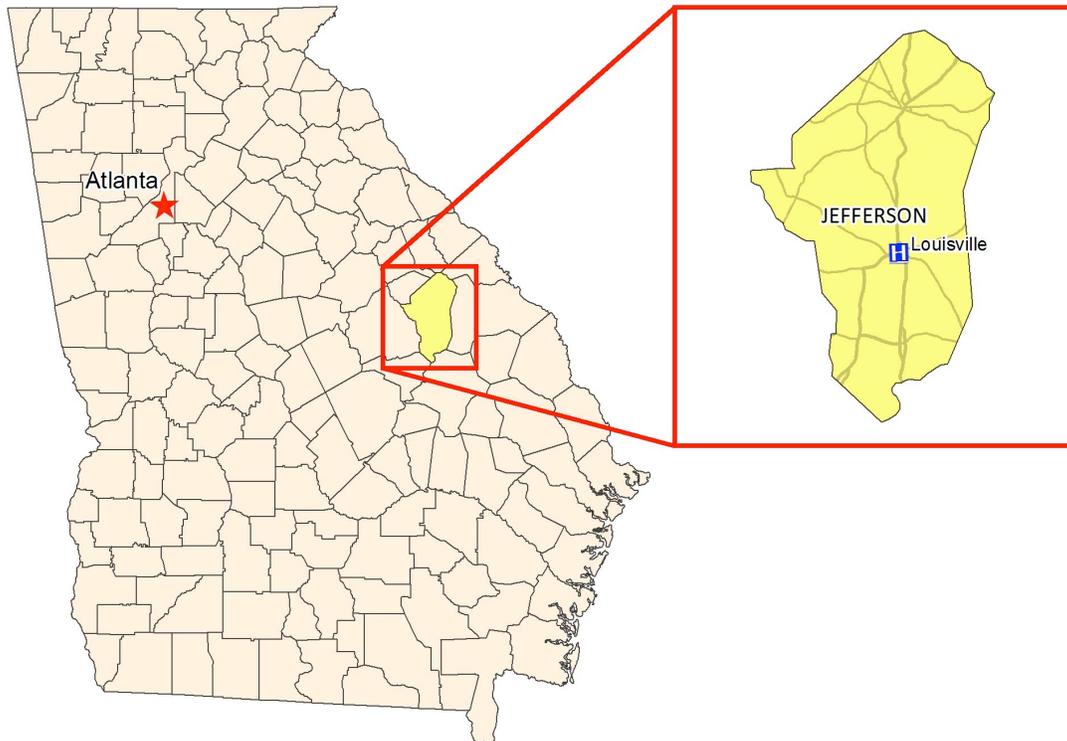


Jefferson Hospital *Community Health Needs Assessment*



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ABOUT THE PROJECT TEAM

Stuart H. Tedders, PhD, MS served as the Principal Investigator for this project. A native of Georgia, Dr. Tedders attended Georgia Southern College where he majored in Biology. After graduating in 1987, he enrolled at Clemson University and received a Masters degree in Medical Entomology. In 1994, he earned a Ph.D. in Public Health from the University of South Carolina. Dr. Tedders is currently a Professor in Epidemiology and serves as the Associate Dean of Academic Affairs in the Jiann-Ping Hsu College of Public Health (JPHCOPH) at Georgia Southern University. During his tenure as a Professor at Georgia Southern University, Dr. Tedders has served as the Director of Rural Health & Research and as the Director of the Office of Public Health Practice & Community Service. He has also served on numerous health-related boards throughout the State of Georgia. Dr. Tedders' research interests involve many elements of population-based rural health. As a self-described “applied epidemiologist”, recent scholarly endeavors have included epidemiological investigations of cancer, tobacco use, maternal and child health, and community assessment in rural Georgia. Dr. Tedders has to his credit nearly 30 peer-reviewed publications, 23 community assessments, 26 technical reports, 10 research monographs, and nine non-peer reviewed publications to his credit. He has more than 18 years experience working with rural Georgia communities.

Raymona H. Lawrence, DrPH, MPH served as the Co-Principal Investigator for this project. Dr. Lawrence is an Assistant Professor of Community Health in the Jiann Ping Hsu College of Public Health at Georgia Southern University. She has worked as the project coordinator for the W. K. Kellogg Foundation’s *New Tools, New Visions 2* initiative and was responsible for coordinating the project which addressed health disparities among four African American communities across Georgia. Dr. Lawrence has also worked as a science educator in the Candler County, Georgia School System, and as a Research Professional in the Titus H.J. Huisman Hemoglobinopathy Laboratory at the Medical College of Georgia. Dr. Lawrence has worked on the Chatham County Safety Net Planning Council’s project to evaluate patient and physician readiness to implement electronic medical records, and was also awarded grant funding for the Medical University of South Carolina’s REACH diabetes grant in Jenkins County, Georgia. She earned her Bachelor of Science Degree in Kinesiology in 2000 and her Master of Public Health degree from Georgia Southern University in 2003. She completed her Doctorate in Public Health-Community Health Behavior and Education from the Jiann-Ping Hsu College of Public Health at Georgia Southern University in December of 2010. She currently serves as a member of the CDCs working group to address sickle cell trait in athletics and the National Heart, Lung, and Blood Institute and Health Resource Services Administration’s uniform medical language in sickle cell disease and thalassemias: Epidemiology & Demography work group. Dr. Lawrence’s research interests include health inequities and health disparities as they relate to African Americans living in rural populations—especially those with chronic diseases such as sickle cell disease.

Marie Denis-Luque, MSPH, MPH served as the Research Manager for this project. Mrs. Denis-Luque emigrated from Haiti to the U.S. in 1991. She lived in Florida until January 2010 when she joined her spouse, Dr. John Luque, a Georgia Southern University faculty member in Statesboro, Georgia. Mrs. Denis-Luque holds two Master's degrees in Public Health from the University of South Florida (USF): Epidemiology and Community & Family Health, and she has extensive national and international experience in Public Health. In 2003, while still in graduate school, she founded Caring for Haitian Orphans with AIDS, Inc., a nonprofit organization that provides care to HIV-positive abandoned children in Haiti. After her graduate studies she worked as an Associate in Research for five years at the USF Chiles Center for Healthy Mothers and Babies, where she sharpened her skills as a qualitative researcher using qualitative data analysis software such as MAXQDA and NVIVO. She later worked as an ethnographer and qualitative data analyst for SmartRevenue, a market research firm. Before taking on her current role at the Jiann-Ping Hsu College of Public Health, she worked as a Project Director on a federal grant assisting HIV-positive women in 15 rural Georgia counties access services, at Georgia Regents University, formerly known as Medical College of Georgia. As the Research Manager in the Community Health Needs Assessment project, she manages and oversees the daily activities; develops and implements a tailored stepwise framework; develops project protocols, procedures and instruments; analyzes the data; and produces quarterly reports.

Dziyana Nazaruk, MPH, MS, served a Graduate Research Assistant for this project. She earned her MPH and MS in Sports Medicine from Armstrong Atlantic State University. She was formerly a Graduate Assistant for the Health & Kinesiology Department at Georgia Southern University where she worked on the project which addresses women's health needs. Her research interests include physical activity intervention, nutrition and obesity prevention.

James Welle, BS served as a Graduate Research Assistant for this project. He is a Master of Public Health candidate the Jiann Ping-Hsu College of Public Health. He is studying in the Community Health Program while focusing on community assessment and community-based diabetes interventions. James developed a research background in immunology while completing the requirements for a Bachelor of Science at the University of Notre Dame.

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EXECUTIVE SUMMARY

Purpose

The purpose of this project was to provide technical assistance to 18 nonprofit hospitals in completing the Community Health Needs Assessment (CHNA) as mandated by the IRS. The CHNA initiative was organized around four specific aims to take place in all 18 target communities by June 30, 2013: *(1) to organize core steering groups to provide assessment support and guidance; (2) to complete community health assessments (needs identification and assets inventory); (3) to prioritize identified community health issues; and (4) to educate core steering group members and community members on the principles and practices of health promotion program planning and evaluation.*

Service (target) Area

- ✓ The target area for the CHNA relied on a county-based definition. Zip code data from each hospital were used to establish the general threshold for determining a county as part of the CHNA target.
- ✓ The specific target area for Jefferson Hospital was Jefferson County.

Community Advisory Committee Membership

- ✓ The Community Advisory Committee (CAC) was a key component of community engagement in the process as required by the IRS mandate. The CAC was composed of 15-25 members representing a cross-section of the defined community (target area).

Site Visits

- ✓ Three community visits (meetings) were scheduled for each site throughout the project period, and each visit had a specific purpose including a general introduction, data collection, and prioritization of health issues.

Data Collection Approaches

- ✓ The secondary data reports were generated using data collected from multiple online sources including the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS), County Health Rankings, the U.S. Census Bureau, and the Georgia Board for Physician Workforce's 2008 Physician Workforce Profile.
- ✓ Primary data were collected using a pilot tested community-based survey. Through the assistance of the CAC, a minimum of 400 surveys were distributed to a cross-section of the defined target area.
- ✓ Primary data were collected using 3 focus groups (6 to 8 members each) in each community. One group consisted of CAC, the persons recruited by each hospital to actively participate in the needs assessment. The other two groups were recruited by CAC members and referrals.

- ✓ Community assets were identified using the two primary data collection methods described above, as well as a compilation of health related resources in the target area, including hospitals, health services, counseling services, youth organizations, community organizations and rehabilitation services.

Prioritization Strategy

- ✓ A two-stage process was used to complete the prioritization of issues in each community. The first stage involved a facilitated discussion of the emergent issues presented during the third site visit. The second stage involved, the Hanlon Method to obtain the final prioritization of issues.

Results: Secondary Data Analysis

- ✓ The majority of the population is African Americans (54%), while Whites constitute the largest minority (approximately 44.4%).
- ✓ Diabetic and mammography screenings are at the state averages.
- ✓ The number of preventable hospital stays is higher than the state average.
- ✓ In 2008, the service area had a total of 18 physicians, mostly Family Practice.

Morbidity

- ✓ Cardiovascular diseases are the largest cause of morbidity, which resemble state averages. Males, especially African-Americans, have the highest rates of cardiovascular diseases.
- ✓ In the service area, African Americans have higher rates of stroke. Their rates are above the state averages.
- ✓ Obstructive Heart Disease (OHD) is higher among white residents in the service area.
- ✓ The rates of respiratory diseases are consistently higher than the state average for each race and gender classification
- ✓ African Americans have the highest rates of asthma in this area. Their rates are also much higher than the state average.
- ✓ The cancer morbidity rate is similar to the state average. The highest rate is among African American males.
- ✓ Hospital discharge rates for diabetes among African Americans are almost three times than that of white residents.
- ✓ African Americans have the highest rates of HIV/AIDS, but these rates are lower than the state average.

- ✓ The rate of sexually transmitted infections is similar to the state average. However, African American females' rates are highest in this service area and the state average.

Mortality

- ✓ Rates of cardiovascular disease mortality in the service area are higher than the state of Georgia average, particularly among African American males.
- ✓ Total stroke mortality rate is higher than the state average, particularly in African American males.
- ✓ Rates of obstructive heart failure were higher than the state average
- ✓ The mortality rates for respiratory disease were higher than the state average. Rates for white males were highest in this service area.
- ✓ The total age-adjusted cancer mortality rate was similar to the state average.
- ✓ The age-adjusted diabetes mortality rate is similar to the state average, but the rates are higher in the African American males.

Maternal and Child Health

- ✓ The percentage of births receiving less than five prenatal care visits is higher in the African American community. Those mothers in the service area receive the recommended number of prenatal care visits at higher rates than the state average
- ✓ The infant mortality rate for African Americans is higher than the state average
- ✓ The percentage of low birth weight babies in the African American population is almost three times higher than in whites.
- ✓ The percentage of low birth weight births for teen mothers is higher among African-Americans than in whites.

Results: Community-Based Survey

- ✓ A total of 313 surveys were completed and returned to Georgia Southern University for analysis.
- ✓ Considerably more females (59.9%) completed this survey than males (40.1%).
- ✓ Most respondents were either white (71.3%) or African American (27.7%).
- ✓ Nearly 52.8% of all participants were between the ages of 25 and 54 years old.
- ✓ Approximately 32.1% of respondents reported having some college education and 8.3% of respondents reported having a high school diploma or the equivalent.

- ✓ Most survey participants (58.5%) indicated they worked full-time while only 6.4% reported part-time work. Approximately 9.3% of participants reported they were unemployed.
- ✓ Nearly 24.6% of participants reported household incomes of less than \$25,000 per year.
- ✓ A considerable proportion of the respondents reported having access to transportation (90%).
- ✓ Overall, quality of life in the community is high. Respondents characterized the community as safe, good place to live and raise children. Moreover, most participants agreed the community had a strong educational system and health care system. However, the economic viability of the community was a concern.
- ✓ Approximately 45.3% of respondents perceived their health status as “good,” and 33% perceived their health status as “very good.”
- ✓ A majority of respondents reported either exercising occasionally (42.6%) or not at all (16%).
- ✓ 62.2% of the female respondents reported completing a self-breast examination.
- ✓ Most respondents (78.5%) reported not using tobacco.
- ✓ Nearly 84% of respondents reported never consuming alcohol (44.2%) or only consuming it occasionally (39.4%).
- ✓ Most respondents reported always (68.1%) or mostly (21.4%) using seatbelts.
- ✓ Prayer (50.3%) was the most commonly reported strategy for controlling stress. However, talking to friends (43.2%), exercise (33.9), and hobbies/sports (30.3%) were also commonly reported.
- ✓ The majority of survey respondents (82.7%) indicated they received physicals on a regular basis.
- ✓ Most (91.8%) respondents reported having a regular doctor.
- ✓ Nearly 69.6% of all respondents indicated having private insurance to pay for health care services. Approximately 18.7% reported being Medicare beneficiaries and 6.7% reported being on Medicaid.
- ✓ Over 70.9% of respondents indicated having a regular dentist.
- ✓ 59.8% of respondents reported seeking health care from a rural health clinic. The emergency room (17.7%) and the health department (1.3%) were additional sites for receiving health care services.
- ✓ 85.9% percent of respondents indicated that cost was not a barrier to receiving health care services.

- ✓ Nearly 80.4% of respondents indicated that cost was not a barrier to filling a prescription medication.
- ✓ Dehydration (36%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room (ER). Ear/nose/throat infections (27.7%), kidney infection (22.6%), diabetes (22.6%), gastroenteritis (18.9), and asthma (18.2) were also commonly reported conditions for emergency room admissions.
- ✓ Among respondents surveyed, 74.8% used hospital services in the last 24 months. Those reporting using hospital services, 90% indicated using services at Jefferson Hospital.
- ✓ Most participants reported using Jefferson Hospital because of convenience (67.8%). However, 28.4% reported being referred by a physician.
- ✓ Laboratory services (48.1%) and radiologic services (45.7%) were the most commonly reported services used by survey respondents. The emergency room was used by 38.5% of those surveyed.
- ✓ Over 91% of those surveyed indicated being satisfied with services while only 5.9% indicated dissatisfaction. The primary reasons for reporting dissatisfaction involved long ER wait times and hospital personnel interaction.
- ✓ Approximately 96.1% of those surveyed indicated using a primary care physician.

Results: Focus Group Analysis Themes

- ✓ Community: ‘Everyone knows everyone’; close knit – like family; small town; friendly and caring people; no traffic; nice weather; low crime; good place to raise children; church involvement; too many fast food restaurants; ‘southern diet’ and lack of personal motivation.
- ✓ Community Issues: Lack of employment opportunities; chronic health conditions; high unemployment linked to lack of health insurance; loss of industry jobs; limited resources; lack of mental health professionals; teen pregnancy; high poverty; increase of single-parent households; grandparents raising grandchildren; lack of motivation to healthy living; lack of entertainment, recreation and shopping; and no privacy.
- ✓ Hospital: Caring staff; great services; everybody is treated equally; good food; effective PR work.
- ✓ Hospital Problems: ER doctors are not local; underutilization; hospital is not well equipped.
- ✓ Recommendations: Sustainability; partnerships; expanded wellness center; prevention education; diabetic and obesity programs; community outreach programs; mobile care.
- ✓ Community Vision: Hospital to stay in community; health education; bring industry into the area; hospital to form nontraditional partnerships; and preventive healthcare.

Community Assets

- ✓ An inventory of community assets and resources is outlined in this report.

Prioritization

- ✓ **The following issues emerged from the data:**
 - A. Chronic Disease Conditions (Heart Disease, Cancer, Etc.)
 - B. Issues Associated with the Hospital (Specialized Equipment, Underutilization, Emergency Room Physicians, Uninsured, Indigent Care, Etc.)
 - C. Partnerships to Promote Economic Development (Lack of Industry, Unemployment/Underemployment, Poverty, Etc.)
 - D. Issues Associated with Healthcare Access (Mental Health Professionals, Uninsured Populations, Etc.)
 - E. Improvement/Coordination/Partnerships of Community Health Education Activities (Obesity, Diabetes, Tobacco, Nutrition, Exercise, Teen Pregnancy, STD, Recreational Activities, Etc.)
- ✓ **Following the prioritization exercise the rank order of community issues included:**
Improvement/Coordination/Partnerships of Community Health Education Activities, Partnerships to Promote Economic Development, Issues Associated with the Hospital, Issues Associated with Healthcare Access, and Chronic Disease Conditions.

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INTRODUCTION

General population health is perhaps the single most important factor in determining the success of a community. The United Health Foundation suggests the overall health status of Georgia is relatively poor, ranking 37th in the nation. Although, some health status indicators are “fair” to “good,” many others such as infant mortality, total mortality, cardiovascular disease, infectious disease, and lack of health insurance consistently rank in the lower quartile. Moreover, the health behaviors of Georgians contribute to poor health, and the state public health officials report that a significant number of residents are obese, smoke cigarettes, are physically inactive, and do not engage in recommended disease screening behaviors. In addition, many Georgians, particularly those residing in rural areas, are at a significant disadvantage socially, culturally, and economically. In short, the poor health of Georgians reduces the efficiency of Georgia’s workforce, increases health care costs, and reduces longevity and quality of life. A comprehensive approach to assessing the population health status of a given community is an effective means of fully understanding the nature of the challenges faced by rural Georgians. The following narrative outlines Georgia Southern University’s conceptual framework for developing a comprehensive profile of health issues in select communities in the state. Moreover, the relation between this conceptual framework and the specific project deliverables will be discussed.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act signed by President Obama on March 23, 2010 required all nonprofit tax-exempt hospitals to complete a community assessment every three years to evaluate the health needs and assets of the community. Regulated by the Internal Revenue Service (IRS), this mandate became effective on March 23, 2012. In addition, these hospitals are required to develop an implementation strategy designed to address priorities identified through the assessment process. Hospitals that do not complete this mandated activity risk losing their nonprofit status and face a \$50,000 penalty. In response to this legislation, the Georgia Department of Community Health through the State Office of Rural Health (SORH) funded faculty from Georgia Southern University’s Jiann-Ping Hsu College of Public Health to assist 18 nonprofit rural hospitals to comply with this federal mandate. Specifically, Georgia Southern University was charged with providing technical assistance to these nonprofit hospitals in addressing the Community Health Needs Assessment (CHNA) mandated as outlined in the Patient Protection and Affordable Care Act.

IRS Compliance

According to the IRS mandate, the implementation strategy must be adopted by the end of the same taxable year in which the CHNA was conducted. The CHNA must be conducted in the taxable year that the written report of its findings is available to the public, and the governing body of the hospital must approve the plan. In addition, the specific processes and methods used for the CHNA, the sources of data, dates of the data collection, and the analytical methods applied. Any information gaps must be identified, and the CHNA must identify all collaborating organizations. Third parties, name, titles, and affiliations of individuals consulted also must be recognized in the CHNA written description.

Moreover, the contribution from federal, tribal, regional, state or local health departments as well as from leaders, representatives, or members of medically underserved, low-income, and minority populations must be recognized in the report. Existing health care facilities and other resources within the community must be addressed to ensure input from all required sources, and the prioritization of all the community health needs identified must follow the CHNA. Upon completion of the CHNA, a written plan must be presented that addresses each of the community health needs. This plan should describe the hospital's plan to meet each identified need, or to explain why the hospital cannot meet a specific need. The implementation strategy must be tailored to the specific hospital facility and must be attached to hospital's annual Form 990. Failure to meet the CHNA with respect to any taxable year may result in the imposition of a \$50,000 excise tax. In addition, failure to meet stated requirements may place hospital's tax exempt status in jeopardy. Outlined below is a checklist pertinent to successful completion of the CHNA and the Implementation Plan.

Timing:

- ✓ The implementation strategy must be adopted by the end of the same taxable year in which the CHNA was conducted
- ✓ The CHNA is considered to be conducted in the taxable year that the written report of its findings is made widely available to the public
- ✓ The implementation strategy is considered to be adopted when it is approved by the governing body of the hospital

Requirements of the CHNA:

- ✓ Description of the community served and the community was defined.
- ✓ Description of the processes and methods used to conduct the CHNA.
- ✓ Description of the sources and dates of the data and other information used in the CHNA.
- ✓ Description of the analytical methods applied to the CHNA.
- ✓ Identification of any information gaps that impact the ability to assess the community's health.
- ✓ A list of all collaborating organizations in conducting the CHNA.
- ✓ Identification of third parties with which the hospital contracted to assist in conducting CHNA, along with qualifications of such third parties.
- ✓ Description of how input from parties representing broad interests of community served were solicited.
- ✓ Description of community interaction.
- ✓ Name and title of at least one individual representing collaborating organizations.

- ✓ Description of how the hospital solicited input from persons with special knowledge of or expertise in public health.
- ✓ Description of how the hospital took into account input from federal, tribal, regional, state or local health departments or agencies, with current data or other information relevant to the CHNA.
- ✓ Description of how the hospital took into account input from leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs.
- ✓ Prioritized description of all of the community health needs identified through the CHNA and the process/criteria used in prioritization of such needs
- ✓ Description of existing health care facilities and other resources within the community available to meet the health needs of the community.
- ✓ Identification (names, titles, and affiliations) of individuals consulted in the CHNA process.

Phases of a Needs Assessment

Simply defined, a community health assessment is a planned and methodical approach to identifying a profile of problems and assets. It is important to note, comprehensive assessments are not only focus on documented or perceived community health issues/problems, but they focus on the positive aspects of the community also known as assets. The community assessment process is the framework by which program planners identify gaps or discrepancies between a real state and an ideal state. In practice, community assessments enable communities to accomplish several important tasks. These specific tasks are best described in general terms and include an ability to illustrate community priorities, validate the need for health initiatives, develop effective health promotion strategies, and identify and leverage community resources to solve problems. Health assessments, if done properly, are a starting point for solving complex community problems. Unfortunately, tangible solutions to these complex problems often prove to be elusive, unrealistic, and/or ineffective. However, a properly conducted health assessment will maximize the likelihood of developing solutions that work.

In most instances, the community assessment process is most effective using a multi-step approach to reach specific thresholds. In order to function effectively, as well as maximize the likelihood of improving health status, the community assessment process should resemble a “Continuous Quality Improvement” loop. The conceptual steps in a generalized model to completing a comprehensive assessment are a five-step process and should include the following: (1) Engaging the Community, (2) Defining the Issues, (3) Establishing Community Priorities, (4) Designing a Strategy for Intervention, and (5) Evaluating the Impact. These steps or phases are explained more thoroughly in the narrative outlined below.

Step 1: Engaging the Community

The community assessment process begins through community engagement. Typically, assessment experts are “outsiders” to the community, so they generally lack credibility in the community. Community engagement is necessary for achieving ownership in the process,

thereby enhancing likely participation in the remaining phases of the assessment. Moreover, community engagement helps to gauge overall community readiness to address specific problems or issues.

Step 2: Defining the Issues

The specific approach used to define the issues in a given community varies according to availability of resources and overall readiness of stakeholders. Although the availability of resources to complete the process is dependent on a number of factors, the ability of a community to tap these resources is static and cannot be controlled in many ways. However, community readiness is a factor that can often be modified depending on the political landscape of the community, the willingness to embrace collaboration, and a commitment to improve the health status. Defining the issues in a given community can vary from a methodologically rigorous approach to a more generalized approach to gathering the necessary data. Additionally, the methodological approaches to defining issues may rely on qualitative, quantitative, or a mixed methods approach.

Step 3: Establishing Community Priorities

After defining the community issues, stakeholders need to adopt a strategy for establishing priorities. This is a particularly important process because the results of the prioritization strategy effectively remove certain issues from consideration due to fiscal, personnel, or readiness constraints of the community. Most often, prioritization strategies rely on multiple considerations including, but not being limited by, the size of the issue, the seriousness of the issue, the ability to modify the issue, and the ethical and legal implications of either modifying or not modifying the issue.

Step 4: Designing a Strategy for Intervention

After completion of the prioritization of issues, as well as gaining consensus on the specific issues to address, the next step in the assessment process involves designing strategies for intervention. Several considerations must be taken into account when designing interventions including the identification of culturally appropriate leverage points for change and establishing measurable and meaningful objectives.

Step 5: Evaluating the Impact

The last step in the assessment process is evaluating the impact of intervention efforts. Typically, evaluation efforts require the community to identify short term, intermediate term, and long term outcomes that reflect a logical progression of desired change. These outcomes must be linked to the measurable objectives established in Step 4. Successful evaluation strategies include defining appropriate metrics that have been innately linked to the specific outcomes, thereby providing the ability to note changes in a particular issue. At the end of Step 5, communities should use the lessons learned from the evaluation to implement continuous quality improvement. This should always involve informing the stakeholders in order to sustain community engagement. Therefore, Step 1 begins again and the entire assessment process repeats itself.

In referencing the five steps of completing a comprehensive community assessment, Georgia Southern University was only funded to complete steps 1 – 3. It is the responsibility of the hospital and governing authority of the hospital to complete steps 4 and 5 of this process in the form of a written implementation plan to the IRS.

Project Purpose

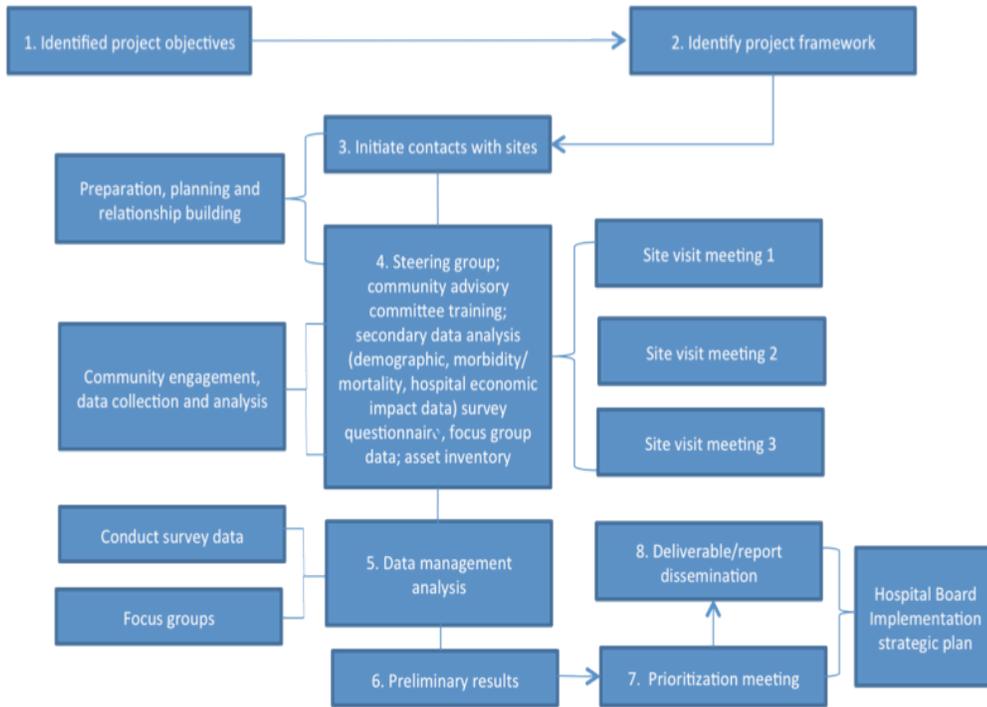
The purpose of this project was to provide technical assistance to 18 nonprofit rural hospitals in completing the Community Health Needs Assessment (CHNA) as mandated by the IRS. A list of all hospitals and public health district contacts involved in this initiative can be found in *Appendix A*. Additionally, a list of local health department administrators is also appended. For the purposes of this project, this initiative was organized around four specific aims that include the following:

1. *To organize core steering groups to provide assessment support and guidance in all 18 target communities by June 30, 2013*
2. *To complete community health assessments (needs identification and assets inventory) of all 18 target communities by June 30, 2013*
3. *To prioritize identified community health issues in all 18 target communities by June 30, 2013*
4. *To educate core steering group members and community members in all 18 target communities about the principles and practices of health promotion program planning and evaluation by June 30, 2013.*

Project Overview

The following graphic represents the conceptual framework for the CHNA project. The project is organized around an 8-step process that includes (1) identifying project objectives, (2) identifying the project framework, (3) initiating contact with the 18 hospital sites, (4) forming the steering groups, advisory groups, and outlining data collection techniques, (5) managing and analyzing the data, (6) reporting preliminary results, (7) prioritizing identified issues, and (8) disseminating the final CHNA document. This report will elaborate more thoroughly on the specifics associated with each step in the methodology section (See Figure below).

Community Health Assessment: A Conceptual Framework[©]



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METHODOLOGY

This section outlines the specific procedures for completing the CHNA project. Please refer to the conceptual framework (above) referenced in the previous section to understand the relation between specific methodological components and progression of the CHNA project. This project was approved by the Institutional Review Board at Georgia Southern University – Project Number: H13001 (*Appendix B*).

Overview of the Communication Process

In order to maximize the likelihood of success, the CHNA project relied on a systematic, methodical, and sustained process of communication among all participating hospitals. In order to facilitate continuous progress toward project deliverables, the project team relied on a multi-varied approach to conveying relevant information. Communication was initiated early and it was sustained on a weekly basis throughout the length of the project. It was determined that an effective and efficient communication process would include keeping the SORH informed of progress. However, the project team at Georgia Southern University relied heavily on telecommunications, either conference calls or one-on-one conversations, in order to complete the CHNA project.

It was essential to include the SORH representatives on all electronic communication, so the decision was made to copy all electronic correspondence to the individual responsible for monitoring grant activity and progress. Routine and systematic communication with the SORH fulfilled two purposes. First, it ensured transparency throughout all project activities. Secondly, it enabled representatives from the SORH to troubleshoot and navigate problems associated with acquiring the required documentation for this project.

Data Templates and Instruction Guides

The logistical challenge of completing the CHNA project was monumental. As a means of facilitating adequate process and controlling variability between sites, a series of data collection templates was created. All sites were strongly encouraged to use the data templates to organize specific activities; however, the use of these templates varied significantly from site to site. Electronic communication was routinely used to remind and encourage sites to complete specific data templates. However, some hospitals either did not or were unable to comply with these repeated requests. The table below illustrates the specific data templates developed throughout the grant period. In addition, a more precise definition of the purpose of each template is highlighted. Appended to this report are the data templates developed by Georgia Southern University. These templates are referenced throughout this report.

Data Template

Data Template	Purpose
CHNA Checklist	A checklist based on documents reviewed on the Patient Protection and Affordable Care Act.
Hospitals and Health Districts	A document that contains information on the 18 rural hospitals and health districts.
County Health Department Administrators	A document that contains information on the local health department administrators located in the 18 rural sites.
Community Advisory Committee List	A table that contains all the names, occupation, business/agency represented, telephone number and email address of CAC members.
Member RSVP List (MTG 3)	A document used by site leaders at each hospital to keep track of attendance of Steering Group and CAC members at Meeting 3.
Site Specific Details	A document used to capture site-specific information about each hospital.
Steering Group Bio-sketch	A table with all Steering Group member contacts and bio-sketches, including a paragraph describing their qualifications, occupations and other professional roles and affiliations.
County Survey Count	A table for site leaders to track of CAC members agreeing to distributed surveys following Meeting 2. Site leaders were to update this table every time they received completed surveys from CAC members.
Focus Group Participants Information	An Excel spreadsheet created with specific tabs to assist site leaders in keeping track of focus group participants. Site leaders were to call participants 24 hours before the scheduled sessions.
Hospital Zip Code Data	A table that contains service (target) area zip code information for the 2011 calendar year.
Site Project Timeline	An Excel spreadsheet for site leaders to work with the members of the steering group in developing a workable timeline that takes into account the fiscal year end.

In addition to data templates, a series of instruction guides were developed to more effectively facilitate progress of the CHNA. Appended to this report are the specific guides developed. However, a general outline of these guides is illustrated below.

- ✓ Potential CAC members
- ✓ Pilot Test Instructions
- ✓ Focus group preparation logistics
- ✓ Community advisory committee recruitment letter
- ✓ IRS compliance Summary

Initiating and Sustaining Community Contact

E-mail was the channel of communication chosen to initiate communication. The purpose of this email message was two-fold: 1) To introduce Georgia Southern University as the institution contracted by the SORH to provide technical assistance for completing the CHNA; and 2) To schedule a conference call within the first two weeks after the initial email. In addition, a project

summary describing the project in more detail, including specific aims, was sent as an attachment to this email (*Appendix C*). The initial email message to all sites was sent on June 4, 2012.

Based on work completed by the National Center for Rural Health Works at Oklahoma State University, it was determined that a project activity outline would be created prior to initiating the conference call (*Appendix D*). The purposes of the project activity outline were: 1) To provide stakeholders with an overview of the Patient Protection and Affordable Care Act (IRS compliance summary) and Georgia Southern University's contract obligation; 2) To provide instructions for defining the site's medical service area; 3) To define the methods by which data will be collected; 4) To provide instructions for forming the steering group membership; and 5) To provide basic instructions for identifying and recruiting potential Community Advisory Committee (CAC) members. The project activity outline was critical in providing the hospital administrators with a fundamental understanding of the expectations of the CHNA project. Specific expectations included, but were not limited to, suggestions on steering group membership, suggestions on CAC membership, roles and responsibilities of all stakeholders, data collection procedures, specific tasks to be completed prior to community meetings, and the purpose of community meetings.

The project team organized conference calls in order to initiate the CHNA. On average, these conference calls lasted approximately 20 minutes. Specific questions asked by hospital site administrators/representatives were either addressed immediately on the call or in a follow-up phone call or email message. Information related to steering group formation, potential CAC members and defining the service area were the primary talking points discussed on this call. At the conclusion of each conference call, sites were asked to provide verbal information concerning their perceived medical service area.

On July 2, 2012, a 30-minute conference call was hosted between the Jefferson Hospital site leader Ms. Tina Biggers and the Georgia Southern University project team.

Steering Group Membership

Each hospital was responsible for forming a Steering Group. The Steering Group consisted of 5-7 members from the hospital. However, hospitals were given the latitude to include other key stakeholders from the community. For Jefferson Hospital (JH), Steering Group members were recruited from the hospital and local health department. These members' names and affiliations included Ralph Randall (CEO, JH), Tina Biggers (Assistant Administrator, JH), Ann York (Physicians' Health Group, JH), Mary Sue Rachels, RN (Nurse, JH), Catherine Hall (HR Director, JH), Rita Culvern (Retired CEO of Jefferson Hospital and former Mayor of Louisville), and Janet Pilcher, RN (Nurse Supervisor Jefferson County Health Department) (*Appendix E*).

The charge of this group was to literally "steer" the CHNA process. One member of this group was designated as the Site Leader. The responsibilities of this person included being the primary point of contact with Georgia Southern University. Additional responsibilities included disseminating relevant data templates, completing data requests, facilitating recruitment to the CAC, organizing group meetings (Steering Group and CAC meetings), facilitating focus group recruitment, tracking survey distribution, and general troubleshooting as it related to the CHNA project. In addition, the Steering Group was responsible for validating the specific medical service area of the CHNA. The medical service area for this initiative is outlined below.

Medical Service Area Definition and Confirmation

The medical service area relied on a county-based definition. However, inclusion or exclusion of a particular county was dependent upon the proportion of hospital visits/stays at each hospital. Specifically, zip code data from each hospital were used to establish the general threshold for determining a county as part of the CHNA target. Although there was some variation with regard to each site, service areas were defined based on the proportions of inpatients and/or outpatients stays/visits during the previous calendar year (2011). Zip code data were designated as either “Primary” or “Secondary.” The threshold for a Primary designation was if the proportion of inpatient and/or outpatients stays/visits was equivalent to at least 10% of all visits/stays. Proportions of stays/visits less than 10% were designated as “Secondary”. Counties included in the target area for this CHNA project were only those with zip codes designated as “Primary.”

For Jefferson Hospital, zip code data were reviewed and forwarded to Georgia Southern University. Based on these data, the medical service area for the CHNA was defined as Jefferson County. The Steering Group members later confirmed this definition. The table below illustrates the proportional distribution of zip code data and the assigned designation.

Counties Served in 2011				
County	Zip Code	Number of Patients Served	Percentage	Designation
Jefferson	30477	21,495	90.3	Primary
	30803			
	30413			
	30434			
	30823			
	30818			
	30833			
Washington	31035	803	3.4	Secondary
	31830			
	31018			
	31082			
	31089			
Burke	30456	671	2.8	Secondary
	30816			
	30441			
	30830			
Glascock	30810	662	2.8	Secondary
	30823			
	30820			
Emanuel	31002	181	1.0	Secondary
	30401			
	31002			
	30446			
	30471			

Community Advisory Committee Membership

The Community Advisory Committee (CAC) is a key component of community engagement in the process as required by the IRS mandate. To formalize the process, we were able to provide the sites with a letter to recruit CAC members (*Appendix F*) and a list of potential CAC members (*Appendix G*). The standard letter was to be tailored to each hospital. The site leaders were instructed to discuss potential meeting dates, times and locations with the steering group to include in the letter before sending it out to those potential recruits. While working with the steering groups, the site leaders were to identify the best strategies that would facilitate CAC member recruitment in the community. For instance, some sites chose to write an article to put in their local newspapers to recruit participants, while others developed a list of potential members, divided the names among steering group members and had them call individuals to invite. However, many sites used multiple recruitment methods to include phone calls, emails, a letter from the hospital and word-of-mouth.

The CAC was composed of 15-25 members representing a cross-section of the defined community (target area). Hospitals, in particular the Steering Groups, were specifically instructed to recruit people, or agencies, representing traditionally underserved and minority populations within the target area. In addition, hospitals were encouraged to seek diversity with respect to race, ethnicity, social, economic, and education backgrounds. The Jefferson Hospital Steering Group met and developed a list of 18 potential CAC members. They divided the list and called potential CAC members to explain the project and request their participation. (*Appendix H*).

Site Visits

After the initial conference call, three community visits (meetings) were scheduled for each site throughout the project period. Each visit had a specific agenda for moving the CHNA forward. A standard PowerPoint presentation was prepared and delivered at each meeting. The specific purpose of each meeting is outlined below.

Meeting 1: The purpose of the first meeting was to make personal contact with the hospitals' site leaders, as well as other key personnel in the hospital. Specifically, the project team presented information about the Patient Protection and Affordable Care Act and the role of community assessment, contractual obligations of Georgia Southern University, a conceptual approach to data collection, instructions for clearly defining the medical service area, project timeline of activities, and brainstorming about Steering Group and CAC recruitment and membership. Though a standard timeline was provided, each site was encouraged to develop a site-specific timeline for project activities. The primary consideration of completing the CHNA project, aside from contractual obligations of the project team, included taking into account the hospital's fiscal year end date. This date corresponds to the required submission of the CHNA and subsequent strategic plan to the IRS. A copy of the Meeting 1 presentation can be found in the Appendix (*Appendix I*).

