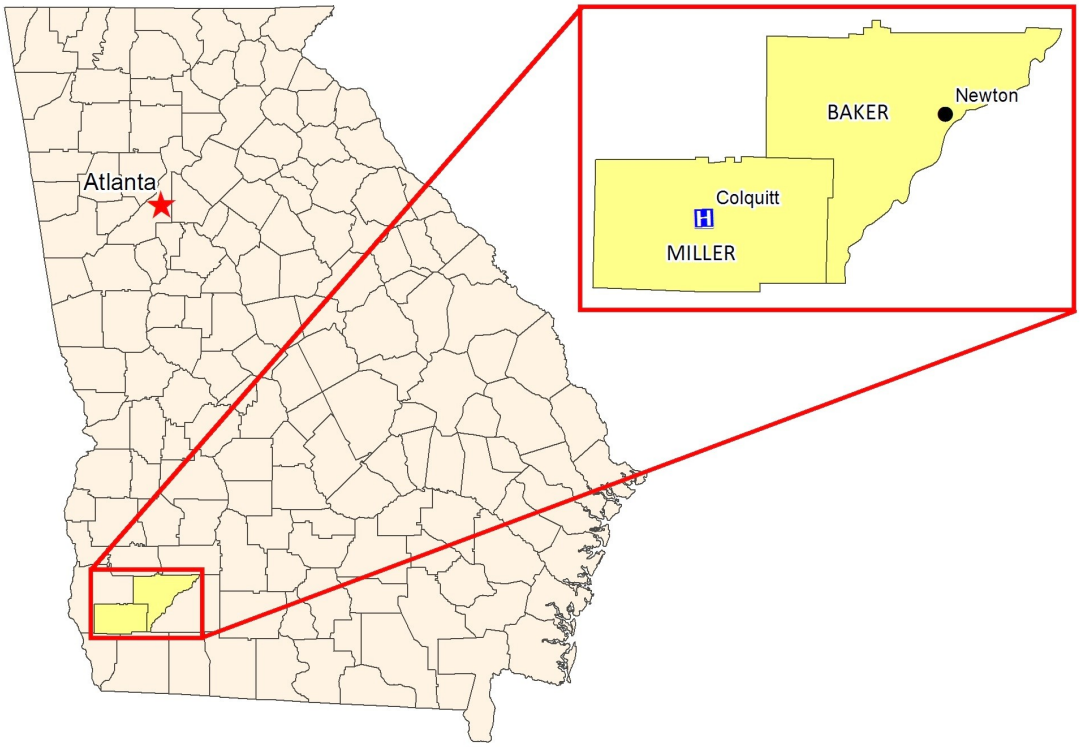
# Miller County Hospital
## *Community Health Needs Assessment*





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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.

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# EXECUTIVE SUMMARY

## Purpose

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

## Service (target) Area

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

- ✓ The specific target area for Miller County Hospital was Miller and Baker 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 one-stage process was used to complete the prioritization of issues in each community. Prioritization involved the Hanlon Method to obtain the final prioritization of issues.

**Results: Secondary Data Analysis**

- ✓ The majority of the population is white (70.0%) in Miller County, while African-Americans constitute the largest minority (approximately 28.0%). In Baker County, 51.0% of the population is white and 47.0% of the population is African-American.

- ✓ Diabetic screenings for Miller County are below the state average, but screenings in Baker County are above the state average.

- ✓ The number of preventable hospital stays in Miller County is much higher than the state average.

- ✓ In 2008, the service area had a total of 12 physicians, mostly Family Practice.

***Morbidity***

- ✓ Cardiovascular diseases are the largest cause of morbidity, and these rates are slightly lower than the state rates across all demographic groups.

- ✓ In the service area, African Americans males have higher rates of stroke.

- ✓ Obstructive Heart Disease (OHD) rates are lower than state rates across all demographic groups.

- ✓ The rates of respiratory diseases are consistently higher than the state average for each race and gender classification.

- ✓ African Americans and white females have the highest rates of asthma as compared to the state rates.

- ✓ The cancer morbidity rate is slightly below the state rate for all demographic groups.

- ✓ Hospital discharge rates for diabetes for all groups are higher than the state rates, particularly among African Americans.

- ✓ African Americans have the highest rates of HIV/AIDS, but these rates are lower than the state average. However, the rate among white females is higher than the state average.

- ✓ The rate of sexually transmitted infections among African American females is similar to the state rate. Among white females, the rate is slightly elevated above the state.

***Mortality***

- ✓ Rates of cardiovascular disease mortality in the service area are similar to observed state rates.

- ✓ Total stroke mortality rate among African American females is higher than the state average.

- ✓ Rates of obstructive heart failure mortality are lower than the state rate across all demographic groups.

- ✓ The mortality rates for respiratory disease were higher than the state rates for African-American males and whites.

- ✓ The total age-adjusted cancer mortality rates among white males and African American females are elevated above the state rates.

- ✓ The age-adjusted diabetes mortality rates for African-Americans and white males are higher than the observed state rates.

***Maternal and Child Health***

- ✓ The percentage of births receiving less than five prenatal care visits is lower that the state rate for both demographic groups.

- ✓ The infant mortality rate for African American is consistent with the observed state rate.

- ✓ The percentage of low birth weight babies in the African American population is more than twice higher than in whites.

- ✓ The percentage of low birth weight births for teen mothers for whites and African-Americans is similar to the state rates.

**Results: Community-Based Survey**

- ✓ A total of 477 surveys were completed and returned to Georgia Southern University for analysis.
- ✓ Considerably more females (71.8%) completed this survey than males (28.2%).
- ✓ Most respondents were either white (60.9%) or African American (36.9%).
- ✓ Nearly 52.0% of all participants were between the ages of 25 and 54 years old.
- ✓ Equal proportions of of respondents reported having some college education or having a high school diploma or the equivalent.
- ✓ Most survey participants (49.3%) indicated they worked full-time while only 9.9% reported part-time work. Approximately 8.1% of participants reported they were unemployed.
- ✓ Over 42.0% of participants reported household incomes of less than $25,000 per year.
- ✓ A considerable proportion of the respondents reported having access to transportation (87.7%).
- ✓ 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.
- ✓ Approximately 45.3% of respondents perceived their health status as "good," and 27.0% perceived their health status as "very good."
- ✓ A majority of respondents reported either exercising occasionally exercising (40.8%) or not at all (13.2%).
- ✓ 52.6% of the female respondents reported completing a self-breast examination.
- ✓ Most respondents (70.8%) reported not using tobacco.
- ✓ 90.1% of respondents reported never consuming alcohol (56.0%) or only consuming it occasionally (34.1%).
- ✓ Most respondents reported always (71.3%) or mostly (18.8%) using seatbelts.
- ✓ Prayer (61.1%) was the most commonly reported strategy for controlling stress. However, talking to friends (36.5%), exercise (35.1%), and hobbies/sports (23.3%) were also commonly reported.

- ✓ The majority of survey respondents (74.1%) indicated they received physicals on a regular basis.
- ✓ Most (85.7%) respondents reported having a regular doctor.
- ✓ 47.7% of all respondents indicated having private insurance to pay for health care services. Approximately 33.3% reported being Medicare beneficiaries and 13.8% reported being on Medicaid.
- ✓ 61.0% of respondents indicated having a regular dentist.
- ✓ 50.4% of respondents reported seeking health care from a private practice.
- ✓ 71.7% percent of respondents indicated that cost was not a barrier to receiving health care services.
- ✓ Nearly 70.0% of respondents indicated that cost was not a barrier to filling a prescription medication.
- ✓ Ear/nose/throat infections (26.0%) were the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room (ER).
- ✓ Among respondents surveyed, 61.9% used hospital services in the last 24 months. Among those reporting using hospital services, 66.5% indicated using services at Miller County Hospital.
- ✓ Most participants reported using Miller County Hospital because of convenience (58.2%). However, 23.4% reported being referred by a physician.
- ✓ The emergency room (56.9%), radiologic services (43.6%) and laboratory services (48.1%) were the most commonly reported services used by survey respondents.
- ✓ 88.0% of those surveyed indicated being satisfied with services while only 6.5% indicated dissatisfaction.
- ✓ Approximately 92.4% of those surveyed indicated using a primary care physician.

**Results: Focus Group Analysis Themes**

- ✓ Community: Peaceful; everybody knows everybody; safe place to live; family oriented; and rural lifestyle.

- ✓ Community Issues: Lack of privacy; lack of resources; shortage of doctors; substance abuse; mental health issues; teenage pregnancy; transportation; lack of jobs.

- ✓ Hospital: Compassionate practitioners; community-friendly; quality care; respect patients' privacy; managed resources wisely; biggest employer in Miller County; and offered a variety of services.

- ✓ Hospital Problems: Hospital staff lacked customer service skills; high physicians' turnover; need to advertise existing service; and long wait in clinic.

- ✓ Recommendations: Health education programs; health fairs in Baker County churches; develop list of services provided; use different mass media to advertise services; free care clinic; offer specialty services (OBGYN, labor and delivery); more specialists; daycare for hospital staff; MRI/CT scan, mammogram in-house; trauma care; cancer care; and morgue.

- ✓ Community Vision: Youth development; health improvement; economic growth.

**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), Behavioral Health Issues (Mental Health, Substance Abuse), Community Health Education (Tobacco, Nutrition, STD, Teen Pregnancy, Etc.), Child Health, Perception of Access to Healthcare (Shortage of Physicians), Access to Transportation

- ✓ **Following the prioritization exercise the rank order of community issues included**: Chronic Disease Conditions ranked highest according to the calculated BPR score. This issue was followed by Community Health Education, Child Health, Perception of Access to Healthcare, Access to Transportation, and Behavioral Health Issues.

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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 than 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 measureable 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*

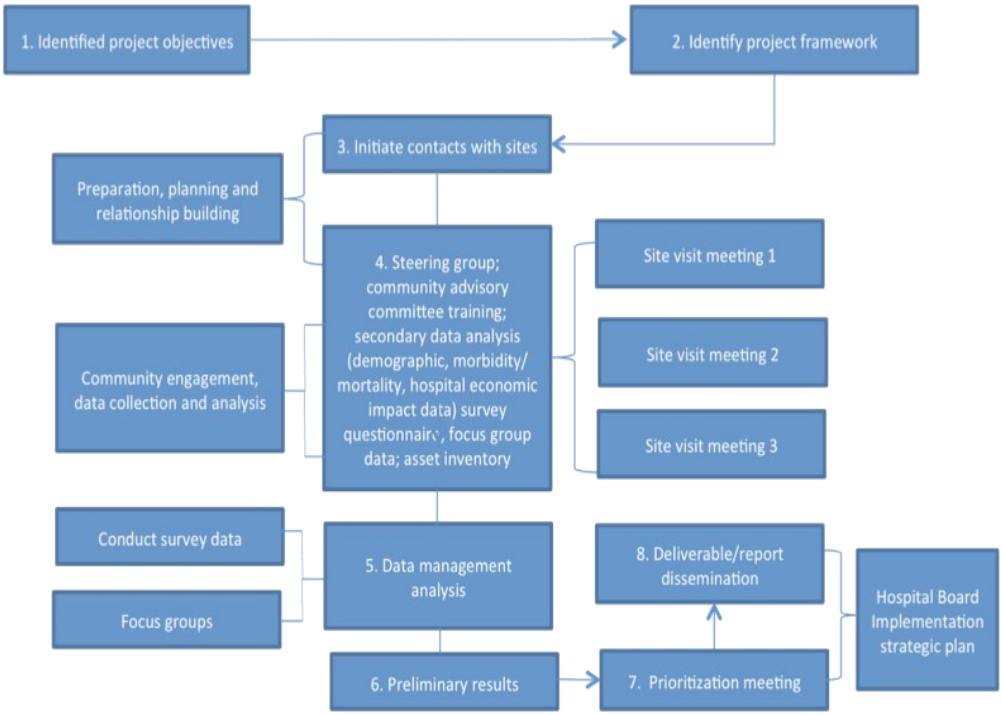
3. *To prioritize identified community health issues in all 18 target communities by June 30, 2013*

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©



# 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 8, 2012, a 15-minute conference call was hosted between the Miller County Hospital CEO, Robin Rau 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 Miller County Hospital, the Steering Group was developed and recruited by the Miller County Hospital CEO with the assistance of Sheila Freeman, Executive Director of Spring Creek Health Cooperative. The members names and affiliations included Robin Rau (CEO, Miller County Hospital), Becky Jones (Pharmacist, Miller County Hospital), Shawn Whittaker (Director of Nursing, Miller County Hospital and Nursing Home), Barbara Means (Pre-K Director, Board of Education), Sheila Freeman (Executive Director, Spring Creek Health), Leigh Ribolzi (Director, Miller County Collaborative Committee), Tracy Pickle (Vice-President, Ameris Bank) and Bo Haywood (Chairman, County Commissioner) (*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 Miller 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 Miller County. However, Baker County was added to the target area because this county represents a significantly underserved area of the region. 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 |
|---|---|---|---|---|
| **Miller** | 39837 | 2978 | 48% | Primary |
| **Early** | 39823 | 1461 | 23% | Primary |
| **Decatur** | 39817 | 541 | 9% | Secondary |
| **Seminole** | 39845 | 451 | 7% | Secondary |
| **Baker** | 39870 | 78 | 1% | 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. After the initial Steering Group meeting on June 22, 2012, the Steering Group and hospital board members were asked to consider and make recommendations on individuals within the counties that could serve on the CAC. (*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 Miller County Hospital Steering Group worked with the hospital board to develop a list of potential CAC members that was representative of all socio-economic groups, faith, ages, and ethnicity in Miller and Baker counties. This list became the invite list for the CAC. The hospital CEO contacted each potential CAC member by phone call or letter.

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 one-stage process relying on the Hanlon Method of Prioritization. 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 Miller 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 30, 2012, a random sample of seven hospital workers 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 September 7, 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.

*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 Miller County Hospital were scheduled on September 12, 2012 and were conducted on October 11-12, 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**

As mentioned previously, a one-stage process was used to complete the prioritization of issues in each community. Specific community issues were presented to the community group during the third meeting. These issues emerged from the secondary and primary data (surveys and focus groups). Prior to the prioritization of issues, participants were asked to discuss these issues and validate that the list indeed reflected the community. 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:

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

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 Miller 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 the relative magnitude of the health problems. As a basis for comparison, the local rates are juxtaposed with state data.

### Demographics

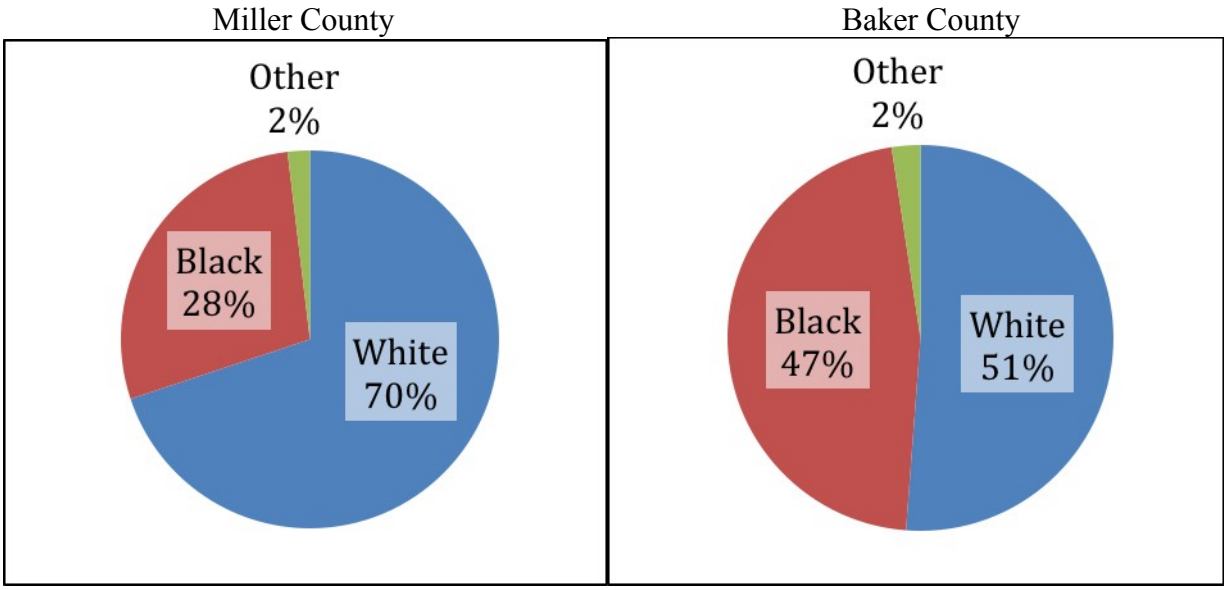
Demographic Characteristics 2010 Census

| | Miller County | Baker County | Georgia |
|---|---|---|---|
| Population† | 6,125 | 3,451 | 9,815,210 |
| Persons under 5 years† | 6.7% | 6.4% | 7.1% |
| Persons under 18 years† | 23.2% | 25.0% | 25.6% |
| Person 65 years and over† | 19.4% | 10.6% | 10.7% |
| Male† | 52.0% | 51.2% | 48.8% |
| Female† | 48.0% | 48.8% | 51.2% |
| White persons† | 69.9% | 51.2% | 59.7% |
| Black persons† | 28.2% | 46.4% | 30.5% |
| Median Household income (2006-2010)† | $33,196 | $27,462 | $49,347 |
| Homeownership rate (2006-2010)† | 69.9% | 66.1% | 67.2% |
| High school graduates† | 73.4% | 75.1% | 83.5% |
| Bachelor's degree or higher† | 9.4% | 12.2% | 27.2% |
| Percent Uninsured‡ | 22% | 24% | 21% |

† U.S. Census Bureau: State & County QuickFacts
‡ County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation

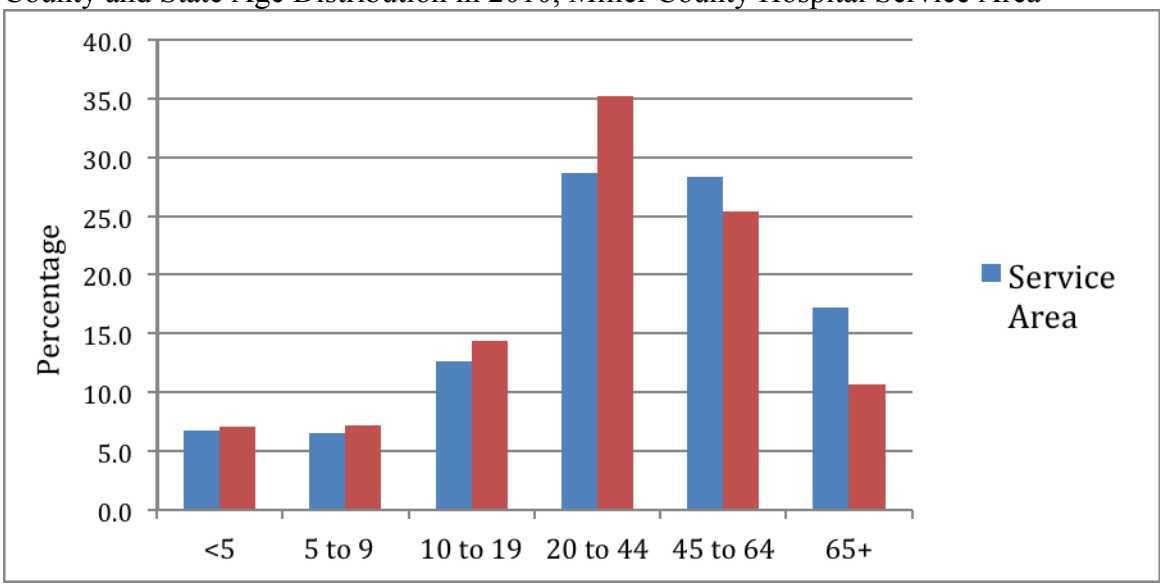
Service Area Demographics: Miller County Hospital's service area is a rural community. The majority of the population is white. African Americans constitute the largest minority. Similar to other rural areas, the percentage of the population with high school diplomas, the proportion of college graduates,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

Proportion of Races




U.S. Census Bureau: State & County QuickFacts

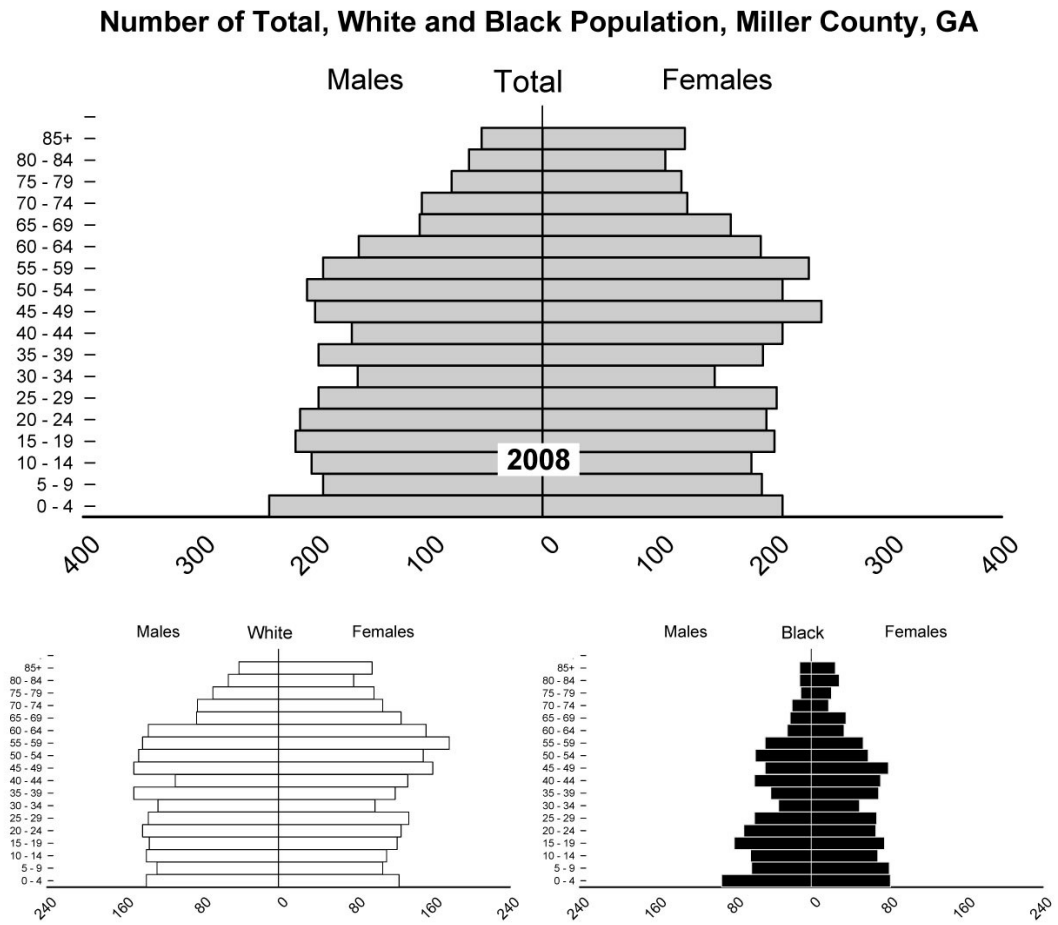
County and State Age Distribution in 2010, Miller County Hospital Service Area




