
COMMUNITY
Health Needs
Assessment
2019
GET HEALTHY
LIVE WELL
TANNER
HEALTH SYSTEM

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Part I: INTRODUCTION

A. Executive Summary

Tanner Health System is a not-for-profit health system with a mission: to provide a continuum of quality healthcare services within our resource capabilities and to serve as a leader in a collaborative effort with the community to provide health education, support services and care for all of our neighbors. It is with this spirit of collaboration toward advancing community health that Tanner was established 70 years ago, when a visionary group of community leaders in west Georgia came together and sought to provide the best healthcare services for their neighbors and loved ones, close to home. Since 1949, Tanner has grown from a single community hospital to a regional comprehensive healthcare provider serving a nine-county area of more than 350,000 people in west Georgia and east Alabama. The health system's facilities include:

- The 201-bed acute care Tanner Medical Center/Carrollton*
- The 40-bed acute Tanner Medical Center/Villa Rica*
- The 25-bed critical access Higgins General Hospital in Bremen*
- The 92-bed inpatient behavioral health facility Willowbrooke at Tanner in Villa Rica
- The 15-bed critical access Tanner Medical Center/East Alabama

* The hospitals that are included as part of this Community Health Needs Assessment (CHNA) report

Tanner also operates Tanner Medical Group, one of metro Atlanta's largest multi-specialty physician groups with about 40 medical practice locations serving the region. The health system's medical staff is composed of more than 300 physicians representing 34 unique medical specialties, from allergies and asthma to urology and vascular surgery.

At Tanner Health System, we recognize that a person's health is interwoven with the health of the community in which they live. We work to help our patients thrive under our care, as well as outside our hospital and clinic walls. A person's health is dependent on many different factors, including physical, social and economic factors such as housing, transportation and employment. As a healthcare leader in our region, we play a significant role in advancing health and partnering with others to facilitate community health improvement. Our efforts are guided in large part by the results of our Community Health Needs Assessment (CHNA), which we perform every three years.

Tanner's CHNA utilizes an organized, systematic approach to identify and address the needs and assets of underserved communities across Tanner's geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease as well as social, environmental and economic barriers to health. The CHNA also informs the creation of a strategy for future community health programming and how to allocate community benefit resources for fiscal years 2020-2022 across Tanner's hospitals. As a not-for-profit organization, Tanner Health System is required by the Internal Revenue Service (IRS) to conduct a CHNA every three years. Our CHNAs align with guidelines established by the Affordable Care Act and comply with IRS requirements.

Using both public health and healthcare utilization data, each hospital identified its geographic area of focus, called a Community Benefit Service Area (CBSA), including the counties of Carroll, Haralson and Heard counties (Tanner's primary service area). The CBSA serves as the geographic target area for the CHNA and for execution of the strategies to address health needs identified. The CHNA will serve as a roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the next three-year cycle. The CHNA process involved local residents, community partners and stakeholders, along with hospital leadership. Each hospital's CHNA was led by a team comprised of members of Tanner's Get Healthy, Live Well coalition that included hospital leaders, community activists, residents, faith-based leaders, hospital representatives, public health leaders and other stakeholders. Coalition members used population-level data and feedback from community focus groups and listening sessions to create recommendations for each hospital's health priorities, potential implementation strategies and to identify key partners. Nearly 135 people were involved in the CHNA process, including those who participated in community focus groups, a listening session or key informant interview.

Upon review, analysis and prioritization of the CHNA findings, the priority areas to be addressed during the FY 2020-2022 Implementation Strategy include:

1. Access to Care
2. Healthy and Active Lifestyles and Education
3. Chronic Disease Education, Prevention and Management
4. Mental/Behavioral Health
5. Substance Misuse
6. Social Determinants of Health

The CHNA report is available to the community on Tanner's website: www.tanner.org. Additionally, copies will be disseminated to the hospital's board and executive leadership; the assessment team; community stakeholders who contributed to the assessment; and multiple community leaders, volunteers and organizations that could benefit from the information. Other communication efforts will include presentations of assessment findings throughout the community. Copies will also be made available for distribution upon request from the hospital. This final joint CHNA report for Tanner Health System's hospitals (Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica and Higgins General Hospital) was approved by the Tanner Medical Center, Inc. Board of Directors on June 10, 2019.

[1] McLeroy, K.R., Bibeau, D., Steckler, A. & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. Health Education Quarterly, 15, 351-77.

B. CHNA Approach and Process

Planning and Implementation

The Community Benefit Department at Tanner Health System oversees and coordinates the CHNA process and deliverables to improve health outcomes throughout the system's service areas. The department drives CHNA program implementation and evaluation of community benefit reporting to the community and regulatory bodies. The department utilizes evidence-based methodologies to leverage internal and external stakeholder relationships and resources (i.e., the multisector Get Healthy, Live Well coalition) to target health disparities and address physical, social and economic contributors to suboptimal health. These efforts focus primarily on improving the health of underserved populations and addressing health disparities with the goal of achieving health equity.

CHNA Guiding Principles and Frameworks

The guiding models for the CHNA were the National Academy of Medicine's Pathways to Health Equity Conceptual Model (Figure 1), the Robert Wood Johnson Foundation's County Health Rankings Model (Figure 2), and the socio ecological model of health. The models provide an understanding of what contributes to the health of communities and how assets and strengths of communities should be identified and leveraged as part of community program development. They also help identify the most effective ways to address individual, organizational, community and policy-level contributors to health in order to realize health equity. These models frame Tanner's community benefit efforts to improve the health status of the people in Tanner's CBSAs.

Figure 1:

CHNA Methodology and Data Collection

The data sources for the CHNA included quantitative secondary population-level data, hospital healthcare utilization data and qualitative community group input sessions. These data were used to broaden the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA process and deliverables. The types of information gathered for each data source were as follows:

» **Secondary Data**: National, state, local health and disparity data, public health priorities and community health improvement plans. Core Indicators: Secondary data was gathered primarily through Community Commons, a publicly available dashboard of multiple health indicators drawn from over a number of national data sources and Online Analytical Statistical Information System (OASIS), the Georgia Department of Public Health's standardized health data repository. US Census American Community Survey Data was also consulted for demographic, education and income statistics. Other data sources are noted in the county health profiles (as seen in Part 3).

» **Hospital Utilization Data**: Patient healthcare utilization were used to identity each hospital's CBSAs and geographic areas of focus for needs assessment and strategy implementation.

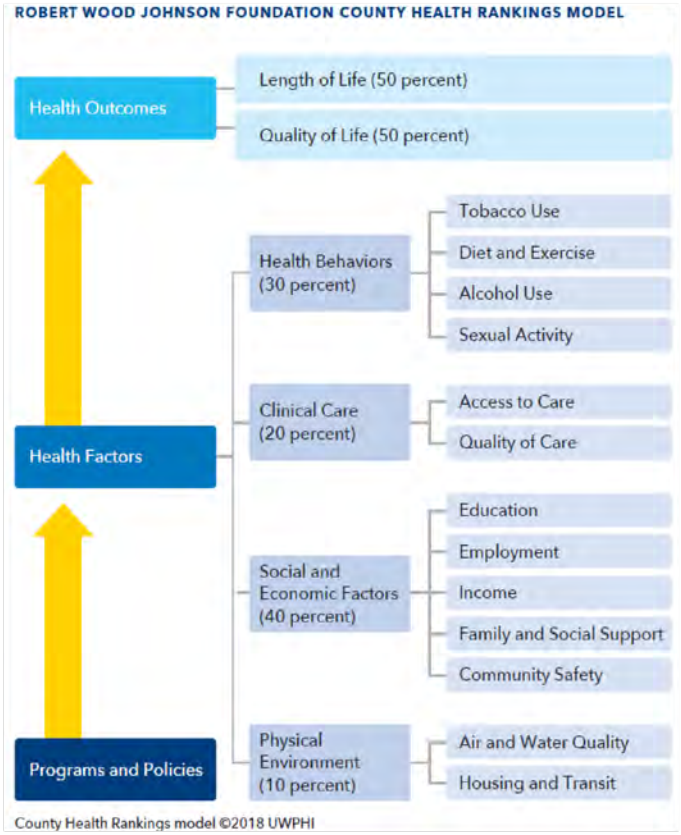
» **Community Input Session Discussions**: Hospitals facilitated community discussions with a diverse group of community stakeholders to identify the most important community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services, and the social determinants of health.

Combined information from all of the above sources were used to:

1. Prioritize identified needs
2. Determine the appropriate hospital role in addressing the health issues prioritized
3. Establish system and hospital specific approaches and outcome measures

This information was then used to develop each hospital's implementation strategies for the next three years.

Figure 2:



Prioritization Process and Criteria

Identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and each hospital's strengths within the context of the system's priorities. Additionally, when selecting final targeted health priorities, Tanner considered additional criteria such as availability of evidence-based approaches and existing partnerships and programming. These components were used to identify priority areas.

Tanner's Get Healthy, Live Well coalition participated in a comprehensive prioritization exercise that involved grouping and ranking identified needs and assets, as well as discussions about what existing and new initiatives and partners should be included in the hospital's three-year implementation plans. The purpose was to determine how to best support the highest prioritized needs, while leveraging identified community assets and resources.


Hospital Strengths/ Priorities
Importance Identified by Community/ Community Assets
Magnitude of Health Issue
Availability of Evidence-Based Approaches
Priority Determination
Severity of Health Issue
Potential Impact of Strategy
Disparity/ Equity-focused
Existing/ Potential Partnerships

Part II: COMMUNITY IMPACT

Evaluation Of Impact Since Previous CHNA

The following pages explore Tanner Health System's commitment to helping residents get access to the health care and community health programs and resources they need. Three years ago, Tanner conducted a CHNA to better understand the community's health concerns and needs. With this information, an action plan was developed to help improve the health of local community members.

The CHNA process should be viewed as a three-year cycle. A key piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact of those actions have made in the community, it is possible to better target resources and efforts during the next round of the CHNA cycle.

Tanner Health System's priority health topics, for each of its hospitals, for FY 2017-2019 were:

1. Access to care
2. Chronic disease prevention and management— with a focus on obesity, heart disease, diabetes and cancer
3. Behavioral health
4. Health education and literacy

Each of the above health topics correlates well to the priority health topics selected for the current CHNA, thus Tanner Health System will be building upon efforts of previous years. Community feedback on Tanner's CHNA and Implementation Strategy was collected in a variety of ways, including: the ongoing monitoring and evaluation of Tanner's community benefit activities and programs through pre- and post- surveys; persistent dialogue among community partners, task forces and volunteers; a dedicated Community Benefit Committee of the Tanner Medical Center, Inc. Board of Directors; annual community health summits; and through comments from key informant interview, community listening session and community focus group participants.

Tanner's long-standing commitment to the community is deeply rooted in its mission. The organization remains committed to improving the community's health, not only through daily patient care activities but also outreach, prevention, education and wellness opportunities.

Improving Access to Care

Tanner Provides Closer Access to Stroke Care

When it comes to a stroke, every second matters. Stroke is a major cause of death and disability among Americans. According to the American Heart Association/American Stroke Association, stroke is the No. 5 cause of death and a leading cause of adult disability throughout the United States. On average, someone in the U.S. suffers a stroke every 40 seconds and nearly 795,000 people suffer a new or recurrent stroke each year.

But with certifications from the American Heart Association/American Stroke Association and The Joint Commission that Tanner's hospitals earned in 2017, residents throughout west Georgia and east Alabama have even closer access to accredited stroke care in the region.

Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica and Higgins General Hospital in Bremen each underwent rigorous onsite reviews in 2017. The Joint Commission experts evaluated compliance with stroke-related standards and requirements, including program management, the delivery of clinical care and performance improvement.

Tanner Medical Center/Carrollton and Tanner Medical Center/Villa Rica each earned an Advanced Certification for Primary Stroke Centers designation from the American Stroke Association and The Joint Commission. And Higgins General Hospital is the only facility in Georgia to earn a designation in Advanced Disease-specific Care Certification for Acute Stroke Ready Hospitals — a similar designation delegated to critical access hospitals.

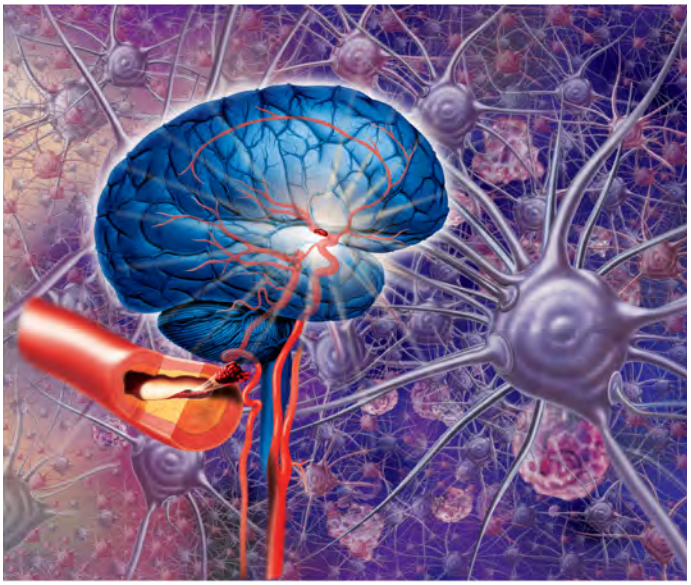
In addition, Tanner's facilities also received accreditation from the state of Georgia, with Tanner Medical Center/Carrollton and Tanner Medical Center/Villa Rica designated as primary stroke centers and Higgins General Hospital designated as a remote treatment stroke center.

Along with establishing accredited stroke centers throughout the

Learn more: Tanner.org/stroke

region, Tanner is also ensuring those centers perform at the top of the industry to ensure high-quality patient care. In 2018, the Carrollton facility earned the Get With The Guidelines Silver Plus Quality Achievement Award for stroke care from the American Heart Association/American Stroke Association, while the Villa Rica hospital earned the Get With The Guidelines Stroke Gold Plus Quality Achievement Award for stroke care.
The awards designate the facilities' performance in meeting specific quality achievement measures for the diagnosis and treatment of stroke patients. Those measures include evaluation of the proper use of medications and other stroke treatments aligned with the most up-to-date, evidence-based guidelines with the goal of speeding recovery and reducing death and disability for stroke patients. It also measures whether patients also receive education on managing their health, getting a follow-up visit scheduled and other care transition interventions before discharge from the hospital.

The silver award confers acknowledgment for 12 consecutive months of demonstrated stroke care performance, while the gold award recognizes stroke care performance of 24 consecutive months or longer.



Tanner Advances Quality of Orthopedic Care

One of the hardest decisions to make when it comes to joint replacement surgery — beyond whether to have one — is where to undergo the surgery.

In west Georgia and east Alabama, Tanner has made that decision easier and advanced the quality of its orthopedic care by earning a gold seal of accreditation from The Joint Commission's Disease-specific Care Certification program.

Launched in 2002, The Joint Commission's Disease-specific Care Certification program is designed to evaluate clinical programs across the continuum of care. Certification requirements address three core areas: compliance with consensus-based national standards; effective use of evidence-based clinical practice guidelines to manage and optimize care; and an organized approach to performance measurement and improvement activities.

The accreditation is a result of a long-standing partnership between Tanner Ortho and Spine Center and the patient care team at Carrollton Orthopaedic Clinic. The accreditation process involved an intensive on-site review that analyzed the center's ability to use clinical outcomes and other performance measures to improve care, the commitment of Tanner Ortho and Spine Center's leadership to improving the quality of care for patients and how the facility prepares patients and caregivers for recovery after the procedure.

Surveyors from The Joint Commission — the largest, most respected accreditor of hospitals and healthcare facilities in the nation — examined Tanner's process for caring for knee and hip replacement patients before surgery, during the procedure and after discharge from the hospital. They also evaluated how well Tanner Ortho and Spine Center's patient care team used evidence-based practices to bolster outcomes and improve patient satisfaction, ensuring that patients received the most advanced standard of care.

In addition, Tanner Ortho and Spine Center is recognized by Blue Cross Blue Shield (BCBS) as a Blue Distinction Specialty Care provider in knee and hip replacement and spine surgery.

Blue Distinction is a national designation program by Blue Cross Blue Shield, developed in collaboration with the medical community to recognize those facilities that demonstrate expertise in delivering quality specialty care — safely, efficiently, and cost effectively. The Blue Distinction Centers for Specialty Care® program is evolving from a quality-focused designation to a more robust Total Value designation with the goal of further differentiating Blue Distinction Centers from other facilities.

With one of every three Americans covered by a Blue Cross Blue Shield (BCBS) plan, the BCBS is committed to taking a proactive role in providing consumers with increased transparency on provider cost and quality. Blue Distinction provides physicians and their referring physicians with the information they need to select specialty care facilities like Tanner Ortho and Spine Center.

Tanner has also earned accolades from independent healthcare ratings firm Healthgrades for its high-quality orthopedic care. Tanner Medical Center/Carrollton has been ranked among the nation's 100 Best

Learn more: TannerOrtho.org

Hospitals for Orthopedic Surgery each year from 2014 through 2019, and in 2019, the facility earned five-star ratings for hip fracture repair and total hip replacement.

Tanner Heart Streamlines Cardiac Care

When minutes matter most, Tanner Health System now offers two fully accredited regional destinations to assess, diagnose and treat anyone experiencing chest pain.

The cardiac care programs at Tanner Medical Center/Carrollton and Tanner Medical Center/Villa Rica earned accreditation from the Society of Cardiovascular Patient Care (SCPC) in 2016.

The chest pain accreditation process included vigorous on-site inspections, interviews with patient care teams and process refinement and evaluation to ensure that chest pain patients will receive the best possible care as quickly as possible.

To achieve accreditation, the health system further streamlined its processes for the diagnosis, treatment and management of chest pain patients, ensuring patients receive medically appropriate lengths of stay after treatment and verifying that its treatment protocols are on par with the latest evidence-based processes.

Tanner Medical Center/Carrollton is one of only a few community hospitals in Georgia offering percutaneous coronary intervention (PCI) — also called angioplasty and stenting — to relieve the symptoms of a heart attack and preserve heart muscle. Tanner expanded the service to Tanner Medical Center/Villa Rica in 2015, providing a second regional destination for lifesaving heart care. Tanner Medical Center/Carrollton also earned the Coronary Intervention Excellence Award from healthcare ratings firm Healthgrades in 2017 for its exceptional interventional cardiology program.

Tanner maintains cardiac care teams on standby around the clock to respond to chest pain patients, with measures in place to move patients into treatment as quickly as possible.

Just more than 30 Georgia and almost 20 Alabama hospitals have been accredited as Chest Pain Centers by the SCPC. Many of these are in more urban areas, such as Atlanta, Augusta, Macon and Savannah.

Cardiac MRI System Comes Online at Tanner

In 2016, Tanner Health System launched a new piece of technology that is helping cardiac and vascular specialists get a better picture of patients' cardiovascular health.

The MAGNETOM Aera 1.5T magnetic resonance imaging (MRI) system from Siemens Healthcare at Tanner Medical Center/Carrollton places Tanner on the leading edge of healthcare providers throughout the country offering non-contrast magnetic resonance angiography, or MRA, as well as heart MRI imaging.

The technologies use the MRI's powerful magnet to manipulate the iron in a patient's blood, read how the iron responds and capture extremely detailed images — all without contrast and without radiation.

The technology places Tanner ahead of other regional providers — and even many larger healthcare providers and research facilities — in offering an innovative alternative to traditional cardiac and vascular imaging.

Non-contrast MRA is used to help diagnose several blood vessel conditions, including problems with the aorta and the blood vessels that supply all major organs and extremities. Similarly, cardiac MRI provides dynamic imaging, allowing physicians to see heart function and the structure of the heart as the heart moves — making diagnoses while watching the heart move with high-definition, almost real-time imaging.

While periodic exposure to low doses of radiation — such as the X-rays used for traditional angiography and cardiac CT imaging — has not been shown to have long-term consequences, providers have been concerned about the safety of patients who have required repeated imaging, as well as patients who have demonstrated a sensitivity to contrast material. Since the MRI uses magnets rather than X-rays, there's no radiation exposure for the patient.

A new piece of technology at Tanner Health System is helping cardiac and vascular specialists get a better picture of patients' cardiovascular health.

Learn more: TannerHeartCare.org

Advancing Toward Open-heart Surgery

As heart disease remains the leading cause of death in west Georgia, Tanner continues to pursue establishment of a truly comprehensive cardiac care program in the region.

The health system is continuing to work with the state to achieve a license to expand its cardiac services to include open heart surgery. Expanding into surgical heart care will complement the well-established interventional cardiac program offered at Tanner, as well as its accredited chest pain centers, robust outpatient cardiac services, cardiac rehabilitation program and more.

The system also features a much larger gantry to better accommodate patients who are uncomfortable in more enclosed spaces.

Tanner looks to demonstrate the value of cardiac and advanced non-contrast imaging in a community care setting, as well as working alongside Siemens on research and development projects — putting Tanner at the innovation forefront for this type of imaging.

In addition, in 2015 Tanner launched a low-cost cardiac calcium scoring service to help detect instances of cardiovascular disease in their earliest stages. Coronary CT calcium scoring allows a medical provider to diagnose the presence and extent of calcified plaque inside the arteries that supply the heart with oxygen-rich blood.

Plaque is the fatty substance that can collect along artery walls. As plaque ages, it becomes calcified, eventually leading to a narrowing of the heart arteries — a condition called atherosclerosis — blocking critical blood flow to the heart.

A coronary CT calcium score scan enables medical providers to detect the calcified plaque in coronary arteries in its early stages and determine an individual's risk for a heart attack. The results of the test are called a "calcium score." The entire scan is fast — typically taking no more than 10 minutes — and painless, with no need for contrast material to be injected.

Though the results of the screening can give your patient care team an opportunity to intervene before a cardiac event — such as a heart attack — happens, many insurance plans do not cover the screening.

Tanner, West Georgia Urology Expands Pelvic Health Services

As women age, their pelvic health isn't usually top of mind. Women are often surprised to learn the issues they experience with using the bathroom, vaginal or pelvic pain or frequent constipation are more than just a typical part of aging. Those symptoms may indicate a pelvic floor disorder — a very common condition.

Pelvic floor disorder is estimated to affect roughly one-third of the women across the country, according to the National Institutes of Health. The pelvic floor is the group of muscles that hold the uterus, cervix, vagina, bladder, bowel, urethra, small intestine and rectum in place so they function properly.

A pelvic floor "disorder" happens when the muscles can no longer hold the pelvic organs properly, often because of a tear, loosening or rip in the muscles.

In partnership with West Georgia Urology, Tanner has worked to expand access to specialized pelvic health services throughout the region.

James Cullison, MD, is board-certified urologist as well as female and pelvic medicine and reconstructive surgery by the American Board of Urology. As a member of the patient care team at West Georgia Urology and a member of the medical staff at Tanner, Dr. Cullison has made is specialized training and services available to women throughout west Georgia and east Alabama.

Older women, particularly those who've had children, are more likely to experience pelvic floor disorders. Fortunately, there are many treatment options to help the pelvic floor muscles work properly again.

Care for pelvic health issues, from trouble urinating to trouble during intercourse, has come a long way in the past few years. Those issues that were once considered part of the aging process are now met with a comprehensive clinical approach to help identify and treat a woman's symptoms.

Pelvic floor conditions we treat at Tanner Health System include:

- Bladder dysfunction, such as incontinence or overactive bladder
- Bowel dysfunction, including fecal incontinence
- Prolapse conditions, including vaginal, uterine or pelvic organ prolapse

Treatment plans often depend on the type of pelvic floor disorder a woman is experiencing. Options now available at Tanner include:

- Biofeedback to help stimulate and strength pelvic nerves and muscles
- Medication
- Minimally-invasive surgery, including pelvic reconstruction surgery
- Physical therapy to help strengthen pelvic muscles

Learn more: TannerWomensCare.org

Tanner Cancer Care Launches Lung Cancer Screening Program

Lung cancer is the leading cause of cancer-related deaths in the United States, claiming more than breast, colon and prostate cancers combined. In 2016, Tanner Cancer Care launched an effort to change that in west Georgia and east Alabama.