Specific tasks to be completed following the first meeting included formation of the Steering Group, beginning the process of recruiting CAC members, aggregating zip code data, defining the target area, discussing a community responsive data collection strategy, developing a project timeline, formalizing the community-based survey, and pilot testing the community-based survey. The Jefferson Hospital Steering Group followed the recommendations provided by the

Georgia Southern team. They compiled a list of 18 potential CAC members of whom 15 agreed to participate.

For sites that already had their Steering Groups formed, Meeting 1 concluded with project activities and next steps that were to be completed in a mutually agreed upon time frame. Most often this time frame was 3 to 4 weeks.

Meeting 2: The purpose of the second meeting was to meet with Community Advisory Committee (CAC) members to provide an overview of project activities and initiate data collection. The specifics of data collection will be discussed later in this section. Similar to the first meeting, the second meeting relied on a standard PowerPoint presentation. The presentation content included an overview of community demographics and key health related indicators, an overview of the project, and instructions for collecting data. Data collection efforts were first initiated by surveying CAC members using the community-based survey. In general, this took approximately 10 to 15 minutes. CAC members were also given instructions for distributing the survey to the community. In addition to survey completion and instructions for distribution, CAC members were asked to volunteer to participate in one of three focus groups to be conducted in the community. These members were also asked to assist the hospital in recruiting potential community members to participate in the remaining two focus groups. Meeting 2 ended with a general and open discussion about the perceived issues in the community. The data gathered from this open discussion were used as preliminary data in preparation for Meeting 3. A copy of the Meeting 2 presentation can be found in the *Appendix J*.

Specific tasks to be completed following the second meeting included monitoring survey distribution, prompting CAC members to forward completed surveys to the hospital, forwarding completed surveys to Georgia Southern University, soliciting individuals to participate in three focus groups, working with Georgia Southern University to schedule focus groups, and negotiating the logistics of hosting the third community meeting.

Meeting 3: The purposes of Meeting 3 were two-fold: 1) to relay the results of data collection to the community; and 2) to prioritize the issues that emerged from data collection. After data collection and analysis were completed, a PowerPoint presentation was prepared by the project team and delivered to Steering Group members, CAC members, and focus group participants. The presentation included an overview of the project, a review of data collection approaches, select secondary data highlights, and select primary data highlights (community-based survey and focus groups).

Prioritization of emerging issues was a central theme of Meeting 3. Prioritization was completed using a two-stage process. The first stage was a generalized discussion of the emergent issues presented. Modification to the issues was facilitated. The second stage was the actual prioritization phase that relied on the Hanlon Method. More specificity with respect to prioritization will be discussed more thoroughly in one of the sections below. A copy of the Meeting 3 presentation can be found in the *Appendix (Appendix K)*.

Site-specific agendas (*Appendix L*) and attendance sheets (*Appendix M*) for each meeting are appended to this report. In addition, economic impact data presented during the second meeting can be found in *Appendix N*. These data were acquired from the SORH through the Georgia Hospital Association.

Data Collection Approaches

Secondary Data Collection and Analysis

The secondary data reports were generated using data collected from multiple online sources. The sources of data for the project were the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS), County Health Rankings, the U.S. Census Bureau, and the Georgia Board for Physician Workforce's 2008 Physician Workforce Profile. Most demographic, physician workforce, preventive care services, insurance rates, and health behavior statistics were reported as percentages. However, all morbidity and mortality data were reported as age-adjusted rates in order to allow for a fair comparison with the state rates. In order to reduce variability of all point estimates, reported rates are based on ten-year aggregates (2001-2010).

All data were exported, stored, and managed in Microsoft Excel. In addition, graphs for the secondary data analysis section were generated using Microsoft Excel. It is worth noting that some slight discrepancies may exist in the data as a result of more data becoming available during the course of the study. Initially, the 2009 morbidity and mortality data were not available on OASIS while Georgia Department of Public Health staff conducted quality checks on the data. During the process of collecting the data, the 2009 data were published in the database.

Primary Data Collection: Survey Development and Distribution

As mentioned previously, a draft community-based survey was provided during the first site visit (community meeting). The steering committee was instructed to make necessary adjustments to the survey and to provide feedback to Georgia Southern University. Upon receiving the survey feedback from each site, the next step in the process was to make the requested changes so that the survey could be pilot tested. Instructions for the pilot test consisted of having 5-7 persons in the community who were representative of the service area take the survey. The instructions for pilot testing (*Appendix O*) were emailed to the site leader with the revised survey, and each site was given one week to complete this activity. Once pilot testing was completed, the site leader was asked to return the results to Georgia Southern University either by email or postal mail. After changes based on pilot test results, were incorporated, a finalized survey was developed (*Appendix P*). While a pilot test was completed with seven participants at the hospital, no changes were made to the survey.

Prior to Meeting 2, 400 copies of the survey were made and taken to the meeting. These surveys were numbered sequentially and distributed at the conclusion of Meeting 2. CAC members were asked to take the surveys and distribute them to their personal network. The decision to distribute a specific number of surveys was left to each CAC member. Therefore, the number distributed by each CAC member varied according to the size of their personal network and their overall willingness to participate in this project. Because the surveys were numbered, the hospital was able to track individual CAC members and the number of surveys they intended on distributing. In some instances, CAC members opted to only take one survey and use their own resources to make additional copies. In this case, the CAC member was asked to keep track of numbers of copies made and distributed. It was the responsibility of the site leader at the hospital to track this information, and total numbers of surveys in the community were known. Although some variability existed among all sites, most communities agreed that the CAC members would be

responsible for getting completed surveys to the hospital. In most instances, CAC members would return the surveys to site leaders, front desk receptionists, or strategically placed drop boxes in the hospital. Each site was given approximately 6 to 8 weeks to forward the completed surveys to Georgia Southern University. Theoretically, it was possible to estimate the total number of surveys distributed in a given community, and all hospitals were strongly encouraged to attempt at least an 80% response rate. Each hospital received a weekly reminder email message requesting an update on the survey distribution process. Specific information included the following: 1) the number of surveys received from CAC members; 2) the number of additional copies of the survey made; 3) (any) changes made to the original data collection strategy; and 4) (any) more time needed to reach the required 80% response rate. All surveys were manually entered into SPSS for Windows. Only descriptive statistics were used for this report.

For Jefferson Hospital, survey completion relied on the efforts of the individual CAC members. At *Meeting 2*, each CAC member took at least 10 questionnaires to distribute and have completed in the community. The site leader instructed CAC members to collect completed surveys from the community so that they could either return them to the hospital by mail or in person.

Primary Data Collection: Focus Groups

Three focus groups (6 to 8 members each) were conducted in each community. As mentioned previously, one focus group was composed of CAC members. The other two focus groups were composed of community members at-large recruited by CAC members. Specific instructions for preparation of focus group work were sent to each site (*Appendix Q*). The purpose of this strategy was to minimize hospital bias and to encourage representation of marginalized groups in the community that may not have been included in the CAC membership. This information was often stressed to site leaders during the focus group recruitment process. To keep track of focus group recruits, a set of instructions and spreadsheet were developed and sent to all site leaders. This information was provided to assist hospitals in understanding the basics about focus group work including the following: participants' eligibility criteria, number of recruits per group, focus group set up and locations, the importance of the reminder call to all participants 24 hours prior to the scheduled session, and post focus group procedures. A series of focus group questions was created prior to conducting any group work (*Appendix R*). On average, the focus groups were scheduled four weeks after survey data collection began.

After all focus groups, the facilitator and note taker (when available) participated in a debriefing session and completed field notes. All focus groups were digitally recorded and transcribed verbatim by a professional transcription service *Verbal, Ink.* and subsequently reviewed by the Georgia Southern University qualitative analysis team (Marie Denis-Luque and Dr. Raymona H. Lawrence) for accuracy. Transcripts were analyzed using the qualitative data analysis software program MAXQDA 10. An *a priori* codebook was developed based on the focus group guide. All transcripts were reviewed and coded by one of the members of the qualitative analysis team. Codes and emerging themes were discussed continually among the qualitative analysis team and agreed on or revised through an iterative process of consensus. Coded segments of the transcripts were placed into a qualitative data analysis matrix and separated by codes (i.e. hospital, hospital issues, community, community issues). All segments from a particular code were read and themes were developed. A grounded theory approach was used to understand the meanings that

the community and the hospital had for the participants as well as their recommendations to the hospital and community vision.

All three focus groups for Jefferson Hospital were scheduled on March 12, 2013 and were conducted on March 28, 2013. All participants completed a demographic form (*Appendix S*) and the informed consent (*Appendix T*), and each focus group lasted an average 75-90 minutes. A list of focus group participants can be found in *Appendix U*.

Community-Based Assets

Community-based assets were identified using the two primary data collection methods described above. Surveys assessed participant level of satisfaction with services in the community, as well as overall utilization of services in the past 24 months. Assets were also identified through the focus group process. In addition to primary data collection efforts, this CHNA created an inventory of health related resources in the target area. The primary goal of asset identification was to create a list of all the groups and organizations that could potentially have a positive influence on community health. In order to provide relevant information about tangible community assets in rural Georgia, the project team used the online version of the Yellow Pages. The inventory included hospitals, health services, counseling services, youth organizations, community organizations and rehabilitation services. The final inventory contained names, phone numbers, addresses, and services offered.

Prioritization Strategy

Prior to the prioritization of issues, participants were asked to discuss the issues presented during the 3rd community meeting. Specifically, they were asked if issues needed to be consolidated or if new issues should be added. After discussion, the Hanlon Method was used for the final prioritization of issues. The Hanlon Method calculates a Basic Priority Rating (BPR) for each problem identified in the assessment process. This prioritization scheme considers four dimensions of each problem and includes the size of the problem (measured by incidence, prevalence or percentage of the population affected) ranked on a scale from 0 to 10 (denoted as A). The seriousness of the problem (measured by economic loss, impact of other populations, or overall severity as indicated by mortality/morbidity) is ranked on a scaled from 0 to 20 (denoted as B), and the effectiveness of interventions (measured by how well previous interventions have worked) is ranked on a scale from 0 to 10 (denoted as C). Finally, a measure known as the PEARL (Propriety, Economics, Acceptability, Resources, and Liability) is ranked on a scale of either 1 or 2 (denoted as D). This last measure (PEARL) assesses issues of ethics, legality, and economics in addressing a given problem. The formula for calculating the BPR is as follows:

$$\text{BPR} = [(A + B)C/3] D$$

Participants were given a prioritization sheet with instructions (*Appendix V*) and asked to complete a final ranking of the mutually agreed upon issues. Given that a PEARL measure assigned as 0 would effectively remove an issue from consideration, participants were not asked to assign a value to the D term in the BPR equation. The results of this exercise yielded the final ranking of issues in a given community. The final calculations to obtain the BPR were completed by the project team.

RESULTS: SECONDARY DATA ANALYSIS

The purpose of this report is to provide a profile of the health characteristics of Jefferson Hospital's service area. This document provides both health statistics and contextual information. The context of the service area's health is framed by the demographic data, socio-economic indicators, health behaviors statistics, and the physician workforce profile. Subsequently, the morbidity and mortality statistics, along with maternal and child health data, are presented in order to understand the relative magnitude of the service area's health problems. As a basis for comparison, local rates are juxtaposed with state data.

Demographics

Demographic Characteristics 2010 Census

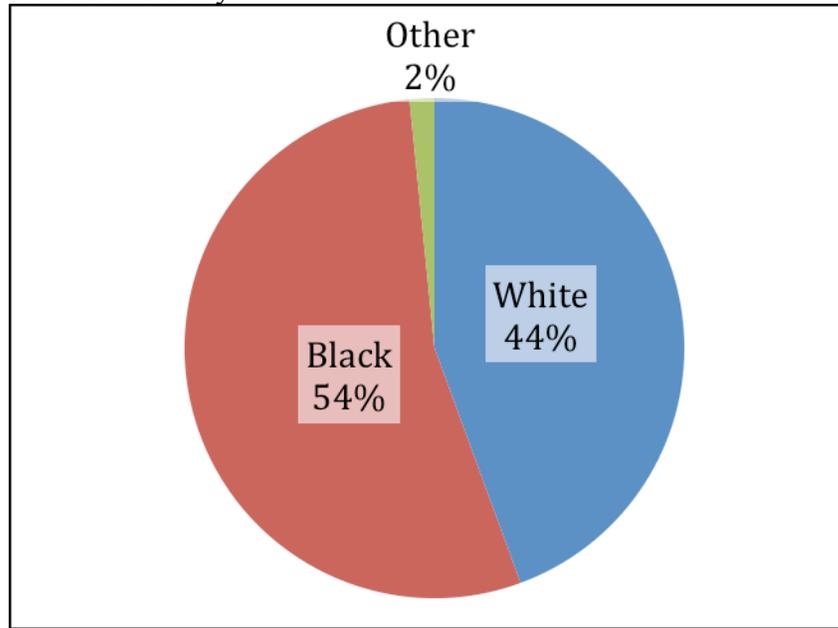
	Jefferson County	Georgia
Population [†]	16,930	9,815,210
Persons under 5 years [†]	6.7%	7.1%
Persons under 18 years [†]	25.1%	25.6%
Persons 65 years and over [†]	15.0%	10.7%
Male [†]	51.4%	48.8%
Female [†]	48.6%	51.2%
White persons [†]	44.4%	59.7%
Black persons [†]	54.0%	30.5%
Median Household income (2006-2010) [†]	\$29,268	\$49,347
Homeownership rate (2006-2010) [†]	70.9%	67.2%
High school graduates [†]	72.6%	83.5%
Bachelor's degree or higher [†]	8.7%	27.2%
Percent Uninsured [‡]	23%	21%

[†] U.S. Census Bureau: State & County QuickFacts

[‡] County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation

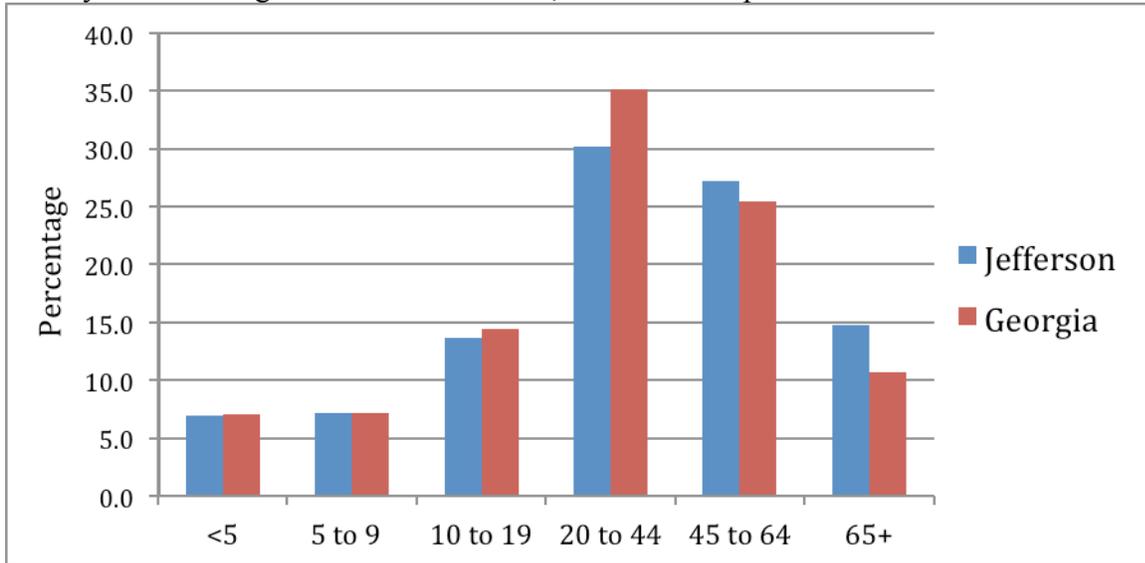
Service Area Demographics: Jefferson Hospital's service area is a rural community. The majority of the population is African American. Similar to other rural areas, the percentage of the population with high school diplomas, the proportion of college graduates, and the medium household income are lower than the state averages.

Proportion of Race in Jefferson County



U.S. Census Bureau: State & County QuickFacts

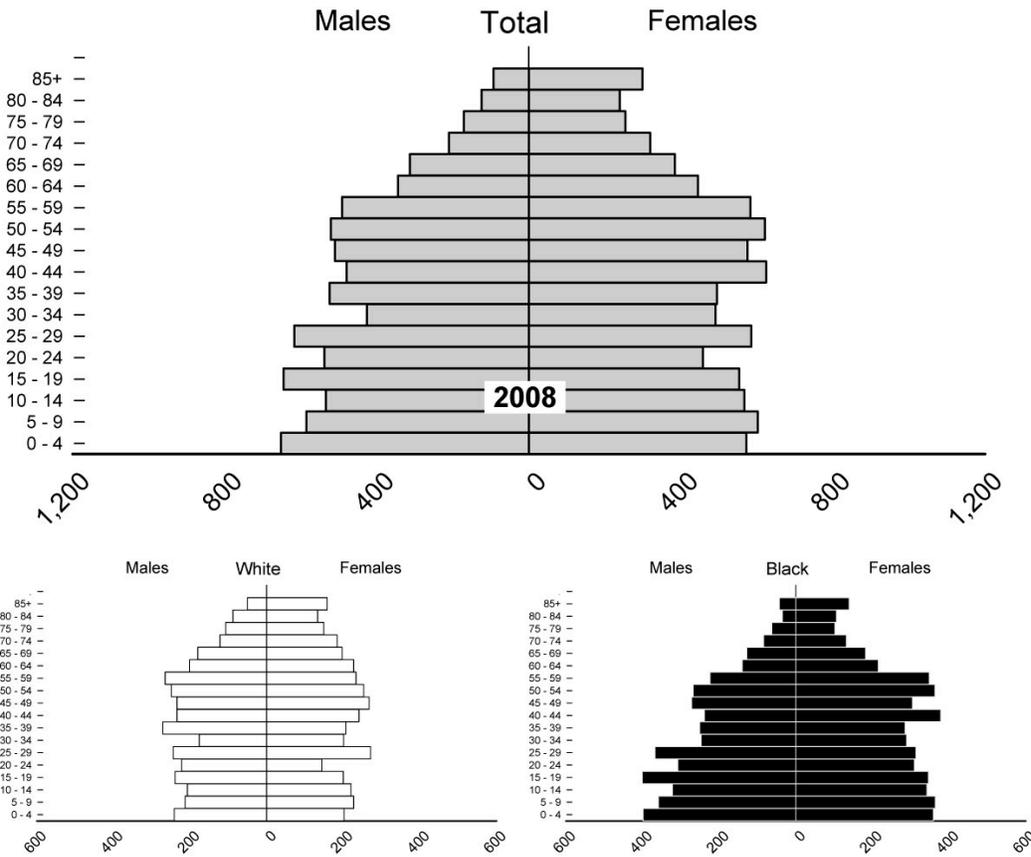
County and State Age Distribution in 2010, Jefferson Hospital Service Area



U.S. Census Bureau: American Fact Finder

Age Distribution: The population distribution is skewed towards the advanced ages. There is a higher proportion of residents in both the 45-64 and 65+ age categories.

Population Pyramids 2008, Jefferson County



OASIS: Georgia Department of Public Health

Health and Socio-Economic Indicators

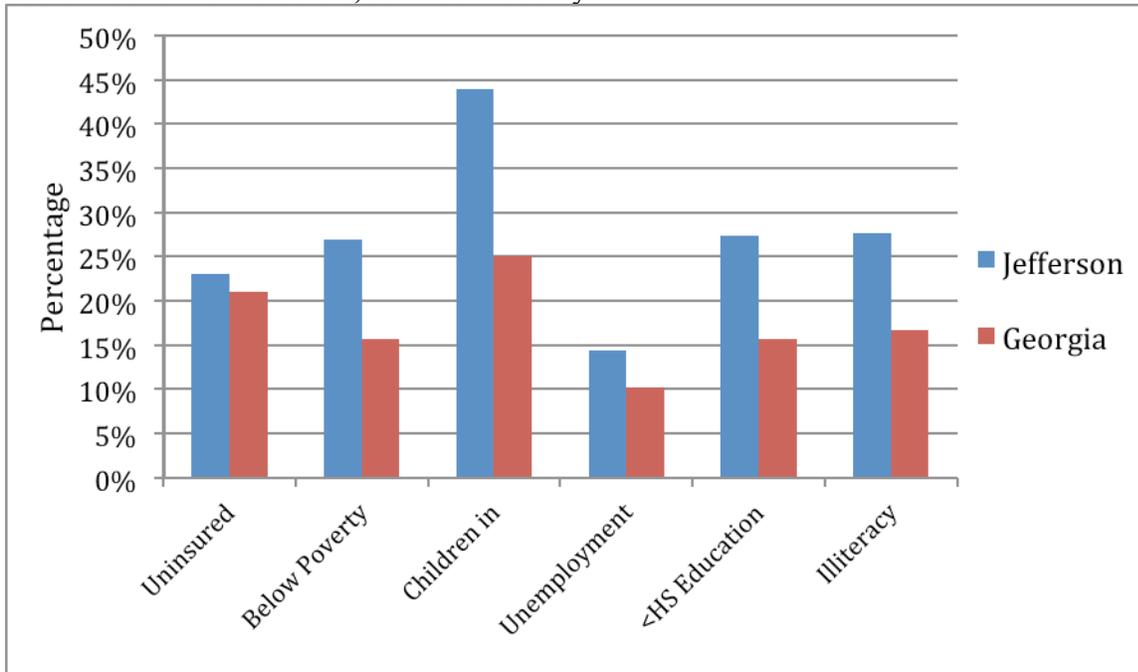
Health Behaviors

	Jefferson County	Georgia
Adult Smoking	13%	19%
Adult Obesity	37%	28%
Physical Inactivity	31%	24%
Excessive drinking	9%	14%

County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation

Health Indicators: Health outcomes in the community are best understood in the context of socio-economic factors and health behaviors since they are powerful influences on a population’s health. The figure indicates that the health of the service area is influenced by social factors. Similar to most rural areas in the state, the proportion of children living in poverty, the percent of uninsured, and the illiteracy rates are higher than the state averages. The health behavior indicators in the table show that while similar to the state averages, the rates of risk-taking behaviors are still problematic in the service area.

Socio-Economic Indicators, Jefferson County



County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation

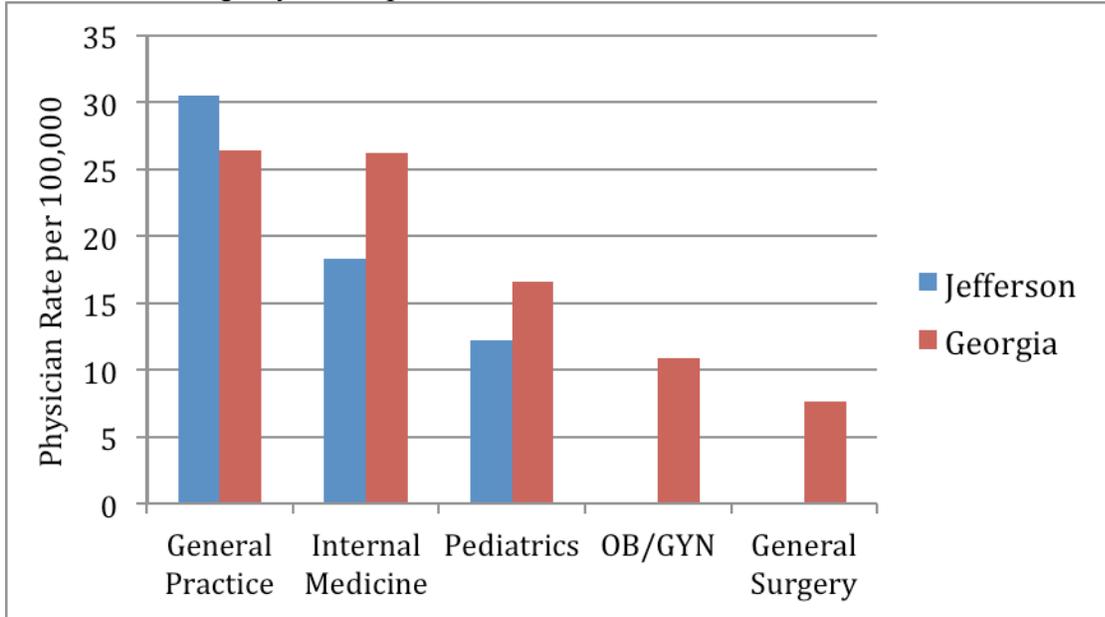
Preventive Care Services

	Jefferson County	Georgia
Diabetic screening	84%	83%
Mammography screening	64%	66%
Preventable hospital stays	96	68

County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation

Physician Workforce Summary

Rate of Practicing Physicians per 100,000 Residents



Georgia Board for Physician Workforce Report 2011

Physician workforce: In 2008, Jefferson County had a total of eighteen practicing physicians. The county did not have a general surgeon or gynecologist. The rates for the other generalist professions are similar to the state averages.

Total Number of Practicing Physicians in 2008

	Family Practice	Internal Medicine	Pediatric	OB/GYN	General Surgery	Total
Jefferson	5	3	2	0	0	18

Georgia Board for Physician Workforce Report 2011

Overview of Morbidity Rates (2001-2010)

Major Sources of Morbidity and Low Birth Weight

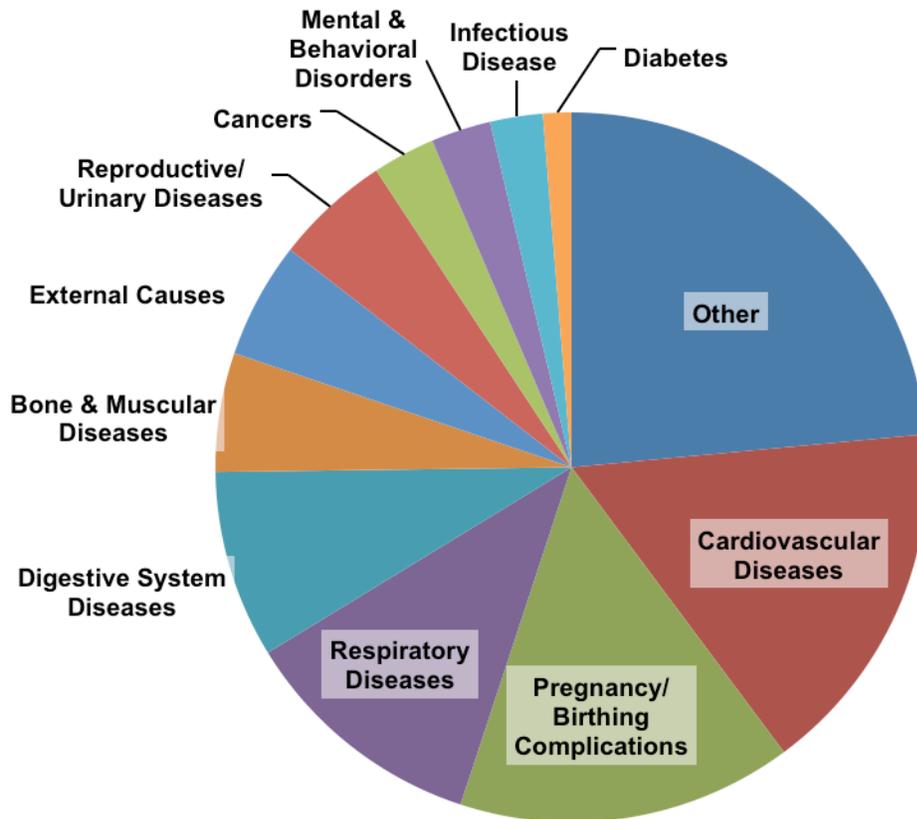
Cause of Morbidity	Service Area	Georgia
All Causes [†]	13,380.5	9,389.3
Major Cardiovascular Disease [†]	1,792.2	1,389.0
Cancers [†]	294.0	274.1
Respiratory Disease [†]	1,578.7	944.1
Infectious Disease [†]	550.1	305.9
Diabetes [†]	299.5	138.0
Low Birth Weight [‡]	11.3%	9.3%

[†]Age-adjusted, deduplicated discharge rate per 100,000. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

[‡] Proportion of live births with weight below 2,500 g

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Proportion of Deduplicated Discharges by Leading Causes of Morbidity



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Overview of Mortality Rates (2001-2010)

Summary of Major Causes of Mortality

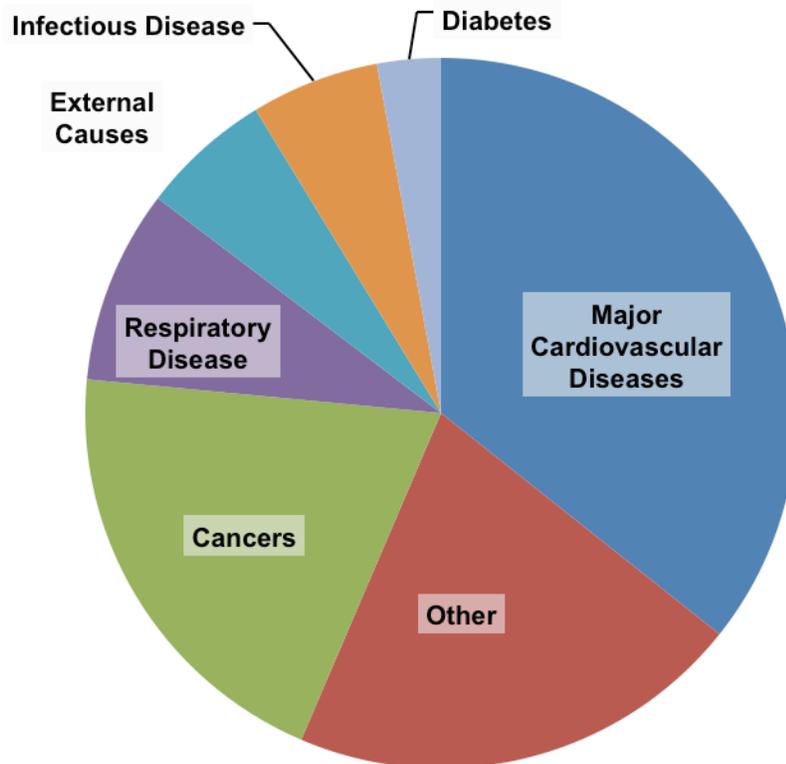
Cause of Death	Service Area	Georgia
All Causes [†]	1,080.20	883.8
Major Cardiovascular Disease [†]	381.4	302.2
Cancers [†]	214.1	185.6
Respiratory Disease [†]	94.6	88.7
Infectious Disease [†]	64.2	30.5
Diabetes [†]	30.7	21.5
Infant Mortality Rate [‡]	10.8	8.1

[†]Age-adjusted Death Rate per 100,000

[‡]Deaths per 1,000 live births

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Proportion of Deaths by Leading Causes of Mortality



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Trends in Morbidity

All Major Cardiovascular Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	177	2,095.9	1,695.4
White	151	1,482.3	1,297.5
Other	5	NSR	1,334.9
Total	334	1,792.2	1,398.8

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

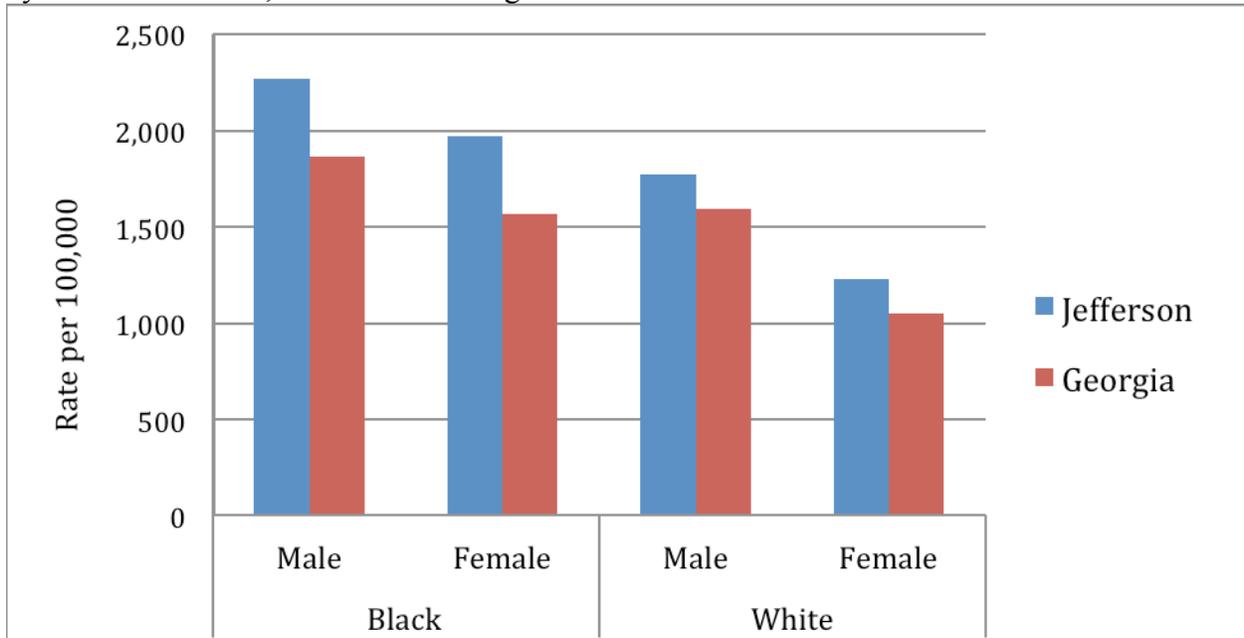
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Major cardiovascular diseases comprise one of the largest causes of morbidity in the service area. Major cardiovascular diseases include high blood pressure, obstructive heart failure, stroke, heart disease, and hardening of the arteries.

All Major Cardiovascular Diseases: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

High Blood Pressure: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	20	231.8	155.9
White	5	48.5	33.3
Other	1	NSR	53.4
Total	25	139.6	64.7

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

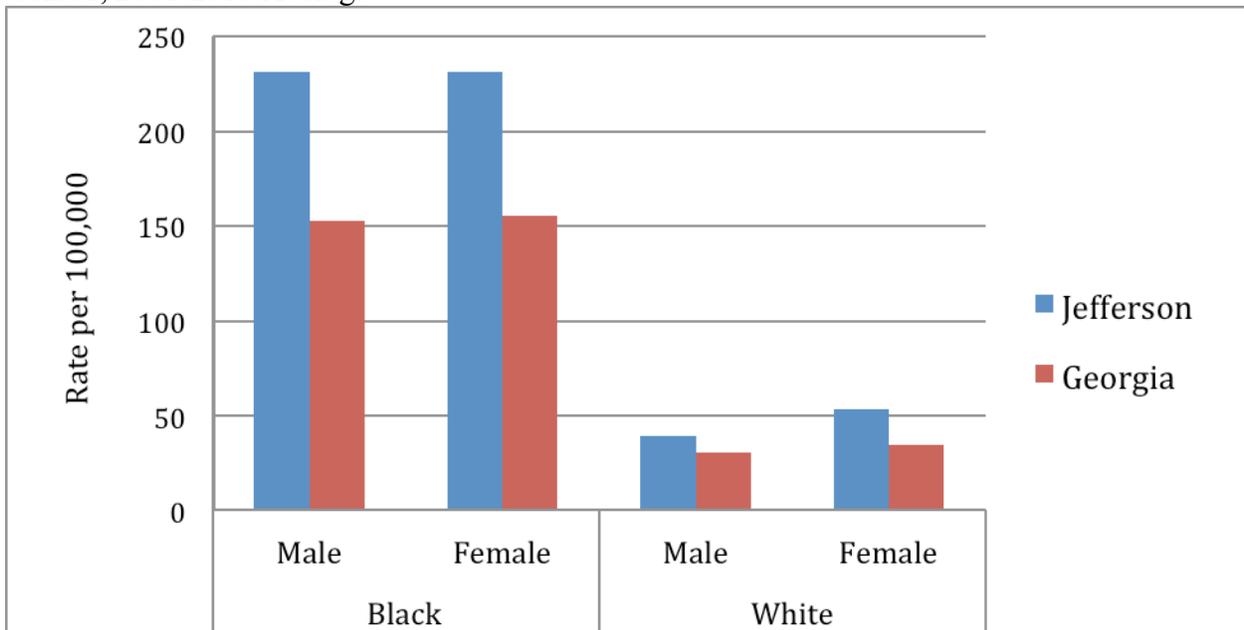
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Hospital discharges for high blood pressure are highest among African Americans. Rates are higher than the state average for all race and gender categories.

High Blood Pressure: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Stroke: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	28	337.7	288.4
White	22	210.8	191.5
Other	1	NSR	226.5
Total	51	271.3	215.8

[†] Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

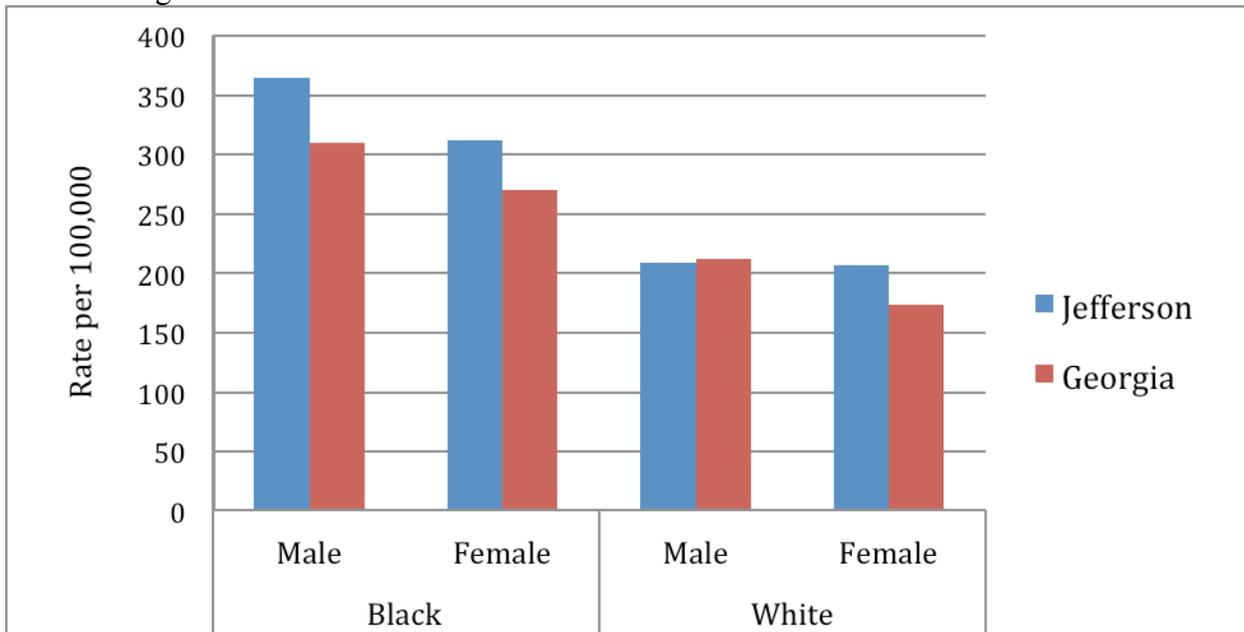
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The stroke rates in the service area are close to what would be expected given the age distribution of the hospital service area.

