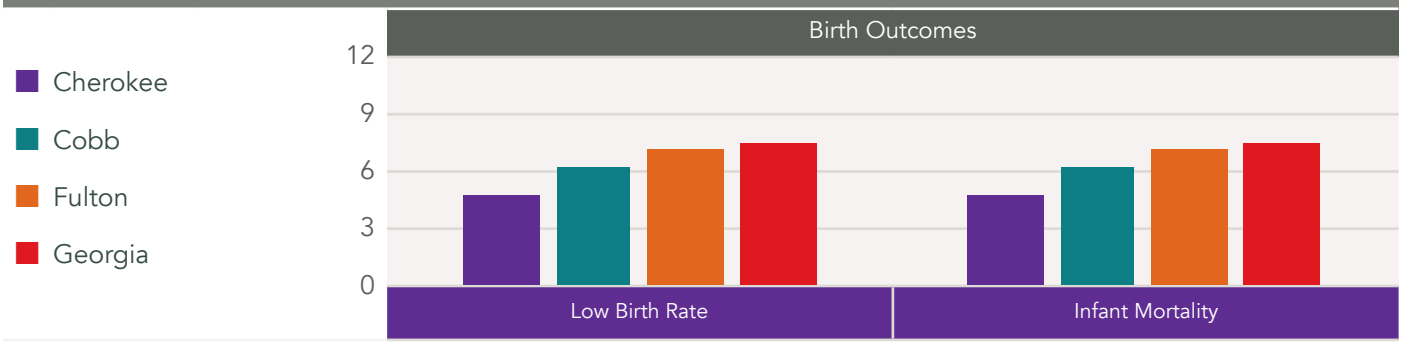
Birth Outcomes

Most birth outcomes in Georgia need improvement when compared to national averages. One of the greatest challenges the state faces in addressing infant outcomes is consistent collection, tabulation and presentation of complete data related to childbirth across the state. According to the 2016 State of the State Report, Georgia continues to face challenges related to the prevalence of low-birth-weight infants and infant mortality, among other issues.[19]

Input gathered from resident focus groups noted the limited education offered to youth about risky sexual behaviors and the lack of adult supervision of youth as driving forces behind teen pregnancy and the rate of sexually transmitted infections (STIs). Latino residents noted that cultural norms related to childbirth often lead to higher rates of teen pregnancy and STIs in the Latino community. In addition, community leaders noted that women without legal immigration status are not seeking prenatal care.

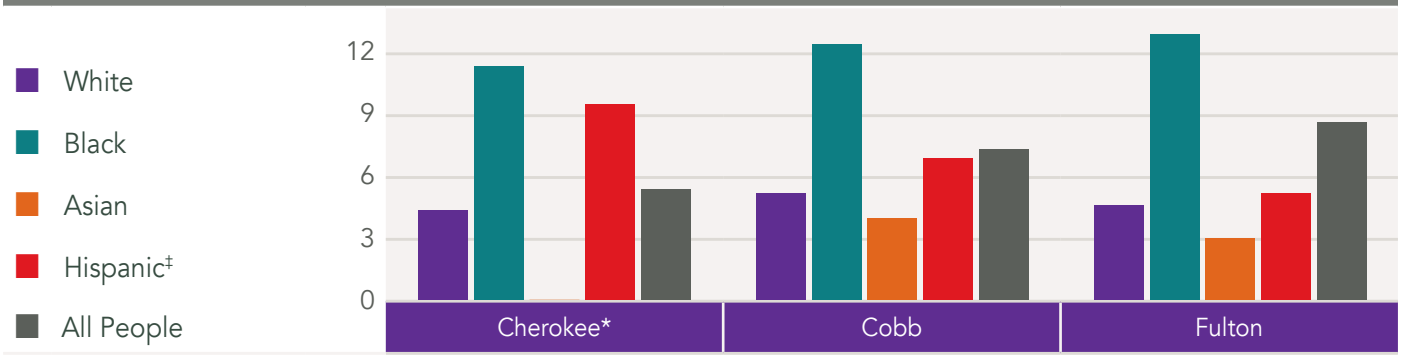
Figures 7 and 8 show that the general population in Cherokee, Cobb and Fulton counties have better birth outcomes than is normal for the state. However, Black residents in all three counties are nearly twice as likely to experience infant mortality as any other race, except Hispanic residents in Cherokee County.

Figure 7 | Low Birth Weight and Infant Mortality by County (2016)†



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

Figure 8 | Infant Mortality by Race/Ethnicity and County (2012-16)†



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

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

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

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

Table 13 shows that assault rates are high in Fulton County.

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

	Cherokee	Cobb	Fulton	Georgia
Assault discharge rate*	5.5	10.6	45.3	19.9
Motor vehicle crash ED visit rate*	874.3	1,019.0	1,035.3	1,168.3
Percent traffic deaths involving alcohol	19.0%	25.0%	23.0%	23.0%

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
** Age adjusted, per 100,000 population*

Behavioral Health

The need for behavioral health resources, particularly for under- and uninsured patients, is a challenge across the state of Georgia. Health Summit participants prioritized behavioral health as one of the most pressing issues in the community, that if addressed, could influence the health of residents. According to the Georgia Hospital Association, about 50,000 people across the state were admitted to Georgia's hospitals for mental health issues in 2016.[20]

According to anecdotal information gathered from community input, behavioral health issues impact all demographics. Focus group residents and Health Summit participants indicated that there is a shortage of psychiatric and inpatient services (crisis care and substance abuse) for adults and children.

Table 14 depicts a slight need for behavioral health providers, with an estimated 83,965 residents living in areas with professional shortages. Meanwhile, mental and behavioral disorders is one of the top five causes of death in all three counties and intentional self-harm (suicide) is one of the top 10 causes of death in Cherokee County. Hospital and community leaders discussed the resistance of residents to seek behavioral healthcare when it is needed for themselves or their children due to limited awareness about signs and symptoms, as well as fear of stigma.

Table 15 shows low provider rates and elevated mortality due to behavioral health and suicide in Cherokee County when compared to Cobb and Fulton counties. It is important to note there is no measure of the rate of behavioral health providers that offer care to uninsured patients. Table 15 also shows a much higher rate of ED use in Fulton County when compared to all other counties in the service area and the state. This may point to barriers to accessing treatment in more appropriate settings.

Input from community residents related to behavioral health also suggested that residents might resist seeking care due to stigma, lack of insurance, unaffordable cost of care, and providers being located too far away from home.

Table 14 | Selected Characteristics of Health Professional Shortage Areas for Mental Health by County†

	Cherokee County	Cobb – Central Marietta	Fulton County Correctional Facilities	South Central Fulton
Number of People in Mental Health HPSA	ND	0	19,278	64,687
Number of Mental Health FTE Needed	ND	1	9.64	0.10

ND: Data was unavailable due to a lack of data reporting or data suppression *ND for rates: Rates based on 1-4 events are not shown*
† *Community Commons CHNA Portal: CHNA.org*

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

Table 15 | Selected Characteristics Health Professional Shortage Areas by County (2016)†				
	Cherokee	Cobb	Fulton	Georgia
Mental health providers*	80	131	191	112
Poor mental health days	3.5	3.4	3.6	3.8
Mental health ED rate*	863.5	953.6	1,398.9	1,083.3
Mental and behavioral disorder mortality (2012-16)*	52.3	48.7	45.9	47.5
Self-harm age-adjusted discharge rate*	29.2	30.3	24.9	33.8
Age-adjusted suicide mortality (2012-16)*	14.1	10.9	10.1	12.2

† *Community Commons CHNA Portal: CHNA.org*
** Per 100,000 population*

Substance Abuse

Substance abuse has become an increasing concern in many parts of the United States in the last decade, specifically related to opioid abuse and overdose. Every primary data source discussed substance use, particularly opioid abuse and overdoses, as a community health priority, including the WellStar North Fulton Regional Health Board and community leaders attending the Health Summit. One resident said this about the presence of drugs in Cherokee County:

> "Most time those people with kids, they move out of the city to get their kids away from that environment. Regardless of where you go, it's there. It might be a little more discreet, because Woodstock got a lot of stuff going on. You would be surprised. I've seen plenty of nights of drug overdoses in the parking lot."

Death due to accidental poisoning and exposure to noxious substances, which includes drug overdoses, is one of the top 10 causes of death in Cherokee and Cobb counties. Table 16 shows that the mortality rate due to drug overdose has more than doubled.

Table 16 | Age-Adjusted Death Rate, Drug Overdoses (2006-2016)†				
	Cherokee	Cobb	Fulton	Georgia
Drug overdoses (2006)*	8.7	8.4	9.5	8.3
Drug overdoses (2016)*	21.0	16.1	15.8	13.6

† *Georgia Department of Public Health Online Analytical Statistical Information System: oasis.state.ga.us*
* *Age-adjusted discharge rate, per 100,000 population*

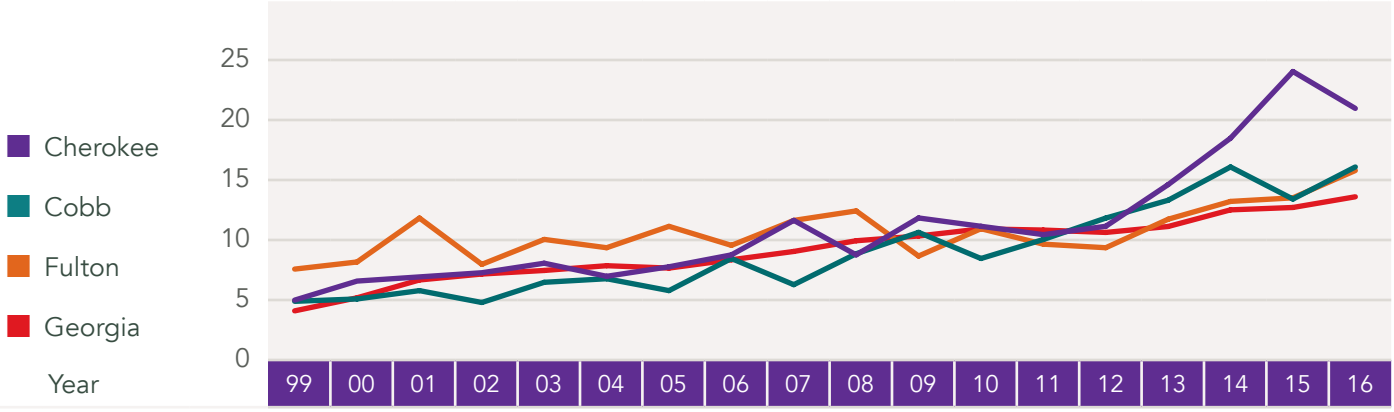
According to a white paper written and presented to the state Senate by the Georgia Prevention Project's Substance Abuse Research Alliance:

- 68 percent of the 1,307 drug overdose deaths in 2015 in Georgia were due to opioid overdoses including heroin
- A statistically significant increase in the drug overdose death rate occurred from 2013 to 2014
- Overdose deaths tripled between 1999 and 2013 in Georgia[21]

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

Figure 9 shows the increase of substance abuse overdoses in Cherokee, Cobb and Fulton counties since 1999. Cherokee County shows the highest rate when compared to the rest of the counties in the service area and state. However, since 2013, all three counties show dramatic increases and higher rates than Georgia.