U.S. Census Bureau: American Fact Finder

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

Figure 3. Population Pyramids 2008, Miller County




OASIS: Georgia Department of Public Health

## Health and Socio-Economic Indicators

Health Behaviors

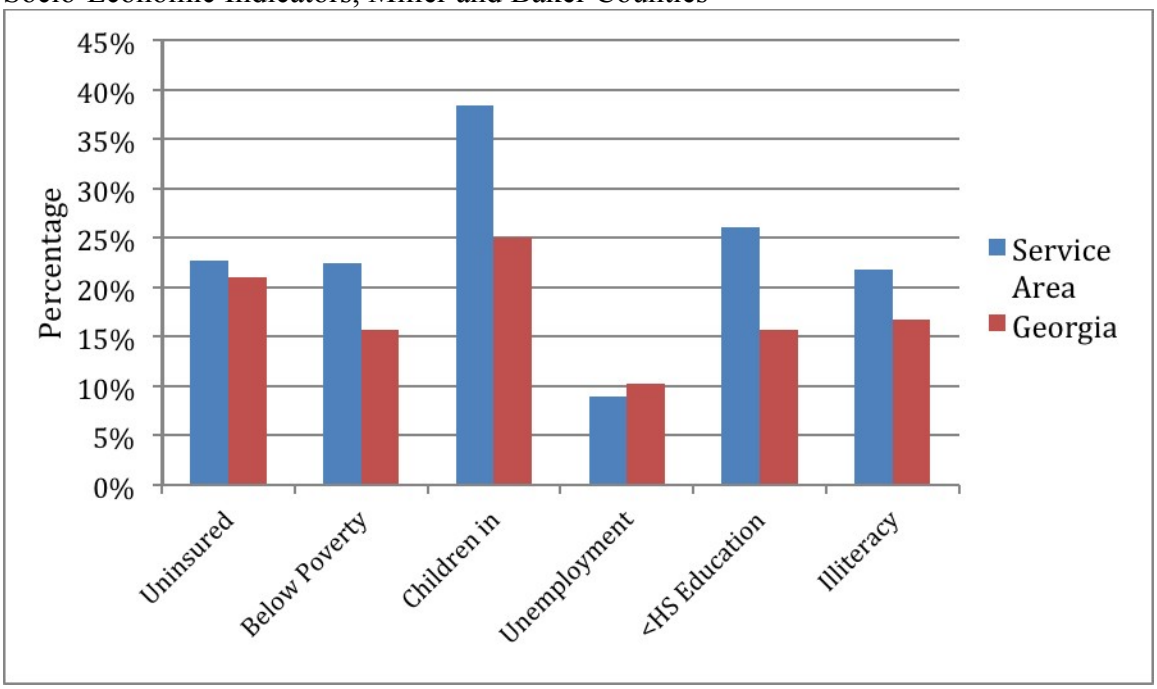
| | Miller County | Baker County | Georgia |
|---|---|---|---|
| Adult Smoking | N/A | N/A | 19% |
| Adult Obesity | 33% | 33% | 28% |
| Physical Inactivity | 34% | 28% | 24% |
| Excessive drinking | N/A | N/A | 14% |

N/A: Not Available
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 below indicates that the health of the service area is influenced by social factors. Like most rural areas in the state, the proportion of children living in poverty, the

percent of uninsured, and the illiteracy rates are higher than the state averages. The health behavior indictors 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, Miller and Baker Counties




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

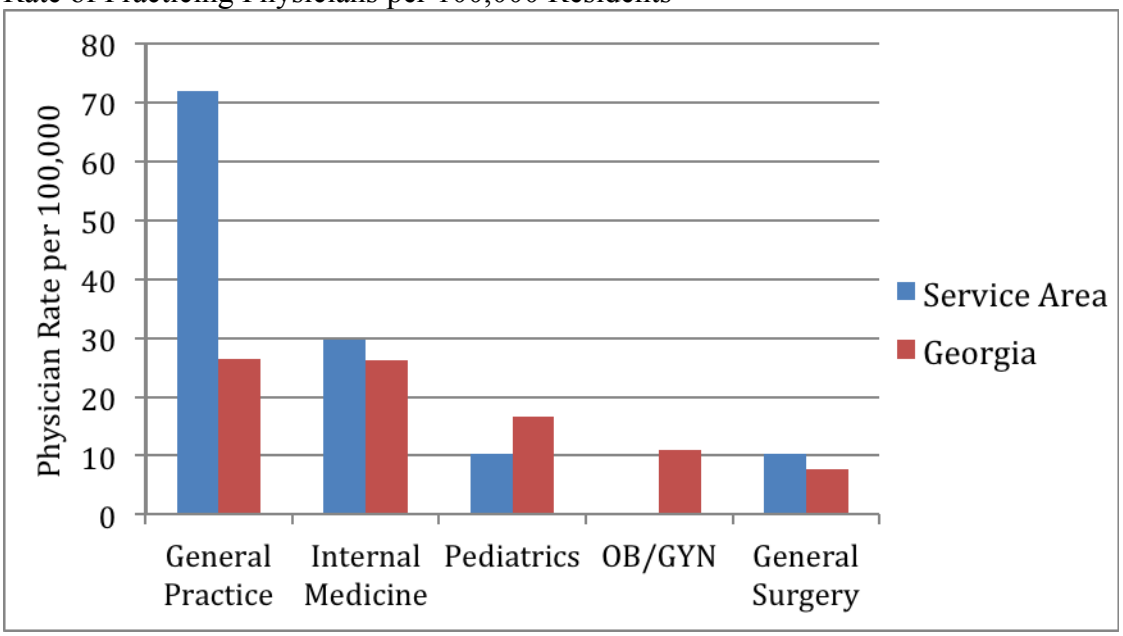
**Preventive Care Services**

| | Miller County | Baker County | Georgia |
|---|---|---|---|
| Diabetic screening | 80% | 90% | 83% |
| Mammography screening | 51% | N/A | 66% |
| Preventable hospital stays | 134 | N/A | 68 |

N/A: Not Available
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, the service area had a total of twelve physicians. The county did not have a gynecologist. The rate of general practice physicians is higher than the state average.

Total Number of Practicing Physicians in 2008

| | Family Practice | Internal Medicine | Pediatric | OB/GYN | General Surgery | Total |
|---|---|---|---|---|---|---|
| Miller | 6 | 1 | 1 | 0 | 1 | 9 |
| Baker | 1 | 2 | 0 | 0 | 0 | 3 |
| Total | 7 | 3 | 1 | 0 | 1 | 12 |

Georgia Board for Physician Workforce Report 2011

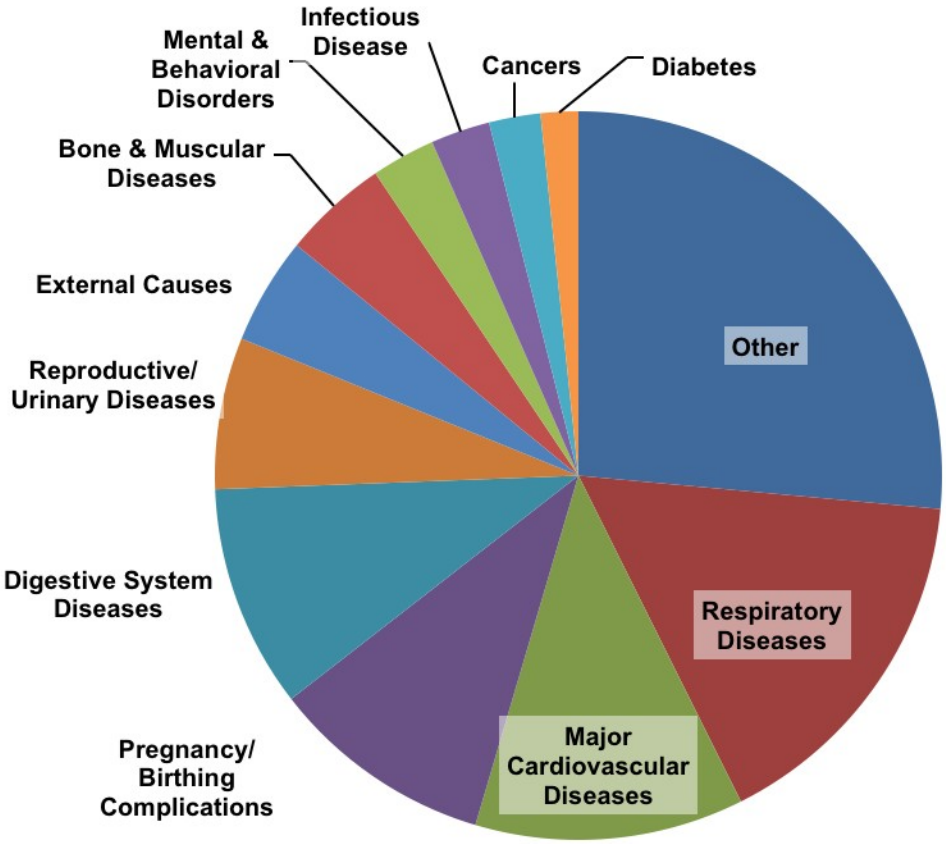
## Overview of Morbidity Rates (2001-2010)

Major Sources of Morbidity and Low Birth Weight

| Cause of Morbidity | Service Area | Georgia |
|---|---|---|
| All Causes† | 10,885.5 | 9,389.3 |
| Major Cardiovascular Disease† | 1,157.0 | 1,389.0 |
| Cancers† | 228.4 | 274.1 |
| Respiratory Disease† | 1,706.0 | 944.1 |
| Infectious Disease† | 292.3 | 305.9 |
| Diabetes† | 180.2 | 138 |
| Low Birth Weight‡ | 10.0% | 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

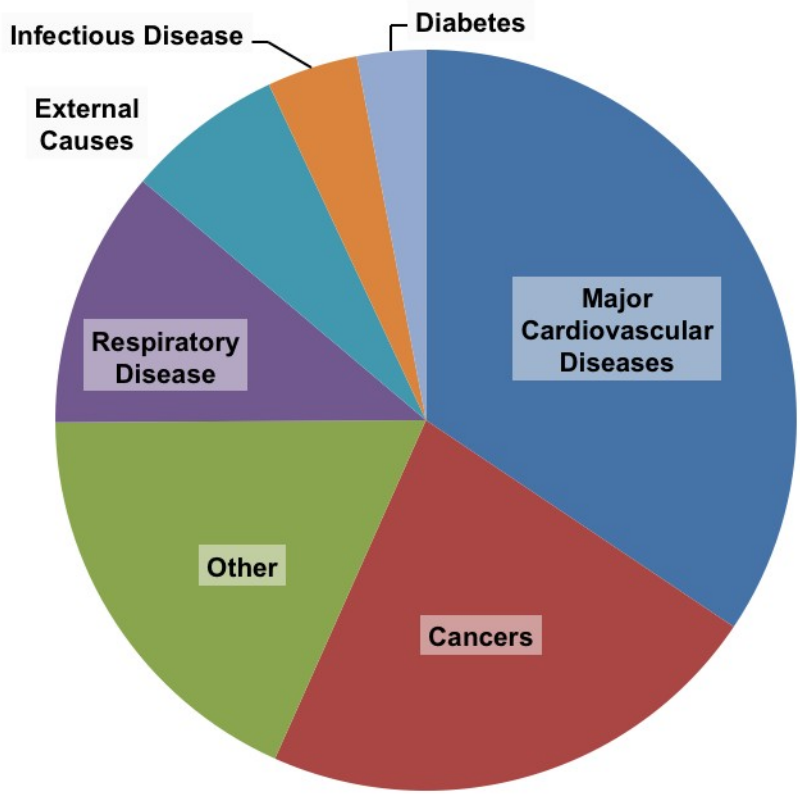
## Overview of Mortality Rates (2001-2010)

Summary of Major Causes of Mortality

| Cause of Death | Service Area | Georgia |
|---|---|---|
| All Causes† | 917.0 | 883.8 |
| Major Cardiovascular Disease† | 302.0 | 302.2 |
| Cancers† | 204.7 | 185.6 |
| Respiratory Disease† | 97.0 | 88.7 |
| Infectious Disease† | 38.9 | 30.5 |
| Diabetes† | 27.5 | 21.5 |
| Infant Mortality Rate‡ | 7.4 | 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

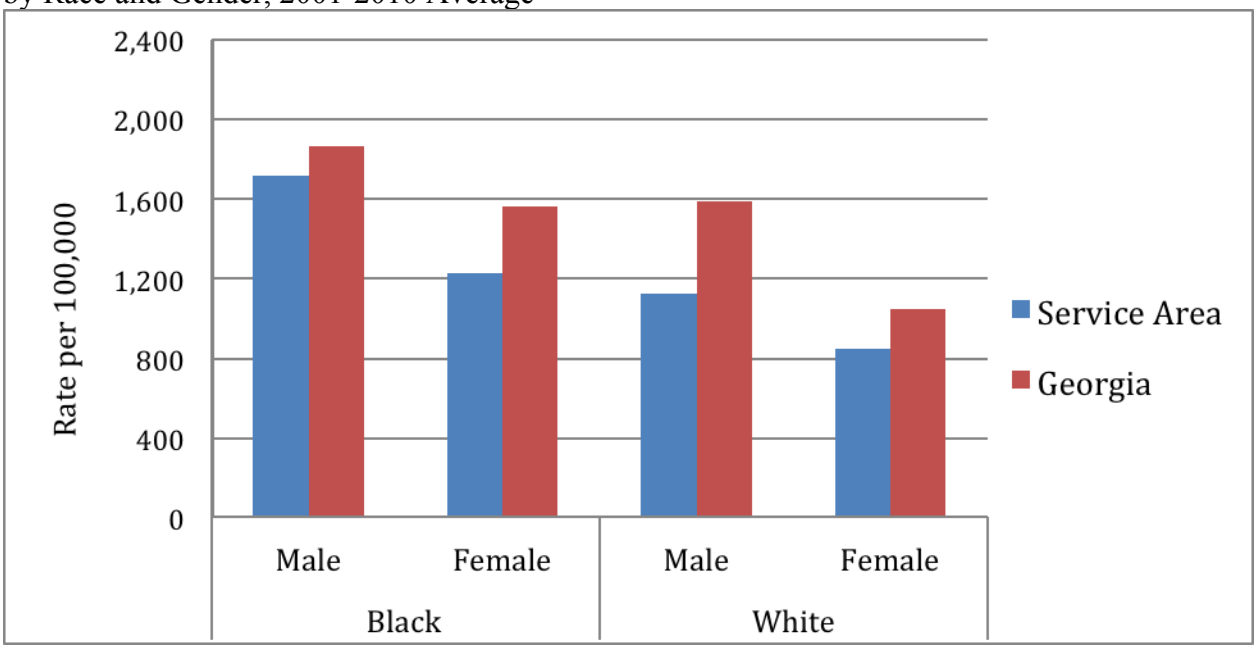
All Major Cardiovascular Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 50 | 1,438.3 | 1695.4 |
| White | 88 | 984.9 | 1297.5 |
| Other | 5 | NSR | 1334.9 |
| Total | 143 | 1,157.0 | 1,398.8 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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




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

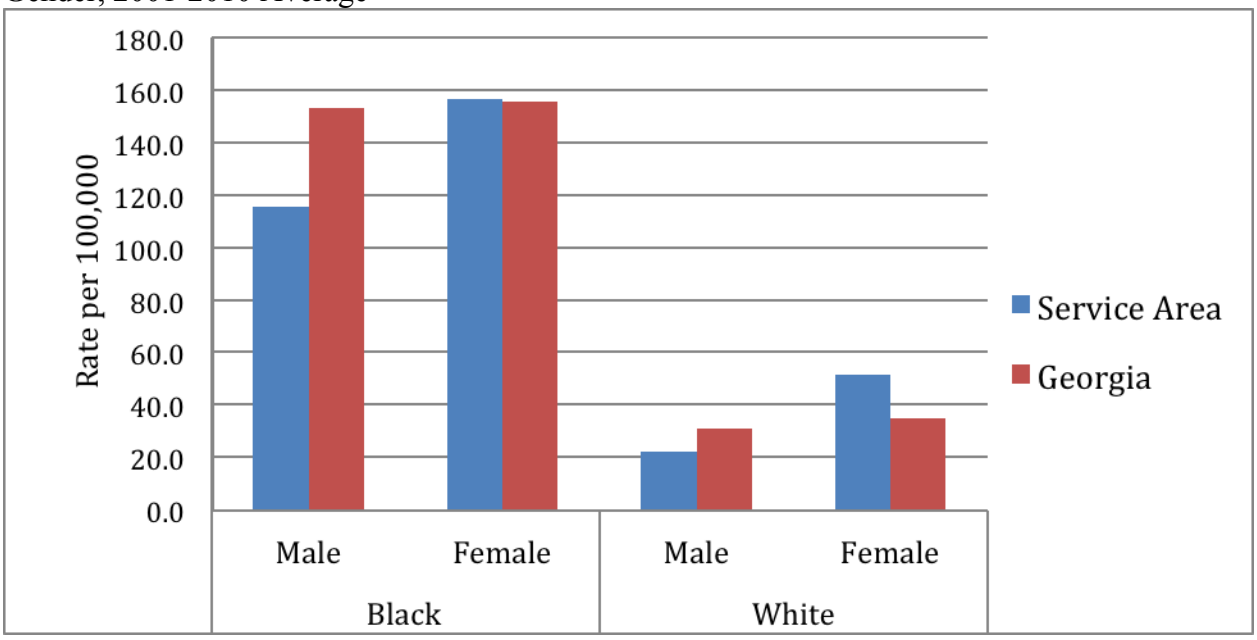
High Blood Pressure: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 5 | 140.3 | 155.9 |
| White | 3 | 38.5 | 33.3 |
| Other | 0 | NSR | 53.4 |
| Total | 8 | 73.4 | 64.7 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Hospital discharges for high blood pressure are highest among African Americans. Rates of high blood pressure are similar to the state averages.

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

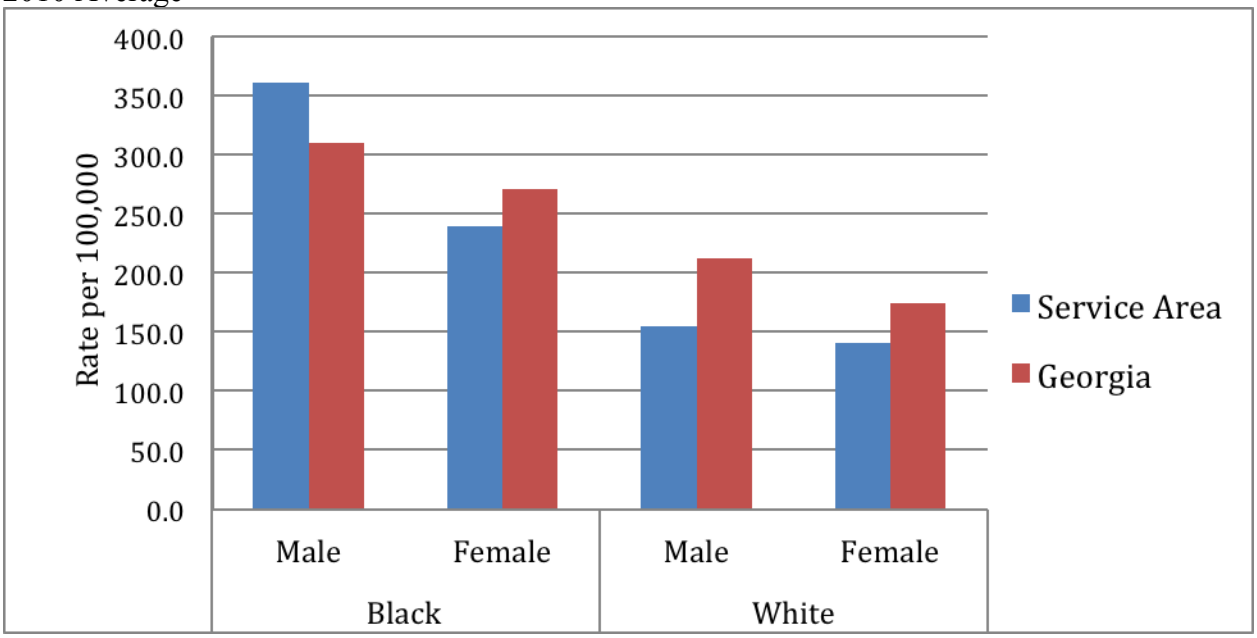
Stroke: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 10 | 293.3 | 288.4 |
| White | 13 | 148.0 | 191.5 |
| Other | 1 | NSR | 226.5 |
| Total | 24 | 191.2 | 215.8 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The 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

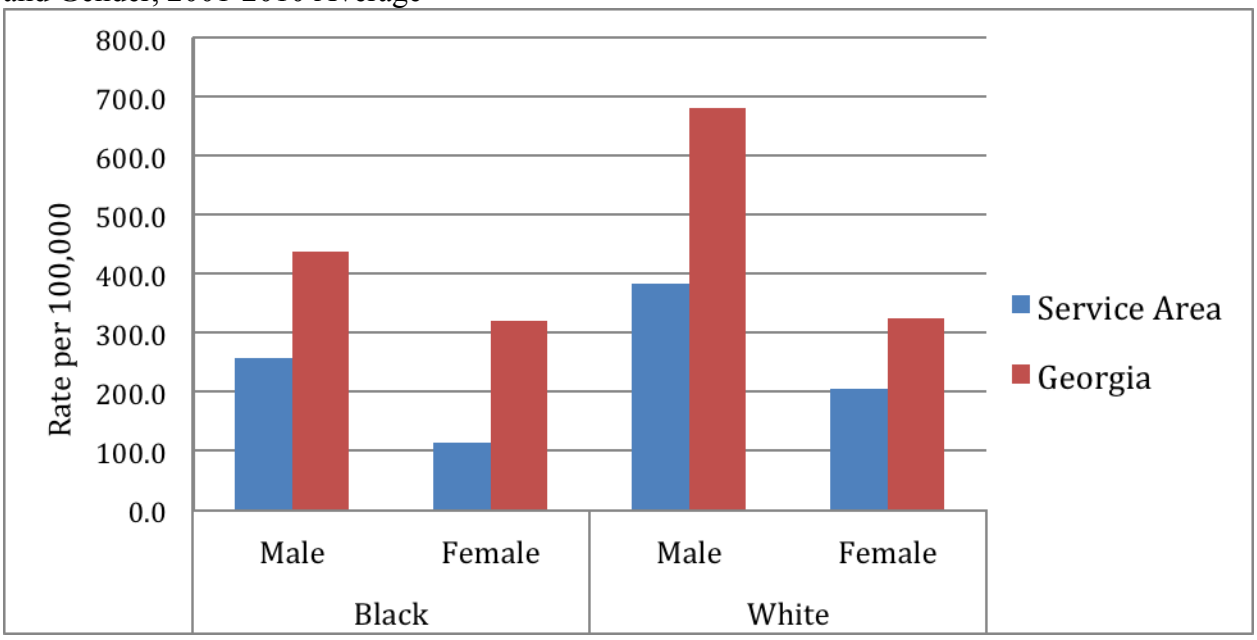
Obstructive Heart Disease: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 6 | 179.6 | 370.3 |
| White | 25 | 293.4 | 489.8 |
| Other | 1 | NSR | 511.4 |
| Total | 33 | 266.8 | 463.1 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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

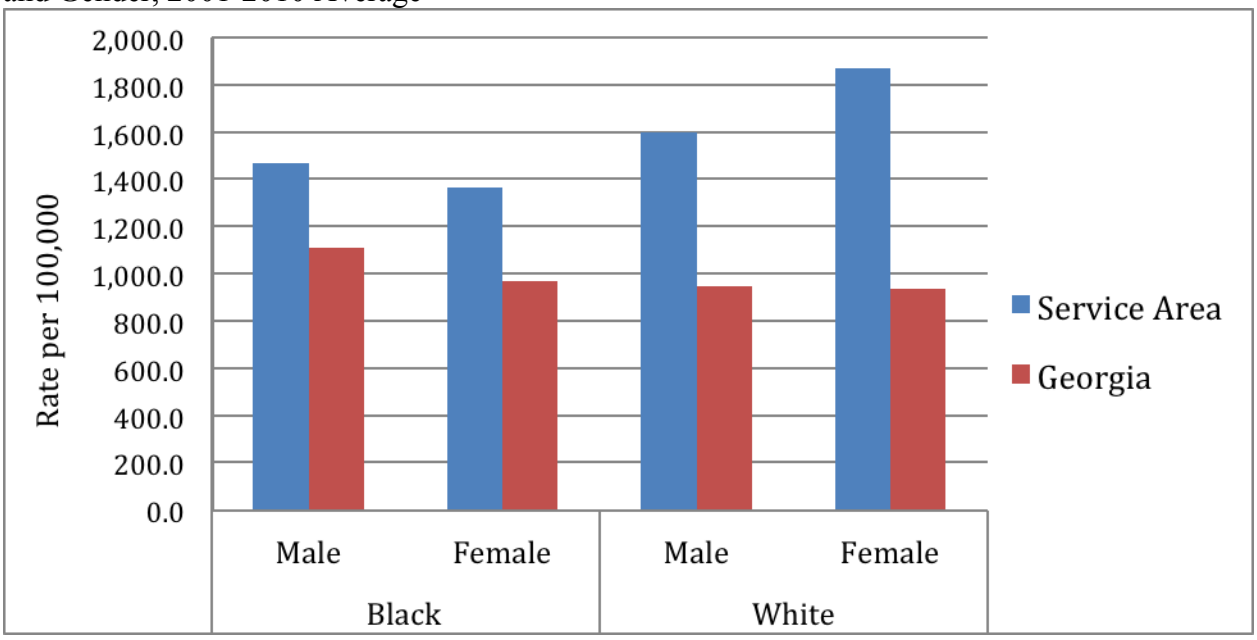
All Respiratory Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 50 | 1,394.3 | 1,018.1 |
| White | 134 | 1,734.4 | 930.6 |
| Other | 11 | NSR | 692.3 |
| Total | 194 | 1,706.0 | 956.4 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of respiratory diseases for the population are higher than the state averages for all gender and race categories.

