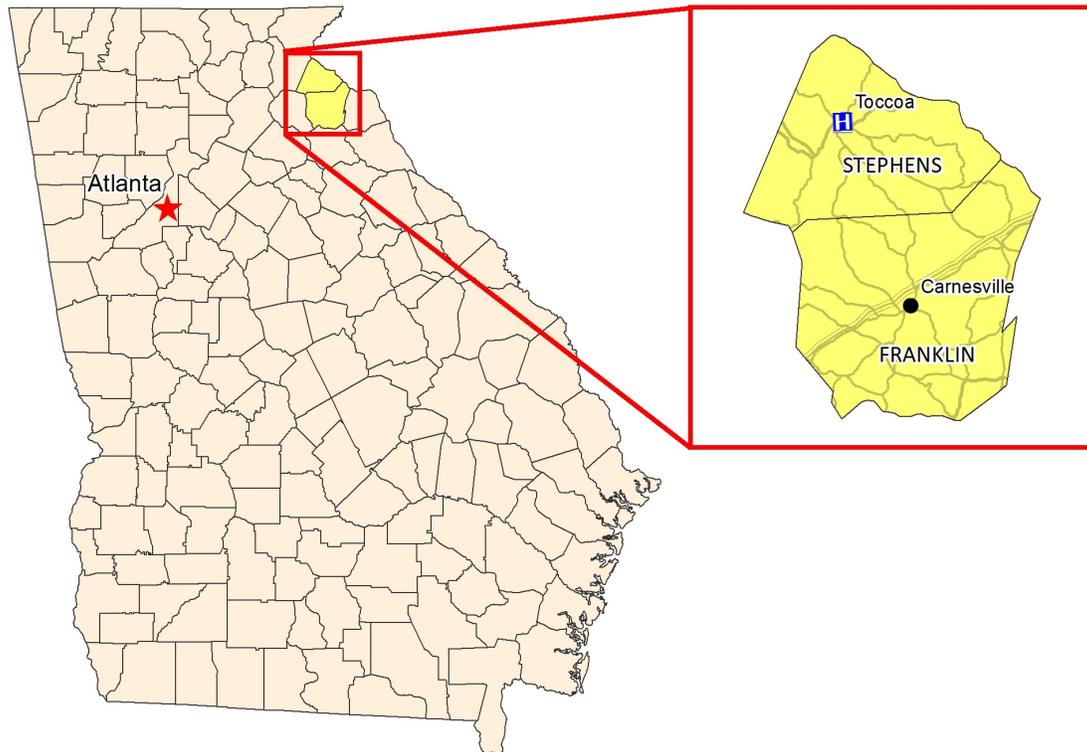


Stephens County Hospital *Community Health Needs Assessment*



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ABOUT THE PROJECT TEAM

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

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

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

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

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

TABLE OF CONTENTS

I. Executive Summary 7

II. Introduction 14

 a. The Patient Protection & Affordable Care Act..... 14

 b. IRS Compliance 14

 c. Phases of a Needs Assessment..... 16

 d. Project Purpose 18

 e. Project Overview..... 18

III. Methodology 20

 a. Overview of the Communication Process..... 20

 b. Data Templates & Instruction Guides..... 20

 c. Initiating & Sustaining Community Contact 21

 d. Steering Group Membership..... 22

 e. Medical Service Area Definition & Confirmation..... 23

 f. Community Advisory Committee Membership..... 23

 g. Sites Visits..... 24

 h. Data Collection Approaches 25

 i. Community-Based Assets 28

 j. Prioritization Strategy 28

IV. Results: Secondary Data Analysis 30

 a. Demographics 30

 b. Health & Social Indicators..... 32

 c. Preventive Care Services 33

 d. Physician Workforce Summary 34

 e. Overview of Morbidity Rates 35

 f. Overview of Mortality Rates..... 36

 g. Trends in Morbidity 37

 h. Trends in Mortality 55

 i. Maternal & Child Health..... 68

V. Results: Community-Based Survey 73

 a. Demographic Characteristics 73

 b. Community Perception 77

 c. Behavioral Patterns 79

 d. Healthcare Seeking Behavior..... 83

 e. Local Hospital Services & Overall Satisfaction 86

VI. Results: Focus Groups 90

 a. Community..... 90

 b. Community Issues..... 92

 c. Hospital 94

 d. Hospital Problems 97

 e. Hospital Recommendations 98

 f. Community Vision..... 101

Stephens County Hospital: Community Health Needs Assessment

VII. Community Assets 103
 a. Stephens County 103
 b. Franklin County 105

VIII. Prioritization 106

IX. Hospital Challenges 107

X. References 108

XI. List of Appendices 109

EXECUTIVE SUMMARY

Purpose

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

Service (target) Area

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

Community Advisory Committee Membership

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

Site Visits

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

Data Collection Approaches

- ✓ The secondary data reports were generated using data collected from multiple online sources including the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS), County Health Rankings, the U.S. Census Bureau, and the Georgia Board for Physician Workforce's 2008 Physician Workforce Profile.
- ✓ Primary data were collected using a pilot tested community-based survey. Through the assistance of the CAC, a minimum of 400 surveys were distributed to a cross-section of the defined target area.

- ✓ Primary data were collected using 3 focus groups (6 to 8 members each) in each community. One group consisted of CAC, the persons recruited by each hospital to actively participate in the needs assessment. The other two groups were recruited by CAC members and referrals.
- ✓ Community assets were identified using the two primary data collection methods described above, as well as a compilation of health related resources in the target area, including hospitals, health services, counseling services, youth organizations, community organizations and rehabilitation services.

Prioritization Strategy

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

Results: Secondary Data Analysis

- ✓ The majority of the population is white (86%), while African-Americans constitute the largest minority (approximately 10%).
- ✓ Diabetic and mammography screenings are at or above the state averages.
- ✓ The number of preventable hospital stays is much higher than the state average.
- ✓ In 2008, the service area had a total of 60 physicians, mostly Family Practice.

Morbidity

- ✓ Cardiovascular diseases are the largest cause of morbidity, which resemble state averages.
- ✓ In the service area, African American females have higher rates of stroke.
- ✓ Obstructive Heart Disease (OHD) is higher among white residents in the service area, especially white males
- ✓ The rates of respiratory diseases are consistently higher than the state average for each race and gender classification. Conversely, rates are highest among African-American males.
- ✓ Although, African Americans have the highest rates of asthma, all race and gender classifications are higher than the state averages.
- ✓ The cancer morbidity rate is slightly higher than the state average. African American population has the highest rates in this service area.
- ✓ Hospital discharge rates for diabetes among African Americans are more than twice higher than that of white residents.

- ✓ African Americans have the highest rates of HIV/AIDS, but these rates are lower than the state average.
- ✓ The rate of sexually transmitted infections is similar to the state average with African American females having the highest rate in the service area.

Mortality

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

Maternal and Child Health

- ✓ The percentage of births receiving less than five prenatal care visits is higher in the African American community. Those rates are similar to the state average.
- ✓ The infant mortality rate for African American is more than twice higher than whites.
- ✓ The percentage of low birth weight babies in the African American population is much higher than in whites.
- ✓ The percentage of low birth weight births for teen mothers is higher among African-Americans than in whites.

Results: Community-Based Survey

- ✓ A total of 355 surveys were completed and returned to Georgia Southern University for analysis.
- ✓ Considerably more females (66.9%) completed this survey than males (33.1%).
- ✓ Most respondents were either white (90.6%) or African American (7.4%).
- ✓ Nearly 56.5% of all participants were between the ages of 25 and 54 years old.

- ✓ Approximately 30.6% of respondents reported having some college education and 28.3% of respondents reported having a high school diploma or the equivalent.
- ✓ Most survey participants (57.5%) indicated they worked full-time while only 7.5% reported part-time work. Approximately 6.9% of participants reported they were unemployed.
- ✓ Nearly 22% of participants reported household incomes of less than \$25,000 per year.
- ✓ A considerable proportion of the respondents reported having access to transportation (97.1%).
- ✓ Overall, quality of life in the community is high. Respondents characterized the community as safe, good place to live and raise children. Moreover, most participants agreed the community had a strong educational system and health care system. However, the economic viability of the community was a concern.
- ✓ Approximately 43.6% of respondents perceived their health status as “good,” and 31.2% perceived their health status as “very good.”
- ✓ A majority of respondents reported either exercising occasionally exercising (40.8%) or not at all (6.4%).
- ✓ 58.1% of the female respondents reported completing a self-breast examination.
- ✓ Most respondents (77.6%) reported not using tobacco.
- ✓ Nearly 93% of respondents reported never consuming alcohol (55.9%) or only consuming it occasionally (32.8%).
- ✓ Most respondents reported always (81.6%) or mostly (13.2%) using seatbelts.
- ✓ Prayer (61.1%) was the most commonly reported strategy for controlling stress. However, talking to friends (35.1%), exercise (42.6%), and hobbies/sports (28.6%) were also commonly reported.
- ✓ The majority of survey respondents (79.1%) indicated they received physicals on a regular basis.
- ✓ Most (85.3%) respondents reported having a regular doctor.
- ✓ Nearly 66.6% of all respondents indicated having private insurance to pay for health care services. Approximately 13.1% reported being Medicare beneficiaries and 6.4% reported being on Medicaid.
- ✓ Over 71.2% of respondents indicated having a regular dentist.

- ✓ 84.7% of respondents reported seeking health care from a private practice. The emergency room (11.3%), community health center (1.4), and the health department (1.2%) were additional sites for receiving health care services.
- ✓ 79.7% percent of respondents indicated that cost was not a barrier to receiving health care services.
- ✓ Nearly 78.4% of respondents indicated that cost was not a barrier to filling a prescription medication.
- ✓ Trauma (22.6%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room (ER). Gastroenteritis (15%), Ear/Nose/Throat infections (11.9%), and dehydration (10.1) were also commonly reported conditions for emergency room admissions.
- ✓ Among respondents surveyed, 68.8% used hospital services in the last 24 months. Those reporting using hospital services, 87.2% indicated using services at Stephens County Hospital
- ✓ Most participants reported using Stephens County Hospital because of convenience (56.9%). However, 31.5% reported being referred by a physician.
- ✓ Radiologic services (55.4%) and laboratory services (38.9%) were the most commonly reported services used by survey respondents. The emergency room was used by 49.8% of those surveyed.
- ✓ Over 86.8% of those surveyed indicated being satisfied with services while only 11.7% indicated dissatisfaction. The primary reasons for reporting dissatisfaction involved long ER wait times and hospital personnel interaction.
- ✓ Approximately 88.6% of those surveyed indicated using a primary care physician.

Results: Focus Group Analysis Themes

- ✓ Community: Beautiful place to live; small town feel; friendly people; safe; great schools system; faith-based community; active community.
- ✓ Community Issues: Lack of industries; lack of jobs; poverty; drug abuse; mental health; teenage pregnancy; child abuse; chronic disease; no sidewalks; recycling plant; and no central transportation.
- ✓ Hospital: Competent and qualified staff and physicians; caring and compassionate service; updated equipment and technology; connect to community through radio and newspaper; major employer; great facility; and conveniently located.

- ✓ Hospital Problems: Parking lot expansion; cafeteria food; lack of oversight and coordination in ER; hospital misdiagnosis; medical billing process; and hospital transportation.
- ✓ Recommendations: Community partnerships; promote services through well-known institutions; offer education programs/prevention and engage on and off campus; follow-up care; improve billing department; volunteerism in Toccoa; improve cafeteria food; outreach in all segments of the county; explain ACA to community; wellness promotion in schools; and proactive role on elderly care.
- ✓ Community Vision: Less poverty; more industries; raise awareness; and prevention programs

Community Assets

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

Prioritization

- ✓ **The following issues emerged from the data:**
 - Chronic Disease Conditions (Heart Disease, Cancer, Respiratory, Diabetes, Etc.)
 - Maternal/Child Health (Infant Mortality, LBW)
 - Teenage Pregnancy
 - Economic Development (Lack of Industry, Jobs, Poverty, Environmental Modifications/Bike Paths/Etc.)
 - Mental Health (Accessibility/Affordability)
 - Behavioral Health Issues (Substance Abuse, Child Abuse, Etc.)
 - Issues Associated with Community Health Education & Outreach (Exercise, Diet, Tobacco, Etc.)
 - Issues Associated with Elder Care (Housing, Boomers, Etc.)
 - Accessibility/Affordability of Transportation
- ✓ **Following the prioritization exercise the rank order of community issues included:**

“Issues Associated with Elder Care” ranked highest according to the calculated BPR score. “Issues Associated with Community Health Education & Outreach,” “Chronic Disease Conditions,” “Behavioral Health Issues,” “Mental Health,” “Economic Development,” “Teenage Pregnancy,” “Maternal/Child Health,” and “Accessibility/Affordability of Transportation” followed this issue.”

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INTRODUCTION

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

The Patient Protection and Affordable Care Act

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

IRS Compliance

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

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

Timing:

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

Requirements of the CHNA:

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

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

Phases of a Needs Assessment

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

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

Step 1: Engaging the Community

The community assessment process begins through community engagement. Typically, assessment experts are “outsiders” to the community, so they generally lack credibility in the community. Community engagement is necessary for achieving ownership in the process, thereby enhancing likely participation in the remaining phases of the assessment. Moreover, community engagement helps to gauge overall community readiness to address specific problems or issues.

Step 2: Defining the Issues

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

Step 3: Establishing Community Priorities

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

Step 4: Designing a Strategy for Intervention

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

Step 5: Evaluating the Impact

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

community engagement. Therefore, Step 1 begins again and the entire assessment process repeats itself.

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

Project Purpose

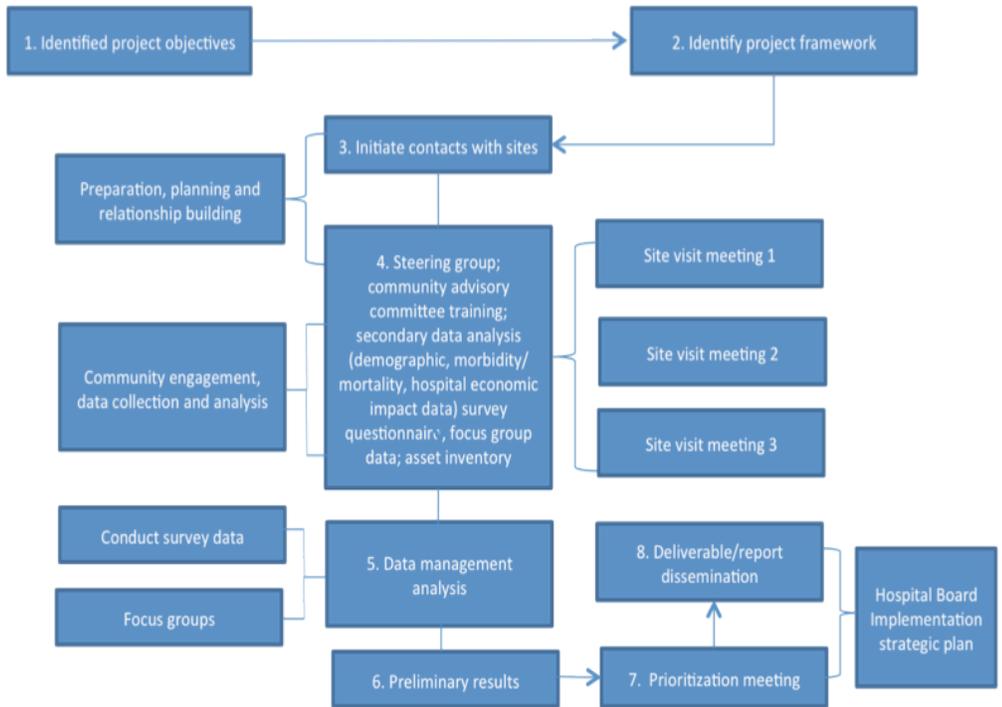
The purpose of this project was to provide technical assistance to 18 nonprofit rural hospitals in completing the Community Health Needs Assessment (CHNA) as mandated by the IRS. A list of all hospitals and public health district contacts involved in this initiative can be found in *Appendix A*. Additionally,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

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

Project Overview

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

Community Health Assessment: A Conceptual Framework[©]



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METHODOLOGY

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

Overview of the Communication Process

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

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

Data Templates and Instruction Guides

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

Data Template

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

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

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

Initiating and Sustaining Community Contact

E-mail was the channel of communication chosen to initiate communication. The purpose of this email message was two-fold: 1) To introduce Georgia Southern University as the institution contracted by the SORH to provide technical assistance for completing the CHNA; and 2) To schedule a conference call within the first two weeks after the initial email. In addition, a project summary describing the project in more detail, including specific aims, was sent as an attachment to this email (*Appendix C*). The initial email message to all sites was sent on June 4, 2012.

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

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

On June 12, 2012, a 30-minute conference call was hosted between the Stephens County Hospital site leader Jeffrey Liard and the Georgia Southern University project team.

Steering Group Membership

Each hospital was responsible for forming a Steering Group. The Steering Group consisted of 5-7 members from the hospital. However, hospitals were given the latitude to include other key stakeholders from the community. For Stephens County Hospital, Steering Group members were recruited from the hospital, the local health department and the community. These members names and affiliations included Mr. Ed Gambrell (CEO, SCH), Jeffrey Liard (Controller, SCH), Faye Taylor (Director of Nursing, SCH), Heidi Wilkinson (Community Health Education, SCH), Karen Palmer, RN (Regional Director, Public Health Department), and Paula Dickerson (Retired teacher) (*Appendix E*).

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

Medical Service Area Definition and Confirmation

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

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

Counties Served in 2011

County	Zip Code	Number of Patients Served	Percentage	Designation
Stephens	30577	36,923	69.02%	Primary
	30557			
	30538			
Franklin	30521	5107	10.53%	Primary
	30520			
	30662			
	30516			
Habersham	30523	2939	6.63%	Secondary
	30563			
	30531			
	30535			
	30511			
Rabun	30525	1711	3.98%	Secondary
	30576			
	30552			
Hart	30643	538	1.14%	Secondary

Community Advisory Committee Membership

The Community Advisory Committee (CAC) is a key component of community engagement in the process as required by the IRS mandate. To formalize the process, we were able to provide the sites with a letter to recruit CAC members (*Appendix F*) and a list of potential CAC members (*Appendix G*). The standard letter was to be tailored to each hospital. The site leaders were instructed to discuss potential meeting dates, times and locations with the steering group to include in the letter before sending it out to those potential recruits. While working with the steering groups, the site leaders were to identify the best strategies that would facilitate CAC member recruitment in the community. For instance, some sites chose to write an article to put in

their local newspapers to recruit participants, while others developed a list of potential members, divided the names among steering group members and had them call individuals to invite. However, many sites used multiple recruitment methods to include phone calls, emails, a letter from the hospital and word-of-mouth.

The CAC was composed of 15-25 members representing a cross-section of the defined community (target area). Hospitals, in particular the Steering Groups, were specifically instructed to recruit people, or agencies, representing traditionally underserved and minority populations within the target area. In addition, hospitals were encouraged to seek diversity with respect to race, ethnicity, social, economic, and education backgrounds. At the first Steering group meeting, the site leader requested for all members in attendance to develop a list of at least five potential CAC members. The ultimate list consisted of 51 individuals who represented both Stephens and Franklin counties. A letter was sent to all potential CAC members that explained the project and asked for their participation. A phone call was placed to those individuals from whom the hospital did not hear after the invitation letter was sent. (*Appendix H*).

Site Visits

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

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

Specific tasks to be completed following the first meeting included formation of the Steering Group, beginning the process of recruiting CAC members, aggregating zip code data, defining the target area, discussing a community responsive data collection strategy, developing a project timeline, formalizing the community-based survey, and pilot testing the community-based survey. The Stephens County Hospital Steering Group compiled a list of 51 potential CAC members. All but one accepted to become members of the committee. The recruitment process was as follows: each Steering Group member made the initial contact while the Stephens County Hospital site leader sent a letter to explain the project to the potential members.

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

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

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

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

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

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

Data Collection Approaches

Secondary Data Collection and Analysis

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

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

Primary Data Collection: Survey Development and Distribution

As mentioned previously, a draft community-based survey was provided during the first site visit (community meeting). The steering committee was instructed to make necessary adjustments to the survey and to provide feedback to Georgia Southern University. Upon receiving the survey feedback from each site, the next step in the process was to make the requested changes so that the survey could be pilot tested. Instructions for the pilot test consisted of having 5-7 persons in the community who were representative of the service area take the survey. The instructions for pilot testing (*Appendix O*) were emailed to the site leader with the revised survey, and each site was given one week to complete this activity. Once pilot testing was completed, the site leader was asked to return the results to Georgia Southern University either by email or postal mail. After changes based on pilot test results, were incorporated, a finalized survey was developed (*Appendix P*). The Stephens County Hospital Steering Group members made site specific changes to the survey instrument, while the site leader located a representative sample to conduct the pilot test. On August 7, 2012, a random sample of six local residents participated in the survey pilot test at the hospital. The results of the pilot test were sent to the Georgia Southern team to make the final changes to the instrument before data collection began on August 16, 2012.

Prior to Meeting 2, 400 copies of the survey were made and taken to the meeting. These surveys were numbered sequentially and distributed at the conclusion of Meeting 2. CAC members were asked to take the surveys and distribute them to their personal network. The decision to distribute a specific number of surveys was left to each CAC member. Therefore, the number distributed by each CAC member varied according to the size of their personal network and their overall willingness to participate in this project. Because the surveys were numbered, the hospital was able to track individual CAC members and the number of surveys they intended on distributing.

In some instances, CAC members opted to only take one survey and use their own resources to make additional copies. In this case, the CAC member was asked to keep track of numbers of copies made and distributed. It was the responsibility of the site leader at the hospital to track this information, and total numbers of surveys in the community were known. Although some variability existed among all sites, most communities agreed that the CAC members would be responsible for getting completed surveys to the hospital. In most instances, CAC members would return the surveys to site leaders, front desk receptionists, or strategically placed drop boxes in the hospital. Each site was given approximately 6 to 8 weeks to forward the completed surveys to Georgia Southern University. Theoretically, it was possible to estimate the total number of surveys distributed in a given community, and all hospitals were strongly encouraged to attempt at least an 80% response rate. Each hospital received a weekly reminder email message requesting an update on the survey distribution process. Specific information included the following: 1) the number of surveys received from CAC members; 2) the number of additional copies of the survey made; 3) (any) changes made to the original data collection strategy; and 4) (any) more time needed to reach the required 80% response rate. All surveys were manually entered into SPSS for Windows. Only descriptive statistics were used for this report.

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

Primary Data Collection: Focus Groups

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

After all focus groups, the facilitator and note taker (when available) participated in a debriefing session and completed field notes. All focus groups were digitally recorded and transcribed verbatim by a professional transcription service *Verbal, Ink.* and subsequently reviewed by the Georgia Southern University qualitative analysis team (Marie Denis-Luque and Dr. Raymona H. Lawrence) for accuracy. Transcripts were analyzed using the qualitative data analysis software program MAXQDA 10. An *a priori* codebook was developed based on the focus group guide. All transcripts were reviewed and coded by one of the members of the qualitative analysis team.

Codes and emerging themes were discussed continually among the qualitative analysis team and agreed on or revised through an iterative process of consensus. Coded segments of the transcripts were placed into a qualitative data analysis matrix and separated by codes (i.e. hospital, hospital issues, community, community issues). All segments from a particular code were read and themes were developed. A grounded theory approach was used to understand the meanings that the community and the hospital had for the participants as well as their recommendations to the hospital and community vision.

All three focus groups for Stephens County Hospital were scheduled on November 14, 2012 and were conducted on December 6, 2012. All participants completed a demographic form (*Appendix S*) and the informed consent (*Appendix T*), and each focus group lasted an average 75-90 minutes. A list of focus group participants can be found in *Appendix U*.

Community-Based Assets

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

Prioritization Strategy

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

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

Participants were given a prioritization sheet with instructions (*Appendix V*) and asked to complete a final ranking of the mutually agreed upon issues. Given that a PEARL measure assigned as 0 would effectively remove an issue from consideration, participants were not asked

to assign a value to the D term in the BPR equation. The results of this exercise yielded the final ranking of issues in a given community. The final calculations to obtain the BPR were completed by the project team.

RESULTS: SECONDARY DATA ANALYSIS

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

Demographics

Demographic Characteristics 2010 Census

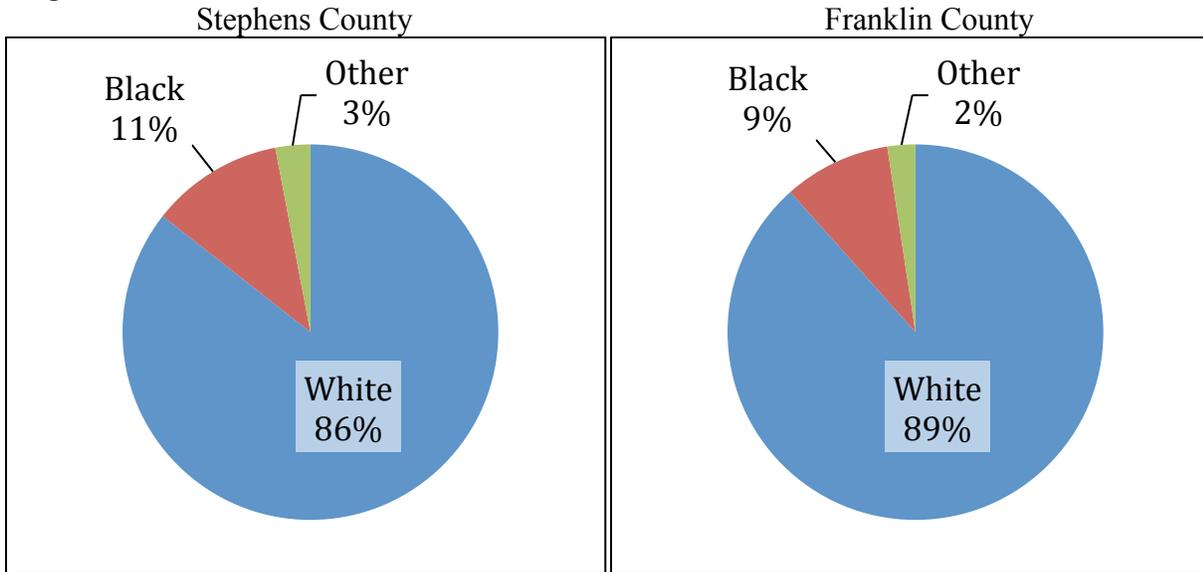
	Stephens County	Franklin County	Georgia
Population [†]	26,175	22,084	9,815,210
Persons under 5 years [†]	6.1%	6.1%	7.1%
Persons under 18 years [†]	22.2%	22.4%	25.6%
Person 65 years and over [†]	17.1%	17.3%	10.7%
Male [†]	52.0%	50.6%	48.8%
Female [†]	48.0%	49.4%	51.2%
White persons [†]	85.6%	88.4%	59.7%
Black persons [†]	11.4%	9.2%	30.5%
Median Household income (2006-2010) [†]	\$34,938	\$36,739	\$49,347
Homeownership rate (2006-2010) [†]	72.0%	71.9%	67.2%
High school graduates [†]	74.8%	74.3%	83.5%
Bachelor's degree or higher [†]	13.3%	13.6%	27.2%
Percent Uninsured [‡]	23%	24%	21%

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

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

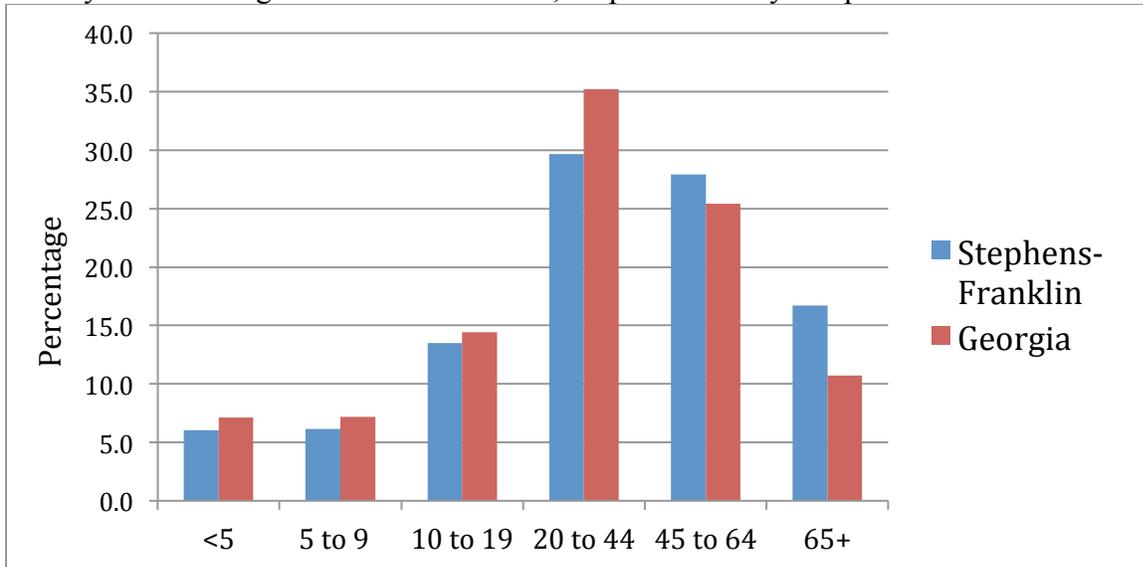
Service Area Demographics: Stephen County Hospital's service area is a rural community. The majority of the population is white. African Americans constitute the largest minority. Similar to other rural areas, the percentage of the population with high school diplomas, the proportion of college graduates,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

Proportion of Races



U.S. Census Bureau: State & County QuickFacts

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

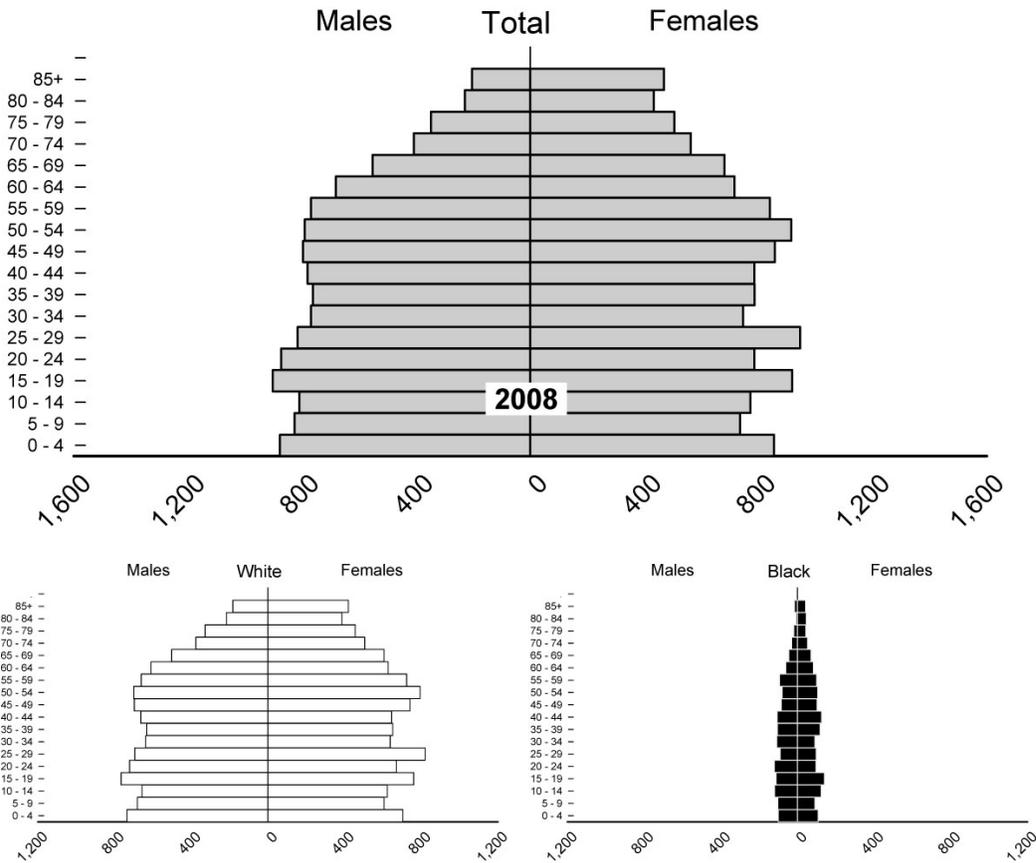


U.S. Census Bureau: American Fact Finder

Age Distribution: Stephen County Hospital’s service area is skewed to the older population categories.