Figure 9 | Age-Adjusted Death Rate Per 100,000 Population Drug Overdoses (1999-2016)†



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

There are existing resources throughout the service area that address the common health outcomes noted in this section.[22] Unfortunately, there is no way to determine the reach and effectiveness of these collective resources in addressing most of the health issues.

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

Community is **Compassion**

RALLYING PEOPLE AND RESOURCES

Community Input

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

Listening Session

A listening session was conducted with the WellStar North Fulton Regional Health Board and key informant interviews were conducted with 32 community leaders. Hospital and community leaders encompassed a wide variety of professional backgrounds including (1) public health expertise, (2) professionals with access to community health-related data and (3) representatives of under-resourced populations. The listening session and interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to CHNA.

Focus Groups

Five focus groups were conducted to gather input from more than 60 residents living and working in the community served by WellStar North Fulton Hospital. Focus group participants were asked to discuss their opinions related to the health status and outcomes; context, facilitating and blocking factors of health; and what is needed to be healthier in their community. The following pages are a summary of the community input gathered for the CHNA process.

Summary of CHNA Community Input

WellStar North Fulton Hospital

Commonly Discussed Health Issues

- **Overutilization of the ED**
- **Disparities among people of color**
- **Substance abuse and overdoses**
- **Poor mental health:**
  - Depression and anxiety
  - Self-harm and suicide
- **Chronic conditions:**
  - Cardiovascular disease
  - Congestive heart failure
  - Hypertension
  - Teen pregnancy
  - Diabetes (type I and II)
  - Obesity (adult and child)
  - Asthma
  - Allergies
  - Sexually transmitted infections
  - Cancer

Commonly Discussed Causes

- **Geographic location of health services coupled with limited transportation options that are fragmented**
- **Limited services available for:**
  - Under- and uninsured (primary, care coordination, dental, and prenatal care)
  - Specialty care
  - Behavioral health (psychiatric and crisis)
  - After-hours care
  - Engaging residents (education and prevention)
- **Low health literacy/ awareness of:**
  - Available services
  - Healthy practices
  - Prevention
  - Insurance options and uses
- **Unaffordable cost:**
  - Prescriptions
  - Insurance (not enough options)
  - Healthy food options
  - Uninsured care
- **Economic insecurity**
- **Poor employment options**
- **Lack of time to be healthy**
- **Prevalence of fast food**
- **Poor access to:**
  - Healthy nutrition
  - Physical activity
  - Health education
- **Lack of safety (crime and poor infrastructure)**
- **Lack of appropriate supervision/risky behavior of youth**
- **Limited culturally and linguistically relevant health services (Black, Asian, Latino, and LGBTQ residents)**
- **Homelessness**
- **Unhealthy cultural preferences and traditions**

Common Recommendations

Engage community partners:

- To reach more parents
- Expand community engagement
- Disseminate educational material about healthy habit to youth (i.e. sex, nutrition, behavioral health awareness, physical education, and drug education)
- Conduct health seminars which will promote health education

Focus on diversity when addressing health needs

Increase the number of bilingual providers to offer culturally and linguistically relevant health services

Invest in local projects to increase healthy options in the area (walkability, parks)

Increase the use of mobile programs:

- To teach healthy habits into youth and their families
- Offer remote services (i.e. telehealth or satellite medical centers)

Increase access to care:

- Increase the number of providers (i.e., safety-net clinics)
- Offer an all-inclusive price menu for insured or uninsured clients
- Provide urgent care services for residents with schedule demands
- Offer alternative transportation options for medical services
- Restructure services covered by insurance

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

Community is **Collaboration**

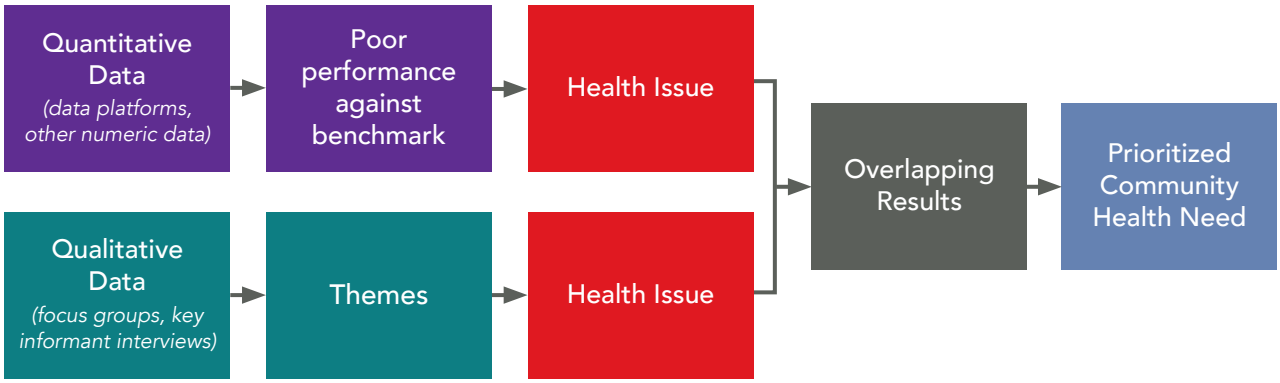
STRONGER TOGETHER

Community Health Priorities

WellStar North Fulton Hospital engaged 19 community and hospital leaders to help establish the community priorities for the community served during a Health Summit, held Feb. 26, 2018, on the hospital campus. Stakeholders represented organizations serving residents in the primary service area of WellStar North Fulton Hospital. An in-depth summary of the results, along with description of the participants, methods used and collection period, is located in the Primary Data and Community Input section of the Appendix.

GHPC presented to community leaders findings from the CHNA generated from analysis of secondary data, key informant interviews, focus groups, and listening sessions (see Figure 10).

Figure 10 | Process Used to Identify the Most Pressing Health Needs



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

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

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

1
Behavioral health

Health Summit participants prioritized behavioral health as one of the most pressing issues in their community. Concerns included lack of awareness and education, stigma, limited behavioral health providers, fragmented referral system, and inadequate resources and protocols for mental health crisis episodes.

2
Parental education and support

Health Summit participants addressed the importance of parental education and the need to offer parents the knowledge and access to resources to make healthier choices, support healthy child development and improve child health.

3
Access to care

Health Summit participants discussed limited access residents have to appropriate care when and where it is needed. Several of the challenges discussed were transportation, awareness of available services, the number of providers, and affordability.

4
Overuse and abuse of opioids

Health Summit participants discussed the opioid epidemic in the WellStar North Fulton Hospital service area. Several of the issues discussed were the increase in opioid abuse, limited awareness about the risk of opioid addiction and the stigma associated with prescribing and using opioids.

Appendix

Consultant Qualifications

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

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

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

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

Secondary Data

(November 2017–February 2018)

County Health Rankings† (2018)	
Cherokee	3
Cobb	7
Fulton	14

Age Distribution	Cherokee	Cobb	Fulton
0-17 yrs.	25.1%	24.3%	22.58%
18-64 yrs.	61.9%	20.0%	66.35%
65+ yrs.	13.0%	11.4%	11.07%

Racial Distribution	Cherokee	Cobb	Fulton
Black	6.2%	26.6%	43.3%
Hispanic	10.1%	12.8%	7.5%
White	79.8%	53.1%	40.3%

Socioeconomic (per 100,000 pop.)	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
Poverty Rate (< 100% FPL) (2011-15)	10.8	12.4	17.6%	14.8	18.4%	15.5%
High School Graduation Rate (2014-15)	86.0%	80.7%	81%	81.5%	81.5%	85.0%
Students Eligible for Free / Reduced Lunch (2014-15)	30.6%	46.2%	57.0%	49.2%	62.4%	52.1%
Unemployment Rate (2017)	4.5	4.8	5.6	5.2	5.7	5.2
Uninsured Population (2011-15)	14.18%	16.57%	15.1%	15.5%	17.1%	13.0%
Health Care Access (per 100,000 pop.)	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
Primary Care Providers (2014)	35.5	71.7	124.2	94.1	72.9	87.8
Dental Providers (2015)	48.8	65.4	68.4	64.9	49.2	65.6
Mental Health Providers (2016)	80	131	191		112.0	
% of Adults with No Regular Doctor (2011-12)	20.4%	21.6%	29.7%	25.5%	26.1%	22.1%
Federally Qualified Health Centers (2016)	1.0	0.9	1.3	1.1	2.1	2.5
% Population in Health Professional Shortage Area (2016)	0.0%	0.0%	9.9%	5.0%	37.9%	33.1%
Health Determinants	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
Tobacco Use - Cigarette Smokers (2006-12)	16.30%	13.9%	13.2%	13.8%	17.8%	18.1%
Inadequate Fruit & Vegetable Consumption (2005-09)	74.5%	70.6%	74.1%	72.9%	75.7%	75.7%
Access to Exercise Facilities (2010/2014)	80.0%	89.0%	90.0%		75.0%	
Commute over 60 Minutes (2011-15)	15.9%	11.2%	8.8%	10.6%	9.4%	8.5%
% Traffic Deaths Involving Alcohol (2011-15)	19.0%	25.0%	23.0%		23.0%	

† *2018 CHR Health Outcomes Rankings out of 159 Georgia Counties www.countyhealthrankings.org*