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

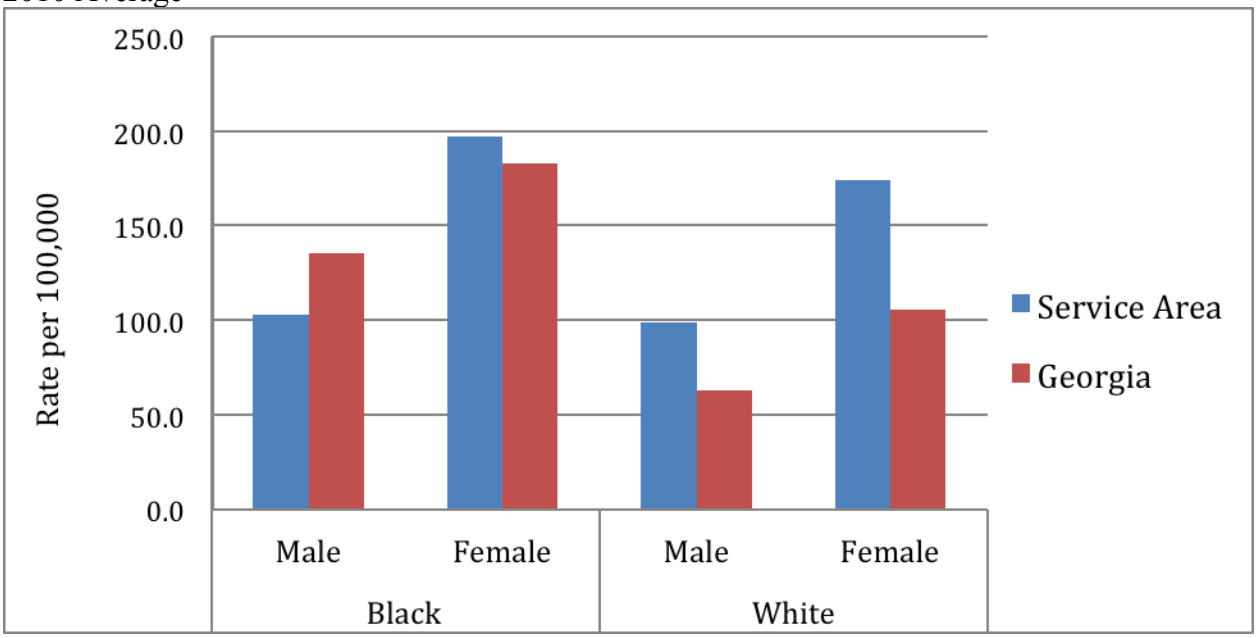
Asthma: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 6 | 154.7 | 164.1 |
| White | 9 | 135.4 | 85.2 |
| Other | 0 | NSR | 75.2 |
| Total | 15 | 144.8 | 108.0 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of asthma are higher than the state averages. Rates are highest among females in the service area.

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




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

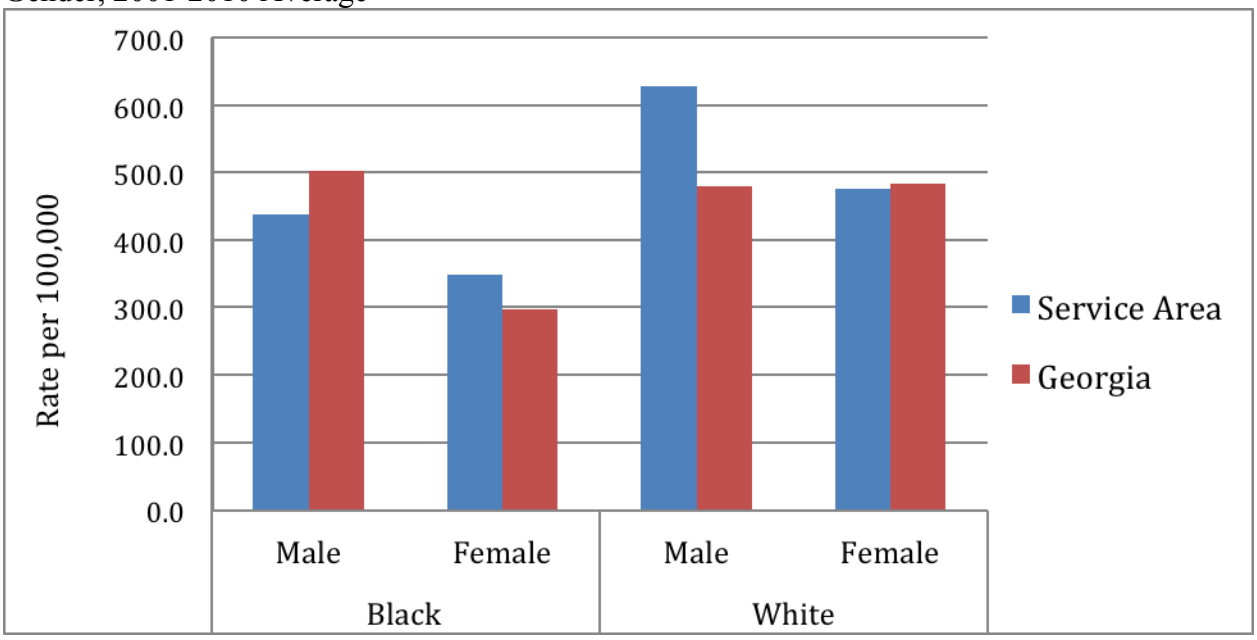
External Causes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 14 | 395.4 | 395.7 |
| White | 42 | 571.0 | 496.5 |
| Other | 2 | NSR | 493.7 |
| Total | 57 | 519.7 | 477.2 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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

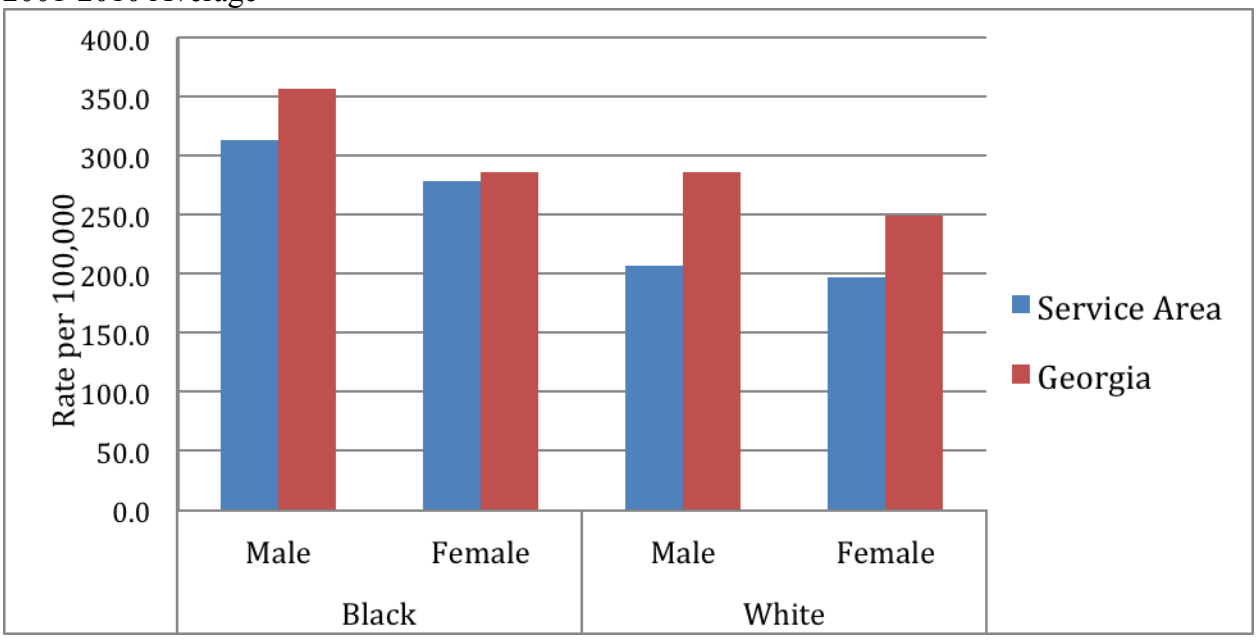
All Cancers: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 10 | 294.3 | 311.1 |
| White | 17 | 200.4 | 262.7 |
| Other | 1 | NSR | 295.8 |
| Total | 27 | 228.4 | 275.2 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Cancer rates in the service area are similar to the state rates. On average, 27 people per year visit the hospital as a result of cancer-related causes.

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

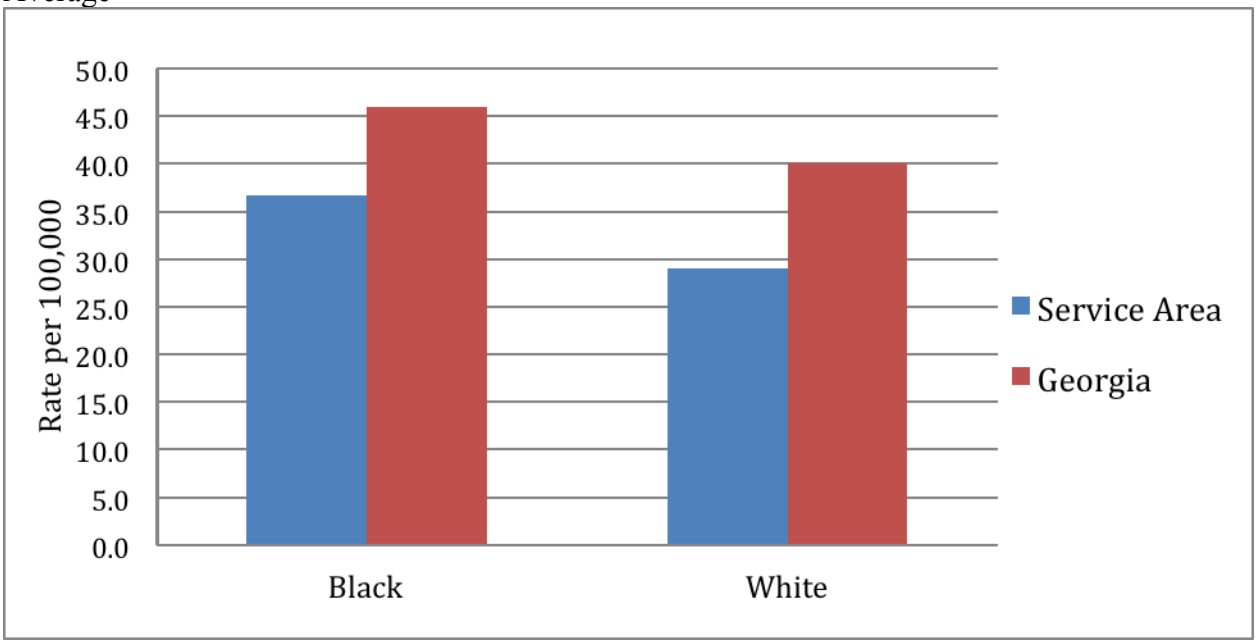
Breast Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Females

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 36.7 | 46.0 |
| White | 2 | 29.0 | 40.1 |
| Other | 0 | NSR | 31.6 |
| Total | 2 | 32.6 | 41.5 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Hospital discharge rates for breast cancer are lower than the state averages.

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




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

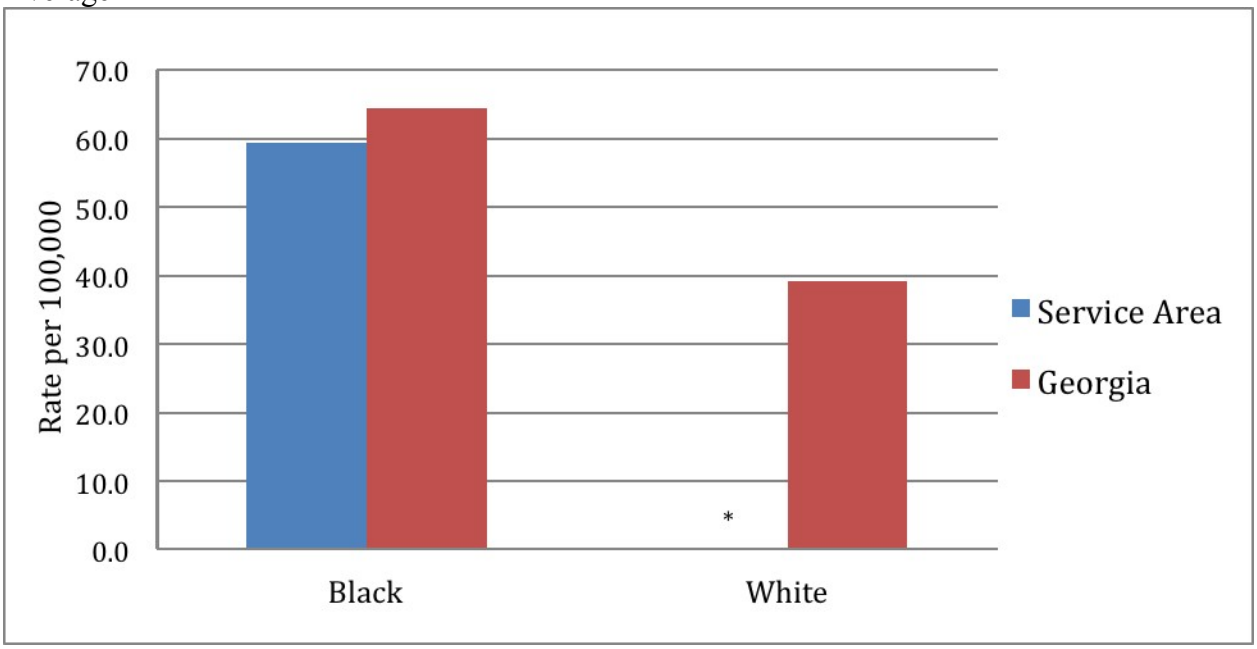
Prostate Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Males

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 59.4 | 64.4 |
| White | < 1 | NSR | 39.1 |
| Other | 0 | NSR | 39.1 |
| Total | 1 | 22.2 | 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 black males in the service area is similar to the state average. Less than one white male per year went to the hospital as a result of prostate cancer. As a result, the rate could not be calculated.

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




* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

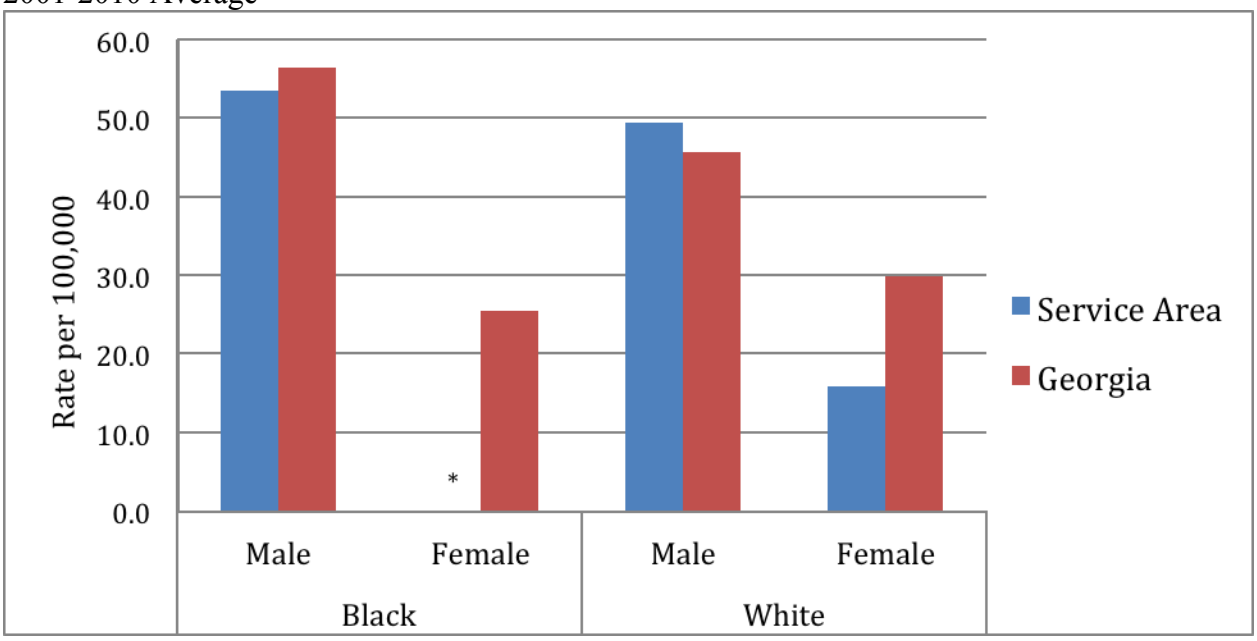
Lung Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 34.8 | 37.3 |
| White | 3 | 30.7 | 36.6 |
| Other | 0 | NSR | 26.7 |
| Total | 4 | 33.7 | 36.6 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: -people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of lung cancer are similar to the state averages. Rates are higher among males in the service area, possibly because of risk-taking behaviors such as smoking. The rates could not be calculated for black females because of the low number of cases.

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




* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

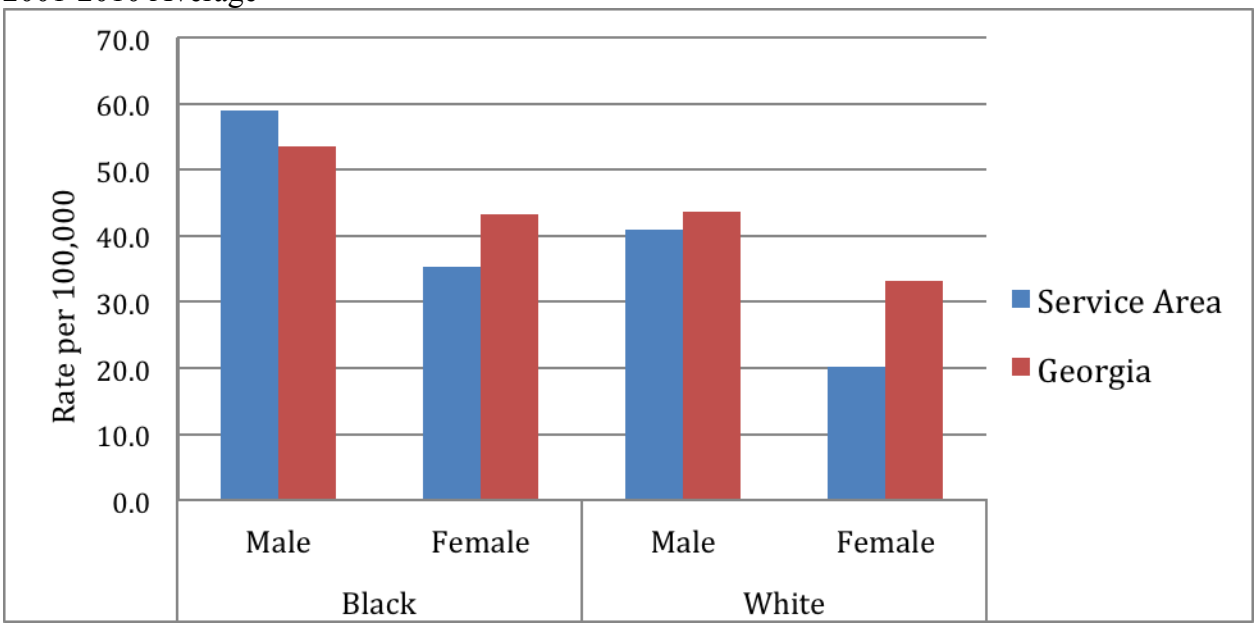
Colon Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 42.6 | 47.3 |
| White | 3 | 30.7 | 37.7 |
| Other | 0 | NSR | 44.5 |
| Total | 4 | 34.2 | 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.