An advanced low-dose CT lung cancer screening can detect lung cancer in its earliest stages, when treatment is most effective. Low-dose CT lung cancer screenings can catch early-stage lung cancer in more patients, contributing to a 20 percent reduction in lung cancer deaths over traditional X-rays.

Low-dose CT lung cancer screenings are quick and simple. Once the patient is positioned in the CT scanner, the scan itself takes less than 60 seconds and requires no needles, medication, contrast or dyes. Patients can eat normally before and following the screening.

Tanner has made the screenings available in Carrollton, Villa Rica, Bremen and Wedowee.

Research has demonstrated that lung cancer screenings with low-dose CT can save lives by detecting lung cancer early, before symptoms can develop, when treatment is most effective. However, not every patient is a candidate for a low-dose CT lung cancer screening, and the screening comes with some risks and limitations.

The American Lung Association estimates that at least 8.6 million Americans meet the high-risk criteria to benefit from an annual low-dose CT lung cancer screening. If only half of those who met the high-risk criteria were screened, more than 13,000 lung cancer deaths could be prevented.

According to the American Lung Association, almost 30 percent of all cancer deaths are caused by lung cancer. It's estimated that more than 158,000 deaths will be caused by lung cancer this year, and more than 224,000 new cases of lung cancer will be diagnosed this year.

Tanner Launches Telemedicine Program

In 2018, Tanner launched a robust, full-featured telemedicine program, changing the way patients experience health care.

Tanner's innovative platform enables physicians to provide patients with a continuum of care and clinical services virtually anywhere. Patients benefit by having convenient access to medical specialists through a real-time video connection over secure, Internet-connected devices. The virtual program allows clinicians to safely, confidentially and securely conduct consultations and discuss exam results, recovery plans, treatment options and even electronically prescribe medications — all from miles away.

In rural communities, telemedicine allows hospitals and other healthcare organizations to tap into the expertise of qualified physicians miles away, ensuring that distance is no barrier to exceptional patient care.

Tanner's medical staff consists of more than 300 physicians representing 34 medical specialties — but with telemedicine, patients in the region also benefit from an even larger team of medical experts from across

the country.

Telemedicine allows people in crisis to receive a behavioral health assessment faster, stroke patients to be evaluated by a qualified neurologist at any time, someone with diabetes to engage with experts who can prescribe an intervention before hospitalization is necessary and more.

The technology platforms are secure, innovative and more closely connect patients with qualified medical providers — and their own health.

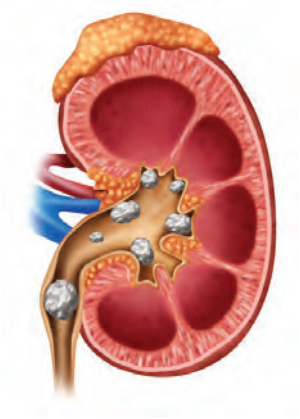
At Tanner, telemedicine is being used to advance:

- Behavioral health, providing virtual access to therapy and behavioral health services and empowering behavioral health specialists — including psychiatrists and therapists — to offer confidential screening and consultative services and follow-up appointments in real-time through live video using the telemedicine program.
- Consultations and specialist referrals, so patient have convenient online appointments with clinical specialists. Through real-time videoconferencing tools, healthcare providers can refer patients to medical specialists, conduct virtual consultations and schedule online appointments to discuss diagnostic exam results and even electronically prescribe medication.
- Neurology services, including virtual stroke therapy and rehabilitation services. Through the telemedicine console and with a nurse's assistance, experts in neurological care can virtually monitor, examine and assess a stroke patient and order a course of lifesaving treatment.
- Tele-ICU and critical care services, putting a virtual physician at the bedside, at the push of a button. Through the telemedicine console, clinical specialists can diagnose routine illness and provide urgent care services to critically ill patients.

Learn more: TannerCancerCare.org

Tanner, West Georgia Urology Launches Kidney Stone Hotline

Each year, more and more people make visits to emergency rooms due to kidney stones. According to the National Kidney Foundation, nearly one in 10 people will experience a kidney stone at some time in their lives.



Tanner Health System, in partnership with the board-certified urologists at West Georgia Urology, Tanner has launched a unique kidney stone hotline to expedite care — and relief from this painful condition.

The 24-hour hotline can be reached at 678-903-1194. Callers will be connected with a Tanner representative who will ask a series of question to determine the caller's level of need based on previous diagnoses and current symptoms. Callers will receive an instant physician referral to follow up with a urologist during regular office hours, often the same day.

Patients with a previously diagnosed kidney stone will receive a call back and treatment within 24 hours. Those with kidney pain without a previous diagnosis or specific cause will receive a call back within one business day to schedule an appointment.

Treatment may involve lithotripsy — a technology that uses sound waves to break up kidney stones — that's available at Higgins General Hospital in Bremen.

Tanner Ortho and Spine Center's New Surgical Robot Gives Patients a Leg Up

A new surgical robot is transforming the way orthopedic surgeons perform joint replacement surgery at Tanner.

Tanner Medical Center/Carrollton has is now offering a new, state-of-the-art Stryker Mako robot for hip and knee joint replacement surgeries. This new technology enables surgeons to perform orthopedic surgery with a greater level of precision, providing patients with a quicker recovery with a more secure and longer-lasting joint replacement.

The new technology is designed to add a customized element to the orthopedic procedure. Surgeons create a preoperative plan that is specific to each patient's anatomy using digital sensors and computerized tomography (CT) scans. The Mako technology uses those scans to build a real-time 3-D visual of the patient's knee or hip. Surgeons then use the 3-D visual to determine the most appropriate placement for the implant — even before making the first incision.

Equipped with the new technology, Tanner Ortho and Spine Center will be able to place the joint replacement within fractions of an inch of the joint's natural position, regardless of a patient's anatomy.

With the Mako robot at Tanner, patients will have access to the most advanced orthopedic knee and hip surgery available. Tanner Medical Center/Carrollton is the ninth hospital in Georgia to purchase a Stryker Mako robot, and it is the first hospital in west Georgia to offer the new robot-assisted orthopedic surgery.

Tanner also offers robotic-assisted surgical procedures — including cholecystectomy (removal of gall bladder), appendectomy (removal of appendix), colectomy (total or partial removal of colon) and hysterectomy (partial or total removal of the uterus) — on the da Vinci Xi and the da Vinci Si robotic-assisted surgery platforms from Intuitive Surgical.

The Stryker Mako robotic surgery platform enables orthopedic surgeons at Tanner to perform hip and knee joint replacement procedures with a greater level of precision than ever before.

Learn more: TannerUrologyCare.org

Learn more: TannerOrtho.org

Tanner's Surgical Services Reaches Robotic-assisted Surgery Milestone

In early 2018, Tanner Health System's surgical services department celebrated surpassing its 1,000th robotic-assisted surgery case since launching the robotics program in March 2013.

Tanner was one of the first health systems in the region to offer robotic-assisted minimally invasive surgery when it installed its first minimally invasive surgical system, the da Vinci Si HD by Intuitive Surgical, one of the most advanced and widely-used robotic surgical systems available at the time.

Since its launch, Tanner's robotics program has grown to include 11 robotic-trained surgeons performing dozens of minimally invasive procedures for general surgery and specialties including urology, gynecology and more. And rather than having a single robotics team, Tanner's entire surgical services team is trained for robotic-assisted procedures.

The da Vinci surgical system enables surgeons to perform complex and delicate procedures through small incisions with a great precision, resulting in minimal scaring, shorter hospital stays, faster, less painful recoveries and — ultimately — improved surgical outcomes for patients.

And Tanner's surgical services continues to focus on expanding its robotic program to offer minimally invasive surgery to patients further throughout the region.

Tanner Medical Center/Carrollton is now home to two da Vinci robots, which includes its newest da Vinci Xi along with the da Vinci Si HD. In addition to its program's expansion in Carrollton, Tanner looks to extend its robotics program to the new state-of-the-art surgical services unit at Tanner Medical Center/Villa Rica, offering a program just as robust as the one in Carrollton.

Learn more: SurgeryAtTanner.org

New 3-D Mammography Tech Leads the Way in Breast Cancer Detection

Mammograms are the gold-standard in breast cancer screening — the most effective method available to detect breast cancer in its earliest stages, when treatment is most effective.

From the middle of the 20th century — when the first large-scale, controlled study found that mammography reduced deaths from breast cancer by a third — mammography has enjoyed widespread acceptance as a safe, effective screening tool.

But like the rest of health care, mammography itself continues to evolve, getting better at finding breast cancer early and saving lives. Now, the latest technology in screening mammography, 3-D mammography — also called tomosynthesis — is leading the way in breast cancer detection, and Tanner Health System has brought this advancement to west Georgia.

In 2017, Tanner's breast health centers in Carrollton, Villa Rica and Bremen introduced 3-D mammography.

The experience of receiving a 3-D mammogram is similar to having a standard 2-D mammogram. In 3-D mammography, X-ray images of the breast tissue are taken and sent digitally to the radiologist who can then identify possible areas of concern.

Three-D mammography produces a clearer, three-dimensional image as the equipment rotates around the breast tissue, taking X-ray images from multiple angles. The images are combined to produce a high-definition digital 3-D image of each breast. Clearer, more detailed images can lead to better rates of detection and more accurate diagnoses, reducing the likelihood of false exam results or the need for patients to return for additional screenings.

Every year, more than 200,000 women are diagnosed with breast cancer in the U.S. Leading research organizations, including the American Cancer Society, have highlighted the importance of following early detection guidelines in cancer survivorship. These studies show that when breast cancer is detected early, there is a much greater chance of successfully treating the disease.

Overcoming breast cancer often hinges on detection, finding the cancer before it can spread to other parts of the body. Through a combination of regular self-exams, clinical breast exams and screening mammograms, patients and their doctors have the best opportunity to detect and successfully treat breast cancer.

Tanner's breast health centers were among some of the first in Georgia to introduce digital mammography about a decade ago — the last major evolution in mammography technology. Now, with 3-D mammography available in Carrollton, Villa Rica and Bremen, the latest and most accurate approach to mammography yet is available close to home. The Tanner breast health centers have been recognized by the National Accreditation Program for Breast Centers, as well as Breast Imaging Centers of Excellence from the American College of Radiology as leaders in quality diagnostic imaging.

Along with installing new 3-D mammography technology, the mammography suite at Higgins General Hospital also got a cosmetic refresh in the past year. Three-D mammography produces a clearer, three-dimensional image as the equipment rotates around the breast tissue, taking X-ray images from multiple angles. The images are combined to produce a high-definition digital 3-D image of each breast.

At Tanner Breast Health, women have access to medical expertise offered by Tanner Health System, as well as the most advanced diagnostic imaging services available and a full range of breast health services including state-of-the-art digital mammography, minimally invasive diagnostic imaging procedures, treatment options, resources and support and more.

Learn More: TannerBreastHealth.org

The new Tanner Medical Center/ East Alabama in Wedowee opened in November 2017, becoming the fifth facility in the Tanner system.

The front lobby of the new Tanner Medical Center/East Alabama. The facility features 15 inpatient rooms, eight emergency department exam rooms, state-of-the-art diagnostic imaging services, a comprehensive rehabilitation program and more.

Tanner Opens New Hospital in Wedowee

In November 2017, Tanner Health System grew to a five-hospital system with the opening of the new Tanner Medical Center/East Alabama.

The new Tanner Medical Center/East Alabama is a more than 50,000-square-foot, three-story modern hospital facility. The hospital provides 24-hour emergency care, critical care support, inpatient and observation beds, a state-of-the-art surgical suite and advanced diagnostic imaging services, including computed tomography (CT), digital X-ray and ultrasound services. The facility features 15 private inpatient beds, eight emergency department exam rooms, a dedicated ambulance bay for medical emergencies and an on-site laboratory with modern analyzers and instrumentation.

The facility joins Tanner's other hospitals — Tanner Medical Center/ Carrollton, Tanner Medical Center/Villa Rica, Higgins General Hospital and the inpatient behavioral health facility Willowbrooke at Tanner in Villa Rica — in a true regional approach to seamless, high-quality health care.

At 7 a.m. CT on Nov. 14, the lights came up and the covers were pulled from the bright red "EMERGENCY" signs at Tanner Medical Center/ East Alabama on South Main Street in Wedowee, Ala., while just more than a mile away, staff at Wedowee Hospital waited for test results and prepared to transfer the hospital's last couple of patients.

By mid-morning, the call went out on the emergency services radio: "Last call for Wedowee Hospital. For 64 years, they have served this area with professional care and selfless compassion. Their dedication to family and community can never be forgotten. Wedowee Hospital has now answered their last call."

The new hospital is the product of a partnership between the Randolph County community and Tanner. In August 2015, Randolph County voters turned out for a special referendum on a 1 percent sales tax to fund a replacement facility for Wedowee Hospital.

The referendum to build a new hospital in Randolph County received wide support among those voters, with 86 percent of voters supporting the new hospital. Community leaders partnered with Carrollton, Ga.-based Tanner Health System to equip and manage the new hospital. Tanner is no stranger to east Alabama, currently operating two regional medical practices through its Tanner Medical Group multi-specialty physician group — Tanner Primary Care of Wedowee and Woodland Family Healthcare.

In May 2016, more than 250 local leaders and Tanner staff gathered for the groundbreaking of the new facility. In late September 2017, several thousand residents took part in open house and ribbon cutting celebrations at the new facility.

New Emergency Department, Surgical Services Center Opens at Tanner Medical Center/Villa Rica

Residents throughout northern Carroll County, western Douglas County and southern Paulding County have a new destination for emergency and surgical care as the new expansion at Tanner Medical Center/Villa Rica opened in December 2018.

Tanner broke ground on the $37 million expansion in January 2017, citing the area's growing population. When the former emergency department and surgical services unit opened with the rest of the Tanner Medical Center/Villa Rica facility in 2003, the city's population was pushing 8,000 residents, according to the U.S. Census Bureau; now, the city's population has crested 15,000 residents and continues to grow, as does the surrounding populations in northern Carroll County, western Douglas County and southern Paulding County that are also served by the hospital.

The new emergency department opened Dec. 5, 2018, offering 37 private exam rooms — more than twice the former unit — as well as on-unit diagnostic imaging services featuring ultrasound, digital X-ray and CT services. The unit is also staffed with board-certified, fellowship-trained emergency medicine physicians and advanced-practice providers, as well as specially trained emergency nurses and other clinicians.

System-wide, Tanner provides care for about 100,000 emergency department visits each year, about a third of which are treated through the emergency department at Tanner Medical Center/Villa Rica. As with most other hospitals, the emergency department is also the leading source of inpatient admissions for the facility.

Along with the new emergency department, the expansion also features a new surgical services center, complete with state-of-the-art surgical

The new emergency department at Tanner Medical Center/Villa Rica opened on Dec. 5, 2018, and the new surgical services unit performed its first cases on Dec. 17, completing a $37 million expansion to the Villa Rica hospital.

suites capable of providing the latest minimally invasive procedures, as well as more involved orthopedic surgeries like total joint replacements. The unit also offers more than twice the number of pre-op rooms compared to the current unit, two new gastroenterology suites and a new post-anesthesia care unit (PACU) for patients to receive care immediately following surgery. The new surgical care unit performed its first cases Dec. 17, 2018.

Tanner Medical Center/Villa Rica's clinical programs have grown in recent years, too. The facility serves as an accredited chest pain center, offering interventional cardiology services featuring angioplasty and stenting, as well as a primary stroke center.

"With our clinical growth, we've become a regional destination for care," said Eric Dalton, administrator for Tanner Medical Center/Villa Rica. "This facility is going to allow us to continue developing the services our community needs for years to come."

The new emergency department lobby at Tanner Medical Center/Villa Rica waits to greet patients. About a third of all emergency department visits throughout the health system receive care through Tanner Medical Center/Villa Rica.

New Operating Suites Come Online at Higgins General Hospital in Bremen

In March 2018, residents throughout west Georgia gained a new state-of-the-art destination for surgical care as new surgical suites began serving patients at Higgins General Hospital in Bremen.

While much of the facility was been renovated and upgraded since becoming part of the Carrollton-based Tanner Health System, Higgins General Hospital's surgical nursing team lead, Tara Southerland, RN, said the last time the hospital had seen a significant upgrade in its surgical services facilities was in 2000 — about 19 years ago.

"It's a dream come true," said Southerland. "We really need the extra space, and we're excited about moving into the new operating suites."

Along with the new operating suites, the expansion provides Higgins General Hospital with a new special procedures lab and a new endoscopic suite, as well as a new post-anesthesia care unit (PACU) and new short stay rooms. The renovation also added a new locker room for staff, new waiting facilities and more. The total cost of the project was about $11 million.

The surgical services unit at Higgins General Hospital provides a wide range of services, from gastroenterology screenings like colonoscopies to general surgical services, plastic surgery, ear, nose and throat care, eye surgery and more.

As part of Tanner Health System, Higgins General Hospital boasts a medical staff of more than 300 physicians, many of whom offer the advanced, minimally invasive surgical options that patients want. Minimally invasive surgery uses smaller incisions than traditional surgery, leading to less risk of complications like infection and faster, more comfortable recoveries.

> *The new surgical services suites at Higgins General Hospital in Bremen ensure the facility is able to provide the latest, most advanced surgical options to patients for years to come.*

Learn more: SurgeryAtTanner.org

Work Continues on Tanner Health Pavilion

When the Tanner Health Pavilion opens along Dixie Street in Carrollton in late 2019, several local Tanner Medical Group practices will relocate to the new 130,000-square-foot medical complex.

Among the practices set to relocate: Tanner Heart & Vascular Specialists, which will vacate its office suite on the fourth floor of Tanner Medical Center/Carrollton.

The relocation will not only make it easier and more convenient for patients to make their appointments, it will also free up space within the hospital for a badly needed expansion of beds.

Tanner will remodel the existing office suite into hospital rooms, adding several private rooms for inpatient care. While the total number of rooms to be gained has not been determined, the renovation will push the facility much closer to its licensed bed capacity, improve bed flow and increase access to vital inpatient care for neighbors throughout Carrollton and the region.

Learn more: Tanner.org

NICU, Maternity Services Expansion Brings Families Together at Tanner Medical Center/Carrollton

Advanced care for the region's tiniest, most medically delicate patients is now available closer to home with the opening of the new Level 3 neonatal intensive care unit (NICU) at Tanner Medical Center/Carrollton.

The Level III NICU at Tanner is designed to provide advanced care for newborns who need it, including those born prematurely, those with physical issues at birth that require medical intervention, and for multiple births, such as twins and triplets.

Tanner showcased the NICU and other baby services during the Hey, Baby! Mom and Baby Fair in September, drawing hundreds of moms-to-be and their loved ones to get a peek at the new unit before it opened for patient care on Oct. 1, 2018.

The first patients, twin boys Weston and Wyatt Gore, were admitted to the unit later in October. They're the sons of Brandon and Tiffany Gore of Bowdon.

"Our plan was to go to 38 weeks, but they were ready to come out, so we had them early at 33 weeks," said Tiffany Gore. "We got here on Thursday and I had the twins that Tuesday."

Prior to the opening of the NICU at Tanner Medical Center/Carrollton, families who needed critical care services for their newborns often had to travel as far away as Atlanta, Columbus or Birmingham. Now, with the services available in Carrollton, parents throughout the region can continue to bond with their babies during their earliest days while the newborns receive the medical attention they need to thrive.

The new NICU at Tanner Medical Center/Carrollton ensures that the care medically delicate newborns need is available close to home for residents throughout west Georgia and east Alabama.

Learn more: TannerMaternityCare.org

Mother Tiffany Gore holds newborn son Wyatt in the new NICU at Tanner Medical Center/Carrollton. Tiffany and her husband, Brandon, welcomed twin boys Weston and Wyatt on Oct. 23. The babies were born at 33 weeks and became the first admissions to the hospital's new NICU.

The new NICU is part of a larger overall expansion and renovation of the maternity center at Tanner Medical Center/Carrollton. Along with the NICU, the hospital has opened new labor and delivery suites, expanding the number of suites from four to six.

The new rooms, built from existing space within the hospital, feature contemporary appointments and design, as well as plenty of space for visitors. Attention has been given to the comfort of loved ones and new mothers alike, with USB chargers built into the walls and furnishings in the room, couches that fold out into beds for partners to room-in comfortably with new mothers, private waiting rooms adjacent to the labor and delivery suites for loved ones to wait during the delivery or to give the mother time to rest, and more. Also, new bathrooms feature spacious, easy-access, ADA-compliant showers.

The new NICU at Tanner Medical Center/Carrollton ensures that the care medically delicate newborns need is available close to home for residents throughout west Georgia and east Alabama.

In 2017, the hospital opened a new postpartum unit, and with the NICU expansion the hospital also added a new nursery. The project is moving in phases within existing space inside Tanner Medical Center/Carrollton, with areas being closed for demolition and renovation as new areas come on line. Upcoming phases include remodeling of existing labor and delivery suites, renovation of the facility's surgical services suite for caesarean sections and construction of a second C-section suite.

Improving Access Care Through Medical Staff Recruitment

The number of medical professionals available in a community has a direct impact on that community's ability to access care. Tanner's primary service area of Carroll, Haralson and Heard counties are all designated as medically underserved areas and health professional shortage areas. To combat this problem and improve access to medical care in the region, Tanner continued its work to recruit more physicians to practice in the area, enabling patients to choose from a greater number of providers in an expanded field of specialties.

In fiscal year 2017, Tanner welcomed 18 new physicians to its medical staff, with specialties covering:

- Anesthesiology
- Obstetrics and Gynecology
- Nephrology
- General surgery
- Emergency medicine
- Psychiatry
- Orthopedic surgery
- Gastroenterology
- Cardiology
- Interventional Cardiology
- Pediatrics
- Internal medicine
- Urgent Care
- Neurology

In fiscal year 2018, Tanner welcomed 15 new physicians to its medical staff, representing specialties in:

- Psychiatry
- Pediatrics
- Internal medicine
- Anesthesiology
- General Surgery
- Urgent Care
- Medical Oncology
- Emergency medicine
- Nephrology
- Family Medicine
- Urology

In fiscal year 2019 (through April 2019), Tanner welcomed 6 new physicians to its medical staff, representing specialties in:

- Obstetrics & Gynecology
- Psychiatry
- Anesthesiology
- Cardiology

Improving Access to Care Through Education

Tanner has continued to offer scholarships to students across the region that are enrolled in medical school or advanced practice provider programs, including providing 20 "Future of Healthcare Scholarships during fiscal years 2017-2018.

Tanner also continues to foster its established, strong partnerships with local community colleges and universities, including the University of West Georgia (UWG) and West Georgia Technical College. Tanner and the University of West Georgia announced a new partnership in 2014 that bolsters opportunities for current and future nurses throughout the region and support the delivery of high quality nursing care. The University of West Georgia's nursing program — which has been renamed the Tanner Health System School of Nursing — is using an investment from Tanner to enhance its facilities while offering scholarship and educational opportunities for those in west Georgia and east Alabama interested in a career in nursing. Tanner also provides clinical opportunities for nursing students throughout the health system's hospitals and clinics.

The Tanner Connections Program is a partnership between Carroll County, Bremen City, Carrollton City and Haralson County school districts, accepting eligible students (who are vetted through Work-Based Learning coordinators) enrolled in the following career pathways:

- Healthcare
- IT
- Marketing
- Engineering
- Food/nutrition
- Criminal justice
- Business office

Connections students first complete orientation with the health system and then work closely with their professional mentor, observing and performing job-related tasks, for at least 15 hours a week at Tanner. More than 250 students from around the region have successfully completed the program since 2010.