Clinical Care & Prevention	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
% Population Receiving SNAP (2014)	7.1%	11.1%	19.0%	14.6%	18.6	14.9%
Adults Never Screened for HIV / AIDS (2011-12)	60.9%	55.1%	45.0%	50.7%	55.1%	62.8%
Physical Inactivity – 18+ yrs. (2013)	19.7%	18.4%	18.0%	18.3%	23.1%	21.8%
Preventable Hospitalization (2014)	55.6	52.0	40.5	47.1	51.8	49.9
Teen Birth Rate (15-19) (2008-14)	22.0	23.0	34.0	NA	39.0	
Other Health Indicators (per 100,000 pop.)	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
Poor physical health days (2015)	3.4	3.5	3.4	NA	3.7	
Poor mental health days (2015)	3.5	3.4	3.6	NA	3.8	
% Reporting poor dental health (2006-10)	12.3%	9.6%	12.4%	11.3%	16.7%	15.7%
Years of Potential Life Lost (YPLL75) (2016)	13,902.0	39,398.5	64,263.5	NA	767,308.0	
Mental health ER rate (2016)	863.5	953.6	1,398.9	NA	1,083.3	
Self-harm age adjusted discharge rate (2012-16)	29.2	30.3	24.9	NA	33.8	
Age adjusted Opioid Overdoses (2006)	8.7	8.4	9.5	NA	8.3	
Age adjusted Opioid Overdoses (2016)	21.0	16.1	15.8	NA	13.6	
Assault age adjusted discharge rate (2012-16)	5.5	10.6	45.3	NA	19.9	
% Diabetes Prevalence (2016)	ND	6.8%	9.2%	NA	10.6%	9.2%
Diabetes age adjusted discharge rate (2016)	97.1	157.7	186.1	NA	187.3	NA
Diabetes age adjusted Mortality rate (2016)	12.8	13.2	17.3	NA	21.8	NA
% Adults Overweight (2016)	ND	37.9%	33.3%	NA	35.1%	35.8%
% Adults Obese (2016)	ND	23.4%	28.8%	NA	29.3%	27.5%
Obs. Heart Disease/Heart Attack age adjusted discharge rate (2012-16)	238.4	190.1	197.6	NA	276.2	
Hypertensive Heart Disease age adjusted discharge rate (2012-16)	7.2	9.1	21.1	NA	14.2	
Asthma ER visit rate (2016)	227.6	504.0	621.9	NA	538.8	
Motor Vehicle Crash ER visit rate (2016)	874.3	1,019.0	1,035.3	NA	1,168.3	

NA: Data was not available

Other Health Indicators (continued)	Cherokee	Cobb	Fulton	CHNA	Georgia	U.S.
HIV prevalence rate (2013)	132	416	1,491	NA	564.0	
HIV new diagnosis (2015)	11	22	72	NA	28.0	
Age-Adjusted STI rate Except Congenital Syphilis (2016)	344.4	717.5	1,260.7	NA	833.0	
Low birth weight (< 2500g) per 1,000 births (2012-16)	4.6	6.1	7.0	NA	7.4	
Infant mortality (Total) (2012-16)	4.6	6.1	7.0	NA	7.4	
Infant mortality (White) (2012-16)	4.1	4.6	3.5	NA	5.2	
Infant mortality (Black) (2012-16)	8.9	10.2	10.7	NA	12.0	

Racial/Ethnic Disparities (per 100,000 pop.)	Cherokee	Cobb	Fulton	White	Black	Asian	Hispanic‡	Georgia	U.S.
% Uninsured Population	14.2%	16.6%	15.1%		19.5%	13.61%	39.0%	17.1%	13.0%
Coronary Heart Disease Mortality, Age-Adjusted Death Rate	60	52.5	67.1			38.1	26.2	83.3	105.7
Stroke Mortality, Age-Adjusted Death Rate	36.2	35.7	40.9			29.6	23.3	42.9	37.3
Breast Cancer Mortality, Age-Adjusted Death Rate	126.9	132.8	135.3	137.6	128.9	82.19	98.6	123.4	123.4
Cancer Mortality, Age-Adjusted Death Rate	153.2	151.9	163.7			91.8	71.6	169.3	166.3
Annual Cervical Cancer Incidence Rate	6.8	6.1	6.9	6.0	8.9			7.7	7.6
Annual Colon and Rectum Cancer Incidence Rate	34.8	39	39.7	35.7	47.7	21.6	32.7	41.7	40.6
Annual Prostate Cancer Incidence Rate	138.6	142.4	170.4	134.9	227.31	55.7	116.8	139.8	123.4
Annual Lung Cancer Incidence Rate	73.2	60.3	54.5	59.2	60.9	23.8	41.2	67.3	62.7
% Population Below 100% FPL	10.8%	12.4%	17.6%	9.1%	23.9%	9.7%	26.9%	18.4%	15.5%
% Children Below 100% FPL	14.4%	17.5%	25.2%	ND	33.9%	8.3%	37.8%	26.0%	21.7%
% Population With Less than High School Diploma (or Equivalent)	10.6%	9.0%	9.1%	7.2%	11.7%	5.7%	35.2%	14.6%	13.4%
% Population with Any Disability	9.3%	8.4%	9.7%	8.5%	11.8%	3.1%	0.9%	12.2%	12.4%

NA: Data was not available

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

2014–2015 Community Need Index (CNI) – WellStar North Fulton Hospital

Zip Code	County	Change (2014-15)	2015 CNI Score	Poverty 65+	Poverty Children	Poverty Single w/kids	Income Score	Limited English	Minority	Culture Score	No High School Diploma	Education Score	Unemployed	Uninsured	Insurance Score	Renting	Housing Score
30093	Gwinnett	0	4.8	9%	38%	49%	4	23%	90%	5	30%	5	11%	22%	5	65%	5
30096	Gwinnett	0	4.2	11%	23%	34%	3	10%	69%	5	10%	3	12%	17%	5	53%	5
30092	Gwinnett	0	3.8	8%	17%	39%	3	7%	50%	5	9%	2	9%	14%	4	43%	5
30114	Cherokee	—	3.6														
30350	Fulton	0.2	3.6	8%	15%	35%	3	4%	53%	5	6%	1	8%	14%	4	65%	5
30076	Fulton	0	3.4	6%	11%	18%	1	9%	45%	5	10%	2	8%	10%	4	40%	5
30009	Fulton	0	3.0	11%	7%	20%	1	5%	40%	5	5%	1	5%	8%	3	48%	5
30328	Fulton	0	3.0	6%	7%	16%	1	3%	35%	4	4%	1	7%	12%	4	42%	5
30066	Cobb	0.2	2.8	7%	13%	31%	2	2%	30%	4	5%	1	9%	10%	4	20%	3
30005	Fulton	0	2.6	11%	3%	13%	1	3%	41%	5	3%	1	6%	5%	2	28%	4
30022	Fulton	0.2	2.6	5%	4%	13%	1	4%	37%	4	4%	1	8%	6%	3	26%	4
30040	Forsyth	—	2.6														
30062	Cobb	0.2	2.6	5%	9%	34%	2	3%	30%	4	5%	1	7%	9%	3	20%	3
30115	Cherokee	—	2.6														
30188	Cherokee	—	2.6														
30004	Fulton	0	2.4	7%	7%	27%	2	2%	34%	4	4%	1	6%	6%	2	22%	3
30068	Cobb	0	2.2	4%	9%	10%	1	2%	22%	4	2%	1	8%	9%	3	18%	2
30075	Fulton	0	2.2	6%	6%	21%	1	3%	22%	4	4%	1	8%	8%	3	19%	2
30028	Forsyth	—	2.0														
30041	Forsyth	—	2.0														
	Cobb	**0.2**	**3.4**	**7%**	**17%**	**34%**	**2.6**	**4%**	**47%**	**4.6**	**9%**	**2.1**	**10%**	**12%**	**4.1**	**32%**	**3.6**
	Fulton	**0.1**	**3.7**	**14%**	**21%**	**37%**	**2.9**	**3%**	**60%**	**4.7**	**10%**	**2.3**	**12%**	**18%**	**4.1**	**45%**	**4.5**
	Forsyth	**0.0**	**3.5**	**9%**	**17%**	**32%**	**2.4**	**7%**	**59%**	**4.9**	**12%**	**2.7**	**10%**	**12%**	**4**	**29%**	**3.3**

Ranked Causes: Age Related Death Rate, State and County Comparison (2012–2016)				
	Cherokee	Cobb	Fulton	Georgia
#1	Ischemic Heart and Vascular Disease (582)	Ischemic Heart and Vascular Disease (1,622)	Ischemic Heart and Vascular Disease (2,800)	Ischemic Heart and Vascular Disease (40,546)
#2	Malignant Neoplasms of the Trachea, Bronchus and Lung (442)	All Other Mental and Behavioral Disorders (1,184)	Essential Hypertension and Hypertensive Renal, and Heart Disease (1,759)	Malignant Neoplasms of the Trachea, Bronchus and Lung (22,516)
#3	All COPD Except Asthma (410)	Cerebrovascular Disease (1,115)	All other Mental and Behavioral Disorders (1,705)	ALL COPD Except Asthma (21,173)
#4	All Other Mental and Behavioral Disorders (388)	Malignant Neoplasms of the Trachea, Bronchus and Lung (1,096)	Cerebrovascular Disease (1,619)	Cerebrovascular Disease (19,602)
#5	Cerebrovascular Disease (316)	All COPD Except Asthma (883)	Malignant Neoplasms of the Trachea, Bronchus and Lung (1,433)	All other Mental and Behavioral Disorders (18,972)
#6	Alzheimer's Disease (219)	Alzheimer's Disease (777)	ALL COPD Except Asthma (1,024)	Alzheimer's Disease (14,356)
#7	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (213)	Accidental Poisoning and Exposure to Noxious Substances (496)	Alzheimer's Disease (1,023)	Essential Hypertension and Hypertensive Renal, and Heart Disease (14,042)
#8	Accidental Poisoning and Exposure to Noxious Substances (177)	Malignant Neoplasms of Colon, Rectum and Anus (467)	Diabetes Mellitus (753)	Diabetes Mellitus (10,849)
#9	All Other Diseases of the Nervous System (174)	All Other Diseases of the Nervous System (435)	Nephritis, Nephrotic Syndrome and Nephrosis (715)	Nephritis, Nephrotic Syndrome and Nephrosis (8,638)
#10	Intentional Self-Harm (Suicide) (166)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (422)	All Other Disease of the Nervous System (665)	Malignant Neoplasms of Colon, Rectum, and Anus (7,604)
Not Top Ten but Significantly High	Pneumonia (156)		Assault/Homicide (567)	
	Malignant Neoplasm of Pancreas (126)		Malignant Neoplasms of Prostate, and Testis (431)	