Population Pyramids 2008, Stephens County

Number of Total, White and Black Population, Stephens County, GA



OASIS: Georgia Department of Public Health

Health and Socio-Economic Indicators

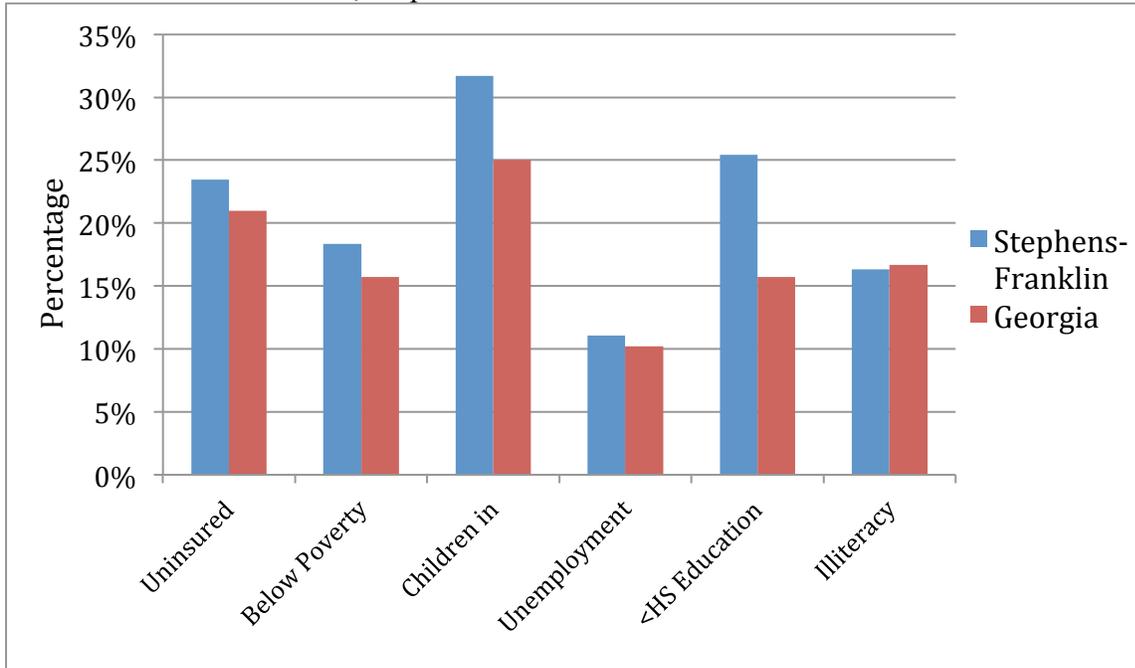
Health Behaviors

	Stephens County	Franklin County	Georgia
Adult Smoking	21%	N/A	19%
Adult Obesity	33%	28%	28%
Physical Inactivity	29%	26%	24%
Excessive drinking	7%	7%	14%

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

Health Indicators: Health outcomes in the community are best understood in the context socio-economic factors and health behaviors since they are powerful influences on a population’s health. The figure indicates that residents in the service area face higher rates of childhood poverty. Unlike most rural areas in the state, the literacy rates and employment rates are similar to the state averages. The health behavior indicators in the table show that while similar to the state averages, the rates of risk-taking behaviors are still problematic in the service area.

Socio-Economic Indicators, Stephens and Franklin Counties



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

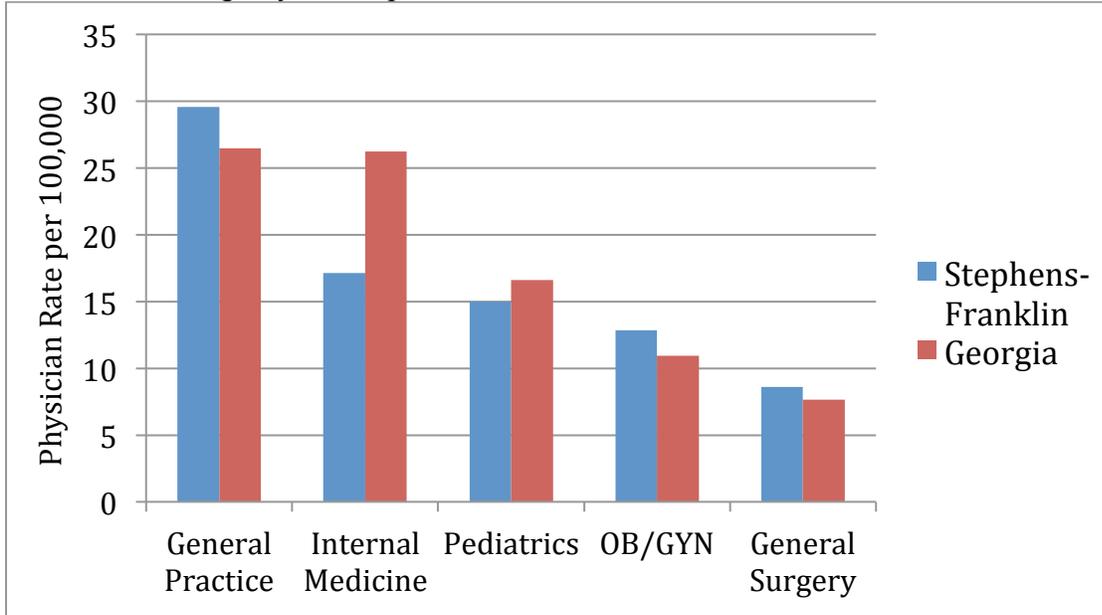
Preventive Care Services

	Stephens County	Franklin County	Georgia
Diabetic screening	89%	89%	83%
Mammography screening	65%	60%	66%
Preventable hospital stays	90	86	68

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

Physician Workforce Summary

Rate of Practicing Physicians per 100,000 residents



Georgia Board for Physician Workforce Report 2011

Physician workforce: In 2008, Stephens and Franklin Counties had a total of sixty practicing physicians. The rates for most physicians are similar to the state average.

Total Number of Practicing Physicians in 2008

	Family Practice	Internal Medicine	Pediatric	OB/GYN	General Surgery	Total
Stephens	5	6	6	4	4	41
Franklin	9	2	1	2	0	19
Total	14	8	7	6	4	60

Georgia Board for Physician Workforce Report 2011

Overview of Morbidity Rates (2001-2010)

Major Sources of Morbidity and Low Birth Weight

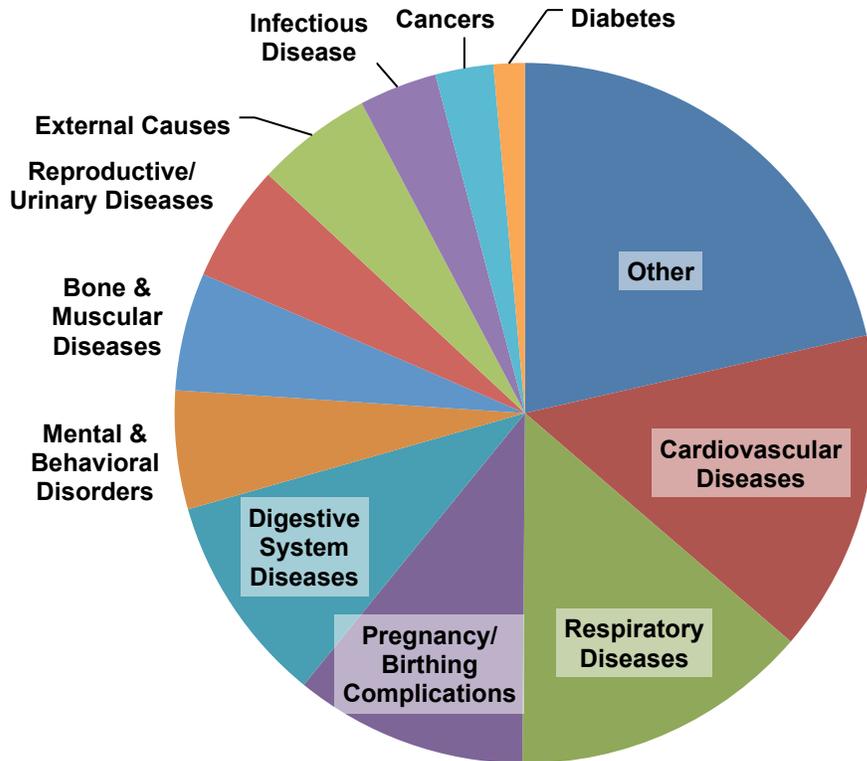
Cause of Morbidity	Service Area	Georgia
All Causes [†]	11769.7	9,389.3
Major Cardiovascular Disease [†]	1582.9	1,389.0
Cancers [†]	284.8	274.1
Respiratory Disease [†]	1592.3	944.1
Infectious Disease [†]	427.8	305.9
Diabetes [†]	169.1	138
Low Birth Weight [‡]	9.0%	9.3%

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

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

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

Proportion of Deduplicated Discharges by Leading Causes of Morbidity



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

Overview of Mortality Rates (2001-2010)

Summary of Major Causes of Mortality

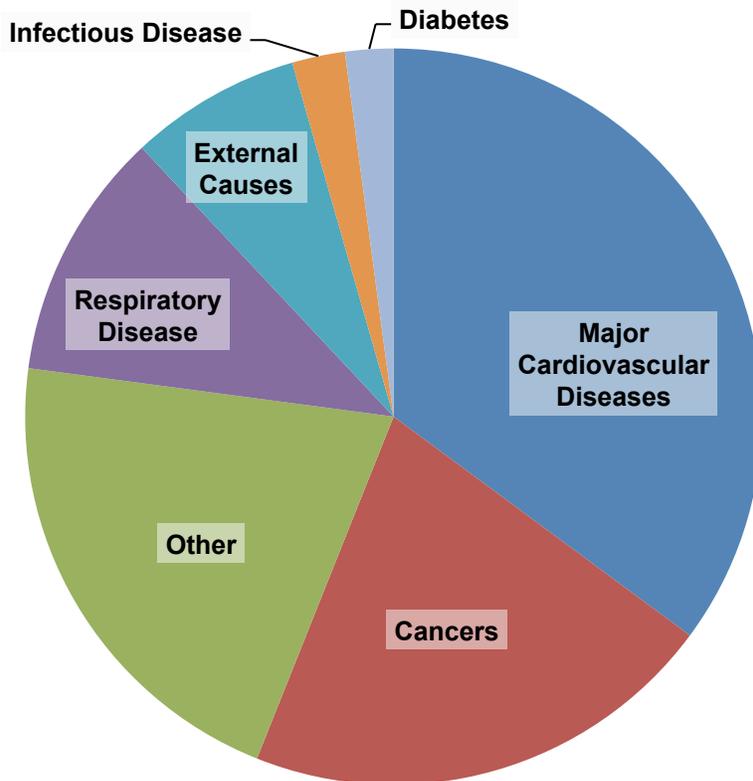
Cause of Death	Service Area	Georgia
All Causes [†]	997.7	883.8
Major Cardiovascular Disease [†]	345.0	302.2
Cancers [†]	201.1	185.6
Respiratory Disease [†]	106.0	88.7
Infectious Disease [†]	23.0	30.5
Diabetes [†]	21.0	21.5
Infant Mortality Rate [‡]	7.2	8.1

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

[‡]Deaths per 1,000 live births

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

Proportion of Deaths by Leading Causes of Mortality



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

Trends in Morbidity

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	88	1922.6	1695.4
White	810	1553.5	1297.5
Other	6	970.7	1334.9
Total	903	1582.9	1,398.8

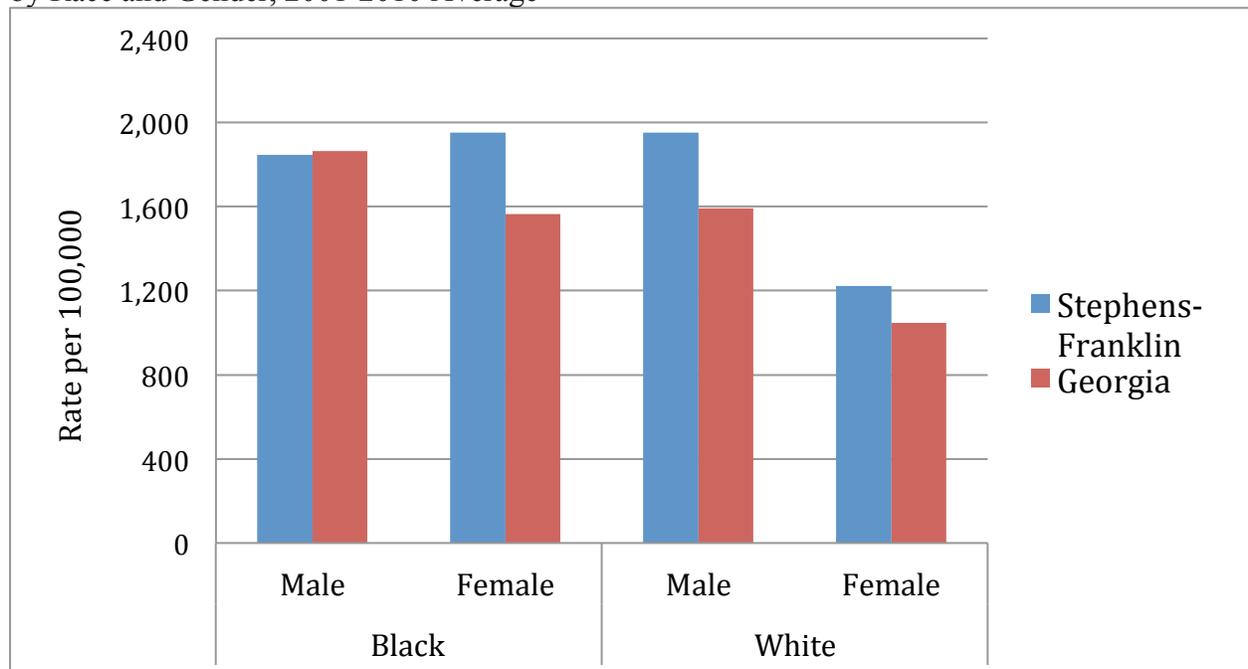
†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

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

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

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

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



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

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	8	183.8	155.9
White	19	40.1	33.3
Other	< 1	NSR	53.4
Total	28	51.8	64.7

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

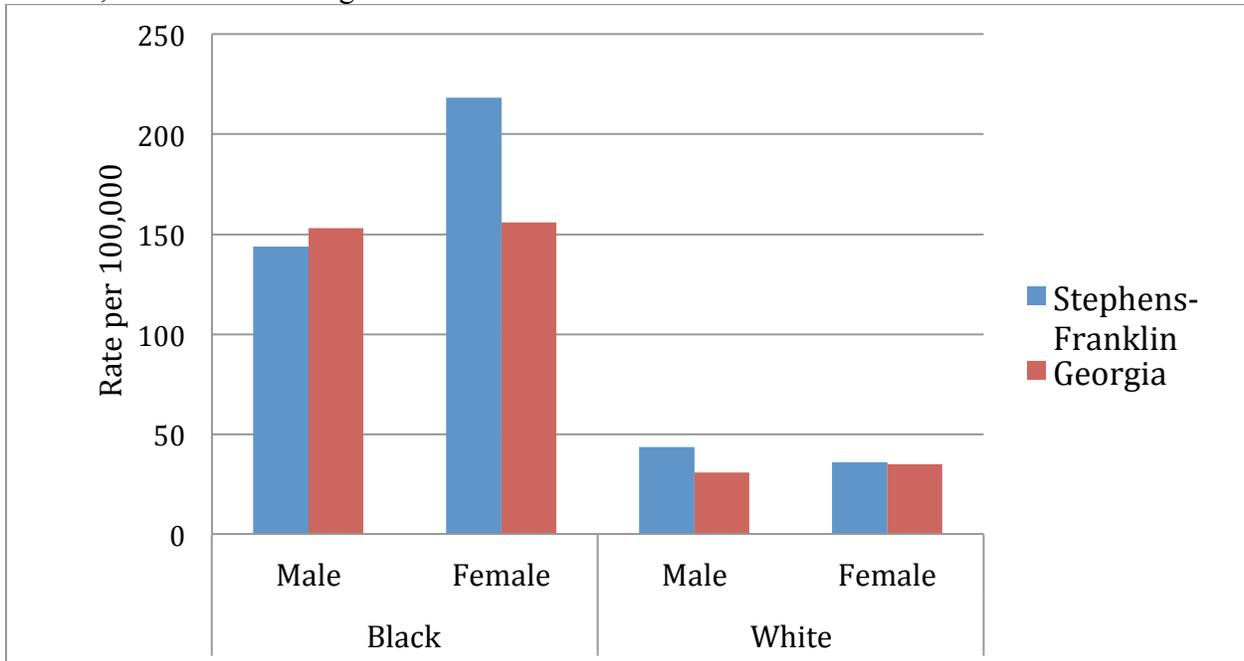
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

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

Hospital discharges for high blood pressure are highest among African Americans. Black females in the service area have the highest rate.

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



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

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	12	277.7	288.4
White	119	227.0	191.5
Other	1	149.6	226.5
Total	132	230.7	215.8

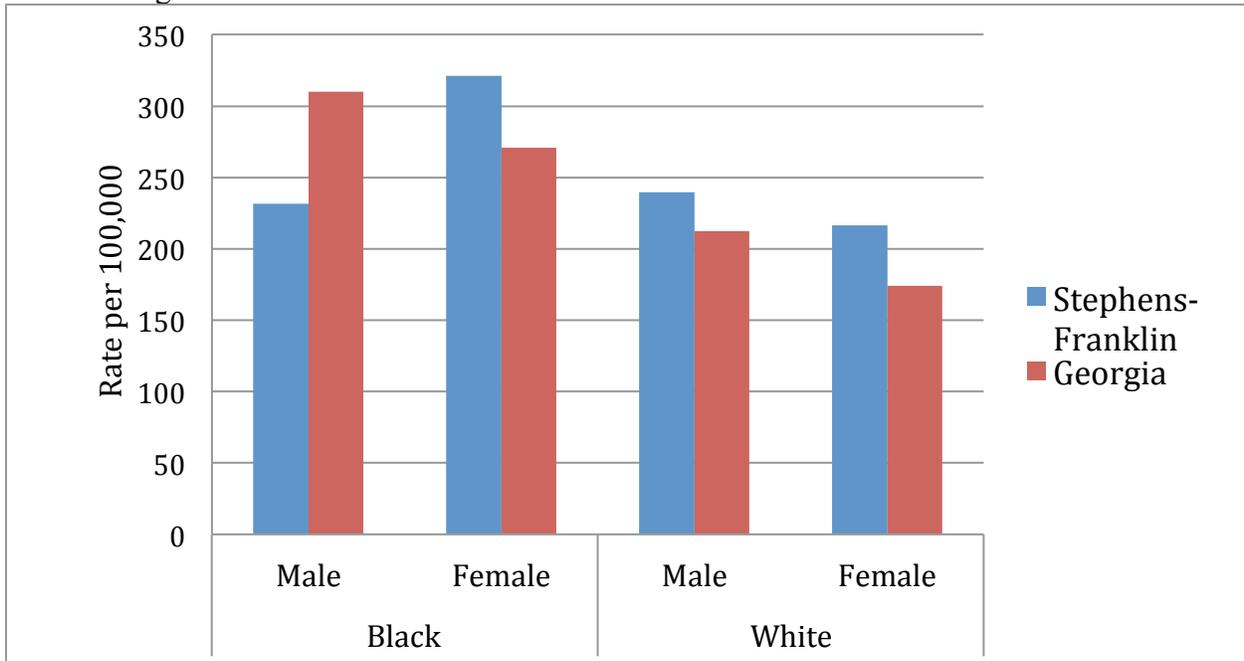
† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

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

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

The age-adjusted rates of stroke for the population are close to what would be expected given the age distribution of the hospital service area.

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



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

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

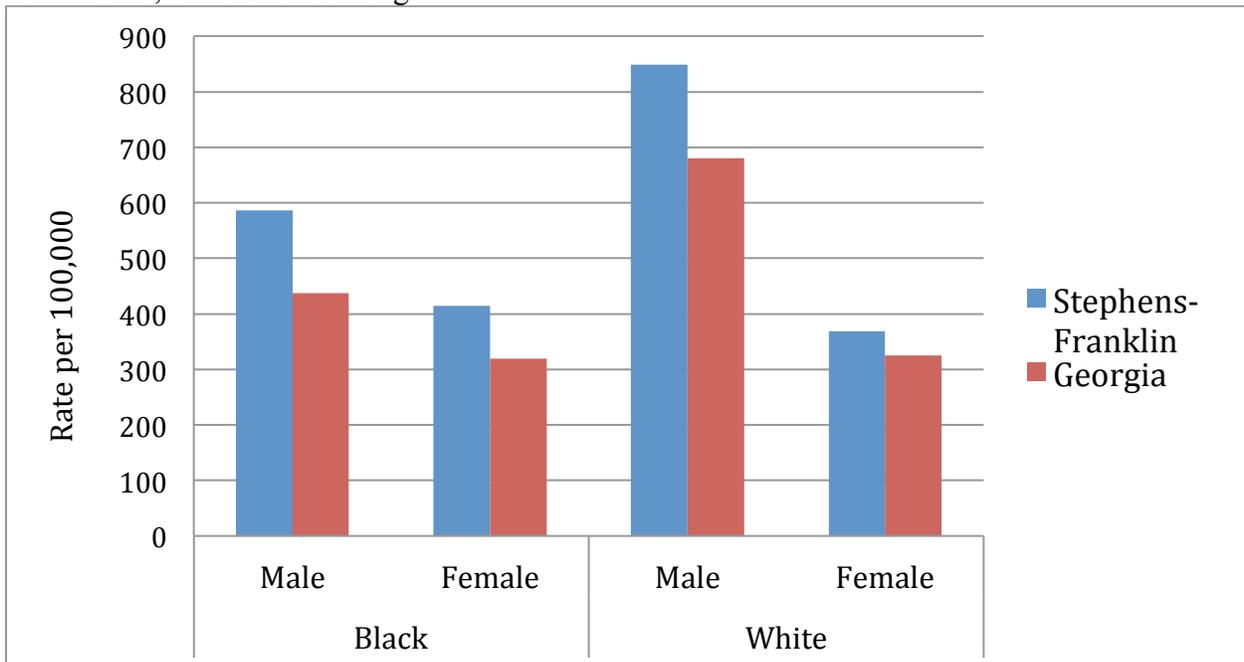
	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	23	492.0	370.3
White	307	588.3	489.8
Other	3	416.9	511.4
Total	332	579.7	463.1

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

[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Obstructive heart disease (OHD) includes hospital discharges from heart attacks. The rates of OHD are higher than the state averages. White males have the highest rates.

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



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

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

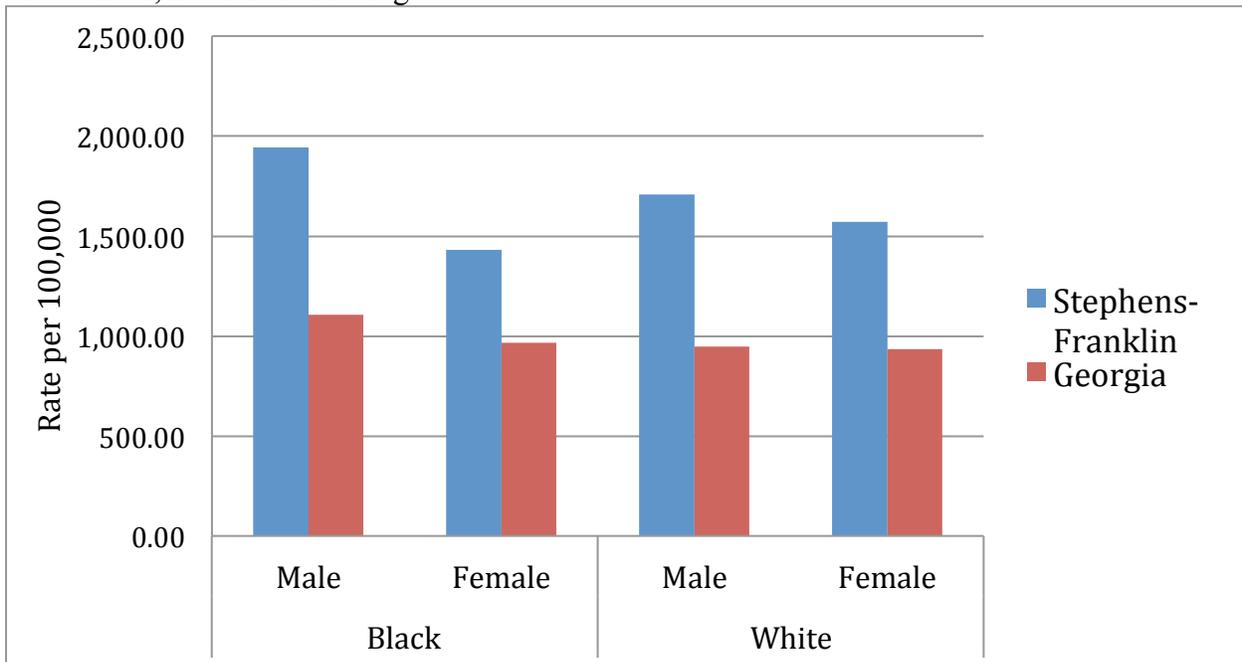
	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	75	1615.0	1018.1
White	760	1617.7	930.6
Other	3	361.3	692.3
Total	838	1592.3	956.4

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

‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of respiratory diseases for the population are more than 50% higher than the state averages. Rates are higher for all race and gender classifications.

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



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

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	15	303.6	164.1
White	70	185.4	85.2
Other	1	66.4	75.2
Total	86	192.5	108.0

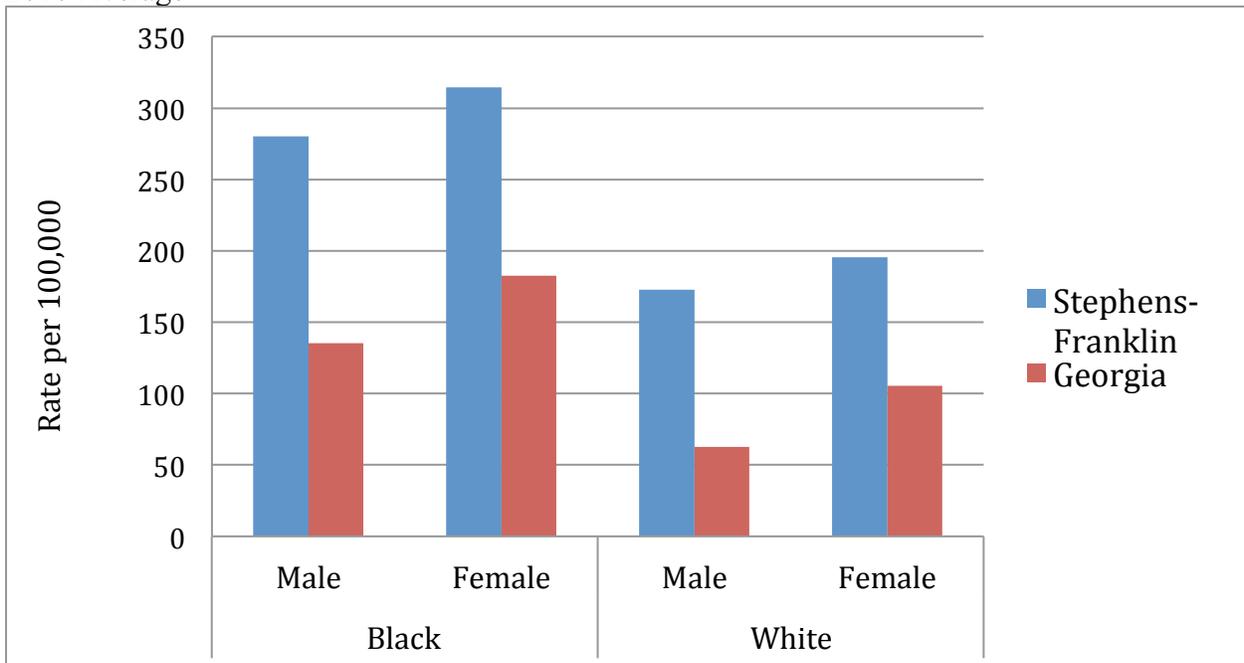
† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

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

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

The rates of asthma for the population are nearly 100% higher than the state averages. All races and genders are affected.