The Tanner Teen Institute is a summer program that runs from June 1 through Aug. 1. The program is a volunteer and leadership development opportunity for teens between the ages of 15 and 18. It includes a combination of informative educational sessions (five sessions) in which students can engage with other medical professionals, and four hours a week of volunteer service (24 total hours) in a designated hospital department.

In addition, Tanner's Get Healthy, Live Well is connecting senior nursing students at the University of West Georgia to a variety of community health opportunities in west Georgia through a preceptorship program that will help them increase knowledge and gain skills in community health work. Get Healthy, Live Well and the UWG's Tanner Health System School of Nursing partnered to create the program, which gives students an opportunity to participate in several community health initiatives that focus on improving nutrition, physical activity and managing or preventing chronic disease. Before beginning the program, students attend an orientation where they learn more about Get Healthy, Live Well and practice skills that will help them communicate better with patients.

Students also learn the skills they need to facilitate one of Get Healthy, Live Well's evidence-based programs like the Diabetes Prevention Program and Freshstart, a tobacco cessation program. Each nursing student is required to complete 20 hours of programming assistance with Get Healthy, Live Well. Since launching in fall of 2016, a total of 342 nursing students have completed the preceptorship program, completing over 7,575 hours as of Spring 2019.

Tanner Launches Nursing Recruitment and Retention Plan

Nurses are the cornerstone of exceptional patient care. Unfortunately, there are not nearly enough nurses to fill all the openings, and the shortage of nurses is going to grow only more acute in the coming years.

According to the U.S. Bureau of Labor Statistics, employment of registered nurses is projected to grow 15 percent from 2016 to 2026 — much faster than the average for all occupations — driven by the aging American population and an increased need for healthcare clinicians to educate and care for patients with various chronic conditions, such as arthritis, dementia, diabetes and obesity.

The American Nurses Association estimates that there will be far more registered nurse jobs available than any other profession by 2022, with half-a-million experienced registered nurses anticipated to retire and a need for more than 1.1 million additional nurses to fill new vacancies and those opened by the retirement of seasoned nurses.

Tanner is responding by launching an effort to expand and support the new generation of nurses who will be filling those ubiquitous white shoes.

Through a partnership with the University of West Georgia, Tanner has helped establish the Tanner Health System School of Nursing, providing clinical opportunities for up-and-coming nurses to gain first-hand experience and supporting scholarship opportunities for area residents, as well as for Tanner team members interested in moving from licensed practical nurse to registered nurse.

Tanner has also launched a nurse extern program, offering senior nursing students an opportunity to achieve clinical experience while gaining a realistic perception of the role of a registered nurse. Nurse externs may select a specialty track of interest for their time in the program, and externs who complete the program receive priority as a graduate nurse for open positions.

Tanner is also helping junior and senior nursing students with financial assistance, including tuition reimbursement and educational assistance programs.

In addition, Tanner has established a clinical ladder, helping nursing students and registered nurses advance their careers by gaining experience and enhancing their skills.

These programs and more are helping Tanner not only recruit new nurses to its team but retain the skilled nurses who have decided to bring their time and talents to Tanner.

Learn more: TannerCareers.org

Decreasing Barriers to Care Through Patient Transportation Services

It seems so simple, but for many patients, their greatest obstacle to care is lack of a ride. In a rural region such as west Georgia, transportation can be one of the most insurmountable barriers to getting adequate medical attention. Residents defer care until someone can take them to the doctor, allowing their condition to deteriorate while they wait.

For cancer patients, the inability to find reliable, regular transportation for their frequent radiotherapy visits and trips for chemotherapy infusions and follow-up appointments means they cannot adhere to their physician's prescribed course of treatment. Through a generous donation to the Tanner Medical Foundation, patients with Tanner Cancer Care now have access to a wheelchair-accessible van that can provide transportation to and from Tanner's Roy Richards, Sr. Cancer Center and other local cancer providers for treatment and follow-up visits.

Through the Cancer Patient Transportation Program, more than half of all the cancer patients in west Georgia received assistance with transportation to continue their lifesaving and life-sustaining treatments during 2017-2019. Tanner Medical Foundation also continues to offer an Indigent Taxi Fund, which provides payment to area taxi services that transport patients who have been discharged home from the hospital.

The family of Wesley Dingler (center), Tim Dingler, Sheila Richie, Callie and Ryann Jordan, donated a 2013 Nissan Rogue, to help Tanner cancer patients who cannot otherwise afford or arrange transportation for medical appointments.

Providing Access to Care for at-risk Populations

To help connect residents with local community resources, Tanner Health System's Get Healthy, Live Well partnered with two organizations to create a searchable online database.

The Community Foundation of West Georgia and Get Healthy, Live Well partnered together to develop and launch WestGeorgiaCares.org, a community resource network website, during Fiscal Year 2017. Help with food, shelter, utilities, education and training, child and adult care, physical and mental health services, substance abuse treatment, prescription drug costs and protective series are just some of the resources residents can find on the website. West Georgia Cares continues to offer area nonprofit organizations, governments and faith-based organizations help in managing their caseloads with more efficiency and effectiveness.

The network also allows agencies to create visit reports, tracking how many people were served, pounds of food distributed, and other factors required by the U.S. Department of Agriculture. Reports recording where clients have been referred for help can be created as well.

In Fiscal Year 2018, Get Healthy, Live Well's Healthy Haralson committee completed a comprehensive CHNA specific to Haralson County and subsequently developed a Community Health Improvement Plan (CHIP) to prioritize the identified needs. The CHIP identified the need to increase the awareness of existing resources in the community as a critical component of improving the effective and efficient use of resources to promote the population's health. During Fiscal Year 2019, Healthy Haralson developed and launched a separate community resource guide specific to Haralson County.

Learn more: GetHealthyLiveWell.org

Advancing Toward Affordable Health Care

Tanner continues to work closely with and provides financial support to two community-based indigent clinics, the Rapha Clinic and Latinos United Carroll County Clinic, to provide low-cost and free medical services to area residents who otherwise could not afford care.

The committee's Increase Awareness of Existing Resources task force is working toward a vision for a socially connected community by enhancing the linkages and partnerships within its network. This translates to shared accountability and a fostering of relationships among network partners to strengthen their impact on the community. Resource mapping through the development and promotion of an online community resource guide and automated phone line is evidenced to lead to:

- Faster identification of relevant programs and services for underserved populations.
- Increased interagency collaboration to serve the population.
- More networking and streamlined resources to allow better support for underserved populations.
- Greater awareness of the community's strengths and gaps in serving the underserved population, allowing agencies to work together to increase the frequency, duration, intensity and quality of existing services and supports in the community.
- More flexibility and choice for those in need.
- More support in navigating the system.
- A more accessible environment for underserved populations

Haralson County's community resource guide lists programs and services available to Haralson County residents.

Available resources include:

- Child and adult care
- Education and training
- Physical and mental health services
- Protective services
- Substance misuse resources

The guide also includes services for residents who need help with basic necessities such as food, shelter and utilities. A free automatic listing of available resources can be accessed by calling 678-647-HELP (4357).

Increasing Access to Care for the Uninsured and Underinsured

Tanner continually evaluates financial assistance and self-pay discount policies and practices to ensure optimal access. Patients are provided with information pertaining to the organization's charity/indigent program at the time of registration and on Tanner's website. Any self-pay or under-insured patients must meet criteria for indigent care to have the cost of their care written off by the health system.

Patients are interviewed, and financial statements are prepared. Patients who meet the criteria for Medicaid eligibility are referred to an outside vendor for assistance. A patient with family income up to 200 percent (2 times) of the Federal Poverty Guidelines (FPG) based on family size receives a 100 percent discount for medically necessary services.

Patients with large, medically necessary medical bills, which have created a financial hardship are considered for a sliding scale discount. The lower the patient's discretionary income and the higher the healthcare bills allows for more charity allowances. Patients whose family income exceeds two times the applicable FPG may also qualify for sliding scale discounts on medically necessary services.

Translation assistance is provided for patients as needed.

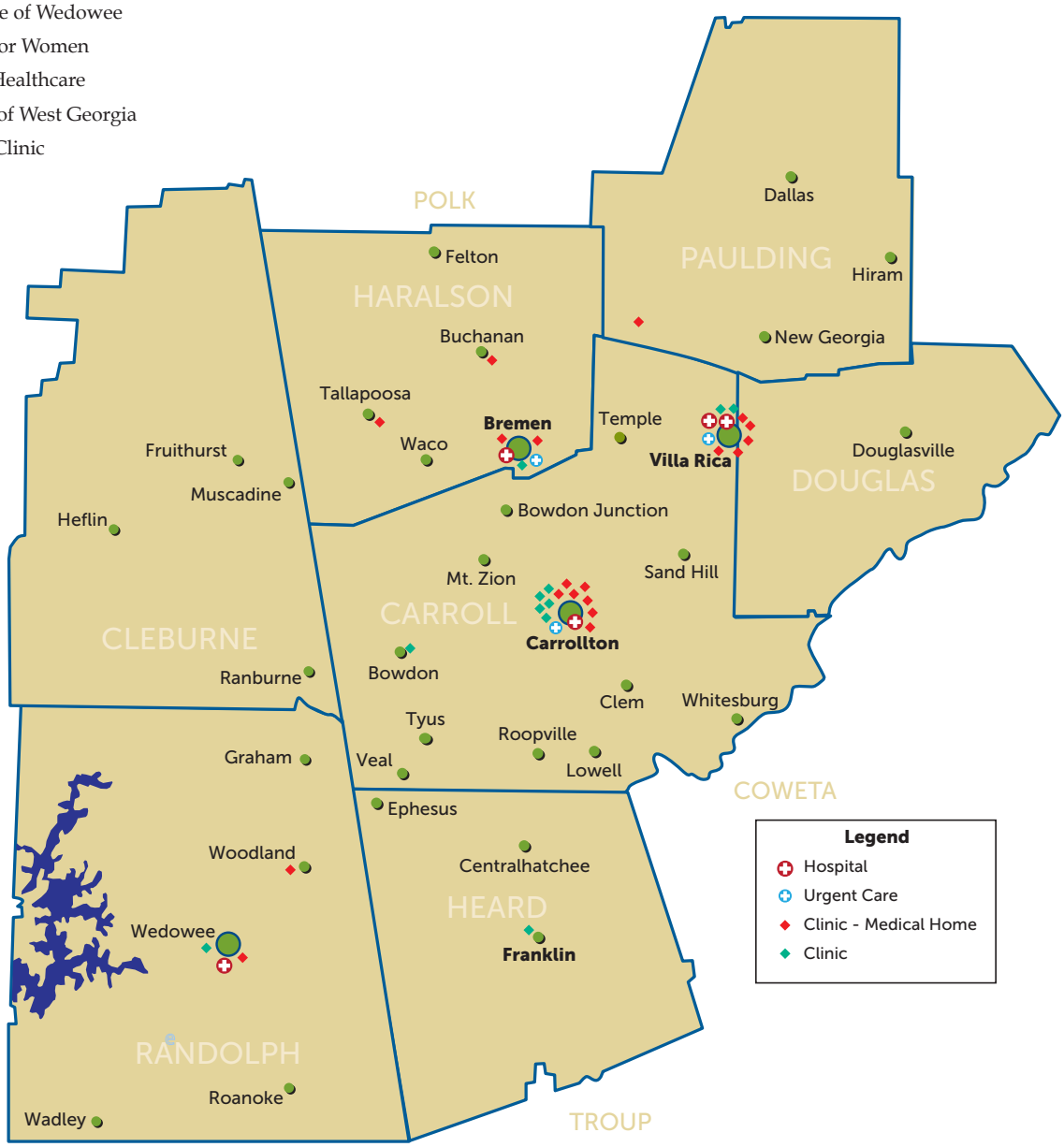
Increasing Access to Patient-centered Medical Homes

During fiscal years 2017-2019, the Patient-Centered Medical Home (PCMH)/Patient-Centered Specialty Practice (PCSP) model of care was expanded into the following practices:

- Woodland Family Healthcare
- West Georgia OB/GYN
- West Georgia Healthcare for Women
- Villa Rica Family Medicine
- Tanner Primary Care of Wedowee
- Tanner Healthcare for Women
- Tallapoosa Family Healthcare
- Infectious Diseases of West Georgia
- Buchanan Medical Clinic

These joined existing PCMH practices that include:

- Carousel Pediatrics
- Tanner Primary Care at Mirror Lake
- Tanner Primary Care of Carrollton
- Tanner Primary Care of Bremen
- Tanner Primary Care of West Paulding



Improving Healthcare Through Technology: One Patient, One Record

Tanner Health System has partnered with Verona, Wis.-based electronic health record (EHR) company Epic Systems Corporation to make health records more consistent, more accessible for providers and patients alike, more meaningful and more user-friendly. Tanner's leadership team made the decision to partner with Epic in late 2017, in consultation with medical staff and after examining several EHR services available in the market. Staff and medical providers participated in nearly a week total of in-depth demonstrations from the EHR services that emerged as finalists.

When fully implemented, Tanner's Epic Focus will provide a full financial, scheduling, clinical and patient portal system for all of Tanner Health System. This means one patient, one record — including one medical list and one bill.

Before Epic implementation, the health system's hospitals and Tanner Medical Group clinics had operated on different electronic health record systems. While both systems are secure and have served their purpose well, the trend in healthcare information technologies has been to consolidate systems. The Epic platform promises "one patient, one record," giving medical providers a single point of contact to document diagnosis, treatments, medical histories and more.

The system provides patients with unparalleled digital access to their records through the popular MyChart application, enabling the health system's patients to review documentation, test results and securely contact their medical providers with questions or concerns. The months-long rollout included an upgrade to the health system's IT infrastructure, as well as the recruitment of additional staff to oversee and manage the new platform. A new training facility was also built at Carrollton's Glen Eagle office park to provide a venue for educating staff on the new platform.

Tanner chose Epic after a months-long review process, bringing together staff from throughout the organization and hosting a series of on-site demonstrations from some of the nation's leading electronic health record vendors, resulting in feedback from more than 700 physicians, clinician and other staff. A substantial majority — almost 80 percent — of those in the decision-making process elected to move to the Epic platform. Epic is one of the world's leading EHR services, keeping the vital health records for more than 190 million people.

Tanner plans to go live with the new electronic health records system at its medical practices in mid-2019 and its hospitals later in the year.

Learn more: TannerEpicFocus.org

Tanner Heart Care Rolls Out Lumedx Upgrade

In 2016, Tanner Heart Care rolled out online a software upgrade that is going to help the program retain its accreditations by streamlining documentation.

The upgrade to the program's Lumedx cardiovascular information system (CVIS) will enhance the structured reporting required by Tanner Heart Care's various accrediting agencies, which check for standardized documentation as a key component of quality patient care.

The Lumedx system itself is a depository for Tanner Heart Care's various images. It allows a cardiologist at Tanner to access images and reports from a patient's angiogram or heart echo from a reading room at the Tanner Heart and Vascular Center in Carrollton or on a laptop in Wedowee.

The structured reporting ensures that documentation meets the various requirements for the agencies that credential the service's echo, nuclear cardiology, catheterization labs and other accredited programs.

Learn more: TannerHeartCare.org

Chronic Disease Education, Prevention and Management

Helping the Community Get Healthy and Live Well

Two threats are increasingly affecting individual quality of life and overall community health in west Georgia: unhealthy lifestyles and the growth of chronic disease. To address the community's healthcare needs, Tanner Health System has developed population health approaches focused on prevention, improved chronic disease management and wellness activities to ultimately increase efficiency and quality of health care and improve the health status of the communities Tanner serves. Tanner has reached out beyond the walls of the hospital by partnering with key community organizations to implement innovative approaches to sustainably improve total population health.

In 2012, Tanner approved a five-year strategic plan that included the development of a community health/community benefit department. Upon completion of a community health needs assessment in 2012, Tanner sought funding to further respond to the burden of chronic disease and obesity in the community. Since then, the health system has attracted over $5.6 million in federal, corporate and private foundation grants to create community solutions for problems created by chronic disease and their underlying risk factors.

Out of those efforts came Get Healthy, Live Well, a robust, multi-sector community coalition established by Tanner in 2012 dedicated to educating, promoting and developing sustained conditions for healthier lifestyles where people, live, learn, work, play and pray in Carroll, Haralson and Heard counties. With the help of more than 270 local, state and national partners, more than 600 community volunteers and more than 35 task forces, Get Healthy, Live Well is helping make communities a healthier place to live, learn, work, play and pray — building an overall culture of health.

Get Healthy, Live Well is engaging people, ideas and resources across multiple settings (community, community institution/organization, health care, faith-based, school and worksite) to develop community solutions for problems created by chronic disease and their underlying risk factors. In just seven years since its establishment, Get Healthy, Live Well is making significant gains to improve the health status of individuals in Carrollton, and has served as a model for rural communities impacting population health on a national scale.

Preventing and Reducing Tobacco Use

Several anti-tobacco initiatives have been launched in west Georgia to promote smoke-free environments, teach youth about the dangers of tobacco use and help current users quit for good. The "Don't Be a Bonehead" campaign brings the anti-tobacco message to a variety of events and has reached over 50,000 residents to date. In addition, over 700 individuals have been served by Freshstart tobacco cessation programs since July 2013.

The Freshstart program has been augmented by the Get Healthy, Live Well Coalition's efforts at assisting over 20 local organizations since 2012 in the implementation of tobacco-free policies, impacting over 60,000 individuals. Those organizations include clinics, universities, schools, housing authorities, worksites and faith-based organizations. Due to these efforts, adults smoking rates in Carroll County showed significant decreases from the 2013 (23 percent) and 2018 (20 percent), according to the County Health Rankings report published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Learn more: GetHealthyLiveWell.org

Improving Nutrition

Get Healthy, Live Well's West Georgia Regional Food System Collaborative continued to work on understanding the systemic infrastructure, policy issues and economic concerns that must be addressed to make healthy food more viable in west Georgia. The group includes more than 30 representatives, including local farmers, business and restaurant owners, chefs, school nutrition directors, master gardeners and concerned citizens. Its task forces have:

- Conducted studies on food insecurity for rural residents
- Hosted networking meetings to encourage schools and restaurants to purchase from local farmers
- Supported efforts to introduce and promote SNAP benefits at two area farmers' markets, making healthy food accessible to 16,500 low-income individuals
- Held workshops on business management for farmers
- Developed a local Farm and Food Resource Guide
- Developed educational point of purchase materials to improve the intake and purchase of healthy food/menu items in local restaurants and convenience stores (including launching a mobile app Menu It, which has over 2,500 registered users
- Worked with three local summer feeding programs and more

Journeyman Farmer Certificate Program

Get Healthy, Live Well recognizes the key need for new farmers in our region to help us supply the fresh fruits and vegetables needed for healthy communities. Although we need new farmers, the barriers would-be farmers face when trying to grow new agricultural businesses from the ground up can be formidable. In partnership with the UGA Extension, and with support from a United States Department of Agriculture (USDA) Community Food Project grant, Get Healthy, Live Well aims to mitigate these barriers through enhanced farmer education programming and opportunities in the region.

Those who complete the Journeyman Farmer Certificate Program can participate in a 20-hour Journeyman Farmer mentorship with local farmers. At the completion of the mentorship program, participants can apply for an 80-hour working internship on a local farm. Interns are provided a stipend of $9 per hour.

Fifty-one individuals completed the Journeyman Farmer Certificate Program during fiscal years 2018 and 2019. Most participants reported overwhelmingly positive feedback about the program format and material covered. The primary takeaways were the knowledge gained in areas of budgeting, resources, planning, SWOT analysis, marketing and record keeping related to improving farming business operations.

Three individuals completed the Journeyman Farmer Mentorship program in August 2018.

Community Gardens

In Fiscal Year 2018, Get Healthy, Live Well's Healthy Haralson committee joined forces with Honda Precision Parts of Georgia, Keep Haralson Beautiful, R.K. Redding Construction, The Blake House and the county's 4-H Club to plant community gardens and flowerbeds at three senior centers in Haralson County. Over 75 community volunteers were involved in the community garden build/planting day and contributed over 435 volunteer work hours.

Power of Produce Club

Get Healthy, Live Well continued the Power of Produce (POP) Club program at area farmers' markets to empower kids to make healthier choices. Every time kids ages 4 to 12 come to the farmers' market and participate in a fun activity, they receive $2 to spend on fresh fruits and vegetables. The program also includes a variety of educational activities around food, nutrition and food growing.

Over Fiscal Years 2017-2019, there have been an average of 200 POP club members per year. The program has garnered overwhelmingly positive feedback from local parents who appreciate that the program encourages healthy eating behavior in a fun, new ways and get kids excited about trying fruits and vegetables.

Food Pantries

During Fiscal Year 2018, Get Healthy, Live Well has worked through four area food pantries to increase the nutritional quality of the food donated and served, and provide education to clients in how to use their limited funds to purchase and prepare healthier foods. These food pantries include Manna House, Community Christian Council, Bowdon Area United Christian Ministries and Open Hands who collectively serve over 1,500 families per month.

Leadership of these food pantries have convened multiple times during the project period to discuss the establishment of guidelines to increase the nutritional quality of their food donations, to be in further alignment with the Dietary Guidelines for Americans.

The food banks were provided with draft guidelines and are actively working with their boards and staff to implement changes and adopt these guidelines at their respective sites. The food bank leadership members discussed the implementation of "Healthy Food Drives" and plan to implement these in the coming months as part of the adoption of the healthy food bank guidelines. Get Healthy, Live Well has also implemented healthy cooking demonstrations on food giveaway days with in-season produce at Bowdon Area Christian Ministries and Manna House, reaching approximately 500 individuals.

The promotion of Supplemental Nutrition Assistance Program (SNAP) and other EBT (Electronic Benefits Transfer) benefits at food giveaway days resulted in an increase in the utilization of these services at the Cotton Mill Farmers' Market each month. Get Healthy, Live Well is currently working on the development of "how to" healthy recipes to be utilized within the food banks and disseminated to food bank patrons each month.

Cooking Matters

Cooking Matters is an evidence-based national program that empowers low-income individuals and families with the skills to prepare healthy and affordable meals. The program, which includes six weekly, two-hour sessions, brings together local culinary and nutrition experts and volunteers to lead hands-on courses. Cooking Matters teaches low-income children, teens and adults how to select tasty and low-cost ingredients, stretch them across multiple meals and use healthy cooking techniques and recipes that help provide the best nourishment possible to their families.

Classes have been taught at Boys and Girls Clubs, housing authorities, senior centers, libraries, churches, universities, schools, community centers and businesses. During Fiscal Years 2017-2019, 24 Cooking Matters class series were held, reaching a total of 279 low-income participants. The Cooking Matters program has had a significant impact on participant's nutrition knowledge and behaviors.

Several low-income adults reported how the course has helped them buy healthier meals with their SNAP benefits, further supporting the health and food security of their families. Several participants learned how to read food labels for the first time and were more empowered to make healthier decisions on their limited budgets.

Participants' responses to post-surveys indicate increased occurrences of:

- Reading food labels to determine nutrition information
- Choosing low-fat dairy options including milk
- Choosing whole grain products
- Choosing lean meats or proteins that are low in fat
- Choosing healthy fast-food or other restaurant options
- Eating food from each food group daily
- Making meals from scratch at home using healthy ingredients
- Helping their families eat healthier

Improving Healthy Food and Physical Activity Access

Workplace Wellness

Get Healthy, Live Well conducted assessments at Carroll EMC, JAC Products, Inc. and Decostar Industries, Inc. to determine current efforts and implement new strategies to increase access to affordable, healthy food and beverages, and promote physical activity. Initiatives included, but were not limited to, weight loss and walking meeting challenges, hydration challenges, providing technical assistance in vending machine policies and fitness center planning and more.