Stroke: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Obstructive Heart Disease: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	32	376.9	370.3
White	54	537.7	489.8
Other	2	NSR	511.4
Total	88	470.2	463.1

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

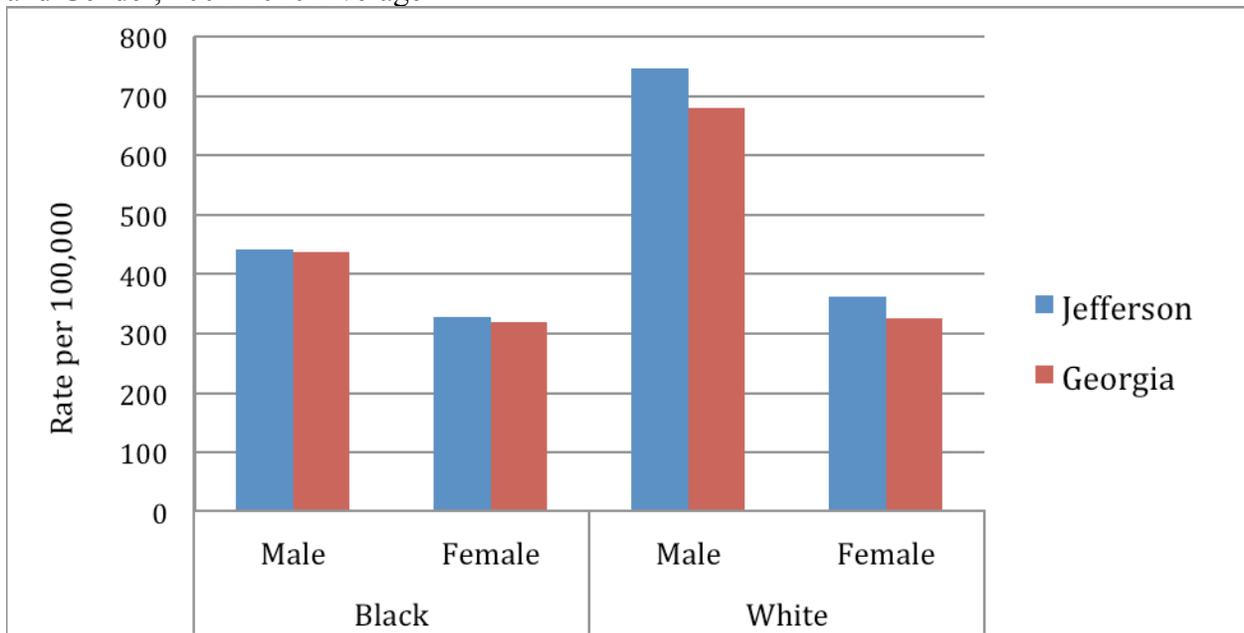
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Obstructive heart diseases (OHD) include hospital discharges from heart attacks. The rates of OHD are similar to the state averages.

Obstructive Heart Disease: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Respiratory Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	143	1,590.8	1,018.1
White	141	1,529.6	930.6
Other	3	NSR	692.3
Total	286	1,578.7	956.4

† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

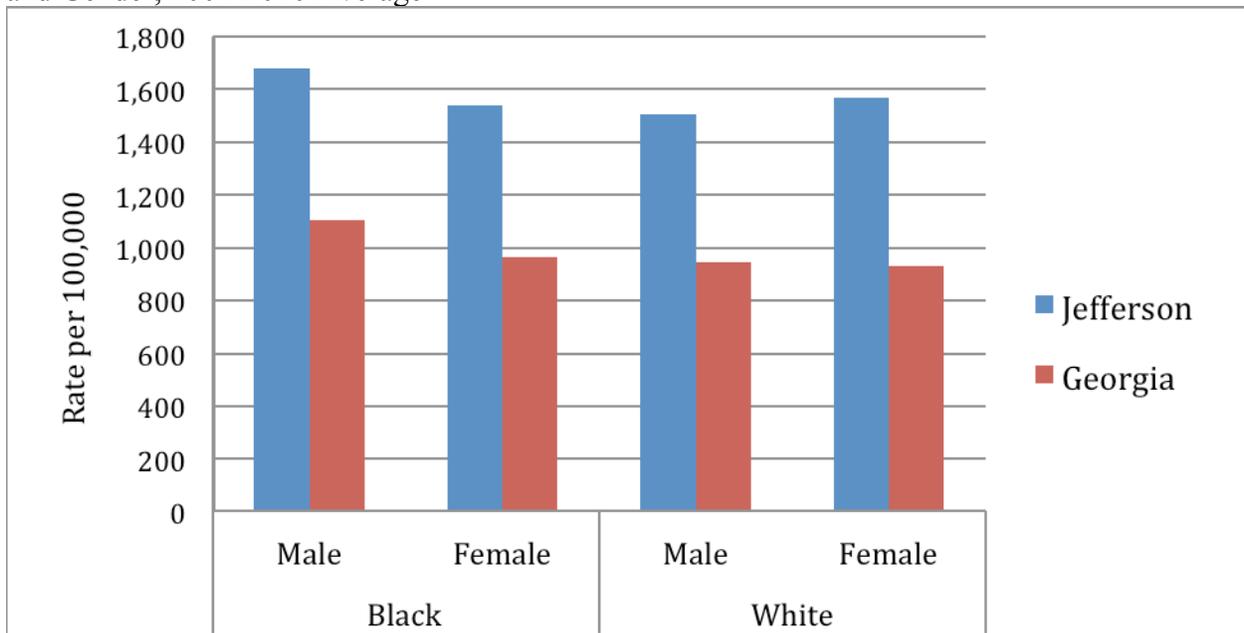
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of respiratory diseases are higher than the state averages. Rates are elevated for all race and gender classifications.

All Respiratory Diseases: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Asthma: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	28	297.4	164.1
White	8	105.8	85.2
Other	< 1	NSR	75.2
Total	37	211.2	108.0

[†] Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

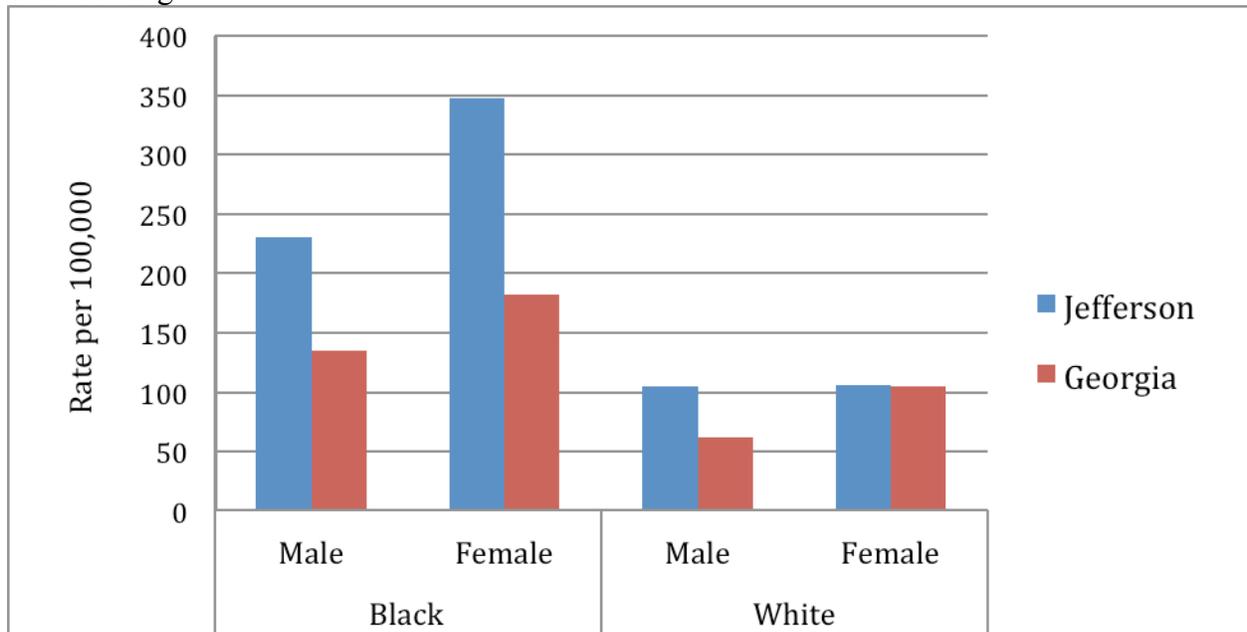
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of asthma are higher than the state averages, especially among black males and black females in the service area.

Asthma: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

External Causes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	48	540.6	395.7
White	56	661.5	496.5
Other	1	NSR	493.7
Total	106	611.8	477.2

† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

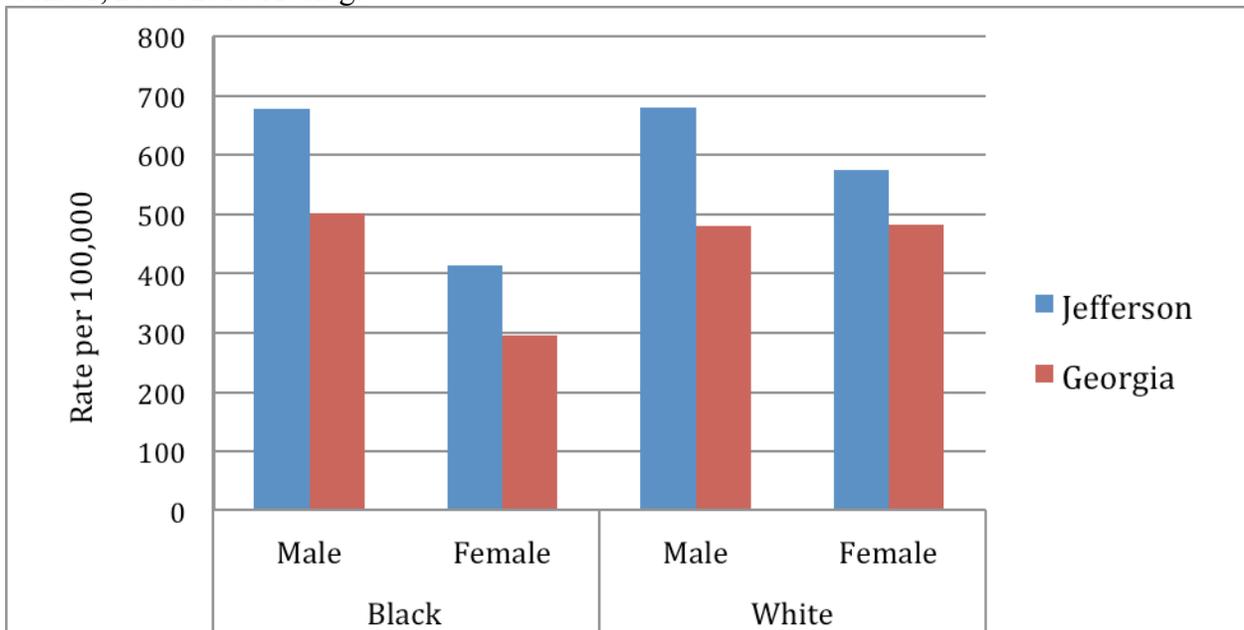
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

External causes of hospital visits include injuries from any type of accident, including intentional and unintentional causes. The hospital discharge rates are higher than the state average for all gender and race classifications.

External Causes: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Cancers: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	28	312.1	311.1
White	27	270.1	262.7
Other	1	NSR	295.8
Total	55	294.0	275.2

[†] Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

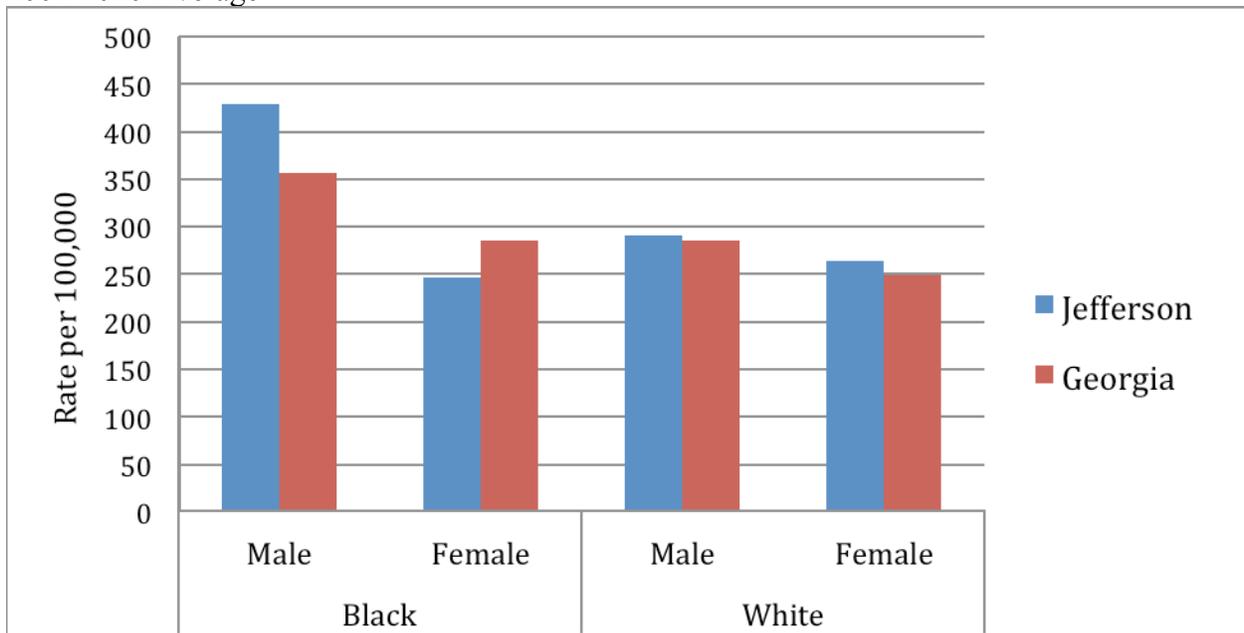
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

On average, 55 people per year visit the hospital as a result of cancer-related causes. Cancer rates in the service area are similar to the state rates.

All Cancers: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Breast Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Females

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	40.4	46.0
White	2	33.5	40.1
Other	< 1	NSR	31.6
Total	4	38.0	41.5

† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

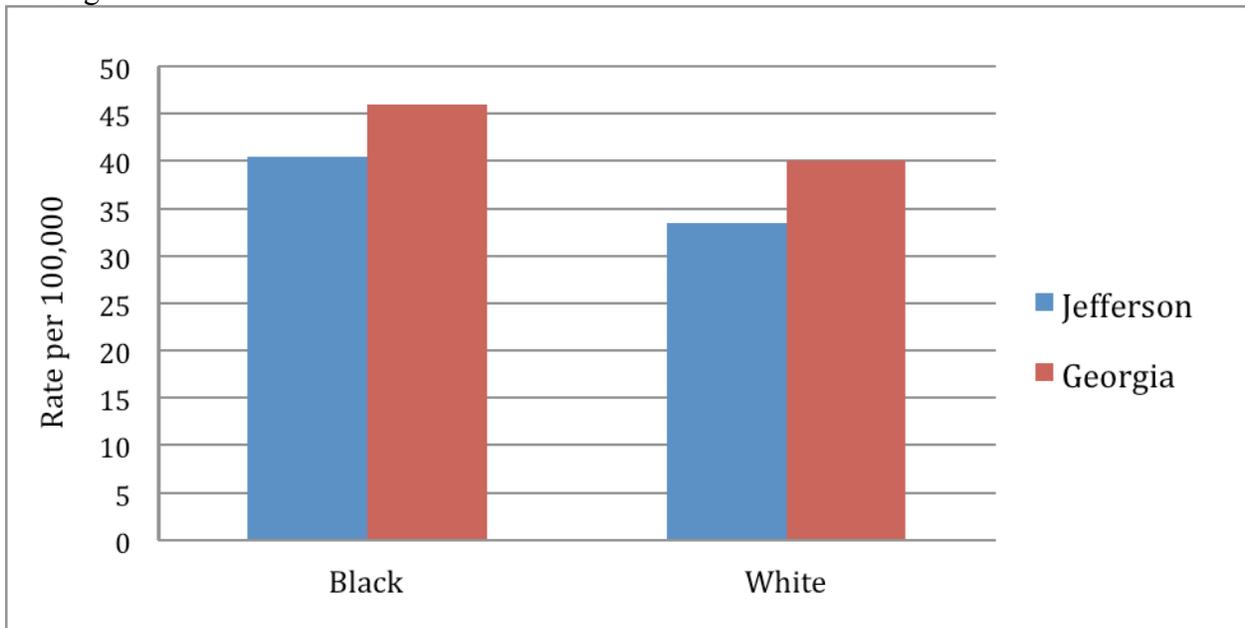
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Hospital discharge rates for breast cancer are similar to the state averages.

Breast Cancer: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Prostate Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Males

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	3	72.3	64.4
White	2	37.5	39.1
Other	< 1	NSR	39.1
Total	5	55.8	44.1

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

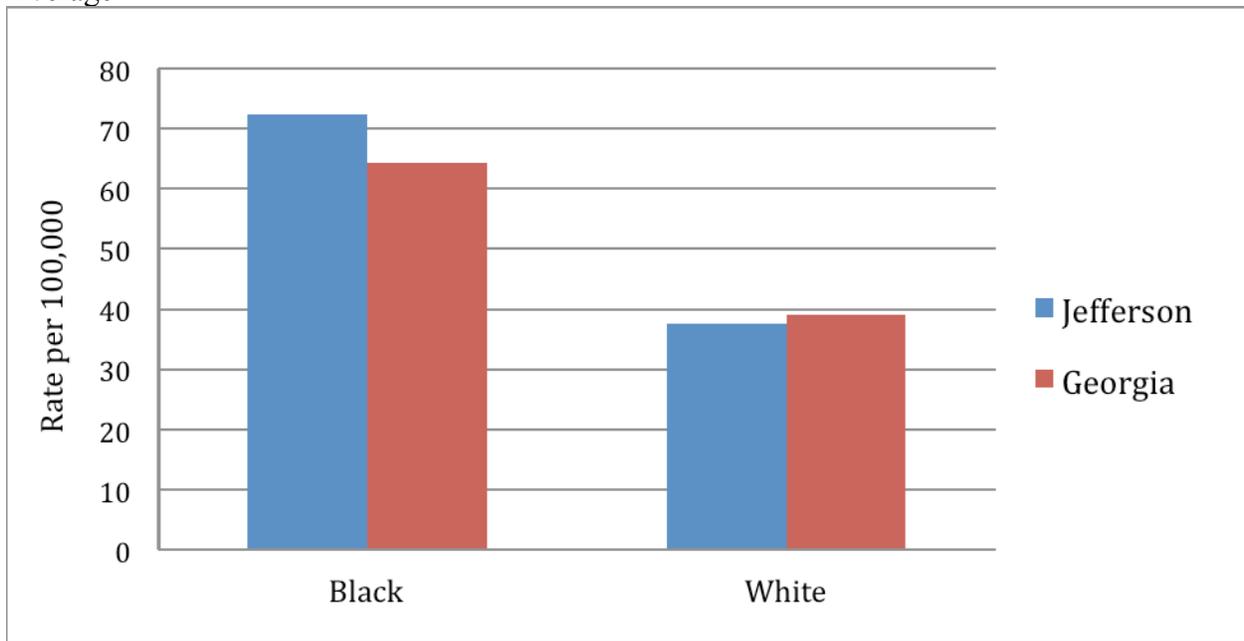
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of prostate cancer are similar to the state averages. Black males have a higher rate than white males.

Prostate Cancer: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Lung Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	4	39.7	37.3
White	4	39.8	36.6
Other	< 1	NSR	26.7
Total	8	39.7	36.6

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: -people are counted only once if readmitted for the same chronic condition during a calendar year.

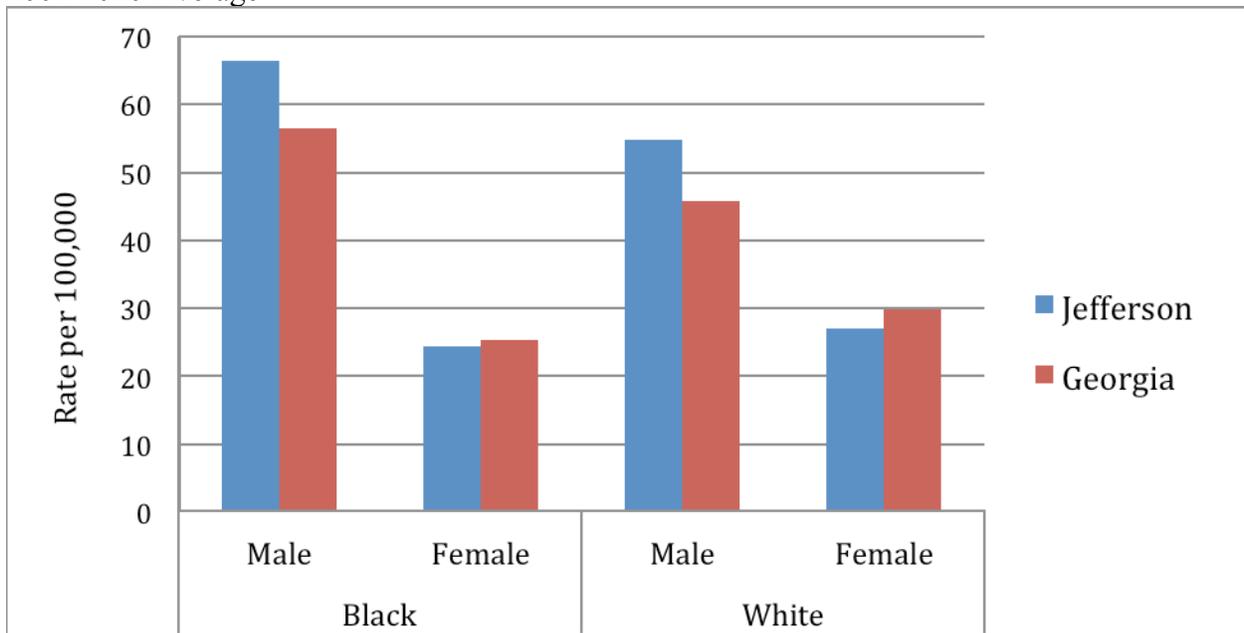
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of lung cancer are similar to the state averages. Rates are higher among males in the service area, possibly because of risk-taking behaviors such as smoking.

Lung Cancer: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Colon Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	6	66.8	47.3
White	4	40.8	37.7
Other	< 1	NSR	44.5
Total	10	53.4	40.1

† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

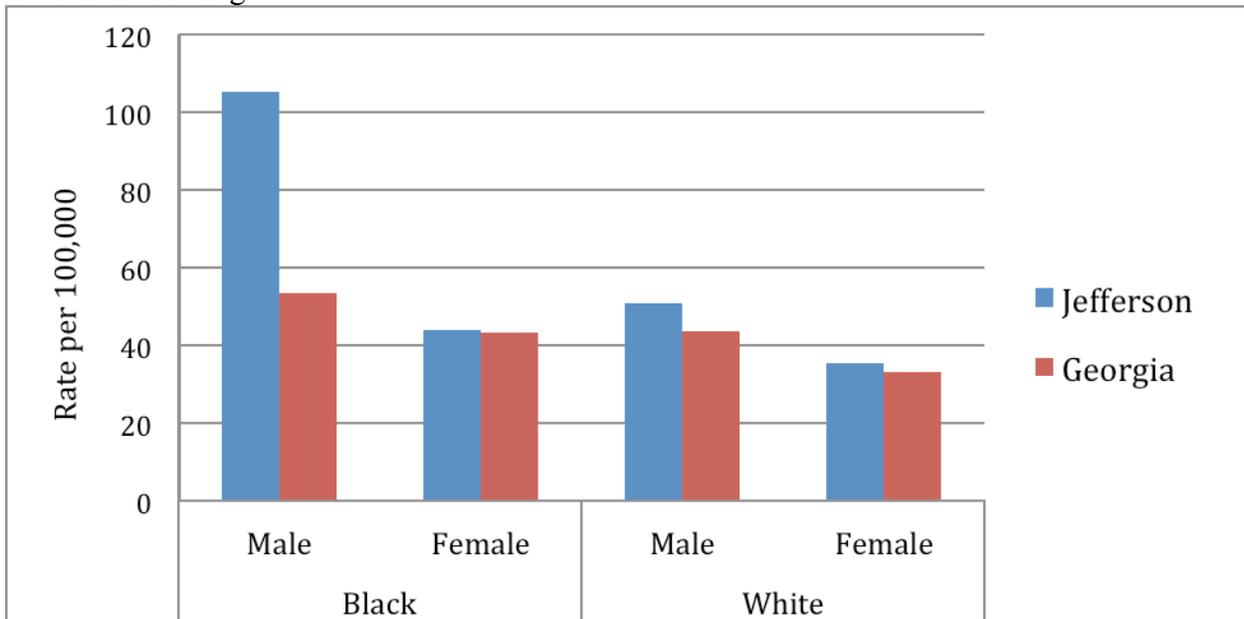
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Black males have rates of colon cancer that are higher than the state average.

Colon Cancer: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Diabetes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	42	478.8	269.7
White	11	127.6	95.8
Other	< 1	NSR	106.5
Total	53	299.5	139.0

[†] Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

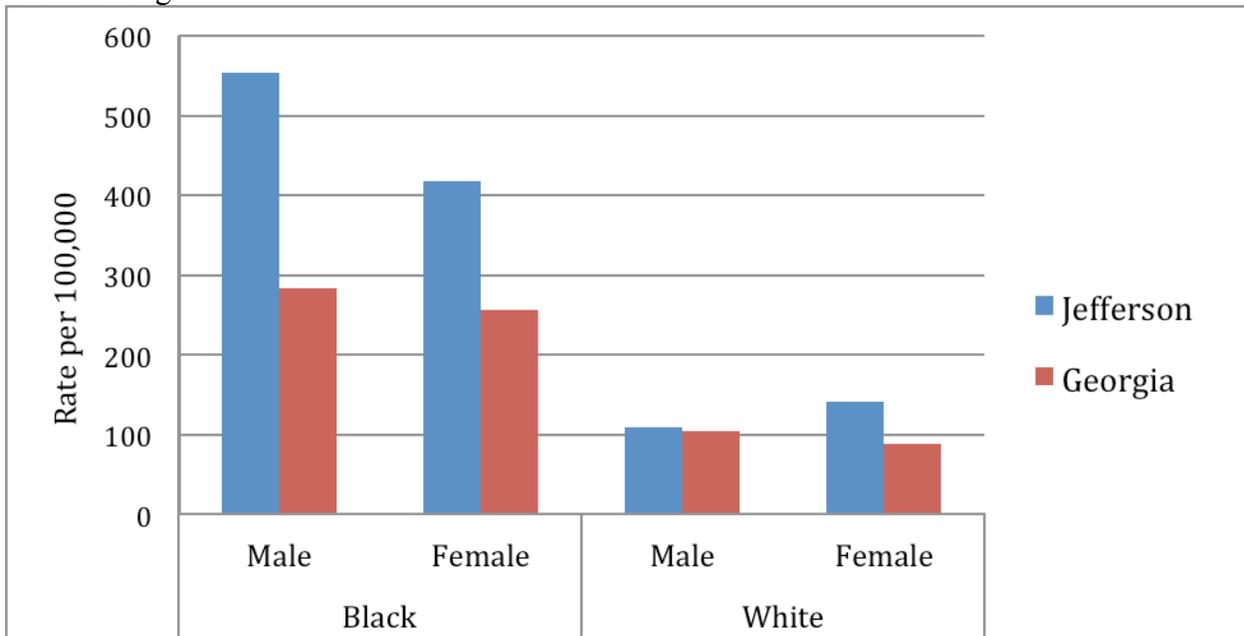
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The hospital visitation rate in the service area is higher than the state average. Black males and black females have elevated rates in comparison with the state average.

Diabetes: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Infectious and Parasitic Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	55	637.1	449.0
White	42	475.0	260.5
Other	1	NSR	279.7
Total	98	550.1	310.1

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

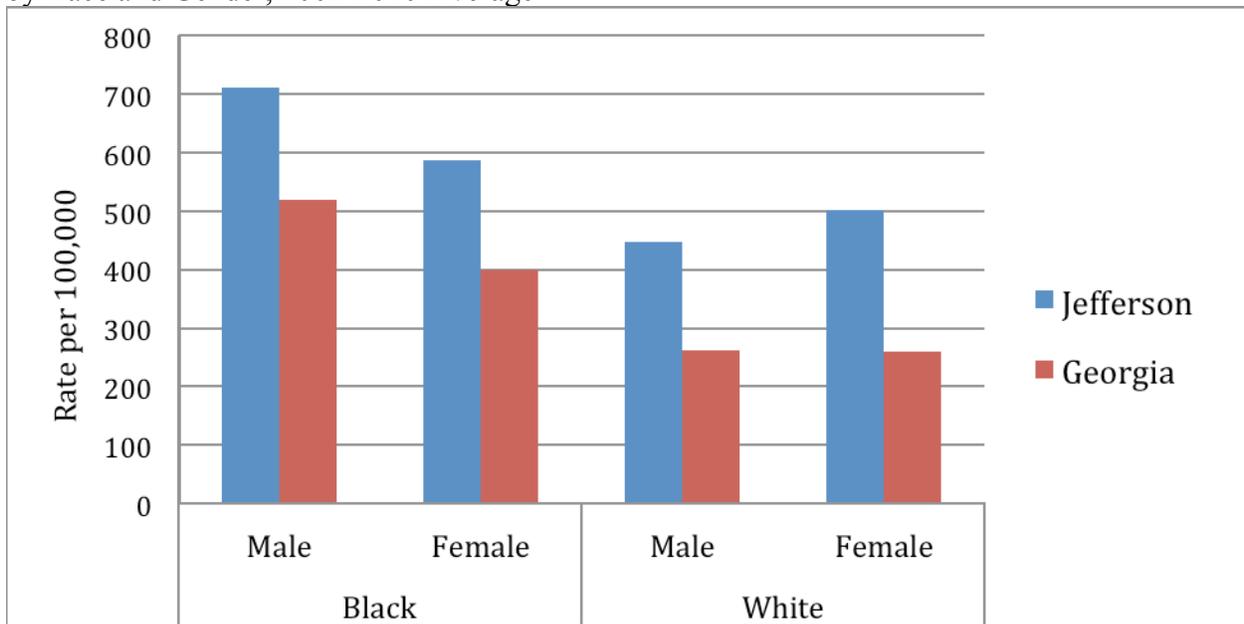
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area’s rates of hospital discharges as a result of infectious and parasitic diseases are higher than the state averages.

All Infectious and Parasitic Diseases: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

HIV/AIDS: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	5	55.0	97.2
White	< 1	NSR	9.3
Other	< 1	NSR	19.7
Total	5	33.5	35.6

[†] Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

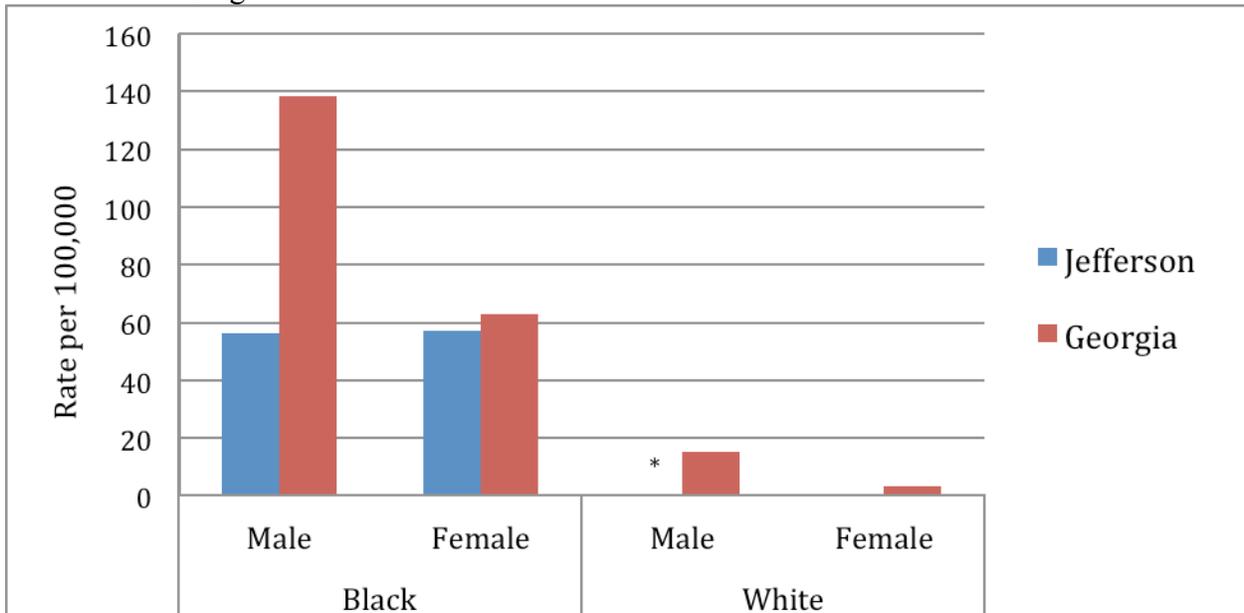
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

From 2001 to 2010, about five people per year went to the hospital as a result of AIDS.

HIV/AIDS: Age-Adjusted, Deduplicated Discharge Rates per 100,000 by Race and Gender, 2001-2010 Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Sexually Transmitted Disease (STD) Rate: Total STD Cases and New STD Cases per 100,000

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	114	1,219.7	1,062.6
White	5	64.2	87.9
Other	< 1	NSR	69.4
Total*	142	845.6	626.2

† Yearly average number of new STD cases per year from 2001-2010

‡ Average STD Incidence rate from 2001-2010

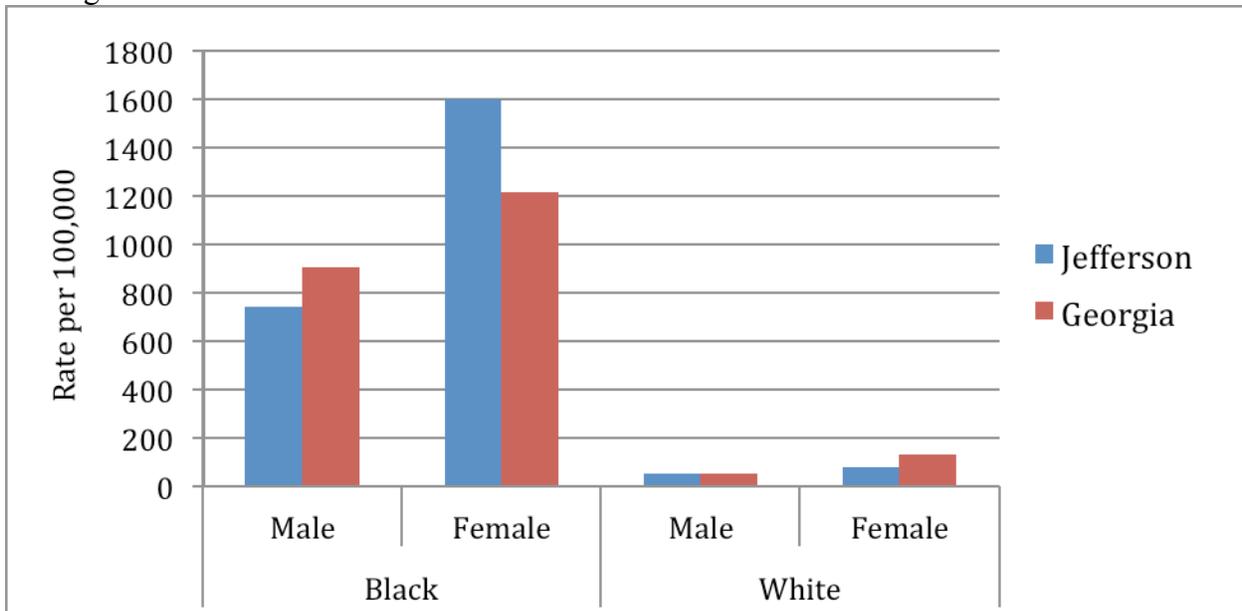
* Total case number includes cases with unknown race

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Typically, females have higher rates of STDs. The primary cause of this phenomenon is the greater susceptibility of female reproductive anatomy to STDs.

Sexually Transmitted Disease Rate: STD Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Chlamydia Rate: New Chlamydia Cases and Cases per 100,000 People

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	81	868.1	636.4
White	4	51.9	63.4
Other	< 1	NSR	46.4
Total*	102	609.0	416.1

† Average number of new STD cases per year from 2001-2010

‡ Average STD Incidence rate from 2001-2010

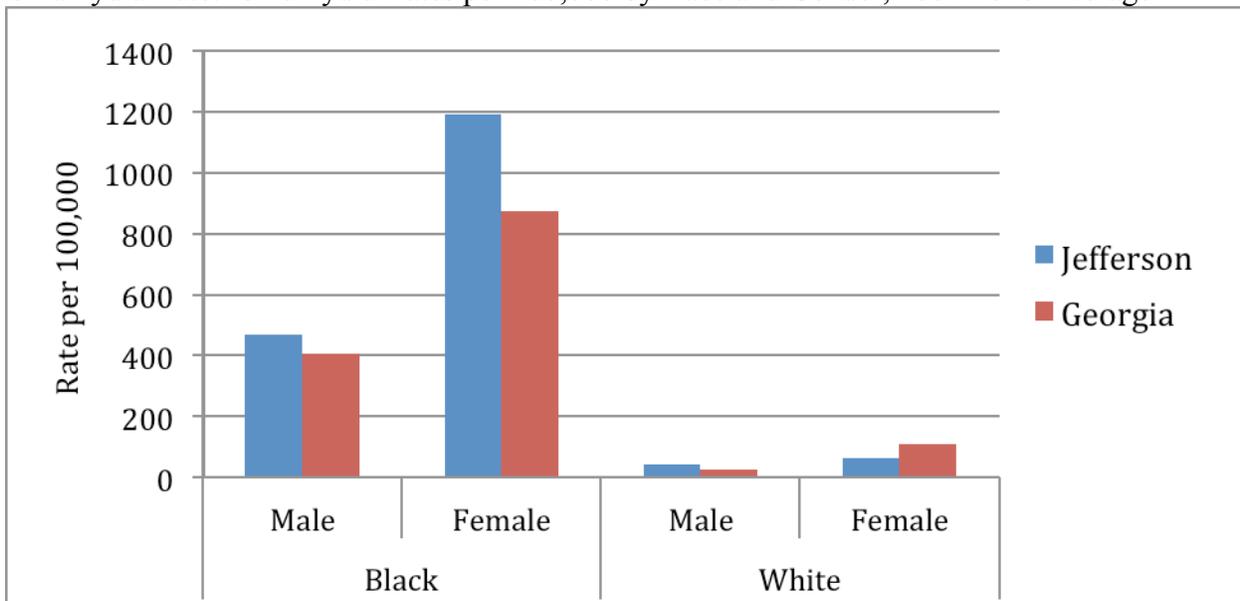
* Total case number includes cases with unknown race

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Black females have the highest chlamydia rates in the service area.