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

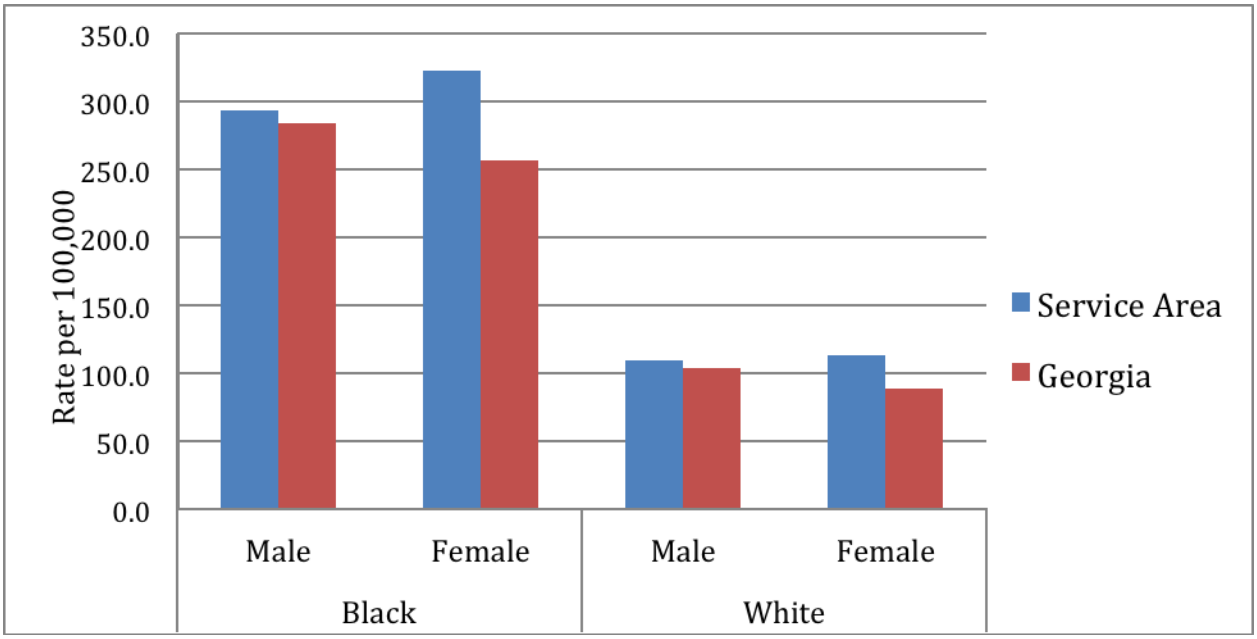
Diabetes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 11 | 313.8 | 269.7 |
| White | 8 | 107.3 | 95.8 |
| Other | 1 | NSR | 106.5 |
| Total | 20 | 180.2 | 139.0 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area's rates of hospital discharges for diabetes are similar to the state averages. Black males and black females have the highest rates.

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

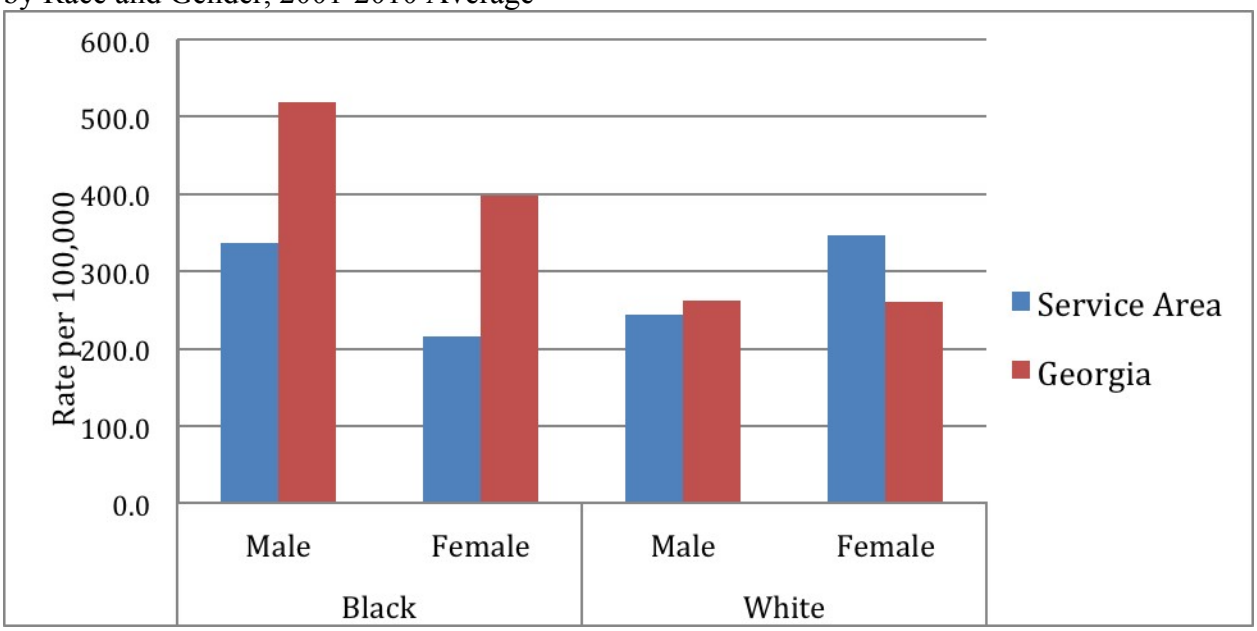
All Infectious and Parasitic Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 9 | 268.4 | 449.0 |
| White | 21 | 297.3 | 260.5 |
| Other | 1 | NSR | 279.7 |
| Total | 32 | 292.3 | 310.1 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area's rates of hospital discharges as a result of infectious and parasitic diseases are lower than the state averages for black males and black females.

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

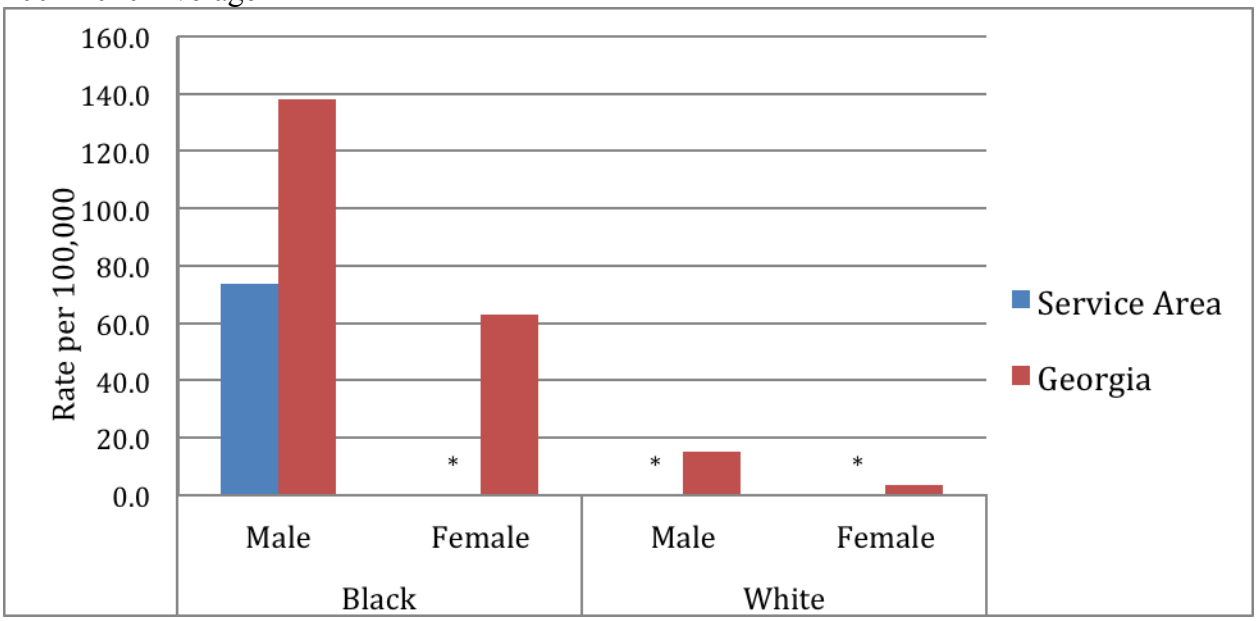
HIV/AIDS: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

| | Service Area (Discharges) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 39.2 | 97.2 |
| White | < 1 | NSR | 9.3 |
| Other | 0 | NSR | 19.7 |
| Total | 2 | 17.9 | 35.6 |

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

From 2001 to 2010, about two people per year went to the hospital as a result of HIV/AIDS. Rates could not be calculated for black females, white males, or white females because there were too few cases to make the rates statistically reliable.

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




* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

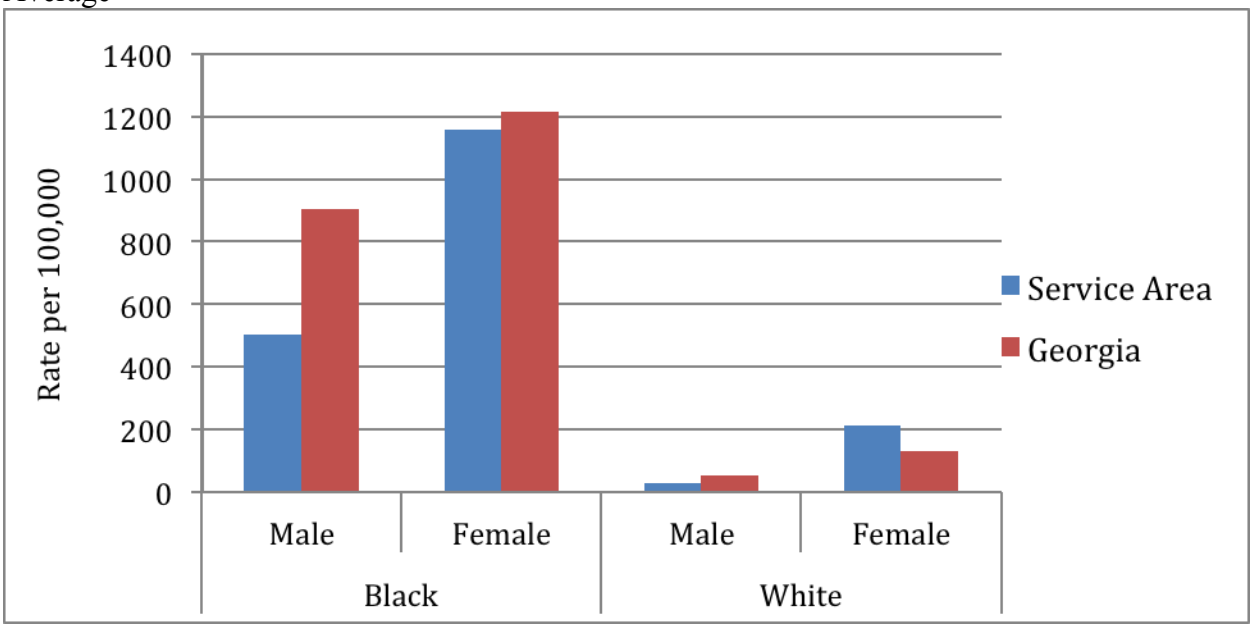
Sexually Transmitted Disease (STD) Rate: Total STD Cases and New STD Cases per 100,000

| | Service Area (Cases) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 31 | 856.5 | 1,062.6 |
| White | 8 | 122.1 | 87.9 |
| Other | 0 | 0 | 69.4 |
| Total⁂ | 61 | 611.3 | 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

Typically, females have higher rates of STDs. The primary factor that contributes to this phenomenon is the fact that female reproductive anatomy is more susceptible to contracting an STD.

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

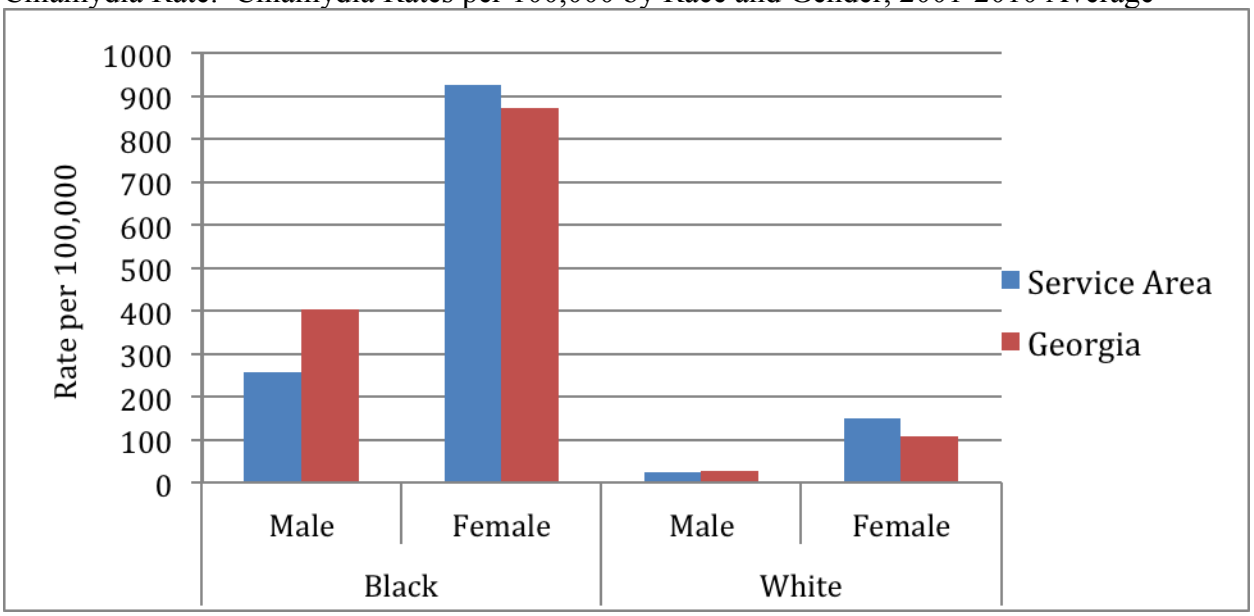
Chlamydia Rate: New Chlamydia Cases and Cases per 100,000 People

| | Service Area (Cases) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 23 | 618.4 | 636.4 |
| White | 6 | 88.4 | 63.4 |
| Other | 0 | 0 | 46.4 |
| Total* | 44 | 443.5 | 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
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The chlamydia rates in the service area are 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

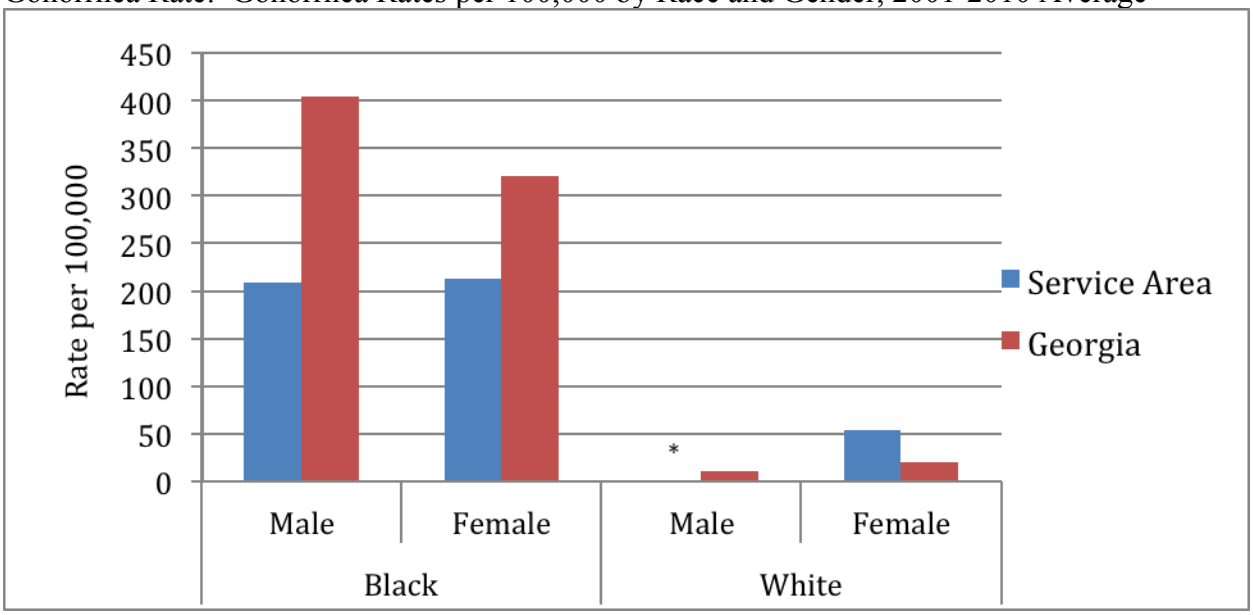
Gonorrhea Rate: New Gonorrhea Cases and Cases per 100,000 People

| | Service Area (Cases) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 8 | 210.7 | 368.5 |
| White | 2 | 30.5 | 16.1 |
| Other | 0 | 0 | 16.8 |
| Total* | 44 | 155.8 | 186.0 |

† Average number of new STD cases per year from 2001-2010
‡ Average STD Incidence rate from 2001-2010
* Total case number includes cases with unknown race
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The gonorrhea rates are lower than the state averages.

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




* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

## Trends in Mortality

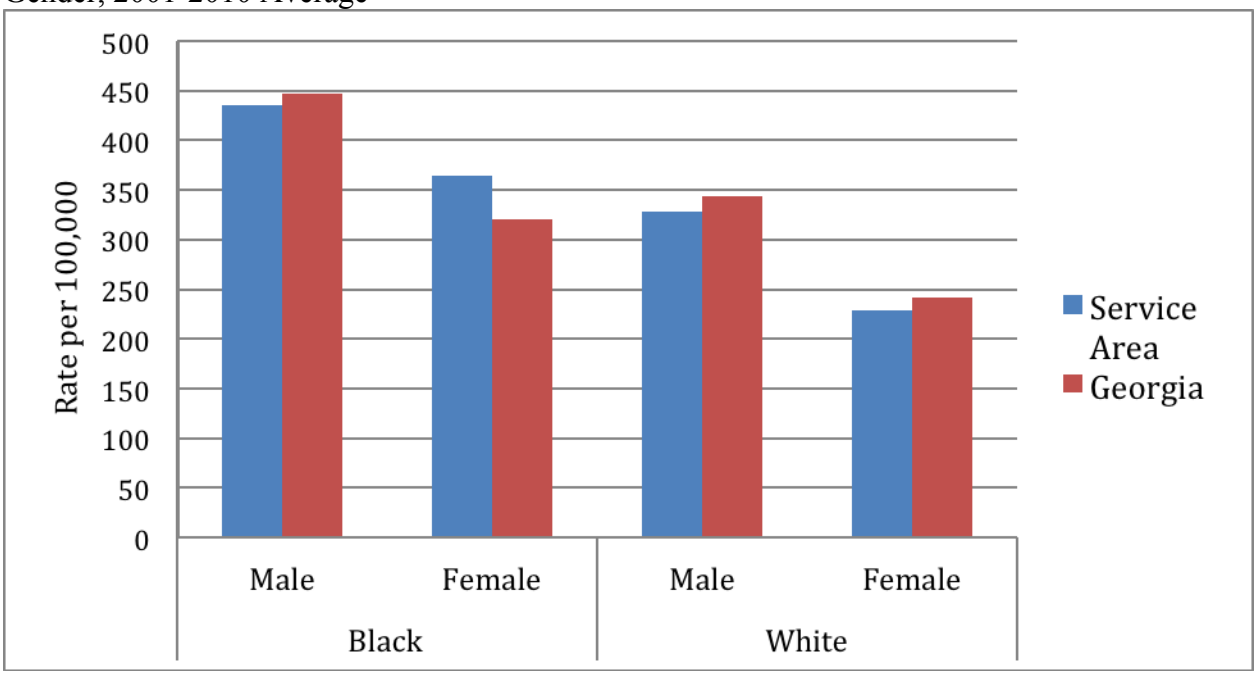
All Major Cardiovascular Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 12 | 390.2 | 380 |
| White | 23 | 269.1 | 291.9 |
| Other | 0 | NSR | 100.0 |
| Total | 36 | 302.0 | 308.3 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

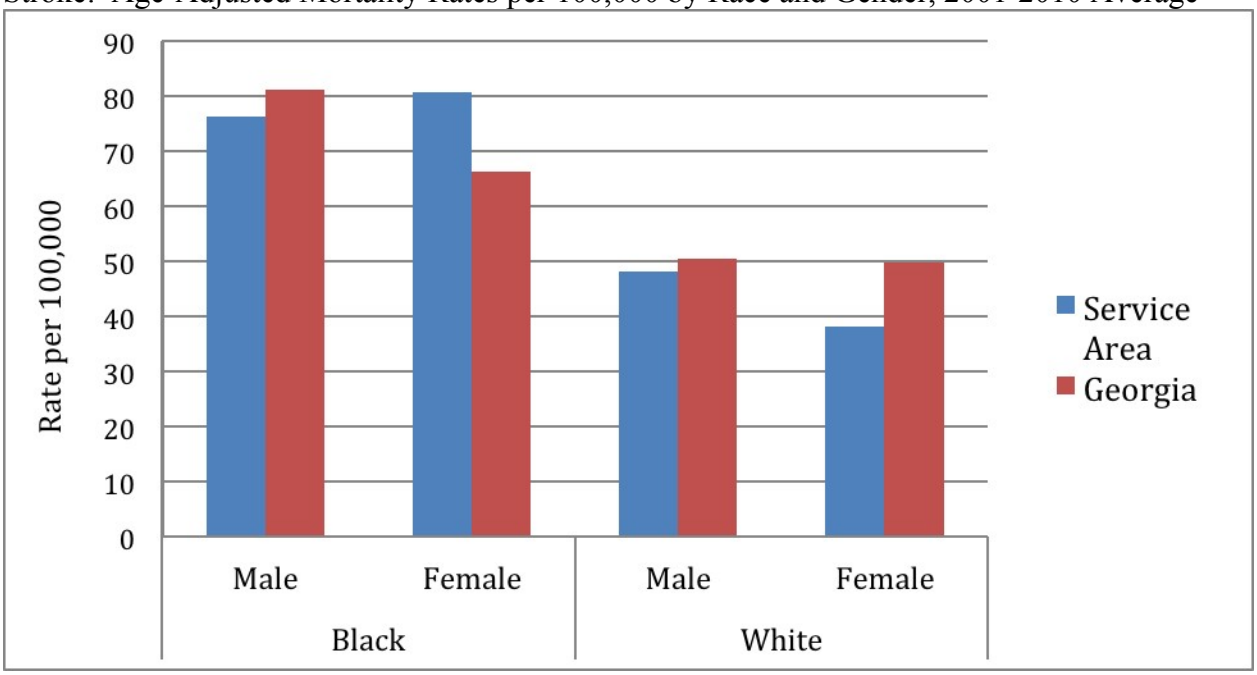
Stroke: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 3 | 78.8 | 74.2 |
| White | 4 | 41.6 | 51.5 |
| Other | 0 | NSR | 24.0 |
| Total | 6 | 51.5 | 56.2 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

On average, six people die per year from stroke-related causes. Stroke mortality rates are similar to the state averages.