Kids 'N the Kitchen

In November 2016, Get Healthy, Live Well launched Kids N' the Kitchen, an interactive teaching kitchen program for grades K-8 that is designed to help teach students healthy cooking skills and improve their nutrition. Not only does Kids 'N the Kitchen help teach students healthy eating habits, it also provides an opportunity for them to take the lessons they learn home and educate their parents. A total of seven carts are utilized for Kids N' the Kitchen and schools apply each semester (fall or spring) to bring the programming to their school.

The rolling steel kitchen's countertop features an induction cooktop, reversible griddle and food processor for cooking demonstrations. The kitchen also includes a stainless-steel pop-up table for additional prep space. Since its launch, Kid N' the Kitchen has implemented 370 lessons, reaching over 16,600 children.

The nutrition carts have visited a total of 12 different schools throughout Carroll, Haralson and Heard counties. Participating schools include:

- Carrollton Elementary School
- Buchanan Primary School
- Central Elementary School
- Villa Rica Middle School
- Whitesburg Elementary School
- Roopville Elementary School
- Sandhill Elementary School
- Tallapoosa Primary School
- Providence Elementary School
- Glanton-Hindsman Elementary School
- Bowdon Elementary School
- Sandhill Elementary School

Outcomes from the program include:

- An increased willingness of children to try fruits and vegetables. Out of a sample of 176 students at Whitesburg Elementary that went through the programming, 100 percent of students tried the food prepared for the lesson, with 42 percent noting that they "loved it."
- Ongoing reporting by teachers and parents about the positive impact the programming has had in influencing healthy eating behaviors among children/families. The also reported an increase in knowledge about the connection between diet and health.

Eat a Rainbow and Kids Exhibit

Get Healthy, Live Well's "Eat a Rainbow," a nutrition theatrical production, has been implemented in 10 schools since its launch in Fiscal Year 2016, reaching over 6,500 students, along with an interactive Kids Exhibit, reaching over 3,500 children to date. The Kids Exhibit and "Eat a Rainbow" post-survey results by students show an increase in knowledge about the wellness topics covered.

Improving Community Design to Promote Health

Through Get Healthy, Live Well's Healthy, Safe and Active Communities committee, community leaders have put complete streets and built environment strategies high on their agendas, moving forward with a variety of infrastructure changes in the community.

Carrollton GreenBelt

The construction and completion of the Carrollton GreenBelt, an 18-mile bike and pedestrian path (the largest paved loop system in the state of Georgia). The GreenBelt provides an opportunity to integrate recreation with transportation, combating several of the negative health trends impacting Carrollton. The trail connects existing neighborhoods with the Carrollton City Schools campus, University of West Georgia, city parks and several commercial shopping areas.

Construction began on the $17 million project in 2011 and the GreenBelt fully opened to the public in 2017. In May 2017, the League of American Bicyclists recognized Carrollton as a Bicycle Friendly Community. In July 2018, Road Runners of American recognized Carrollton as a Runner Friendly Community in July 2018.

Policy and Built Design

The city of Carrollton adopted a Complete Streets Policy during Fiscal Year 2017. Notable built design changes include the addition of bike lanes, sidewalks and traffic pattern reconfigurations to accommodate bicycles and safer crosswalks.

In August 2018, the city of Villa Rica developed and adopted a comprehensive master trail plan (Gold Nugget Trail) to promote connectivity to destinations such as parks, neighborhoods and business districts and encouraging active healthy living. The city of Bremen completed a plan for an additional walking trail and added and/or repaired multiple sidewalks throughout the city.

The University of West Georgia (UWG) developed a master bike plan, with the addition of multiple bike lanes and pedestrian friendly corridors. Additions include a 1.25-mile bicycle track and GreenBelt connector around the perimeter of the campus. In November 2017, UWG was recognized by the League of American Bicyclists as a Bike-Friendly University.

Carrollton Bike Share

Through a partnership with the city of Carrollton, Tanner Health System, Southwire Company, UWG and Friends of Carrollton GreenBelt, a wide-reaching bike share program (with over 50 cruiser bikes) was launched in February 2017. Bike share provides the city's residents and visitors with a convenient, affordable and healthy way to get around town. Since the launch, the Carrollton bike share averages more than 500 rides per month on the rental bicycles, making it one of the more robust bike-share programs in the Southeast. Since the launch, there have been over 26,000 rides made through the bike-share program, which has over 10,000 active users.

Safe Routes to School

Get Healthy, Live Well continued to promote the Safe Routes to School (SRTS) program at Carrollton City Schools. The program encourages increased student physical activity through safe and active transport to and from school, as well as infrastructure improvements and student traffic education. After new bike racks and walking lanes were installed in August 2015, a 500 percent increase in walking and cycling to school was realized.

Move It Mondays

Going for 30 minutes of exercise a day, at least five days a week, is a great way to get and stay in shape. Get Healthy, Live Well is helping people get started with Move It Mondays, an eight-week program designed to turn walkers into joggers. In partnership with the West Georgia Track Club, Get Healthy, Live Well developed the free program to help participants add distance and increase their pace over the course of eight weeks. Move It Mondays has certified coaches and experienced runners available to encourage and motivate participants.

Since the program began in the fall of 2015, there have been 282 participants who have logged more than 3,000 miles.

Increasing Access Clinical and Community-based Services

Faith-Based Wellness

Local faith-based organizations represent a substantial, and largely untapped, voluntary-sector resource for community health improvement efforts in small, rural communities. During the Centers for Disease Control and Prevention's Partnerships to Improve Community Health (PICH) project period, Get Healthy, Live Well's faith-based wellness efforts focused on improving health and reducing chronic disease and related risk factors. The project included the engagement of 14 area faith-based institutions (including focused efforts in 11 African American faith-based organizations), representing over 4,865 congregants, in the implementation of evidence-based strategies aimed at addressing:

- Tobacco use and exposure
- Poor nutrition
- Physical inactivity
- Lack of access to chronic disease prevention, risk reduction and management opportunities

Get Healthy, Live Well conducted initial Policy, System and Environmental (PSE) assessments within the selected faith-based organizations to determine current efforts and prioritize evidence-based strategies based upon identified needs within each organization. Interventions have included the adoption of smoke-free and/or tobacco-free policies. They have also included the development of wellness councils to promote healthy lifestyle behaviors within the faith-based organization and community, including the training of congregation members in wellness programming promoting the following:

- Tobacco cessation
- Physical activity and nutrition
- Community gardens
- Physical activity groups
- Wellness challenges
- And more

Research shows faith-based health promotion interventions that engage congregations as change agents result in improved health status and medical outcomes such as better disease control, earlier diagnosis, and fewer comorbidities for the community. Over Fiscal Years 2017-2019, 26 church lay leaders have been trained to implement the following Get Healthy, Live Wells evidence-based programming:

- Freshstart tobacco cessation program
- National Diabetes Prevention Program
- Cooking Matters
- Living Well Workshop (Chronic Disease Self-Management Program)
- Living Well with Diabetes

A comprehensive evaluation was conducted of the Get Healthy, Live Well in Faith initiative to determine if the initiative's efforts impact PSE change and health among African American church members. This

evaluation was an observational, longitudinal cohort study with pre- and post-observations of variables occurring over two years (May 2015 to June 2017). The sampling plan implemented included a convenience sample of 11 African American churches, with a sample size of 776 church members aged 18 and older.

The key evaluation findings were as follows:

- Tobacco and water policies were adopted by 100 percent of the churches
- 90 percent of the churches integrated physical activity into church activities
- 82 percent of the churches implemented an evidence-based program during the intervention
- The percentage of church members with hypertension, Stage 1 or 2, decreased, from 81 percent to 61 percent
- Church members reported improved nutrition knowledge each year from 24 percent (very knowledgeable) to 32 percent
- The percentage of church members who visited a healthcare professional 10 or more times in 12 months decreased each year, from 6 percent to 0 percent

Tanner Health Source

Get Healthy, Live Well's employee wellness program employs registered dietitians, exercise specialists and health coaches who work with employees and lead group classes to help employees lose weight, manage chronic diseases and adopt healthier habits. Each year, Get Healthy, Live Well provides free wellness assessments to all employees that include a cholesterol screening, blood glucose reading, BMI check and more. Tanner employees also have 24-hour access to Tanner Health Source exercise facilities, which feature cardio and weight-training equipment, at its hospital campuses in Carrollton, Villa Rica and Bremen.

These investments have paid dividends in improved health for Tanner's employees. Over the past eight years, the average BMI of Tanner's workforce has dropped from 35 in 2010 to 30.15 in 2018. The average blood pressure reading for employees also has dropped, from 125/76 in 2010 to 117/78.

Get Healthy, Live Well Class Instructors

Get Healthy, Live Well has trained over 200 people to teach its evidence-based wellness programs. Those numbers include:

- Two master trainers and over 60 lay leaders in the Living Well programs
- One master trainer and 49 lifestyle coaches in the National Diabetes Prevention Program (DPP)
- Six Freshstart leaders
- 87 Cooking Matters facilitators
- 19 program facilitators of Kids N Fitness

Increasing Physician Referrals

Get Healthy, Live Well has made it a priority to expand its community health efforts with an innovative community-clinical linkages (CCL) model that creates a bridge between the clinic or doctor's office and its evidence-based programs, which include the following:

- National Diabetes Prevention Program (DPP)
- Living Well with Chronic Disease Program
- Living Well with Diabetes Program
- Freshstart Tobacco Cessation Program

Tanner's Get Healthy, Live Well staff provides updates to physicians on patient referrals, progress and outcomes. Since launching a robust CCL linkages referral process in early 2016, over 1,800 individuals have been referred to a Get Healthy, Live Well program, with nearly 100 area clinicians currently providing referrals.

Diabetes Prevention Program

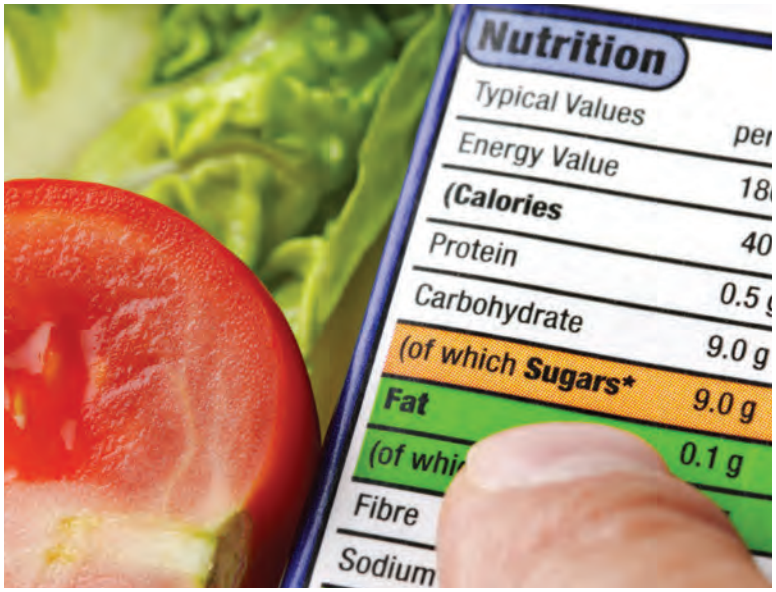
The National Diabetes Prevention Program (DPP) from the Centers for Disease Control and Prevention includes dietary coaching, lifestyle intervention and moderate physical activity — all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The program consists of 16 "core" sessions (one per week for an hour) of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity and behavior change strategies for weight control. After the 16 core sessions, less intensive monthly follow-up meetings help ensure that the participants maintain healthy behaviors.

The primary goal of the intervention is at least 5 percent average weight loss among participants, which is evidenced to result in a 58 percent lower risk of getting diabetes, according to CDC estimates. Since 2014, DPP has helped over 400 residents slash their risk for developing type 2 diabetes. In January 2017, Tanner was the first hospital in Georgia to receive CDC Full Recognition for participant achievement of DPP program goals (e.g., weight loss, physical activity).

This CDC Full Recognition status was subsequently achieved again by Tanner in July 2018 and March 2019 for continued effective DPP program delivery after receiving an average of 5.5 percent participant weight loss at the end of the 12-month instruction.

A survey of 61 individuals who completed the DPP program — representing a 51-percent completion rate — showed they achieved remarkable results, which include:

- Less missed work due to health issues in the previous month
- Less health issues that interfere with daily activities
- Reduction in the number of participants currently experiencing arthritis or gout
- Significant reduction in those with high cholesterol
- Significant reduction in overweight or obesity
- Improved confidence and tools/skills to take care of health (self-management)



Living Well with Diabetes

The Diabetes Self-Management Program (Living Well with Diabetes) is a two-hour workshop held once a week for six weeks. The workshop, which is led by two trained leaders, is designed for people diagnosed with type 2 diabetes. The typical class size is 12 to 16 people.

Topics covered include:

- Techniques to deal with the symptoms of diabetes, which include fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration
- Appropriate exercise for maintaining and improving strength and endurance
- Healthy eating
- Appropriate use of medication
- Working more effectively with health care providers

During the workshop, participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. A recent research study shows that participants who completed the program had significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating and reading food labels. They demonstrate improvement in patient activation and self-efficacy. They also spent fewer days in the hospital, and there was a trend toward fewer outpatient visits and hospitalizations, yielding a cost to savings ratio of approximately 1:4.

A survey of 77 individuals who completed the Living Well With Diabetes program — representing a 43-percent completion rate — showed they achieved the following results:

- Self-assessed health improved by a quarter of a unit on a 4-point scale (0=poor to 4=excellent)
- The obesity rate fell a huge 14.7 percentage points (from 49.3 percent to 34.7 percent), and this was accompanied by a marginally significant increase in the frequency of reading nutrition labels
- Statistically significant improvements in three different aspects of confidence in taking care of one's health/interacting with one's doctor

Living Well with Chronic Disease

The Chronic Disease Self-Management Program (Living Well Workshop) is a two-hour workshop held weekly for six weeks. People with various chronic health problems (hypertension, arthritis, cancer, depression, heart disease, diabetes and more) attend the workshop, which is facilitated by two trained leaders. Family members and informal caregivers are also encouraged to attend.

Topics covered include:

- Techniques to deal with frustration, fatigue, pain and isolation
- Appropriate exercise for maintaining and improving strength, flexibility and endurance
- Appropriate use of medications
- Communicating effectively with family, friends and health professionals
- Nutrition
- Decision making
- How to evaluate new treatments

A recent research study shows that participants who completed the program demonstrated significant improvements in:

- Exercise
- Cognitive symptom management
- Communication with physicians
- Self-reported general health
- Health distress
- Fatigue
- Disability
- Social/role activities limitations
- Participants also spent fewer days in the hospital, and there was a trend toward fewer outpatient visits and hospitalizations, yielding a cost to savings ratio of approximately 1:4

A survey of 77 individuals who completed the Living Well Workshop — representing a 49-percent completion rate — showed they achieved the following results:

- Greater confidence and tools/skills to take care of health (self-management)
- Greater confidence in management of health-related tasks and activities that reduce the need for doctor care
- Confidence in health-related self-management other than taking medication

Freshstart Tobacco Cessation Program

Freshstart is the American Cancer Society's group-based tobacco cessation counseling program. The Freshstart program is designed to help smokers, chewers and dippers quit tobacco and develop coping skills to combat the psychological and physical side effects of cessation. This straightforward, upbeat program is intended to stress the positives of the tobacco cessation experience — the reasons to quit and the benefits of quitting — while honestly exploring the very real, unpleasant feelings that are a part of beating the addiction.

The program is easy to fit into a busy lifestyle since classes meet one hour a week for four weeks and are held free of charge by trained facilitators on a rolling basis every month at a variety of locations. Since July 2013, over 700 individuals have participated in the program.

A survey of 67 individuals who completed Freshstart showed they achieved the following results:

- Significant improvement in confidence in controlling cravings
- Sizable reduction in the probability of using tobacco (6.3 percentage points)
- Significant reduction in likelihood of having hypertension/high blood pressure

Increasing Access to Preventive Services

Tanner has been proactive in encouraging residents to undergo recommended health screenings based on a variety of factors (including age, health habits, lifestyle, etc.) using emails, direct mail pieces, flyers, exposure at community events and more to raise awareness.

The health system has encouraged residents to make use of free online health risk assessments for a variety of health conditions — including diabetes, heart disease and colorectal cancer — as a means not only of educating residents about their own health risks but also to raise awareness of the critical need for regular health screenings.

Tanner has also produced numerous pieces of educational collateral to encourage routine screenings across all its services lines, from pediatrics to women's care, cancer care, heart care, urologic care and others.

In addition, in the past three years the health system has held 9 screening events, offering free cholesterol and blood pressure screenings, prostate screenings and more.

With breast cancer being the most common type of cancer diagnosed in west Georgia women, and early detection being the key to successfully battling the disease, Tanner's Mammography on the Move digital mammography unit hit the road, removing barriers of time, awareness and access that prevent women from getting mammograms. The mobile unit visited over 200 sites during fiscal year 2017, with locations that included community events, indigent clinics, businesses, churches, civic groups and more, providing 1,030 mammograms and 200 bone density exams to area women. The mobile unit visited 163 sites during fiscal year 2018, providing 718 mammograms and 113 bone density exams to area women.

Partnering in Community Health

Following the completion of the 2016 CHNA, the Tanner-led Get Healthy, Live Well Coalition was restructured to align with the priority areas addressed through the FY 2016-2018 Community Health Implementation Strategy. Since the restructuring, the coalition has grown to include more than 35 task forces, more than 270 local, state and national partners and over 600 community volunteers. Get Healthy, Live Well volunteers have provided an average of 5,500 hours of service per year, an estimated worth of $133,000 per year.

The coalition's efforts have received multiple accolades for effectively addressing public health challenges through collaborative efforts. These accolades include receiving the following awards or designations:

- Georgia Department of Public Health's Partner Up! For Public Health Hero, 2013
- Georgia Hospital Association's Community Leadership Award, July 2014
- Georgia Alliance of Community Hospital's Large Hospital of the Year Award, October 2014
- National Center for Healthcare Leadership's Leadership Challenge Award, August 2015
- American Hospital Association's NOVA Award, July 2016
- Georgia Department of Public Health's Healthy Georgia Community Innovation Award, October 2016
- Finalist for the International Hospital Federation's Excellence Award for Corporate Social Responsibility, August 2017.
- Finalist for the American Hospital Association Foster McGaw Prize, November 2018.
- Finalist for the Robert Wood Johnson Foundation Culture of Health Prize (City of Carrollton), March 2019.

Mental Health Access

Increasing Access to Mental Health Services

Willowbrooke at Tanner continued to implement and expand its school-based behavioral health therapy services in the region.

Through a three-year Rural Health Care Services Outreach grant from the Health Resources and Health Administration, Willowbrooke's West Georgia Regional School-Based Behavioral Health Consortium led a Rural School-Based Mental Health (SBMH) initiative. From 2015 through May 2018, 10 rural schools in the Carroll, Haralson and Heard County School districts received mental health awareness training and school-based therapeutic services.

These trainings and therapeutic services were supported by community members and school-level behavioral intervention teams that included school personnel and Willowbrooke at Tanner's mental health clinicians. The goals of the SBMH program are to:

- Establish and promote a collective vision and framework for a continuum of school-based behavioral health services in West Georgia
- Increase access to high-quality, school-based behavioral health services and supports in west Georgia
- Improve the mental, emotional and behavioral health status of children and adolescents in west Georgia

From July 2015 through June 2018, 2,728 school-based therapeutic sessions were provided to 269 rural, west Georgia youth. The majority (greater than 50 percent) of youth receiving clinical services improved in the areas of child behavioral/emotional needs and child strengths. They also showed a decrease in traumatic stress symptoms, utilizing the Child and Adolescent Needs and Strengths Assessment (CANS).

Georgia Department of Education School Climate Rating scores increased or were maintained in 80 percent of participating schools. Nearly 6,000 school staff and 3,000 parents were exposed to mental health awareness training through the rural SBMH program.

Across the three counties, youth mental health consortia were formed and included 45 unique school and community partners. The school personnel and the school-based mental health clinicians reported that the student referral process was efficient and easy. The support that clinicians provided to students contributed to decreases in challenging behavior, improved academic outcomes, improved relationships with families, and improved social/emotional functioning.

Due to the ongoing demonstration of the success of SBMH services in the Carroll, Haralson and Heard County school districts, Willowbrooke at Tanner has expanded its services into the Carrollton City, Douglas County and Polk County school districts. Currently, Willowbrooke at Tanner is partnering with eight school systems to have 12 licensed behavioral health counselors in 39 elementary, middle and high schools, offering direct access to mental health services to hundreds of school-aged children and their families.

youth with the best opportunity to succeed in school, at home and throughout their lives. YMHFA teaches individuals who work and interact with young people to respond when a child is experiencing a behavioral health challenge or crisis.

The program doesn't teach participants how to diagnose mental health issues; rather, it teaches them to utilize a five-step action plan for how to help and support young people in both non-crisis and crisis situations. These situations include experiencing thoughts of suicide, self-harming or substance abuse.

YMHFA trainings are held for child advocates such as social workers, school counselors, members of the Department of Juvenile Justice, as well as other individuals who may regularly interact with children. These advocates include church youth group leaders, teachers, coaches, school counselors, family members, EMS first responders, other medical professionals and more. Trainings have been held in Bartow, Carroll, Coweta, Douglas, Haralson, Paulding and Polk counties, making a huge impact in the community and in the lives of many young people around the region.

Since 2015, Willowbrooke at Tanner has conducted 137 YMHFA trainings, trained 2,339 individuals in the community and have had more than 1,180 children referred to services in this area due to members of the community taking the YMHFA training.

Since 2015, Willowbrooke at Tanner has conducted 137 Youth Mental Health First Aid Trainings and trained 2,339 individuals in the community.

Reducing the Stigma

According to the National Alliance on Mental Illness, 50 percent of all mental illness begins by age 14, and what's more, one in five children ages 13 to 18 are either currently struggling with a mental health issue or will at some point during childhood. Those are certainly staggering statistics, and what may be even more startling is the fact that these national statistics don't exclude west Georgia's and east Alabama's young people — and many of them, too, may be struggling with a mental health issue.

To help address this problem, Willowbrooke at Tanner — the behavioral health service of Tanner Health System — offers a public education program to train adults in the community on how to help children and adolescents who are struggling with mental health issues. The Youth Mental Health First Aid (YMHFA) program is designed to help provide

Over the past two fiscal years, Willowbrooke at Tanner has offered a program, "Recognizing the Warning Signs of Adolescent Suicide," to help those in attendance understand — and empower them to prevent — teen suicides. The program featured current regional statistics related to suicide; actual suicide signs and symptoms to watch for; healthy talking points for parents, teachers, teens and peers; and a question-and-answer session with a panel of behavioral health experts from Willowbrooke at Tanner. This program was held in Carrollton, Tallapoosa and Cartersville, drawing large, engaged crowds (averaging 200 people per program).

In March 2018, Willowbrooke at Tanner offered the program, "Close to Home: The Sobering Truth about Alcohol and Opioids," in Carrollton to help those in attendance understand the prevalence of substance abuse, learn how to recognize the signs of addiction, and where to get help. The discussion was part of Tanner Health System's free Advancing Your Health Education series, providing residents with access to free health information from the region's leading health experts and covering a wide range of topics.

Enhancing Substance Abuse Treatment

Willowbrooke at Tanner continued to promote and provide substance abuse services through Regain at Willowbrooke. This program is offered on Willowbrooke at Tanner's Villa Rica campus and provides intensive, outpatient substance abuse treatment three evenings a week after working hours. Treatment is led by a psychiatrist and licensed professional counselor with a background in substance abuse, and the course of treatment typically lasts six to 12 weeks.
In 2016, a new behavioral health practice was opened in Villa Rica — Behavioral Health of West Georgia. The practice is led by two psychiatrists, John W. Miller, MD.