Chlamydia Rate: Chlamydia Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Gonorrhea Rate: New Gonorrhea Cases and Cases per 100,000 People

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	32	338.7	368.5
White	1	8.2	16.1
Other	0	0.0	16.8
Total*	38	227.8	186.0

† Average number of new STD cases per year from 2001-2010

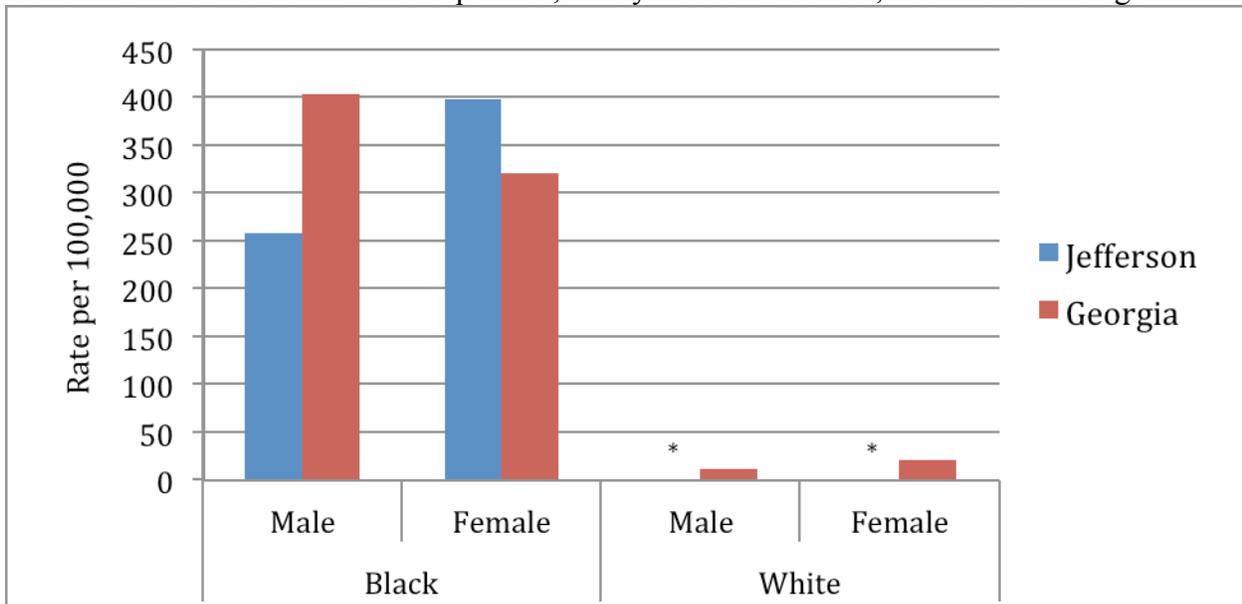
‡ Average STD Incidence rate from 2001-2010

* Total case number includes cases with unknown race

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Gonorrhea rates in the service area are similar to the state averages. Rates could not be calculated for white males and white females because there were an insufficient number of cases to calculate a statistically reliable rate.

Gonorrhea Rate: Gonorrhea Rates per 100,000 by Race and Gender, 2001-2010 Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Trends in Mortality

All Major Cardiovascular Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	34	464.4	380
White	31	326.6	291.9
Other	< 1	NSR	100.0
Total	65	388.0	308.3

† Average number of deaths per year from 2001-2010

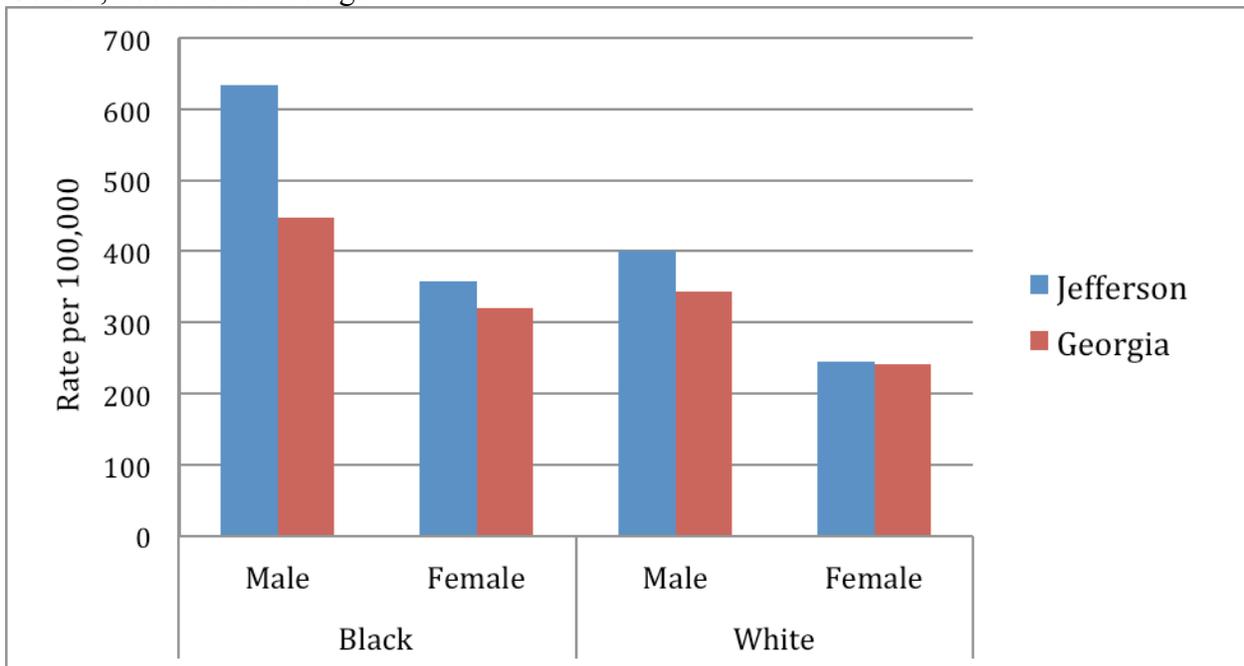
‡ Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Major cardiovascular diseases include high blood pressure, obstructive heart disease, stroke, and hardening of the arteries. As an aggregate, cardiovascular diseases are the leading cause of mortality in the service area.

All Major Cardiovascular Diseases: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Stroke: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	7	90.7	74.2
White	5	55.5	51.5
Other	< 1	NSR	24.0
Total	12	69.1	56.2

[†] Average number of deaths per year from 2001-2010

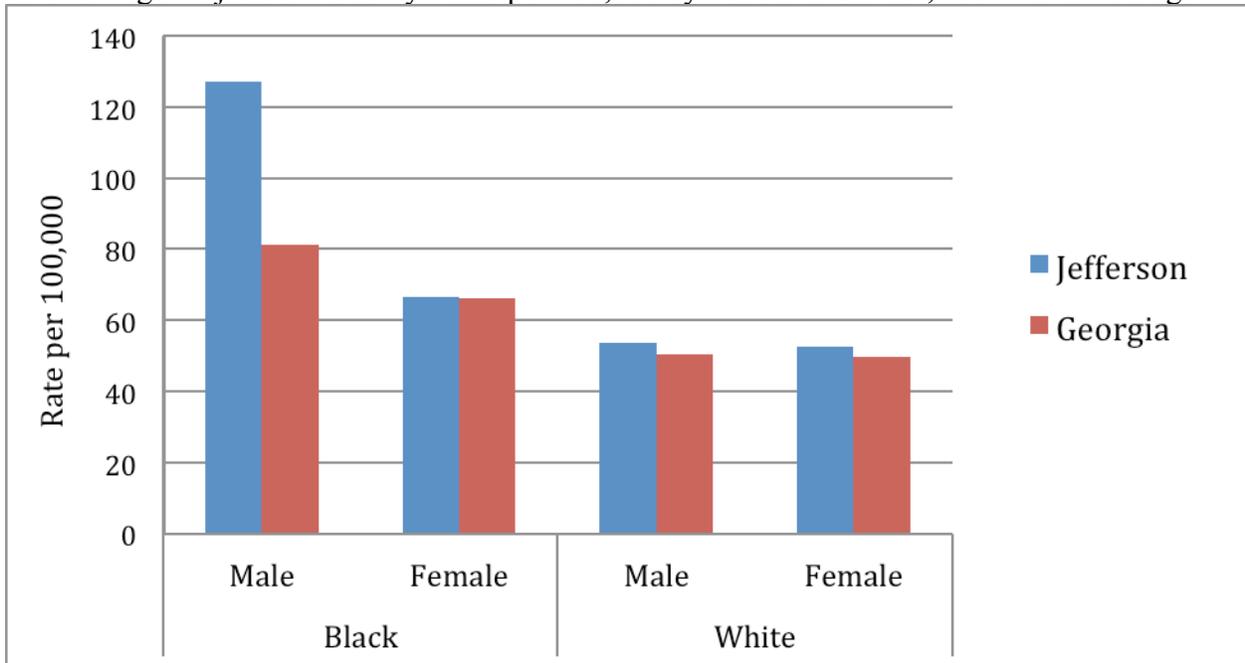
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

On average, twelve people die per year from stroke-related causes. Rates are elevated for black males.

Stroke: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

High Blood Pressure: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	3	46.3	25.4
White	2	19.3	8.7
Other	< 1	NSR	3.8
Total	5	30.7	12.1

[†] Average number of deaths per year from 2001-2010

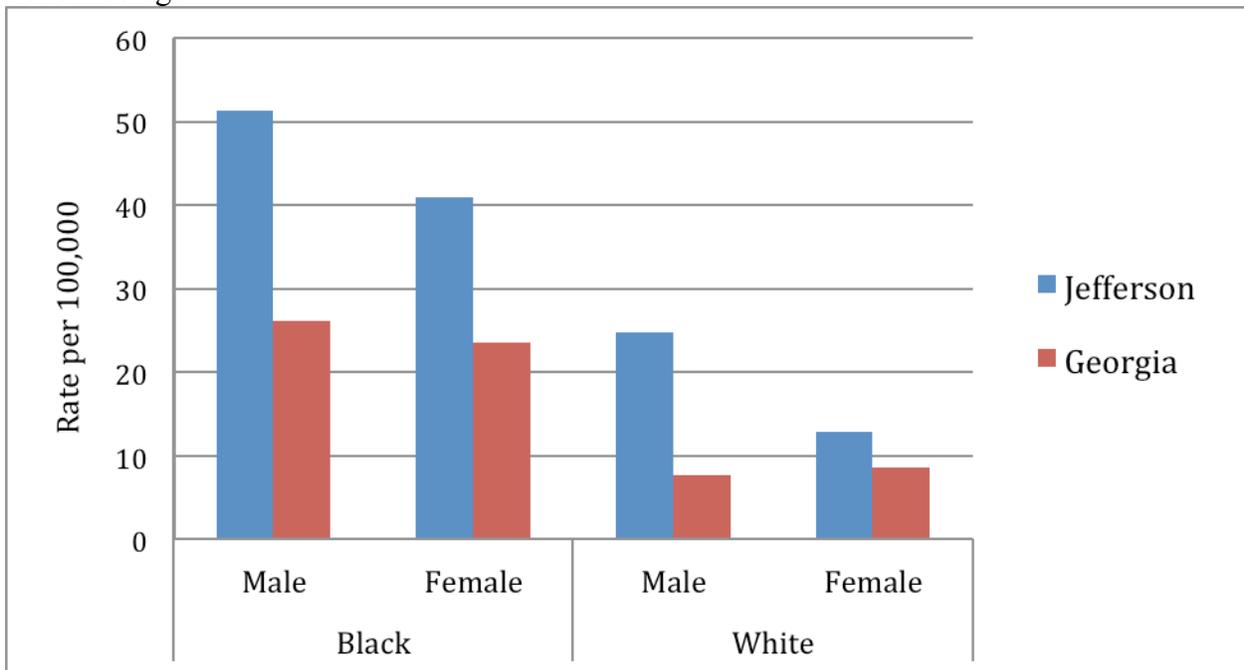
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

High blood pressure mortality comprises a small proportion of deaths in comparison with other types of cardiovascular diseases. Mortality rates are higher in the service area compared with the state average.

High Blood Pressure: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Obstructive Heart Disease: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	11	144.5	124.7
White	13	135.9	119.3
Other	< 1	NSR	35.8
Total	24	141.2	119.0

[†] Average number of deaths per year from 2001-2010

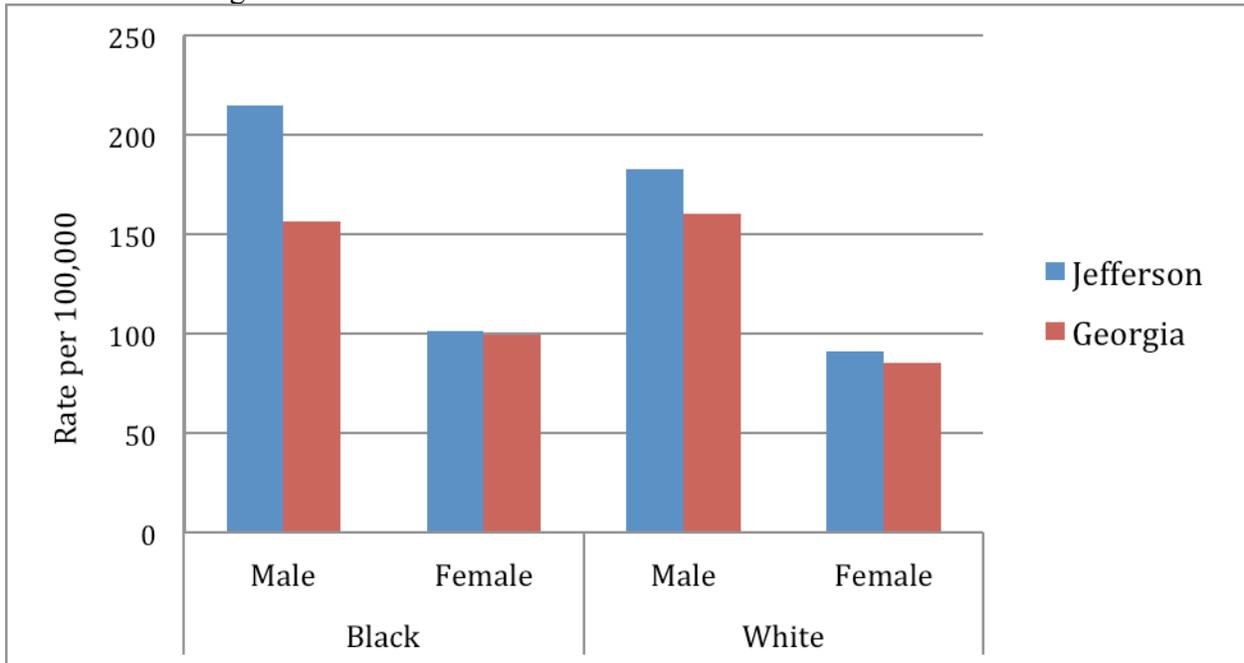
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Heart attacks are included within the obstructive heart disease (OHD) classification. Mortality rates are highest among males in the service area.

Obstructive Heart Failure: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Respiratory Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	6	78.7	67.8
White	9	95.6	97.4
Other	< 1	NSR	22.9
Total	15	89.4	90.3

[†] Average number of deaths per year from 2001-2010

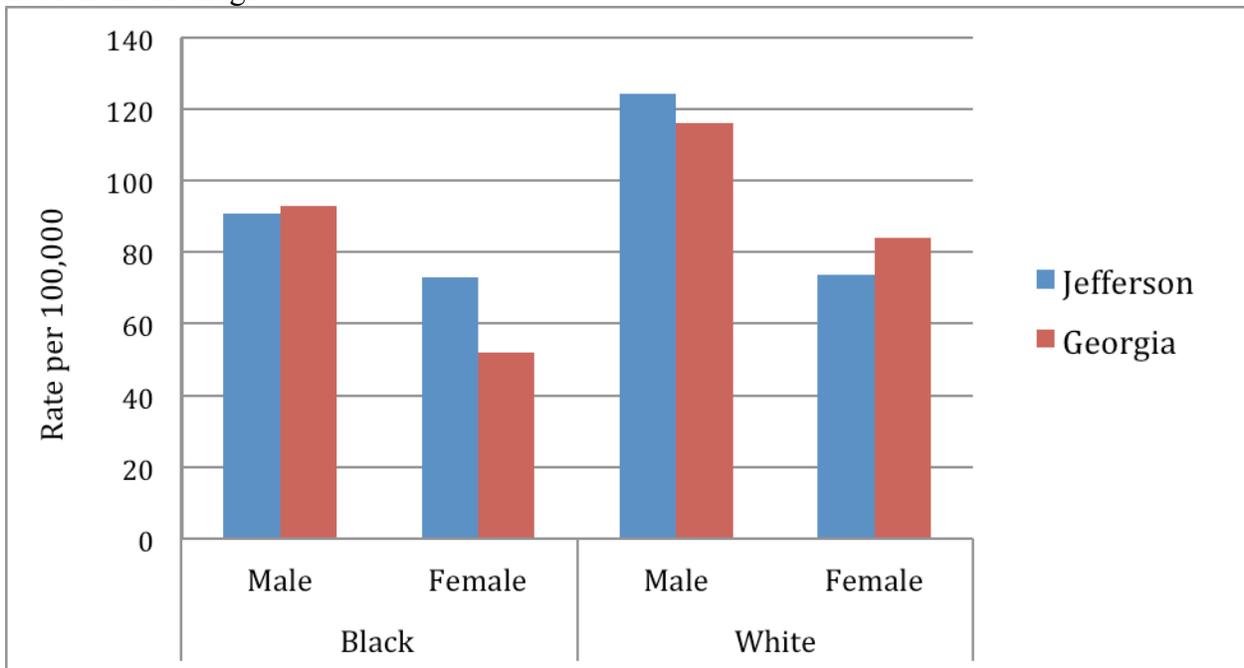
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted mortality rates in the service area are similar to the state averages. White males have the highest rate.

All Respiratory Diseases: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Cancers: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	17	222.0	213.8
White	20	211.4	182.2
Other	< 1	NSR	71.6
Total	36	215.7	186.8

[†] Average number of deaths per year from 2001-2010

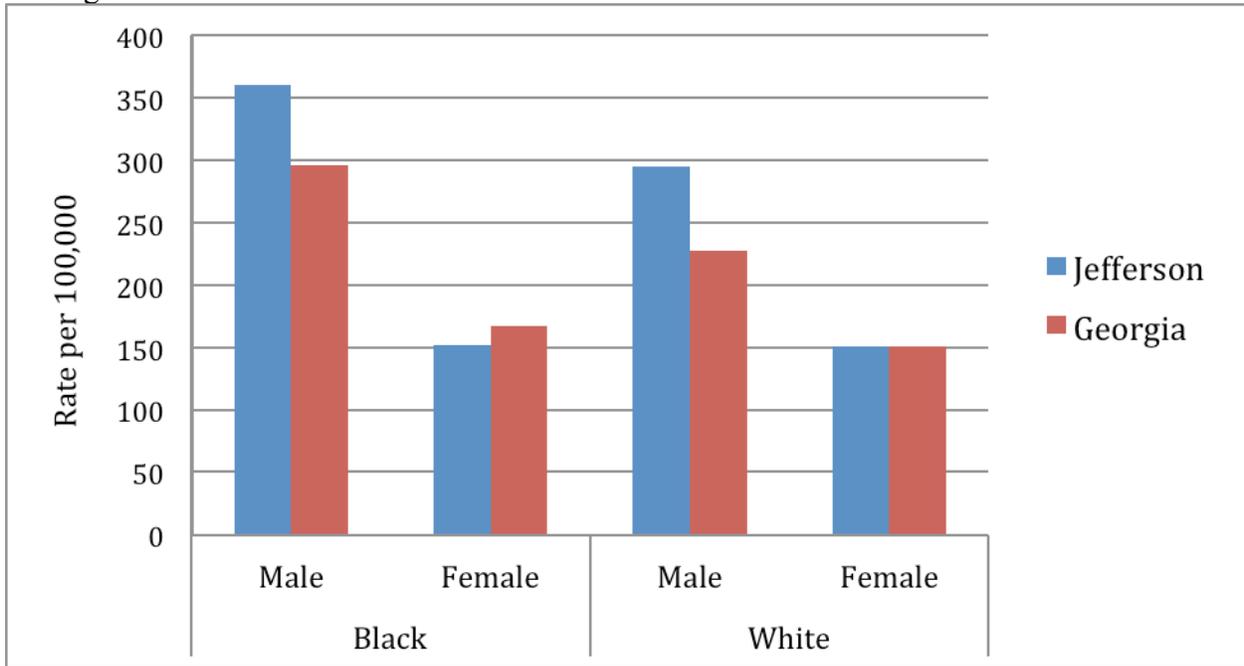
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

On average, the service area experiences 36 cancer deaths per year. The mortality rates in the service area are similar to the state averages.

All Cancers: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Breast Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Females

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	30.3	30.3
White	1	25.9	22.3
Other	< 1	NSR	7.6
Total	3	27.9	24.0

[†] Average number of deaths per year from 2001-2010

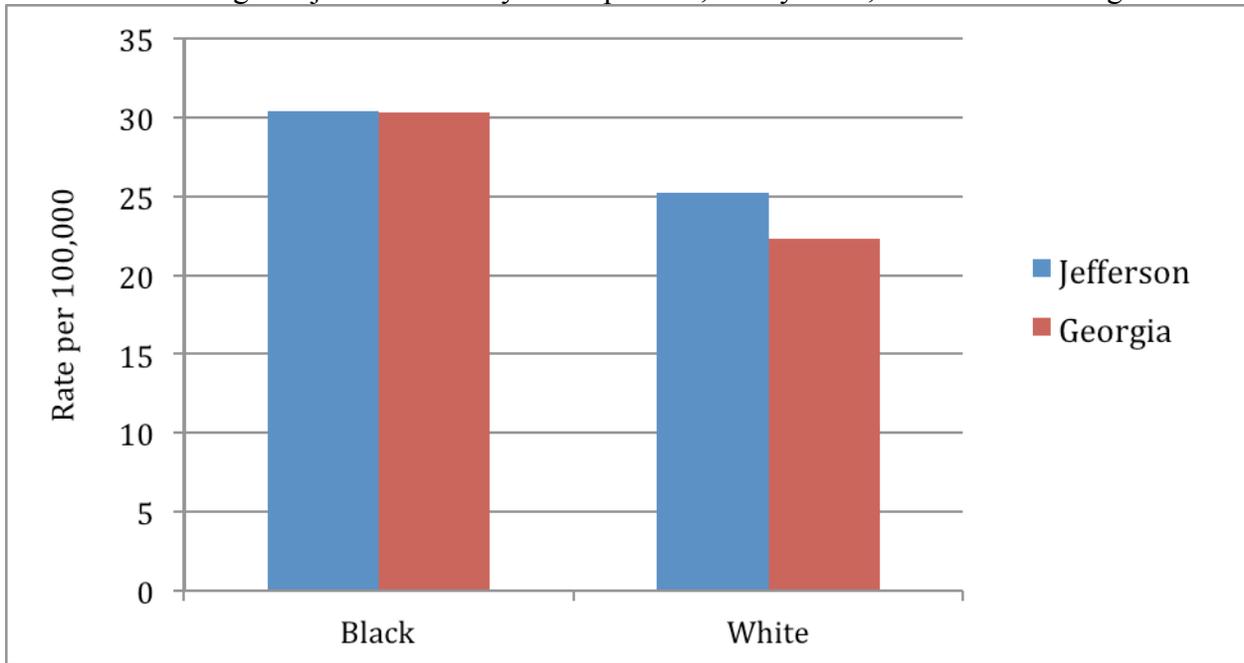
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The breast cancer mortality rate is similar to the state average. On average, three people in the service die per year from breast cancer.

Breast Cancer: Age-Adjusted Mortality Rates per 100,000 by Race, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Prostate Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Males

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	70.0	63.8
White	< 1	NSR	22.2
Other	< 1	NSR	7.1
Total	2	35.0	29.3

[†] Average number of deaths per year from 2001-2010

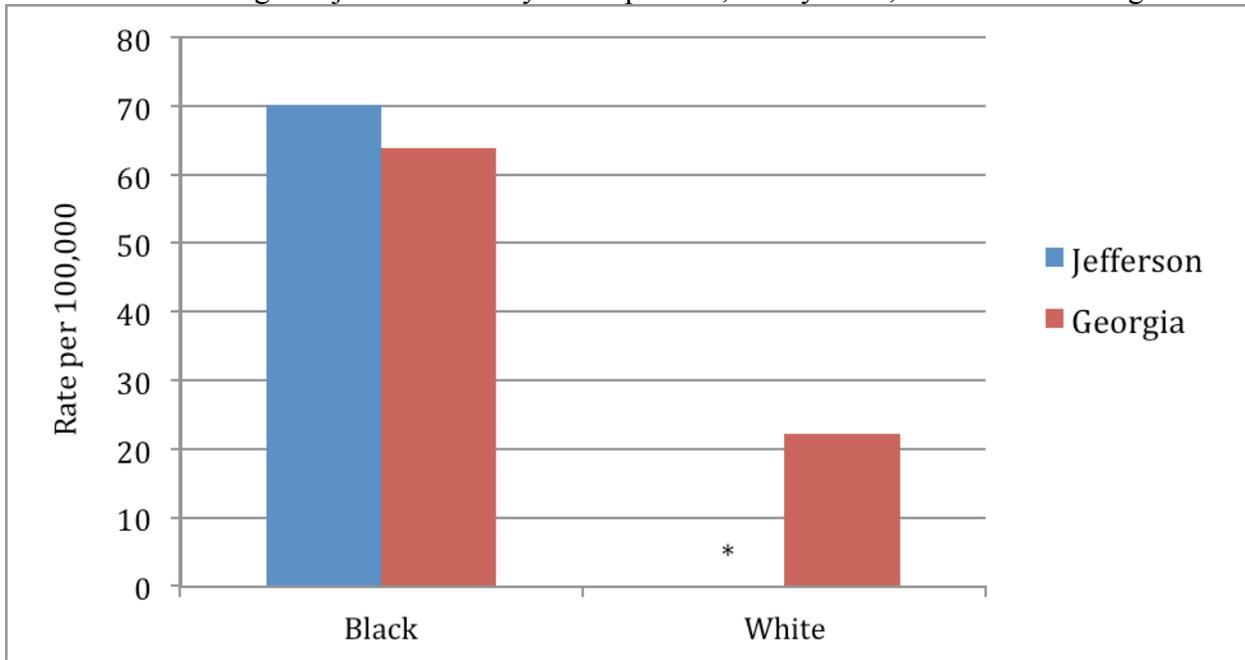
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rate for white males could not be reported because there were an insufficient number of deaths to calculate a statistically reliable rate.

Prostate Cancer: Age-Adjusted Mortality Rates per 100,000 by Race, 2001-2010 Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Colon Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	32.1	24.4
White	1	12.7	16.1
Other	< 1	NSR	7.9
Total	4	20.9	17.7

[†] Average number of deaths per year from 2001-2010

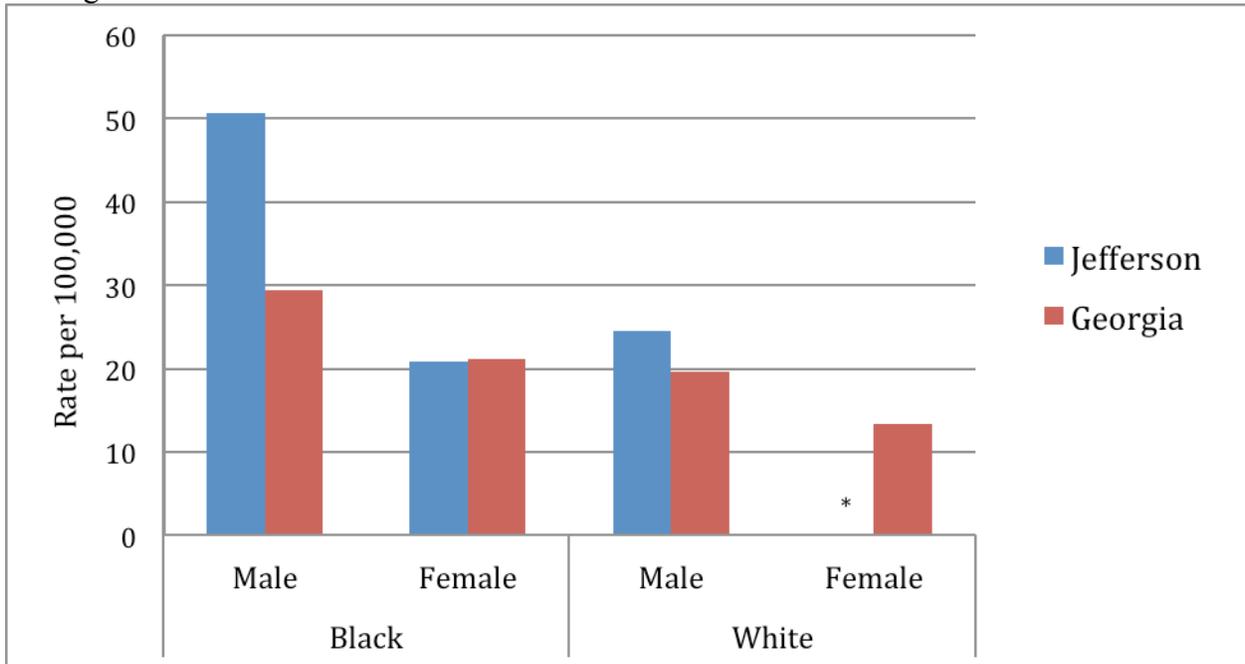
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Black males have a mortality rate that is higher than the state average.

Colon Cancer: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Lung Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	4	59.3	51.3
White	7	73.1	58.1
Other	< 1	NSR	16.0
Total	11	67.4	55.7

[†] Average number of deaths per year from 2001-2010

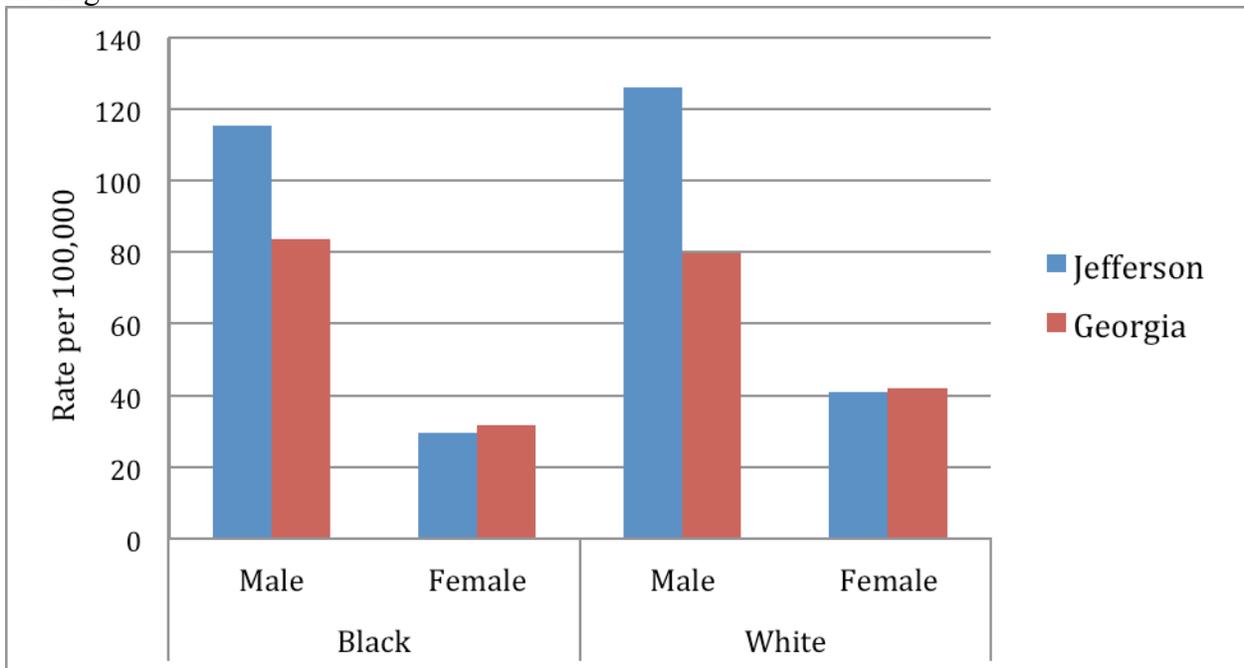
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The lung cancer rates are higher for males than females in the service area. Health behaviors, such as smoking, could be a factor in the difference.

Lung Cancer: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

All Infectious Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	7	87.8	56.1
White	4	38.5	22.9
Other	< 1	NSR	9.5
Total	10	62.3	30.9

[†] Average number of deaths per year from 2001-2010

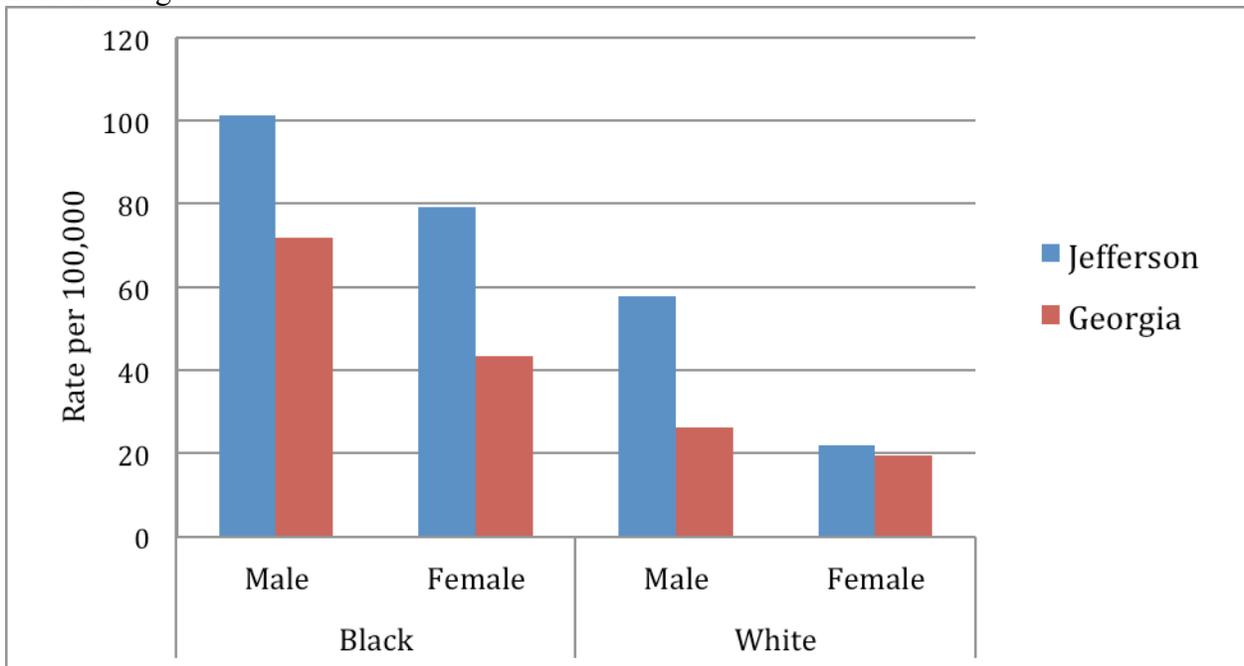
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The mortality rates for infectious diseases are higher among black males, black females, and white males in the population.

All Infectious Diseases: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

HIV/AIDS: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	22.7	19.7
White	< 1	NSR	2.3
Other	< 1	NSR	0.7
Total	2	13.1	7.1

[†] Average number of deaths per year from 2001-2010

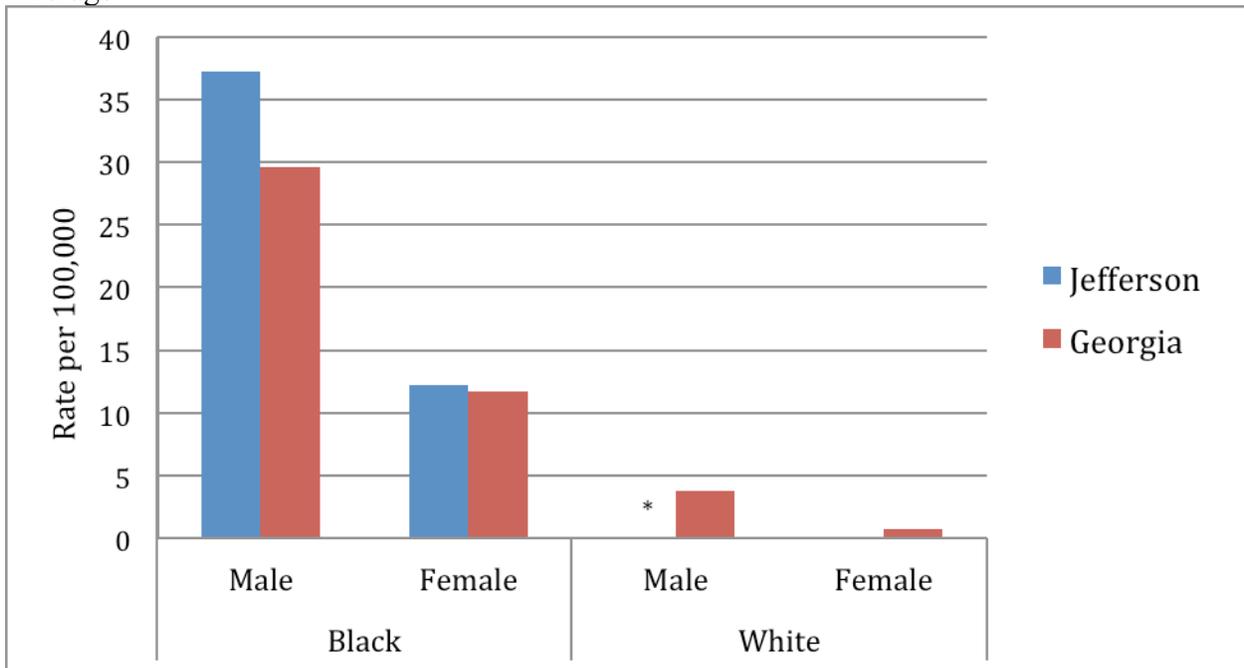
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area experienced an average of two deaths per year as a result of AIDS. Statistically reliable rates could not be calculated for white males. No deaths occurred among white females.

HIV/AIDS: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010
Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Diabetes: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	3	45.3	38.4
White	1	13.9	17.4
Other	< 1	NSR	9.8
Total	5	27.7	21.7

[†] Average number of deaths per year from 2001-2010

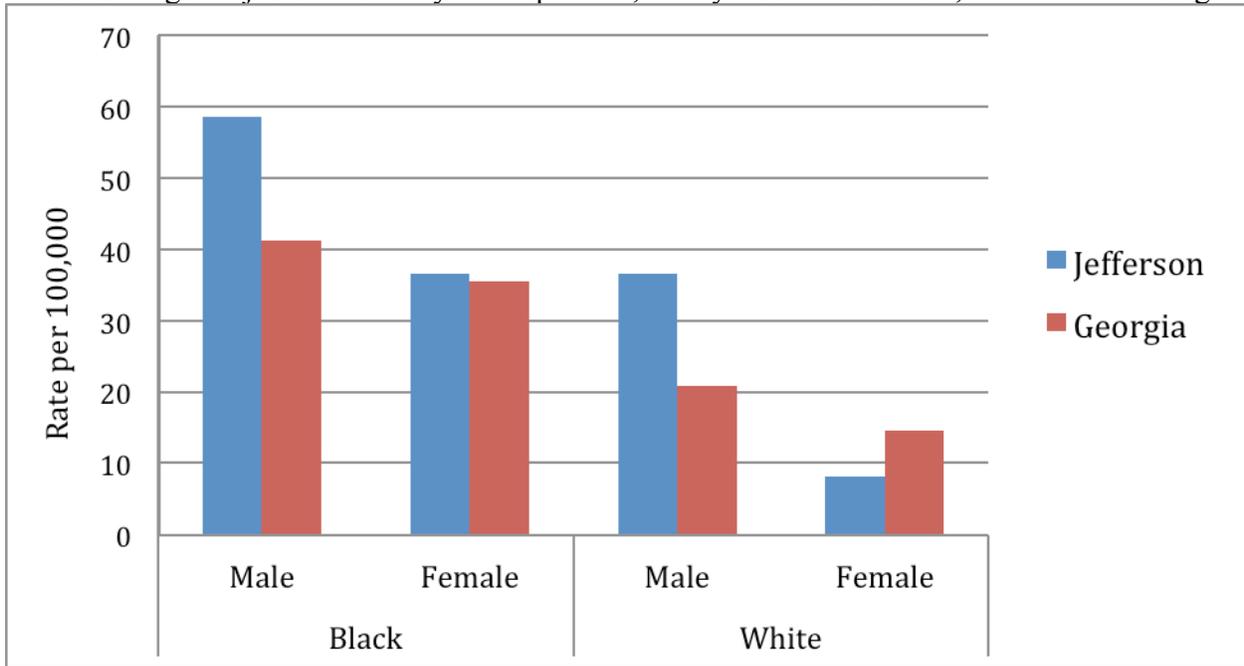
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The total diabetes mortality rate similar to the state average.