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



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

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

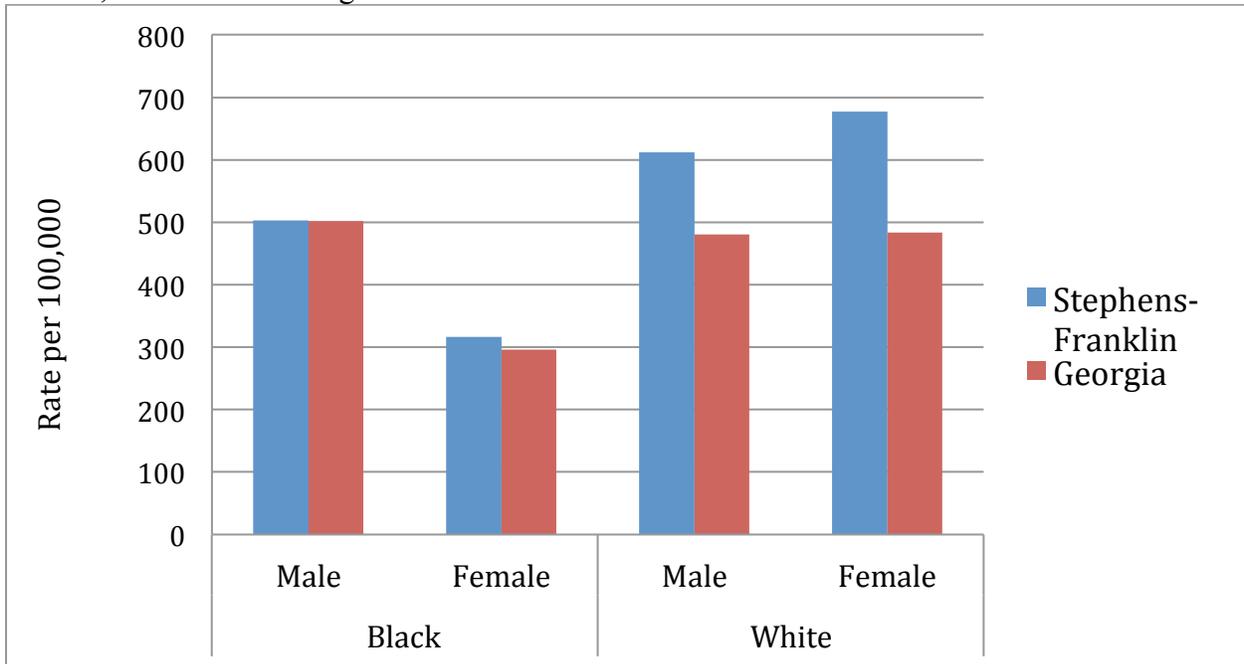
	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	19	402.5	395.7
White	305	664.8	496.5
Other	2	347.7	493.7
Total	326	636.4	477.2

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

‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

External causes of hospital visits include injuries from any type of accident, including both intentional and unintentional causes. The hospital discharge rates are similar to the states averages for blacks and higher for whites.

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



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

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

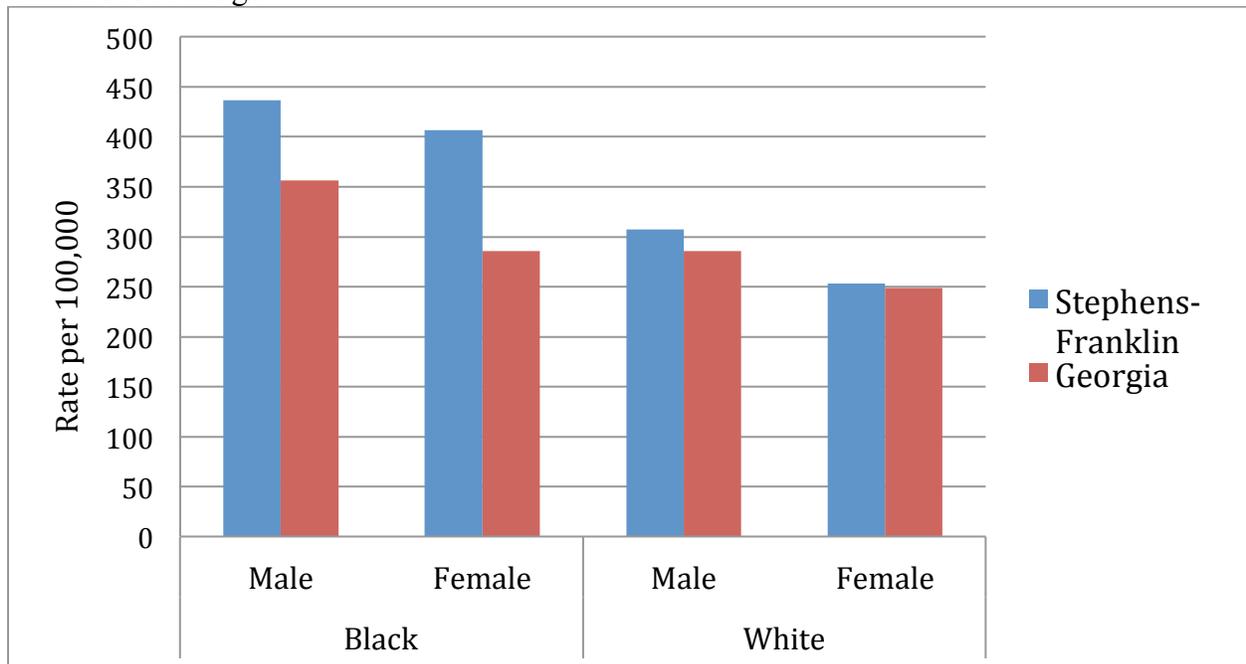
	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	19	411.3	311.1
White	142	274.2	262.7
Other	1	230.6	295.8
Total	162	284.8	275.2

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

‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The cancer rates are similar to the state averages. Black males and black females have higher rates than the state averages.

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



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

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

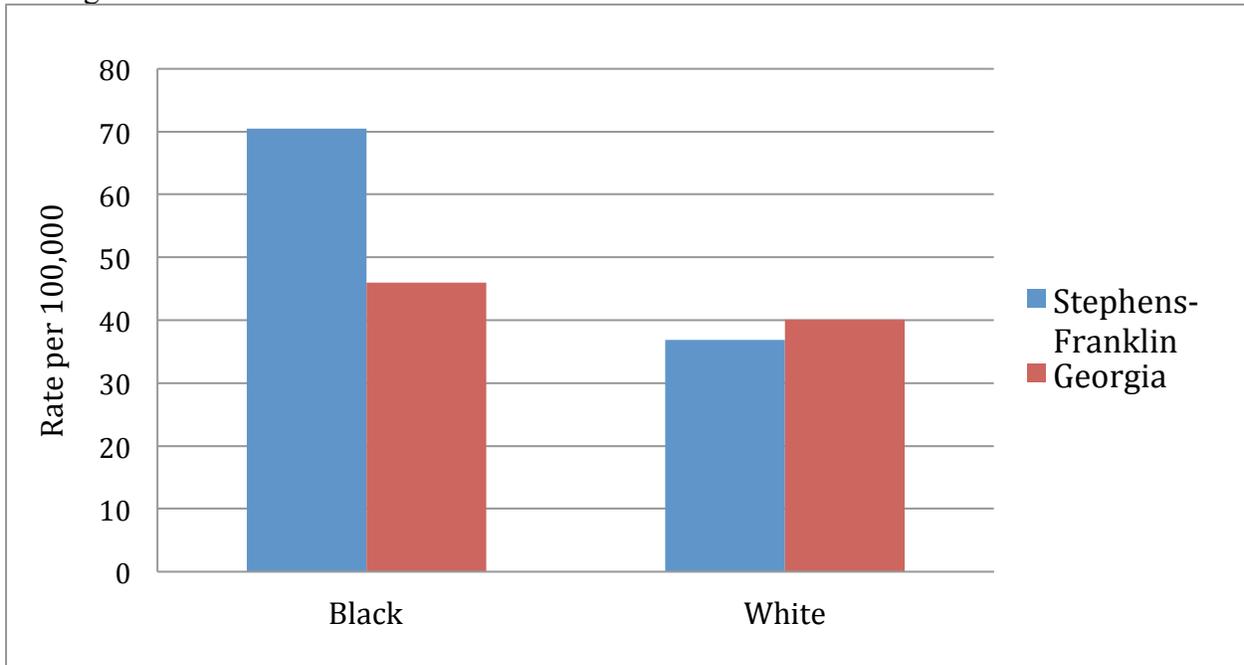
	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	70.5	46.0
White	10	36.9	40.1
Other	0	0.0	31.6
Total	12	39.4	41.5

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

‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The breast cancer hospital discharge rate is higher among African-American females.

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



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

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	98.5	64.4
White	8	30.8	39.1
Other	< 1	NSR	39.1
Total	10	36.1	44.1

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

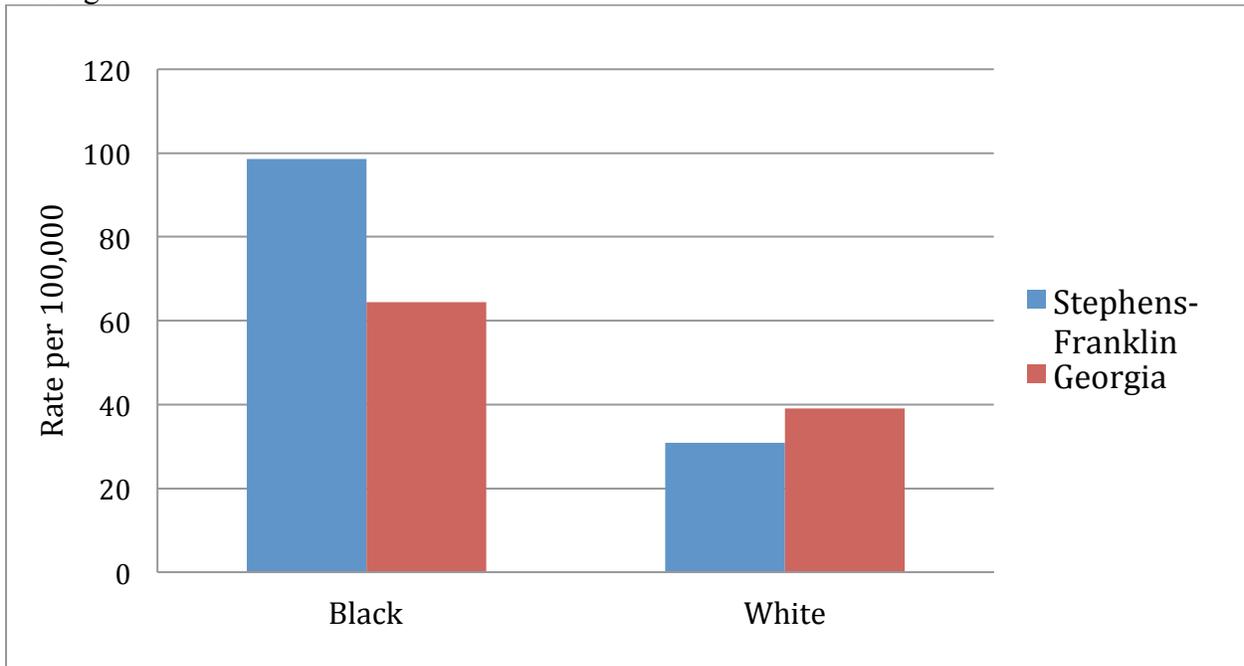
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

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

The rate of prostate cancer in the service area was higher than the state average for black males.

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



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

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

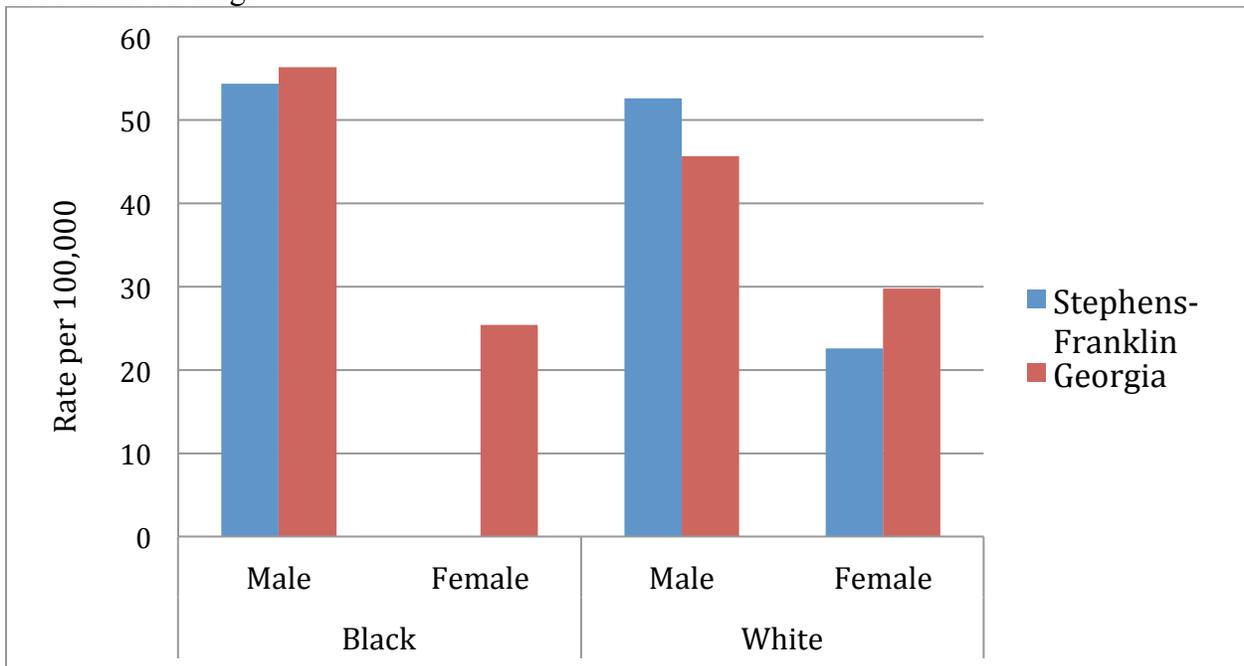
	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	1	26.4	37.3
White	19	35.4	36.6
Other	0	0.0	26.7
Total	20	34.4	36.6

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

[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of lung cancer were similar to the state averages. Rates are higher in males, possibly because of risky behaviors such as smoking. From 2001-2010, no African-American females in the service area were discharged from the hospital as the results of lung cancer.

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



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

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

	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	4	84.3	47.3
White	27	51.1	37.7
Other	< 1	NSR	44.5
Total	31	53.8	40.1

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

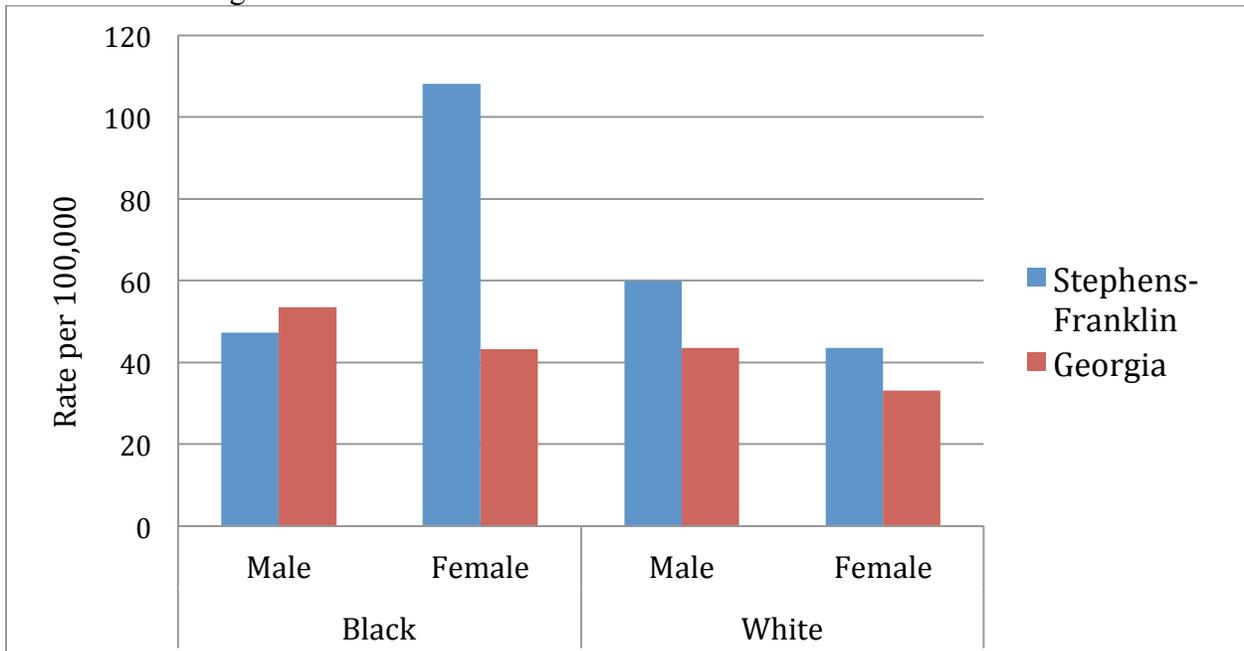
[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010

NSR: Not statistically reliable

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

The service area's rates of colon cancer are similar to the state averages except for black females. The rate of colon cancer among black females is more than 200% higher than the state average.

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



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

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

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	17	365.2	269.7
White	70	150.9	95.8
Other	1	71.8	106.5
Total	88	169.1	139.0

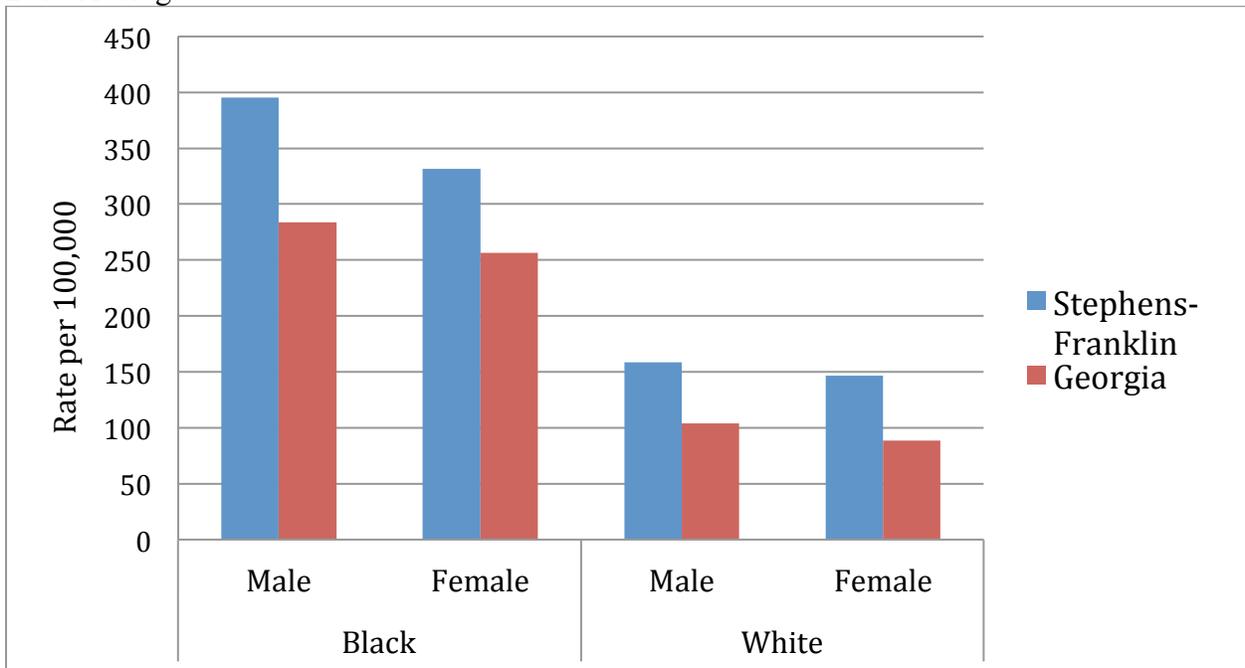
† Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.

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

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

The service area's rates of hospital discharges for diabetes are higher than the state averages.

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



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

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

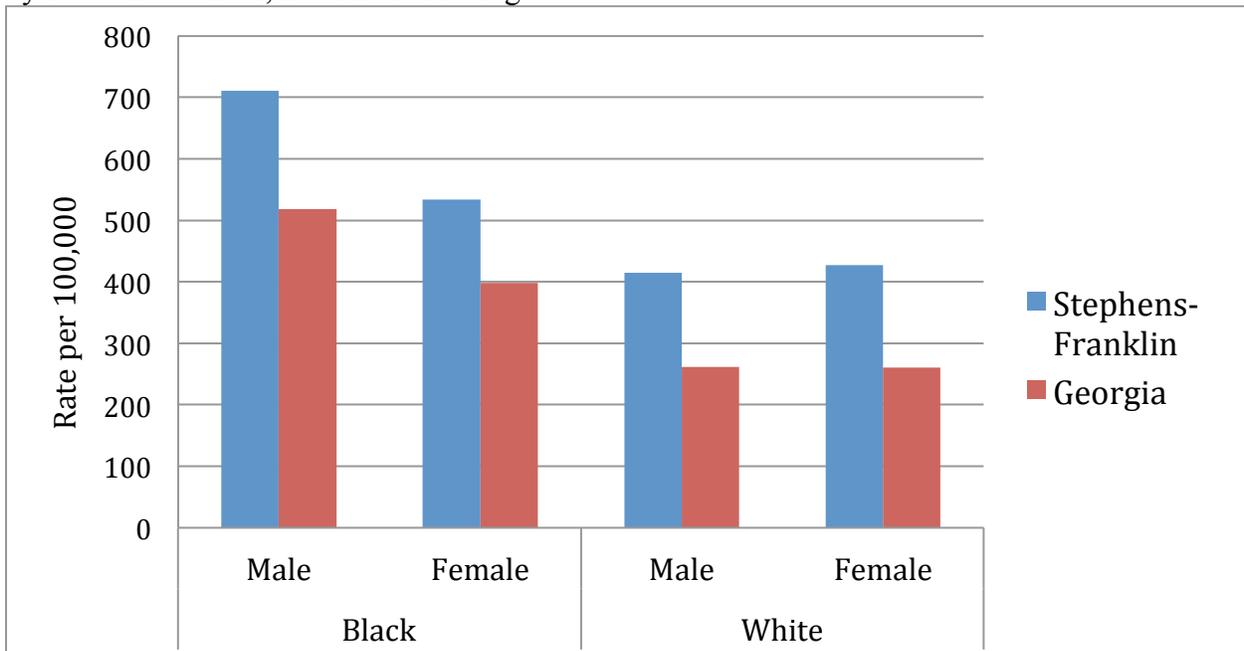
	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	27	592.8	449.0
White	190	418.5	260.5
Other	1	110.6	279.7
Total	218	427.8	310.1

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

‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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



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

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

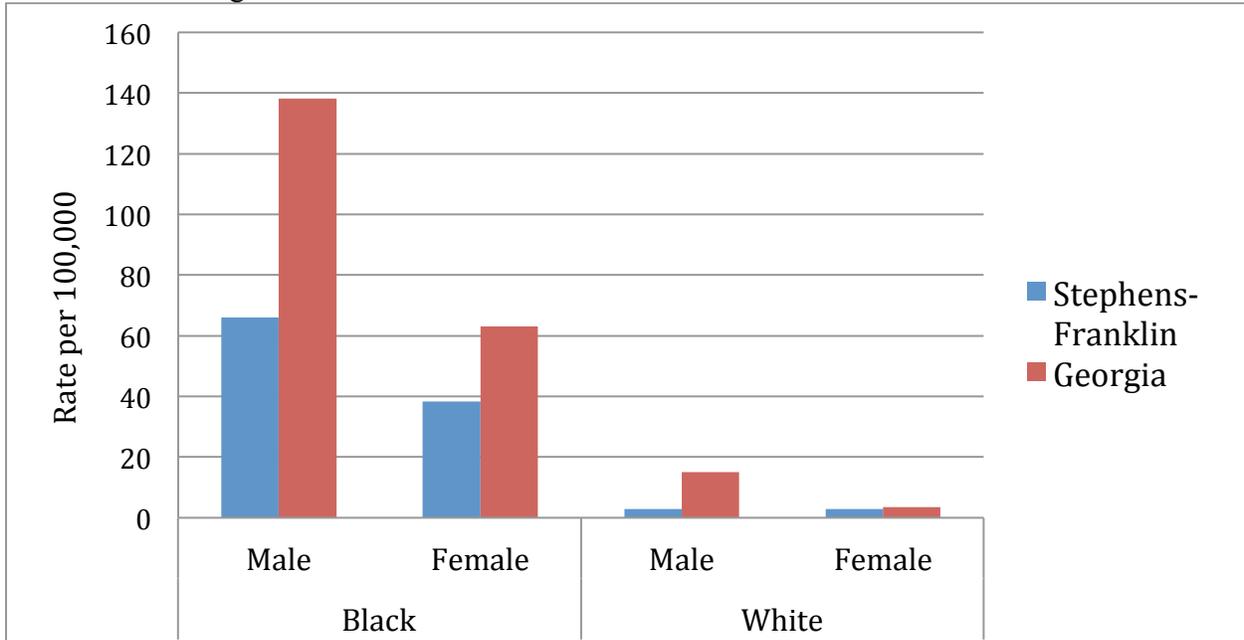
	Service Area (Discharges) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	52.1	97.2
White	1	2.9	9.3
Other	0	0.0	19.7
Total	3	7.8	35.6

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

[‡] Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
 Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

From 2001-2010, about three people per year went to the hospital as a result of HIV/AIDS. The rates of HIV/AIDS are lower than the state averages, but they still exist in the population.

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



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

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

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	45	935.4	1062.6
White	43	103.3	87.9
Other	1	70.5	69.4
Total*	144	304.3	626.2

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

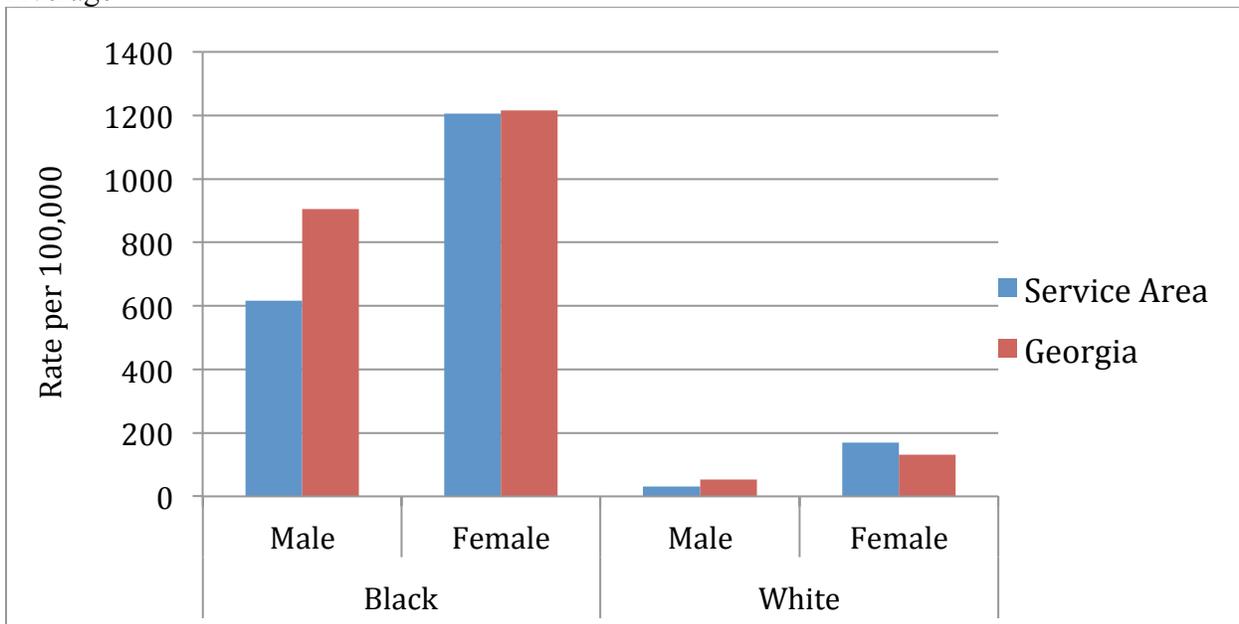
‡ Average STD Incidence rate from 2001-2010

* Total case number includes cases with unknown race

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

In general, females have higher rates of STDs. Two factors contribute to this phenomenon. 1) Female reproductive anatomy is more susceptible to contracting an STD, and 2) females are less likely to have symptoms for common STDs and therefore less likely seek treatment. The rates of STDs are similar to the state averages.

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



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

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

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	26	539.2	636.4
White	34	81.7	63.4
Other	< 1	NSR	46.4
Total*	102	215.3	416.1

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

‡ Average STD Incidence rate from 2001-2010

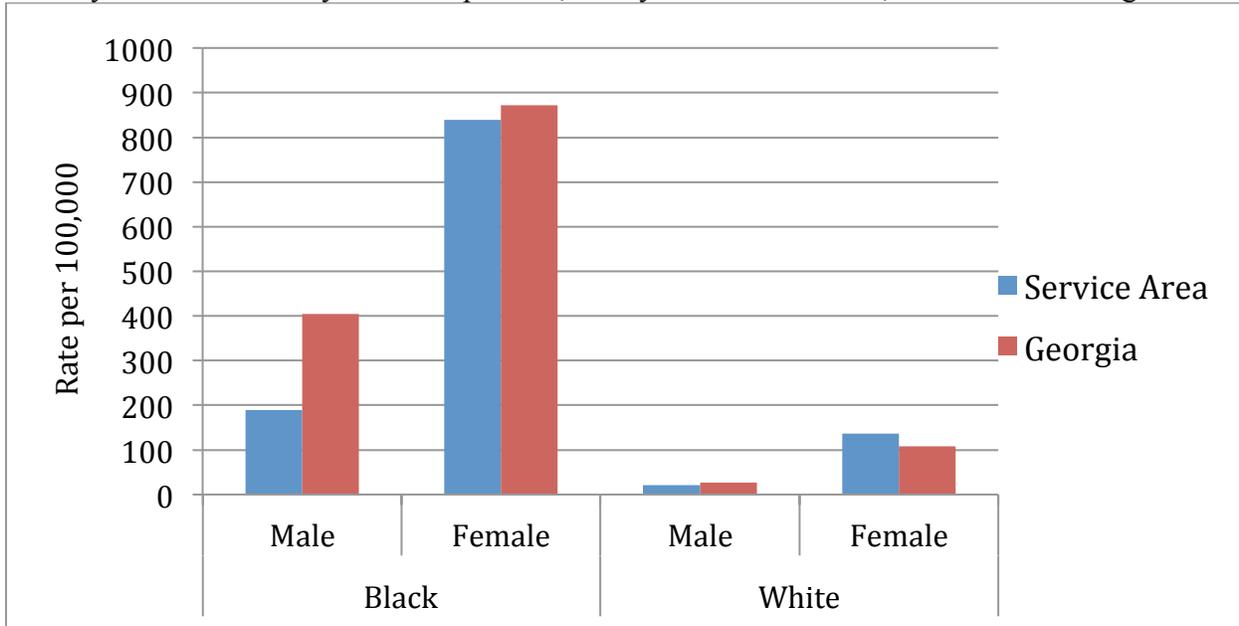
* Total case number includes cases with unknown race

NSR: Not statistically reliable

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

The chlamydia rate in the service area is similar to the state averages.