Partnering in Mental Health

Willowbrooke at Tanner has a strong history of successfully collaborating with other agencies, including area juvenile/truancy courts, the Department of Family and Children Services, the Department of Juvenile Justice, physician offices and schools. Willowbrooke at Tanner staff and administration frequently attend community meetings with these agencies and organizations, allowing for the identification of community needs to be shared, and for Tanner to get involved with assistance, when necessary.

During fiscal years 2017-2019, Willowbrooke at Tanner held multiple educational seminars for mental health professionals, including licensed professional counselors, social workers and marriage and family therapists. Most of the seminars offered Continuing Education Units (CEUs) to attendees.

Improving Health Literacy

In an effort to empower people to take an active role in their health and overcome barriers to care, Tanner Health System has been working to raise awareness about the information and services available in the community.

Advancing Health

In Fall 2016, Tanner Health System launched the "Advancing Your Health Education Series" to provide reliable health information through community forums, featuring experts from cardiology, obstetrics and gynecology, urology, orthopedics, cancer and more.

Since then, the health system has hosted 22 events, impacting 1,226 people.

Improving Patient Communications

In 2018, Tanner instituted a new, robust customer relationship management system to help facilitate more targeted communications among patients and the region at large. The system allows the health system to use available data on individuals to formulate "recipes," allowing the health system to use more discretion in its communications. For instance, someone of a known age with a known history of tobacco use might be sent communications encouraging them to undergo a low-dose CT lung cancer screening, as they would benefit most from a screening that could identify lung cancer in its earliest stages.

Similarly, invitations to sign up for free maternity classes or download Tanner's maternity care app can be targeted to women who are expecting. The more targeted communications facilitate an improved response, as people in the region are learning more about the services and health information they may need. The system also allows greater insight on the part of the health system, as we can see what types of communications, what messaging and what services elicit the most response.

Advancing Health with MyChart

In 2019, Tanner will launch the Epic electronic health record platform — including the platform's innovative, industry-leading MyChart patient portal. Unlike Tanner's previous patient portal that allows limited functionality, MyChart will enable patients to get more direct communications about programs and services that matter to them, such as upcoming Diabetes Prevention Program classes, health screening events, free online health risk assessments and more.

Providing Language Access

Tanner has contracted with a vendor that provides real-time "language line" interpreter services over the phone. Posters at points of communication with patients offer these services in some of the world's most-used languages, including Chinese, German, Hindi, Spanish, Vietnamese and others. The language of the poster informs patients that these interpretation services for those with limited English proficiency are available at no charge.

Part III: COMMUNITY SERVED

A. Geographic Area Served

For the purposes of the 2019 CHNA, each of Tanner Health System's hospitals identified a geographic area to serve over the next three-year CHNA cycle. These Community Benefit Service Areas (CBSAs) were selected based on hospital patient utilization data; proximity to the hospital, and/or an existing presence of programs and partnerships within these communities. Tanner Health System's CBSA is defined as Carroll, Haralson and Heard counties, consisting of 1,077 square miles of predominately rural area (53 percent) with a total population of 158,798 (US Census Bureau, Population Estimates 2017).

In order to reduce duplication and make the best use of available resources, Tanner collaborated with each of its hospitals for the production of one system-wide CHNA to satisfy the ACA requirement for Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica and Higgins General Hospital. Due to the close proximity of these hospitals, these facilities work collaboratively to leverage existing assets and resources throughout Tanner's CBSA to best meet the health needs of their communities.

Geographic and demographic data for each of the covered counties is presented separately on the following pages, along with highlights of the most critical health needs identified in the particular counties.

Tanner Medical Center/Carrollton CBSA

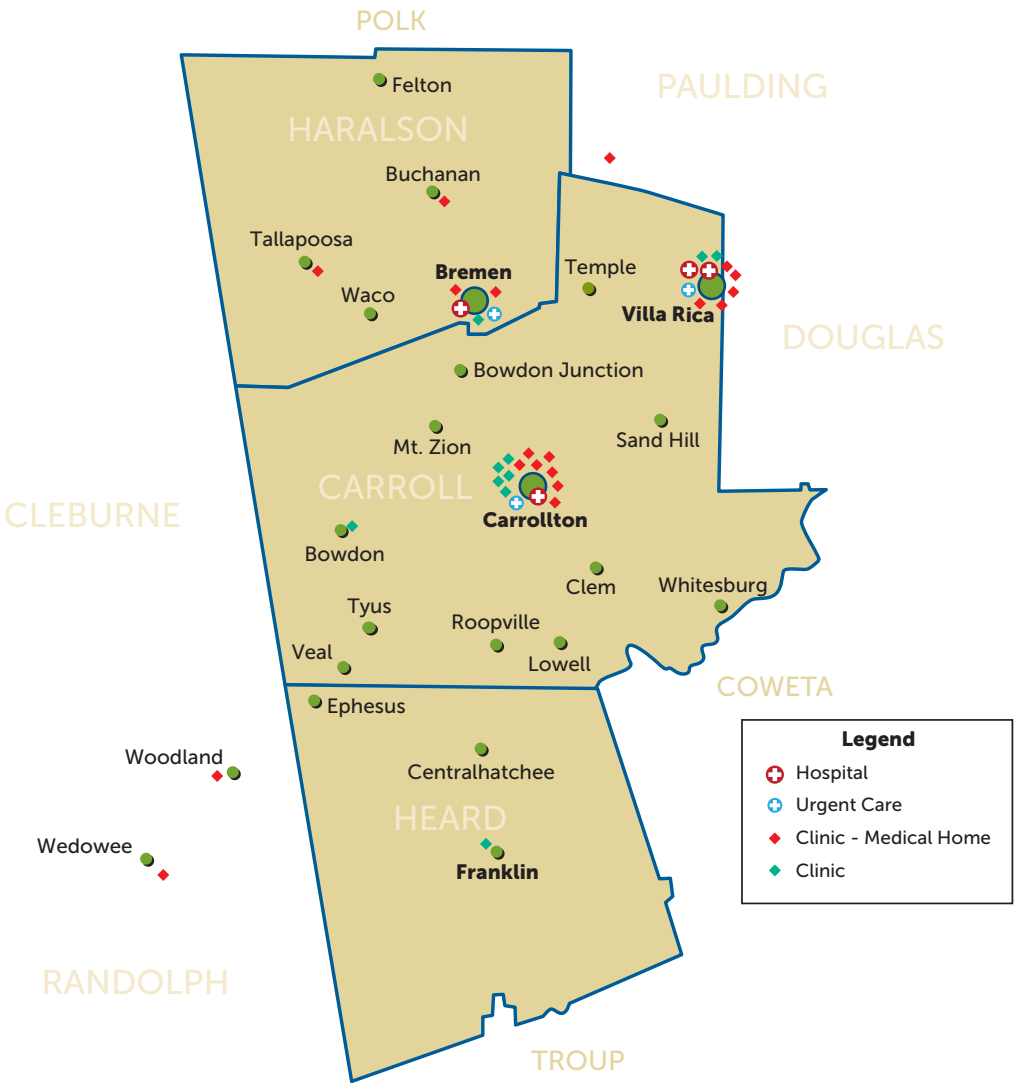
Carroll and Heard counties

Tanner Medical Center/Villa Rica CBSA

Carroll County

Higgins General Hospital CBSA

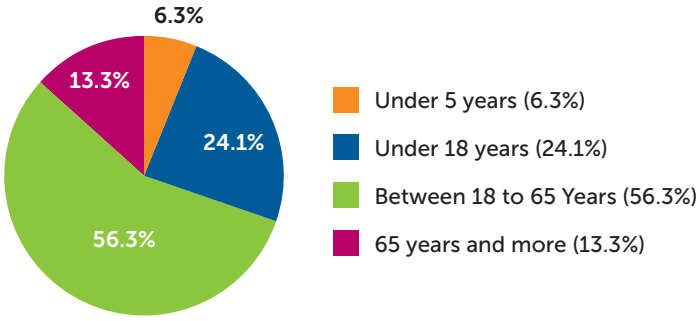
Haralson County



B. County Health Profiles

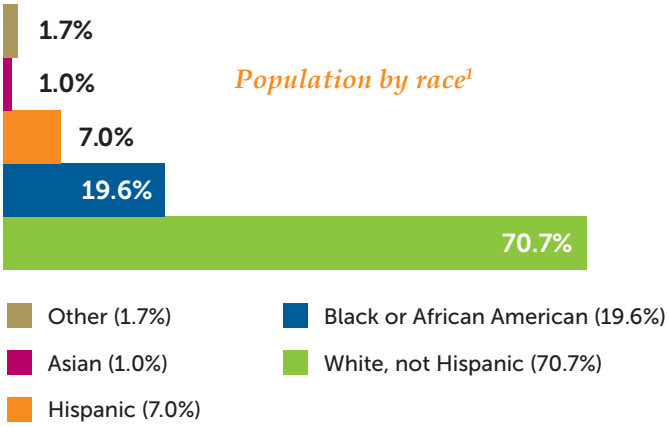
CARROLL COUNTY

74 OF 159 COUNTIES



Population by age[1]

Carroll County Total Population: 117,812



Population by race[1]

Population

The population of Carroll County was estimated at 117,812 by the 2017 US Census Bureau, reflecting a 6.5% population increase since the 2010 Census. The population is spread out over 499 square miles, translating into a population density of 227.95 persons per square mile. Approximately 46,228 residents (41.83%) live in rural areas of the county. In 2017, Carroll County residents 65 years or older were 13.3% of the population, consistent with the state average (13.3%). Whites (70.7%) make up the majority of the population, followed by African Americans/Blacks (19.6%) and Hispanics (7.0%).

Top 5 Industries

County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**74**
Mortality (Length of Life)	93
Morbidity (Quality of Life)	62
Health Factors	**72**
Health Behaviors	104
Clinical Care	55
Social and Economic Factors	49
Physical Environment	151

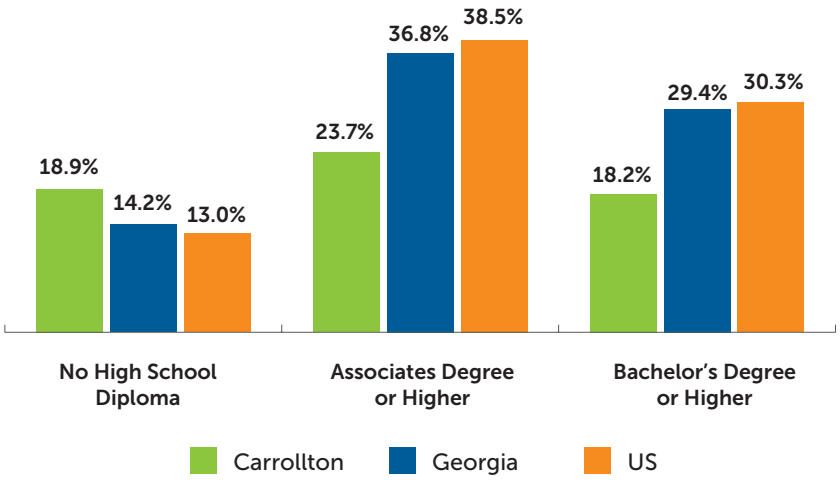
Economy

Carroll County's median household income, of $45,486 is slightly lower than the state median income of $51,037.[2] The unemployment rate (4.40%) is slightly higher than the state average (4.20%).[4] The county's percentage of children (25.98%), adults (18.20%) and seniors (11.50%) living in poverty exceeds the state average in all three indicators.[2]

[1] US Census Bureau, Population Estimates, 2017
[2] US Census Bureau, American Community Survey, 2012-2016
[3] County Health Rankings, 2018
[4] US Department of Labor, Bureau of Labor Statistics, 2018-June
[5] Carroll County Business Patterns, 2016
[6] GA Department of Public Health, OASIS

Education

Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Carroll County with no high school diploma (18.9%) exceeds state and national figures.[2] Concurrently, the population age 25+ in Carroll County with an Associate's Degree or Higher (23.7%) and Bachelor's Degree or Higher (18.2%) fall significantly below state and national figures.

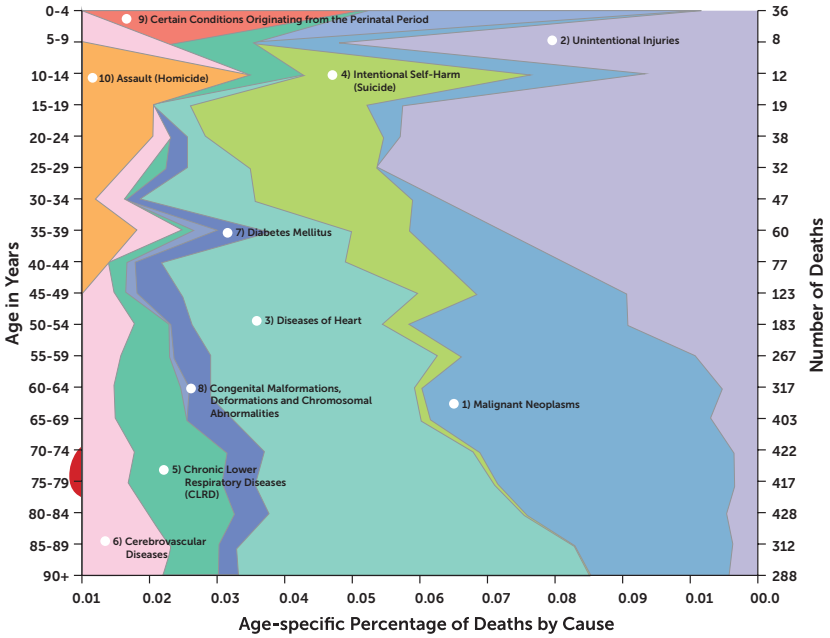


Health Disparities

Race Disparities[6]	White	Black	Ratio
High Blood Pressure Discharge Rate	20.1	117.0	5.821
High Blood Pressure ED Visit Rate	323.3	1,143.5	3.537
All STD except Congenital Syphilis	188.9	855.0	4.526

Lifespan Histomap of Mortality, Carroll County, GA, 2013-2017

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



*Using NCHS Rankable Causes

TOP 10 CAUSES OF DEATH[6]

1. Ischemic Heart and Vascular Disease
2. All COPD Except Asthma
3. Malignant Neoplasms of the Trachea, Bronchus and Lung
4. Cerebrovascular Disease
5. Alzheimers Disease
6. Diabetes Mellitus
7. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
8. All Other Mental and Behavioral Disorders
9. All Other Endocrine, Nutritional and Metabolic Diseases
10. Motor Vehicle Crashes

Carroll County Health Profile

Red numbers indicate parameters worse than the national average.
Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	4.40%	4.20%	4.20%	Percentage of population 16 years or older that is unemployed.	US Department of Labor, Bureau of Labor Statistics, 2018-June
Temporary Assistance for Needy Families (TANF)	2.30%	1.86%	2.67%	Percentage households receiving public assistance income, including TANF. Separate payments received for hospital or other medical expenses, SSI or noncash benefits such as Food Stamps.	US Census, American Community Survey, 2012-2016.
Population Receiving SNAP Benefits	20.13%	15.29%	13.05%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.	US Census, American Community Survey, 2012-2016.
Adults in Poverty	18.20%	16.20%	14.20%	Percentage of adult population aged 18 to 64 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Seniors in Poverty	11.50%	10.40%	9.30%	Percentage of population aged 65 or older living below the poverty line.	US Census, American Community Survey, 2012-2016.
Children in Poverty	25.98%	25.39%	21.17%	Percentage of population aged 0 to 17 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Population with No High School Diploma	18.89%	14.16%	13.02%	Percentage of population 25 years and older without a high school diploma or equivalency (GED).	US Census, American Community Survey, 2012-2016.
High School Dropout Rate	3.10%	5.20%	4.00%	Percentage of youth aged 16 to 19 years old who are not in high school nor high school graduate.	Kids Count, US Census, American Community Survey, Five Year Estimates, 2012-2016.
Access to a Vehicle	5.80%	6.70%	8.70%	Percentage of occupied households with no motor vehicle.	US Census, American Community Survey, 2012-2016.
Income Inequality (GINI Index)	0.45	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measures GINI Index income inequality ranging from 0 to 100.	US Census, American Community Survey, 2012-2016.
Total Homeless Persons	21	1,843	192,875	Number of unsheltered homeless persons based on point-in-time counts and predictions.	Georgia Department of Community Affairs, 2013 Report on Homelessness, 2017. *US Department of Housing and Urban Development, Office of Community Planning and Development, The 2017 Annual Homeless Assessment Report to Congress, 2017.
Substandard Housing Conditions	30.87%	32.67%	33.75%	Percentage of renter or owner occupied housing units having one or more of the following substandard conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, having 1.01 or more occupants per room, selected monthly owner costs as a percentage of household income greater than 30 percent, and gross rent as a percentage of household income greater than 30 percent.	US Census, American Community Survey, 2012-2016.
Premature Death Rate	9,300	7,300	5,300	Years of potential life lost before age 75 per 100,000.	County Health Rankings 2018, National Center for Health Statistics, 2014-2016.

Carroll County Health Profile

Diabetes and Obesity					
Diabetes Prevalence	**11.00%**	11.00%	8.00%	Percentage of population over 20 years old that have been diagnosed with diabetes.	County Health Rankings 2018. CDC, National Diabetes Surveillance System, 2014.
Diabetes prevalence, Medicare population	**28.24%**	27.47%	26.55%	Percentage of Medicare fee-for-service population with diabetes.	Centers for Medicare and Medicaid Services, 2015.
Diabetes management-hemoglobin A1c test in Medicare patients	**85.20%**	85.30%	85.20%	Percentage of diabetic Medicare patients who have had hemoglobin A1c test for blood sugar levels.	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2014.
Diabetes Deaths	**28.4**	21.7	24.7	Number of Age-Adjusted Diabetes Deaths per 100,000 population.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Center for Disease Statistics, 2015
Obesity	**33%**	30%	26%	Percentage of population 20 years or older with a self reported BMI greater than 30.0.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Physical Inactivity	**30%**	24%	20%	Percentage of population 20 years or older that self reported no leisure time for physical activity.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Recreational and fitness facility access	**8.14**	9.77	11.01	Number of recreation and fitness facilities per 100,000 population.	US Census, County Business Patterns, 2016.
Fast-food restaurant access	**76.90**	83.10	77.06	Number of fast food restaurants per 100,000 population.	US Census, County Business Patterns, 2016.
Grocery store access	**23.52**	18.12	21.18	Number of grocery stores per 100,000 population.	US Census, County Business Patterns, 2016.
SNAP-authorized store access	**12.76**	10.57	8.25	Number of SNAP-authorized food stores per 100,000 population.	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2017.
WIC-authorized store access	**17.1**	17.9	15.6	Number of authorized food stores accepting WIC benefits and carry WIC foods/food categories per 100,000.	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
Population with low food access	**51.16%**	30.82%	22.43%	Percentage of population living in designated food deserts via census tract.	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015.
Food Insecurity	**16%**	16%	10%	Percentage of population that experienced food insecurity in a designated year.	County Health Rankings, 2018. Map the Meal Project, Feeding America, 2015.
HIV/AIDS and STDs					
HIV Prevalence	**267.71**	512.74	353.16	Prevalence rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
HIV Screenings	**56.62%**	55.12%	62.79%	Percentage of adults between 18-70 years old with self reports of having not been screened for HIV.	CDC, Behavioral Risk Factor Surveillance System, 2012.
Chlamydia Incidence	**653.29**	516.5	456.08	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.

Carroll County Health Profile

HIV/AIDS and STDs					
Gonorrhea Incidence	**178.01**	137.8	110.73	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
STD Incidence for Youth	**27.8**	29.8	n/a	Rate per 1,000 of youth, ages 15-19, who have been diagnosed with a sexually transmitted disease.	Kids Count, Georgia Department of Human Resources, Division of Public Health, Epidemiology Branch, 2016.
Maternal and Infant Health					
Teen Births	**46.1**	45.3	36.6	Births to women between 15-19 years old per 1,000 of the female population between 15-19 years old.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Vital Statistics System, 2006-2012.
Low Birth Weight Babies	**8.20%**	9.60%	8.17%	Percentage of births with low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Very Low Birth Weight Babies	**1.40%**	1.80%	1.40%	Percentage of births with very low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Infant Mortality Rate	**6.2**	7.5	5.9	Number of infant deaths per 1,000 live births.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Births and Tobacco	**11.00%**	5.50%	7.20%	Percent of live births where mother used tobacco during pregnancy.	OASIS. Maternal/Child Web Query, 2013-2017; CDC National Center for Health Statistics, 2016.
Premature Births	**8.40%**	11.00%	9.85%	Percent of births before 37 weeks of gestation.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Cardiovascular Health					
Heart Disease Hospital Discharge Rate	419.70	276.20	n/a	Age-Adjusted Hospital Discharge rate per 100,000 population with ischemic heart disease (incl. heart attack).	OASIS, Hospital Discharge Web Query, 2012-2016.
Heart Disease Medicare Population	26.81%	25.25%	26.46%	Percentage of Medicare fee-for-service population with ischemic heart disease.	Centers for Medicare and Medicaid Services, 2015.
High Blood Pressure Medicare Population	61.13%	59.88%	54.99%	Percentage of Medicare fee-for-service population with high blood pressure.	Centers for Medicare and Medicaid Services, 2015.
High Cholesterol Medicare Population	48.15%	46.68%	44.61%	Percentage of Medicare fee-for-service population with hyperlipidemia which is most commonly associated with high cholesterol.	Centers for Medicare and Medicaid Services, 2015.
Heart Disease Mortality Rate	**218.40**	58.87	168.2	The age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.	CDC, National Vital Statistics System, 2012-2016.
Stroke Mortality Rate	**50.70**	43.15	36.9	The age-adjusted rate of death due to cerebrovascular disease (stroke).	CDC, National Vital Statistics System, 2012-2016.

Carroll County Health Profile

Respiratory Health					
Air Pollution-Particulate Matter	10.2	10.1	6.7	The average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.	County Health Rankngs, 2018; CDC's National Environmental Public Health Tracking Network, 2012.
Lung Cancer Incidence	82.5	64.9	60.2	Annual age-adjusted incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2011-2015.
Lung Disease Mortality	58.6	8.57	41.3	Age adjusted death rate due to chronic lower respiratory disease per 100,000 population.	Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016.
Adult Smoking	20%	18%	14%	The percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Mental Health and Substance Misuse					
Suicide Mortality Rate	16.9	12.7	13.5	Age-Adjusted Death Rate per 100,000 population by suicide.	OASIS, Mortality Web Query, 2013-2017.CDC, National Center for Health Statistics, 2016.
Drug Overdose Deaths	20	13	10	Drug Overdose Deaths are the number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances	County Health Rankings 2018; CDC Wonder, Compressed Mortality File, 2014-2016.
Mental Health and Substance Misuse					
Poor Mental Health Days	4.1	3.8	3	Poor Mental Health Days is based on BRFSS survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Frequent Mental Distress	13%	13%	10%	The percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Liquor Store Access	3.62	9.59	11	This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310	US Census Bureau, County Business Patterns, 2016.