2015 Atlanta Zip Code 5-Year Cumulative New Diagnoses Data – AIDSVu											
Zip Code	Zip Code Cases	Male Cases	Female Cases	Black Cases	White Cases	Hispanic‡ Cases	Asian Cases	Age 13-24 Cases	Age 25-44 Cases	Age 45-59 Cases	Age 60+ Cases
30004	20	12	8	7	7	-1	-1	-1	9	7	-1
30005	10	6	-1	-1	-1	-1	-1	-1	-1	-1	-1
30009	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1
30022	26	24	-1	13	9	-1	-1	5	15	5	-1
30040	15	12	-1	-1	8	-1	-1	-1	7	-1	-1
30041	10	8	-1	-1	8	-1	-1	-1	5	-1	-1
30062	33	31	-1	13	12	8	-1	7	18	5	-1
30066	29	25	-1	11	11	5	-1	6	14	7	-1
30068	9	8	-1	-1	-1	-1	-1	-1	-1	-1	-1
30075	27	21	6	14	6	7	-1	-1	15	7	-1
30076	42	36	6	18	11	13	-1	5	27	10	-1
30092	50	39	11	36	9	-1	-1	10	32	7	-1
30093	87	64	23	54	9	22	-1	19	56	9	-1
30096	69	61	8	47	5	14	-1	22	38	9	-1
30115	10	8	-1	-1	6	-1	-1	-1	-1	-1	-1
30188	21	19	-1	7	8	-1	-1	6	8	7	-1
30328	46	43	-1	25	9	8	-1	11	24	10	-1
30350	107	95	12	85	10	6	-1	30	69	8	-1

Missing 30114 and 30028

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

2015 Atlanta Zip Code Prevalence Data – AIDSVu											
Zip Code	Zip Code Rate	Male Rate	Female Rate	Black Rate	White Rate	Hispanic† Rate	Asian Rate	Age 13-24 Rate	Age 25-44 Rate	Age 45-59 Rate	Age 60+ Rate
30004	177	280	79	996	89	197	-1	-1	185	246	219
30005	139	209	73	420	117	340	-1	-1	129	226	-1
30009	247	339	166	931	148	-1	-1	-1	209	484	210
30022	171	313	41	768	104	231	-1	-1	212	230	139
30040	137	223	55	649	100	265	-1	-1	152	209	105
30041	71	114	29	813	55	172	-1	-1	82	121	-1
30062	243	420	76	964	143	391	-1	-1	374	309	115
30066	231	354	115	969	110	369	-1	71	288	343	127
30068	198	339	66	1360	113	455	-1	-1	278	318	-1
30075	225	372	85	1233	116	416	-1	71	208	374	146
30076	424	654	198	1502	225	369	-1	118	463	732	210
30092	733	1316	184	2228	277	467	-1	145	1007	905	421
30093	865	1267	417	2021	688	463	205	156	977	1558	713
30096	564	845	299	1629	273	420	62	102	640	936	289
30115	152	258	49	476	125	346	-1	-1	107	316	-1
30188	194	311	86	980	114	456	-1	-1	218	313	95
30328	590	1116	130	2216	288	740	-1	172	751	983	192
30350	1262	2166	473	3207	274	942	-1	314	1770	1700	311

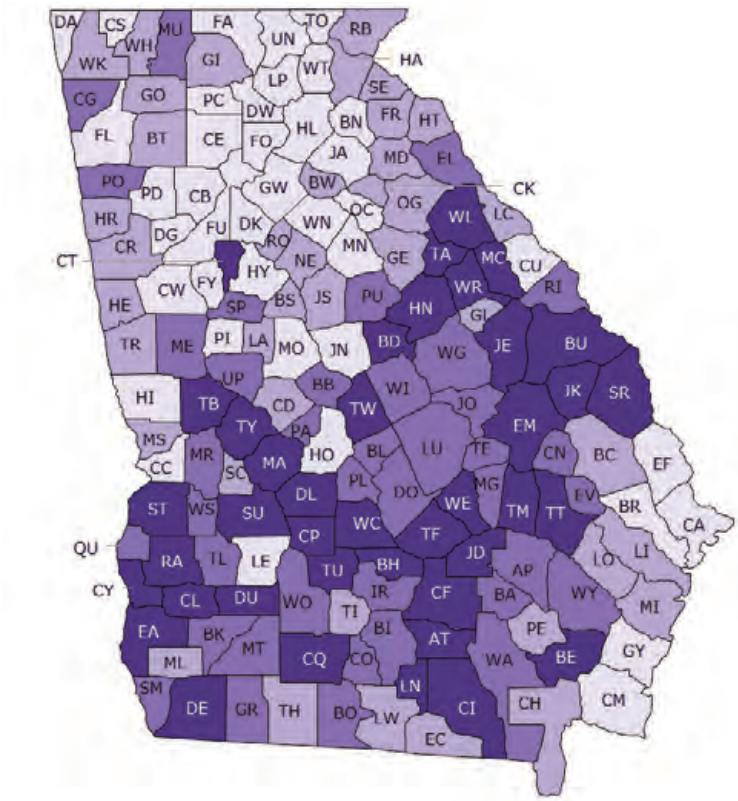
Missing 30114 and 30028

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

Maps

Health Outcomes

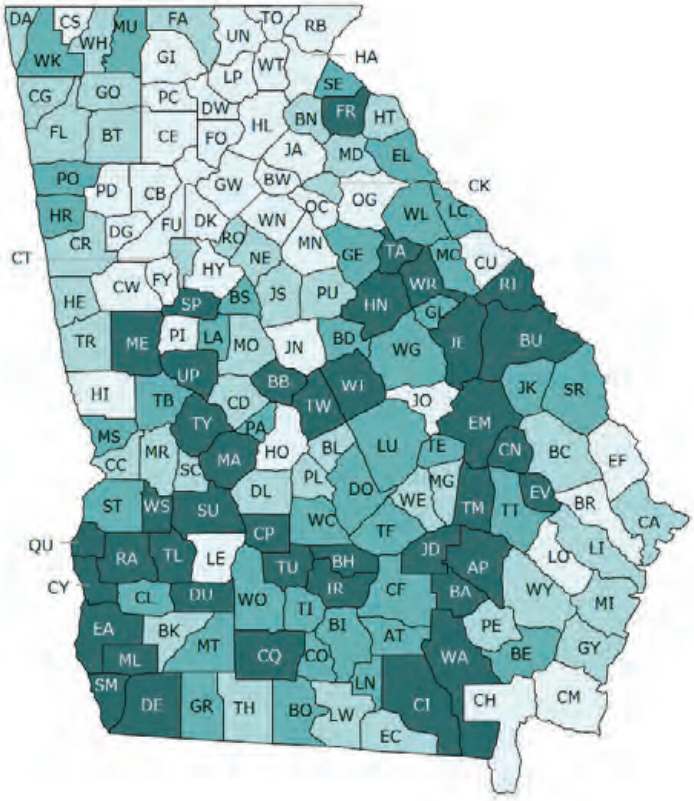
The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.



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

Health Factors

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



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

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

Primary Data and Community Input

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

CHNA Collaborators

Collaborator	Areas of Service
Beltline Marla Oros, *Deputy Executive Director*	Key Informant
Bethesda Community Clinic Karen Fegely, *Chief Executive Officer*	Key Informant
Caravita Homecare Beth Cayce, *CEO*	Summit Participant
Center for Pan Community Services Cobb and Douglas Public Health Karuna Ramachandran, *Health Programs Director* Keun Kim, *Director of Marketing & Development*	Key Informant
Cherokee Christian Ministerial Association Fred Goodwin, *President*	Key Informant
Cherokee County Board of Education Barbara Jacoby, *Director of Public Information, Communication and Partnerships*	Key Informant
Cherokee County Chamber of Commerce Pamela Carnes, *Executive Director*	Key Informant
Cherokee County Division of Family and Children Services Charity Kemp, *Director*	Key Informant
Cherokee County Senior Services Nathan Brandon, *Director*	Key Informant
Cherokee FOCUS Sonia Carruthers, *Chief Executive Officer*	Key Informant
Children's Hospital of Atlanta Emily VanderWiele, *Physician Practice Operations Leader* Dr. Lennon	Key Informant

Collaborator	Areas of Service
City of Canton Lorrie Waters, *Manager – Human Relations*	Key Informant
City of Roswell Nancy Diamond, *Council Member / North Fulton Regional Health Board Vice Chair*	Listening Session
Cobb and Douglas Public Health Lisa Crossman, *Deputy Director*	Key Informant
Community Foundation of Greater Atlanta Lesley Grady, *Senior Vice President-Community*	Key Informant
East Cobb Business Association	Key Informant
Fulton County Board of Commissioners Cleta Winslow, *Council Member-District 4* Joan Garner, *Commissioner-District 4* Marvin Arrington, *District 5*	Listening Session
Fulton County Schools Katha Stuart, *District 1 Representative, Fulton County Board of Education / North Fulton Regional Health Board Member*	Key Informant
G. Cecil Pruett Community Center Family John Hicks, *Executive Director*	Key Informant
Gauger & Associates Kim Gauger, *North Fulton Regional Health Board Chair*	Listening Session
Georgia Department of Public Health Dr. Taylor, *District Health Director District 1-2 North GA*	Key Informant
Georgia House of Representatives Rep. Roger Bruce, *District 61*	Key Informant