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

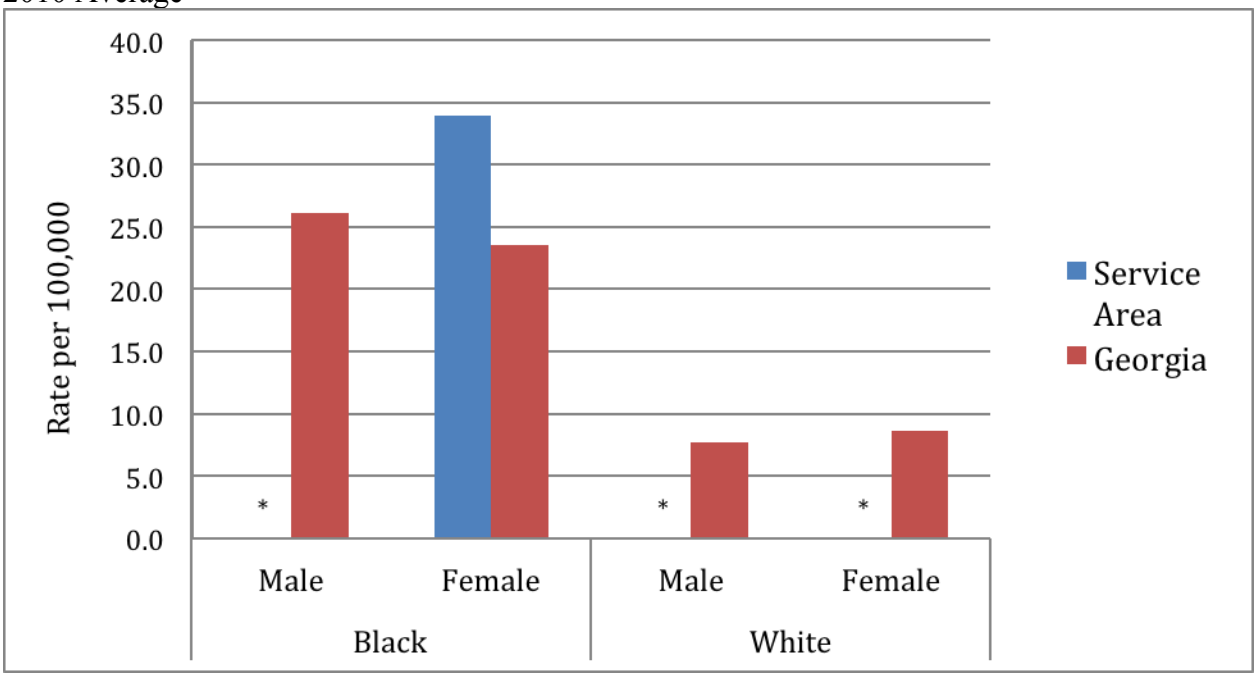
High Blood Pressure: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 32.2 | 25.4 |
| White | 1 | 9.8 | 8.7 |
| Other | 0 | NSR | 3.8 |
| Total | 2 | 14.9 | 12.1 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Mortality rates for blood pressure comprise a small proportion of deaths in comparison with other types of cardiovascular diseases. High blood pressure mortality rates could not be calculated for black males, white males, or white females. The number of deaths in the service area was not enough to make the rates statistically reliable.

High Blood Pressure: 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

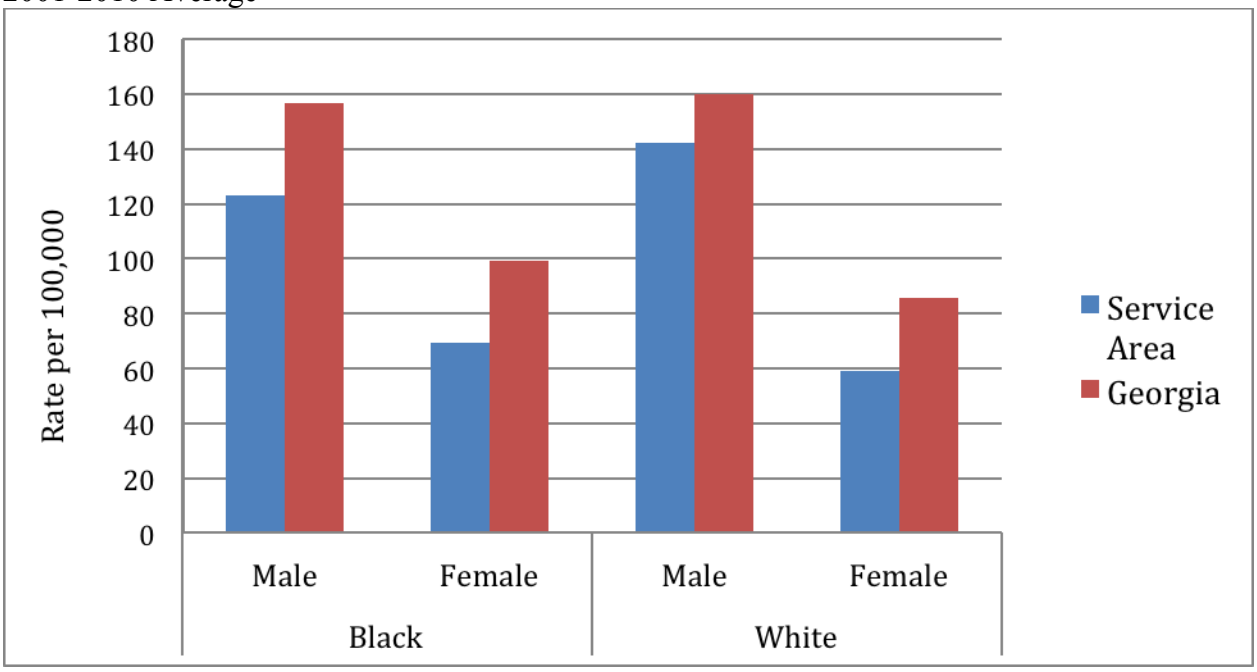
Obstructive Heart Disease: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 3 | 94.0 | 124.7 |
| White | 8 | 89.8 | 119.3 |
| Other | 0 | NSR | 35.8 |
| Total | 11 | 91.6 | 119.0 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Heart attacks are included within the obstructive heart disease (OHD) classification. Mortality rates of OHD are lower than 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

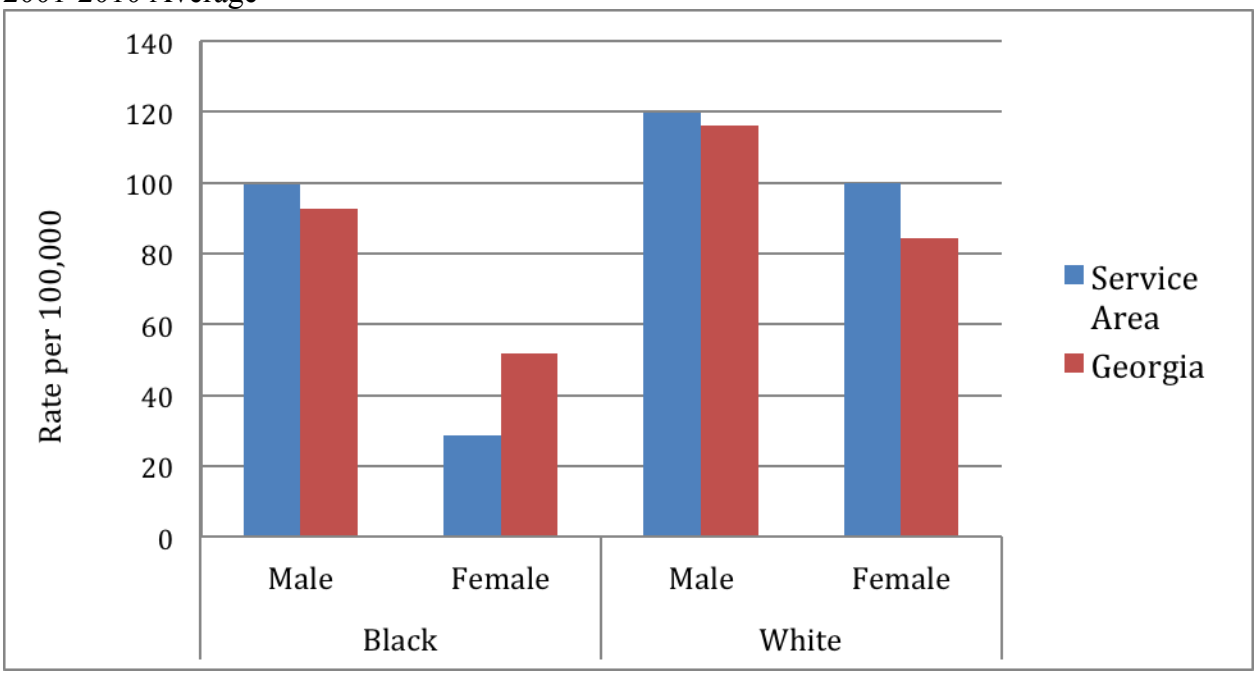
All Respiratory Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 2 | 62.4 | 67.8 |
| White | 10 | 109.6 | 97.4 |
| Other | 0 | NSR | 22.9 |
| Total | 12 | 97.0 | 90.3 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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

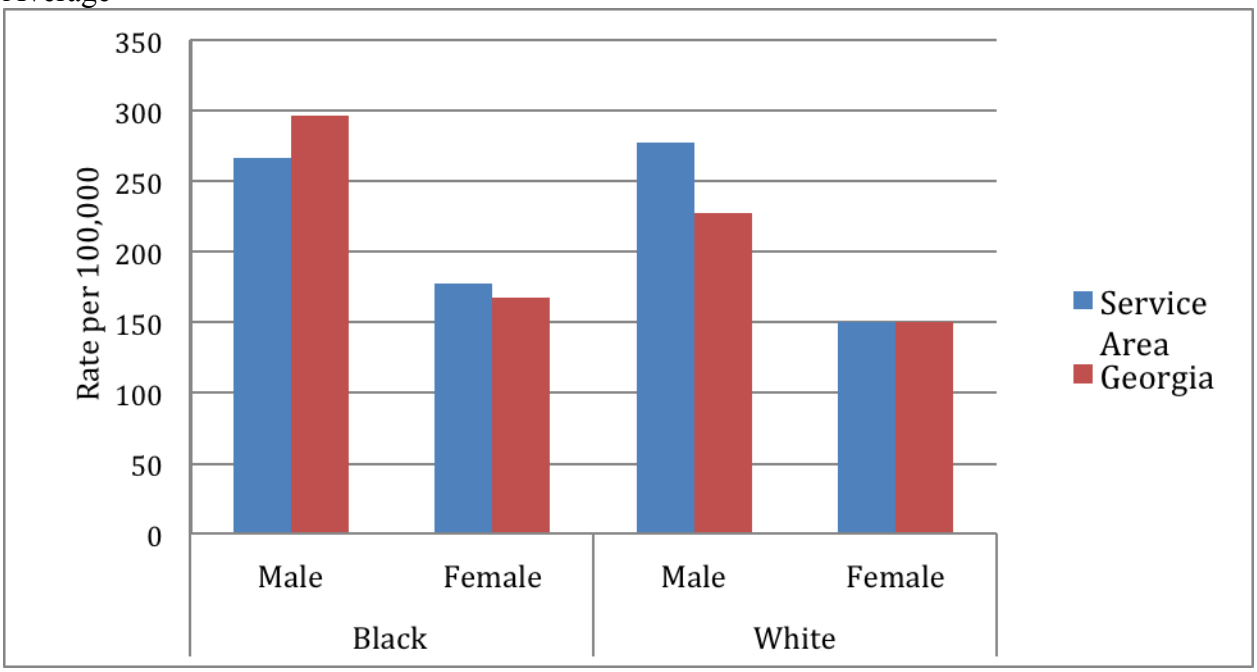
All Cancers: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 7 | 211.0 | 213.8 |
| White | 16 | 201.6 | 182.2 |
| Other | 0 | NSR | 71.6 |
| Total | 23 | 204.7 | 186.8 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted mortality rates for the service area were similar to the state averages. On average, the service area experiences 23 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

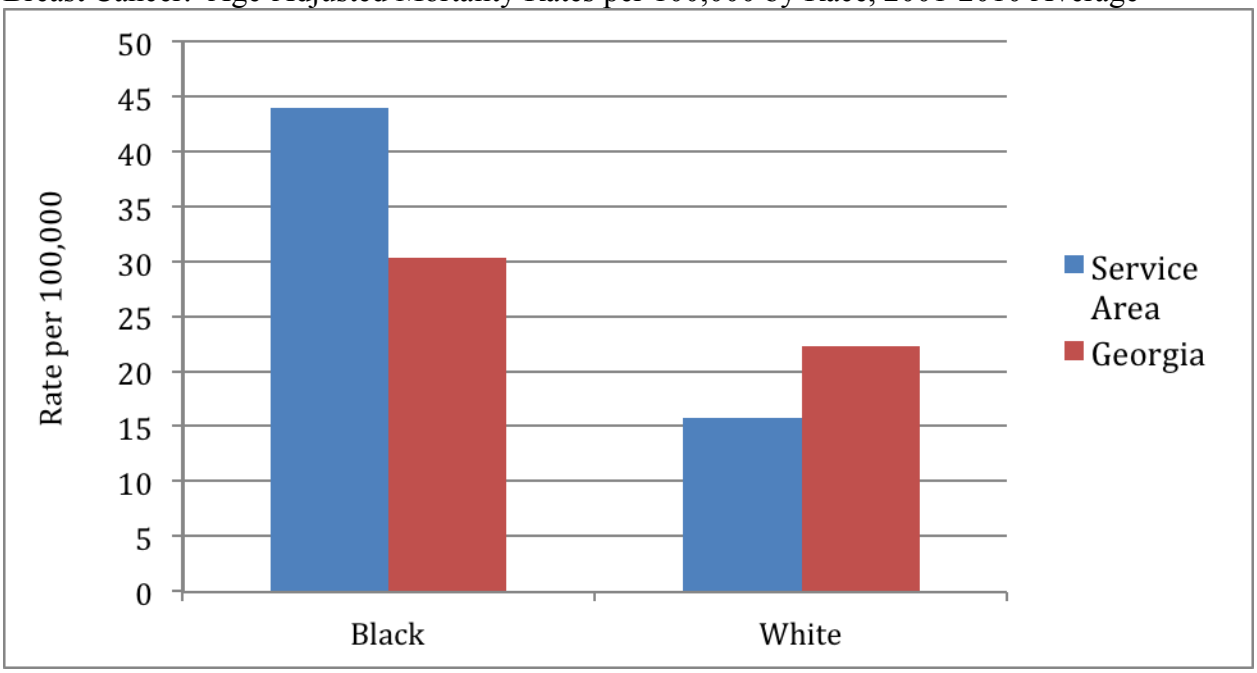
Breast Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Females

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 44.0 | 30.3 |
| White | 1 | 15.8 | 22.3 |
| Other | 0 | NSR | 7.6 |
| Total | 2 | 27.0 | 24.0 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The breast cancer mortality rate for black females is higher than the state average. On average, two people in the service die per year as a result of breast cancer.

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




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

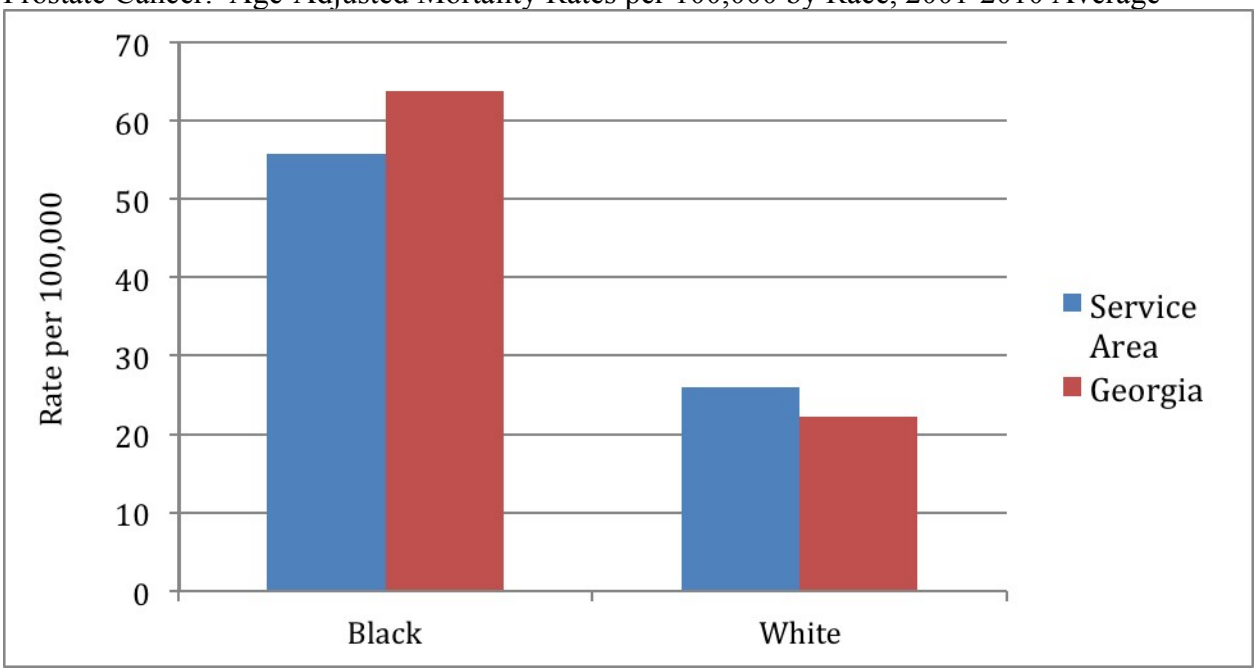
Prostate Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Males

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 55.8 | 63.8 |
| White | 1 | 26.0 | 22.2 |
| Other | 0 | NSR | 7.1 |
| Total | 1 | 32.8 | 29.3 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted mortality rates for prostate cancer in the area are 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

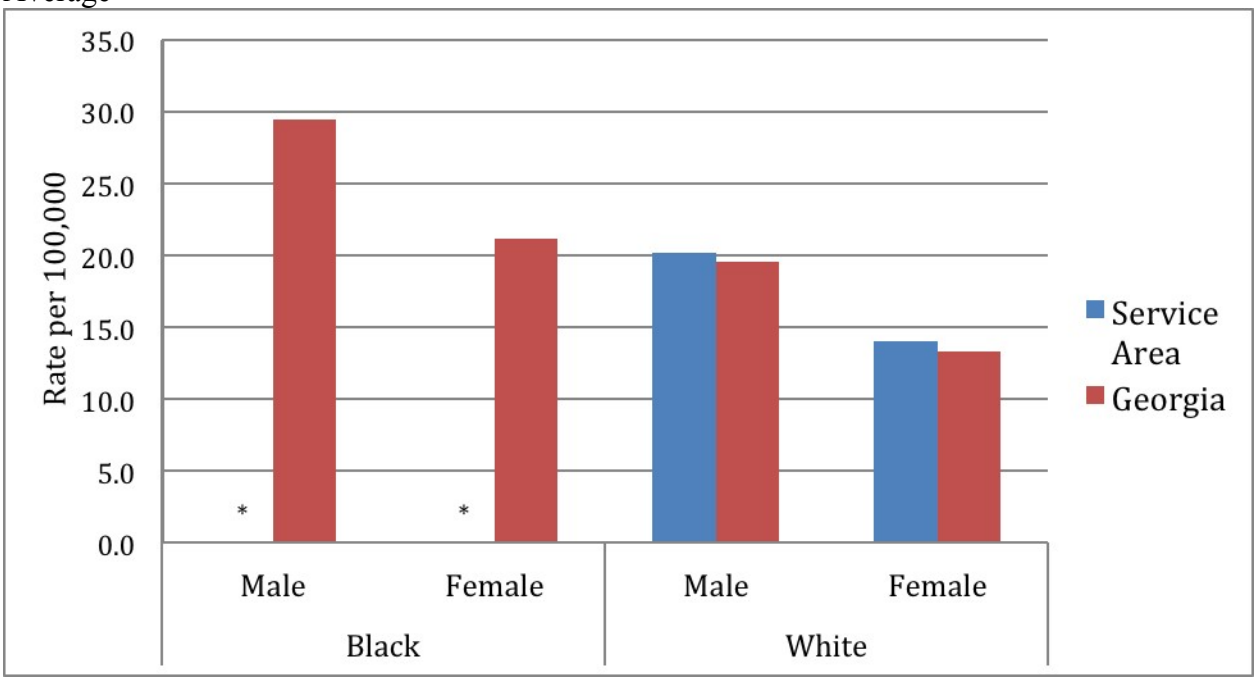
Colon Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 14.8 | 24.4 |
| White | 1 | 16.9 | 16.1 |
| Other | 0 | NSR | 7.9 |
| Total | 2 | 16.2 | 17.7 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The colon cancer rates for white males and white females are similar to the state averages. The rates for black males and black females could not be calculated because there were insufficient deaths to make the rates statistically reliable.