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



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

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

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	17	346.4	368.5
White	9	20.5	16.1
Other	< 1	NSR	16.8
Total*	39	82.6	186.0

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

‡ Average STD Incidence rate from 2001-2010

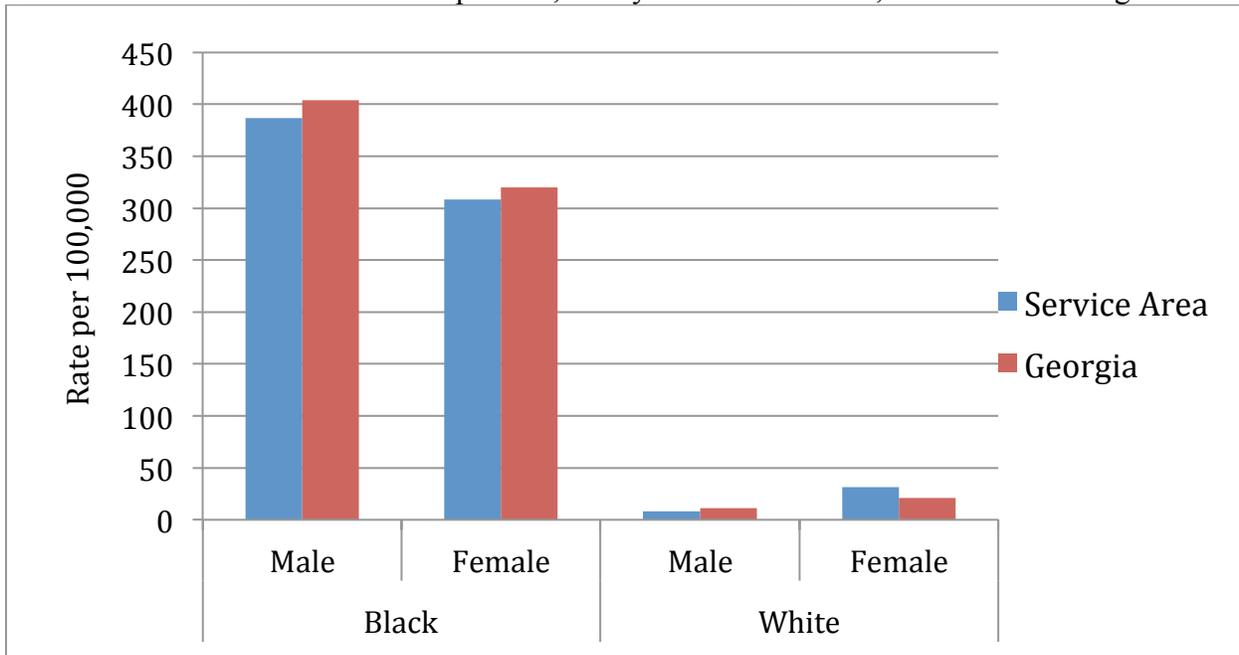
* Total case number includes cases with unknown race

NSR: Not statistically reliable

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

The gonorrhea rates are similar to the state averages.

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



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

Trends in Mortality

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	16	399.9	380
White	158	342.4	291.9
Other	< 1	NSR	100.0
Total	174	345.0	308.3

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

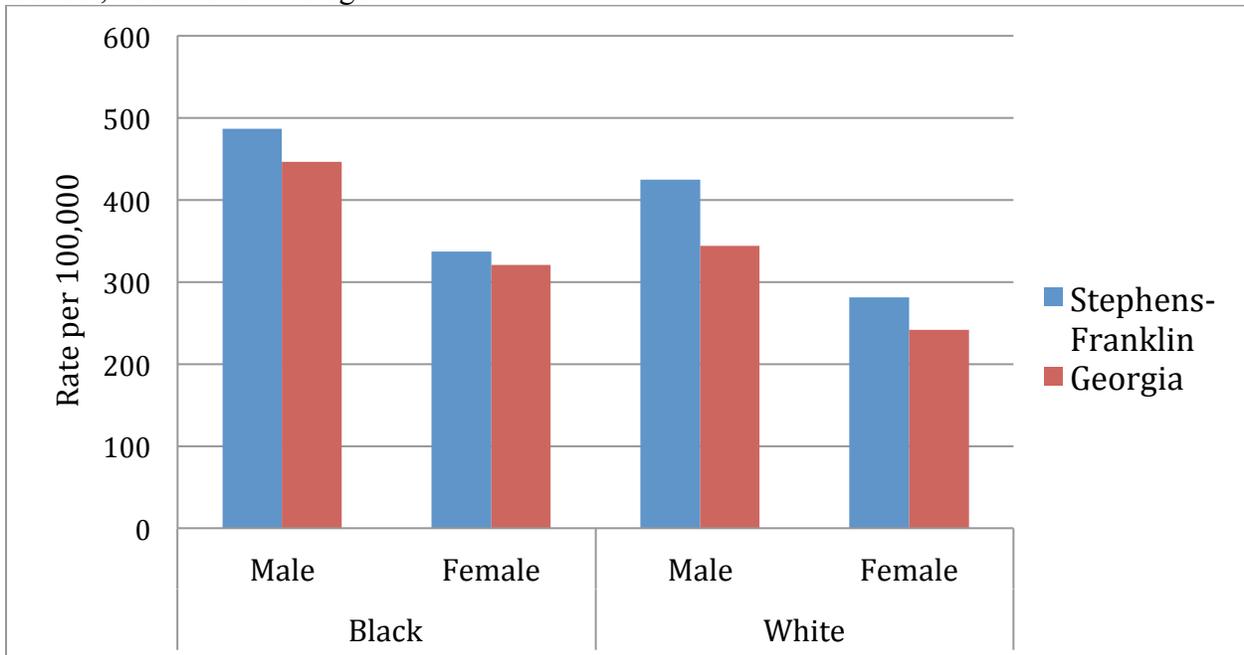
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

Major cardiovascular diseases include high blood pressure, obstructive heart failure, stroke, heart disease, and hardening of the arteries. As an aggregate, cardiovascular diseases are the largest cause of morbidity and mortality in the service area. The rates in the service area are similar to the state averages.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	4	90.3	74.2
White	27	58.5	51.5
Other	< 1	NSR	24.0
Total	31	60.9	56.2

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

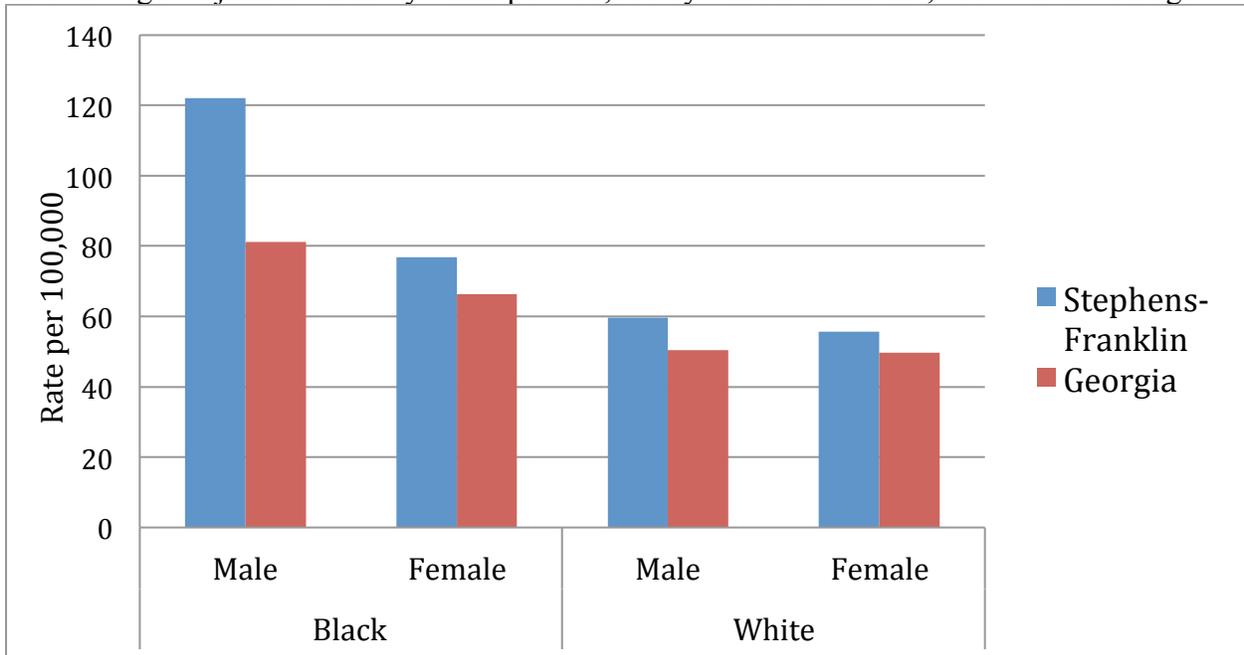
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

Black males have the highest rates of stroke in the service area. Their rate is 50% above the state average.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	1	24.4	25.4
White	3	6.4	8.7
Other	0	0.0	3.8
Total	4	7.7	12.1

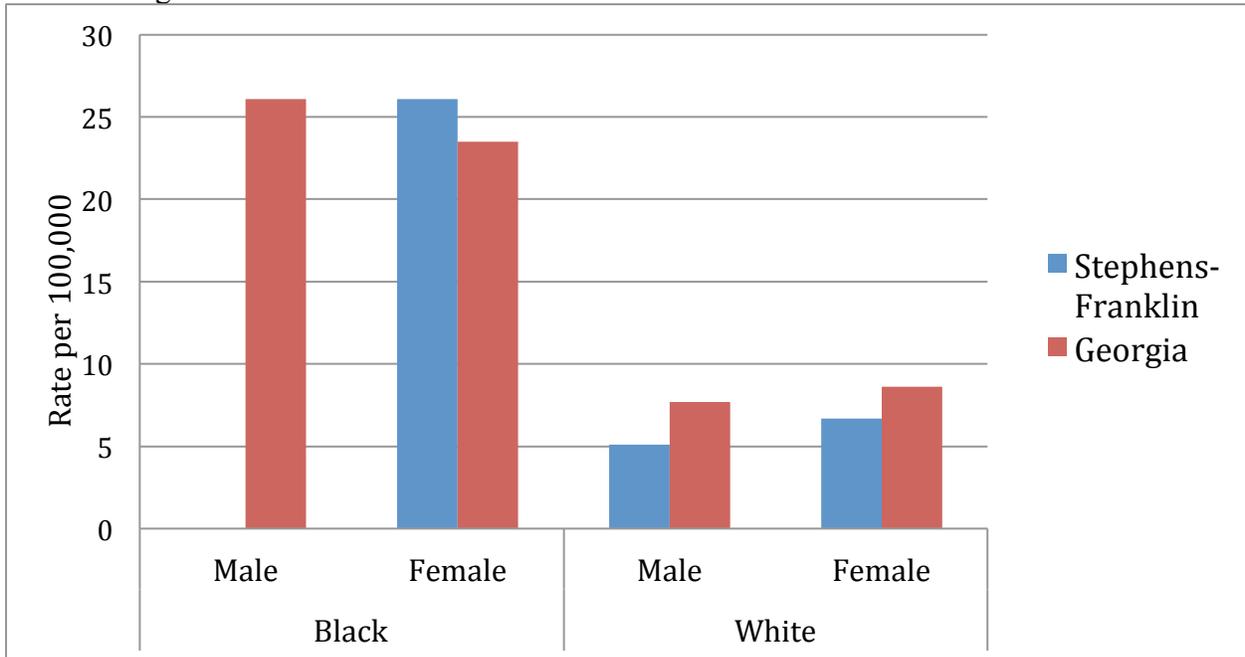
[†] Average number of deaths per year from 2001-2010

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

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

Mortality rates for blood pressure comprise a small proportion of deaths in comparison with other type of cardiovascular diseases. Since very few black males died from high blood pressure from 2001-2010, their mortality rate could not be calculated. The mortality rates for high blood are similar to the state averages.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	4	104.3	124.7
White	63	136.0	119.3
Other	< 1	NSR	35.8
Total	68	133.0	119.0

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

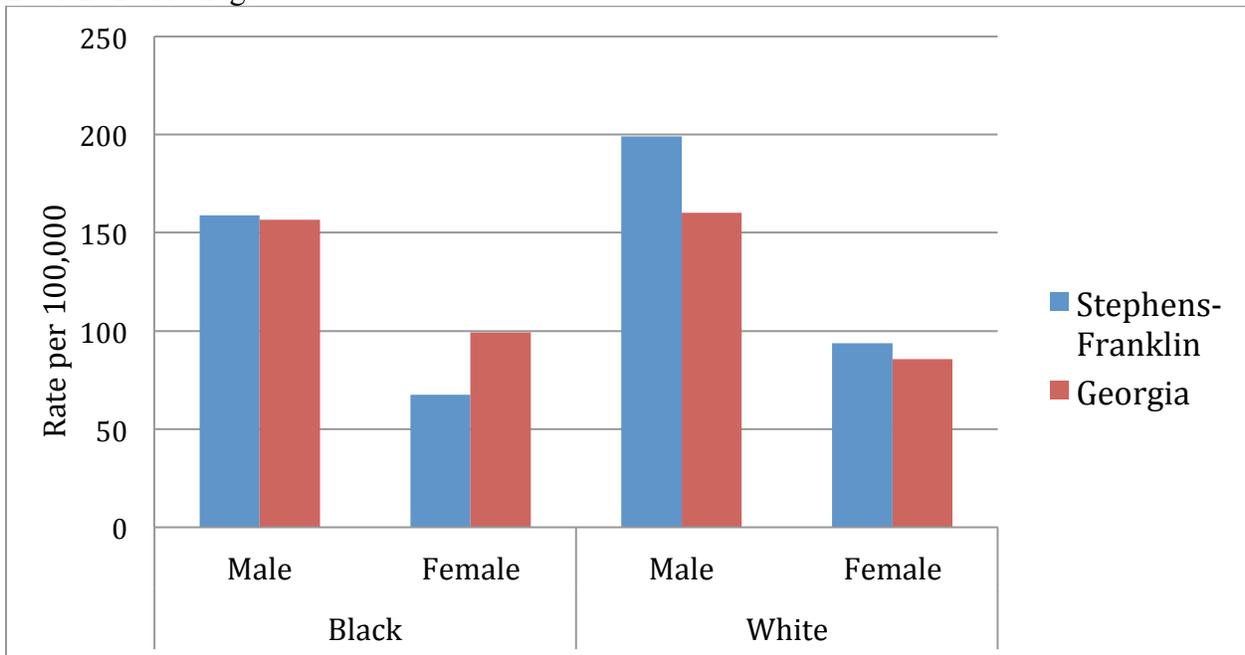
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

Obstructive heart disease (OHD) includes mortality from heart attacks. Rates of OHD are similar to the state averages.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	3	80.2	67.8
White	51	109.0	97.4
Other	0	0.0	22.9
Total	54	106.0	90.3

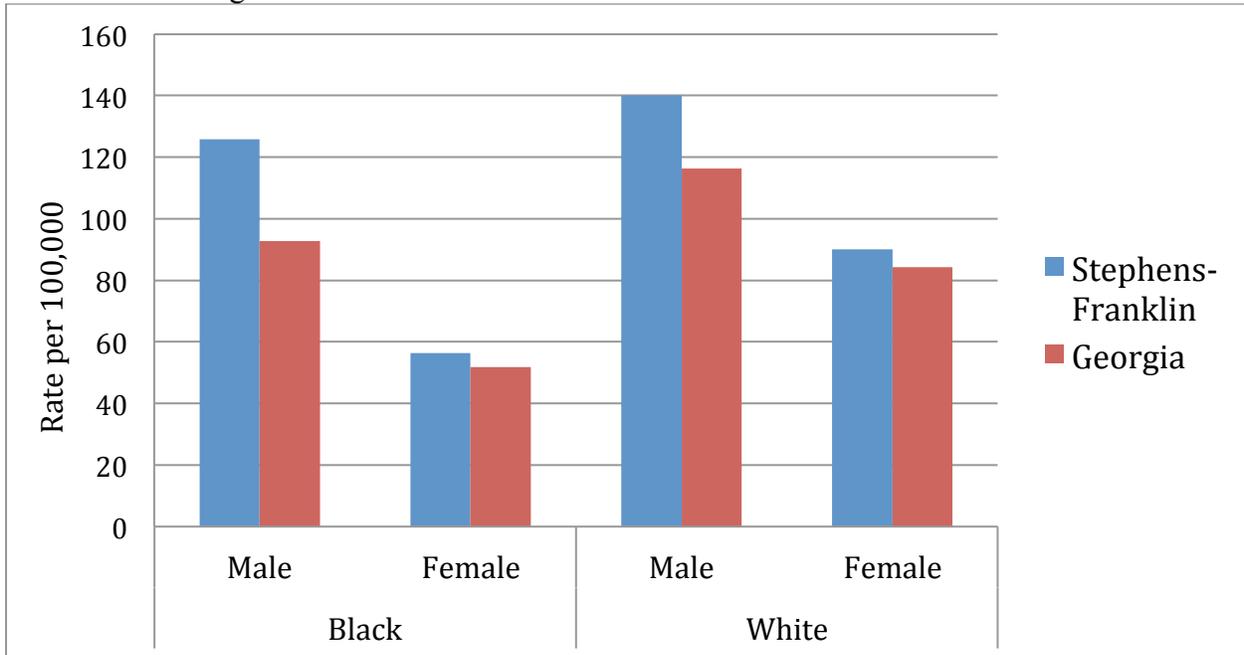
† Average number of deaths per year from 2001-2010

‡ Age-adjusted mortality rate from 2001-2010

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

The age-adjusted mortality rates in the service area are similar to the state averages.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	10	257.7	213.8
White	94	198.2	182.2
Other	< 1	NSR	71.6
Total	104	201.1	186.8

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

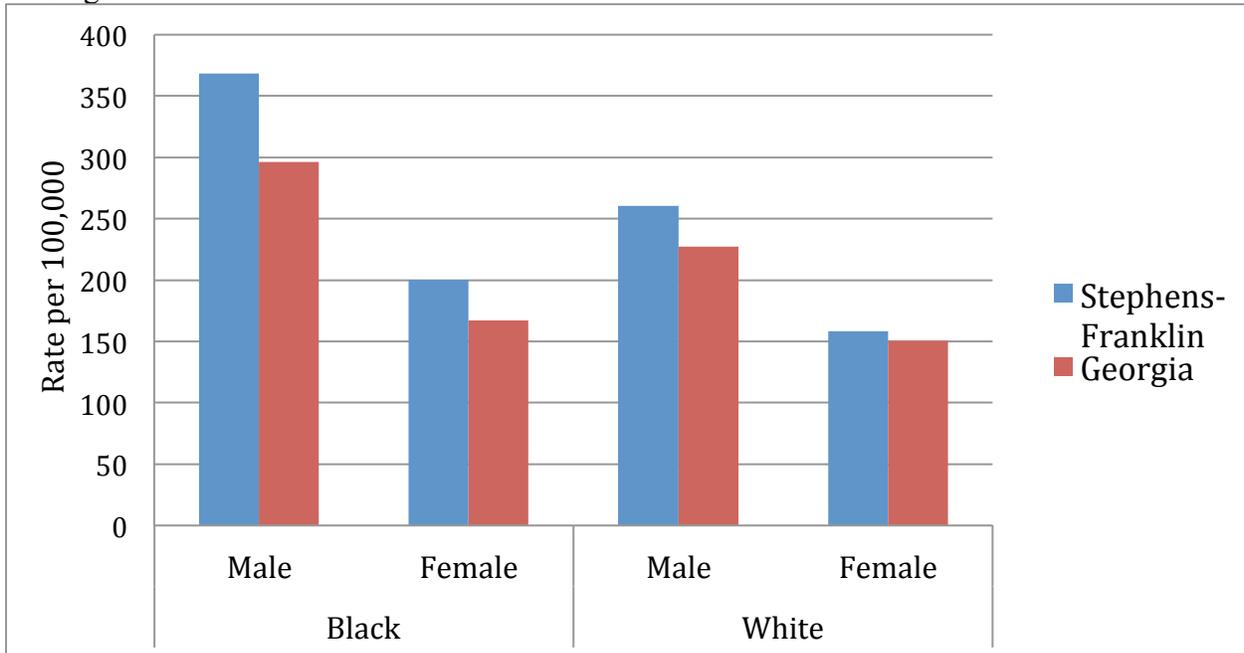
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

The age-adjusted mortality rates for the service area were similar to the state averages. On average, the service area experiences 104 cancer deaths per year.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	< 1	NSR	30.3
White	6	23.7	22.3
Other	0	0.0	7.6
Total	7	22.7	24.0

† Average number of deaths per year from 2001-2010

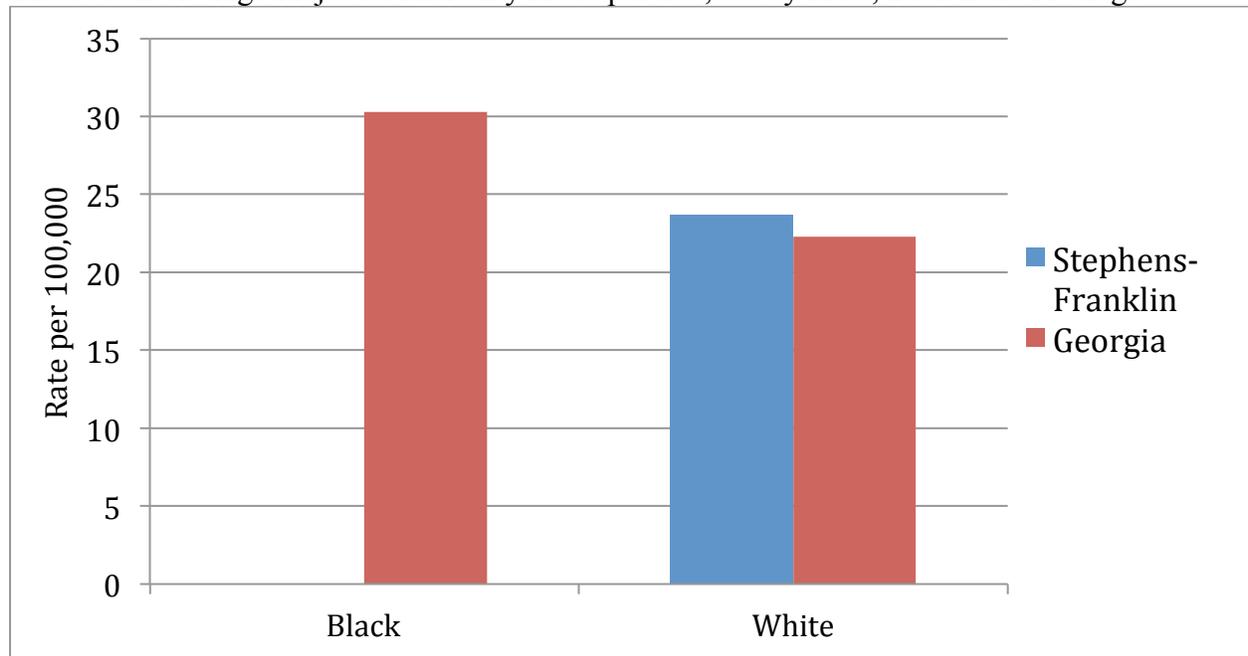
‡ Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

Breast cancer mortality rate in the service area is similar to the state average. On average, seven people die from breast cancer per year in the service area. Since from 2001-2010 there were less than one death per year among black females, the mortality rate could not be calculated for the figure.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	1	61.7	63.8
White	4	26.5	22.2
Other	0	0.0	7.1
Total	5	28.3	29.3

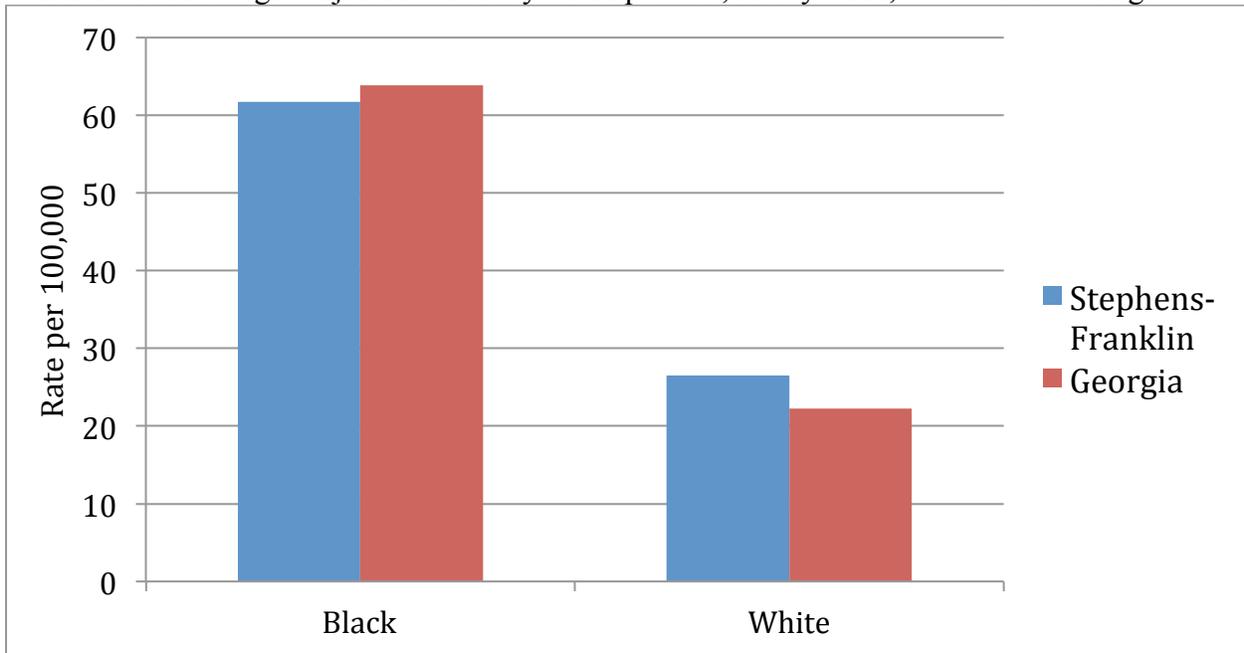
[†] Average number of deaths per year from 2001-2010

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

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

The age-adjusted mortality rates for prostate cancer in the area were similar to the state averages.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	38.2	24.4
White	11	22.7	16.1
Other	0	0.0	7.9
Total	12	24.0	17.7

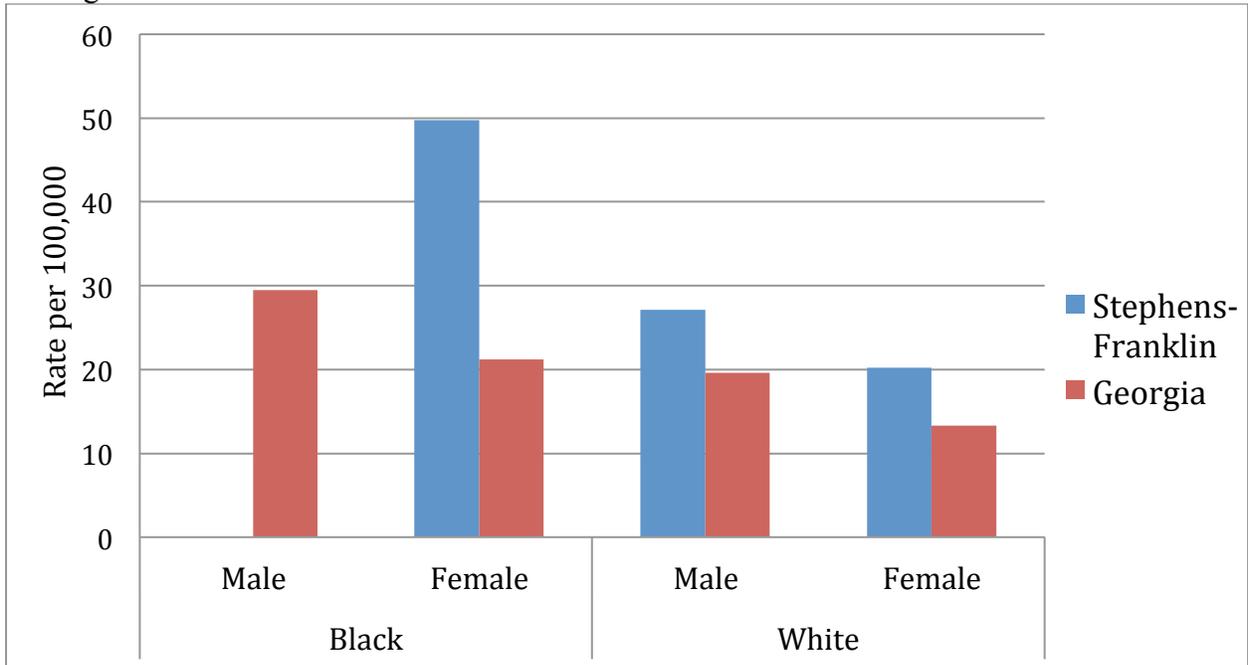
† Average number of deaths per year from 2001-2010

‡ Age-adjusted mortality rate from 2001-2010

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

The mortality rates for colon cancer higher than the state averages. Since there were less than one death per year from 2001-2010, the rate for black males could not be calculated.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	56.7	51.3
White	29	60.7	58.1
Other	< 1	NSR	16.0
Total	32	59.8	55.7

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

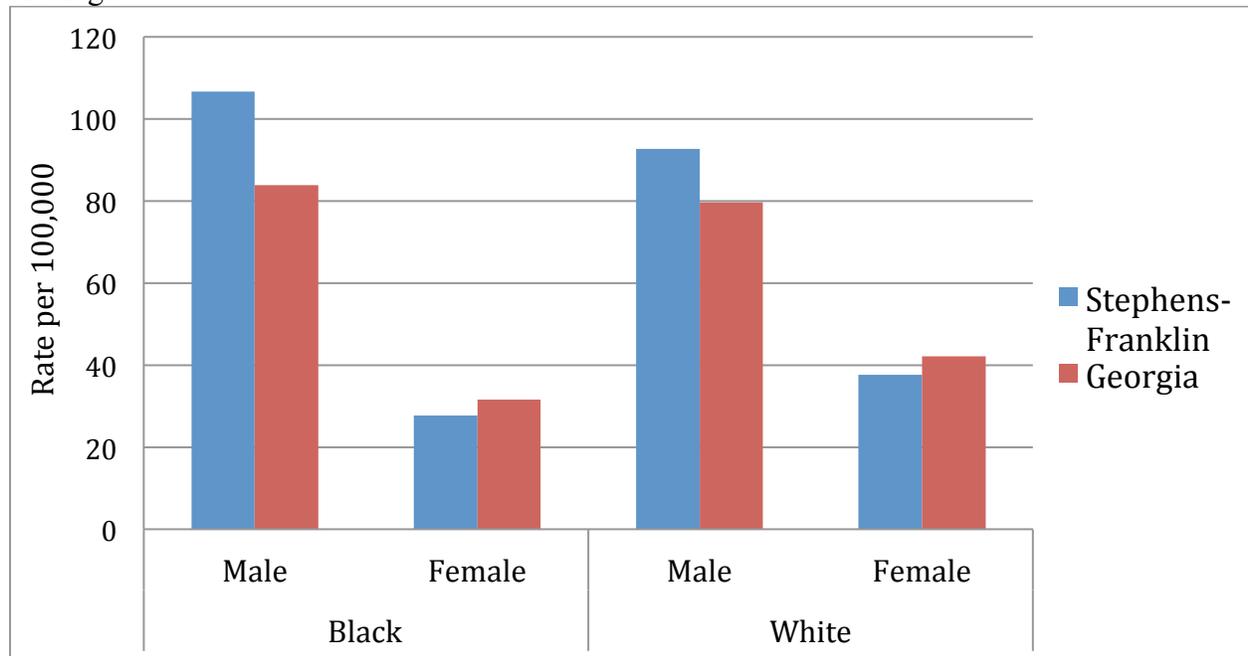
[‡] Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