Diabetes: Age-Adjusted Mortality Rates per 100,000 by Race and Gender, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Maternal and Child Health

Prenatal care: Number and Proportion of Births Less Than 5 Prenatal Care Visits

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	6	5.0%	7.4%
White	2	3.0%	4.1%
Other	0	0.0%	4.0%
Total	8	4.3%	5.1%

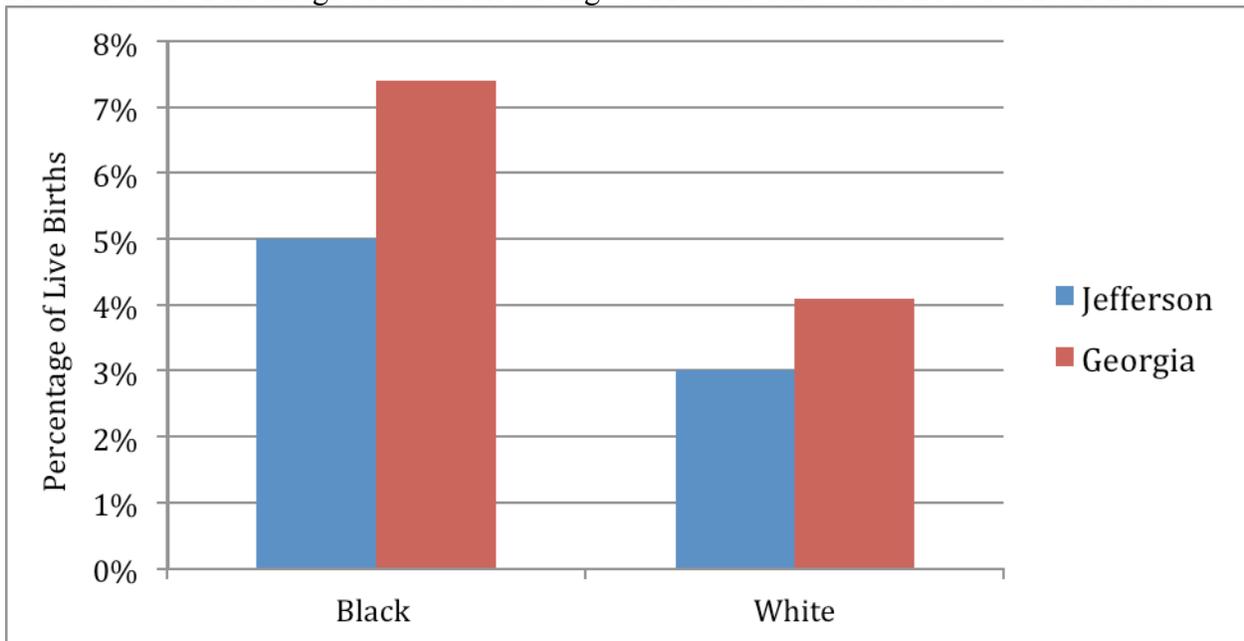
†Average number of births without at least 5 prenatal care visits per calendar year from 2001-2010.

‡ Percentage of births without at least 5 prenatal care visits per year from 2001-2010.

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Mothers in the service area receive the recommended number of prenatal care visits at higher rates than the state average.

Prenatal Care: Percentage of Births Receiving <5 Prenatal Care Visits Between 2001-2010



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Infant Mortality Rate: Deaths & Mortality Rates per 1,000 Live Births

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	3	15.9	12.9
White	< 1	NSR	6.2
Other	0	0.0	11.7
Total	3	10.8	8.1

[†] Average number of infant deaths (aged 0-11 months) per year from 2001-2010

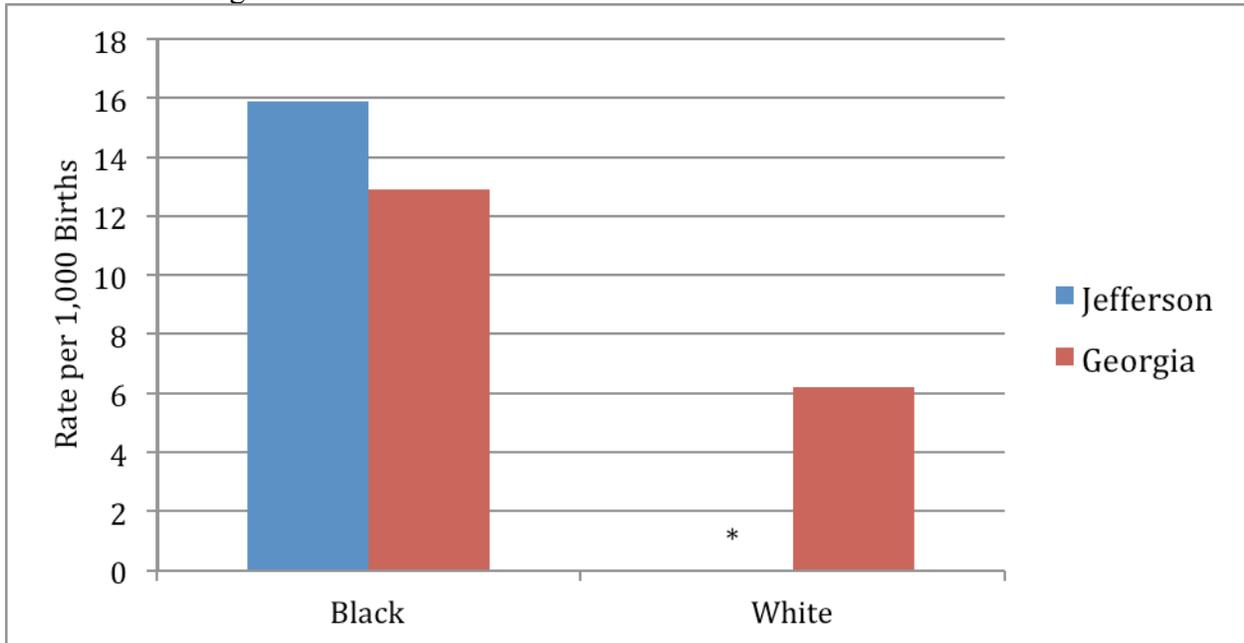
[‡] Average Infant Mortality Rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The infant mortality rate in the service area is higher than the state average.

Infant Mortality Rate: Age-Adjusted Mortality Rates per 1,000 Live Births by Race and Gender, 2001-2010 Average



* Insufficient number of deaths to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Low Birth Weight: Percentage of Births Less Than 2500g (5lbs 8oz.)

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	24	14.4%	13.8%
White	5	5.9%	7.1%
Other	< 1	NSR	8.4%
Total	29	11.3%	9.3%

† Average number of low birth births per year from 2001 to 2010

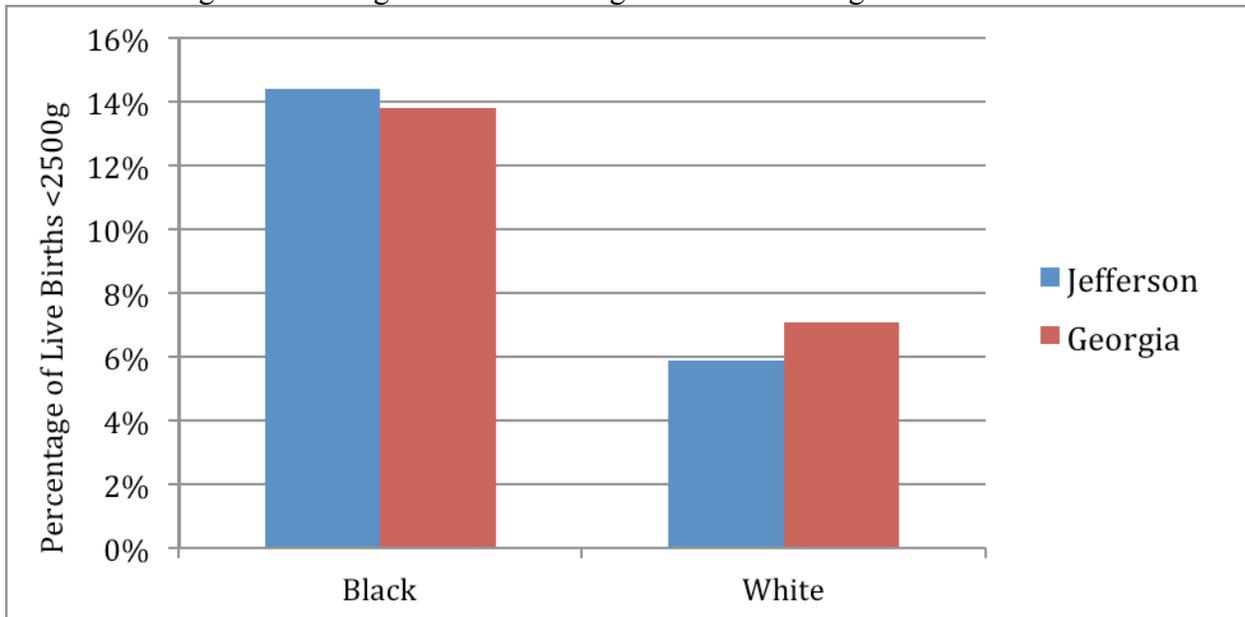
‡ Ten year average low birth weight rate from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The percentage of low birth weight babies is similar to the state average. African Americans in the service area have higher rates of births weighing less than 5lbs 8oz.

Low Birth Weight: Percentage of Births Having a Low Birth Weight from 2001-2010



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Low Birth Weight for Teen Births: Percentage of Births Less Than 2500g (5lbs 8oz.) for Mothers Aged 10-19

	Service Area (Births) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	6	15.4%	14.8%
White	1	5.1%	8.5%
Other	< 1	NSR	10.6%
Total	7	13.8%	11.4%

[†] Average number of low birth weight births from 2001-2010 for mothers aged 10-19

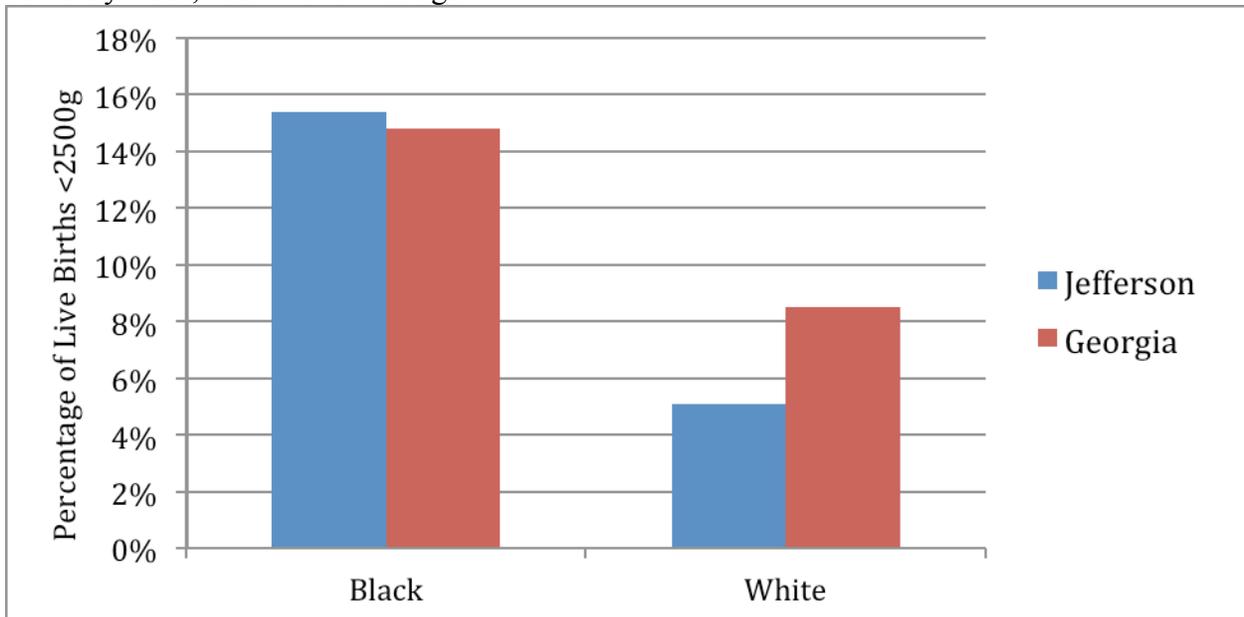
[‡] Average Percentage of Birth below 2500g for mothers aged 10-19 from 2001-2010

NSR: Not statistically reliable

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Teen mothers are those younger than 20 years old. The proportion of teen mothers that had a child weighing less than 5lb 8oz is similar to the state average.

Low Birth Rate Percentage: Percentage of Live Births under 2500g for Mothers Females Aged 10-19 by Race, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Teen Birth Rate: Live Births per 1,000 Females Aged 10-19

	Service Area (Births) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	37	46.9	30.5
White	10	22.8	20.9
Other	1	67.2	31.8
Total	48	38.7	25.0

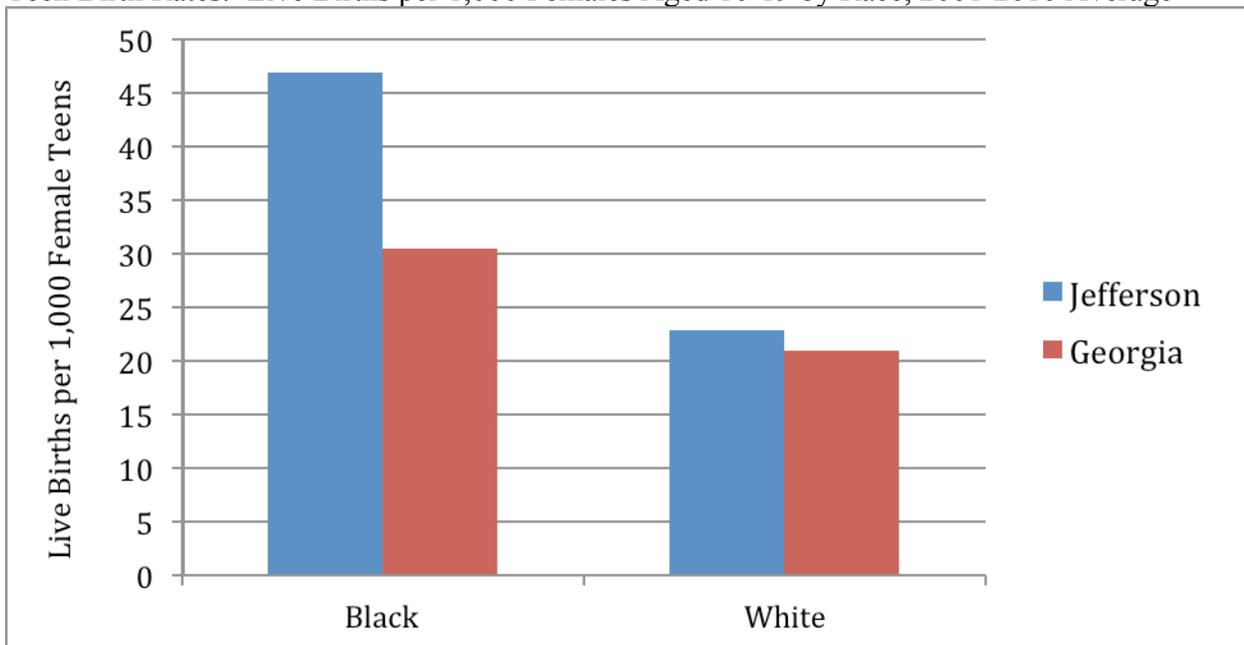
[†] Average number of births from 2001-2010

[‡] Average Teen Birth Rate from 2001-2010

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Teen births are those to mothers younger than 20 years old. The teen birth rate for African Americans is higher than state average. On average, 48 births per year occur to teen mothers that reside within the hospital service area.

Teen Birth Rates: Live Births per 1,000 Females Aged 10-19 by Race, 2001-2010 Average



Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

RESULTS: COMMUNITY-BASED SURVEY

A total of 400 surveys were distributed in the community. Among these, 313 were completed and returned to Georgia Southern University for analysis thereby yielding a response rate of 78.3%. The distribution of surveys by zip code is displayed below. As indicated, two participants failed to report zip code (0.6%). As is the case with most survey work, missing values are most likely noted with all assessed variables. However, the remaining variables outlined below will not include missing data and the analysis will be limited only to those participants addressing a specific survey question. Therefore, table values not equaling 313 indicate the presence of missing values.

Distribution of Participants by Zip Codes

Zip Code	Frequency	Valid Percent
30477	49	15.7
30803	13	4.2
30413	25	8.0
30434	140	44.7
30823	16	5.1
Other	68	21.7
Missing	2	0.6
Total	313	100.0

Demographic Characteristics

The following section contains specific information related to the demographic characteristics of all participants completing this community-based survey.

Distribution of Participants by Gender

Gender	Frequency	Valid Percent
Male	125	40.1
Female	187	59.9
Total	312	100.0

As is typical with community-based efforts, considerably more females (59.9%) completed this survey than males (40.1%).

Distribution of Participants by Race/Ethnicity

Race	Frequency	Valid Percent
White, Non-Hispanic	221	71.3
Black/African-American	86	27.7
Hispanic/Latino	1	0.3
Other	2	0.6
Total	310	100.0

Most respondents were white (71.3%). However, a significant proportion of survey participants were African American (27.7%). This number is representative of the racial demographics observed for the service area.

Distribution of Participants by Age

Age	Frequency	Valid Percent
18-24	24	7.7
25-34	46	14.7
35-44	60	19.2
45-54	59	18.9
55-64	73	23.4
65+	50	16.0
Total	312	100.0

Nearly 53.0% of all participants completing the community-based survey were between the ages of 25 and 54 years old. Only 7.7% of participants were 18 to 24 years old, and 23.4% of participants were between the ages of 55 and 64. Approximately 16.0% of all participants were 65 years old or older. Therefore, the age distribution suggests an adequate cross-section of participation.

Distribution of Participants by Marital Status

Marital Status	Frequency	Valid Percent
Single	72	23.1
Married	200	64.1
Separated	3	1.0
Living Together	2	0.6

Divorced	19	6.1
Widowed	15	4.8
Other	1	0.3
Total	312	100.0

Most participants (64.1%) were married while 23.1% of participants were single.

Distribution of Participants by Educational Status

Level Of Education	Frequency	Valid Percent
< High School	26	8.3
High School/GED	91	29.2
Some College	100	32.1
Bachelor's Degree	55	17.6
Advanced Degree	22	7.1
Other	18	5.8
Total	312	100.0

Approximately 32.1% of respondents reported having some college education, and 29.2% of respondents reported having a high school diploma or the equivalent. Only 8.3% of respondents indicated they had less than a high school education.

Distribution of Participants by Employment Status

Employment Status	Frequency	Valid Percent
Student	9	2.9
Full-Time	182	58.5
Part-Time	20	6.4
Retired	19	6.1
Self-Employed	45	14.5
Unemployed	29	9.3
Not Seeking Employment	7	2.3
Total	311	100.0

Most survey participants (58.5%) indicated they worked full-time while only 6.4% reported part-time work. Approximately 9.3% of individuals completing the community-based survey reported being unemployed.

Distribution of Participants by Household Income

Household Income	Frequency	Valid Percent
< \$25,000	72	24.6
\$25,000-\$49,999	61	20.8
\$50,000-\$74,999	68	23.2
\$75,000-\$99,999	39	13.3
\$100,000+	33	11.3
Do Not Wish To Disclose	20	6.8
Total	293	100.0

Nearly 25.0% of participants reported household incomes of less than \$25,000 per year. Other income categories were fairly evenly distributed.

Distribution of Participants by Home Ownership Status

Home Ownership	Frequency	Valid Percent
Yes	220	71.2
No	89	28.8
Total	309	100.0

Most survey participants (71.2%) reported owning their home.

Distribution of Participants by Access to Transportation

Access To Transportation	Frequency	Valid Percent
Yes	279	90.0
No	31	10.0
Total	310	100.0

A considerable proportion of those surveyed reported having access to transportation (90.0%). However, it is important to note that this does not necessarily indicate they own transportation.

Distribution of Participants by Number of Dependents in the Household

Number Of Dependents	Frequency	Valid Percent
0	133	43.5
1	82	26.8
2	51	16.7
3+	40	13.1
Total	306	100.0

Most respondents indicated no dependents were living in the household (43.5%), but over 13.0% of those surveyed reporting having 3 or more dependents.

Community Perception

This section illustrates factors related to community perception. Specifically, participants were asked to rate their community in terms of quality of life, economic growth, safety, and education.

Individual Perception of Quality of Life in the Community

My Community Is A:		
A Good Place To Live	Frequency	Valid Percent
Strongly Agree	106	35.2
Agree	165	54.8
No Opinion	13	4.3
Disagree	14	4.7
Strongly Disagree	3	1.0
Total	301	100.0

Among those surveyed, 90.0% of participants either “agree” (54.8%) or “strongly agree” (35.2%) that their community is a good place to live.

Individual Perception of the Economy

My Community Has:		
Strong Economic Growth	Frequency	Valid Percent
Strongly Agree	10	3.3
Agree	47	15.5
No Opinion	46	15.2

Disagree	153	50.5
Strongly Disagree	47	15.5
Total	303	100.0

However, most participants feel that economic growth in the community is not optimal. Among those responding to this survey, 66.0% of participants either “disagree” (50.5%) or “strongly disagree” (15.5%) that economic growth is adequate in their community.

Individual Perception of the Health Care System

My Community Has A:		
Strong Healthcare System	Frequency	Valid Percent
Strongly Agree	44	14.7
Agree	176	58.9
No Opinion	50	16.7
Disagree	26	8.7
Strongly Disagree	3	1.0
Total	299	100.0

Most participants “agree” (58.9%) or “strongly agree” (14.7%) the health care system is strong in their community.

Individual Perception of the Family Oriented Nature of the Community

My Community Is A:		
Good Place To Raise Children	Frequency	Valid Percent
Strongly Agree	83	27.6
Agree	163	54.2
No Opinion	34	11.3
Disagree	18	6.0
Strongly Disagree	3	1.0
Total	301	100.0

Among those responding to this survey, 81.8% of participants either “agree” (54.2%) or “strongly agree” (27.6%) that the community is a good place to raise children.

Individual Perception of Community Safety

My Community Is A:		
Safe Community	Frequency	Valid Percent
Strongly Agree	73	24.8
Agree	177	60.2
No Opinion	26	8.8
Disagree	17	5.8
Strongly Disagree	1	0.3
Total	294	100.0

Most participants agree that the community is a safe place to live. Approximately 85.0% of respondents either “agree” (60.2%) or “strongly agree” (24.8%) that the community is safe.

Individual Perception of the Educational System

My Community Has A:		
Strong Educational System	Frequency	Valid Percent
Strongly Agree	55	18.2
Agree	141	46.5
No Opinion	59	19.5
Disagree	38	12.5
Strongly Disagree	10	3.3
Total	303	100.0

The educational system of the community ranked fairly high. Nearly 64.7% of those responding indicated that they either “agree” (46.5%) or “strongly agree” (18.2%) that the community has a solid educational system.

Behavioral Patterns

This section illustrates participant responses to a series of behavioral questions. The tables below indicate community patterns in terms of perceived health status, exercise, tobacco use, alcohol use, seatbelt use, diet, and self-breast exam habits (females only). In addition, coping mechanisms for stress are indicated.

Perception of Individual Health Status

Perceived Health Status	Frequency	Valid Percent
Excellent	23	7.4
Very Good	102	33.0
Good	140	45.3
Fair	35	11.3
Poor	9	2.9
Total	309	100.0

Approximately 45.3% of respondents perceived their health status to be “good” and 33.0% perceived their health status to be “very good”. Only 7.4% of participants stated their health status was “excellent”.

Distribution of Patterns of Exercise

Frequency Of Exercise	Frequency	Valid Percent
Not At All	50	16.0
Occasionally	133	42.6
1-2 Times/Week	65	20.8
3-4 Times/Week	45	14.4
5+ Times/Week	19	6.1
Total	312	100.0

Approximately 58.6% of respondents reported either not exercising (16.0%) or only occasionally exercising (42.6%). Only 6.1% of those participating in this survey reported exercising 5 or more times per week.

Distribution of Monthly Self-Breast Exam

Self Breast Exam	Frequency	Valid Percent
Yes	107	62.2
No	65	37.8
Total	172	100.0

Only female participants were asked to respond to the question concerning monthly self-breast examination. According to those surveyed, 62.2% of women reported completing a self-breast examination.

Distribution of Tobacco Use

Tobacco Use	Frequency	Valid Percent
Yes	67	21.5
No	245	78.5
Total	312	100.0

Most participants (78.5%) reported not using tobacco.

Distribution of Alcohol Use

Alcohol Use	Frequency	Valid Percent
Not At All	137	44.2
Occasionally	122	39.4
1-2 Times/Week	32	10.3
3-4 Times/Week	13	4.2
5+ Times/Week	6	1.9
Total	310	100.0

Nearly 84.0% of participants reported never consuming alcohol (44.2%) or only consuming it occasionally (39.4%).

Distribution of Seat Belt Use

Seat Belt Use	Frequency	Valid Percent
Always	213	68.1
Mostly	67	21.4
Sometimes	30	9.6
Never	3	1.0
Total	313	100.0

The distribution of seatbelt use in the community is very high. Most participants reported always (68.1%) or mostly (21.4%) using seatbelts.

Distribution of the Perception of Diet

Diet	Frequency	Valid Percent
High Fat	28	9.0
Medium Fat	165	52.9
Low Fat	64	20.6
5 Servings Of Fruits/Vegetables Daily	24	7.7
2-4 Servings Of Fruits/Vegetables Daily	101	32.5
Rarely Eat Fruits/Vegetables	22	7.1

Participants were asked to indicate any all aspects of their personal diet that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Approximately 52.9% of respondents indicated their diet was medium in fat content. Over 32.0% of those surveyed reported consuming 2 to 4 servings of vegetables each day.

Strategies for Controlling Stress

Controlling Stress	Frequency	Valid Percent
Exercise	105	33.9
Hobbies/Sports	94	30.3
Eat More Than Usual	49	15.8
Eat Less Than Usual	7	2.3
Smoke	24	7.7
Use Alcohol/Drugs	10	3.2
Take Medication	28	9.0
Talk To Friends	134	43.2
Talk To A Counselor	3	1.0
Direct It To Others	15	4.8
Prayer	156	50.3

Participants were asked to indicate any all mechanisms of coping with stress that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Prayer (50.3%) was the most commonly reported strategy for controlling stress. However, talking to friends (43.2%), exercise (33.9%), and hobbies/sports (30.3%) were also commonly reported to control stress.

Healthcare Seeking Behavior

This section attempts to assess the healthcare seeking behavior of survey participants. Specific questions asked include routine checkups/physicals, healthcare providers, healthcare insurance, healthcare location, and healthcare barriers.

Distribution Reporting to Receive Regular Physicals

Regular Physicals	Frequency	Valid Percent
Yes	254	82.7
No	53	17.3
Total	307	100.0

The majority of survey participants (82.7%) indicated they received physicals on a regular basis.

Distribution Reporting to Have a Regular Doctor

Regular Doctor/Healthcare Provider	Frequency	Valid Percent
Yes	281	91.8
No	25	8.2
Total	306	100.0

Most (91.8%) participants reported having a regular doctor.

Participants were asked to disclose all types of insurance, so the data illustrated below represents multiple responses. Therefore, the percent totals do not equal 100%.

Distribution of Insurance Type

Insurance Type	Frequency	Valid Percent
Uninsured	27	8.8
Pay Out Of Pocket	14	4.7
Medicaid	20	6.7
Medicare	56	18.7
Medicare Part D	27	9.0
Private Insurance	208	69.6

Nearly 70.0% of all respondents indicated having private insurance to pay for health care services. Medicare (27.7%) and Medicaid (6.7%) were reported by 34.4% of survey participants.

Distribution Reporting to Have a Regular Dentist

Regular Dentist	Frequency	Valid Percent
Yes	217	70.9
No	89	29.1
Total	306	100.0

Over 70.9% of respondents indicated having a regular dentist.

The table below illustrates specific locations of services received by survey participants. Multiple responses were solicited with this particular survey question, so percent totals do not equal 100%.

Distribution of Healthcare Service Location

Location Of Healthcare Services	Frequency	Valid Percent
Rural Health Clinic	186	59.8
Hospital Emergency Department	55	17.7
Health Department	4	1.3
Other	77	25.0

According to the data above, 59.8% of participants reported seeking health care from a rural health clinic. The emergency room (17.7%) and the health department (1.3%) were additional sites for receiving health care services.

Distribution Reporting Cost as a Barrier to Healthcare

Cost As A Barrier To Healthcare	Frequency	Valid Percent
Yes	44	14.1
No	268	85.9
Total	312	100.0

Approximately 85.9% of respondents indicated that cost was not a barrier to receiving health care services.

Distribution Reporting Cost as a Barrier to Filling Prescription Medication

Cost As A Barrier To Prescription Medication	Frequency	Valid Percent
Yes	61	19.6
No	250	80.4
Total	311	100.0

Nearly 80.0% of respondents indicated that cost was not a barrier to filling a prescription medication.

The table below illustrates specific conditions of participants, or family members of participants, admitted to the Emergency Room at the hospital. Any relevant condition was indicated so percent totals do not equal 100%.

Distribution Reporting Ambulatory Care Conditions

Conditions	Frequency	Valid Percent
Dehydration	36	36.0
Gastroenteritis	17	18.9
Kidney Infection	21	22.6
Bleeding/Perforated Ulcer	4	4.9
Pelvic Inflammatory Disease	1	1.3
Ear/Nose/Throat Infection	26	27.7
Cellulitis	3	3.7
Dental Conditions	6	7.1
Diabetes	21	22.6
Asthma	16	18.2
Angina	9	10.5
Hypertension	16	18.2
Congestive Heart Failure	9	10.6
COPD	5	6.0
Trauma	53	45.7

Trauma (45.7%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room. The prevalence of other conditions presenting to the emergency room are outlined above.

Local Hospital Services and Overall Satisfaction

Among participants surveyed, 74.8% used hospital services in the last 24 months.

Distribution of Health Care Utilization

Location	Frequency	Valid Percent
Jefferson Hospital	208	90.0
Other	23	10.0
Total	231	100.0

Among those reporting using hospital services, 90.0% indicated using services at Jefferson Hospital.

Survey participants were asked about their experience with the local hospital and hospital services. In addition, general levels of satisfaction with this facility and its services were also assessed.

Reason for Healthcare Utilization

Reason	Frequency	Valid Percent
Physician Referral	59	28.4
Close/Convenient	141	67.8
Insurance	10	4.8
Quality Of Care	45	21.6
Availability Of Specialty Care	12	5.8
Other	11	5.3

Most participants reported using the local hospital because of convenience (67.8%). However, 28.4% reported being referred by a physician.

Distribution of Services Utilized

Services	Frequency	Valid Percent
Radiology	95	45.7
Laboratory	100	48.1
Other Outpatient	48	23.1
Inpatient Services	17	8.2
Emergency Room	80	38.5

Other	11	5.3
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Respondents indicated using a variety services at the local hospital. Radiologic services (45.7%) and laboratory services (48.1%) were the most commonly reported services used by survey participants. The emergency room was used by 38.5% of those surveyed.

Level of Satisfaction with Services

Level Of Satisfaction	Frequency	Valid Percent
Satisfied	187	91.2
Dissatisfied	12	5.9
Don't Know	6	2.9
Total	205	100.0

Over 91.2% of those surveyed indicated being satisfied with services while only 5.9% indicated dissatisfaction.

Distribution Reporting Utilizing a Primary Care Physician

Primary Care Doctor	Frequency	Valid Percent
Yes	197	96.1
No	8	3.9
Total	205	100.0

Approximately 96.1% of those surveyed indicated using a primary care physician. Among those participants indicating to not use a primary care physician (3.9%), the table below illustrates the type of medical care provider utilized for routine healthcare.

Provider Location for Routine Care

Location Of Provider in the Absence of Primary Care	Frequency	Valid Percent
Health Department	4	20.0
Rural Health Clinic	6	31.6
Emergency Room	3	15.8
Specialist	1	5.3
Other	1	5.3

As indicated above, the rural health clinic (31.6%), the health department (20.0%), and the emergency room (15.8%) were most often utilized in the absence of a primary care physician.

Utilization of Primary Care at the Local Hospital

Primary Care At The Hospital	Frequency	Valid Percent
Yes	182	88.3
No	22	10.7
Don't Know	2	1.0
Total	206	100.0

Nearly 88.3% of those surveyed reported using primary care services at the local hospital.

Level of Satisfaction with the Primary Care Provider

Level Of Satisfaction	Frequency	Valid Percent
Satisfied	179	97.3
Dissatisfied	4	2.2
Don't Know	1	0.5
Total	184	100.0

Among those using primary care providers at the hospital, the vast majority (97.3%) was satisfied with the services received.

Distribution Reporting Ease of Appointment with a Primary Care Provider

Ability To Get An Appointment	Frequency	Valid Percent
Yes	193	95.1
No	3	1.5
Don't Know	7	3.4
Total	203	100.0

Most respondents (95.1%) indicated they were able to schedule an appointment with the primary care provider at the local hospital.

RESULTS: FOCUS GROUP ANALYSIS

Introduction: Participants' Characteristics

Jefferson Hospital was encouraged to recruit groups of 6-8 participants to take part in the three focus groups. One group consisted of community advisory committee members (CAC), persons among the group of people the hospital recruited to actively participate in the needs assessment. The other two groups were recruited by CAC members and referrals. On March 28, 2013, 28 participants took part in the three focus groups in the Administrative Conference Room at the hospital. The first focus group session took place at 10:00AM and consisted of CAC members, while the second and third groups were comprised of CAC members' referrals and were at 1:00PM and 3:00PM, respectively.

The three focus groups consisted of 28 participants: 17 women and 11 men. Sixty-seven percent of the sample was Caucasian (19) and nine were African Americans. All of the participants spoke English. Twenty of the 28 participants lived in Louisville, two in Avera, two in Wadley, two in Wrens, and two lived in Bartow and Grovetown, respectively. Participants' ages ranged from 25 to 76 years old, with a median age of 58 years. Participants' education levels were as follows: eight advanced degrees; eight college degrees; nine had some college; and three completed high school. Participants' annual income levels included eight with 100k or more; eight persons with 75k – 100k; eight with income levels 50k – 75k; three person with 25k – 50k; and one participant provided no answer to that question. The following sections divide the focus group discussions by common thread or topic.

Community

Theme: 'Everyone knows everyone'; close knit – like family; small town; friendly and caring people; no traffic; nice weather; low crime; good place to raise children; church involvement; too many fast food restaurants; 'southern diet' and lack of personal motivation.

The majority of the participants reported, Jefferson County was a small rural town, close knit community where everyone knew everyone and got along. Jefferson County residents were described to be friendly and caring, which participants said made the county a good place to raise children. Moreover, participants shared residents of Jefferson County enjoyed the nice weather, the low traffic flow and low crime. Further, participants said that most residents of Jefferson County were often involved in church and community activities.

"We seem to be a close-knit community. Everyone seems to, I think, get along fairly well, from one end of the county to the other."

"Well, for me, personally, it's raising children here. It's really convenient to know everybody and have the sense that people know your child... that type of sense of close community is very appealing when you're raising children... It's more of a community feel and not quite so anonymous."

"There's a lot of people involved in churches... A lot of hunting, fishing, recreation... I think it's great to have a network of people, whether you're related to them or not, they care about you. I think we're a very caring community and supportive of each other."

“...If you read our police blotter, it’s mostly traffic offences or, occasionally, somebody will go a little off the chain and hurt somebody, but we normally solve those crimes when they happen.”

However, some participants recognized the downsides to everyone knowing everyone, since the familiarity of community members sometimes led to rumors.

“When you do have a confrontation with somebody, everybody’s going to know about it. That kind of thing. So there is no keeping secrets or anything because everybody’s going to know.”

When it came to resources, a number of participants believed Jefferson County offered a great variety of activities through its recreational departments throughout the county for both adults and children. These resources included three recreation facilities that were conveniently located in certain parts of Jefferson County; Family YMCA; and wellness center. Regarding the Family YMCA, several participants shared that city government employees can join this facility at no cost.

“We have in Wrens, the Family Y that runs our facility. And the city pays for the employees to go out there. And it goes real well. They have classes. And I don’t do much in the winter, but I do go out there in the spring and the summer and exercise.”

“We’ve got facilities everywhere in all three towns. With the rec department and the gym, these kids can go play basketball after school. Then you got your older kids that come in and they play basketball in the afternoon. And you got your tracks.”

Other community resources mentioned were two parks; tracks and sidewalks; a number of farmer’s markets; food pantry; and a church funded feeding program. However, a small number of participants talked about the availability of recreational areas that are not being used because some residents lacked transportation; therefore, cannot get to those facilities.

“We have tracks in all of our communities where people can walk and exercise.”

“We have a farmer’s market every year, a couple of them, as a matter of fact.”

When participants were asked about their ability to start and maintain a healthy lifestyle in Jefferson County, several discussed the availability of too many fast food restaurants in the community; the ‘southern diet’; and increased poverty. With reference to the ‘southern diet’, participants argued that their way of eating in the south coupled with the lack of personal motivation for getting involved in physical activities may be a barrier for most residents in living a healthy lifestyle.

“... The Southern diet. We just love to eat fried, fried and more fried... It’s high content, high cholesterol food. The food that tastes good is not good for us. We have plenty of it.”

A lot of fast food... They're trying to feed the children and they're trying to feed all of them with this amount of money."

Other barriers mentioned were poverty and lack of education. They said many low income residents who received government assistance did not have the necessary resources to promote healthy living. One participant shared,

"Poverty and education. A large population is poverty and you have to stretch your dollar. And it's just like what we said eating healthy is not cheap. To buy fresh fruits and vegetables is much more expensive than to buy a bag of Cheetos."

Community Issues

Theme: Lack of employment opportunities; chronic health conditions; high unemployment linked to lack of health insurance; loss of industry jobs; limited resources; lack of mental health professionals; teen pregnancy; high poverty; increase of single-parent households; grandparents raising grandchildren; lack of motivation to healthy living; lack of entertainment, recreation and shopping; and no privacy.

Regarding concerns and issues that challenged Jefferson County, a majority of the participants discussed the limited employment opportunities in the County. This caused many residents to either travel out of town for work or leave town altogether. They alleged many young people left Jefferson County in search of better opportunities to never return.

"Not enough jobs... There's a lot of people losing their jobs."

"...A lot of people, because a lot of the people who actually have jobs in Louisville and in Jefferson County, have to commute for those jobs, because there are no jobs here..."

"We have high unemployment here, which is like about 14 percent, it's been averaging that. Then we have a lot of individuals who are on assistance."

"...We have a problem with the students leaving, going off to college and then young families not getting back here. A lot of that will be an economic reason."

Participants also spoke about the disappearance of industry jobs in the area as an issue that the community faced, which led to high unemployment and an increase in the number of uninsured residents.

