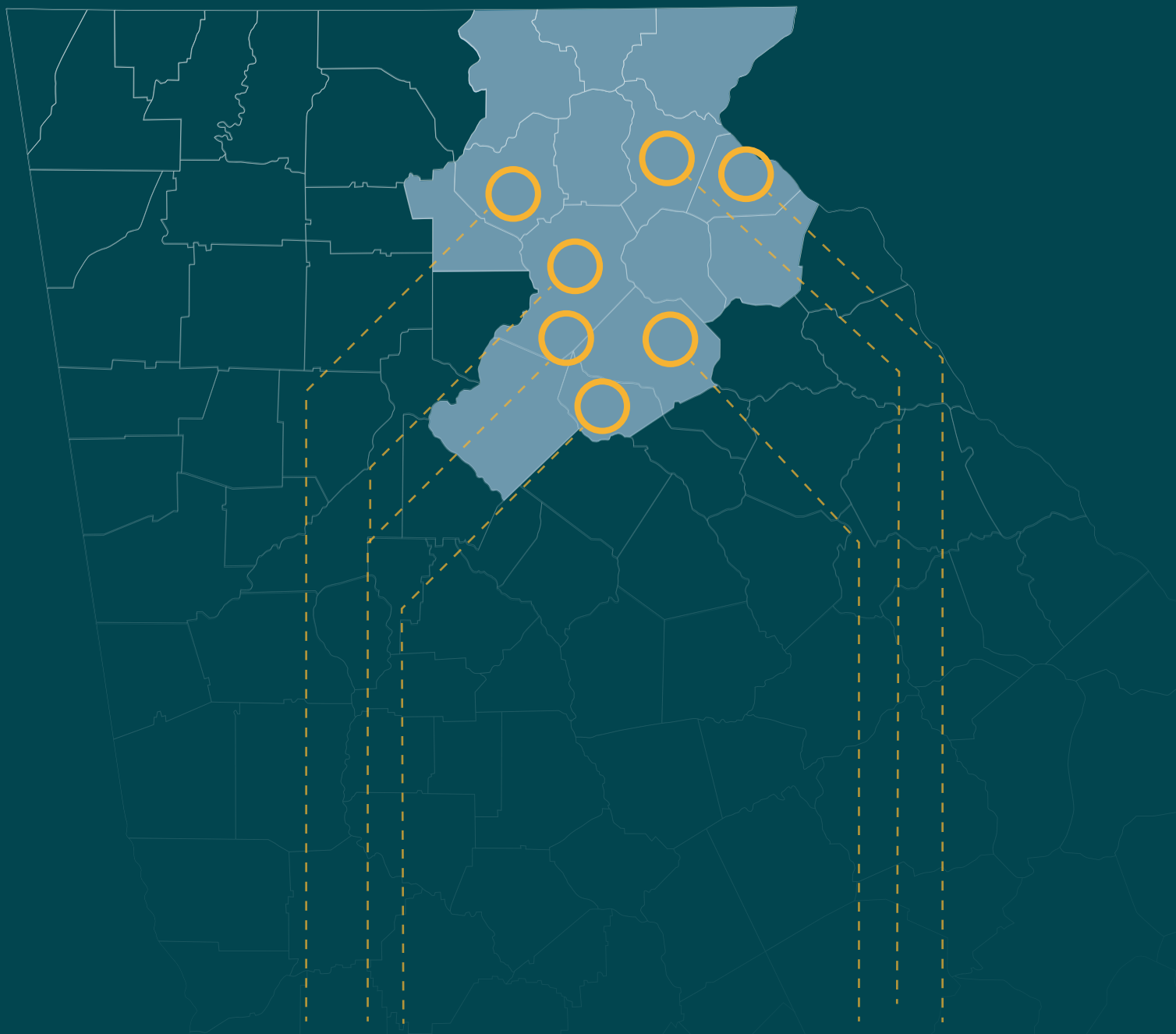
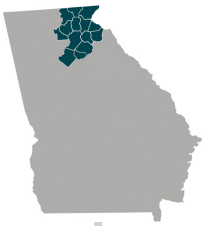


Northeast Georgia Regional
COMMUNITY HEALTH NEEDS ASSESSMENT

FY22



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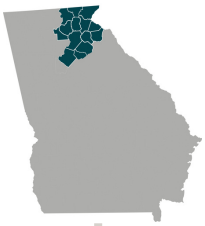


Executive Summary

As part of their commitment as a partnership of not-for-profit organizations, a collection of five hospitals and other community agencies studied northeast Georgia's community health needs for its 2022 Community Health Needs Assessment (CHNA), a triennial process required by the Internal Revenue Service due to each hospital's tax-exempt status. A CHNA is a measurement of the relative health or well-being of a given community, and it is both the activity and end-product of identifying and prioritizing unmet community health needs. This assessment is conducted by gathering and analyzing data, soliciting community feedback, and evaluating previous work and future opportunities.

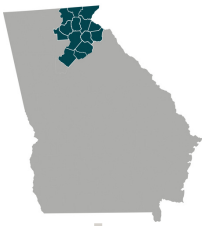
The following organizations partnered to conduct a CHNA for communities they serve in the northeast Georgia region:

District 2 Public Health
Good News Clinics
Habersham Medical Center
Northeast Georgia Medical Center Gainesville/Braselton
Northeast Georgia Medical Center Barrow
Northeast Georgia Medical Center Lumpkin
Stephens County Hospital

Through this assessment, the CHNA partners worked to better understand local health challenges, identify health trends, determine gaps in the current health delivery system, and craft a plan to address those gaps and the identified health needs.

The communities served by each of the partners overlapped and combined to include all or part of 14 counties in northeast Georgia. These communities reflect the following service areas:

- **Habersham Medical Center (HMC):** Habersham, Banks, and Rabun counties
- **NGMC Primary Service Area (PSA):** Hall County
- **NGMC Greater Braselton Service Area (GBSA):** Barrow and Jackson counties, parts of Gwinnett and Hall counties
- **NGMC Secondary Service Area 400 (SSA 400):** Dawson and Lumpkin counties
- **NGMC Secondary Service Area North (SSA North)**: Banks, Habersham, Rabun, Stephens, Towns, Union, and White counties
- **Stephens County Hospital (SCH):** Stephens and Franklin counties



Executive Summary

Approach

Public Goods Group (PGG) was engaged by the partners to collect and analyze quantitative data for the CHNA and over 190 public health indicators were examined in the communities represented in the map to the right. A breakdown of the counties by service area can be found in Appendix Seven of the full CHNA report. Using this data, needs were identified through benchmark analyses, comparing region indicators against Georgia and national values.

A qualitative assessment was then conducted to solicit the input of more than 4,900 people through six channels: focus groups, interviews, in-person surveys, a multi-lingual online community survey, an online employee survey, and listening sessions. The community survey was open to the public and the employee survey was open to all employees of each partner organization. Participants in listening sessions, focus groups, and one-on-one interviews were individuals or organizations serving and/or representing the interests of medically underserved, low-income, and/or minority populations in the community. A list of participants can be found in Appendix Three of the full CHNA.

The outcome of the quantitative analysis was then compared with the qualitative findings to create a list of health needs in the community.

Each health need was assigned to one of four quadrants in a health needs matrix (shown to the right), which helped to identify the top

High data + low qualitative: Data shows an issue but not a community priority	**High data + high qualitative:** Both data and the community identify this is an issue
Low data + low qualitative: Neither the data nor the community see the issue as pressing	**Low data + high qualitative:** Data doesn't identify an issue but the community does

Executive Summary

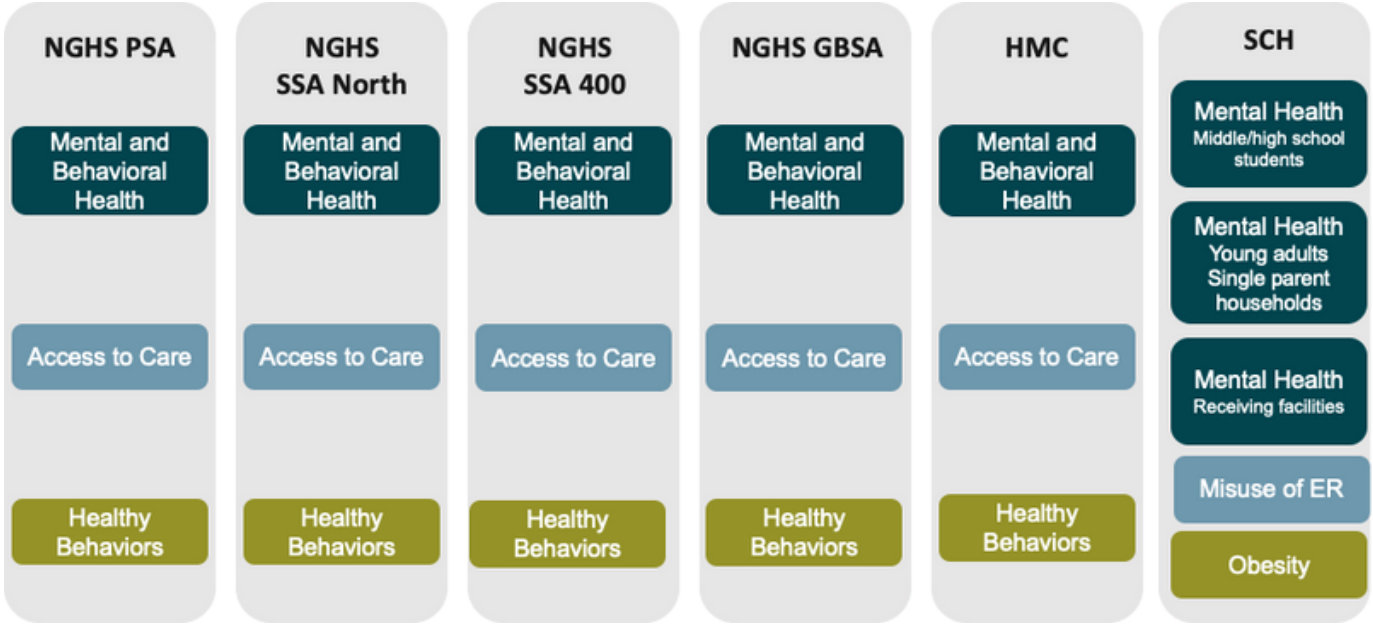
health needs for each community. Needs falling in the top right quadrant – high data and high qualitative – were further analyzed during the prioritization process.

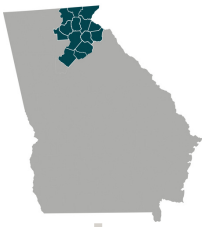
Priority Health Needs

In May 2022, the CHNA partners and advisors consisting of board members and community leaders hosted three prioritization sessions to determine the priorities each entity would address over the next three years. Criteria used to select the priorities included:

- Root cause and disproportionate impact on disadvantaged community members
- Magnitude and extent of the issue within the community
- Ability for CHNA partners to make an impact on the issue

As a result of this process, the following health priorities were identified as the focus of each CHNA partner's work over the next three years:





Executive Summary

For each priority, the CHNA partners will work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators on that priority by implementing programming and investment in areas that directly address issues related to income and poverty and individuals who face particular challenges in accessing care due to disability, race, English proficiency, educational attainment, and other areas of socioeconomic status.

The CHNA was approved by:

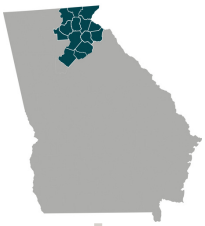
- **The Hospital Authority of Habersham County:** September 20, 2022
- **Northeast Georgia Medical Center Board of Directors:** August 30, 2022
- **Stephens County Hospital Authority Board:** September 20, 2022

The full CHNA report is publicly available via partner websites and upon request. Community members can access the reports through the following ways:

- **Habersham Medical Center:** habershammedical.com
- **Northeast Georgia Health System:** nghs.com/community-benefit-resources
- **Stephens County Hospital:** stephenscountyhospital.com

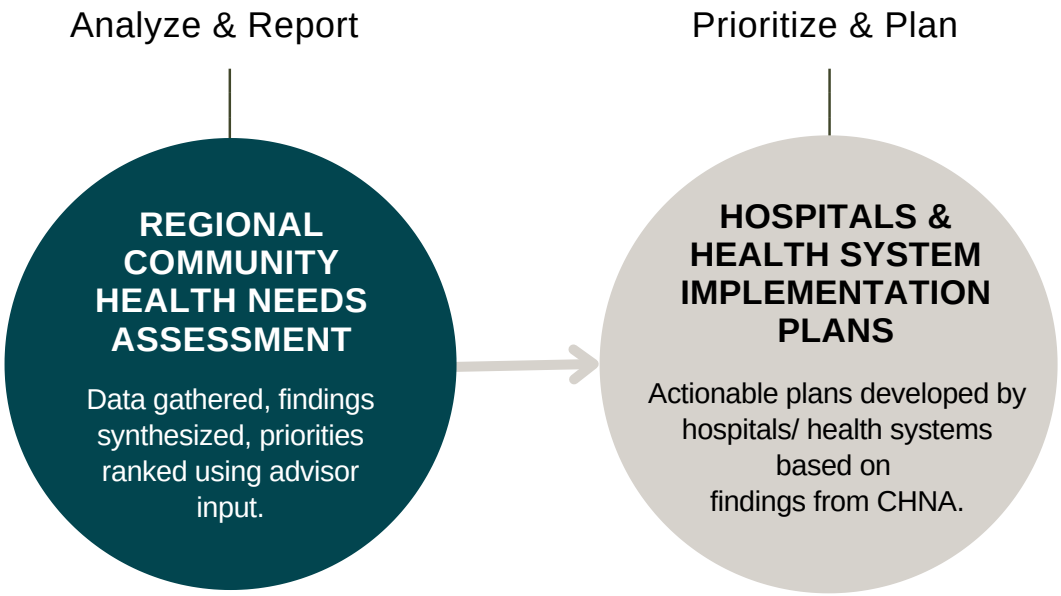
An interactive data platform created through Tableau is available to all community members at **www.NortheastGeorgiaCHNA.com**. This platform provides access to both ZIP code and county-level public health indicators found throughout the CHNA, including demographics, socioeconomic indicators, disease prevalence, insurance coverage, and preventable hospitalizations. Additionally, downloadable data sheets for each service area are available that provide a summary of key health, economic, and demographic indicators. The downloadable data sheets are available to the community at **nghs.com/community-benefit-resources**.

Hospital partners are currently creating their CHNA implementation plans, which will be board approved on or before February 15, 2023. These strategies outline a three-year plan as to how each hospital will address the identified health priorities and will contain goals and tactics to make sustainable and meaningful changes within each of the six communities. Implementation strategies are made available to the public, and hospitals report annually on their progress towards their goals. Both the CHNA and the subsequent implementation strategies were designed to fully meet Internal Revenue Service regulations, as found in the Internal Revenue Code Section 501(r).



Overview and Methodology

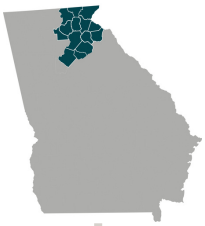
The Northeast Georgia CHNA was led by NGMC and consulting organizations PGG and the ThoMoss Group, whose organizational overviews are found in Appendix Five. The CHNA partners guided the work, providing oversight and input throughout the process. The process has two primary components:



Through convening partner NGMC, CHNA partners met monthly to review data findings, discuss process, make key decisions, and provide guidance for the CHNA process.

Public health and economic data were analyzed for each identified service area. More than 190 health indicators were examined, with a focus on clinical indicators, health outcomes, and social determinants of health. Social determinants of health are the external factors that impact an individual's health, including economic stability, education, housing, food access, neighborhoods, built environments, and other similar factors. All indicators were for the last year for which data was available, which is noted throughout the report.

Once data was gathered, PGG conducted a benchmark analysis of service area data against state rates and national values. The benchmark analysis, which can be found in the online data resource Tableau, helped us gauge how a particular issue compares against the state and other communities, allowing CHNA partners to understand the severity of a



Overview and Methodology

given issue. This data was first shared with CHNA partners in February 2022 and again with both partners and advisors during the May 2022 prioritization process.

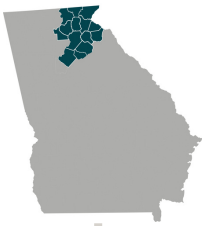
Throughout the data collection process, special attention was paid to those disproportionately impacted by social determinants of health, including low-income and minority populations. These groups tend to have worse health statuses than others, often due to factors outside their control. Because of this, demographic, race, and income information were included for all indicators where possible and appropriate. Finally, internal hospital data were reviewed to include data on utilization, financing for low-income patients, and certain chronic conditions.

In February and March 2022, the ThoMoss Group interviewed key stakeholders with particular expertise or knowledge of the various service areas to gain each community's perspective. Thirty-five representatives of local and regional public health entities, minority populations, faith-based communities, local business owners, philanthropic communities, mental health agencies, elected officials, and individuals representing our most vulnerable patients were interviewed.

Additionally, the staff of Good News Clinics, District 2 Public Health, and the Housing Authority to consumers conducted in-person interviews with approximately 190 community members representing those settings. These conversations were designed to capture respondents' perceptions of how well their health care needs were being met and what obstacles interfered with their needs.

Eight focus groups were conducted for the following communities and groups, and the number of participants for each are noted in parentheses.

- NGMC Primary Service Area (15)
- NGMC Greater Braselton Service Area (11)
- NGMC Secondary Service Area 400 (5)
- NGMC Secondary Service Area North (7)
- Hall County Family Connection Network (15)
- African American stakeholders, hosted by the Newtown Florist Club (13)
- Gwinnett Human Services Division (5)
- Hispanic and Latino stakeholders, hosted by the Hispanic Alliance (26)



Overview and Methodology

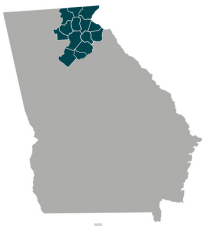
In March 2022, an electronic community-based survey to solicit community input was released and widely advertised to the community via press releases, partner websites, and social media. Survey questions can be found in Appendix Eleven. Approximately 4,200 community members completed the survey, which was available in English, Spanish, and Vietnamese. An employee survey was also released through each partner organization. Approximately 460 employees throughout all CHNA partner organizations responded. Results from this survey can be found in Appendix Twelve.

After collecting all data, health matrices were created for all service area to demonstrate where certain issues show up in both qualitative and quantitative data. These matrices can be found within each service area's subsection of this report. This data was ranked according to prevalence, how it compared to benchmarked values, the prevalence of the topic from interviews, focus groups, listening sessions, and surveys. The information was then categorized in one of four ways:

- **Low data + low qualitative:** Neither the benchmark analysis nor the community demonstrated a particular indicator was a significant issue.
- **Low data + high qualitative:** The benchmark analysis did not identify the indicator as a comparatively significant problem but the community members interviewed or surveyed relayed it was as significant issue.
- **High data + low qualitative:** The benchmark analysis shows a particular indicator was an issue but it was not mentioned often, if at all, by community members interviewed or surveyed.
- **High data + high qualitative:** Both the community and the benchmark analysis identified a particular indicator as a significant issue.

These matrices were presented to partners and advisors during the first of the three prioritization meetings. This meeting, held on May 10, 2022, included both CHNA partners and advisors, who reviewed a summary of data and the health matrices.

On May 13, 2022, the CHNA partners convened to review the health issues that fell within the area of both high data and high qualitative and to complete a health importance worksheet to score the issue. An example of this health importance worksheet can be found in Appendix Eight.



Overview and Methodology

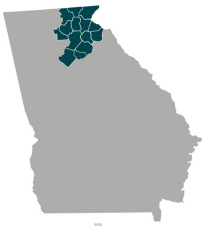
Each identified health need was scored through three lenses:

- **Root cause:** Is the issue caused by a social determinant of health or a root cause problem? Is this a challenge that disproportionately impacts low-income, uninsured, or otherwise vulnerable populations? Would addressing this issue potentially address other community issues?
- **Magnitude:** Is this is a significant issue within the community? Is the problem severe and could lead to long-term disability or death?
- **Ability to make an impact:** Does the hospital and/or community have an ability to make an impact on this problem? Does the community support our addressing this issue?

Each health need could receive a score up to 15, with higher scores indicating the need closely aligns with the above three areas. Once each significant issue was scored, ranking sheets for each service area was created and identified the top ten issues within that particular area. These rankings, which can be found within each service area's report in this CHNA, gave the partners insight as to which issues emerged as potential priorities.

On May 19, 2022, partners and advisors convened a third time to review the ranking sheets and determine potential health priorities. All service areas were represented with the exception of Stephens County Hospital, who held a separate meeting with their advisors on July 13, 2022. From these two meetings came suggested priorities that carried common themes of mental and behavioral health, health behaviors, and access to care across all partners.

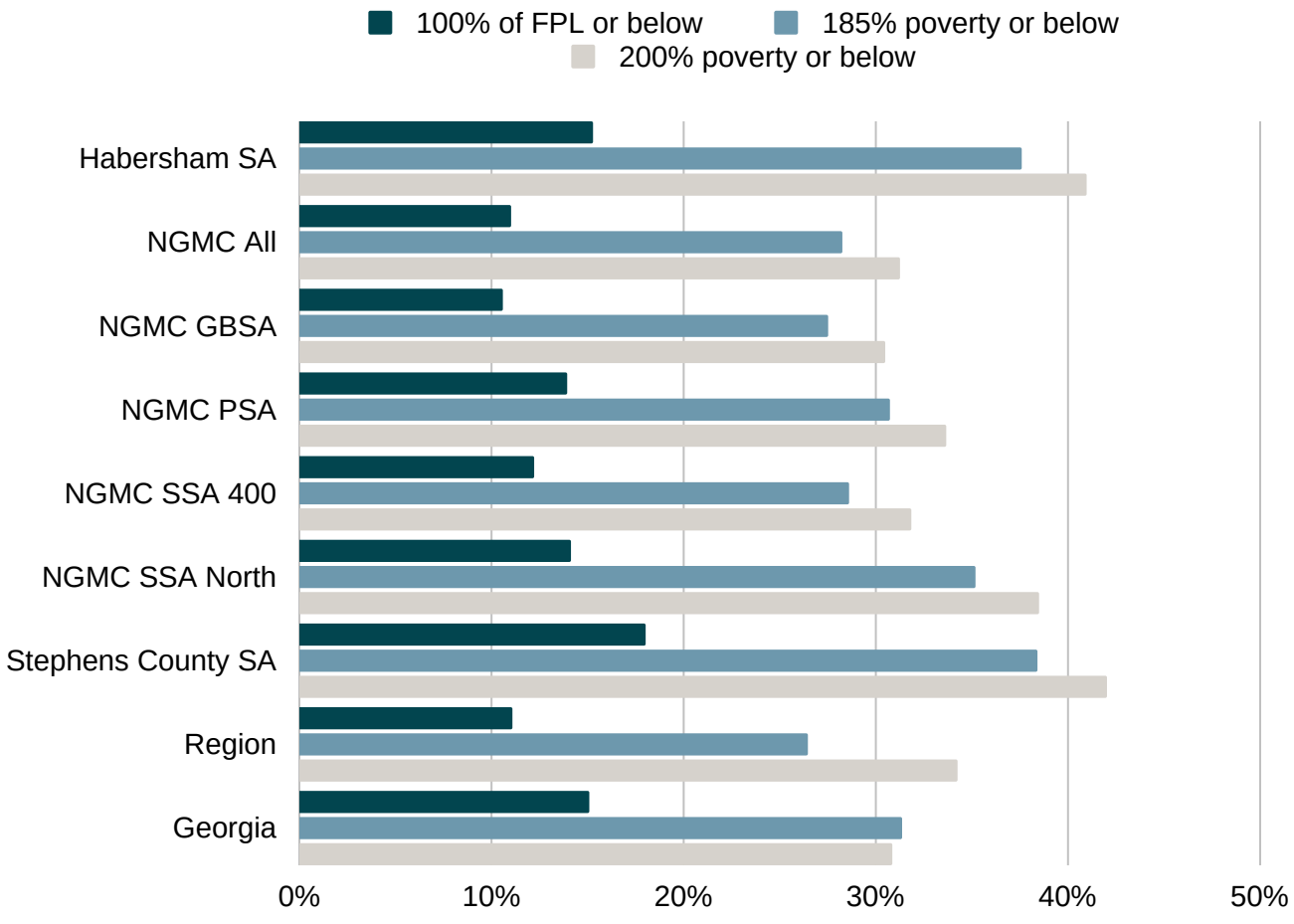
Each hospital presented its recommended priorities to senior leadership and their boards of directors for input and approval in August and September 2022. The hospitals then crafted implementation strategies that outline the tactics they will undertake to address the approved health priorities in 2023, 2024, and 2025.



Key Themes

Both data and community input emphasized **the importance of addressing socioeconomic barriers to good health**, as issues of income and poverty are key concerns. Poverty is the most significant indicator of health as, in general, poorer people are sicker than their richer counterparts. Those living at or near poverty are more likely to die from cancer, heart disease and diabetes due to several factors that go beyond income, such as education, housing, and access to foods. In 2020, a family of four earning a gross household income of $26,200 was considered to live at 100 percent of the Federal Poverty Level.

Poverty Rates by Service Area, 2020



Source: US Census Bureau, American Community Survey. 2020.

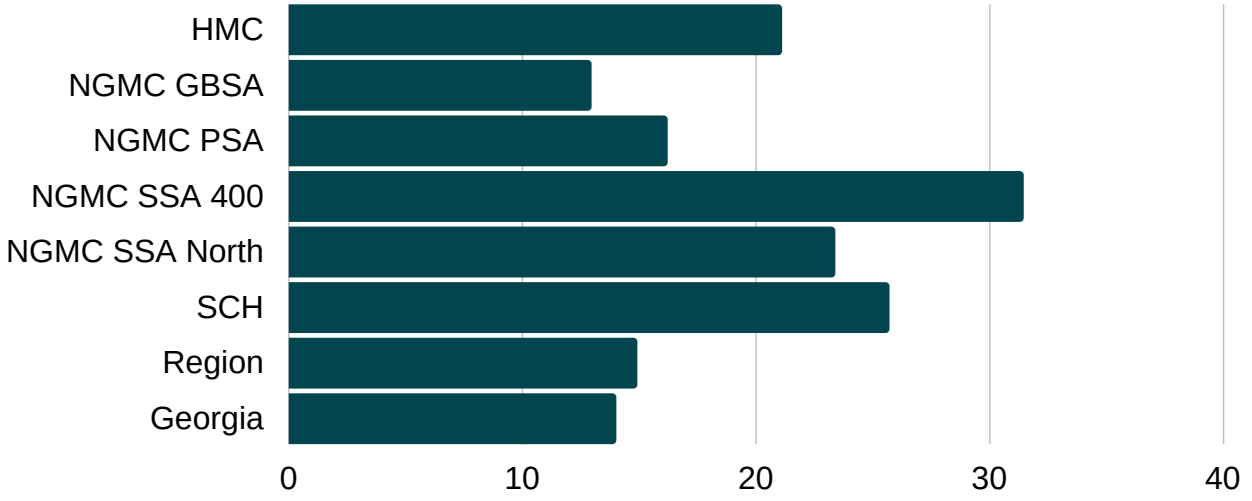
As demonstrated in the chart, when we examine "near-poverty," or income levels that still put a community member at great risk, rates can reach more than 40 percent of the community.

Key Themes

Mental and behavioral health remains a key concern for the community, as there are not enough providers to address the need. Additionally, there are stigmas associated with mental health as well as underlying issues that may drive addiction, stress, depression, and other mental health issues. While the quantitative data is still catching up to the impacts of COVID-19, community feedback is clear: more resources are needed to address mental and behavioral health.

One key indicator of mental health is suicide rates. The chart below demonstrates the average annual suicide death rate between 2016 and 2020. As demonstrated, some areas are impacted more by this than others.

Age-Adjusted Average Annual Suicide Death Rate, 2016 to 2020



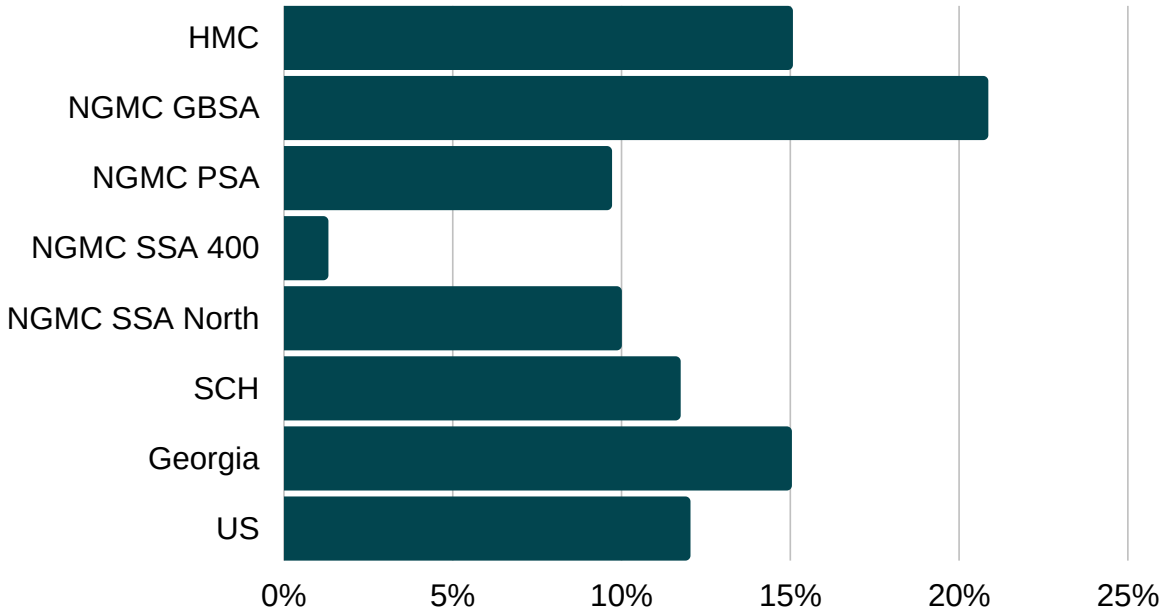
Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.

The rate of deaths of despair (deaths related to suicide), alcohol-related disease, and/or drug overdose) was 37.2 deaths for every 100,000 people each year on average between 2016 and 2020. This issue was most prevalent in SSA 400, which includes Dawson and Lumpkin counties. Both data and community input reflect the need for more mental health providers within the region. **In all service areas, there were only 105 mental health providers for every 100,000 people, far less than state and national averages, indicating a mental health care provider gap.**

Key Themes

Access to care continues to be a significant issue that shows up in several ways, including both preventative and specialty services, as well as resources for low-income individuals who do not have insurance. Health affordability was repeatedly named as an issue in our community survey, as costs feel too high for many. This issue is most prevalent among the uninsured, a rate that can vary significantly across service areas.

Percentage of the Population as Uninsured, On Average Between 2016 and 2020



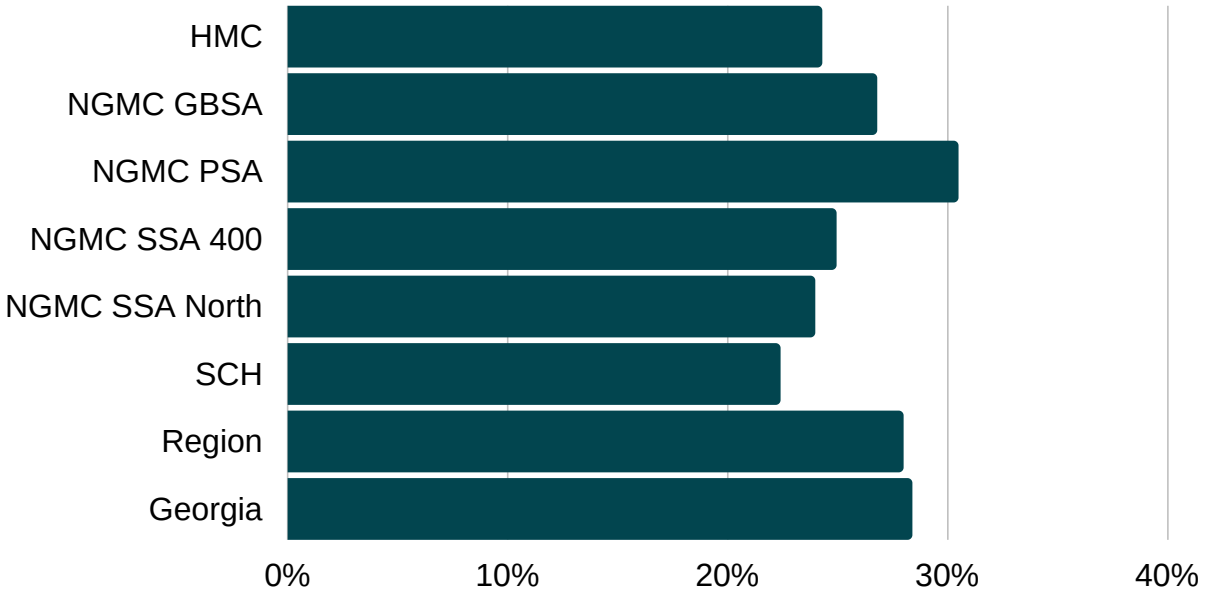
Source: US Census Bureau, American Community Survey. 2016-20.

Additionally, **19 percent of the population lives within at least one health professional shortage area related to primary care, dental care, or mental health.** In 2018, approximately 75 percent of females aged 50 to 74 had a mammogram within the previous two years and 84 percent of women below age 65 had a pap smear within the last three years, and both statistics were lower than the Georgia average. Approximately 76 percent of adults had a routine check-up within the last year, as reported in 2019. **That year, only 34 percent of women and 31 percent of men aged 65 and older were up-to-date on core preventative services.**

Key Themes

For much of the community, **health education and health literacy are critical in addressing community health issues**, and most noted the need for education and resources that are viable for the target population, particularly around healthy behaviors and vulnerable populations, including what they eat and if they exercise. For example, obesity rates continue to rise and, in most service areas, **at least a quarter of the population reported a body mass index of 30 or higher, indicating obesity.**

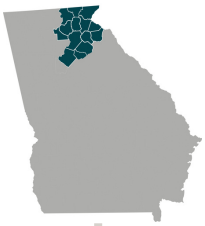
Obesity Rates by Service Area, 2019



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019.

Approximately 166,750 community members throughout the region live in a food desert, meaning their neighborhood does not have a healthy food source, an indicator that could lead to obesity.

Additionally, 18 percent of the total population reported excessive drinking in 2019, a figure that is likely underreported. That year, 17 percent of the population reported they were smokers.

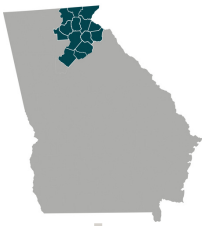


Sources

For our quantitative data, we examined 190 indicators from approximately 145 sources, including:

- District 2 Public Health
- Georgia Department of Public Health
- US Department of Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS)
- US HHS, Health Resources and Services Administration
- Centers for Disease Control (CDC) and Prevention, Behavioral Risk Factor Surveillance System
- University of Wisconsin Population Health Institute, County Health Rankings
- Johns Hopkins University
- National Center for Health Statistics
- US Census Bureau
- US Department of Agriculture (USDA)
- Georgia Bureau of Investigation
- US Department of Labor
- US Department of Commerce
- National Center for Education Statistics
- USDA Rural Development
- Federal Bureau of Investigation, FBI Uniform Crime Reports
- Dartmouth College Institute for Health Policy & Clinic Practice
- Nielsen
- State Cancer Profiles
- Institute for Health Metrics and Evaluation
- US HHS Substance Abuse and Mental Health Services Administration
- CMS National Plan and Provider Enumeration System
- US Department of Housing and Urban Development
- Federal Financial Institutions Examination Council
- CDC National Vital Statistics System
- CMS Geographic Variation Public Use File
- CMS Mapping Medicare Disparities Tool
- CDC Atlas of Heart Disease and Stroke
- Internal hospital data, including disparities data related to COVID-19

A full list of all sources and the type of indicator to which each source is aligned are found in Appendix Ten.



Habersham Medical Center Service Area

The Habersham Medical Center Service Area (HMC) is comprised of Banks, Habersham, and Rabun County, which is highlighted on the map to the right.

In 2020, 80,963 people lived in the 880-square-mile community. This service area was mostly rural, as 71 percent of the combined population lived in a rural setting in 2020.

When examining by age:

- 21 percent of the population were 17 or younger
- 59 percent were between 18 and 64
- 20 percent were over 65

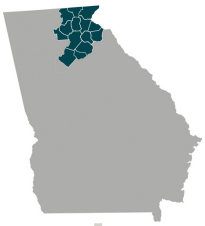
High school graduation rates were high as of 2020, with 91 percent of the area's population graduating. By comparison, only 85 percent of state residents held a high school diploma. Twenty-eight percent had an associate's degree or higher, and 12 percent held a bachelor's degree. Approximately 20 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 82 percent of community members were White
- 2 percent were Black or African American
- 11 percent were Hispanic or Latino
- 2 percent were Asian
- 3 percent were either multiple races or another race

Eight percent of service area residents were veterans in 2020 and the majority were over the age of 65. Fourteen percent of all adults aged 18 to 65 had served in the military, and 16 percent of all men in the service area were veterans, as compared to less than one percent of all females.

Eighteen percent of the service area population lived with a disability in 2020, a rate higher than the state and national rates of 12 and 13 percent, respectively. When separated by age, 43 percent of all adults aged 65 and older lived with a disability that year, as compared to five percent of children and 15 percent of adults aged 18 to 64.



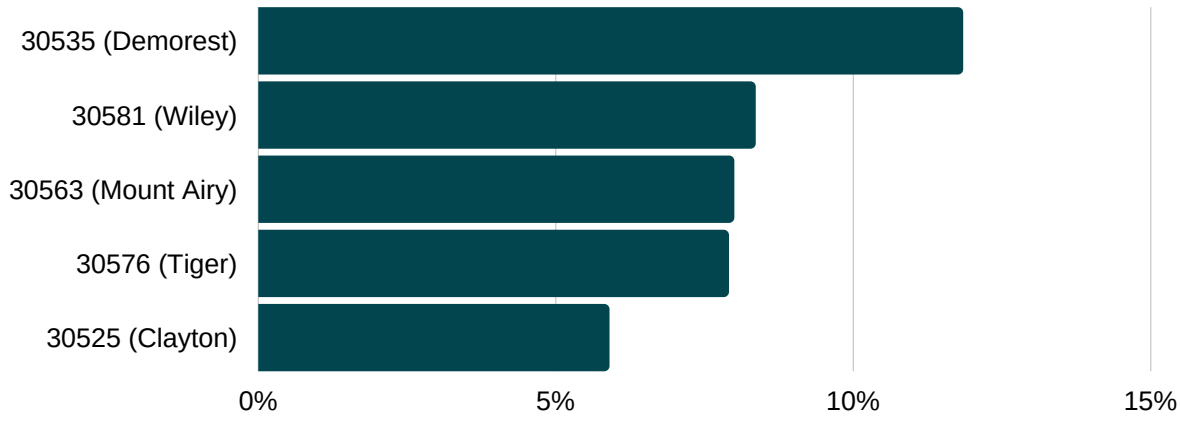
Demographics

In 2020, seven percent of the population identified as being born outside of the US, and five percent did not possess US citizenship status. Of the total population, three percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English “very well.” Spanish was the most common of those languages, followed in second by the broad category of Asian languages.

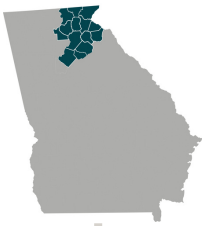
Within the service area, the population increased by four percent between 2010 and 2020, which was less significant than the state and national average of 11 percent and seven percent, respectively.

Minority populations increased far more than their White counterparts, which decreased by one percent during that time. By contrast, Black or African American populations grew by 12 percent, Asian populations grew by less than one percent, and Hispanic/Latino populations grew by 24 percent. Those identifying outside those four primary race or ethnic categories grew by 98 percent.

ZIP Codes with Highest Percentage of Population Change, 2010-2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 21 percent of the service area were children and youth 17 and younger. In the 2019 to 2020 school year, three percent of children were homeless, meaning nearly 350 school-age children had no stable home at some point that school year.

Of all children, 47 percent lived at or below 200 percent of the FPL, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30581 (Riley), where 100 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

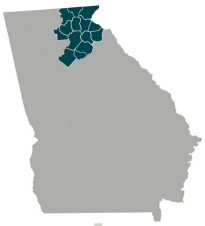
Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. in 2020, the service area had four Head Start programs, resulting in eight programs per every 10,000 children under five years old. This rate was between the state and national rates of seven and 11, respectively. That year, 42 percent of children aged three to four were enrolled in preschool, a rate below the state and national average of 49 percent and 47 percent, respectively.

English and Math 4th-Grade Proficiency

Of all students tested, 55 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was better than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 45 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was better than the statewide rate of 54 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 27 births per every 1,000 females aged 15 to 19, a statistic much higher than state and national rates of 23 and 19, respectively.**



Income and Economics

In 2020, the average household income was $67,331, less than state and national average incomes, which were $85,691 and $91,547, respectively. Within the service area, we see the following variation in average household income by ZIP codes:

Highest Incomes:

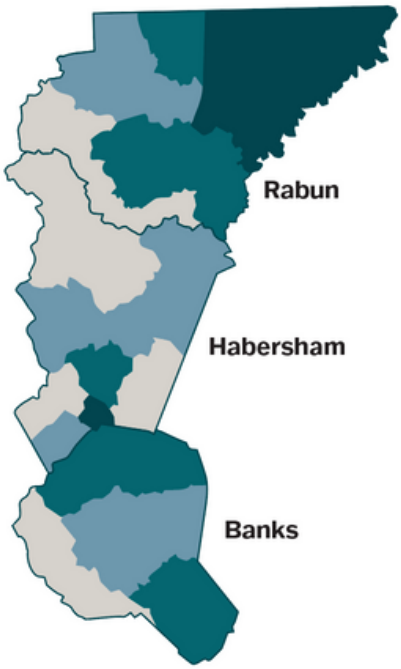
1. 30568 (Rabun Gap): $92,329
2. 30543 (Gillsville): $80,224
3. 30547 (Homer): $76,055
4. 30525 (Clayton): $74,710
5. 30576 (Tiger): $74,565

Lowest Incomes:

1. 30562 (Mountain City): $43,620
2. 30573 (Tallulah Falls): $49,424
3. 30510 (Alto): $50,258
4. 30537 (Dillard): $53,391
5. 30535 (Demorest): $61,895

Poverty and the Community

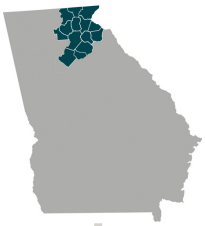
Approximately 15 percent of the service area lived in poverty in 2020**.** That year, the FPL placed a family of four as having a total household income of $26,200. The five poorest ZIP codes within the service area are: 30581 (Wiley), 30537 (Dillard), 30568 (Rabun Gap), and 30562 (Mountain City).



The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent of the FPL and below.

- 20% or more live at or below poverty
- 15.1% to 20%
- 10.1% to 15%
- 10% or less

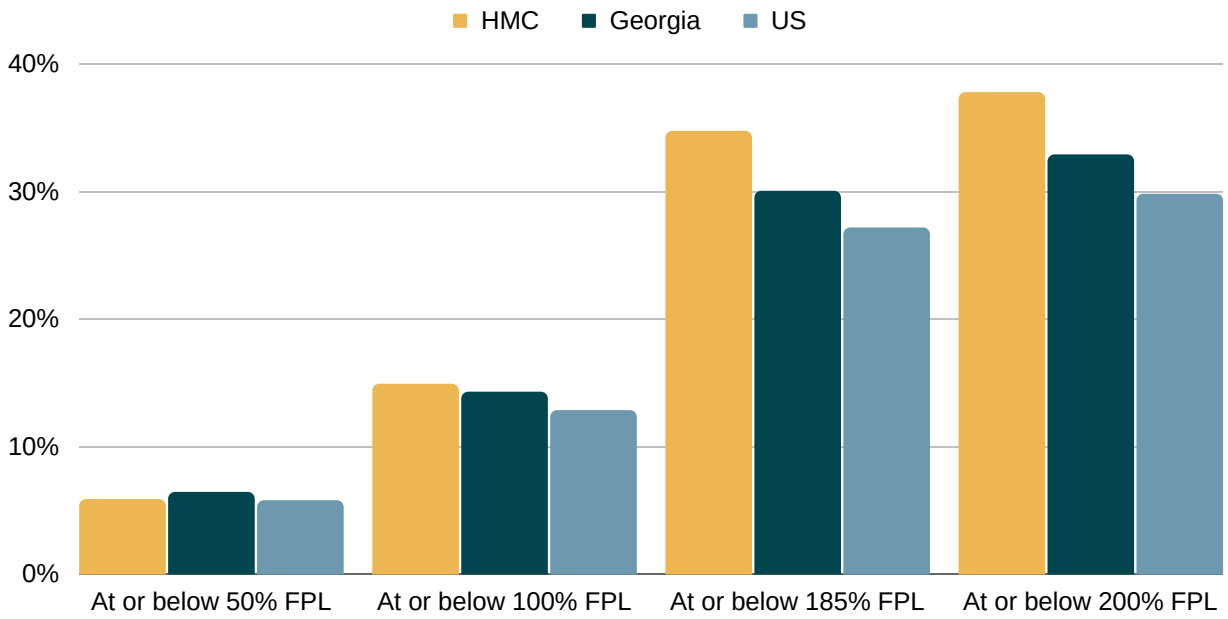
Source: US Census Bureau, American Community Survey. 2016-20.



Income and Economics

Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.

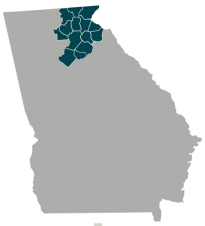
Poverty by Percentage of FPL, 2016 to 2020



Source: US Census Bureau, American Community Survey. 2016-20.

Public Assistance Income

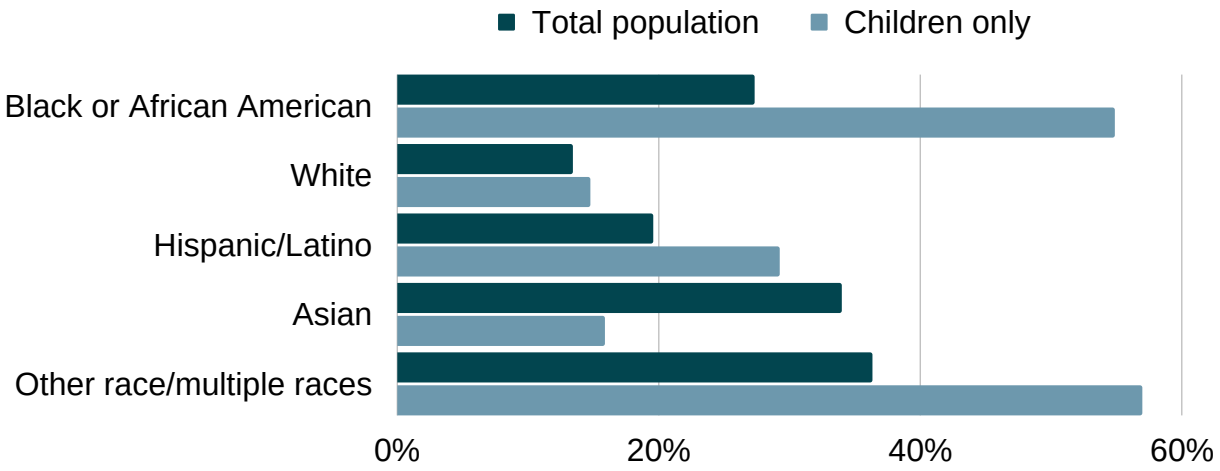
Within the service area, two percent of all households received some form of public assistance. This was on par with the state and national rates. Within the service area, ZIP code 30573 (Tallulah Falls) and ZIP code 30525 (Clayton) received the most public assistance. This indicator reports the percentage of households receiving public assistance income. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP.



Income and Economics

When broken down by age and race, the below poverty trends emerge. As demonstrated in the chart below, most minorities within the service area are more likely to live in poverty than their White counterparts.

Populations Living in Poverty, by Race or Ethnicity, 2016 to 2020



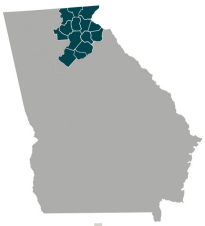
Source: US Census Bureau, American Community Survey. 2016-20.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. In the service area, 11 percent of the service area's population received SNAP benefits in 2019. The ZIP code with the highest percentage of SNAP beneficiaries was 30547 (Homer), where 11 percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Fifty-four percent of service area children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure lower than the state rate of 56 percent and higher than the national rate of 42 percent. Free or reduced-price lunches were served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. High levels of free or reduced cost lunch demonstrates areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net loss of 66 businesses. There were 1,355 establishment "births" and 1,421 "deaths" contributing to that change. The rate of change was a four percent decrease over the ten-year period, which was on par with the state average of four percent. The area's gross domestic product was $2,563 (millions) in 2020, up by 32 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerge as the largest:

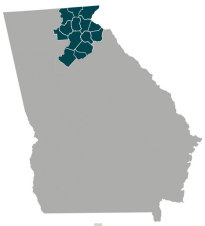
Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Manufacturing	4,898	$58,309
Retail trade	4,106	$28,851
Accommodation and food services	3,623	$21,153

Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

In 2020, the total labor force for the service area was 35,176 residents, and the labor force participation rate was 53 percent. Total unemployment in the service area in July 2022 equaled three percent. Unemployment creates financial instability and barriers to access, including insurance coverage, health services, healthy food, and other necessities contributing to poor health status. This rate has steadily dropped since January 2018, when the unemployment rate was four percent. In 2021, the unemployment rate was nearly four times less than the rate in 2012.



Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

Age-Adjusted Death Rates

Ischemic heart and vascular disease - 1

Alzheimer's disease - 2

All COPD except asthma - 3

Trachea, bronchus and lung cancer - 4

Cerebrovascular disease - 5

All other diseases of the nervous system - 6

All other mental and behavioral disorders (usually dementia) - 7

Essential hypertension and hypertensive renal and heart disease - 8

All other endocrine, nutritional, and metabolic diseases - 9

COVID-19 - 10

Premature Death Rates

Motor vehicle crashes - 1

Ischemic heart and vascular disease - 2

Accidental poisoning and exposure to noxious substances - 3

Suicide - 4

Trachea, bronchus and lung cancer - 5

All COPD except asthma - 6

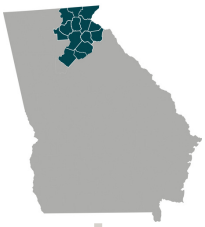
Cerebrovascular disease - 7

Certain conditions originating in the perinatal period - 8

All other diseases of the nervous system - 9

Congenital malformations, deformations, and chromosomal abnormalities - 10

Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022. Both age-adjusted death and premature death are defined in Appendix Six.



Health Outcomes

Heart Disease

Heart disease was among the leading causes of death in the service area. **Between 2016 and 2020, the age-adjusted death rate for heart disease was 168 deaths for every 100,000 people, which was better than state average but worse than the national average.** Approximately seven percent of all adults had been diagnosed with coronary heart disease in 2019, a figure that jumped to 26 percent when looking only at Medicare beneficiaries. Both figures have remained somewhat steady over the last decade.

There were similar trends in stroke deaths. **Between 2016 and 2020, the age-adjusted death rate was 45 deaths per 100,000 people, which was worse than the state and national rates of 43 and 38 deaths per 100,000 people.**

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 11 hospitalizations per every 1,000 Medicare beneficiaries, below the state and the national rate of 12. **The stroke hospitalization rate of ten hospitalizations per every 1,000 Medicare beneficiaries was higher than the state rate of nine and the national rate of eight.**

Cancer

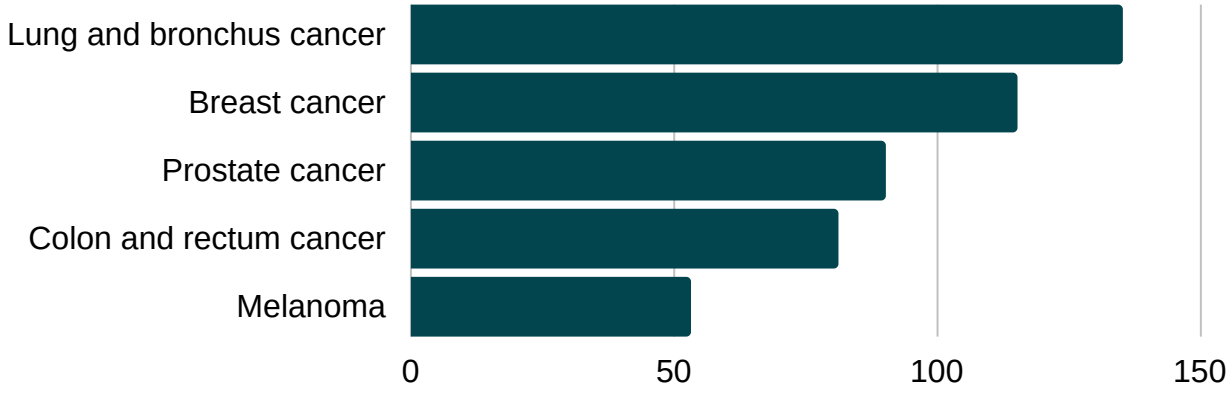
Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 150 deaths per every 100,000 people, which was between the state and national rates of 153 and 149, respectively. When looking at county rates, Habersham County had a higher cancer death rate with 153 deaths from cancer for every 100,000 people, as compared to Banks County and Rabun County death rates of 143 and 150 deaths for every 100,000 people, respectively. **Males are more likely to die from cancer than females, with a rate of 181 deaths per every 100,000 men. For women, this rate drops to 124 deaths for every 100,000 women.**

The cancer incidence rate was also higher, with approximately 501 cancer incidences for every 100,000 people in Habersham County, as compared to Banks County and Rabun County rates of 471 and 463 cancer incidences for every 100,000 people, respectively, on average each year between 2014 and 2018.

Health Outcomes

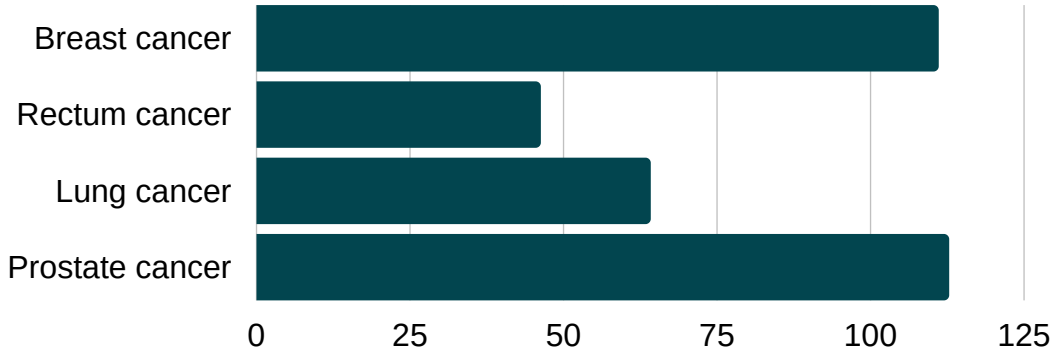
Within the service area, there were an average 516 new cases of cancer diagnosed each year between 2014 and 2018, resulting in a cancer incidence rate of 485 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018



The below chart shows the incidence rate for the most common cancers within the community.

Annual Average Cancer Incidence Rate, Per Every 100,000 People, 2014 to 2018

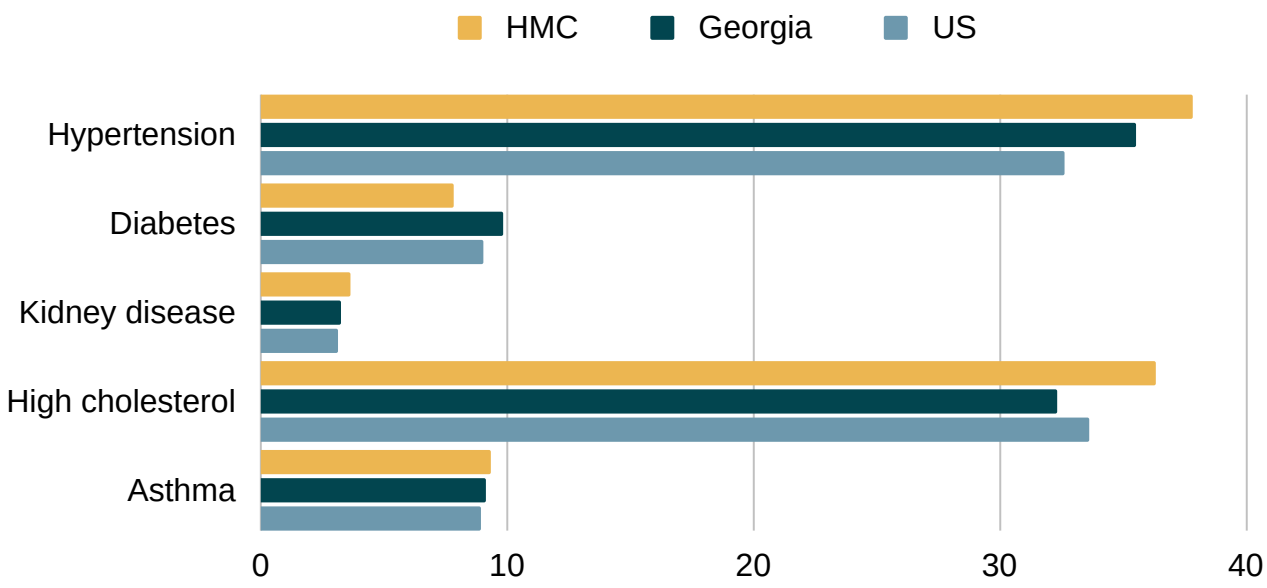


Source for both charts: State Cancer Profiles. 2014-18.

Health Outcomes

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

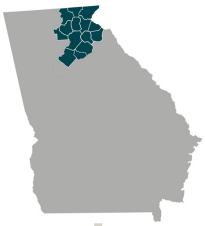
Percent of Population Reporting Key Chronic Conditions, 2018



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 72 percent of all Medicare beneficiaries had chronic conditions, with 28 percent having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note that this doesn't equal 100 percent, as some community members have two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
54%	21%	3%	28%	21%	4%

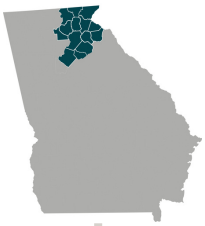
Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

In 2020, about 28 percent of the population was enrolled in some form of Medicare, the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 73, and 17 percent were eligible for Medicaid due to low incomes.

Medicaid Populations

In 2020, 21 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was on par with the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 37 percent of children under 18, ten percent aged 18 to 64, and 15 percent of adults aged 65 and older were enrolled in Medicaid.



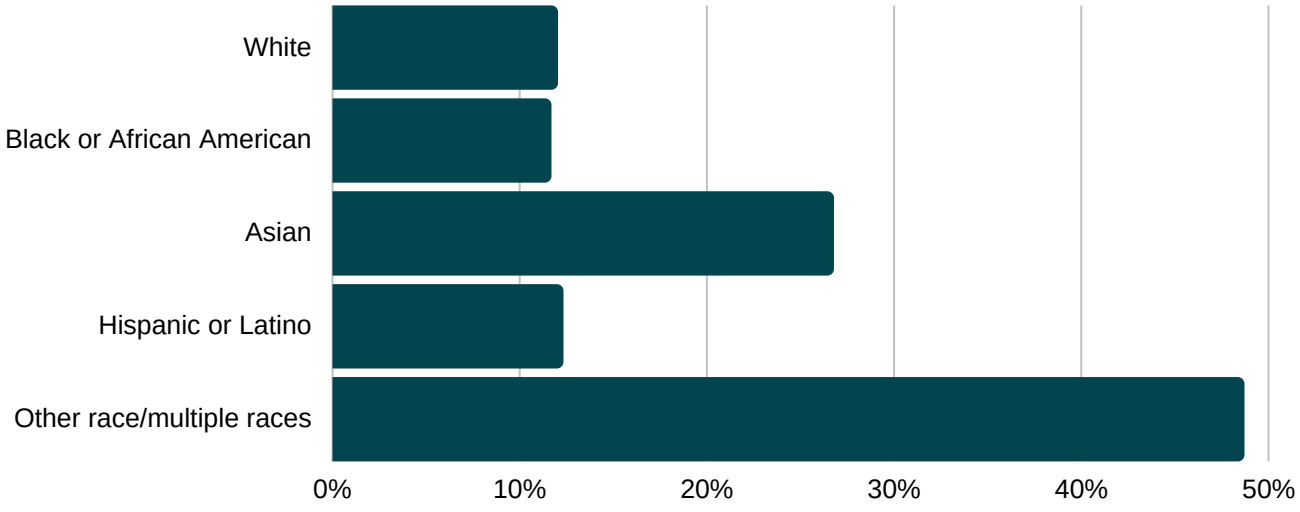
Clinical Care and Prevention

I**n the service area, on average between 2016 and 2020, 15 percent of the population were uninsured, a figure above the state rate of 13 percent and the national rate of nine percent.** When looking only at adults aged 18-64, the uninsured rate jumps to 25 percent. Approximately ten percent of all children were uninsured in 2020, a figure much higher than the state and national rates of seven percent and six percent, respectively. This was a figure, though, that has steadily decreased over the last few years. For example, in 2011, 13 percent of all children were uninsured.

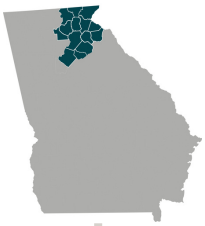
This trend was seen across all populations, as the number of total uninsured has steadily declined over the years. **For example, in 2011, 31 percent of the service area's non-elderly adult population was uninsured, six percentage points more than in 2020**. Even so, the uninsured rate remains relatively high, and likely has a significant impact on the ability of community members to access primary and specialty care.

Within the HMC service area, there are some disparities of insurance rates. For example, Asian populations were more than twice as likely as White and Black populations to be uninsured within the service area between 2016 and 2020. In further contrast, the rate of uninsured skyrockets to nearly 50 percent when looking at other races or multiple race populations.

Uninsured by Race or Ethnicity, 2016 to 2020



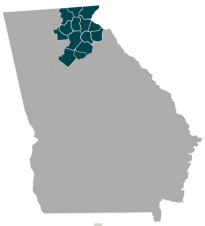
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

Combined, in FY20 and FY21, approximately 2,930 patients received financial assistance for their care at Habersham Medical Center. Below is a list of the top ten ZIP codes by volume of patients receiving care covered by financial assistance at the hospital during the last two fiscal years. Please note that the hospital also provided financial assistance to patients outside these ten ZIP codes.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30533 (Dahlonega)	697	30533 (Dahlonega)	751
30534 (Dawsonville)	183	30534 (Dawsonville)	227
30528 (Cleveland)	119	30528 (Cleveland)	140
30564 (Murrayville)	65	30564 (Murrayville)	85
30506 (Gainesville)	64	30506 (Gainesville)	75
30501 (Gainesville)	29	30501 (Gainesville)	31
30504 (Gainesville)	13	30504 (Gainesville), 30507 (Gainesville)	15
30507 (Gainesville)	12	30527 (Clermont)	12
30554 (Lula), 30527 (Clermont)	11	30554 (Lula), 30542 (Flowery Branch), 30041 (Cumming)	10
30041 (Cumming)	10	30040 (Cumming)	8



Clinical Care and Prevention

Health Professions Shortages and Provider Ratios

In the HMC service area, as of June 2022, there were 11 designated health professions shortage areas: four primary care, three dental health, and four mental health.

- Primary care: There were 47 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 1,439 people within the service area, a measure worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 2,953 people, a figure worse than the state rate of one provider for every 1,910 people and the national rate of one provider for every 1,397 people.

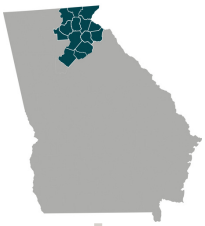
Primary Care and Routine Check-Ups

In 2019, 76 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, which was on par with both state and national averages. For Medicare recipients, this number increases to 86 percent of all beneficiaries having visited a doctor in the previous 12 months. **Seventy percent of Black populations received preventative care, as compared to an average 88 percent among other populations.**

In 2018, about 29 percent of men and 31 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services. The percentage of women up to date on their core preventative services was below state and above national averages, while the male percentage was on par with the state average and below the national average.

Dental Care and Dental Outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection, and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status. Within the service area, in 2018, 57 percent of adults went to the dentist in the past 12 months, which was lower than state and national rates. **That year**, **19 percent of community members reported having lost all or most of their natural teeth because of tooth decay or gum disease.**



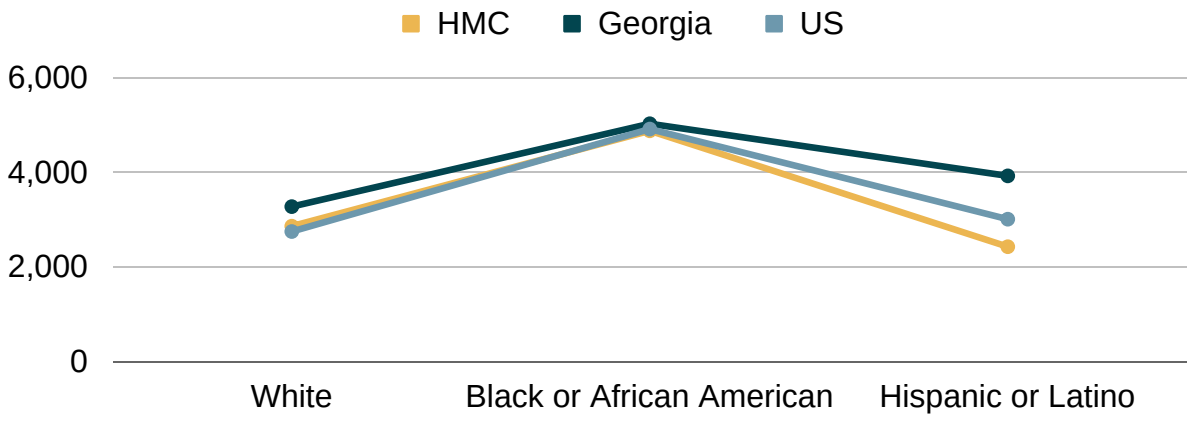
Clinical Care and Prevention

Emergency Department Visits
In 2020, Medicare beneficiaries visited the emergency department 5,650 times, resulting in an ED visit rate of 544 stays per every 1,000 beneficiaries, between the state and national rates of 551 and 535, respectively.

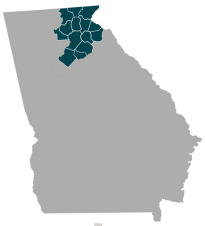
Inpatient Stays
In 2020, 14 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 209 stays per every 1,000 beneficiaries. This was lower than the state inpatient stay rate of 230 and the national inpatient stay rate of 223 during the same time.

Preventable Hospitalizations Among Medicare Beneficiaries
Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,128 per every 100,000 beneficiaries, which was lower than the state rate of 3,503 and higher than the national rate of 2,865 hospitalizations. As with other health indicators, the indicator shifts when looking at race or ethnicity.

Preventable Hospitalizations Per Every 100,000 Beneficiaries, by Race or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 52 deaths for every 100,000 people, which is far worse than the state and national averages of 38 and 47, respectively.**

Within the service area, the age-adjusted death rate for suicide was 20 per every 100,000 people. This rate was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. For both deaths of despair and suicide, this was far more prevalent among White populations.

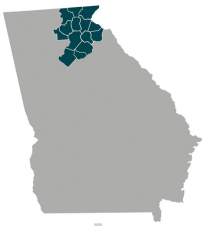
Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data was available, service area residents reported an average of six poor mental health days over the last 30 days, which was greater than the state average of five poor mental health days. Additionally, in 2019, 18 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage was slightly greater than the state rate of 16 percent and much greater than the national rate of 14 percent. Although data is not yet available, these statistics likely increased during 2020 and 2021 when the mental impact of COVID-19 was felt throughout all communities.

Opioid and Substance Use

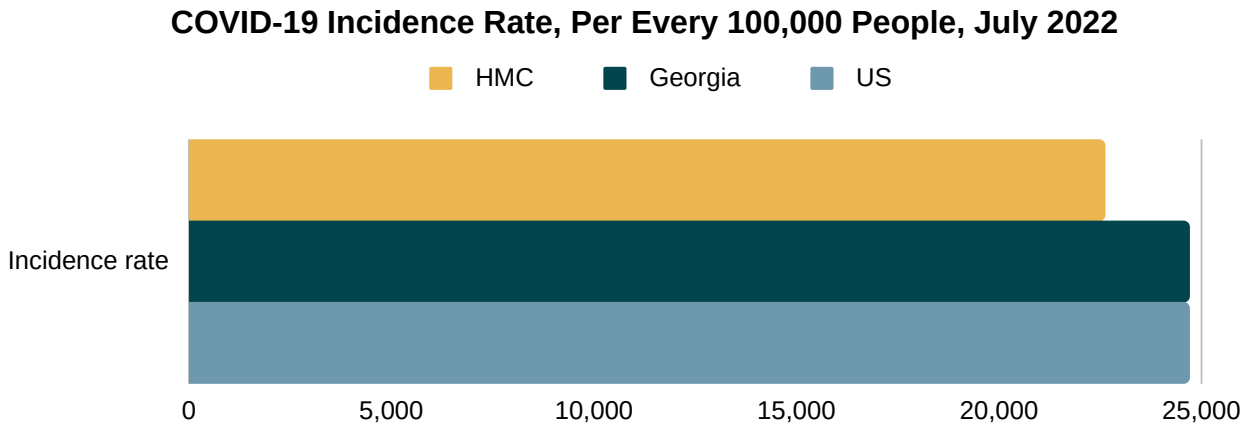
In 2020, providers in the service area prescribed an average 37 opioid prescriptions per every 100 people, a figure that has been steadily decreasing each year. Within the service area, the age-adjusted death rate for opioid overdose was 11 deaths per 100,000 people. This was on par with the state average of ten and better than the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

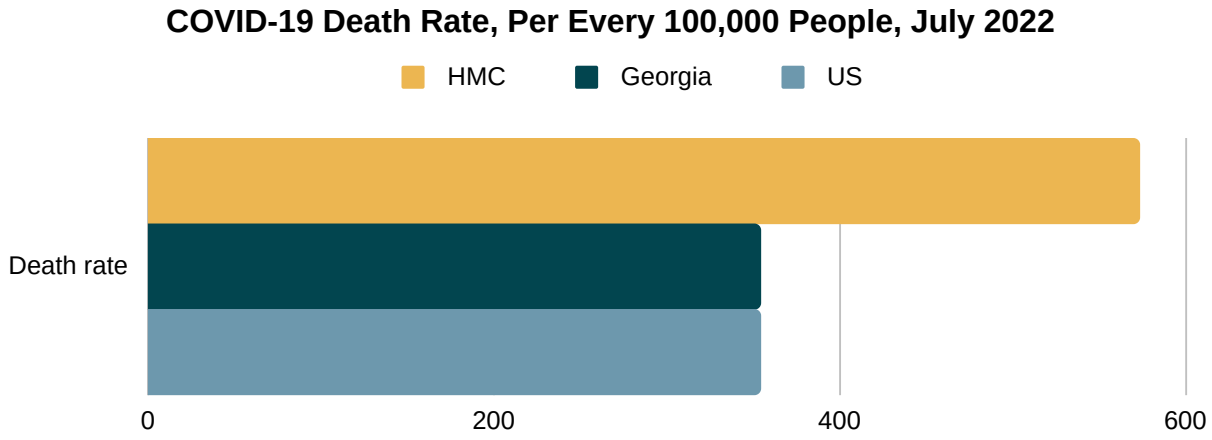
In 2019, Medicare opioid drug claims accounted for four percent of total prescription drug claims. This percentage was better than the state percentage of five and on par with the national percentage of four, respectively.



COVID-19

In July 2022 in the HMC service area, the COVID-19 incidence rate was below both state and national rates, though the death rate was much higher.





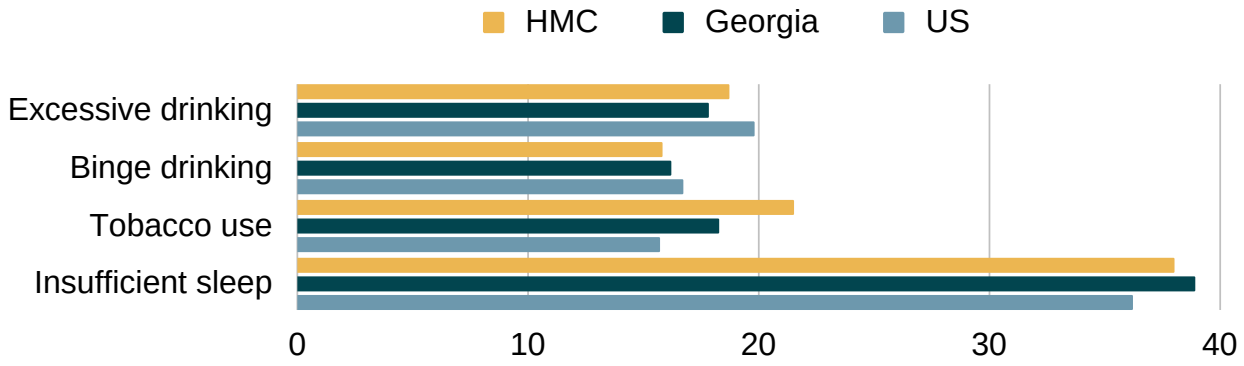
Source: Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES. 2022.

Approximately 48 percent of the service area was fully vaccinated in July 2022, with an estimated 16 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.73, which is a score of how challenging vaccine rollout may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).

Health Behaviors

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

Percent of Population Reporting Unhealthy Behaviors, 2019

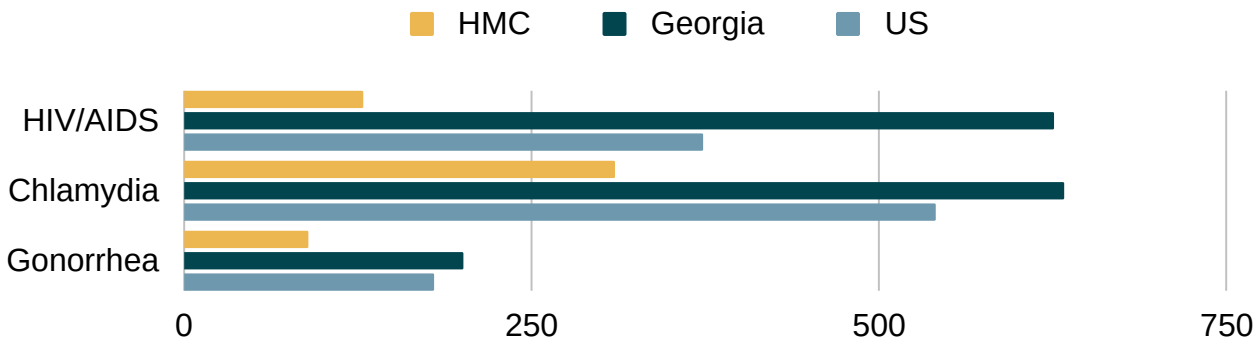


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

Binge drinking is defined as adults having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates were far below that of state and national rates.

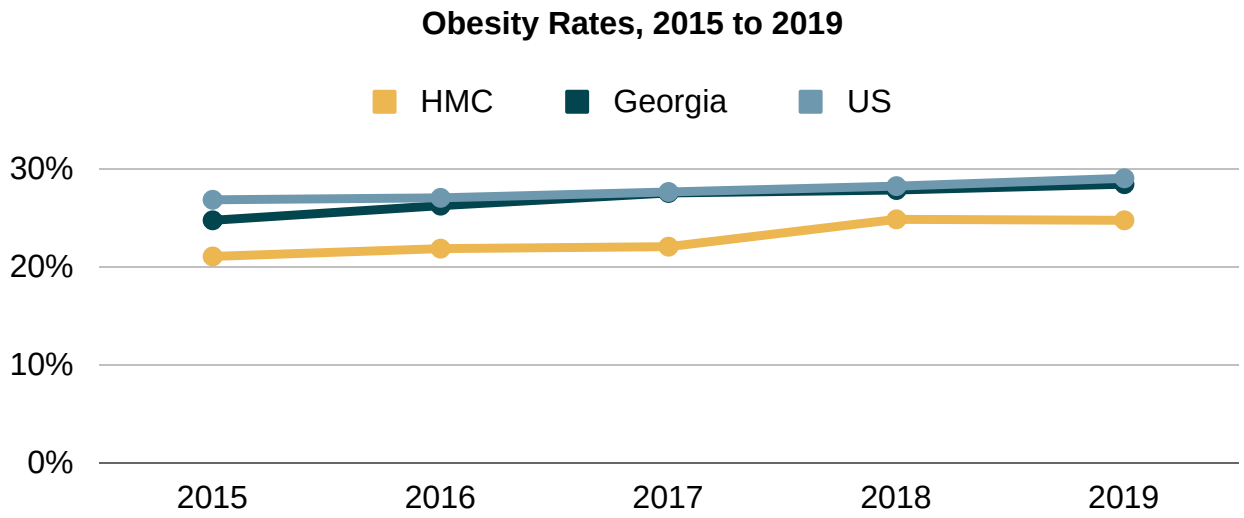
Sexually Transmitted Disease Rates, per every 100,000 people, 2018



Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.

Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. **In 2019, 25 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 or more.** Obesity rates have generally increased over the last ten years. Obesity is directly linked to many health issues, including diabetes and heart disease.



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

Within the service area in 2019, 23 percent of adults aged 20 and older self-reported no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

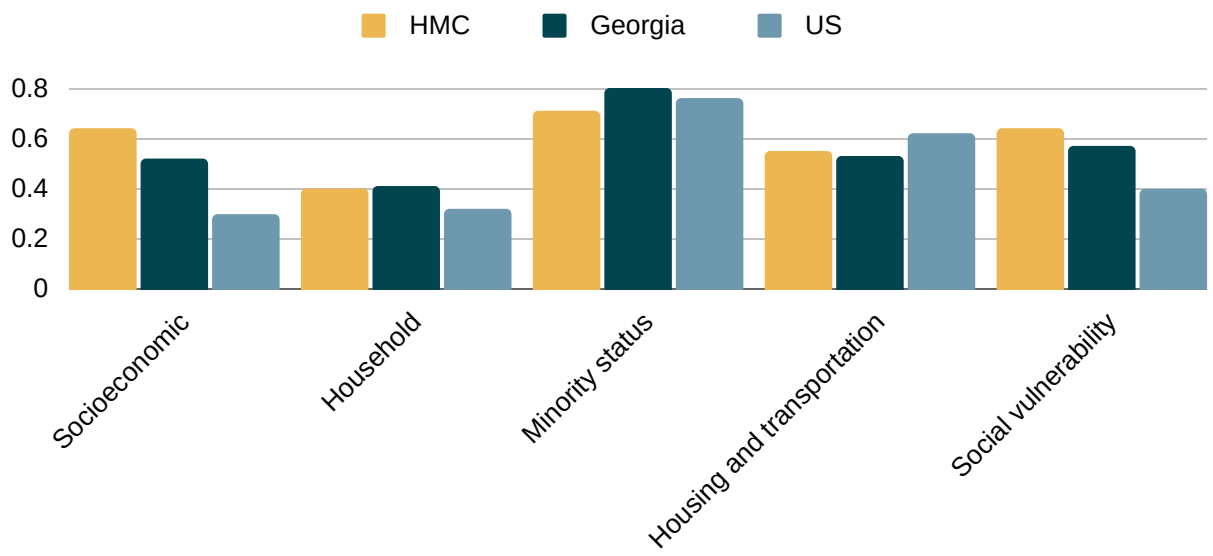
Walking or Biking to Work

Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if commuting by walking or biking is by choice. In 2019, about one percent of the service area's population walked or biked to work. Certain ZIP codes saw higher physical commutes, such as 30552 (Lakemont), where 54 people regularly walked or biked to work in 2019.

Socioeconomic Factors: Social Vulnerability Index

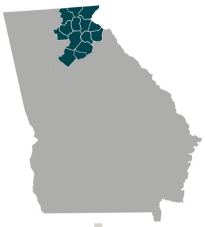
The CDC's Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss experienced from a disaster.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

The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. The service area had a social vulnerability index score of 0.67, much greater than the state score of 0.57 and the national score of 0.40. Broken down by themes:



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

A particular area where the service area scored poorly was socioeconomic indicators, meaning poverty, uninsurance rates, educational attainment, lack of access to a vehicle, lack of access to healthy foods, and other similar indicators were particularly challenging in this community.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person's physical and mental health.

The average monthly owner cost for a home within the service area was $897 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $709. COVID-19 significantly impacted housing, so these figures likely increased since then.

Cost-Burdened Households

Of all occupied households in the service area, 25 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately **11 percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.**

Renters bear the strain of this the most, with 42 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure drops to 29 percent. **Approximately 47 percent of renters pay rent that is at least 50 percent of their household income.**

Substandard Housing

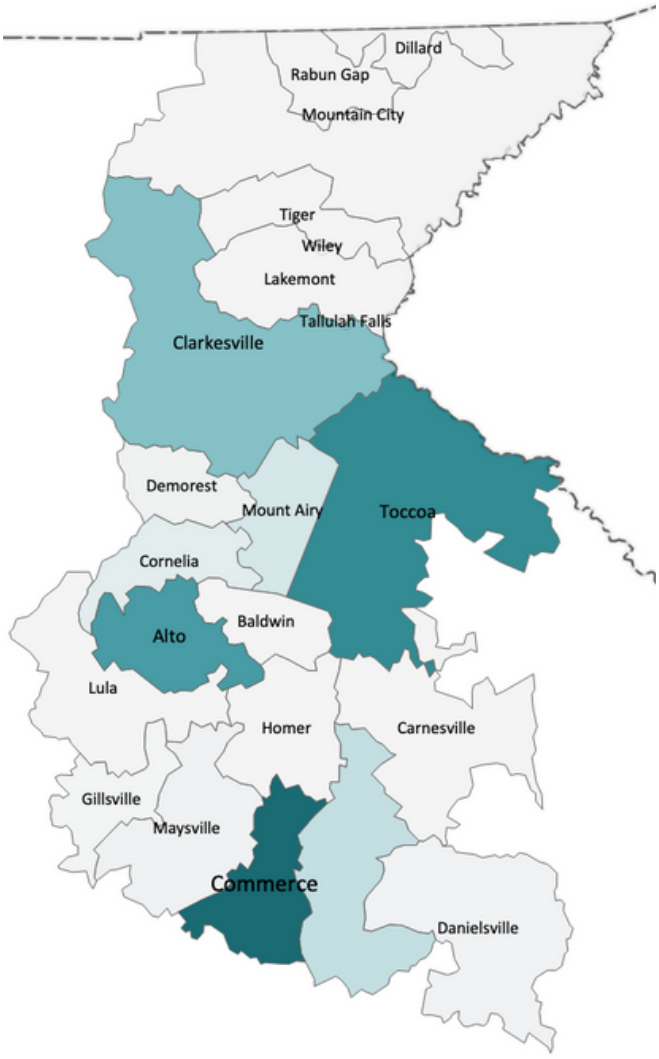
This indicator reports the number and percentage of the owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, 5) gross rent as a percentage of household income greater than 30 percent. **Twenty-seven percent of all households in the service area have one or more substandard conditions, which was lower than the state and national averages of 30 and 31 percent, respectively.**

Socioeconomic Factors: Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially if they are already low-income.

Communities that lack affordable and nutritious food are commonly known as “food deserts.” **The service area has one food desert census tract, meaning about 4,000 people did not have ready access to healthy foods.**

The map to the right illustrates food deserts within the service area. The darker the color, the more prevalent the issue.

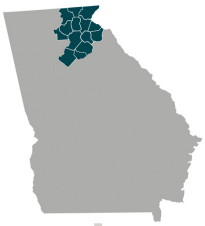


Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The service area has a food insecurity rate of ten percent, meaning those community members were unsure how they will access adequate food at some point during the year.

That said, many of these community members were ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school meals, the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all the food-insecure children in the service area, 12 percent were ineligible for public assistance programs. Of everyone living with food insecurity, approximately 26 percent were ineligible for any public assistance.

Eleven percent of the total population in the service area had low food access, meaning those community members likely struggled to access healthy foods.



Community Input

As part of the qualitative data gathering process, two community members from this service area were interviewed to solicit their input on community health. Below is a summary of themes that emerged from those interviews.

Barriers to health:

- Lack of transportation
- Lack of/inadequate insurance
- Poverty
- Affordable nutritious food
- Health education

Gaps in health services:

- Mental health
- Preventative care
- Maternal health/obstetrics/gynecology

Opportunities to improve health:

- Health education
- Healthy cooking
- Online medical care

Sources of health information:

- Internet
- Network news
- Peers/gossip
- Social media

Populations most impacted by barriers:

- Hispanic/Latino populations
- The elderly
- Indigent populations
- Undocumented persons

Top health needs:

- Diabetes
- Heart disease
- Blood pressure
- Maternal health
- Specialty care

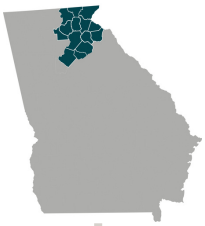
Gaps in mental health and vulnerable populations:

- Hispanic/Latino populations
- Elderly populations
- Migrant/undocumented populations
- Women

Gaps in mental health:

- Prescription drugs
- Transportation

Part of the HMC service area overlaps with NGMC SSA North's service area and the community input given during the SSA North focus group is relevant to the HMC service area. That focus group information can be found beginning on page 178.



Community Input

In March and April 2022, 25 physicians and other key leaders were interviewed regarding community needs, specialty care, and related topics. These interviewees discussed issues within Habersham, Rabun, Stephens, Towns, and White counties, primarily rural communities that come with unique challenges. Both Habersham and Rabun counties are within HMC's service area.

General observations:

- Primary care physicians can find themselves spending several hours a day trying to help patients with emotional and psychiatric needs.
- Obesity and diabetes are major problems, and there is a specific need to address obesity in children.
- Rural areas mean rural roads, which create long drives for people to access essential health care services such as specialty care.
- Many specialists see telemedicine as a practical way to address acute needs, especially for patients in rural areas.

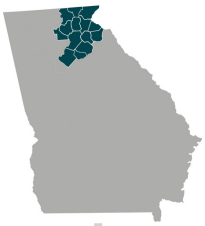
Four main needed specialties were named: cardiology, neurology, pulmonology, and endocrinology. Thirteen additional specialties came up in some interviews. These included psychiatry, orthopedics, gastroenterology, and neonatology.

Opportunities for health education exist, particularly for:

- Heart care
- Diabetes education and management
- Nutrition
- Coping and life skills, including resources for parents and youth

Key quotes:

- "This is a challenging population with lots of lifestyle issues that promote cardiovascular disease."
- "There are huge mental health needs we deal with all the time because there is nobody else to do it."
- "We are not very healthy."
- "Transportation is a massive problem. There are lots of elderly who should not be driving. Poor people drive poor, unreliable cars."



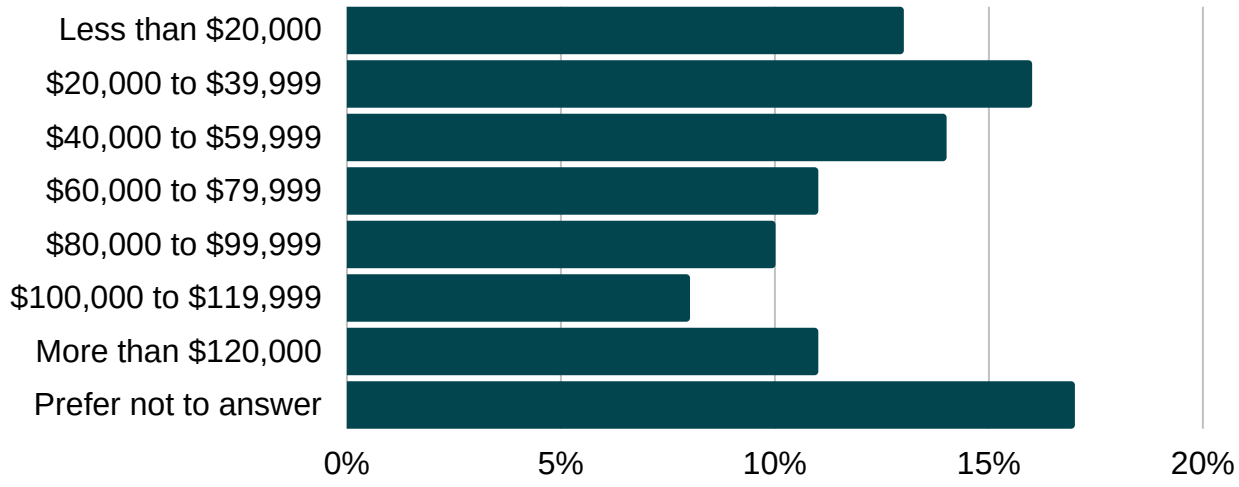
Community Survey

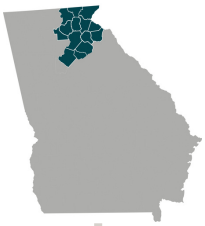
In March 2022, approximately 470 community members living within the Habersham Medical Center service area completed an electronic community-based survey widely advertised to the community via partners' websites, press releases and social media. All survey questions can be found in Appendix Eleven. Please note that the following survey data was for selected indicators. All answers from the survey can be found online at **nghs.com/community-benefit-resources** via the Tableau data tool.

Of all respondents:

- 24 percent were male, 72 percent were female, and 4 percent preferred not to answer
- 92 percent were White, 2 percent were Hispanic or Latino, 2 percent were African American or Black, and 4 percent preferred not to answer
- 3 percent were 25 or younger, 8 percent were between ages 26 and 34, 11 percent were between ages 35 and 44, 13 percent were between ages 45 and 54, 27 percent were between ages 55 and 64, 26 percent were between ages 65 and 74, and the remaining 12 percent were 75 and older
- 94 percent had some form of health insurance, and 86 percent lived in households where all members had some form of health insurance

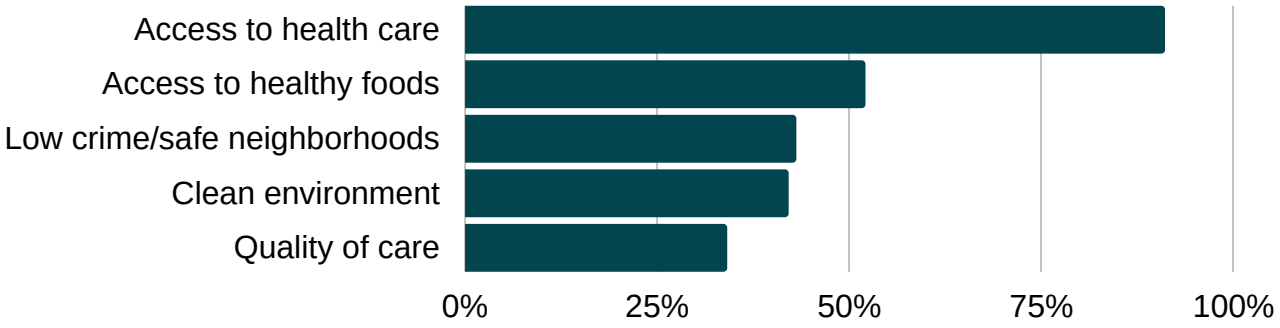
Below is a breakdown of the annual household income for all respondents.



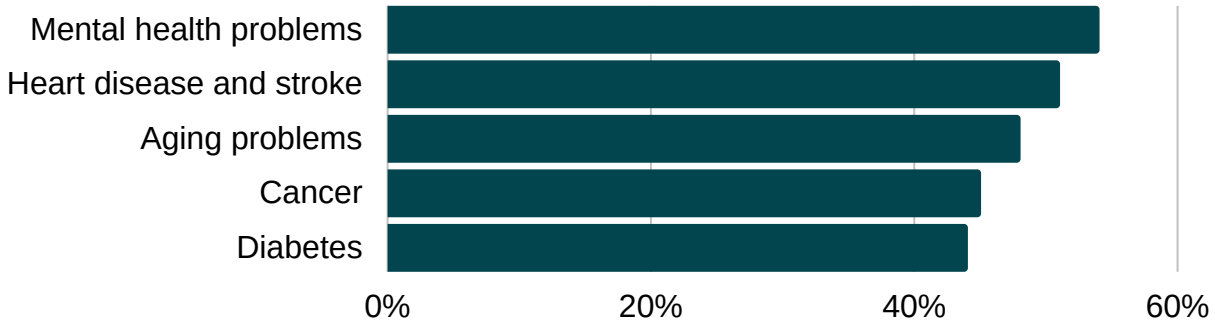


Community Survey

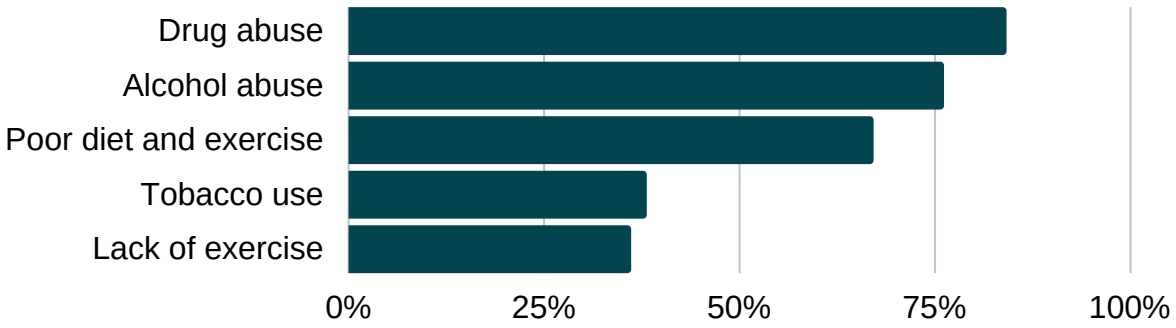
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below are the top five answers.

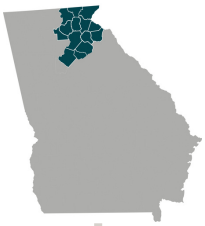


Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below are the top five answers.



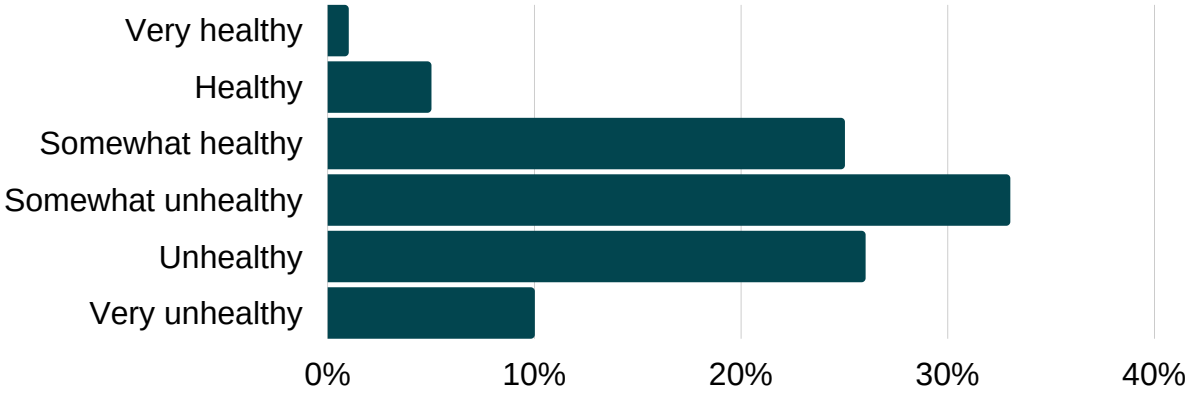
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



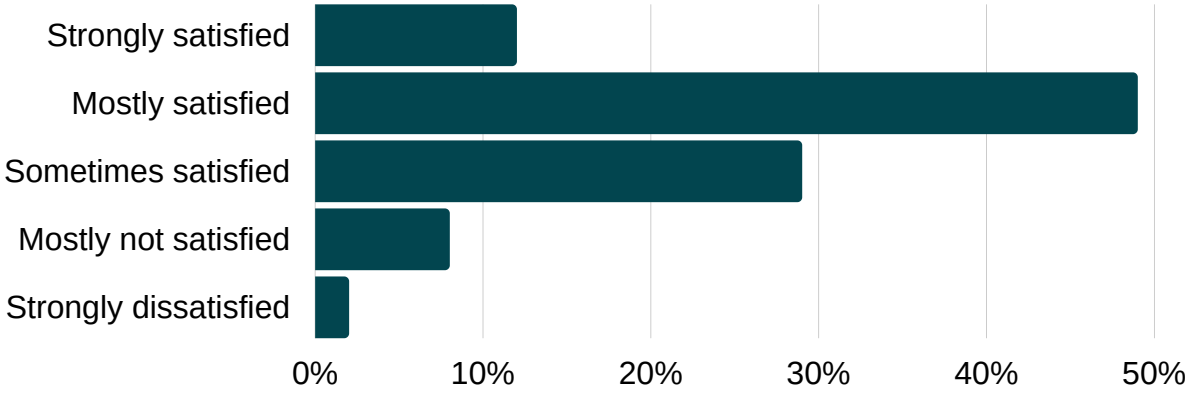


Community Survey

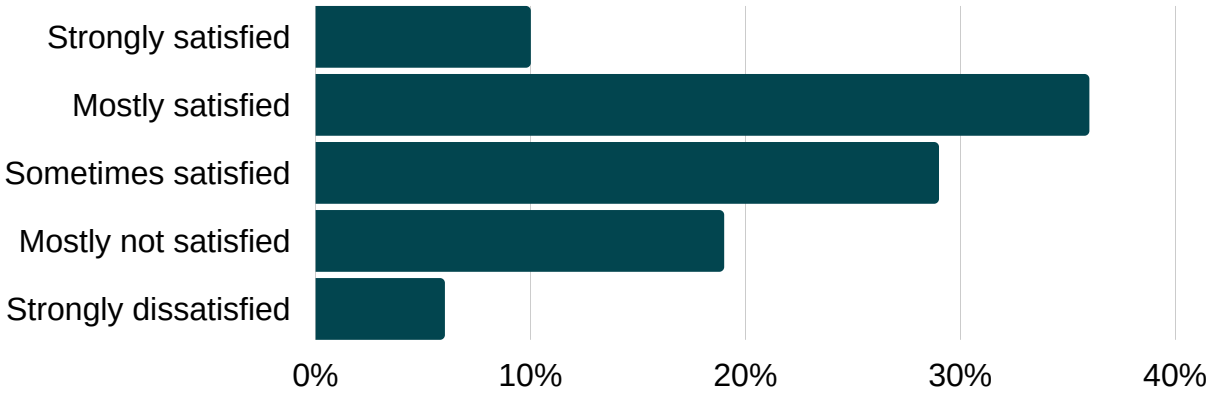
Q: How would you rate the overall health of our community?

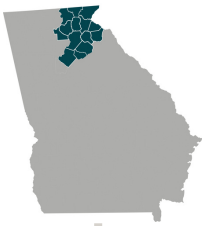


Q: How How satisfied are you with the quality of life in your community?



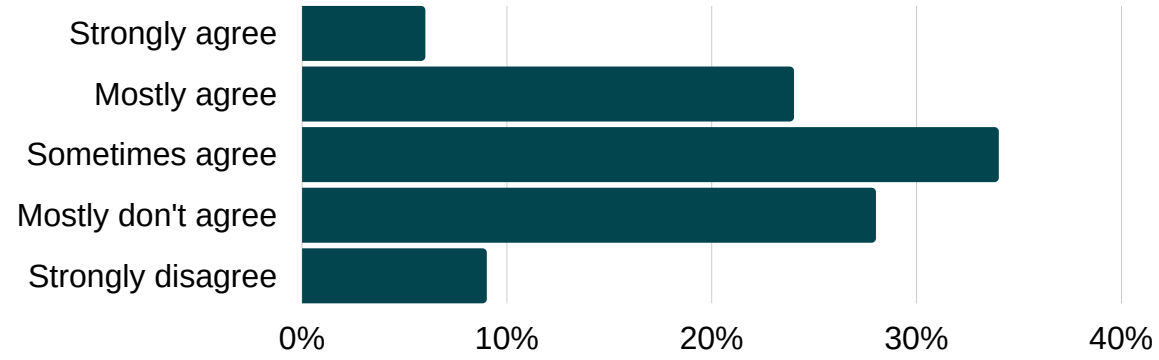
Q: How satisfied are you with the health care system in your community?



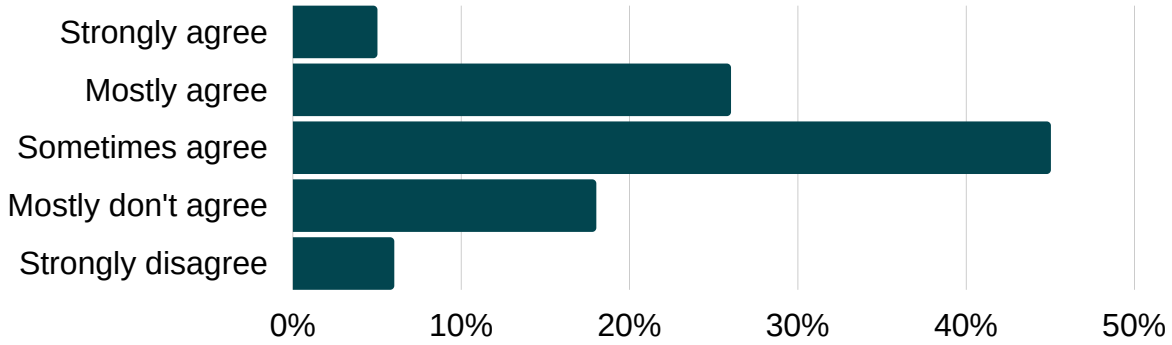


Community Survey

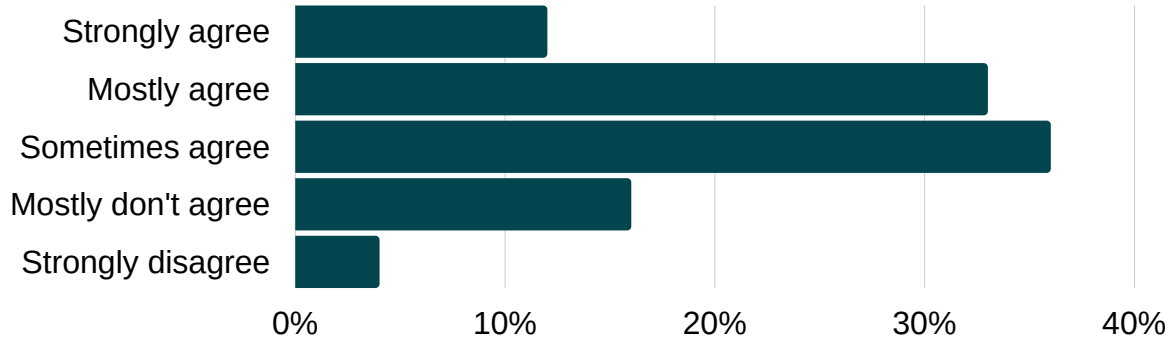
Q: Do you feel there are enough health and social services in your community?

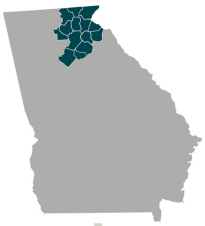


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



Q: Do you feel there are networks of support for individuals and families during times of stress and need?

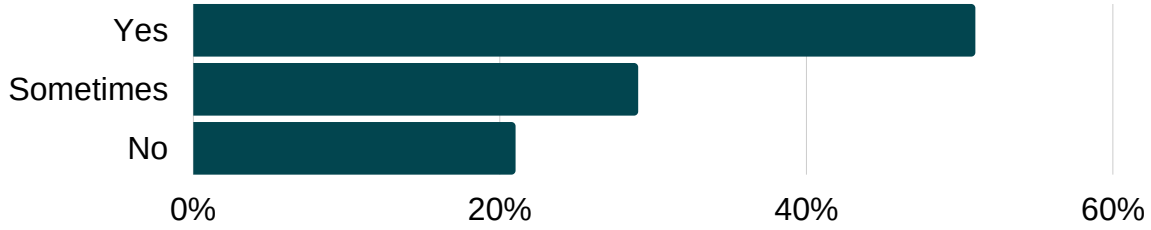




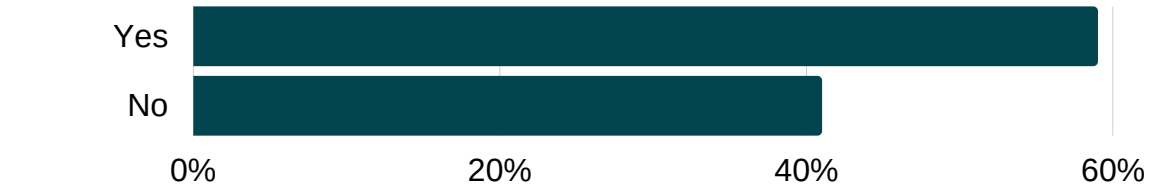
Community Survey

Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?

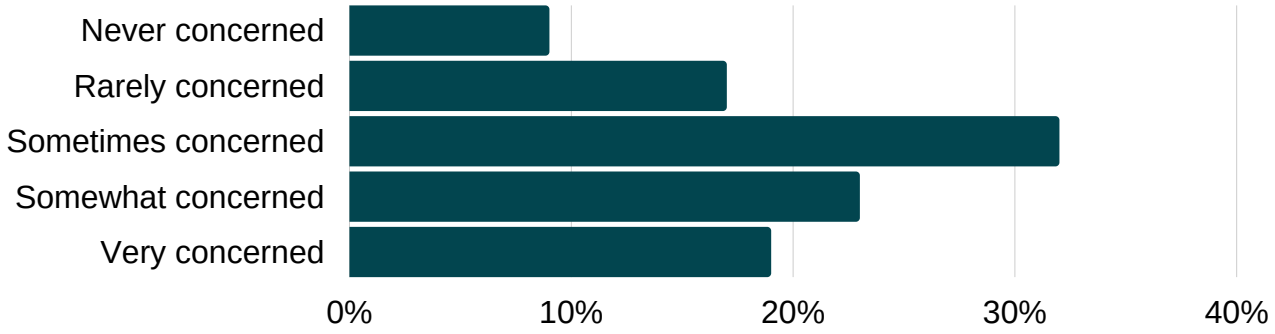
Q: Do you have a hard time paying for medications for you and your family?

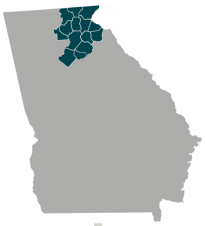


Q: Does anyone in your family currently have medical debt?



Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

The matrix below demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for the HMC service area.

High data + low qualitative

- Access to care: preventable hospitalizations, ED visits
- Cancer, particularly lung
- COPD
- Alzheimer's disease
- Endocrine disease
- Gastrointestinal disease
- Musculoskeletal disease
- Reproductive disease
- Hypertension
- Pneumonia
- Disability
- Education
- Infectious disease
- Tobacco
- Physical activity
- Food insecurity
- Housing costs
- Respiratory disease
- Septicemia

High data + high qualitative

- Access to care: insurance status, cost, providers
- Access to dental care: providers
- Access to mental health care: providers
- Cardiovascular disease
- Diabetes
- Disability
- Fair or poor mental health
- COVID-19: vaccination rates, deaths
- Poverty/income
- Substance abuse and overdose deaths: opioids, fentanyl, alcohol
- Health behaviors
- Mental health: suicide
- Obesity

Low data + low qualitative

- Bone and muscle disease
- Nervous system disease
- Fair or poor physical health status
- Child mortality
- Teen pregnancy
- Segregation
- Social isolation
- Tobacco use

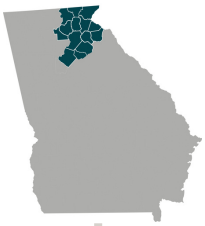
Low data + high qualitative

- Maternal and child health
- Injury
- Violence – child abuse and domestic
- Stigma around mental health*
- Health education and information*
- Employment*
- Homelessness*
- Politics*
- Community growth*

*No quantitative data available

Once the top health needs were identified, CHNA partners completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does an SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

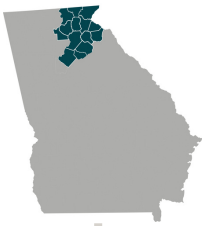
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – Diabetes	14.5
1 – Mental Health: Suicide, Fair or Poor Mental Health	14.5
2 – Access to Mental Health Care: Providers	13
3 – COVID-19: Vaccination Rates, Deaths	12.5
3 – Substance Abuse and Overdose Deaths	12.5
4 – Access to Dental Care: Providers	11
4 – Heart Disease	11
4 – Health Behaviors	11
5 – Disability	10
5 – Poverty/Income	10
5 – Obesity	10
6 – Access to Care: Insurance Status, Cost, Providers	8.5

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting held in May 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental and behavioral health**
- **Access to care**
- **Healthy behaviors**

Although not selected as priorities, there are additional issues of concern for the residents within the Habersham Medical Center service area, including heart disease, obesity, and disability. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



NGMC Primary Service Area

The NGMC Primary Service Area (PSA) for NGMC Gainesville is comprised of Hall County, which is highlighted on the map to the right.

In 2020, 201,434 people lived in the 393 square mile community. This service area was mostly urban, as 79 percent of the combined population lived in an urban setting in 2020.

When broken down by age:

- 25 percent of the population were 17 or younger
- 60 percent were between 18 and 64
- 15 percent were over 65

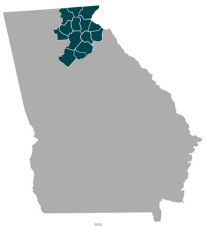
High school graduation rates were high as of 2020, with 86 percent of the area's population graduating. This was on par with the 85 percent of state residents who held a high school diploma. Thirty-one percent had an associate degree or higher, and 15 percent held a bachelor's degree. Approximately 21 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 60 percent were White
- 7 percent were Black or African American
- 29 percent were Hispanic or Latino
- 2 percent were Asian
- 2 percent were either multiple races or some other race

Seven percent of service area residents were veterans in 2020, and the majority were over the age of 65. Fifteen percent of all adults aged 18 to 65 had served in the military, and 13 percent of all men in the service area are veterans, as compared to one percent of all females.

Approximately 12 percent of the service area population lived with a disability in 2020, a rate higher than state and national rates. When separated by age, 34 percent of all adults aged 65 and older lived with a disability that year, as compared to three percent of children and ten percent of adults aged 18 to 64.



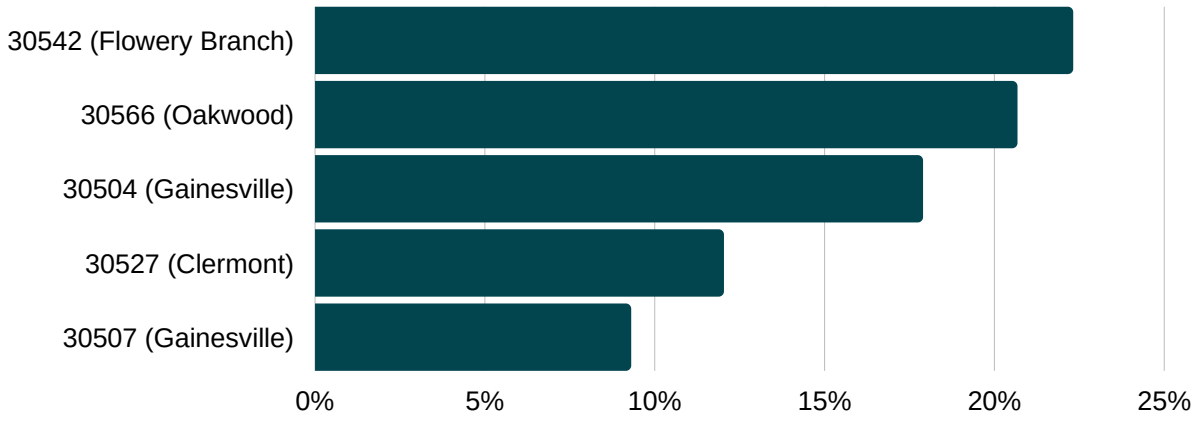
Demographics

In 2020, nearly 16 percent of the population identified as being born outside of the US, and 12 percent did not possess US citizenship status. Of the total population, six percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and older speaks only English at home, or no household member speaks a language other than English at home and speaks English "very well." Spanish was the most common of those languages, followed second by the broad category of Asian languages.

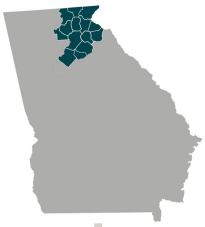
Within the service area, the population increased by nearly 15 percent between 2010 and 2020, which was higher than the state and national population percentage changes of 11 percent and seven percent, respectively.

Minority populations increased far more than their White counterparts, which grew by five percent during that time. By contrast, Black or African American populations grew by 12 percent, Asian populations grew by 32 percent, and Hispanic/Latino populations grew by 22 percent. Those identifying outside those four primary race or ethnic categories grew by 113 percent.

ZIP Codes with the Highest Percentage Change in Populations, 2010 to 2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 25 percent of the service area were children and youth 17 and younger. In the 2019-2020 school year, three percent of children were homeless, meaning nearly 874 school-age children had no stable home at some point that year.

Of all children, 47 percent lived at or below 200 percent of the FPL, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30501 (Gainesville), where 66 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

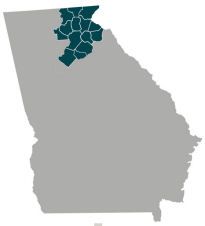
Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also often providing health care and food support. The service area had two Head Start programs, resulting in one program per 10,000 children under five years old in 2020. This rate was far below the state and national rates of seven and 11, respectively. **In 2020, 40 percent of children aged three to four were enrolled in preschool, a rate below the state and national averages of 49 percent and 47 percent, respectively.**

English and Math 4th-Grade Proficiency

Of all students tested, 67 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was worse than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 61 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was worse than the statewide rate of 54 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 29 births per every 1,000 females aged 15 to 19, a statistic much higher than state and national rates of 23 and 19, respectively.**



Income and Economics

In 2020, the average household income was $88,046, which is between the state and national average incomes, which are $85,691 and $91,547, respectively. Within the service area, we see the following variation of average household income, by ZIP codes:

Highest Incomes:

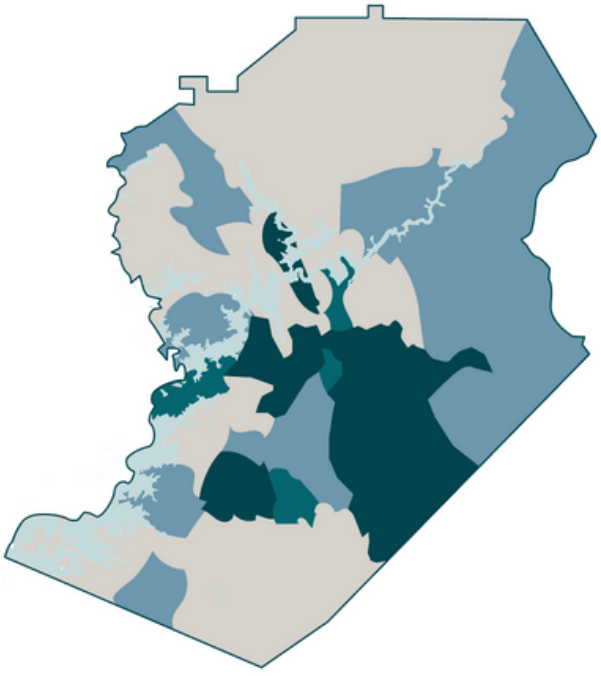
1. 30519 (Buford): $122,277
2. 30506 (Gainesville): $107,378
3. 30542 (Flowery Branch): $105,593
4. 30543 (Gillsville): $80,224
5. 30504 (Gainesville): $79,306

Lowest Incomes:

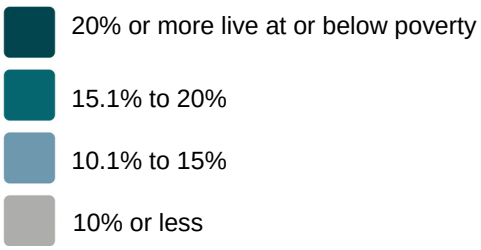
1. 30510 (Alto): $50,258
2. 30554 (Lula): $64,455
3. 30507 (Gainesville): $67,877
4. 30501 (Gainesville): $70,985
5. 0564 (Murrayville): $74,738

Poverty and the Community

Approximately 14 percent of the service area lived in poverty in 2020. That year, the FPL was $26,200 for a family of four. The five poorest ZIP codes within the service area are: 30507 (Gainesville), 30501 (Gainesville), 30566 (Oakwood), 30504 (Gainesville) and 30564 (Murrayville).



The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent the FPL and below.

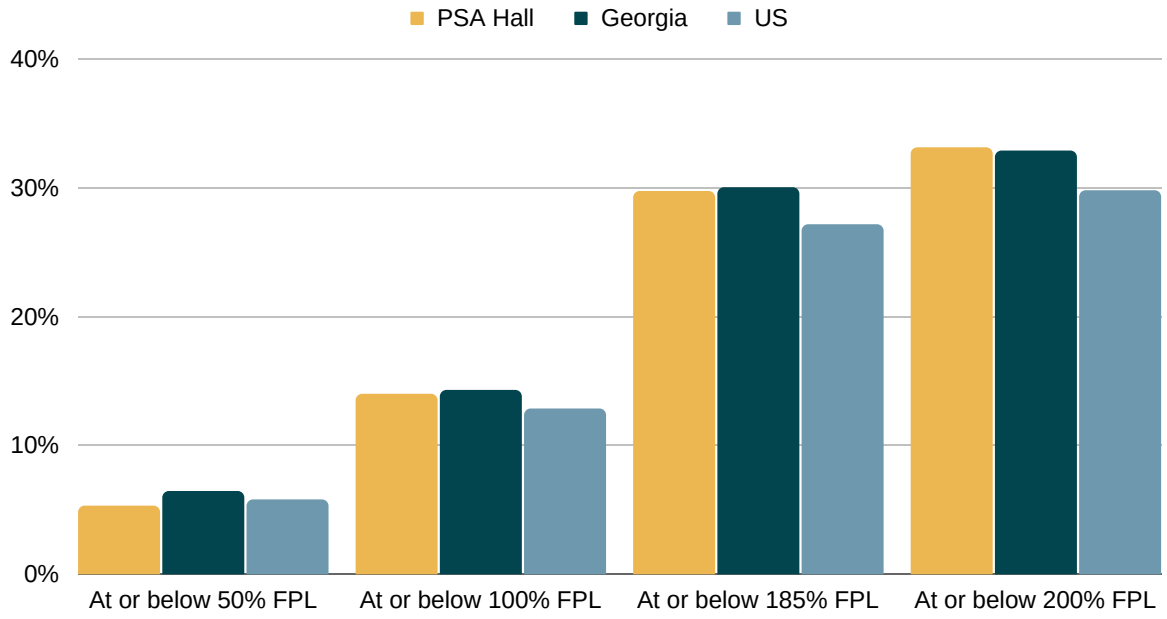


Source: US Census Bureau, American Community Survey. 2016-20.

Income and Economics

Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.

Poverty by Percentage of FPL, 2016 to 2020

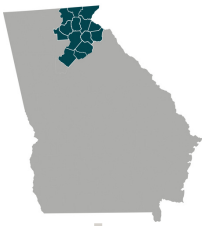


Source: US Census Bureau, American Community Survey. 2016-20.

Public Assistance Income

This indicator reports the percentage of households receiving public assistance income. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP.

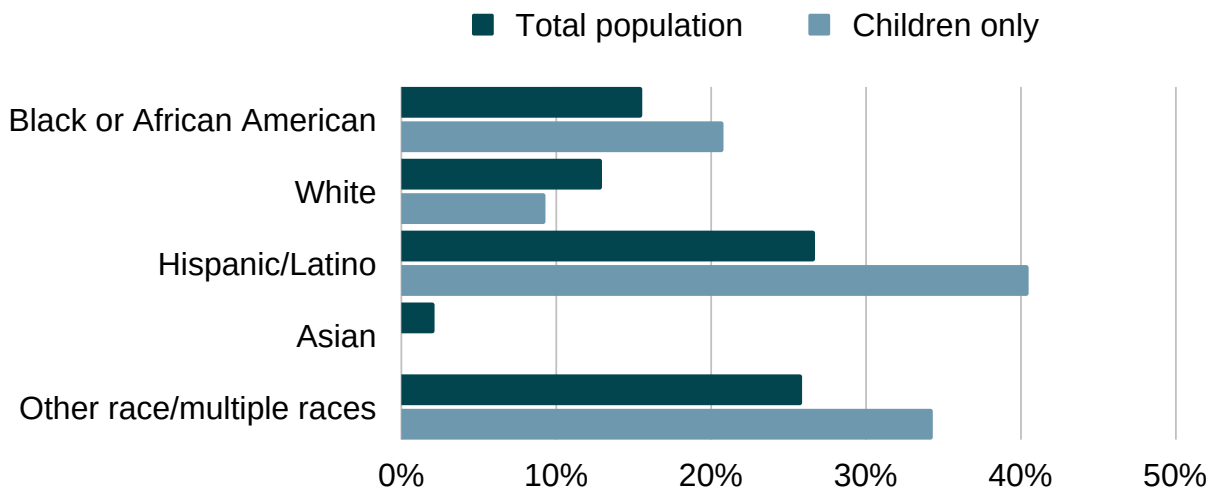
Within the service area, two percent of all households received some form of public assistance. This was on par with the state and national rate of two percent. Within the service area, ZIP code 30507 (Gainesville) had the highest level of public assistance income, with four percent of its population having received benefits.



Income and Economics

When broken down by age and race, the below poverty trends emerge. As demonstrated in the chart below, most minorities within the service area are more likely to live in poverty than their White counterparts.

Populations Living in Poverty, By Race or Ethnicity, 2016 to 2020



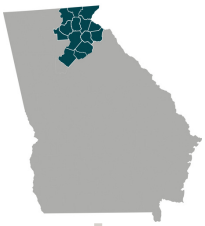
Source: US Census Bureau, American Community Survey. 2016-20. Information was not available for Asian children.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. In the service area, nine percent of the service area's population received SNAP benefits in 2019. The ZIP code with the highest utilization of SNAP benefits was 30554 (Lula), where nine percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Nearly 55 percent of service area children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure slightly below the state rate of 56 percent and far above the national rate of 42 percent. Free or reduced-price lunches were served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. High levels of free or reduced-cost lunch demonstrate areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net gain of 210 businesses. There were 4,108 establishment "births" and 3,898 "deaths" contributing to that change. The rate of change was six percent over the ten-year period, which was higher than the state average of four percent. The area's gross domestic product was $11,879.59 (millions) in 2020, up by about 64 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerge as the largest.

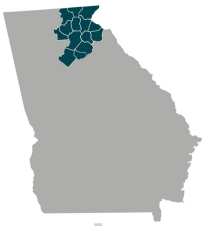
Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Manufacturing	21,397	$61,138
Health care and social assistance	14,920	$68,616
Government and government enterprises	11,574	$62,089

Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

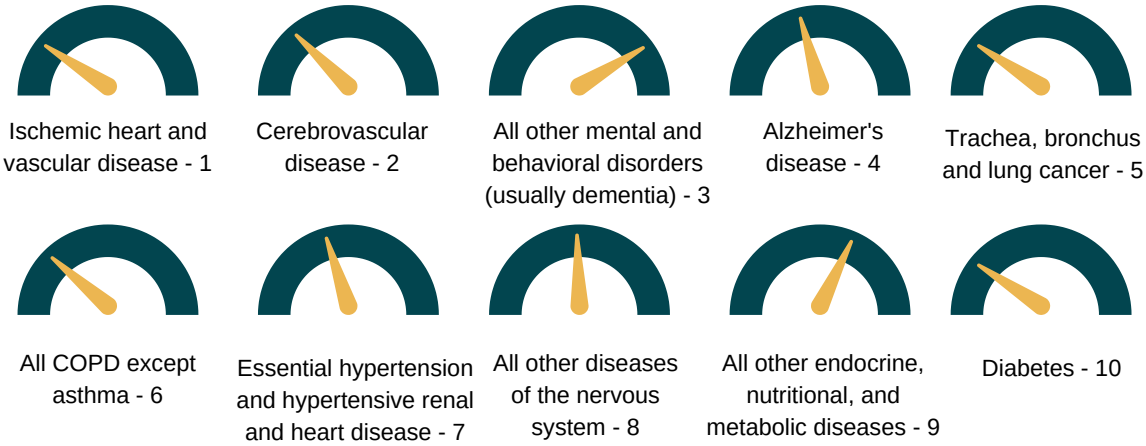
In 2020, the total labor force was 99,244 people, and the labor force participation rate was 63 percent. Total unemployment in the service area in July 2022 equaled two percent. Unemployment creates financial instability and barriers to access, including insurance coverage, health services, healthy food, and other necessities contributing to poor health status. This rate had steadily dropped since January 2021, when the unemployment rate was three percent. In 2021, the unemployment rate was nearly four times less than the rate in 2012.



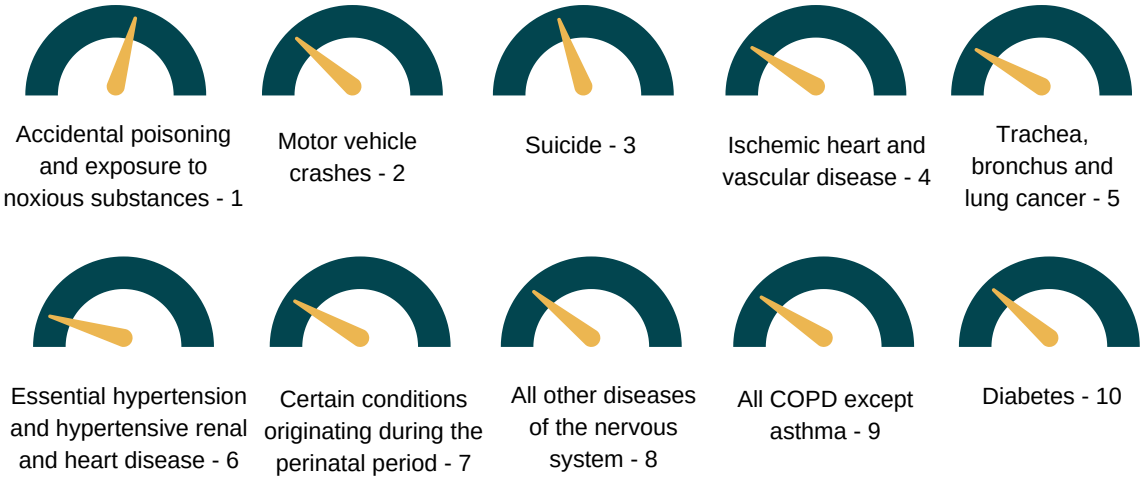
Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

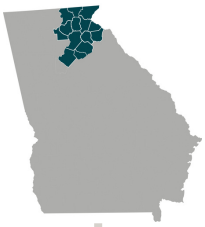
Age-adjusted Death Rates



Premature Death Rates



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022.
Both age-adjusted death and premature death are defined in Appendix Six.



Health Outcomes

Heart Disease

Heart disease was among the leading causes of death in the service area. **Between 2016 and 2020, the age-adjusted death rate was 144 deaths for every 100,000 people, which was better than the both the state average and national average.** Approximately six percent of all adults had ever been diagnosed with coronary heart disease in 2019, a figure that jumps to 26 percent when looking only at Medicare beneficiaries. Both figures have remained somewhat steady over the last decade.

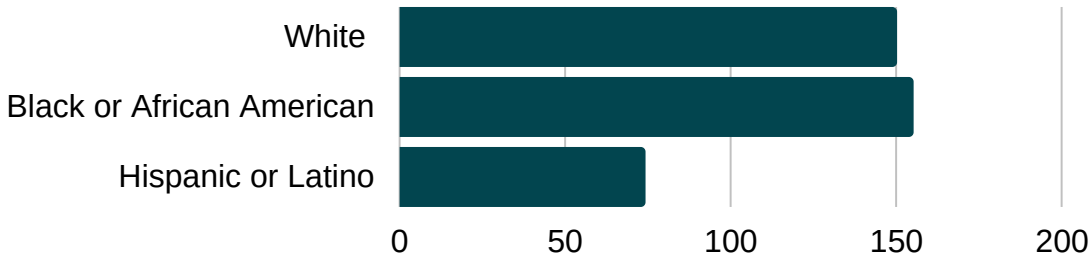
There are similar trends in stroke deaths. **Between 2016 and 2020, the age-adjusted death rate was 40 deaths per 100,000 people, which was better than the state rate of 43 deaths per every 100,000, but worse than the national rate of 38 deaths per every 100,000.**

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was ten hospitalizations per every 1,000 Medicare beneficiaries, below the state and national rate of 12. The hospitalization rate for stroke of 11 hospitalizations per every 1,000 Medicare beneficiaries was higher than the state rate of nine and the national rate of eight.

Cancer

Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 149 deaths per every 100,000 people, which was lower than the state rate of 153 and on par with the national rate of 149. The death rates shift when drilling down to race and ethnicity.

Cancer Deaths by Race or Ethnicity, Per Every 100,000 People

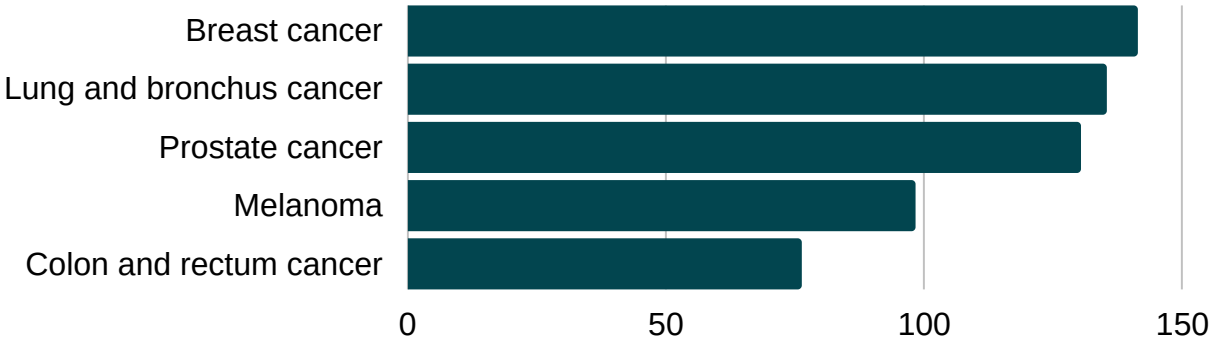


Source: State Cancer Profiles. 2014-18. Please note data was not available for Asian populations.

Health Outcomes

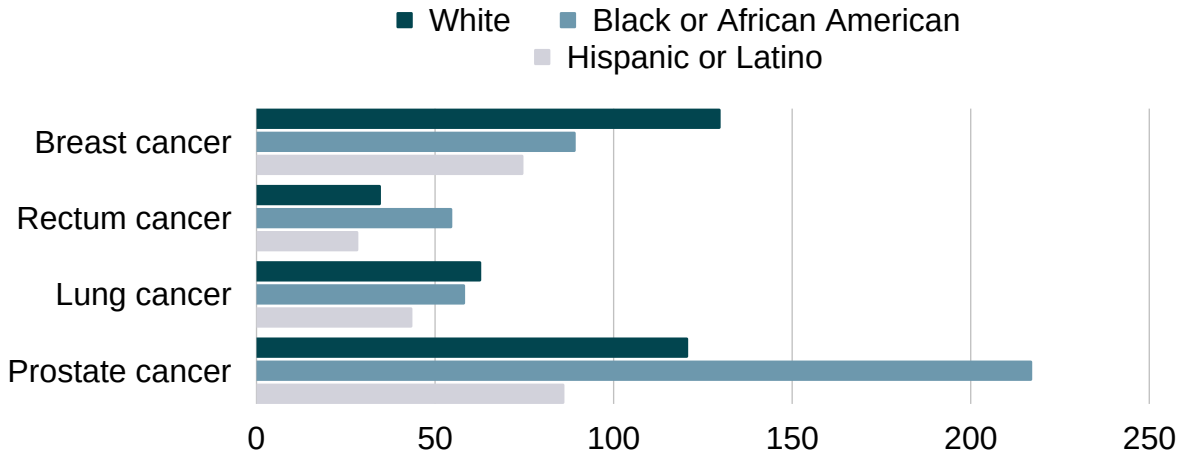
Within the service area, there were an average 1,074 new cases of cancer diagnosed each year between 2014 and 2018, resulting in a cancer incidence rate of 499 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018



When breaking down by race, incidence rates shift. As shown, Black or African American populations had higher incidences of prostate cancer, while White populations had higher rates of breast cancer.

Cancer Incidence by Race, Per Every 100,000 People, 2014 to 2018

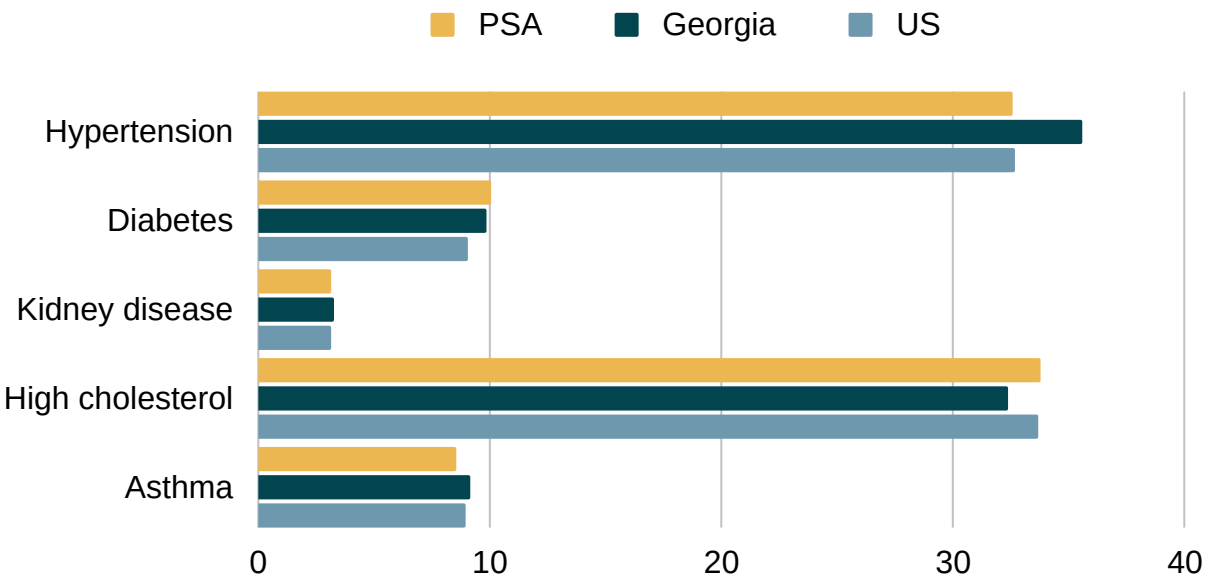


Source for both charts: State Cancer Profiles. 2014-18. Demographic information was not available for Asian populations.

Health Outcomes

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

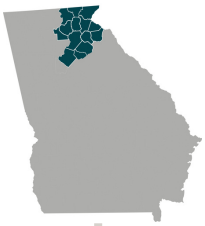
Percent of Population Reporting Key Chronic Conditions, 2018



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 73 percent of all Medicare beneficiaries had multiple chronic conditions, and 18 percent having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note this doesn't equal 100 percent, as some community members had two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
62.89%	14.82%	2.21%	20.11%	20.43%	2.08%

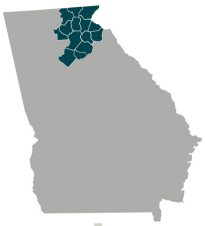
Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

In 2020, a fifth of the population was enrolled in some form of Medicare, which is the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 73, and 12 percent were also eligible for Medicaid due to low incomes.

Medicaid Populations

In 2020, 20 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was on par with the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 39 percent of children under the age of 18, seven percent of those between 18 and 64, and 17 percent of adults aged 65 and older were enrolled in Medicaid.



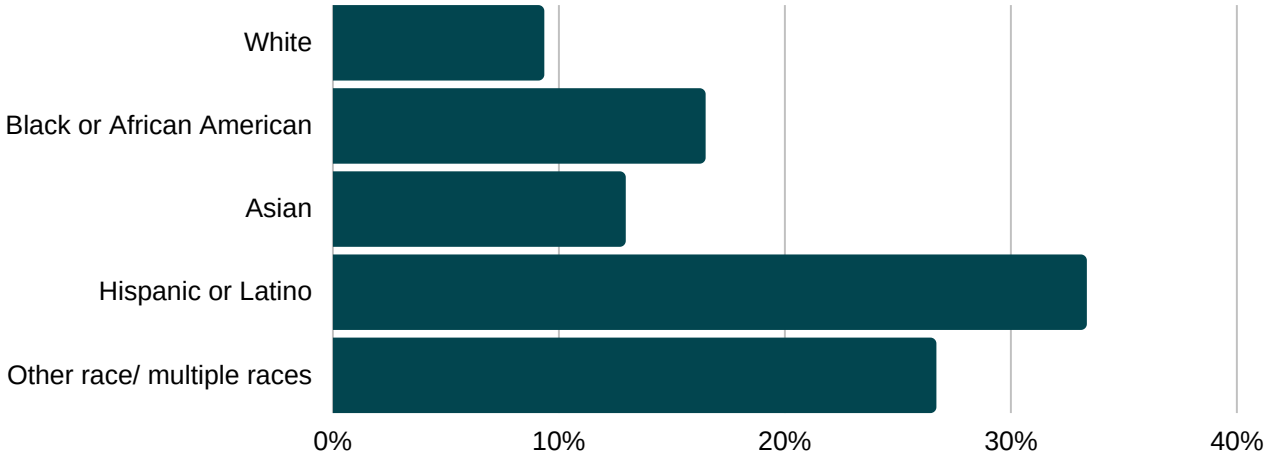
Clinical Care and Prevention

In the service area, on average between 2016 and 2020, 17 percent of the population were uninsured, a figure greater than the state rate of 13 percent and the national rate of nine percent. When looking only at adults aged 18-64, the uninsured rate jumps to 26 percent. **Approximately 11 percent of all children were uninsured in 2020, a figure much higher than the state and national rates of seven percent and six percent, respectively.**

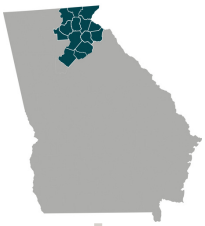
This is a figure, though, that has steadily decreased over the last few years. For example, in 2011, 12 percent of all children were uninsured. This trend was seen across all populations, as the number of total uninsured has steadily declined over the years. For example, in 2011, 31 percent of the service area's non-elderly adult population was uninsured, five percentage points more than in 2020. Even so, the uninsured rate remains relatively high, and likely has a significant impact on the ability of community members to access primary and specialty care.

In PSA, minorities are more likely than their White counterparts to be uninsured. This is particularly true for Hispanic and Latino populations who are three times more likely to be uninsured than White populations.

Uninsured by Race or Ethnicity, 2016 to 2020



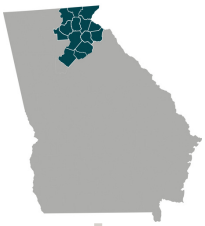
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

In FY21, approximately 1,850 patients received care through the public insurance program Medicaid at NGMC Gainesville. Below is a list of the top ten ZIP codes by volume of patients receiving care through Medicaid coverage at the hospital during the last two fiscal years. Please note the hospital treated Medicaid-covered patients from locations outside of these ten ZIP codes as well.

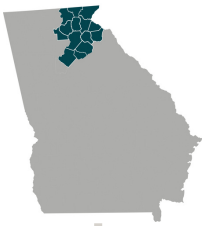
ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30501 (Gainesville)	3,131	30501 (Gainesville)	3,042
30507 (Gainesville)	2,683	30507 (Gainesville)	2,513
30504 (Gainesville)	2,220	30504 (Gainesville)	2,151
30506 (Gainesville)	1,631	30506 (Gainesville)	1,703
30528 (Cleveland)	1,285	30528 (Cleveland)	1,430
30542 (Flowery Branch)	888	30533 (Dahlonega)	1,130
30533 (Dahlonega)	861	30542 (Flowery Branch)	866
30534 (Dawsonville)	620	30534 (Dawsonville)	833
30577 (Toccoa)	618	30577 (Toccoa)	793
30566 (Oakwood)	536	30554 (Lula)	511



Clinical Care and Prevention

Between FY20 and FY21, approximately 2,930 patients received financial assistance for their care at NGMC Gainesville. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years. Please note the hospital provided financial assistance to patients outside of these ten ZIP codes as well.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30501 (Gainesville)	2,806	30501 (Gainesville)	2,618
30507 (Gainesville)	2,104	30507 (Gainesville)	2,005
30504 (Gainesville)	1,765	30504 (Gainesville)	1,700
30506 (Gainesville)	1,416	30506 (Gainesville)	1,372
30528 (Cleveland)	1,041	30528 (Cleveland)	982
30542 (Flowery Branch)	910	30533 (Dahlonega)	856
30533 (Dahlonega)	858	30542 (Flowery Branch)	839
30534 (Dawsonville)	578	30534 (Dawsonville)	584
30566 (Oakwood)	529	30566 (Oakwood)	493
30554 (Lula)	432	30577 (Toccoa)	441



Clinical Care and Prevention

Health Professions Shortages and Provider Ratios

In PSA Hall, as of June 2022, there were two designated Health Professions Shortage Areas: one primary care and one mental health.

- Primary care: There were 60 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 1,059 people within the service area, a measure far worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 2,025 people, a figure worse than the state rate of one provider for every 1,910 people and the national rate of one provider for every 1,397 people.

Primary Care and Routine Check-Ups

In 2019, 75 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, which was on par with both state and national averages. For Medicare recipients, this number jumps to 87 percent of adult beneficiaries, which was above both state and national averages. **Eighty percent of Black populations received preventative care, as compared to 87 percent among other populations.**

In 2018, about 33 percent of men and 31 percent of women aged 65 and older were up-to-date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services. The percentage for men was above both state and national averages, while the percentage for women rests between state and national averages.

Dental Care and Dental Outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status. Within the service area, in 2018, 61 percent of adults went to the dentist in the past 12 months, which was on par with state rates but lower than national rates. **That year, 17 percent of the service area reported having lost all or most of their natural teeth because of tooth decay or gum disease.**

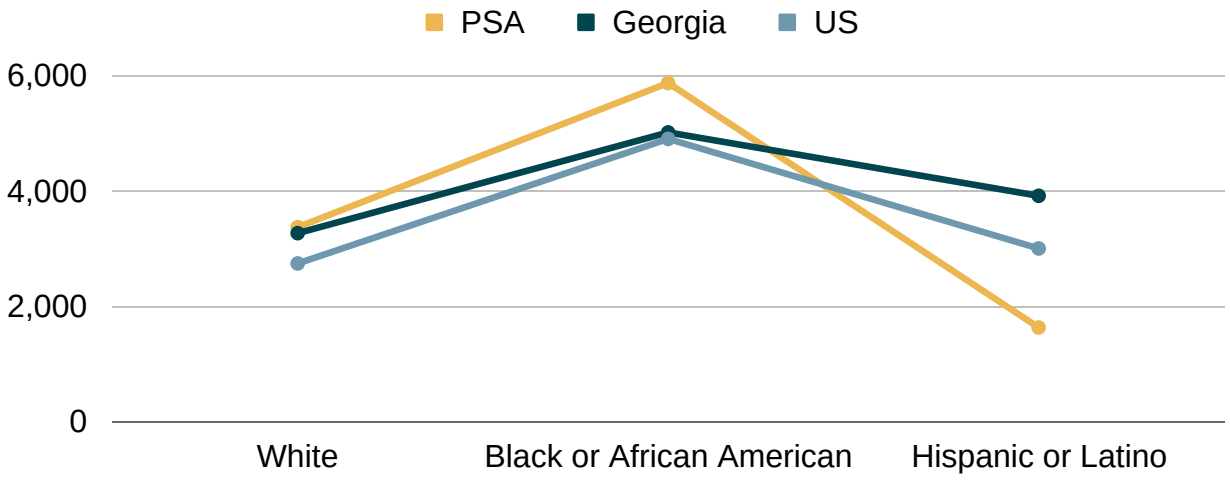
Clinical Care and Prevention

Emergency Department Visits
In 2020, Medicare beneficiaries visited the emergency department 34,588 times, resulting in an ED visit rate of 472 visits per every 1,000 beneficiaries, less than state and national rates of 551 and 535, respectively.

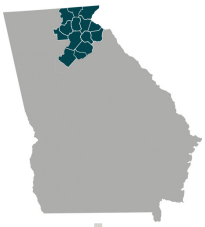
Inpatient Stays
In 2020, 15 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 215 stays per every 1,000 beneficiaries. This was lower than the state rate of 230 and the national rate of 223 inpatient stays during the same time.

Preventable Hospitalizations Among Medicare Beneficiaries
Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,427 per every 100,000 beneficiaries, which was between the state rate of 3,503 hospitalizations and the national rate of 2,865 hospitalizations. As with other health indicators, this value shifts when looking at race or ethnicity.

Preventable Hospitalizations by Race or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020.
Please note data only available for three races.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 42 deaths for every 100,000 people.** This rate was between the state and national averages of 38 and 47 deaths for every 100,000 people, respectively.

Within the service area, the age-adjusted death rate for suicide was 16 deaths for every 100,000 people, which was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. For both deaths of despair and suicide, this was much more prevalent among White populations.

Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data was available, service area residents reported an average of five poor mental health days over the last 30 days, which was on par with the state average of five. Additionally, in 2019, 16 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage was lower than the state rate of 16 percent, but on par with than the national rate of 14 percent. Although the data is not yet available, these statistics likely increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community.

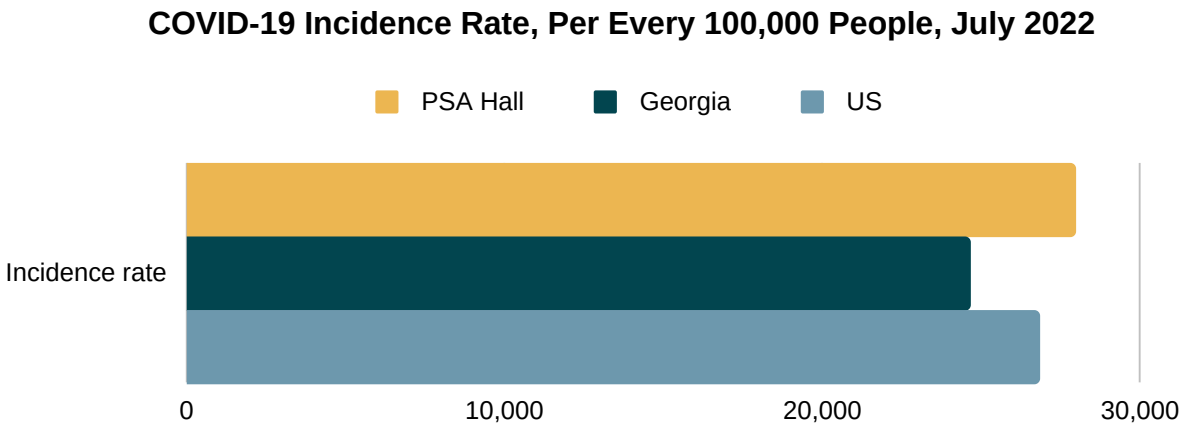
Opioid and Substance Use

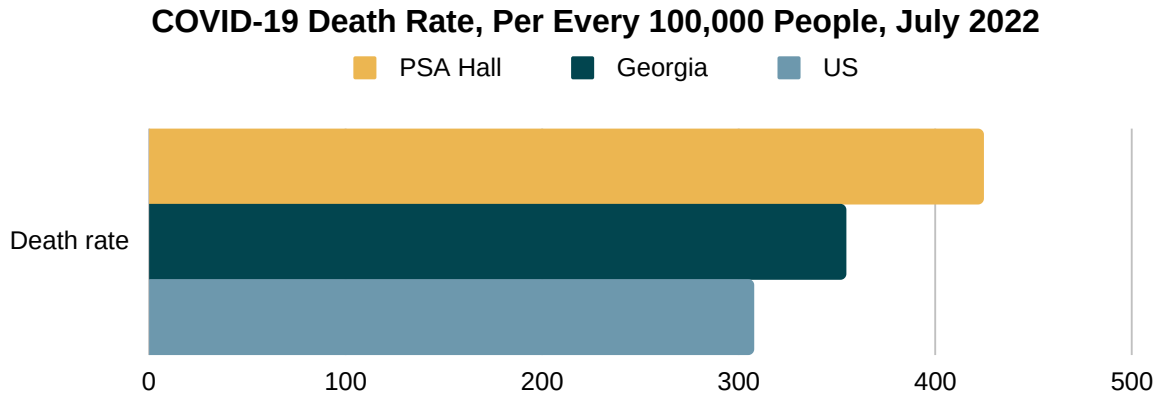
In 2020, providers in the service area prescribed an average 78 opioid prescriptions per every 100 people, which is a figure that has been steadily decreasing each year. Within the service area, the age-adjusted death rate for opioid overdose was 12 deaths per 100,000 people. This was worse than the state average of ten but less than the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

In 2019, Medicare opioid drug claims accounted for six percent of total prescription drug claims. This percentage was higher than the state rate of five percent and the national rate of four percent, respectively.

COVID-19

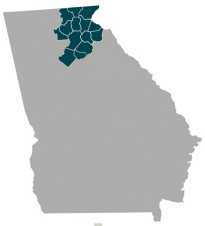
In PSA, as of July 2022, both COVID-19 incidence rates and death rates were above national averages.





Source for both charts: Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES. 2022.

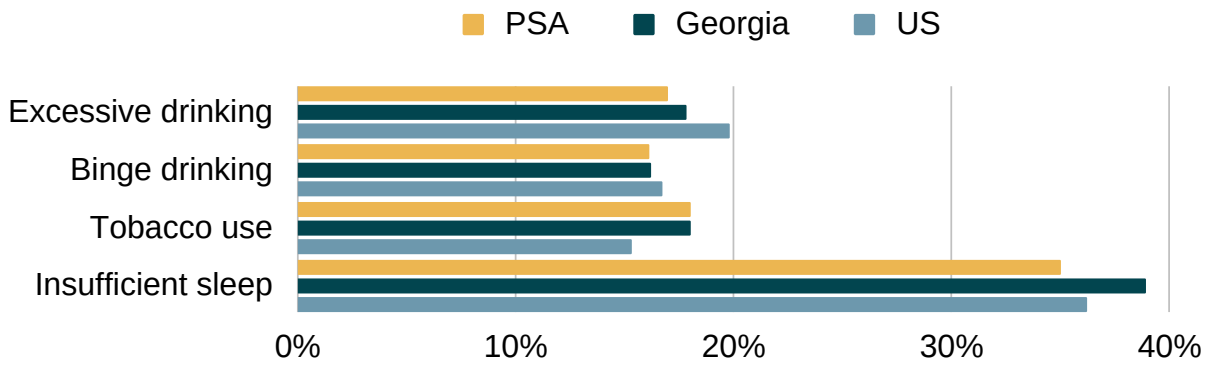
Approximately 56 percent of the service area was fully vaccinated as of July 2022, with an estimated 15 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.63, which is a score of how challenging vaccine rollout may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).



Health Behaviors

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

Percent of Population Reporting Unhealthy Behaviors, 2019

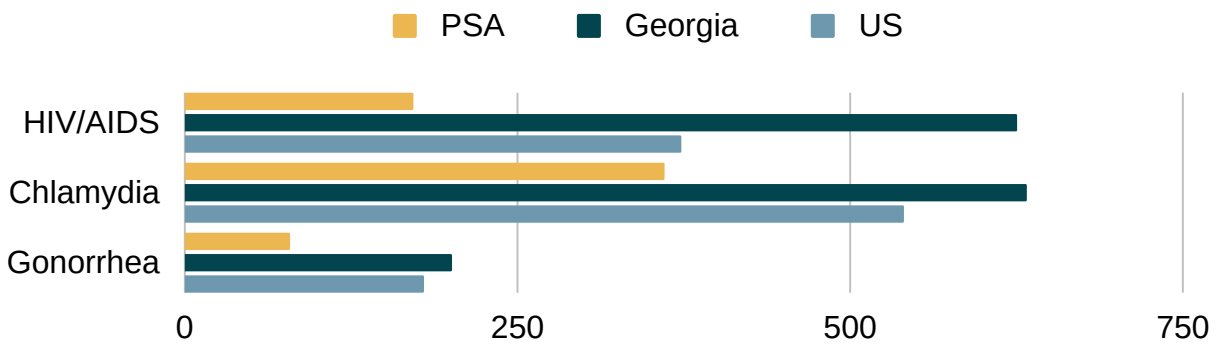


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates are generally below that of state and national rates.

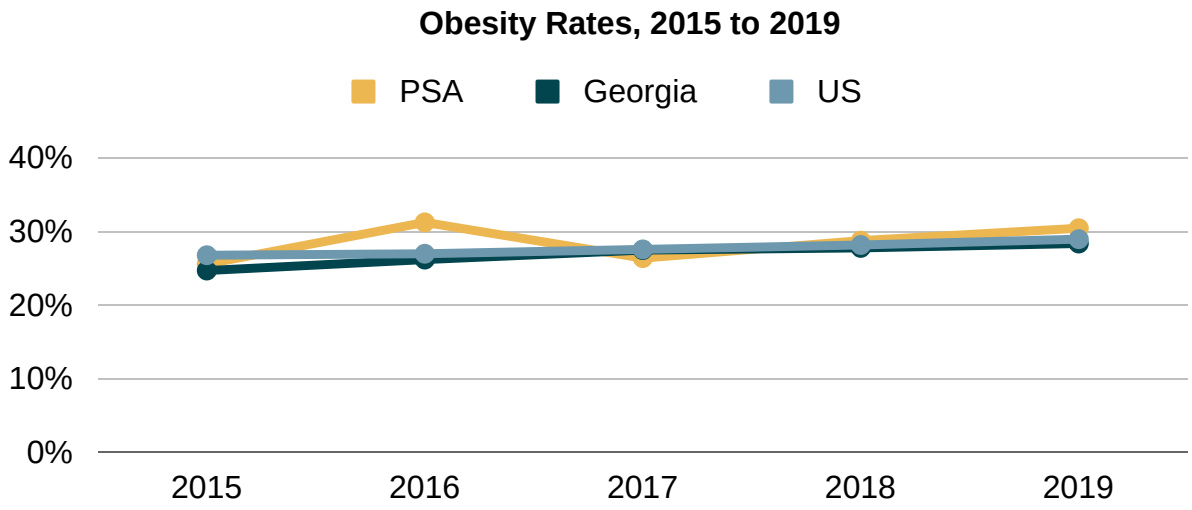
Sexually Transmitted Disease Rates, per every 100,000 people, 2018



Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.

Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. **In 2019, 30 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 or more.** Obesity rates have generally increased over the last ten years. Obesity is directly linked to several health issues, including diabetes and heart disease.



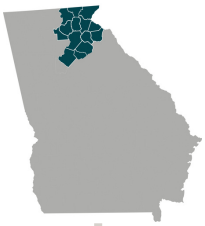
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

Within the service area in 2019, 25 percent of adults aged 20 and older self-reported no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Walking or Biking to Work

Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if it is by choice. In 2019, approximately one percent of the service area's population walked or biked to work. Certain ZIP codes saw higher physical commutes such as 30501 (Gainesville), where 652 people walked or biked to work in 2019.

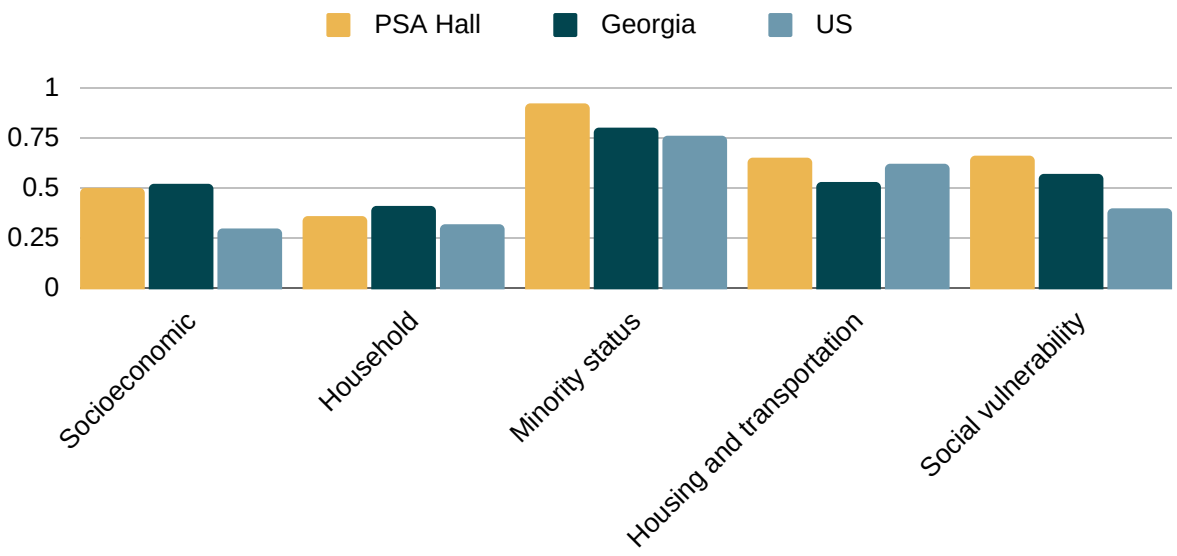


Socioeconomic Factors: Social Vulnerability Index

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

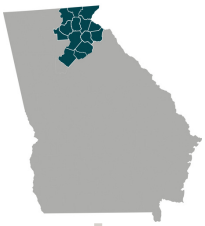
The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. The service area had a social vulnerability index score of 0.66, higher than the state score of 0.57 and the national score of 0.40.

Social Vulnerability Index, by Theme, 2018



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

A particular area where the service area scored poorly was minority status, meaning minorities -- specifically Black and Hispanic or Latino populations -- tend to experience worse conditions in the service area. Generally, they have lower-incomes, live more in substandard housing, have higher rates of obesity, have a higher incidence rate of diabetes, are more likely to be hypertensive, and generally have poorer health outcomes.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person's physical and mental health.

The average monthly owner cost for a home within the service area was $1,200 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $1,041. COVID-19 significantly impacted housing, so these figures have likely increased since then.

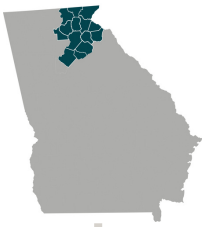
Cost-Burdened Households

Of all occupied households in PSA Hall, 27 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately twelve percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.

Renters bear the strain of this the most, with 45 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure drops to 25 percent. **Approximately 59 percent of renters pay rent that is at least 50 percent of their household income.**

Substandard Housing

This indicator reports the number and percentage of the owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. **Approximately 29 percent of all households in the service area had one or more substandard conditions. This was lower than the state and national averages of 30 and 31 percent, respectively.**



Socioeconomic Factors: Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially if they are already low-income.

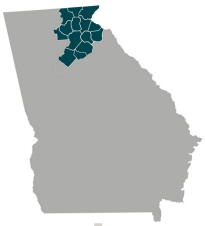
Communities that lack affordable and nutritious food are commonly known as “food deserts.” The service area has four food desert census tracts, meaning about 19,000 people did not have ready access to healthy foods.

The map to the right demonstrates food deserts within PSA. The darker the color, the more prevalent the issue.

Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The service area has a food insecurity rate of eight percent, meaning those community members were unsure how they will access adequate food at some point over the last year. That said, many of these community members are ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school meals, the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all food-insecure children in the service area, approximately 29 percent were ineligible for any public assistance.

Low food access is defined as living more than half a mile from the nearest supermarket, supercenter, or large grocery store. According to the 2019 Food Access Research Atlas database, **25 percent of service area residents had low food access that year, meaning those community members likely struggled to access healthy foods.**



Community Input

On February 07, 2022, 38 members of the NGHS Advisory Committee convened to discuss the CHNA and community needs, having already completed an online survey soliciting their thoughts on community health. During the meeting, NGHS Community Health Improvement Director Christy Moore and The ThoMoss Group CEO Phillippa Lewis Moss provided board members with a project overview. Members were then assigned to one of four breakout rooms representing the NGHS service area where they live, work and/or volunteer.

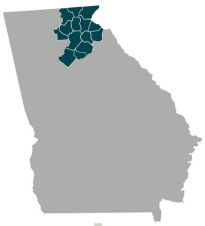
Once in the breakout room, participants were greeted by a facilitator from The ThoMoss Group. Each facilitator shared the responses from the online survey for the service area and then led the group through an exercise that narrowed the survey answers to three top responses.

PSA was described as:

- A caring and benevolent community with many non-profit organizations, churches, and civic groups that work together and give their time, talent, and financial resources.
- A generous community. Attendees commented on the philanthropic nature of so many community members and their willingness to help others.
- Disconnected and shallow, where resourceful community members make their obligatory contribution without ever truly understanding the social determinants of the health which causes the harm they seek to repair.
- An area can offer opportunities and challenges as long as it continues to grow culturally and economically.

PSA Hall’s most pressing gaps impacting the community's health involve issues of equity and access. It is a community of “the haves and the have-nots.” Participants in PSA-Gainesville identified mental health as an important health issue. Many community members are either unaware of the problem or don’t realize the community is in a crisis. There is a belief that more must be done to spread the word and eliminate the stigma. Lastly, given the fast-growing aging population, the availability of long-term care resources was also identified as a priority issue. The underlying health issues facing the community are numerous.

Still, the top three issues are lack of affordable housing and social and racial isolation made worse by the COVID-19 pandemic. Participants believe there should be attention given to



Community Input

vulnerable groups, including the poor and economically disadvantaged, and elderly residents who cannot afford assisted living or in-home caregiving. The barriers that prevent clients from seeking health care include the high cost of healthcare, such as deductibles and out-of-pocket expenses. When asked about current events such as COVID-19, participants noted that church attendance and offerings had dropped by 70 percent.

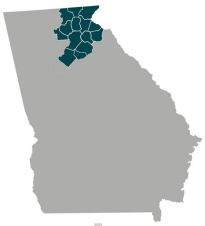
Participants also expressed concern about the increase in animosity directed toward Asian-Americans. Participants highlighted that United Way, Newtown Florist Club, and other organizations are taking steps to improve communication with law enforcement, advocate for vulnerable populations, and encourage community-wide dialogue regarding equity, diversity, and inclusion.

PSA has many community resources, including:

- Brenau Mental Health–Sliding scale services
- Church-First Baptist
- Church-First Presbyterian
- Church-Gainesville First United Methodist
- Education from NGMC
- Food Bank of Northeast Georgia
- Food Pantries
- Food-Chattahoochee Baptist Association
- Food-Faith-based Pantries
- Food-Free Chapel Sunshine Seniors
- Food-Georgia Mountain Food Bank
- Food-Good News at Noon
- Food-Hispanic Alliance
- Gateway House
- Good News at Noon
- Good News Clinics
- Hall County Health Department
- Lakewood Baptist
- Legacy Link
- My Sister's Place
- NGMC Indigent Care
- North Georgia Food Bank
- North Georgia Works!
- P.I.T.C.H. Program
- United Way Compass Center

The community's behavioral health resources include:

- 211
- Avita Community Partners
- Brenau Psychology Department
- Churches
- Good News Clinic
- Laurelwood
- NAMI
- Northeast Georgia Health System
- Police Education for Mental Health
- Private Counselors
- PTSA Organization
- Rape Response and similar agencies
- United Way's Mental Health First Aid Training



Community Input

On February 08, 2022, a focus group of 13 Hall County Family Connection Network (HCFCN) members were convened. When asked to rate the community's health on a scale of one to five, HCFCN members scored 3.3. HCFCN members also view Hall County area as caring. There are several non-profit organizations and a robust health system. In direct contrast to this descriptor, participants noted that the community is also one of haves and have-nots.

The community's most prevalent conditions or diseases were mental health and diabetes. When asked what is most concerning about the community's health that may be preventing it from achieving an excellent health status, respondents said a lack of affordable care/insurance. The top three unmet health service needs are mental and behavioral health, access to care, and insurance. Some underlying causes of the community's health issues include food insecurity and bad eating habits. The poor are the most vulnerable population that health systems should pay special attention to. The lack of insurance is the most significant barrier preventing HCFCN participants, their clients, or other community members from seeking health care and improving their health.

The community’s faith-based resources include the following:

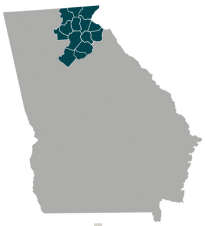
- United Way
- Good News at Noon – separate from Good News Clinics
- St. Vincent de Paul
- North Georgia Works!
- My Sister’s Place
- St. Johns – Food bank
- Good Samaritan – Food bank

What are your community’s free or low-cost clinic resources?

- Avita Community Partners
- The P.I.T.C.H. Program, in which paramedics assist community members in various ways to help avoid preventable emergency department visits

What are your community’s food pantry resources?

- Salvation Army
- Good Samaritan
- United Way – Outdoor pantries, giving pantries



Community Input

When asked to reflect on current events such as COVID-19 and their impact on the community, participants spoke at length about COVID-19 sickness and death. People were impacted personally and professionally, having lost family, co-workers, or extended family. Some philanthropic legends were lost to COVID-19. Some businesses had to close and may never return.

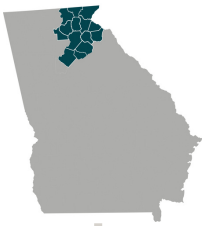
When asked to reflect on social issues, community members said:

- The United Way's One Hall Initiative was innovative in discussing difficult topics such as race.
- There is a lopsided perception that subsidized housing favors underserving and problematic individuals.
- There is concern about the increased hatred directed toward Asian-Americans.
- Young people in Gainesville City Schools seem more knowledgeable and understanding of these issues than many adults.
- The Newtown Florist Club has done a great job advocating and promoting change.

Newtown Florist Club Focus Group

On February 26, 2022, Phillippa Lewis Moss of The ThoMoss Group facilitated a focus group session with a group of eight African American community members brought together by the Newtown Florist Club to discuss the health issues/concerns of the Black community. When asked to rate the health of our community on a scale of one to five, participants provided a score of three. The top health issues facing the African American community include the health outcomes produced by fear, unhealthy lifestyle, high blood pressure, diabetes, poor eating habits, and lack of exercise.

Barriers to good health include a lack of insurance and difficulty accessing doctors. Opportunities to improve the health of the community include health education. Significant emphasis was placed on the importance of people creating healthy lifestyles (slowing down, avoiding stress, proper meal preparation, staying connected). Single parents are particularly at risk for poor health outcomes because they do so much for their children and others. There is a need for greater access to healthy food by having more neighborhood grocery stores and vegetable stands. When asked about the impact on communities due to current events such as COVID-19, participants described their experience of COVID-19 as a "journey" for everyone in the community.



Community Input

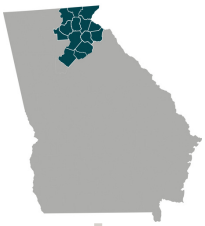
It challenged public health agencies and the health system to make messages concise. There were lessons that can be applied to other programs. Participants acknowledged that some of the trust issues are a function of poor communication between providers and community members. Education and relationship building with providers is essential.

The top barriers to good health in the African American community include a lack of transportation and access to parks and places to exercise. There is a need for accessible community centers, pools, and walking trails. Additionally, some people fear going to the doctor or hospital. Medical professionals must explain medical conditions to patients so that the patients understand them. It is also important to build relationships with the patients to create trust. Opportunities for the health system to improve the health of the African American community include health education, disseminating information about community resources and encouraging fathers to be in the household to lessen the burden on mothers and offer emotional support to the children.

Participants acknowledged that mental health, behavioral health, and substance abuse issues continue to plague the community. There is great concern about children in the community and how they deal with stress. The last three to five years have particularly stressed the African American community. Depression and anxiety are on the rise. Substances that are being abused include marijuana, alcohol, crack, and cocaine. Young people are also starting to vape.

There are also significant mental abuse, unhealthy lifestyles, and people suffering from past traumas. The unexpressed weight African Americans carry regarding education, law enforcement, and housing can create mental health stress and impact physical health. If they can access help, there’s the issue of clinical cultural competence, which deserves more in-depth work. Another issue impacting the health of African Americans is the lack of trust in utilizing services and facilities. Some of this trust reflects actual experiences that older generations have passed down. Some individuals are fearful of doctors and medicines.

The community is concerned that health providers are over-medicating African American patients. Some community members seek care outside of the area for maternal care and prostate issues. Participants shared that many African Americans sought information from



Community Input

state and national organizations when asked about the community impact of current events such as COVID-19. In hindsight, there was a disconnect between the initial messaging that COVID-19 disproportionately impacted Latinos, only to learn later that African Americans were dying at a much higher rate than Latinos and others. When asked if African Americans feel welcome at the hospital and other provider offices, participants confirmed that they feel welcome; however, confusion occurs once an individual is in the exam room. There is a need for greater communication between the staff and the patient to describe the appointment process so that expectations are set and managed.

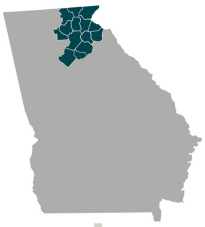
Hispanic Alliance Focus Group

On March 28, 2022, Phillippa Lewis Moss from The ThoMoss Group led a focus group of 23 participants representing the Latino community of PSA. When asked to describe the Gainesville community, participants spoke about the cultural diversity of the area as well as the beauty of the land/geography.

The group also spoke to the complexity of the Latino community. While Latinos have many shared experiences, they are also very different, complex, and layered. For example, multiple languages and dialects are spoken within the Latino community. Some experienced frustration when receiving an official communication from the school, health system, or other entities that overlooked important language and dialect distinctions and instead used faulty computer-generated translation. Latino community members often are not getting “correct” information. Several participants expressed a desire for non-Latino community members to become curious about who they are and spend time getting to know and understand them.

There is also an unfair perception that Latino students and their parents are uneducated because they have not mastered English. At the same time, some Latino individuals bring unique customs, rituals, and even health remedies with questionable outcomes. Sixty-six percent of the Latino community is poor and experiencing poor health.

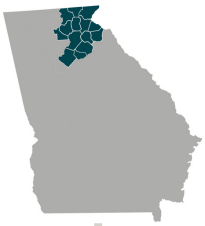
The lack of accurate information, non-traditional work hours, and language barriers prevent some Latinos from accessing good health care services. Many clinics and community service providers close between 5 and 7 pm. The group expressed frustration that many community resources are unavailable to undocumented residents. Some service providers are not



Community Input

friendly and can be off-putting to Latino community members. Fortunately, the Hispanic Alliance is a great resource for many Latinos. Many Latino individuals get their health information and other news via social media, including Facebook, Twitter, and Instagram. Many Latinos do not read mainstream newspapers or listen to local news stations.

Participants repeated concerns expressed by other focus groups that PSA is a community of haves and have-nots. Many wealthy people live in a bubble and are unaware of the barriers that many in the Latino community face. When asked to identify the top health issues, participants identified obesity, women's healthcare, mental health, preventative care, prenatal care, and pediatric care. Some participants indicated that there is still a stigma surrounding mental health. However, those willing to avail themselves of services cannot find bilingual service providers and must wait months for attention.



Community Input

As part of the qualitative data gathering process, 16 community members were interviewed during February and March 2022 to solicit their input on community health. Below is a summary of themes that emerged from those interviews.

Barriers to health:

- Lack of transportation
- Lack of/inadequate insurance
- Poverty
- Lack of affordable housing
- Lack of affordable nutritious foods

Gaps in health services:

- Mental health
- Self-care education
- Diabetes
- Pediatric care
- Nutrition

Opportunities to improve health:

- Health education

Sources of health information:

- Social media
- Internet
- Facebook
- Word of mouth
- Service providers

Populations most impacted by barriers:

- Hispanic/Latino populations
- The elderly
- Minorities
- Migrant populations
- Indigent populations

Top health needs:

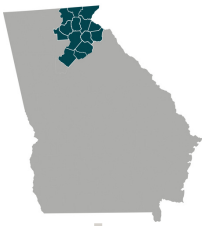
- Health education
- Mental health
- Diabetes
- Geriatric/elder care
- Indigent care

Gaps in mental health and vulnerable populations:

- Hispanic/Latino populations
- Indigent and homeless populations
- Teens and young adults
- Sex-trafficked individuals
- The elderly

Gaps in mental health:

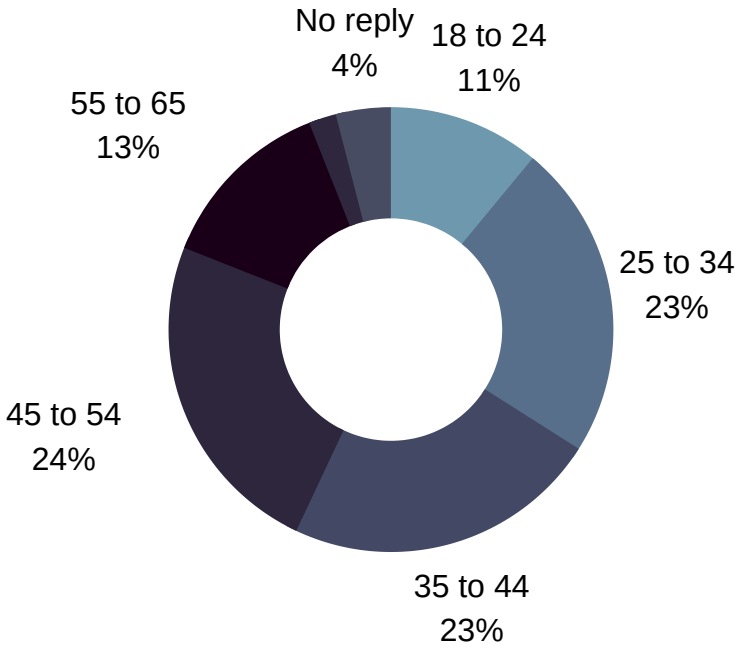
- Affordability
- Stigma
- Access
- Education



Community Input

From February to March 2022, staff of Good News Clinics, District 2 Health Department and Gainesville Public Housing conducted face-to-face interviews with 190 clients in the NGHS primary service area of Gainesville. The brief four question survey was designed to gather respondents' perception of how well their health care needs were being met and what, if any, obstacles interfered with their needs. Demographic information and answers are below.

Age of respondents:



Gender:

- 58 percent female
- 5 percent male
- 37 percent didn't reply

Race/ethnicity:

- 42 percent Latino or Hispanic
- 20 percent White
- 7 percent Black or African American
- 31 percent didn't reply

Health insurance:

- 20 percent had health insurance
- 71 percent did not
- 9 percent didn't reply

Q: What are your most pressing health problems?

- Annual check-ups
- Cardiology care
- Prenatal care
- Dental care
- Blood pressure

Q: How well are your health needs being met?

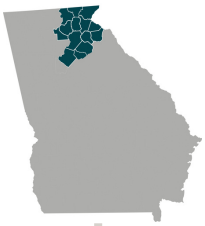
- 75 percent: Somewhat well
- 10 percent: Somewhat poorly or poorly
- 15 percent: Didn't answer

Q: What are barriers to good health?

- Insurance: lack of, inadequate, co-pays
- Money
- Transportation

The top five reported health issues:

- COVID-19
- Diabetes
- Obesity
- Alcohol and drug addiction
- Cancer



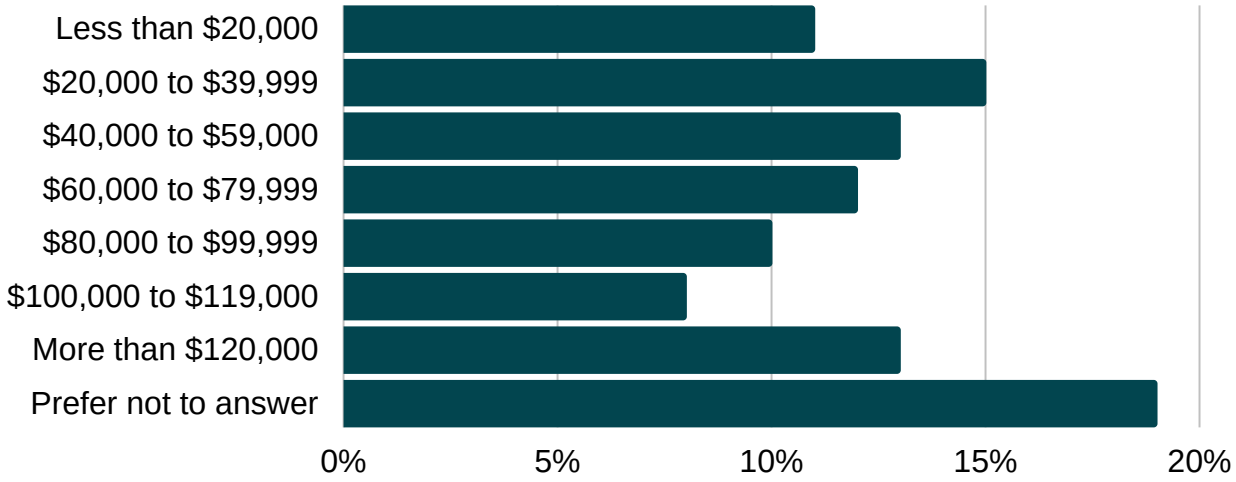
Community Survey

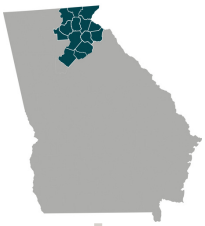
In March 2022, approximately 885 community members living within PSA completed an electronic community-based survey widely advertised to the community via partners' websites, press releases and social media. All survey questions can be found in Appendix Eleven. Please note that the following survey data was for selected indicators. All answers from the survey can be found online at **nghs.com/community-benefit-resources** via the Tableau data tool.

Of all respondents:

- 69 percent were female, 27 percent were male, 1 percent identified outside those two genders, and 3 percent preferred to not answer
- 86 percent were White, 6 percent were Hispanic or Latino, 4 percent were African American or Black, and 4 percent preferred not to answer
- 3 percent were 25 or younger, 7 percent were between ages 26 and 34, 9 percent were between ages 35 and 44, 16 percent were between ages 45 and 54, 22 percent were between ages 55 and 64, and the remaining 42 percent were 65 and older; 1 percent preferred to not answer
- 95 percent had some form of health insurance and 87 percent lived in households where all members had some form of health insurance

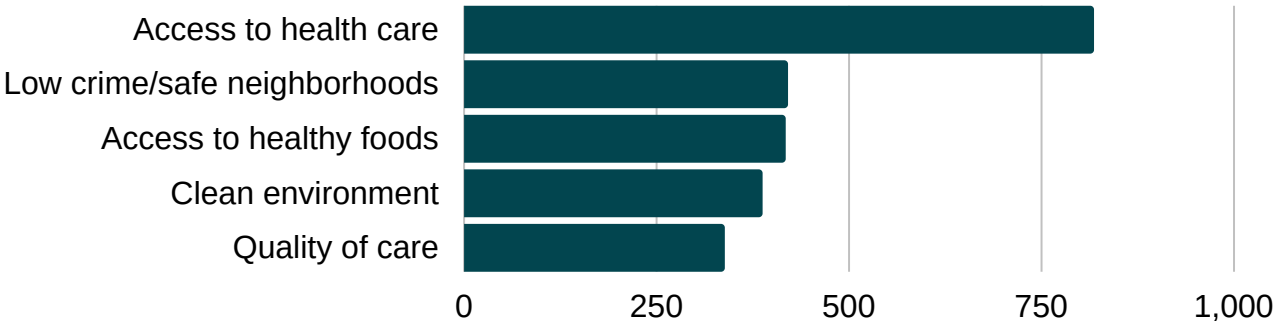
Below is a breakdown of the annual household income for all respondents.



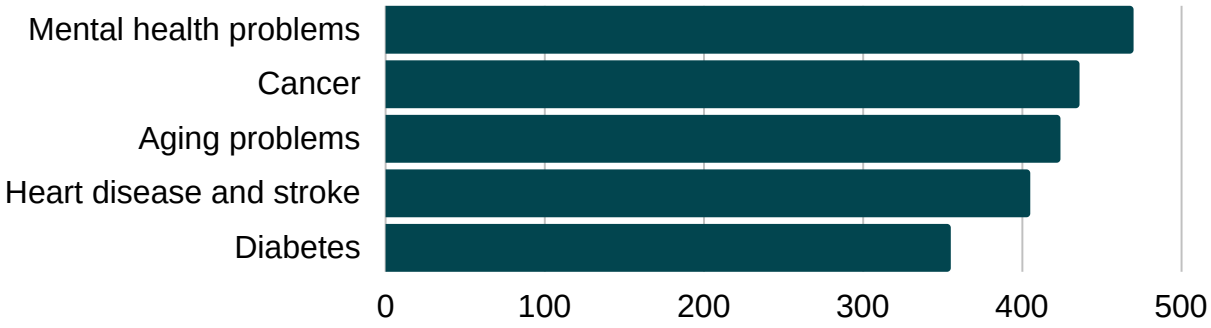


Community Survey

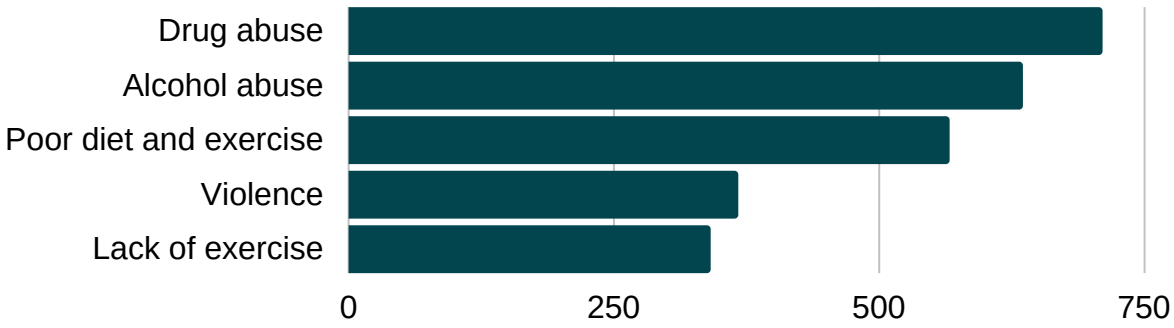
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. Below are the top five answers.

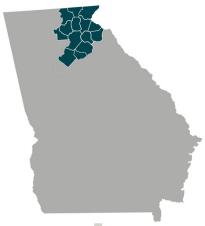


Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. Below are the top five answers.



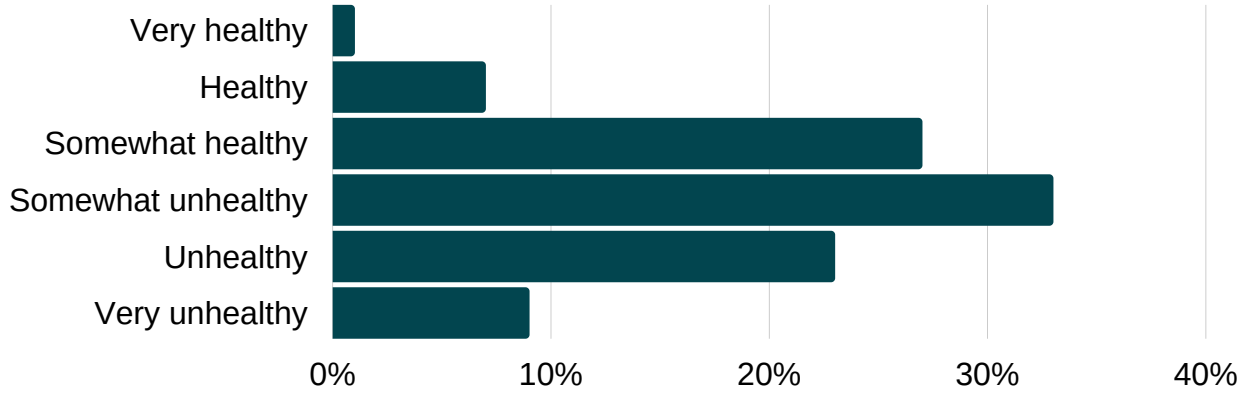
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. Below are the top five answers.



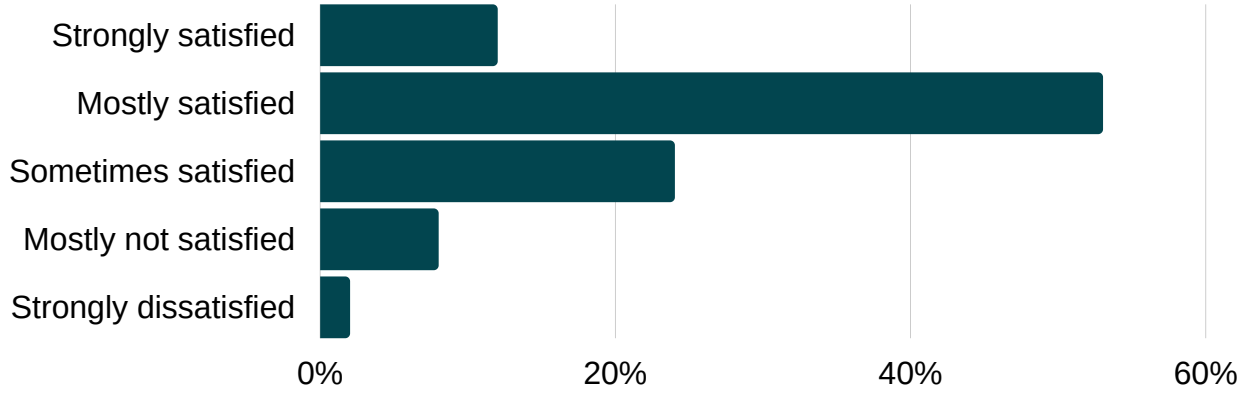


Community Survey

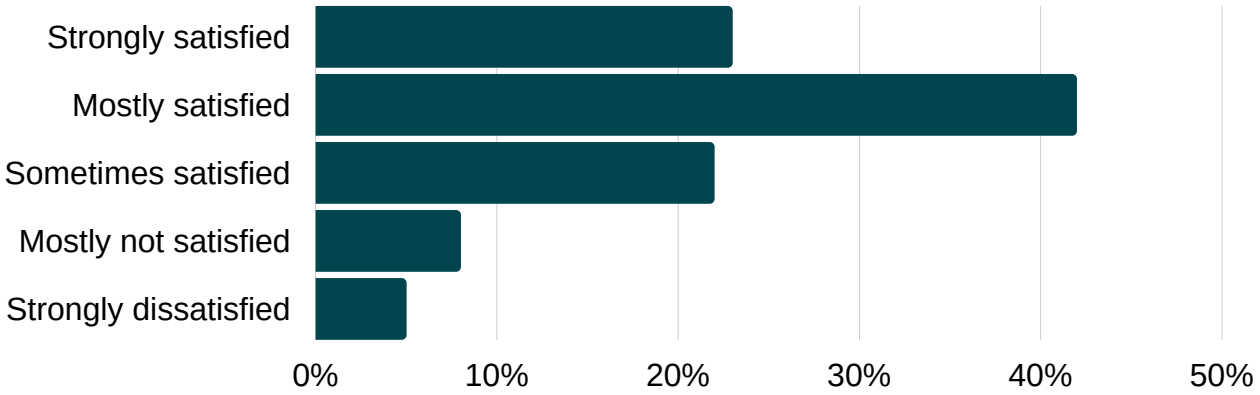
Q: How would you rate the overall health of our community?

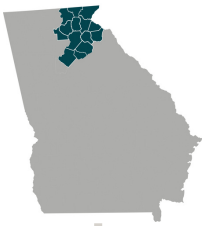


Q: How how satisfied are you with the quality of life in your community?



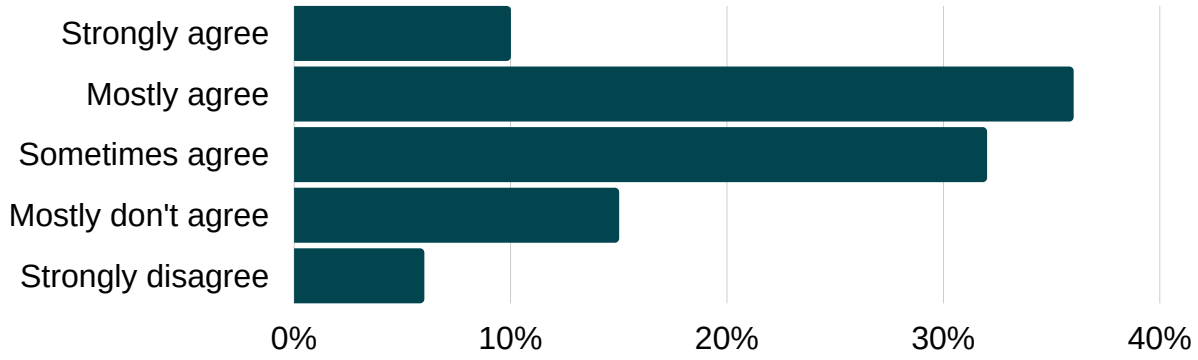
Q: How satisfied are you with the health care system in your community?



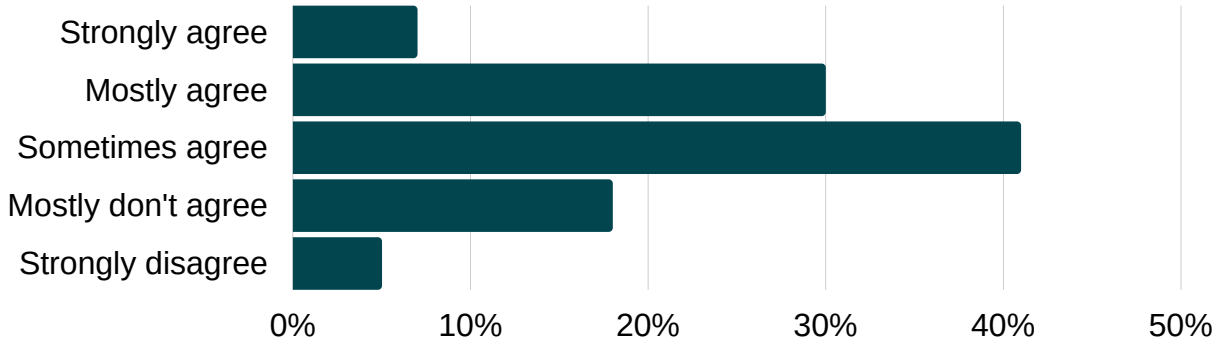


Community Survey

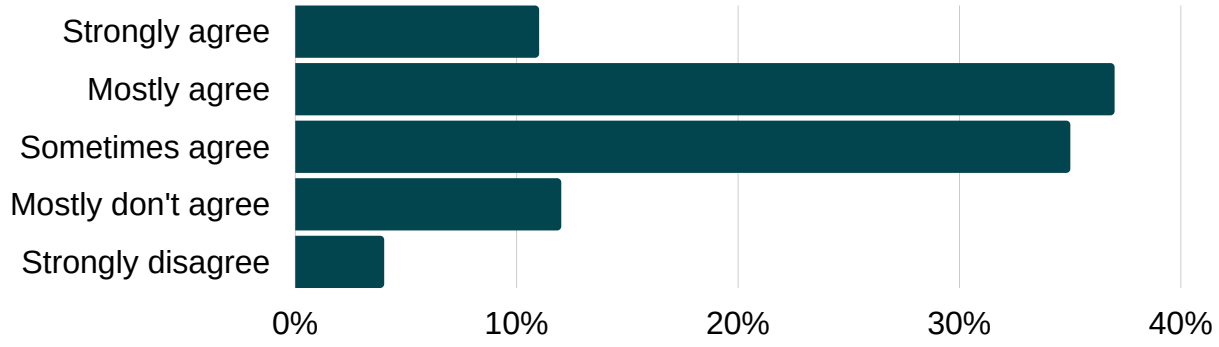
Q: Do you feel there are enough health and social services in your community?

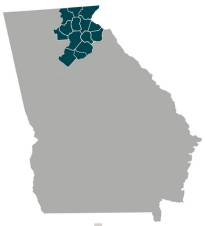


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



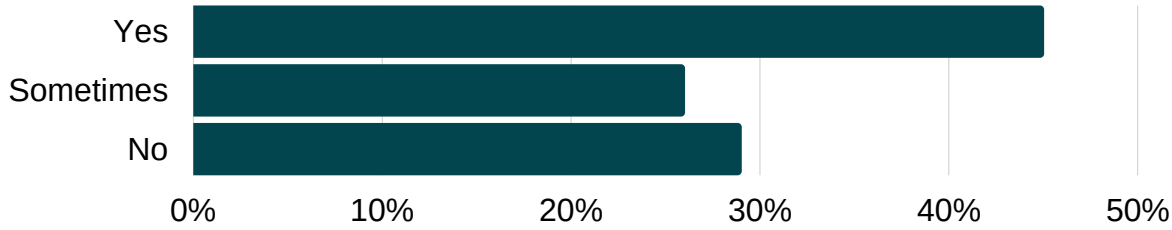
Q: Do you feel there are networks of support for individuals and families during times of stress and need?



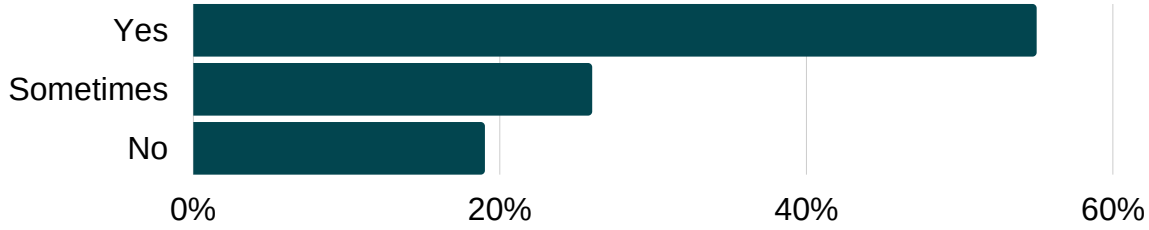


Community Survey

Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?

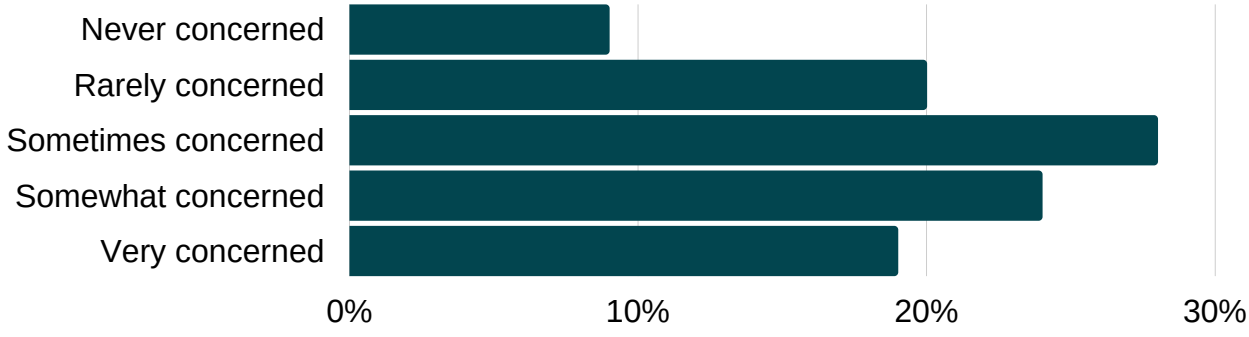


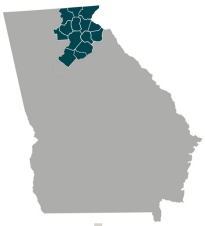
Q: Do you have a hard time paying for medications for you and your family?



Q: Does anyone in your family currently have medical debt?

Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

The below matrix demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for PSA.

High data + low qualitative

- Alzheimer's disease
- Septicemia
- Pneumonia
- Infectious disease
- Injury and death
- Disability
- Linguistically isolated households
- High school graduation rates/no high school diploma
- Long and isolated commutes
- Head Start and preschool enrollment
- Low-income children
- No high school diploma
- Sexual assault
- Fair or poor physical health

High data + high qualitative

- Dental health: tooth loss, dental health providers
- Access to care: preventable hospitalizations, primary care, insurance status
- Cancer, particularly lung
- Heart disease
- Preventable services for women
- Diabetes
- Mental health: providers, suicide
- Substance abuse: opioids, fentanyl, alcohol
- Health behaviors
- Food insecurity
- Fair or poor mental health
- COVID-19: vaccination rates
- Obesity

Low data + low qualitative

- Asthma
- COPD
- Gastrointestinal disease
- Genitourinary disease
- Nervous system disease
- Reproductive and urinary disease
- Incarceration
- Violent crime: assault
- STD incidence
- Musculoskeletal disease
- Respiratory disease
- Kidney disease
- Violent crime: homicide
- Broadband and internet access

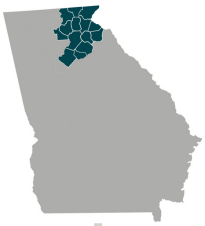
Low data + high qualitative

- Sources of health information*
- Health education, both mental and physical*
- Geriatric/elder care
- Sex trafficking*
- Stigma around mental health care
- Transportation*
- Pediatric care

*No quantitative data available

Once the top health needs were identified, CHNA partners discussed and completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does a SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

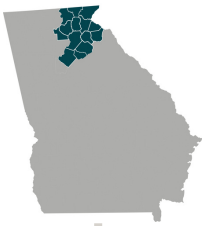
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – Diabetes	15
1 – Heart Disease	15
2 – Health Behaviors	14
2 – Obesity	14
3 – Cancer, particularly lung	13.6
4 – Mental Health: Providers, Suicide, Poor or Fair Mental Health	13.5
4 – Preventable Services for Women	13.5
5 – Access to Care: Preventable Hospitalizations, Primary Care, Insurance Status	13
6 – Substance Abuse	12.5
7 – Food Insecurity	12
8 – Dental Health: Tooth Loss, Dental Health Providers	11.5
9 – COVID-19: Vaccination Rates	10

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting held on May 19, 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental and behavioral health**
- **Access to care**
- **Healthy behaviors**

Although not selected as priorities, there are additional issues of concern for the residents within PSA, including food insecurity, dental health, and obesity. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



NGMC Greater Braselton Service Area

The Greater Braselton Service Area (GBSA) is comprised of Banks, Barrow, and Jackson counties, as well as three ZIP codes within Gwinnett County and one within Hall County.

In 2020, 320,370 people lived in the 853-square-mile community. This service area was about half urban and half rural.

When broken down by age:

- 25 percent of the population were 17 or younger
- 61 percent were between 18 and 64
- 14 percent were over 65

High school graduation rates were high as of 2020, with 91 percent of the area's population graduating. By comparison, only 85 percent of state residents held a high school diploma. Thirty percent had an associate degree or higher, and 21 percent held a bachelor's degree. Approximately 15 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 76 percent were White
- 8 percent were Black or African American
- 10 percent were Hispanic or Latino
- 3 percent were Asian
- 3 percent were either multiple races or some other race

Seven percent of service area residents were veterans in 2020, and the majority were over the age of 65. Fifteen percent of all adults aged 18 to 65 had served in the military, and 14 percent of all men in the service area are veterans, as compared to one percent of all females.

Fourteen percent of the service area population lived with a disability in 2020, a rate higher than the state and national rates of 12 and 13 percent, respectively. When separated by age, 40 percent of all adults aged 65 and older lived with a disability that year, as compared to five percent of children and ten percent of adults aged 18 to 64.

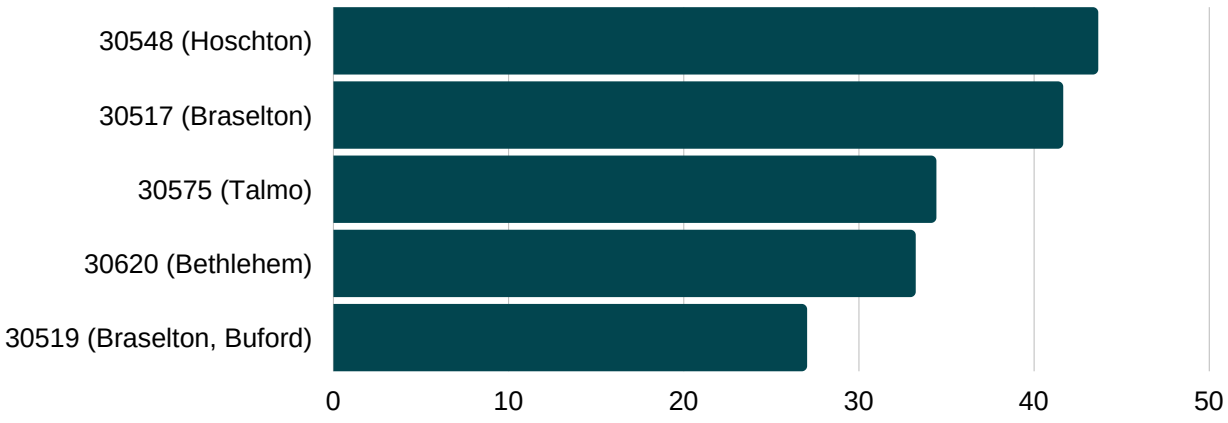
Demographics

In 2020, nearly seven percent of the population identified as being born outside of the US, and six percent did not possess US citizenship status. Of the total population, six percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and older speaks only English at home, or no household member speaks a language other than English at home and speaks English “very well.” Spanish was the most common of those languages, followed second by the broad category of Asian languages.

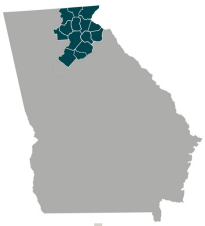
Within the service area, the population increased by nearly 20 percent between 2010 and 2020, which was higher than the state and national population percentage changes of 11 percent and seven percent, respectively.

Minority populations increased at a higher rate than their White counterparts, which grew by nine percent during that time. By contrast, Black or African American populations grew by 28 percent, Asian populations grew by 45 percent, and Hispanic/Latino populations grew by 70 percent. Those identifying outside those four primary race or ethnic categories grew by 274 percent.

ZIP Codes with the Highest Percentage Change in Populations, 2010 to 2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 25 percent of the service area were children and youth 17 and younger. In the 2019 to 2020 school year, two percent of children were homeless, meaning nearly 600 school-age children had no stable home at some point that year.

Of all children, 39 percent lived at or below 200 percent of the FPL, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30530 (Commerce), where more than 60 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

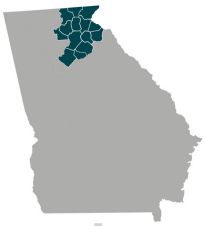
Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. The service area had seven Head Start programs, resulting in five programs per 10,000 children under five years old in 2020. This rate was below the state and national rates of seven and 11, respectively. **In 2020, 43 percent of children aged three to four were enrolled in preschool, a rate below the state and national average of 49 percent and 47 percent, respectively.**

English and Math 4th-Grade Proficiency

Of all students tested, 55 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was better than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 47 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was better than the statewide rate of 54 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 20 births per every 1,000 females aged 15 to 19, a statistic between the state and national rates of 23 and 19, respectively.**



Income and Economics

In 2020, the average household income was $98,580, which was higher than state and national average incomes, which were $85,691 and $91,547, respectively. Within the service area, we see the below variation in average household income by ZIP codes.

Highest Incomes:

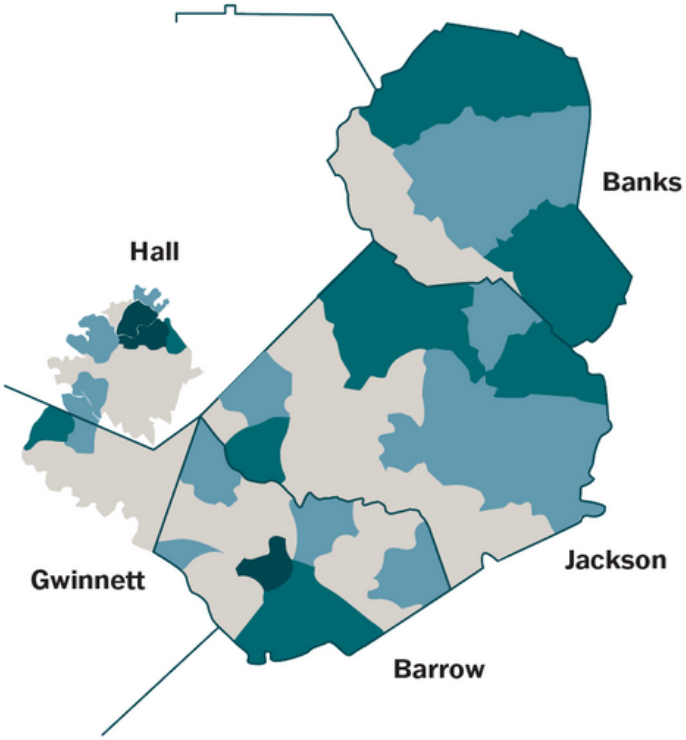
1. 30517 (Buford, Braselton): $153,109
2. 30548 (Hoschton): $119,983
3. 30519 (Buford): $118,656
4. 30542 (Flowery Branch): $114,881
5. 30622 (Bogart): $108,581

Lowest Incomes:

1. 30510 (Hollingsworth): $58,101
2. 30558 (Maysville): $64,374
3. 30529 (Commerce): $64,875
4. 30554 (Lula): $70,970
5. 30567 (Pendergrass): $80,223

Poverty and the Community

Approximately 13 percent of the service area lived in poverty in 2020. That year, the FPL placed a family of four as having a total household income of $26,200.



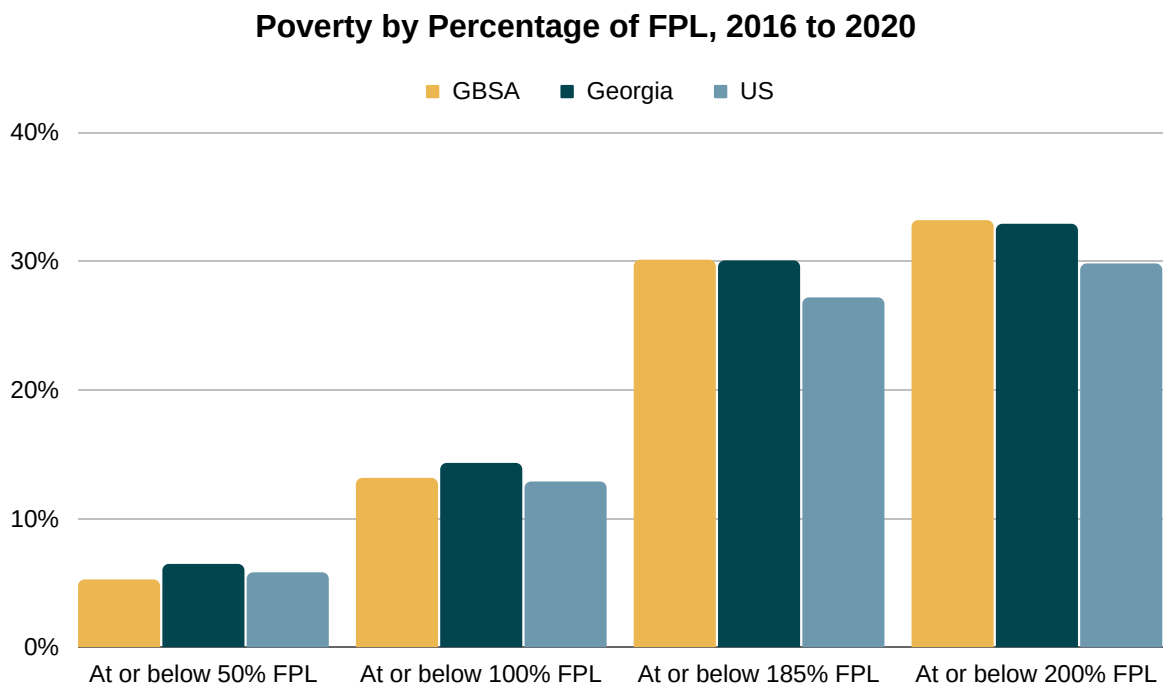
The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent the FPL and below.

- 20% or more live at or below poverty
- 15.1% to 20%
- 10.1% to 15%
- 10% or less

Source: US Census Bureau, American Community Survey. 2016-20.

Income and Economics

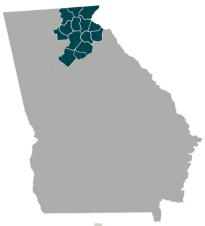
Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will generally still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.



Source: US Census Bureau, American Community Survey. 2016-20.

Public Assistance Income

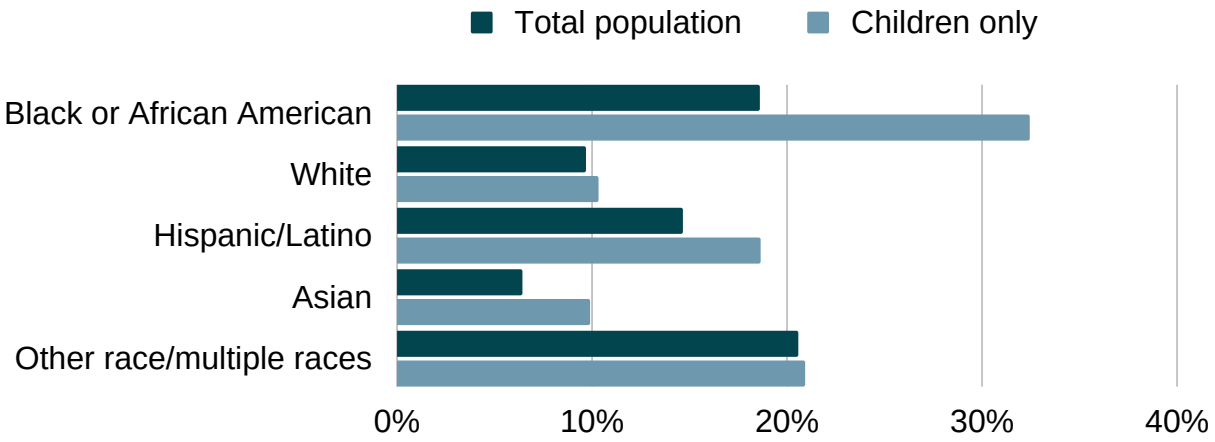
Within the service area, two percent of all households received some form of public assistance. This was on par with the state and national rate of two percent. Within the service area, ZIP code 30375 (Talmo) had the highest level of public assistance income, with ten percent of the population having received benefits. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP.



Income and Economics

When broken down by age and race, the below poverty trends emerge. As demonstrated in the chart below, most minorities within the service area are more likely to live in poverty than their White counterparts.

Populations Living in Poverty, By Race or Ethnicity, 2016 to 2020



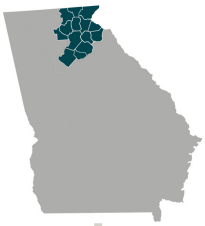
Source: US Census Bureau, American Community Survey. 2016-20.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. **In the service area, 11 percent of the service area's population received SNAP benefits in 2019.** The ZIP code with the highest percentage of SNAP beneficiaries was 30567 (Pendergrass), where 21 percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Approximately 39 percent of service area children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure far less than state and national rates of 56 percent and 42 percent, respectively. Free or reduced-price lunches were served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. High levels of free or reduced-cost lunch demonstrate areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net gain of 231 businesses. There were 2,857 establishment "births" and 2,626 "deaths" contributing to the change. The rate of change was ten percent over the ten-year period, which was higher than the state average of four percent.

The area's gross domestic product was $6,371.69 (millions) in 2020, up by about 86 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerged as the largest.

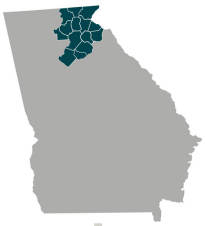
Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Retail Trade	4,567	$28,270
Food Services	2,845	$21,699
Construction	2,051	$22,313

Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

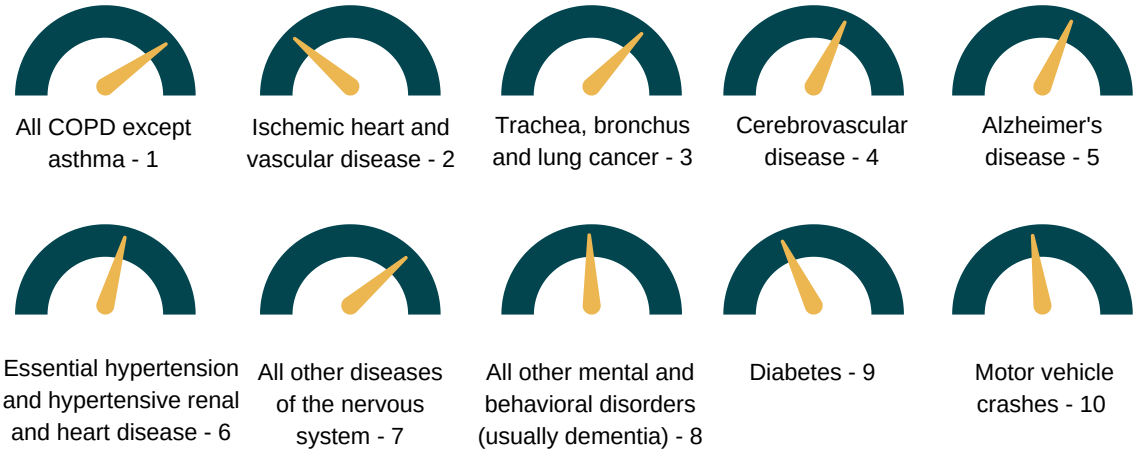
In 2020, the total labor force for the service area was 161,245 people, and the labor force participation rate was 67 percent. Total unemployment in the service area in July 2022 equaled two percent. This rate has steadily dropped since January 2021, when the unemployment rate was three percent. In 2021, the unemployment rate was more than four times less than the rate in 2012.



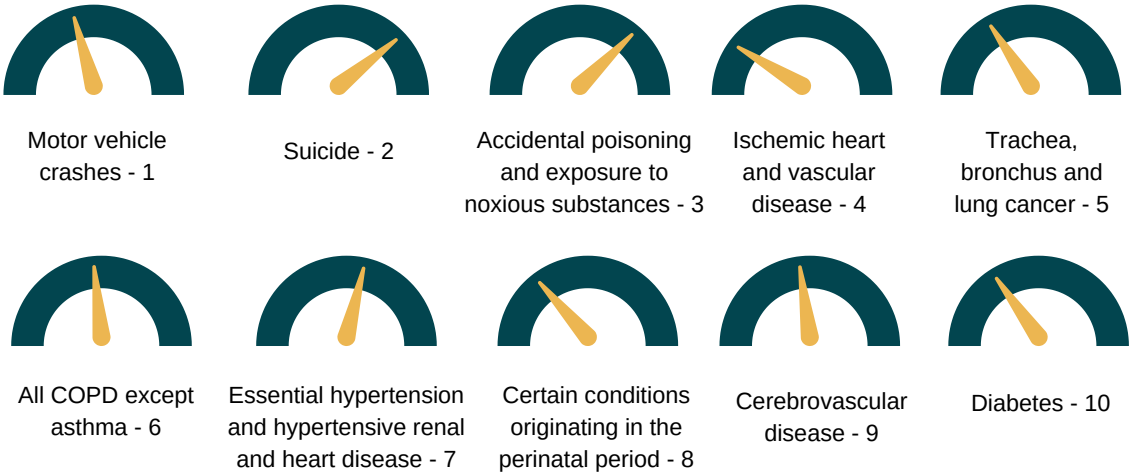
Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

Age-adjusted Death Rates



Premature Death Rates



Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022. Both age-adjusted death and premature death are defined in Appendix Six.

Health Outcomes

Heart Disease

Heart disease was among the leading causes of death in the service area. **Between 2016 and 2020, the age-adjusted death rate was 179 deaths for every 100,000 people, which was worse than both the state average and national average.** Approximately seven percent of all adults had been diagnosed with coronary heart disease in 2019, a figure that jumped to 28 percent when looking only at Medicare beneficiaries. Both figures have remained somewhat steady over the last decade.

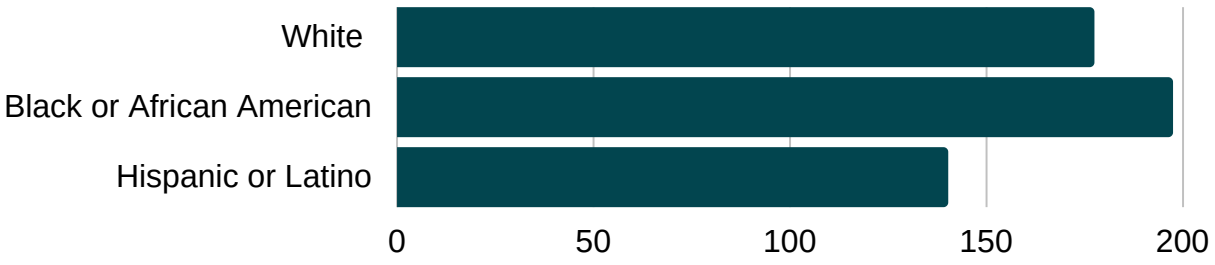
There were similar trends in stroke deaths. **Between 2016 and 2020, the age-adjusted death rate was 47 deaths per 100,000 people. This was worse than the state rate of 43 and the national rate of 38 deaths per every 100,000 people.**

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 12 hospitalizations per every 1,000 Medicare beneficiaries, which was on par with the state and national rates of 12. **The hospitalization rate for stroke of ten hospitalizations per every 1,000 Medicare beneficiaries was higher than the state rate of nine and the national rate of eight.**

Cancer

Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 174 deaths per every 100,000 people, which was higher than the state and national rates of 153 and 149, respectively. The death rates shift when looking at race and ethnicity.

Cancer Deaths by Race or Ethnicity, Per Every 100,000 People

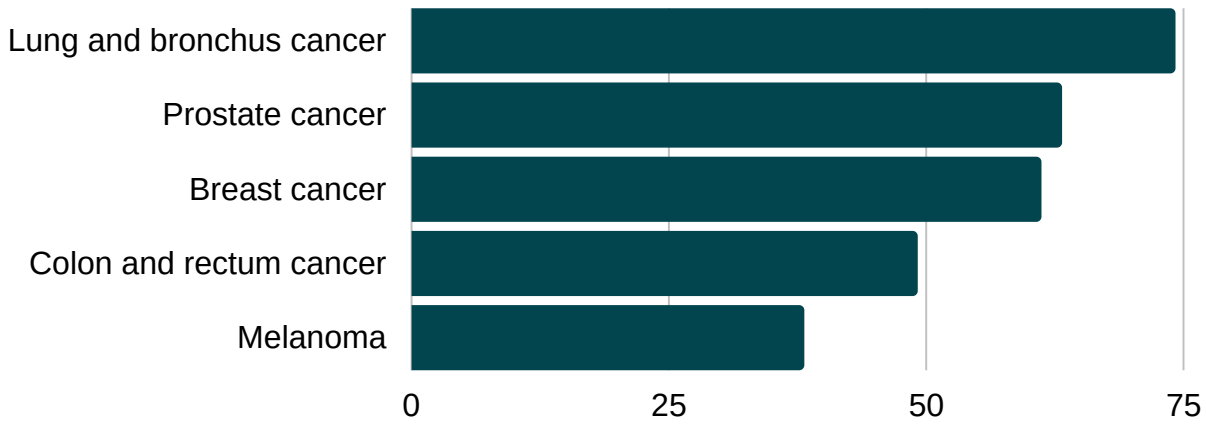


Source: State Cancer Profiles. 2014-18. Please note data was not available for Asian populations.

Health Outcomes

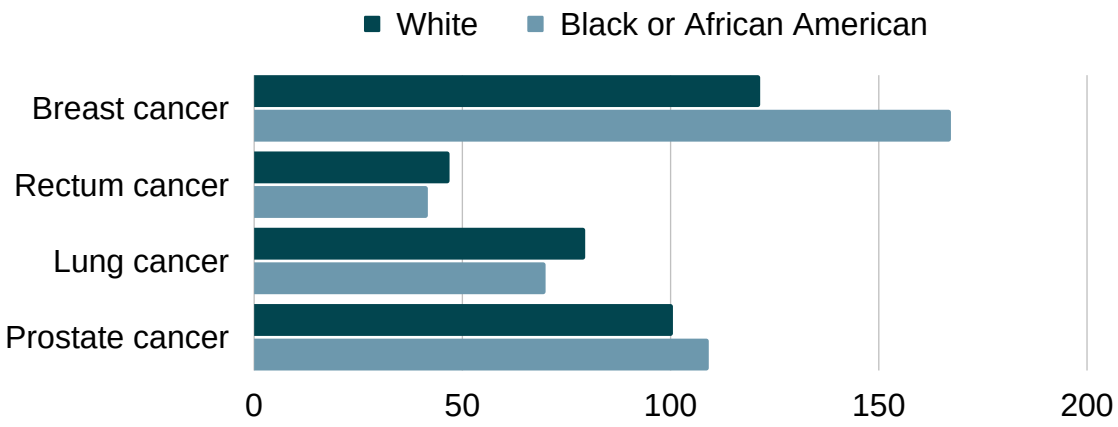
Within the service area, there were an average of 890 new cases of cancer diagnosed each year, resulting in a cancer incidence rate of 507 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018



When breaking down by race, incidence rates shift. As shown below, Black populations are more likely to be diagnosed with breast and prostate cancer.

Cancer Incidence by Race, Per Every 100,000 People, 2014 to 2018

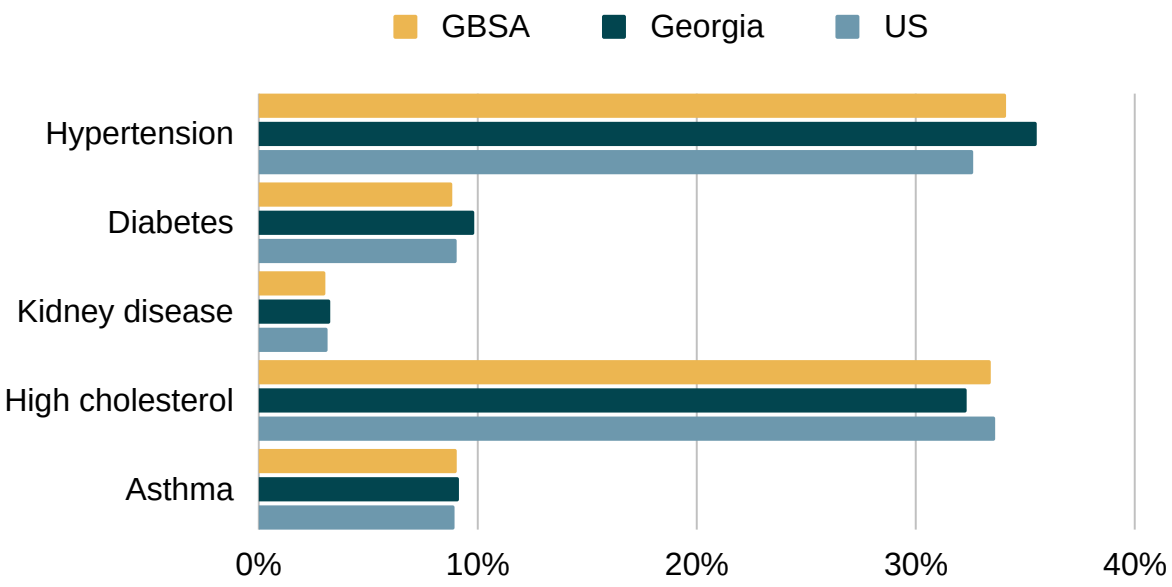


Source for both charts: State Cancer Profiles. 2014-18. Demographic information is only available for White and Black or African American populations in this service area.

Health Outcomes

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

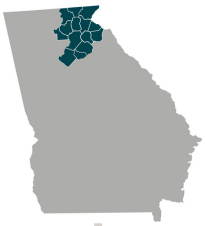
Percent of Population Reporting Key Chronic Conditions, 2018



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 72 percent of all Medicare fbeneficiaries had multiple chronic conditions, with 33 percent having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note that this doesn't equal 100 percent, as some community members had two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
63.69%	14.04%	2.77%	18.89%	20.4%	2.43%

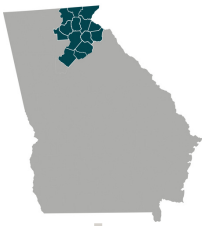
Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

In 2020, about 19 percent of the population was enrolled in some form of Medicare, the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 71, and 17 percent were also eligible for Medicaid due to low incomes.

Medicaid Populations

In 2020, more than 20 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was on par with the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 39 percent of children under 18, ten percent aged 18 to 64, and 12 percent of adults aged 65 and older were enrolled in Medicaid.



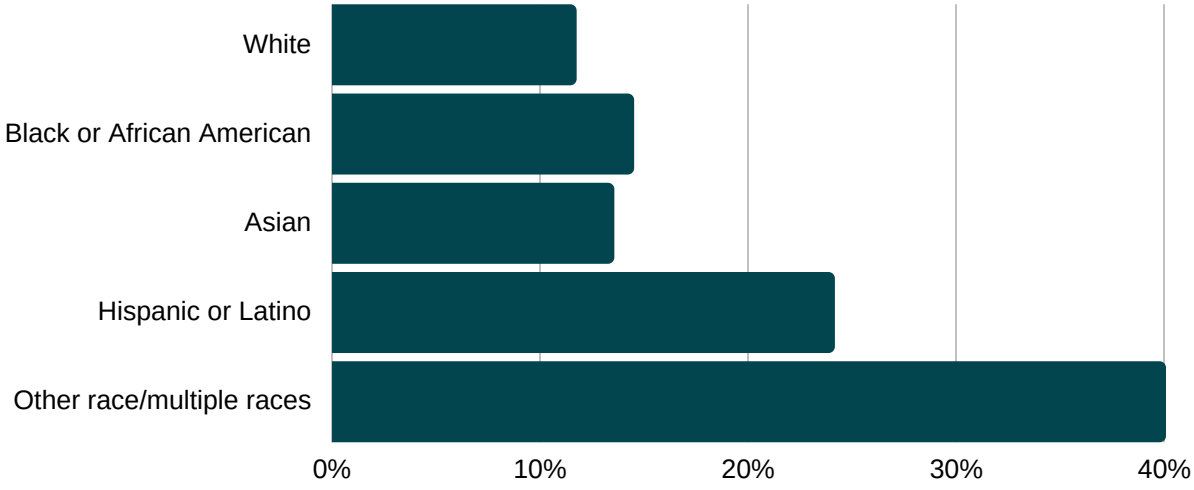
Clinical Care and Prevention

In the service area, on average between 2016 and 2020, 13 percent of the population was uninsured, a figure on par with the state rate of 13 percent and above the national rate of nine percent. When looking only at adults aged 18-64, the uninsured rate jumped to 21 percent. Approximately nine percent of all children were uninsured in 2020, a figure much higher than the state and national rates of seven percent and six percent, respectively.

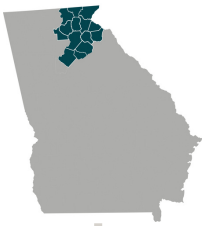
The number of uninsured has steadily declined over the years. For example, in 2012, 28 percent of the service area's non-elderly adult population was uninsured, a full 15 percentage points higher.

As with most all indicators, race or ethnicity matters when it comes to uninsured children. In the service area, 12 percent of White, 13 percent of Black or African American, and 32 percent of Hispanic or Latino children were uninsured. When looking at the total population, we see similar trends, with those that are either a race or ethnicity outside of those already named or are of multiple races showing uninsurance levels just at 40 percent.

Uninsured by Race or Ethnicity, 2016 to 2020



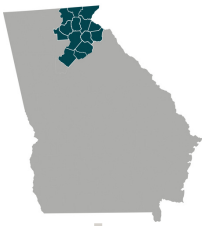
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

In FY21, approximately 7,800 patients received care through the public insurance program Medicaid at NGMC Braselton. Below is a list of the top ten ZIP codes by volume of patients receiving care through Medicaid coverage at the hospital during the last two fiscal years. Please note the hospital treated Medicaid patients from locations outside of these ten ZIP codes as well.

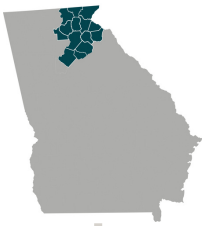
ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30680 (Winder)	879	30680 (Winder)	938
30542 (Flowery Branch)	864	30542 (Flowery Branch)	907
30519 (Buford)	617	30519 (Buford)	692
30517 (Braselton)	476	30517 (Braselton)	529
30011 (Auburn)	467	30011 (Auburn)	507
30518 (Buford)	447	30549 (Jefferson)	484
30549 (Jefferson)	398	30518 (Buford)	462
30548 (Hoschton)	386	30548 (Hoschton)	444
30019 (Hoschton)	290	30507 (Gainesville)	339
30507 (Gainesville)	268	30019 (Hoschton)	325



Clinical Care and Prevention

In FY21, approximately 7,600 patients received financial assistance for their care at NGMC Braselton. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years. Please note that the hospital also provided financial assistance to patients outside these ten ZIP codes.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30542 (Flowery Branch)	932	30542 (Flowery Branch)	950
30680 (Winder)	910	30680 (Winder)	859
30519 (Buford)	570	30519 (Buford)	593
30011 (Auburn)	472	30011 (Auburn)	461
30517 (Braselton)	454	30517 (Braselton)	445
30518 (Buford)	391	30548 (Hoschton)	404
30548 (Hoschton)	390	30549 (Jefferson)	358
30549 (Jefferson)	343	30518 (Buford)	356
30507 (Gainesville)	288	30507 (Gainesville)	325
30019 (Hoschton)	269	30019 (Hoschton)	247



Clinical Care and Prevention

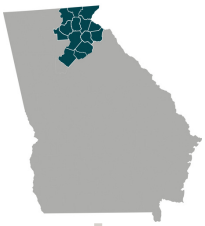
Health Professions Shortages and Provider Ratios
In GBSA, as of June 2022, there were six designated health professions shortage areas: two primary care, two dental health, and two mental health.

- Primary care: There were 39 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 2,652 people within the service area, a measure far worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 3,483 people, a figure worse than the state rate of one dentist for every 1,910 people and the national rate of one dentist for every 1,397 people.

Primary Care and Routine Check-ups
In 2019, 76 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, which was on par with both state and national averages. For Medicare recipients, the percentage jumps to 87 percent of all beneficiaries having visited a doctor in the previous 12 months. **Eighty percent of Black populations received a routine check-up, as compared to 88 percent among other populations.**

In 2018, about 28 percent of men and 32 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services. Both of these statistics were below state and national averages.

Dental Care and Dental Outcomes
Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection, and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status. Within the service area, in 2018, 58 percent of adults went to the dentist in the past 12 months, which was lower than state and national rates. **That year, 16 percent of the service area reported having lost all or most of their natural teeth because of tooth decay or gum disease.**



Clinical Care and Prevention

Emergency Department Visits

In 2020, Medicare beneficiaries visited the emergency department approximately 9,000 times, resulting in an ED visit rate of 566 visits per every 1,000 beneficiaries, which was higher than both state and national rates of 551 and 535, respectively.