The age-adjusted lung cancer death rates are similar to the state averages. The rates for males are nearly twice the rates for females. Health behaviors, such as smoking habits, could be the explanation for the difference.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	45.9	56.1
White	10	20.9	22.9
Other	0	0.0	9.5
Total	12	23.0	30.9

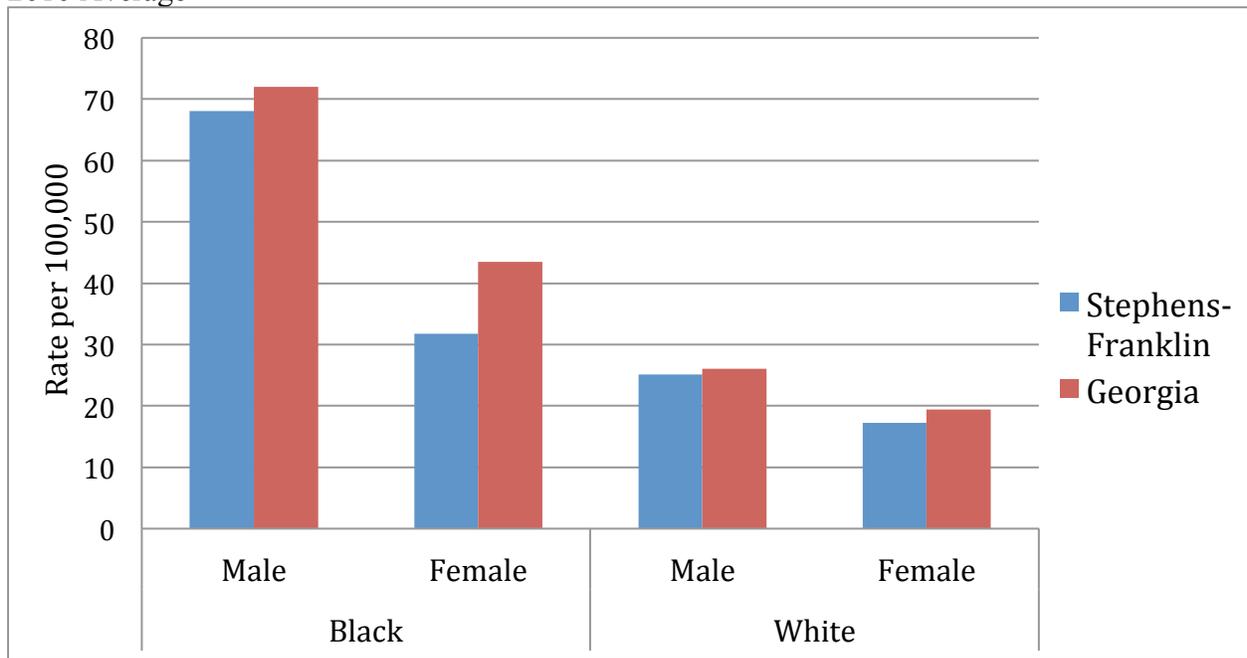
[†] Average number of deaths per year from 2001-2010

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

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

The mortality rates for infectious diseases are similar to the state averages. Rates for black males are 100% higher than any other category.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	< 1	NSR	19.7
White	< 1	NSR	2.3
Other	0	0.0	0.7
Total	1	1.7	7.1

† Average number of deaths per year from 2001-2010

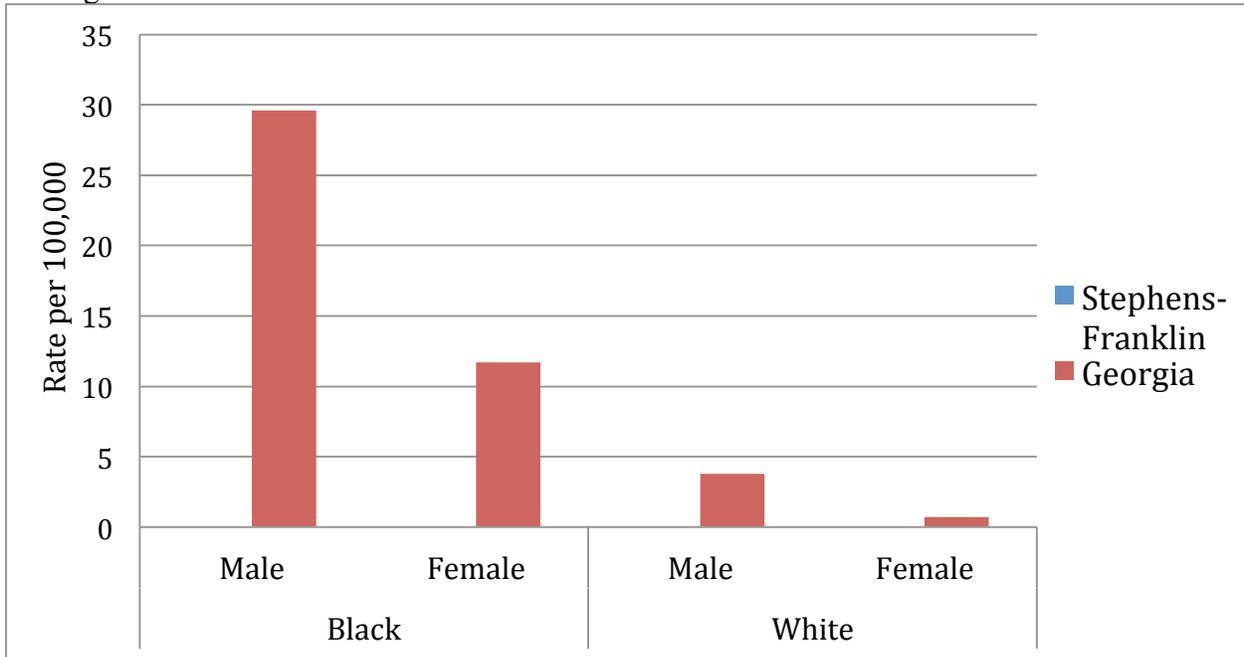
‡ Age-adjusted mortality rate from 2001-2010

NSR: Not statistically reliable

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

The service area experienced about one AIDS death per year over the last ten years. The rates for each race could not be calculated. As a result, the figure only displays the state rates.

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



* Insufficient number of deaths to calculate a rate

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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	2	51.3	38.4
White	9	18.4	17.4
Other	0	0.0	9.8
Total	11	21.0	21.7

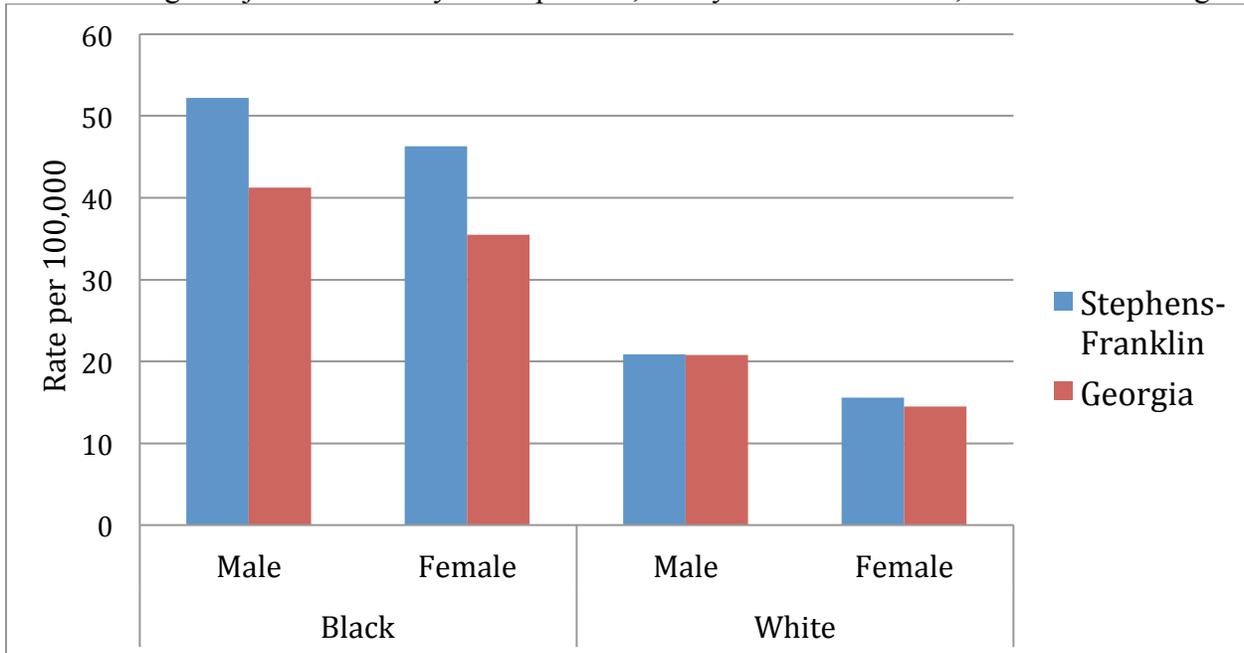
[†] Average number of deaths per year from 2001-2010

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

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

Both black males and black females have higher rates of diabetes mortality than the state averages.

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



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

Maternal and Child Health

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

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	4	7.7%	7.4%
White	15	4.0%	4.1%
Other	1	6.9%	4.0%
Total	19	4.5%	5.1%

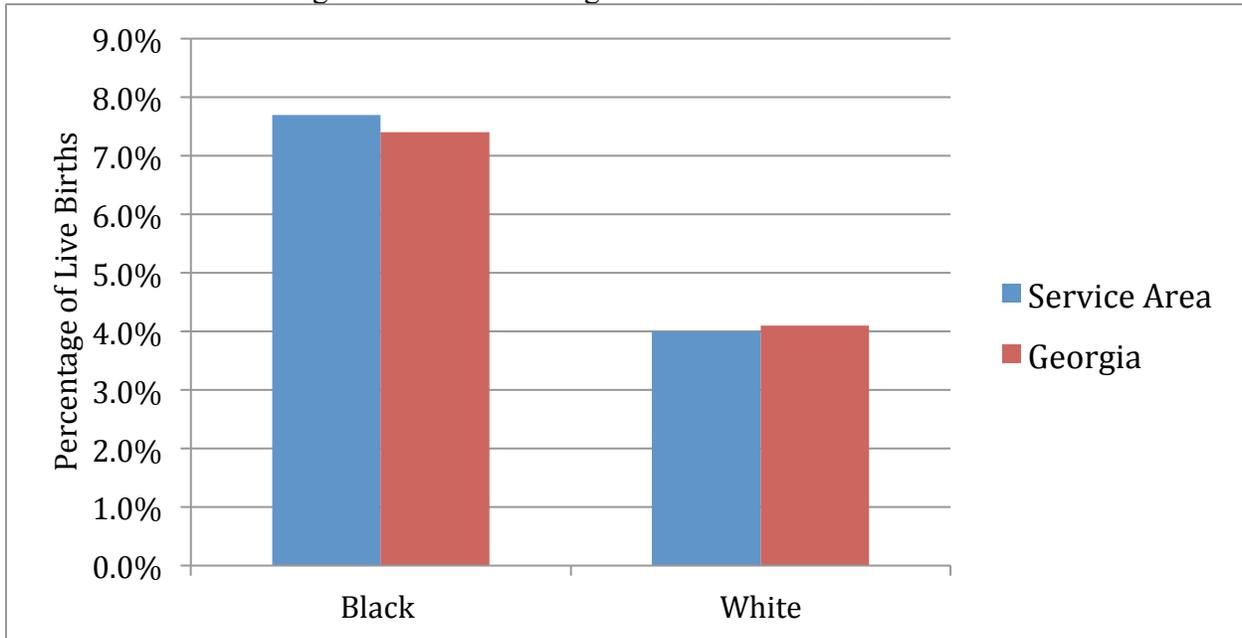
† Average number of births without at least 5 prenatal care visits per calendar year from 2001-2010.

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

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

The percentage of births receiving less than five prenatal care visits is similar to the state averages. African Americans are less likely to receive the recommended number of prenatal care visits.

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



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

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

	Service Area (Deaths) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	1	13.9	12.9
White	3	6.3	6.2
Other	< 1	NSR	11.7
Total	4	7.2	8.1

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

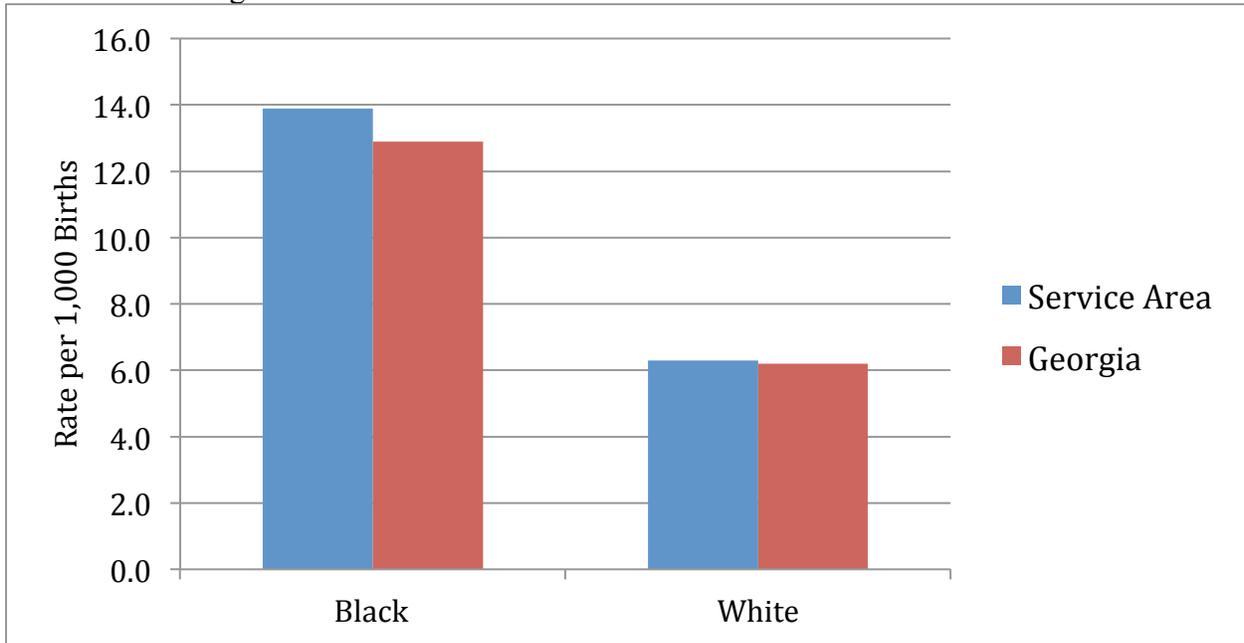
[‡] Average Infant Mortality Rate from 2001-2010

NSR: Not statistically reliable

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

The infant mortality rate in the service area is similar to the state average. African Americans in the service area have a higher infant mortality rate.

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



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

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

	Service Area (Births) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	11	14.6%	13.8%
White	43	8.1%	7.1%
Other	1	11.4%	8.4%
Total	55	9.0%	9.3%

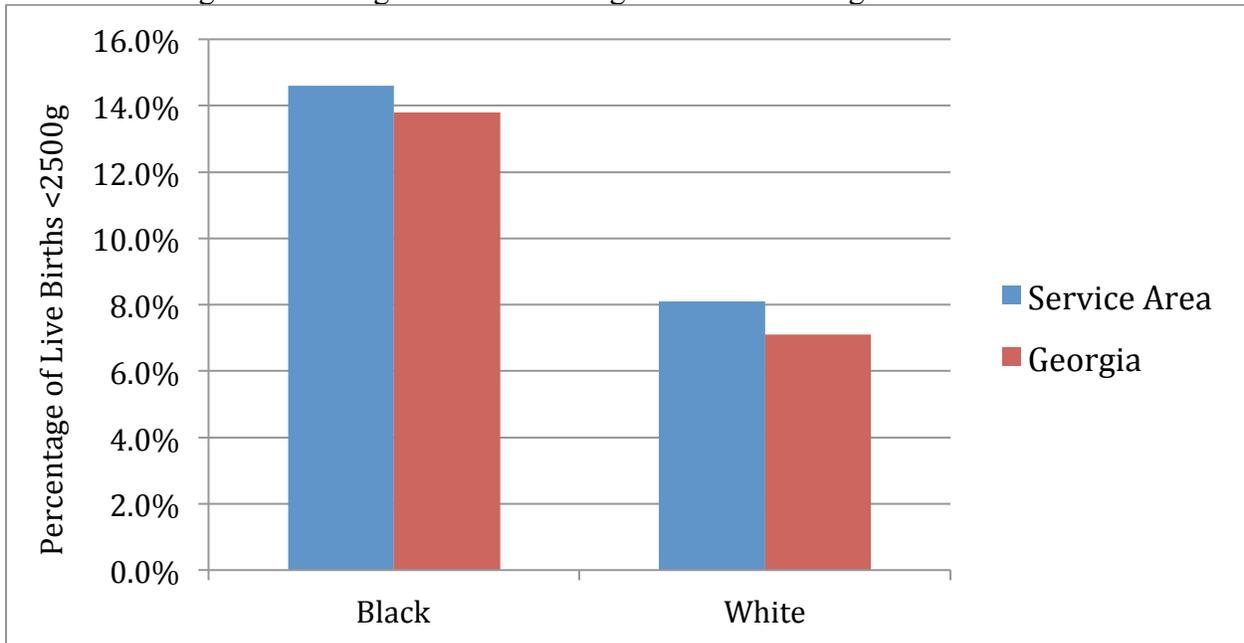
[†]Average number of low birth births per year from 2001 to 2010

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

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

The percentage of low birth weight babies is similar to the state average. As with prenatal care visits, African Americans have poorer outcomes than whites in the service area.

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



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

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

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	14.1%	14.8%
White	8	9.3%	8.5%
Other	< 1	NSR	10.6%
Total	10	10.0%	11.4%

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

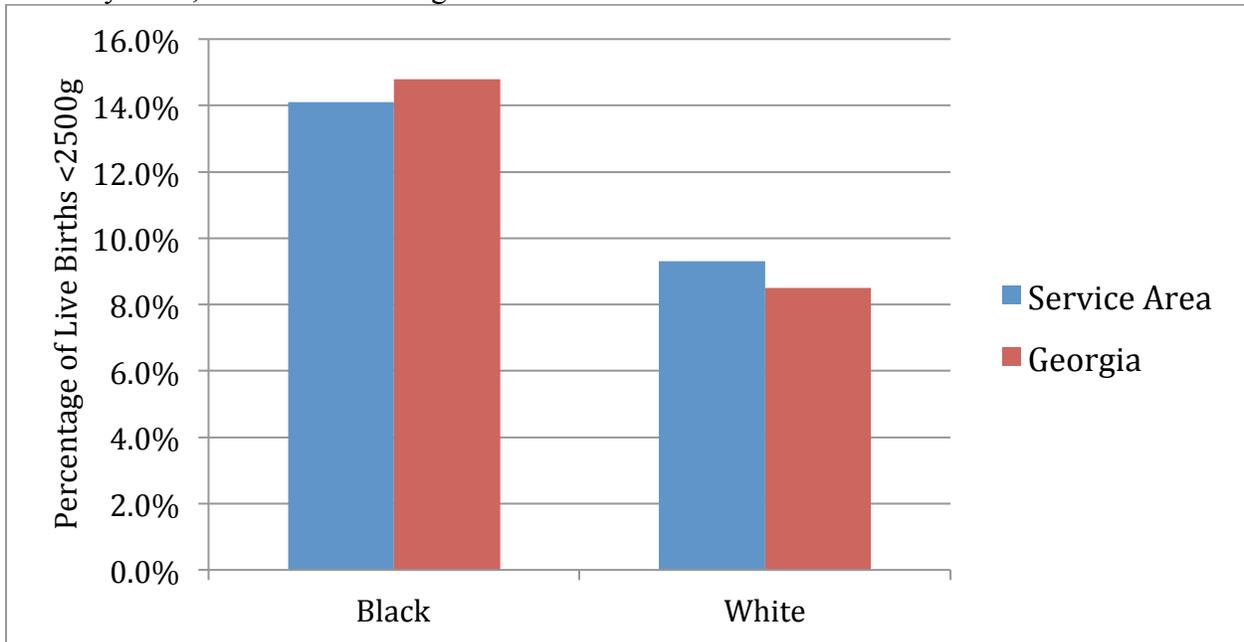
‡ Average Percentage of Birth below 2500g for mothers aged 10-19 from 2001-2010

NSR: Not statistically reliable

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

Teen mothers are those aged 10-19 years old. The proportion of teen mothers that had a child weighing less than 5lb 8oz is similar to the state average.

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



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

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

	Service Area (Births) [†]	Service Area (Rate) [‡]	Georgia (Rate) [‡]
Black	15	36.2	30.5
White	81	29.8	20.9
Other	1	13.9	31.8
Total	98	30.5	25.0

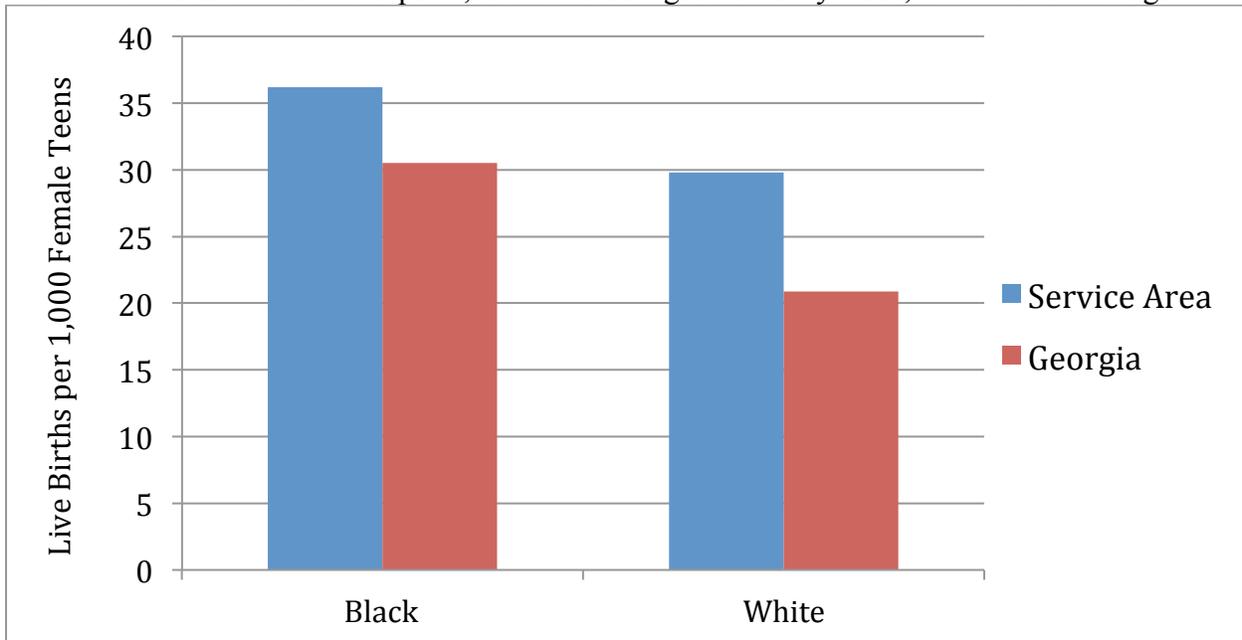
[†] Average number of births from 2001-2010

[‡] Average Teen Birth Rate from 2001-2010

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

The teen birth rates are higher than the state averages. On average, 98 births occur to teen mothers in the hospital service area.

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



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

RESULTS: COMMUNITY-BASED SURVEY

A total of 513 surveys were distributed in the community. Among these, 355 were completed and returned to Georgia Southern University for analysis thereby yielding a response rate of 69.2%. The distribution of surveys by zip code is displayed below. As indicated, five participants failed to report zip code (1.4%). As is the case with most survey work, missing values are most likely noted with all assessed variables. However, the remaining variables outlined below will not include missing data and the analysis will be limited only to those participants addressing a specific survey question. Therefore, table values not equaling 355 indicate the presence of missing values.

Distribution of Participants by Zip Codes

Zip Code	Frequency	Valid Percent
30577	239	67.3
30557	23	6.5
30538	38	10.7
30523	7	2.0
30553	7	2.0
Other	36	10.1
Missing	5	1.4
Total	355	100.0

Demographic Characteristics

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

Distribution of Participants by Gender

Gender	Frequency	Valid Percent
Male	117	33.1
Female	236	66.9
Total	353	100.0

As is typical with community-based efforts, considerably more females (66.9%) completed this survey than males (33.1%).

Distribution of Participants by Race/Ethnicity

Race	Frequency	Valid Percent
White, Non-Hispanic	318	90.6
Black/African-American	26	7.4
Hispanic/Latino	1	0.3
Asian/ Pacific Islander	3	0.9
American Indian/Alaskan	1	0.3
Other	2	0.6
Total	351	100.0

Most respondents were white (90.6%). This number is representative of the racial demographics observed for the service area.

Distribution of Participants by Age

Age	Frequency	Valid Percent
18-24	17	4.8
25-34	42	11.9
35-44	78	22.0
45-54	80	22.6
55-64	86	24.3
65+	51	14.4
Total	354	100.0

Nearly 57.0% of all participants completing the community-based survey were between the ages of 25 and 54 years old. Only 4.8% of participants were 18 to 24 years old, and 24.3% of participants were between the ages of 55 and 64. Approximately 14.4% of all participants were 65 years old or older.

Distribution of Participants by Marital Status

Marital Status	Frequency	Valid Percent
Single	50	14.1
Married	259	73.0
Separated	5	1.4

Stephens County Hospital: Community Health Needs Assessment

Living Together	5	1.4
Divorced	23	6.5
Widowed	13	3.7
Total	355	100.0

Most participants (73.0%) were married while 14.1% of participants were single. The relative proportions of other categories were minimal.

Distribution of Participants by Educational Status

Educational Level	Frequency	Valid Percent
< High School	17	4.8
High School/GED	100	28.3
Some College	108	30.6
Bachelor's Degree	65	18.4
Advanced Degree	47	13.3
Other	16	4.5
Total	353	100.0

Approximately 30.6% of respondents reported having some college education, and 28.3% of respondents reported having a high school diploma or the equivalent. Only 4.8% of respondents indicated they had less than a high school education.

Distribution of Participants by Employment Status

Employment Status	Frequency	Valid Percent
Student	8	2.3
Full-Time	199	57.5
Part-Time	26	7.5
Retired	58	16.8
Self-Employed	22	6.4
Unemployed	24	6.9
Not Seeking Employment	9	2.6
Total	346	100.0

Most survey participants (57.5%) indicated they worked full-time while only 7.5% reported part-time work. Approximately 6.9% of individuals completing the community-based survey reported being unemployed.

Distribution of Participants by Household Income

Household Income	Frequency	Valid Percent
< \$25,000	76	22.0
\$25,000-\$49,999	88	25.5
\$50,000-\$74,999	60	17.4
\$75,000-\$99,999	34	9.9
\$100,000+	44	12.8
Do Not Wish To Disclose	37	10.7
Don't Know/Not Sure	6	1.7
Total	345	100.0

Approximately 22.0% of participants reported household incomes of less than \$25,000 per year. Other income categories were fairly evenly distributed.

Distribution of Participants by Home Ownership Status

Home Ownership	Frequency	Valid Percent
Yes	272	77.1
No	81	22.9
Total	353	100.0

Most survey participants (77.1%) reported owning their home.

Distribution of Participants by Access to Transportation

Access To Transportation	Frequency	Valid Percent
Yes	339	97.1
No	10	2.9
Total	349	100.0

A considerable proportion of those surveyed reported having access to transportation (97.1%). However, it is important to note that this does not necessarily indicate they own transportation.

Distribution of Participants by Number of Dependents in the Household

Number Of Dependents	Frequency	Valid Percent
0	142	40.8
1	90	25.9
2	68	19.5
3+	48	13.8
Total	348	100.0

Most respondents indicated no dependents were living in the household (40.8%), but over 13.8% of those surveyed reporting having 3 or more dependents.

Community Perception

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

Individual Perception of Quality of Life in the Community

My Community Is A:		
Good Place To Live	Frequency	Valid Percent
Strongly Agree	99	31.1
Agree	179	56.3
No Opinion	25	7.9
Disagree	14	4.4
Strongly Disagree	1	0.3
Total	318	100.0

Among those surveyed, 87.4% of participants either “agree” (56.3%) or “strongly agree” (31.1%) that their community is a good place to live.

Individual Perception of the Economy

My Community Has:		
Strong Economic Growth	Frequency	Valid Percent
Strongly Agree	9	2.8
Agree	34	10.7
No Opinion	43	13.5

Disagree	165	51.9
Strongly Disagree	67	21.1
Total	318	100.0

However, most participants feel that economic growth in the community is not optimal. Among those responding to this survey, 73.0% of participants either “disagree” (51.9%) or “strongly disagree” (21.1%) that economic growth is adequate in their community.

Individual Perception of the Health Care System

My Community Has A:		
Strong Healthcare System	Frequency	Valid Percent
Strongly Agree	37	11.7
Agree	156	49.5
No Opinion	63	20.0
Disagree	52	16.5
Strongly Disagree	7	2.2
Total	315	100.0

Most participants “agree” (49.5%) or “strongly agree” (11.7%) the health care system is strong in their community.

Individual Perception of the Family Oriented Nature of the Community

My Community Is A:		
Good Place To Raise Children	Frequency	Valid Percent
Strongly Agree	70	21.9
Agree	180	56.3
No Opinion	47	14.7
Disagree	21	6.6
Strongly Disagree	2	0.6
Total	320	100.0

Among those responding to this survey, 78.3% of participants either “agree” (56.3%) or “strongly agree” (21.9%) that the community is a good place to raise children.

Individual Perception of Community Safety

My Community Is A:		
Safe Community	Frequency	Valid Percent
Strongly Agree	52	17.1
Agree	178	58.6
No Opinion	45	14.8
Disagree	27	8.9
Strongly Disagree	2	0.7
Total	304	100.0

Most participants agree that the community is a safe place to live. Approximately 75.7% of respondents either “agree” (58.6%) or “strongly agree” (17.1%) that the community is safe.

Individual Perception of the Educational System

My Community Has A:		
Strong Education System	Frequency	Valid Percent
Strongly Agree	63	19.7
Agree	159	49.7
No Opinion	60	18.8
Disagree	30	9.4
Strongly Disagree	8	2.5
Total	320	100.0

The educational system of the community ranked fairly high. Over 69.0% of those responding indicated that they either “agree” (49.7%) or “strongly agree” (19.7%) that the community has a solid educational system.

Behavioral Patterns

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

Perception of Individual Health Status

Perceived Health Status	Frequency	Valid Percent
Excellent	40	11.6
Very Good	108	31.2
Good	151	43.6
Fair	35	10.1
Poor	10	2.9
Don't Know/Not Sure	2	0.6
Total	346	100.0

Approximately 43.6% of respondents perceived their health status to be “good” and 31.2% perceived their health status to be “very good”. Only 11.6% of participants stated their health status was “excellent”.