"The job market here has become a problem. Things are closed, and that involves other problems like, [...], the job I worked on, it closed, and that involves health insurance and all the other things that goes with it, so that's a major problem."

"With the loss of jobs, you know, it impacts everything, because people sometimes have to leave the community altogether, move away. I think on your job, you probably had an opportunity to relocate if you wanted to, but your roots are here, you don't want to do that."

“I think one of the problems here... We don't have any industry. We don't have any jobs. That's why the people aren't coming back from college, 'cause there are no jobs for them. The population is decreasing in the county. There's no health care. We have a lot of people without health insurance.”

Yet other community concerns cited were a number of chronic health conditions to include diabetes, obesity and hypertension. A few participants assumed that many in the community lack the education and personal responsibility to practice healthy living.

“We have a high rate of diabetes... But at one time we had three dialysis clinics here... It was just amazing how many diabetic cases we have in this community. What's causing it, I don't know, but it's a grave disease in this community, at epidemic levels.”

“I'm very concerned about obesity in children. We're seeing that more and more in children.”

Participants thought the lack of mental health professionals in Jefferson County was a problem. They alleged patients with mental health problems are brought to Jefferson Hospital often waited for hours without receiving the appropriate care before they were either asked to leave or transported to other counties.

“Mental health issues... When someone decompensates and they come into the emergency room, then we tie up an emergency room for hours to get someone to come in to assess that person. And then once they're assessed, they usually have to send them out of county.”

“...With the school system, we have a huge need for mental health resources and they're virtually non-existent. We have counselors, but they're not really – they're equipped to be guidance counselors and they do what they can.”

Furthermore, participants said they traveled outside of town in search of specialized medical care, entertainment and shopping. Several of the participants believed not having access to these services in town may be costing Jefferson County a lot of much needed tax revenues.

“You have to travel just to get simple things... That's one of the things that we never had any access to, is being able to find some of the basic needs we have... And those are things that promote a tax base in your community.”

“I think the small town is good and bad in several different ways. Everybody's showing the good, but the resources are limited. If you do want to go have a particular specialist doctor, you have to go to Augusta.”

“If you want to go to a movie, you have to drive. It's just not like you can just run out and do something and come home. It would have to be a planned excursion, that kind of thing. So those are definitely problems.”

Other community concerns that were discussed by several participants were teen pregnancy; increase poverty; single-parent headed households; and grandparents raising grandchildren.

“In line with health, our teen pregnancy rate right now is a question. A number of teens seem to only have sex on their mind and they end up getting pregnant, which in turn causes us to have young people who may be dropping out a little bit early, which may be affecting our graduation rates.”

“We got a lot of parents that’s unwed, got a lot of mothers that have the kids and things like that happening. And they’re growing up in a one-parent environment and it’s real tough.”

“We have a number of grandparents who are raising these children. The parents are either incarcerated or they’ve just moved on. And there are a lot of them that are not very well equipped and they have health issues themselves. And it’s very difficult as a grandparent to take on that full responsibility.”

Hospital

Theme: Caring staff; great services; everybody is treated equally; good food; effective PR work.

Participants were pleased with the hospital’s caring staff and services. They believed that for being a rural hospital, the hospital provided excellent care and the people at the hospital performed at the “*top level*”. Several participants mentioned that they have received personal attention and felt that hospital’s staff really cared about them. One participant said,

“Because when you come to our hospital, you’re more than your Social Security number and your payer source.”

Another person said,

“And the people here go out of their way, and I’m not just saying that because I work here, but they go out of their way to try to help people.”

One participant elaborated further on the point of quality care and caring staff,

“We have a hospital that for the size hospital we are, I think we provide probably top care for a hospital and care. And all of the people that work here are concerned. We have a very unique situation for a small town. And what we do provide, I think is at top level.”

Participants also began to explain why so many community members utilize this hospital. They mentioned that patients are not discriminated against by the hospital’s staff based on their insurance status and that everyone is treated equally,

“It’s all about the people and meeting the need of that person. Whether they have insurance or not, they’re not treated any differently than someone that does have

insurance. And it's kind of well known. That's why a lot of people come here, because they know they're gonna get care there."

Besides caring staff and great services, participants also mentioned that they are satisfied with the quality of food at the hospital. One participant said,

"I've been here, my mother, my grandmother was here, I have used it recently. The best food of any of the hospitals is right here."

Participants also recognized that the hospital has had significant improvements in the public relation arena. According to participants, the services are well advertised and the community members are always updated on the hospital's activity. One participant said,

"I think their PR has helped us become more aware of what the hospital offers."

Another participant further elaborated on this point,

"I think it's certainly becoming more aware of it over the last few years when the hospital really started a fairly – I thought – you say periodically... I thought it was a pretty aggressive advertising program just on the radio having the department heads on the radio saying this is what we do and you can have it done right here."

Participants seemed to be well aware of the provided services. When they were asked about services that the hospital provides, participants named *mammograms, X-ray, ER, inpatient services, cardiology, GYN, podiatry, neurology, physical therapy, respiratory services, cardiopulmonary services, wellness center, family practice, pediatric care, prenatal care, swing beds, outpatient infusion, outpatient surgery, dermatologist, lab work, and urology*. When participants were asked about services they would like to see in the future, they listed *local subspecialists, ear, eye, and nose doctor, orthopedist, and oncology services*.

Hospital Problems

Theme: ER doctors are not local; underutilization; hospital is not well equipped

Three major themes emerged when participants were asked to discuss hospital issues. First, participants believed that because the ER doctors are not local, they are not connected to the community and they cannot provide the same quality of care as the doctor from the community who has personal relations with their patients. One participant elaborated on this point,

"I think the people that are in the emergency room don't have the – they're not connected to the community. They don't feel any loyalty to it."

Another participant added,

"So they don't treat'm with that special care that the everyday employees give you. I think that's what people are missing. And a lot of people, they only have the interaction with the ER, because maybe they don't have the insurance or whatever to go to the doctor, so they go to the ER where they can be treated. So then they get that vision."

Secondly, several participants believed that the hospital was underutilized and that it could potentially create some issues for sustainability in the future. One participant explained,

“I feel sorry that we don’t have enough population in the hospital all the time, because at one time when my mother was in here, they were down to five clients for one night. I can realize that they can’t run a facility of this magnitude with just five patients.”

Lastly, a few participants felt the reason that people have been sent to other hospitals is the fact that the hospital is not well equipped. One participant said,

“And I think that may be why they have to send them to Augusta or wherever, because we’re not equipped for whatever the situation is. Because like you said, my mother had cancer, she had hepatitis, and my dad had cancer. And my grandmother, and once it was diagnosed it was sent elsewhere.”

Hospital Recommendations

Theme: Sustainability; partnerships; expended wellness center; prevention education; diabetic and obesity programs; community outreach programs; mobile care.

Overall, participants were very satisfied with the hospital. They were very happy to have this hospital in the community and wanted to see the hospital open. They believed the hospital plays a significant role in bringing industry in the community, attracting more people to the community, and improving quality of life. Also, participants wanted to see more partnerships between the hospital and other entities in the community. One participant said,

“And I think the hospital is important in that, but they’re not the only ones that can convey that message. If the schools and the churches and the hospital could work together more to help that mindset, ’cause it’s almost a brick wall sometimes.”

Participants also expressed the desire to see more improvement in the wellness center at the hospital. One participant said,

“I would like to see the wellness center expanded. I know they’ve done a lot with it recently but I think it could definitely be more. What they have done is really good, but I think it could be more.”

When talking about the things that hospital can do to improve the health of the community, the majority of the participants believed that more emphasis should be put on prevention. They felt that the hospital invests a lot into treatment; however, preventive education could eradicate a lot of the health problems that the community obtains. One participant elaborated on this point,

“I’ll tell you one thing I wish would happen in the next 10 to 15 years in this community, is that the hospital and doctors focused on treatment as well as prevention in some coordinated way. When you go to see the doctor, it’s mainly for diagnosis and for treatment. Well, if we could flip that switch to where we could see the community in a

mode of prevention. That may be pulling the rug from under them because the healthier the community is, the less need for doctors. But if that could coexist...

Participants also felt that the hospital should do more to battle diabetes and obesity problems in the community. They wanted to see some type of nutrition counseling for children that are already suffering from these health problems. One participant said,

"We also need one for people that have already been diagnosed too. If we had somewhere when we had these obese children to send them for some nutrition counseling that would be wonderful."

Another participant added

"Or send their mamas for it too."

Another participant also elaborated on the issue of diabetes and lack of resources to address it,

"And, also, there's no diabetic educator around, which I'm finding that a lot. The school systems have a lot of diabetics. And there are a lot of problems going on there with the children at school with diabetes. And then they don't seem to know what they should be eating, what they shouldn't be eating, that kind of thing."

Participants wished to see the hospital reach out to the community members more through health fairs and workshops, in order to bring more people to the hospital. One participant explained,

"I think one of those things that it can do is to, maybe, improve on the outreach services. For instance, men, in general, don't go to the hospital; don't go to the doctor like they should. I'm guilty of it myself. But if we had outreach services that could go out into the community and do diabetes workshops and do male health issues, cover male health issues, that may reach some people that may not walk through the door where they can meet somewhere else."

One participant recognized the issue of transportation in the community and suggested to implement mobile care in order to reach as many people as possible. One participant explained,

"And you had to have that person where they can go to the places. Like, if we wanted to teach people in Wadley, that nurse would have to make herself available. Because just like we just said with transportation, it would be hard for those people to come from Wadley to Louisville even if she was centered here, he was centered here. So you have to have that ability to be able to go wherever in the county whether it's the senior citizen's center, which would be an awesome place to have a class or different places like that where they'd have to be able to be mobile so that we could service the whole county."

Community Vision

Theme: Hospital to stay in community; health education; bring industry into the area; hospital to form nontraditional partnerships; and preventive healthcare.

When participants were asked about their vision for Jefferson County, several stated they would like to see Jefferson Hospital remain in the community. They said they would like to see the hospital form nontraditional collaborations with local churches and the school system to deliver community-wide health education messages.

“...If the schools and the churches and the hospital could work together more to help that mindset, 'cause it's almost a brick wall sometimes.”

“To keep this hospital viable. To develop a preventive health program that would offer people who would come here.”

“Maybe if the churches take on the ideologies from its leadership, its pastors... If there was a way to get from the black community pastors involved in a ministerial association that could promote health care...”

“I'd like to see more education on healthcare, overall health. That takes time, and it takes a lot of effort, but I think if people were educated and they knew the ramifications of bad choices, what could really happen and see what could happen, I think maybe that could have an impact.”

Further, participants recognized that the hospital may not be sustainable without having industry in the community; therefore, they would like to have industries return to the area to create the tax revenues needed to support the hospital.

“...If we can promote ourselves and come up with incentives to bring more industries here – and some of them would have to be on a starter level to get folks working again – that would have a lot to do with what happens to the success of the hospital and everything else that's in this county. Because right now our county officials have a job implementing what we have or maintaining with far less money than what we have been able to bring in.”

“When you have more industry, you have more business, then you have more people that have health insurance.”

A number of them shared the importance of access to preventative care for all in the community.

“...I think it's a lack of commitment, a lack of education to doing the things that promote healthy living... to educate the community on living well and how to avert having a problem with diabetes... a mass education program on how to live healthy, what it takes, and then a commitment on the part of the citizens to do those things.”

COMMUNITY ASSETS

Jefferson County Assets

Name of the company	Phone number	Address	Services
Jefferson Hospital	(478) 625-7000	1067 Peachtree St, Louisville, GA 30434	Hospitals, Medical Centers, Medical Clinics
A R Medical	(478) 625-7587	809 Peachtree St, Louisville, GA 30434	Medical Clinics, Medical Centers, Medical Information & Research
RAI Dialysis Svc	(478) 625-9566	1069 Peachtree St, Louisville, GA 30434	Clinics
Louisville Dialysis	(478) 625-3311	1201 Peachtree St, Louisville, GA 30434	Clinics
Nephrologycenters Of America	(478) 625-3311	1201 Peachtree St, Louisville, GA 30434	Clinics, Dialysis Services, Physicians & Surgeons, Nephrology (Kidneys)
DNA Paternity Testing Centers	(855) 884-2895	Serving the Louisville Area	Medical Clinics, Paternity Testing, Drug Testing
Private STD Testing Center	(866) 903-7791	Serving the Louisville Area	Medical Clinics, Testing Labs, Paternity Testing
Central Savannah River	(706) 547-4045	501 N Main St, Wrens, GA 30833	Youth Organizations & Centers
Sylvan Learning Center	(866) 404-3173	Serving the Louisville Area	Youth Organizations & Centers, Special Education, Educational Services

PRIORITIZATION

As outlined below, five health-related issues emerged from the data.

- F. Chronic Disease Conditions (Heart Disease, Cancer, Etc.)
- G. Issues Associated with the Hospital (Specialized Equipment, Underutilization, Emergency Room Physicians, Uninsured, Indigent Care, Etc.)
- H. Partnerships to Promote Economic Development (Lack of Industry, Unemployment/Underemployment, Poverty, Etc.)
- I. Issues Associated with Healthcare Access (Mental Health Professionals, Uninsured Populations, Etc.)
- J. Improvement/Coordination/Partnerships of Community Health Education Activities (Obesity, Diabetes, Tobacco, Nutrition, Exercise, Teen Pregnancy, STD, Recreational Activities, Etc.)

During the 3rd meeting, these data were presented to participants. The table below illustrates the results of the prioritization exercise.

Prioritization Results

Community Issue	# Ranking Issue	Size of Problem*	Seriousness of Problem*	Effectiveness of Possible Intervention*	Basic Priority Ranking
Chronic Disease Conditions	16	7.5	13.3	3.9	27.3
Issues Associated with the Hospital	16	7.7	13.2	5.3	37.0
Partnerships to Promote Economic Development	16	6.8	12.2	6.3	40.0
Issues Associated with Healthcare Access	16	7.2	11.5	5.4	33.5
Improvement/Coordination/Partnerships of Community Health Education Activities	16	7.6	11.4	6.6	41.6

*Represent average score of all participants ranking a particular issue

According to the results, “Improvement/Coordination/Partnerships of Community Health Education Activities” ranked highest according to the calculated BPR score. This issue was followed by “Partnerships to Promote Economic Development,” “Issues Associated with the Hospital,” “Issues Associated with Healthcare Access,” and “Chronic Disease Conditions.”

HOSPITAL CHALLENGES

All hospitals faced challenges related to completing the CHNA project. Without exception, each hospital expressed concern about the methodological approach to completing this particular mandate. These anxieties were alleviated as the CHNA project progressed and the project team was able to provide mentorship and fundamental training related to completing the assessment. However, other challenges unique to each hospital were noted. The bullet list below outlines those challenges navigated by Jefferson Hospital.

- The timely receipt of requested documents was a challenge. This was due in large part to the need to balance current job responsibilities and roles with the demands of the CHNA initiative.
- The site was often late in responding to requests and updates, often asking for extension to established deadlines.

REFERENCES

1. Behavioral Risk Health Surveillance System (2013). Retrieved from <http://www.cdc.gov/brfss/>
2. Center for Rural Health, The University of North Dakota School of Medicine and Health Sciences. Checklist for Community Health Needs Assessment Written Report and Implementation Strategy. Retrieved from Ruralhealth.und.edu/projects/flex/files/checklist_chna.pdf
3. County Health Rankings and Roadmaps (2012). Retrieved from <http://www.countyhealthrankings.org/app/georgia/2012/pulaski/county/1/overall>
4. Oasis Morbidity and Mortality Web Query Tool (2012). *Georgia Department of Public Health*. Retrieved from <http://oasis.state.ga.us/oasis/oasis/qryMorbMort.aspx>
5. Oasis Maternal and Child Health Web Query Tool (2012). *Georgia Department of Public Health*. Retrieved from <http://oasis.state.ga.us/oasis/oasis/qryMCH.aspx>
6. OASIS Animated Charting Tool - Population Pyramids (2010). *Georgia Department of Public Health*. Retrieved from <http://oasis.state.ga.us/oasis/oasis/countypop/index.aspx>
7. Physician Workforce Primary Care/Core Specialties (2008). *Georgia Board for Physician Workforce*. Retrieved from <http://gbpw.georgia.gov/sites/gbpw.georgia.gov/files/imported/GBPW/Files/2008%20Physician%20Profile-%20Final%208-11.pdf>
8. The Yellow Pages (2012). Retrieved from <http://www.yellowpages.com> and <http://www.yp.com>
9. United Health Foundation (2012). Retrieved from <http://www.americashealthrankings.org>
10. U.S. Census Bureau: State and County Quickfacts (2011). Retrieved from <http://quickfacts.census.gov/qfd/states/13/13235.html>

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APPENDIX A

Hospital	County	Health District	District Director	Email Address	Contact
Bacon Regional Hospital	Bacon	Southwest	Rosemarie Parks, M.D., M.P.H.	rdparks@dhr.state.ga.us	912-285-6002
Chatuge Regional Hospital	Towns	North	David N. Westfall, M.D., CPE	dnwestfall@dhr.state.ga.us	770-535-5743
Clinch County Hospital	Clinch	Southwest	Rosemarie Parks, M.D., M.P.H.	rdparks@dhr.state.ga.us	912-285-6002
Evans Memorial Hospital	Evans	Southwest	Rosemarie Parks, M.D., M.P.H.	rdparks@dhr.state.ga.us	912-285-6002
Jasper Memorial Hospital	Jasper	North Central	David N. Harvey, M.D.	dnharavey@dhr.state.ga.us	478-751-6303
Jeff Davis Hospital	Jeff Davis	Southwest	Rosemarie Parks, M.D., M.P.H.	rdparks@dhr.state.ga.us	912-285-6002
Jefferson Hospital	Jefferson	East Central	Ketty M. Gonzalez, M.D., M.S	kmgonzalez@gdph.state.ga.us	706-729-2190
Miller County Hospital	Miller	Southwest	Zsolt Koppanyi, M.D., M.P.H.	zhkoppanyi@dhr.state.ga.us	706-321-6300
Monroe County Hospital	Monroe	North Central	David N. Harvey, M.D.	dnharavey@dhr.state.ga.us	478-751-6303
Morgan Memorial Hospital	Morgan	Northwest	Claude A. Burnett, M.D., M.P.H.	cabmd@dhr.state.ga.us	706-583-2870
Phoebe Worth Medical Center	Worth	Southwest	Zsolt Koppanyi, M.D., M.P.H.	zhkoppanyi@dhr.state.ga.us	706-321-6300
Taylor Regional Hospital	Pulaski	South Central	Lawton Davis, M.D.	ldavis@dhr.state.ga.us	478-275-6545
Union General Hospital	Union	North	David N. Westfall, M.D., CPE	dnwestfall@dhr.state.ga.us	770-535-5743
Washington County Medical Center	Washington	North Central	David N. Harvey, M.D.	dnharavey@dhr.state.ga.us	478-751-6303
Memorial Hospital & Manor	Decatur	Southwest	Zsolt Koppanyi, M.D., M.P.H.	zhkoppanyi@dhr.state.ga.us	706-321-6300
Meadows Regional Medical Center	Toombs	Southwest	Rosemarie Parks, M.D., M.P.H.	rdparks@dhr.state.ga.us	912-285-6002
Stephens County Hospital	Stephens	North	David N. Westfall, M.D., CPE	dnwestfall@dhr.state.ga.us	770-535-5743
Louis Smith Memorial Hospital	Lanier	South	William R. Grow, MD, FACP	wrgrow@dhr.state.ga.us	229-333-5290

Health Department CEOs contact Information

Hospital	County Health Department (physical location)	CEO	Email Address	HD Phone #
Bacon Regional Hospital	101 N Wayne Street Alma, GA 31510	Cathy Taylor, BSN		912-632-4712
Chatuge Regional Hospital	1104 Jack Dayton Circle Young Harris, GA 30582	Roxanne Barrett, RN Beth Jones, Nurse Manager	rsbarrett@dhr.state.ga.us	706-896-2265
Clinch County Hospital	285 Sweet Street Homerville, GA 31634	Keisha Welch, Nurse Manager	dbioness9@dhr.state.ga.us	912-487-2199
Evans Memorial Hospital	4 N Newton Street Claxton, GA 30417			912-739-2088
Jasper Memorial Hospital	336 E Greene Street Monticello, GA 31064	Lisa Kersey, General Operations Generalist	lkersey3@dhr.state.ga.us	706-468-6850
Jeff Davis Hospital	30 E Sycamore Street Hazlehurst, GA 31539	Paty Ellis, Nurse Manager	paellis@dhr.state.ga.us	912-375-2425
Jefferson Hospital	2501 US 1 North Louisville, GA 30430			478-625-3716
Miller County Hospital	250 West Pine Street Colquitt, GA 39837	Suzanne Fetner, Director	ssfetner@dhr.state.ga.us	229-758-3344
Monroe County Hospital	106 Martin Luther King, Jr. Drive Forsyth, GA 31029	Janet Freeman, Nurse Manager	jifreeman@dhr.state.ga.us	478-992-5082
Morgan Memorial Hospital	2005 South Main St. Suite 200 Madison, GA 30650	Mary Alice Gilbert, Nurse Manager	madilbert@dhr.state.ga.us	706-752-1266
Phoebe Worth Medical Center	1012 West Franklin Street Sylvester, GA 31791			229-777-2150
Taylor Regional Hospital	301 N Lumpkin Hawkinsville, GA 31036			478-783-1361
Union General Hospital	67 Chase St. Blairsville, GA 30512	Janice Lance, Nurse Manager		706-745-6292
Washington County Medical Center	201 Morningside Drive Sandersville, GA 31082	Deryl Scarboro, Nurse Manager	dhscarboro@dhr.state.ga.us	478-552-3210
Memorial Hospital & Manor	928 West Street Bainbridge, GA 39819	Sherry Hutchins, Director	silhutchins@dhr.state.ga.us	229-248-3055
Meadows Regional Medical Center	714 NW Broad Street Lyons, GA 30436	Tabitha Hutto, Nurse Manager		912-526-8108
Stephens County Hospital	64 Boulevard Suite 120 Toccoa, GA 30577			706-282-4507
Louis Smith Memorial Hospital	53 West Murrell Street Lakeland, GA 31635	Maggie King, Nurse Manager		229-482-3294

APPENDIX B

Georgia Southern University
Office of Research Services & Sponsored Programs

Institutional Review Board (IRB)

Phone: 912-478-0843

Fax: 912-478-0719

IRB@GeorgiaSouthern.edu

Veazey Hall 2021

P.O. Box 8005

Statesboro, GA 30460

To: Dr. Stuart Tedders
Dr. Raymona Lawrence

CC: Charles E. Patterson
Vice President for Research and Dean of the Graduate College

From: Office of Research Services and Sponsored Programs
Administrative Support Office for Research Oversight Committees
(IACUC/IBC/IRB)

Initial Approval Date: 08/14/12

Expiration Date: 06/30/13

Subject: Status of Application for Approval to Utilize Human Subjects in Research

After a review of your proposed research project numbered H13001 and titled "Community Health Needs Assessment," it appears that (1) the research subjects are at minimal risk, (2) appropriate safeguards are planned, and (3) the research activities involve only procedures which are allowable. You are authorized to enroll up to a maximum of 4,500 subjects.

Therefore, as authorized in the Federal Policy for the Protection of Human Subjects, I am pleased to notify you that the Institutional Review Board has approved your proposed research.

If at the end of this approval period there have been no changes to the research protocol; you may request an extension of the approval period. Total project approval on this application may not exceed 36 months. If additional time is required, a new application may be submitted for continuing work. In the interim, please provide the IRB with any information concerning any significant adverse event, **whether or not it is believed to be related to the study**, within five working days of the event. In addition, if a change or modification of the approved methodology becomes necessary, you must notify the IRB Coordinator **prior** to initiating any such changes or modifications. At that time, an amended application for IRB approval may be submitted. Upon completion of your data collection, you are required to complete a *Research Study Termination* form to notify the IRB Coordinator, so your file may be closed.

Sincerely,



Eleanor Haynes
Compliance Officer

APPENDIX C



The Patient Protection Affordable Care Act signed by President Obama on March 23, 2010, indicated that effective on March 23, 2012, all nonprofit tax exempt hospitals are required to complete a community assessment every three years to evaluate the health needs and assets of the community and to develop an action plan designed to address identified priorities. Hospitals that do not complete this mandated activity risk losing their nonprofit status and may face a \$50,000 penalty.

Project Purpose and Goal: In response to this legislation, the Georgia Department of Community Health sought the expertise of the faculty from Georgia Southern University Jiann-Ping Hsu College of Public Health to assist 18 rural hospitals in addressing this federal mandate. Specifically, the purpose of this project is to provide technical assistance to nonprofit hospitals in addressing the Community Health Needs Assessment (CHNA) as mandated by the Internal Revenue Service (IRS) in accordance with the Patient Protection and Affordable Care Act. This new IRS mandate requires a structure with which all nonprofit hospitals must comply.

Contract Objectives: As is required in the State contract, the Georgia Southern University team is required to complete the following objectives by June 30, 2013 in all 18 communities. (1) *To organize a steering group to provide assessment support and guidance;* (2) *To complete all community health needs assessments to include needs identification and asset inventory;* (3) *To prioritize identified community health issues;* and (4) *To educate core steering group members and community members.* In this pilot study, the Georgia Southern team will use a mixed methods (qualitative and quantitative data sources and methods) approach and seek to standardize the process so that the participating hospitals will have a template that may be used to repeat this practice in the future as required by the IRS. Toward the latter part of the project, the team will recruit one of the 18 hospitals to participate in a health promotion workshop. The purpose of this workshop is to prioritize the information revealed in the needs assessment, devise an action plan, and plan effective strategies to address the community needs.

Jiann-Ping Hsu College of Public Health Team Contact Information

Marie Denis-Luque, MSPH, MPH
Project Manager
Email: mdenislucque@georgiasouthern.edu
Phone: (912) 478-1343

Stuart Tedders, PhD, MS
Principal Investigator
Email: stedders@georgiasouthern.edu
Phone: (912) 478-1922

APPENDIX D



Community Health Needs Assessment Project Activity Outline

1. Steering committee is to consist of up to 7 members
2. Suggestions for steering committee membership
 - a. Hospital administrator
 - b. Hospital marketing personnel
 - c. Health department representative
 - d. Hospital governing board member
 - e. Local government representative
 - f. Social service agency representative
 - g. Other community members to consider
 - i. Patient representative
 - ii. Community leader
 - iii. Other relevant community representation
3. Steering committee roles/responsibilities
 - a. Identify and designate Medical Service Area
 - b. Identify community leaders to serve in on the Community Advisory Committee (CAC)
 - i. A group of **15-25 members** which represents a cross-section of the medical service area
 - c. Develop **press releases** to get the word out to the community
 - d. Draft invitation letters to send to potential CAC members
 - e. Select someone from the group to take meeting notes
 - f. Develop and circulate meeting agendas
 - g. Assist in data collect strategies and timeline development
 - h. Participate in all site steering committee activities
4. Activities **prior** to Steering Committee **meeting 1** (Facilitator and steering committee)
 - a. Identify and designate Medical Service Area
 - b. Start to gather information on potential CAC members
 - c. Overview of hospital services and community benefits
 - d. Community input tool
 - i. Survey questionnaire
 - ii. Focus group

Community Health Needs Assessment Project Activity Outline

5. Steering committee **meeting 1**
 - a. Purpose and Responsibilities
 - b. Share Hospital Medical Service Area
 - c. Share Hospital Services/Community Benefits
 - d. Develop project activity timeline and data collection strategies
 - e. Present Community Input Tool 1
 - i. Survey Questionnaire

6. Activities **prior** to Steering Committee **meeting 2**
 - a. Complete all work as planned in meeting 1
 - b. Select/Invite CAC
 - c. Host **at least one** meeting with the CAC
 - i. Summary and circulate information on meeting
 - d. Demographic & economic impact data report
 - e. Health indicator/health outcome data report

7. Steering Committee **meeting 2**
 - a. Review Reports and other completed activities from Meeting 1
 - b. Present economic impact report/discussion
 - c. Distribute survey questionnaire to sites for data collection
 - d. Present Community Input Tool 2
 - i. Focus Groups
 - a. Strategies/Responsibilities
 - e. Present Health Indicator/Health Outcome Data

8. Activities **prior** to Steering Committee **meeting 3**
 - a. Host **at least one** meeting with CAC
 - i. Summarize and circulate information on meeting
 - b. Report progress on survey questionnaire data collection
 - i. Complete at least 70% of survey data
 - c. Review and comment on Community Input Tool 2
 - d. Plan three focus group sessions (8-10 persons/group)

9. Steering Committee **meeting 3**
 - a. Review Reports from **Meetings 1 & 2**
 - b. Continue discussion of Community Health Needs
 - c. List and prioritize Community Health Needs
 - d. Develop possible implementation

Community Health Needs Assessment Project Activity Outline

10. Post-Meeting Activities **meeting 4**

- a. List and prioritize Community Health Needs
- b. Develop possible implementation and strategic/responsibilities
- c. Publish Community Health Needs
- d. Develop Action Plan
- e. Implement Action Plan with Partners

APPENDIX E

**Jefferson Hospital
Steering Group Member Bio-sketch**

Name	Bio-sketch
<p>Ralph Randall, FACHE Jefferson Hospital CEO</p>	<p>Ralph Randall has served as Jefferson Hospital's CEO since February, 2011. He has 30 years healthcare administration experience. Randall holds a BS in Biology and a Masters in Business Administration. He is a Fellow of the American College of Healthcare Executives. He is a member of the Georgia Hospital Association (GHA), the GHA Center for Rural Health and the 2012 - 2013 Leadership GHA Class. He serves on the Region 6 EMS Council and is Vice Chair of the Regional Trauma Advisory Committee.</p>
<p>Tina Biggers Jefferson Hospital Assistant Administrator</p>	<p>Tina Biggers has been with Jefferson Hospital for over 20 years. She is currently the Assistant Administrator and handles managed care and physician relations.</p>
<p>Ann York Jefferson Hospital (Physicians' Health Group – RHCs)</p>	<p>Ann York has been with Jefferson Hospital for over 9 years. She is currently the Practice Manager of three hospitals owned Rural Health Clinics.</p>
<p>Mary Sue Rachels, RN Jefferson Hospital</p>	<p>Mary Sue Rachels graduated from Barren School of Nursing in 1958 and did one year traineeship in Public Health Nursing at Peabody College in Nashville, TN Experience in Public Health in 1960 in Bibb County, Ga and in 1968 in North Carolina. Has worked at Jefferson Hospital since 1971 in the following departments: Medical Surgical Nursing Emergency Room Operating Room/Central Supply Addiction Unit Director of Nursing for 15 years. During those years, also was involved in In-service education for Nursing Service and was responsible for Infection Control for the entire hospital Retired in 2003— Presently working part-time at Joint Commission/PI Coordinator</p>
<p>Catherine Hall Jefferson Hospital</p>	<p>Catherine Hall has been the Director of Human Resources and Social Services for Jefferson Hospital for over 25 years. She is responsible for recruitment and processing of staff; Orientation; Benefits administration; Workers'</p>

	<p>Compensation administration: ensures compliance with all local, state, and federal rules and regulations as they pertain to EEOC, ADA, FMLA and HIPAA. She's responsible for unemployment claims and payroll. She has an associate degree in Social Work. She is responsible for assessments, transfers to Nursing Homes: Director of the Swing bed program: Participates in Utilization Review with Interqual and EHR.</p>
<p>Rita Culvern (retired CEO of Jefferson Hospital)</p>	<p>Rita Culvern graduated from St. Joseph's Infirmary School of Nursing, Atlanta, Georgia in 1964. After graduating she worked as staff nurse, OR/ER Nursing Supervisor, Utilization Review Coordinator, and for five years was Director of Nursing Services. She was appointed to CEO of Jefferson Hospital in December 1990 and served in that capacity until she retired in April 2007.</p>
<p>Janet Pitcher, RN Nurse Supervisor Jefferson County Health Department</p>	<p>Janet Pitcher, RN has been the Nurse Manager at Jefferson County Health Department for the last 10 years. She has worked at Jefferson County Health Department as a Public Health Nurse for 28 years. During this time I have been involved with many county organizations and have worked closely with the Jefferson County Board of Education to provide school nurse services. She received her BSRN at Medical College of GA in 1976.</p>

APPENDIX F

PROPOSED COMMUNITY ADVISORY COMMITTEE INVITATION LETTER

Dear (County/Community) Leader:

(Hospital Name) is requesting your assistance in conducting a community health needs assessment. "The Patient Protection and Affordable Care Act" passed in 2010 requires all not-for-profit hospitals to conduct a community health needs assessment every three years.

We need your help! To meet this requirement, we need a Community Advisory Committee (CAC) of 15-25 community leaders (gatekeepers) that represents a cross-section of medical service area. You were selected because of your leadership position in the (County/Community). If you agree to help us, your responsibilities will be to provide counsel for this assessment initiative. More specifically, the process will require your participation at a minimum of three meetings, scheduled on (Meeting One Date, Time, and Place), (Meeting One Date, Time, and Place), and (Meeting One Date, Time, and Place). Light refreshments will be provided at all meetings.

The first two meetings will typically last from 1 to 1 ½ hours. At the **first meeting**, we will provide an overview of the new legislative requirements and present information illustrating the economic contribution of the hospital to the community. In addition, we will present community specific economic, demographic, and health related data that should be of interest. Lastly, we will have you complete a community health survey questionnaire and ask you to take five or six surveys to be completed by community members in your network. A brief training session for survey data collection tips will also be provided.

At the **second meeting**, six to eight volunteers from the CAC will be needed to complete the first of three focus groups. The focus groups will be conducted by researchers at Georgia Southern University, and this allows us to more thoroughly understand the health-related issues that face our community. Prior to your possible participation in the focus group, we will need your recommendation in identifying and contacting 12-16 people in the community to take part in the other two focus groups.

At the **third meeting**, the summary results of the community health survey and focus groups will be shared with you. During this meeting, we will be asking you to help us to prioritize the health issues of our community. We will also ask for your suggestions as to how the community can best develop strategies to address these issues.

Your input on the community health needs of (County/Community) is important. (Hospital Name) not only wants to meet the requirements of this federal mandate, but we also want to be proactive in providing for the health care needs in our (County/Community). However, we cannot do this alone. Since your input is important, we would greatly appreciate your willingness to serve on this important committee. Please let us know of your availability to participate as soon as possible. Together, we can work to improve the overall health status of our (County/Community).

Sincerely,

APPENDIX G

Potential Community Advisory Committee Members

City government(s); city manager, mayor, city council members
County government(s); county commissioners, county officers
State government; human services, health department, state legislators
Tribal government(s); tribal leaders, health care coordinator, local IHS representative
Health care providers
Hospital administrator and other key hospital personnel
Hospital board members
Physicians
Dentists
Optometrists
Chiropractors
Clinics or community health centers
Mental health professionals: psychiatrist, psychologist, counselors
Nurse practitioners
Physician assistants
Therapists-physical, massage, speech, rehabilitation, occupational
Pharmacists
Medical equipment suppliers
Home health providers
Hospice
Nursing homes, assisted living facilities, and adult day services
School health
Others
Emergency medical services (ambulance services)
Local public health officials
Chamber(s) of commerce
Economic development groups; coalitions, councils of government, sub-state planning districts
Industry business; manufacturing, banks, phone companies, retail sales (Main St. businesses), groceries, realtors, insurance, fishing, farming, forestry, mining, petroleum, etc.
Public education; superintendent, principals, school nurse
Technology education (formerly vo-tech)
Higher education
Private education
Volunteer organizations; local food banks, soup kitchens
Religious leaders; ministerial alliance, ministers
Minority or disparate population groups or group leaders
Service organizations: Kiwanis, Lions, Rotary, Toastmasters, etc.
Social service organizations
Other community leaders

APPENDIX H

JEFFERSON HOSPITAL
Community Advisory Committee Members

Name	Occupation	Business/Agency	County	Phone	Email
Lisa Stoms	Quality Manager	Jefferson Hospital	Jefferson	478-625-7000 Ext. 200	lstoms@jeffersonhosp.com
Louise Stoms	Retired Hospice Nurse	Hospice	Jefferson	478-625-7000 Ext. 200	
Dr. Nancy Cox	Physician	Physicians' Health Group – RHC	Jefferson	478-252-8900	ncoxmnd@jeffersonhosp.com
Carl Wagster	EMS Director	Rural Metro	Jefferson		
Amy Bedingfield	Nurse Practitioner	Jefferson Hospital Prenatal Center	Jefferson	478-625-7000 Ext. 288	abedingff@georgiahealth.edu
Donna Hutcheson	LPN	Physicians' Health Group – RHC	Glascocock	478-625-8471	
John Johnson	Manager	Goody's Clothing Store	Jefferson	478-625-3390	John66ford@yahoo.com
Lil Easterlin	Director	Chamber of Commerce	Jefferson	478-625-8134	leasterlin@jeffersoncounty.org
Donna Miller	Director	Ogeechee Behavioral Health	Jefferson	478-455-2283	
Randall Jones	Insurance Agent	Woodman of the World	Jefferson	706-466-1901	
David Gunn	Pharmacist	Gunn Drug	Jefferson	478-252-5626	
Jimmy Fleming	Pharmacist	Barney's	Jefferson	478-625-8980	
Chester Johnson	Fire Dept. Captain	Jefferson County Fire Department	Jefferson	762-245-9940	
Ott Stephens	Radio	WPEH	Jefferson	478-625-7248	WPEH@classicsouth.net
Ashlee Arrington	Occupational Therapist	Jefferson Hospital	Jefferson	478-625-7000 Ext. 244	aarrington@jp.jeffersonhosp.com
Linda Weeks	Retired School Nurse Health Occupations Instructor	Jefferson County School System	Jefferson	706-547-6724 Cell: 706-825-3513	lkrweeks@hotmail.com

APPENDIX I

COLLEGE PUBLIC HEALTH  **GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

Community Health Needs Assessment Project:
 A State Initiative
 Stuart Tedders, PhD, MS
 Principal Investigator
 Marie Denis-Luque, MSPH, MPH
 Project Manager

COLLEGE PUBLIC HEALTH

Objectives

- New IRS mandate of nonprofit hospitals
- Project overview
- The contact
- Participating hospitals
- Data methods and sources
- Next steps
- Proposed timeline
- Thoughts and ideas



Community Vital Signs

COLLEGE PUBLIC HEALTH

New IRS mandate

The Patient Protection Affordable Care Act (PPACA) signed by President Obama on March 23, 2010, indicated that effective on March 23, 2012, all nonprofit tax exempt hospitals are required to complete a community health needs assessment every three years to evaluate the health needs and assets of the community and to develop an action plan designed to address identified priorities. Hospitals that do not complete this mandated activity risk losing their nonprofit status and face a \$50,000 penalty.



COLLEGE PUBLIC HEALTH

Project overview

The purpose of this project is to provide technical assistance to 18 nonprofit hospitals in addressing the Community Health Needs Assessment (CHNA) as mandated by the Internal Revenue Service (IRS) in accordance with the Patient Protection and Affordable Care Act.