Collaborator	Areas of Service
Homeless Initiative Cathryn Marchman, *Executive Director of Partners for H.O.M.E*	Key Informant
Home Town Mortgage *Steve Beecham, President / North Fulton Regional Health Board Member*	Listening Session
Arthur Lechas *North Fulton Regional Health Board Member* *Former Mayor of Alpharetta, GA*	Listening Session
Mercy Care Salvador Arias, *Board member* Tom Andrews, *President*	Key Informant
National Alliance on Mental Illness	Key Informant
North Fulton Community Charities Barbara Duffy, *Executive Director*	
North Star Church	Key Informant
Providence Women's Healthcare Shelley Dunson Allen, MD */ North Fulton Regional Health Board Member*	Summit Participant Listening Session
Resurgens Orthopaedics Michael Quackenbush, *Physician*	Summit Participant
Resurgens Orthopaedics Angelo Difelice, M.D. */ North Fulton Regional Health Board Member*	Listening Session
Revved Up Kids, Inc. Alli Neal, *Executive Director*	Listening Session
Roswell Inc.	Summit Participant
Senior Services North Fulton Heather Terry, *Community Relations Director* Tanya Morris, *Client Services Director*	Summit Participant
Smyrna City Government	Key Informant
Spectrum Neurosurgical Charles Weaver, M.D. */ North Fulton Regional Health Board Member*	Listening Session

Collaborator	Areas of Service
STAR House Foundation, Inc. Monica Oliveira, *Executive Director*	Summit Participant
Summit Counseling Shawn Murphy, *Director of Development* Cathy Murphy, *Director of Community Outreach*	Summit Participant
United Way Demetrius Jordan, *Regional Director* Ginneh Baugh, *Sr. Director – Measurement & Knowledge*	Key Informant
WellStar Health System and WellStar North Fulton Hospital Lori Allen, *Regional Development Director* Jacque Alt, *VP Chief Nursing Officer* Kristen Caudell, *Director, Community Education & Outreach* Jon-Paul Croom, *SVP, North Fulton Hospital President* Jenna Garber, *Vice President-Human Resources* Karim Godamunne, M.D., *VPMA / North Fulton Regional Health Board Member* Mark Gravlee, M.D., *North Fulton Regional Health Board Member* Allen M. Hoffman, MD, *Executive Director* Lindsey Petrini, *VP, North Fulton Hospital Chief Operations Officer* Joyce Robinson, *Regulatory Manager* Diane Sanders, *Community Education Coordinator* Shara Wesley, *Director, Community Benefit*	Listening Session and/or Summit Participant
West End Clinic Karen Williams, *Associate Vice President-Programs*	Key Informant
YMCA	Key Informant
Young Women's Christian Association	Key Informant

WellStar North Fulton Hospitals'

Community Health Summit

The following is a summary of the WellStar North Fulton Hospital Health Summit held Feb. 26, 2018 on the hospital campus. The Health Summit was facilitated by the Georgia Health Policy Center (GHPC) in partnership with WellStar and lasted approximately three hours. The 19 participants included WellStar team members and community stakeholders. Community stakeholders represented organizations serving residents in the primary service area of WellStar North Fulton Hospital. The organizations that participated in the Health Summit included:

The organizations that took part in the Health Summit included:

- STAR House Foundation Inc.
- Senior Services North Fulton
- Revved Up Kids Inc.
- Resurgens Orthopaedics
- WellStar North Fulton Hospital
- Summit Counseling
- North Fulton Community Charities
- Providence Women's Healthcare
- Caravita Homecare

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

Group Recommendations and Problem Identification

Participants prioritized four community health needs of residents within WellStar North Fulton Hospital's primary service area: behavioral health, parental education and support, access to care, and overuse and abuse of opioids. The following is a summary of the input participants offered when asked about contributing factors, potential solutions and community resources to address the health priorities.

Behavioral Health

Health Summit participants prioritized behavioral health as one of the most pressing issues in their communities. Concerns included lack of awareness and education, stigma, limited behavioral health providers, fragmented referral system, and inadequate resources and protocols for mental health crisis episodes.

Contributing Factors:

- There is limited awareness among residents about behavioral health diagnoses, symptoms, treatment options, and preventive measures (i.e., early detection), which may contribute to stigma and a resistance to seeking care.
- Residents may resist seeking care until symptoms are acute and they present in an emergency situation.
- Residents often seek care for behavioral health symptoms in the ED, where behavioral health resources may not be available.
- There is a general lack of behavioral health and substance abuse services to meet adult and pediatric needs. WellStar North Fulton hospital does not offer behavioral health beds.
- The referral system for behavioral health services is fragmented and poses challenges in service navigation and care continuity for patients.
- The lack of behavioral health providers limits the access residents have, both insured and uninsured, to appropriate care.

Recommendations:

- Increase the services available for adults and children in crisis situations that need hospitalization to decrease the use of local EDs for behavioral health needs.
- Increase educational resources that are culturally and linguistically sensitive and targeted at youth and under-resourced communities.
- Hospitals could host health fairs focused on behavioral health in geographic areas where traditionally under-resourced and high-risk populations live. WellStar hospitals could include behavioral health in their health fair materials.
- Hospitals could partner with local nonprofit organizations and homeless liaisons to increase awareness and outreach.
- Offer an anonymous hotline focused on promoting preventive behaviors and resources to avoid crisis care.
- WellStar North Fulton Hospital could integrate behavioral health into their services for adults and children.
- Integrate behavioral health screenings into routine screenings to improve early detection and diagnosis, while reducing stigma.

Parental Education and Support

Health Summit discussions addressed the importance of parental education in the community. Participants discussed the need to offer parents the knowledge and access to resources to make healthier choices, support health child development, and improve child health.

Contributing Factors:

- Families do not always have the support they need to provide protective and preventive care to their children.
- Limited health literacy among parents contributes to unhealthy behaviors among youth, i.e., poor food choices, physical inactivity, untreated behavioral health, etc.
- Parents are unaware of available resources and services, resulting in delayed care-seeking and the use of inappropriate resources (i.e., ED overutilization).
- Parents do not always know how to address issues in a way that promotes healthy child development.

Recommendations:

- Develop partnerships with local schools, community centers and faith-based organizations in under-resourced areas to reach more parents.
- Increase the use of mobile programs in schools, grocery stores, churches, and community centers to teach healthy habits to youth and their families.
- Linguistically and culturally sensitive community education should be designed to inform parents and children about nutrition, physical activity, behavioral health, and available resources that best address these subjects.
- Offer health education using software applications integrated into electronic devices provided to all students in public schools within the service area.
- Record and live stream health education events and classes into patient waiting rooms (e.g., pediatric offices, departments of health and human services, etc.).

Overuse and Abuse of Opioids

Health Summit participants discussed the opioid epidemic in the WellStar North Fulton Hospital service area. Several of the issues related to opioids discussed were the increase in opioid abuse, limited awareness about the risk of opioid addiction and the stigma associated with prescribing and using opioids.

Contributing Factors:

- There is an increased prevalence of opioid abuse among residents regardless of socioeconomic status or demographics.
- Participants delineated opioid abuse into two populations: (1) younger users are most often not using their own prescription for recreational purposes, and (2) older populations that may have had surgery and become dependent on opioids that were prescribed for pain management.
- Some users have limited knowledge of the risks and addictive side effects of opiates.
- Some providers may be unknowingly overprescribing opioids.
- Opioid prescriptions are not being properly disposed, which is increasing access to the drug for recreational users.
- Opioid use is being highly publicized and stigmatized, which may deter users from seeking assistance.

Recommendations:

- Offer education and outreach in a community-based setting (e.g., schools, hospital waiting rooms, etc.) to inform residents about appropriate use, storage and disposal of opiates. This also includes side effects, treatment options and the uses of Narcan.
- Require educational sessions prior to receiving an opiate prescription in an attempt to reduce overprescribing and dependence on opiates.
- Promote alternative treatments (non-addictive) for pain management.
- Marketing resources for behavioral health and substance abuse should be distributed in locations where parents can access them (grocery stores, schools, etc.).

Access to Care

Health Summit participants discussed limited access residents have to appropriate care when and where it is needed. Several of the challenges discussed were transportation, awareness of available services, the number of providers, and affordability.

Contributing Factors:

- There are not enough safety net providers in the area, leaving under- and uninsured residents with limited options for care.
- Underinsured residents are finding it difficult to afford deductibles, copays and overall healthcare costs.
- Residents do not fully understand their insurance options affecting their ability to access the right care in the right place at the right time.
- Providers do not always accept all insurance options. Residents may have to travel outside of their area to a provider that will accept the type of insurance they have.
- Technology is becoming more necessary to access some healthcare elements, such as lab results, after-hour care, lab report access, telemedicine, emailing the physician, etc.
- Some residents may not be able to navigate the health resources in their community or do not possess technological skills/devices needed to effectively navigate.
- There is a need for comprehensive transportation among seniors who experience extensive wait times and families that have unreliable transportation resources.

Recommendations:

- WellStar North Fulton Hospital could advocate for improved insurance and affordability.
- Further develop partnerships with local providers and community organizations to better meet the needs in the area.
- There was dialogue about making healthcare mobile, by supplying resources to the community (i.e., schools and community-based organizations) and dispatching midlevel providers to assist with fulfilling healthcare needs. This model would reach limited English-speaking residents and those who would otherwise have barriers to healthcare.
- WellStar could host health fairs in under-resourced communities (i.e., apartment complexes).
- Transparency in healthcare costs would encourage preventive care and allow individuals to understand their fiscal responsibilities prior to seeking care.

Listening Sessions

WellStar North Fulton Regional Health Board (January 2018)

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

Youth mental health

- Specifically, anxiety issues. Many parents are afraid of their kids – induced by chemical use.
- Cyber bullying is a growing problem and puts additional pressure on students.
- It would be wise to address mental health issues of aging population.
- At North Fulton, inpatient mental health is coming soon with two psychologists onboarding at hospital.

Opioid use

- Not so much seen in the schools, but we know it's a problem in the cities.
- The city of Alpharetta is engaged in heroin addiction crisis that started from opioid use. Some pain clinics in the city have been raided to get opioids.
- College clinics are quick to prescribe anti-anxiety meds to students – a potential pathway to abuse – where have we lost track?

Some barriers to these health problems cited:

- iPhone – a vehicle for comparison, cyber bullying, depression.
- Lack of resources for families to get confidential help – not sure parents know how to navigate through mental health issues – many don't know what is normal behavior and what is not – need education and a way for parents to be able to talk for support and help. Suicide often comes as a surprise to parents.
- The stigma of dealing with mental health or substance abuse is a barrier to getting needed help.
- Lack of awareness of health coverage (what's covered/available).

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

Mental Health

Parent to Parent Program

- Parent to Parent of Georgia offers a variety of services to Georgia families impacted by disabilities or special healthcare needs
- They have a Fulton County Hispanic Support Group, facilitated by Parent to Parent of Georgia. Meetings are held once a month.