Distribution of Patterns of Exercise

Level Of Exercise	Frequency	Valid Percent
Not At All	22	6.4
Occasionally	140	40.8
1-2 Times/Week	69	20.1
3-4 Times/Week	75	21.9
5+ Times/Week	37	10.8
Total	343	100.0

Over 47.0% of respondents reported either not exercising (6.4%) or only occasionally exercising (40.8%). Only 10.8% of those participating in this survey reported exercising 5 or more times per week.

Distribution of Monthly Self-Breast Exam

Self-Breast Exam	Frequency	Valid Percent
Yes	129	58.1
No	93	41.9
Total	222	100.0

Only female participants were asked to respond to the question concerning monthly self-breast examination. According to those surveyed, 58.1% of women reported completing a self-breast examination.

Distribution of Tobacco Use

Tobacco Use	Frequency	Valid Percent
Yes	78	22.4
No	270	77.6
Total	348	100.0

Most participants (77.6%) reported not using tobacco.

Distribution of Alcohol Use

Alcohol Use	Frequency	Valid Percent
Not At All	193	55.9
Occasionally	113	32.8
1-2 Times Each Week	26	7.5
3-4 Times Each Week	9	2.6
5 Or More Times Each Week	4	1.2
Total	345	100.0

Nearly 89.0% of participants reported never consuming alcohol (55.9%) or only consuming it occasionally (32.8%).

Distribution of Seat Belt Use

Seatbelt Use	Frequency	Valid Percent
Always	284	81.6
Mostly	46	13.2
Sometimes	15	4.3
Never	3	0.9
Total	348	100.0

The distribution of seatbelt use in the community is very high. Most participants reported always (81.6%) or mostly (13.2%) using seatbelts.

Distribution of the Perception of Diet

Diet	Frequency	Valid Percent
High Fat	20	5.7
Medium Fat	172	49.1
Low Fat	85	24.3
5 Servings Of Fruits/Vegetables Daily	45	12.9
2-4 Servings Of Fruits/Vegetables Daily	141	40.3
Rarely Eat Fruits/Vegetables	13	3.7

Participants were asked to indicate any all aspects of their personal diet that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Forty nine percent of respondents indicated their diet was medium in fat content. Over 40.0% of those surveyed reported consuming 2 to 4 servings of vegetables each day.

Strategies for Controlling Stress

Controlling Stress	Frequency	Valid Percent
Exercise	149	42.6
Hobbies/Sports	100	28.6
Eat More Than Usual	48	13.7
Eat Less Than Usual	8	2.3
Smoke	24	6.9
Alcohol/Drugs	10	2.9
Medication	30	8.6
Talk To Friends	123	35.1
Talk To Counselor	8	2.3
Direct It To Others	12	3.4
Prayer	214	61.1
Other	32	9.1

Participants were asked to indicate any all mechanisms of coping with stress that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Prayer (61.1%) was the most commonly reported strategy for controlling stress.

However, talking to friends (35.1%), exercise (42.6%), and hobbies/sports (28.6%) were also commonly reported to control stress.

Healthcare Seeking Behavior

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

Distribution Reporting to Receive Regular Physicals

Regular Physicals	Frequency	Valid Percent
Yes	273	79.1
No	72	20.9
Total	345	100.0

The majority of survey participants (79.1%) indicated they received physicals on a regular basis.

Distribution Reporting to Have a Regular Doctor

Regular Doctor	Frequency	Valid Percent
Yes	291	85.3
No	50	14.7
Total	341	100.0

Most (85.3%) participants reported having a regular doctor.

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

Distribution of Insurance Type

Insurance Type	Frequency	Valid Percent
Uninsured	36	10.5
Pay Out Of Pocket	26	7.6
Medicaid	22	6.4
Medicare	45	13.1
Medicare Part D	16	4.7
Private Insurance	229	66.6

Nearly 67.0% of all respondents indicated having private insurance to pay for health care services. Medicare (17.8%) and Medicaid (6.4%) were reported by 24.2% of survey participants.

Distribution Reporting to Have a Regular Dentist

Regular Dentist	Frequency	Valid Percent
Yes	245	71.2
No	99	28.8
Total	344	100.0

Over 71.0% of respondents indicated having a regular dentist.

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

Distribution of Healthcare Service Location

Location To Receive Healthcare	Frequency	Valid Percent
Private Practice	293	84.7
Emergency Department	39	11.3
Health Department	4	1.2
Community Health Center	5	1.4
Other	28	8.1

According to the data above, 84.7% of participants reported seeking health care from a private practice. The emergency room (11.3%), the community health center (1.4%), and the health department (1.2%) were additional sites for receiving health care services.

Distribution Reporting Cost as a Barrier to Healthcare

Cost As A Barrier To Healthcare	Frequency	Valid Percent
Yes	70	20.3
No	275	79.7
Total	345	100.0

Approximately 79.7% of respondents indicated that cost was not a barrier to receiving health care services.

Distribution Reporting Cost as a Barrier to Filling Prescription Medication

Cost As A Barrier To Prescription Medication	Frequency	Valid Percent
Yes	74	21.6
No	269	78.4
Total	343	100.0

Nearly 78.0% of respondents indicated that cost was not a barrier to filling a prescription medication.

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

Distribution Reporting Ambulatory Care Conditions

Conditions	Frequency	Valid Percent
Dehydration	33	10.1
Gastroenteritis	49	15.0
Kidney Infection	31	9.5
Bleeding/Perforated Ulcer	10	3.1
Pelvic Inflammatory Disease	4	1.2
Ear/Note/Throat Infection	39	11.9
Cellulitis	7	2.1
Dental Conditions	11	3.4
Diabetes	19	5.8
Asthma	18	5.5
Angina	31	9.5
Hypertension	29	8.8
Congestive Heart Failure	15	4.6
COPD	3	0.9
Trauma	74	22.6

Trauma (22.6%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room.

Local Hospital Services and Overall Satisfaction

Among participants surveyed, 68.8% used hospital services in the last 24 months.

Distribution of Health Care Utilization

Location	Frequency	Valid Percent
Stephens County Hospital	197	87.2
Some Other Hospital	29	12.8
Total	226	100.0

Among those reporting using hospital services, 87.2% indicated using services at Stephens County Hospital.

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

Reason for Healthcare Utilization

Reason For Choosing Location	Frequency	Valid Percent
Physician Referral	64	31.5
Quality Of Care	31	15.2
Closer/Convenient	116	56.9
Availability Of Specialty Care	6	2.9
Insurance	12	5.9
Other	18	8.8

Most participants reported using the local hospital because of convenience (56.9%). However, 31.5% reported being referred by a physician.

Distribution of Services Utilized

Services	Frequency	Valid Percent
Radiology	113	55.4
Laboratory	79	38.9
Inpatient Services	49	24.1
Other Outpatient Services	35	17.2
Emergency Room	101	49.8

Medlink	3	1.5
Oncology	3	1.5
Other	12	5.9

Respondents indicated using a variety services at the local hospital. Emergency room services (49.8%), radiologic services (55.4%) and laboratory services (38.9%) were the most commonly reported services used by survey participants.

Level of Satisfaction with Services

Level Of Satisfaction	Frequency	Valid Percent
Satisfied	171	86.8
Dissatisfied	23	11.7
Don't Know	3	1.5
Total	197	100.0

Over 86.0% of those surveyed indicated being satisfied with services while only 11.7% indicated dissatisfaction.

Distribution Reporting Utilizing a Primary Care Physician

Use Primary Care For Routine Care	Frequency	Valid Percent
Yes	178	88.6
No	23	11.4
Total	201	100.0

Approximately 88.6% of those surveyed indicated using a primary care physician. Among those participants indicating to not use a primary care physician (11.4%), the table below illustrates the type of medical care provider utilized for routine healthcare.

Provider Location for Routine Care

Provider Type If Primary Care Not Used	Frequency	Valid Percent
Community Health Clinic	6	18.8
Medlink	2	6.3
Health Department	2	6.3
Open Arms Clinic	3	9.4

Stephens County Hospital: Community Health Needs Assessment

Emergency Room Hospital	5	15.6
Specialist	6	18.8
Other	8	25.0
Total	32	100.0

As indicated above, the community health clinic (18.8%), specialists (18.8%), and the emergency room (15.6%) were most often utilized in the absence of a primary care physician.

Utilization of Primary Care at the Local Hospital

Visited Primary Care At Stephens County Hospital	Frequency	Valid Percent
Yes	154	76.6
No	39	19.4
Don't Know	8	4.0
Total	201	100.0

Nearly 77.0% of those surveyed reported using primary care services at the local hospital.

Level of Satisfaction with the Primary Care Provider

Level Of Satisfaction	Frequency	Valid Percent
Satisfied	130	89.7
Dissatisfied	9	6.2
Don't Know	6	4.1
Total	145	100.0

Among those using primary care providers at the hospital, the vast majority (89.7%) was satisfied with the services received.

Distribution Reporting Ease of Appointment with a Primary Care Provider

Ability To Get Appointment	Frequency	Valid Percent
Yes	126	94.0
No	6	4.5
Don't Know	2	1.5
Total	134	100

Most respondents (94.0%) indicated they were able to schedule an appointment with the primary care provider at the local hospital.

RESULTS: FOCUS GROUP ANALYSIS

Introduction: Participants' Characteristics

Stephens County Hospital was encouraged to recruit groups of 6-8 participants to take part in the three focus groups. One group consisted of community advisory members (CAC), persons among the group of people the hospital recruited to actively participate in the needs assessment. The other two groups were recruited by CAC members and referrals. Twenty-one participants took part in the three focus groups. All three focus groups took place on December 6, 2012 in the training classroom at the hospital. The first and third focus groups consisted of 15 CAC referrals while the second consisted of six CAC members.

The three focus groups consisted of 21 participants: 13 women and eight men. Ninety percent of the sample was Caucasian (19) and two African American. All of the participants spoke English. Sixteen of the 21 participants lived in Toccoa; two lived in Eastanollee, while three lived in Carnesville, Demorest and Lakemont. Participants' ages ranged from 34 years old to 79 years old, with a median age of 65. Participants' education levels were as follows: eight advanced degrees; seven college degrees; two had some college; and four completed high school. Participants' annual income levels included four with 100k or more; three persons with 75k – 100k; five with income levels 50k – 75k; six persons with 25k – 50k; one person reported having a household income level below 25K; and two participants provided no answer to that question. The following sections divide the focus group discussions by common thread or topic.

Community

Theme: Beautiful place to live; small town feel; friendly people; safe; great schools system; faith-based community; active community.

Most of the participants described Stephens and Toccoa Counties as a beautiful place to live and raise children. Participants explained that it is a very close community with a small town feel, where people know each other well. One participant said,

“Well I like Toccoa and Stephens County because it's a small town atmosphere. It's very laid back. You don't know everybody, but you know a lot of people. The ones you don't know by name you know by sight. So it's a very enjoyable place to live I think.”

Many participants enjoyed the fact that the community was so interconnected. They believed that people are very friendly in Stephens County and supportive of one another. One participant explained why it is enjoyable to live in Stephens County,

“The natural beauty, the quality of the people. The good neighbors who are committed to each other.”

However, Stephens County is no different than many other small rural communities in the U.S. where people enjoy the freedom and feel safe to live their lives. One participant said,

“I feel very safe where I live. And like [participant] was raised in Baltimore, I was born and raised in Washington, DC. So we can sort of identify with the less crowding, less of everything that you have to put up with in a big city.”

Many participants talked about how proud they were of the local school system. They felt that schools are getting better each year and the graduation rates look good. One participant said,

“We have a wonderful school system that we're very proud of, which is improving. The physical structure is improving. The grades seem to be improving. The results seem to be improving. We have what's generally considered a competent medical facility.”

Several participants talked about the role of churches in the community. They believed that churches contribute a lot to a sense of community and collaborate with other organizations to make the life of people in Stephens County better. One participant talked about the role of churches in the community,

“There's a real strong [bond] in this community faith-based network that I appreciate because I interact with the families and I don't think maybe Rayburn County is in some ways a whole lot different than Stephens, except they probably have a little more work to do, but I see our families in desperate situations right now.”

When asked what makes it easy to maintain a healthy lifestyle in Stephens County, participants explained that the community was very active. There were various programs for seniors, wellness programs, and walking trails. A few of the participants expressed, YMCA was an asset to the community and it offered many wellness programs. The community members were able to use their insurance to pay for the YMCA services,

“People like the YMCA. They have programs; too, for the seniors where a lot of it's funded by the insurance company you belong to, the health. You can go take exercise a couple days a week. Structured exercise or you can go five out of six days a week if you want to just on that card. It's a good program in that sense.”

When asked about some barriers to a healthy lifestyle, the prevailing themes were unhealthy food at schools and lack of financing. Several participants felt that in order to ensure that the whole family is physically active, one needs to spend a significant amount of money which an average family could not afford,

“And even for recreational sports for children, it's too much for the average family. To have to pay – if you have a child that plays one sport, fine, but if you have a child that wants to be active and play two or three different sports and you gotta pay \$75.00....”

Participants believed that American Red Cross, social capital, health department services, churches, and the mental health center were very important community assets to address some of the mental and drug abuse issues. One participant talked about the mental health center and churches,

“Well, I don't know how to elaborate. Just that there's no need to say that there's not a problem. We have a mental health center and a lot of people use those resources because

they have community groups. We have some churches that have AA groups that meet some.

Community Issues

Theme: Lack of industries; lack of jobs; poverty; drug abuse; mental health; teenage pregnancy; child abuse; chronic disease; no sidewalks; recycling plant; and no central transportation.

According to participants, one of the main issues this community faces is lack of industries. Several participants believed that the location was to blame for this issue due to the fact that the community was situated between two major highways. Participants felt the community was dying due to lack of industries and, as a result of that, there were no jobs in Stephens County. The lack of jobs has driven people to other communities in search of opportunities. One participant said that this problem is relevant not only to young people but to people of all ages,

“Lack of opportunity for all the age ranges. It’s not just the young generation. It is I think worse for them, but it goes through all the ranges of ages up to people that wanna work part time after they retired. The opportunity just is not there.”

Participants felt that lack of industries was linked to other issues in the community. One of the listed problems was poverty. One participant said,

“But you have the skills. Like you said, you could have skills, but there’s nothing you can do with them, because there are no jobs.”

Another participant continued,

“Which leads to the 18 that are in poverty, and that’s statistics for this county. 18 percent live below the level of poverty.”

Participants also felt that lack of jobs resulted in young people becoming involved in drug abuse and drug sales. According to one participant, because there are no opportunities and high rates of poverty, many young adults choose to be involved with drugs to find an easy solution to their financial and emotional problems. A great majority of the participants talked about people in the community with mental health issues. However, some participants felt that not enough attention was given to the problem of mental health when compared to other problems. One participant believed that lack of jobs, poverty, drug abuse, and mental health issues are interconnected,

“Well, I think drug-related and alcohol-related – relates to mental deficiencies, I guess.”

Another participant continued,

“Depends on the drugs. Because then without the drugs, they go – they can’t handle themselves, and I see this every day that I come to work. That somebody was on some medication, and if they don’t get this medication, they’re so used to having it in their system, that they’re just not a happy person without it, and you’re not a happy person around them.”

Another participant added,

“I think there are mental health problems here, but it’s less talked about than drugs.”

Participants felt that there was a problem of teenage pregnancy and single parenting in Stephens County. Many participants also mentioned child abuse. One participant suggested that it was the result of lack of parenting,

“I see that a lot, too, and I think it’s because of lack of parenting. They’re not taught to be a parent. And so this child to them is a trophy, a doll or something. And the first time they angry they don’t think about this child can be cold or get sick, so they just grab ’em and run out. ’Cause I happen to be in the store on day and I had a coat on and scarf, and this baby had on no socks and little thin shirt, and I’m going, “Sweetheart, did you know not think to put some socks on your baby?” And she just turned around and looked at me..”

Participants also mentioned chronic disease being a significant issue in the community. Chronic diseases such as obesity, cancer, and diabetes were listed by the participants. Diabetes was one of the most frequently mentioned health problems that affected not only adults but also started to affect children as well. One participant expressed that by saying,

“An issue for the elderly is Type II Diabetes. [We don’t have a] huge amount of children in the school system [with type 2 diabetes], but we have about four or five in each school that have Type I Diabetes right now. We have six schools. So that’s a good number of people.”

While participants enjoyed living in Stephens County, they talked about the negative aspects of having a recycling plant in the community. They mentioned that it created a bad smell and environmental pollution. One participant stated,

“It’s a recycling plant. It’s setup to recycle waste from the chicken plants, but it’s recycling human waste now and occasionally it smells like an outhouse.”

Another participant continued,

“My kids go to Liberty and a lot of times they can’t even go out for recess because the smell is so overwhelming. I know Lanier right there is having a lot of trouble even with the smell on their shipments going out for clothing. They’re very often methane gas and it’s in the old Coats & Clark, but it’s pretty rank.”

One participant mentioned,

“We have our first environmental issue with Wilbrow’s which is creating discord socially and actually some respiratory issues for the children that are in the area especially because it’s putting out terrible fumes. Never did we have something like that going on before.”

Other aspects of the community that participants did not like were lack of sidewalks and central transportation system. Participants explained that due to lack of sidewalks; they don't feel safe to let children ride their bikes outside. Also, due to lack of a central transportation system, people were not able to get around, and it created an additional burden for the ambulance service. One participant said,

"See, that's the problem. You're back to the transportation issue. There is no centralized transportation. So if you don't have a car you can't get out here unless you come by ambulance. So it becomes a frequent flyer issue for even the ambulance service because they can't just take Raven Transit to the hospital or take Habersham Transit somewhere, the Red Rabbit like Gainesville has."

Hospital

Theme: Competent and qualified staff and physicians; caring and compassionate service; updated equipment and technology; connect to community through radio and newspaper; major employer; great facility; and conveniently located.

Participants were asked to offer positive feedback about the Stephens County Hospital. A majority shared that the staff was competent, qualified, and provided compassionate medical care to the community. Further, several stated they were pleased with the hospital for keeping its equipment and technology updated. Participants also noted they appreciated the fact that the staff working at the hospital is mostly from the community.

"...They've got some great doctors. If you go to the emergency room -- I shouldn't name the names, but [physician] down there. One of the kindest most gentlemen you would ever wanna meet in the emergency room situation."

"I have got to use this hospital more than I care to even think about, and one thing that always sticks in my mind is we are very fortunate in the quality and caliber of the staff in this hospital...I don't remember ever having a bad problem with anybody...The people are great...Food's gone downhill. I gotta tell you that."

"They're just so caring and compassionate and they are concerned about your feelings. So just very caring people."

"...I also think that the staff, a lot of energy is put into keeping up all their certifications and keeping that current. The staff is mostly community-based. So they're looking after their own folks and they're very aware of that."

One participant who used the services of Stephens County Hospital over the years and knew about its administration said,

"...All this does come from the top down – they basically are always...trying to improve what they do and how they do it...This hospital when a new piece of equipment, they don't wait for something to break. You can read about it in the paper. They're always trying to improve what they do."

A number of the participants mentioned the hospital was a major employer in Toccoa and had a long history in the community. A few of them shared, the hospital had a great facility and was conveniently located. Yet another positive feedback provided was Stephens County Hospital used radio and newspaper to talk with the community about available resources and upcoming events. In addition, they said the hospital had a health oriented publication that was widely distributed in Toccoa and that the hospital assisted the community with health events.

“I know they do newspaper as well and they also have their own little newsletter that they send out around the different businesses that they give out.”

“I think they do a pretty good job of that with radio announcements periodically. I hear them quite often actually.”

“The radio sometimes tell you that there’s certain things that’s going on that’s offered at the hospital. So if you’re listening to your radio or you’re reading your papers, it’s common knowledge.”

“I have used their services in the community and church groups or civic groups just by calling and asking, ‘Do you have somebody that could come and talk about breast cancer awareness? Do you have somebody that can come and talk about nutrition?’ And that type of thing. They’ve been very open and somebody’s been able to come and do that in the community.”

Overall, participants were very knowledgeable about the activities of the hospital. Some of them even knew that the hospital had hospitalists on staff and said having them have helped improve services. Less frequently discussed but equally important, a few participants mentioned that Stephens County Hospital had a great relationship with the school system and the County EMTs.

“I’d like to say that at Stephens County, we now have on staff the hospitalists. They’re two doctors and two nurse practitioners here 24/7. And this has been a plus for the hospital. If you come here and you don’t have a doctor, you will be seen by someone. And so as far as I can tell, they’re very thorough...So I say that’s a plus for the hospital.”

“I think the hospitalist has been a wonderful addition to this hospital and they do follow-up with primary care, which is good.”

Although many thought the hospitalists on staff improved services at the hospital, a number of participants thought that some of the local doctors were resistant to the hospitalists at the hospital.

“But every physician does not turn their patient over to the hospitalist. Some of the doctors will. As time goes on, I think you’ll see more and more of ’em do it, but right now, only certain doctors will release their patient to a hospitalist here.”

Moreover, most of the participants were familiar with the services offered at the Stephens County Hospital. They stated the hospital had a community education department that delivered

education programs in most areas of the community. Several discussed the diabetes education program and indicated that they appreciated that the program was delivered by a diabetic dietician. The following were services name by participants: obstetric/birth center to include water birth; pulmonary/respiratory and physical therapy; diagnostic tests (mammography, EXG, x-rays); social services; surgery; wound care; orthopedist; laboratory; internists; cardiac rehab; laboratory; cancer center; assisted/independent living; and hospitalists.

“There's a really strong education department here that probably is underutilized in the community.”

“They offer classes to the community. When I was diagnosed with diabetes they had a free course here and I came and took it, but it was just because somebody here at the hospital told me that they had it.”

“I think the main thing they have here is the cardiac rehab. That is very vital. I've gone through it myself so I know how valuable it can be.”

“I know that we do have the cancer center now, but I don't know how specialized. A lot of people are still going other places.”

“The birth center or whatever it's called. That's lovely in there, and I've had the privilege of going in and welcoming a couple babies into the world of friends.”

Regarding services and programs participants would like to have at the hospital, the majority said they would like to have more specialists; specifically, they would like to have these specialists: urologist, cardiologist, endocrinologist, gerontologist, neurologist, mental health professionals, gastroenterologist and vascular surgeon. Programs and services mentioned were in-patient hospice care, adult daycare, wellness, comprehensive cancer care and disease management.

“We've got a wonderful dietician here as well. She herself is a diabetic. Could be another resource to be teaching out in the community.”

“If would be nice if we had an in-patient hospice facility where if they couldn't stay at home, if there wasn't someone to care for them that there was an option.”

“I'd like to see more done with cancer... We very often had to go to Gainesville or to Athens in order to get proper treatment because it wasn't offered here.”

“We don't even have the ability to adequately hospitalize a mental health patient here with the appropriate care. They need to be shipped off in order to get that.”

Hospital Problems

Theme: Parking lot expansion; cafeteria food; lack of oversight and coordination in ER; hospital misdiagnosis; medical billing process; and hospital transportation.

Among the many areas that needed improvement at Stephens County Hospital, participants stated that the parking lot needed to be expanded. Since a number of the parking spaces were often reserved for the doctors, a few participants requested for the hospital to expand the parking lot area. As one participant said,

“They could expand the parking lot. You have to hunt for a place to park. I’ve got a bad back and bad knees, and it’s hard for me to walk across that parking lot.”

Participants also shared that quality of the food in the cafeteria has changed dramatically from once being healthy to now mostly processed. They wish to see the hospital use the assistance of local farms to improve the food quality.

“As far as the food, I’m thinking of the children’s standpoint, the nutrition in the cafeterias is terrible. It’s terrible. And I think in this kind of community with farms and stuff, that if they could do a program to have more fresh food instead of processed lunch.”

Several participants said they would like to see better oversight in the ER and improve efficiency in pre-operation and outpatient care. Additionally, a number of them discussed episodic misdiagnosis of family members’ conditions which led to fatal results. The following quotes were representations of recent episodes of hospital misdiagnosis of serious conditions.

“My family had one bad experience here. My [...] came up here with chest pains. Obviously serious heart problem. They kept [...] overnight and sent [...] home and said there was nothing wrong and two weeks later [...] died from a massive heart attack. It didn’t sit very well. [...] maybe was shoved out the door too fast here and maybe the diagnosis wasn’t right or something. I don’t know, but it was within two weeks of having another heart attack.”

“...My {spouse} was misdiagnosed. [...] had a spot on [...] breast and for four years was told that it was probably due to aging until it turned into cancer. When we had it treated at the Mayo Clinic they reviewed the prior x-rays and said they just missed it. That to me is a major fault.”

In addition to hospital misdiagnosis, more than a few participants shared, the billing department at Stephens County Hospital consistently sent incomplete billing documents to patrons. Some participants expressed frustrations for receiving medical bills for services rendered years earlier.

“I came one time to get a mammogram, and the girl told me...I owed \$100.00...And so she said that I owed \$100.00 and something from – now this hadn’t been but a couple years ago from 1980. She says, ‘I can’t tell you what it’s for, but you owe it.’”

“...I think if something could be done to facilitate the billing process. There was a mix-up. {...} had Medicare and private insurance, and there was a mix-up with a bill that got sent somewhere wrong and then got sent somewhere else, and like two years after {...} died, I get a bill from this hospital for \$26,000.00.”

A small number of participants said the current mental health assessment provided through telemedicine was ineffective and that the hospital needed to find more effective alternative solutions. Similarly, a few participants discussed there were some people in the community who used the ambulance system as a mean of transport to and from the hospital, even minor conditions. Some of these participants assumed most of these elderly people were without caregivers or without their own means of transportation to get to the hospital.

“I know anytime, too, someone gets stuck out here because you can't walk to anything from here. A lot of times people will come by ambulance out here and then they have no way of getting home.”

Recommendations

Theme: Community partnerships; promote services through well-known institutions; offer education programs/prevention and engage on and off campus; follow-up care; improve billing department; volunteerism in Toccoa; improve cafeteria food; outreach in all segments of the county; explain ACA to community; wellness promotion in schools; and proactive role on elderly care.

A majority of the participants knew that Stephens County Hospital offered numerous programs and services; however, many were not sure whether all segments of the community knew of the services provided by the hospital. They proposed for the hospital to develop nontraditional partnerships with institutions that were familiar to all in the community. The main goal of these nontraditional partnerships will be to promote the programs, activities and services of the hospital in the community. The following institutions were among the recommended partnerships: churches, Senior Center (AARP group), school system and civic clubs (Kiwanis, Lions and Rotary), local health department (WIC program). Precisely, participants said the hospital should use churches to promote its programs in all parts of the community to extend to those who may not be able to attend health related seminars at the hospital. Further, the hospital was encouraged to take advantage of the spirit of volunteerism to get a lot of work accomplished in the community.

“They may look at doing outreach into some areas where people can't get to the hospital for the classes...There's certain churches that meet or everyone come to the church. If people don't have things to do during the day and they're already in that area and they can just get there easily, that might be better to get the information out.”

“The churches is an excellent idea because the closer you can keep people to their homes, the more likely they are to come to a function.”

“Possibly look at using some to the local churches in parts of the community where we have the biggest problems as far as diabetes and nutrition, and see if the hospital can set up some programs within the churches where they can pass on information, even send

people to attend programs, set up programs to help educate the parents and the children at the same time.”

“We have active Lions, Kiwanis, Rotary...Kiwanis and all those groups. Yeah, I'm sure the doctors could if they were willing to promote the hospital.”

“Toccoa is very big on volunteers. There is quite a feeling of it is part of your responsibility to volunteer and to try to help make things better.”

Further, several participants alleged that the hospital could benefit from a case management system to improve case follow up, especially to prevent hospital misdiagnosis.

“Maybe there needs to be some kind of an assigned person for each case that oversees all the things that need to be done. That they manage your case and coordinate with the doctors.”

“We need some way to be able to facilitate follow-up care once they leave...But to have as many re-admissions as we have, folks with the ongoing chronic problems, there's better ways to manage that out into the community that somehow if we can take what we're teaching them and get out into where they are to make an impact on their lives there, not just here at the hospital, there should be some kind of a transitional thing.”

“...In a perfect world I think there'd be greater oversight over the emergency room here. Review of the cases as they come through. Who handled the cases and exactly what occurred. I think that's the biggest complaint I hear in the community and the ones that I deal with are people that were turned out too quickly, assessed too briefly and missed and wind up going to Gainesville or Habersham in order to be appropriately treated.”

“...There should be a way they keep up with things in accounting. I don't know what system they have down there, but it's ridiculous...To wait until somebody has passed two years or a year before you send the bill out, or to wait till somebody come for a test two years later and you say, 'Well, you owe this amount of money,' and when you don't get a bill, you don't get any statement.”

A small number of the participants encouraged the hospital to work with the school system to co-sponsor community-wide events to promote health screenings and prevention through health fairs. These participants' interests remained on improving the health of young children. Other ideas provided were essentially focused on nutrition to include cooking classes for kids and their parents.

“Health fairs, maybe even something in cooperation with the public school system, especially with the diabetes 'cause I imagine that starts pretty young. They get these bad habits of eating the wrong kinds of food. And I'm sure the school system would be amenable.”

Participants also discussed the development of wellness promotion classes in the local school system. Moreover, they said they would like to see the hospital perform some type of research to

determine the most prevalent chronic condition(s) in Stephens County before designing prevention programs. Likewise, a participant suggested having a pilot program to investigate the prevalence of diabetes among children in Northeast Georgia. This participant proposed a prevention program among this population of children to counteract the effects of diabetes.

“...I wonder if the hospital might not be well time spent if they looked at what are the most frequent types of ailments that occur in this immediate area, and then try to match the need with the people to supply and cover that need.”

“...Northeast Georgia has a diabetic epidemic. We have to reach our children. We need to begin a pilot program at one elementary school, stick with that for a whole year, and then see if the – yeah, do an assessment and see if the parents are receptive, along those lines.”

Further, another participant suggested that having a 24/7 on-call clinician would greatly serve the community. This participant shared an experience with a dying spouse while having no doctor to talk to during this medical crisis, when said,

“I would really like to see a doctor that is on call here all the time that you could talk to...My {...} just passed away with cancer...I called when my {...} had got swollen...I called here and told 'em who I was so on and so forth and asked for [the doctor] to call me. And [the doctor] hasn't called me to this day.”

Other recommendations made were for the hospital to provide dental services; more specialists; explain the Affordable Care Act to community; and make available transportation for those in the community who abused the ambulance system to get to and from the hospital for non-emergencies.

When it came to improving the community, a majority of the participants said, Stephens County Hospital can improve the health of the population by engaging the community through the provision of prevention education programs. In order of frequency, the following were topics they suggested: teen pregnancy, diabetes, anti-tobacco for teens, hypertension, obesity, nutrition, breakfast program in the schools, and breast cancer awareness. To deliver the suggested programs and activities, a number of participants mentioned for the hospital to have its designated public relations person and that for this person to become the ‘go to person’ for the community.

“I think to improve the health of the community you're talking about prevention...I think with prevention comes education and engaging the community...I guess offering more educational programs on various health topics to include the community.”

“Maybe a breakfast program in the schools involving the dietary people from the hospital to hit some of those people that – some of those kids that don't get breakfast in the morning before they come to school.”