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




* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

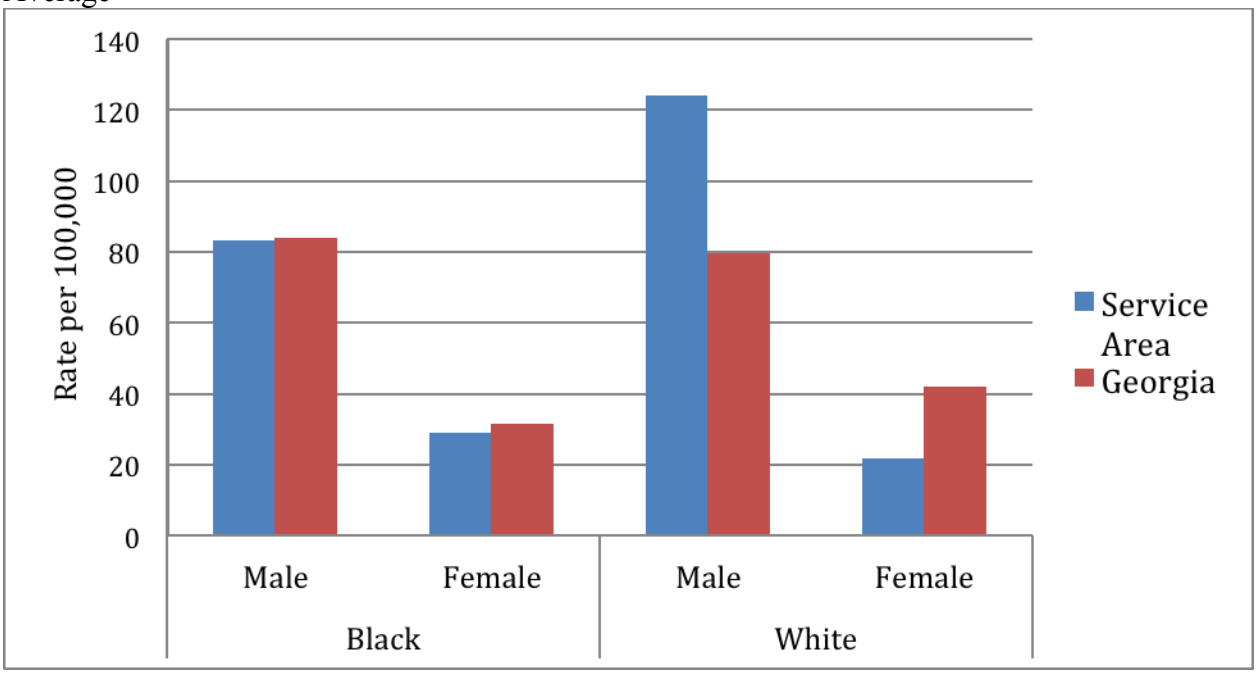
Lung Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 2 | 50.8 | 51.3 |
| White | 6 | 65.6 | 58.1 |
| Other | 0 | NSR | 16.0 |
| Total | 7 | 62.1 | 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 mortality rate for white males is higher than the state average. The rates for males are approximately three times higher than those of females. Health behaviors, such as smoking habits, could be the cause of 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

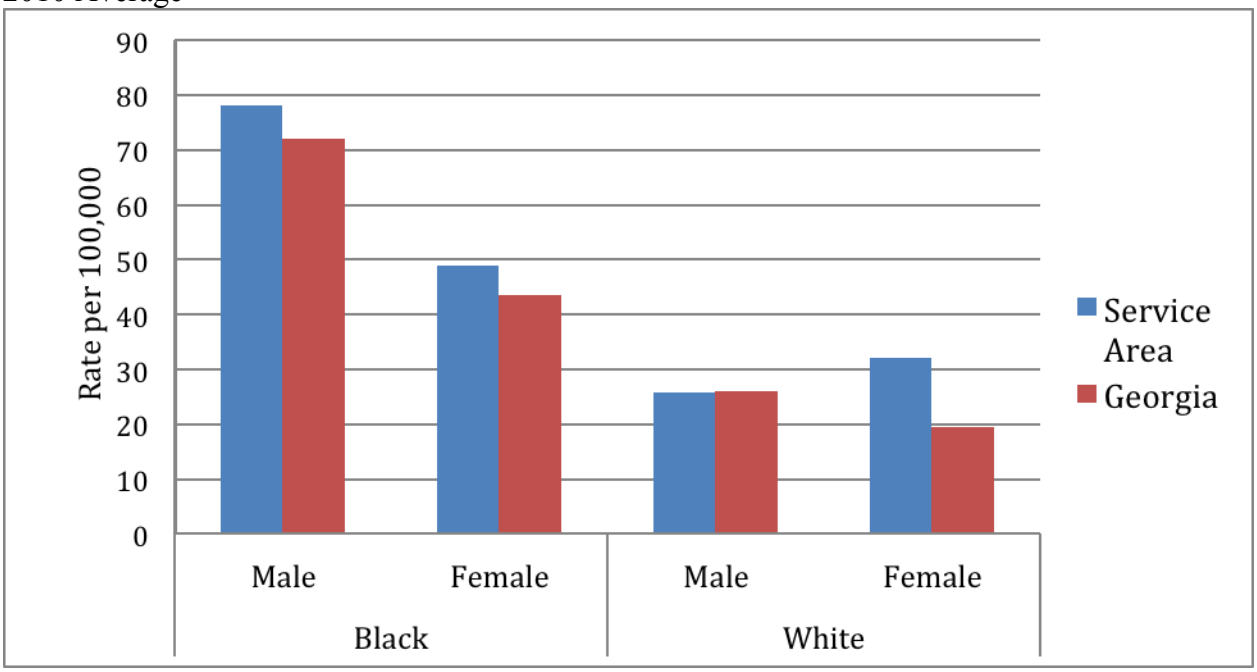
All Infectious Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 2 | 60.5 | 56.1 |
| White | 2 | 28.1 | 22.9 |
| Other | 0 | NSR | 9.5 |
| Total | 4 | 38.9 | 30.9 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The mortality rates for infectious diseases are similar to the state averages.

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

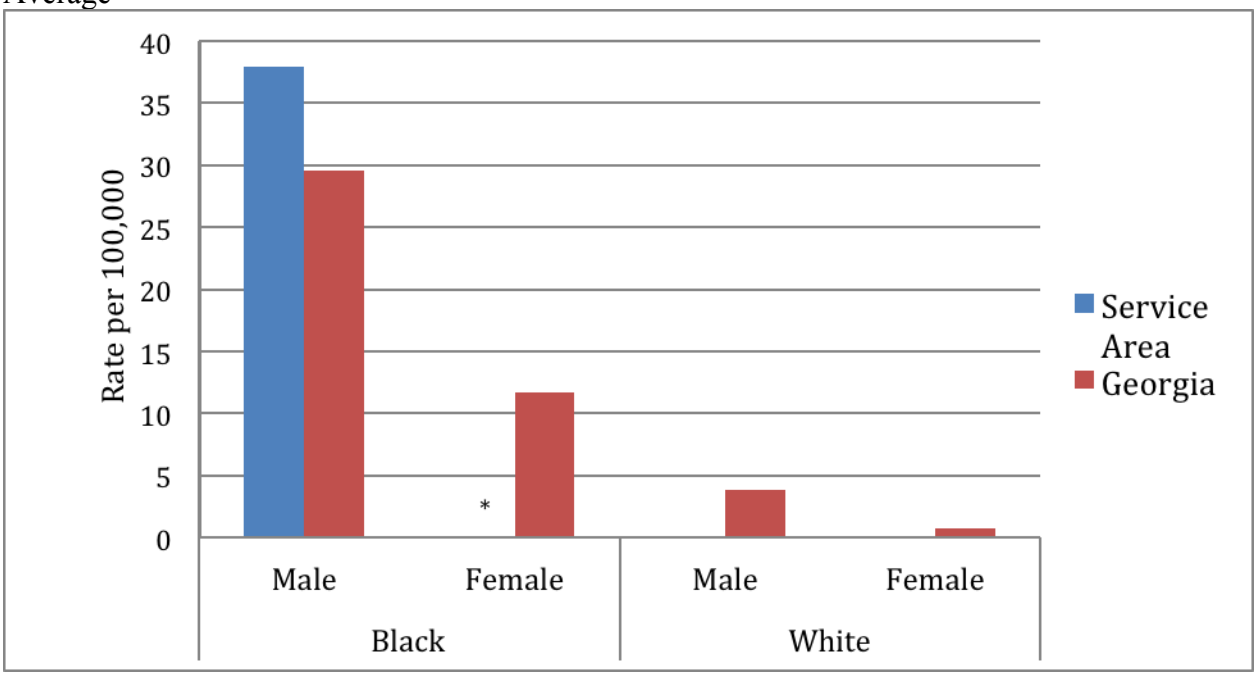
HIV/AIDS: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 23.6 | 19.7 |
| White | 0 | 0.0 | 2.3 |
| Other | 0 | NSR | 0.7 |
| Total | 1 | 8.1 | 7.1 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area experienced approximately one death per year as a result of AIDS.

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

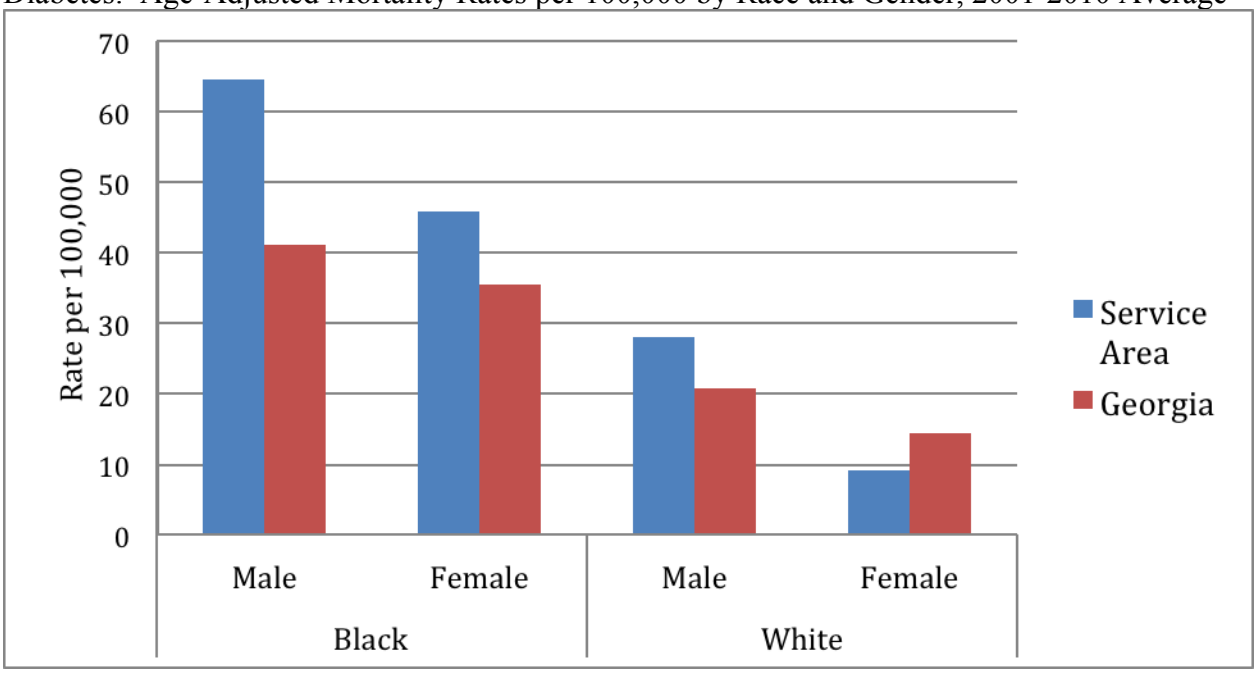
Diabetes: Deaths & Age-Adjusted Mortality Rates per 100,000

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 2 | 54.4 | 38.4 |
| White | 2 | 17.4 | 17.4 |
| Other | 0 | NSR | 9.8 |
| Total | 3 | 27.5 | 21.7 |

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The diabetes mortality rates are higher than the state averages. Rates are highest for black males.

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

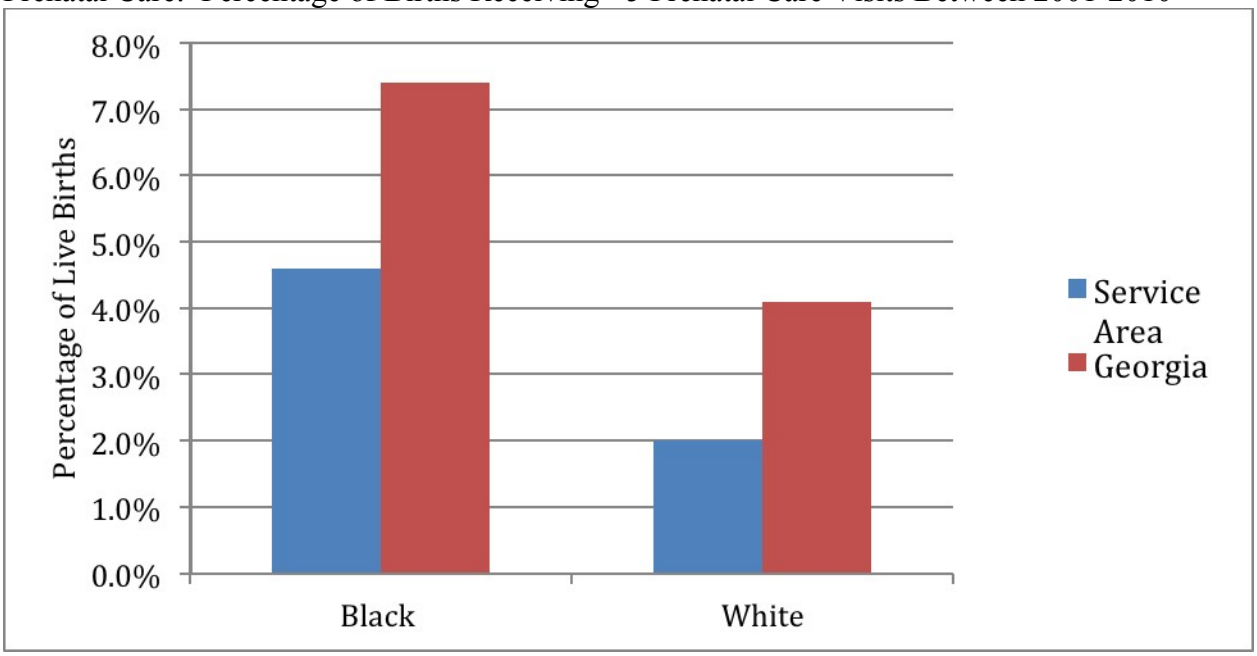
Prenatal care: Number and Proportion of Births Less Than 5 Prenatal Care Visits

| | Service Area (Births) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 2 | 4.6% | 7.4% |
| White | 1 | 2.0% | 4.1% |
| Other | 0 | 0.0% | 4.0% |
| Total | 3 | 3.1% | 5.1% |

†Average number of births without at least 5 prenatal care visits per calendar year from 2001-2010.
‡ Percentage of births without at least 5 prenatal care visits per year from 2001-2010.
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

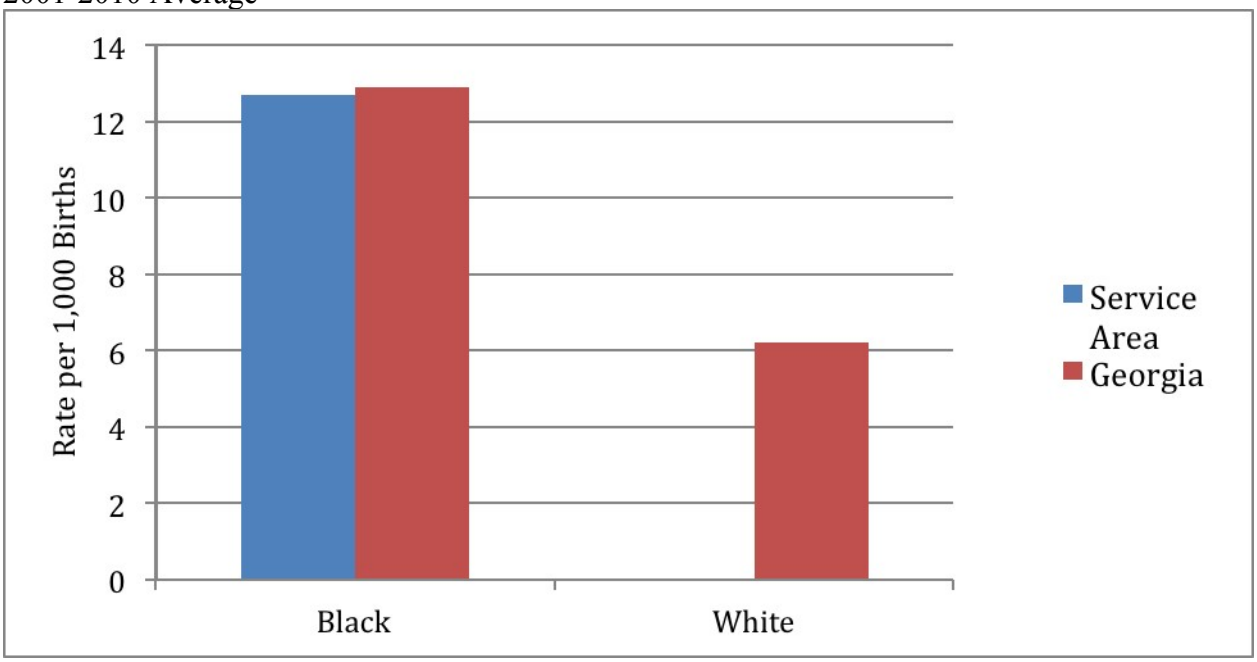
Infant Mortality Rate: Deaths & Mortality Rates per 1,000 Live Births

| | Service Area (Deaths) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 12.7 | 12.9 |
| White | < 1 | NSR | 6.2 |
| Other | 0 | 0.0 | 11.7 |
| Total | 1 | 7.4 | 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 for African Americans. The rates could not be calculated for the white population in the service area because there was less than one infant death per year.

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

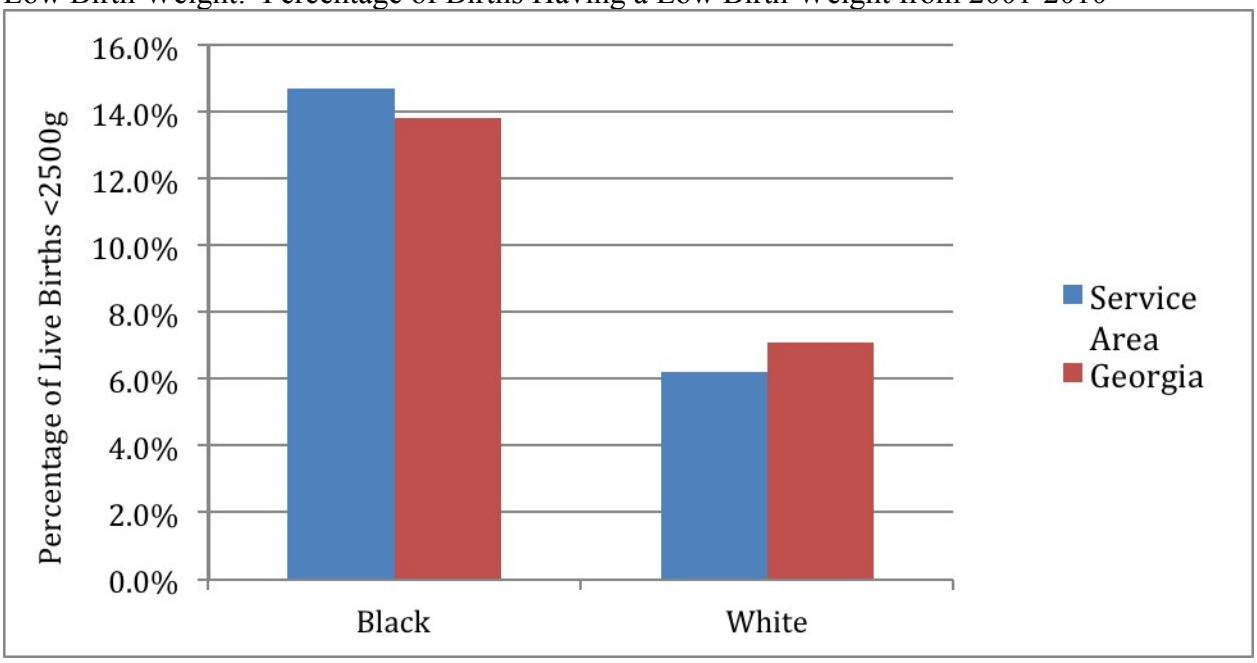
Low Birth Weight: Percentage of Births Less Than 2500g (5lbs 8oz.)

| | Service Area (Births) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 8 | 14.7% | 13.8% |
| White | 4 | 6.2% | 7.1% |
| Other | < 1 | NSR | 8.4% |
| Total | 12 | 10.0% | 9.3% |

†Average number of low birth births per year from 2001 to 2010
‡ Ten year average low birth weight rate from 2001-2010
NSR: Not statistically reliable
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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




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

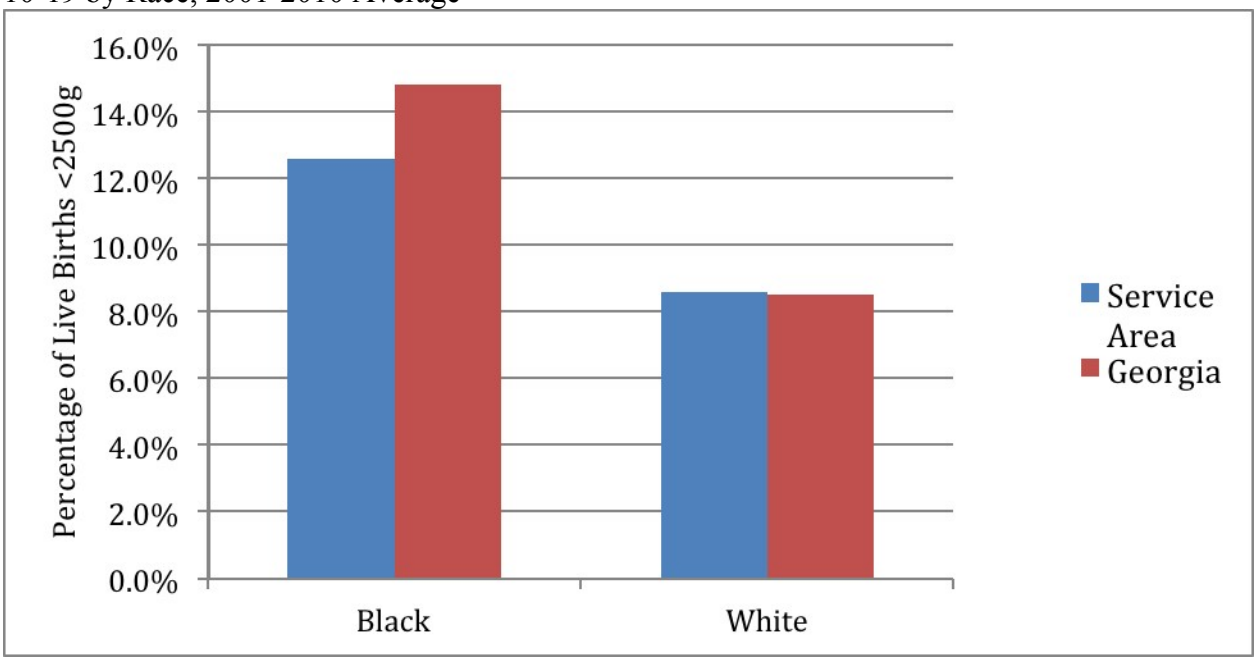
Low Birth Weight for Teen Births: Percentage of Births Less Than 2500g (5lbs 8oz.) for Mothers Aged 10-19

| | Service Area (Births) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 1 | 12.6% | 14.8% |
| White | 1 | 8.6% | 8.5% |
| Other | 0 | 0.0% | 10.6% |
| Total | 2 | 10.7% | 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
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

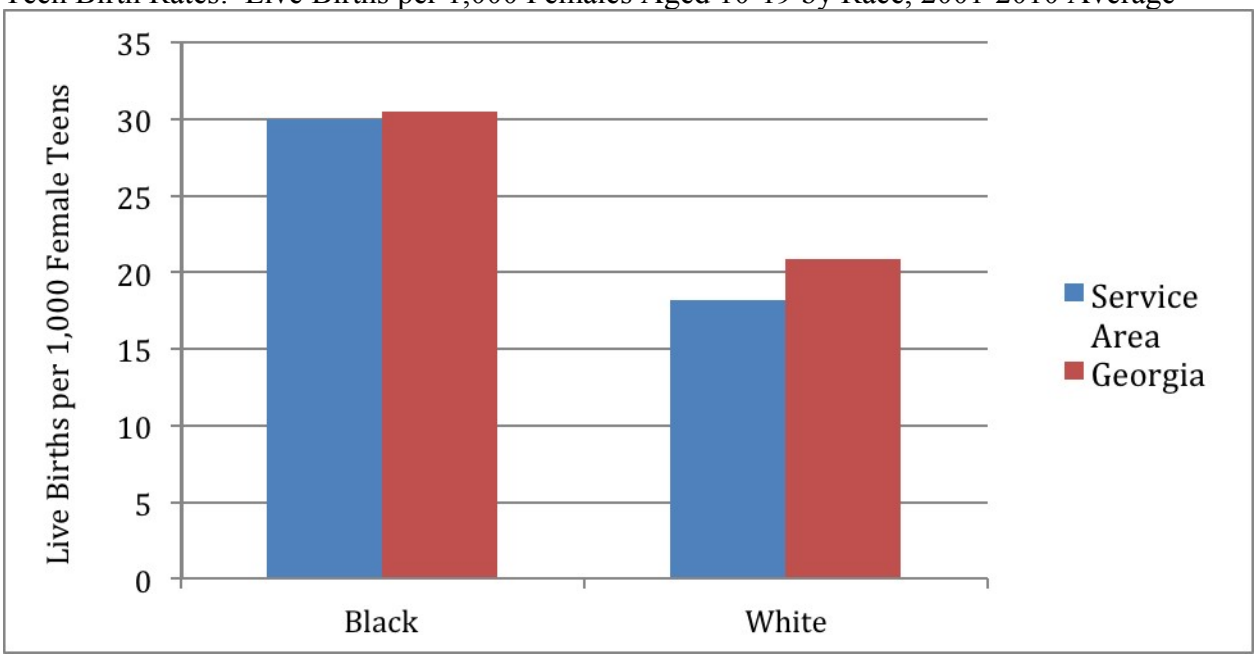
Teen Birth Rate: Live Births per 1,000 Females Aged 10-19

| | Service Area (Births) † | Service Area (Rate) ‡ | Georgia (Rate) ‡ |
|---|---|---|---|
| Black | 10 | 30 | 30.5 |
| White | 7 | 18.2 | 20.9 |
| Other | 1 | 75.8 | 31.8 |
| Total | 18 | 24.2 | 25.0 |

† Average number of births from 2001-2010
‡ Average Teen Birth Rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Teen births are those to mothers younger than 20 years old. The teen birth rates are similar to the state averages. On average, 18 teen births occur in the hospital service area per year.