3070 Presidential Parkway, Suite 130
Atlanta, GA 30340-3720
770-451-5484
Toll Free: 800-229-2038
www.p2pga.org

The Summit Counseling Center

- Affiliated with Mount Pisgah Methodist Church
- Mental health resources for students and families
- David Smith, executive director
- Partnering with North Fulton High School and three middle schools
- Subsidized by the United Way
- With over 30 years of nonprofit leadership experience, Shawn is Summit Counseling's ambassador to our surrounding community. His primary role is to assess needs and cultivate strategic "Partner in Caring" relationships while working together with Summit's therapists to address the growing mental health challenges facing our community.

2750 Old Alabama Rd.
Suite 200
Johns Creek, GA 30022
678-893-5300
http://summitcounseling.org/

Police Departments

- Take many mental health calls and follow a de-escalation model now

Will To Live Foundation

- Teen suicide awareness and prevention
- They do school presentations
- Strategies:
  - Raising awareness – of teen suicide in our communities
  - Increasing education – around mental illnesses and their stigmas
  - Delivering hope – to teens everywhere via our Life Teammates concept and program

5805 State Bridge Road, No. G212
Johns Creek, GA 30097
https://will-to-live.org/

North Fulton Mental Health Collaborative

- Quarterly meetings
- Katha Stuart with Fulton County Schools participates
- Summit Counseling is the integrator
- Mission: Connecting and energizing our community stakeholders to provide a life span behavioral healthcare system for North Fulton County. This group is open to all behavioral healthcare stakeholders in our community.
- Per Facebook page, The North Fulton Mental Health Collaborative received a generous grant from United Way of Greater Atlanta in North Fulton County. Funds from this grant will be used to engage Cindy Cheatham, senior adviser and president, Good Advisors LLC, to help us identify strategic opportunities and address critical needs that can bring meaningful improvement to mental health services in North Fulton County.

678-893-5300

Partner with community psychiatrists

Collective Impact Program regarding school performance and how life affects it (overlap map/tools)

Collective impact, the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Collaboration is nothing new. The social sector is filled with examples of partnerships, networks, and other types of joint efforts. However, collective impact initiatives are distinctly different. Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants.

Source: https://ssir.org/articles/entry/collective_impact

Ministerial component with youth and adults

- Possible involvement of the WellStar Congregational Health Network

Opioid

"Old Ellis Point" – The Insight Drug Program

- Drug rehabilitation (inpatient and outpatient)
- They have parent support groups

Clint Stonebreaker
5110 Old Ellis Pt
Roswell, GA 30076
770-751-8383
http://theinsightprogram.com/georgia-locations/

Justice System

- They punish but don't address root cause
- See city of Atlanta's diversion program

North Fulton Rotary Club Task Force

- Clubs partnering and working with Roswell High School
- Developing "shock and awe" video for students
- Board members Katha Stuart and Brian Hansford and WellStar Foundation Development Officer Lori Smith on task force
- The Roswell Rotary is coordinating the awareness and education segment geared toward the high schools. They commented that there is so much misinformation within the schools, this age group, and by parents ("not-my-kid" attitude). The committee plans to produce a video campaign and educational seminars/meetings. (Local rotary clubs are taking other topics to focus on like the recovery piece).

Under-Resourced

No Longer Bound

- Offers a 12-month-long residential regeneration process to rescue addicts, regenerate men, and reconcile families.
- They offer family recovery support classes for addiction

Edward Bailey, Executive Director
770-886-7873 ext. 200
edward@nolongerbound.com
2725 Pine Grove Road
Cumming, GA 30041
https://nolongerbound.com/

North Fulton Community Charities

- NFCC serves the Fulton County portions of the following zip codes: 30004, 30005, 30009, 30022, 30024, 30075, 30076, 30092, and 30097.
- To build self-sufficiency and prevent homelessness and hunger in our community by providing emergency assistance and enrichment programs. List of services: https://nfcchelp.org/services/overview/ includes mobile outreach and food bank

11270 Elkins Rd.
Roswell, GA 30076

https://nfcchelp.org/For information about education and enrichment programs contact:

Eden Purdy
epurdy@nfcchelp.org
678-387-4458

For classes and registration information, contact the Education Center at 678-387-4478.

3. **Is there anything you would like to add or you think would be helpful for us to know to help**:

- Meet cited priority health needs
- Expand community outreach and engagement
- Advocate on key policies to promote better health?
- It's how we do things in addition to what we do that's important – we must change paradigm.
- We must have a diversity focus when we address health needs.
- Partnerships with nonprofits can provide an inroad to diversity. Roswell has a high Jewish population and Alpharetta has a mosque and a high population of people from India.

Safety net clinics in North Fulton

North Fulton Regional Health Center
3155 Royal Drive
Alpharetta, GA 30022
404-332-1876

North Fulton Government Service Center
7741 Roswell Road
Sandy Springs, GA 30350
404-612-CARE (2273)

Key Informant Summary

(December 2017–January 2018)

Georgia Health Policy Center (GHPC) conducted interviews with community leaders. Leaders asked to participate in the interview process encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health–related data, and (3) representatives of under-resourced populations. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the study.

Methodology

The following qualitative data was gathered during individual interviews with 32 stakeholders in communities served by the WellStar North Fulton Hospital. Each interview was conducted by GHPC staff and lasted approximately 45 minutes. All respondents were asked the same set of questions developed by GHPC. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents in the community served by WellStar North Fulton Hospital, as well as ways to address those concerns.

There was a diverse representation of community-based organizations and agencies among the 32 stakeholders interviewed. The organizations represented included:

- Beltline
- Bethesda Community Clinic
- Center for Pan Community Services Cobb and Douglas Public Health
- Cherokee Christian Ministerial Association
- Cherokee County Board of Education
- Cherokee County Chamber of Commerce
- Cherokee County Division of Family and Children Services
- Cherokee County Senior Services
- Cherokee Focus
- Children's Hospital of Atlanta
- City of Canton
- Cobb and Douglas Public Health
- Community Foundation of Greater Atlanta
- East Cobb Business Association
- Fulton County Board of Commissioners
- G. Cecil Pruett Community Center Family
- Georgia Department of Public Health
- Georgia House of Representatives
- Homeless Initiative
- Mercy Care
- National Alliance on Mental Illness
- North Star Church
- Smyrna City Government
- United Way
- WellStar North Fulton Regional Health Board*
- West End Clinic
- YMCA
- Young Women's Christian Association

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

Major Health Challenges:

- Common health issues:
  - Obesity
  - Cardiovascular diseases
  - Diabetes (type I and II)
  - Hypertension
- Mental health:
  - Depression/anxiety
  - Self-harm/suicide
  - Substance abuse (opioid/heroin)
- Disparities among people of color
- Overutilization of ED
- High prevalence of untreated/ undiagnosed mental issues
- Increased penal population

Context and Drivers:

Fulton County:

- Geographic location (distance, ready access to full-service hospitals, less comprehensive care, transportation)
- Awareness of available services
- Financial status (lack of stable employment, poverty, limited access to comprehensive insurance, gentrification, lack of affordable or reliable transportation, unaffordability of prescriptions)
- Access for under- and uninsured residents (distance, availability of appointments, unable to take off to seek care, unaffordable medications)
- Educational attainment (poor health literacy)
- Racial health disparities
- Lack of community engagement
- Limited access to primary care (geographic location, limited safety net providers and FQHCs, telehealth)
- Lack of appropriate resources (less comprehensive care offered compared to more affluent areas)
- Access to healthy nutrition (food deserts, cultural preference, lack of fresh foods and community gardens, poor nutritional education)
- Access to behavioral healthcare (need a comprehensive referral system)

Cherokee County:

- Limited providers (adult and pediatric health services)
- Insurance (affordability, discontinuity in provider acceptance)
- Undocumented residents (no insurance access, unaffordable care, limited care options, fear of seeking care)
- High Latino and low-income-earning populations
- Language barriers
- Awareness of resources
- Lack of physical activity
- Access to behavioral health (affordability)

Cobb:

- Poor nutrition (food deserts, lack of awareness)
- Rise in poverty
- Access to care (limited access to affordable insurance, reduction in safety net providers in 2014-15, lack of culturally sensitive services)
- High-risk sexual behaviors
- Disparities between North Cobb (high resources) and South Cobb (low resources)
- Lack of affordable housing
- Transportation
- Need for affordable skilled nursing for low-income seniors
- Low educational attainment
- Limited awareness of available resources
- Latino population in Windy Hill Road area of Marietta/Smyrna with limited English-speaking skills
- Limited physical exercise (high commute times, desk jobs)

Resident Focus Group Summaries

(October 2015–January 2018)

Purpose

This assessment engaged community residents to develop a deeper understanding of the health needs of the community WellStar North Fulton Hospital serves, as well as the existing opinions and perspectives related to health status.

Methodology

GHPC recruited and conducted four focus groups among residents living in the community served by WellStar North Fulton Hospital. GHPC designed facilitation guides for focus group discussions. Residents were recruited using a third-party recruiting firm. Recruitment strategies focused on residents that had characteristics representative of the broader service area, specifically, areas that experience disparities and low socioeconomic status.

Focus groups lasted approximately 1.5 hours, during which time trained facilitators led six to 12 participants through a discussion about the health of their community, health needs, resources available to meet health needs, and recommendations to address community health needs. All participants were offered appropriate compensation ($50) for their time and a light meal. The following focus groups were conducted by GHPC between January 2016 and January 2018:

- WellStar North Fulton Hospital Service Area Residents – Duluth, Ga. (Jan. 10, 2018)
- Cherokee County Residents – Canton, Ga. (Jan. 8, 2016)
- Spanish-Speaking Residents – Marietta, Ga. (Oct. 9, 2015)
  Powder Springs, Ga. (Nov. 2, 2015)
- Cobb County Residents — Mableton, Ga. (Nov. 17, 2015)

Focus groups were recorded and transcribed with the informed consent of all participants. GHPC analyzed and summarized data from the focus groups to determine similarities and differences across populations related to the collective experience of healthcare, health needs, and recommendations, which are summarized in this section.)