“I think in order to reach the community you have to have an outreach coordinator. You have to have one person who you say this is your job. Make us recognizable. Let the community know we care and get out there and make an impact. That's their job.”

A number of participants recommended that the hospital use fear appeals methods to bring the reality of the diseases and condition to the community. One participant who had a child who used tobacco said in exasperation there was no support in the school system for children with this issue, but would like to see the hospital help tackle this problem.

“Tobacco use is a big issue in our County, especially teenagers using tobacco. Chewing and they think it's okay. I'm sure you see it in schools, these issues at the high school and everything, but as far as education, just like our funding with the state is cut. Pretty much all we do is refer them to the stop quit line. You need to call this number...They need to see some of that gross stuff. Well you can't help when the coaches are doing it...?”

“...Maybe some sort of a little five-minute film thing that maybe the local stations could help us with to exemplify the – or to share the research and then exemplify some of the things that could happen, like to feet and eyes and other parts of the body with diabetes.”

A suggestion specific to the aging population, a few participants would like to see the hospital take the leadership role in elderly care.

“I think by continuing to plan ahead for an aging population so that they'll be ready to meet the needs when time arises for people like me.”

Community Vision

Theme: Less poverty; more industries; raise awareness; and prevention programs.

Regarding community vision, areas discussed included having more industries coming into the community, and less poverty. When talking about community vision, participants expressed, they want to improve awareness about chronic diseases and the importance of healthy lifestyle. One participant talked about the importance of educating community members on conditions like diabetes and hypertension,

“Well, certainly we've talked about improving awareness, but you take conditions like diabetes and hypertension. You're not in any pain. You don't think about going to the doctor, but you still need to know about it. Those type of things. If we could raise the awareness on just a few of those I think it would help.”

Several participants also felt that diabetes was a big concern for the community. They recognized the importance of not only treatment of diabetes but also prevention programs. One participant explained by saying,

“I keep coming back to the diabetes. It seems if we just focus on the fact you've got diabetes and you're on insulin or you're on Metformin or some other form, but it's a lot greater than that, because you've got to bring in the people to make sure that they care for their feet. You gotta make sure they care for their eyes. You've gotta make sure that

they got the right diet. So it requires a multi-faceted approach. Otherwise, you're gonna have I think a lot more people with serious diabetes..."

COMMUNITY ASSETS**Stephens County Assets**

Name of the company	Phone number	Address	Services
Stephens County Hospital	(706) 282-4200	163 Hospital Dr, Toccoa, GA 30577	Hospitals, Surgery Centers, Medical Centers
Stephen County 911	(706) 779-3911	338 Virginia Dr, Eastanollee, GA 30538	Hospitals, Emergency Care Facilities
Boys & Girls	(706) 886-3771	71 W Whitman St, Toccoa, GA 30577	Youth Organizations & Centers, Clubs
Camp Fire Usa-Georgia Council	(404) 527-7125	92 Camp Toccoa Dr, Toccoa, GA 30577	Youth Organizations & Centers, Clubs
Ty Cobb Regional Medical Center	(706) 356-7800	367 Clear Creek Rd, Lavonia, GA 30553	Hospitals
Stephens County Hospital Personal Care Homes	(706) 282-1197	351 Wilkinson Pkwy, Toccoa, GA 30577	Hospitals
My Senior Care	(888) 258-9535	Eastanollee Area	Personal Care Homes, Assisted Living & Elder Care Services, Elderly Homes
A Preferred Women's Health Center	(800) 438-4094	Eastanollee Area.	Abortion Services
ResCare HomeCare	(706) 282-0060	74 Highway 123, Toccoa, GA 30577	Home Health Services, Nurses-Home Services, Alzheimer's Care & Services
Care South Homecare Pro	(706) 297-7159	602 Skyview Ln, Toccoa, GA 30577	Home Health Services, Nurses
Tugaloo Home Health-Amedisys	(706) 886-5442	8000 Rock Quarry Road Ext, Toccoa, GA 30577	Home Health Services, Hospices
Clary Care Ctr	(706) 282-1197	249 Hospital Dr, Toccoa, GA 30577	Home Health Services, Assisted Living Facilities, Personal Care Homes

Stephens County Hospital: Community Health Needs Assessment

The Wilkinson Center	(706) 886-2977	269 Hospital Dr, Toccoa, GA 30577	Home Health Services, Nursing Homes-Skilled Nursing Facility, Rest Homes
Stephens County Mental Health	(706) 282-4560	1763 Fernside Dr, Toccoa, GA 30577	Mental Health Services, Suicide Prevention Service, Drug Abuse & Addiction Centers
Avita Community Partners	(706) 886-6521	5700 Fernside Dr, Toccoa, GA 30577	Mental Health Services
Gold's Gym	(706) 886-2222	748 Big A Road, Toccoa, GA 30577	Health Clubs, Exercise & Physical Fitness Programs, Gymnasiums
Gathany Jeannie	(706) 886-7560	1651 E Tugalo St, Toccoa, GA 30577	Health & Welfare Clinics
Americanwork Inc	(706) 827-9937	467 W Doyle St, Toccoa, GA 30577	Mental Health Services
Toccoa Life Care Ctr	(706) 886-0177	282 W Doyle St, Toccoa, GA 30577	Pregnancy Counseling, Abortion Alternatives
Zitowitz Paul LCSW ACSW	(706) 886-3148	274 Big A Rd, Toccoa, GA 30577	Counseling Services, Marriage, Family, Child & Individual Counselors, Social Workers
Toccoa Counseling Ctr	(706) 886-1335	141 W Savannah St # 104, Toccoa, GA 30577	Counseling Services, Marriage, Family, Child & Individual Counselors, Alcoholism Information & Treatment Centers
Cornerstone Counseling	(706) 244-1745	38 Falls Rd, Toccoa, GA 30577	Counseling Services
Drug & Alcohol Treatment Centers-US	(888) 296-6597	Eastanollee Area	Counseling Services, Physicians & Surgeons, Addiction Medicine, Psychological Examiners

Franklin County Assets

Name of the company	Phone number	Address	Services
Franklin County 911	(706) 356-4991	7011 Highway 145, Carnesville, GA 30521	Hospitals, Medical Clinics, Urgent Care
Wee Care Plus Therapy	(706) 245-1822	461 Cook St, Royston, GA 30662	Hospitals
Royston Chiropractic Clinic	(706) 461-2811	1157 E Main St, Royston, GA 30662	Health & Welfare Clinics, Chiropractors & Chiropractic Services
Ty Cobb Regional Medical Center	(706) 356-7800	367 Clear Creek Rd, Lavonia, GA 30553	Hospitals
Georgia Women's Care Pc	(706) 246-0800	72 Advocate Dr, Royston, GA 30662	Medical Clinics, Physicians & Surgeons, Obstetrics And Gynecology

PRIORITIZATION

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

- A. Chronic Disease Conditions (Heart Disease, Cancer, Respiratory, Diabetes, Etc.)
- B. Maternal/Child Health (Infant Mortality, LBW)
- C. Teenage Pregnancy
- D. Economic Development (Lack of Industry, Jobs, Poverty, Environmental Modifications/Bike Paths/Etc.)
- E. Mental Health (Accessibility/Affordability)
- F. Behavioral Health Issues (Substance Abuse, Child Abuse, Etc.)
- G. Issues Associated with Community Health Education & Outreach (Exercise, Diet, Tobacco, Etc.)
- H. Issues Associated with Elder Care (Housing, Boomers, Etc.)
- I. Accessibility/Affordability of Transportation

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

Prioritization Results

Community Issue	# Ranking Issue	Size of Problem*	Seriousness of Problem*	Effectiveness of Possible Intervention*	Basic Priority Ranking
Chronic Disease Conditions	11	8.3	17.0	5.9	48.9
Maternal/Child Health	11	5.1	12.0	4.5	26.3
Teenage Pregnancy	11	6.0	13.0	5.2	33.4
Economic Development	11	9.1	16.0	4.4	35.8
Mental Health	11	5.5	13.0	6.1	36.7
Behavioral Health Issues	11	7.6	14.0	6.5	46.8
Issues Associated with Community Health Education & Outreach	11	7.1	12.0	7.7	49.2
Issues Associated with Elder Care	11	8.4	14.0	6.8	51.7
Accessibility/Affordability of Transportation	11	4.0	8.2	4.9	19.9

*Represent average score of all participants ranking a particular issue

According to the results, “Issues Associated with Elder Care” ranked highest according to the calculated BPR score. “Issues Associated with Community Health Education & Outreach,” “Chronic Disease Conditions,” “Behavioral Health Issues,” “Mental Health,” “Economic Development,” “Teenage Pregnancy,” “Maternal/Child Health,” and “Accessibility/Affordability of Transportation” followed this issue.”

HOSPITAL CHALLENGES

All hospitals faced challenges related to completing the CHNA project. Without exception, each hospital expressed concern about the methodological approach to completing this particular mandate. These anxieties were alleviated as the CHNA project progressed and the project team was able to provide mentorship and fundamental training related to completing the assessment. However, other challenges unique to each hospital were noted. Overall, Stephens County Hospital took a proactive role in communicating with the technical assistance team at Georgia Southern University. All necessary documents requested were provided within the reasonable time allotted. Nonetheless, the main challenge Stephens County Hospital experienced was having its CAC members return all completed surveys to the hospital on a timely fashion.

REFERENCES

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LIST OF APPENDICES

- A. Hospital, Health District, and Local Public Health Contacts
- B. Institutional Review Board Approval
- C. CHNA Project Summary Sheet
- D. Project Activity Outline
- E. Steering Group Members
- F. Sample Invitation Letter to Potential CAC Members
- G. Potential CAC Membership list
- H. CAC Members
- I. Meeting 1 Presentation
- J. Meeting 2 Presentation
- K. Meeting 3 Presentation
- L. Meeting Agendas
- M. Meeting Attendance Rosters
- N. Economic Impact Report
- O. Survey Pilot Instructions
- P. Community Health Survey
- Q. Focus Group Preparation (Logistics & Instructions)
- R. Focus Group Questions
- S. Focus Group Demographic Sheet
- T. Focus Group Informed Consent
- U. Focus Group Attendance Roster
- V. Prioritization Sheet

APPENDIX A

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

Health Department CEOs contact Information

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

APPENDIX B

Georgia Southern University
Office of Research Services & Sponsored Programs

Institutional Review Board (IRB)

Phone: 912-478-0843

Fax: 912-478-0719

IRB@GeorgiaSouthern.edu

Veazey Hall 2021

P.O. Box 8005

Statesboro, GA 30460

To: Dr. Stuart Tedders
Dr. Raymona Lawrence

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

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

Initial Approval Date: 08/14/12

Expiration Date: 06/30/13

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

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

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

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

Sincerely,



Eleanor Haynes
Compliance Officer

APPENDIX C



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

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

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

Jiann-Ping Hsu College of Public Health Team Contact Information

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

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

APPENDIX D



Community Health Needs Assessment Project Activity Outline

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

Community Health Needs Assessment Project Activity Outline

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

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

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

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

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

Community Health Needs Assessment Project Activity Outline

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

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

APPENDIX E

Stephens County Hospital
Steering Group Members

Sectors	Members	Title	Business	E-mail	Phone Contact	Address
Health	Jeffrey Laird	Controller	Stephens County Hospital	jlaird@stephenscountyhospital.com	(706) 282-4281	163 Hospital Drive, Toccoa, GA 30577
Health	Heidi Wilkinson	Community Health Educator	Stephens County Hospital	hwilkinson@stephenscountyhospital.com	(706) 282-4140	163 Hospital Drive, Toccoa, GA 30577
Health	Faye Taylor	Director of Nursing	Stephens County Hospital	ftaylor@stephenscountyhospital.com	(706) 282-4253	163 Hospital Drive, Toccoa, GA 30577
Health	Ed Gambrell	CEO	Stephens County Hospital	egambrell@stephenscountyhospital.com	(706) 282-4250	163 Hospital Drive, Toccoa, GA 30577
Public Health	Karen Palmer, RN	Regional Director	Public Health Department	khpalmer@dhr.state.ga.us	(706) 282-4507	222 North Boulevard Street, Toccoa, GA 30577
Education	Paula Dickerson	Retired Teacher	Retired	N/A	(706) 282-4200	547 Gross Creek Drive Toccoa, GA 30577

Steering Group Members Bio-sketches

Name	Bio-sketch
Jeffrey Laird	Jeff has worked in the health care accounting field since graduation from Marshall University in 1982.
Edward Gambrell	Edward has a background in healthcare accounting and has served as CEO of Stephens County Hospital for the past 26 years.
Faye Taylor, RN	Faye has worked at Stephens County Hospital for over 30 years serving in many different roles and jobs including RN, ER Nurse Manager and Director of Nursing.
Heidi Wilkinson	Heidi is a new college graduate who has begun working for Stephens County Hospital in the role of industrial health, advertising and public relations.
Paula Dickerson	Paula is a retired school educator whose husband is a practicing attorney in Toccoa.
Karen Palmer	Karen is an RN who has worked at a couple hospitals in the area including Stephens County Hospital, has served as RN at the County Health Department and currently serves as the regional Health Department RN Administrator for the multi-county area.

APPENDIX F

PROPOSED COMMUNITY ADVISORY COMMITTEE INVITATION LETTER

Dear (County/Community) Leader:

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

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

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

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

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

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

Sincerely,

APPENDIX G

Potential Community Advisory Committee Members

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

APPENDIX H

**Stephens County Hospital
Community Advisory Committee Members**

Name	Occupation	Business/Agency	County	Phone Number	Email
Rev. Jerrell Beatty		Tates Creek Baptist Church	Stephens	706-886-3930	
Sherry Beavers		Open Arms Clinic	Stephens	706-491-8639	Sherry06@windstream.net
Jason Beckerdite		Caterpillar	Stephens		
Rev. Scott Borderud		First Alliance Church	Stephens	706-886-5948	
Rev. Wade Bridges		New Bethel Church	Franklin		
Cynthia Brown	Admin/PR	North Georgia Technical College	Stephens & Habersham		
Michelle Burks		Amedisys	Stephens	706-599-3501	Michelle.burks@amedisys.com
Rev. Tony Byrd		Zebulon Baptist	Stephens	706-886-5270	
Rev. Tommy Childress		New Bethel Baptist Church	Franklin	706-384-7428	
Rev. Andy Childs		Ebenezer Baptist	Stephens		
Janet Cordes		Powerhouse for Kids	Stephens		
Charles Craig		Patterson Pump	Stephens		
Mary Demmler		St. Matthias Episcopal Church	Stephens	706-886-4413	
Oliver Dersey-Linda Arnold		Boys & Girls Club	Stephens	706-886-3771	
Robin Dake		YMCA	Stephens		
Dr. Robert Edmonds	Chiropractor	Edmonds Clinic	Stephens		
Dr. Karen Eschedor	Physician		Franklin	706-356-1111	
Clay Fisher		TruVista	Stephens	706-886-2727	
Rev. Paul Garrison		Hill Street Baptist	Stephens	706-886-0711	
Michelle Jamieson		Open Arms Clinic	Stephens	706-491-7418	Golfer45@yahoo.com

**Stephens County Hospital
Community Advisory Committee Members**

Marie (J. Kaup) Brownlow	School Nurse	Stephens County Schools	Stephens	706-886-9415	
Rev. David Keister					
Gary Lance			Stephens	706-886-8341	gilance@windstream.net
Rev. Dennis Ledford		TruVista	Stephens	706-886-6257	
Dr. Beth Lowery	Dentist		Stephens	706-886-1893	
Rev. Wayne Marcus		Tom's Creek Baptist Church	Stephens	706-779-2474	
Meri Morgan		Morgan Concrete	Stephens		
Juanita Norris	Nurse Practitioner	Toccoa Clinic	Stephens		
Leone Osborne	Owner	Osborne Wood Products, Inc.	Stephens		
Tina Powell			Stephens	706-599-2052	rlsavage@windstream.net
Adrian Praher	Physical Therapist	Flexx Sports and Rehab	Stephens		
Dr. Angela Reese	Pediatrician	Our Kids	Stephens	706-886-1309	
Greg Roach		North Georgia Technical College	Stephens		
Dr. Kay Royal	Optometrist		Stephens	706-886-5214	oodocOO@hotmail.com
Ricky Sanders		Sanders Oil	Franklin		
Kellie Savage	Nursing Home	Pruitt	Stephens	706-886-8491	ksavage@uhs-pruitt.com
Greg Savage	Banking	First Citizens Bank & Trust	Stephens	706-886-9421	
Steve Spruill	Pharmacist	Maddox Drugs	Stephens	706-886-3119	
Von Stephens	Home Health	Care South	Stephens	706-716-0736	vstephens@caresouth.com
Dr. Kimberly Stroud	Physician	Toccoa Clinic	Stephens		
Suzanne Sullivan	Pharmacist	Sullivan Drugs	Franklin		
Sharon Thomason	Respiratory	Next to Me	Stephens	706-886-6649	

**Stephens County Hospital
Community Advisory Committee Members**

	Therapist	Medical Supplies				
Rev. John Thomas			Stephens	706-491-4762		
Dr. Dale Twilley	Dentist		Stephens	706-886-1424		
Rev. Charles White						
Sherrie Whiten	Admin	Stephens County Schools	Stephens	706-886-9415		
Kathy Whitmire	Healthcare Consulting	Home Town Health	Franklin & Stephens	706-491-3493		
Cassandra Wilkins		GEM Southeast	Stephens			
Judy Williams		Amedisys	Stephens	706-491-2314		Judy.williams@amedisys.com
Connie Worley		Kiokin' It	Stephens			

APPENDIX I

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

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

COLLEGE PUBLIC HEALTH

Objectives

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

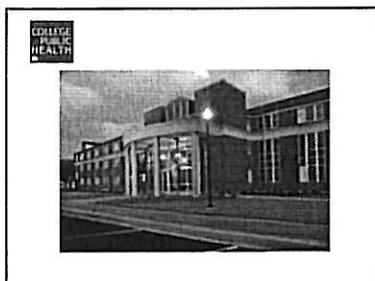


Community Vital Signs

COLLEGE PUBLIC HEALTH

New IRS mandate

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



COLLEGE PUBLIC HEALTH

Project overview

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

COLLEGE PUBLIC HEALTH

The contract

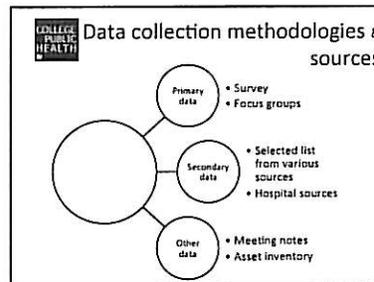
- To organize a steering group to provide assessment support and guidance;
- To complete all community health needs assessments to include asset inventory;
- To prioritize identified community health issues; and
- To educate steering group members and community members




COLLEGE PUBLIC HEALTH

Participating Hospitals

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



APPENDIX J

Community Health Needs Assessment

Stuart H. Tedders, PhD, MS
Marie Denis-Luque, MSPH, MPH

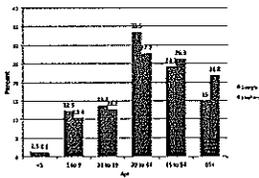
Objectives

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

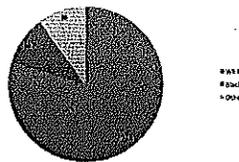
A Brief Snapshot of the Community

Stephens County

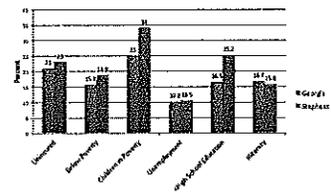
Age



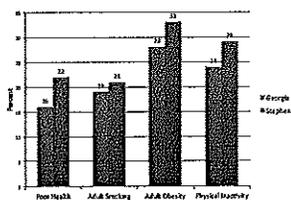
Race



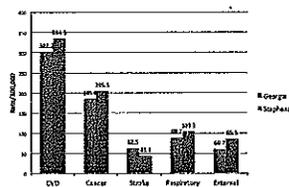
Socio-Economic Status Indicators



Health Status Indicators



Health Status Indicators



Why Are We Here?

The IRS Mandate

Project Overview

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

What is a Community Health Assessment?

The Process

Simply Defined

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

In a Nutshell ...

Health Assessments Are the Starting Point for Solving Complex Community Problems

Three Phases of Completing a Community Health Assessment

Completing a Community Health Assessment

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

Focus Group 101

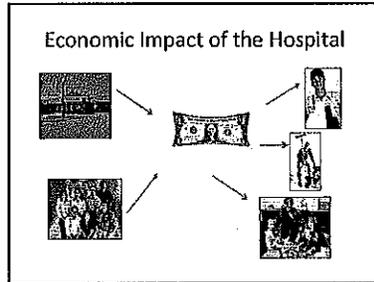
- Small group (5 to 10 people) discussions designed to obtain information about values, attitudes, and perceptions
- Focus groups are moderated
- Responses are recorded and analyzed
- Intention is NOT to reach consensus on issues

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

Because YOU ARE the Community

Specifically, We Need ...

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



Economic Impact of the Hospital

• Total Output/Income Generated	\$117,594,726
• Total Household Earnings Generated	\$57,127,774
• Number of Hospital Jobs Generated	1,398
• Overall Community Benefit	5,376,591
– Uncompensated Indigent Care	
– Uncompensated Charity Care	
– Etc.	

Survey Completion

Community Advisory Committee

Survey Distribution/Focus Group Recruitment

Helpful Hints

Helpful Hints

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

HOWEVER ...

Make sure everyone knows that participation is VOLUNTARY

Do not coerce participation

Actual Administration of Surveys

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

Next Steps

Conducting Focus Groups

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

It Is Time To Hear From You

Discussion of the issues

For Additional Information

Please contact:

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Principal Investigator
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Phone: (912) 478-1922
or
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Research Manager
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Phone: (912) 478-1343

APPENDIX K

Community Health Assessment

Prioritization of Issues

Stuart H. Tiddlers, PhD, MS
 Raymona Lawrence, DPH, MPH
 Marie Denis Luque, MSPH, MPH
 Dazyana Hlazenuk, MPH, MS
 James White, BS

Johns Hopkins Center of Public Health
 Georgia Southern University



Objectives

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



Purpose of the Project



Purpose

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

– Service/Target Area:

- Stephens County
- Franklin County



Community Health Assessment (CHA)

A Review of the Process



Community Health Assessment

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



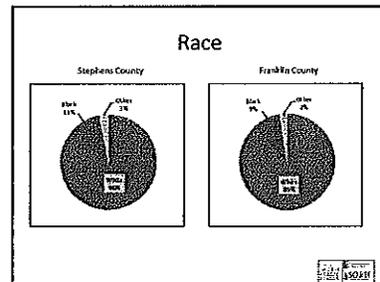
Phases of a CHA

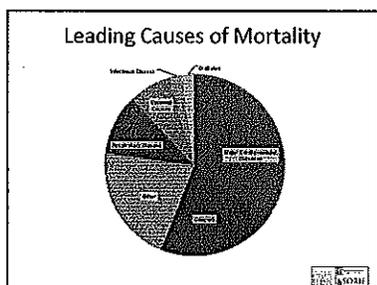
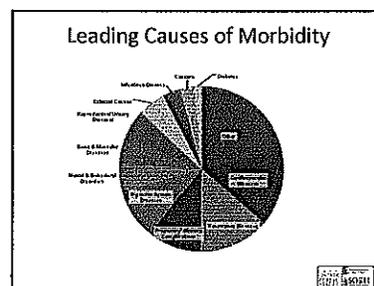
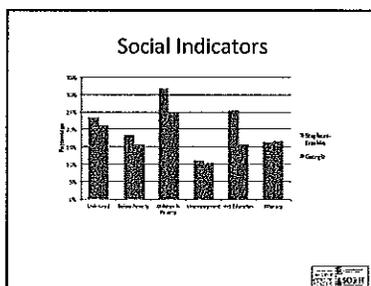
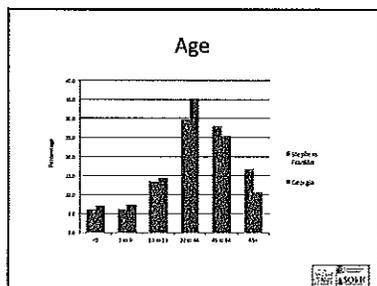
- ✓ Phase 1: Engage the Community In an Open and Honest Discussion of the Issues
- ✓ Phase 2: Collect Data to Document the Issues
 - ✓ Secondary data analysis
 - ✓ Primary data analysis: Community based survey
 - ✓ Primary data analysis: Focus group discussions
- Phase 3: Prioritization of the Issues



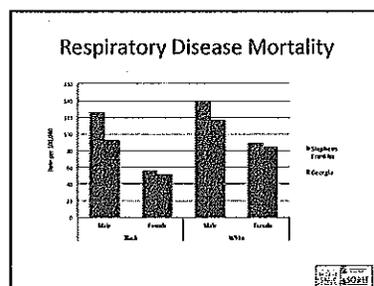
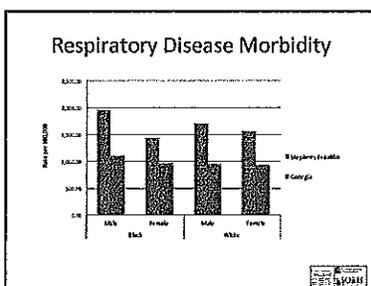
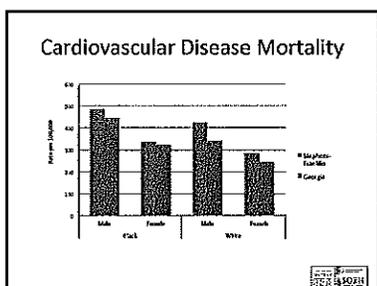
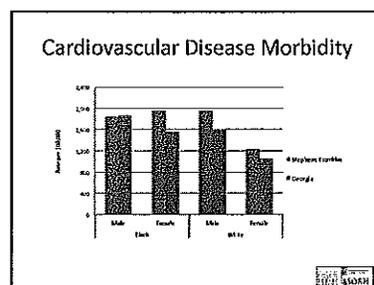
Secondary Data

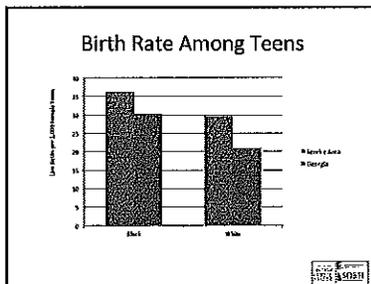
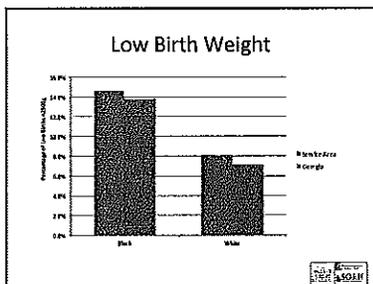
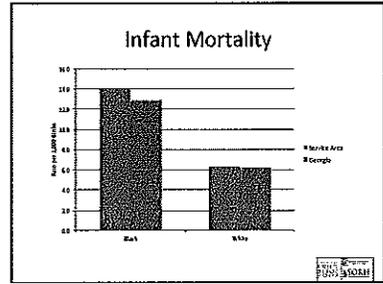
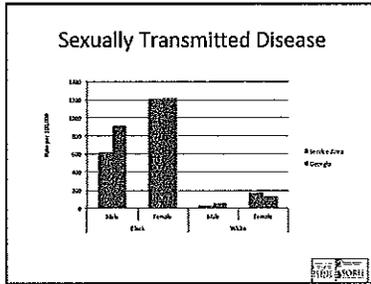
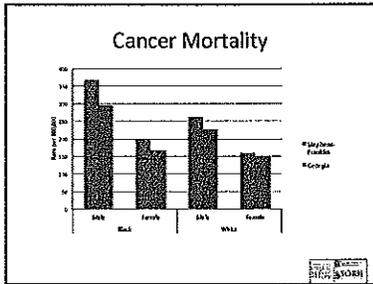
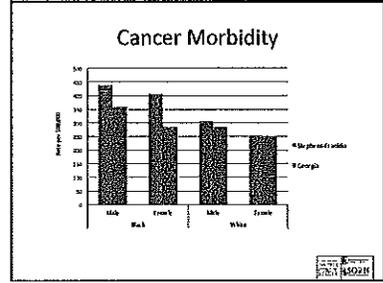
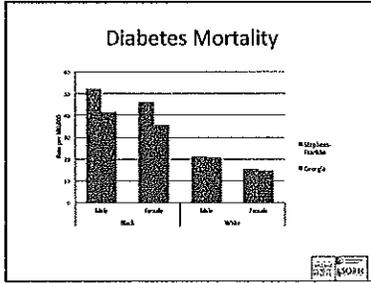
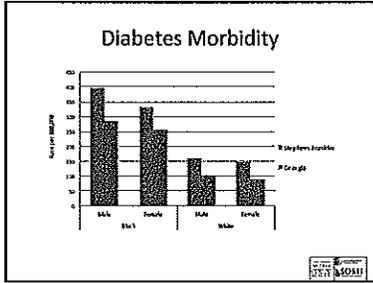
Highlights



Select Trends in Morbidity & Mortality

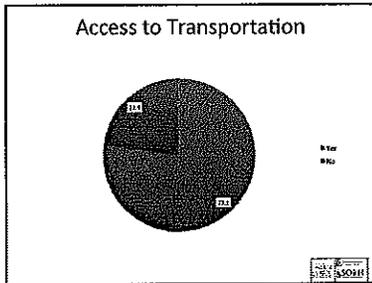
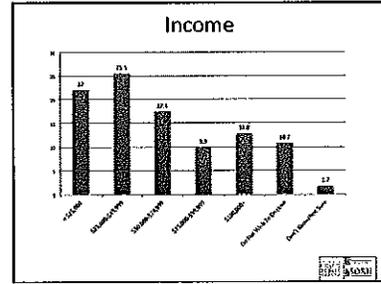
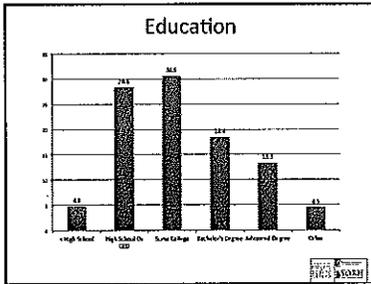
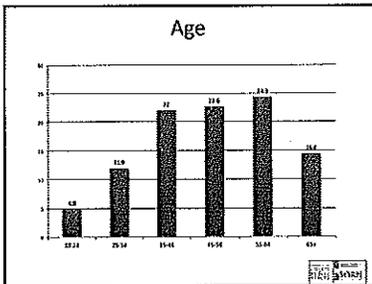
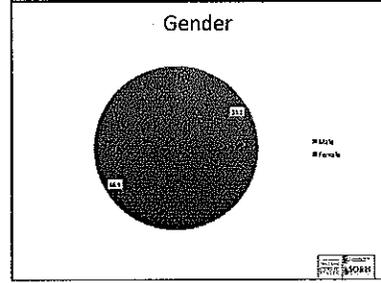
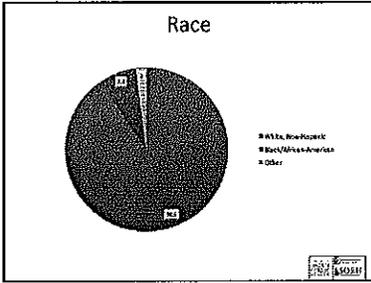




Primary Data: Community-Based Survey
Highlights

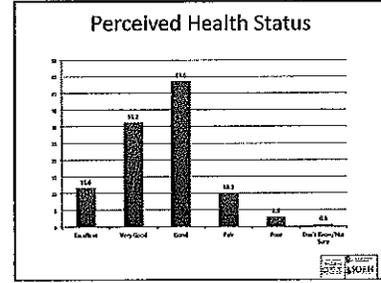
Community Based Survey

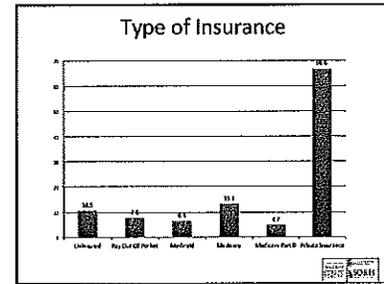
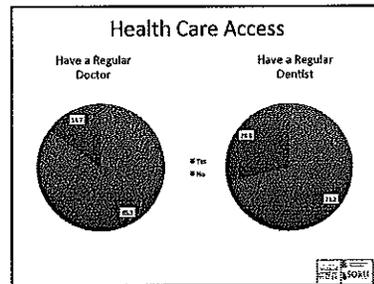
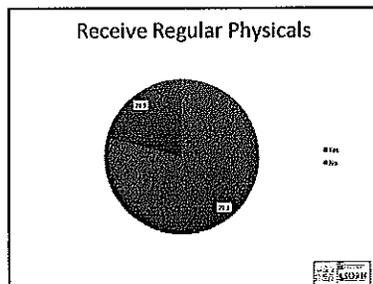
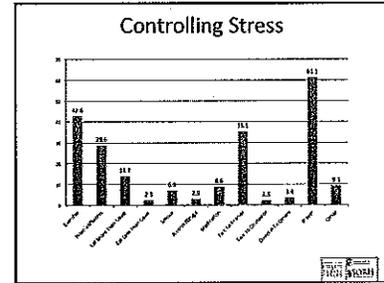
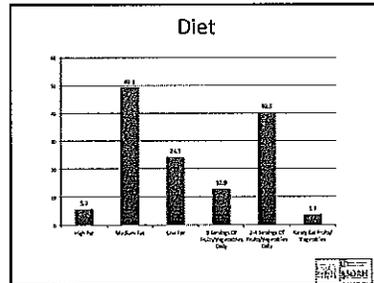
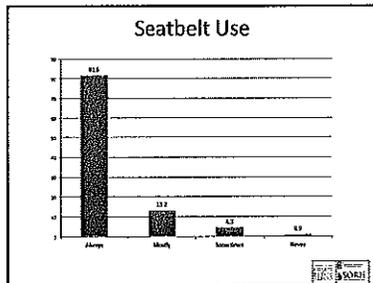
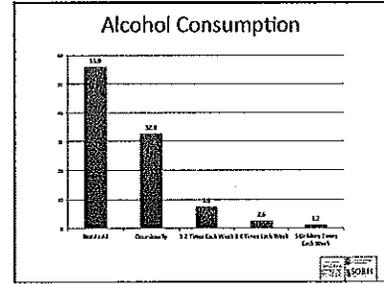
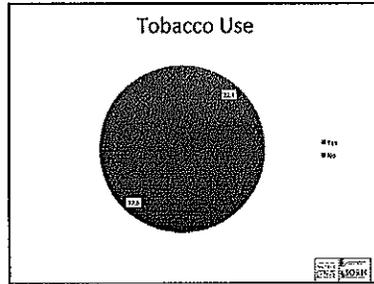
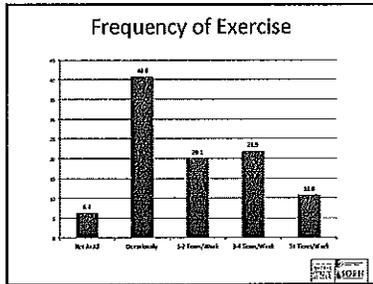
- Target Area
 - Stephens County
 - Franklin County
- 355 of 513 surveys were returned to Georgia Southern University for analysis
 - 69.2% response rate
- 68.8% of participants used hospital services in the last 24 months
 - Among these participants, 87.2% of services were obtained at Stephens County Hospital.