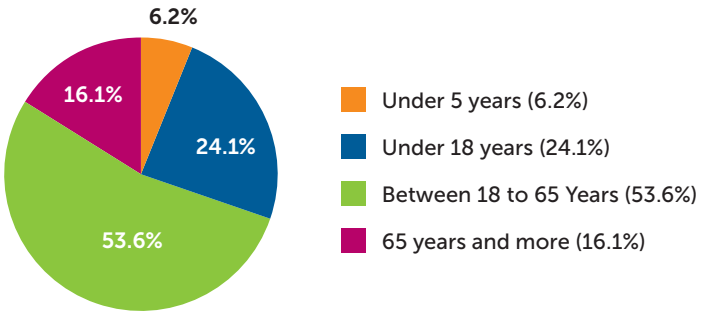
Carroll County Health Profile

Mental Health and Substance Misuse					
Excessive Drinking	**17%**	15%	13%	The percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Alchohol-impaired driving deaths	**26%**	23%	13%	The percentage of motor vehicle crash deaths with alcohol involvement.	County Health Rankings 2018; Fatality Analysis Reporting System, 2012-2016.
Cancers					
Breast Cancer Deaths	**25.3**	22.1	20.9	Number of Age-Adjusted Breast Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Breast Cancer Incidence	**120.2**	125.2	124.7	Age-Adjusted incidence rate (cases per 100,000) population of females with breast cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Deaths	**17.7**	15.3	14.5	Number of Age-Adjusted Colorectal Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Incidence	**48.7**	41.8	39.2	Age-Adjusted incidence rate (cases per 100,000) population with colorectal cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Deaths	**20.2**	22.5	19.5	Number of Age-Adjusted Prostate Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Incidence	**107.3**	123.3	109	Age-Adjusted incidence rate (cases per 100,000) population with prostate cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Deaths	**57.5**	46.2	43.4	Number of Age-Adjusted Lung Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Incidence	**82.5**	64.9	60.2	Annual Age-Adjusted lung cancer incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.

Carroll County Health Profile

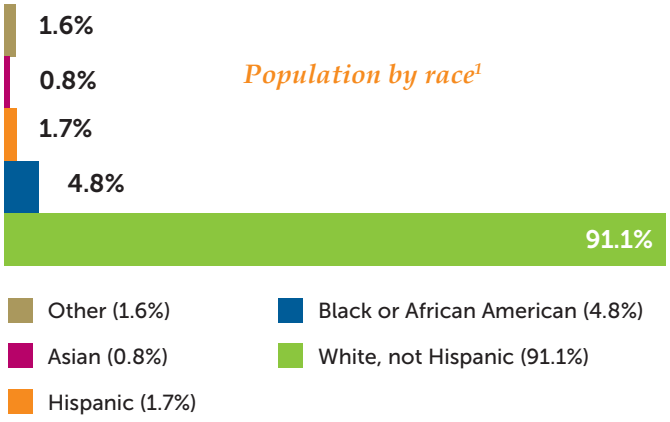
Injury Prevention and Safety					
Firearm Fatalities	**12**	14	7	The number of deaths due to firearms, per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2012-2016.
Violent Crime	**288**	374	62	The number of violent crimes reported per 100,000 population.	County Health Rankings 2018, The Uniform Crime Reporting (UCR) Program, 2012-2014.
Child Abuse and/or Neglect	**14.3**	7.00	n/a	Unduplicated count of children with a substantiated incident of child abuse and/or neglect, per 1,000.	Kids Count, Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services, 2016.
Motor Vehicle Crash Deaths	**20**	13	9	The number of deaths due to traffic accidents involving a vehicle per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2010-2016.
Access to Care					
Uninsured Adults	**20%**	19%	7%	The percentage of the population ages 18 to 64 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Uninsured Children	**7%**	7%	3%	The percentage of the population under age 19 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Primary Care Physicians	**2,250:1**	1,520:1	1,030:1	The ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics.	County Health Rankings 2018, Area Health Resource File/American Medical Association, 2015.
Dentists	**3,420:1**	1,980:1	1,280:1	The ratio of the population to total dentists.	County Health Rankings 2018, Area Health Resource File/National Provider Identification File, 2016.
Mental Health Providers	**1,060:1**	830:1	330:1	The ratio of the population to total mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Other Primary Care Providers	**1,199:1**	1,146:1	782:1	The ratio of the population to total number of other primary providers, including nurse practitioners, physician assistants and clinical nurse specialists.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Preventable Hospital Stays	**42**	50	35	The hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.	County Health Rankings 2018, CMS Dartmouth Atlas of Health Care, 2015.

HARALSON COUNTY



Population by age[1]

Haralson County Total Population: 29,256



Population by race[1]

Population

The population of Haralson County was estimated at 29,256 by the 2017 US Census Bureau, reflecting a 1.7% population increase since the 2010 Census. The 77.36% rural population is spread out over 282.17 square miles, translating into a population density of 101.6 persons per square mile. In 2017, Haralson County residents 65 years or older were 16.1% of the population, slightly higher than the state average (13.3%). Whites (91.1%) make up the majority of the population, followed by African Americans/Blacks (4.8%) and Hispanics (1.7%).

Top 5 Industries

County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**85**
Mortality (Length of Life)	118
Morbidity (Quality of Life)	48
Health Factors	**58**
Health Behaviors	53
Clinical Care	32
Social and Economic Factors	85
Physical Environment	100

Economy

Haralson County's median household income, of $42,281 is slightly lower than the state median income of $51,037.[2] The unemployment rate (4.20%) is on par with the state average (4.20%).[4] The county's percentage of children (29.20%), adults (19.20%) and seniors (10.30%) living in poverty exceeds the state average in all three indicators.[2]

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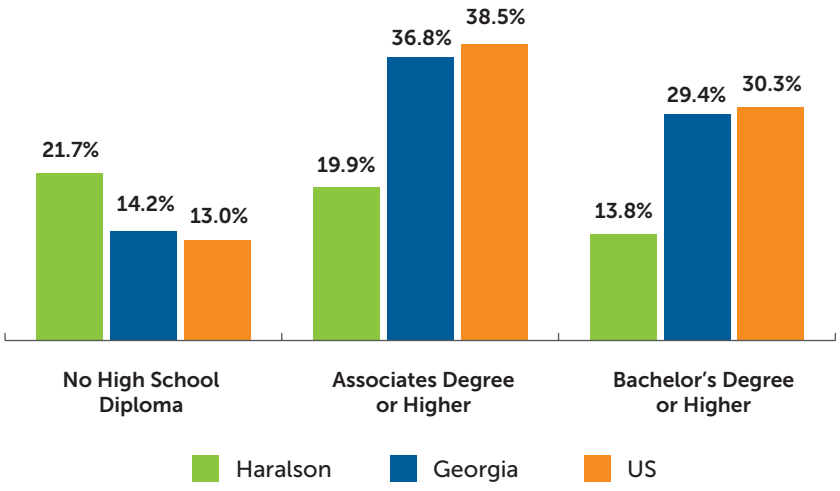
Education

Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Haralson County with no high school diploma (21.7%) exceeds state and national figures.[2] Concurrently, the population age 25+ in Carroll County with an Associate's Degree or Higher (19.9%) and Bachelor's Degree or Higher (13.8%) fall significantly below state and national figures.

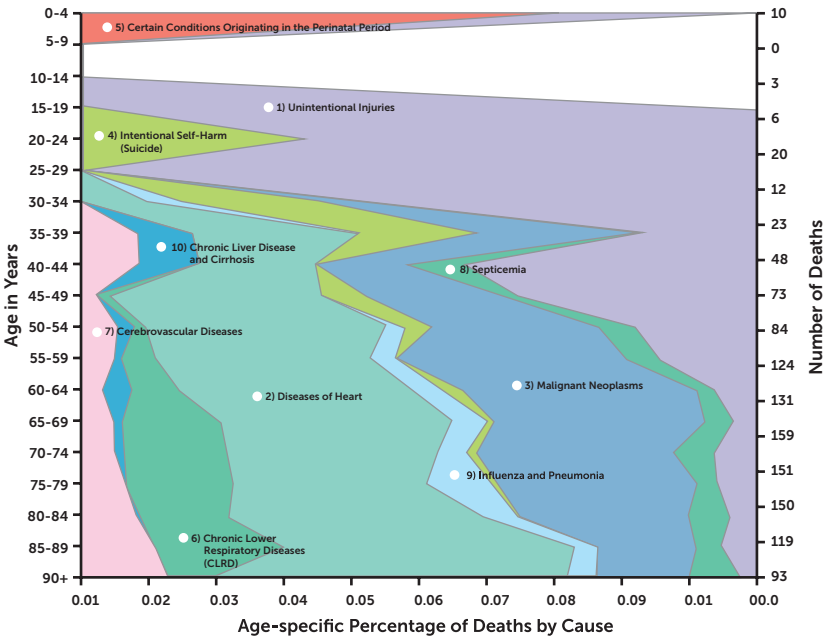


Health Disparities

Race Disparities[6]	White	Black	Ratio
Diabetes ED Visit Rate[6]	394.0	1,217.5	3.090
All STD except Congenital Syphilis[6]	188.8	989.6	5.264

Lifespan Histomap of Mortality, Haralson County, GA, 2013-2017

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



*Using NCHS Rankable Causes

TOP 10 CAUSES OF DEATH[6]

1. Ischemic Heart and Vascular Disease
2. All COPD Except Asthma
3. Malignant Neoplasms of the Trachea, Bronchus and Lung
4. Alzheimers Disease
5. Cerebrovascular Disease
6. Septicemia
7. All Other Mental and Behavioral Disorders
8. Pneumonia
9. Motor Vehicle Crashes
10. All Other Diseases of the Nervous System

Haralson County Health Profile

Red numbers indicate parameters worse than the national average.
Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	4.20%	4.20%	4.20%	Percentage of population 16 years or older that is unemployed.	US Department of Labor, Bureau of Labor Statistics, 2018-June
Temporary Assistance for Needy Families (TANF)	2.76%	1.86%	2.67%	Percentage households receiving public assistance income, including TANF. Separate payments received for hospital or other medical expenses, SSI or noncash benefits such as Food Stamps.	US Census, American Community Survey, 2012-2016.
Population Receiving SNAP Benefits	18.79%	15.29%	13.05%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.	US Census, American Community Survey, 2012-2016.
Adults in Poverty	19.20%	16.20%	14.20%	Percentage of adult population aged 18 to 64 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Seniors in Poverty	10.30%	10.40%	9.30%	Percentage of population aged 65 or older living below the poverty line.	US Census, American Community Survey, 2012-2016.
Children in Poverty	29.20%	25.39%	21.17%	Percentage of population aged 0 to 17 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Population with No High School Diploma	21.71%	14.16%	13.02%	Percentage of population 25 years and older without a high school diploma or equivalency (GED).	US Census, American Community Survey, 2012-2016.
High School Dropout Rate	4.00%	5.20%	4.00%	Percentage of youth aged 16 to 19 years old who are not in high school nor high school graduates.	Kids Count, US Census, American Community Survey, Five Year Estimates, 2012-2016.
Access to a Vehicle	5.10%	6.70%	8.70%	Percentage of occupied households with no motor vehicle.	US Census, American Community Survey, 2012-2016.
Income Inequality (GINI Index)	0.45	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measures GINI Index income inequality ranging from 0 to 100.	US Census, American Community Survey, 2012-2016.
Total Homeless Persons	11	1,843	192,875	Number of unsheltered homeless persons based on point-in-time counts and predictions.	Georgia Department of Community Affairs, 2013 Report on Homelessness, 2017. *US Department of Housing and Urban Development, Office of Community Planning and Development, The 2017 Annual Homeless Assessment Report to Congress, 2017.
Substandard Housing Conditions	27.34%	32.67%	33.75%	Percentage of renter or owner occupied housing units having one or more of the following substandard conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, having 1.01 or more occupants per room, selected monthly owner costs as a percentage of household income greater than 30 percent, and gross rent as a percentage of household income greater than 30 percent.	US Census, American Community Survey, 2012-2016.
Premature Death Rate	10,400	7,300	5,300	Years of potential life lost before age 75 per 100,000.	County Health Rankings 2018, National Center for Health Statistics, 2014-2016.

Haralson County Health Profile

Diabetes and Obesity					
Diabetes Prevalence	11.00%	11.00%	8.00%	Percentage of population over 20 years old that have been diagnosed with diabetes.	County Health Rankings 2018. CDC, National Diabetes Surveillance System, 2014.
Diabetes prevalence, Medicare population	28.06%	27.47%	26.55%	Percentage of Medicare fee-for-service population with diabetes.	Centers for Medicare and Medicaid Services, 2015.
Diabetes management-hemoglobin A1c test in Medicare patients	89.20%	85.30%	85.20%	Percentage of diabetic Medicare patients who have had hemoglobin A1c test for blood sugar levels.	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2014.
Diabetes Deaths	13.5	21.7	24.7	Number of Age-Adjusted Diabetes Deaths per 100,000 population.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Center for Disease Statistics, 2015
Obesity	30%	30%	26%	Percentage of population 20 years or older with a self reported BMI greater than 30.0.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Physical Inactivity	25%	24%	20%	Percentage of population 20 years or older that self reported no leisure time for physical activity.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Recreational and fitness facility access	3.47	9.77	11.01	Number of recreation and fitness facilities per 100,000 population.	US Census, County Business Patterns, 2016.
Fast-food restaurant access	76.44	83.10	77.06	Number of fast food restaurants per 100,000 population.	US Census, County Business Patterns, 2016.
Grocery store access	13.90	18.12	21.18	Number of grocery stores per 100,000 population.	US Census, County Business Patterns, 2016.
SNAP-authorized store access	12.16	10.57	8.25	Number of SNAP-authorized food stores per 100,000 population.	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2017.
WIC-authorized store access	34.9	17.9	15.6	Number of authorized food stores accepting WIC benefits and carry WIC foods/food categories per 100,000.	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
Population with low food access	16.45%	30.82%	22.43%	Percentage of population living in designated food deserts via census tract.	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015.
Food Insecurity	14%	16%	10%	Percentage of population that experienced food insecurity in a designated year.	County Health Rankings, 2018. Map the Meal Project, Feeding America, 2015.

Haralson County Health Profile

HIV/AIDS and STDs					
HIV Prevalence	127.1	512.74	353.16	Prevalence rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
HIV Screenings	86.41%	55.12%	62.79%	Percentage of adults between 18-70 years old with self reports of having not been screened for HIV.	CDC, Behavioral Risk Factor Surveillance System, 2012.
Chlamydia Incidence	263.2	516.5	456.08	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Gonorrhea Incidence	84.23	137.8	110.73	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
STD Incidence for Youth	15.2	29.8	n/a	Rate per 1,000 of youth, ages 15-19, who have been diagnosed with a sexually transmitted disease.	Kids Count, Georgia Department of Human Resources, Division of Public Health, Epidemiology Branch, 2016.
Maternal and Infant Health					
Teen Births	60.2	45.3	36.6	Births to women between 15-19 years old per 1,000 of the female population between 15-19 years old.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Vital Statistics System, 2006-2012.
Low Birth Weight Babies	8.50%	9.60%	8.17%	Percentage of births with low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Very Low Birth Weight Babies	1.40%	1.80%	1.40%	Percentage of births with very low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Infant Mortality Rate	7.6	7.5	5.9	Number of infant deaths per 1,000 live births.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Births and Tobacco	13.40%	5.50%	7.20%	Percent of live births where mother used tobacco during pregnancy.	OASIS. Maternal/Child Web Query, 2013-2017; CDC National Center for Health Statistics, 2016.
Premature Births	9.20%	11.00%	9.85%	Percent of births before 37 weeks of gestation.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Cardiovascular Health					
Heart Disease Hospital Discharge Rate	481.80	276.20	n/a	Age-Adjusted Hospital Discharge rate per 100,000 population with ischemic heart disease (incl. heart attack).	OASIS, Hospital Discharge Web Query, 2012-2016.
Heart Disease Medicare Population	27.48%	25.25%	26.46%	Percentage of Medicare fee-for-service population with ischemic heart disease.	Centers for Medicare and Medicaid Services, 2015.
High Blood Pressure Medicare Population	63.65%	59.88%	54.99%	Percentage of Medicare fee-for-service population with high blood pressure.	Centers for Medicare and Medicaid Services, 2015.
High Cholesterol Medicare Population	52.53%	46.68%	44.61%	Percentage of Medicare fee-for-service population with hyperlipidemia which is most commonly associated with high cholesterol.	Centers for Medicare and Medicaid Services, 2015.

Haralson County Health Profile

Cardiovascular Health					
Heart Disease Mortality Rate	**247.30**	58.87	168.2	The age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.	CDC, National Vital Statistics System, 2012-2016.
Stroke Mortality Rate	**45.90**	43.15	36.9	The age-adjusted rate of death due to cerebrovascular disease (stroke).	CDC, National Vital Statistics System, 2012-2016.
Respiratory Health					
Air Pollution-Particulate Matter	**9.9**	10.1	6.7	The average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.	County Health Rankngs, 2018; CDC's National Environmental Public Health Tracking Network, 2012.
Lung Cancer Incidence	**89.0**	64.9	60.2	Annual age-adjusted incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2011-2015.
Lung Disease Mortality	**75.1**	8.57	41.3	Age adjusted death rate due to chronic lower respiratory disease per 100,000 population.	Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016.
Adult Smoking	**20%**	18%	14%	The percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.

Haralson County Health Profile

Mental Health and Substance Misuse					
Suicide Mortality Rate	**14.3**	12.7	13.5	Age-Adjusted Death Rate per 100,000 population by suicide.	OASIS, Mortality Web Query, 2013-2017.CDC, National Center for Health Statistics, 2016.
Drug Overdose Deaths	**32**	13	10	Drug Overdose Deaths are the number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances	County Health Rankings 2018; CDC Wonder, Compressed Mortality File, 2014-2016.
Poor Mental Health Days	**4**	3.8	3	Poor Mental Health Days is based on BRFSS survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Frequent Mental Distress	**13%**	13%	10%	The percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Liquor Store Access	**3.47**	9.59	11	This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310	US Census Bureau, County Business Patterns, 2016.
Excessive Drinking	**16%**	15%	13%	The percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Alchohol-impaired driving deaths	**24%**	23%	13%	The percentage of motor vehicle crash deaths with alcohol involvement.	County Health Rankings 2018; Fatality Analysis Reporting System, 2012-2016.

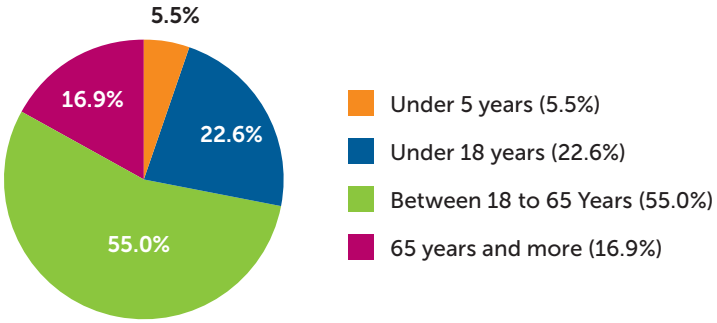
Haralson County Health Profile

Cancers					
Breast Cancer Deaths	**25.2**	22.1	20.9	Number of Age-Adjusted Breast Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Breast Cancer Incidence	**97.8**	125.2	124.7	Age-Adjusted incidence rate (cases per 100,000) population of females with breast cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Deaths	**17.3**	15.3	14.5	Number of Age-Adjusted Colorectal Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Incidence	**44.0**	41.8	39.2	Age-Adjusted incidence rate (cases per 100,000) population with colorectal cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Deaths	**3 or fewer (n/a)**	22.5	19.5	Number of Age-Adjusted Prostate Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Incidence	**99.2**	123.3	109	Age-Adjusted incidence rate (cases per 100,000) population with prostate cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Deaths	**61.3**	46.2	43.4	Number of Age-Adjusted Lung Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Incidence	**89.0**	64.9	60.2	Annual Age-Adjusted lung cancer incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Injury Prevention and Safety					
Firearm Fatalities	**20**	14	7	The number of deaths due to firearms, per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2012-2016.
Violent Crime	**673**	374	62	The number of violent crimes reported per 100,000 population.	County Health Rankings 2018, The Uniform Crime Reporting (UCR) Program, 2012-2014.
Child Abuse and/or Neglect	**18.0**	7.0	n/a	Unduplicated count of children with a substantiated incident of child abuse and/or neglect, per 1,000.	Kids Count, Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services, 2016.
Motor Vehicle Crash Deaths	**26**	13	9	The number of deaths due to traffic accidents involving a vehicle per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2010-2016.

Haralson County Health Profile

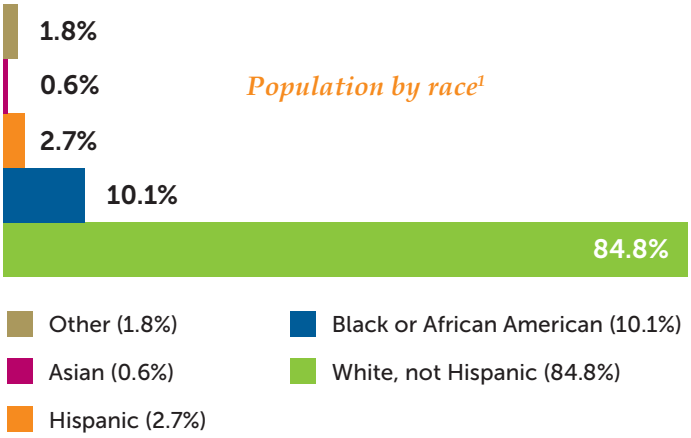
Access to Care					
Uninsured Adults	**18%**	19%	7%	The percentage of the population ages 18 to 64 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Uninsured Children	**7%**	7%	3%	The percentage of the population under age 19 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Primary Care Physicians	**2,060:1**	1,520:1	1,030:1	The ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics.	County Health Rankings 2018, Area Health Resource File/American Medical Association, 2015.
Dentists	**4,840:1**	1,980:1	1,280:1	The ratio of the population to total dentists.	County Health Rankings 2018, Area Health Resource File/National Provider Identification File, 2016.
Mental Health Providers	**1,610:1**	830:1	330:1	The ratio of the population to total mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Other Primary Care Providers	**4,149:1**	1,146:1	782:1	The ratio of the population to total number of other primary providers, including nurse practitioners, physician assistants and clinical nurse specialists.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Preventable Hospital Stays	**43**	50	35	The hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.	County Health Rankings 2018, CMS Dartmouth Atlas of Health Care, 2015.

HEARD COUNTY



Population by age[1]

Heard County Total Population: 11,730



Population

The population of Heard County was estimated at 11,730 by the 2017 US Census Bureau, reflecting a -0.8% population decrease since the 2010 Census. The 100% rural population is spread out over 296 square miles, translating into a population density of 39.09 persons per square mile. In 2017, Heard County residents 65 years or older were 16.9% of the population, slightly higher than the state average (13.3%). Whites (84.8%) make up the majority of the population, followed by African Americans/Blacks (10.1%) and Hispanics (2.7%).