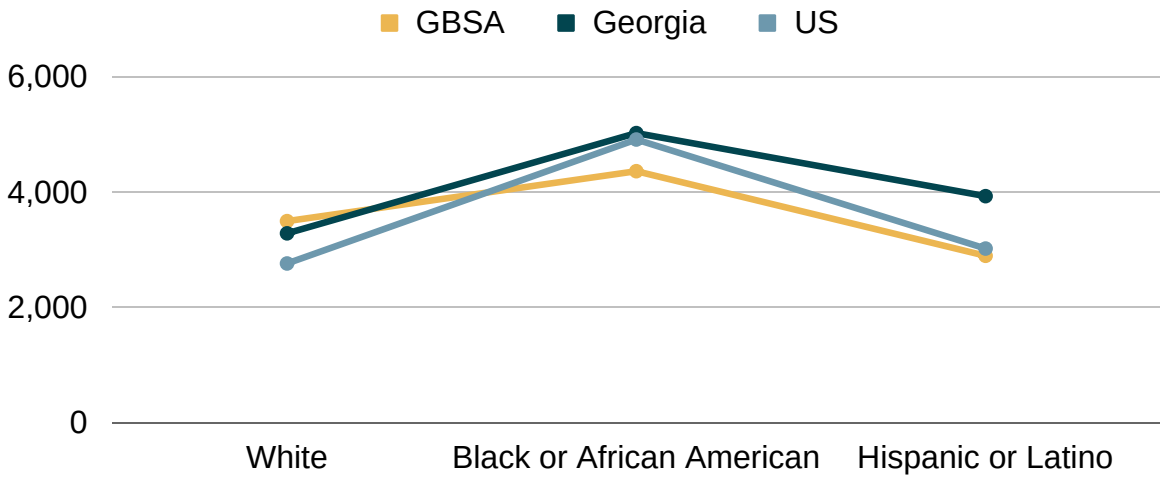
Inpatient Stays

In 2020, 15 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 238 stays per every 1,000 beneficiaries. This was higher than the state rate of 230, and the national rate of 223 inpatient stays during the same time.

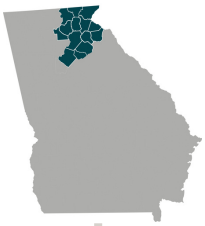
Preventable Hospitalizations Among Medicare Beneficiaries

Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,569 per every 100,000 beneficiaries, higher than the state rate of 3,503 hospitalizations and the national rate of 2,865 hospitalizations. As with other health indicators, the indicator shifts when looking at race or ethnicity.

Preventable Hospitalizations Per Every 100,000 Beneficiaries, by Race or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020.
Please note data only available for three races.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 49 deaths for every 100,000 people.** This rate was worse than the state and national averages of 38 and 47 deaths for every 100,000 people, respectively.

Within the service area, the age-adjusted death rate for suicide was 18 deaths for every 100,000 people. This rate was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. For both deaths of despair and suicide, this was much more prevalent among White populations.

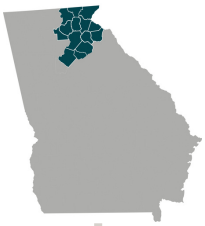
Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data was available, service area residents reported an average of five poor mental health days over the last 30 days, which was on par with the state average of five poor mental health days. Additionally, in 2019, 17 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage was slightly greater than the state rate of 16 percent and much greater than the national rate of 14 percent. Although data is not yet available, these statistics likely increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community.

Opioid and Substance Use

In 2020, providers in the service area prescribed an average 46 opioid prescriptions per every 100 people, which was a figure that has been steadily decreasing each year. Within the service area, the age-adjusted death rate for opioid overdose was 12 deaths per 100,000 people. This was worse than the state average of ten but less than the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

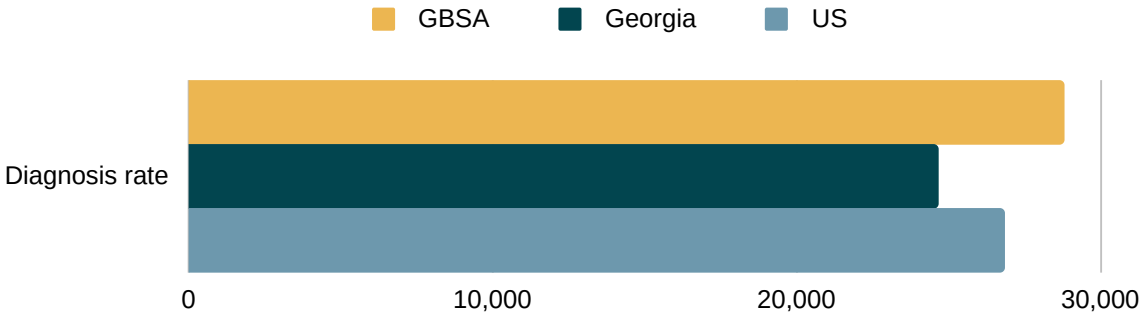
In 2019, Medicare opioid drug claims accounted for five percent of total prescription drug claims. This percentage was on par with the state rate of five percent and higher than the national rate of four percent.



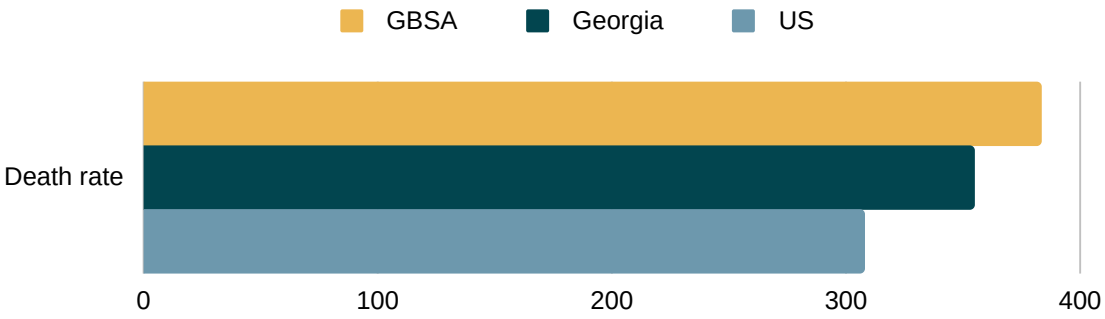
COVID-19

In GBSA, as of July 2022, both COVID-19 incidence rates and death rates were above state and national rates.

COVID-19 Incidence Rate, Per Every 100,000 People, July 2022

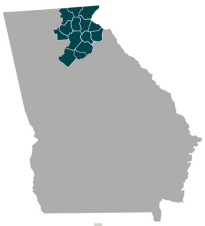


COVID-19 Death Rate, Per Every 100,000 People, July 2022



Source for both charts: Johns Hopkins University. Accessed via ESRI. 2022.

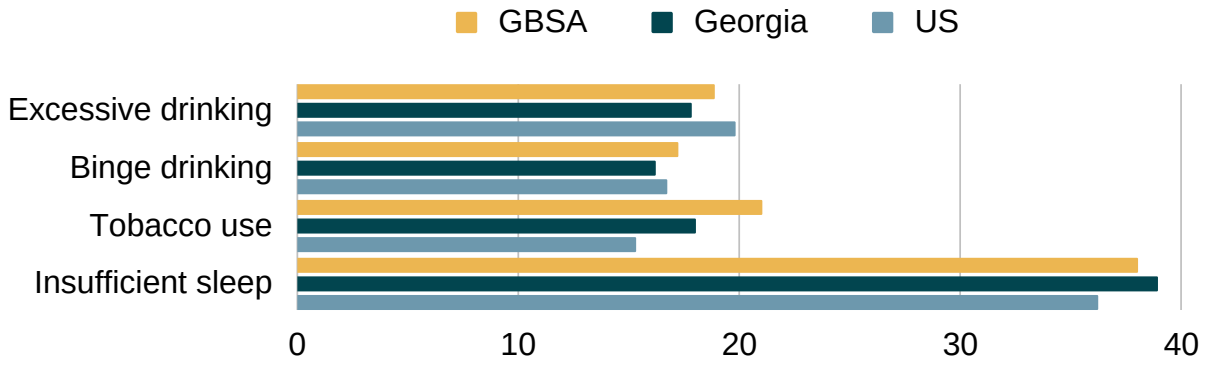
Approximately 51 percent of the service area was fully vaccinated as of July 2022, with an estimated 16 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.68, which showed how challenging vaccine rollouts may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).



Health Behaviors

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

Percent of Population Reporting Unhealthy Behaviors, 2019

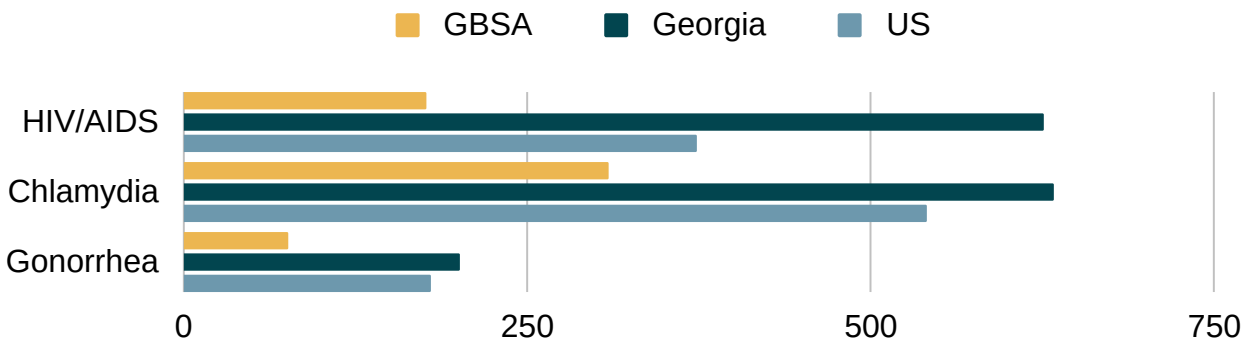


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates were generally below that of state and national rates.

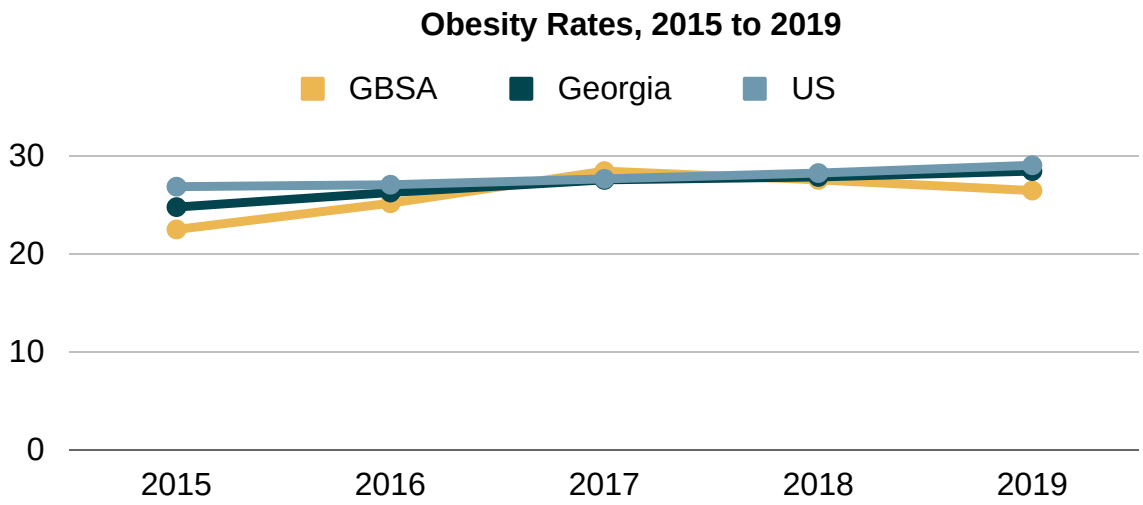
Sexually Transmitted Disease Rates, Per every 100,000 People, 2018



Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.

Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. **In 2019, 26 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 or more.** Obesity rates have generally increased over the last ten years. Obesity was directly linked to several health issues, including diabetes and heart disease.



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

Within the service area in 2019, 25 percent of adults aged 20 and older self-report no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Walking or Biking to Work

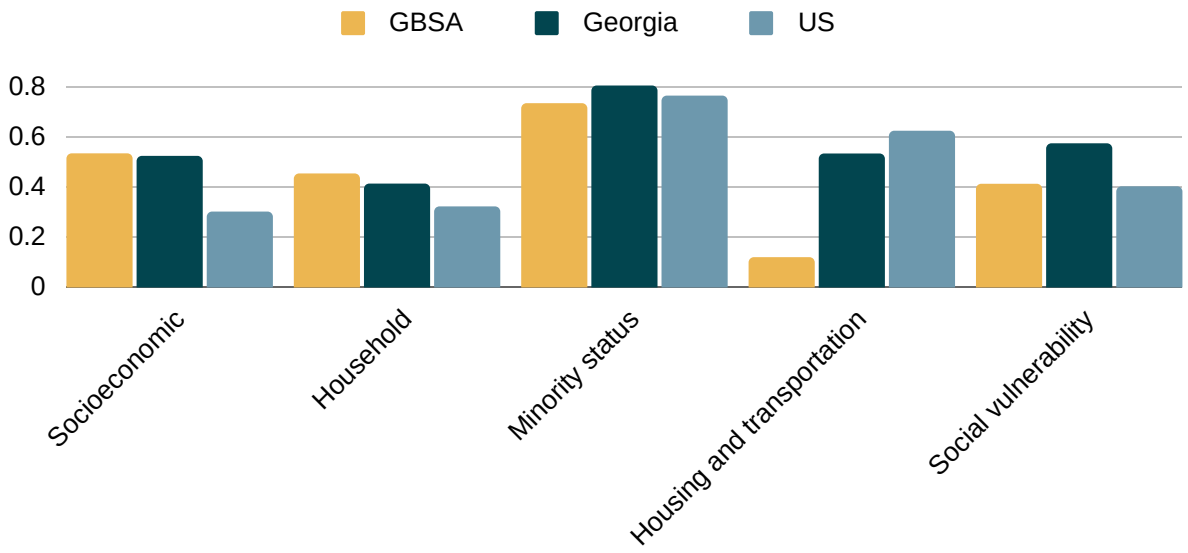
Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if commuting by walking or biking is by choice. In 2019, less than one percent of the service area's population walked or biked to work. This was likely due to the rural nature of nearly half the service area.

Socioeconomic Factors: Social Vulnerability Index

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

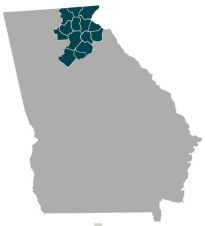
The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. **The service area had a social vulnerability index score of 0.41, much lower than the state score of 0.57 and on par with the national score of 0.40.**

Social Vulnerability Index, By Theme, 2018



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

The area where the service area scored lowest was minority status, meaning minorities - specifically, Black and Hispanic/Latino populations - tend to experience worse conditions in the service area. Generally speaking, based on data, they had lower incomes, lived more in substandard housing, had higher rates of obesity, had a higher incidence rate of diabetes, were likely to be hypertensive, and generally had poorer outcomes.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person’s physical and mental health.

The average monthly owner cost for a home within the service area was $1,137 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $847. COVID-19 significantly impacted housing, so these figures likely increased since then.

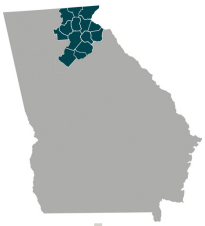
Cost-Burdened Households

Of all occupied households in GBSA, 26 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately ten percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.

Renters bear the strain of this the most, with 40 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure drops to 24 percent. **Approximately 42 percent of renters paid rent that's at least 50 percent of their household income.**

Substandard Housing

This indicator reports the number and percentage of the owner and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. **One-quarter of all households in the service area have one or more substandard conditions. This was lower than the state and national averages of 30 and 31 percent, respectively.**

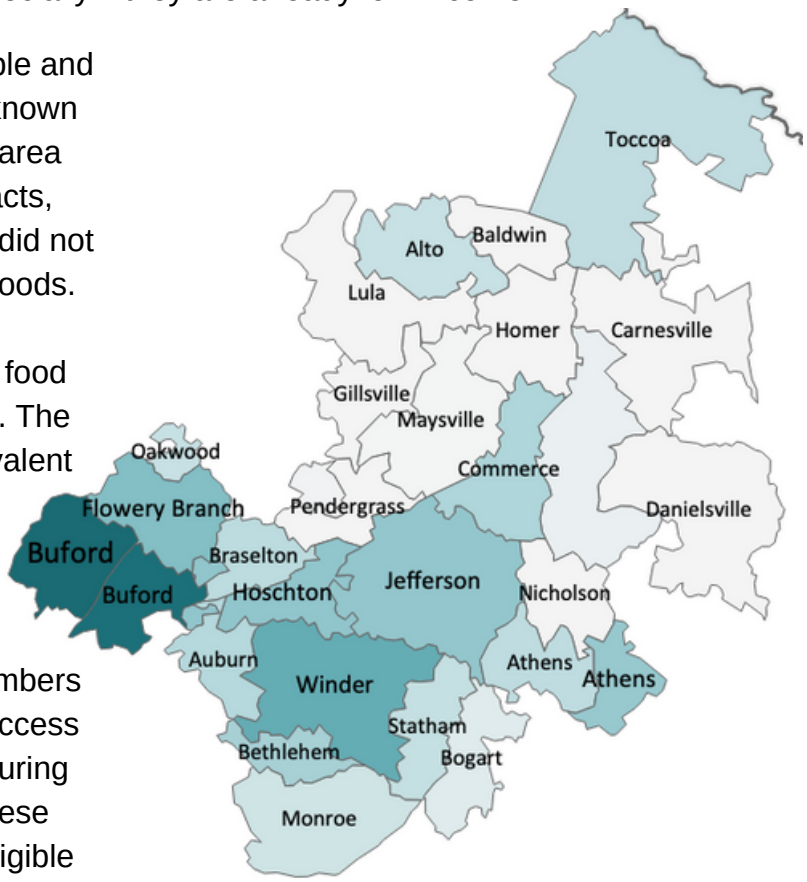


Socioeconomic Factors: Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially if they are already low-income.

Communities that lack affordable and nutritious food are commonly known as “food deserts.” The service area had five food desert census tracts, meaning about 22,000 people did not have ready access to healthy foods.

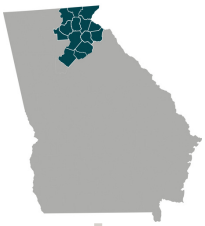
The map to the right illustrates food deserts within the service area. The darker the color, the more prevalent the issue.



Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The service area had a food insecurity rate of ten percent, meaning those community members were unsure how they would access adequate food at some point during the year. That said, many of these community members were ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all food-insecure children in the service area, 27 percent were ineligible for public assistance programs. Of everyone living with food insecurity, approximately 26 percent were ineligible for any public assistance.

Low food access is defined as living more than half a mile from the nearest supermarket, supercenter, or large grocery store. According to the 2019 Food Access Research Atlas database, 32 percent of service area residents had low food access that year, meaning those community members likely struggled to access healthy foods.



Community Input

In February 2022, seven advisory board members attended a focus group for GBSA. Participants described this area as growing, changing, aging, and segmented. When asked to name prevalent conditions or diseases in the community, GBSA focus group members cited diabetes, heart disease, and mental/behavioral health.

Poverty and limited awareness of health facilities and resources were identified as issues preventing residents from achieving excellent health. The top unmet health service needs were mental health and healthy lifestyle awareness. Tied for third were a lack of knowledge and obesity. The underlying causes of these health issues include the fact that communities were segmented, had inadequate affordable housing, and continued social isolation brought on by COVID-19.

Low-income community members, persons with mental health issues, and the elderly were the vulnerable populations on which the health system should focus its attention. GBSA stakeholders cited the lack of medical insurance and knowledge as the primary barriers preventing community members from seeking health care and improving their health.

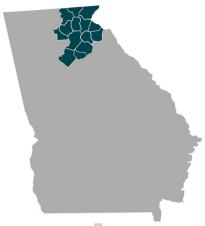
Food pantry resources include:

- The YMCA of Georgia Piedmont
- The YMCA of Clarke County
- The Barrow County Benevolence Cooperative
- The Hispanic Alliance

Community mental and behavioral health services resources include:

- The HUB, located at Gainesville High School
- The Social Empowerment Center
- The Ministry Village

When asked about current events such as COVID-19 in the community, participants agreed that everyone was impacted in some way. Employees either got ill themselves or had to provide care for family members. Many organizations rely on a pool of volunteers, such as poll workers, which was greatly diminished. Many businesses were spared because owners could access federal relief loans. Isolation among elderly residents was taken to new heights. When invited to speak about the impact of current social issues on the community, GBSA stakeholders spoke to the growing influence of diversity, equity and inclusion in the workplace, political divisiveness, and the challenges that come with a growing and increasingly diverse community.



Community Input

The ThoMoss group interviewed seven community members to solicit their input on community health as part of the qualitative data gathering process. Below is a summary of themes that emerged from those interviews.

Barriers to health:

- Affordable and nutritious foods
- Insurance
- Education
- Poverty
- Transportation

Gaps in health services:

- Labor and delivery
- Cardiology
- Cancer care
- Dental care
- Elder care

Opportunities to improve health:

- Health education
- Preventative care

Sources of health information:

- Gwinnett Cares
- Gwinnett Health Care
- Roundtable
- Facebook
- Social media
- Church

Populations most impacted by barriers:

- Hispanic/Latino populations
- African American populations
- The elderly
- Low-income populations
- Migrant and undocumented persons

Top health needs:

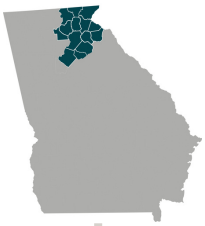
- Preventative healthcare
- Maternal health
- Infant health
- Cancer care
- Geriatric care

Gaps in mental health and vulnerable populations:

- Across the board
- Drug users
- Homeless populations

Gaps in mental health:

- Alcohol
- Marijuana
- Methamphetamine



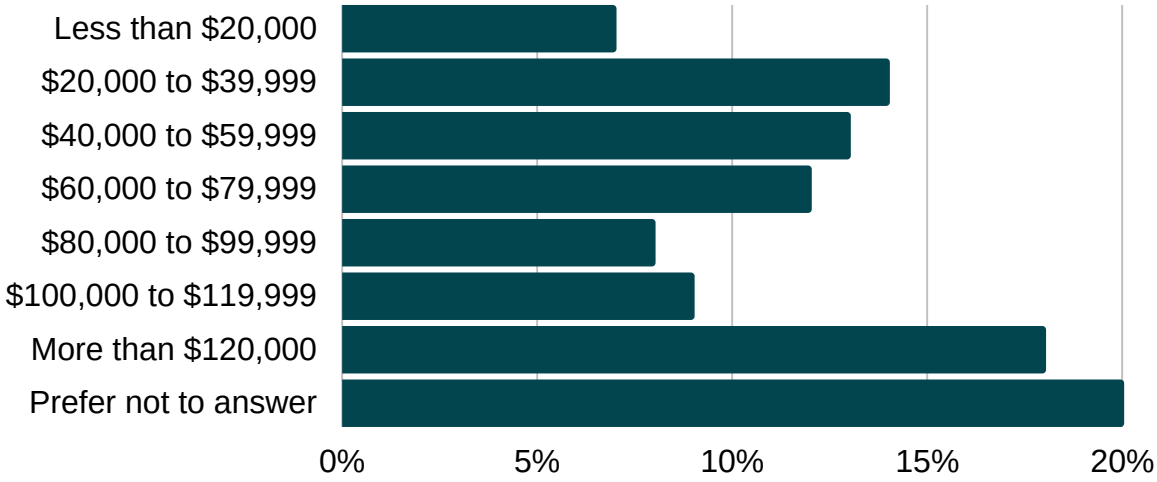
Community Survey

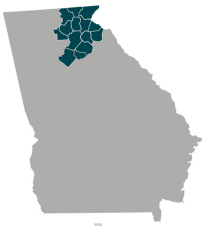
In March 2022, approximately 1,300 community members living within the GBSA service area completed an electronic community-based survey widely advertised to the community via press releases and social media. All survey questions can be found in Appendix Eleven. Please note that the following survey data was for selected indicators. All answers from the survey can be found online at **nghs.com/community-benefit-resources** via the Tableau data tool.

Of all respondents:

- 32 percent were male, 65 percent were female, and 3 percent preferred not to answer
- 87 percent were White, 6 percent were African American or Black, 2 percent were Hispanic or Latino, and 5 percent preferred not to answer
- 2 percent were 25 or younger, 5 percent were between ages 26 and 34, 9 percent were between ages 35 and 44, 14 percent were between ages 45 and 54, 23 percent were between ages 55 and 64, 29 percent were between ages 65 and 74, 16 percent were 75 and older; 2 percent preferred not to answer
- 96 percent had some form of health insurance, and 90 percent lived in households where all members had some form of health insurance

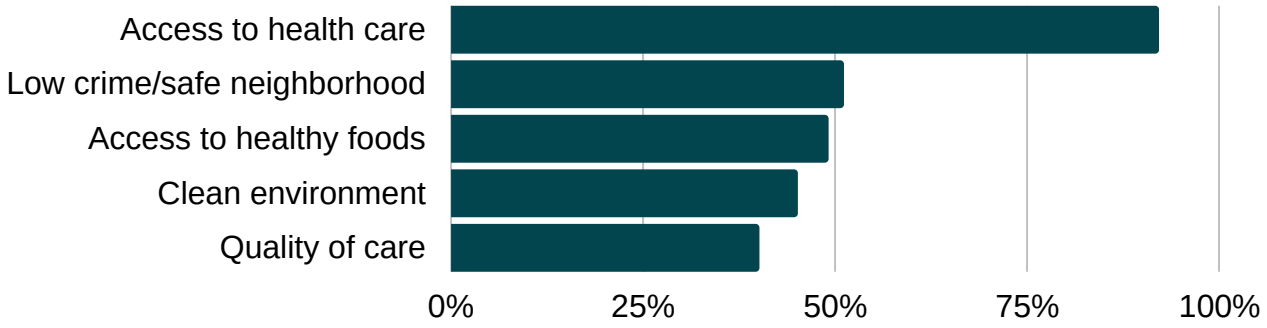
Below is a breakdown of the annual household income for all respondents.





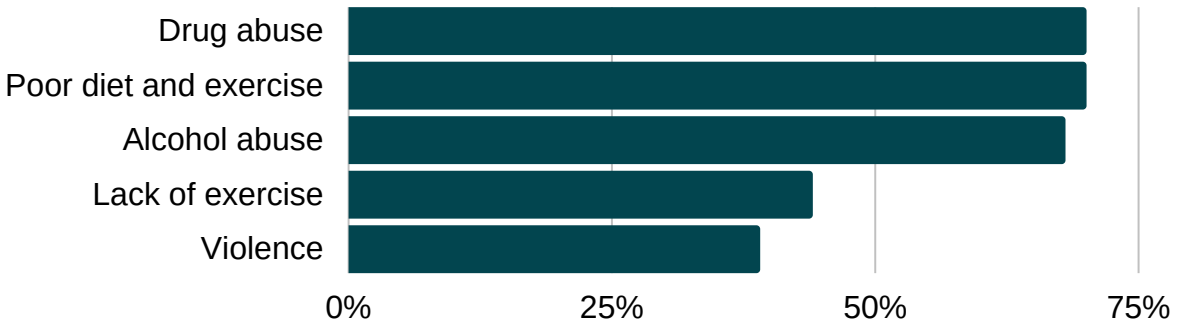
Community Survey

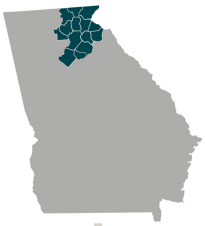
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below were the top five answers.



Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below were the top five answers.

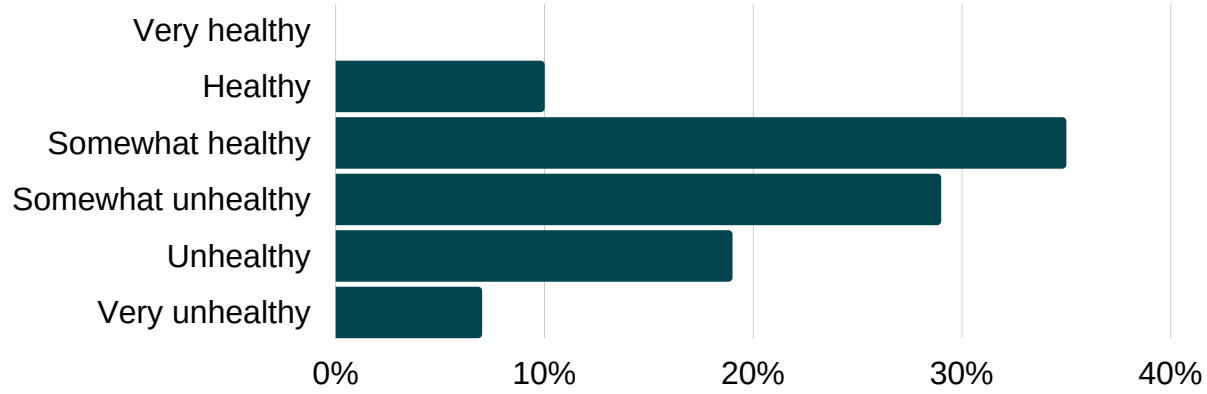
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



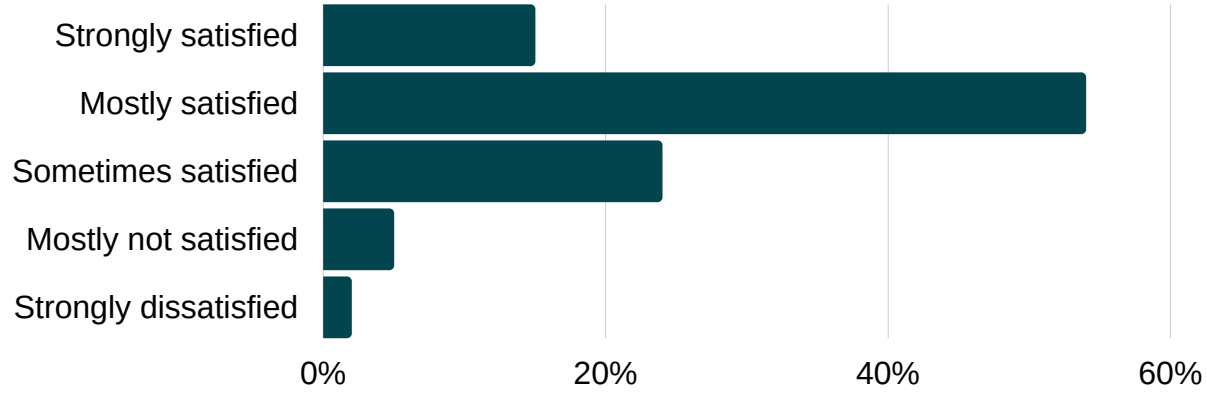


Community Survey

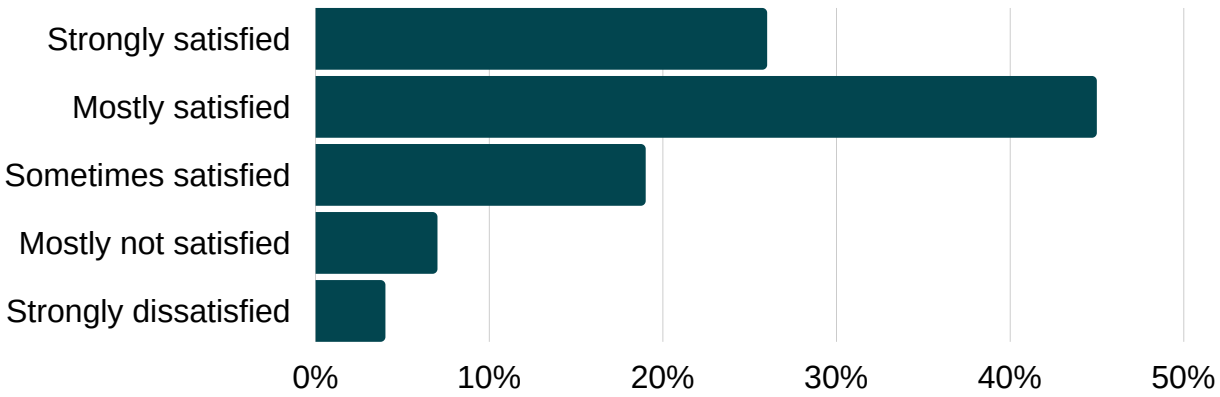
Q: How would you rate the overall health of our community?

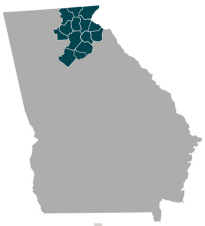


Q: How how satisfied are you with the quality of life in your community?



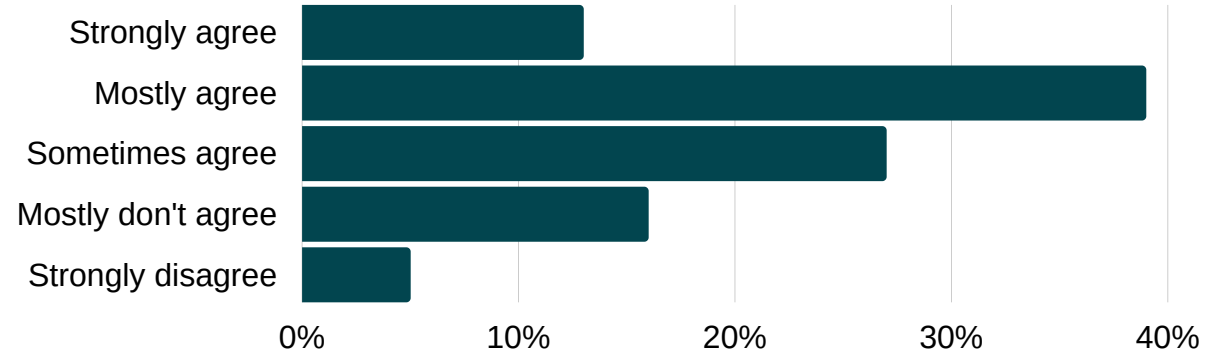
Q: How satisfied are you with the health care system in your community?



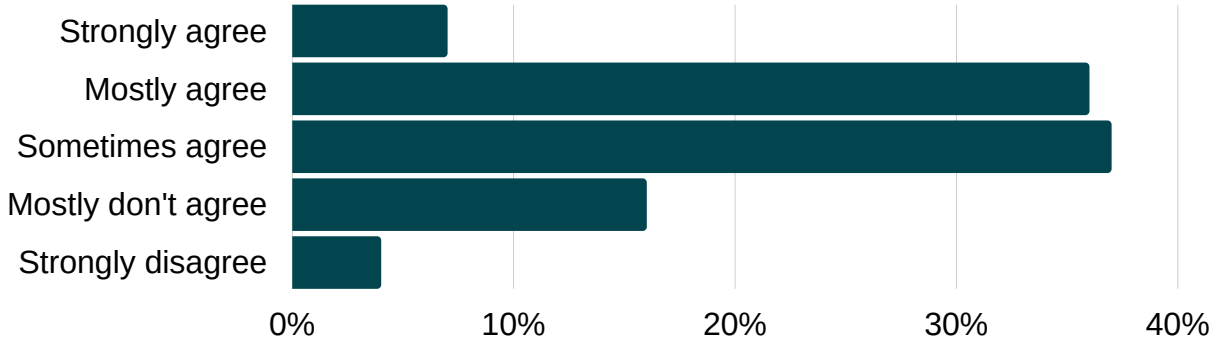


Community Survey

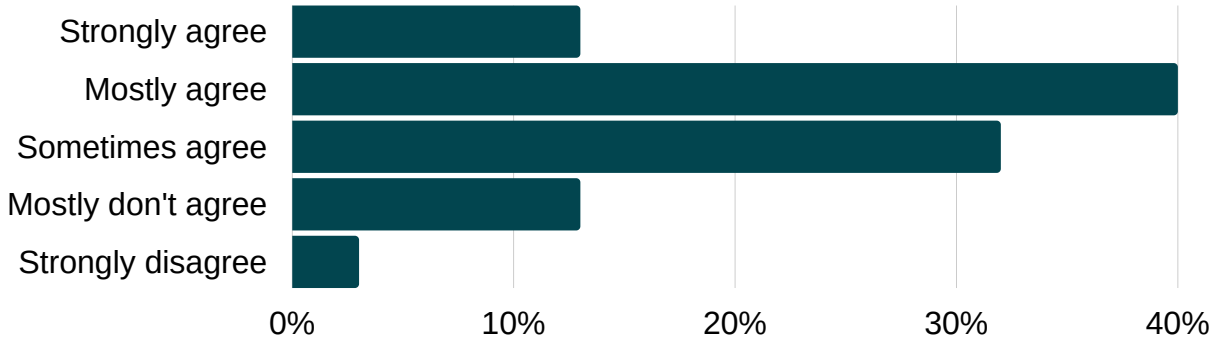
Q: Do you feel there are enough health and social services in your community?

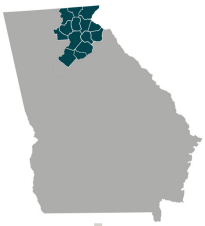


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



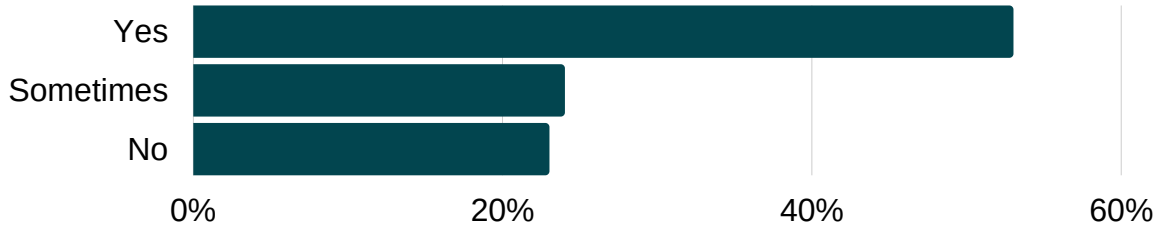
Q: Do you feel there are networks of support for individuals and families during times of stress and need?



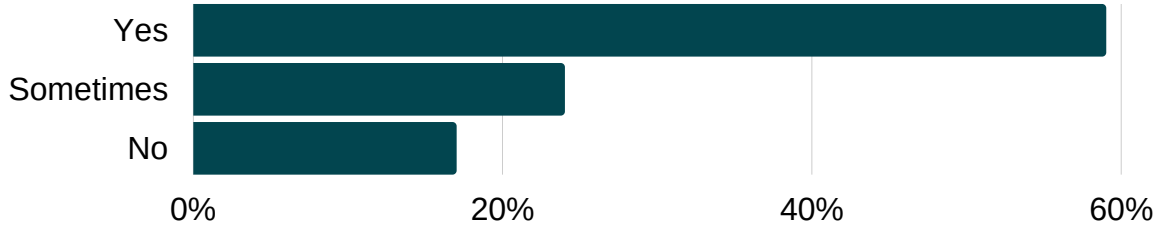


Community Survey

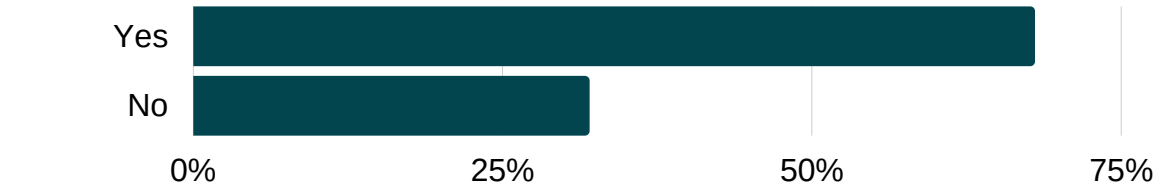
Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?



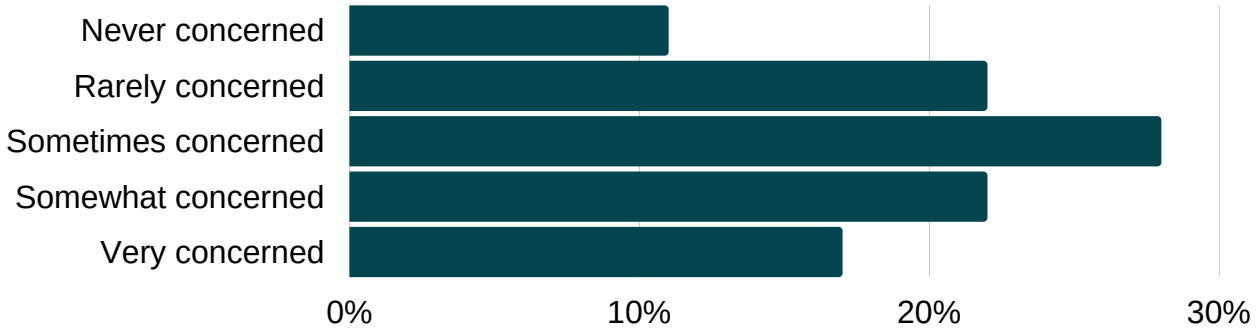
Q: Do you have a hard time paying for medications for you and your family?

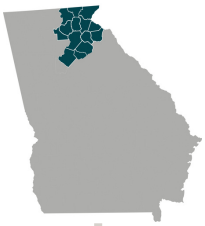


Q: Does anyone in your family currently have medical debt?



Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

The below matrix demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for the GBSA service area.

High data + low qualitative

- COPD
- Affordable housing
- Septicemia
- Infectious disease
- Disability
- Low-income children
- Graduation rates
- Preschool enrollment
- High blood pressure
- Kidney disease
- Stroke
- Sexual assault
- Teen births
- Homeless children and youth
- Households with no computer
- Linguistically isolated households
- Tobacco use
- Asthma
- Early childhood education
- Core preventative services for women

High data + high qualitative

- Access to dental care: routine care, providers
- Access to care: insurance status, primary care providers
- COVID-19: vaccination rates
- Cancer, esp. lung, colon
- Heart disease
- Diabetes
- Obesity
- Mental health: providers, suicide
- Social isolation
- Income and poverty
- Substance abuse: opioids, fentanyl, alcohol
- Health behaviors
- Poor mental health
- Poor physical health

Low data + low qualitative

- Asthma
- Gastrointestinal disease
- Genitourinary disease
- Nervous system disease
- Fair or poor health status
- Older adults living alone
- Single-parent households
- Teen births
- Pneumonia
- STDs
- Alzheimer's disease
- Life expectancy
- Sexual assault
- Violent crime

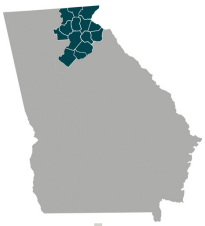
Low data + high qualitative

- Physical health education*
- Mental health education*
- Mental health stigma*
- Sources of health information*
- Transportation*
- Immigrant, undocumented, and/or refugee status
- Infant health
- Maternal health
- Politics*
- Trust*
- Coordination of care*

*No quantitative data available

Once the top health needs were identified, CHNA partners completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does an SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

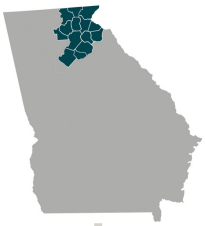
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – COVID-19: Vaccination Rates	15
1 – Diabetes	15
1 – Mental Health: Providers, Suicide, Poor or Fair Mental Health	15
2 – Health Behaviors	14.5
3 – Obesity	13
3 – Substance Abuse and Overdose Deaths	13
4 – Access to Care: Insurance Status, Primary Care, Providers	12
4 – Access to Dental Care: Providers	12
4 – Poverty/Income	12
5 – Social Isolation	11
5 – Heart Disease	11
6 – Cancer, esp. lung and colon	10
6 – Poor Physical Health	10

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting in May 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental and behavioral health**
- **Access to care**
- **Healthy behaviors**

Although not selected as priorities, there are additional issues of concern for the residents within the GBSA service area, including cancer, poverty, and heart disease. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



NGMC Secondary Service Area 400

Secondary Service Area 400 (SSA 400) is comprised of Lumpkin and Dawson counties, which are highlighted in the map to the right.

In 2020, 58,286 people lived in the 493.77-square-mile community. This service area was mostly rural, as 82 percent of the combined population lived in a rural setting in 2020.

When broken down by age:

- 19 percent of the population were 17 or younger
- 62 percent were between 18 and 64
- 19 percent were over 65

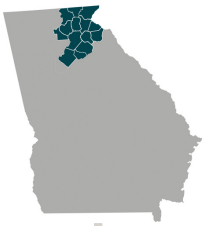
High school graduation rates were high as of 2020, with 96 percent of the area's population graduating. By comparison, only 85 percent of state residents held a high school diploma. Twenty-one percent had attended some college, and 20 percent held a bachelor's degree. Approximately 13 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 91 percent were White
- 2 percent were Black or African American
- 5 percent were Hispanic or Latino
- Less than 1 percent were Asian
- 2 percent were either multiple races or some other race

Seven percent of service area residents were veterans in 2020, and the majority were over the age of 65. Fifteen percent of all adults aged 18 to 65 had served in the military, and 14 percent of all men in the service area are veterans, as compared to one percent of all females.

Fourteen percent of the service area population lived with a disability in 2020, a rate higher than the state and national rates of 12 and 13 percent, respectively. When separated by age, 33 percent of all adults aged 65 and older lived with a disability that year, as compared to five percent of children and ten percent of adults aged 18 to 64.



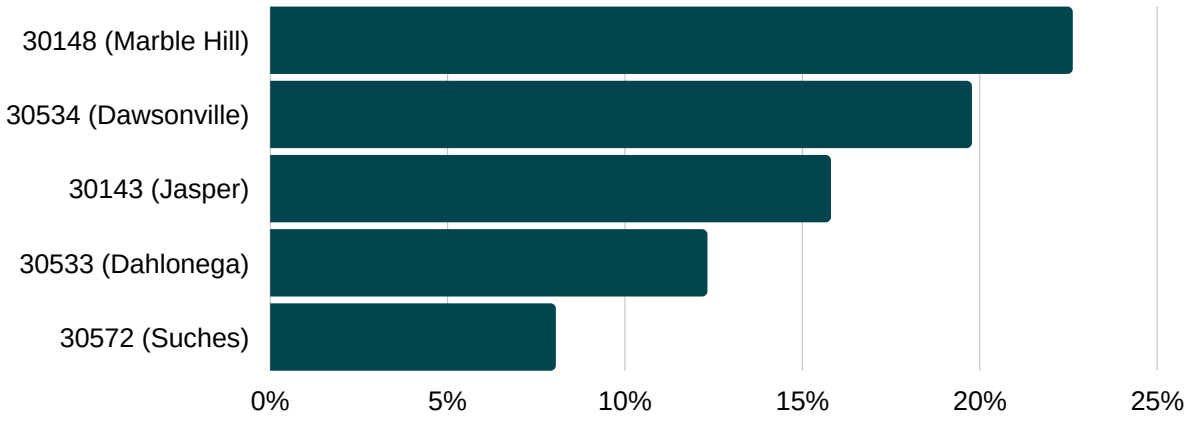
Demographics

In 2020, nearly four percent of the population identified as being born outside of the US, and two percent did not possess US citizenship status. Of the total population, less than one percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and older speaks only English at home, or no household member speaks a language other than English at home and speaks English “very well.” Spanish was the most common of those languages, followed second by the broad category of Asian languages.

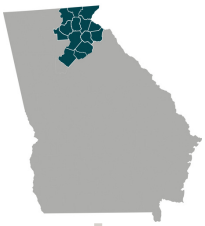
Within the service area, population within the community increased by more than 15 percent between 2010 and 2020, which was higher than the state and national population percentage changes of 11 percent and seven percent, respectively.

Minority populations increased far more than their White counterparts, which grew by nine percent during that time. By contrast, Black or African American populations grew by 50 percent, Asian populations grew by 91 percent, and Hispanic/Latino populations grew by nearly 50 percent. Those identifying outside those four primary race or ethnic categories grew by nearly 270 percent.

ZIP Codes with the Highest Percentage Change in Populations, 2010 to 2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 19 percent of the service area were children and youth 17 and younger. In the 2019 to 2020 school year, four percent of children were homeless, meaning nearly 287 school-age children had no stable home at some point that year.

Of all children, 40 percent lived at or below 200 percent of the FPL, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30148 (Marble Hill), where 100 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. The service area had three Head Start programs, resulting in ten programs per 10,000 children under 5 years old in 2020. This rate was between the state and national rates of seven and 11, respectively. **In 2020, 38 percent of children aged three to four were enrolled in preschool, a rate below the state and national averages of 49 percent and 47 percent, respectively.**

English and Math 4th-Grade Proficiency

Of all students tested, 52 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was better than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 43 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was better than the statewide rate of 53.9 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 14 births per every 1,000 females aged 15 to 19, a statistic much lower than state and national rates of 23 and 19, respectively.**

Income and Economics

In 2020, the average household income was $85,309, which was slightly less than state and national average incomes, which were $85,691 and $91,547, respectively. Within the service area, we see the following variation of average household income, by ZIP codes. Please note that some ZIP codes are located primarily in another county, though some portion of the ZIP code is within the service area.

Highest Incomes

1. 30534 (Dawsonville): $91,261
2. 30143 (Jasper): $84,256
3. 30533 (Dahlonega): $79,281
4. 30564 (Murrayville): $74,738
5. 30536 (Ellijay): $74,724

Lowest Incomes:

1. 30148 (Marble Hill): $51,796
2. 30572 (Suches): $53,078
3. 30528 (Cleveland): $71,697
4. 30536 (Ellijay): $74,724
5. 30564 (Murrayville): $74,738

Poverty and the Community

Approximately 12 percent of the service area lived in poverty in 2020. That year, the FPL placed a family of four as having a total household income of $26,200.

The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent the FPL and below.

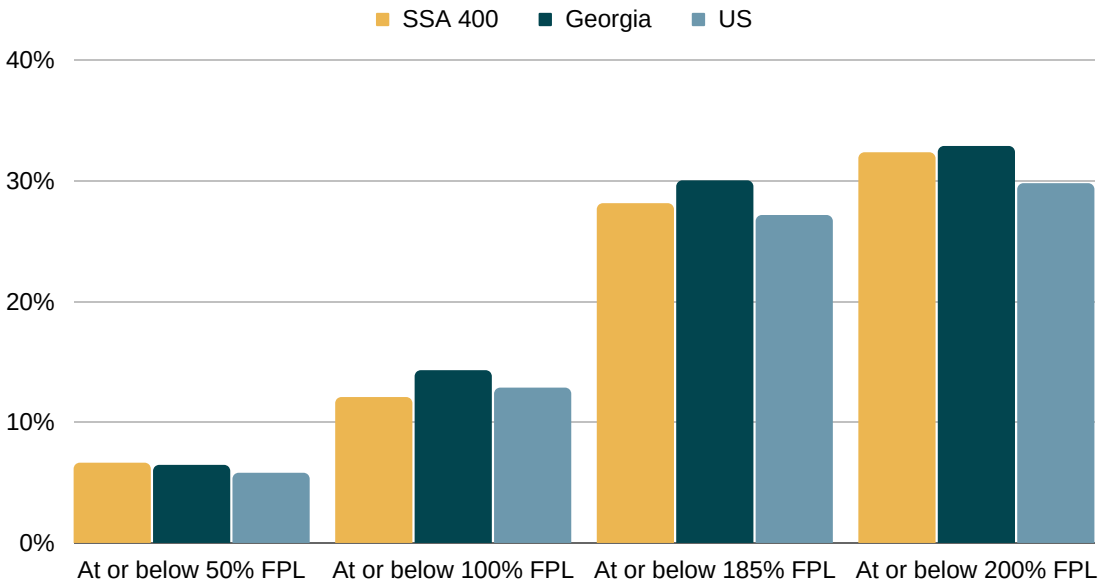
- 20% or more live at or below poverty
- 15.1% to 20%
- 10.1% to 15%
- 10% or less

Source: US Census Bureau, American Community Survey. 2016-20.

Income and Economics

Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.

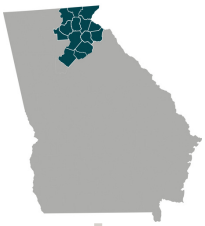
Poverty by Percentage of FPL, 2016 to 2020



Source: US Census Bureau, American Community Survey. 2016-20.

Public Assistance Income

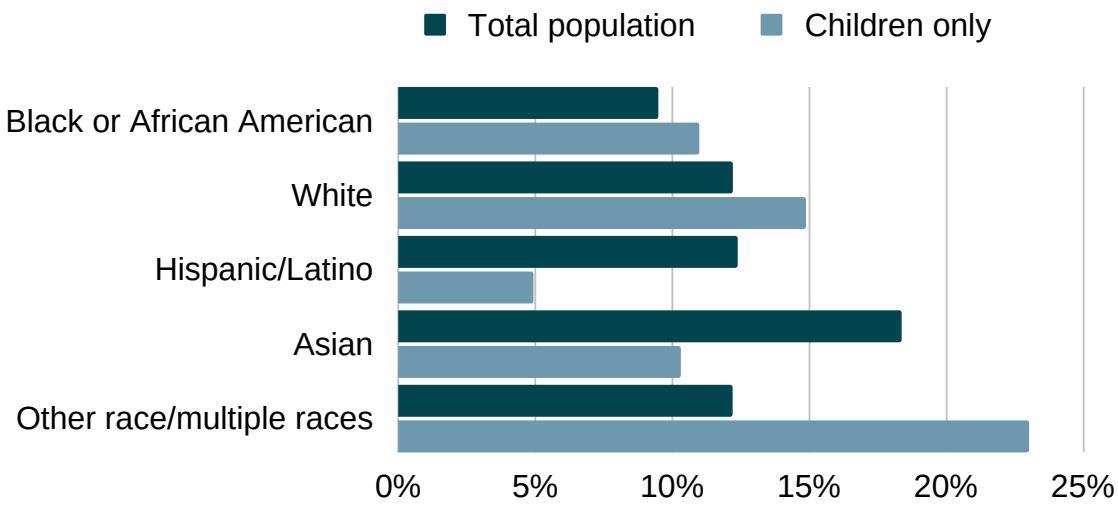
Within the service area, one percent of all households received some form of public assistance. This was better than the state rate and national rate of two percent. Within the service area, ZIP code 30572 (Suches) had the highest level of public assistance income, with ten percent of the population having received benefits. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP.



Income and Economics

When broken down by age and race, the below poverty trends emerge. Both White and mixed-race children tend to be poorer within SSA 400.

Populations Living in Poverty, By Race or Ethnicity, 2016 to 2020



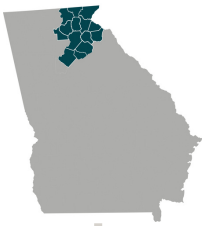
Source: US Census Bureau, American Community Survey. 2016-20.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. In the service area, nearly eight percent of the population received SNAP benefits in 2019. The ZIP code with the highest utilization of SNAP benefits was 30536 (Ellijay), where 11 percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Thirty-nine percent of service area children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure far less than state and national rates of 56 percent and 42 percent, respectively. Free or reduced-price lunches are served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. Reduced cost lunch demonstrates areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net loss of four businesses. 1,188 establishment "births" and 1,192 "deaths" contributed to that change. The rate of change was -0.39 percent over the ten-year period, which was much lower than the state average of four percent.

The area's gross domestic product was $1,875 (millions) in 2020, up by about 53 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerged as the largest.

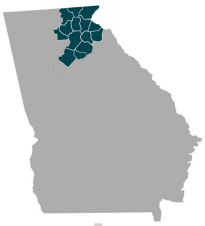
Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Retail Trade	4,567	$28,270
Food Services	2,845	$21,699
Construction	2,051	$22,313

Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

In 2020, the labor force for the service area was 29,847 people, and the labor force participation rate was 61 percent. Total unemployment in the service area in July 2022 equaled two percent This rate had steadily dropped since January 2021, when the unemployment rate was three percent. In 2021, the unemployment rate was nearly four times less than the rate in 2012.



Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

Age-adjusted Death Rates

Ischemic heart and vascular disease - 1

All COPD except asthma - 2

Trachea, bronchus and lung cancer - 3

Alzheimer's disease - 4

Cerebrovascular disease - 5

Suicide - 6

All other mental and behavioral disorders (usually dementia) - 7

All other diseases of the nervous system - 8

Essential hypertension and hypertensive renal and heart disease - 9

Accidental poisoning and exposure to noxious substances - 10

Premature Death Rates

Suicide - 1

Accidental poisoning and exposure to noxious substances - 2

Ischemic heart and vascular disease - 3

Motor vehicle crashes - 4

Trachea, bronchus and lung cancer - 5

All COPD except asthma - 6

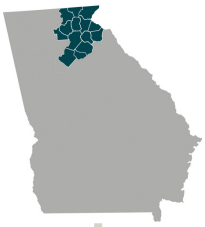
Essential hypertension and hypertensive renal and heart disease - 7

Alcoholic liver disease - 8

Certain conditions originating in the perinatal period - 9

Cerebrovascular disease - 10

Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022. Both age-adjusted death and premature death are defined in Appendix Six.



Health Outcomes

Heart Disease

Heart disease was among the leading causes of death in the service area. **Between 2016 and 2020, the age-adjusted death rate was 172 deaths for every 100,000 people, which was better than the state average but worse than the national average.** Approximately six percent of all adults had been diagnosed with coronary heart disease in 2019, a figure that jumped to 26 percent when looking only at Medicare beneficiaries. Both figures have remained somewhat steady over the last decade.

There are similar trends in stroke deaths. **Between 2016 and 2020, the age-adjusted death rate was 40 deaths per 100,000 people, which is better than the state rate of 43 but worse than the national rate of 38 deaths per every 100,000 people.**

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 12 hospitalizations per every 1,000 Medicare beneficiaries, which was on par with the state and national rates of 12. **The hospitalization rate for stroke of ten hospitalizations per every 1,000 Medicare beneficiaries was higher than the state rate of nine and the national rate of eight.**

Cancer

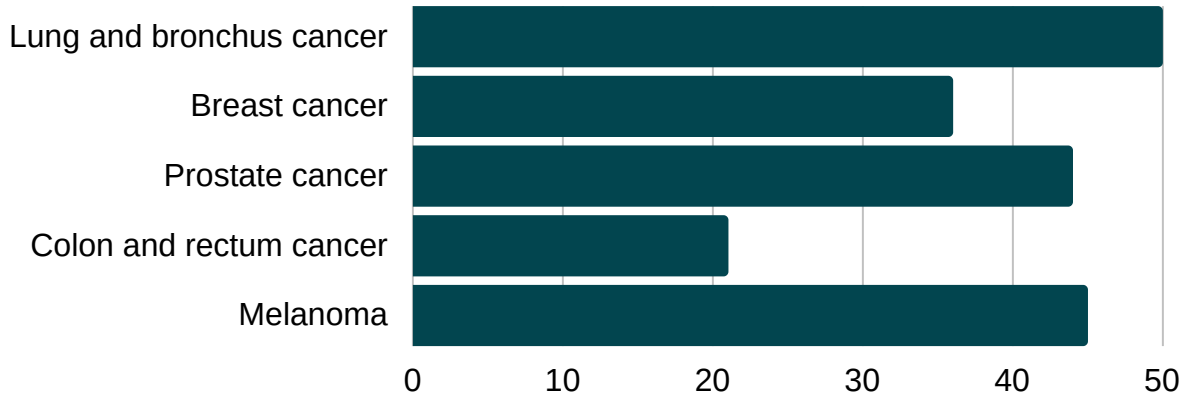
Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 151 deaths per every 100,000 people, which was between the state and national rates of 153 and 149, respectively. When looking at county rates, Lumpkin County had a higher cancer death rate than Dawson County, with 154 deaths from cancer for every 100,000 people, as compared to 147 deaths for every 100,000 people. Males are more likely to die from cancer than females, with a rate of 177 deaths per every 100,000 men. For women, this rate drops to 127 deaths for every 100,000 women.

The cancer incidence rate was also higher, with approximately 543 cancer incidences for every 100,000 people in Lumpkin County, as compared to 449 cancer incidences for every 100,000 people in Dawson County, on average each year between 2014 and 2018.

Health Outcomes

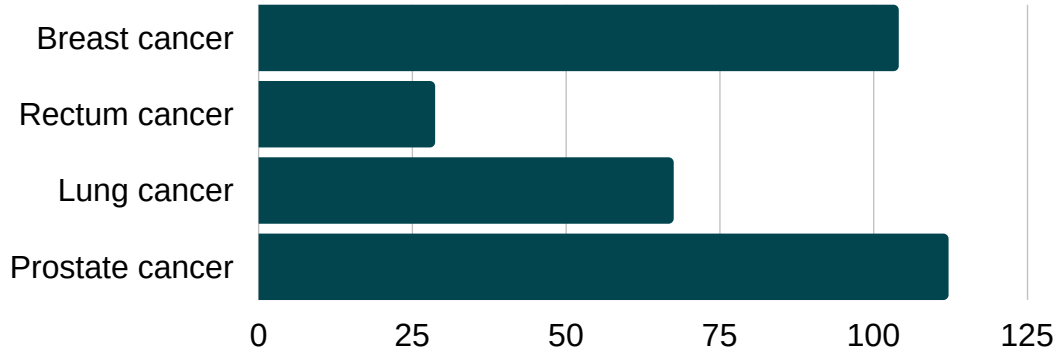
Within the service area, there were an average 355 new cases of cancer diagnosed each year between 2014 and 2018, resulting in a cancer incidence rate of 500 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018



Even though there are more annual cases for lung cancer, prostate cancer has the highest incidence rate within the service area.

Annual Average Cancer Incidence Rate, Per Every 100,000 People, 2014 to 2018

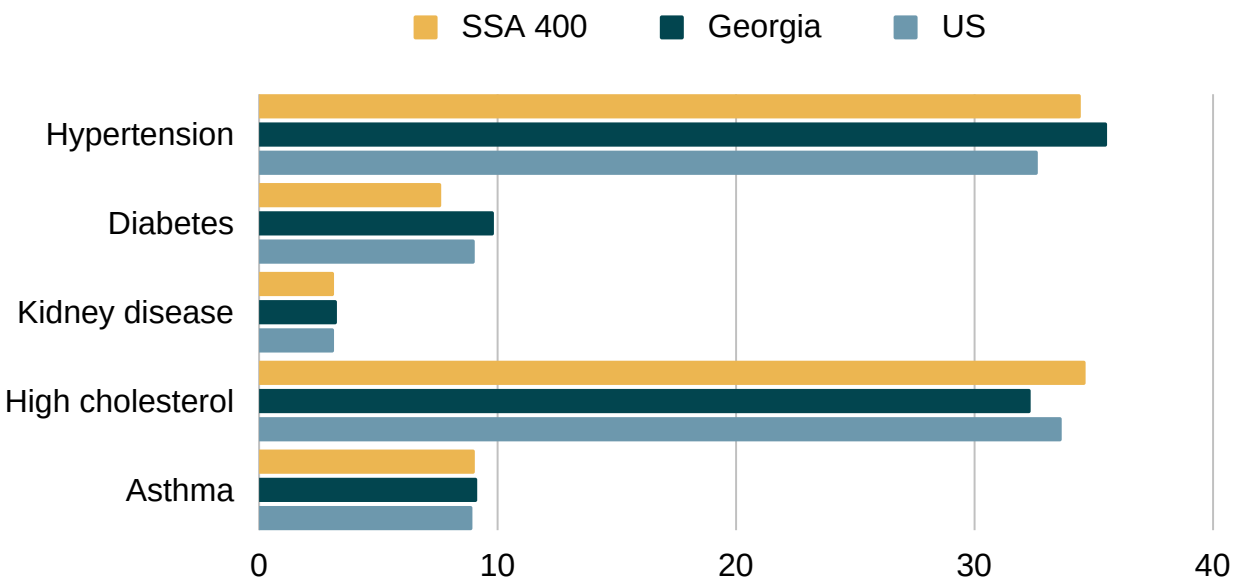


Source for both charts: State Cancer Profiles. 2014-18.

Health Outcomes

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

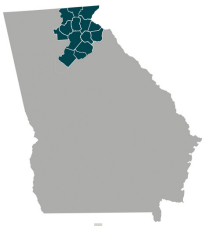
Percent of Population Reporting Key Chronic Conditions, 2018



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 71 percent of all Medicare beneficiaries had multiple chronic conditions, with 26 percent having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note this doesn't equal 100 percent, as some community members have two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
64.22%	20.75%	2.94%	23.39%	12.79%	2.17%

Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

Approximately 23 percent of the population was enrolled in some form of Medicare in 2020, the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 72, and 14 percent were also eligible for Medicaid due to low incomes.

Medicaid Populations

In 2020, 13 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was far below the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 30 percent of children under the age of 18, five percent aged 18 to 64, and ten percent of adults aged 65 and older were enrolled in Medicaid.

Clinical Care and Prevention

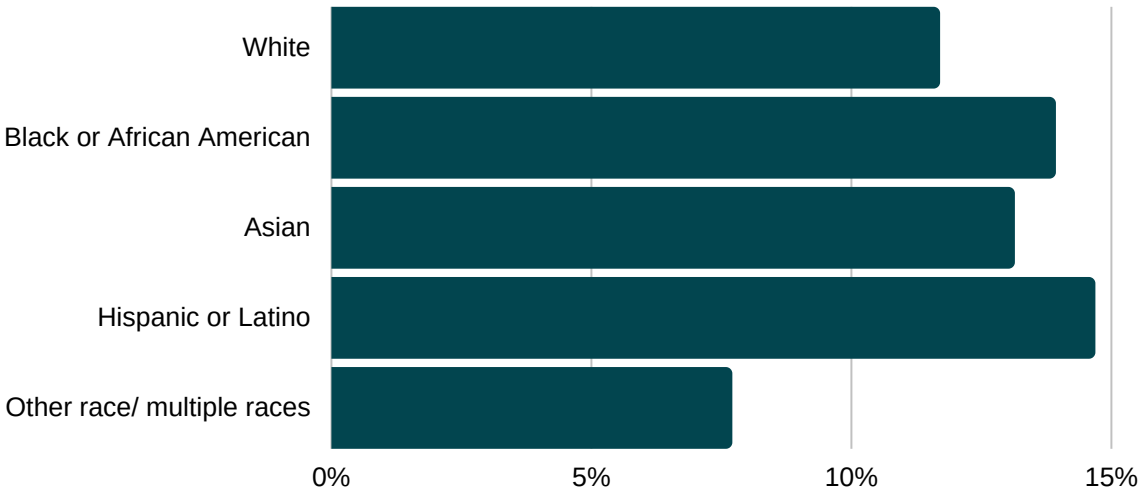
In the service area, on average between 2016 and 2020, 12 percent of the population was uninsured, a figure below the state rate of 13 percent and above the national rate of nine percent. When looking only at adults aged 18-64, the uninsured rate jumped to 21 percent.

Approximately ten percent of all children were uninsured in 2020, a figure much higher than the state and national rates of seven percent and six percent, respectively. However, this figure has steadily decreased over the last few years. For example, in 2011, 12 percent of all children were uninsured.

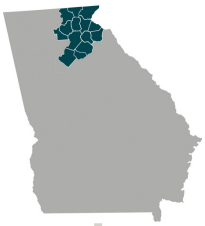
This trend was seen across all populations, as the number of total uninsured steadily declined over the years. For example, in 2011, 27 percent of the service area's non-elderly adult population was uninsured, seven percentage points more than in 2020. Even so, the uninsured rate remains relatively high, and likely had a significant impact on those community member's ability to access primary and specialty care.

When looking at race and ethnicity, most minorities were far more likely than their White counterparts to be uninsured.

Uninsured by Race or Ethnicity, 2016 to 2020



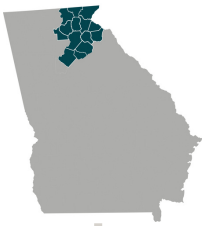
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

In FY21, approximately 1,850 patients received care through the public insurance program Medicaid at NGMC Lumpkin. Below is a list of the top ten ZIP codes by volume of patients receiving care through Medicaid coverage at the hospital during the last two fiscal years. Please note the hospital treated Medicaid patients from locations outside of these ten ZIP codes as well.

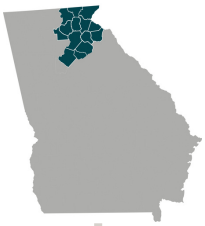
ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30533 (Dahlonega)	905	30533 (Dahlonega)	1,025
30534 (Dawsonville)	234	30534 (Dawsonville)	268
30528 (Cleveland)	159	30528 (Cleveland)	186
30564 (Murrayville)	82	30564 (Murrayville)	115
30506 (Gainesville)	62	30506 (Gainesville)	64
30501 (Gainesville)	14	30527 (Clermont)	22
30527 (Clermont)	14	30041 (Cumming)	16
30527 (Clermont)	11	30028 (Cumming)	13
30041 (Cumming)	10	30501 (Gainesville)	10
30028 (Cumming)	9	30527 (Clermont)	10



Clinical Care and Prevention

Combined in FY20 and FY21, approximately 2,930 patients received financial assistance for their care at NGMC Lumpkin. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years. Please note the hospital provided financial assistance to patients outside of these ten ZIP codes as well.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30533 (Dahlonega)	697	30533 (Dahlonega)	751
30534 (Dawsonville)	183	30534 (Dawsonville)	227
30528 (Cleveland)	119	30528 (Cleveland)	140
30564 (Murrayville)	65	30564 (Murrayville)	85
30506 (Gainesville)	64	30506 (Gainesville)	75
30501 (Gainesville)	29	30501 (Gainesville)	31
30504 (Gainesville)	13	30504 (Gainesville), 30507 (Gainesville)	15
30507 (Gainesville)	12	30527 (Clermont)	12
30554 (Lula), 30527 (Clermont)	11	30554 (Lula), 30542 (Flowery Branch), 30041 (Cumming)	10
30041 (Cumming)	10	30040 (Cumming)	8



Clinical Care and Prevention

Health Professions Shortages and Provider Ratios

In SSA 400, as of June 2022, there were four designated health professions shortage areas: one primary care, one dental health, and two mental health.

- Primary care: There were 49 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 1,005 people within the service area, a measure far worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 2,786 people, a figure worse than the state rate of one provider for every 1,910 people and the national rate of one provider for every 1,397 people.

Primary Care and Routine Check-ups

In 2019, 76 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, a measure that was on par with both state and national averages. For Medicare recipients, this number increased to 87 percent of adult beneficiaries, which was above both state and national averages.

I**n 2018, about 32 percent of men and 33 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services.** The percentage of women up to date on their core preventative services was above state and national averages, while the male percentage was above the state average but below the national average.

Dental Care and Dental Outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection, and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status. Within the service area, in 2018, 63 percent of adults went to the dentist in the past 12 months, which was above the state rates but below the national rates. **That year, 15 percent of the service area reported having lost all or most of their natural teeth because of tooth decay or gum disease.**

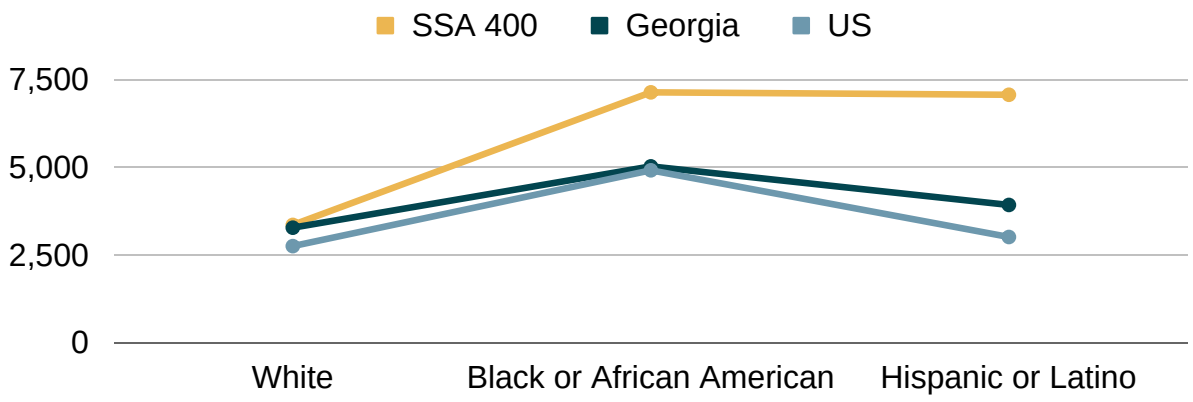
Clinical Care and Prevention

Emergency Department Visits
In 2020, Medicare beneficiaries visited the emergency department 3,610 times, resulting in an ED visit rate of 513 per every 1,000 beneficiaries, which was lower than both state and national rates of 551 and 535, respectively.

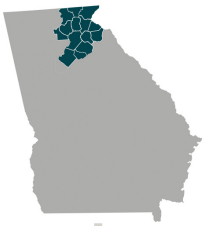
Inpatient Stays
In 2020, 14 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 208 stays per every 1,000 beneficiaries. This was lower than the state rate of 230, and the national rate of 223 inpatient stays during the same time.

Preventable Hospitalizations Among Medicare Beneficiaries
Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,141 per every 100,000 beneficiaries, which is between the state rate of 3,503 hospitalizations and the national rate of 2,865 hospitalizations. As with other health indicators, the indicator shifts when looking at race or ethnicity.

Preventable Hospitalizations Per Every 100,000 beneficiaries, by Race or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Please note data only available for three races.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 73 per every 100,000 total population.** This percentage was far worse than the state and national averages of 38.1 and 47.1, respectively.

Within the service area, the age-adjusted death rate for suicide was 34 deaths for every 100,000 people. This rate was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. For both deaths of despair and suicide, this was far more prevalent among White populations.

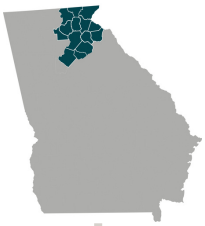
Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data was available, service area residents reported an average of five poor mental health days over the last 30 days, which was on par with the state average of five poor mental health days. Additionally, in 2019, 17 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage was slightly greater than the state rate of 16 percent and much greater than the national rate of 14 percent. Although data is not yet available, these statistics likely increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community.

Opioid and Substance Use

In 2020, providers in the service area prescribed 26 opioid prescriptions per every 100 people, which was a figure that had steadily decreased each year. Within the service area, the age-adjusted death rate for opioid overdose was 18 deaths per 100,000 people. This was far worse than both the state average of ten and the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

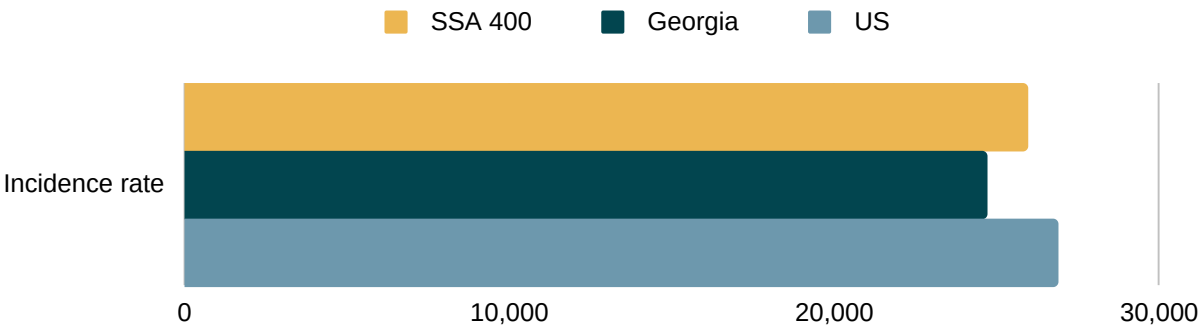
In 2019, Medicare opioid drug claims accounted for three percent of total prescription drug claims. This percentage was better than the state and national percentages of five percent and four percent, respectively.



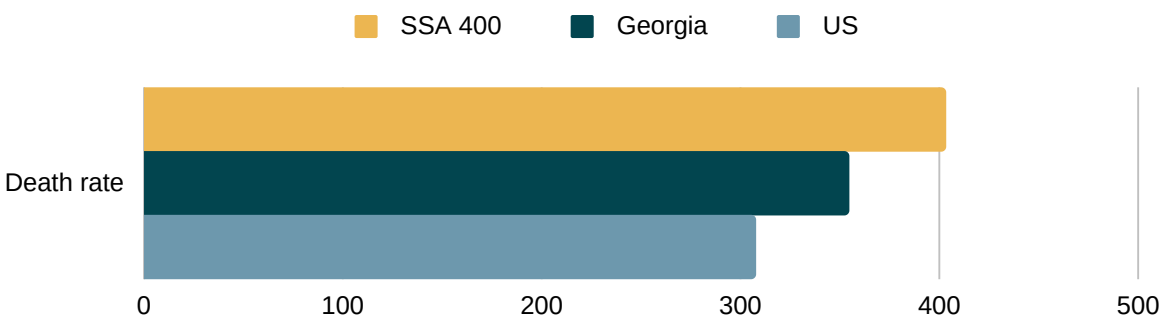
COVID-19

In SSA 400, as of July 2022, the COVID-19 incidence rate was below the national rate but the death rate was far above the national rate.

COVID-19 Incidence Rate, Per Every 100,000 People, July 2022

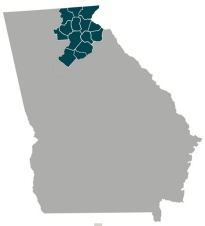


COVID-19 Death Rate, Per Every 100,000 People, July 2022



Source for both charts: Johns Hopkins University. Accessed via ESRI. 2022.