Community Perception

Statement	Agree or Strongly Agree
Is a Good Place to Live	87.4%
Has Strong Economic Growth	13.5%
Has a Strong Health Care System	61.2%
Is a Good Place to Raise Children	78.3%
Is a Safe Community	75.7%
Has a Strong Education System	69.4%





Methods

- Focus Groups
 - Three Focus Groups
 - One: Community Advisory Committee
 - Two: Community members
- Participants
 - 21 Participants
 - Men: 8 Women: 13
 - White: 19 Black: 2
- Age Range
 - 34-79

Results

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

Community

Theme: Beautiful place to live; small town feel, friendly people; safe, great schools system; faith-based community; active community.

"Well I like Toccoa and Stephens County because it's a small town atmosphere. It's very laid back. You don't know everybody, but you know a lot of people. The ones you don't know by name you know by sight. So it's a very enjoyable place to live I think."

Community Issues

Theme: Lack of industries; lack of jobs; poverty; drug abuse; mental health; teenage pregnancy; child abuse; chronic disease; no sidewalks; recycling plant; and no central transportation.

"There's] lack of opportunity for all the age ranges. It's not just the young generation. It's I think worse for them, but it goes through all the ranges of ages up to people that wanna work part time after they retired. The opportunity just is not there."

"An issue for the elderly is Type II Diabetes. [We don't have a] huge amount of children in the school system [with type 2 diabetes], but we have about four or five in each school that have Type I Diabetes right now. We have six schools. So that's a good number of people."

Hospital

Theme: Competent and qualified staff and physicians; caring and compassionate service; updated equipment and technology; connect to community through radio and newspaper; major employer, great facility, and conveniently located.

"... They've got some great doctors. If you go to the emergency room -- I shouldn't name the names, but [physician] down there. One of the kindest most gentlemen you would ever wanna meet in the emergency room situation."

"I have got to use this hospital more than I care to even think about, and one thing that always sticks in my mind is we are very fortunate in the quality and caliber of the staff in this hospital...I don't remember ever having a bad problem with anybody... The people are great...Food's gone downhill. I gotta tell you that."

Hospital Problems

Theme: Parking lot expansion; cafeteria food; lack of oversight and coordination in ER; hospital misdiagnosis; medical billing process; and hospital transportation.

"They could expand the parking lot. You have to hunt for a place to park. I've got a bad back and bad knees, and it's hard for me to walk across that parking lot."

"My family had one bad experience here. My [] came up here with chest pains. Obviously serious heart problem. They kept [] overnight and [] [] home and said there was nothing wrong and two weeks later [] died from a massive heart attack. It didn't sit very well. [] maybe was shoved out the door too fast here and maybe the diagnosis wasn't right or something. I don't know, but it was within two weeks of having another heart attack."

Recommendations

Theme: Community partnerships; promote services through well-known institutions; offer education programs/prevention and engage on and off campus; follow-up care; improve cafeteria food; outreach in all segments of the county; explain ACA to community; wellness promotion in schools; and preventive role on elderly care.

"Possibly look at using some of the local churches in parts of the community where we have the biggest problems as far as diabetes and nutrition, and see if the hospital can set up some programs within the churches where they can pass on information, even send people to attend programs, set up programs to help educate the parents and the children at the same time."

Community Vision

Theme: Less poverty; more industries; raise awareness; and prevention programs

"Well, certainly we've talked about improving awareness, but you talk conditions like diabetes and hypertension. You're not in any pain. You don't think about going to the doctor, but you still need to know about it. Those type of things. If we could raise the awareness on just a few of those I think it would help."

Emergent Community Issues

Generating Consensus for the Strategic Plan
Issues to be Prioritized

- A. Chronic Disease Conditions (Heart Disease, Cancer, Respiratory, Diabetes, Etc.)
- B. Maternal/Child Health (Infant Mortality, LBW)
- C. Teenage Pregnancy
- D. Economic Development (Lack of Industry, Jobs, Poverty, Environmental Modifications/Bike Paths/Etc.)
- E. Mental Health (Accessibility/Affordability)
- F. Behavioral Health Issues (Substance Abuse, Child Abuse, Etc.)
- G. Issues Associated with Community Health Education & Outreach (Exercise, Diet, Tobacco, Etc.)
- H. Issues Associated with Elder Care (Housing, Boomers, Etc.)
- I. Accessibility/Affordability of Transportation



Prioritization of the Issues



The Basics of Health Prioritization

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

Prioritization is an exercise based on
"WHAT YOU THINK!"



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



Instructions for Prioritization

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



Issues to be Prioritized

- A. Chronic Disease Conditions (Heart Disease, Cancer, Respiratory, Diabetes, Etc.)
- B. Maternal/Child Health (Infant Mortality, LBW)
- C. Teenage Pregnancy
- D. Economic Development (Lack of Industry, Jobs, Poverty, Environmental Modifications/Bike Paths/Etc.)
- E. Mental Health (Accessibility/Affordability)
- F. Behavioral Health Issues (Substance Abuse, Child Abuse, Etc.)
- G. Issues Associated with Community Health Education & Outreach (Exercise, Diet, Tobacco, Etc.)
- H. Issues Associated with Elder Care (Housing, Boomers, Etc.)
- I. Accessibility/Affordability of Transportation



Thank You!

For Additional Information About This Project:

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or

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APPENDIX L

Meeting Agenda
Stephens County
Tuesday, July 17, 2012
1PM-2:30PM

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

Meeting 2: Agenda
Stephens County Hospital
Thursday, August 16, 2012
3:00PM-5:00PM

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

Meeting 3: Agenda
Stephens County Hospital
Friday, May 3, 2013
1:00PM-3:00PM

- | | | |
|------|---|--------------------|
| I. | Introductions | Site team leader |
| II. | Project Purpose | Dr. Tedders |
| III. | Community Health Assessment | Dr. Tedders |
| | Review of the Process | |
| | Review of Secondary Data | |
| | Review of Primary Data: Survey & Focus Groups | |
| | Emergent Community Issues | |
| | Narrowing the List: Multi-Voting Exercise | |
| | Prioritization of the Issues | |
| IV. | Group Discussion | Dr. Tedders |
| V. | Prioritization process | Dr. Tedders & Team |
| VI. | Adjourn | |

APPENDIX M

Name	Agency/Business	Phone number(s)	Preferred Email address
TERRY LARA Controller	Stephens County Hospital	(706) 282-4281	jlarid@stephenscountyhospital.com
Heidi Wilkinson Community Health Educator	Stephens County Hospital	706-282-4140	hwilkinson@stephenscountyhospital.com
Faye Taylor Director of Nursing	"	706-282-4253	ftaylor@stephenscountyhospital.com
ED GAMBRELL ADMINISTRATOR	"	706-282-4250	egambrell@stephenscountyhospital.com

LAST	FIRST	CONFIRMED	Attendance Sign-in August 16 Meeting
Allgood	Ellen	8/15/12 HJW **	
Beatty	Rev. Jerrell	8/13/12 HJW **	
Beavers	Sherry	8/9/12 HJW	
Beckerdtie	Jason		
Borderud	Rev. Scott	8/14/12 HJW	
Bridges	Rev. Wade		
Brown	Cynthia	8/8/12 JBL	
Brownlow	Marie (J. Kaup)	8/10/12 HJW	
Burks	Michelle	8/13/12 HJW	
Byrd	Rev. Tony		
Childress	Rev. Tommy		
Childs	Rev. Andy	8/15/12 HJW	
Cothran	Angie	8/14/2012 HJW	
Dake	Robin	8/7/12 HJW **	
Dorsey	Oliver	8/14/12 HJW **	
Edmonds	Dr. Robert		
Eschedor	Dr. Karen		
Fisher	Clay	8/7/12 HJW	
Garrison	Rev. Paul		
Jamieson	Michelle	8/13/12 HJW	
Keister	Rev. David	8/13/12 HJW	
Lance	Gary	8/13/12 HJW	
Leford	Rev. Dennis	8/9/12 JBL	
Marcus	Rev. Wayne	8/13/12 HJW	
Morgan	Merl	8/10/12 HJW	
Norris	Juanita	**	
Osborne	Leone		
Powell	Tina	8/13/12 HJW	
Prather	Adrian		
Roach	Greg	8/13/12 HJW	
Royal	Dr. Kay	**	
Savage	Kellie	8/13/12 HJW	
Savage	Greg	8/7/12 HJW	
Sprull	Steve	8/10/12 HJW	
Stephens	Von	8/13/12 HJW	
Stowe	Jerry		
Stroud	Dr. Kimberly	8/10/12 HJW	
Sullivan	Suzanne		
Thomas	Rev. John	8/8/12 HJW	
Thomason	Sharon	8/13/12 HJW	
White	Rev. Charles		
Whiten	Sherrie	8/10/12 HJW	
Whitmire	Kathy	8/13/12 JBL	
Williams	Judy	8/13/12 HJW	

Steering Committee

Dickerson	Paula		
Gambrell	Ed		
Laird	Jeff		
Palmer	Karen		
Segars	Alesia		
Taylor	Faye		
Wilkinson	Heidi		

Georgia Southern University

Denis-Luque	Marie		
Tedders	Dr. Stuart		

Don Austin

Donna Sue Campbell - District 2 Public Health
D. on T. Johnson

Stephens Co. MTG-2

Barbara Steiner for Service Unit

	Whiten
	Whitmire
	Kathy
	Cassandra
	Williams
	Judy
	Woodruff
	Marilyn
	Worley
	Conlie
	Cothran
	Alligood
	Ellen
	Shelton
	Jeff-Lane
	Miss Sears
	Ms. Wilkinson
	Ed GAMBRETT

Community Health Needs Assessment Minutes and Notes

July 17, 2012 (1:00pm - 3:00pm)

The Steering Committee met with Dr. Stuart Tedders and Marie Denis-Luque from Georgia Southern University's College of Public Health (GSU) concerning the process of conducting a Community Health Needs Assessment (CHNA). GSU was awarded a grant to assist small, rural communities with this effort and the community Hospital in complying with the 501(r) requirements relating to the CHNA. The meeting concluded with a decision to have Dr. Tedders and Marie meet with the Community Advisory Committee (CAC) on the afternoon of Thursday, August 16 at 3:00pm to discuss the process and train on survey data collection techniques.

After the meeting with Dr. Tedders and Marie, the Steering Committee discussed additional members of the committee to include Paula Dickerson from the Hospital Board of Trustees and Karen Palmer, RN from the Health Department. The group then discussed possible members of the CAC which Jeff Laird began to comprise the list for a future mailing to invite the CAC members to the scheduled meeting on Thursday, August 16.

August 1, 2012

A copy of the proposed survey instrument was distributed to all Steering Committee members to review and provide feedback on the usefulness, ease of reading and understanding and content of the survey.

August 2, 2012

A marked up copy of the survey was returned to Marie at GSU.

August 3, 2012

Jeff Laird began the process of compiling addresses and other contact information of potential CAC members and preparing the letter and envelopes for a mailing.

August 4, 2012

The invitations to the potential CAC members were mailed. The letter asked that the potential CAC member contact either Jeff or Heidi Wilkinson by phone as to their acceptance to serve. Heidi has offered to follow-up by phone towards the end of next week on those not heard from.

August 7, 2012

A pilot group was gathered and 5 individuals took the survey. There were many suggestions from this group for changes and clarifications in the survey to make it more user friendly and easier to understand. These recommendations along with a copy of each survey was forwarded to Marie at GSU.

August 8, 2012

Three additional invitations were mailed out to individuals identified by Heidi from the Carnesville area in an attempt to stretch our effort in that section of our market area. (Susanne Sullivan of Sullivan's Drug Store, Ricky Sanders or Sanders Oil, Rev. Wade Bridges of New Bethel Church)

August 13, 2012

Received 4 returned invitation for incorrect addresses. Gave those to Heidi as she is following up by phone on each invitation sent out.

Spoke with Marie this morning, updated on progress and everything looks good for Thursday meeting.

Also spoke with Dr. Tedders this afternoon. They would like a representative from the Hospital to give a short (4-5 minute) overview of services, economic impact on community, etc. I will get with Mr. Gambrell on Tuesday morning to discuss this.

Also attempted to add Marie to the share list for this document as well as the invitation acceptance document. Will see if it works. If not, I can assign her a temporary account at the stephenscountyhospital.com domain on Thursday.

APPENDIX N



MEMORANDUM

DATE: May 10, 2012

TO: Hospital and Health System CEOs

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

SUBJECT: Economic Impact Report

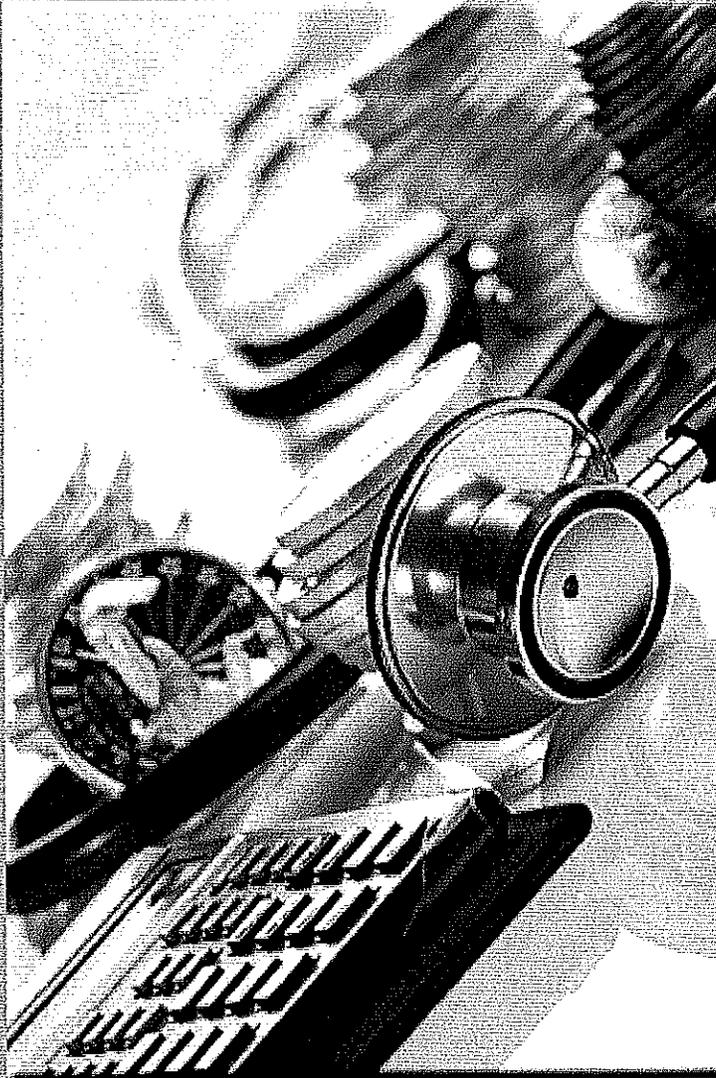
In an effort to assist you in communicating the economic impact of your hospital to local media, business, civic, and other community leaders, we have developed a hospital specific report to be used in your local community. This report is based on a study performed by the American Hospital Association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

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

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

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

Georgia Hospitals - Vital Economic Engines for Georgia's Economy



Economic Impact Report



Economic Impact Report

Executive Summary

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

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

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

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

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

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

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

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

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

Sources:

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

Technical Note:

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

Worksheet S-3, Part II: Hospital Wage Index Information—Column 3, Line 1—Total Salaries
Worksheet A: Total Facility Costs—Column 7, Line 5—Employee Benefits—Net Expense for Allocation

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

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

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

Stephens County Hospital

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$50,836,385
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$117,594,726
Hospital Payroll and Benefits	\$30,738,646
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$57,127,774
Number of Hospital Jobs (Full and Part Time)	650
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	1,398

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$1,967,712
Uncompensated Charity Care Provided	\$187,067.59
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$3,221,811
Other Free Uncompensated Care	\$0
TOTAL:	<u>\$5,376,591</u>

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

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

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

Center for Rural Health Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010



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

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

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

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

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

Rural Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010



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

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

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

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

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

Congressional District 10, Rep. Paul Broun

Economic Impact on the Local and State Economy
Calendar Year 2010



SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	\$1,731,290,926
Georgia Output Multiplier ¹	2.3132
Total Output/Income Generated	\$4,004,822,170
Hospital Payroll and Benefits	\$864,045,537
Georgia Earnings Multiplier ²	1.8585
Total Household Earnings Generated	\$1,605,828,630
Number of Hospital Jobs (Full and Part Time)	16083
Georgia Employment Multiplier ³	2.15
Georgia Full Time Jobs Created⁴	34,578

SECTION II: Community Benefit	
These numbers represent the actual cost⁵ incurred by the hospital	
Uncompensated Indigent Care Provided	\$56,717,468
Uncompensated Charity Care Provided	\$13,523,031.74
Uncompensated Bad Debt Incurred on Health Care Services Provided	\$76,315,680
Other Free Uncompensated Care	\$7,267,483
TOTAL:	\$153,823,663

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

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

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

State of Georgia

Economic Impact on the Local and State Economy
Calendar Year 2010



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

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

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

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

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

APPENDIX O

Instrument Pilot Test Instructions

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

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

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

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

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

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

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

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

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

APPENDIX P

County Health Assessment Survey

Thank you for taking time to give us your input.

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

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

Please select only one answer unless otherwise instructed.

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Contact Information

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I. DEMOGRAPHIC

1. What is your gender?

- Male
- Female

2. What is your ethnicity/race?

- White, Non-Hispanic
- Black/African-American
- Hispanic/Latino
- Asian/Pacific Islander
- American Indian/Alaskan

Native

Other: _____

3. Which of the following age ranges best describes you?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 or older

4. What is your marital status?

- Single
- Married
- Separated
- Living Together
- Divorced
- Widowed
- Other

5. What is your highest level of education?

- Less than High School
- High School or GED
- Some College
- Bachelor's degree (BA, BS)
- Advanced degree (MA, PhD)
- Other: _____

II. ECONOMIC STATUS

6. What best describes your current employment status?

- Student
- Full-Time
- Part-Time
- Retired
- Self-Employed
- Unemployed
- Not Seeking Employment

7. What is your household income?

- Under \$25,000
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 or more
- Do not wish to disclose
- Don't know /not sure

8. Do you own your home?

- Yes
- No

9. Do you have access to your own means of transportation?

- Yes
- No

10. What is your residential zip code?

- 30577
- 30557
- 30538
- 30523
- 30553
- Other: _____

11. How many people live in your household? _____.

12. How many of these people have jobs? _____.

13. How many of the people live with you who are dependent on you?

- None
- 1
- 2
- 3 or more

III. HOSPITAL

14. Have you or anyone in your household used the service of a hospital in the last 24 months?

- Yes
- No (Skip to Question #28)
- Don't know (Skip to Question #28)

15. At which hospital were services received?

- Stephens County Hospital
- Some other hospital. List the city or cities where the hospital(s) was located

_____ then
Skip to Question #29.

16. You responded that you or someone in your household received services at Stephens County Hospital, why did you or family member choose Stephens County Hospital?

- Physician referral
- Quality of care
- Closer, more convenient
- Availability of Specialty Care
- Insurance
- Other: _____

17. What hospital services were used at Stephens County Hospital?

- Radiological Imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
- Laboratory
- Inpatient services
- Other Outpatient services
- Emergency room (ER)
- MedLink
- Oncology
- Other (Please list)

18. How satisfied were you or someone else in your household with the services received at Stephens County Hospital?

- Satisfied (Skip to Question #21)
- Dissatisfied
- Don't know (Skip to Question #22)

19. Why were you *dissatisfied* with the services at Stephens County Hospital? (Skip to Question #21)

Answer: _____

20. Why were you *satisfied* with the services at Stephens County Hospital?

Answer: _____

21. Do you use a primary care (family) doctor, physician assistant or nurse practitioner for most of your routine health care?

- Yes
- No
- Don't know

If no, what kind of medical provider do you use for routine care?

- Community Health Clinic
- MedLink
- Health Department
- Open Arms Clinic
- Emergency Room Hospital
- Specialist
- Other _____

25. Why were you *satisfied* with the quality of physician care affiliated with Stephens County Hospital?

Answer: _____

26. Are you able to get an appointment with the primary care (family) doctor, physician assistant or nurse practitioner affiliated with Stephens County Hospital when you need one?

- Yes
- No
- Don't know

27. What services would you like to see offered at Stephens County Hospital?

Answer: _____

IV. YOUR COMMUNITY

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

22. Have you or someone else in your household been to a primary care (family) doctor, physician assistant or nurse practitioner affiliated with Stephens County Hospital?

- Yes
- No (Skip to Question #27)
- Don't know (Skip to Question #27)

23. How *satisfied* were you or someone else in your household with the quality of the physician care or (physician assistant or nurse practitioner) care received at the Stephens County Hospital? Would you say you were

- Satisfied (Skip to Question #25)
- Dissatisfied
- Don't know (Skip to Question #28)

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

V. INDIVIDUAL BEHAVIORS and HABITS

24. Why were you *dissatisfied* with the quality of physician care affiliated with Stephens County Hospital?

Answer: _____

29. How often do you exercise?

- Not at all
- Occasionally
- 1-2 times each week
- 3-4 times each week
- 5 or more times each week

**** (If Male, Skip Question #30)**

30. Do you do a monthly breast self-exam?

- Yes
- No

VI. HEALTHCARE SEEKING BEHAVIOR and CONDITIONS

31. Do you use tobacco products?
(cigarettes, cigars, chewing & dipping tobacco)
Yes
No

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

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

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

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

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

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

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

39. What type of health insurance do you have?
Uninsured. I don't have health insurance (Go to Question #42)
I pay out of pocket (Go to Question #42)
Medicaid
Medicare
Medicare Part D
Private (HMO, PPO)

40. How long have you had this health insurance? (Specify: _____.)

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

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

43. Where do you usually go when you are sick or need health care?
(Check all that apply)
Private practice/ family doctor
Hospital Emergency Department
Health Department
Community Health Center
Other (Please specify) _____

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

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

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

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

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

Answer: _____

Thank you again for completing the survey!

APPENDIX Q

Community Health Needs Assessment Project Focus group Preparation Logistics

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

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

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

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

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

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

APPENDIX R

COMMUNITY HEALTH NEEDS ASSESSMENT FOCUS GROUP GUIDE

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

The first few questions are about your community in general:

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

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

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

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

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

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

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

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

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

COMMUNITY VISION

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

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

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

APPENDIX S



DEMOGRAPHIC QUESTIONS

1. Gender: _____

2. What year were you born? _____

3. What is your ethnicity/race?

4. What languages do you speak?

5. What is your occupation?

a. Are you a manager? Yes / No

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

6. Name of Organization where you work:

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

8. How long have you worked there?

9. What is your zip code? _____

10. What town do you live in?

11. Children in the home

under 18: _____

over 18: _____

12. What is your level of education? (*Circle*)

High School

Some College, Technical School

College Degree

Advanced Degree

13. What is your household income?

Under \$25,000

\$25,000 to \$49,999

\$50,000 to \$74,999

\$75,000 to \$99,999

\$100,000 or more

Don't know /not sure

**THANK YOU FOR YOUR
PARTICIPATION**

APPENDIX T

WHAT IS THE PROJECT ABOUT?

The purpose of this research project is to:

- 1) Help 18 rural nonprofit hospitals in addressing the Community Health Needs Assessment as mandated by the Internal Revenue Service (IRS) in accordance with the Patient Protection and Affordable Care Act.
- 2) Empower rural communities and underserved populations by providing a snapshot of overall community health status.

You are being asked to take part in the research project because you have valuable insight into your community.

WHAT WILL YOU BE ASKED TO DO?

If you want to take part, you will be asked to:

- Participate in a 60-90 minute discussion about the health status of your community.

WHAT WILL YOU GET OUT OF BEING IN THE PROJECT?

- Results from the focus groups will be used to determine the health status of your community and will assist in completing a community health assessment.

- This will assist your community hospital in completing IRS requirements for a community health assessment.

ARE THERE RISKS TO TAKING PART?

Taking part in this research study should not put you at risk. You may be uncomfortable sharing some health related information. However, you can be sure that none of the information from the focus group will be connected to you. It is confidential and will not be shared with anyone.

ARE THERE COSTS TO TAKING PART?

There are no costs to taking part in the study other than the time to participate in the discussion.

DO YOU HAVE TO TAKE PART?

You do not have to be part of the study if you do not want to. Taking part in the study is up to you. You can stop taking part at any time. If you decide to stop, no one will be angry or upset with you.

IS WHAT I SAY IN THE FOCUS GROUP PRIVATE?

Focus groups will be recorded. However, to protect your privacy, your name will not be included in the focus group data. This information will not be connected to you in any way. All data will be reported as a summary of information.

WHO ARE THE PEOPLE RUNNING THIS STUDY? CAN I CALL THEM?

The Principal Investigator for this research study is Dr. Stuart Tedders. His telephone number is (912) 478-1922. He is the Associate Dean of the Jiann Ping Hsu College of Public Health at Georgia Southern University. His address is PO Box 8015, Statesboro, GA 30460. His email address is stedders@georgiasouthern.edu

You may also contact:

Office of Research Services and Sponsored Programs

Georgia Southern University
P.O. Box 8005

Statesboro, GA 30460-8005

Phone: 912-478-5465

Fax: 912-478-0719

E-mail: research@georgiasouthern.edu

AGREEMENT STATEMENTS

Do you have any questions about the research study?

YES NO

Do you agree to take part in the research study?

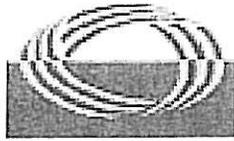
YES NO

If you sign your name below, it means that you agree to take part in the research study.

Signature of Participant

Printed Name of Participant

Date



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



SORH

GEORGIA STATE OFFICE OF RURAL HEALTH

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JIANN-PING HSU
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HEALTH

The Community Health
Needs Assessment Project

The Community Health
Needs Assessment
Project

APPENDIX U

12/6

Stephens County

2:30- CAC

FG 2

- Dale Austin ✓
- Sherry Beavers ✓
- Kellie Savage ✓
- Sherrie Whiten ✓
- Marie Brownlow ✓
- Paula Dickerson ✓
- Gary Lance ✓
- Karen Palmer ✓

(6)

12:00

FG 1

- Ken Robb ✓
- Justine Moore ✓
- Peggy Swafford ✓
- Kathy Boon ✓
- Dr. Carlene Hoffman ✓
- Kim Stewart ✓
- Lacy Dillard ✓

Gordon Broome ✓

Cecil Swafford ✓

(9)

5:00

FG 3

- David Tate ✓
- Bobbie Martin ✓
- Laura Coleman ✓
- Marilyn Woodruff ✓
- Aaron Plaisted ✓
- Bill Standard ✓

(6)

Stephens Co + Habersham Co.

APPENDIX V