COLLEGE PUBLIC HEALTH

The contract

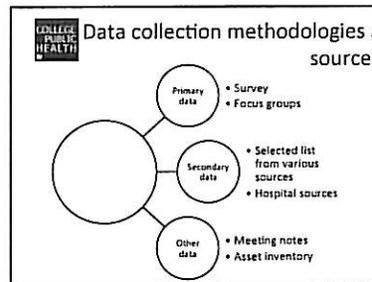
- To organize a steering group to provide assessment support and guidance;
- To complete all community health needs assessments to include asset inventory;
- To prioritize identified community health issues; and
- To educate steering group members and community members




COLLEGE PUBLIC HEALTH

Participating Hospitals

Health District	Counties	Hospitals
North	Towson, Union, Stephens	Cherokee Regional, Union General, Stephens County
North Central	Jasper, Monroe, Washington	Jasper Memorial, Monroe County, Washington County Regional
Northeast	Morgan	Morgan Memorial
South Central	Pulaski	Taylor Regional
East Central	Jefferson	Jefferson Hospital
South	Lenoir	Louis Smith Memorial
Southwest	Bacon, Evans, Jeff Davis, Clinch, Talbot	Bacon County, Evans Memorial, Jeff Davis, Clinch, Meadows Regional
Southwest	Miller, Decatur, Worth	Miller County Memorial Hospital & Manor, Private Worth Medical



COLLEGE PUBLIC HEALTH

Next Steps

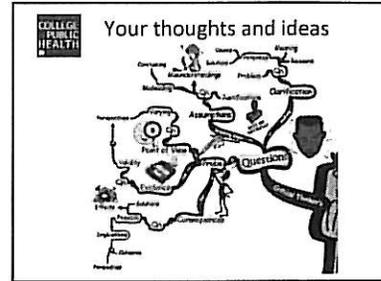


- Formation of steering group and Community Advisory Committee (CAC)
- Identify medical service area
- Get consensus on draft survey
- activity timeline
- Develop data collection strategy (ies)

COLLEGE PUBLIC HEALTH

Proposed Timeline

	June - August	Sept - Dec	Jan - Mar (2013)	Apr - May 2013
Activities	Preparation and planning community engagement data collection	Data collection and analysis	Data collection and analysis	Deliverables and dissemination
	<ul style="list-style-type: none"> • Form steering group and CAC • Establish regular meetings with group • Develop memorandum of CAC • Determine medical service area • Provide feedback on survey • Develop data collection strategy (ies) for survey • Begin data collection 	<ul style="list-style-type: none"> • Complete data collection surveys and focus group • Assess inventory • Data collection and analysis (1st & 2nd) 	<ul style="list-style-type: none"> • Data collection and analysis (3rd & 4th) • Assess mapping data collection • Report write up 	<ul style="list-style-type: none"> • Report write up and data dissemination



APPENDIX J

Community Health Needs Assessment

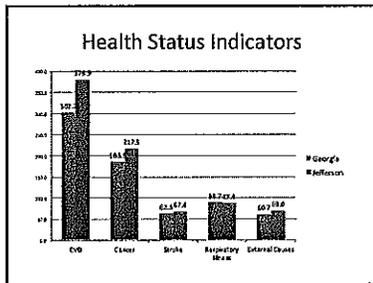
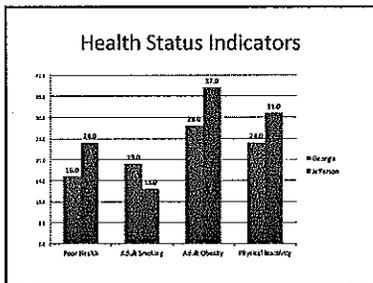
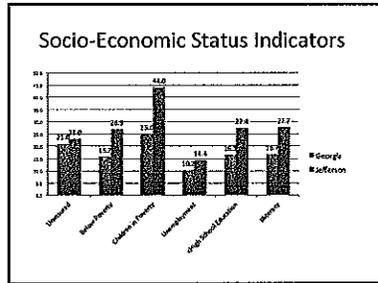
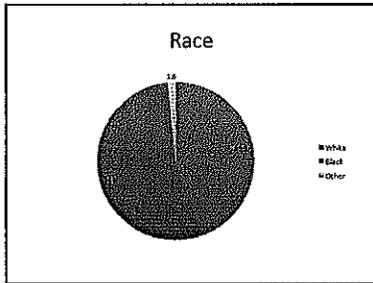
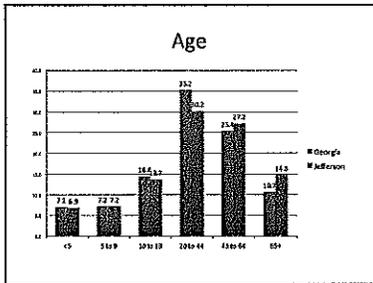
Stuart H. Tedders, PhD, MS

Objectives

- A Brief Snapshot of the Community
- Hospital Economic Impact
- Project Overview
- Survey Completion
- Instructions (survey distribution/focus groups)
- Open Discussion of the Issues

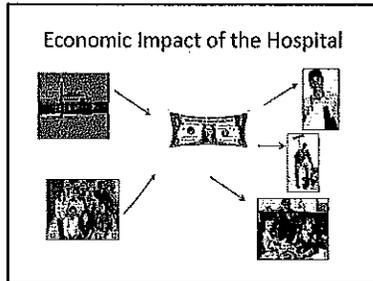
A Brief Snapshot of the Community

Jefferson County



Why Are We Here?

The IRS Mandate



Project Overview

- To provide technical assistance to 18 nonprofit hospitals in completing the **Community Health Needs Assessment** as mandated IRS.

What is a Community Health Assessment?

The Process

Simply Defined

- A community health assessment is a planned and methodical approach to identifying a profile of problems and assets.

In a Nutshell ...

Health Assessments Are the Starting Point for Solving Complex Community Problems

Three Phases of Completing a Community Health Assessment

Completing a Community Health Assessment

- Phase 1: Engage the Community in an Open and Honest Discussion of the Issues
- Phase 2: Collect Data to Document the Issues
 - Cross-section of the population – disparate and underserved populations in particular
 - Surveys
 - Focus Groups
- Phase 3: Prioritize Issues

Focus Group 101

- Small group discussions designed to obtain information about values, attitudes, and perceptions
- Focus groups are moderated
- Responses are recorded and analyzed
- Intention is **NOT** to reach consensus on issues

Why You Are So Important in Completing an Assessment of the Community?

Because **YOU ARE** the Community

- Specifically, We Need ...
- You to help us collect data by completing the survey and distributing the survey
 - Church congregations, peers, clients, etc
 - 6 to 8 of you to volunteer to participate in one of the three focus groups to talk about the issues
 - You to recruit 12 to 16 other community members to participate in the two additional focus groups to talk about the issues

Survey Completion
Community Advisory Committee

Survey Distribution/Focus Group Recruitment
Helpful Hints

- Helpful Hints
- Sometimes it is a challenge to get people to participate, but it may help if you can ...
 - Get people **EXCITED** about participating by stressing the **IMPORTANCE** of this project
 - Reassure people the survey is anonymous
 - When people agree to participate ...
 - Stress the **IMPORTANCE** of completing **ALL** sections of the survey
 - Stress the **IMPORTANCE** of **Answering Questions Honestly**
- HOWEVER ...**

Make sure everyone knows that participation is **VOLUNTARY**
Do not coerce participation

Next Steps

- Actual Administration of Surveys
- Recruit potential participants from your personal network ... **REMEMBER**
 - A cross-section of the community is **VERY IMPORTANT**
 - Reaching disparate and underserved populations is **VERY IMPORTANT**
 - Feel free to offer assistance to complete the survey (e.g., limited English language, low literacy, vision problems, etc.)
 - Get the completed surveys back to the hospital point of contact as soon as possible

- Conducting Focus Groups
- Focus groups will be conducted within the same time frame
 - Consider volunteering to participate in the 1st Focus Group
 - Help us to recruit other community member who would be willing to participate in the 2nd and 3rd Focus Group ... **REMEMBER**
 - A cross section of the community is **VERY IMPORTANT**
 - Reaching disparate and underserved populations is **VERY IMPORTANT**

It Is Time To Hear From You

Discussion of the Issues

For Additional Information

Please contact:

Stuart Tedders, PhD, MS
Principal Investigator
Email: sttedders@georgiasouthern.edu
Phone: (912) 478-1922
or
Marie Denis-Luque, MSPH, MPH
Research Manager
Email: mdenisluque@georgiasouthern.edu
Phone: (912) 478-1343

APPENDIX K

Community Health Assessment

Prioritization of Issues

Stuart H. Tedders, PhD, MS
 Raymesta Lawrence, DrPH, MPH
 Marie Deme Lugo, MSPH, MPH
 Dzyana Hatzaruk, MPH, MS
 James White, BS
 Johns Hopkins Center for Public Health
 Georgia State University



Objectives

- Purpose of the Project
- Community Health Assessment
 - A Review of the Process
 - Secondary Data
 - Primary Data: Community-based Survey & Focus Groups
- Emergent Community Issues
 - Group Discussion
- Prioritization of the Issues



Purpose of the Project



Purpose

- To provide technical assistance to 18 nonprofit hospitals in completing the Community Health Needs Assessment as mandated IRS.

-- Service/Target Area:

- Jefferson County



Community Health Assessment (CHA)

A Review of the Process



Community Health Assessment

- A planned and methodical approach to identifying a profile of problems and assets.
- A starting point for solving complex community problems



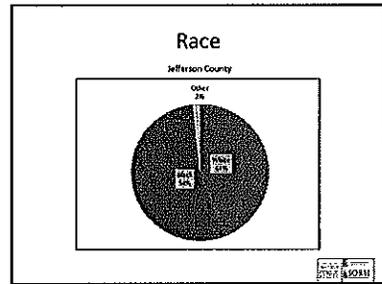
Phases of a CHA

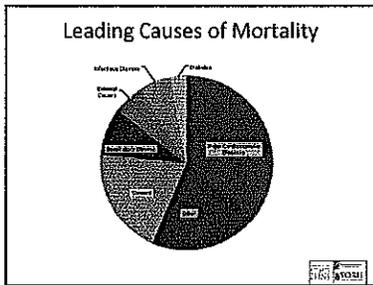
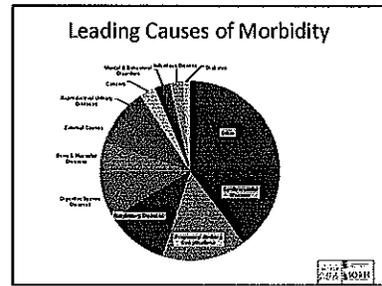
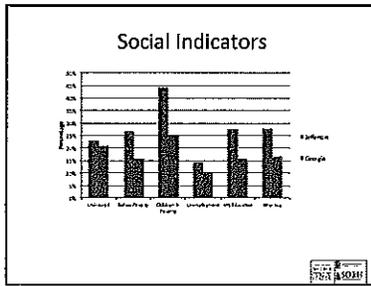
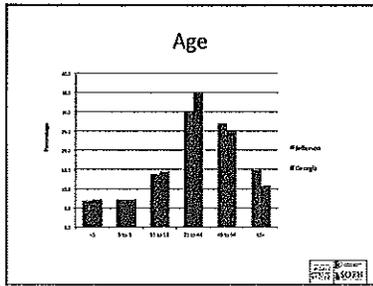
- ✓ Phase 1: Engage the Community in an Open and Honest Discussion of the Issues
- ✓ Phase 2: Collect Data to Document the Issues
 - ✓ Secondary data analysis
 - ✓ Primary data analysis: Community based survey
 - ✓ Primary data analysis: Focus group discussions
- Phase 3: Prioritization of the Issues



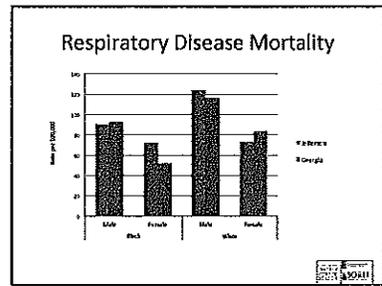
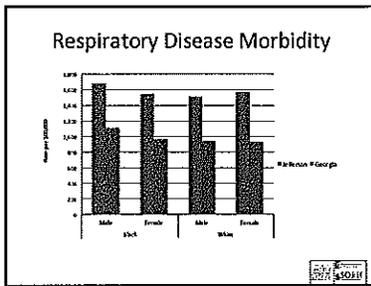
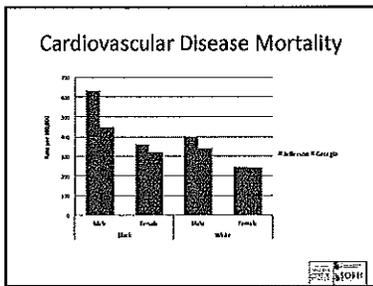
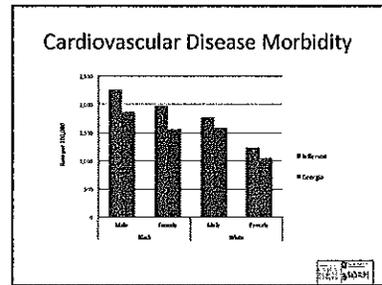
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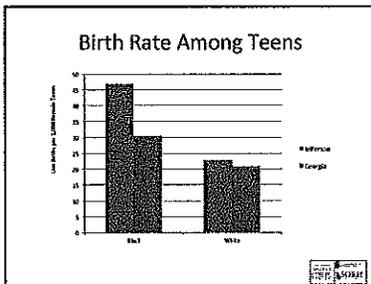
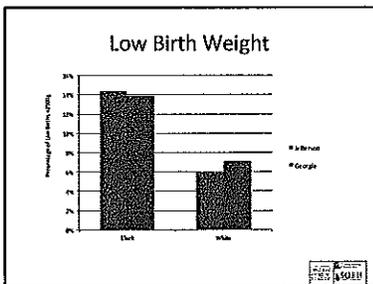
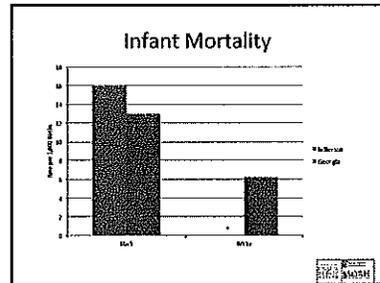
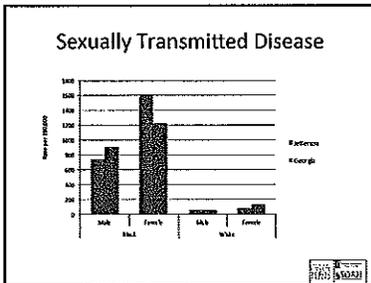
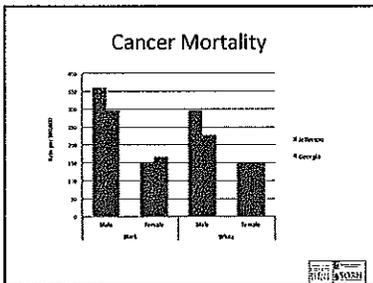
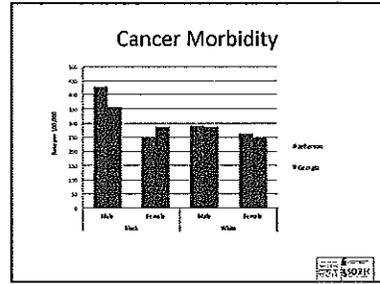
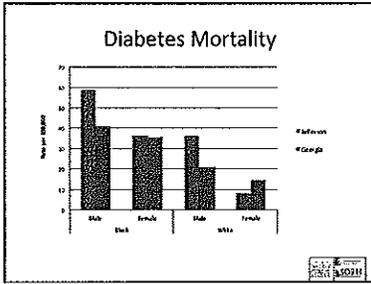
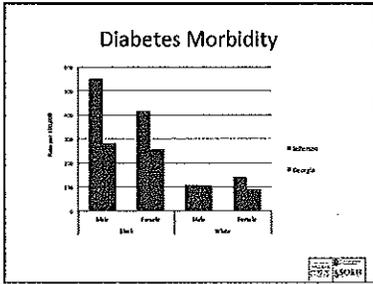
Highlights



Select Trends in Morbidity & Mortality

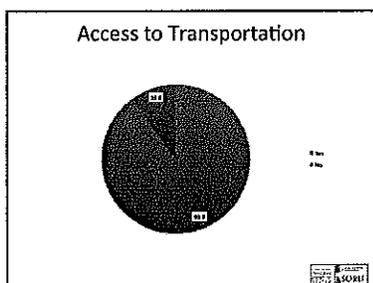
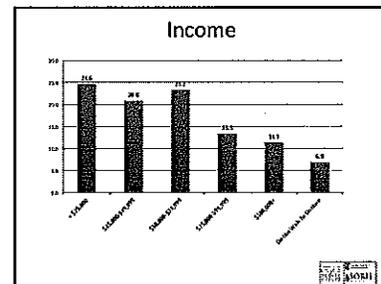
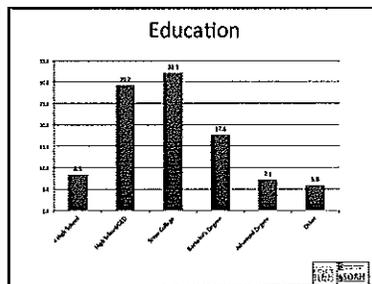
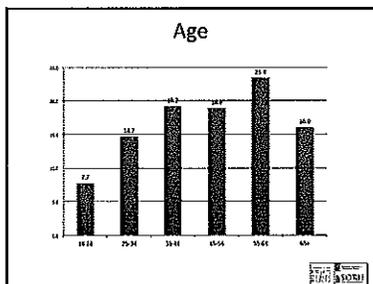
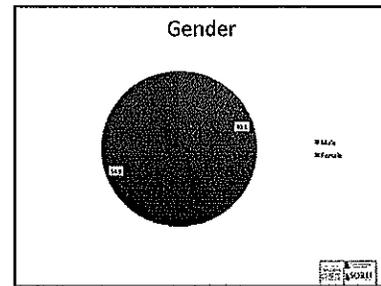
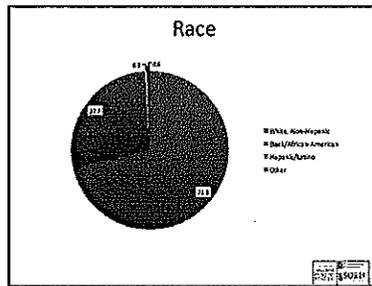




Primary Data: Community-Based Survey
Highlights

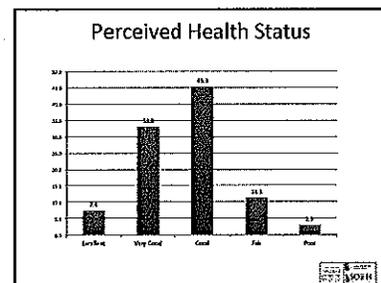
Community Based Survey

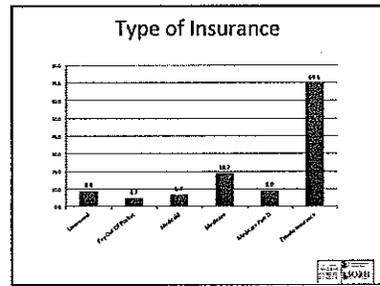
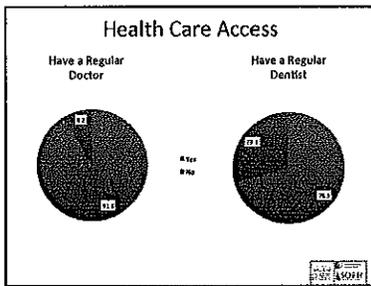
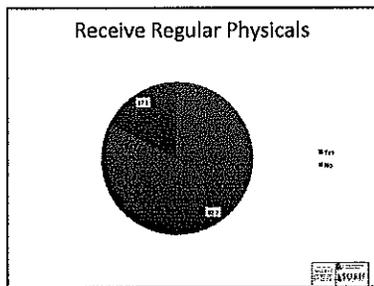
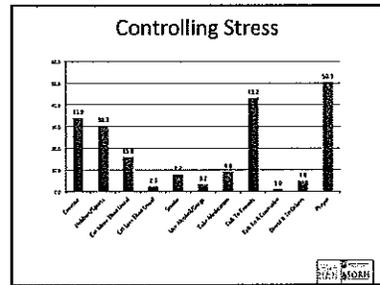
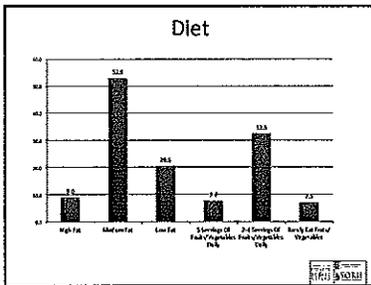
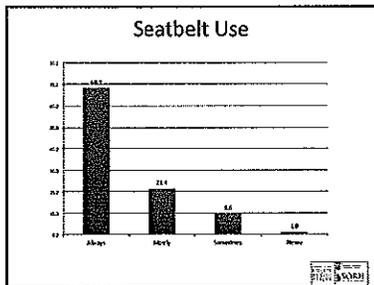
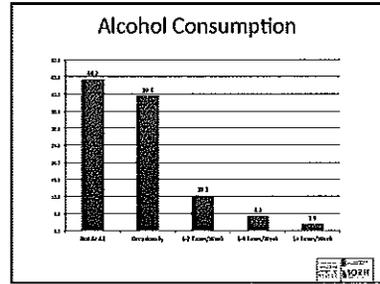
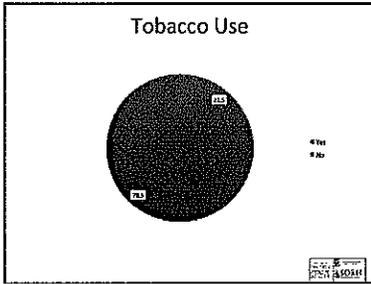
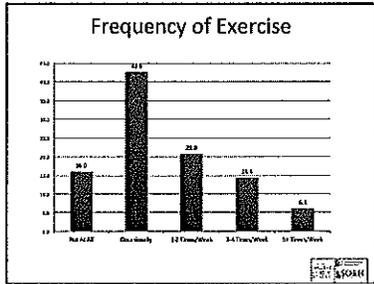
- Target Area
– Jefferson County
- 313 of 400 surveys were returned to Georgia Southern University for analysis
– 78.3% response rate
- 74.8% of participants used hospital services in the last 24 months
– Among these participants, 90.0% of services were obtained at Jefferson Hospital.

Community Perception

My Community:	"Agree" or "Strongly Agree"
Is a Good Place to Live	90.0%
Has Strong Economic Growth	18.0%
Has a Strong Health Care System	73.6%
Is a Good Place to Raise Children	81.8%
Is a Safe Community	85.0%
Has a Strong Education System	64.7%



Methods

- Focus Groups
 - Three Focus Groups
 - One: Community Advisory Committee
 - Two: Community members
- Participants
 - 28 Participants
 - Men: 11 Women: 17
 - Whites: 19 Black: 9
- Age Range
 - 26-76

Results

- Community
- Community Issues
- Hospital
- Hospital Problems
- Recommendations
- Community Vision

Community

Theme: "Everyone knows everyone"; close knit - like family; small town; friendly and caring people; no traffic; nice weather; low crime; good place to raise children; church involvement; too many fast food restaurants; 'southern diet' and lack of personal motivation.

"We seem to be a close-knit community. Everyone seems to, I think, get along fairly well, from one end of the county to the other."

"There's a lot of people involved in churches... A lot of hunting, fishing, recreation... I think it's great to have a network of people, whether you're related to them or not, they care about you. I think we're a very caring community and supportive of each other."

Community Issues

Theme: Lack of employment opportunities; chronic health conditions; high unemployment linked to lack of health insurance; loss of industry jobs; limited resources; lack of mental health professionals; teen pregnancy; high poverty; increase of single-parent households; grandparents raising grandchildren; lack of motivation to healthy living; lack of entertainment, recreation and shopping; and no privacy.

"Not enough jobs... There's a lot of people losing their jobs."

"We have a high rate of diabetes... But at one time we had three diabetes clinics here... It was just amazing how many diabetic cases we have in this community. What's causing it, I don't know, but it's a grave disease in this community, at epidemic levels."

Hospital

Theme: Caring staff; great services; everybody is treated equally; good food; effective PR work.

"We have a hospital that for the size hospital we are, I think we provide probably top care for a hospital and care. And all of the people that work here are concerned. We have a very unique situation for a small town. And what we do provide, I think is at top level."

"It's all about the people and meeting the need of that person. Whether they have insurance or not, they're not treated any differently than someone that does have insurance. And it's kind of well known. That's why a lot of people come here, because they know they're gonna get care there."

Hospital Problems

Theme: ER doctors are not local; underutilization; hospital is not well equipped.

"So they [ER doctors] don't treat in with their special care that the everyday employees give you. I think that's what people are missing. And a lot of people, they only have the interaction with the ER, because maybe they don't have the insurance or whatever to go to the doctor, so they go to the ER where they can be treated. So then they get that vision."

"I feel sorry that we don't have enough population in the hospital all the time, because at one time when my mother was in here, they were down to five clients for one night. I can realize that they can't run a facility of this magnitude with just five patients."

Recommendations

Theme: Sustainability; partnerships; expanded wellness center; prevention education; diabetic and obesity programs; community outreach programs; mobile care.

"I'll tell you one thing I wish would happen in the next 10 to 15 years in this community. Is that the hospital and doctors focused on treatment as well as prevention in some coordinated way. When you go to see the doctor, it's mainly for diagnosis and/or treatment. Well, if we could flip that switch to where we could see the community in a mode of prevention. That may be pulling the rug from under them because the healthier the community is, the less need for doctors. But if that could occur..."

Community Vision

Theme: Hospital to stay in community; health education; bring industry into the area; hospital to form nontraditional partnerships; and preventive healthcare.

"To keep this hospital viable. To develop a preventive health program that would offer people who would come here."

"... if we can promote our selves and come up with incentives to bring more industries here - and some of them would have to be on a starter level to get folks working again - that would have a lot to do with what happens to the meters of the hospital and everything else that's in this county. Because right now our county officials have a job implementing what we have or maintaining with far less money than what we have been able to bring in."

Emergent Community Issues

Generating Consensus for the Strategic Plan Issues to be Prioritized

- A. Chronic Disease Conditions (Heart Disease, Cancer, Etc.)
- B. Issues Associated with the Hospital (Specialized Equipment, Underutilization, Emergency Room Physicians, Uninsured, Indigent Care, Etc.)
- C. Partnerships to Promote Economic Development (Lack of Industry, Unemployment/Underemployment, Poverty, Etc.)
- D. Issues Associated with Healthcare Access (Mental Health Professionals, Uninsured Populations, Etc.)
- E. Improvement/Coordination/Partnerships of Community Health Education Activities (Obesity, Diabetes, Tobacco, Nutrition, Exercise, Teen Pregnancy, STD, Recreational Activities, Etc.)



Prioritization of the Issues



The Basics of Health Prioritization

- Prioritization is a process designed to allow groups to assess the *“Relative Importance”* of a given community health issue.
- Issues are *“rated”* in terms of:
 - The *“Size”*
 - The *“Seriousness”*
 - The *“Ability to Solve or Address”*

Prioritization is an exercise based on **“WHAT YOU THINK!”**



- **“Size of the Issue”?**
 - How many people are affected by the issue?
- **“Seriousness of the Issue”?**
 - What are the consequences of **NOT** addressing the problem? Death? Disability? Impact on Other?
- **“Ability to Solve or Change the Issue”?**
 - In the context of your community and its resources, is this a problem that can be solved easily?



Instructions for Prioritization

- Using the table provided, rate each issue identified in terms of:
 - Size..... Rate from 1 – 10
 - Seriousness..... Rate from 1 – 20
 - Solutions..... Rate from 1 – 10
- Simply write the number (on the scale) that seems to make sense to you
- This is an exercise based on **WHAT YOU THINK!**
 - There are **NO RIGHT** or **WRONG ANSWERS**



Issues to be Prioritized

- A. Chronic Disease Conditions (Heart Disease, Cancer, Etc.)
- B. Issues Associated with the Hospital (Specialized Equipment, Underutilization, Emergency Room Physicians, Uninsured, Indigent Care, Etc.)
- C. Partnerships to Promote Economic Development (Lack of Industry, Unemployment/Underemployment, Poverty, Etc.)
- D. Issues Associated with Healthcare Access (Mental Health Professionals, Uninsured Populations, Etc.)
- E. Improvement/Coordination/Partnerships of Community Health Education Activities (Obesity, Diabetes, Tobacco, Nutrition, Exercise, Teen Pregnancy, STD, Recreational Activities, Etc.)



Thank You!

For Additional Information About This Project:

Stuart Tedders, PhD, MS
Principal Investigator
Email: stedders@georgia-southern.edu
Phone: (912) 478-1922

or

Marie Denis-Lague, MSPH, MPH
Research Manager
Email: mdeinlague@georgia-southern.edu
Phone: (912) 478-1943



APPENDIX L

Meeting 1: Agenda
Jefferson Hospital
Wednesday, July 25, 2012
11:30AM-1PM

- | | | |
|-------|---|-----------------------|
| I. | Introductions | Site team leader |
| II. | Overview of community assessment process | Dr. Stuart Tedders |
| III. | Medical service area | Site team leader |
| | a. Steering group | |
| | b. Community advisory committee | |
| | i. Cross-section medical service area | |
| IV. | Hospital services/community benefits | Site team leader |
| V. | Community input tool | Dr. Tedders and Marie |
| | a. Feedback from steering group on current survey | |
| | b. Survey participants recruitment strategies and efforts | |
| VI. | Develop strategy and timeline | Site team leader |
| VII. | Planning next meeting | Marie |
| VIII. | Adjourn | |

Meeting 2: Agenda
Jefferson Hospital
Thursday, January 17, 2013
10AM-12PM

- | | | |
|-------|--|--------------------------------|
| I. | Introductions | Site team leader |
| II. | Project overview | Dr. Tedders |
| III. | County health indicators | Dr. Tedders |
| IV. | Hospital economic impact on local economy | Dr. Tedders |
| V. | Survey completion (community advisory group) | Dr. Tedders and
Ms. Biggers |
| VI. | Survey distribution/focus group recruitment | Dr. Tedders and
Ms. Biggers |
| VII. | Community discussion | Dr. Tedders |
| VIII. | Adjourn | |

Meeting 3: Agenda
Jefferson Hospital
Wednesday, June 26, 2013
10AM-12PM

- | | | |
|-------|--|--------------------------------|
| I. | Introductions | Site team leader |
| II. | Project overview | Dr. Tedders |
| III. | County health indicators | Dr. Tedders |
| IV. | Hospital economic impact on local economy | Dr. Tedders |
| V. | Survey completion (community advisory group) | Dr. Tedders and
Ms. Biggers |
| VI. | Survey distribution/focus group recruitment | Dr. Tedders and
Ms. Biggers |
| VII. | Community discussion | Dr. Tedders |
| VIII. | Adjourn | |

APPENDIX M

** did not obtain purposefully*

Jefferson Hospital
Steering Group Members

Sectors	Members	Title	Business	E-mail	Phone Contact	Address
Hospital	Ralph X. Randall	CEO		rkrandall@jeffersonhosp.com	(478) 625-7000 ext. 201	
Hospital	Tina Biggers	Assistant Admin group (Group Leader)		tbiggers@jeffersonhosp.com	(478) 625-7000 ext. 200	
Hospital	Catherine Hall	Social Service		chall@jpijeffersonhosp.com	(478) 625-7000 ext. 242	
	Rita Culvern	Retired Jefferson Hospital CEO				
	Mary Sue Rachels	Retired Jefferson Hospital		Marysuerachels37@hotmail.com	(478) 625-7000 ext. 207	
Hospital	Ann York	PHG Practice Manager (Rural Health Clinics) (L'ville, Wrens, & Wadley)		ayork@ip.jeffersonhosp.com	(478) 625-8471	
Health Department	Janet Pilcher	Nurse Manager Jefferson Co. Health Dept.		jrpilcher@dhr.state.ga.us	(478) 625-3716	

1/8

JEFFERSON HOSPITAL
Community Advisory Committee Members

Attendance
Record

11/7/13

Name	Occupation	Business/Agency	County	Phone	Email
Lisa Storms	Quality Manager	Jefferson Hospital	Jefferson	478-625-7000 Ext. 200	lstorms@ip.jeffersonhosp.com
Louise Storms	Retired Hospice Nurse	Hospice	Jefferson	478-625-7000 Ext. 200	
Dr. Nancy Cox	Physician	Physicians' Health Group - RHC	Jefferson	478-252-8900	ncoxmd@ip.jeffersonhosp.com
Carl Wagster	EMS Director	Rural Metro	Jefferson		
Amy Beddingfield	Nurse Practitioner	Jefferson Hospital Prenatal Center	Jefferson	478-625-7000 Ext. 289	abedingf@georgiahealth.edu
Donna Hutcheson	LPN	Physicians' Health Group - RHC	Glascok	478-625-8471	
John Johnson	Manager	Goody's Clothing Store	Jefferson	478-625-3390	john66ford@yahoo.com
Lil Easterlin	Director	Chamber of Commerce	Jefferson	478-625-8134	leasterlin@jeffersoncounty.org
Donna Miller	Director	Ogeechee Behavioral Health	Jefferson	478-455-2283	
Randall Jones	Insurance Agent	Woodman of the World	Jefferson	706-466-1901	
David Gunn	Pharmacist	Gunn Drug	Jefferson	478-252-5626	
Jimmy Fleming	Pharmacist	Barney's	Jefferson	478-625-8980	
Chester Johnson	Fire Dept. Captain	Jeff. Co. Fire Dept	Jefferson	762-245-9940	
Ott Stephens	Radio	WPEH	Jefferson	478-625-7248	WPEH@classicssouth.net
Ashlee Arrington	Occupational Therapist	Jefferson Hospital	Jefferson	478-625-7000 Ext. 244	aarrington@ip.jeffersonhosp.com

Name	Occupation	Business/Agency	County	Phone	Email
✓ Linda Weeks	Retired School Nurse Health Occupations Instructor	Jefferson County School System	Jefferson	706-547-6724 Cell: 706-825-3513	lkrweeks@hotmail.com

**Jefferson Hospital
 Prioritization (Meeting 3)
 June 26, 2013
 Sign-in Sheet**

Name (Print)	Affiliation(s)	Phone Number
Michelle Reaves		706-339-7476
William Evans	Jefferson County CI	478-625-4012
Janet Pilcher	Jefferson Co Health Dept	478-625-3716
Teresa Salter, Don	Jefferson Hospital	478-625-7000
Mary Sue Rachel	Jefferson Hospital	478-252-5596
Anne L. Dardun	Clerk of Superior Court	478-625-7922
Morie L. Standberry (Bill Smith)	Retired educator Minister FBC Louisville	478-625-8658 478-494-8745
Brooks B. Davis	Jefferson Hospital	478-625-7200
Patsy Whaley	Ga. State Office of Rural Health	229-401-3092
Cathleen Clark	Jefferson County Chamber of Commerce	(478) 625-8134
Lil Easterlin	Jefferson County Chamber of Commerce	(478) 625-8134
Catherine Hall	Jefferson Hospital	(478) 625-7000
Richard T. Stoop	City of Louisville	478-625-3166
[Signature]	"	478-206-0946

Name (Print)	Affiliation(s)	Phone Number
Jessica Guy	Jefferson Hospital	478-625-7000 ext. 200
Steve Wideler	Jefferson Hospital	478-625-7000 ext. 200
Alton Smider, Jr.		

APPENDIX N



MEMORANDUM

DATE: May 10, 2012

TO: Hospital and Health System CEOs

FROM: Robert E. Bolden, FHFMA
Vice President of Data Services

SUBJECT: Economic Impact Report

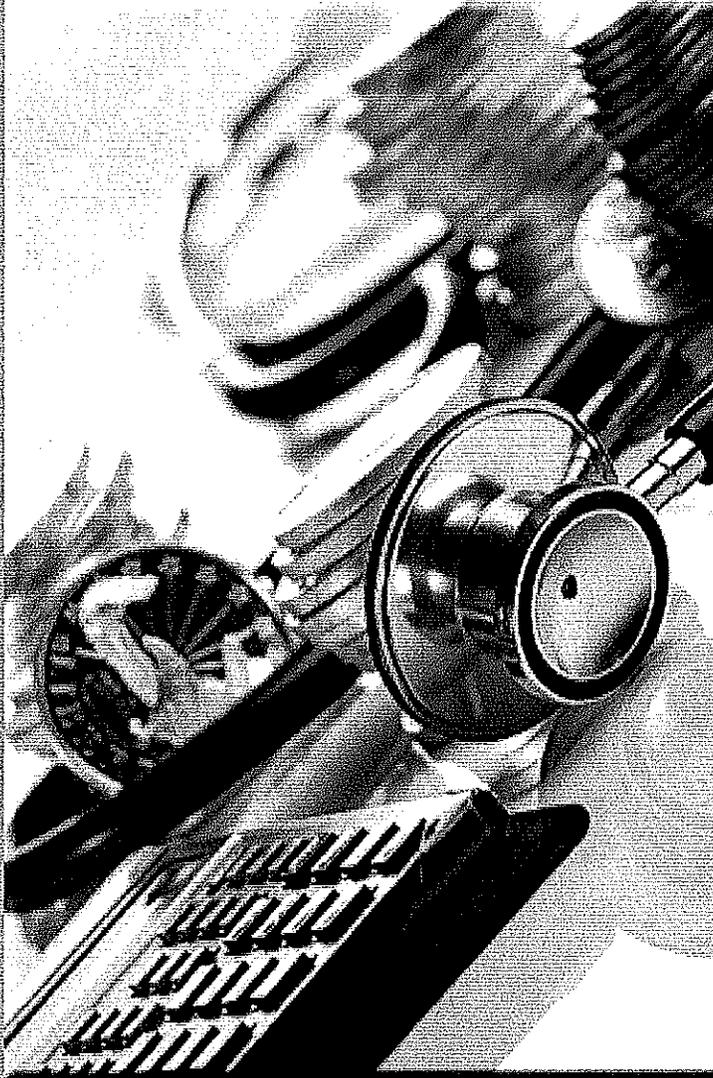
In an effort to assist you in communicating the economic impact of your hospital to local media, business, civic, and other community leaders, we have developed a hospital specific report to be used in your local community. This report is based on a study performed by the American Hospital Association (and updated with the most currently available economic multipliers from the Bureau of Economic Analysis, United States Department of Commerce). The enclosed report describes the \$38 billion impact hospitals and health systems contribute to the state's economy, as well as the economic impact of your individual hospital. This information is also being sent to the Public Relations Director and Government Relations staff at your hospital.

The data used to compile this report comes from the DCH Division of Health Planning Hospital Financial Survey for 2010. The 2010 data is the latest data that is currently available from the Georgia Department of Community Health. This report provides an excellent opportunity for you to share the importance of your local hospital to the media in a positive manner. To assist in that effort, we have included a model press release for you to use with your local media by inserting information specific to your facility into the press release. We also encourage you to share this information with decision makers in your community including legislators, Chambers of Commerce, and civic clubs. The enclosed press release about the Economic Impact Reports will be distributed to the media on May 23, 2012 and is embargoed until that time.

If you have any questions concerning the content of the economic impact report, contact Robert Bolden, Vice President of Data Services at GHA (770) 249-4505, rbolden@gha.org. If you have questions regarding the press releases or communicating with the media, contact Kevin Bloye, Vice President of Public Relations, at (770) 249-4504, kbloye@gha.org

The enclosed Economic Impact Report is made available through the sponsorship of the Georgia Hospital Health Services (GHHS) subsidiary of the Georgia Hospital Association.