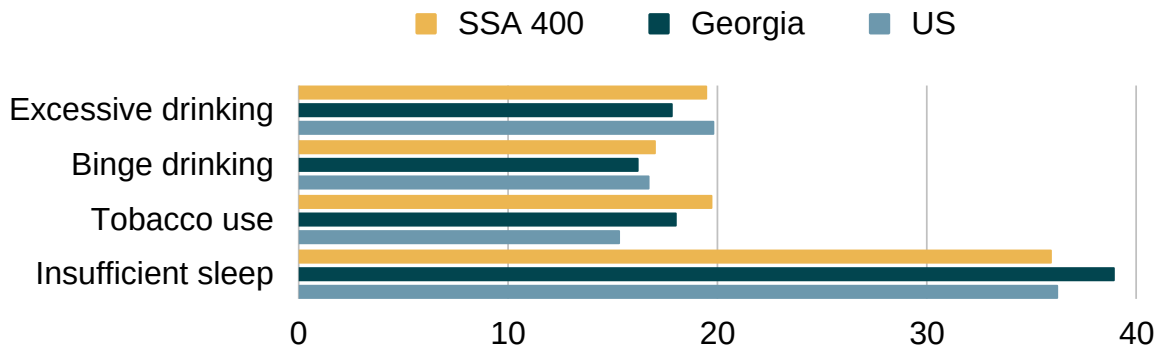
Approximately 45 percent of the service area was fully vaccinated as of July 2022, with an estimated 15 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.53, which showed how challenging vaccine rollout may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).



Health Behaviors

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

Percent of Population Reporting Unhealthy Behaviors, 2019

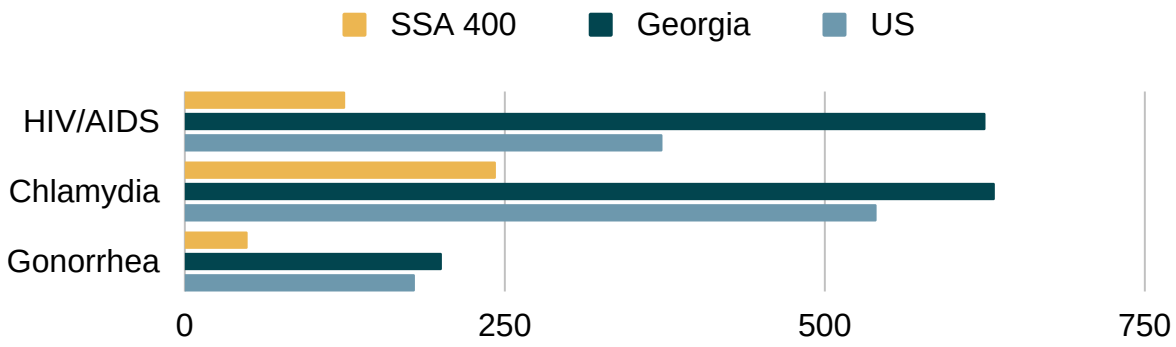


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

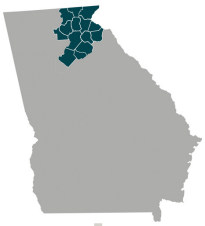
Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates are generally below that of state and national rates.

Sexually Transmitted Disease Rates, per every 100,000 people, 2018

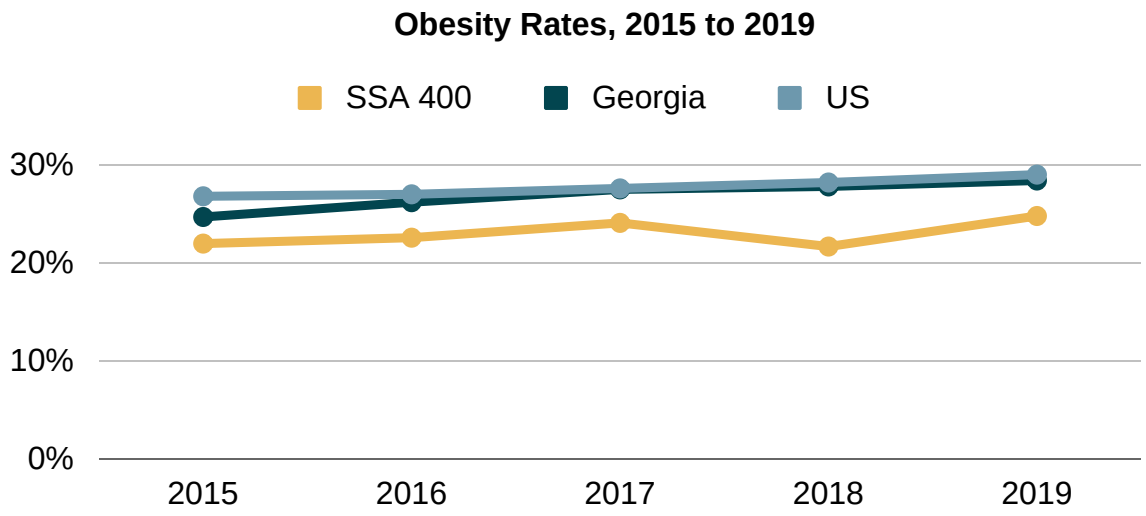


Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.



Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. **In 2019, 25 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 or more.** Obesity rates have generally increased over the last ten years. Obesity is directly linked to several health issues, including diabetes and heart disease.



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

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

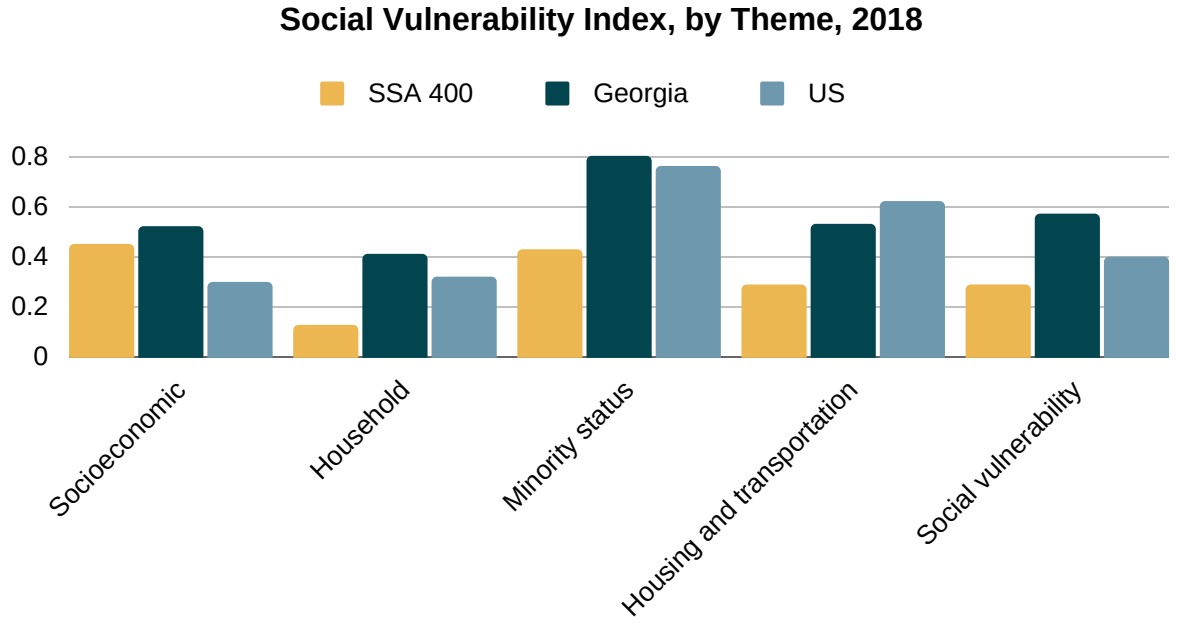
Walking or Biking to Work

Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if commuting by walking or biking is by choice. In 2019, three percent of the service area's population walked or biked to work. Certain ZIP codes saw higher physical commutes, such as 30533 (Dahlonega), where 726 people walked or biked to work in 2019.

Socioeconomic Factors: Social Vulnerability Index

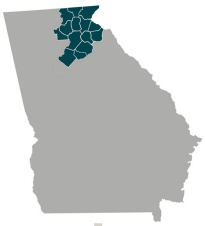
The CDC's Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss experienced from a disaster.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

The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. The service area had a social vulnerability index score of 0.29, much lower than the state score of 0.57 and the national score of 0.40. Broken down by themes:



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

The area where the service area scored lowest was household status, meaning the service area had a high level of vulnerable households. This includes households where the majority of occupants are aged 65 or older, aged 17 or younger, are comprised of a senior living alone, had at least one household member with a significant disability, or is a single-parent household.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person's physical and mental health.

The average monthly owner cost for a home within the service area was $1,133 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $879. COVID-19 has had a significant impact on housing, so these figures have likely increased since then.

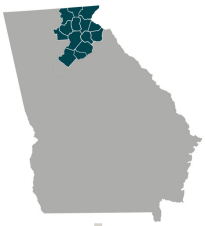
Cost-Burdened Households

Of all occupied households in SSA 400, 24 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately 12 percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.

Renters bear the strain of this the most, with 43 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure dropped to 27 percent. **Approximately 49 percent of renters paid rent that's at least 50 percent of their household income.**

Substandard Housing

This indicator reports the number and percentage of the owner and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. **A quarter of all households in the service area had one or more substandard conditions. This was lower than the state and national averages of 30 and 31 percent, respectively.**



Socioeconomic Factors: Low Food Access and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, especially if they are already low-income.

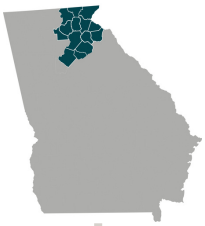
Low food access is defined as living more than 0.5 miles from the nearest supermarket, supercenter, or large grocery store. According to the 2021 Food Access Research Atlas database, one percent of the total population in the service area had low food access, meaning about 416 service area residents may have struggled to access healthy foods.

Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The map to the right illustrates areas of low food access within the service area. The darker the color, the more prevalent the issue. Note that some cities appear as at least a small portion of that city is located within the service area. The service area had a food insecurity rate of 11 percent, meaning those community members were unsure how they would access adequate food at some point over the year. That said, many of these community members were ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school meals, the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all the food-insecure children in the service area, 27 percent were ineligible for public assistance programs. Of everyone living with food insecurity, approximately 32 percent were ineligible for any public assistance.

Grocery Stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. In 2020, there were seven grocery establishments in the report area, equaling a rate of 12 grocery stores per every 100,000 people. This was lower than both the state and national rates, which were 16 and 19, respectively.



Community Input

The meeting for the SSA 400 stakeholder engagement group was held on February 07, 2022. Participants described this area as one with pockets of wealth and poverty, lack of health insurance, and rural areas. When asked to rate the health status of the community on a scale of one to five, with five being the highest, stakeholders from SSA-400 scored an average 1.6. The community's most prevalent conditions and diseases include heart disease, diabetes, and cancer.

When asked to identify their greatest concerns about the community's health that may be preventing it from achieving an excellent health status, stakeholders cited inadequate transportation, poor habits, and distance to reach a specialist. SSA-400 stakeholders identified the top three unmet health needs as lack of/inadequate health insurance, mental health, and 24-hour care centers. Underlying causes of the community's health issues include income, poverty, poor diet/habits, lack of education, and physical exercise.

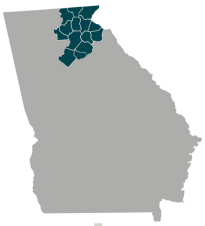
The vulnerable groups or populations the group advised health systems to provide targeted interventions to include:

- The elderly
- People in rural areas
- The underemployed

The barriers preventing clients or other community members from seeking health care and improving their health include:

- Long travel times to specialists
- Inadequate 24-hour facilities (employees work shift jobs)
- Lack of social connections – not encouraged by previous generations

The community’s faith-based resource is the Community Helping Place. The community’s free or low-cost clinic resource is the Good Shepherd Clinic.



Community Input

The community's food pantry resources include: Place of Dawson (formerly known as Ric-Rac); War Hill; Community Helping Place; The University of North Georgia Food Pantry; and, Hightower Association of Baptist Churches

The community's mental and behavioral health resources include Jeremiah's Place, residents in the women and children shelter, and the school system. When asked how the community had been impacted by current events such as COVID-19, participants indicated that they had personally and professionally experienced illness and deaths. Social isolation has been particularly difficult. When asked to consider how social issues have impacted the community, stakeholders noted the stress caused by political divisiveness.

As part of the process, The ThoMoss group interviewed three community members to solicit their input on community health. Below is a summary of themes that emerged from those interviews.

Barriers to health:

- Lack of transportation
- Lack of/inadequate insurance
- Poverty
- Race/language/undocumented persons

Gaps in health services:

- Mental health
- Preventative care
- Maternal health/obstetrics/gynecology
- Health education

Opportunities to improve health:

- Health education
- Specialty services
- Preventative care

Sources of health information:

- Internet
- Fox News
- Peers
- Television

Populations most impacted by barriers:

- Hispanic/Latino populations
- The elderly
- Indigent populations
- Undocumented persons

Top health needs:

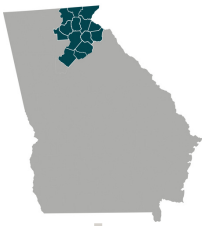
- Diabetes
- Heart disease
- Blood pressure
- Maternal health
- Specialty care

Gaps in mental health and vulnerable populations:

- Hispanic/Latino populations
- Everyone
- Migrant communities
- Minorities

Gaps in mental health:

- Prescription drugs and older adolescents



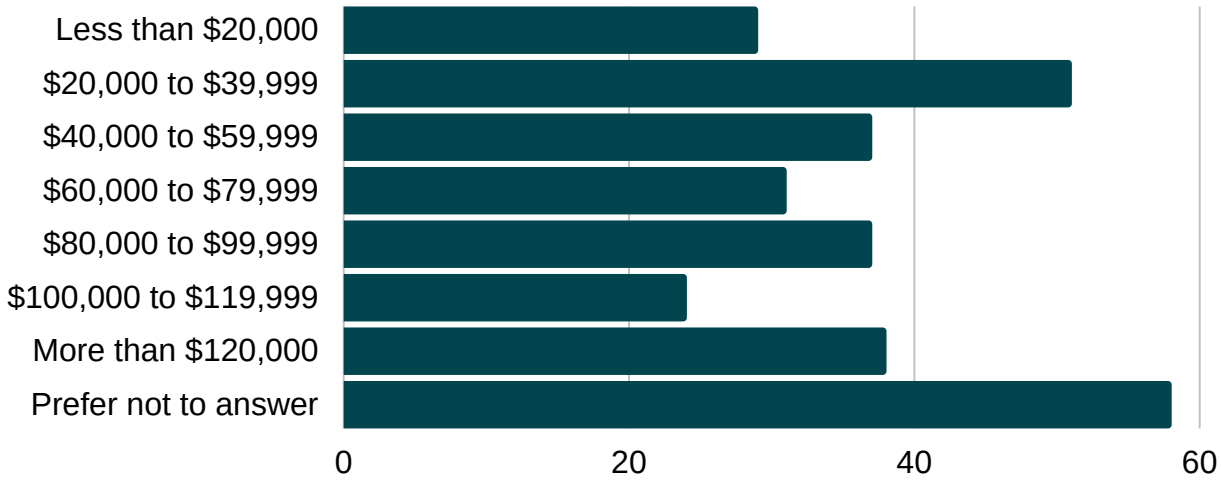
Community Survey

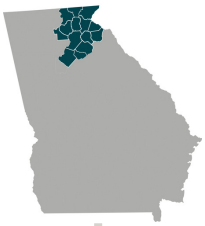
In March 2022, approximately 313 community members living within SSA 400 completed an electronic community-based survey widely advertised to the community via CHNA partners' websites, press releases and social media. All survey questions can be found in Appendix Eleven. Please note that the following survey data was for selected indicators. All answers from the survey can be found online at **nghs.com/community-benefit-resources** via the Tableau data tool.

Of all respondents:

- 29 percent were male, 67 percent were female, and 4 percent preferred to not answer
- 93 percent were White, 2 percent were Hispanic or Latino, 2 percent were African American or Black, and 3 percent preferred not to answer
- 3 percent were 25 or younger, 2 percent were between ages 26 and 34, 7 percent were between ages 35 and 44, 18 percent were between ages 45 and 54, 22 percent were between the ages of 55 and 64, 35 percent were between ages 65 and 74, and the remaining 12 percent were 75 and older. One percent declined to answer.
- 96 percent had some form of health insurance and 87 percent lived in households where all members had some form of health insurance

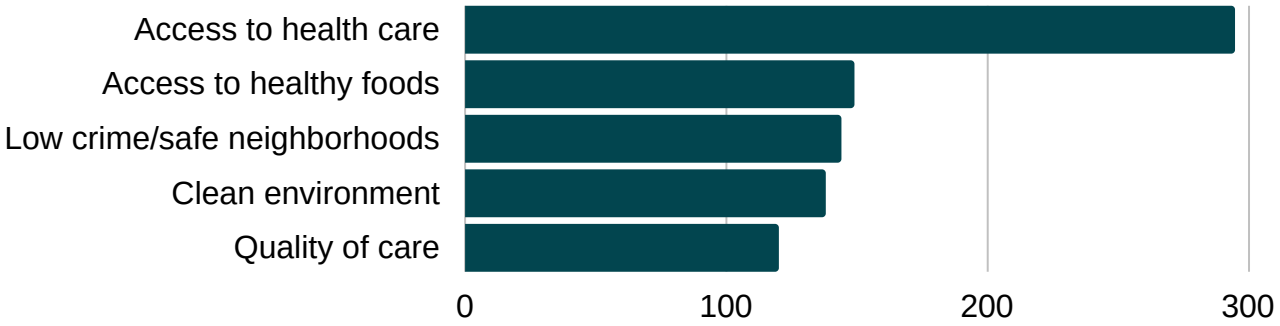
Below is a breakdown of the annual household income for all respondents.



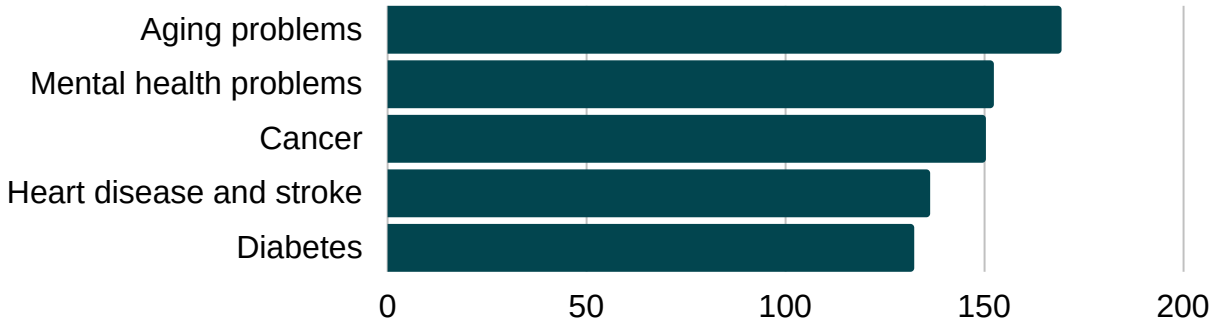


Community Survey

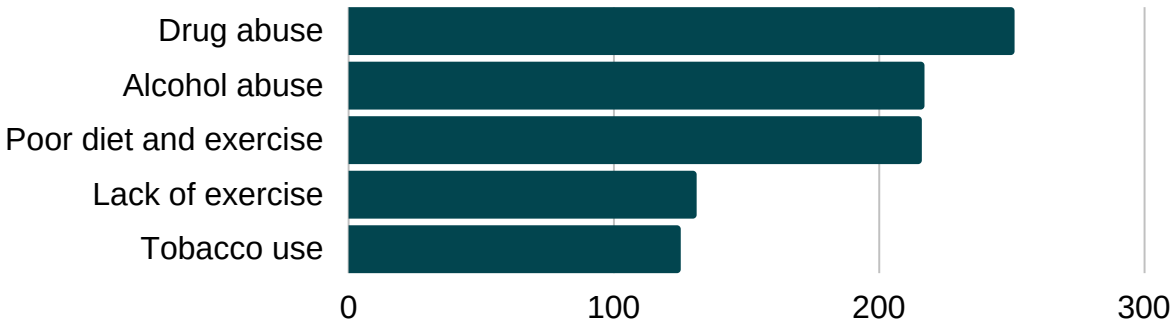
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below are the top five answers.

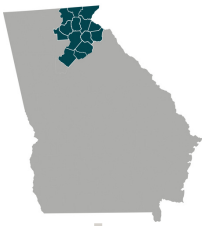


Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below are the top five answers.



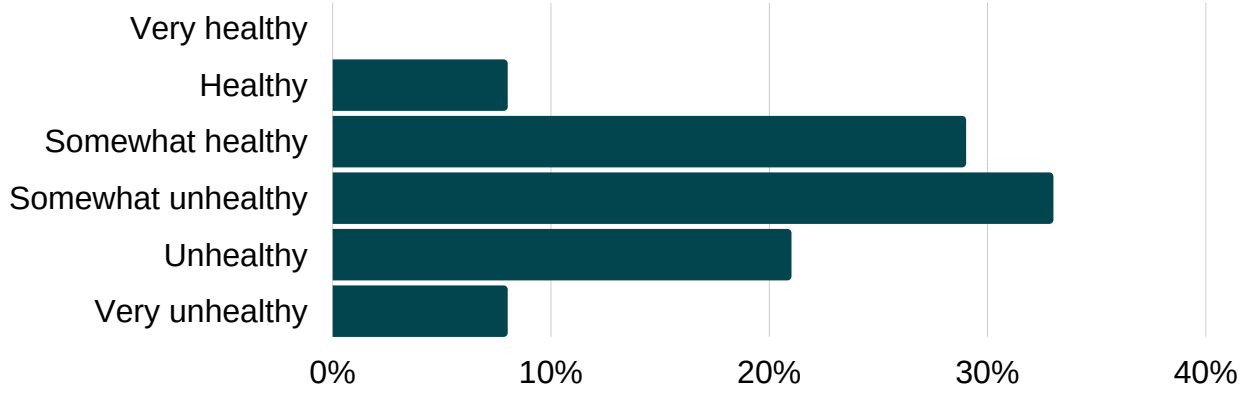
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



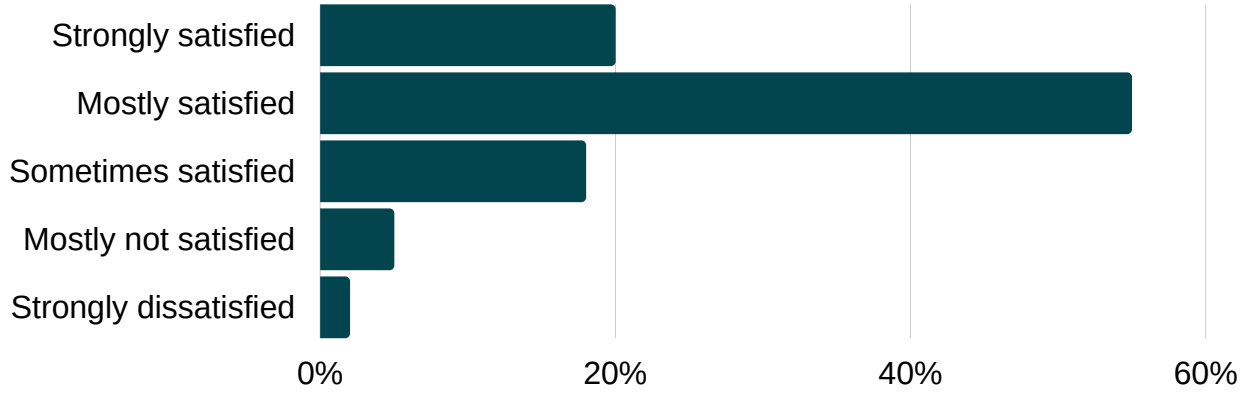


Community Survey

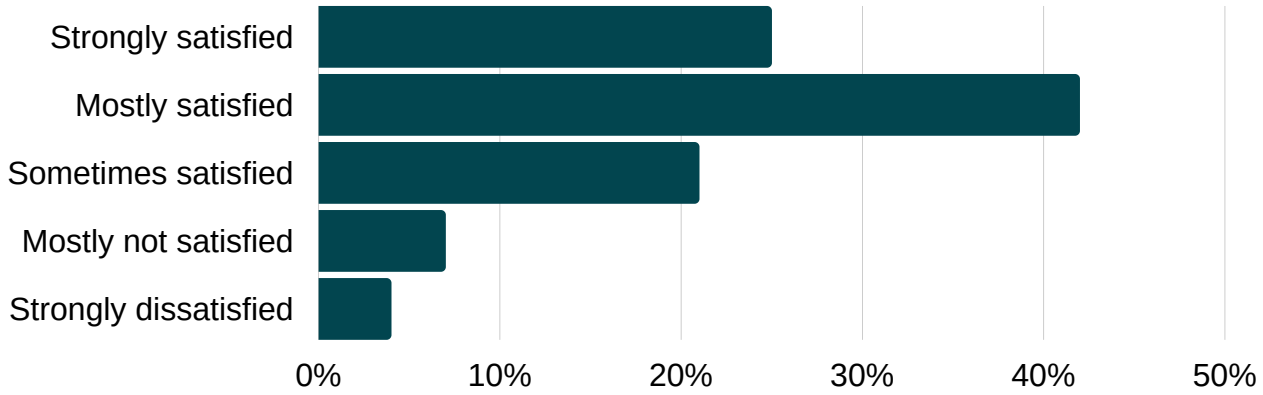
Q: How would you rate the overall health of our community?

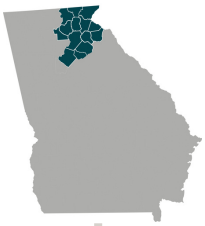


Q: How how satisfied are you with the quality of life in your community?



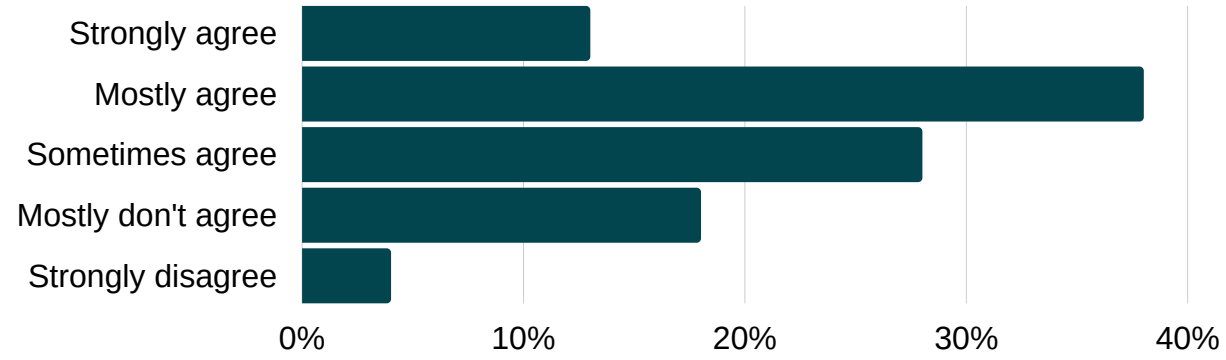
Q: How satisfied are you with the health care system in your community?



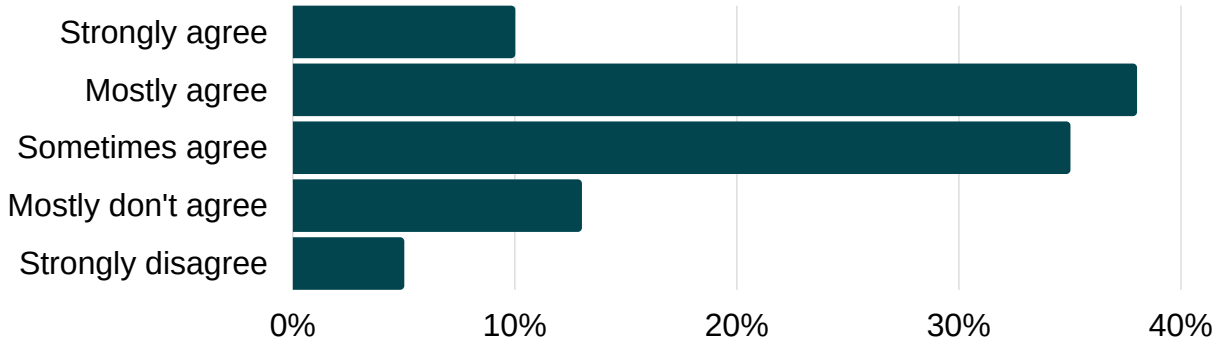


Community Survey

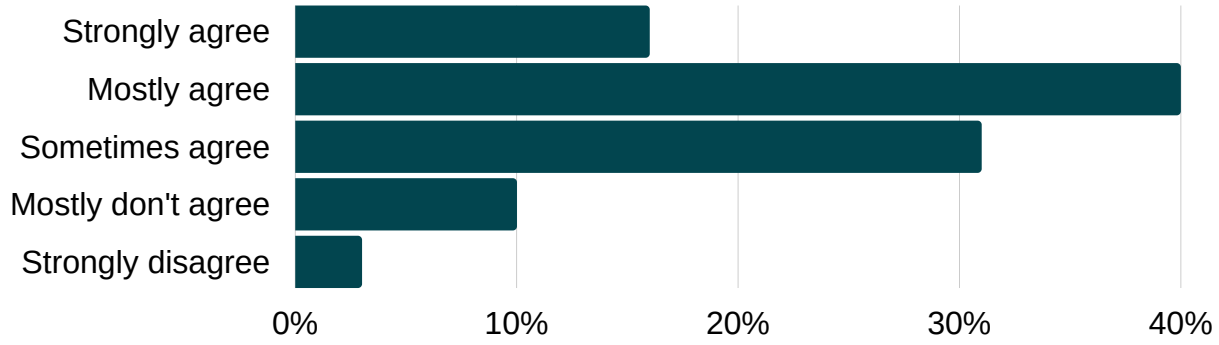
Q: Do you feel there are enough health and social services in your community?

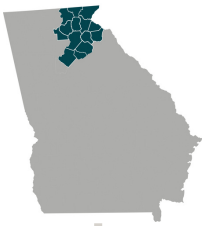


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



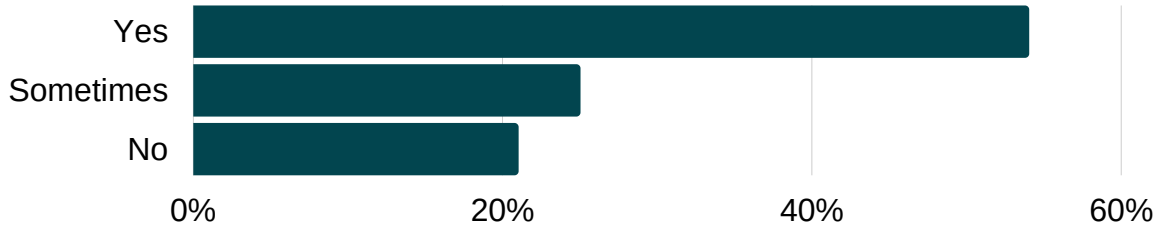
Q: Do you feel there are networks of support for individuals and families during times of stress and need?



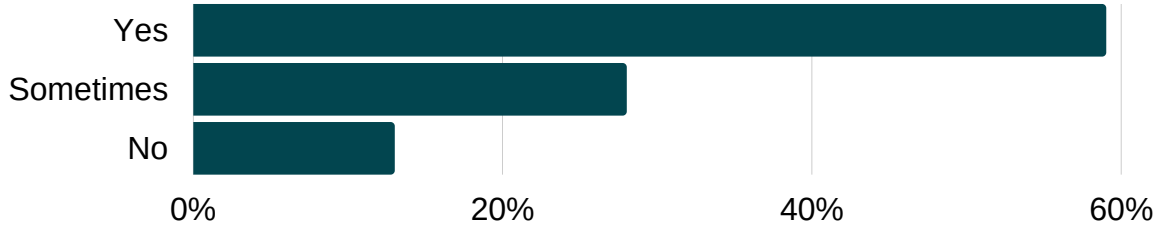


Community Survey

Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?

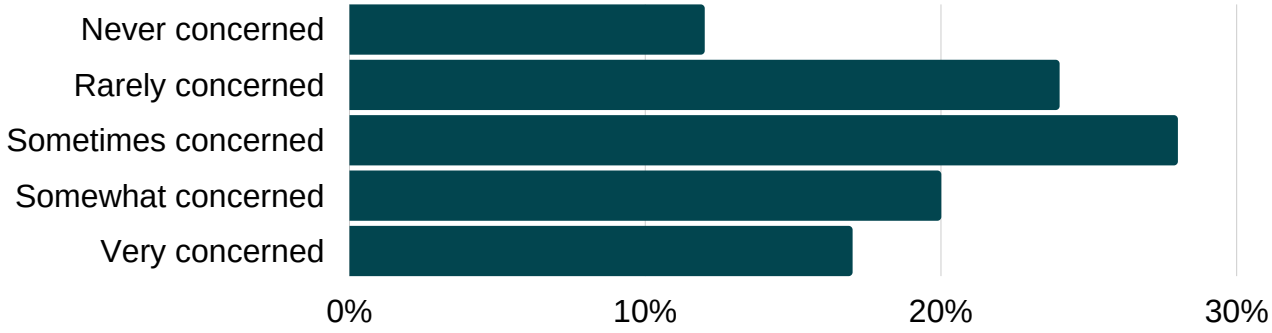


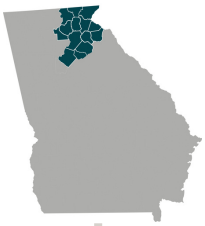
Q: Do you have a hard time paying for medications for you and your family?



Q: Does anyone in your family currently have medical debt?

Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

he matrix below demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for the SSA 400 service area.

High data + low qualitative

- Access to care: preventable hospitalizations, ED visits
- Cancer, particularly lung
- COPD
- Alzheimer's disease
- Endocrine disease
- Gastrointestinal disease
- Musculoskeletal disease
- Reproductive disease
- Hypertension
- Respiratory disease
- Septicemia
- Pneumonia
- Disability
- Education
- Infectious disease
- Tobacco
- Physical activity
- Food insecurity
- Housing costs

High data + high qualitative

- Access to care: insurance status, cost, providers
- Access to dental care: providers
- Access to mental health care: providers
- Cardiovascular disease
- Diabetes
- Disability
- Fair or poor mental health
- COVID-19: vaccination rates, deaths
- Poverty/income
- Substance abuse and overdose deaths: opioids, fentanyl, alcohol
- Health behaviors
- Mental health: suicide
- Obesity

Low data + low qualitative

- Bone and muscle disease
- Nervous system disease
- Fair or poor physical health status
- Child mortality
- Teen pregnancy
- Segregation
- Social isolation
- Tobacco use

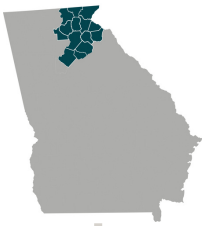
Low data + high qualitative

- Maternal and child health
- Injury
- Violence – child abuse and domestic
- Stigma around mental health*
- Health education and information*
- Employment*
- Homelessness*
- Politics*
- Community growth*

*No quantitative data available

Once the top health needs were identified, CHNA partners completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does a SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

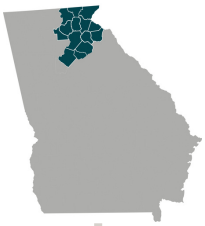
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – Access to care	15
1 – Diabetes	15
1 – Heart disease	15
1 – Mental health: Providers, suicide, depression, poor or fair mental health	15
2 – Stroke	13.5
3 – Food insecurity	13
3 – Poverty and income	13
4 – Obesity	12.5
5 – Cancer deaths and incidences	12
5 – Substance abuse	12
6 – Social isolation	10
7 – COVID-19: Vaccination rates	8
8 – Access to dental care: Providers	5

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting held on May 19, 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental and behavioral health**
- **Access to care**
- **Healthy behaviors**

Although not selected as priorities, there are additional issues of concern for the residents within the SSA 400 service area, including cancer, stroke, and heart disease. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



NGMC Secondary Service Area North

NGMC Secondary Service Area North (SSA North) is comprised of Banks, Rabun, Stephens, Towns, Union, and White County, which is highlighted on the map to the right.

In 2020, 127,469 people lived in the 1,511 square-mile community. This service area is mostly rural, as 84 percent of the combined population lived in a rural setting in 2020.

When broken down by age:

- 18 percent of the population were 17 or younger
- 57 percent were between 18 and 64
- 25 percent were over 65

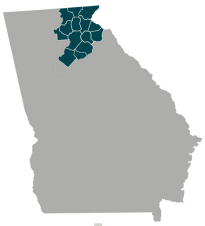
High school graduation rates were high as of 2020, with 92 percent of the area's population graduating. By comparison, only 85 percent of state residents held a high school diploma. Thirty percent had an associate degree or higher, and 12 percent held a bachelor's degree. Approximately 16 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 89 percent were White
- 4 percent were Black or African American
- 5 percent were Hispanic or Latino
- Less than 1 percent were Asian
- 2 percent were either multiple races or some other race

Ten percent of service area residents were veterans in 2020 and the majority were over the age of 65. Eighteen percent of all adults aged 18 to 65 had served in the military, and 20 percent of all men in the service area were veterans, as compared to two percent of all women.

Nearly 19 percent of the total service area population lived with a disability in 2020, a rate higher than the state and national rates of 12 and 13 percent, respectively. When separated by age, 37 percent of all adults aged 65 and older lived with a disability that year, as compared to four percent of children and 15 percent of adults aged 18 to 64.



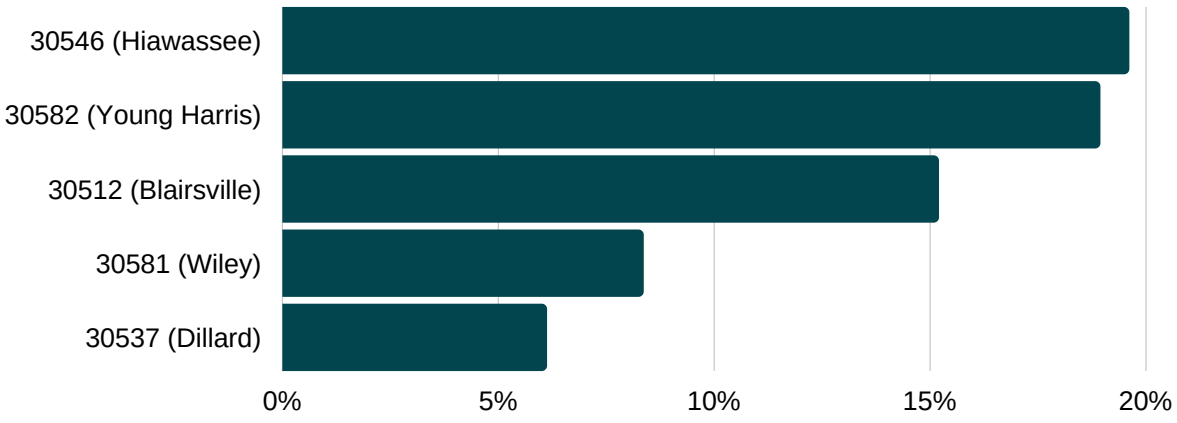
Demographics

In 2020, nearly three percent of the population identified as being born outside of the US, and two percent did not possess US citizenship status. Of the total population, one percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English “very well.” Spanish was the most common of those languages, followed second by the broad category of Asian languages.

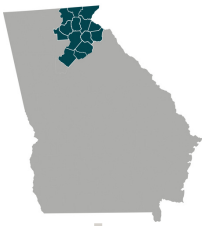
Within the service area, the population increased by six percent between 2010 and 2020, which was lower than the state and national population percentage changes of 11 percent and seven percent, respectively.

Minority populations increased far more than their White counterparts, which grew by two percent during that time. By contrast, Black or African American populations grew by five percent, Asian populations grew by 17 percent, and Hispanic/Latino populations grew by 29 percent. Those identifying outside those four primary race or ethnic categories grew by 141 percent.

ZIP Codes with the Highest Percentage Change in Populations, 2010 to 2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 18 percent of the service area were children and youth 17 and younger. In the 2019-2020 school year, three percent of children were homeless, meaning nearly 470 school-age children had no stable home at some point that year.

Of all children, 49 percent lived at or below 200 percent of the FPL in 2020, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30581 (Wiley), where 100 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. The service area had seven Head Start programs, resulting in 11 programs per 10,000 children under five years old in 2020, which was above the state rate of seven and on par with the national rate of 11. In 2020, 28 percent of children aged three to four were enrolled in preschool, a rate below the state and national average of 49 percent and 47 percent, respectively.

English and Math 4th-Grade Proficiency

Of all students tested, 56 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was better than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 47 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was better than the statewide rate of 54 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 24 births per every 1,000 females aged 15 to 19, a rate above state and national rates of 23 and 19, respectively.**

Income and Economics

In 2020, the average household income was $66,613, which is less than state and national average incomes, which are $85,691 and $91,547, respectively. Within the service area, we see the following variation of average household income, by ZIP codes:

Highest Incomes:

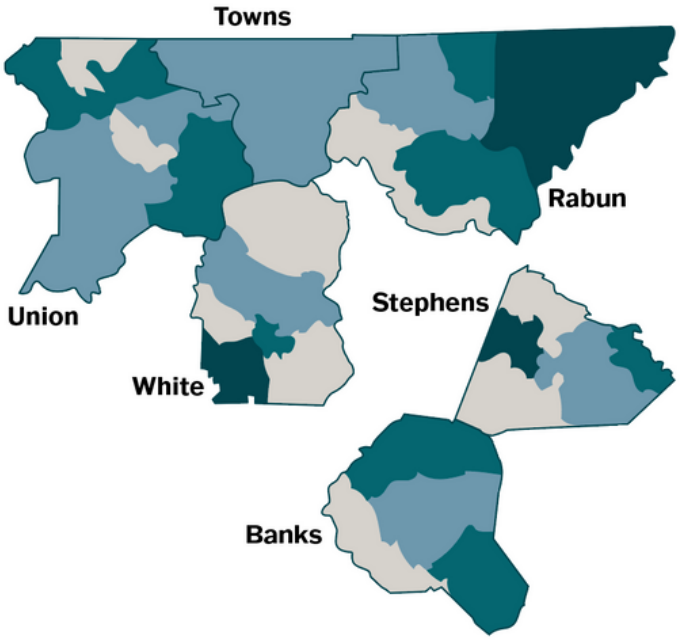
1. 30568 (Rabun): $92,329
2. 30547 (Homer): $76,055
3. 30545 (Helen): $74,970
4. 30571 (Sautee Nacoochee): $74,949
5. 30525 (Clayton): $74,710

Lowest Incomes:

1. 30562 (Mountain City): $43,620
2. 30573 (Tallulah Falls): $49,424
3. 30572 (Suches): $53,078
4. 30538 (Eastanollee): $55,130
5. 30577 (Toccoa): $56,967

Poverty and the Community

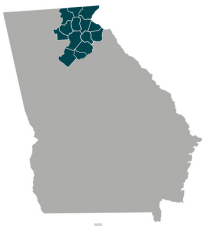
Approximately 14 percent of the service area lived in poverty in 2020. In 2022, the FPLplaced a family of four as having a total household income of $27,750.



The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent the FPL and below.

- 20% or more live at or below poverty
- 15.1% to 20%
- 10.1% to 15%
- 10% or less

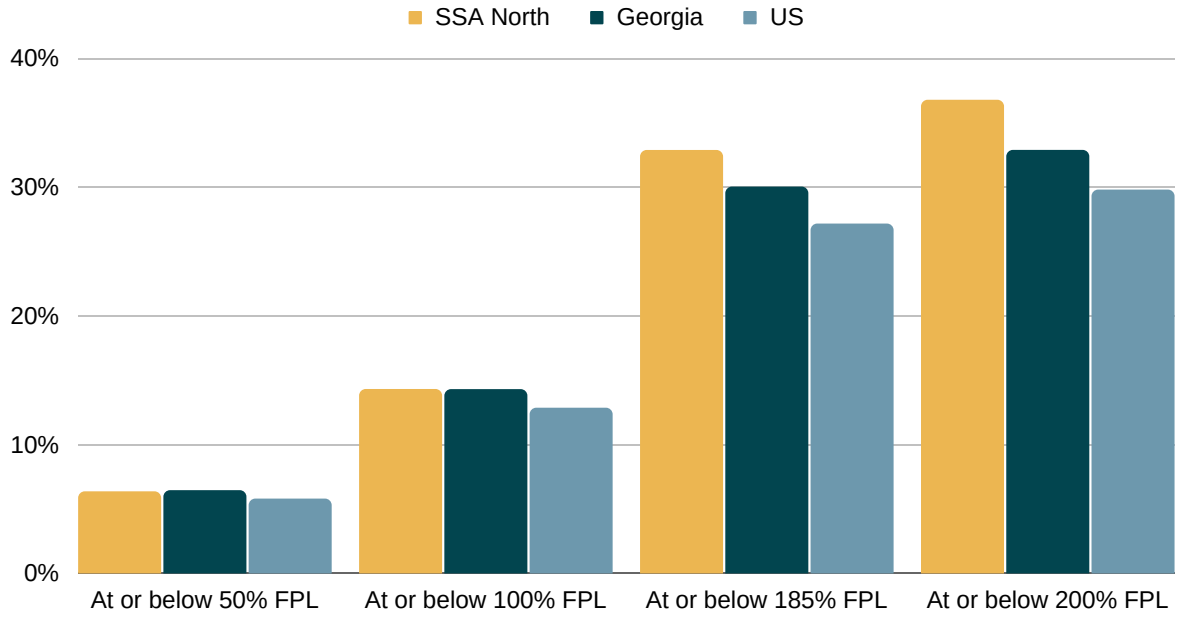
Data Source: US Census Bureau, American Community Survey. 2016-20.



Income and Economics

Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.

Poverty by Percentage of FPL, 2016 to 2020



Source: US Census Bureau, American Community Survey. 2016-20.

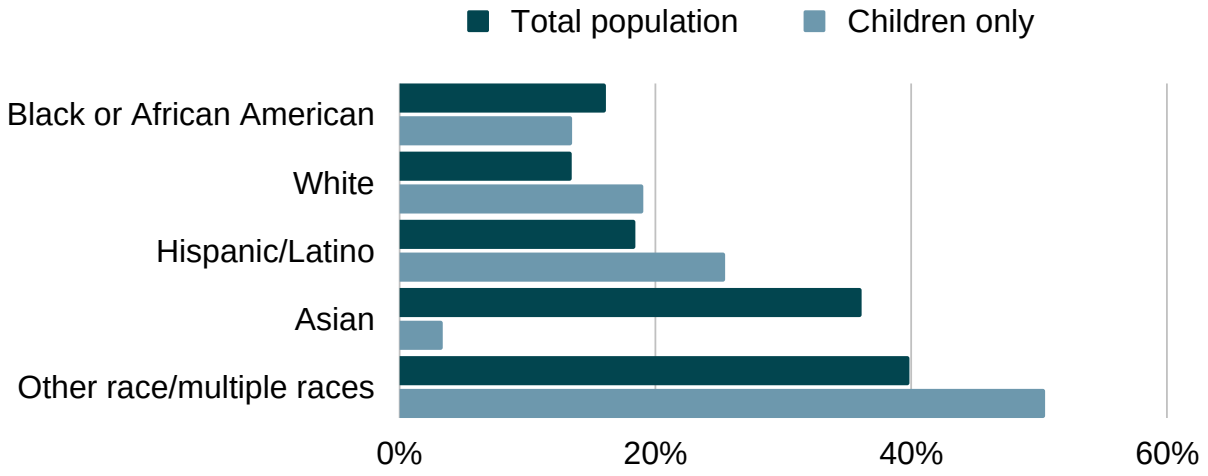
Public Assistance Income

Within the service area, one percent of all households received some form of public assistance. This was lower than the state and national rate of two percent. Within the service area, ZIP code 30573 (Tallulah Falls) had the highest level of public assistance income, with 42 percent of the population receiving benefits. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP.

Income and Economics

When broken down by age and race, the below poverty trends emerge. As demonstrated in the chart below, most minorities within the service area are more likely to live in poverty than their White counterparts.

Populations Living in Poverty, By Race or Ethnicity, 2016 to 2020



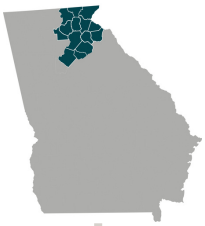
Source: US Census Bureau, American Community Survey. 2016-20.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. In the service area, 12 percent of the population received SNAP benefits in 2019. The ZIP code with the highest percentage of SNAP beneficiaries was 30538 (Eastanollee), where 21 percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Nearly half of all children in the service area qualified for free or reduced-price lunch in the 2019 to 2020 school year, a figure between the state and national rates of 56.44 percent and 42.16 percent, respectively. Free or reduced-price lunches are served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. High levels of free or reduced cost lunch demonstrates areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net loss of 202 businesses. 2,381 establishment "births" and 2,583 "deaths" contributed to that change. The rate of change was negative eight percent over the ten-year period, which is much lower than the state average of four percent.

The area's gross domestic product was $4,195.47 (millions) in 2020, up by about 46 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerge as the largest:

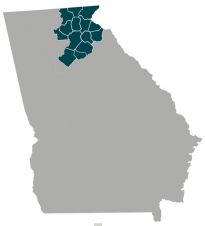
Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Retail Trade	6,996	$26,782
Food Services	6,198	$22,226
Construction	4,878	$23,433

Data Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

In 2020, the total labor force for the service area was 54,455 people, and the labor force participation rate was 51 percent. Total unemployment in the service area in July 2022 equaled two percent. This rate had steadily dropped since January 2021, when the unemployment rate was three percent. In 2021, the unemployment rate was more than four times less than the rate in 2012.



Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

Age-adjusted Death Rates

Ischemic heart and vascular disease - 1

All COPD except asthma - 2

Alzheimer's disease - 3

Trachea, bronchus and lung cancer - 4

Cerebrovascular disease - 5

All other mental and behavioral disorders (usually dementia) - 6

Essential hypertension and hypertensive renal and heart disease - 7

All other diseases of the nervous system - 8

Diabetes - 9

Colon, rectum, or anal cancer - 10

Premature Death Rates

Motor vehicle crashes - 1

Ischemic heart and vascular disease - 2

Suicide - 3

Accidental poisoning and exposure to noxious substances - 4

Trachea, bronchus and lung cancer - 5

All COPD except asthma - 6

Diabetes - 7

Cerebrovascular disease - 8

All other diseases of the nervous system - 9

Congenital malformations, deformations, and chromosomal abnormalities - 10

Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022. Both age-adjusted death and premature death are defined in Appendix Six.

Health Outcomes

Heart Disease

Heart disease is among the leading causes of death in the service area. Between 2016 and 2020, the age-adjusted death rate was 177 deaths for every 100,000 people, which is better than the state average but worse than the national average. **Approximately six percent of all adults had been diagnosed with coronary heart disease as of 2019, a figure that jumps to 25 percent when looking only at Medicare beneficiaries.** Both figures have remained somewhat steady over the last decade.

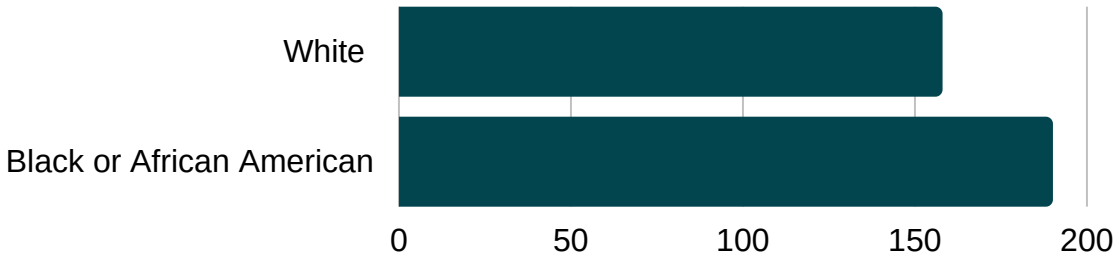
There are similar trends in stroke deaths. Between 2016 and 2020, the age-adjusted death rate was 42 deaths per 100,000 people, which was better than the state rate of 43 deaths but worse than the national rate of 38 deaths per every 100,000 people.

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 12 hospitalizations per every 1,000 Medicare beneficiaries, which was par with the state and national rate of 12. The hospitalization rate for stroke was nine hospitalizations per every 1,000 Medicare beneficiaries, which was on par with both the state and national rate.

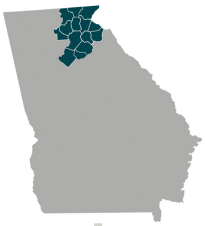
Cancer

Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 156 deaths per every 100,000 people, which was higher than the state and national rates of 153 and 149, respectively. The death rates shift when looking at race and ethnicity. Data was only made available for White and Black or African American populations.

Cancer Deaths by Race or Ethnicity, Per Every 100,000 People



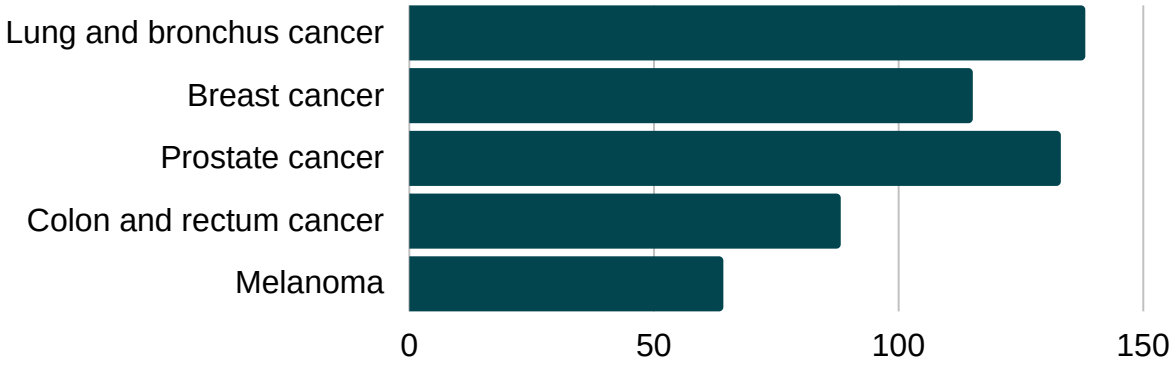
Source: State Cancer Profiles. 2014-18. Please note data was not available for Asian populations.



Health Outcomes

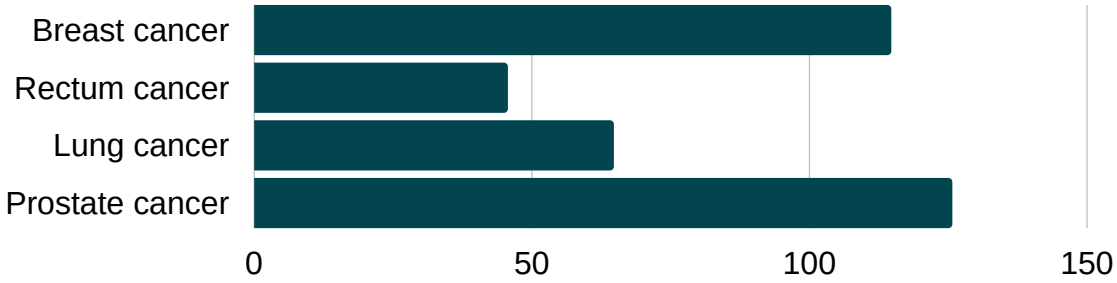
Within the service area, there were an average 971 new cases of cancer diagnosed each year between 2014 and 2018, resulting in a cancer incidence rate of 503 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018

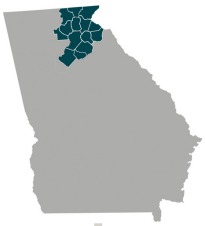


The below chart shows the incidence rate for the most common cancers within the community.

Annual Average Cancer Incidence Rate, Per Every 100,000 People, 2014 to 2018



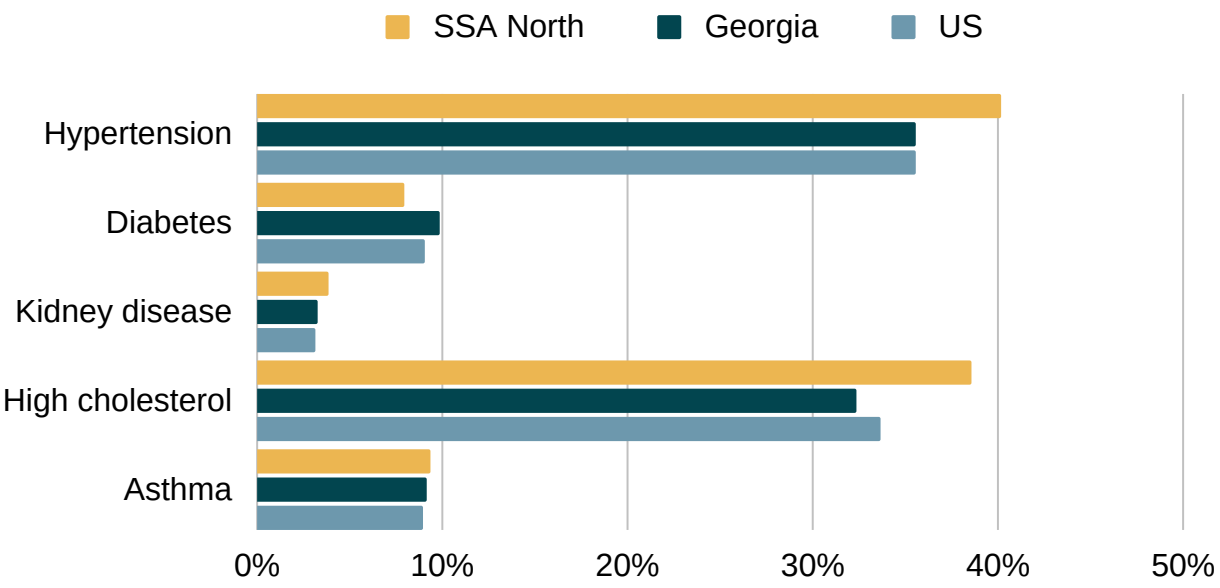
Source for both charts: State Cancer Profiles. 2014-18. Demographic information is only available for White and Black or African American populations in this service area.



Health Outcomes

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

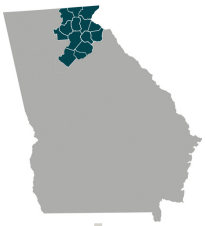
Percent of Population Reporting Key Chronic Conditions, 2018



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 72 percent of all Medicare beneficiaries had multiple chronic conditions, with 28 percent of beneficiaries having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note this doesn't equal 100 percent, as some community members have two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
51.89%	20.22%	3.33%	32.70%	20.90%	4.37%

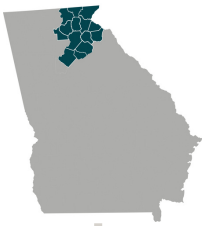
Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

In 2020, about 20 percent of the population was enrolled in some form of Medicare, the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 73, and 15 percent were also eligible for Medicaid due to low incomes. The majority of Medicare recipients in the service area were White.

Medicaid Populations

In 2020, 21 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was on par with the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 44 percent of children under the age of 18, 11 percent aged 18 to 64, and 12 percent of adults aged 65 and older were enrolled in Medicaid.



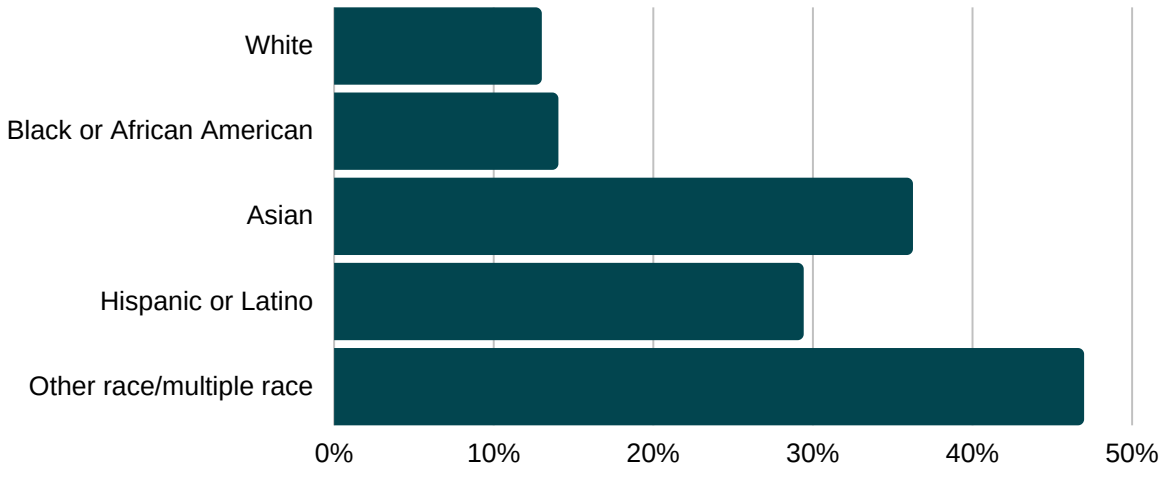
Clinical Care and Prevention

In the service area, on average between 2016 and 2020, 14 percent of the population were uninsured, a figure above the state rate of 13 percent and the national rate of nine percent. When looking only at adults aged 18-64, the uninsured rate jumps to 23 percent. **The number of uninsured has steadily declined over the years.** For example, in 2012, 28 percent of the service area's non-elderly adult population was uninsured.

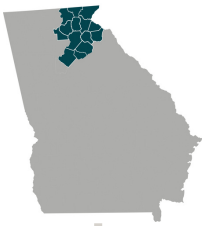
Approximately ten percent of all children were uninsured in 2020, a figure much higher than the state and national rates of seven percent and six percent, respectively. This is a figure, though, that has also steadily decreased over the last few years. For example, in 2011, 12 percent of all children were uninsured.

In SSA North, minorities are more likely to be uninsured than their White counterparts. In particular, Asian and multiple race/other race populations were most likely to be uninsured. Hispanic or Latino populations also carried high levels of uninsurance, at nearly 30 percent.

Uninsured by Race or Ethnicity, 2016 to 2020



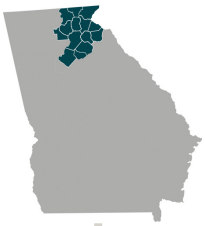
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

In FY21, approximately 4,000 patients received care through the public insurance program Medicaid at NGMC Barrow. Below is a list of the top ten ZIP codes by volume of patients receiving care through Medicaid coverage at the hospital during the last two fiscal years. Please note the hospital treated Medicaid patients from locations outside of these ten ZIP codes as well.

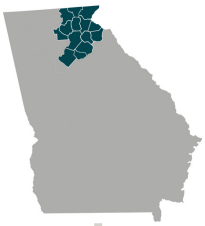
ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30680 (Winder)	2,019	30680 (Winder)	2,043
30620 (Bethlehem)	392	30620 (Bethlehem)	422
30011 (Auburn)	363	30011 (Auburn)	360
30666 (Statham)	194	30666 (Statham)	217
30549 (Jefferson)	160	30549 (Jefferson)	206
30655 (Monroe)	90	30655 (Monroe)	90
30548 (Hoschton)	67	30656 (Monroe)	74
30656 (Monroe)	60	30548 (Hoschton)	65
30019 (Dacula)	52	30019 (Dacula)	57
30052 (Loganville)	31	30052 (Loganville)	41



Clinical Care and Prevention

In FY21, approximately 3,300 patients received financial assistance for their care at NGMC Barrow. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years. Please note the hospital provided financial assistance to patients outside of these ten ZIP codes as well.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30680 (Winder)	1,516	30680 (Winder)	1,444
30011 (Auburn)	322	30011 (Auburn)	301
30620 (Bethlehem)	288	30620 (Bethlehem)	260
30549 (Jefferson)	156	30549 (Jefferson)	172
30666 (Statham)	155	30666 (Statham)	139
30548 (Hoschton)	76	30548 (Hoschton)	80
30019 (Dacula)	58	30019 (Dacula)	56
30542 (Flowery Branch)	49	30517 (Braselton), 30542 (Flowery Branch), 30656 (Monroe)	49
30655 (Monroe)	45	30501 (Gainesville)	38
30655 (Monroe)	41	30655 (Monroe)	34



Clinical Care and Prevention

Health professions shortages and provider ratios

In SSA North, as of June 2022, there were 14 designated health professions shortage areas: six primary care, two dental health, and six mental health.

- Primary care: There were 49 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 1,168 people within the service area, a measure far worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 3,206 people, a figure worse than the state rate of one provider for every 1,910 people and the national rate of one provider for every 1,397 people.

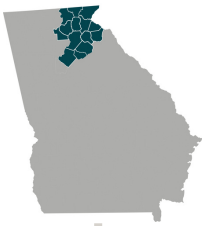
Primary care and routine check-ups

In 2019, 78 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, a measure that is on par with both state and national averages. For Medicare recipients, this number increases to 86 percent of all beneficiaries having visited a doctor in the previous 12 months. As with most all other indicators, race and income play heavily into this. **Seventy-nine percent of Black populations received routine check-ups, as compared to 86 percent among White populations.**

In 2018, about 30 percent of men and 32 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services. Both of these statistics are below state and national averages.

Dental care and dental outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status.Within the service area, in 2018, 60 percent of adults went to the dentist in the past 12 months. **That year, 17 percent of the service area reported having lost all or most of their natural teeth because of tooth decay or gum disease.**



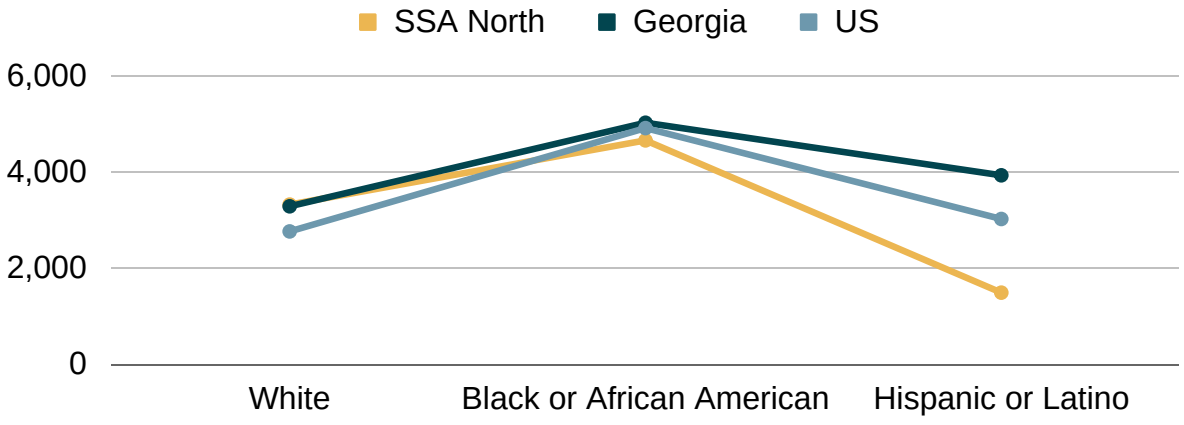
Clinical Care and Prevention

Emergency Department Visits
In 2020, Medicare beneficiaries visited the emergency department 11,464 times, resulting in an ED visit rate of 535 visits per every 1,000 beneficiaries, on par with the state and national rates of 551 and 535, respectively.

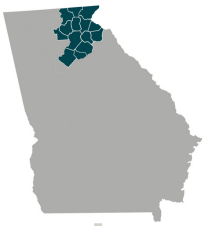
Inpatient Stays
In 2020, 14 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 202 stays per every 1,000 beneficiaries. This was lower than the state rate of 230 and the national rate of 223 inpatient stays during the same time.

Preventable Hospitalizations Among Medicare Beneficiaries
Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,226 per every 100,000 beneficiaries, which was lower than the state rate of 3,503 hospitalizations but higher than the national rate of 2,865 hospitalizations. As with other health indicators, the indicator shifts when looking at race or ethnicity.

Preventable Hospitalizations Per Every 100,000 Beneficiaries, by Race or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Please note data only available for three races.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 58 deaths for every 100,000 people.** This rate is far worse than the state and national averages of 38 and 47 deaths for every 100,000 people, respectively.

Within the service area, the age-adjusted death rate for suicide was 25 deaths for every 100,000 people. This rate was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. For both deaths of despair and suicide, this was far more prevalent among White populations.

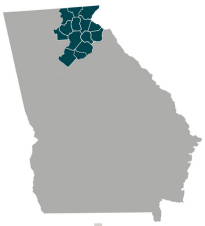
Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data is available, service area residents reported an average of six poor mental health days over the last 30 days, which is greater than the state average of five poor mental health days. Additionally, in 2019, 18 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage is slightly greater than the state rate of 16 percent and much greater than the national rate of 14 percent. Although data is not yet available, these statistics likely increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community.

Opioid and Substance Use

In 2020, providers in the service area prescribed an average 51 opioid prescriptions per every 100 people, which is a figure that has been steadily decreasing each year. Within the service area, the age-adjusted death rate for opioid overdose was 15 deaths per 100,000 people. This was far worse than the state average of ten but less than the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

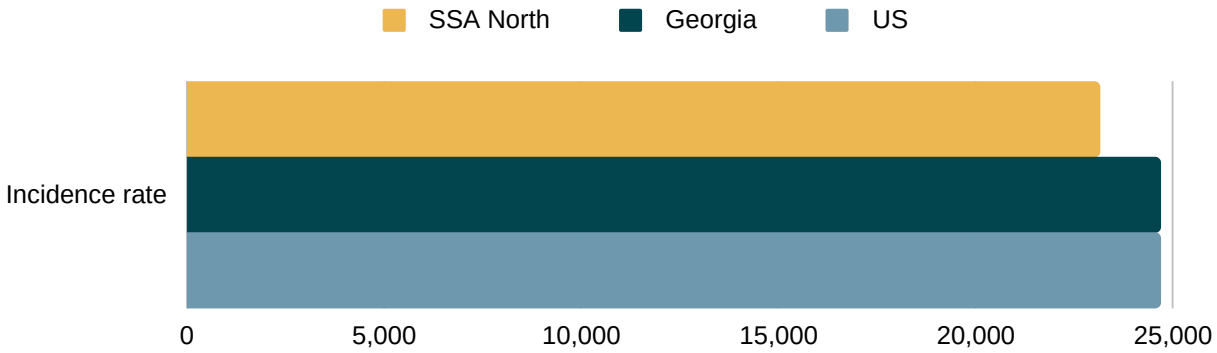
In 2019, Medicare opioid drug claims accounted for five percent of total prescription drug claims. This percentage was on par with the state rate of five percent and worse than the national rate of four percent.



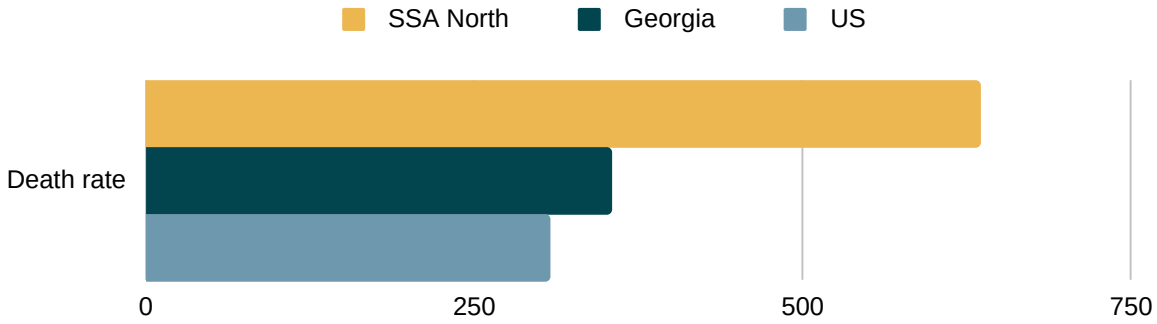
COVID-19

In SSA North, as of July 2022, the COVID-19 incidence rate was below state and national rates, but the death rate was far above both state and national rates.

COVID-19 Incidence Rate, Per Every 100,000 People, July 2022

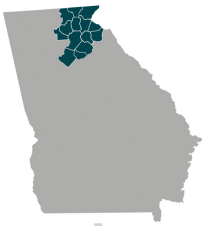


COVID-19 Death Rate, Per Every 100,000 People, July 2022



Source for both charts: Johns Hopkins University. Accessed via ESRI. 2022.

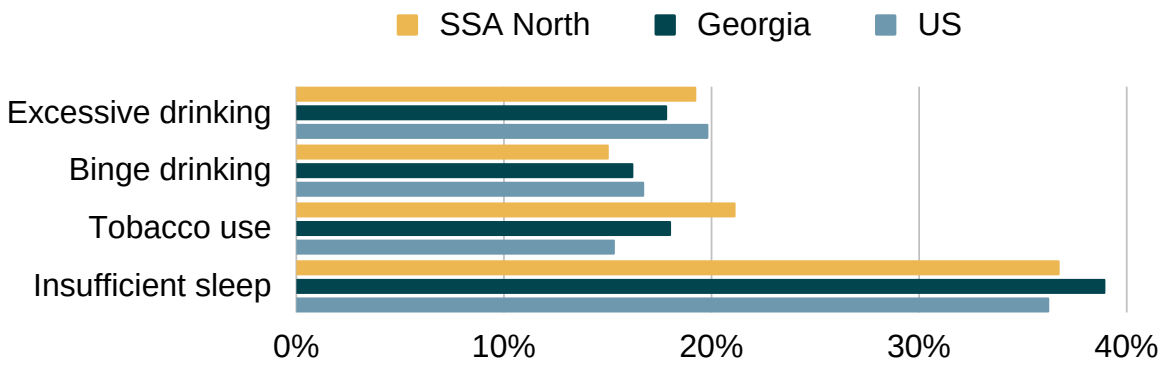
Approximately 49 percent of the service area was fully vaccinated as of July 2022, with an estimated 15 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.61, which showed how challenging vaccine rollouts may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).



Health Behaviors

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

Percent of Population Reporting Unhealthy Behaviors, 2019

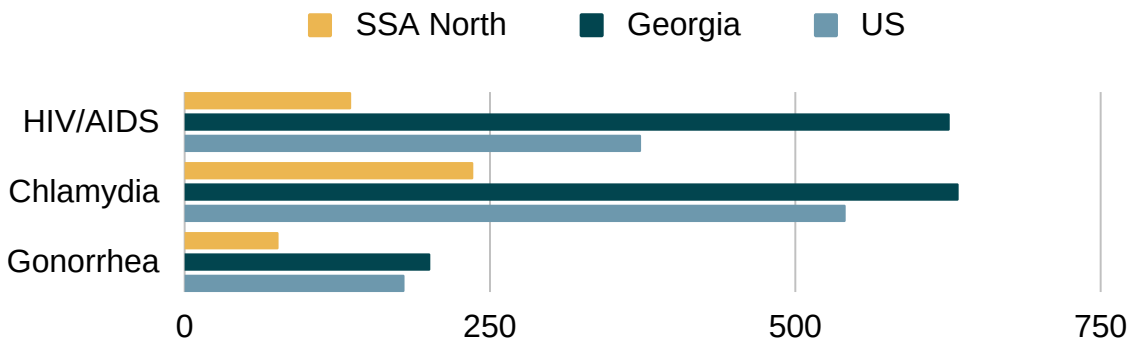


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

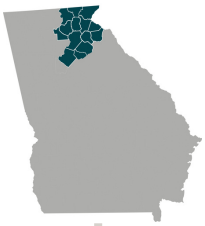
Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates were below that of state and national rates.

Sexually Transmitted Disease Rates, per every 100,000 people, 2018

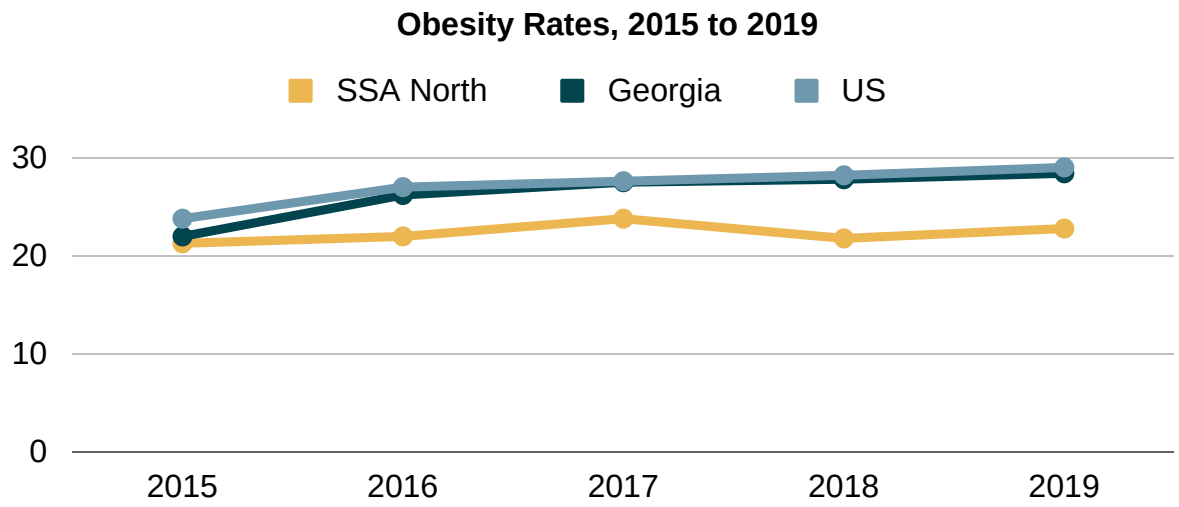


Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.



Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. I**n 2019, 23 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 or more.** Obesity rates have generally increased over the last ten years. Obesity is directly linked to several health issues, including diabetes and heart disease.



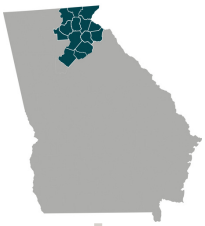
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

Within the service area in 2019, 21 percent of adults aged 20 and older self-reported no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Walking or Biking to Work

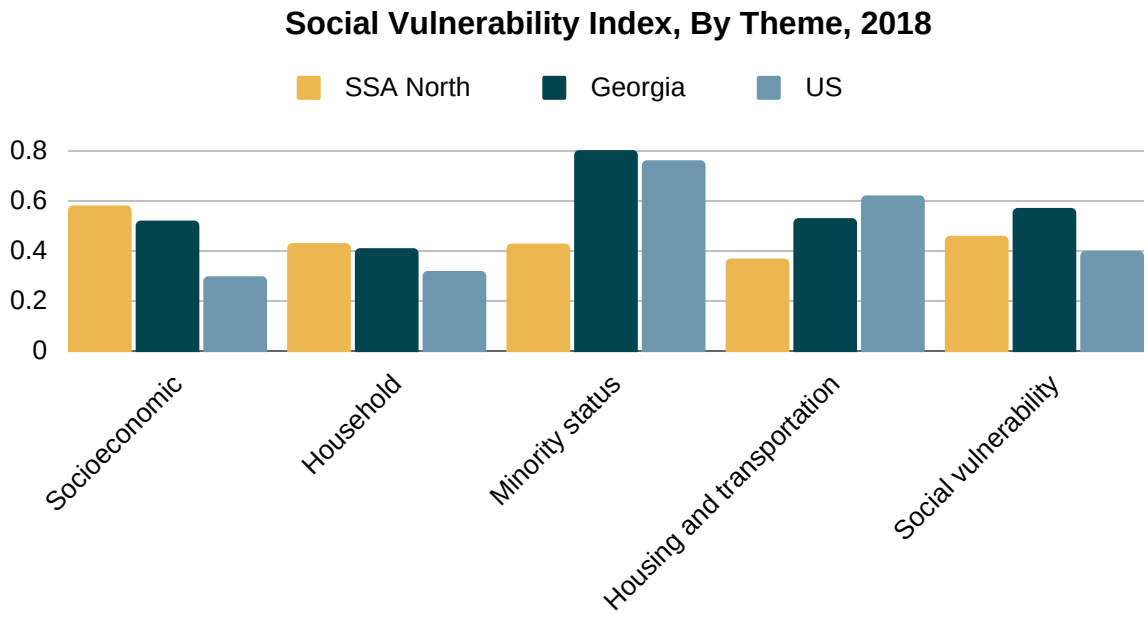
Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if commuting by walking or biking is by choice. In 2019, about two percent of the service area's population walked or biked to work. Certain ZIP codes saw higher physical commutes, such as 30573 (Tallulah Falls), where ten people walked or biked to work in 2019.



Socioeconomic Factors: Social Vulnerability Index

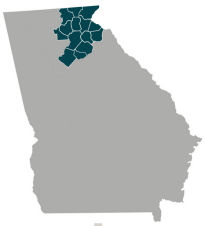
The CDC's Social Vulnerability Index is the degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, that may affect that community's ability to prevent human suffering and financial loss experienced from a disaster.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

The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. The service area had a social vulnerability index score of 0.46, between the state score of 0.57 and the national score of 0.40. Broken down by themes:



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

The area where the service area scored lowest was socioeconomic status, which references issues of income, poverty, employment, and education, all of which score poorly enough for the community to be considered particularly vulnerable in that area.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person's physical and mental health.

Overall, the average monthly owner cost for a home within the service area was $881 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $718. COVID-19 has had a significant impact on housing, so these figures have likely increased since then.

Cost-Burdened Households

Of all occupied households in SSA North, 25 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately 11 percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.

Renters bear the strain of this the most, with 42 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure drops to 30 percent. **Approximately 42 percent of renters pay rent that's at least 50 percent of their household income.**

Substandard Housing

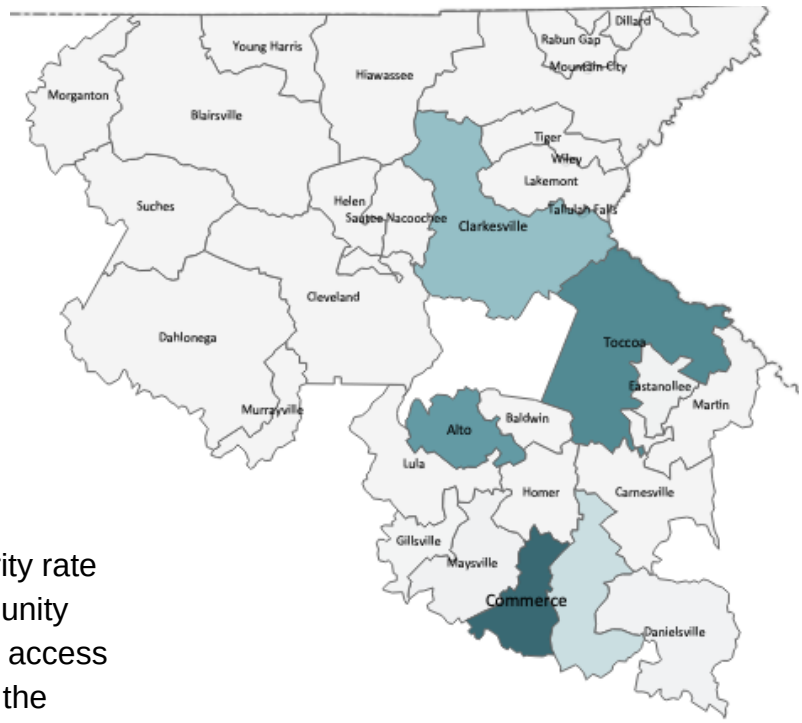
This indicator reports the number and percentage of the owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. **One-quarter of all households in the service area have one or more substandard conditions, which is lower than the state and national averages of 30 and 31 percent, respectively.**

Socioeconomic Factors: Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially if they are already low-income.

Communities that lack affordable and nutritious food are commonly known as “food deserts.” The service area had two food desert census tracts, meaning about 6,601 people did not have ready access to healthy foods.

The map to the right illustrates food deserts within the service area. The darker the color, the more prevalent the issue.

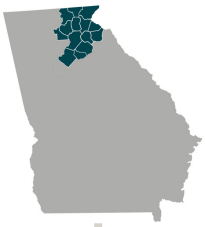


Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The service area had a food insecurity rate of 11 percent, meaning those community members were unsure how they will access adequate food at some point during the year.

That said, many of these community members are ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school meals, the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all food-insecure children in the service area, 12 percent were ineligible for public assistance programs. Of everyone living with food insecurity, approximately 23 percent were ineligible for any public assistance.

According to the 2019 Food Access Research Atlas database, 3.28 percent of the total population in the service area have low food access, meaning those community members likely struggled to access healthy foods.



Community Input

In February 2022, the SSA North focus group convened and three Advisory Board members participated in the breakout session. When asked to rate the community's health on a scale of one to five, SSA North participants scored 2.3. Participants described this area as service-oriented, rural agricultural driven, and religiously oriented. Transportation to services is difficult for some in more rural areas.

The community's most prevalent conditions or diseases were identified as aging, COPD, and poor nutrition. What most concerns stakeholders about the community's health are low educational attainment, food insecurity, and drug abuse. The greatest unmet health service needs are mental health and men’s health. The underlying causes of the community's health issues include mental health and lack of affordable housing. No groups were listed as being particularly vulnerable. Barriers that prevent people from accessing healthcare include cultural barriers like language, as some residents speak Spanish.

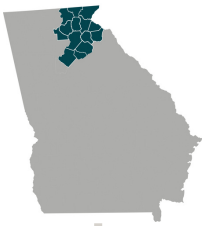
The community’s faith-based resources include:

- Women Shelters: Circle of Hope, My Sister’s House
- Shirley’s: Soup Kitchen in Toccoa and Clarkesville
- Forensic Children’s Center (Rabun and Toccao), Harmony House (Rabun)

The free or low-cost clinic resources include:

- Habersham County Health Department, which is adjacent to Avita Mental Health Center and the Senior Center

The community’s food pantry resource is the Lavonia pop-up pantries. No additional resources were provided when asked about the community’s mental and behavioral health services resources. Participants indicated that the impact was personally and professionally significant when asked to reflect on the community impact of current events such as COVID-19, illness and loss of life. When asked to comment on the community impact of social issues, stakeholders noted that the community is split politically.



Community Input

In 2021, Union General Hospital conducted a CHNA, in which it interviewed seven key community stakeholders. The results of these interviews are below.

- 100 percent of stakeholders indicated Union County:
  - Has a good health care system in the county
  - Is a good place to raise children
  - Is a good place to grow old
  - Is a safe place to live
  - Has clean water

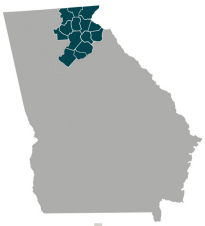
- COVID-19 testing, hospital services, immunizations, women's health services, Medicaid, and WIC were the most common beneficial services to residents based on the responses.

- Most needed services that aren't currently available included dental services for low-income adults, rapid testing for COVID-19 as well as a greater frequency of testing, better news coverage, and better input from the community regarding government purchases.

- Greatest community strengths included schools, health care, churches, recreation, and hospital services.

- Most common responses to challenges facing the community were the lack of dental providers for adults, care for the homeless, care for those with mental illness, division based on income level, the lack of attention given to rural areas, and maintaining a balance between growth in the county and maintaining attributes of culture and heritage.

- Major health concerns facing residents include:
  - Aging population
  - COVID-19
  - Heart disease
  - Nutrition



Community Input

In 2021, Chatuge Regional Hospital conducted a CHNA in which it interviewed four key community stakeholders. The results of these interviews are below.

- 100 percent of stakeholders indicated Towns County:
  - Has a good health care system in the county
  - Is a good place to raise children
  - Is a good place to grow old
  - Has plenty of support for individuals and families during times of stress and need
  - Is a safe place to live
  - Has clean water

- Availability of health care was the most common beneficial service to residents based on the responses.

- 100 percent of stakeholders indicated mental health and drug and alcohol treatment are the most needed services that are not currently available.

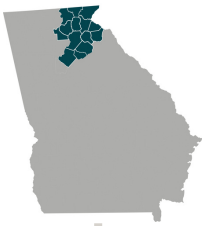
- Most common responses to challenges regarding the retirement community is the need to have more programs geared toward geriatric health and services to support our population.

- The county’s greatest strength is that it is a safe place to live and retire

- The county struggles with attracting more specialized physicians as well as general practice physicians.

- Major health concerns facing residents include: smoking, obesity, heart disease, diabetes, respiratory diseases, high radon levels resulting from granite mountains, mental health, the aging population with limited family support requiring eldercare, and better infrastructure to support the increasing population.

- Immunizations, general labs, and sliding-scale family planning services are Towns County's most beneficial programs.



Community Input

In March and April 2022, 25 physicians and other key leaders were interviewed regarding community needs, specialty care, and related topics. These interviewees discussed issues within Habersham, Rabun, Stephens, Towns, and White counties, primarily rural communities that come with unique challenges. Rabun, Stephens, Towns, and White counties are within SSA North's service area.

General observations:

- Primary care physicians can find themselves spending several hours a day trying to help patients with emotional and psychiatric needs.
- Obesity and diabetes are major problems, and there is a specific need to address obesity in children.
- Rural areas mean rural roads, which create long drives for people to access essential health care services such as specialty care.
- Many specialists see telemedicine as a practical way to address acute needs, especially for patients in rural areas.

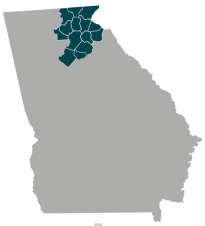
Four main needed specialties were named: cardiology, neurology, pulmonology, and endocrinology. Thirteen additional specialties came up in some interviews. These included psychiatry, orthopedics, gastroenterology, and neonatology.

Opportunities for health education exist, particularly for:

- Heart care
- Diabetes education and management
- Nutrition
- Coping and life skills, including resources for parents and youth

Key quotes:

- "This is a challenging population with lots of lifestyle issues that promote cardiovascular disease."
- "There are huge mental health needs we deal with all the time because there is nobody else to do it."
- "We are not very healthy."
- "Transportation is a massive problem. There are lots of elderly who should not be driving. Poor people drive poor, unreliable cars."



Community Input

As part of the qualitative data gathering process, two community members from this service area were interviewed to solicit their input on community health. Below is a summary of themes that emerged from those interviews.

Barriers to health:

- Insurance
- Transportation
- Poverty
- Affordable nutritious foods
- Health education

Gaps in health services:

- Mental health
- Preventative care
- Maternal health/obstetrics/gynecology
- Health education

Opportunities to improve health:

- Health education
- Specialty services
- Preventative care

Sources of health information:

- Internet
- Fox News
- Peers/gossip
- Television

Populations most impacted by barriers:

- Hispanic/Latino populations
- The elderly
- Indigent populations
- Undocumented persons

Top health needs:

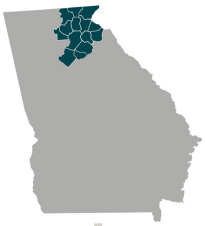
- Diabetes
- Heart disease
- Blood pressure
- Maternal health
- Specialty care

Gaps in mental health and vulnerable populations:

- Hispanic/Latino populations
- Everyone
- Migrant communities
- Minorities

Gaps in mental health:

- Prescription drugs and older adolescents



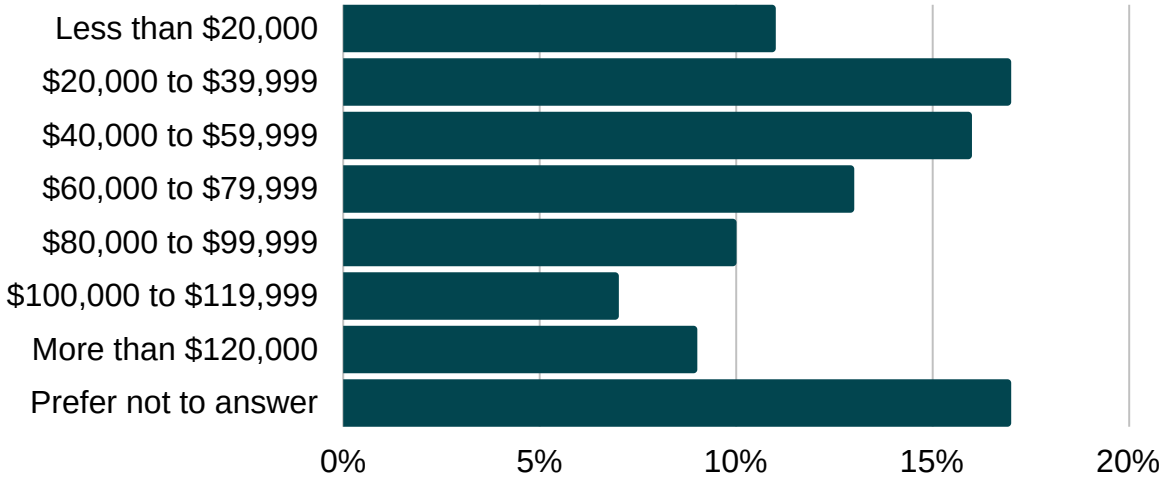
Community Survey

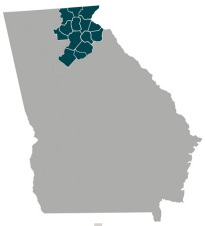
In March 2022, approximately 960 community members living within SSA North completed an electronic community-based survey widely advertised to the community via the partners' websites, press releases and social media. All survey questions can be found in Appendix Eleven. Please note that the following survey data was for selected indicators. All answers from the survey can be found online at **nghs.com/community-benefit-resources** via the Tableau data tool.

Of all respondents:

- 27 percent were male, 70 percent were female, and 3 percent preferred to not answer
- 93 percent were White, 2 percent were African American or Black, 1 percent were Hispanic or Latino, and 4 percent preferred not to answer
- 2 percent were 25 or younger, 6 percent were between ages 26 and 34, 9 percent were between ages 35 and 44, 12 percent were between ages 45 and 54, 26 percent were between ages 55 and 64, 31 percent were between ages 65 and 74, and the remaining 13 percent were 75 and older
- 96 percent had some form of health insurance and 88 percent lived in households where all members had some form of health insurance

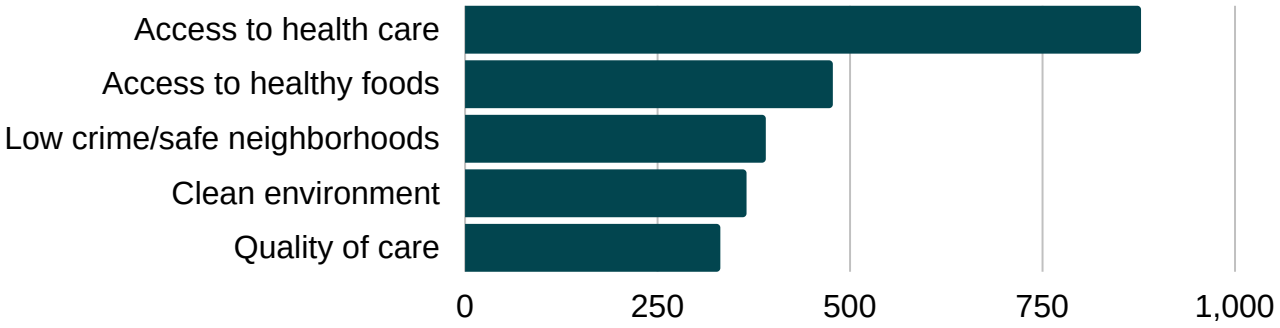
Below is a breakdown of the annual household income for all respondents.



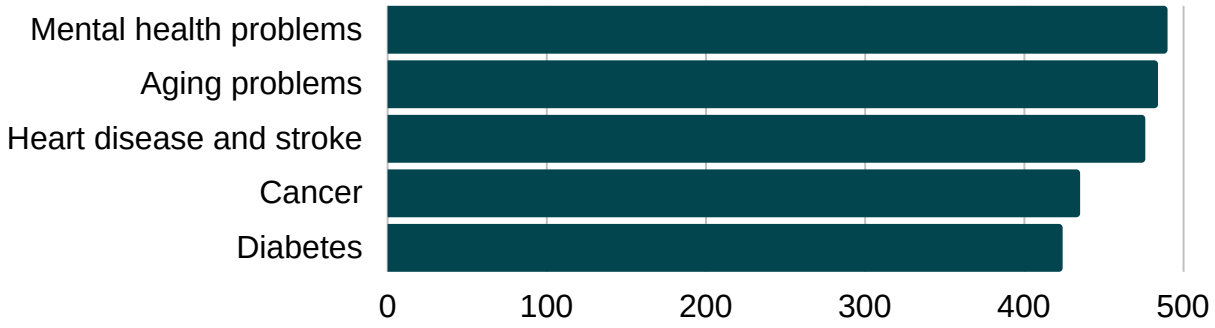


Community Survey

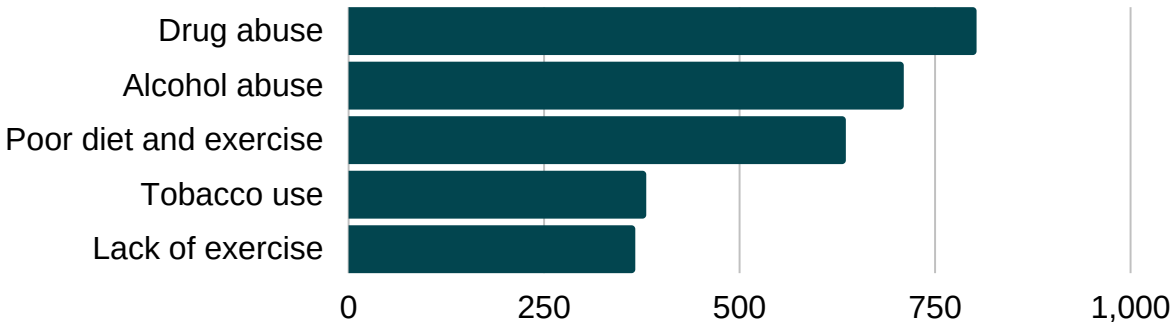
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below are the top five answers.

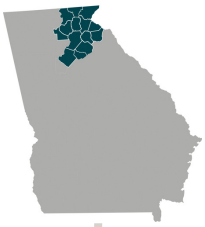


Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below are the top five answers.



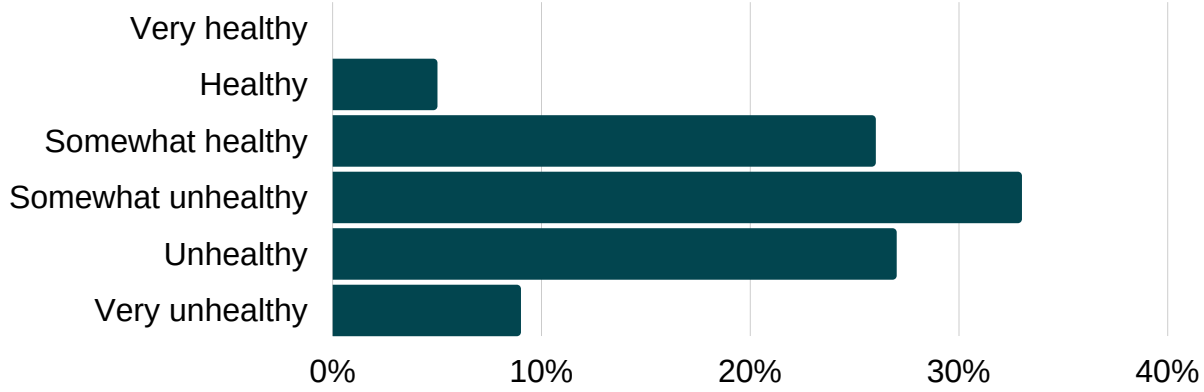
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



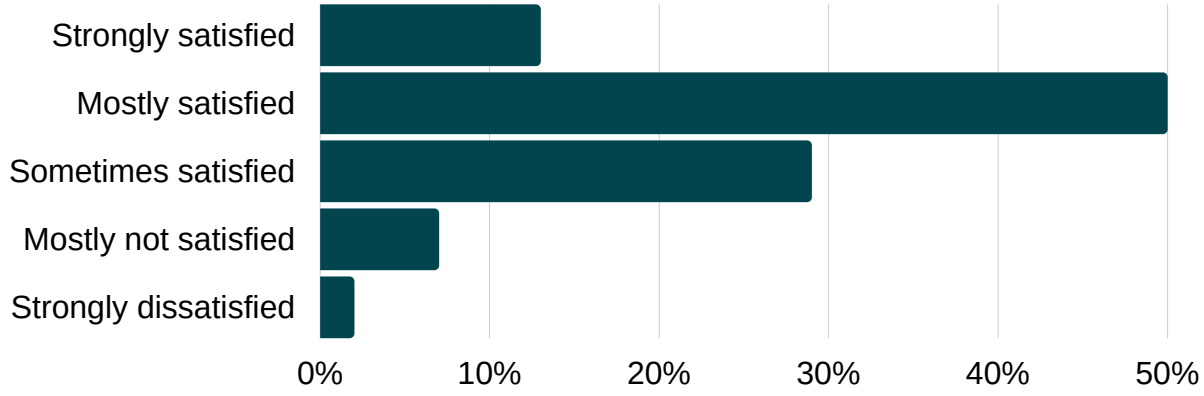


Community Survey

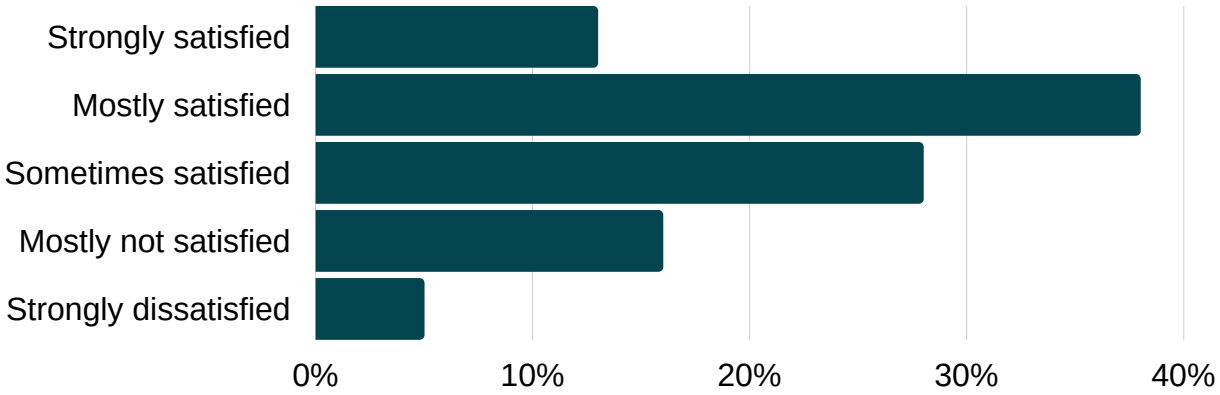
Q: How would you rate the overall health of our community?

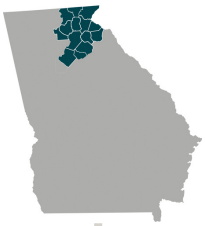


Q: How how satisfied are you with the quality of life in your community?



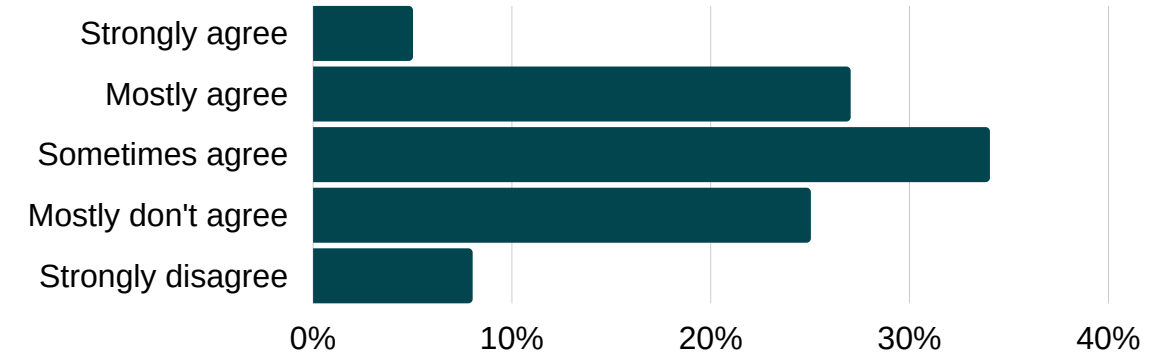
Q: How satisfied are you with the health care system in your community?



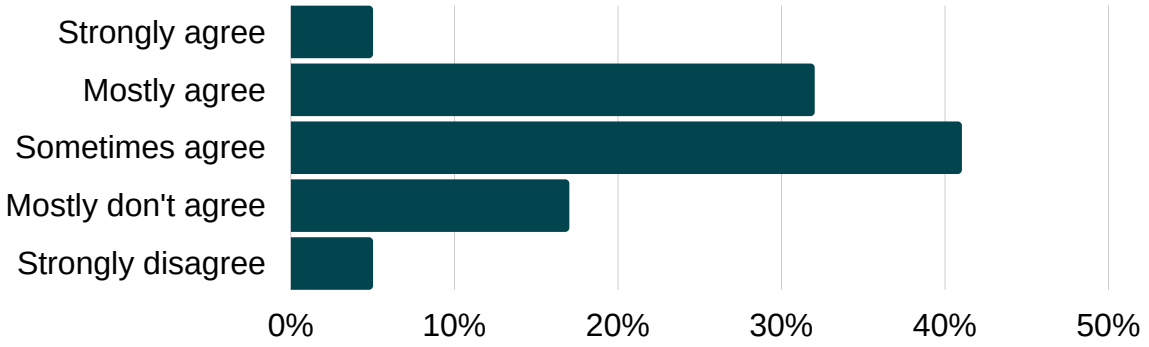


Community Survey

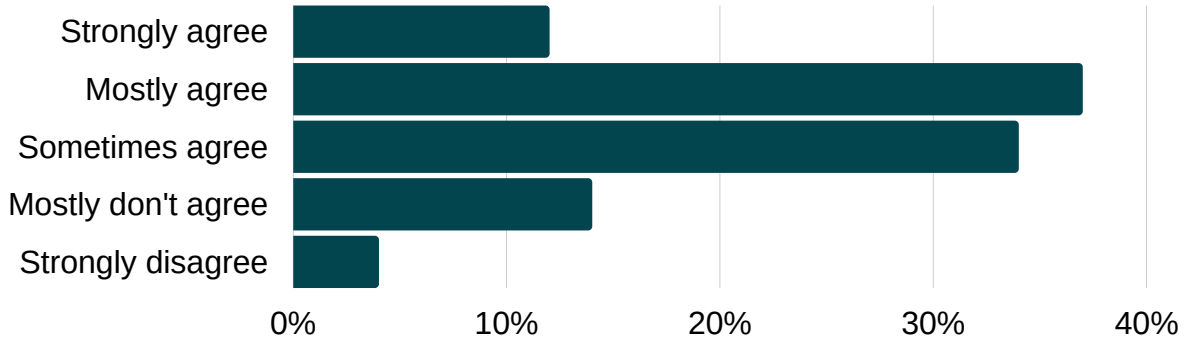
Q: Do you feel there are enough health and social services in your community?

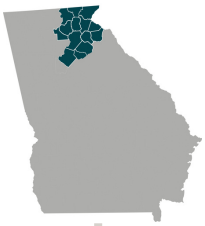


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



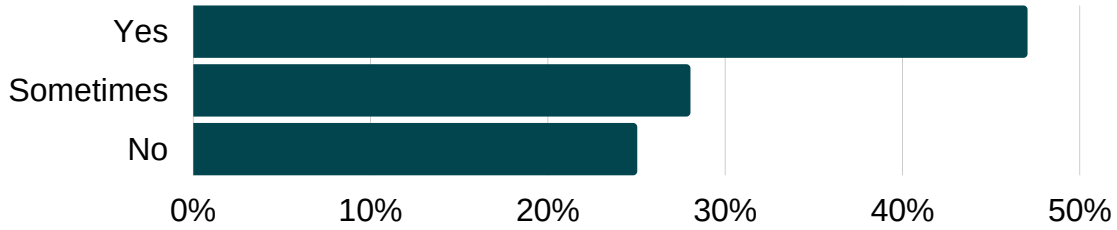
Q: Do you feel there are networks of support for individuals and families during times of stress and need?



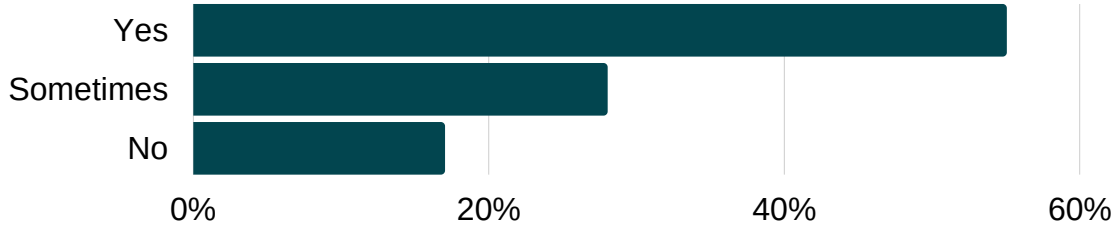


Community Survey

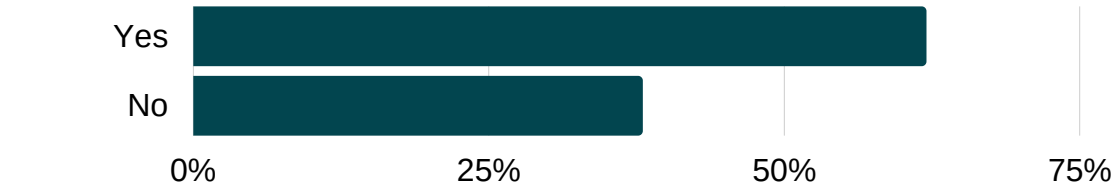
Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?



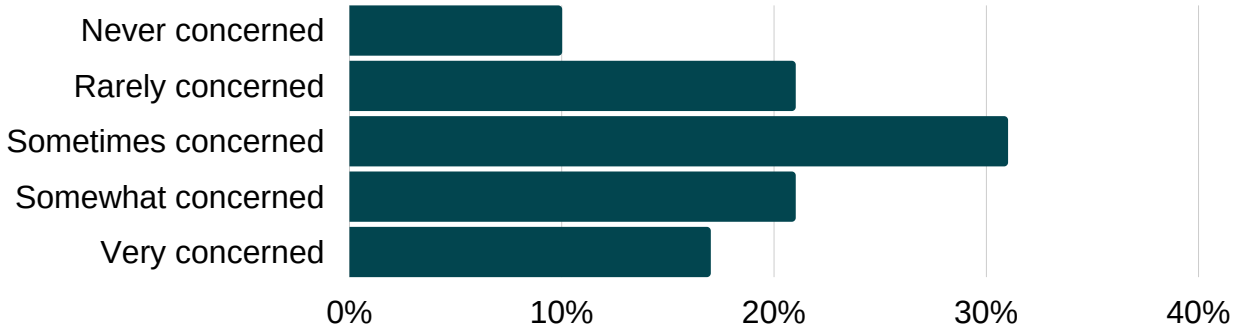
Q: Do you have a hard time paying for medications for you and your family?

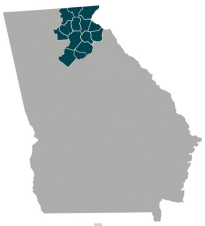


Q: Does anyone in your family currently have medical debt?



Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

The below matrix demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for the SSA North service area.

High data + low qualitative

- Alzheimer's disease
- COPD
- Musculoskeletal disease
- Respiratory disease
- Septicemia
- Pneumonia
- Infectious disease
- Injury and death
- Disability
- Maternal and child health
- Violence: child abuse
- Smoking
- Rates of high school drop out
- Homeless children and youth
- Sexual assault
- Women's cancer screenings
- Cancer, particularly lung, colon, and rectum
- Motor vehicle crashes
- Premature death
- Firearm deaths

High data + high qualitative

- Access to dental care
- Access to care: preventable hospitalizations, primary care providers
- Heart disease
- Fair or poor mental health
- Food insecurity
- Housing costs
- Obesity
- Geriatric care
- Mental health: providers, suicide
- Social isolation
- Poverty and income
- Substance abuse: opioids, fentanyl, alcohol
- Health behaviors
- COVID-19: Deaths, vaccination rates and sentiment

Low data + low qualitative

- Asthma
- Gastrointestinal disease
- Genitourinary disease
- Nervous system disease
- Reproductive and urinary disease
- Fair or poor health status

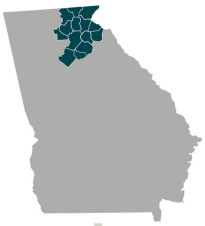
Low data + high qualitative

- Physical health education*
- Mental health education*
- Mental health stigma*
- Transportation*
- Immigrant, Undocumented, and/or Refugee Status
- Politics*
- Trust*
- Coordination of care*
- High radon levels resulting from granite mountains

*No quantitative data available

Once the top health needs were identified, CHNA partners completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does a SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

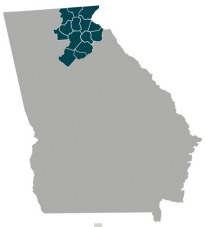
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – COVID-19: Deaths, Vaccination Rates, Sentiment	15
1 – Mental Health: Fair or Poor Mental Health, Providers, Suicide	15
1 – Healthy Behaviors	15
1 – Heart Disease	15
1 - Obesity	15
2 – Poverty and income	14.5
3 – Access to Care: Preventable Hospitalizations, Primary Care Providers	14
3 – Food Insecurity	14
3 – Substance Abuse	14
4 – Access to Dental Care	12
4 – Geriatric Care	12
5 – Social Isolation	11.5
6 – Housing Costs	11

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting held on May 19, 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental and behavioral health**
- **Access to care**
- **Healthy behaviors**

Although not selected as priorities, there are additional issues of concern for the residents within the SSA North service area, including heart disease and obesity. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



Stephens County Hospital Service Area

The Stephens County Hospital Service Area (SCH) is made up of Stephens and Franklin counties, which are highlighted on the map to the right.

In 2020, 48,949 people lived in the 440.21 square-mile community. This service area is mostly urban, as 72 percent of the combined population lived in an urban setting in 2020.

When broken down by age:

- 22 percent of the population were 17 or younger
- 58 percent were between 18 and 64
- 20 percent were over 65

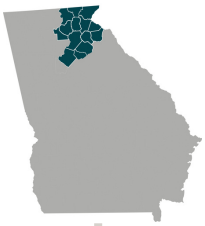
High school graduation rates were high as of 2020, with 91 percent of the area's population graduating. By comparison, only 85 percent of state residents held a high school diploma. Twenty-six percent had an associate degree or higher, and 10 percent held a bachelor's degree. Approximately 18 percent of the total population had no high school diploma.

When examining the community by race and ethnicity, in 2020:

- 82 percent were White
- 10 percent were Black or African American
- 4 percent were Hispanic or Latino
- 1 percent were Asian
- 3 percent were either multiple races or some other race

Nine percent of service area residents were veterans in 2020, and the majority were over the age of 65. Sixteen percent of all adults aged 18 to 65 had served in the military, and 18 percent of all men in the service area are veterans, as compared to one percent of all females.

Nineteen percent of the service area population lived with a disability in 2020, a rate higher than the state and national rates of 12 and 13 percent, respectively. When



Demographics

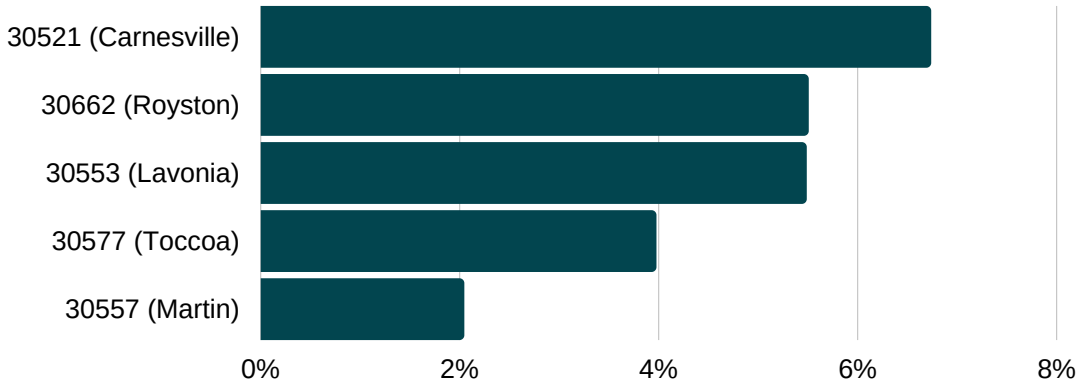
separating by age, 45 percent of all adults aged 65 and older lived with a disability that year.

In 2020, three percent of the population identified as being born outside of the US, and two percent did not possess US citizenship status. Of the total population, one percent lived in limited English-speaking households in 2020. A limited English-speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English "very well." Spanish was the most common of those languages, followed second by the broad category of Asian languages.

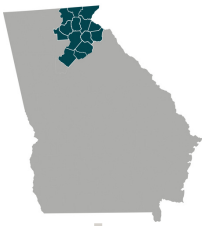
Within the service area, the population increased by four percent between 2010 and 2020, which was lower than the state and national population percentage changes of 11 percent and seven percent, respectively.

Minority populations increased far more than their White counterparts, which decreased by one percent during that time. By contrast, Black or African American populations grew by four percent, Asian populations grew by 64 percent, and Hispanic/Latino populations grew by 32 percent. Those identifying outside those four primary race or ethnic categories grew by 84 percent.

ZIP Codes with the Highest Percentage Change in Populations, 2010 to 2020



Source: US Census Bureau, Decennial Census. 2020.



Demographics: Children and Youth

According to the Census Bureau, about 22 percent of the service area were children and youth 17 and younger. In the 2019 to 2020 school year, two percent of children were homeless, meaning nearly 170 school-age children had no stable home at some point that year.

Of all children, 49 percent lived at or below 200 percent of the FPL, which was $52,400 in annual gross household income for a family of four that year. The highest percentage of poor children was in the ZIP code 30662 (Royston), where 65 percent of children lived in poverty in 2020.

Head Start and Preschool Enrollment

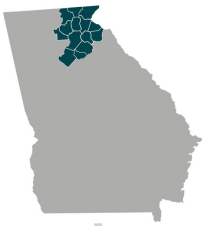
Head Start is a program designed to help children from birth to age five who come from families at or below the poverty level to help these children become ready for kindergarten while also providing the needed requirements to thrive, including health care and food support. The service area had two Head Start programs, resulting in seven programs per 10,000 children under five years old in 2020, which was on par with the state rate of seven and below the national rate of 11. **In 2020, 32 percent of children aged three to four were enrolled in preschool, a rate below the state and national average of 49 percent and 47 percent, respectively.**

English and Math 4th-Grade Proficiency

Of all students tested, 65 percent of 4th graders tested "not proficient" or worse in the English Language Arts portion of state standardized tests in the 2018-2019 school year. This was worse than the statewide rate of 61 percent. Up until 4th grade, students are learning to read. After 4th grade, they read to learn, making these statistics key for future success. For the math portion, of all students tested, 57 percent of 4th graders tested "not proficient" or worse on the state test that same school year. This was worse than the statewide rate of 54 percent of children testing "not proficient" or worse.

Teen Births

Teen mothers face unique challenges and are statistically more likely to drop out of high school, live in poverty, be uninsured, and have certain health conditions like Type 2 diabetes much younger than other adults. Their children are also statistically more likely to have children at a young age. **In 2019, the teen birth rate was 34 births per every 1,000 females aged 15 to 19, a statistic much higher than state and national rates of 23 and 19, respectively.**



Income and Economics

In 2020, the average household income was $60,344, which was significantly less than state and national average incomes, which are $85,691 and $91,547, respectively. Within the service area, we see the following variation of average household income, by ZIP codes:

Highest Incomes:

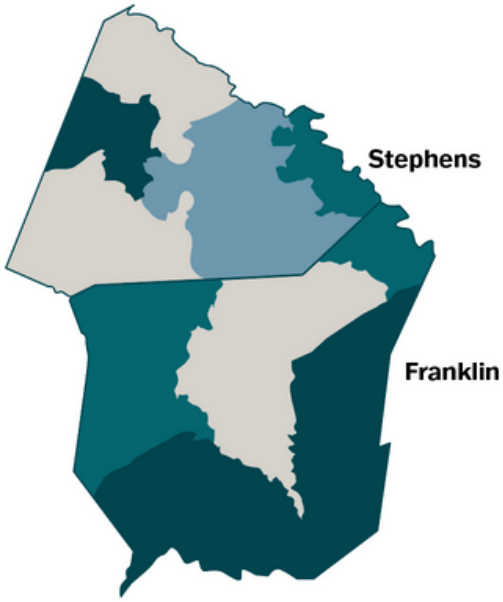
1. 30521 (Carnesville): $74,318
2. 30553 (Lavonia): $74,149
3. 30557 (Martin): $67,700
4. 30520 (Canon): $59,039
5. 30577 (Toccoa): $56,967

Lowest Incomes:

1. 30662 (Royston): $52,884
2. 30538 (Eastanollee): $55,130
3. 30577 (Toccoa): $56,967
4. 30520 (Canon): $59,039
5. 30557 (Martin): $67,700

Poverty and the Community

Approximately 17 percent of the service area lived in poverty in 2020. That year, the FPL placed a family of four as having a total household income of $26,200. The five poorest ZIP codes within the service area are: 30662 (Royston), 30520 (Canon), 30553 (Lavonia), 30557 (Martin), and 30577 (Toccoa).



The map to the left demonstrates pockets of poverty throughout the service area, by Census tract in 2020 and at 100 percent the FPL and below.

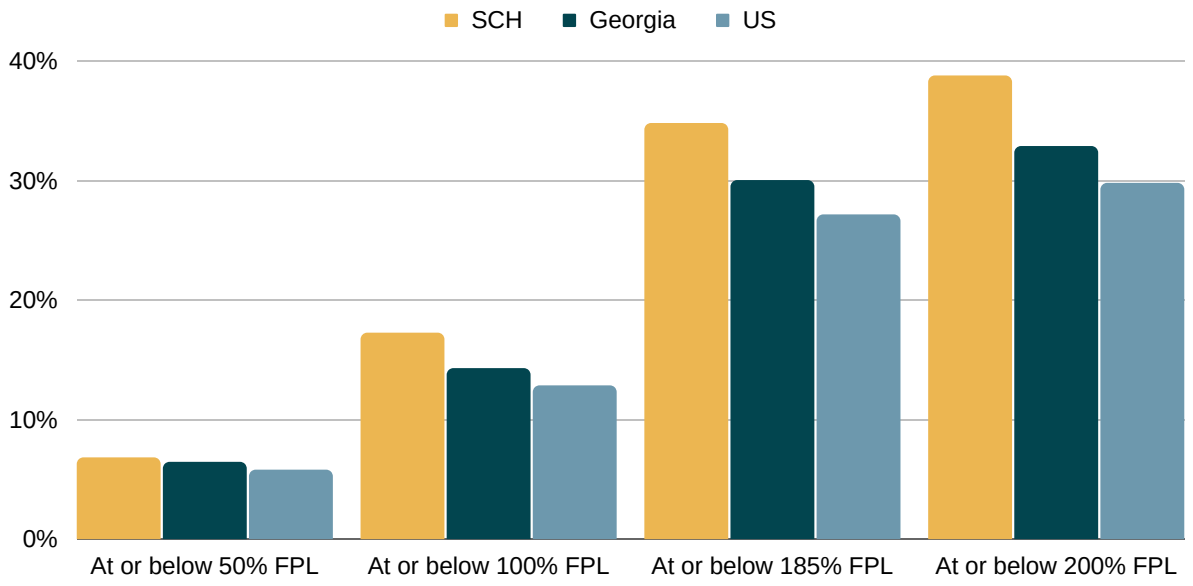
- 20% or more live at or below poverty
- 15.1% to 20%
- 10.1% to 15%
- 10% or less

Source: US Census Bureau, American Community Survey. 2016-20.

Income and Economics

Poverty exists even when living above the FPL. Populations at or below 200 percent of the FPL are considered to be near poverty and will generally still struggle to afford life's basic requirements. In 2020, a family of four with an annual income of $52,400 lived at 200 percent of the FPL.

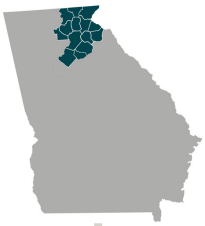
Poverty by Percentage of FPL, 2016 to 2020



Source: US Census Bureau, American Community Survey. 2016-20.

Public Assistance Income

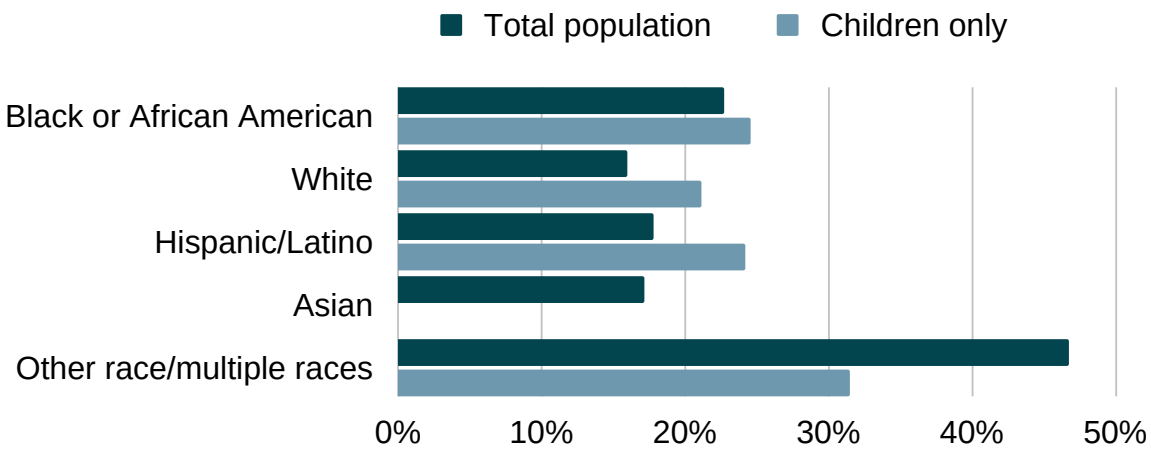
This indicator reports the percentage of households receiving public assistance income. Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). This does not include Supplemental Security Income (SSI) or non-cash benefits such as SNAP. Within the service area, two percent of all households received some form of public assistance. This was on par with the state and national rate of two percent. Within the service area, ZIP code 30557 (Martin) had the highest level of public assistance income, with four percent of the population receiving benefits.



Income and Economics

When broken down by age and race, the below poverty trends emerge. As demonstrated in the chart below, most minorities within the service area are more likely to live in poverty than their White counterparts.

Populations Living in Poverty, By Race or Ethnicity, 2016 to 2020



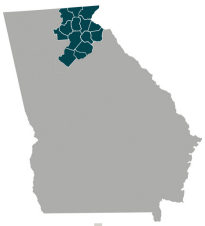
Source: US Census Bureau, American Community Survey. 2016-20. Please note information was not available for Asian children.

SNAP Benefits

The Georgia Food Stamp Program (Supplemental Nutrition Assistance Program, or SNAP) is a federally-funded program that provides monthly benefits to low-income households to help pay for the cost of food. In the service area, 18 percent of the service area's population received SNAP benefits in 2019. The ZIP code with the highest percentage of SNAP beneficiaries was 30577 (Toccoa), where 20 percent of the population was enrolled in the program.

Free or Reduced-Cost Lunch

Additionally, 58 percent of service area children qualified for free or reduced-price lunch in the 2019-2020 school year, a figure above state and national rates of 56 percent and 42 percent, respectively. Free or reduced-price lunches were served to qualifying students in families with income under 185 percent (reduced price) or under 130 percent (free lunch) of the FPL. High levels of free or reduced-cost lunch demonstrate areas of poverty and potentially limited food access within their community.



Income and Economics

Between 2009 and 2019, the area saw a net loss of 80 businesses. There were 762 establishment "births" and 842 "deaths" contributing to the change. The rate of change was negative eight percent over the ten-year period, which was much less than the state average of four percent. The area's gross domestic product was $1,796.3 (millions) in 2020, up by about 33 percent from 2010**.** The gross domestic product is the total value of all goods produced and services provided in a year. This is an important indicator, as it can help measure the community's economic health. Of all industries in the community, three emerged as the largest.

Top Three Industries by Number of Employed, 2019

Industry	Number Employed	Average Wage
Manufacturing	3,921	$55,737
Retail Trade	2,664	$29,188
Other services	1,727	$25,731

Source: US Department of Commerce, US Bureau of Economic Analysis. 2019.

Unemployment and Labor Force Participation

In 2020, the total labor force for the service area was 21,556 people, and the labor force participation rate was 54 percent. Total unemployment in the service area in July 2022 equaled three percent. Unemployment creates financial instability and barriers to access, including insurance coverage, health services, healthy food, and other necessities contributing to poor health status. This rate has steadily dropped since January 2021, when the unemployment rate was four percent. In 2021, the unemployment rate was more than four times less than the rate in 2012.

Health Outcomes

Below were the ten leading causes of both age-adjusted and premature death between 2016 and 2020. The dials indicate how severe the rate was compared to the rest of the state. The further to the right the dial is, the more severe that issue was within the service area compared to Georgia.

Age-adjusted Death Rates

Ischemic heart and vascular disease - 1

Alzheimer's disease - 2

All COPD except asthma - 3

Trachea, bronchus and lung cancer - 4

Cerebrovascular disease - 5

Essential hypertension and hypertensive renal and heart disease - 6

All other diseases of the nervous system - 7

All other mental and behavioral disorders (usually dementia) - 8

Colon, rectum, and anal cancer - 9

Diabetes - 10

Premature Death Rates

Ischemic heart and vascular disease - 1

Suicide - 2

Motor vehicle crashes - 3

Accidental poisoning and exposure to noxious substances - 4

Trachea, bronchus and lung cancer - 5

All COPD except asthma - 6

All other diseases of the nervous system - 7

Diabetes - 8

Essential hypertension and hypertensive renal and heart disease - 9

Cerebrovascular disease - 10

Source: Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, 2022. Both age-adjusted death and premature death are defined in Appendix Six.

Health Outcomes

Heart Disease

Heart disease was among the leading causes of death in the service area. **Between 2016 and 2020, the age-adjusted death rate was 251 deaths for every 100,000 people, which was worse than both state and national averages.** Approximately seven percent of all adults had ever been diagnosed with coronary heart disease in 2019, a figure that jumps to 27 percent when looking only at Medicare beneficiaries. Both figures had remained somewhat steady over the last decade.

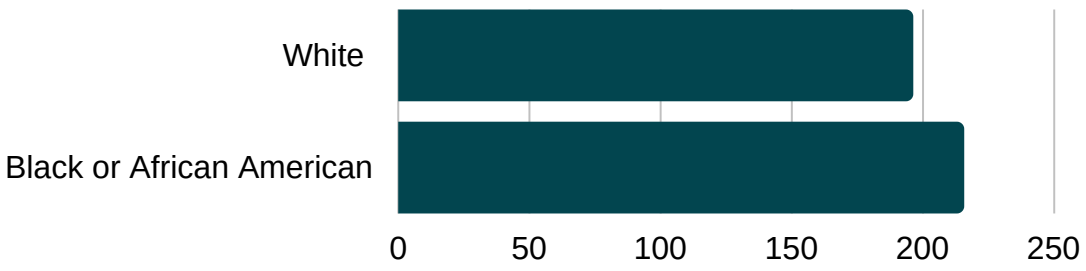
There are similar trends in stroke deaths. **Between 2016 and 2020, the age-adjusted death rate was 54 deaths per 100,000 people, which was worse than the state rates of 43 and the national rate of 38 deaths per every 100,000.**

The hospitalization rates for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. **The cardiovascular disease hospitalization rate in 2018 was 12 hospitalizations per every 1,000 Medicare beneficiaries, on par with the state and national rate of 12.** The hospitalization rate for stroke of nine hospitalizations per every 1,000 Medicare beneficiaries was similar to the state rate of nine and the national rate of eight.

Cancer

Cancer remains a critical issue within the community and is among the top causes of death in the service area. The average annual cancer death rate between 2016 and 2020 was 192 deaths per every 100,000 people, which was higher than the state and national rates of 153 and 149, respectively. The death rates shift when drilling down to race and ethnicity.

Cancer Deaths by Race or Ethnicity, Per Every 100,000 people

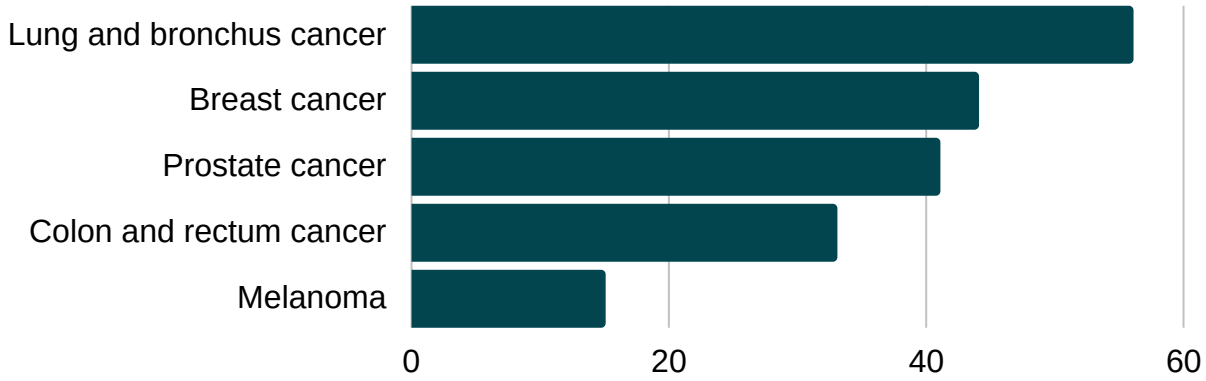


Source: State Cancer Profiles. 2014-18. Please note information was available only for White and Black populations.

Health Outcomes

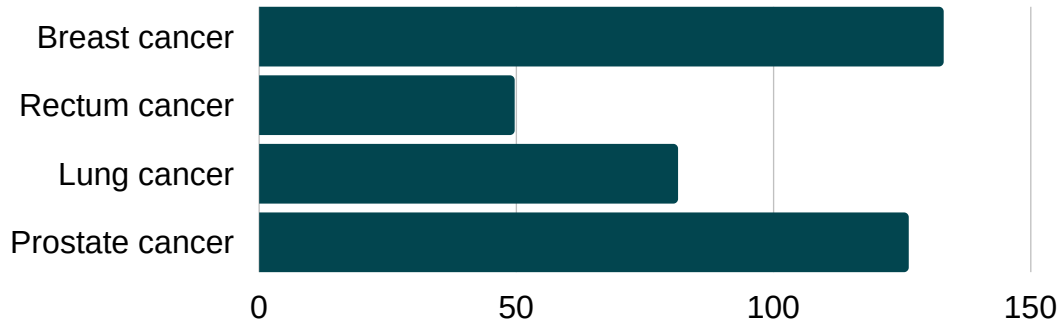
Within the service area, there were an average 325 new cases of cancer diagnosed each year between 2014 and 2018, resulting in a cancer incidence rate of 506 cases per every 100,000 people.

Average Annual New Cancer Cases, By Site, 2014 to 2018

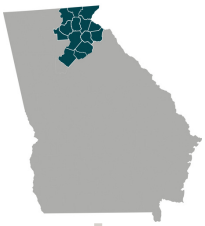


The below chart shows the incidence rate for the most common cancers within the community.

Annual Average Cancer Incidence Rate, Per Every 100,000 People, 2014 to 2018



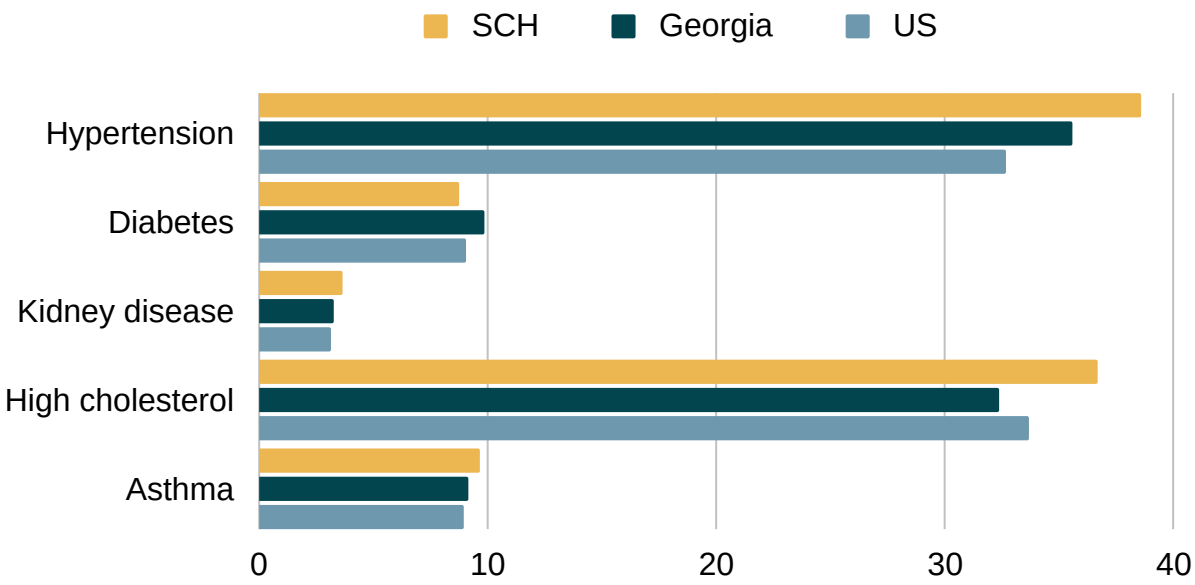
Source for both charts: State Cancer Profiles. 2014-18.



Health Outcomes

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

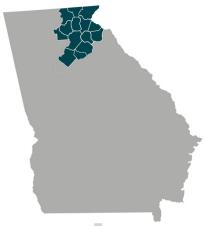
Percent of Population Reporting Key Chronic Conditions, 2018



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2018.

Multiple Chronic Conditions Among Medicare Populations

This indicator reports the number and percentage of the Medicare population with multiple chronic conditions. Within the service area, 76 percent of all Medicare beneficiaries had multiple chronic conditions, with 35 percent having had six or more chronic conditions.



Clinical Care and Prevention

Insurance status is directly related to a person's ability to access care, particularly for non-emergent and specialty care. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. The table below demonstrates the type of insurance for those with coverage in 2020 by the percentage of the population. Note this doesn't equal 100 percent, as some community members have two types of coverage.

Insurance Coverage by Type, 2020

Employer or Union	Self-purchased	TRICARE	Medicare	Medicaid	VA
54.22%	14.55%	2.72%	26.99%	26.67%	3.21%

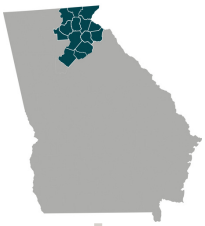
Source: US Census Bureau, American Community Survey. 2016-20. TRICARE is a federal health care program for uniformed service members, retirees, and their families.

Medicare Populations

In 2020, about 27 percent of the population was enrolled in some form of Medicare, the federal insurance program for adults aged 65 and older, populations with disabilities, and populations with end-stage renal disease. The average age for a Medicare recipient within the service area was 72, and 22 percent were also eligible for Medicaid due to low incomes.

Medicaid Populations

In 2020, more than 26 percent of the population was enrolled in Medicaid, the state-federal public insurance program for low-income populations. The percentage of Medicaid enrollment was above the state and national average of 20 and 22 percent, respectively. Of the total population, approximately 49 percent of children under 18, 12 percent aged 18 to 64, and 24 percent of adults aged 65 and older were enrolled in Medicaid.



Clinical Care and Prevention

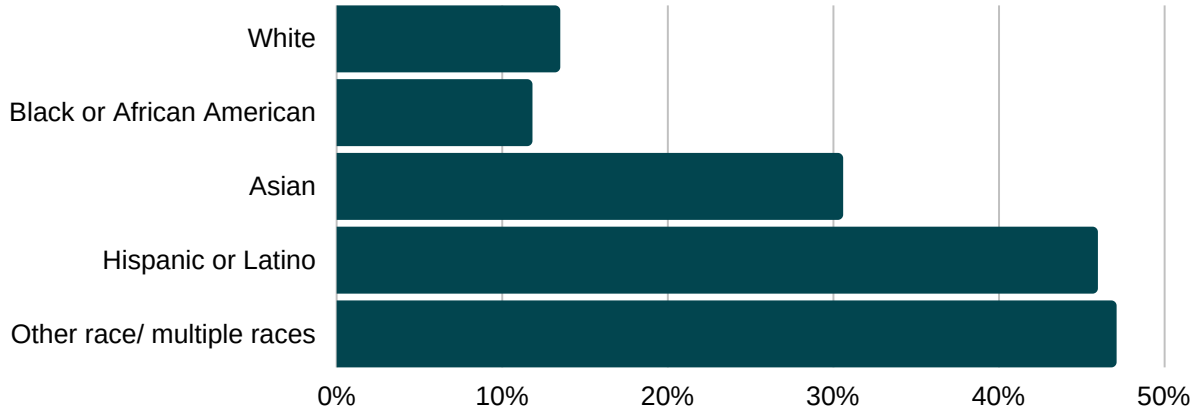
In the service area, on average between 2016 and 2020, 15 percent of the population were uninsured, a figure above the state rate of 13 percent and national rate of nine percent. When looking only at adults aged 18-64, the uninsured rate jumped to 21 percent.

Approximately eight percent of all children were uninsured in 2020, a figure higher than the state and national rates of seven percent and six percent, respectively. This is a figure, though, that also has steadily decreased over the last few years. For example, in 2011, ten percent of all children were uninsured.

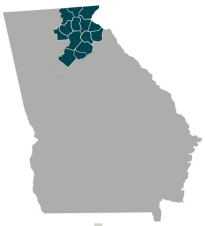
This trend was seen across all populations, as the number of total uninsured has steadily declined over the years. For example, in 2011, 27 percent of the service area's non-elderly adult population was uninsured, four full percentage points more than in 2020. Even so, the uninsured rate remains relatively high, and likely has a significant impact on those community member's ability to access primary and specialty care.

When looking at race and ethnicity, Asian, Hispanic or Latino populations, and other race or multiple race populations were most likely to be uninsured in the Stephens County service area.

Uninsured By Race or Ethnicity, 2016 to 2020



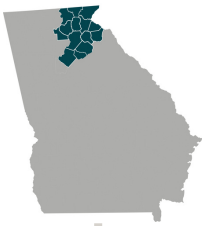
Source: US Census Bureau, American Community Survey. 2016-20.



Clinical Care and Prevention

Combined in FY20 and FY21, approximately 877 patients received financial assistance for their care at Stephens County Hospital. Below is a list of the top ten ZIP codes by volume of patients receiving financial assistance at the hospital during the last two fiscal years. Please note the hospital provided financial assistance to patients outside of these ten ZIP codes as well.

ZIP code	No. of patients - FY20	ZIP code	No. of patients - FY21
30577 (Toccoa)	1012	30577 (Toccoa)	516
30557 (Martin)	208	30557 (Martin)	49
30538 (Eastanollee)	91	30538 (Eastanollee)	48
30523 (Clarkesville)	71	30553 (Lavonia)	27
30553 (Lavonia)	35	30525 (Clayton)	10
30525 (Clayton)	24	30521 (Carnesville)	7
30531 (Cornelia)	13	30563 (Mount Airy)	5
30563 (Mount Airy)	11	30576 (Tiger)	5
30552 (Lakemont)	10	30552 (Lakemont)	4
30521 (Carnesville)	9	30510 (Alto)	4



Clinical Care and Prevention

Health Profession Shortages and Provider Ratios

In SCH, as of June 2022, there were five designated health professions shortage areas: two primary care, one dental health, and two mental health.

- Primary care: There were 47 primary care providers for every 100,000 service area residents, which was worse than both state and national rates of 67 and 77, respectively.
- Mental health: There was one mental health provider for every 1,240 people within the service area, a measure far worse than the state rate of one provider for every 633 people and the national rate of one provider for every 354 people.
- Dental care: There was one dentist for every 3,307 people, a figure worse than the state rate of one dentist for every 1,910 people and the national rate of one dentist for every 1,397 people.

Primary Care and Routine Check-Ups

In 2019, 77 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, which was on par with both state and national averages. For Medicare recipients, that amount jumps to 87 percent of all beneficiaries having visited a doctor in the previous 12 months. **Eighty-three percent of Black populations received routine care, as compared to 88 percent for other populations.**

In 2018, about 29 percent of men and 30 percent of women aged 65 and older were up to date on their core preventative services, including routine cancer screenings, vaccinations, and other age-appropriate services. The percentage of women up to date on their core preventative services was below state and above national averages, while the male percentage was on par with the state average and below the national average.

Dental Care and Dental Outcomes

Dental care is crucial to health, as dental conditions that go unchecked can lead to decay, infection and tooth loss. Dental health also directly impacts physical health as well as a person's socioeconomic status. Within the service area, in 2018, 56 percent of adults went to the dentist in the past 12 months, which was lower than state and national rates. **That year, 20 percent of the service area reported having lost all or most of their natural teeth because of tooth decay or gum disease.**

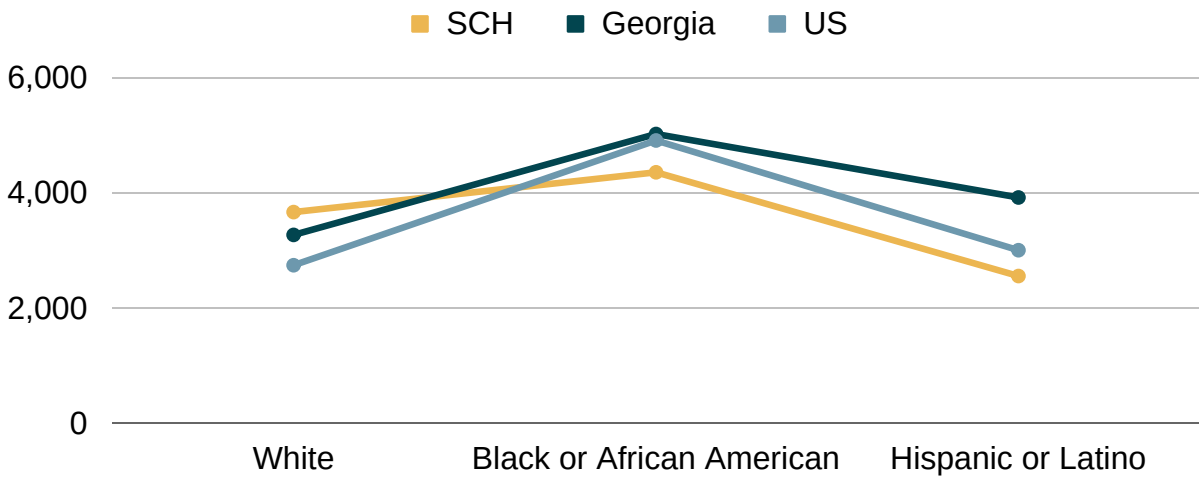
Clinical Care and Prevention

Emergency Department Visits
In 2020, Medicare beneficiaries visited the emergency department 3,850 times, resulting in an ED visit rate of 586 per every 1,000 beneficiaries, higher than state and national rates of 551 and 535, respectively.

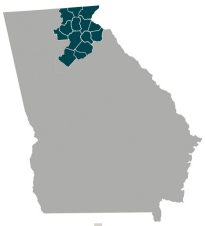
Inpatient Stays
In 2020, 31 percent of Medicare beneficiaries had at least one hospital inpatient stay, resulting in 586 stays per every 1,000 beneficiaries. This was higher than the state rate of 230 and the national rate of 223 inpatient stays during the same time.

Preventable Hospitalizations Among Medicare Beneficiaries
Preventable hospitalizations are admissions to a hospital for certain acute illnesses (e.g., dehydration) or worsening chronic conditions (e.g., diabetes) that might not have required hospitalization had these conditions been managed successfully by primary care providers in outpatient settings. In 2020, the preventable hospitalization rate was 3,645 per every 100,000 beneficiaries, higher than the state rate of 3,503 hospitalizations and the national rate of 2,865 hospitalizations. As with other health indicators, the indicator shifts when looking at race or ethnicity.

Preventable Hospitalizations by Race Or Ethnicity, 2020



Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Please note data only available for three races.



Mental Health

Deaths of Despair

Deaths of despair -- suicide, drug and alcohol poisoning, and alcoholic liver disease—are at their highest rate in recorded history, according to the CDC. **Within the service area, the age-adjusted death rate for deaths of despair was 64 deaths for every 100,000 people.** This rate was far worse than the state and national averages of 38 and 47 deaths for every 100,000 people, respectively.

Within the service area, the age-adjusted death rate for suicide was 26 deaths for every 100,000 people. This rate was worse than the state and national averages of 14 suicide deaths for every 100,000 people, respectively. Both deaths of despair and suicide were far more prevalent among White populations.

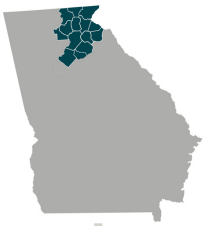
Poor Mental Health Days and Frequent Mental Distress

In 2019, the last year for which data was available, service area residents reported an average of six poor mental health days over the last 30 days, which was higher than the state average of five poor mental health days. Additionally, in 2019, 19 percent of adults reported being in frequent mental distress, with 14 or more poor mental health days within 30 days. This percentage was slightly higher than the state rate of 16 and much greater than the national rate of 14 percent. Although data is not yet available, these statistics likely increased in 2020 and 2021, when the severe mental impact of COVID-19 was felt throughout the community.

Opioid and Substance Use

In 2020, providers in the service area prescribed 58 opioid prescriptions per every 100 people, which is a figure that has steadily decreased each year. Within the service area, there are a total of 29 deaths due to opioid overdose. This represents an age-adjusted death rate of 12 per every 100,000 people. This was worse than the state average of ten but less than the national average of 16 deaths. White men were far more likely than any other demographic to die from an opioid-related overdose.

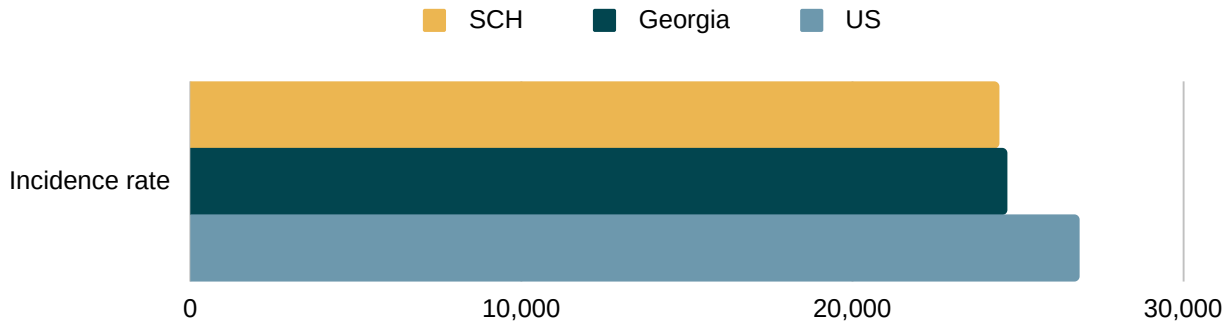
In 2019, Medicare Part D opioid drug claims accounted for four percent of total prescription drug claims. This percentage was better than the state rate of five percent and on par with the national rate of four percent, respectively.



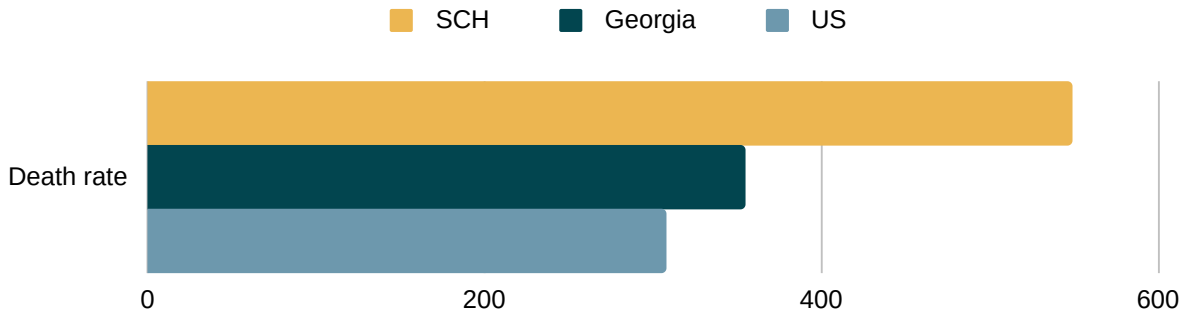
COVID-19

In the SCH service area, as of July 2022, COVID-19 incidence rates were below state and national averages, though the death rate was much higher than both.

COVID-19 Incidence Rate, Per Every 100,000 People, July 2022



COVID-19 Death Rate, Per Every 100,000 People, July 202



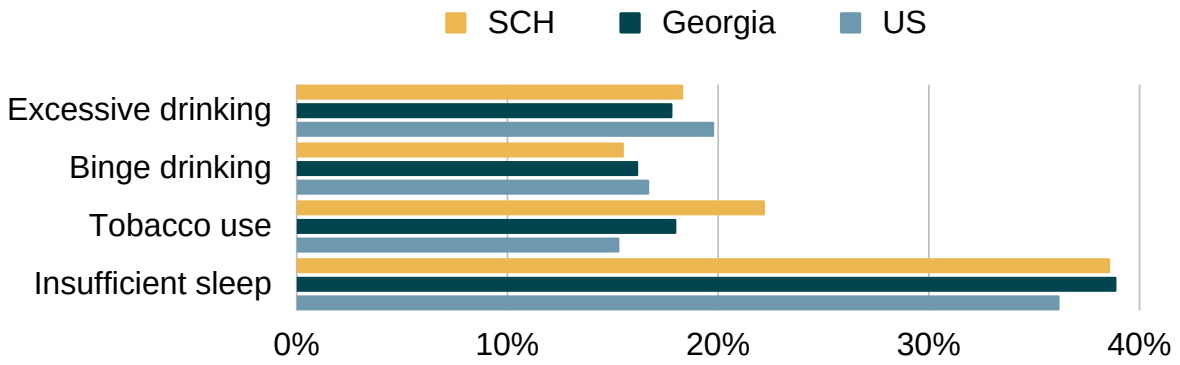
Source for both graphs: Johns Hopkins University. Accessed via ESRI. 2022.