Top 5 Industries

County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**52**
Mortality (Length of Life)	78
Morbidity (Quality of Life)	35
Health Factors	**62**
Health Behaviors	46
Clinical Care	111
Social and Economic Factors	60
Physical Environment	65

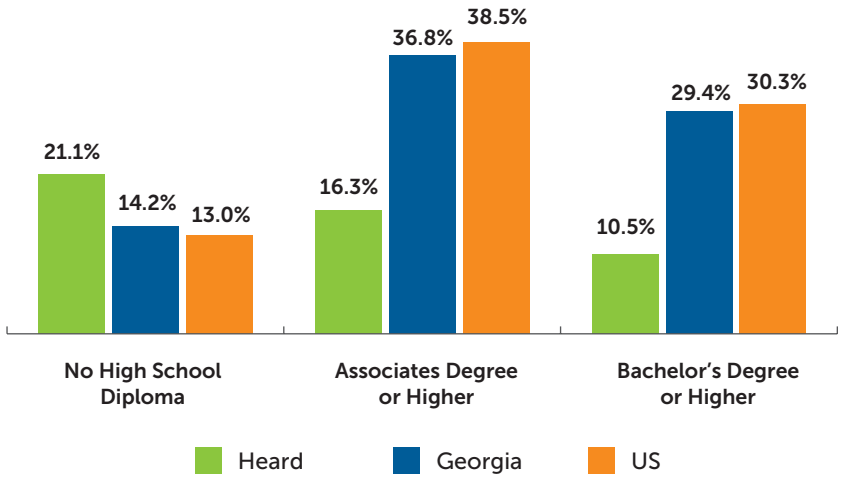
Economy

Heard County's median household income, of $44,185 is slightly lower than the state median income of $51,037.[2] The unemployment rate (4.3%) is slightly higher than the state average (4.20%).[4] The county's percentage of children (23%), adults (15.50%) and seniors (14%) living in poverty exceeds the state average in all three indicators.[2]

[1] US Census Bureau, Population Estimates, 2017
[2] US Census Bureau, American Community Survey, 2012-2016
[3] County Health Rankings, 2018
[4] US Department of Labor, Bureau of Labor Statistics, 2018-June
[5] Carroll County Business Patterns, 2016
[6] GA Department of Public Health, OASIS

Education

Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Heard County with no high school diploma (21.1%) exceeds state and national figures.[2] Concurrently, the population age 25+ in Carroll County with an Associate's Degree or Higher (16.3%) and Bachelor's Degree or Higher (10.5%) fall significantly below state and national figures.

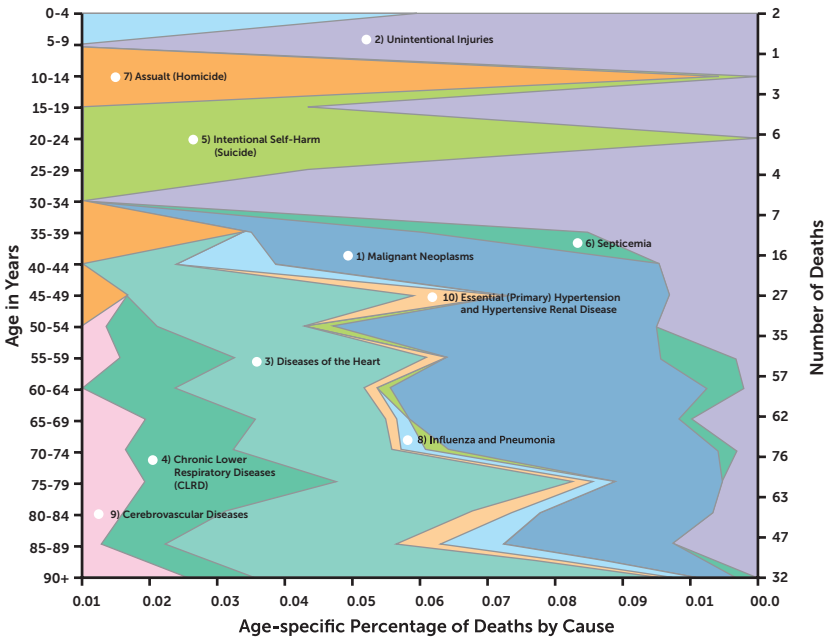


Health Disparities

Race Disparities[6]	White	Black	Ratio
Diabetes Hospital Discharge Rate	116.2	365.0	3.147
High BP Hospital Discharge Rate	25.4	201.4	7.929
High BP ED Visit Rate	355.1	1,143	3.219
All STD except Congenital Syphilis	162.3	691.1	4.258

Lifespan Histomap of Mortality, Heard County, GA, 2013-2017

Based on the Top 10 Causes* of Years of Potential Life Lost (YPLL)



*Using NCHS Rankable Causes

TOP 10 CAUSES OF DEATH[6]

1. All COPD Except Asthma
2. Malignant Neoplasms of the Trachea, Bronchus and Lung
3. Ischemic Heart and Vascular Disease
4. Cerebrovascular Disease
5. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
6. All Other Mental and Behavioral Disorders
7. Malignant Neoplasms of Colon, Rectum and Anus
8. Alzheimers Disease
9. Diabetes Mellitus
10. Motor Vehicle Crashes

Heard County Health Profile

Red numbers indicate parameters worse than the national average.
Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	**4.30%**	4.20%	4.20%	Percentage of population 16 years or older that is unemployed.	US Department of Labor, Bureau of Labor Statistics, 2018-June
Temporary Assistance for Needy Families (TANF)	**2.09%**	1.86%	2.67%	Percentage households receiving public assistance income, including TANF. Separate payments received for hospital or other medical expenses, SSI or noncash benefits such as Food Stamps.	US Census, American Community Survey, 2012-2016.
Population Receiving SNAP Benefits	**24.47%**	15.29%	13.05%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits.	US Census, American Community Survey, 2012-2016.
Adults in Poverty	**15.50%**	16.20%	14.20%	Percentage of adult population aged 18 to 64 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Seniors in Poverty	**14.00%**	10.40%	9.30%	Percentage of population aged 65 or older living below the poverty line.	US Census, American Community Survey, 2012-2016.
Children in Poverty	**23.00%**	25.39%	21.17%	Percentage of population aged 0 to 17 years old living below the poverty line.	US Census, American Community Survey, 2012-2016.
Population with No High School Diploma	**21.13%**	14.16%	13.02%	Percentage of population 25 years and older without a high school diploma or equivalency (GED).	US Census, American Community Survey, 2012-2016.
High School Dropout Rate	**7.00%**	5.20%	4.00%	Percentage of youth aged 16 to 19 years old who are not in high school nor high school graduates.	Kids Count, US Census, American Community Survey, Five Year Estimates, 2012-2016.
Access to a Vehicle	**4.90%**	6.70%	8.70%	Percentage of occupied households with no motor vehicle.	US Census, American Community Survey, 2012-2016.
Income Inequality (GINI Index)	**0.4**	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measures GINI Index income inequality ranging from 0 to 100.	US Census, American Community Survey, 2012-2016.
Total Homeless Persons	**6**	1,843	192,875	Number of unsheltered homeless persons based on point-in-time counts and predictions.	Georgia Department of Community Affairs, 2013 Report on Homelessness, 2017. *US Department of Housing and Urban Development, Office of Community Planning and Development, The 2017 Annual Homeless Assessment Report to Congress, 2017.

Heard County Health Profile

Social and Economic Indicators					
Substandard Housing Conditions	28.41%	32.67%	33.75%	Percentage of renter or owner occupied housing units having one or more of the following substandard conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, having 1.01 or more occupants per room, selected monthly owner costs as a percentage of household income greater than 30 percent, and gross rent as a percentage of household income greater than 30 percent.	US Census, American Community Survey, 2012-2016.
Premature Death Rate	8,900	7,300	5,300	Years of potential life lost before age 75 per 100,000.	County Health Rankings 2018, National Center for Health Statistics, 2014-2016.
Diabetes and Obesity					
Diabetes Prevalence	13.00%	11.00%	8.00%	Percentage of population over 20 years old that have been diagnosed with diabetes.	County Health Rankings 2018. CDC, National Diabetes Surveillance System, 2014.
Diabetes prevalence, Medicare population	30.70%	27.47%	26.55%	Percentage of Medicare fee-for-service population with diabetes.	Centers for Medicare and Medicaid Services, 2015.
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Diabetes Deaths	24.7	21.7	24.7	Number of Age-Adjusted Diabetes Deaths per 100,000 population.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Center for Disease Statistics, 2015.
Obesity	30%	30%	26%	Percentage of population 20 years or older with a self reported BMI greater than 30.0.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Physical Inactivity	27%	24%	20%	Percentage of population 20 years or older that self reported no leisure time for physical activity.	County Health Rankings, 2018. CDC, National Diabetes Surveillance System, 2014.
Recreational and fitness facility access	0	9.77	11.01	Number of recreation and fitness facilities per 100,000 population.	US Census, County Business Patterns, 2016.
Fast-food restaurant access	42.25	83.10	77.06	Number of fast food restaurants per 100,000 population.	US Census, County Business Patterns, 2016.
Grocery store access	8.45	18.12	21.18	Number of grocery stores per 100,000 population.	US Census, County Business Patterns, 2016.
SNAP-authorized store access	7.61	10.57	8.25	Number of SNAP-authorized food stores per 100,000 population.	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2017.
WIC-authorized store access	8.5	17.9	15.6	Number of authorized food stores accepting WIC benefits and carry WIC foods/food categories per 100,000.	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
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Food Insecurity	15%	16%	10%	Percentage of population that experienced food insecurity in a designated year.	County Health Rankings, 2018. Map the Meal Project, Feeding America, 2015.

Heard County Health Profile

HIV/AIDS and STDs					
HIV Prevalence	279.76	512.74	353.16	Prevalence rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
HIV Screenings	n/a	55.12%	62.79%	Percentage of adults between 18-70 years old with self reports of having not been screened for HIV.	CDC, Behavioral Risk Factor Surveillance System, 2012.
Chlamydia Incidence	199	516.5	456.08	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
Gonorrhea Incidence	34.61	137.8	110.73	Rate per 100,000 population.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2014.
STD Incidence for Youth	19.1	29.8	n/a	Rate per 1,000 of youth, ages 15-19, who have been diagnosed with a sexually transmitted disease.	Kids Count, Georgia Department of Human Resources, Division of Public Health, Epidemiology Branch, 2016.
Maternal and Infant Health					
Teen Births	59.7	45.3	36.6	Births to women between 15-19 years old per 1,000 of the female population between 15-19 years old.	US Department of Health & Human Services, Health Indicators Warehouse, CDC, National Vital Statistics System, 2006-2012.
Low Birth Weight Babies	7.40%	9.60%	8.17%	Percentage of births with low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Very Low Birth Weight Babies	1.10%	1.80%	1.40%	Percentage of births with very low birth weight.	OASIS. Maternal/Child Web Query. 2013-2017; CDC National Center for Health Statistics, 2016.
Infant Mortality Rate	n/a	7.5	5.9	Number of infant deaths per 1,000 live births.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.
Births and Tobacco	17.60%	5.50%	7.20%	Percent of live births where mother used tobacco during pregnancy.	OASIS. Maternal/Child Web Query, 2013-2017; CDC National Center for Health Statistics, 2016.
Premature Births	10.00%	11.00%	9.85%	Percent of births before 37 weeks of gestation.	OASIS, Morbidity/Mortality Web Query, 2013-2017; CDC National Vital Statistics, 2016.

Heard County Health Profile

Cardiovascular Health					
Heart Disease Hospital Discharge Rate	**398.90**	276.20	n/a	Age-Adjusted Hospital Discharge rate per 100,000 population with ischemic heart disease (incl. heart attack).	OASIS, Hospital Discharge Web Query, 2012-2016.
Heart Disease Medicare Population	**28.22%**	25.25%	26.46%	Percentage of Medicare fee-for-service population with ischemic heart disease.	Centers for Medicare and Medicaid Services, 2015.
High Blood Pressure Medicare Population	**60.57%**	59.88%	54.99%	Percentage of Medicare fee-for-service population with high blood pressure.	Centers for Medicare and Medicaid Services, 2015.
High Cholesterol Medicare Population	**48.99%**	46.68%	44.61%	Percentage of Medicare fee-for-service population with hyperlipidemia which is most commonly associated with high cholesterol.	Centers for Medicare and Medicaid Services, 2015.
Heart Disease Mortality Rate	**201.00**	58.87	168.2	The age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.	CDC, National Vital Statistics System, 2012-2016.
Stroke Mortality Rate	**37.00**	43.15	36.9	The age-adjusted rate of death due to cerebrovascular disease (stroke).	CDC, National Vital Statistics System, 2012-2016.
Respiratory Health					
Air Pollution-Particulate Matter	**9.9**	10.1	6.7	The average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers.	County Health Rankngs, 2018; CDC's National Environmental Public Health Tracking Network, 2012.
Lung Cancer Incidence	**99.8**	64.9	60.2	Annual age-adjusted incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program, 2011-2015.
Lung Disease Mortality	**93**	8.57	41.3	Age adjusted death rate due to chronic lower respiratory disease per 100,000 population.	Centers for Disease Control and Prevention, National Vital Statistics System, 2012-2016.
Adult Smoking	**19%**	18%	14%	The percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.

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Mental Health and Substance Misuse					
Suicide Mortality Rate	**12.7**	12.7	13.5	Age-Adjusted Death Rate per 100,000 population by suicide.	OASIS, Mortality Web Query, 2013-2017.CDC, National Center for Health Statistics, 2016.
Drug Overdose Deaths	**n/a**	13	10	Drug Overdose Deaths are the number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances.	County Health Rankings 2018; CDC Wonder, Compressed Mortality File, 2014-2016.
Poor Mental Health Days	**4.0**	3.8	3	Poor Mental Health Days is based on BRFSS survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Frequent Mental Distress	**13%**	13%	10%	The percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Liquor Store Access	**0**	9.59	11	This indicator reports the number of beer, wine, and liquor stores per 100,000 population, as defined by North American Industry Classification System (NAICS) Code 445310.	US Census Bureau, County Business Patterns, 2016.
Excessive Drinking	**17%**	15%	13%	The percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average.	County Health Rankings 2018; Behavioral Risk Factor Surveillance System (BRFSS), 2016.
Alchohol-impaired driving deaths	**23%**	23%	13%	The percentage of motor vehicle crash deaths with alcohol involvement.	County Health Rankings 2018; Fatality Analysis Reporting System, 2012-2016.

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Cancers					
Breast Cancer Deaths	**25.2**	22.1	20.9	Number of Age-Adjusted Breast Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Breast Cancer Incidence	**101.1**	125.2	124.7	Age-Adjusted incidence rate (cases per 100,000) population of females with breast cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Deaths	**21.7**	15.3	14.5	Number of Age-Adjusted Colorectal Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Colorectal Cancer Incidence	**55.6**	41.8	39.2	Age-Adjusted incidence rate (cases per 100,000) population with colorectal cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Deaths	**n/a**	22.5	19.5	Number of Age-Adjusted Prostate Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Prostate Cancer Incidence	**99.2**	123.3	109	Age-Adjusted incidence rate (cases per 100,000) population with prostate cancer.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Deaths	**68.8**	46.2	43.4	Number of Age-Adjusted Lung Cancer Deaths per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.
Lung Cancer Incidence	**99.8**	64.9	60.2	Annual Age-Adjusted lung cancer incidence rates per 100,000 population.	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2011-2015.

Heard County Health Profile

Injury Prevention and Safety					
Firearm Fatalities	**n/a**	14	7	The number of deaths due to firearms, per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2012-2016.
Violent Crime	**189**	374	62	The number of violent crimes reported per 100,000 population.	County Health Rankings 2018, The Uniform Crime Reporting (UCR) Program, 2012-2014.
Child Abuse and/or Neglect	**7.7**	7.0	n/a	Unduplicated count of children with a substantiated incident of child abuse and/or neglect, per 1,000.	Kids Count, Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services, 2016.
Motor Vehicle Crash Deaths	**23**	13	9	The number of deaths due to traffic accidents involving a vehicle per 100,000 population.	County Health Rankings 2018, CDC Compressed Mortality File, 2010-2016.
Access to Care					
Uninsured Adults	**19%**	19%	7%	The percentage of the population ages 18 to 64 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Uninsured Children	**7%**	7%	3%	The percentage of the population under age 19 that has no health insurance coverage.	County Health Rankings 2018, US Census Bureau Small Area Health Insurance Estimates (SAHIE) program, 2015.
Primary Care Physicians	**5,770:1**	1,520:1	1,030:1	The ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics.	County Health Rankings 2018, Area Health Resource File/American Medical Association, 2015.
Dentists	**n/a**	1,980:1	1,280:1	The ratio of the population to total dentists.	County Health Rankings 2018, Area Health Resource File/National Provider Identification File, 2016.
Mental Health Providers	**3,830:1**	830:1	330:1	The ratio of the population to total mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Other Primary Care Providers	**5,744:1**	1,146:1	782:1	The ratio of the population to total number of other primary providers, including nurse practitioners, physician assistants and clinical nurse specialists.	County Health Rankings 2018, CMS, National Provider Identification Registry, 2017.
Preventable Hospital Stays	**58**	50	35	The hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration.	County Health Rankings 2018, CMS Dartmouth Atlas of Health Care, 2015.

Part IV: COMMUNITY INPUT

A. Key Informant Interviews

Key informant (KI) interviews are qualitative in-depth interviews with individuals who know what is going on in a community or region. The purpose of KI interviews is to collect information from a wide range of people—including community leaders, professionals, or residents—who have firsthand knowledge about the community. KI interviews were completed the week of January 7-11, 2019 by a Georgia Health Policy Center (GHPC) representative.

Participants:

KI interviews were conducted with four adults, 3 females and 1 male. The participants represented economic development, non-profit foundation, private and public business sectors, and local government. All were long-time residents of the region, 25+ years.

Executive Summary:

Key Informant (KI) interviewees were a diverse mix of leaders from across the region. They varied in their knowledge about organizations, activities, services and resources available in west Georgia. They were candid about the issues that positively or negatively impacted the health of residents and made suggestions about the actions that could be taken in the region to improve the health of residents. The KI interviews revealed four primary themes regarding health in the region:

1. Chronic conditions – obesity, diabetes, hypertension were specific concerns
2. Access to healthcare services for all residents regardless of income or insurance status
3. Provision of and access to adequate and coordinated mental and behavioral health services throughout the region
4. Social determinants of health – interviewees referred to conditions and behaviors that impact long-term health: poverty, low income, employment, lack of affordable housing, poor diet and food insecurity, physical inactivity, tobacco, substance misuse/abuse

Progress on 2016 Health Priorities:

The KI participants were quick to praise Tanner for its leadership role and work to improve health in the region. All four interviewees volunteered successes that tied to progress on the 2016 CHNA health priorities, including:

- The enhanced collaboration among and between the Get Healthy, Live Well Coalition members to impact health of residents.
- The City of Carrollton building connections between sidewalks to improve walkability.
- Progress on mental health services has been made with more providers in schools and more services and outreach by Willowbrooke at Tanner.
- Implementation of evidence-based programs for chronic disease prevention, smoking cessation and nutrition and cooking were cited as important successes.

Root Causes / Barriers to Achieving Good Health:

- All four (4) interviewees identified poverty and lack of access to health care as root causes for poor health in the region
- Other root causes included lack of education, health insurance and limited incomes that led families to make trade-offs: between medicine and food, or healthcare visits and prescriptions, for example
- Lack of knowledge about available resources: this included health services, social services, and health programs
- Limited understanding of how to manage mental health issues (where to go) and the stigma associated with mental health
- Lack of support for the working poor, including accommodating health care and social services with extended hours, nights and weekends
- Single parent households and the lack of parenting skills were cited as contributing to poor health in children and youth
- Apathy or lack of motivation about managing health conditions

Interventions That Will Make A Difference:

Participants gave both general and specific comments in response to the question "What interventions do you think will make a difference?" General comments were about getting the information to the "grass roots," to the people that need it the most; more free programs for the underprivileged residents; ensure fair and equitable treatment for those without insurance by clinicians; and continuing efforts in the African American churches. Specific programs and policies that were suggested included:

- Transportation policies: Exploring land use and transportation policies that will support walking, non-motorized transport, and convenient affordable public transportation in cities in the region was noted as having high potential impact. The Greenbelt and Safe Routes to School efforts in Carrollton were cited as great examples of enhancing non-motorized connectivity.
- Affordable health insurance: Actions that would reduce health insurance premiums and ensure that residents could have health insurance may enhance the number of residents receiving preventive screenings and early diagnosis of chronic conditions.
- Coaches that help residents work through health care access barriers: If Tanner could provide health coaches that would help patients integrate care across multiple clinical settings, use telemedicine, improve home health access and home visiting programs, and ensure prescriptions are filled and taken, this would help many of our senior residents and those with severe chronic conditions.
- Build on existing Get Healthy, Live Well efforts: Cooking Matters, cooking carts in the schools, nutrition education and the chronic disease prevention programs from Tanner have been impactful. Expand offerings to ensure the highest need populations are participating and that they are held at locations where the residents disparately impacted by health concerns may convene, such as food pantries, churches, etc.
- Parenting Classes and Supports: Centering Pregnancy is a group-based program that integrates the three major components of care: health assessment, education and support. Eight to twelve women who are pregnant and with similar due dates meet together, learning self-care skills, participating in a facilitated discussion, and developing a support network with other group members.

B. Community Listening Sessions, Focus Groups

Primary qualitative data was collected through three community focus groups and a community listening session from residents and area community leaders that represent the broad interests of the community, gathering input from a total of 128 individuals throughout Carroll, Haralson and Heard counties. Participants were identified and recruited by Tanner Health System's Community Benefit Department. The focus groups and listening sessions were conducted by Georgia Health Policy Center representatives using focus group and listening session and discussion guides drafted by the Georgia Health Policy Center. The focus group questions and listening session format/questions and an informed consent were reviewed and approved by the Georgia State University Institutional Review Board. For the community listening session, information was also collected using a web-based audience response system from Poll Everywhere in which audience members used personal devices (smart phones, tablets, laptops) to select an answer from multiple choice questions and other question formats. Listening session attendees without a smart device were provided a paper copy of the questions to complete.

The purpose of the listening sessions and focus groups were to identify community health challenges, needs and concerns affecting residents as well as solutions to health issues. Specifically, listening group and focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. The listening sessions and focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities in the Tanner Health System service area. Listening session and focus group feedback is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.), and therefore, is not factual and is inherently subjective in nature.

a. Community Listening Session

The following qualitative data were gathered for Tanner Health System during a community listening session (CLS) in Carroll County at Tanner Medical Center/Carrollton on January 31, 2019.

Descriptive Characteristics: Listening Session Participants

» **Number of Session Attendees**: 87

» **County of Residence (n=81)**:

- 83% Carroll County
- 12% Haralson County
- 4% Heard County
- 1% Other

» **Years in Region (n=79)**: The majority of **participants have lived in west Georgia for 15+ years**

- 4% less than 1 year
- 14% 1 to 5 years
- 1% 6 to 10 years
- 16% 11 to 15 years
- 65% More than 15 years

» **Age (n=80)**:

- 2.5% 18 to 24 years
- 12.5% 25 to 34 years
- 15% 35 to 44 years
- 20% 45 to 54 years
- 20% 55 to 64 years
- 30% Age 65 or older

» **Education Completed (n=84)**:

- 0% Some High School
- 9.5% High School/GED
- 17% Some College
- 9.5% Technical college/Trade/Vocational Training
- 31% College Graduate
- 32% Post-graduate Work or Degree

Executive Summary

Eighty-seven west Georgia community residents, the majority from Carroll County, attended a community listening session (CLS) designed to gather information on participant feelings about health and health needs in the community. Participants were asked questions about health-related challenges, existing health programs and ideas for new health initiatives. During the listening session, participants were asked to provide feedback in four ways:

1. Technology: a web-based audience response system, Poll Everywhere, was used to gather demographic information and to allow participants to provide feedback on various health behaviors, community health issues and healthcare concerns
2. Facilitated tabletop discussions
3. Large group report outs
4. "What is A Healthy Community?" visioning project

The "top five concerns that need to be addressed to improve health & wellbeing" in the west Georgia region as identified by the participants were:

1. Mental Health
2. Nutrition / Poor Diet / Food Insecurity
3. Obesity / Overweight
4. Physical Inactivity
5. Chronic Diseases / Diabetes

Health Issues

Appendix A contains a comprehensive list of health topics affecting residents in the region. The list was created from Tanner information, county-level data and focus groups conducted for the 2019 CHNA. Poll Everywhere was used to identify participants perceived major health conditions by age group. A total of 80 CLS attendees responded to the question. The topic within each category that received the highest percentage of responses from the individual voting are:

» **Infants & Children**: Nutrition & Poor Diet (n=54, 68%)

» **Teens & Young Adults**: Mental Health (anxiety, depression, suicide, etc.) (n=48, 60%)

» **Adults**: Obesity (n=18, 23%), Diabetes (n=13, 17%), Mental Health (n=11, 14%)

» **Senior Adults**: Dementia/Alzheimer's Disease (n=27, 33%); Diabetes (n=13, 16%)

Social Determinants of Health

Tabletop facilitators were asked to lead a discussion with their table members and reach agreement on the top 3 Social Determinants of Health (SDOH) issues that are of greatest concern for west Georgians. Appendix B provides a summary of the rankings of SDOH. The list below with numbers in parentheses represents those three SDOH topics that received the most "top 3" rankings from the participants.