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 680 surveys were distributed in the community. Among these, 477 were completed and returned to Georgia Southern University for analysis thereby yielding a response rate of 70.1%. The distribution of surveys by zip code is displayed below. As indicated, seven participants failed to report zip code (1.5%). 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 477 indicate the presence of missing values.

**Distribution of Participants by Zip Codes**

| Zip Code | Frequency | Valid Percent |
|---|---|---|
| 39837 | 326 | 68.3 |
| 39870 | 49 | 10.3 |
| Other | 95 | 19.9 |
| Missing | 7 | 1.5 |
| Total | 477 | 100 |

As indicated, 95 survey participants indicated a zip code other than those listed on the survey (19.9%). Zip codes from the "other" category are as follows: 31765 (n = 1), 39813 (n = 3), 39817 (n = 10), 39818 (n = 1), 39819 (n = 8), 39823 (n = 15), 39825 (n = 3), 29828 (n = 1), 39834 (n = 1), 39837 (n = 7), 39841 (n = 8), 39845 (n = 11), 39846 (n = 2), 39848 (n = 2), 39848 (n = 1), 39859 (n = 1), 39861 (n = 1), 39862 (n = 18), and 39870 (n = 1).

### 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 | 133 | 28.2 |
| Female | 339 | 71.8 |
| Total | 472 | 100 |

As is typical with community-based efforts, considerably more females (71.8%) completed this survey than males (28.2%).

**Distribution of Participants by Race/Ethnicity**

| Race/Ethnicity | Frequency | Valid Percent |
|---|---|---|
| White, Non-Hispanic | 284 | 60.9 |
| Black/African-American | 172 | 36.9 |
| Hispanic/Latino | 3 | 0.6 |
| Asian/ Pacific Islander | 1 | 0.2 |
| Other | 6 | 1.3 |
| Total | 466 | 100 |

Most respondents were white (60.9%). However, a significant proportion of survey participants were African American (36.9%). This number is representative of the racial demographics observed for the service area.

**Distribution of Participants by Age**

| Age | Frequency | Valid Percent |
|---|---|---|
| 18-24 | 36 | 7.6 |
| 25-34 | 69 | 14.6 |
| 35-44 | 97 | 20.5 |
| 45-54 | 79 | 16.7 |
| 55-64 | 85 | 18.0 |
| 65+ | 107 | 22.6 |
| Total | 473 | 100 |

Nearly 52.0% of all participants completing the community-based survey were between the ages of 25 and 54 years old. Only 7.6% of participants were 18 to 24 years old, and 18.0% of participants were between the ages of 55 and 64. Approximately 22.6% of all participants were 65 years old or older. Therefore, the age distribution suggests an adequate cross-section of participation.

**Distribution of Participants by Marital Status**

| Marital Status | Frequency | Valid Percent |
|---|---|---|
| Single | 128 | 27.0 |
| Married | 229 | 48.3 |
| Separated | 14 | 3.0 |

| | | |
|---|---|---|
| Living Together | 10 | 2.1 |
| Divorced | 38 | 8.0 |
| Widowed | 55 | 11.6 |
| Total | 474 | 100 |

Most participants (48.3%) were married while 27.0% of participants were single. With the exception of widowed (11.6%), the relative proportions of other categories were minimal.

**Distribution of Participants by Educational Status**

| Level Of Education | Frequency | Valid Percent |
|---|---|---|
| Less Than High School | 61 | 12.9 |
| High School Or GED | 156 | 33.1 |
| Some College | 156 | 33.1 |
| Bachelor's Degree | 52 | 11.0 |
| Advanced Degree | 32 | 6.8 |
| Other | 15 | 3.2 |
| Total | 472 | 100 |

Approximately 33.1% of respondents reported having some college education, and 33.1% of respondents reported having a high school diploma or the equivalent. Only 12.9% of respondents indicated they had less than a high school education.

**Distribution of Participants by Employment Status**

| Employment Status | Frequency | Valid Percent |
|---|---|---|
| Student | 19 | 4.1 |
| Full-Time | 230 | 49.3 |
| Part-Time | 46 | 9.9 |
| Retired | 101 | 21.6 |
| Self-Employed | 16 | 3.4 |
| Unemployed | 38 | 8.1 |
| Not Seeking Employment | 17 | 3.6 |
| Total | 467 | 100 |

Most survey participants (49.3%) indicated they worked full-time while only 9.9% reported part-time work. Approximately 8.1% of individuals completing the community-based survey reported being unemployed.

**Distribution of Participants by Household Income**

| Household Income | Frequency | Valid Percent |
|---|---|---|
| <$25,000 | 195 | 42.3 |
| $25,000-$49,999 | 101 | 21.9 |
| $50,000-$74,999 | 52 | 11.3 |
| $75,000-$99,999 | 36 | 7.8 |
| $100,000+ | 31 | 6.7 |
| Don't Know/Not Sure | 46 | 10.0 |
| Total | 461 | 100 |

Nearly 42.3% 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 | 290 | 61.8 |
| No | 179 | 38.2 |
| Total | 469 | 100 |

Most survey participants (61.8%) reported owning their home.

**Distribution of Participants by Access to Transportation**

| Access To Transportation | Frequency | Valid Percent |
|---|---|---|
| Yes | 412 | 87.7 |
| No | 58 | 12.3 |
| Total | 470 | 100 |

A considerable proportion of those surveyed reported having access to transportation (87.7%). 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 | 206 | 44.9 |
| 1 | 111 | 24.2 |
| 2 | 72 | 15.7 |
| 3+ | 70 | 15.3 |
| Total | 459 | 100 |

Most respondents indicated no dependents were living in the household (44.9%), but over 15.0% of those surveyed reporting having 3 or more dependents.

**Community Perception**

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

**Individual Perception of Quality of Life in the Community**

| My Community Is A: | | |
|---|---|---|
| Good Place To Live | Frequency | Valid Percent |
| Strongly Agree | 170 | 37.8 |
| Agree | 211 | 46.9 |
| No Opinion | 53 | 11.8 |
| Disagree | 13 | 2.9 |
| Strongly Disagree | 3 | 0.7 |
| Total | 450 | 100 |

Among those surveyed, 84.7% of participants either “agree” (46.9%) or “strongly agree” (37.8%) 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 | 41 | 9.4 |
| Agree | 84 | 19.3 |
| No Opinion | 115 | 26.4 |
| Disagree | 148 | 34.0 |
| Strongly Disagree | 47 | 10.8 |
| Total | 435 | 100 |

However, most participants feel that economic growth in the community is not optimal. Among those responding to this survey, 44.8% of participants either "disagree" (34.0%) or "strongly disagree" (10.8%) 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 | 61 | 14.1 |
| Agree | 160 | 37.0 |
| No Opinion | 128 | 29.6 |
| Disagree | 68 | 15.7 |
| Strongly Disagree | 15 | 3.5 |
| Total | 432 | 100 |

Most participants "agree" (37.0%) or "strongly agree" (14.1%) 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 | 124 | 28.0 |
| Agree | 218 | 49.2 |
| No Opinion | 76 | 17.2 |
| Disagree | 22 | 5.0 |
| Strongly Disagree | 3 | 0.7 |
| Total | 443 | 100 |

Among those responding to this survey, 77.2% of participants either "agree" (49.2%) or "strongly agree" (28.0%) 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 | 104 | 23.7 |

| | | |
|---|---|---|
| Agree | 250 | 56.9 |
| No Opinion | 65 | 14.8 |
| Disagree | 15 | 3.4 |
| Strongly Disagree | 5 | 1.1 |
| Total | 439 | 100 |

Most participants agree that the community is a safe place to live. Approximately 80.6% of respondents either "agree" (56.9%) or "strongly agree" (23.7%) that the community is safe.

**Individual Perception of the Educational System**

| **My Community Has A:** | | |
|---|---|---|
| Strong Education System | Frequency | Valid Percent |
| Strongly Agree | 63 | 14.4 |
| Agree | 120 | 27.3 |
| No Opinion | 133 | 30.3 |
| Disagree | 100 | 22.8 |
| Strongly Disagree | 23 | 5.2 |
| Total | 439 | 100 |

Nearly 42.0% of those responding indicated that they either "agree" (27.3%) or "strongly agree" (14.4%) 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**

| Health Status | Frequency | Valid Percent |
|---|---|---|
| Excellent | 34 | 7.7 |
| Very Good | 120 | 27.0 |

| | | |
|---|---|---|
| Good | 201 | 45.3 |
| Fair | 74 | 16.7 |
| Poor | 12 | 2.7 |
| Don't Know/Not Sure | 3 | 0.7 |
| Total | 444 | 100 |

Approximately 45.3% of respondents perceived their health status to be "good" and 27.0% perceived their health status to be "very good". Only 7.7% of participants stated their health status was "excellent".

**Distribution of Patterns of Exercise**

| Level Of Exercise | Frequency | Valid Percent |
|---|---|---|
| Not At All | 61 | 13.2 |
| Occasionally | 188 | 40.8 |
| 1-2 Times/Week | 102 | 22.1 |
| 3-4 Times/Week | 63 | 13.7 |
| 5+ Times/Week | 47 | 10.2 |
| Total | 461 | 100 |

Fifty four percent of respondents reported either not exercising (13.2%) or only occasionally exercising (40.8%). Only 10.2% of those participating in this survey reported exercising 5 or more times per week.

**Distribution of Monthly Self-Breast Exam**

| Monthly Self-Breast Exam | Frequency | Valid Percent |
|---|---|---|
| Yes | 161 | 52.6 |
| No | 145 | 47.4 |
| Total | 306 | 100.0 |

Only female participants were asked to respond to the question concerning monthly self-breast examination. According to those surveyed, 52.6% of women reported completing a self-breast examination.

**Distribution of Tobacco Use**

| Tobacco Use | Frequency | Valid Percent |
|---|---|---|
| Yes | 136 | 29.2 |
| No | 329 | 70.8 |
| Total | 465 | 100 |

Most participants (70.8%) reported not using tobacco.

**Distribution of Alcohol Use**

| Alcohol Use | Frequency | Valid Percent |
|---|---|---|
| Not At All | 261 | 56.0 |
| Occasionally | 159 | 34.1 |
| 1-2 Times/Week | 23 | 4.9 |
| 3-4 Times/Week | 13 | 2.8 |
| 5+ Times/Week | 10 | 2.1 |
| Total | 466 | 100 |

Nearly 90.1% of participants reported never consuming alcohol (56.0%) or only consuming it occasionally (34.1%).

**Distribution of Seat Belt Use**

| Seatbelt Use | Frequency | Valid Percent |
|---|---|---|
| Always | 333 | 71.3 |
| Mostly | 88 | 18.8 |
| Sometimes | 41 | 8.8 |
| Never | 5 | 1.1 |
| Total | 467 | 100 |

The distribution of seatbelt use in the community is very high. Most participants reported always (71.3%) or mostly (18.8%) using seatbelts.

**Distribution of the Perception of Diet**

| Diet | Frequency | Valid Percent |
|---|---|---|
| Rarely Eat Fruit/Vegetables | 50 | 11.0 |

| | | |
|---|---|---|
| 2-4 Servings Fruits/Vegetables | 219 | 48.1 |
| 5 Servings Fruits/Vegetables | 45 | 9.9 |
| High Fat | 56 | 12.3 |
| Medium Fat | 162 | 35.6 |
| Low Fat | 128 | 28.1 |

Participants were asked to indicate any all aspects of their personal diet that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Over 35.0% of respondents indicated their diet was medium in fat content, and 48.1% of those surveyed reported consuming 2 to 4 servings of vegetables each day.

**Strategies for Controlling Stress**

| Controlling Stress | Frequency | Valid Percent |
|---|---|---|
| Exercise | 161 | 35.1 |
| Hobbies/Sports | 107 | 23.3 |
| Eat More | 49 | 10.7 |
| Eat Less | 31 | 6.7 |
| Smoke | 61 | 13.3 |
| Alcohol/Drugs | 17 | 3.7 |
| Medication | 40 | 8.7 |
| Talk To Friends | 168 | 36.5 |
| Talk To A Counselor | 8 | 1.7 |
| Direct To Others | 22 | 4.8 |
| Prayer | 281 | 61.1 |
| Other | 37 | 8.1 |

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 (36.5%), exercise (35.1%), and hobbies/sports (23.3%) were also commonly reported to control stress.

**Healthcare Seeking Behavior**

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

**Distribution Reporting to Receive Regular Physicals**

| Regular Physicals | Frequency | Valid Percent |
|---|---|---|
| Yes | 326 | 74.1 |
| No | 114 | 25.9 |
| Total | 440 | 100 |

The majority of survey participants (74.1%) indicated they received physicals on a regular basis.

**Distribution Reporting to Have a Regular Doctor**

| Regular Doctor | Frequency | Valid Percent |
|---|---|---|
| Yes | 377 | 85.7 |
| No | 63 | 14.3 |
| Total | 440 | 100 |

Most (85.7%) 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 | 55 | 12.1 |
| Pay Out Of Pocket | 42 | 9.2 |
| Medicaid | 63 | 13.8 |
| Medicare | 121 | 26.5 |
| Medicare Part D | 31 | 6.8 |
| Private Insurance | 216 | 47.4 |

Over 47.0% of all respondents indicated having private insurance to pay for health care services. Medicare (26.5%) and Medicaid (13.8%) were reported by 40.3% of survey participants.

**Distribution Reporting to Have a Regular Dentist**

| Regular Dentist | Frequency | Valid Percent |
|---|---|---|
| Yes | 280 | 61.0 |

| | | |
|---|---|---|
| No | 179 | 39.0 |
| Total | 459 | 100 |

Approximately 61.0% 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 Of Heath Care | Frequency | Valid Percent |
|---|---|---|
| Private Practice | 229 | 50.4 |
| Emergency Room | 81 | 17.8 |
| Health Department | 25 | 5.5 |
| Miller County Medical Center | 125 | 27.5 |
| Colquitt Complete Care | 51 | 11.2 |
| Other | 39 | 8.6 |

According to the data above, 50.7% of participants reported seeking health care from a private practice. The emergency room (17.8%), the Miller County Medical Center (27.5%), and Colquitt Compete Care (11.2%) 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 | 129 | 28.3 |
| No | 327 | 71.7 |
| Total | 456 | 100 |

Nearly 72.0% 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 | 140 | 30.5 |
| No | 319 | 69.5 |
| Total | 459 | 100 |

Nearly 70.0% 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 | 43 | 12.7 |
| Gastroenteritis | 37 | 10.9 |
| Kidney Infection | 27 | 8.0 |
| Bleeding/Perforated Ulcer | 5 | 1.5 |
| STD | 1 | 0.3 |
| Ear/Nose/Throat Infection | 88 | 26.0 |
| Cold/Flu | 50 | 14.8 |
| Cellulitis | 9 | 2.7 |
| Dental Conditions | 19 | 5.6 |
| Diabetes | 42 | 12.4 |
| Asthma | 24 | 7.1 |
| Chest Pain | 70 | 20.8 |
| Hypertension | 54 | 16.0 |
| Congestive Heart Failure | 21 | 6.2 |
| COPD | 11 | 3.3 |
| Trauma | 45 | 13.3 |
| Back Pain | 37 | 10.9 |
| Anxiety | 19 | 5.6 |
| Psychiatric Problems/Suicide | 3 | 0.9 |

| | | |
|---|---|---|
| Prescription Refills | 16 | 4.7 |
| Shortness Of Breath | 24 | 7.1 |
| Pregnancy Related Problems | 20 | 5.9 |
| Allergic Reaction | 16 | 4.7 |

Ear/nose/throat infections (26.0%) were the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room. Chest pain (20.8%), hypertension (16.0%), cold/flu (14.8%), hypertension (16.0%), trauma (13.3%), and dehydration (12.7%) were also commonly reported conditions for emergency room admissions.

**Local Hospital Services and Overall Satisfaction**

Among participants surveyed, 61.9% used hospital services in the last 24 months.

**Distribution of Health Care Utilization**

| Hospital | Frequency | Valid Percent |
|---|---|---|
| Miller County Hospital | 189 | 66.5 |
| Other | 95 | 33.5 |
| Total | 284 | 100.0 |

Among those reporting using hospital services, 66.5% indicated using services at Miller 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 | Frequency | Valid Percent |
|---|---|---|
| Physician Referral | 43 | 23.4 |
| Quality Of Care | 21 | 11.4 |
| Closer/Convenience | 107 | 58.2 |
| Availability of Specialty Care | 7 | 3.8 |
| Insurance | 14 | 7.6 |
| Other | 13 | 7.1 |

Most participants reported using the local hospital because of convenience (58.2%). However, 23.4% reported being referred by a physician.

**Distribution of Services Utilized**

| Services | Frequency | Valid Percent |
|---|---|---|
| Radiologic Imaging | 79 | 43.6 |
| Laboratory | 87 | 48.1 |
| Inpatient Services | 27 | 14.9 |
| Other Outpatient Services | 21 | 11.6 |
| Emergency Room | 103 | 56.9 |
| Medication/Prescription Assistance | 8 | 4.4 |
| Colonoscopy | 8 | 4.4 |
| Sleep Study | 1 | 0.6 |
| Physical/Occupational Therapy | 11 | 6.1 |
| Other | 7 | 3.9 |

Respondents indicated using a variety services at the local hospital. Radiologic services (43.6%), emergency room (56.6%), and laboratory services (48.1%) were the most commonly reported services used by survey participants.

**Level of Satisfaction with Services**

| Level Of Satisfaction | Frequency | Valid Percent |
|---|---|---|
| Satisfied | 162 | 88.0 |
| Dissatisfied | 12 | 6.5 |
| Don't Know | 10 | 5.4 |
| Total | 184 | 100 |

Approximately 88.0% of those surveyed indicated being satisfied with services while only 6.5% indicated dissatisfaction. The primary reasons for reporting dissatisfaction were long ER wait times and hospital personnel interaction.

**Distribution Reporting Utilizing a Primary Care Physician**

| Utilization of Primary Care Provider | Frequency | Valid Percent |
|---|---|---|
| Yes | 171 | 92.4 |
| No | 13 | 7.0 |
| Don't Know | 1 | 0.5 |
| Total | 185 | 100 |

Approximately 92.4% of those surveyed indicated using a primary care physician. Among those participants indicating to not use a primary care physician (7.0%), the table below illustrates the type of medical care provider utilized for routine healthcare.

**Provider Location for Routine Care**

| Health Care Location Among Those Reporting Not To Use Primary | Frequency | Valid Percent |
|---|---|---|
| Health Department | 7 | 14.9 |
| Emergency Room | 12 | 25.5 |
| Specialist | 13 | 27.7 |
| Other | 12 | 25.5 |

As indicated above, specialists (27.7%), the emergency room (25.5%), and the health department (14.9%) were reported to be utilized in the absence of a primary care physician.

**Utilization of Primary Care at the Local Hospital**

| Location | Frequency | Valid Percent |
|---|---|---|
| Miller County Medical Center | 99 | 55.3 |
| Colquitt Complete Care | 37 | 20.7 |
| No | 36 | 20.1 |
| Don't Know | 7 | 3.9 |
| Total | 179 | 100 |

Approximately 55.3% of those surveyed reported using primary care services at the local hospital.

**Level of Satisfaction with the Primary Care Provider**

| Level of Satisfaction | Frequency | Valid Percent |
|---|---|---|
| Satisfied | 135 | 93.8 |
| Dissatisfied | 3 | 2.1 |
| Don't Know | 6 | 4.2 |
| Total | 144 | 100 |

Among those using primary care providers at the hospital, the vast majority (93.8%) was satisfied with the services received.

**Distribution Reporting Ease of Appointment with a Primary Care Provider**

| Ability To Get An Appointment | Frequency | Valid Percent |
|---|---|---|
| Yes | 131 | 89.1 |
| No | 12 | 8.2 |
| Don't Know | 4 | 2.7 |
| Total | 147 | 100 |

Most respondents (89.1%) indicated they were able to schedule an appointment with the primary care provider at the local hospital.

# RESULTS: FOCUS GROUP ANALYSIS

**Introduction: Participants' Characteristics**

Miller County Hospital was encouraged to recruit groups of 6-8 participants to take part in 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 participants took part in the three focus groups. Two of the three focus groups took place at the Miller County Family Resource Center simultaneously at 10:00AM on October 11, 2012, while the third took place the next day at 9:00AM at the Baker County Courthouse. The first focus group consisted of seven CAC members, the second and third sessions were comprised of CAC members and CAC members' referrals, six and seven, respectively.

The three focus groups consisted of 20 participants: 13 women and seven men. Fifty-five percent of the sample was Caucasian (11) and nine were African American. All of the participants spoke English. Twelve of the 20 participants lived in Colquitt, five in Newton, and two were residents of Brinson and Damascus, respectively. One participant did not answer the resident question. Participants' ages ranged from 28 to 74 years old, with a median age of 51 years. Participants' education levels were as follows: three advanced degrees; eight college degrees; eight had some college education; and one participant reported to have completed only high school. Participants' annual income levels included four with 100k or more; three persons with 75k – 100k; one with income levels 50k – 75k; eight people reported income levels of 25k – 50k; and three reported having income levels less than 25k. The following sections divide the focus group discussions by common thread or topic.

**Community**

*Theme*: Peaceful; everybody knows everybody; safe place to live; family oriented; and rural lifestyle.