Approximately 48 percent of the service area was fully vaccinated as of July 2022, with an estimated 16 percent of adults hesitant about receiving the vaccination. The service area had a COVID-19 vaccine coverage index (CVAC) of 0.70 which showed how challenging vaccine rollouts may be in some communities compared to others, with values ranging from zero (least challenging) to one (most challenging).

Health Behaviors

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

Unhealthy Behaviors, 2019

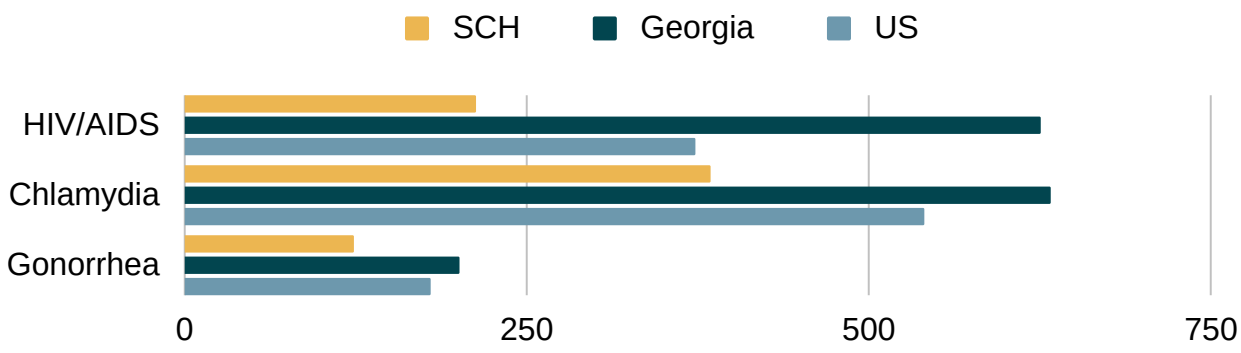


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2019.

All rates likely increased during 2020 and 2021 due to the impact of COVID-19 on mental health. Please note that binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on occasion in the past 30 days. Excessive drinking is when binge drinking episodes occur multiple times within the last 30 days. Insufficient sleep is defined as regularly sleeping less than seven hours a night.

Sexually transmitted diseases remain an issue throughout the service area, though rates are generally below that of state and national rates.

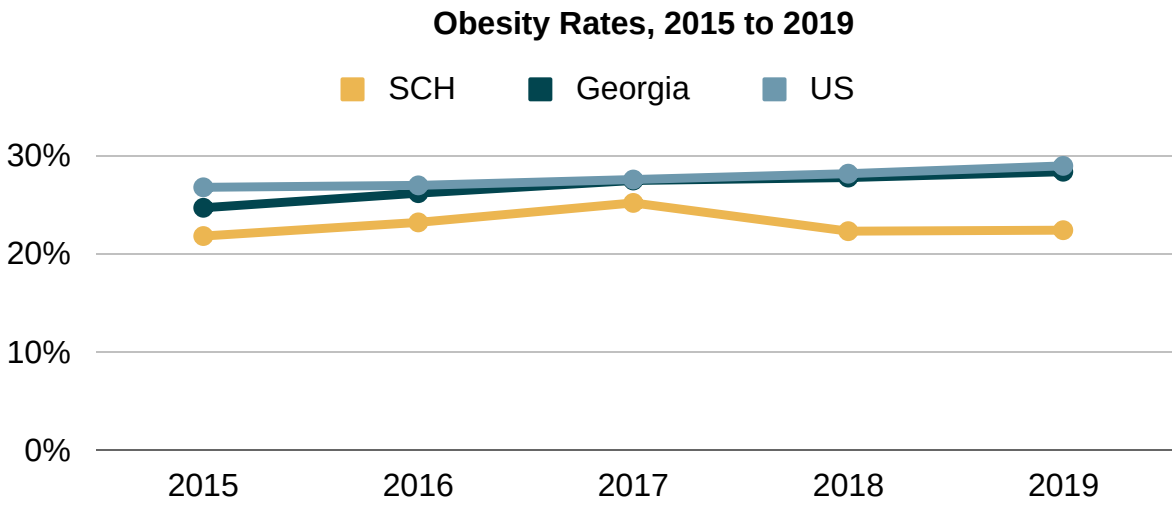
Sexually Transmitted Disease Rates, 2018



Source: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2018.

Health Behaviors

Certain health behaviors strongly impact overall health, including obesity and physical inactivity. **In 2019, 22 percent of service area residents aged 20 and older were obese, meaning they had a body mass index of 30 percent or more.** Obesity rates have generally increased over the last ten years. Obesity is directly linked to several health issues, including diabetes and heart disease.



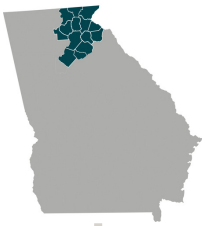
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019

Physical Inactivity

Within the service area in 2019, 22 percent of adults aged 20 and older self-reported no active leisure time, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Walking or Biking to Work

Incorporating walking or biking into daily routines, such as commuting to work, provides a significant health benefit and can indicate a healthier lifestyle if commuting by walking or biking is by choice. In 2019, about two percent of the service area's population walked or biked to work. Certain ZIP codes saw higher physical commutes, such as 30662 (Royston), where 197 people walked or biked to work in 2019.

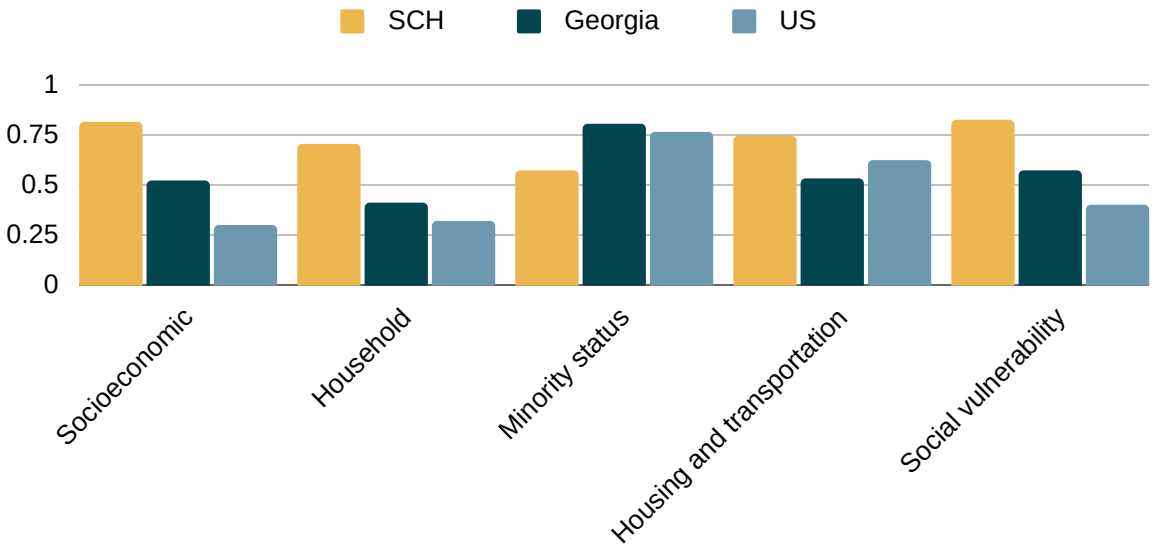


Socioeconomic Factors: Social Vulnerability Index

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

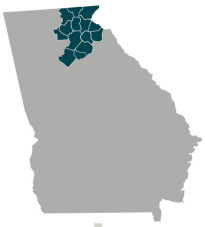
The social vulnerability index measures the degree of social vulnerability in counties and neighborhoods, where a higher score indicates higher vulnerability. The service area had a social vulnerability index score of 0.82, much higher than the state score of 0.57 and the national score of 0.40. Broken down by themes:

Social Vulnerability Index, By Theme, 2018



Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2018.

The only area where the service area scored poorly was socioeconomic status, meaning that many community members have lower-incomes, live more in substandard housing, have higher rates of obesity, have a higher incidence rate of diabetes, are more likely to be hypertensive, and generally have poorer outcomes.



Socioeconomic Factors: Housing

Housing and health often go hand-in-hand, as housing instability and homelessness often have a significant and negative impact on a person's physical and mental health.

Overall, the average monthly owner cost for a home within the service area was $819 each month in 2020, according to the Census Bureau's American Community Survey. The average gross rent was $641. COVID-19 has had a significant impact on housing, so these figures have likely increased since then.

Cost-Burdened Households

Of all occupied households in SCH, 24 percent were considered cost-burdened in 2020, meaning their housing costs were 30 percent or more of total household income. Approximately ten percent of households had costs that exceeded 50 percent of household income, which places the household under significant financial strain.

Renters bear the strain of this the most, with 40 percent of all renters within the service area facing rent that was 30 percent or more of their household income. When looking at owner-occupied homes, this figure drops to 27 percent. **Approximately 43 percent of all renters pay a rent that was at least 50 percent of their household income.**

Substandard Housing

This indicator reports the number and percentage of the owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent. **Approximately one-quarter of all households in the service area had one or more substandard conditions. This was lower than the state and national averages of 30 and 31 percent, respectively.**

Socioeconomic Factors: Food Deserts and Food Insecurity

Food insecurity happens when a person or family does not have the resources to afford to eat regularly. This can happen due to affordability issues, particularly for households facing unemployment, and especially if they are already low-income.

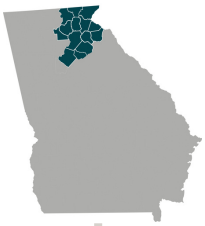
Communities that lack affordable and nutritious food are commonly known as “food deserts.” The service area has two food desert census tracts, meaning about 6,601 people did not have ready access to healthy foods.

The map to the right illustrates food deserts within the service area. The darker the color, the more prevalent the issue.

Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.

The service area has a food insecurity rate of 14 percent, meaning those community members were unsure how they would access adequate food at some point over the last year. That said, many of these community members are ineligible for public assistance via SNAP, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), free or reduced-cost school meals, and the Commodity Supplemental Food Program (CSFP), or The Emergency Food Assistance Program (TEFAP). In 2020, of all the food-insecure children in the service area, 15 percent were ineligible for public assistance programs. Of everyone living with food insecurity, approximately 24 percent were ineligible for any public assistance.

According to the 2019 Food Access Research Atlas database, six percent of service area residents had low food access, meaning those community members likely struggled to access healthy foods.



Community Input

In July 2022, the Stephens County Hospital service area stakeholder focus group unanimously identified mental health care as the single largest health issue in their respective workplaces, homes, and communities. The group identified the following priorities:

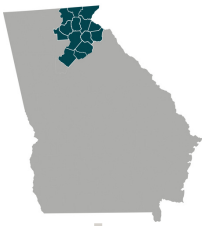
- Middle and high school-aged children's access to mental health care
- Young adult access to mental health care
- Enhancing the interdisciplinary clinical relationship between law enforcement and care providers
- Reducing the number of non-emergent visits to the emergency room
- Obesity

One focus group member attested to the current backlog of over 200 referrals of middle and school-aged children to providers. There is a dramatic and severe lack of resources and facilities for young children in the service area and providers to assess or provide basic care, so backlogs are not unusual. Wait times for initial appointments are months-long, which distracts and demotivates parents from the emergency nature of the initial referral.

The fear is that young people with unresolved troubles could have mental health issues that transform into more complicated issues that could result in any of the following: Substance abuse, self-harm, law enforcement and criminal activity, harmful relationships, truancy and/or school dropout, early and/or unhealthy pregnancy, single-parent households, or a basic inability to thrive in adult environments.

Similarly, the focus group seeks to prioritize access to young adults over age 18 and single-parent households. The only reason this group is separated from the previous group is age. The rationale is the same: backlogs, resources, facilities, providers, and fears of worsening conditions. However, circumstances are very different when patients are considered adults in the eyes of the law at age 17. The hope in prioritizing this demographic is to prevent long-term issues for the patients and communities. In both demographics, the correlation between mental health care needs and COVID-19 was acknowledged but not considered the sole contributing factor.

Next, enhancing the interdisciplinary clinical relationship between law enforcement and care providers regarding the behavioral health population was also prioritized. Often, these two fields work together on patients when substance abuse, mental health disorders, violent



Community Input

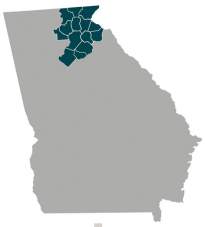
tendencies, or other issues complicate difficult situations. However, there is no current standard procedure that is primarily beneficial to the patient that is also acceptable to health care providers and law enforcement personnel. Results of the non-standardized relationship include a lack of information at intake and extended wait times from emergency departments to treatment facilities.

Of particular interest are circumstances in which a patient is to be held during an episode of manic behavior, whether it is a mental health breakdown, violent criminal outburst, or a combination of the two. It is unclear what the procedure is when a case presents a clear criminal activity followed by the perpetrator professing self-harm, schizophrenic tendencies, or displaying other overt mental health behaviors in apparent attempts to postpone criminal prosecution. Due to law enforcement being restricted in cases of mental health and the safety of provider staff frequently at stake, a clear procedure will benefit both parties, which will benefit the patient.

Another identified priority is reducing non-emergent emergency room visits, especially in rural healthcare environments where resources are already scarce. Emergency patients are often transported via EMS for a significant time, reducing the staff's time to address heart attacks, strokes, or worse. The time loss could be fatal if those nurses and physicians are otherwise occupied with non-emergent cases.

When those without medical insurance use the emergency room as their primary care provider, resources are diverted in a way that can lead to a staffing, supply, or bed shortage in the event of a true emergency. The group is particularly concerned about dental care being sought after as well as minor aches and pains and seasonal illnesses such as common allergies, sinus infections, the flu, or strep throat.

Lastly, obesity is a significant health problem affecting over one-third of the American population, and the focus group determined obesity as a comorbidity that should be prioritized. After reviewing the top causes of premature death for both counties and one of the top reasons why residents from both counties visited the Stephens County Hospital emergency department, obesity was recognized as one of the single preventable and correctable comorbidities for nearly all of them. Because this variable is preventable and correctable, the group felt it was most likely to exemplify the most improvement, thus improving the most underlying conditions and preventing more premature deaths and unnecessary emergency room visits.



Community Input

As part of the qualitative data gathering process, The ThoMoss group interviewed one community member to solicit their input on community health. Below is a summary of themes that emerged from that interview.

Barriers to health:

- Insurance
- Health coordination
- Language barriers

Gaps in health services:

- Preventative care

Sources of health information:

- Internet

Gaps in mental health:

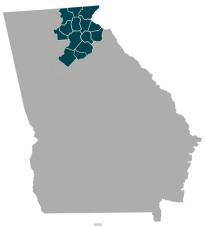
- Avita using Old Paradigm

Populations most impacted by barriers:

- The elderly
- Indigent populations
- Children and teens

Gaps in mental health and vulnerable populations:

- Hispanic/Latino populations
- Women
- Migrant and undocumented communities
- The elderly



Community Survey

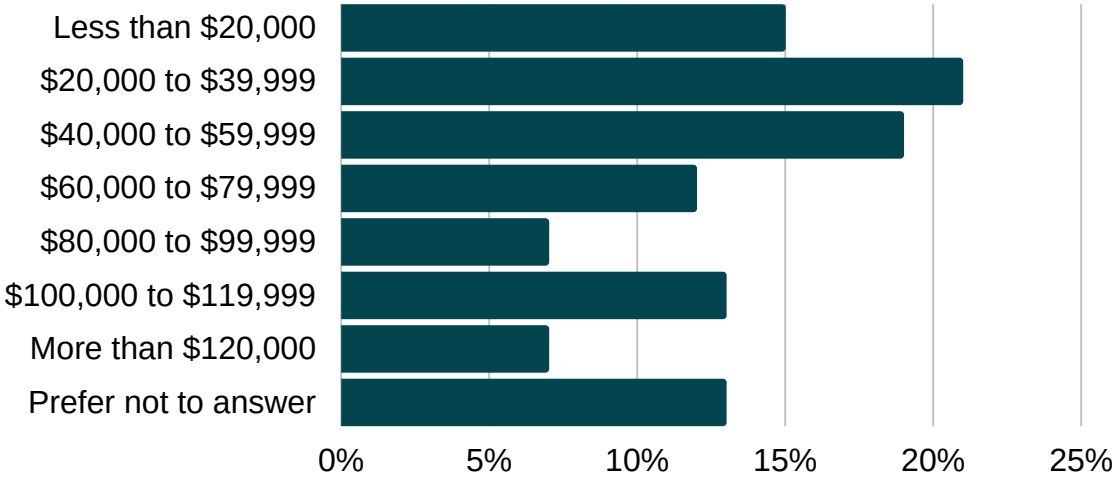
In March 2022, approximately 260 community members living within the Stephens County Hospital service area completed an electronic community-based survey widely advertised to the community via partners' websites, press releases and social media. All survey questions can be found in Appendix Five.

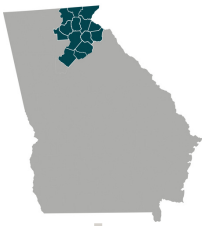
Please note the following survey data are for selected indicators. All answers from the survey can be found online at www.nghs.com/community-benefit-resources.

Of all respondents:

- 25 percent were male, 73 percent were female, and 2 percent preferred to not answer
- 92 percent were White, 5 percent were African American or Black, 2 percent were Hispanic or Latino, and 1 percent preferred not to answer
- 1 percent were 25 or younger, 8 percent were between ages 26 and 34, 11 percent were between ages 35 and 44, 13 percent were between ages 45 and 54, 28 percent were between ages 55 and 64, 31 percent were between ages 65 and 74, and the remaining 8 percent were 75 and older
- 93 percent had some form of health insurance and 83 percent lived in households where all members had some form of health insurance

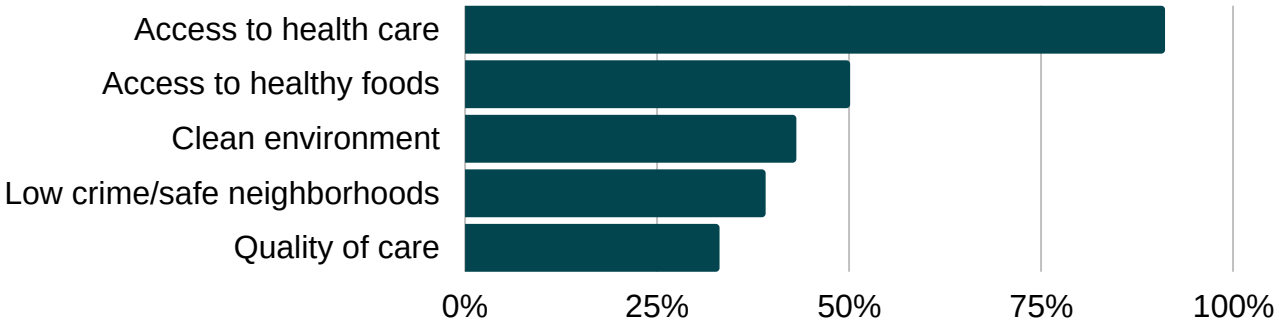
Below is a breakdown of the annual household income for all respondents.





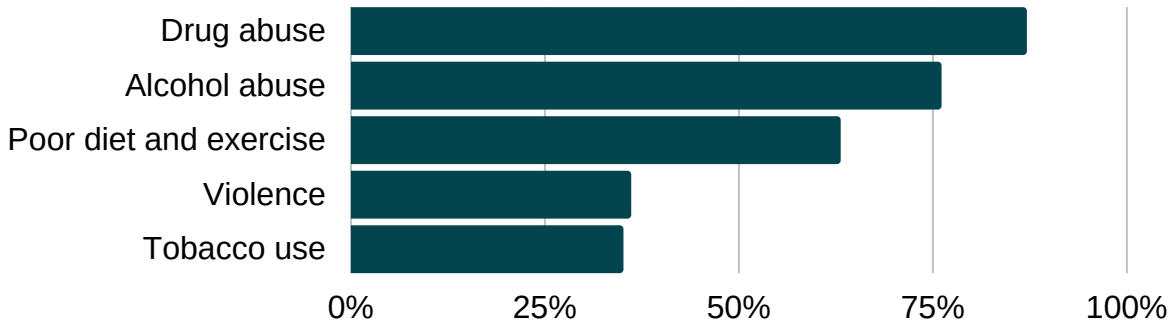
Community Survey

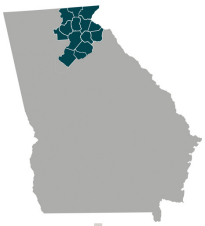
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below are the top five answers.



Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below are the top five answers.

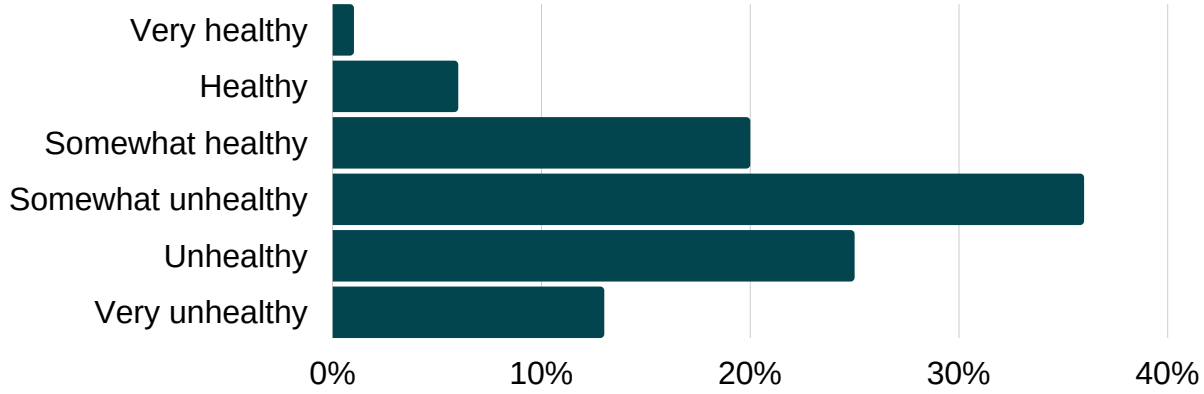
Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



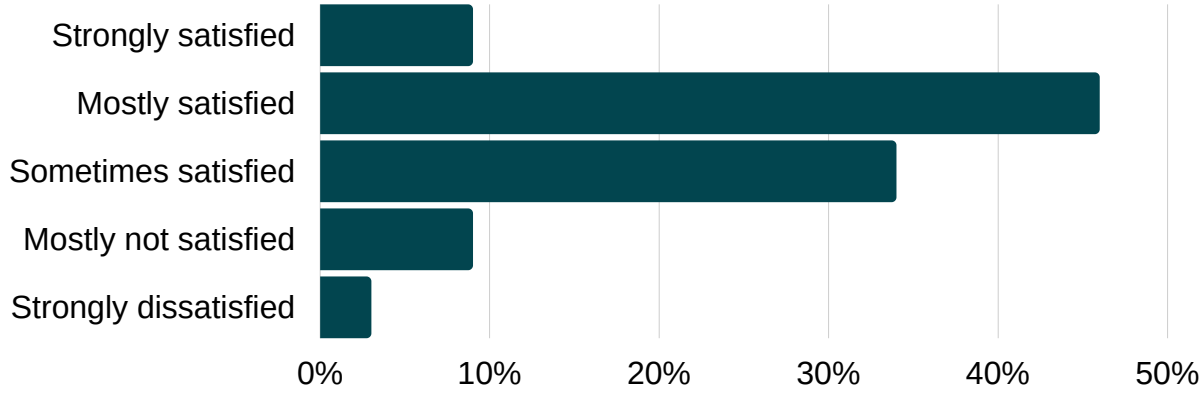


Community Survey

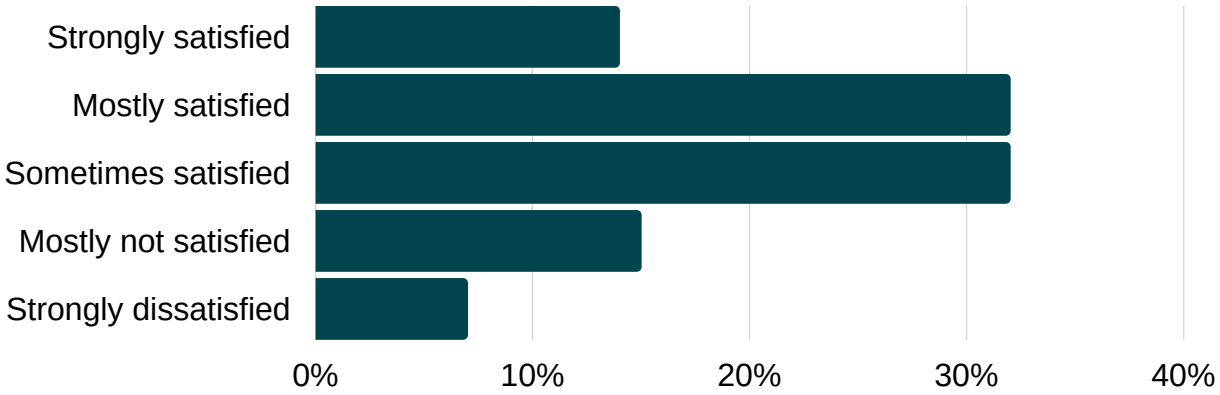
Q: How would you rate the overall health of our community?

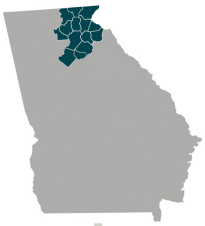


Q: How satisfied are you with the quality of life in your community?



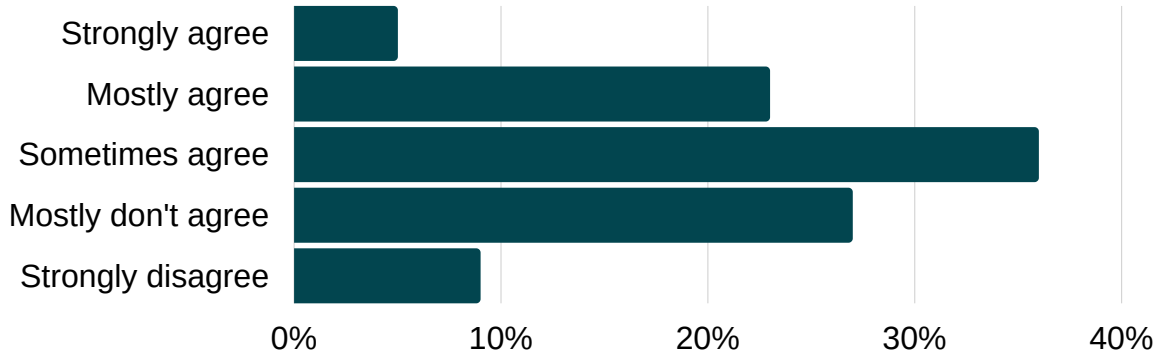
Q: How satisfied are you with the health care system in your community?



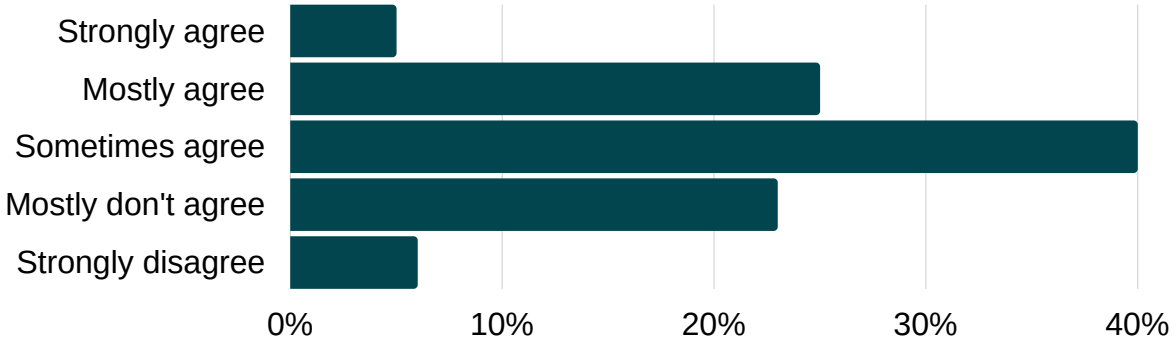


Community Survey

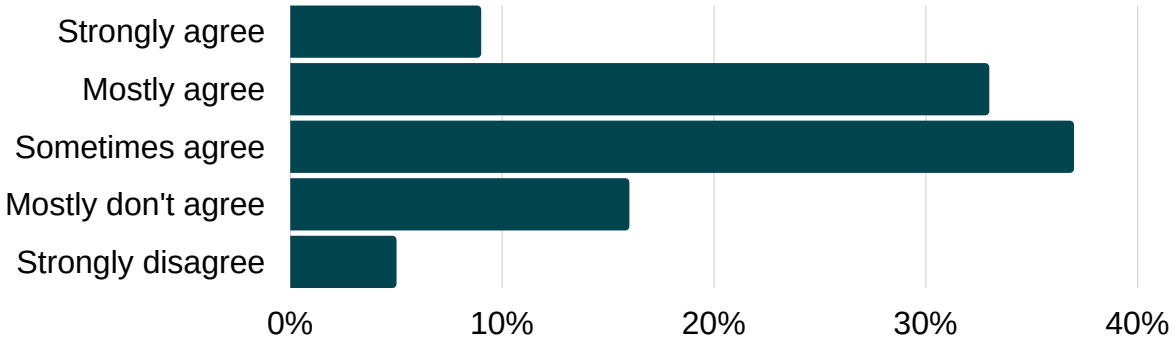
Q: Do you feel there are enough health and social services in your community?

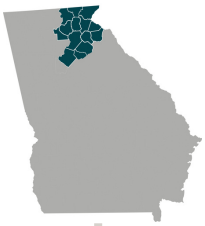


Q: Do you feel the community trusts each other to work together to make it a healthier place for all?



Q: Do you feel there are networks of support for individuals and families during times of stress and need?

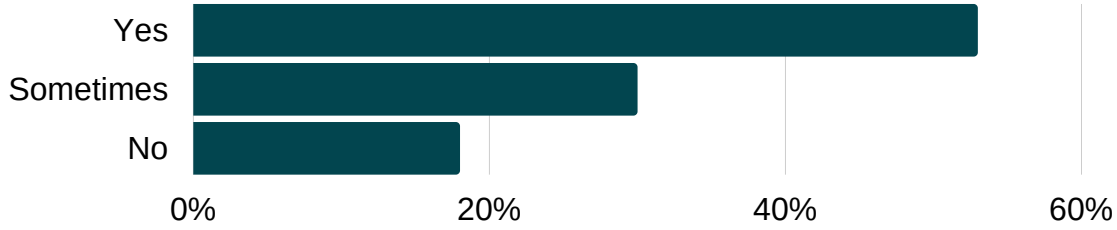




Community Survey

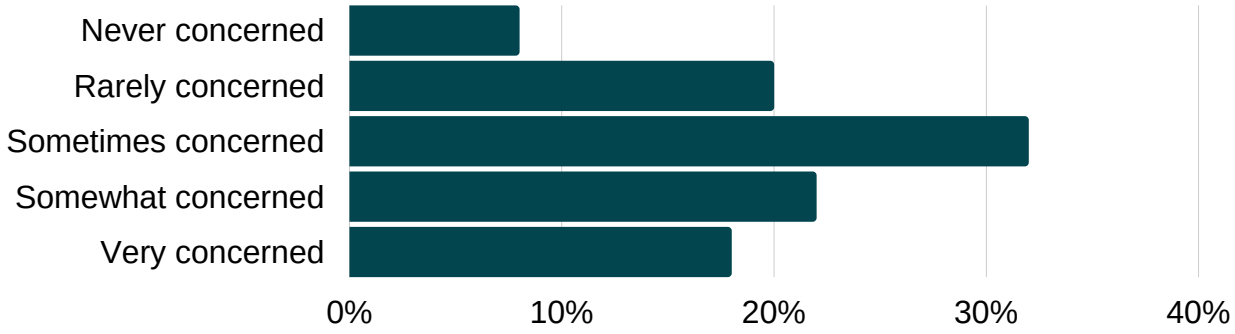
Q: Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?

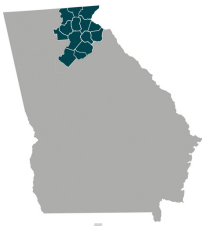
Q: Do you have a hard time paying for medications for you and your family?



Q: Does anyone in your family currently have medical debt?

Q: How concerned are you or anyone in your household about paying for your healthcare?





Prioritization and FY22 Priorities

The below matrix demonstrates where health issues showed up in both health data and community input. This collective data were captured and issues were ranked according to prevalence, how they compared to state data, how often they were mentioned in stakeholder interviews and focus groups, and what was mentioned in the surveys. The below represents this information for the SCH service area.

High data + low qualitative

- Access to care: preventable hospitalizations, ED visits
- Cancer, particularly lung
- COPD
- Alzheimer's disease
- Endocrine disease
- Gastrointestinal disease
- Reproductive and urinary disease
- Smoking
- Pneumonia
- Disability
- Education
- Infectious disease
- Fair or poor physical health status
- Pneumonia
- Infectious Disease
- Disability
- Housing costs

High data + high qualitative

- Access to care: insurance status, cost
- Access to dental care
- Access to mental health care
- Cardiovascular disease
- Diabetes
- Transportation
- Mental health: suicide, providers
- COVID-19
- Poverty/income
- Social isolation
- Substance abuse: opioids, fentanyl, alco
- Health behaviors
- Fair or poor mental health
- Obesity

Low data + low qualitative

- Bone and muscle disease
- Nervous system disease
- Child mortality
- Teen pregnancy
- Segregation
- Social isolation
- Arthritis
- Musculoskeletal disease
- Nervous system disease
- Septicemia
- Air quality
- Single parent households

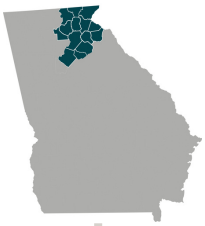
Low data + high qualitative

- Sources of health information*
- Health education, both mental and physical*
- Stigma around mental health care*
- Politics*

*No quantitative data available

Once the top health needs were identified, CHNA partners completed health importance worksheets, which scored each of the health needs in three main areas:

- Root cause: Does a SDH cause this problem?
- Magnitude: Is this significant, severe, and/or could lead to long-term disability or death?
- Ability to make an impact: Can we change this?



Prioritization and FY22 Priorities

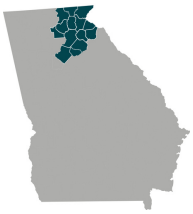
Scores from the health needs importance worksheets were used to create a health needs ranking, which allowed advisors and partners to see what emerged as top health needs. Those results are below.

Health Need	Health Need Importance Score
1 – Access to Mental Health Care	15
1 – Heart Disease	15
1 – Substance Abuse	15
2 – Health Behaviors	14
2 – Obesity	14
3 – Access to Care: Insurance Status, Cost	13
3 – Access to Dental Care	13
3 – Diabetes	13
3 – Poverty and Income	13
4 – Social Isolation	12
5 – COVID-19	11
6 – Transportation	10

Once the health importance worksheets were completed, CHNA partners and advisors discussed each identified health need in a meeting held on July 13, 2022. From that discussion came recommended priorities for the hospital to address within the service area. Those priorities are:

- **Mental health: middle and high school students**
- **Mental health: young adults and single-parent households**
- **Mental health: receiving facilities**
- **Misuse of emergency room**
- **Obesity**

Although not selected as priorities, there are additional issues of concern for the residents within the Stephens County Hospital service area, including diabetes, poverty, and transportation. The hospital will work to address these issues when possible, and many interventions in place to address the chosen priorities likely will have a positive impact on the other issues as well.



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Appendix One: Limitations

There are several limitations to this CHNA. Publicly-available community health data is delayed and does not reflect current state. This is particularly important during times of COVID-19, when many health, economic, and other community data has been severely impacted. Among these indicators are mental and behavioral health, access to care, health behaviors (especially sexually transmitted diseases and alcohol use), average household income, cost of living, population growth, and migration patterns.

Additionally, many indicators reflect self-reported data. For example, a commonly used source is the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), which solicits and tracks certain public health indicators. These include alcohol use, physical inactivity, and tobacco use, among others. These indicators are often underreported due to several reasons, the most frequent being the human tendency to understate unhealthy behaviors.

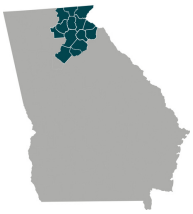
Finally, race and ethnicity information were not uniformly available for all service areas due to the limited number of minorities within certain areas. When possible, data reflects disparities among races, however, that data may not be reflected in all service areas.

Appendix Two: CHNA Advisors

The below is a list of CHNA advisors. Those present at the May 19, 2022, prioritization session are noted with an "*" beside their name.

Northeast Georgia Health System

***Phillipa Lewis Moss:** Board Member, NGMC, United Way, NGCF, JEMC, Co-Chair, NGMC CHNA
***Dr. Monica Newton:** Physician, Co-Chair, NGMC CHNA
***Jessica Dudley:** President, United Way Hall County
***Staci Tunkel:** Director of Operations, NGHS Foundation



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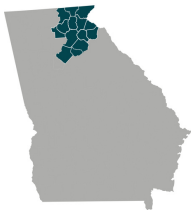
***Kay Hall:** NGMC Lumpkin
Jo Brewer: Retired, Chair of Good Shepherd Clinic, Dawsonville
***Camille Viera Hewell:** NGHS Advisory Council
***Pastor Stephen Samuel:** NGMC Board Member
Martha Randolph: NGMC Board Member, Chair of Hospital Authority
***Dr. Antonio Rios:** Chief, NGHS Population Health
***Paul Nelson:** NGHS Case Management
TD Teasley: State Trooper, NGHS Advisory Council
***Marsha Stringer:** Chair, Newtown Florist Club Health Disparities Committee
***Heather Standard:** NGMC Barrow, present at May 19, 2022, prioritization session
***Maria Hernandez:** Good News Clinics Care Coordinator
***Liz Coates:** Executive Director, Good News Clinics,
***Dr. Zach Taylor:** District 2 Public Health Director

Habersham Medical Center

***Jeanne Buffington:** HMC Community Partner, Rape Response
Pastor Andy Chambers: HMC Chaplain, First Presbyterian Church, Cornelia
Lynn Echols: HMC Board Authority Member, HMC Foundation Board Member, Black Bear Lodge
***Brent Edwards:** HMC Foundation Board Member, Georgia Power
Dr. Laura Heringer: HMC Physician, Internal Medicine
Mayor John Barrow: City of Cornelia
Carol Johnson: HMC Community Partner, Grace Gate
***Teri Newsome:** HMC Board Authority Member, Georgia Department of Public Health
***Harold Pickett:** Chair, Habersham Chamber of Commerce, Georgia Power
Perry Retting, Ph.D.: HMC Foundation Board Member, Piedmont University
Pastor Christian Roman: Iglesia Nueva Vida A/D
***Erika Lopez-Gill:** District 2 Public Health
***Amy Stratton:** District 2 Public Health
Melissa Miller: Executive Director, Grace Gate Clinic
Tyler Williams: CEO, HMC



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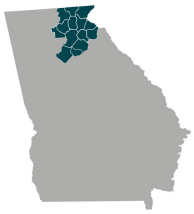
Stephens County Hospital

Note: All were present at the July 13 prioritization meeting.

Dawn Jameson: Stephens County Hospital
Joley Strickland: Stephens County Hospital
Christopher Stephens: Stephens County Hospital
Ira Racadag: Stephens County Hospital
Stephen Stewart: Stephens County Sheriff's Office
Randy Shirley: Stephens County Sheriff's Office
Ryan Parks: Franklin County EMS
Misty Rice: District 2 Public Health
Tonya Powers: Franklin County Development Authority
Nikki Croy: Franklin County School System
RaDonna Powers: City of Lavonia



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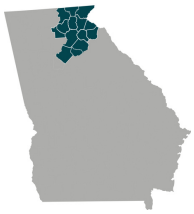
Appendix Three: Community Focus Group Members and Interviewees

Below are the stakeholders and focus group members engaged throughout the community input process. Please note the person is identified by either his or her role or the population he or she represents, as well as the county he or she represents.

One-on-one interviews, conducted in February and March 2022

Adam Raulerson, NGHS staff, Hall County
Alison Ward, Public health, Hall County
Andrea English, K-12 education, Hall County
Andrea Pereira, Nonprofit community, Hall County
Andy Chambers, Faith-based community, Habersham County
Antonio Rios, NGHS staff, physician, Hall County
Blake McCarrin, News and media, Barrow County
Chris Bray, Nonprofit community, Hall County
Chuck Jones, Business community, Hall County
Deb Bailey, NGMC staff, Hall County
Ellen Petree, K-12 education, Barrow County
Greg Lang, Nonprofit community, charitable clinics, Gwinnett County
Harold Pickett, Business community, Habersham County
Jeanne Buffington, Nonprofit community, Hall County
Jennifer Scott, K-12 education, Barrow County
Jennifer Scott Benford, Policymaker, Barrow County
JoAnne Taylor, Policymaker, Lumpkin County
Jody Wall, Higher education, Lumpkin County
Joy Tolbert, K-12 education, Banks County
Kate Maine, Higher education, Lumpkin County
Katie Crumley, Nonprofit community, Hall County
Kay Blackstock, Nonprofit community, Hall County
Liz Coates, Nonprofit community, charitable clinics, Hall County
Mark Madison, Nonprofit community, Rabun County
Melissa Wood, Business community, Habersham
Michele Prater, Nonprofit community, Hall County
Molly Lima, Policymaker, Habersham
Pat Graham, Policymaker, Barrow County



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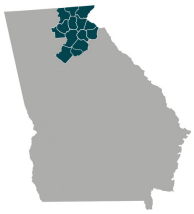
Paul Nelson, NGHS staff, Hall County
Perry Rettig, Higher education, Habersham County
Steffanie Sorrells, Business community, Barrow County
Tammy Soles, NGHS staff, Hall County
Wendy Glassbrener, Nonprofit community, Hall County
Wesley Seabolt, Mental health, Stephens County

Northeast Georgia Advisory Council Focus Group, hosted February 07, 2022

Amy Whitley, Business community, retired, Hall County
Andrew Davenport, Business community, Hall County
Anjana Freeman, Government, Hall County
Ben McDaniel, Government, Barrow County
Brad Baucom, Nonprofit community, Hall County
Camille Viera, Business community, Hall County
Cathy Bowers, Healthcare administration, retired, Hall County
Charlotte Sosebee, Government, Athens-Clarke County
Cindy Green, Business community, Barrow, Gwinnett, Jackson, and Hall counties
D Higgins, Business community, Habersham County
David Wimpy, Government, Lumpkin County
Deborah Mack, Government, Retired, Hall County
Drew Echols, Business community, Banks and Habersham counties
Edward Mienie, Higher education, Lumpkin County
Glennis Barnes, Business community, Hall County
Hardy Johnson, Policymaker, Barrow, Gwinnett, Jackson, and Hall counties
Heather NeSmith, K-12 education, Habersham County
Jane Taylor, Nurse educator, Retired, Lumpkin County
Jeff Shoemaker, Government, Hall and White counties
Jessica Dudley, Nonprofit community, Hall County
Joe Vogt, Business community, Jackson and Winder counties
Lauren Samples, Business community, Dawson and Hall counties
Marty Losoff, Healthcare administration, retired, Jackson County
Mike Berg, Business community, government, retired, Dawson County
Mike Giles, Business community, Hall County
Norma Hernandez, Business community, nonprofit community, Hall County
Pamela Elfenbein, Higher education, Habersham and Hall counties



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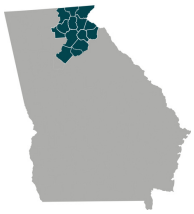
Phuoc “Joe” Tu, Faith-based community, Hall County
Randy Dellinger, Business community, Gwinnett County
Ruth Wade, Business community, Hall County
Sandra Williams, Government, retired, Hall County
Sheila Sánchez, Business community, Hall County
Susan Baker, Business community, retired, White County
Susan Harbin, Business community, retired, Franklin and Hart counties
TeDarrius Teasley, Government, Hall County
Thom Price, Business community, Jackson County
Trey McPhaul, Business community, Hall County
Wanda Azpeitia, Business community, Barrow, Gwinnett, and Hall counties

Hall County Family Connection Network Focus Group, hosted February 08, 2022

Annaliza Thompson, Government, Gwinnett County
Cindy Levi, Nonprofit community, Hall County
Cynetia Banks, Government, retired, Hall County
Jeremy Williams, K-12 education, Hall County
Jessi Emmett, Government, Hall County
Jessica Dudley, Nonprofit community, Hall County
Ken Gossage, Nonprofit community, homeless community, Hall County
Kevin Bales, K-12 education, Hall County
Maria Calkins, Nonprofit community, public housing, Hall County
Siaban Ming, NGHS staff, Hall County
Vanesa Sarazua, Nonprofit community, Gwinnett County

African American Advocacy Focus Group, hosted by Newtown Florist Club on February 26, 2022

Beverly Turner, Hall County
Charlene Williams, Hall County
Dalinda Luster, Hall County
Pastor Frank Medina, Hall County
Jonathan Rucker, Hall County



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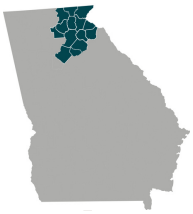
Kaneesha Robinson, Hall County
Marsha Stringer, Hall County
Reverend Rose Johnson Mackey, Hall County

Hispanic Advocacy Focus Group, hosted by Hispanic Alliance on March 29, 2022

Carrie McGarity, Hall County
Bianca Prieto, Hall County
Christian Salas, Hall County
Eduardo Nino-Moreno, Hall County
Elisa Lopez, Hall County
Evelyn Arevalo, Hall County
Jenny Chapple, Hall County
Laura Rodriguez, Hall County
Lisa Echols, Hall County
Luiz Ruiz, Hall County
Maria Shelton, Hall County
Marco Valentino, Hall County
Margarita Munoz, Hall County
Maria Iniguez, Hall County
Mayra Hernandez, Hall County
Natasha Young, Hall County
Rebeca Ruelas, Hall County
Sara Pedraza, Hall County
Semuel Maysonet, Hall County
Sheila Sanchez, Hall County
Vanesa Sarazua, Hall County
Veronica Gomez, Hall County

Government Human Service Providers Focus Group, hosted March 11, 2022

Carion Marcelin, Gwinnett County
Dwayne Tolson, Gwinnett County
Regina Miller, Gwinnett County
Tina Fleming, Gwinnett County
Lindsay Dorset, Gwinnett County



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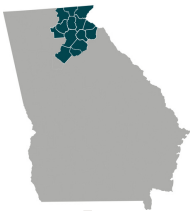
Appendix Four: Biographies of CHNA Team

Monica Newton, DO, MHP, FAAFP
Co-Chair, One Hall Mental Behavioral Health Committee
Co-Chair, NGMC's Community Health Needs Assessment
Founding Program Director, NGMC Family Medicine

Dr. Monica Newton is an accomplished physician, educator, and community leader. She began her education at Auburn University, studying premed-psychology, followed by medical school at Midwestern University in Chicago. While in Family Medicine residency at the University of Alabama at Birmingham, she obtained a Master of Public Health in International Health with an emphasis in project planning. This education has served her very well over the years leading many successful projects. From founding a family medicine residency program in Northeast Georgia to initiating a now 20-year-old mobile rural free clinic called "Doc on the Spot," her career has made a lasting impact.

After serving as an Associate Professor at the UAB Selma Family Medicine residency program for 11 years, Dr. Newton moved with her family to Gainesville, GA, and joined Northeast Georgia Physicians Group (NGPG). She has served in many leadership roles here, including Quality Chair, Primary and Urgent Care Chair, and the Medical Director of our MSSP/ACO plan. She has practiced the full scope of family medicine, from Obstetrics to ICU medicine and end-of-life care. Her leadership style has empowered her to serve in many state and national roles, including the AAFP National Commission on Education, the Georgia Academy of Family Physicians Vice Speaker, and as an elected official on the City Council of Selma, AL. Her conversational teaching style engages audiences and helped earn her the Georgia Academy of Family Physicians Educator of the Year for 2021.



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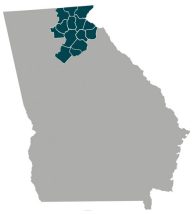
Phillippa Lewis Moss
Co-Chair, NGMC's Community Health Needs Assessment
Chair, NGMC Board of Directors
Co-Founder, The ThoMoss Group

Phillippa Lewis Moss is the Director of the Gainesville-Hall Community Service Center. The Community Service Center is a jointly supported agency of the City of Gainesville and Hall County that has been in operation for over three decades. During this time, the center has been home to Meals on Wheels, Senior Life Center, Hall Area Transit Community Outreach, Center for Family Prosperity, counseling and psychotherapy, parenting education, and more.

Moss' educational background includes a Bachelor of Arts in Political Science from the University of California Irvine, a Master of Public Administration from the University of Southern California, and a Master of Conflict Management from Kennesaw State University. She is a registered mediator with the Georgia Commission on Dispute Resolution. She leads racial equity conversations across the southeast, founding The ThoMoss Group with business partner Lisa Thomas. She is also the Administrative Director for the Gainesville-Hall County Community Council on Aging, a member of the Gainesville Kiwanis Club, a graduate of Leadership Long Beach, Leadership Hall, Leadership Gwinnett, and serves on several boards, including Salvation Army, Jackson EMC Foundation, Hall County Family Connection Network, United Way, Northeast Georgia Medical Center Board, Vision 2030, and the Greater Hall County Chamber of Commerce.

Christy Moore, MBA
Director, Community Health Improvement
Northeast Georgia Health System

Gainesville native Christy Moore has worked in community health for over 25 years. In her role, she directs the system-wide community health improvement plan to improve the health status of the communities served. This includes oversight of regional community health needs assessments, resulting implementation plans, and community benefit reporting for all hospital affiliates. She facilitates community partnerships working alongside employees, administration, and community partners to positively impact the health of the people in our region.



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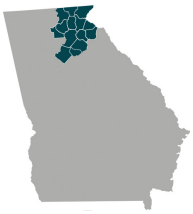
Moore earned her bachelor's degree in Journalism from the University of Georgia and a Master's of Business Administration with a concentration in healthcare management from Brenau University. She currently serves on the Board of Directors for Good News Clinics, Jackson EMC Foundation, and United Way of Hall County. She is a past President of the Rotary Club of South Hall County, a sustainer in the Junior League of Gainesville-Hall County, and a graduate of Leadership GHA (Georgia Hospital Association), Leadership Hall County. She has been recognized as a Silver Shovel Award winner by the Greater Hall Chamber of Commerce.

Holly Lang
Founder, Public Goods Group

Health economist Holly Lang has worked for nearly two decades in health care delivery, financing, and community benefit within health systems. Lang is the founder and CEO of Public Goods Group, and has authored numerous community health needs assessments in various markets and has worked on many related projects.

Lang graduated with distinction from the London School of Economics with her master's in health economics, policy, and management and, in 2017, she was awarded the school's Brian Abel-Smith prize for her economic research on the impact of Medicaid expansion on US hospitals and community benefit programming. She regularly partners with federal agencies and national not-for-profit organizations in conducting economic research on issues related to community benefit. Lang is also the founder of Fair Play, a research and policy not-for-profit organization addressing medical debt, health costs and access issues. Additionally, she serves as board chair for the Georgia Charitable Care Network and the Murder Accountability Project. She's worked as a health policy reporter, a patient advocate, a hospital director, and an economist. She is a native Georgian and has worked within the state throughout her career.



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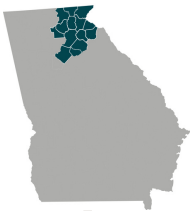
Appendix Five: Overviews of Consulting Organizations

The ThoMoss Group

The ThoMoss Group is a consulting firm consisting of leaders who dare to tackle sensitive and complex community issues. Led by co-founders, Lisa Thomas and Phillippa Lewis Moss, the organization has 75 years of combined experience in the areas of community development, business development, change management, non-profit management and conversations related to diversity, equity, and inclusion. We are particularly adept at bringing diverse populations and uplifting all voices to problem solve and create anew. Our engagement style is demanding, respectful, and thought-provoking. Our conversations leave participants with an experience of being fully expressed, open to self-examination, and receptive to diverse viewpoints; all necessary components to shifting any critical conversation.

Public Goods Group

Public Goods Group is a consulting company that creates sustainable solutions for populations that are particularly vulnerable to the global affordability and health equity issues that face us locally. We provide services related to community benefit, health equity and establishing programs for underserved populations. We've led multiple initiatives and reforms in health care financing delivery models, including overhauls of hospital and health system financial assistance programs, successful Congressional campaigns establishing equity in transplant organ allocation, development of innovative socioeconomic programming, and the formation of Federally Qualified Health Centers and other charitable clinics. We've authored multiple community health needs assessment in a variety of markets and, in partnership with national organizations, created a framework for how hospitals can incorporate health equity in their CHNAs and community benefit work. Our clients include hospitals, health systems, think tanks, governments, and private corporations. Public Goods Group is headquartered in Savannah, Georgia.



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Appendix Six: Key Terms

Age-adjusted death rates: A statistical process applied to rates of disease, death, injuries, or other health outcomes which allows communities with different age structures to be compared.

Health equity: The state in which everyone can attain full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance.

Medicaid: A state-federal public health insurance program for low-income individuals and those with disabilities.

Medicare: A federal health insurance program for people 65 or older, some younger people with disabilities, and people with End-Stage Renal Disease.

Medicare beneficiaries: A person who is enrolled in Medicare.

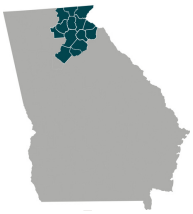
Premature death rates: Rates of deaths that occurs before the average age of death in certain populations.

Qualitative data: The descriptive and conceptual findings collected through interviews, focus groups, surveys, and observation.

Quantitative data: Any set of information that can be numerically recognized and analyzed.

Social determinants of health: An individual's personal circumstances that impact their health and well-being. This includes political, socioeconomic, and cultural factors, as well as how easily someone can access health care, education, a safe place to live, and nutritious food.

TRICARE: A federal health care program for uniformed service members, retirees, and their families.



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Appendix Seven: Counties by Service Area

Counties	HMC	NGMC GBSA	NGMC PSA	NGMC SSA 400	NGMC SSA North	SCH
Banks	X	X			X	
Barrow		X				
Dawson				X		
Franklin						X
Gwinnett		X				
Habersham	X				X	
Hall		X	X			
Jackson		X				
Lumpkin				X		
Rabun	X				X	
Stephens					X	X
Towns					X	
Union					X	
White					X	

Appendices

Appendix Eight: Health Importance Worksheet

The below worksheet was used by CHNA partners to score health needs based on three framing questions. Worksheets were used for each significant health need and were completed by CHNA partners in a working session held May 13, 2022.

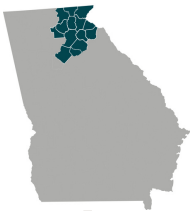
FY22 Northeast Georgia Community Health Needs Assessment: Health Need Importance Worksheet

Service area: **Significant health need:**

Instructions: Please score the health need based as it fits the below criteria on a scale of 0 to 5, with 0 being the lowest score and 5 being the highest. You can use incremental scores (such as 4.5).

Criteria	Score (0-5)	Notes
Root cause: Is the issue caused by a social determinant of health or a root cause problem? Is this a challenge that disproportionately impacts low-income, uninsured, or otherwise vulnerable populations? Would addressing this issue potentially address other community issues?		
Magnitude: Is this is a significant issue within the community? Is the problem severe and could lead to long-term disability or death?		
Ability to make an impact: Does the hospital and/or community have an ability to make an impact on this problem? Does the community support our addressing this issue?		
Total score		

The scores from the worksheets were then compiled and used to create the health rankings lists for all service areas, which can be found within each service area's subsection of this CHNA.



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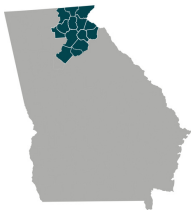
Appendix Nine: Focus Group Questions

The following questions were used to guide each of the focus groups that were conducted in February and March 2022. Please note that additional questions were asked of the African American and Hispanic groups as they articulated unique interests and/or concerns during the discussion.

1. Rate the health status of the community on a scale of one to five.
2. Describe the community.
3. What are the most pressing gaps that impact the health of the community?
4. What are some of the underlying health issues/prevalent conditions?
5. Who are the most vulnerable groups/populations?
6. What are the barriers that prevent individuals from seeking health care?
7. What are the top 3 health needs?
8. What are the biggest gaps that impact the health of the community?
9. What are the most important health issues impacting the community?
10. What are the underlying health issues?
11. How has COVID-19 impacted the community?
12. What existing community resources do you rely on?

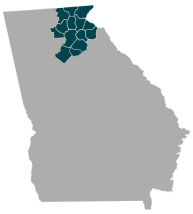


Appendices

Appendix Ten: Sources

We utilized numerous data sources throughout the CHNA process. Due to the high volume of sources in this report, we did not individually cite each statistic. A list of all sources and the area to which they correspond can be found below.

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



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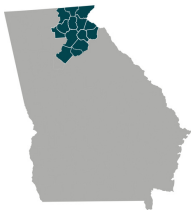
Category	Data Source
Income and Economics	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income and Economics	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income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



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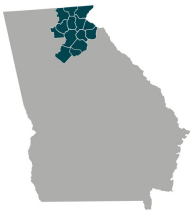
Category	Data Source
Housing and Families	US Department of Housing and Urban Development, 2019.
Housing and Families	US Department of Housing and Urban Development, US Census Bureau, American Community Survey, 2019.
Housing and Families	Eviction Lab, 2016.
Housing and Families	US Census Bureau, American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



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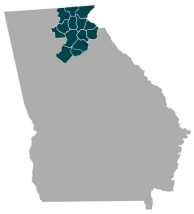
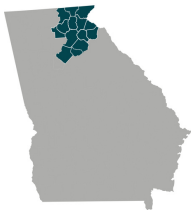
Category	Data Source
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
Other Social & Economic Factors	Opportunity Insights, 2018.
Other Social & Economic Factors	US Census Bureau, American Community Survey, 2015-19.
Other Social & Economic Factors	Centers for Medicare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



Appendices

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



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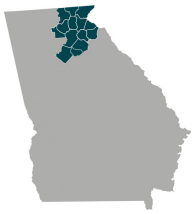
Category	Data Source
Physical Environment	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-20.
Physical Environment	Climate Impact Lab, 2018.
Physical Environment	Multi-Resolution Land Characteristics Consortium,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



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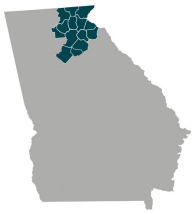
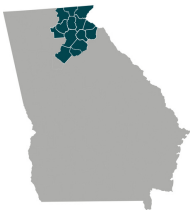
Category	Data Source
Physical Environment	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.
Physical Environment	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Clinical Care and Prevention	Centers for Medicare and Medicaid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



Appendices

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



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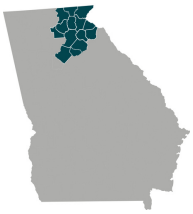
Category	Data Source
Health Outcomes	State Cancer Profiles, 2014-18.
Health Outcomes	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Health Outcomes	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion,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



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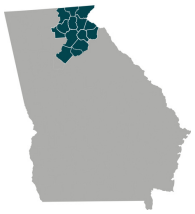
Category	Data Source
Health Outcomes	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Health Outcomes	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Healthcare Workforce	Centers for Medicare and Medicaid Services, CMS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



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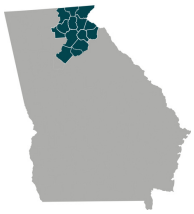
Category	Data Source
Healthcare Workforce	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
COVID-19	Johns Hopkins University, 2022.
COVID-19	Google Mobility Reports, Feb 01, 2022.
COVID-19	Centers for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

Appendix 11: Community Survey Questions

In March 2022, the CHNA partners published a community survey designed to gather the input and feedback of the broader community. The following are the survey questions.

Text provided with the survey. Northeast Georgia Health System along with District 2 Public Health, Habersham Medical Center, Good News Clinics, and Stephens County Hospital are studying the region's community health needs. We invite you to take this 15-minute survey so that your feedback can be heard and included in identifying health priorities which area hospitals, in partnership with the communities they serve, will work on to improve health status of citizens. Thank you for your time and input.

Please note this survey was provided in English, Spanish, and Vietnamese.



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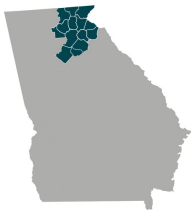
Community Health

For this first set of questions, we're going to ask you what you feel is necessary to build a strong and healthy community.

1. **In the following list, what do you think are the five most important factors for a healthy community? We consider this to be those factors which most improve the quality of life in a community.**
   - Access to health care (e.g., family doctor)
   - Access to healthy food
   - Arts and cultural events
   - Civic participation
   - Clean environment
   - Emergency preparedness
   - Ethnic and cultural diversity
   - Good place to raise children
   - Healthy behaviors and lifestyles
   - High retirement rates
   - Low adult death and disease rates
   - Low crime / safe neighborhoods
   - Low infant deaths
   - Low level of child abuse
   - Parks and recreation
   - Quality of care
   - Quality housing and/or housing availability
   - Quality jobs and economic stability
   - Religious or spiritual values
   - Social cohesion
   - Strong school district
   - Strong family life
   - Transportation and walkability
   - Other: Please describe



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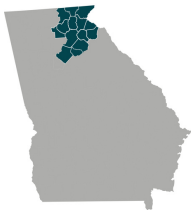
2. In the following list, what do you think are the five most important health problems in our community? Please check five.

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



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3. In the following list, what do you think are the five most critical risky behaviors in our community?

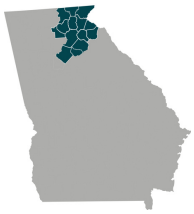
- Alcohol abuse
- All-terrain vehicles (4-wheelers, etc.)
- Drug abuse
- Dropping out of school
- Incarceration/ institutionalization
- Issues related to race or ethnicity
- Lack of exercise
- Lack of maternity care or maternal care education
- Motor vehicle accidents
- Not getting vaccinations to prevent disease, including COVID-19
- Not using birth control
- Not using seat belts / child safety seats
- Poor diet and exercise
- Tobacco use

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

- Very unhealthy
- Unhealthy
- Somewhat unhealthy
- Somewhat healthy
- Healthy
- Very healthy

Next, we want to learn more about how you feel about the quality of life in your community. Please read the questions and circle the number that best states your opinion about quality of life using this scale:

5: Strongly agree
4: Mostly agree
3: Sometimes agree
2: Mostly don't agree
1: Strongly disagree



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5. How satisfied are you with the quality of life in your community? (Consider your sense of safety, well-being, participation in community life and associations, etc.)

6. How satisfied are you with the health care system in your community?(Consider access, cost, availability, quality, and options in health care)

7. Is your community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)

8. Is your community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, Meals on Wheels, etc.)

9. Is there economic opportunity in your community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)

10. Is your community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)

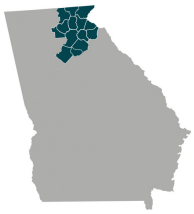
11. Do you feel there are networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?

12. Do you feel that all community members believe they – both by themselves and together – can make the community a better place to live?

13. Do you feel there are enough health and social services in your community?

14. Do you feel the community trusts each other to work together to make it a healthier place for all?

15. Do you feel you have "a say" in doing things to make the community a better place to live?



Appendices

About you and your family
These next set of questions focus on you and your family.

16. How would you rate your own personal health?

- Very unhealthy (three or more chronic conditions such as heart disease or diabetes)
- Unhealthy (one or two chronic conditions such as heart disease or diabetes)
- Somewhat healthy
- Somewhat unhealthy
- Healthy
- Very healthy (no chronic conditions such as high blood pressure, diabetes, etc. or risky behaviors such as smoking, and excessive drinking)

17. How long do you think a healthy person could expect to live?

- 60-70
- 70-80
- 80-90
- 100+

18. How would you rank the general health of your household?

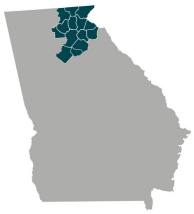
- Very unhealthy
- Unhealthy
- Somewhat unhealthy
- Somewhat healthy
- Healthy
- Very healthy

19. Do you have any form of health insurance?

- Yes
- No

20. How do you pay for your health care? Please check all that apply.

- Cash
- Through private health insurance (e.g., Aetna, Blue Cross, Cigna, Humana, Kaiser, United Healthcare, etc.)



Appendices

- Medicaid
- Medicare
- Veterans' Administration health care
- Indian Health Services
- Other: Please describe

21. Do you feel you have enough resources, whether through insurance or your own money, to cover your and your household's health care costs?

- Yes
- No
- Sometimes

22. Do you have a hard time paying for medications for you or your family?

- Yes
- No

23. Do you or anyone in your household currently have any medical debt?

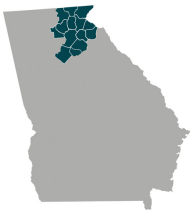
- Yes
- No

24. If yes, is that money owed to:

- A doctor's office
- A dentist
- The hospital
- A mental health provider
- Other: Please describe

25. How worried are you or anyone in your household about paying for your healthcare?

- Very concerned
- Somewhat concerned
- Sometimes when something comes up but not often
- Rarely concerned
- Never concerned



Appendices

26. In the last year, have you worried that you would not have enough food to eat?

- Yes, we have had some concerns about food.
- No, we have had enough resources.
- We've sometimes had tough times but are mostly alright

27. In the last year, have you worried about how you would pay your rent or mortgage?

- Yes, this has been a concern
- No, we've had enough resources to pay for our housing
- We have had some concern but have managed to cover housing costs

28. Do you feel COVID-19 has impacted your family?

- Yes
- No

29. If yes, has it impacted your:

- Employment
- Health
- Overall finances
- Mental well-being
- Childcare

30. What challenges do you feel you face in your community?

31. What resources do you feel you need to be healthy?

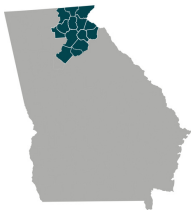
Demographics

Finally, we want to learn more about you and your household.

32. What is your zip code?

33. What is your age range?

34. What is your gender?



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35. How would you best describe yourself? Check all that apply.

- African American/Black
- Asian
- Native Hawaiian/Other Pacific Island
- Hispanic/Latino
- Native American/Alaska Native
- White/Caucasian
- Middle Eastern/North African
- Other: Please describe
- Prefer not to answer

36. What is your marital status?

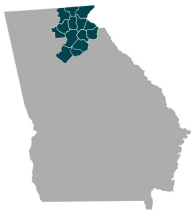
- Married
- Separated
- Divorced
- Co-habitating
- Single
- Prefer not to answer

37. What is the highest level of education you've achieved?

- Some high school
- High school/GED
- Some college
- Bachelor's degree
- Master's degree or higher
- Trade School/ Technical/ Vocational training
- Prefer not to answer

38. How many people do you consider to be part of your household? This includes everyone who lives at your house, even if you aren't related to them.

- Adults (18+)
- Children (1 month to 17 years)
- Total:



Appendices

39. What is your household income each year before taxes? This should account for everyone living in your house.

- Less than $20,000
- $20,000 to $39,999
- $40,000 to $59,999
- $60,000 to $79,999
- $80,000 to $99,999
- $100,000 to $119,999
- More than $120,000
- Prefer not to answer

40. What is your current employment status?

- Employed, working full-time
- Employed, working part-time
- Not employed, looking for work
- Retired
- Disabled, not able to work
- Prefer not to answer

41. Have you or anyone in your house who is old enough to work faced unemployment within the last year?

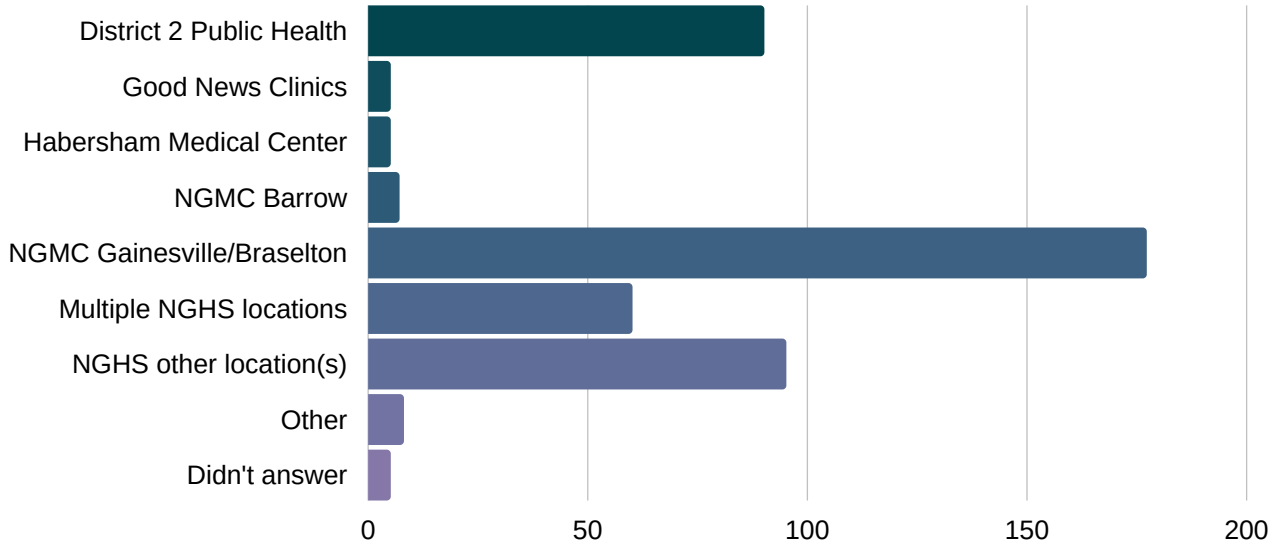
42. Is there anything else you'd like us to know?

Appendices

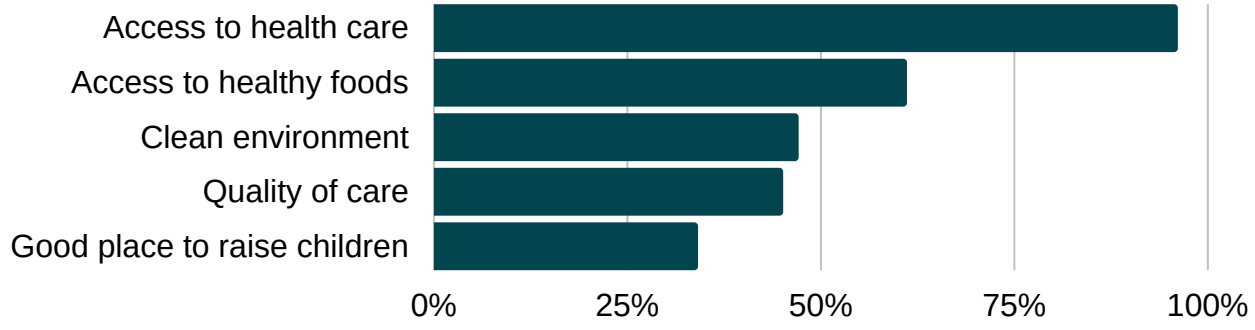
Appendix 12: Employee Survey

In February 2022, an electronic survey soliciting the input of employees launched, and CHNA partners widely advertised the survey through internal communication mechanisms. Approximately 460 employees responded. Below are the questions and a summary of responses.

Respondents worked at:



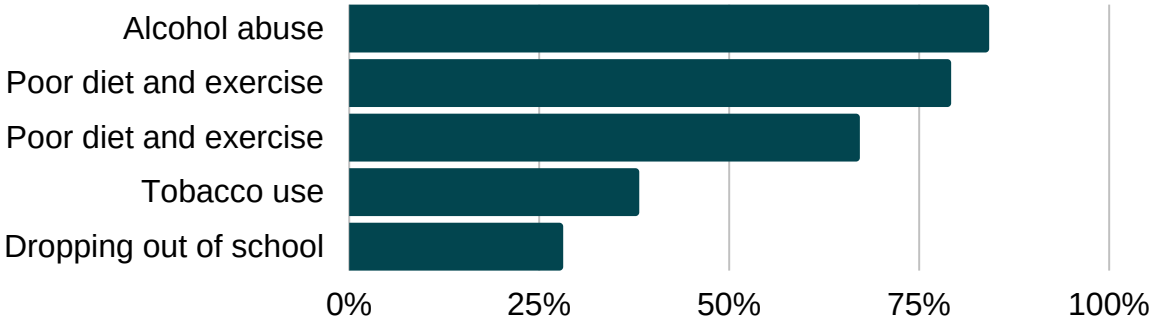
Q: What do you think are the five most important factors for a healthy community?
Respondents were provided a list. The below are the top five answers.



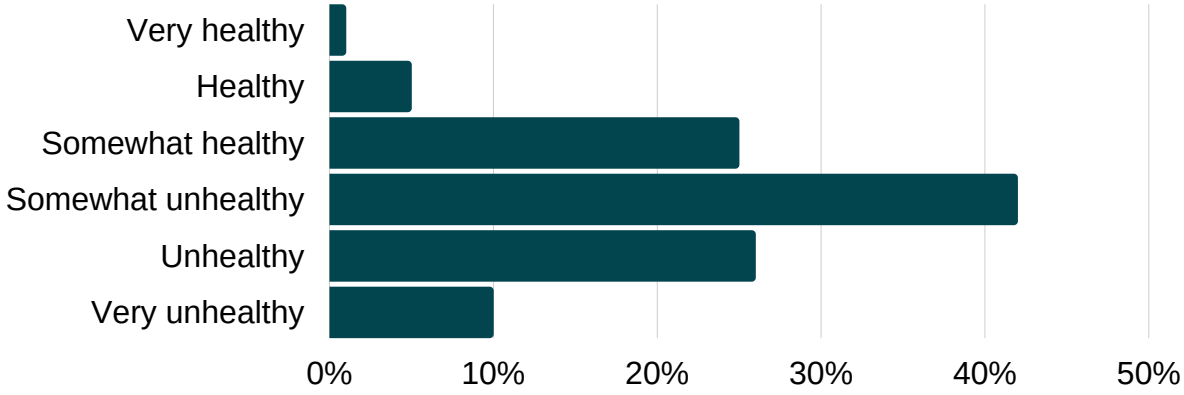
Appendices

Q: What do you think are the five most important health problems in our community?
Respondents were provided a list. The below are the top five answers.

Q: What do you think are the five critical risky behaviors in our community?
Respondents were provided a list. The below are the top five answers.



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



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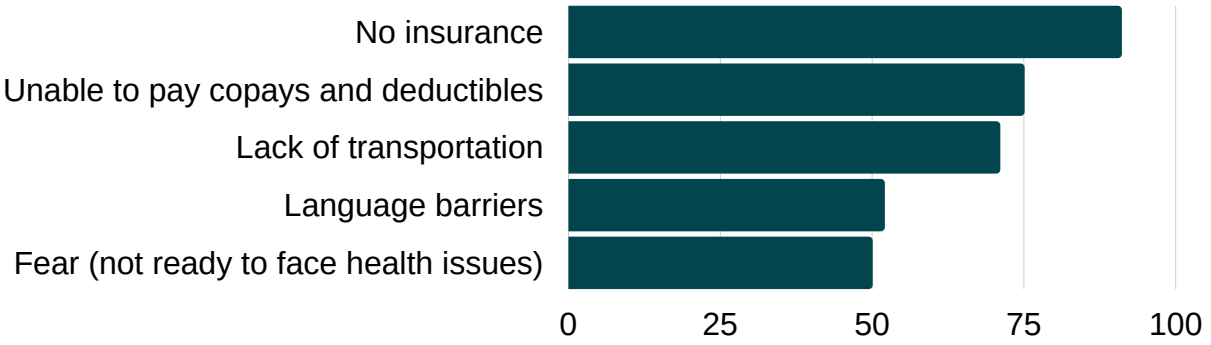
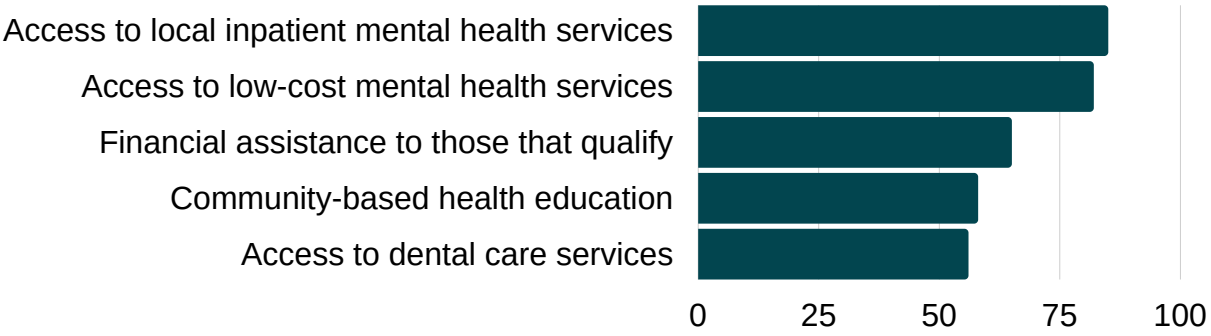
Q: What issues do you think may prevent community members from accessing care? Respondents were provided a list. The below are the top five answers**.**



Q: Of the following, what do you think are the top five most important actions in improving the health of community members living in Northeast Georgia? Respondents were provided a list. The below are the top five answers**.**

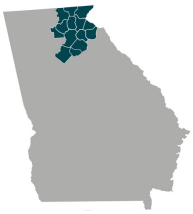


Q: What is your vision for a healthy community? Some selected answers are below.