Georgia Hospitals - Vital Economic Engines for Georgia's Economy



Economic Impact Report



Economic Impact Report

Executive Summary

Hospitals play a vital role in the economic activity of the communities they serve. Economic impact arises directly from the sales, wages and employment generated by business activity. It also arises indirectly through the “ripple” effect of businesses purchasing goods and services from other local businesses, and through health care workers spending wages and other income for household goods and services. These linkages tend to distribute the impact of an activity or event very broadly through the economy. Georgia hospitals are direct employers, purchasers of equipment, supplies and services, and investors in capital projects. This report summarizes the estimated economic impact of the hospital and the actual cost to the hospital of community benefits provided in the form of indigent care, charity care, bad debt expense, and other free care as reported in the 2010 Georgia Department of Community Health Hospital Financial Survey. The enclosed Economic Impact Report shows that hospitals in Georgia provided more than \$1.5 billion in uncompensated costs to provide indigent, charity, other free care, and bad debt expense to the citizens of Georgia. This report is a tool hospitals can use as they work with local elected officials and in their community relations efforts. Nationwide, hospital care is the largest component of the health care sector, which itself is a growing segment of the U.S. economy. In 2009, the health care sector represented 17.3% of Gross Domestic Product (GDP)—a measure of economic output—or approximately \$2.34 trillion. Hospitals accounted for \$725 billion of that total.

The information contained in this report is based on a study prepared by the American Hospital Association in 2006—“Beyond Health Care: The Economic Contributions of Hospitals” (updated January 2010), and updated with the most currently available Regional Input-Output Modeling System (RIMS II) economic multipliers for hospitals and nursing and residential care facilities. These RIMS II economic multipliers are developed by the Bureau of Economic Analysis, United States Department of Commerce. The economic multipliers attempt to model the resulting impact of a change in autonomous spending in one industry on the “circular flow” of spending within an economy as a whole. An increase in demand for health care services will elicit increases that support health care, as well as its ancillary industries. These multipliers have been applied to individual hospital expenditures to create a report that estimates the economic impact of individual hospitals.

Individual hospital expenditure data was obtained from the 2010 Georgia Department of Community Health Division of Health Planning Annual Hospital Financial Survey. [Note: The 2010 data is the latest data that is currently available from the Department of Community Health]. It should be emphasized that this report reflects the economic impact of only the hospital expenditures. It does not include the impact of other services provided by a health care system, such as home health, skilled nursing facility, affiliated clinics, physician practices, etc. The economic impact of an entire health care system can be estimated by taking the consolidated health system expenditures and multiplying it by the economic multipliers provided in the report.

The report is divided into two sections. Section I contains information about the overall economic impact of the hospital. Section II contains selected information about the Community Benefit provided by the hospital in the form of indigent care, charity care, other free care and bad debt. These numbers are reported as actual cost to the hospital. Actual cost is reported in order to not overstate the true level of community benefit provided. For example, to calculate the cost of indigent care provided, the amount of indigent care charges reported on the 2010 Division of Health Planning Annual Hospital Financial Survey is multiplied by the hospital cost-to-charge ratio, also reported on the 2010 Division of Health Planning Annual Hospital Financial Survey. The Hospital Payroll and Benefits data was gathered from Medicare Cost Report Data for the applicable year.

While GHA reviews the reasonableness of the hospital data provided by the Division of Health Planning, Department of Community Health, there may be data entry errors in the attached report. If you believe there are differences in the numbers contained in your enclosed Economic Impact Report and the numbers submitted to the Division of Health Planning, please contact Robert Bolden, Vice-President of Data Services, at GHA to obtain a corrected Economic Impact report, (770) 249-4505, rbolden@gha.org

An economic impact report is provided for each individual hospital, the state as a whole, the Metropolitan Statistical Area where the hospital is located, and the Congressional district where the hospital is located. Health systems also receive a consolidated report of the economic impact of all the hospitals in their system.

Georgia hospitals are a fundamental building block for the state's economy. In many communities, hospitals are one of the largest employers and most significant creators and sustainers of jobs and income. In Georgia, hospitals employ more than 150,000 full and part-time people and have a payroll that exceeds \$8 billion dollars annually. Health care is a significant force that contributes to the economic stability and growth across all regions of the state. Hospitals often serve as an integral part of the overall package used to attract industry to the community. A strong health care system can help attract and maintain business and industry growth, attract and retain retirees, and create jobs in the local area. In addition, hospitals serve as the foundation which supports a wide variety of other health care services including physician practices, long-term care providers, home health agencies, rehab providers, etc.

Georgia hospitals play a key role in the economic development and growth in the State of Georgia. Therefore, it is especially important that policymakers, legislators, and business leaders clearly understand the implications of the decisions they make that impact hospitals. GHA hopes that you will find the information in this report useful as you work with local legislators, policymakers, and the community you serve. Many Georgia residents, particularly the poor and elderly in rural areas of the state, may have difficulty accessing hospital services unless legislators understand the important role hospitals play in the local economy and make the financial stability of hospitals a budget priority.

If you have any questions about the report, please contact Robert E. Bolden, GHA Vice-President of Data Services, rbolden@gha.org or Kevin Bloye, Vice President of Public Relations, kbloye@gha.org

Sources:

- *AHA: Trendwatch Chartbook 2010, The Economic Contribution of Hospitals*
- *American Hospital Association: "Beyond Health Care: The Economic Contribution of Hospitals", Summer 2006, Updated January 2010*
- *RIMS-II Multipliers, Total Multipliers for Output, Earnings, Employment, and Value Added by State, Hospitals and Nursing and Residential Care Facilities, Bureau of Economic Analysis, United States Department of Commerce*
- *2010 Annual Hospital Financial Survey, Division of Health Planning, Department of Community Health*
- *Hospital Medicare Cost Report Data*
- *Georgia Hospital Association Membership Directory*

Technical Note:

GHA obtains the hospital payroll and benefits data for the Economic Impact Reports from the Medicare Cost Report database. The data for hospital and payroll benefits is taken from the following locations in the Medicare Cost Report file:

Worksheet S-3, Part II: Hospital Wage Index Information—Column 3, Line 1—Total Salaries

Worksheet A: Total Facility Costs—Column 7, Line 5—Employee Benefits—Net Expense for Allocation

If there is no data in Worksheet S-3, Part II: Column 3, Line 1—Total Salaries, we next check to see if there is any data regarding payroll in Worksheet A: Total Facility Costs—Column 1, Line 101—Salary Expense.

If there is not any data in Worksheet A, Column 1, Line 101, we enter N/A in the Economic Impact Report. If a hospital has N/A in their Economic Impact report, they can contact GHA with their payroll and benefits data and we will create a revised Economic Impact Report for them.

Data taken from the Centers for Medicare and Medicaid Services (CMS) Medicare Cost Report are as reported by the hospital. The HCRIS database is updated by CMS quarterly and changes from one quarter to another quarter are common due to cost report audits, provider appeals, reopening of cost reports, submission of revised data by providers, etc. For the Economic Impact Report, GHA uses the most current data available for a hospital at the time the Economic Impact Reports are generated.

Jefferson Hospital

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$9,214,908
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$21,315,925
Hospital Payroll and Benefits	\$8,086,198
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$15,028,199
Number of Hospital Jobs (Full and Part Time)	169
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	363

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$595,242
Uncompensated Charity Care Provided	\$29,916.99
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$737,870
Other Free Uncompensated Care	\$93,017
TOTAL:	<u>\$1,456,046</u>

1 Georgia Output Multiplier - Estimates the change in output for a given change in demand. For example, an increase in healthcare demand of \$1,000,000 increases the output of all Georgia industries by 2.3132 x \$1,000,000 = \$2,472,700 after all "rounds" of spending are totaled. 2 Georgia Earnings Multiplier - Increased demand for healthcare also increases demand for healthcare labor, and increases labor demand in peripheral and supporting industries, resulting in increased wages paid. 3 Georgia Employment Multiplier - Estimates of the number of all full and part time jobs that regional industries provide in order for the healthcare industry to provide the additional \$1,000,000 of output to final demand. 4 Georgia full-time jobs created - This number does not include the number of people directly employed by the hospital. 5 Note--these numbers are reported at cost--not reported charges. Actual cost was calculated by multiplying reported charges by the hospital cost-to-charge ratio.

Sources of Data: 2010 Georgia Department of Community Health Division of Health Planning Hospital Financial Survey; 2009 & 2010 Medicare Cost Report Data; GHA Membership Directory; Beyond Health Care: The Economic Contribution of Hospitals, American Hospital Association, June 2010 update, AHA Trendwatch Chartbook 2010.

Analysis based on Regional Input-Output Modeling System (RIMS II) multipliers for hospitals NAICS Code 622, released December 2011, Bureau of Economic Analysis, U.S. Department of Commerce. Multipliers are based on the 2008 Annual Input-Output Table for the Nation and 2008 regional data.

Center for Rural Health Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$1,548,309,567
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$3,581,549,690
Hospital Payroll and Benefits	\$971,307,700
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$1,805,175,360
Number of Hospital Jobs (Full and Part Time)	28,013
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	60,228

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$50,987,718
Uncompensated Charity Care Provided	\$14,764,958.35
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$121,842,475
Other Free Uncompensated Care	\$5,889,217
TOTAL:	<u>\$193,484,368</u>

1 Georgia Output Multiplier - Estimates the change in output for a given change in demand. For example, an increase in healthcare demand of \$1,000,000 increases the output of all Georgia industries by 2.3132 x \$1,000,000 = \$2,472,700 after all "rounds" of spending are totaled. 2 Georgia Earnings Multiplier - Increased demand for healthcare also increases demand for healthcare labor, and increases labor demand in peripheral and supporting industries, resulting in increased wages paid. 3 Georgia Employment Multiplier - Estimates of the number of all full and part time jobs that regional industries provide in order for the healthcare industry to provide the additional \$1,000,000 of output to final demand. 4 Georgia full-time jobs created - This number does not include the number of people directly employed by the hospital. 5 Note--these numbers are reported at cost--not reported charges. Actual cost was calculated by multiplying reported charges by the hospital cost-to-charge ratio.

Sources of Data: 2010 Georgia Department of Community Health Division of Health Planning Hospital Financial Survey; 2009 & 2010 Medicare Cost Report Data; GHA Membership Directory; Beyond Health Care: The Economic Contribution of Hospitals, American Hospital Association, June 2010 update, AHA Trendwatch Chartbook 2010.

Analysis based on Regional Input-Output Modeling System (RIMS II) multipliers for hospitals NAICS Code 622, released December 2011, Bureau of Economic Analysis, U.S. Department of Commerce. Multipliers are based on the 2008 Annual Input-Output Table for the Nation and 2008 regional data.

Rural Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$1,983,154,860
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$4,587,433,822
Hospital Payroll and Benefits	\$1,200,348,950
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$2,230,848,524
Number of Hospital Jobs (Full and Part Time)	32,176
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	69,178

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$74,566,898
Uncompensated Charity Care Provided	\$22,374,133.51
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$130,994,200
Other Free Uncompensated Care	\$7,805,609
TOTAL:	<u>\$235,740,841</u>

1 Georgia Output Multiplier - Estimates the change in output for a given change in demand. For example, an increase in healthcare demand of \$1,000,000 increases the output of all Georgia industries by 2.3132 x \$1,000,000 = \$2,472,700 after all "rounds" of spending are totaled. 2 Georgia Earnings Multiplier - Increased demand for healthcare also increases demand for healthcare labor, and increases labor demand in peripheral and supporting industries, resulting in increased wages paid. 3 Georgia Employment Multiplier - Estimates of the number of all full and part time jobs that regional industries provide in order for the healthcare industry to provide the additional \$1,000,000 of output to final demand. 4 Georgia full-time jobs created - This number does not include the number of people directly employed by the hospital. 5 Note--these numbers are reported at cost--not reported charges. Actual cost was calculated by multiplying reported charges by the hospital cost-to-charge ratio.

Sources of Data: 2010 Georgia Department of Community Health Division of Health Planning Hospital Financial Survey; 2009 & 2010 Medicare Cost Report Data; GHA Membership Directory; Beyond Health Care: The Economic Contribution of Hospitals, American Hospital Association, June 2010 update, AHA Trendwatch Chartbook 2010.

Analysis based on Regional Input-Output Modeling System (RIMS II) multipliers for hospitals NAICS Code 622, released December 2011, Bureau of Economic Analysis, U.S. Department of Commerce. Multipliers are based on the 2008 Annual Input-Output Table for the Nation and 2008 regional data.

Congressional District 12, Rep. John Barrow

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$1,074,168,206
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$2,484,765,894
Hospital Payroll and Benefits	\$548,037,284
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$1,018,527,292
Number of Hospital Jobs (Full and Part Time)	20233
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	43,501

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$38,575,512
Uncompensated Charity Care Provided	\$11,238,693.87
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$45,726,559
Other Free Uncompensated Care	\$3,916,930
TOTAL:	\$99,457,695

1 Georgia Output Multiplier - Estimates the change in output for a given change in demand. For example, an increase in healthcare demand of \$1,000,000 increases the output of all Georgia industries by 2.3132 x \$1,000,000 = \$2,472,700 after all "rounds" of spending are totaled. 2 Georgia Earnings Multiplier - Increased demand for healthcare also increases demand for healthcare labor, and increases labor demand in peripheral and supporting industries, resulting in increased wages paid. 3 Georgia Employment Multiplier - Estimates of the number of all full and part time jobs that regional industries provide in order for the healthcare industry to provide the additional \$1,000,000 of output to final demand. 4 Georgia full-time jobs created - This number does not include the number of people directly employed by the hospital. 5 Note--these numbers are reported at cost--not reported charges. Actual cost was calculated by multiplying reported charges by the hospital cost-to-charge ratio.

Sources of Data: 2010 Georgia Department of Community Health Division of Health Planning Hospital Financial Survey; 2009 & 2010 Medicare Cost Report Data; GHA Membership Directory; Beyond Health Care: The Economic Contribution of Hospitals, American Hospital Association, June 2010 update, AHA Trendwatch Chartbook 2010.

Analysis based on Regional Input-Output Modeling System (RIMS II) multipliers for hospitals NAICS Code 622, released December 2011, Bureau of Economic Analysis, U.S. Department of Commerce. Multipliers are based on the 2008 Annual Input-Output Table for the Nation and 2008 regional data.

State of Georgia

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$16,435,716,117
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$38,019,098,522
Hospital Payroll and Benefits	\$8,114,440,277
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$15,080,687,254
Number of Hospital Jobs (Full and Part Time)	153,364
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	329,733

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$524,433,651
Uncompensated Charity Care Provided	\$218,478,004
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$665,704,510
Other Free Uncompensated Care	\$95,291,552
TOTAL:	<u>\$1,503,907,717</u>

1 Georgia Output Multiplier - Estimates the change in output for a given change in demand. For example, an increase in healthcare demand of \$1,000,000 increases the output of all Georgia industries by 2.3132 x \$1,000,000 = \$2,472,700 after all "rounds" of spending are totaled. 2 Georgia Earnings Multiplier - Increased demand for healthcare also increases demand for healthcare labor, and increases labor demand in peripheral and supporting industries, resulting in increased wages paid. 3 Georgia Employment Multiplier - Estimates of the number of all full and part time jobs that regional industries provide in order for the healthcare industry to provide the additional \$1,000,000 of output to final demand. 4 Georgia full-time jobs created - This number does not include the number of people directly employed by the hospital. 5 Note--these numbers are reported at cost--not reported charges. Actual cost was calculated by multiplying reported charges by the hospital cost-to-charge ratio.

Sources of Data: 2010 Georgia Department of Community Health Division of Health Planning Hospital Financial Survey; 2009 & 2010 Medicare Cost Report Data; GHA Membership Directory; Beyond Health Care: The Economic Contribution of Hospitals, American Hospital Association, June 2010 update, AHA Trendwatch Chartbook 2010.

Analysis based on Regional Input-Output Modeling System (RIMS II) multipliers for hospitals NAICS Code 622, released December 2011, Bureau of Economic Analysis, U.S. Department of Commerce. Multipliers are based on the 2008 Annual Input-Output Table for the Nation and 2008 regional data.

APPENDIX O

Instrument Pilot Test Instructions

A typical pilot test involves administering a small number of surveys to a group of individuals that have characteristics similar to the proposed target population. This allows you to simulate the data collection process without investing a lot of time and energy. The importance of simulating the actual data collection process on a small scale is to assess how effective the survey works in a "real world" situation. Any problems you note (outlined below) should be addressed prior to administering the survey to the target population.

In order to conduct this pilot test, please identify at least 5 to 7 people who are representative of the service area. Information gleaned from this select group of people will significantly enhance the likelihood of successful data collection. Specific items to look for include, but are not limited to:

- Questions that respondents don't understand;
- Ambiguous questions;
- Questions that combine two or more issues in a single question (double-barreled questions); and
- Questions that make respondents uncomfortable.

It is important for us to keep track of how long it takes for respondents to complete the survey, so please record the time of completion for each pilot subject. In addition, please take some time with the respondent to discuss his or her experience. Below are some questions that you may want to ask them.

1. How long did it take you to complete the instrument?
2. What do you think this instrument is about?
3. For what purposes do you think this information will be used?
4. What problems, if any, did you have completing the instrument?
5. Are the directions clear?
6. Are the instructions clear on what to do with the instrument after completing it?
7. Are there any words/language issues in the instrument that people might not understand?
8. Did you find any of the questions to be unnecessary or too sensitive?
9. Were any questions difficult to answer?

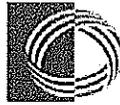
10. [For a specific survey question that is problematic, you may consider asking the following:] What do you think this question is asking?

- a. How would you phrase this question in your own words?
- b. Did the answer choices allow you to answer as you intended?
- c. Is there anything you would change about the instrument?

Through appropriate consultation with the site, we will modify the survey based on the information you have gathered.

****After completing the pilot test, please copy the completed instrument for your records; return the original completed surveys to us via postal mail or electronically (you can also choose to scan the completed surveys) within 5 business days.**

APPENDIX P



County Health Assessment Survey

Thank you for taking time to give us your input.

This survey is being conducted in 18 rural counties in Georgia.
The information you provide will assist in identifying the
community's needs, assets and resources.

Your participation in this survey is completely voluntary.
Please do not include any identifying information such as
name, address, etc. Completion of this survey indicates your
consent to participate in this research study. Only data from
persons 18 years old or older will be used in this research. The
answers you give will be safeguarded to the fullest extent
possible in accordance with applicable statutes. No individual
responses will be reported, so please answer every question
as honestly as you can.

Please select only one answer unless otherwise instructed.

Contact Information

Georgia Southern University Information
Stuart H. Tedders, PhD, MS
Principal Investigator
Phone: (912) 478-1922
Email: stedderts@georgiasouthern.edu

Marie Denis-Luque, MSPH, MPH
Research Manager
Phone: (912) 478-1343
Email: mdenisluque@georgiasouthern.edu

Please return this survey to:

Jefferson Hospital
ATTN: Tina Biggers
P.O. Box 528
1067 Peachtree Street
Louisville, GA 30434

For Questions regarding the survey please call
Tina Biggers at (478) 625-7000 ext. 207

DEMOGRAPHIC

1. What is your gender?
Male
Female
2. What is your ethnicity/race?
White, Non-Hispanic
Black/African-American
Hispanic/Latino
Asian/Pacific Islander
Other: _____
3. Which of the following age ranges best describes you?
18-24
25-34
35-44
45-54
55-64
65 or older
4. What is your marital status?
Single
Married
Separated
Living Together
Divorced
Widowed
Other: _____
5. What is your highest level of education?
Less than High School
High School or GED
Some College
Bachelor's degree (BA, BS)
Advanced degree (MA, PhD)
Other: _____

ECONOMIC STATUS

6. What best describes your current employment status?
Student
Full-Time
Part-Time
Self-Employed
Retired
Unemployed
Not Seeking Employment

7. What is your household income?
Under \$25,000
\$25,000 to \$49,999
\$50,000 to \$74,999
\$75,000 to \$99,999
\$100,000 or more
Don't know /not sure
 8. Do you own your home?
Yes
No
 9. Do you have access to your own means of transportation?
Yes
No
 10. What is your residential zip code?
30477
30803
30413
30434
30823
Other: _____
 11. How many people live in your household?

 12. How many of these people have jobs?

 13. How many of the people live with you who are dependent on you?
None
1
2
3 or more
- HOSPITAL**
14. Have you or anyone in your household used the service of a hospital in the last 24 months?
Yes
No (Skip to Question #29)
Don't know (Skip to Question #29)
 15. At which hospital were services received?
Jefferson Hospital
Some other hospital. List the city or cities where the hospital(s) was located
_____ then
(Skip to Question #27)

16. You responded that you or someone in your household received services at Jefferson Hospital, why did you or family member choose Jefferson Hospital?
Physician referral
Closer, more convenient
Insurance
Quality of care
Availability of Specialty Care
Other: _____
17. What hospital services were used at Jefferson Hospital?
Radiological Imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
Laboratory
Other Outpatient services
Inpatient services
Emergency room (ER)
Other (List) _____
18. How satisfied were you or someone else in your household with the services received at Jefferson Hospital?
Satisfied (Skip to Question #20)
Dissatisfied
Don't know (Skip to Question #21)
19. Why were you dissatisfied with the services at Jefferson Hospital? (Skip to Question #21)
Answer: _____

20. Why were you satisfied with the services at Jefferson Hospital?
Answer: _____

21. Do you use a primary care (family) doctor, physician assistant or nurse practitioner for most of your routine health care?
 Yes (SKIP to Question #23)
 No
 Don't know

27. Are you able to get an appointment with the primary care (family) doctor, physician assistant or nurse practitioner at Jefferson Hospital when you need one?
 Yes
 No
 Don't know

22. If no, what kind of medical provider do you use for routine care?
 Health Department
 Rural Health Clinic
 Emergency Room Hospital
 Specialist
 Other: _____

28. What services would you like to see offered at Jefferson Hospital?
 Answer: _____

23. Have you or someone else in your household been to a primary care (family) doctor, physician assistant or nurse practitioner at Jefferson Hospital?
 Yes
 No (Skip to Question #29)
 Don't know (Skip to Question #29)

24. How satisfied were you or someone else in your household with the quality of the physician care or (physician assistant or nurse practitioner) care received at Jefferson Hospital? Would you say you were...
 Satisfied (Skip to Question #26)
 Dissatisfied
 Don't know (Skip to Question #29)

25. Why were you dissatisfied with the quality of physician care at Jefferson Hospital?

Answer: _____

26. Why were you satisfied with the quality of physician care at Jefferson Hospital?

Answer: _____

YOUR COMMUNITY

29. Please read the following statements and check the ONE response that best reflects your opinion for each.

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
My community is a good place to live.					
My community has strong economic growth.					
My community has a strong health care system.					
My community is a good place to raise children.					
My community is a safe community.					
My community has a strong education system.					

INDIVIDUAL BEHAVIORS & HABITS

30. How often do you exercise?
 Not at all
 Occasionally
 1-2 times each week
 3-4 times each week
 5 or more times each week

32. Do you use tobacco products?
 Yes
 No

- ***(If Male, Skip Question #31)*
 31. Do you do a monthly breast self-exam?
 Yes
 No

33. How often do you use alcohol?
 Not at all
 Occasionally
 1-2 times each week
 3-4 times each week
 5 or more times each week

34. Do you use a seat belt every time you drive or ride in a car?
 Always
 Mostly
 Sometimes
 Never

35. How would you describe your diet?
(Check all that apply)
 High fat
 Medium amount of fat
 Low fat
 I eat at least 5 servings of fruits/vegetables daily
 I eat 2-4 servings of fruits/vegetables daily
 I rarely eat fruits/vegetables

36. How do you control stress in your life?
(Check all that apply)
 Exercise
 Hobby/sports
 Eat more than normal
 Eat less than normal
 Smoke
 Drink alcohol or use drugs
 Take medication
 Talk to friends
 Talk to professional counselor
 Take it out on other people
 Prayer
 Other: _____

HEALTHCARE SEEKING BEHAVIOR & CONDITIONS

37. Please rate your overall health status
(Check ONE):
 Excellent
 Very Good
 Good
 Fair
 Poor
 Don't know/ Not sure

38. Do you get regular physicals and/or healthcare?
 Yes
 No
 If no, how do you get healthcare?

39. Do you have a regular doctor or health care provider?
 Yes
 No

40. What type of health insurance do you have?
 Uninsured *(Go to Question #43)*
 I pay out of pocket *(Go to Question #43)*
 Medicaid
 Medicare
 Medicare Part D
 Private (HMO, PPO)

41. How long have you had this health insurance? *Specify:* _____

42. If you have private insurance, who pays for it?
 My employer pays for the majority of the cost
 I (or my family) pays for the majority of the cost
 Employer and (or my family) share the cost
 Other *(Specify):* _____

43. Do you have a dentist you see regularly?
 Yes
 No

44. Where do you usually go when you are sick or need health care?
(Check all that apply)
 Rural Health Clinic
 Hospital Emergency Department
 Health Department
 Other *(Specify):* _____

45. Was there a time in the past 12 months, when you needed to see a healthcare provider but could not because of cost?
 Yes
 No

46. Was there a time in the past 12 months, when you avoided filling a prescription because you couldn't afford to do so?
 Yes
 No

QUESTION 47
GO TO NEXT PAGE

47. Have you or anyone in your household been to the emergency room (ER) for any of the following conditions? (Check all that apply)

Top 10 Ambulatory Care Sensitive Conditions	Check Mark
Dehydration	<input checked="" type="checkbox"/>
Gastroenteritis	<input type="checkbox"/>
Kidney infection	<input type="checkbox"/>
Bleeding or perforated ulcer	<input type="checkbox"/>
Pelvic inflammatory disease	<input type="checkbox"/>
Ear, nose and throat infections	<input type="checkbox"/>
Cellulitis	<input type="checkbox"/>
Dental conditions	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>
Chronic obstructive pulmonary disease	<input type="checkbox"/>
Trauma (auto accident, sprain, strain, fracture)	<input type="checkbox"/>
None	<input type="checkbox"/>

My medical condition was not listed. I have this or these conditions:

Answer: _____

Thank you again for completing the survey!

APPENDIX Q

Community Health Needs Assessment Project Focus group Preparation Logistics

According to experts in the field of qualitative research, *a focus group is a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment.* Discussions are relaxed and often participants enjoy sharing their ideas and perceptions. Focus groups are often conducted by **two trained facilitators** one of whom is a co-moderator. **Georgia Southern University will provide trained facilitators and bring all needed equipment** (tape recorder, notepad, name tents and pens/pencils. Whatever else we will need).

A typical **focus group size** is between 5-10 participants. In this initiative, there will be three groups consisting of 6-8 people.

Participant selections: Select participants who are relevant to the project and have the potential to contribute valuable information to the topic. Make sure the community advisory committee (CAC) members know there will be no monetary incentive for these participants. Also let them know if there will be any refreshments provided during the focus groups. In addition to refreshments, for instance, if your budget allows, you can put together a small gift basket (hospital pen/notepad/bracelet/candy etc.) to give to participants after the meeting.

When planning your site's **3 focus groups**, here are some things you will need to think about:

**If the focus groups are scheduled to take place at least three weeks in advance, you need to give them two reminder calls instead of one.*

	Recruiting participants: Were the participants selected to represent a cross-section of the service area? Are the selected participants able to provide knowledgeable information on the topic?
	After the CAC members provided you with potential focus group participants – ask CAC members to make the initial contact to let them know that someone from the hospital will be contacting them to inform about the date, time and location of the focus group.
	Decide on a date, time and location before you contact potential participants. If need be, meet with your steering group members to make these decisions.
	<i>*Note: All the three focus groups will be scheduled to take place within hours of each other, unless stated otherwise.</i>
	Locate a comfortable venue. A place within the hospital or community where people can easily find and come to share what's on their mind on the topic. It is recommended to have a circle shaped table. If you can't get one, arrange the seating so that people are close to each other.
	Reminder call: Make a second call to each participant <u>24 hours before</u> the focus group to remind them of their participation in the focus group. During that call remind them that they will need to arrive at the location <u>at least 15 minutes</u> in advance.
	After the focus groups are completed, call participants to thank them or send them a thank you card/letter.

APPENDIX R

COMMUNITY HEALTH NEEDS ASSESSMENT FOCUS GROUP GUIDE

Good morning (*afternoon*) everyone. My name is *[insert name]* and this is *[insert name]* and he/she will be taking notes and handling other things that may come up during our time together while I focus all my attention on what you have to share with us. Thank you again for agreeing to participate in this discussion about the health of your community. We're having these types of conversations with 18 rural communities in Georgia. The information we gather will help identify the community's needs, assets, and resources. You're here because you're a member of the community and have a unique view of what is happening in *[insert community name]*. Participating in this discussion is up to you. You can stop at any time. If you need to excuse yourself, please know there will be no penalty. We encourage you to answer the questions honestly. Our discussion today will be recorded. Please speak loud and clearly. Your answers will not be reported individually, so they cannot be linked to you in any way. Please refer to the handout in front of you [**GO THROUGH INFORMED CONSENT PROCESS**]. Now that we have gone through the consent process, let us begin...

The first few questions are about your community in general:

1. Tell us a little bit about living in *[insert community name]*. [**PROBE**: How does it feel to live in this community?]
 - a. What do you like about living in *[insert county name]*?
 - b. What don't you like about living in *[insert county name]*?

2. You told be a lot about living in this community, what can you tell me about the health of people living in this community? [**PROBES**: What makes it easy to maintain a healthy lifestyle in *[insert community name]*? How easy is it to start and maintain a healthy lifestyle in your community? How difficult is it to start and maintain a healthy lifestyle in your community? **Other probes** (*if needed*) → how could (churches, retirees, volunteers, civic organizations and non-profits) assist the community to become healthy?]

3. When you think of some of the '*not-so-good*' things that go on in your community, what comes to mind? [**PROBES**: if there is no mention of jobs or economic difficulties, *ASK*, what's it like trying to get a job in *[insert community name]*? **Other probes** → what challenges have you noticed with issues of: 1) illegal drug use, 2) prescription drug abuse, 3) alcohol abuse, 4) mental health, 5) child abuse, 6) safety and security, and 7) gang activity?

Next let's talk about the hospital [insert name]

4. Now, let's talk a little bit about the hospital, what are some great things about the hospital? What are some not so great things about the hospital? [**PROBE**: why did you say that? What else can you think of?]

5. What services are offered at *[insert name hospital]*? [**PROBES**: Do you think the community knows about these services? If no, why did you say that? How well do you think the community uses these hospital services? What percentage of people do you think use the emergency department for primary care? Why did you think that? **OTHER PROBES** (*if participants seem to not talk about medical services provided by the hospital*) → Radiological Imaging (X-rays, MRI, CT scan, ultrasound, mammogram); Laboratory; Medication/Prescription Assistance; Colonoscopy, Sleep Study; Physical or Occupational Therapy; Speech Therapy and others]

Note to moderator: What we're looking for here is to find out what the participants know about the medical services the hospital provides. Any wellness programs, support groups and other services available to the community [diabetes, Alzheimer and cancer support groups]

6. What services would you like to see offered at *[insert hospital]*? [**PROBES:** Why do you think these services will be important to this community? Let say, the hospital was able to bring these services to the community, how would you suggest/recommend for the hospital to get the word out into the community?]

7. Ok. We've talked about the services you would like to see offered at the hospital, how do you think the *[insert name hospital]* can help improve the health of the **[insert community name]**].

COMMUNITY VISION

8. Now that we've talked about what the hospital can do to help improve health in the community, I would like to know, how you would like to see the health of the community improve in the future? [**PROBE:** If your vision were to become true, what would this community look like in five years? More Access to Services? People participating in activities that are considered "healthy" like walking, biking, etc.?]

9. You all have given us some good information. What else can you add to this discussion? [**PROBES:** Have we covered everything you want to tell us about your community? What have we missed? What do you think people who are doing community assessments should really be asking? Any other comments?]

Thanks again for your time and invaluable information. We'll use this information to help your community to better serve you. Please call [CONTACT INFO] if you have any further questions or comments. Again, thank you for your willingness to assist in making your community a healthier place.

APPENDIX S



DEMOGRAPHIC QUESTIONS

1. Gender: _____

2. What year were you born? _____

3. What is your ethnicity/race?

4. What languages do you speak?

5. What is your occupation?

a. Are you a manager? Yes / No

b. If *yes*, how many people do you
manage? _____

6. Name of Organization where you work:

7. Do you work part-time or full-time?

8. How long have you worked there?

9. What is your zip code? _____

10. What town do you live in?

11. Children in the home

under 18: _____

over 18: _____

12. What is your level of education? (*Circle*)

High School

Some College, Technical School

College Degree

Advanced Degree

13. What is your household income?

Under \$25,000

\$25,000 to \$49,999

\$50,000 to \$74,999

\$75,000 to \$99,999

\$100,000 or more

Don't know /not sure

**THANK YOU FOR YOUR
PARTICIPATION**

APPENDIX T

WHAT IS THE PROJECT ABOUT?

The purpose of this research project is to:

- 1) Help 18 rural nonprofit hospitals in addressing the Community Health Needs Assessment as mandated by the Internal Revenue Service (IRS) in accordance with the Patient Protection and Affordable Care Act.
- 2) Empower rural communities and underserved populations by providing a snapshot of overall community health status.

You are being asked to take part in the research project because you have valuable insight into your community.

WHAT WILL YOU BE ASKED TO DO?

If you want to take part, you will be asked to:

- Participate in a 60-90 minute discussion about the health status of your community.

WHAT WILL YOU GET OUT OF BEING IN THE PROJECT?

- Results from the focus groups will be used to determine the health status of your community and will assist in completing a community health assessment.

- This will assist your community hospital in completing IRS requirements for a community health assessment.

ARE THERE RISKS TO TAKING PART?

Taking part in this research study should not put you at risk. You may be uncomfortable sharing some health related information. However, you can be sure that none of the information from the focus group will be connected to you. It is confidential and will not be shared with anyone.

ARE THERE COSTS TO TAKING PART?

There are no costs to taking part in the study other than the time to participate in the discussion.

DO YOU HAVE TO TAKE PART?

You do not have to be part of the study if you do not want to. Taking part in the study is up to you. You can stop taking part at any time. If you decide to stop, no one will be angry or upset with you.

IS WHAT I SAY IN THE FOCUS GROUP PRIVATE?

Focus groups will be recorded. However, to protect your privacy, your name will not be included in the focus group data. This information will not be connected to you in any way. All data will be reported as a summary of information.

WHO ARE THE PEOPLE RUNNING THIS STUDY? CAN I CALL THEM?

The Principal Investigator for this research study is Dr. Stuart Tedders. His telephone number is (912) 478-1922. He is the Associate Dean of the Jiann Ping Hsu College of Public Health at Georgia Southern University. His address is PO Box 8015, Statesboro, GA 30460. His email address is stedders@georgiasouthern.edu

You may also contact:

Office of Research Services and Sponsored Programs

Georgia Southern University
P.O. Box 8005

Statesboro, GA 30460-8005

Phone: 912-478-5465

Fax: 912-478-0719

E-mail: research@georgiasouthern.edu

AGREEMENT STATEMENTS

Do you have any questions about the research study?

YES NO

Do you agree to take part in the research study?

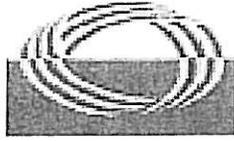
YES NO

If you sign your name below, it means that you agree to take part in the research study.

Signature of Participant

Printed Name of Participant

Date



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



SORH

GEORGIA STATE OFFICE OF RURAL HEALTH

JIANN-PING HSU
COLLEGE
of
PUBLIC
HEALTH

Principle Investigator
Stuart Tedders, PhD
P.O. Box 8015
Statesboro, GA 30460
(912) 478-1922

JIANN-PING HSU
COLLEGE
of
PUBLIC
HEALTH

The Community Health
Needs Assessment Project

The Community Health
Needs Assessment
Project

APPENDIX U

**JEFFERSON HOSPITAL
FOCUS GROUP MEETINGS
March 28, 2013**

FOCUS GROUP	TIME	NAME	CONTACT INFORMATION
1	10:00 a.m. - 12:00 p.m.	Dr. Nancy Cox	478-252-8900
		Mary Sue Rachels	
		Bonnie Miller	
		Janet Plicher	478-625-3716 or 706-830-5265
		John Johnson	
		Chester Johnson	478-625-3789 or 762-245-9940
		Lil Easterlin	478-625-8134
		Lisa Stoms	478-625-7000
		<i>Arny Bednigheld</i>	
		<i>CAE</i>	
2	1:00 p.m. - 3:00 p.m.	Rainell Jones	706-466-1901
		Wanda Darisaw	478-625-7200
		Molly Howard	
		Walden Evans	
		Marie Handberry	706-825-0986
		Jadee Hodge	706-547-3001
Bill Smith	478-494-8745		
3	3:00 p.m. - 5:00 p.m.	Julia Wells	
		Nancy McGraw	
		April Durden	
		Judy Jones	
		Michelle Reaves	478-625-7041
		Becky Harrison	770-365-8254
		Sajath Thomas	
		Cathleen Clark	
		Alton Spells	478-342-0126
		Marry Morgan	
		Rickey Sapp	
		Amie Hodges	

JEFFERSON HOSPITAL
 FOCUS GROUP MEETINGS
 JANUARY 28, 2013

10:00 A.M.
 (CAC Committee)

<u>NAME</u>	<u>COMPANY</u>	<u>CONTACT INFORMATION</u>
Mary Sue Rachels	Jefferson Hosp	478-252-5594
Lisa STOMS	Jefferson Hospital	706-830-5068
Janet R Pilcher	Jefferson Co Health Dept	Work - 478-625-3716 Home 706 -547-3942
John Johnson	Goody's Jefferson	478-625-7338
Wil Easton	Chamber of Commerce Development Authority	478-625-8134
Nancy Cox	Jefferson Hosp	478-252-8900
Charles Johnson	Jeff. Co. 5 HHS/Farm Comm	478-625-3789
Amy Bridgford	Jeff. Hosp.	(478) 625-9111

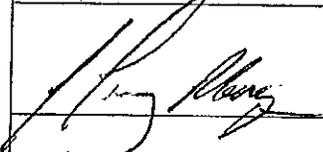
JEFFERSON HOSPITAL
 FOCUS GROUP MEETINGS
 JANUARY 28, 2013

1:00 P.M.

<u>NAME</u>	<u>COMPANY</u>	<u>CONTACT INFORMATION</u>
✓ Daniel Dodge	City of Lexington	706-547-3000
✓ Marie J. Handberry	Prachtree Plaza of Louisville	478-625-8658
✓ William EVANS	JEFFERSON COUNTY PRISON	478 625-4012
✓ Bill Smith	First Baptist Church	478-494-8945
✓ RANDALL JONES	WOODMEN OF THE WORLD	478-252-239
✓ Wanda B Daris	Jefferson Hospital	478-625-7200 478-625-3806
✓ Donnie Hodges	Jefferson Co. Board of Ed.	478-625-7626
✓ Bobb, Bobb	Technical College	706-551-0941

JEFFERSON HOSPITAL
 FOCUS GROUP MEETINGS
 JANUARY 28, 2013

3:00 P.M.

<u>NAME</u>	<u>COMPANY</u>	<u>CONTACT INFORMATION</u>
Becky Hamison	Thomas Jefferson Academy	Cell 770-365-8254
Alton W. Spells, Jr.	World Financial Group	Cell 706-339-1277
Jules Wells	Wrens Middle School	(706) 547-6580
Anne Durden	Clerk of Superior Ct.	706-625-7922
Michelle Reeves	(Student) Augusta Technical	706-339-7475
Cathleen Clark	Jefferson County Chamber of Commerce	(478) 342-0120
Judy Jones	Rape Crisis Sexual Assault Services	706-832-0792
Nancy McGraw	Jefferson City Tax Commissioner	wk 478-625-7736
Asaiah Damm	—	478-625-369
	Megan city of Full	478-625-3166
Richard T. SAPP	Louisville city administrator	478-625-3166
M. Echev McMur	commissioner's office	478-494-5325

APPENDIX V