Target Population:
North Fulton Residents

Location:
Duluth, Georgia

Number of Participants:
9

Major Health Challenges:

- Obesity/overweight (adult and child)
- Poor mental health
- High blood pressure
- Asthma/allergies
- Congestive heart failure (cardiovascular disease)
- Cancer

Context and Drivers:

- Economic instability (affordability of food and housing, poor job market, cost of medicines)
- Low health literacy
- Physical inactivity (affordability, distance to recreational center/ park, poor infrastructure, low walkability, time constraints due to excessive traffic, unconducive school curriculum, resource quality is influenced by area demographics, cultural preference)
- Traffic (time constraints, stress influences food choices)
- Access to healthy foods (time constraints, affordability, prevalence of fast food in proximity, food quality in schools)
- Limited resources in lower socioeconomic areas
- Access to care (affordability for under- and uninsured, low number of specialists)
- Insurance (limited options, affordability)
- Transportation (fragmented)

Recommendations:

- Invest in projects/developments that will increase walkability of the area (i.e., future development that spans over GA 400)
- Prioritize education dissemination in youth to encourage healthy habits before adulthood

Target Population:
Cherokee County Residents

Location:
Canton, Georgia (2)

Number of Participants:
7

Major Health Challenges:

- Substance abuse (including overdose incidents): Acid, meth, prescriptions pills, underage alcohol use
- Asthma
- Poor mental health
- Diabetes
- Obesity/overweight

Context and Drivers:

- Access to healthy foods (cultural preference, time constraints)
- Limited health education
- Insurance awareness (payment protocol)
- Transportation
- Physical inactivity (distance, time constraints, poor infrastructure, limited resources, safety)
- Access to care (affordability, poor-quality facilities, distance to quality care, cultural barriers)
- Cultural norms (tobacco use, food choices)
- Crime

Recommendations:

- Build more parks to promote physical activity
- Increase education dissemination for youth (i.e., sex and drug education)
- Initiate payment reform by offering an all-inclusive price menu for insured or uninsured clients
- Increase the number of providers in the community
- Offer remote services (i.e., telehealth or satellite medical centers)
- Provide urgent care services for residents with schedule demands
- Offer alternative transportation options for medical services

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Target Population:
Spanish-Speaking Residents

Location:
Marietta, Georgia
Powder Springs, Georgia

Number of Participants:
11
8

Major Health Challenges:

- Cancer
- Poor mental health
- High blood pressure/hypertension
- Substance abuse (alcohol, tobacco)
- Obesity
- Teen pregnancy
- Diabetes
- Poor dental health
- Asthma/allergies
- STIs

Context and Drivers:

- Limited health education and marketing
- Low health literacy
- Access to healthy foods (nutritional education, affordability, time constraints, cultural preference)
- Economic insecurity
- Lack of resources (caregivers for family members, finances)
- Physical inactivity (affordability, distance, poor infrastructure, time constraints, childcare, transportation, safety)
- Limited parental oversight
- Access to care (limited providers, need extended hours, limited preventive programs, limited safety net facilities, affordability, distrust, poor quality, under- and uninsured, language barriers)
- Fragmented care for uninsured

Recommendations:

- Exploration of alternative cancer treatments (marijuana)
- Restructure services covered by insurance
- Integrate sufficient bilingual healthcare professional or interpreters for residents with limited English skills
- Provide linguistically and culturally sensitive resources
- Implement programs in local organizations to create a platform to ensure education dissemination and activities that focus on sex education, nutrition, importance of preventive care, mental health, addiction, physical education, and etc.
- Designate events (i.e., health fairs) at local parks and organizations to encourage physical activity and health education
- Provide integrated/comprehensive care that is linguistically related to the populations served (i.e., Spanish)

Target Population:
Cobb County Residents

Location:
Mableton, Georgia

Number of Participants:
12

Major Health Challenges:

- Diabetes
- High blood pressure
- Obesity
- Mental illness: depression, PTSD, anxiety
- Substance abuse

Context and Drivers:

- Economic instability (affordability of prescriptions, unemployment)
- Access to healthy foods (affordability, time constraints, fast food restaurant density)
- Access to care (affordability, under- and uninsured, limited safety net facilities and resources, distance)
- Health education (lack of nutrition/ health education, poor education dissemination in community, inadequate patient education for preventive and follow-up care)

Recommendations:

- Integrate wellness coaches into community health strategies
- Collaborate with local faith-based organizations to conduct health seminar, which will promote health education
- Orchestrate a healthcare provider volunteer program to address disparities in the community – this would include offering services, feedback, and referrals for vulnerable populations

Primary Data Collection Tools

Key Informant Questionnaire

(2018–2019)

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

Context

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

Improved Stayed the same Declined Don't know

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

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

Community Capacity

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

Moving the Needle

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

Wrap Up

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

Focus Group Discussion Guide

Community Health Needs Assessment

Overview of Purpose of Discussion and Rules of a Focus Group

Facilitator introduces self and thanks those in attendance for participating

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

Explain about focus groups:

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

Participant Introductions

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

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

Health Concerns for Your Family

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

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

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

Health Concerns in the Community

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

Facilitator: Present community-appropriate data summary to participants.

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

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

Closing

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

Community Facilities, Assets and Resources

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

Health Departments

East Cobb Public Health Center 4958 Lower Roswell Road, Suite 120 Marietta, GA 30068 678-784-2180 **Acworth Public Health Center** 4489 Acworth Industrial Drive Acworth, GA 30101 770-974-3330 **Marietta Public Health Center** 1650 County Services Parkway Marietta, GA 30008 770-514-2300 **Cobb County Health Center** 1650 County Services Parkway Marietta, GA 30008 770-514-2300	Cobb & Douglas Public Health, with our partners, promotes and protects the health and safety of the residents of Cobb and Douglas counties. We work to achieve healthy people in healthy communities by: ■ Preventing epidemics and spread of disease ■ Protecting against environmental hazards ■ Preventing injuries ■ Promoting and encouraging healthy behaviors ■ Responding to disasters and assisting in community recovery ■ Assuring the quality and accessibility of healthcare
Cherokee County Health Department Canton Office: 1219 Univeter Road Canton, GA 30115 770-345-7371 Woodstock Office: 7545 North Main Street, Suite 100 Woodstock, GA 30188	Provides some sliding scale community services with tracking and follow-up.
Fulton County Department of Health and Wellness (FCDHW) Fulton County Public Health 10 Park Pl S.E., 5th Floor Atlanta, GA 30303 404-613-1205 **The Fulton County Department Of Behavioral Health & Developmental Disabilities** Fulton County Government Center 141 Pryor Street, Suite 1031 Atlanta, GA 30303 404-613-7013 www.livebetterfulton.org	Fulton County Department of Health and Wellness (FCDHW) is the largest testing site in the state of Georgia. Over 700 people each year learn that they have been infected with HIV in our clinic. Our clients are introduced to the HIV Clinic physicians on the same day they may learn their HIV positive status. Enrollment in the HIV Clinic offers an individual a full service outpatient clinic with a TEAM approach to educate and support the patient and families living with HIV. ■ Mental Health – Our behavioral health centers offer a wide range of services & addictive disease treatment at community-based locations. ■ Developmental Disabilities – Three regional centers provide clients with life skills training tailored to their particular disability. Mobility training and day habilitation are also provided. ■ Addictive Diseases – We provide a variety of specialty outpatient treatment services for adults with chronic chemical dependencies. Treatment is also available for individuals who have both mental health and substance abuse ("co-occurring") disorders.

Primary Care: Safety Net Clinics & Federally Qualified Health Centers	
The Family Health Center at Cobb 805 Campbell Hill Street Marietta, GA 30060 770-919-0025	Focuses on outreach, disease prevention and patient education regardless of insurance status of a patient's ability to pay.
Good Samaritan Health Center at Cobb 1605 Roberta Drive SW Marietta, GA 30008 770-419-3120 www.goodsamcobb.org	Good Sam is working to remove the barriers preventing low-income families from obtaining access to quality healthcare in the Atlanta area. Providing full circle of health services including: medical, dental, mental, nutrition and health education we are helping to reverse the healthcare gap in our community and set families on a path to achieving long-term health.
Mercy Care at City of Refuge 1300 Joseph E. Boone Blvd. Atlanta, GA 30314 678-843-8790 **Mercy Care at Gateway Center** 275 Pryor Street SW Atlanta, GA 30303 678-843-8840 **Mercy Care at St. Jude's Recovery Center** 160 Pine Street Atlanta, GA 30308 678-843-8544	As your medical home, Mercy Care offers comprehensive services that meet the majority of primary physical and mental health and wellness needs. Services are planned and delivered by a team that works together for your health. These services include primary medical care for adults and children, primary dental care, vision care, mental and behavioral health assessment and counseling, prescriptions, health screenings, and health education.
Bethesda Community Clinic 111 Mountain Brook Dr., Suite 100 Canton, GA 30115 678-880-9654	Bethesda Community Clinic is a Christ-centered 501(c)3 nonprofit dedicated to providing quality, affordable healthcare services to Cherokee County's "working poor" (based on family size and income at or below 150 percent of the national poverty guidelines), as well as the uninsured and underinsured (people who can only afford major medical insurance).
Senior Wellness Center Cobb County Senior Center 1150 Powder Springs Road, Suite 100B Marietta, GA 30080 470-956-2500	Serves people ages 55-64 that are uninsured.

Transportation	
Transportation Options Program for Seniors (TOPS) TOPS Program Manager: 770-993-1906 ext. 234 http://www.ssnorthfulton.org/senior-services/transportation/	The TOPS program is designed to provide medical transportation for seniors age 60+ in the Senior Services North Fulton service area: Alpharetta, Johns Creek, Milton, Mountain Park, Roswell and Sandy Springs. Trips can be arranged for appointments with doctors, dentists, eye doctors, for treatments ordered by your doctor – or to get a flu shot.
Get Around Town Easily (GATE) Program GATE Mobility Manager: 770-993-1906 ext. 242	Seniors and adults with disabilities who are unable to drive need the ability to pick up prescriptions, grocery shop, visit the bank, or simply get a haircut. Our grant funded GATE (Get Around Town Easily) Transportation Program allows north Fulton seniors and adults with disabilities to purchase a transportation account that can be used with selected drivers in the GATE program.
Non-Emergency Medical Transportation (NEMT) Schedule Transportation: Logisticare: 1-888-224-7981 (Central) 1-888-224-7985 (Southwest) 1-888-224-7988 (East) Medicaid Member Call Center: 866-211-0950	The Non-Emergency Medical Transportation (NEMT) program provides eligible members transportation needed to get to their medical appointments. To be eligible for these services, members must have no other means of transportation available and are only transported to those medical services covered under the Medicaid program.
MARTA Route & Schedule Info: 404-848-5000 Customer Service: 404-848-5000 MARTA Mobility: 404-848-5826 http://www.itsmarta.com/	MARTA serves Fulton and DeKalb counties through a bus and rail system. MARTA maps are available online or at any station. To advocate and provide safe, multi-modal transit services that advance prosperity, connectivity and equity for a more livable region.
CobbLinc Customer Service: 431 Commerce Park Drive Marietta, GA 30060 770-427-4444 770-427-2222 cobbtransit@cobbcounty.org	CobbLinc is your number one public transportation option throughout Cobb County and to Downtown Atlanta via Fixed, Express or Paratransit services. CobbLinc strives to provide a transit network that is convenient, accessible, customer-focused, safe, reliable and efficient.
CATS: Cherokee Area Transportation System County Wide Dispatch: 770-345-6238 Fixed Routes: 770-345-6238 Van Pool: 800-826-4967 EXPRESS Service: 404-463-4782	Our mission at CATS is to provide excellence in all areas of service that we provide to the citizens of Cherokee County.