"For our organization to be a beacon of light, hope, resources, education and help in the chaos that we are living in, to really show the community that we do care."

"Community-based health education and health programs widely available focusing on low-income communities."

"One that trusts, respects, and supports each other, and understands how important mental health is to our physical well-being."



Appendices

Appendix 13: Stephens County Hospital Progress on FY19 CHNA Priorities

Stephens County Hospital's identified areas of focus from 2019 were:

- Substance Abuse
- Access to Care
- Behavioral and Mental Health
- Maternal and Child Health

The hospital assisted the North Georgia Center for Wellness and Recovery open which is a non-profit residential substance abuse treatment facility. This was a community collaborative to focus on the substance abuse issues facing our community.

The hospital expanded its primary care provider practice since the last CHNA and opened our immediate care clinic, both in response to increasing access to care. They also redesignated our primary care clinic as a Rural Health Clinic, which allows them to operate on a sliding fee scale making care more affordable for those who are uninsured. A significant portion of patient visits are also conducted through telemedicine, also lending to increased ease of access to care.

The hospital also opened its inpatient Senior Behavioral Health Unit to address mental health issues in our community and look to expand this to outpatient treatment as well.

In expanding its primary care base, the hospital added family medicine physicians who can treat patients of all ages, as to ensure increased access for the children in the community.

Appendix 14: NGMC Progress on FY19 CHNA Priorities

Each year, NGMC publishes a report detailing progress on their FY19 CHNA priorities. These reports are provided in the following pages and can also be found online at **nghs.com/community-benefit-resources**.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IMPLEMENTATION PLAN 2020 PROGRESS REPORT

Based on a comprehensive Community Health Needs Assement conducted in 2019, NGHS indentified five important health priorities and corresponding outcome measures. This document is interactive and provides 2020 progress in reaching stated goals of the 2020-2022 CHNA Implementation Plan at nghs.com/2020-plan.

Northeast Georgia Medical Center

LINKS

View the CHNA report and other resources including a series of videos that showcase our strong partnerships in community health efforts, such as with health access for indigent populations, mental health, COVID-19 and more:

https://www.nghs.com/cbr

Community Health Needs Assessment

Partnering to Address Mental Health

Partnering to Slow COVID-19

Partnering to Meet the Needs of the Uninsured

Partnering to Provide EMS in Barrow County

2020 PROGRESS

FIVE PRIORITIES + COVID 19 RESPONSE

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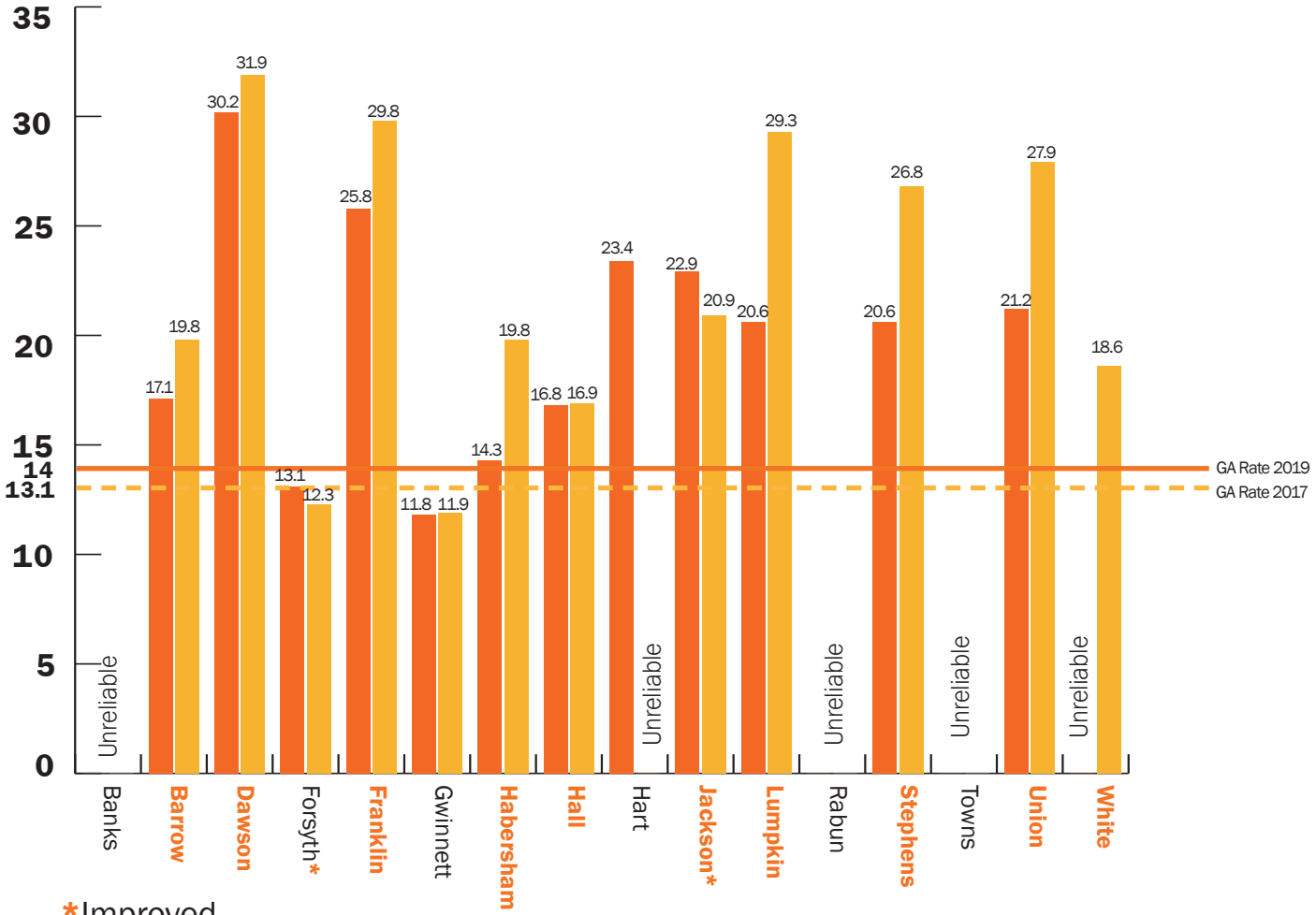
Outcome Measure:

10 of the 16 Northeast Georgia counties have a suicide rate higher than the state rate of 14 per 100,000 population (compared to 10 out of 16 counties as our baseline from the CHNA). Dawson County has the highest suicide rate at 31.9. The suicide rate in Hall County is at 16.9, above the state rate.

2014 - 2017 Suicide Rates, CDC wonder. GA rate 13.1

2016 - 2019 Suicide Rates, CDC wonder. GA rate 14



*Improved

Unreliable means the rate is calculated with a numerator under 20.

Mental and Behavioral Health

GOAL: Working with the community, create a comprehensive system of integrated services that recognizes and treats the mental and behavioral health needs of people when and where they need care. Areas of focus have been identified as **Access, Collaboration and Education** to improve measurable outcomes for mental & behavioral health in our community through United Way's One Hall Mental & Behavioral Health Subcommittee of which NGHS is a part, starting in Hall County and spreading out into the region.

Strategy Updates:

ACCESS:

- NGHS, United Way of Hall County, and other non-profits in Hall County are working together to create **a shared data platform** that will be used to make referrals and provide a universal method to track outcomes, resulting in better coordinated care for clients.

- Kalpana Prasad, MD, has been named program director for NGMC's **planned psychiatry physician residency program** and is in the process of recruiting faculty and completing the program's accreditation application to submit to the Accreditation Council for Graduate Medical Education.

- **NGPG Psychiatry** opened two new locations and added six new physicians and four advanced practice providers.

- **Funds from the 2021 Medical Center Open will benefit the Justice and Mental Health Collaborative led by the Gainesville Police Department.** Born out of the **United Way's One Hall Mental and Behavioral Health Subcommittee**, this co-responder program incorporates a fully licensed clinician to respond alongside a law enforcement officer when mental illness is a factor. They act as a liaison between the police officer and the community and provide a coordinated community policing response with access to a variety of agencies.

- The **My GCAL app**, launched by the Department of Behavioral Health and Developmental Disabilities (DHBDD), was designed to reach Georgia's youth in times of need. GCAL is staffed by caring professionals who are available 24/7 to address behavioral health crises. NGHS will continue to raise awareness of the app and has promoted it through One Hall communications, community education forums, NGHS staff and other community partners.

See how NGHS is Partnering to Address Mental Health at

https://www.nghs.com/cbr

GET IT ON Google Play

Download on the App Store

Mental and Behavioral Health

COLLABORATION:

- NGMC's Emergency Departments and Neonatal Intensive Care Unit (NICU) continue to partner with the Georgia Council on Substance Abuse to implement the **CARES (Certified Addiction Recovery Empowerment Specialists) program. The ED CARES Grant** for the Emergency Department and the **NICU CARES Grant** for the NICU were renewed. NICU Managers and Peer Recovery Coaches were instrumental in policy change in Georgia and the entire U.S. that will keep mother and baby together while mother is receiving treatment for recovery. Peer Recovery Coaches have touched 1,550 individuals in 2020, with nearly 6,000 since the program began in 2017.

- NGMC is a co-founding partner of the **Partnership for a Drug Free Hall**, a community collaborative which provided free education about addiction, intervention, and recovery. More than 200 people were reached through live forums and 2,111 people viewed informative videos on Facebook during the pandemic. Three NGHS staff are active members of the executive committee.

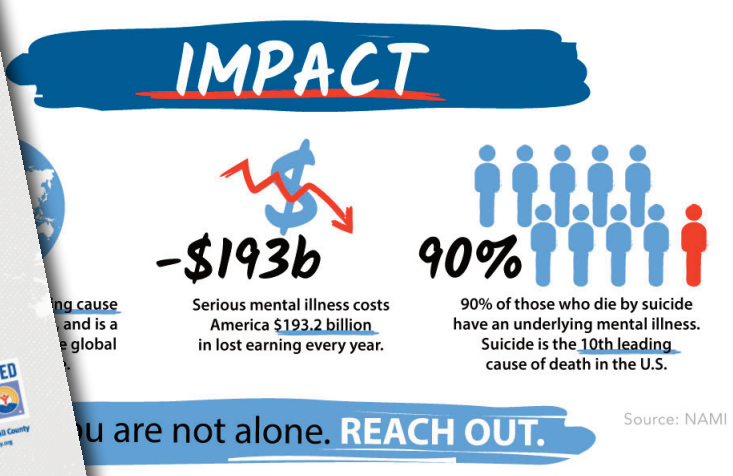
EDUCATION:

- NGHS is partnering with District 2 Public Health, which has developed an **Opioid Surveillance & Prevention Program** to gather real-time data on overdose morbidity and mortality. The Public Health Analyst for this program will assist partners with developing local and district prevention and response strategies and with rolling out the High Intensity Drug Trafficking Areas (HIDTA) Overdose Detection Mapping Application Program (ODMAP) across the State of Georgia.

EDUCATION (CONTINUED):

• **NGHS is a partner in United Way's One Hall Mental and Behavioral Health Subcommittee.** As part of this collaborative's work, the **Reach Out Campaign** to destigmatize the need for mental health services reached about 141,000 people in 2020 through events, activities and social media, including:

- Testimonial videos featuring community leaders.
- Hosting senior adult panels on how to navigate the mental health issues associated with COVID-19 and long-term sheltering in place.
- With help from the Wisdom Keepers, collected over 1,100 letters from youth and distributed to senior adults.
- Ben Nemtin (a #1 New York Times best-selling author who suffered from crippling depression) presented to 40 students at Gainesville High School's Hub. This session is posted at https://www.unitedwayhallcounty.org/ben-nemtin for free community access.
- Celebrating **Healthcare Heroes** during the pandemic through messages of encouragement.



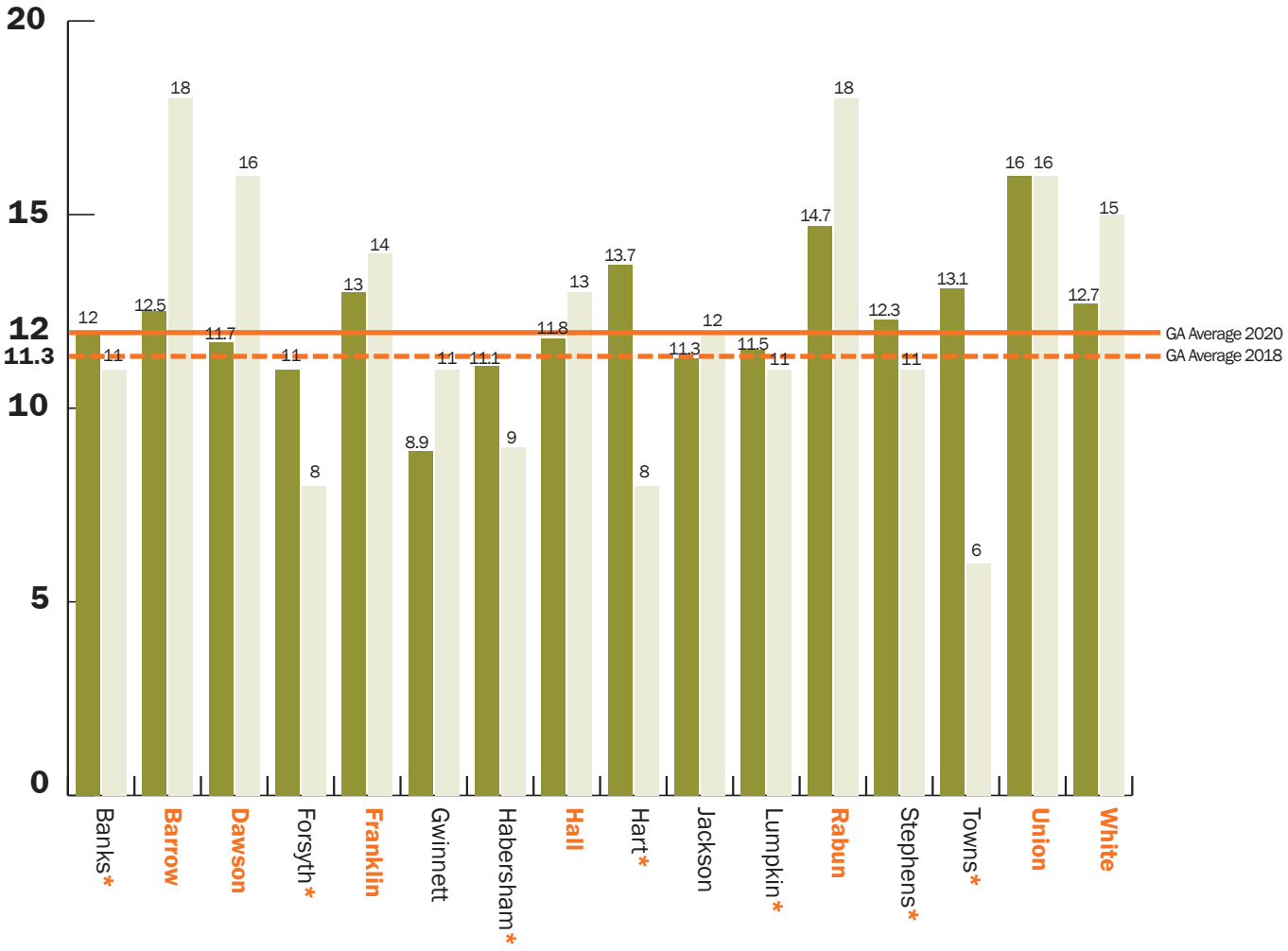
To learn more about the Reach Out campaign, go to: unitedwayhallcounty.org/reachout

Diabetes

7 of 16 counties in Northeast Georgia have a higher rate of Diabetes prevalence in adults than the state benchmark of 12 (a decrease from 12 out of 16 counties as our baseline from the CHNA).

Source: CDC Diabetes Interactive Atlas, 2018 Health Rankings - State benchmark 11.3 (**data from 2014**)

Source: CDC Diabetes Interactive Atlas, 2020 Health Rankings - State benchmark 12 (**2020 Health Rankings used data from 2016**)



*Improved

Source: https://www.countyhealthrankings.org/app/georgia/2020/measure/outcomes/60/datasource

Outcome Measure:

Prevent incidence of gestational diabetes giving unborn children a better chance for more positive health outcomes

One of the greatest opportunities for impact on population health is preventing gestational diabetes, which is diabetes that develops during a woman's pregnancy.

Strategy Updates:

• **NGMC will focus preventative education and early intervention for women in prenatal care with risk factors for gestational diabetes, prior to receiving the glucose tolerance test(s)**. Failure of the glucose tolerance test(s) indicates gestational diabetes which places these women at future risk of developing Type 2 Diabetes. **A pilot program is being developed within one of the markets identified with highest rates for Diabetes.**

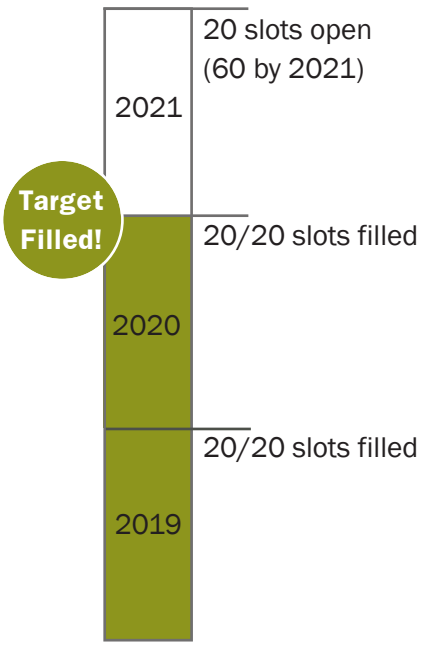
• NGHS partnered with Longstreet Clinic to standardize diabetes care across the System. Dr. Evgenia Korytnaya, Medical Director for Diabetes and Endocrinology, leads the collaborative committee of multidisciplinary teams focused on Diabetes Care. The Ambulatory subcommittee of this collaborative created a **Gestational Diabetes Pathway** and shared with providers.

• NGMC Diabetes Educators of the Diabetes Prevention Program are Certified Lifestyle Coaches and work with women diagnosed with Gestational Diabetes, offering education classes tailored to them.

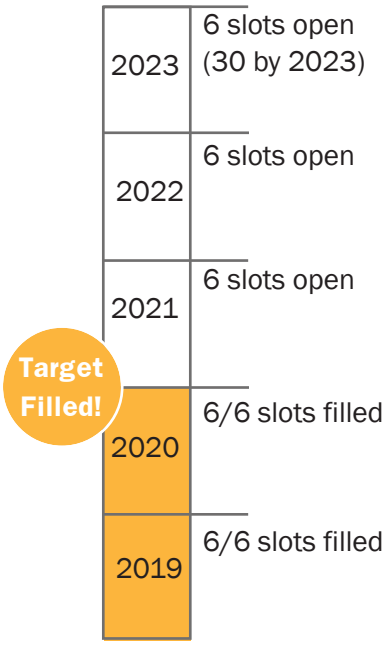
Outcome Measure:

GME Residency Fill Slots
Working toward 200 residency slots in various specialties by 2025.

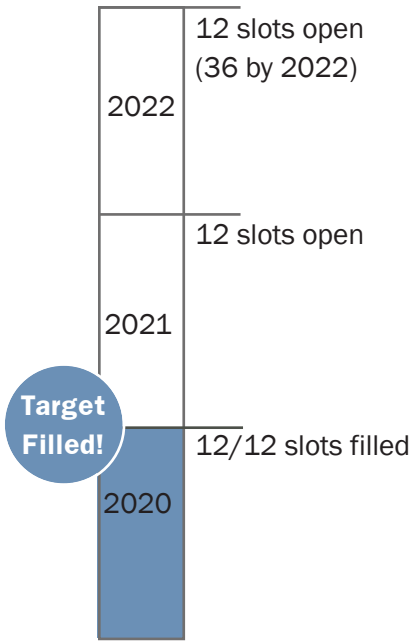
Internal Medicine
(3 yr program)



General Surgery
(5 yr program)



Family Medicine
(3 yr program)



Accreditation received by the Accreditation Council for Graduate Medical Education (ACGME) for the following specialties in 2021:

- Emergency Medicine: 36 total positions to fill
- Obstetrics & Gynecology: 24 total positions to fill
- Psychiatry: 24 total positions to fill

Strategy Updates:

• Under the leadership of Dr. Bedri Yusuf, **a coordinated regional program** was created to assure appropriate and timely access to specialty and surgical care. Designed to eliminate the barriers to care for the region's indigent and underinsured, work continues to improve standard work and processes have been improved greatly with high physician involvement.

• NGMC partners with indigent clinics throughout the region. Over 1,000 flu vaccines were provided to the community, including **Good News Clinics, Good Shepherd Clinic in Dawson County, Community Helping Place in Dahlonega, and Open Arms Clinic in Toccoa**. A Joint COVID-19 testing event was held at Good News Clinics in partnership with NGHS and the Department of Public Health where 1,300 individuals were tested.

• **Prenatal Program with the Hall County Health Department** continues with a goal of Healthy Pregnancies and Deliveries. In 2020, NGMC provided support of over $200,000.

• **A paramedicine pilot program was developed** with a goal to empower patients to better manage their healthcare and understand their options. With a grant from Cigna, one paramedic was hired and provided with a designated handicapped vehicle. As a program of NGHS, P.I.T.C.H. — Paramedics Improving The Community's Health — is committed to ensuring the community has access to the care it needs. Community paramedics help patients by meeting them at their home to:

- Provide and connect them to primary care services
- Seek out available community resources
- Complete post hospital follow-up care
- Discover education and health programs
- Discuss overall health and mental happiness

This type of program is being done around the country where other hospitals are seeing a 60%-80% reduction in ED visits.

See how NGHS is Partnering to Meet the Needs of the Uninsured at https://www.nghs.com/cbr

Strategy Updates:

• NGHS continues cutting-edge **clinical research** in 2020. With the onset and evolution of the COVID-19 pandemic, NGMC initiated and participated in clinical trials focused on COVID-19 including the Expanded Access to Convalescent Plasma for the Treatment of COVID-19 Trial.

• Through our partnership with Emory University, NGMC patients have access to Winship's more than 275 existing therapeutic clinical trials and research projects. Additionally, NGMC is a partner in a statewide cancer research group that received funding from the National Cancer Institute (NCI) to help improve care for cancer patients.

• In 2020, NGMC provided financial support for **Foothills Area Health Education Center**, a community-driven, non-profit corporation, with the mission to increase the supply and distribution of healthcare providers, especially in medically underserved areas.

Digital front door: Using technology to better serve the community, NGHS is developing ways to improve access to care without the need for a traditional medical encounter in a physician's office or hospital setting, such as:

- Expanded E-Visit Options using MyChart
- Online Urgent Care Wait Times – see current wait times, save your spot in line, and set text reminders with directions at nghs.com/urgent
- Online Physician Search and Scheduling
- Care Management after Orthopedic Surgery – patients who have orthopedic surgery at NGMC have the option to prepare for their surgery and manage their recovery at home
- Video Visits for Telehealth

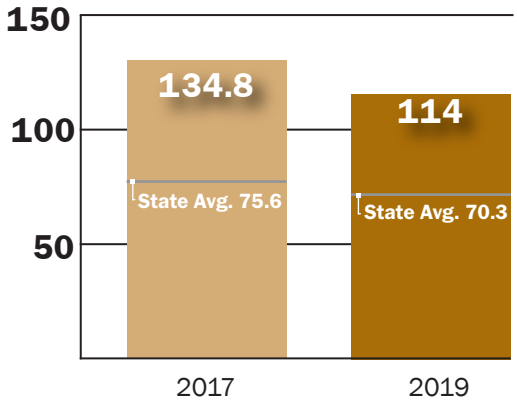
Outcome Measure:

Decrease heart disease death rate in Lumpkin County

Updated Progress:

Heart Disease Death Rate in Lumpkin County decreased from 134.8 in 2017 to 114 in 2019.

(source: CDC Wonder, 2019, age-adjusted rate)



Strategy Updates:

• NGMC adapted the **Tar Wars** program into a virtual package for Barrow County School System so students could participate online at home or in class during COVID-19. The virtual lesson plan was successfully piloted in December 2020 and implemented to 2,100 fourth and fifth grade students in Spring 2021. NGHS is partnering with the Georgia Healthy Family Alliance to promote the dangers of smoking and vaping with schools region-wide.

• While the timeline for expansion in Lumpkin County has been extended due to the restraints of the pandemic, The Heart Center of NGMC welcomed an additional eight physicians and five Advanced Practice Providers.

• NGHS is **investing in stroke care** and welcomed its first Neurointerventionalist, Dr. Sung Lee, to support the system's stroke program which is now performing thrombectomies. As of 2020, the team performed over 20 cases, 8 of which were emergent stroke procedures, thrombectomies.

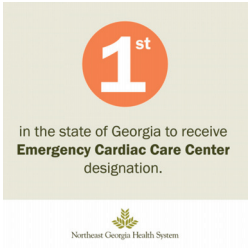
• NGMC Gainesville has been accredited as a Primary Stroke Center since 2010, the first hospital in Georgia to gain this accreditation from DNV Healthcare. In 2020, NGMC Barrow and NGMC Braselton were also accredited as Primary Stroke Centers. Primary Stroke Center certification means that a hospital can provide treatment to a broad range of stroke conditions along with some acute therapies, and admit patients to a designated stroke unit specifically assigned for stroke care. Primary Stroke Centers also act as a resource center for other facilities in the region, including being a main transfer site for stabilized stroke patients. Visit www.nghs.com/stroke-care to learn the signs and symptoms of a stroke.

Strategy Updates:

• NGHS provided support to the **American Heart Association**, benefitting research and local community education. In addition to a sponsorship, employee donations totaled $12,500 for the Heart Walk. Carol Burrell, President and CEO of NGHS, was the keynote speaker at the 2020 Go Red For Women event, where The Heart Center of NGMC provided free carotid screenings for attendees.

• NGHS continues to lead the way in life-saving heart and vascular care by becoming **the first health system in the state with hospitals designated as Emergency Cardiac Care Centers** by the Georgia Department of Public Health (DPH). This achievement extends far beyond the walls of our system – connecting first responders, emergency departments and cardiologists throughout the region to ensure each patient receives the level of care they need. The Georgia DPH uses a three-level designation system to rank the capabilities of each facility:

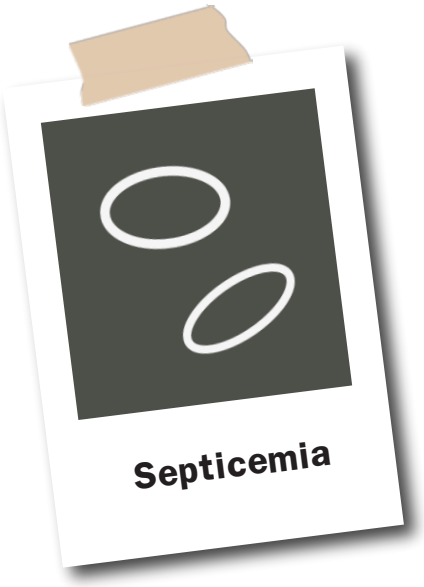
- NGMC Gainesville received Level 1 designation (hospitals perform open heart surgery and interventional cardiac catheterizations).
- NGMC Braselton received Level 2 designation (hospitals perform interventional cardiac catheterizations).
- NGMC Barrow and NGMC Lumpkin both received Level 3 designation (hospitals stabilize patients until they are transported to a Level 1 or Level 2 center).



• A collaborative effort between Northeast Georgia Medical Center and EMS in 18 counties across the region ensures fast and efficient treatment to patients suffering severe heart attacks known as STEMI (S-T Segment Elevation Myocardial Infarction). The STEMI Program makes sure information about the heart attack is sent to NGMC while the ambulance is en route, so a cardiologist is waiting to restore the patient's blood flow almost immediately after arrival. Due to COVID-19 restrictions, the STEMI conference was not planned, however, Jackson County EMS hosted the RESTART forum where three speakers from NGHS provided education for EMS professionals. This is an example of NGHS' continued collaboration with EMS to educate them and build systems of care for STEMI, cardiogenic shock, and cardiac arrest patients.

• NGHS continues to put a significant emphasis on educating the community regarding hands-only bystander CPR and access to AED's. We know that the community's response to cardiac arrest will have great influence on a person's chance of survival because when a patient suffers from sudden cardiac arrest, without CPR, there is a 10% increase in mortality for every minute that passes without CPR. With an average EMS response time of 8 minutes, we see just how important this is. AED's are also becoming more available in public settings. NGHS will continue to educate the public that non clinical bystanders can perform CPR, use an AED, and play a significant role in saving a life.

Septicemia



Outcome Measure:

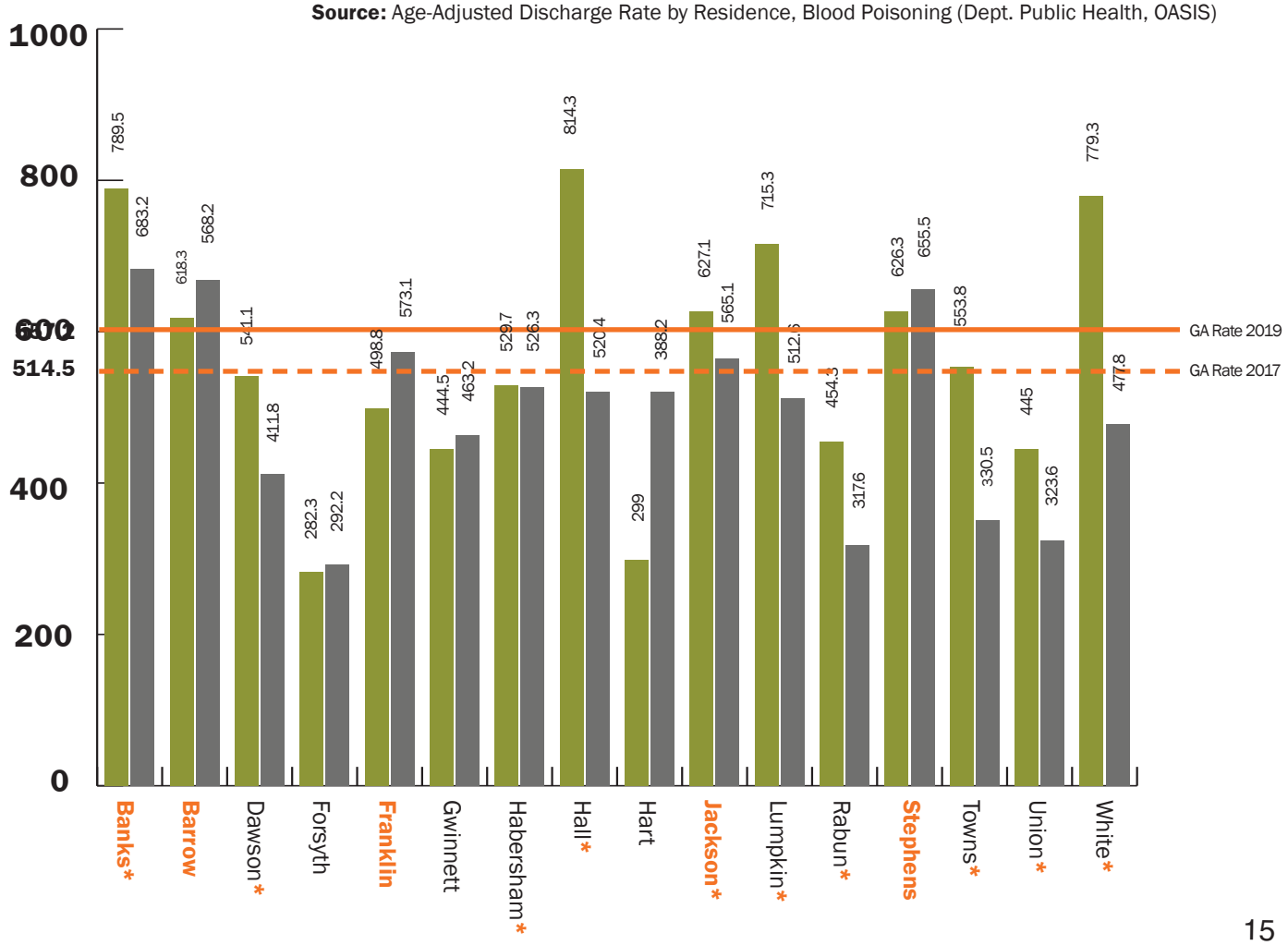
5 of 16 counties in Northeast Georgia have sepsis rates above the state average of 557.2 (a decrease from our baseline of 10 out of 16 counties from the CHNA).

In an effort to lower the overall sepsis rate in Norhteast Georgia, a target has been set for two regional providers to achieve a target of 8.09, however, due to the restrictions of COVID-19, partnerships have been delayed and regional collaborative work had been put on hold until 2021. **The 2020 Mortality Rate for NGMC overall is 9.82%, above target of 8.09.** Of the 395 sepsis deaths in 2020, 116 of these deaths were in COVID patients. This leaves 279 non-COVID sepsis deaths. The rate with COVID deaths removed was 7.15%, below target of 8.09.

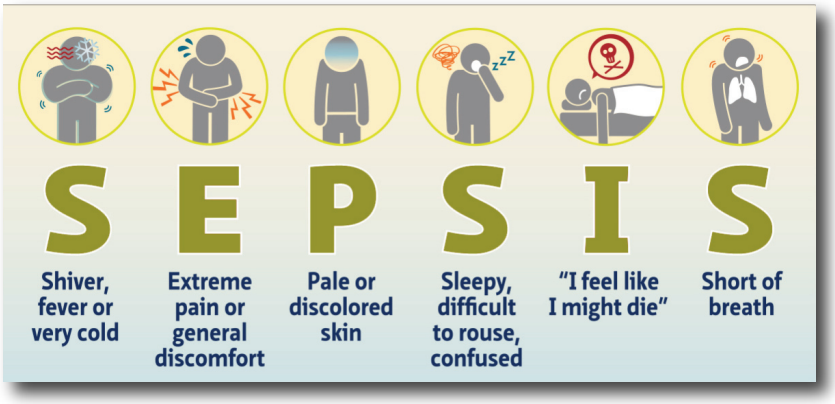
Blood Poisoning (Septicemia) 2017 Discharge Rate per 100,000 Population (age-adjusted) CHNA o/c; **GA Benchmark = 514.5**

2019 Age-Adjusted Discharge Rate; **GA Benchmark = 557.2**

Source: Age-Adjusted Discharge Rate by Residence, Blood Poisoning (Dept. Public Health, OASIS)



*Improved



Strategy Updates:

- Funding from the NGHS Foundation has been granted to create a **Sepsis Regional Population Health Team** that will use evidence-based protocols throughout the region to decrease the number of deaths due to sepsis.

- The development of the **Sepsis Regional Collaborative** to share an evidence-based protocol toolkit has begun with identification of key stakeholders from regional partners.

- **A Sepsis Alert Team was created.** In 2020, **five Sepsis Nurse Navigators were hired** and the **Sepsis Coordinator became the Nurse Manager**. Coupled with the implementation of the Epic Sepsis Predictive Model, the Sepsis Alert Team was able to provide concurrent review on over 1,276 patients where 182 patients had a change in their treatment plan as the result of the review.

- **Community education** was provided at healthy aging events and a two part Sepsis Lecture Series was developed and delivered virtually to three assisted living facilities.

NGMC's Response to COVID 19:

The **COVID-19 pandemic** became a primary focus for the organization as it did for hospitals and communities across the nation. We had to remain flexible to address the rising needs in the community through the following activities:

COVID-19 Outreach in Partnership with Community Leaders: By mid-April, Latino communities were some of the hardest hit by COVID-19. At that time, approximately 50% of the individuals in Hall county confirmed to have COVID-19 were Latino, which was disproportionate considering only 29% of Hall County's population is Latino. This prompted the creation of an **NGHS outreach group and community-wide collaboration to support and educate the Latino community through grassroots efforts**.

In partnership with Good News Clinics, NGHS hosted two events that offered free COVID-19 testing for low-income or uninsured Hall County residents. At the first event on April 19, more than 300 people were tested, and the outcome was staggering- with nearly 50 percent testing positive. At the second event on April 28, roughly 1,020 people were tested and about one-third were positive.

The prevalence of COVID-19 in these communities led to the creation of the **Gainesville Against COVID-19 Task Force** which included local Hispanic leaders, NGHS physicians, the Northeast Georgia Latino Chamber of Commerce and many others. Together, the Task Force targeted the business community and coined the mantra, "No Mask, No Service."

Working in tandem, NGHS' outreach group and the Gainesville Against COVID-19 Task Force helped to support and educate the Latino community with outreach efforts that included:

- Providing bilingual educational fliers and posters
- Distributing facemasks and cleaning supplies to local businesses and schools

- Organizing additional testing events with Emory University's Rollins School of Public Health and NGHS
- Hosting educational Zoom meetings for community groups and churches
- Producing specialized videos for local audiences such as taxi companies on how to travel safety with passengers and disinfect vehicles
- Providing health education messaging that the community could use within their circles of influence.
- Posting daily updates on NGHS' public website and social media channels to share information on the number of confirmed COVID-19 positive patients being treated in NGHS facilities, patients awaiting test results, and Hall County-specific information. Resources and trends for COVID-19 are available to the public at www.nghs.com/covid-19.

Community COVID-19 Leadership Coalition: A community-wide collaborative was formed in September 2020 that included NGHS, Longstreet Clinic, Good News Clinic, District 2 Public Health, Greater Hall Chamber of Commerce, City and County Government and other local organizations to implement a unified plan for the Hall County-Gainesville area to prevent the spread of COVID-19, with a goal to meet and sustain the World Health Organization's target of no more than 5% of those tested are positive for COVID-19 – protecting the mental and physical health of all area residents and supporting a healthy economy going forward. From this, local businesses and government entities joined together to create the **"We are hALL IN" campaign** to set the standard for COVID-19 prevention. Those who are "hALL IN" pledge to wear a mask when appropriate, practice social distancing and abode by other health and safety guidelines. For worksite resources and more, go to www.wearehallin.com.

Implementing Epic at Good News Clinic: In June 2020, Good News Clinics (GNC) joined NGHS on the same electronic health record (EHR) system, called Epic. **With the assistance of local donors, the NGHS Foundation was able to accelerate the implementation of Epic for GNC**, which provides free medical care to underinsured and uninsured residents in Hall County. **Sharing the same EHR system helped to streamline communication and record sharing between NGHS and GNC, improving care for patients with COVID-19 and other illnesses throughout the community.**

In light of COVID-19, NGHS implemented a plan to increase access to flu vaccinations in the community. NGHS provided over **1,000 free flu vaccines** to the community through distribution to **Good News Clinics, Good Shepherd Clinic in Dawson County, Community Helping Place in Dahlonega, and Open Arms Clinic in Toccoa.**

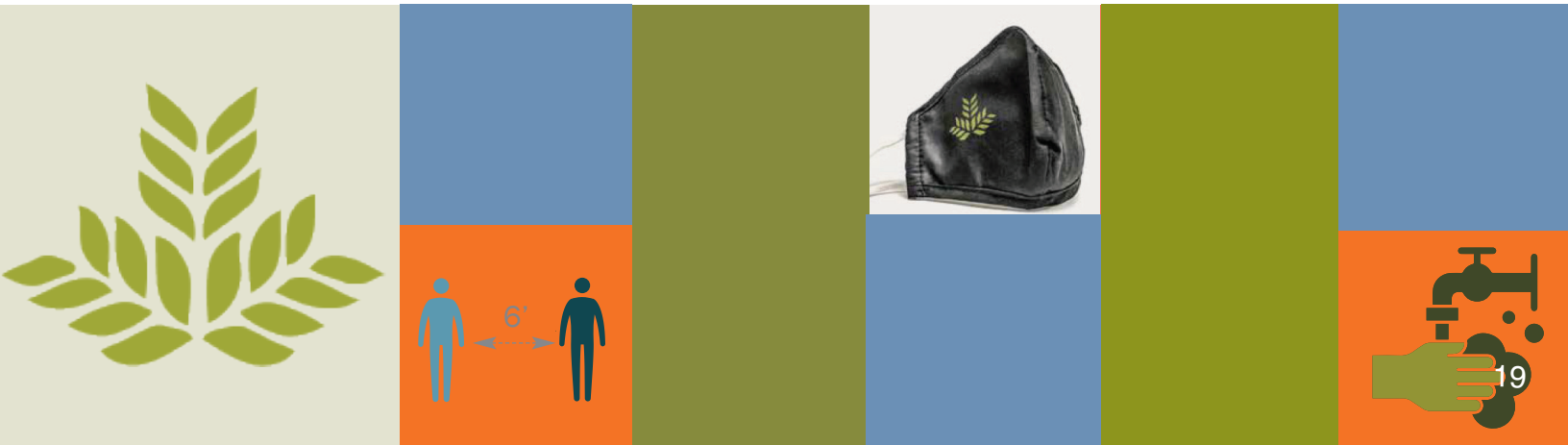
Health System Collaboration Across the State: NGHS participated in a social media campaign with some of our peers in Atlanta – namely Emory, Grady, Piedmont, Wellstar and CHOA. The #3Ws campaign encourages people to Wear a mask; Watch your distance; and Wash your hands.

Mask-Making and Supply Distribution by NGHS Staff: NGHS staff made 13,222 masks in 6 weeks and distributed to the community to a screening event at Good News Clinics, Gainesville and Hall County Schools, Jackson County and Banks County. The NGHS Foundation was a drop-off location for masks and community donations that were distributed to United Way of Hall County and other sites.

Community Roundtables with Regional Skilled Nursing Facilities: NGHS hosted three community roundtables (via Zoom) with nursing homes and assisted living facilities in the northeast Georgia region to share current activities and lessons learned as the region's Skilled Nursing Facilities manage clinical and operational issues related to the COVID-19 pandemic.

COVID-19 Education with School Systems: In partnership with District 2 Public Health, NGHS hosted a community webinar with school systems across the northeast Georgia region to answer questions and share recommendations for school nurses and administrators related to the COVID 19 pandemic as they manage issues and guidelines in the school.

Secured State and Federal Resources: Working with state and federal officials, NGHS was able to secure many resources to assist in our pandemic response efforts. These include one of four mobile medical units made available in the state — adding 20 medical/surgical beds for patients with less severe cases of COVID-19, additional staff for critical care testing and increased allocations of the drug Remdesivir, which has been instrumental in our successful treatment plans.



Emergency Response Leadership Recognized as a State Model: NGHS' Emergency Preparedness Manager **Matthew Crumpton** received the **Georgia Commendation Medal** from the **Georgia National Guard** for his tireless service and leadership during the COVID-19 pandemic.

NGHS is grateful to have a generous and supportive community who celebrated **Healthcare Heroes** through positive messages, videos, food donations and volunteering.

More than $1Million has been donated to the **NGHS Foundation Covid-Relief Fund** to help:

- Distribute more than $125,000 of meals and snacks to frontline staff – supporting local businesses and economy
- Improve the COVID patient experience through distraction and connection tools
- Provide over $250,000 in emergency PPE
- Secure emergency equipment and tools necessary to treat and assist COVID recovery
- Deliver thousands of self-care kits to frontline staff
- Encourage staff through signs, cards and messages of hope

Stretching our Resources: volunteers under the age of 65 and without underlying health conditions, including a significant number of college students, were able to volunteer mainly as front entrance screeners and with PPE projects outside of the clinical areas. **Over 160 volunteers have contributed nearly 10,000 hours in support of COVID-19 relief efforts**.

Early in the pandemic, NGHS persevered through the supply shortage, thanks to the creativity and ingenuity of employees, community members who made masks, face shields and isolation gowns, and the generosity of the poultry industry and other companies who donated their PPE supplies. **NGHS' employee sewing team and community sewers produced more than 10,000 N95 mask covers, using donated linen**. This team also produced almost 1,000 fabric isolation gowns and more than 800 masks for Good News Clinics.

Questions?
Contact: Christy Moore,
Director, Community Health Improvement
770-219-8097 | christy.moore@nghs.com

Northeast Georgia Medical Center

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

2021 PROGRESS REPORT

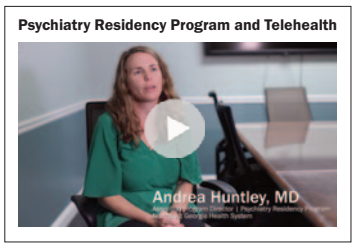
Northeast Georgia Medical Center

Based on a comprehensive Community Health Needs Assessment (CHNA) conducted in 2019, Northeast Georgia Health System identified five important health priorities and corresponding outcome measures. This document is interactive and provides 2021 progress in reaching stated goals of the 2020-2022 CHNA Implementation Plan.
To view this report, please visit nghs.com/2021-plan.

LINKS

Visit the url below to view the CHNA report and other resources, such as a series of videos that showcase our strong partnerships in community health efforts. These efforts include health access to indigent populations, mental health, COVID-19 and more:

https://www.nghs.com/cbr



Mental health needs increased dramatically during the pandemic. NGHS pivoted to provide virtual health appointments - including those for mental health - to help meet these needs.

2021 NGHS Accomplishments Highlight video

The community came together to support and encourage NGHS team members during COVID.

2021 PROGRESS

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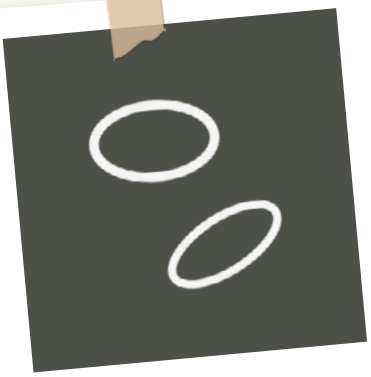
FIVE PRIORITIES + COVID 19 RESPONSE



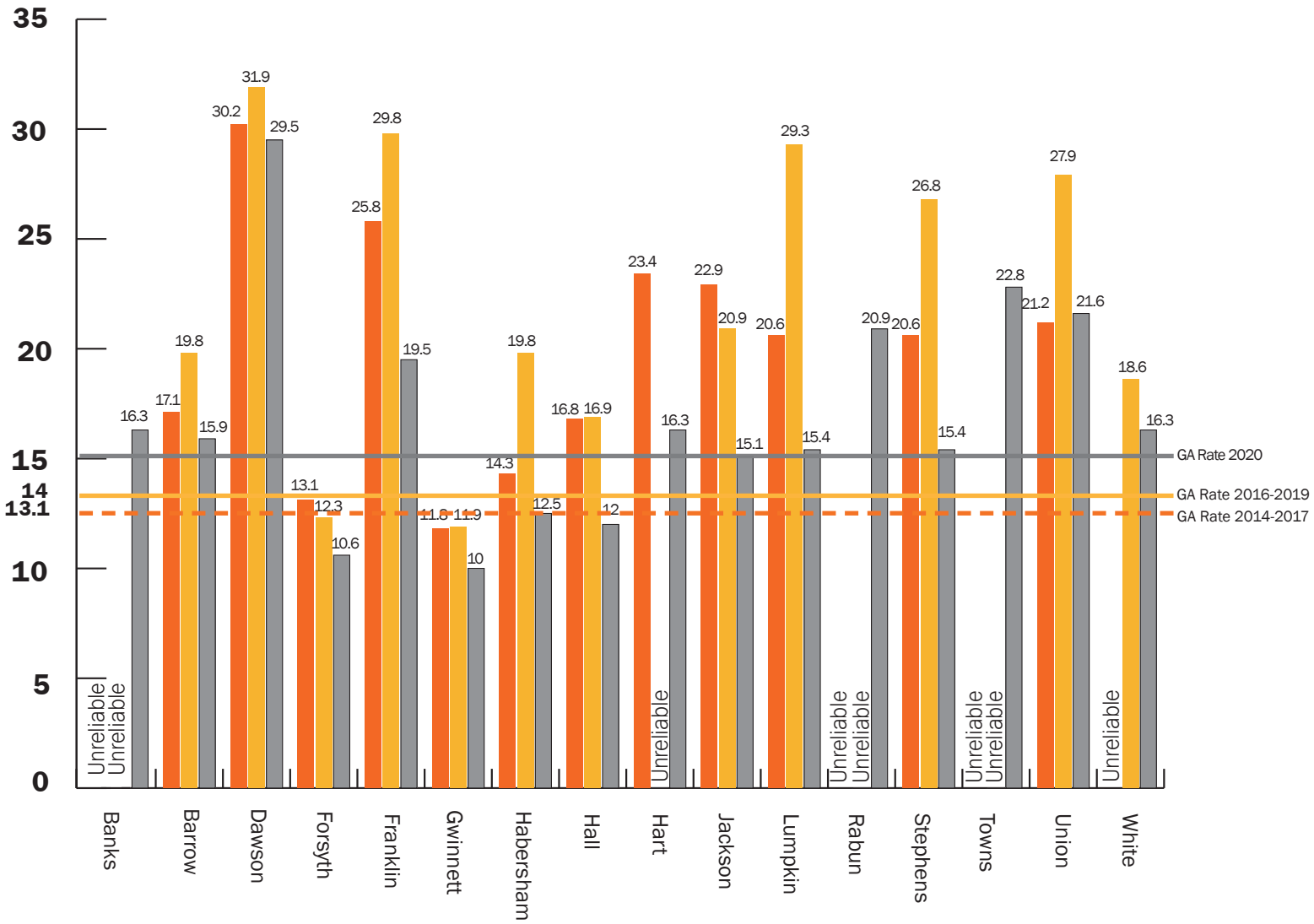
Outcome Measure:

11 of the 16 northeast Georgia counties have a suicide rate higher than the state rate of 15.1 per 100,000 population (compared to 10 out of 16 counties used as the baseline from the CHNA). Dawson County has the highest suicide rate of 29.5. The suicide rate in Hall County is 12 per 100,000 population, which is below the state rate.

2014 - 2017 Suicide Rates, CDC wonder. GA rate 13.1

2016 - 2019 Suicide Rates, CDC wonder. GA rate 14

2020 Suicide Rates, CDC wonder. GA rate 15.1



CDC Wonder data indicates improvements across the region in the most recent time period of 2020; the CHNA executive committee is working to better understand the data behind this trend.

Mental and Behavioral Health

GOAL: Working with the community, create a comprehensive system of integrated services that recognizes and treats the mental and behavioral health needs of people when and where they need care. Areas of focus have been identified as **Access, Collaboration and Education** to improve measurable outcomes for mental and behavioral health in our community through United Way's One Hall Mental & Behavioral Health subcommittee, of which NGHS is a partner. The program initially launched in Hall County and is now expanding into the northeast Georgia region.

Strategy Updates:

ACCESS:

Among many efforts to provide mental health resources in the age of COVID, NGHS experts and United Way Hall County led Facebook Live panel discussions focused on providing senior adults and their caregivers tangible information to navigate the mental health implications associated with COVID-19 and the effects of long-term sheltering in place.

Funds from the **2021 Medical Center Open golf tournament benefited the Justice and Mental Health Collaborative** led by the Gainesville Police Department. In its second year, the program is expanding to hire a second mental health counselor to respond alongside a law enforcement officer when mental illness is a factor. Counselors act as liaisons between the officer and the community, providing a coordinated community policing response with access to a variety of agencies.

Graduate Medical Education:
In 2021, Northeast Georgia Medical Center's (NGMC) Psychiatry Physician Residency program launched, recruited faculty and gained accreditation from the Accreditation Council for Graduate Medical Education. Interviews to fill six physician resident opportunities will take place in 2022.

Peer Coach Program Continues:
Thanks to a grant from the Georgia Council of Substance Abuse, NGHS PEER coach program continued in the Emergency Department (ED) for the fifth year, and in the Neonatal Intensive Care Unit (NICU) for the third year. This innovative approach of using PEER coaches to assist victims of substance abuse is unique. NGHS' ED program is the only one of its kind in Georgia, and the NICU program is the only one in the nation.

Mental and Behavioral Health Partnerships

NGHS continues to play an integral role in the One Hall Mental and Behavioral Health Community Initiative, which is co-chaired by Monica Newton, DO.

Raising awareness of and resources for mental health is the region's top health priority; and it takes everyone coming together with a unified approach to recognize and treat the behavioral health needs of people where and when they need care.

This need was confirmed through data from United Way of Hall County's Community Game Plan and NGHS Community Health Needs Assessment (CHNA), along with input from 60 stakeholders participating in community listening sessions.

- More than 12 collaborative organizations participated, representing thousands of Hall County residents
- More than 30 participants consistently attended monthly meetings

ACCESS – Getting people what they need when they need it

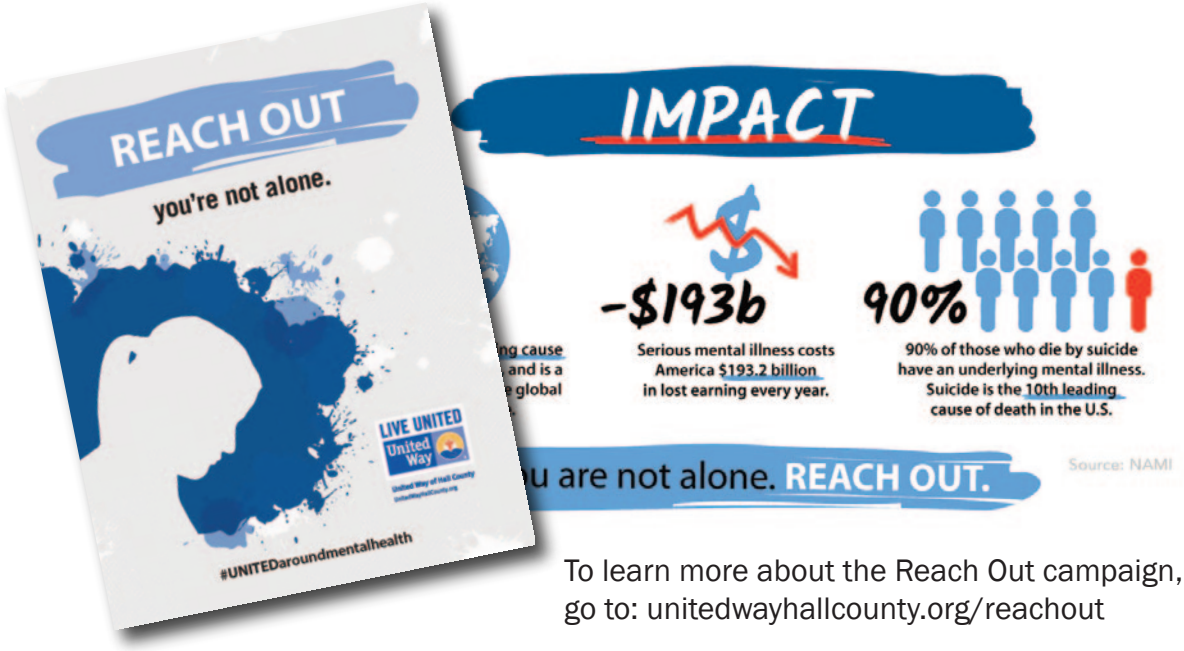
- Implemented a Digital Shared Data Platform to make referrals for services and better coordinated care
- Community workgroup identified functional requirements and a vendor to provide platform

COLLABORATION – Partnering for a healthier community

- Added mental health clinicians on staff at the Gainesville Police Department to respond to mental health calls. After one year of the Mental Health Justice Initiative, 87 people connected to resources with 32 of those following up with resources and receiving support.

EDUCATION – Continued partnership with the United Way's One Hall Mental and Behavioral Health subcommittee to destigmatize mental health and create a unified voice in Hall County for mental health

- Launched a community-wide Reach Out campaign to educate citizens about the importance of mental healthcare
- 95 social media posts reached more than 110,000 viewers
- Trained 24 One Hall Advocates to lead community conversations about mental health and racial equity
- Created Reach Out website and Facebook Live events
- 72,000 pieces of collateral distributed in English and Spanish
- Banners and bus stop ads elicited 270,000 views
- 21 community testimonial videos shared and 17 blogs published
- More than 3,400 people trained in Mental Health First Aid



To learn more about the Reach Out campaign, go to: unitedwayhallcounty.org/reachout

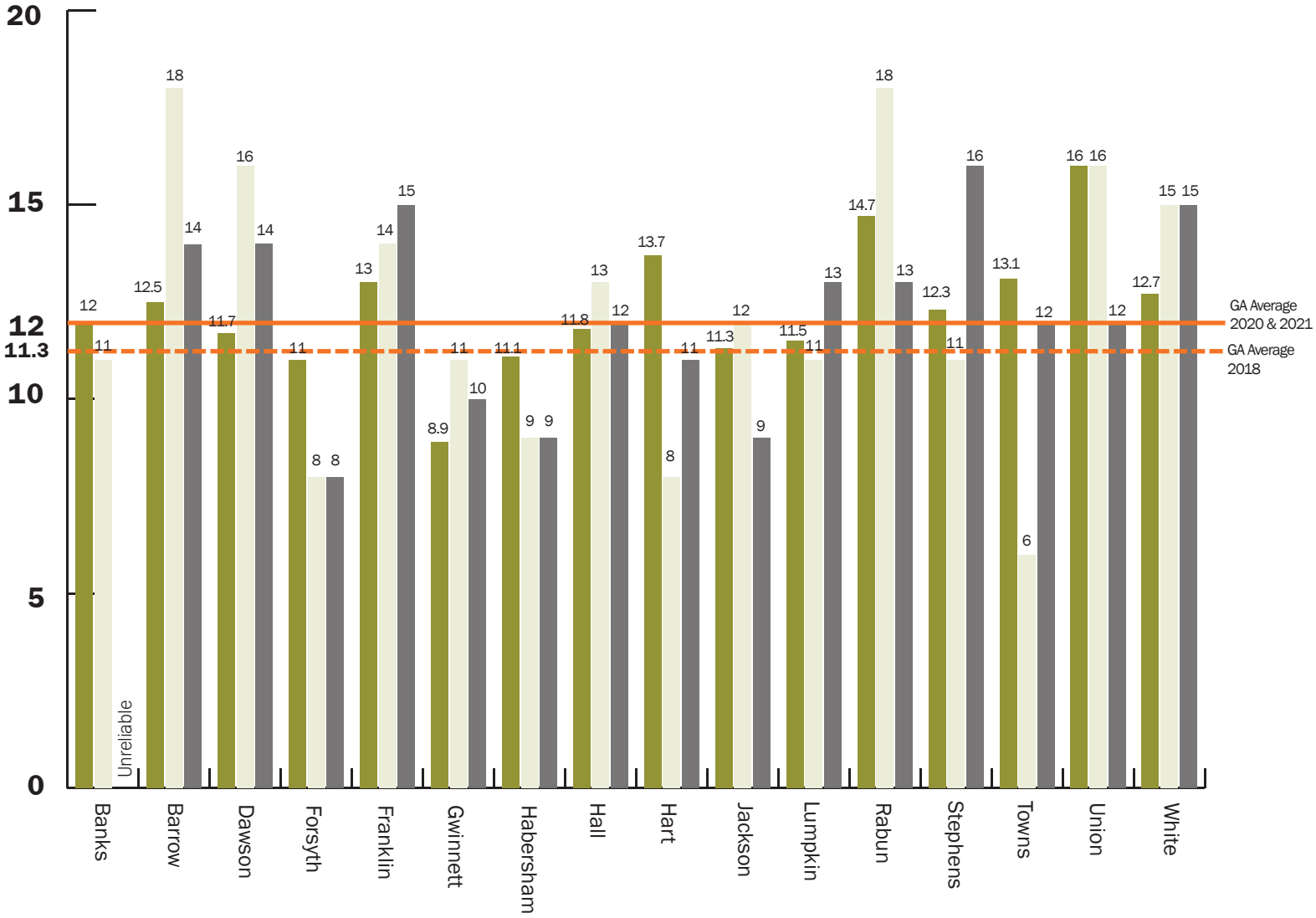
Updated Progress:

7 of 16 counties in northeast Georgia have a higher rate of Diabetes prevalence in adults than the state benchmark of 12.
(A decrease from 12 out of 16 counties as the baseline from the CHNA).

Source: CDC Diabetes Interactive Atlas, 2018 Health Rankings - State benchmark 11.3 (**data from 2014**)

Source: CDC Diabetes Interactive Atlas, 2020 Health Rankings - State benchmark 12 (**2020 Health Rankings used data from 2016**)

Source: CDC Diabetes Interactive Atlas, 2021 Health Rankings - State benchmark 12 (**2021 Health Rankings used data from 2017**)



Outcome Measure:

Prevent incidence of gestational diabetes in mothers, giving unborn children a better chance for more positive health outcomes.

One of the greatest opportunities for impact on population health is preventing gestational diabetes, which is diabetes that develops during a woman's pregnancy.

Strategy Updates:

In 2021, work continued on preventative education and early intervention for women in prenatal care with risk factors for gestational diabetes, prior to receiving the glucose tolerance test(s).

Northeast Georgia Medical Center also **implemented gestational diabetes and adult Type 1 and 2 clinical pathways**, enabling the NGHS team to provide better health care and better patient outcomes at a lower cost; increased the number of patients screened for diabetes up to 12 weeks postpartum if gestational diabetes was present; and educated providers on the treatment of hypoglycemia and hyperglycemia to prevent hospital admissions.

Outcome Measure:

Graduate Medical Education (GME) residency filled slots working toward 200 residency slots in various specialties by 2023.

The expansion of GME programs will help ensure more physicians are trained in the region to provide quality care to the community.

New Residency and Fellowship Programs Achieve Initial Accreditation

NGMC Graduate Medical Education (GME) expanded to six residency programs, and three new residency programs achieved ACGME accreditation this year:

NEW RESIDENCY AND FELLOWSHIP PROGRAMS ACHIEVE INITIAL ACCREDITATION

PROGRAM	DURATION	SLOTS (PER YEAR)	STARTS
EMERGENCY MEDICINE	3-YEAR	12	JULY 2022
PSYCHIATRY	4-YEAR	6	JULY 2022
OB/GYN	4-YEAR	5	JULY 2023

NGMC also received initial accreditation for two new fellowship programs

FELLOWSHIP PROGRAMS	DURATION	SLOTS (PER YEAR)	STARTS
CARDIOVASCULAR DISEASE	3-YEAR	6	JULY 2022
HOSPICE & PALLIATIVE MEDICINE	1-YEAR	2	JULY 2023

Strategy Updates:

The 53-acre site for the proposed **NGMC Lumpkin replacement hospital** is located on Georgia 400, south of Highway 60 in Dahlonega. The project was in the design development phase before pausing due to the COVID-19 health emergency. The project restart has begun.

In October, NGHS broke ground on the **Medical Plaza in Jefferson,** an 11,000-square-foot facility that will include Urgent Care, Family Medicine, Georgia Heart Institute and Northeast Georgia Physician Group (NGPG) specialty practices.

NGHS continued to **expand HealtheConnection (HeC)**, the regional Health Information Exchange (HIE) covering a 19-county area in northeast Georgia as well as four surrounding counties in neighboring states. HIE enables healthcare providers to view electronically-shared files including facility/provider visits, emergency department visits, imaging orders, referrals, meds, etc. Currently, there are more than 609 participating providers, with more subscribers joining each month.

Access to Care

Tracy Vardeman, NGHS' chief strategy executive and chair of **One Hall's Mental Health Collaborative Access subcommittee**, is working to expand the data platform to provide more patient information and sharing capabilities in 2022.

The P.I.T.C.H program – Paramedics Improving the Community's Health – continued to empower patients to better manage their healthcare and understand their options. PITCH connects patients to primary care and other services and resources, educates about health programs and prevention, and addresses overall health and mental happiness. Twenty patients have "graduated" and now address most of their health issues with their new primary care physician, rather than at Emergency Department (ED) visits. Unnecessary ED visits were reduced from 19 to 0 in these original patient groups. Partnering with Graduate Medical Education, family medicine residents are allowed to accompany the PITCH paramedics to patient home visits.

NGHS continues to provide financial support for **Foothills Area Health Education Center (AHEC)**, a community-driven, non-profit corporation with the mission to increase the workforce of healthcare providers, especially in medically underserved areas.

In June, NGMC and Longstreet Clinic opened the doors of a new, collaborative cancer center. The **Braselton Cancer Center** houses both Longstreet Clinic's Medical Oncology and Hematology and Northeast Georgia Physician Group (NGPG) Radiation Oncology in a state-of-the-art, easily accessible and collaborative space.

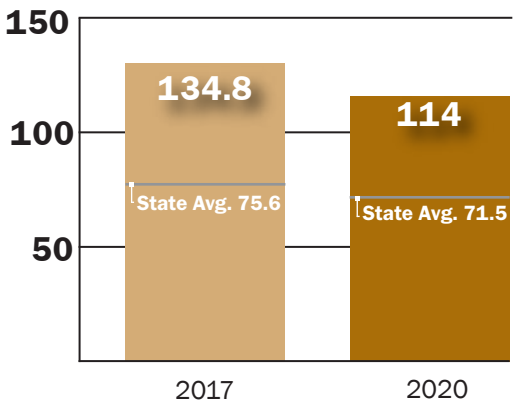
University of North Georgia Educational Partnership Program Expands
NGHS greatly expanded the Dedicated Education Unit (DEU) pilot with the University of North Georgia (UNG), enabling nursing and physical therapy students to gain hands-on, clinical experience at NGMC Gainesville and NGMC Lumpkin, as well as NGPG's Urgent Care and primary care facilities. In Fall 2021, the program expanded from two DEUs to nine, increasing the number of students participating from 10 to 40. The innovative DEU program pairs junior and senior level students with a staff RN who guides the immersive learning experience.

Outcome Measure:

Decrease heart disease death rate in Lumpkin County.

Updated Progress:

Heart disease death rate in Lumpkin County decreased from 134.8 in 2017 to 114 in 2020.



Strategy Updates:

NGMC Welcomes New Heart & Vascular Leader

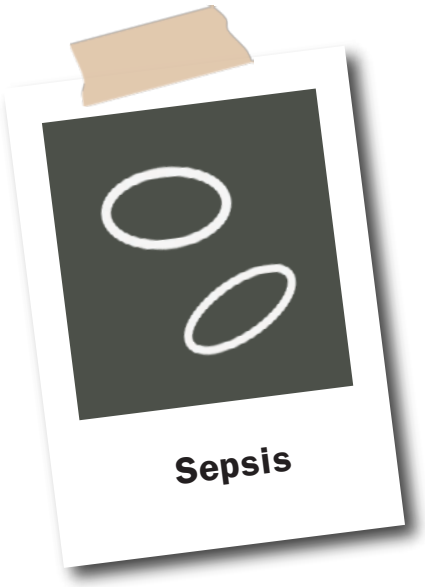
Northeast Georgia Medical Center (NGMC) welcomed internationally recognized physician leader, Habib Samady, MD, to help launch Georgia Heart Institute (GHI). As the president of Georgia Heart Institute, Dr. Samady is working to strengthen and grow services, ultimately improving and enhancing care for patients throughout the region.

NGMC Gainesville received **Comprehensive Stroke Center certification from DNV**, the highest certification awarded to hospitals for their treatment of serious stroke events. NGMC performed 219 interventional neurosurgeries in 2021.

Strategy Updates:

NGMC Braselton and NGMC Barrow continued their vital partnership with Barrow County Schools by supporting the **Tar Wars program**, which has educated more than 2,000 fourth and fifth grade students since 2019 about the dangers of smoking and vaping. The curriculum was delivered virtually in 2021 with teachers conducting in-class exercises and quizzes. 87.5% of students who participated indicated they learned something new about the dangers of smoking and vaping.

The **STEMI (S—T Elevation Myocardial Infarction)** program continued as a collaborative effort between NGMC and EMS in 18 counties across the region ensuring fast and efficient treatment of patients suffering from severe heart attacks. While en route to NGMC, EMS team members are enabled to relay vital patient information and alert Emergency Department staff so a cardiologist is waiting to restore the patient's blood flow almost immediately upon arrival.

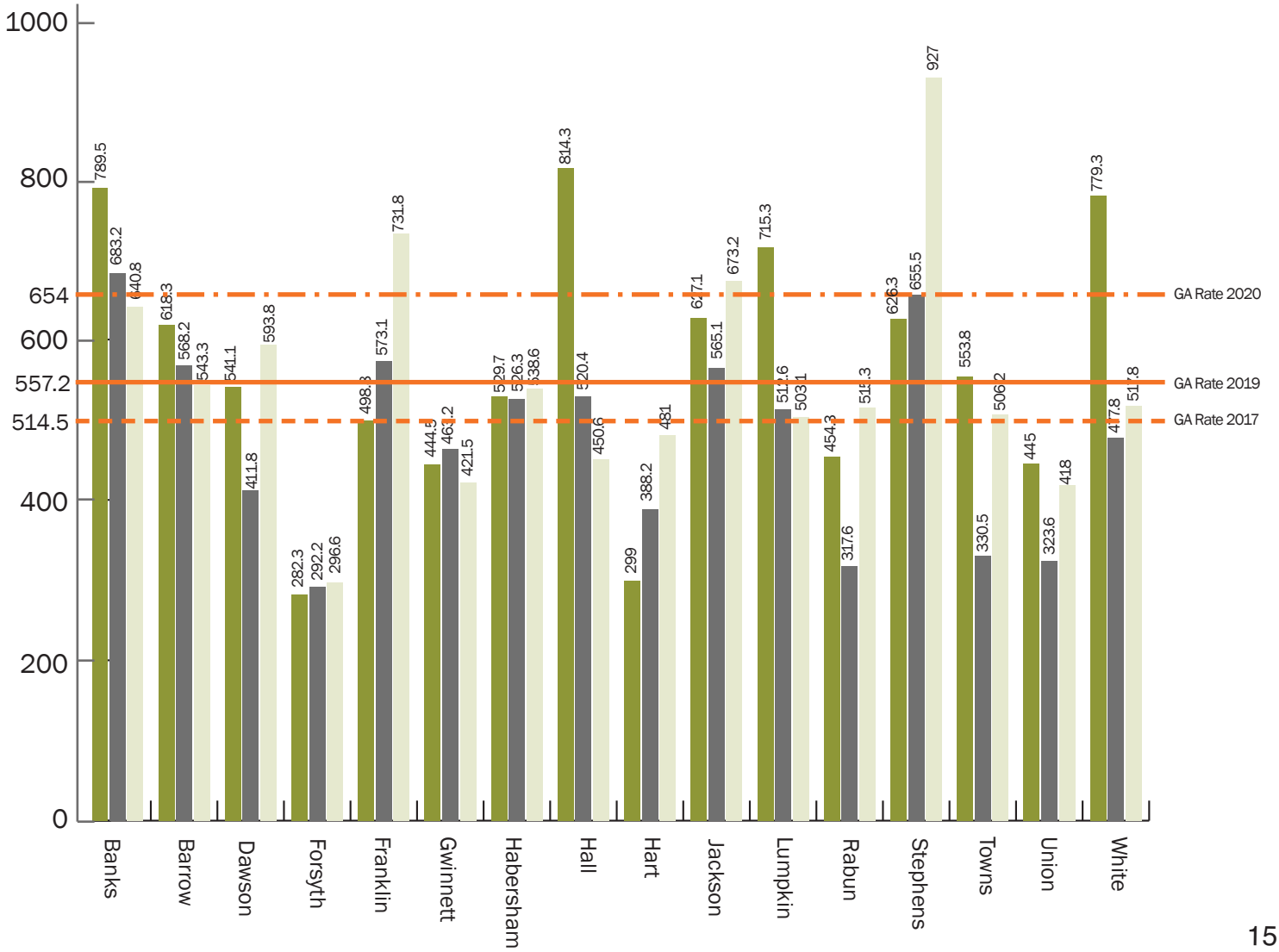


Outcome Measure:

3 of 16 counties in northeast Georgia have sepsis rates above the state average of 654. (A decrease from the baseline of 10 out of 16 counties from the CHNA. The 2020 rate increased due to COVID patient/sepsis deaths.)

- Blood Poisoning (Septicemia) 2017 Discharge Rate per 100,000 Population (age-adjusted) CHNA o/c; **GA Benchmark = 514.5**
- 2019 Age-Adjusted Discharge Rate; **GA Benchmark = 557.2**
- 2020 Age-Adjusted Discharge Rate; **GA Benchmark = 654**

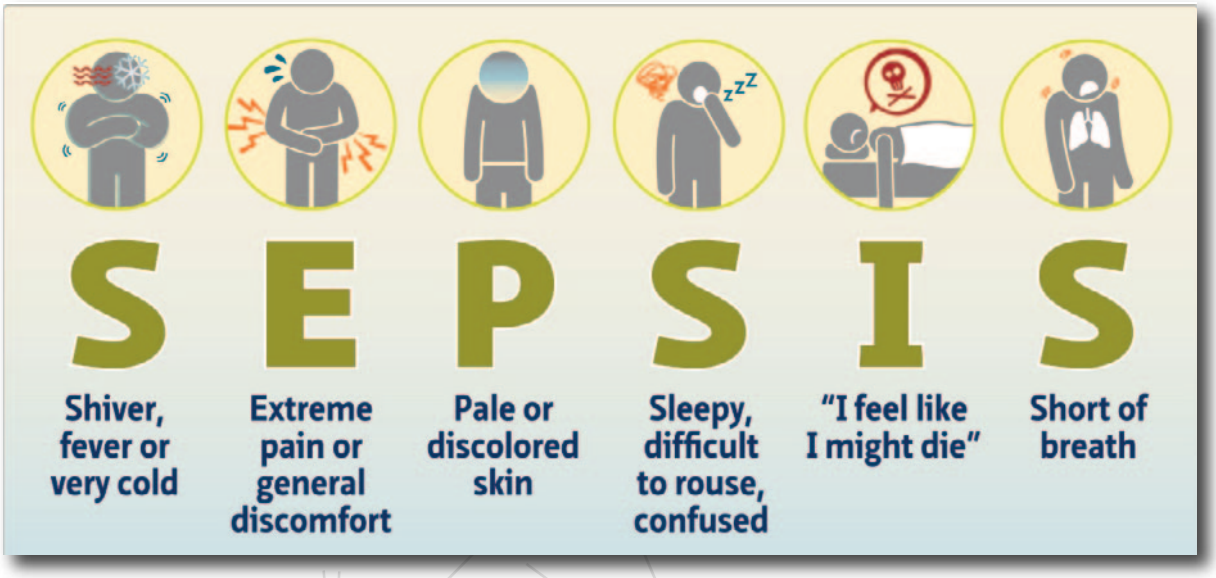
Source: Age-Adjusted Discharge Rate by Residence, Blood Poisoning (Dept. Public Health, OASIS)



Strategy Updates:

In 2021, the **Sepsis Alert Team** continued to evaluate, monitor and respond to patients with sepsis infection. The 2021 mortality rate for NGMC overall was 14.27, above the target of 8.09. Of the 677 deaths in 2021, 333 of these were COVID-19 patients.

In 2022, the regional partnership will educate and enable regional providers to collaborate on best practices.



NGMC's Response to COVID 19:

As NGHS continued the fight against COVID-19, staff and physicians dug even deeper to care for the community in the following ways:

• NGHS led a **Community Vaccine Coalition** that focused on distributing vaccines and encouraging community vaccination in a collaborative effort. Members of the coalition include: NGHS, Northeast Georgia Physicians Group, Longstreet Clinic, District 2 Public Health, Good News Clinics, Hall County Emergency Management Association, local school systems, poultry industry representatives and leaders within the Hispanic and African American communities.

• The **hALL IN Campaign** continued for a second year, chaired by community leader Rob Fowler. hALL IN was created in 2020 as a vehicle for community collaboration to help reduce the spread of COVID-19 in the community. This year, the coalition's work focused on community vaccination efforts and continued education and guidance of businesses and the community at large to help reduce the effects of COVID-19 in the region.

• NGHS was honored with the **Lake Lanier Convention and Visitors Bureau Chairman's Award** for the commitment and efforts during the COVID-19 pandemic.

"Hall County took things seriously and put NGHS in the driver's seat where they belonged. NGHS not only served those who were ill, they helped protect the health of everyone, putting the right information in the hands of business owners, elected officials, clergy and other community leaders."
– Stacey Dickson, President, Lake Lanier Convention and Visitors Bureau

NGHS, in partnership with leading community organizations, hosted **Community Conversations**, with Newtown Florist Club, St. John Baptist Church and District 2 Public Health, engaging a panel discussion on COVID-19 in the African American community. The panel shared case data on COVID-19 by race and ethnicity, answered questions about COVID-19 and discussed myths about the virus and vaccination, reaching more than 949 people.

NGHS Hospital-Community Partnerships Featured at National American Hospital Association Conference

NGHS and its COVID hospital-community partnerships were featured at the American Hospital Association's (AHA) joint virtual conference of the Association of Community Health Improvement and Institute for Diversity and Health Equity titled, "Accelerating Health Equity."

Hospital-community partnership work at NGHS was one of three partnerships featured, titled, "The Power of Partnerships: Moving Ideas into Action to Advance Health Equity."

Christy Moore, Director of Community Health Improvement, and Semuel Maysonet, Hispanic Outreach Committee member and NGMC board member, represented the organization on the speakers' panel.

In October, the Greater Hall Chamber of Commerce transformed their annual **HealthSmart** event to a community vaccine day, administering nearly 300 COVID-19 vaccines and boosters, as well as 300 flu shots to a diverse group of people from the community.

Questions?
Contact: Christy Moore
Director, Community Health Improvement
770-219-8097 | christy.moore@nghs.com

Northeast Georgia Medical Center