Most of the participants described Miller County as a peaceful place to live, where everybody knows everybody. They enjoyed that the community has a small town atmosphere and it is a great place to raise children. Also, participants mentioned that a lot of people came there to retire which causes the community to age,

> *"I like that you know everyone practically, and you can look at it as most of us live here have lived here for a long time, and many people go away and work for many years so they can afford to come back and live where we've lived all the time. People like to retire here. We have a lot of retired people. Of course, that makes our community older and in need of healthcare."*

Participants believed that because most people want to protect the community, the crime rate is low in Miller County. In addition, participants felt that the community has a friendly feel and it is a close-knit group of people. One participant said,

> *"It's quiet. It's quiet, it's calm, and it's a very close-knit group of people. Everybody knows everybody. Well, not so much me right now, but I'm working on it. But a very close-knit group."*

Another participant stated,

> *"It's very peaceful; it's very laid back, a good community to raise children in for the most part."*

One participant continued,

> *"You don't have much violent crimes either. That's something to be thankful about."*

One participant further elaborated on the point of low crime rate,

> *"Well, population is the first thing about it. And like I said, here, since it's so small, I'd say 90-something percent of the population here want to protect the community. If they know someone's doing something they shouldn't be doing, they will report them to protect the community…"*

Many participants mentioned that they enjoyed living a rural life where everything is easily reachable. One participant said,

> *"I like the lifestyle. The things we have to do for a small town. My husband likes the fact that he can do six errands and be back home and not have driven two miles*."

Another participant stated,

> *"I think, for the most part, people like it because it's a rural setting. You know your commercial people. You go to the bank. You know the post office. You have a personal connection with your neighbors. If they need help, they will call you."*

When asked what makes it easy to maintain a healthy lifestyle, many participants believed that the rural way of living helps to prevent many health issues. One participant elaborated,

> "*You're not exposed to a lot of things that you are in bigger cities as far as health issues. City living you advance to more things, so any time you advance towards things and people, health issues can come up in all different types of aspects."*

Another participant continued,

> *"Yeah, like with a larger city you're more populated in tight areas. Here, less population, more rural, you're kind of scattered out more, so maybe like less…*"

One participant mentioned that the community offers a health fair to promote health and to educate community members,

> "*And we do have a small knit community that promotes health as well. We just had a health science fair that went very well, that makes it easier, and you'll be more knowledgeable also*."

Participants also briefly mentioned the Baptist church and recreational department as additional sources for health promotion.

When asked what makes it hard to maintain a healthy lifestyle in Miller County, the major theme was lack of healthy food options. Participants mentioned that the community does not have enough educational programs about healthy eating habits, has only one grocery store, and many buffet places,

> *"Well, we have one grocery store, and I mean, if it's something that people don't buy, they're not going to – I mean enough people don't buy, they won't order it."*

> *"We've got three restaurants here that serve only buffet at lunch and some at night. And when you're paying $9.50 and $10.00 a plate, what are you thinking in your mindset? "I'm going to get my money's worth." So you're overeating. So that is a lot of the mindset here, I believe."*

Several participants felt that a healthy lifestyle mostly depends on the income. They expressed their perceptions about people with lower socio-economic status that do not utilize medical services as needed. One participant stated,

> *"Being diagnosed with those problems, a lot of people – and if you're low income, it's a very low socioeconomic population – and you don't go to the doctor's regularly –"*

Due to the fact that mental health issues were relevant in the community, a few of the participants expressed that state contract and Primary Health Care center were some of the assets to battle this issue. One participant explained,

> *"There are people that can't pay for insurance or don't have a household income that allows them to participate in any kind of insurance or program. So the state gives funding to mental health to see the people that have no means of paying."*

Another participant said,

> *"We have a mental health person who comes from the Albany area. There was awhile they stopped at all. We had a five day a week service here in the Primary Healthcare Center for a good while."*

**Community Issues**

| *Theme*: Lack of privacy; lack of resources; shortage of doctors; substance abuse; mental health issues; teenage pregnancy; transportation; lack of jobs |
|---|

Even though the participants enjoyed that the community is interconnected, they recognized some limitations of having close relationships with each other. One participant said,

> *"Because it's a small town, everyone knows everyone, it's hard to not have personal agendas with different things and not for the betterment of the community sometimes, if that makes sense."*

When asked about other issues affecting the citizens of Miller County, many participants mentioned lack of resources. Several participants expressed that especially for younger children there is nothing to do.

> *"There's nothing to do for anyone, really. You've got to go somewhere else to do anything. Unless you like riding four-wheelers and fishing, other than that, there's nothing really much you can do*."

Another participant continued,

> *"Well, I have to agree with [participant]. With me having children, if we want to do something, we have to go out of the county because there's nothing here for them to do to entertain them."*

Participants also talked about the limited internet access. They believed that lack of internet limits peoples' opportunities in Miller County to find a job or to educate themselves.

Many participants felt that the community lacks specialty doctors. They said that there were no doctors' offices and if you have anything other than ordinary head cold or high blood pressure or a little diabetes or something like that, you have to go out of town for it. One participant believed that there is a connection between lack of resources in the area and the shortage of doctors,

> *"I think part of the reason that a lot of those services aren't available; it's also hard to recruit physicians here. It's really hard. Sometimes you have some great physicians that want to come here but their families don't, because there's more to offer in bigger cities."*

The majority of the participants felt that one of the biggest issues in the community was substance abuse. When asked about particular drugs that are prevailing in Miller County, participants mentioned marijuana, cocaine, and methamphetamines.

> *"Talking about marijuana and cocaine, primarily and methamphetamine is a real problem. Even some of the drugs, that you would expect to find in larger cities, make their way here occasionally. But meth and cocaine and marijuana primarily…*"

Prescription drugs were also a concern among several participants. They believed that it is very easy to obtain prescription drugs in this community.

> *"But you've got prescription drugs going around, they don't have to go to a doctor to get it, they go from door to door to get it."*

> *"I know somebody personally right now who goes to the doctor and says, "I just need a refill." There you go. And then goes down the street to the other doctor, "I need a refill." And then they go out and sell them."*

Participants also discussed alcohol and mental health issues. They believed that the community does not have adequate sources to address these issues and as a result of that people get diagnosed as criminals,

> *"Mental health facility, the state mental health facility is more than 60 miles away, and many times, mental health – people with mental issues encounter law enforcement because they get diagnosed as a criminal when, actually, their problem is mental. And they get hauled to 60 miles away to a mental hospital, and due to overload and funding issues; I've heard deputies say they beat them back home. "I took them down there, but they were back home by the time I was."*

Teenage pregnancy and single parenting were viewed as other important problems that the community is dealing with. One participant believed that lack of financing was not the reason for high rates of teenage pregnancy; rather it is something that the community has to face on a regular basis,

> *"But teen pregnancy and single parent households is a problem. Of course, teen pregnancy, we found, was not related entirely to economics because one of the area private schools, people went to school there, and their rate was exactly the same as the state rate. So it's not tied to socioeconomics entirely. It's just a new day."*

Several participants believed that deprivation of transportation affects the community members' daily functioning significantly and that it is a problem for children to get to school. One participant explained,

> *"I think transportation is a huge issue for this community. So many of our families have to rely on – I know as far as getting kids to and from school – the buses. If they don't have the bus situation, their kids either have to walk to school, sometimes a pretty good distance, or they can't come to functions because they can't get here."*

Several participants mentioned that transportation is a shortfall in this community that limits the access to healthcare services. One participant said,

> *"Whether it's education or recreation or other opportunities but especially healthcare, one of the tremendous shortfalls in this county is transportation."*

Another participant continued,

> *"…And the distance that people have to travel to get healthcare. So, if you don't have a way to travel it's hard to get to the healthcare."*

Another participant also mentioned lack of jobs in Miller County as an important issue. One participant talked about the fact that after young people finish high school, they leave the community to find jobs elsewhere,

> *"The only problem I find, the opportunities for young people. There are very few, and most of our young people, when they leave school or they leave the county because there are no jobs…and that's my concern."*

**Hospital**

*Theme*: Compassionate practitioners; community-friendly; quality care; respect patients' privacy; managed resources wisely; biggest employer in Miller County; and offered a variety of services.

A number of the focus group participants shared, Miller County Hospital remained a community friendly hospital. The hospital had respectable and compassionate practitioners who knew the patient population. Its administration encouraged and welcomed community participation through the sponsorship of many community events. Several participants even stated, the hospital felt like a big family affair.

> *"The doctors that we have and the PAs that we have are really good. They do a really good job."*

> *"They know a lot of people in the community. Just like after they've been there awhile, even though they're not from here, they get to knowing a heap of people. They'll really work on you good."*

> *"Everybody who works there is probably related in some kind of way. And the people who come all the time, they feel they're home, because it's just like a family gathering there."*

> *"If you walk in, everybody calls you by name."*

> *"You have a lot of people there employed and the majority of the people who go up there and get treated are kin to somebody in the hospital, it might be a nurse, or the clerk checking you in…"*

Overall, patients' privacy is respected; however, there were some participants who expressed concerns. They assumed it may be because the town is small and that they fear those attending to them at the hospital may share their health conditions with others in the community.

> *"…And as far as staff at the hospital, we have a good staff. They give it their best shot. A heap of people are not going to say they're great at times when you're in there, but overall, they'll do just as much as a big hospital can do."*

> *"Your personal business is way under the covers …they cover that real good, and that's important…It's just between you and that physician who's working with you."*

Several participants shared the significance of having the Miller County Hospital in the community. They shared, it was important for the community to make use of its services so that it can remain functional. Further, a small number of participants pointed out that the hospital was the largest employer in Miller County and that they would like to see more of the residents use the facility.

> *"I would certainly like to see the locals use the hospital more. If our hospital closes, and it has been that close many, many, many times, that's the largest payroll in our town. They've got over 200 employees. If that payroll did not come in to Colquitt, can you imagine what it would do to the grocery stores, to the gas stations, to the restaurants, to the school, to everything? To the churches."*

Further, participants said, for a hospital its size in a small community, Miller County Hospital offered many services. They credited the provision of these services to the efforts of the current hospital administrator in lieu of carefully managing limited resources.

> *"I think for the size of our hospital, the size of our community, they offer a lot of things. I was shocked with some of the services they offer."*

Another participant articulated the 'no wait time' period in the emergency room (ER) for services. This participant said it's best to go to the ER for care rather than a local doctors' office.

> *"If you go to the doctor's office you've got to stay 45 minutes to an hour, but the emergency room is lots quicker."*

A majority of the participants were able to name services provided at Miller County Hospital. In order of frequency, the following services were named: mobile unit that provided CT scan, mammograms and MRI; laboratory; physical and respiratory therapy; wound care; minor surgeries; telemedicine; weight watchers; emergency room; swing bed; x-rays; bone density; and sleep study. However, a number of participants believed the services provided by Miller County Hospital were only known by a few people in the community, and that knowledge of the type of services was dependent on social ranking. In other words, the people who knew all the services provided by Miller County Hospital were business leaders in the community.

**Hospital Problems**

*Theme*: Hospital staff lacked customer service skills; high physician turnover; need to advertise existing service; and long wait in clinic.

Concerning areas for improvement for Miller County Hospital, a small number of participants indicated that the hospital staff was sometimes impolite and rude, which may be a sign of complacency in their employment posts. They said, since 'everyone knew everyone' in the town, they often experienced a lack of professionalism from hospital staff. These two participants shared experiences with hospital staff at the Miller County Hospital, when said,

> *"I'm not saying the majority of them are that way…I've had real good experiences with most of them. But there's a couple that when you are in contact with them they're rude to you on more than one occasion and you've got done anything, I kind of would like to grab them by the nape of their neck and say, 'Do you really want your job?'"*

> *"Well, if they feel like you know everybody, they just feel comfortable treating you the way they would treat anybody on a normal day. They don't think about being professional."*

Moreover, participants also mentioned the hospital's inability to retain physicians. That is, participants desired consistency in the physicians from whom they received care at Miller County Hospital.

> *"And there's such a high turnover with the doctors, you'll get comfortable with one doctor, but a year later you've got a whole other doctor."*

The following limitations were mentioned by a small number of the participants: parking problems, the need to have a security system and a waiting or receptionist area at the hospital.

> *"Parking is really a problem. When you go as a visitor, in the front there, they're all taken. I think, a lot of times, it's employees that park there. They should be further away because you're driving, trying to find a place to park, and some of the visitors are in pretty poor health, too, and they struggle to get in."*

> *"When I enter in our hospital…you walk in and there's the nurse's station, and they're all busy and working. No one greets you at the door, no one says 'hi' or really smiles, they just are doing their job, I guess."*

> *"And there is no security. When you walk in, you walk in to that hospital, walk down those halls…It could be nothing for somebody to walk in that hospital and not like the person that's in there and literally hurt the person."*

**Hospital Recommendations**

*Theme*: Health education programs; health fairs in Baker County churches; develop list of services provided; use different mass media to advertise services; free care clinic; offer specialty services (OBGYN, labor and delivery); more specialists; daycare for hospital staff; MRI/CT scan, mammogram in-house; trauma care; cancer care; and morgue.

Focus group participants made several recommendations to Miller County Hospital aiming at improving existing services in Miller County, along with making services accessible to Baker County residents. These recommendations included to create health awareness and education programs; to use Baker County churches to have health fairs in different areas of the county; to develop a basic list of services provided by the hospital so that the community will know where to go when in need; to use word-of-mouth to publicize available hospital services in the community; and to use the school system and public meetings to communicate different hospital events and programs to the community.

> *"I would love to see them offer more stuff, free services like that. I know [Phoebe] does an awful lot of free one and two hour classes where parents come in and ask questions, create a diet plan for diabetes, asthma clinics going all the time. And it wouldn't cost...I would come in as the school and help with my part. [Collaborative] would probably be*

*able to jump in, but it wouldn't cost the hospital anything to just offer, here it is, we'll help back it, as far as supporting it through the community. An hour or two, pay a supplement, once a year, because they wouldn't have to come to every meeting."*

*"…As far as actually seeing a full list in front of you, other than at the hospital, I've never seen a full list published showing everything they've offered."*

Other recommendations were to open a free clinic to be opened in the weekends to provide screening and diagnostic examinations and other basic services; to allow the community to use the hospital facility to host public meetings; to promote community involvement in their activities; and to use other forms of media including Facebook to advertise hospital services.

*"If maybe they had…I forget what we call it…a public relations person whose job it was to just go around to get the word out, to get the churches and schools and businesses to let people know about Miller County Hospital."*

*"If Miller County could have a little bit more of accessibility to healthcare at this hospital to where…they don't have to pay nothing…They ought to set up more stuff like that like on the weekends and just give free clinic, something like that there, and that'll let people know what illnesses they've got."*

When participants were asked, what services they would like to see offered at Miller County Hospital, they stated they would like to have more specialty services namely: OBGYN, labor and delivery, pediatrics services and trauma care. Furthermore, they would like to have radiology and imaging to be in-house not the mobile unit that visited the hospital twice a month.

*"Pediatrics. Your closest pediatrician is in Johnsonville…I think Swafford sees peds, but they don't specialize in it…I would love to see a pediatrician that would stay here, not stay six months and leave, to get to know our kids and to be able to know our cases and we feel comfortable enough taking kids there not just for minor things but for major things."*

*"I wish they could afford to have their own CT machine and MRI rather than having the truck come."*

*"I wish we could actually have our own mammography here, because you schedule it and it only comes in once or twice a month."*

Other services those participants would like to see offered at the Miller County Hospital included mortuary, cancer treatment, end of life and psychiatric units.

*"The Miller County Hospital needs to get a morgue…We're getting a lot of people here that's from out of town…New York City, Tennessee in the hospital and in the nursing home, and if their loved one is going to visit them while they're living, they're definitely going to visit them when they die."*

**Community Vision**

*Theme*: Youth development; health improvement; economic growth

Regarding community vision, participants expressed, they want to see the community concentrate more on youth development. One participant believed that due to lack of activities for children, there are a lot of minor arrests in Miller County,

> *"For the community, for the kids and stuff, give them something to occupy their minds besides just arresting them for loud music. We get a lot of accounts right here, they're arresting them for live music. And the kids came by and you're charging them $900 for a ticket. The parents ain't able to buy that, and you're throwing them worse in a hole. Stuff like this here is more important instead of just looking for the little things the kids are messing up on."*

Another participant wanted to see more recreational facilities for the children,

> *"That's one of the things I don't like about… I'd like to have a nice complex for our kids. We've got a rec department or whatever, but like he said, when you go to Bainbridge there's a big nice complex."*

Other aspects of the community that the participants would like to see improved include community health. Several participants believed that family-oriented health programs might be effective. One participant said,

> *"But we have got to make a mindset. We don't have time, okay. You don't have time to take care of your body, to live an extra year or two, because that's what's happening. If we're not taking care of ourselves on a good diet and exercise, I don't care what medication you're putting in your body, it's not going to help you."*

Another participant continued,

> *"I was thinking if you could do something in conjunction, while the kids are down there at football practice, have the adults up here, the ones that aren't working that are just sitting there watching."*

One participant proposed the involvement of business in health promotion of their workers,

> *"I think the businesses need to make a stand and say, "I'm going to give my employees 30 minutes to only go exercise." Not to run an errand, not to go to the post office or whatever, but "I'm going to give you 30 minutes to do something healthy."*

Other areas discussed included less drug abuse, economic growth, and having more businesses coming into the community. This participant expressed the community vision by saying,

> *How about increasing business opportunities, you know, new businesses, so that more people would have decent paying jobs. And what we were talking about earlier where*

*even if you have a job and you have insurance, you still have to pay so much out of your pocket.*

## COMMUNITY ASSETS

### Miller County Assets

| Name of the company | Phone number | Address | Services |
|---|---|---|---|
| Miller County Hospital | **(229) 758-3385** | 209 N Cuthbert St, Colquitt, GA 39837 | Hospitals, Rehabilitation Services, Nursing Homes-Skilled Nursing Facility |
| Spring Creek Health | (229) 758-6064 | 304 W Pine St, Colquitt, GA 39837 | Health & Welfare Clinics, Clinics, Medical Clinics |
| Miller County Medical Center | (229) 758-4179 | 201 N Cuthbert St, Colquitt, GA 39837 | Medical Centers |
| Colquitt Physical Therapy | (229) 758-5214 | 210 W Main St, Colquitt, GA 39837 | Medical Clinics, Physical Therapists |
| Archbold Health Services | (229) 758-3739 | 155 E Pine St, Colquitt, GA 39837 | Medical Clinics, Oxygen Therapy Equipment-Wholesale & Manufacturers |
| Miller County Neighborhood Svc | (229) 758-2848 | 360 S 4th St, Colquitt, GA 39837 | Marriage, Family, Child & Individual Counselors, Social Service Organizations |
| Southwest Georgia Community Action Council Inc. | (229) 758-3860 | 739 N 4th St, Colquitt, GA 39837 | Community Organizations |
| Drug & Alcohol Treatment Centers-US | (888) 357-4287 | Serving the Colquitt Area | Counselors-Licensed Professional, Psychological Clinics |
| All About Treatment | (877) 414-5329 | Serving the Colquitt Area. | Counseling Services, Drug Abuse & Addiction Centers, Alcoholism |

| | | | |
|---|---|---|---|
| | | | Information & Treatment |
| Reproductive Biology Associates | (888) 635-2684 | Serving the Colquitt Area | Pregnancy Information & Services, Infertility Counseling, Pregnancy Counseling |
| Community Development Corp | (229) 758-9633 | 171 S Cuthbert St, Colquitt, GA 39837 | Social Service Organizations |
| Albany Area Community Service Board | (229) 758-2565 | 500 N Martin Luther King Jr St, Colquitt, GA 39837 | Social Service Organizations |
| Miller County Of | (229) 758-3344 | 250 W Pine St, Colquitt, GA 39837 | Social Service Organizations, Government Offices, Mental Health Services |

**Baker County Assets**

| Name of the company | Phone number | Address | Services |
|---|---|---|---|
| SWGHD Central Billing | (229) 734-4701 | 327 Sunset Ave SW # 2, Newton, GA 39870 | Health & Welfare Clinics, Social Service Organizations |
| Baker County Primary Health Care Center | (229) 734-5250 | 100 Sunset Ave SW, Newton, GA 39870 | Clinics, Physicians & Surgeons, Family Medicine & General Practice, Physicians & Surgeons, Internal Medicine |
| DNA Paternity Testing Centers | (855) 884-2895 | Serving the Newton Area | Medical Clinics, Paternity Testing, Drug Testing |
| Private STD Testing Center | (866) 903-7791 | Serving the Newton Area | Medical Clinics, Testing Labs, |

| | | | |
|---|---|---|---|
| | | | Paternity Testing |
| Baker County Neighborhood Service Center | (229) 734-4070 | 139 Roosevelt St, Newton, GA 39870 | Marriage, Family, Child & Individual Counselors, Social Service Organizations |
| East Baker Historical Society | (229) 734-7075 | 156 Roosevelt Ave NW, Newton, GA 39870 | Community Organizations, Social Service Organizations |

## PRIORITIZATION

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

A. Chronic Disease Conditions (Heart Disease, Cancer, Respiratory, Diabetes)
B. Behavioral Health Issues (Mental Health, Substance Abuse)
C. Community Health Education (Tobacco, Nutrition, STD, Teen Pregnancy, Etc.)
D. Child Health
E. Perception of Access to Healthcare (Shortage of Physicians)
F. Access to Transportation

During the 3rd meeting, these data were presented to participants. Following the multi-voting procedure, it was determined that only six of these issues would be prioritized using the Hanlon Method. 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 (Heart Disease, Cancer, Respiratory, Diabetes) | 12 | 8.4 | 15.0 | 7.8 | 62.0 |
| Behavioral Health Issues (Mental Health, Substance Abuse) | 12 | 7.4 | 13.0 | 5.2 | 35.2 |
| Community Health Education (Tobacco, Nutrition, STD, Teen Pregnancy, Etc.) | 12 | 7.9 | 14.0 | 7.7 | 56.3 |
| Child Health | 12 | 7.4 | 14.0 | 6.8 | 48.7 |
| Perception of Access to Healthcare (Shortage of Physicians) | 12 | 6.0 | 13.0 | 6.6 | 42.1 |
| Access to Transportation | 12 | 6.5 | 13.0 | 6.1 | 39.9 |

*Represent average score of all participants ranking a particular issue

According to the results, "Chronic Disease Conditions" ranked highest according to the calculated BPR score. This issue was followed by "Community Health Education," "Child Health," "Perception of Access to Healthcare," "Access to Transportation," and "Behavioral Health Issues."

## HOSPITAL CHALLENGES

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

- Three months into the project there was a shift in site leadership role. The CEO of the hospital (initial contact and site leader) enlisted the assistance of the Spring Creek Health Cooperative to help with the data collection, focus group participant recruitment and other logistics.
- *On survey data collection*
    - An additional 280 copies of the survey was made. Efforts to secure the return of completed surveys were not coordinated, which impacted the survey response rate.
    - Incomplete records were kept on the number of surveys distributed in the community.
    - CAC members did not receive clear instructions on where to return completed surveys; therefore, they returned them to more than one location, this created additional disruption in the collection of completed surveys.
- The timely receipt of requested documents was a challenge. This was due in part to the need to balance current work related responsibilities and roles with the demands of the CHNA initiative.
- *On focus groups*
    - In recruiting participants for the focus groups, the site leader separated the focus groups by gender. However, upon arrival at the sites where the focus groups were to be conducted, the moderators mixed the groups.

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## LIST OF APPENDICES