Behavioral Health	
The Summit Counseling Center 2750 Old Alabama Rd., Suite 200 Johns Creek, GA 30022 678-893-5300 http://summitcounseling.org/	The Summit Counseling Center provides professional counseling, consultation and education services utilizing an integrated approach to care for the whole person – Body, Mind, Spirit, and Community.
Will-To-Live Foundation 5805 State Bridge Rd. #G212 Johns Creek, GA 30097 https://will-to-live.org/	"We are dedicated to preventing teen suicide by improving the lives and the 'Will To Live' of teenagers everywhere through education about mental health and encouraging them to recognize the love and hope that exists in each other."
The Insight Drug Program 5110 Old Ellis Pt. Roswell, GA 30076 770-751-8383 http://theinsightprogram.com/georgia-locations/	The Insight Program has provided substance abuse treatment for teens and young adults since 1987. The Insight Program provides all its services through a philosophy called Enthusiastic Sobriety. Making sobriety attractive to teens and young adults is challenging. Insight has been successful in creating a program that reaches young people in a way that is inviting and fun. The Insight Program offers a number of services including: intensive outpatient substance abuse treatment, outpatient substance abuse treatment, individual counseling, family counseling, support group meetings, parent support groups, and sober social functions. Insight staff members are also available for speaking engagements. Insight treatment programs are licensed in Georgia and North Carolina.
No Longer Bound 2725 Pine Grove Road Cumming, GA 30041 770-886-7873 https://nolongerbound.com/	No Longer has Bound created organized opportunities for hurting families to recover from the damage of addiction. We assist families with restoring trust, releasing expectations, and repairing broken relationships in order to reconcile them to health and wholeness.

Resource Assistance	
North Fulton Community Charities 11270 Elkins Rd. Roswell, GA 30076 https://nfcchelp.org/	NFCC is a leader in North Fulton offering assistance to over 4,200 families. Annually, food is distributed over 23,000 times, over 1,300 families utilize clothing vouchers, and $1.2 million dollars is expended for direct aid to our clients in need of financial assistance. Our Education Center offers an array of classes and opportunities to help 1,200 adults move toward financial stability and self-sufficiency. Although the demand for these services has increased significantly since its founding, NFCC continues to help hands-on, one family at a time.
The Drake House 10500 Clara Drive Roswell, GA 30075 www.thedrakehouse.org	The Drake House works with many agencies to identify mothers and children in need in North Fulton. Once accepted into The Drake House, these mothers and children are supported with every resource necessary to move them toward financial self-sufficiency, employment, and stable housing.
Homestretch 89 Grove Way Roswell GA 30075 770-642-9185 https://homestretch.org	HomeStretch guides working homeless families with minor children in north metro Atlanta toward increased self-reliance and stability by providing life skills education, mentoring and supportive housing
STAR House Foundation, Inc. 890-F Atlanta Street, #138 Roswell, GA 30075 678-384-4550 info@starhousefoundation.org	STAR House Foundation is a non-profit organization in Roswell, Georgia that makes a difference in kids' lives by providing an after school tutoring and mentoring program for under-resourced children throughout North Fulton County
Revved Up Kids P.O. Box 5145 Alpharetta, GA 30023-5145 678-526-3335 contact@revvedupkids.org www.revvedupkids.org	Revved Up Kids offers personal safety and self-defense training classes for boys and girls through 8th grade, and for teen girls age 11 and older.

Implementation Strategy

Building a Culture of Health

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

Background

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

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

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

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

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

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

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

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

Review of Priority Health Needs

Leaders of Georgia State University's Georgia Health Policy Center helped guide the WellStar North Fulton Hospital through the prioritization process at the Health Summit. From the significant health needs identified by CHNA research conducted, the following health needs were valuated as priority for the community WellStar North Fulton Hospital serves:

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

Action areas for implementation to improve community health are influenced by the full spectrum of the public health system, in which WellStar North Fulton Hospital plays a vital role:[4,5]

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

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

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

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

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

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

The scope of WellStar's healthcare footprint and its commitment to its mission makes WellStar North Fulton Hospital a linchpin and integrator in the community for delivering care, interventions and education to improve overall population health and health equity in the community we serve. This involves providing community benefit programming to address priority health needs via collaborative partners who provide care access, services and resources to under-resourced populations.

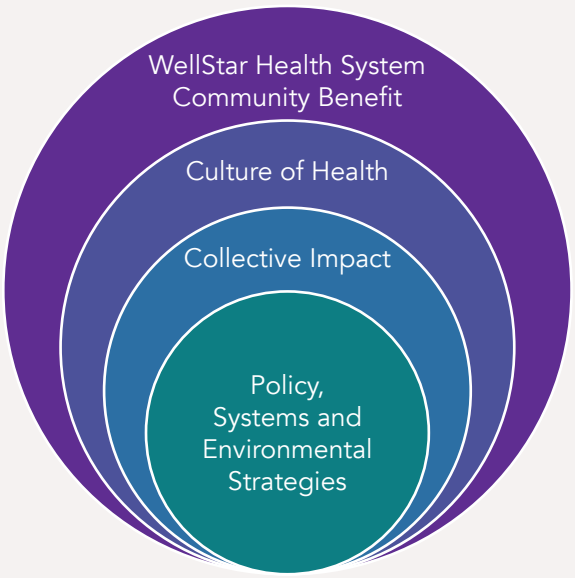
Implementation Strategy Framework and Guiding Principles

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

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

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

Framework and Guiding Principles



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

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

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

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

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

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

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

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

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

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

Collective Impact Approach

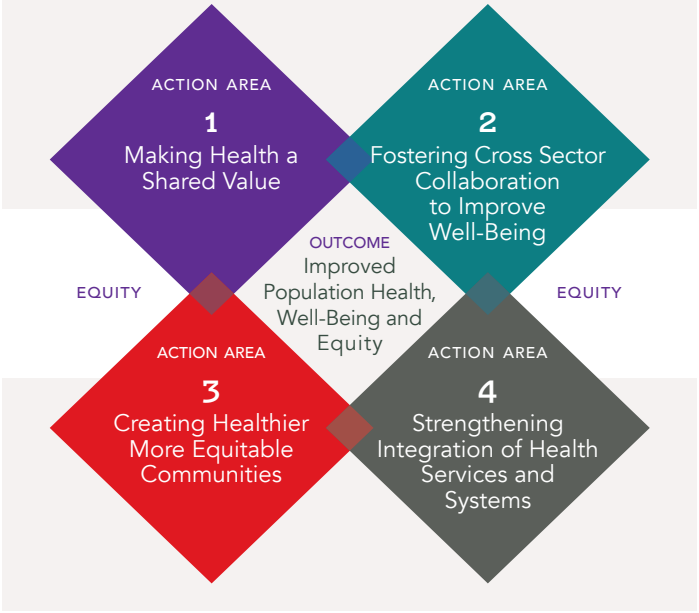
Collective Impact is an approach to tackle deeply entrenched and complex social problems like social determinants of health. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant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

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

Policy, Systems and Environmental Change Strategies

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

Culture of Health Action Framework



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

Collective Impact Approach

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

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

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

† *National Association of County and City Health Officials*

Implementation Strategy to Address Priority Health Needs

WellStar North Fulton Hospital is dedicated to improving the health of the community we serve. With the unique needs identified by our community partners and consideration given to the Culture of Health Framework; the implementation strategy focuses on two key focus areas.

Two-Prong Approach

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

Community-Driven Solutions:

Live Well

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

Live Well works collaboratively with both internal and external community partners, such as community safety net clinics, congregations and other community-based organizations and companies serving under-resourced populations, to address priority health needs. For WellStar North Fulton Hospital, a Live Well priority is increasing parental education and support with topics such as behavioral health, risks of opioid use and community outreach events/screenings focused on prevention and management of chronic diseases.

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

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

WellStar Opioid Stewardship

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

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

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

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

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

GOAL #2: Improve collaboration and communication between the WellStar team and law enforcement. (State goal)
Objective # 2.1: Increase access to naloxone to first responders, educators and parents and provide training on how to administer the opioid overdose reversal drug to help save lives.
Objective # 2.2: Assist GDPH's efforts to reduce the supply of opioids in WellStar strategic markets.
Objective # 2.3: Improve training and education of law enforcement and first responders about HIPAA (what information can and cannot be shared).

GOAL #3: Help shape opioid public policy at local, state and federal levels.
Objective # 3.1: Promote public policies that help prevent opioid misuse.
Objective # 3.2: Help ensure government supports the prevention / treatment services and recovery programs that make the most impact on community health as it relates to opioid misuse.
Objective # 3.3: Provide timely updates to WellStar leadership and team regarding new opioid regulations and/or community resource deficiencies.

Community-Driven Solutions:

Community Transformation Grants

The Community Transformation Grants Program will be a new community benefit initiative. This annual, competitive grant program allows WellStar North Fulton Hospital to further the mission by addressing critical health issues in the community served.

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

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

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

Building a Sustainable Infrastructure:

Community Benefit Capacity Building

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

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

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

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

Health Needs Not Addressed

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

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

Evaluation of Action

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

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

In addition, did the program:

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

Next Steps[12]

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

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

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

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