6. 1) Poverty (11)
7. 2) Healthcare access (8)
8. 3) Social & emotional support (5)

Group Suggestions/Recommendations:

This section summarizes the top recommendations made by CLS participants to address the key concerns identified in the tabletop discussions, audience response technology and written feedback.

» **Access to health care**: More free or low costs services/service providers, including preventive health screenings and clinics that accept Medicaid and Medicare are needed in the region.

» **Improve communication/build awareness**: Building awareness among residents in the region about existing programs, resources and services was important. Reaching specific audiences through use of technology and alternative forms of communication was suggested ("meet them where they are"). Using social media as well as more basic communication strategies (signage at grocery stores & libraries, announcements from the pulpits, etc.) with multiple partners helping to disseminate the information about classes and services was important to the listening session participants.

» **Education**: Health education, classes and services were of great interest to the audience. Programming in rural areas and in locations where those families with limited income, transport, or access convene or can best access the programming was important to the CLS participants. Classes for caregivers, parents, and specific support groups were also requested. Finally, schools as a conduit for health content (nutrition, activity, sexual health/STDs, vaping/tobacco, drugs, mental health) beginning in early care into adulthood was identified by the majority of table groups.

» **Food system/nutrition**: Healthy food access and poor diet was a top concern for this CLS group. Access to healthy food (especially in certain areas), cost of healthy food, limited farmers' markets or vegetable stands, and convenient availability of nutrition education and cooking classes were mentioned as concerns and areas for action.

Final Word

Participants were asked to enter into Poll Everywhere one or two words that they would like to be able to use to describe the region in five years. The word cloud below presents the words submitted, with the largest words representing the most prevalent responses.

Listening Session Appendix A:

Age Group	Major health conditions/diseases in your community *Bold = top answer in age category*	
Infants and children	*Asthma* *ADD / ADHD* *Low birth weight Infant mortality (death)* ***Nutrition – poor diet (68%)***	*Obesity / Overweight* *Oral / dental health* *Physical Inactivity* *Other*
Teenage youth & young adults	*Alcohol misuse Drug/substance misuse* ***Mental Health - anxiety, depression, suicide, etc. (60%)*** *Nutrition – poor diet* *Obesity / Overweight*	*Oral / dental health* *Physical Inactivity Pregnancy* *Sexually transmitted diseases* *Tobacco Use (cigarettes, smokeless tobacco, vaping)* *Other*
Adults	*Alcohol Misuse* *Cancer Diabetes* *Drug / substance misuse – Rx drugs, opioids, etc.* *Heart Disease Hypertension (high blood pressure)* *Mental health conditions - anxiety, depression, suicide, etc.* ***Obesity / Overweight (23%)***	*Oral / dental health* *Physical Inactivity* *Sexually transmitted diseases* *Stroke Tobacco Use (cigarettes, smokeless tobacco, vaping)* *Other Tobacco Use Other*
Older adults / seniors	*Alcohol misuse* *Cancer Diabetes* ***Dementia/Alzheimer's (33%)*** *Drug / substance misuse – Rx drugs, opioids, etc.* *Heart Disease* *Hypertension (high blood pressure)* *Mental Health - depression, anxiety, suicide, etc.*	*Nutrition / poor diet* *Obesity / Overweight* *Oral/dental health Physical Inactivity Stroke Tobacco Use (cigarettes, smokeless tobacco, vaping) Other*

Listening Session Appendix B:

Social Determinants of Health (SDOH)
– Top 3 Issues (total top 3 ranking votes)

1. Poverty (11)
2. Healthcare access (8)
3. Social & emotional support (5)

Rank	SDOH Topic
1	***Poverty (4)*** *– access issues (1)* *Healthcare access (4) – lack of HC access, affordable or lack of insurance (3), more Primary Care providers* *Ability to read & write* *Social isolation* *Social & emotional support* *Access to food/healthy food / food insecurity*
2	***Healthcare access (3)*** *– affordable healthcare (1)* ***Social & emotional support (3)*** *Poverty (2)* *Housing costs – lack of affordable housing* *Ability to read & write / overall health education* *Jobs / Employment* *Parenting – learned behavior*
3	***Poverty (5)*** ***Access to food / healthy food (2)*** *Healthcare access / affordable healthcare* *Social & emotional support* *Jobs & employment* *Internet access* *Social isolation*

b. Carroll County Focus Group

Qualitative data was gathered during a focus group conducted with community leaders in Carroll County, Georgia, at Tanner Medical Center/Carrollton on January 18, 2019.

Participants

- Attendees: 17 focus group participants – 11 Females, 6 Males
- Sectors represented: non-profit, education (primary and secondary), county and state government, business and industry, healthcare, senior services, legislative and non-profits.
- Majority of the group have lived in west Georgia/Carroll County for 10+ years. (Exceptions: those who worked in the region but did not live there).

Issue Identification

During the discussion group process, four primary themes were identified that impact the health of county residents:

1. Mental and behavioral health services – particularly for youth, need for more general and specialty mental health services and promotion of the availability of those services
2. Obesity, diabetes and other chronic conditions resulting from physical inactivity and poor diet
3. Substance misuse – prescription alcohol, drugs, opioids, illegal drugs and vaping were specifically named
4. Social determinants of health / prevention efforts – particularly in families with young children who are in poverty; topics named included affordable housing, transportation, health care access and insurance

Progress on 2016 Priorities:

Attendees commented on several areas of progress in the 2016 priority areas and healthcare services arena, including:

- The availability of chronic disease prevention programs through Tanner, churches and other settings with various partner organizations
- The Carroll Connection transportation service that is available for a low cost and by appointment
- The focus at the college (University of West Georgia) on health and wellness, including the wellness lab that has been established
- Improvement in behavioral health services, especially with Willowbrooke and in schools
- Health education and literacy efforts have been expanded within the school systems
- The Willowbrooke at Tanner discussion on alcohol and opioid addiction held at Tabernacle Baptist Church in March 2018 to bring attention to the opioid/drug crisis in the region was well-attended and "a valuable sharing and learning opportunity."

Attendees were candid about the issues that positively or negatively impacted the health of residents. A summary of the concerns and barriers are presented below.

Specific Concerns/Issues:

- The closing of mental health facilities in the state at a time when mental health is one of the most critical issues impacting the population was a concern.
- Specific mental health services are needed such as for children and adults who have suffered sexual abuse or other severe trauma.
- The ever-growing senior citizen population and how will the region meet their housing, healthcare and other service needs.
- There is a need for more foster care families in Carroll County.
- Lack of affordable housing, especially for the elderly, disabled populations, young adults (transitioning from parent's home or college) and others who are on fixed incomes.
- Lack of healthy behavior (poor nutrition and physical inactivity) leading to obesity, diabetes and other chronic conditions.
- Segments of the population who are under-insured or uninsured and who might not seek medical care or establish a relationship with a primary care physician.

Barriers to Achieving Good Health:

- Time/Busy Lives were challenging for participants with work and family obligations, preventing them from focusing on health.
- There are many healthcare providers, health programs and other services offered in Carroll County -- a lack of knowledge or lack of interest in utilizing the services is an issue.
- Social media/technology use that results in comparisons.
- Lack of community support and social isolation particularly for seniors.
- Transportation that is convenient and low cost was identified as a concern. It was recognized that Carroll Connection was established for local transportation, but the small fee ($6 round-trip) may be too high for some residents, appointments filled up rapidly, and the operating hours were not ideal, especially for individuals who start work or school early or finish very late.

What Contributes To An Unhealthy Community

Focus group attendees were asked to identify issues and concerns they have observed in Carroll County that have contributed to an unhealthy community.

- Substance Misuse: Opioid epidemic, prescription drug abuse, alcohol, illegal drug use, vaping
- Vulnerable Families and Children: Several participants commented during the focus group about the need for support for families, especially parents with infants and toddlers and children in need of foster care. It was noted that parents need help with parenting skills and being good role models in order to raise healthy, productive children.
- Services and stigma associated with mental/behavioral health: it was noted that both youth and adults are struggling with anxiety, depression, panic attacks, suicidal ideations and other mental health concerns.
  - ◊ Stigma: Youth may feel they cannot talk to adults in their school or their parents. Adults may be concerned about such a diagnosis and the response from their friends, family or employment.
  - ◊ Lack of diverse providers: Families who are African American or Hispanic may not use mental health counseling or health services, especially if there are no providers of color or Spanish speaking.
- Access to Quality Food and Grocery Stores: Participants commented that food banks and churches were doing an excellent job of making food available to families who need it, but they also noted that certain neighborhoods and more rural areas of the county do not have access to a grocery store or farm stand with healthy food options.
- Environmental Issues: Tobacco use, smoking, secondhand smoke; pollen, water quality, emissions/air quality
- Lack of transportation: Particularly for those living in poverty, disabled or elderly; flexible, convenient, and low cost were some of the adjectives used to describe the needed transportation.
- Poverty: Poverty is impacting many Carroll County residents but those residents who are immigrants or of residents of color are impacted to a greater extent.
- Lack of affordable housing: For senior citizens, for low income families and for newly transitioning students (from home or college dorm to an apartment) were specifically named as populations of concern.
- Lack of knowledge about available services and programs or lack of motivation to participate in available programs.

Group Suggestions/Recommendations

» **Get information and feedback from a diverse audience, particularly those residents we are trying to impact with health care and services**: It was noted that residents of color and families from countries other than the U.S. were not represented in the room. Including the diversity that is Carroll County in this discussion around the creation of a healthy community is important. Low-income residents, church members, non-U.S. residents, public safety, transportation and college students were some examples.

» **Differentiation in programming and leadership to meet the needs of diverse residents**: To engage residents and address some of the social determinants of health identified by focus group participants, it is important to ensure programming, health providers, services, etc. are culturally sensitive. Programming that is provided in the locations by residents, that is offered by providers and program leaders who are representative of those diverse populations across the county and ensuring content reflects their culture and input is important.

» **Mental health service integration**: Focus group participants stated throughout the discussion that while mental health services in the region had increased, there was a need for better coordination of care across mental health service providers.

» **Continue to explore opportunities for healthy food access**: Having and promoting community gardens and farmers' markets is important, but it is also necessary to have them in locations (churches and senior centers, for example) that are convenient to the residents who need access to healthy food and who will embrace gardening and farm stand produce. Focus group participants commented that the families they serve who are from other countries (Honduras, Vietnam, etc.) are not able to find their preferred food.

» **Expand, promote, create demand for existing health resources and services like the evidence-based programs of Get Healthy, Live Well (GHLW)**: Focus group participants spoke very highly of the GHLW initiative and its various programs, but want to explore how to increase demand for these programs and services. More communication and referrals from unlikely channels, such as clinicians, churches and non-profit service providers, to increase awareness and utilization of the programs is critical to improve chronic disease management and to ensure residents most at risk are able to take advantage of available services and support.

» **Increase support for families with [young] children**: Parent education, positive parental support, and starting early with nutrition, physical activity and health content integrated into the early childhood and school settings are important. Also, for all families and youth, promoting the reduction in social media use was noted.

C. Villa Rica Focus Group

The following qualitative data were gathered during a focus group conducted with community leaders in Villa Rica, Georgia, at the Tanner Medical Center/Villa Rica on January 17, 2019.

Participants

- Attendees: 10 focus group participants - 5 women, 5 men
- Sectors represented: education, city government, parks and recreation, private businesses, housing, faith-based organizations, and non-profit organizations.

Issue Identification

During the discussion group process, several themes were identified that impact the health of Villa Rica residents:

1. Mental health/behavioral health, including coordination of care across providers.
2. Substance misuse/abuse – specifically, an inpatient substance misuse treatment program.
3. Health care services and lack of health insurance – access to health care in Villa Rica is reasonably good, but the expense and lack of insurance are concerns for focus group participants.
4. Prevention of chronic disease – the Get Healthy, Live Well initiatives (programs, gardens, school and community health education) are important.

Specific Concerns/Issues:

- Poor eating habits and fast food: Poor diet was linked to many chronic diseases, including obesity and diabetes.
- Lack of affordable health care: While the Tanner hospital, urgent care and other clinics were acknowledged as valuable, the availability of low cost or no cost health care for residents who were underinsured or uninsured was noted.
- Access to care: Two issues arose in this topic: 1) one participant noted that if you have a young child who is sick outside of regular clinic hours, there is no pediatric care location; 2) another participant was concerned about the lack of specialty behavioral healthcare providers for children with autism, dyslexia and other conditions that compromise social and emotional learning.
- Lack of community engagement in available programs and services: Participants perceived that residents who may need support for health behavior change are not participating in the health programs that are offered at the Villa Rica library and the hospital.
- Mental health services: Concern was raised about the need for additional mental health services and providers for children and adults.
- Substance abuse/misuse: Use of methamphetamines, opioids and prescription drugs.
- Walkability and safe commuting: It was noted that having sidewalks that do not connect or the lack of sidewalks in certain areas of Villa Rica inhibit walkability and result in safety concerns when walking in downtown.

Barriers to Achieving Good Health:

- Cost/Income – the ability to pay health insurance premiums or buy healthy food or access physical activity opportunities is hampered by income or the expense of these items.
- Specialty care providers – the lack of pediatric and certain other specialists in Villa Rica, especially clinics that have alternative hours.
- Transportation and community connectivity – neighborhoods and downtown are not connected by safe sidewalks, bike lanes, etc. Working to create a transportation plan that accommodates pedestrian mobility is important.

Group Suggestions/Recommendations:

» **Ensure the city is appealing and clean**: Certain parts of Villa Rica don't look very clean, smell good, and are "just drab." Ensuring that citizens take pride in their area and want to keep it beautiful starts with a clean city. The increasing population requires investment in green space in the community.

» **Expand parks and recreation offerings**: Continue with special programming for senior citizens and invest in updating and renovating the REC facilities, including playground facilities.

» **Healthcare services**: No matter what the age of the resident, Villa Ricans should be able to access health care (physical, dental, mental) and to find a clinician that can meet their needs. It would also be important to reduce the number of residents who lack health insurance.

» **Walkability/neighborhood connectivity**: Ensuring that residents can safely walk between neighborhoods and to downtown would be ideal. Building the first four miles of the planned trail in Villa Rica could help address this issue.

» **Increase corporate presence and partnerships**: One participant noted that in order to create the green space and services that are of interest, a greater number of corporations that will engage in philanthropy and community investment are needed in Villa Rica. Cleaning up the city, enhancing green spaces, and ensuring we have adequate housing will attract business and practitioners alike.

» **Affordable housing**: It was advised that the lack of affordable, attractive housing is a concern for Villa Rica. The waiting list is long. One attendee noted that families are living in motels. The city is working on a plan to create new housing programs for seniors and young families.

d. Heard County Focus Group

Qualitative data were gathered during a focus group with 14 participants in Heard County, Georgia, at the City of Franklin Community Center on January 15, 2019.

Participants:

- Attendees: 14 focus group participants - 10 women, 4 men
- Sectors represented: economic development, education, extension, senior services, public health, city and county government, and non-profits.

Issue Identification:

During the discussion group process, three primary concerns were identified that impact the health of county residents:

1. Access to primary health care – particularly for low income, uninsured families who are seeking low cost or no cost health services
2. Behavioral health/mental health – the loss of a mental health service provider 8 months earlier has had an impact on available services/appointments
3. Chronic disease prevention and health promotion/education – focusing on addressing unhealthy behaviors including tobacco, vaping, drugs, physical inactivity and poor diet

Specific Concerns/Issues:

- Very limited mental, dental and vision health care: There is a Pathway building but limited services are provided in the county.
- Lack of transportation: Getting to medical appointments, especially for senior citizens, is a challenge.
- Lack of availability of primary and specialty care services.
- Cost of health care access for those under/uninsured: Low or no-cost healthcare is needed.
- Lack of health care workforce in the county
- Lack of grants and financial resources to support health-related services and programs

Creating A Healthy Community:

Attendees were asked to comment on what will contribute to Heard County becoming a healthier place to live. Responses are presented below:

- Educating "people outside this room" about the services and resources available in the county and around the region; ensure that those interested are given the contact information and a way to get to the services.
- Increase the number of mental/behavioral health providers in the county. One participant suggested there should be mental health screening for patients coming into the hospital and then referral to and follow-up by the appropriate service provider within the county.
- Expanding Cooking Matters, Chronic Disease Self-Management and other evidence-based classes through Get Healthy Live Well.
- More active population – there are limited, organized recreation opportunities for adults in the county.
- Urgent care center – with one part-time doctor in the county, participants believed having an urgent care facility and/or a school-based health clinic would be beneficial – providing on-site care to children and youth could be efficient and effective.
- Transportation services – public transportation is by appointment and not available after 5 pm or on weekends. The Area Agency on Aging has a transportation voucher program for residents 60+ years. Senior residents can schedule transportation to take them to medical and other appointments outside of Heard County and the transport will wait for the resident.

Group Suggestions/Recommendations:

» **Focus on healthy youth**: The social, emotional and physical health of youth were a major concern. The school-based health clinic was of great interest with the education representatives indicating the school board was willing to establish a clinic, but a partnership with a service provider was needed. Education on the dangers of tobacco products and teenage pregnancy prevention were also important to the group.

» **Clinic services**: 1) Both Tanner and Franklin Primary Care require payment for services. We need a clinic that provides free services or services on a sliding scale based on income. 2) An urgent care facility with traditional and non-traditional hours that would not require a multi-day wait to get an appointment is needed. 3) Public health has hired a full-time nurse who will begin March 1, 2019.

» **Access to healthy food, cooking and nutrition education**: One grocery store and a Subway in the county means limited access to healthy foods. Having cooking carts in the schools and Cooking Matters classes would help residents learn more about healthy cooking and healthy eating.

» **Inform leaders about and expand collaborative efforts to achieve successful change**: The existing Family Connection Partnership collaborative meets consistently and has a larger number of partners participating. Ensuring there is communication with community leaders about new resources and services is critical. Also, engaging the local pharmacist and grocery store owner may help achieve certain goals.

» **Inform residents**: Participants believed that there are health-related resources and services available to help but residents are not always aware of these or choosing to use the services. Inviting representatives from across the economic spectrum would help the collaborative and community leaders create a strategy for serving all residents. Three Rivers Regional Commission and the Area Agency on Aging have offered both chronic disease self-management and diabetes self-management classes as well as Tai Chi in collaboration with Tanner. This programming could be expanded.

C. Healthy Haralson: The Two Georgias Initiative

Rural communities experience a variety of challenges when faced with providing and accessing quality health services. Geographic isolation, limited employment opportunities, lack of transportation and low numbers of service providers are only a few of the barriers that rural residents face. Recognizing the barriers that prevent people from receiving the care they need and adopting healthier habits, Healthy Haralson — a committee of Tanner Health System's Get Healthy, Live Well — is leading the charge to address these critical needs. In June 2017, the Healthcare Georgia Foundation awarded Tanner Health System The Two Georgias Initiative grant to improve health outcomes for Haralson County residents.

The mission of Healthy Haralson

Healthy Haralson is dedicated to advancing health equity among rural Haralson County residents by improving health care and fostering social, economic and educational environments that promote health and eliminate health disparities.

Healthy Haralson funding and governance

The Two Georgias Initiative is a five-year investment in rural communities represented by Community Health Partnerships (CHP) implementing bold and visionary Community Health Improvement Plans (CHIP) comprised of innovative solutions to better health and health care among their residents. Tanner was one of only 11 nonprofit organizations in the state to receive the award.

Tanner's Two Georgias Initiative project works through Healthy Haralson to plan, coordinate and implement a comprehensive CHIP in Haralson County. During the first year of the project, Tanner partnered with the University of West Georgia to conduct an in-depth CHNA, asset mapping and gap analysis of Haralson County, which was utilized to develop the plan. The CHNA incorporated data from both quantitative and qualitative sources. Quantitative data input included primary research—community surveys with 32 total respondents — and secondary research (vital statistics and other existing health-related data). Qualitative data input included primary research gathered through eight community focus groups (gathering input from 52 area residents) and 10 key stakeholder interviews. These data were used to diversify the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA. The focus groups and key informant interviews were comprised of area residents, partners and persons who represent the broad interests of the community, including members of medically underserved, low-income, youth, senior and minority populations. In addition, a comprehensive asset map was developed in partnership with the Data and Visualization Lab at the University of West Georgia in January 2018. Upon analysis of community health needs assessment/gap analysis and asset mapping data and results, a comprehensive work session was held in January 2018 with Healthy Haralson stakeholders, with 18 community representatives in attendance. These key stakeholders worked in teams based upon each priority initiative identified to devise scenarios that they thought would give Haralson County the best overall outcomes in terms of health, equity and healthcare system efficiency. Based upon this information, a clear set of priorities with actionable steps were identified in which to develop and finalize the (CHIP). The CHIP was approved by the Healthy Haralson leadership group and the Tanner Medical Center, Inc. Board of Directors.
Upon final review, analysis and prioritization of the CHNA findings, the priority areas to be addressed in Healthy Haralson's CHIP Plan (July 2018-June 2021) include:

1. Substance Abuse
2. Healthy Lifestyle and Education
3. Youth Mental Health
4. Increase Awareness of Existing Resources
5. Increase Provider Resources
6. Senior Needs

Part V: SIGNIFICANT HEALTH NEEDS

A. Prioritized Description Of Significant Health Needs

As mentioned previously, the identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and each hospital's strengths within the context of the system's priorities. Additionally, when selecting final targeted health priorities, Tanner considered additional criteria such as availability of evidence-based approaches and existing partnerships and programming. These components were used to identify priority areas.

Tanner's Get Healthy, Live Well coalition participated in a comprehensive prioritization exercise that involved grouping and ranking identified needs and assets, as well as discussions about what existing and new initiatives and partners should be included in the hospital's three-year implementation plans. The purpose was to determine how to best support the highest prioritized needs, while leveraging identified community assets and resources.

Through this process of evaluation, six priority health issues were selected from the broader list of priorities identified in the CHNA as specific areas of focus for each of Tanner's Health System's hospitals (Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica, Higgins General Hospital) Community Health Implementation Strategy, including:

1. Access to Care
2. Healthy and Active Lifestyles and Education
3. Chronic Disease Education, Prevention and Management
4. Mental/Behavioral Health
5. Substance Misuse
6. Social Determinants of Health

Over the next three years (fiscal year's 2020-2022), each of Tanner Health System's hospitals will execute the Implementation Strategy, to be presented in a separate document. Plans will focus on the execution of programming for identified priority areas, systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes relative to internal measures and local and national public health goals.

B. Moving Forward

Through the CHNA process, Tanner has identified the greatest health needs among each of its hospital's communities. This will help the health system ensure that its resources are appropriately directed toward clinical program development, services, outreach, prevention, education and wellness opportunities where the greatest impact can be made. Now that the community's health needs have been identified, it is time to move forward in implementing the strategies that will help people in Tanner's service area get and stay healthy.

Tanner is dedicated to making west Georgia a healthier place to live, learn, work, play and grow. With the help of community partners, the initiative has successfully implemented programs that help west Georgia residents with the healthcare and preventative services they need. The health system will continue its work to develop and sustain partnerships to address the community health needs identified in the CHNA.


GET HEALTHY
LIVE WELL
TANNER
HEALTH SYSTEM