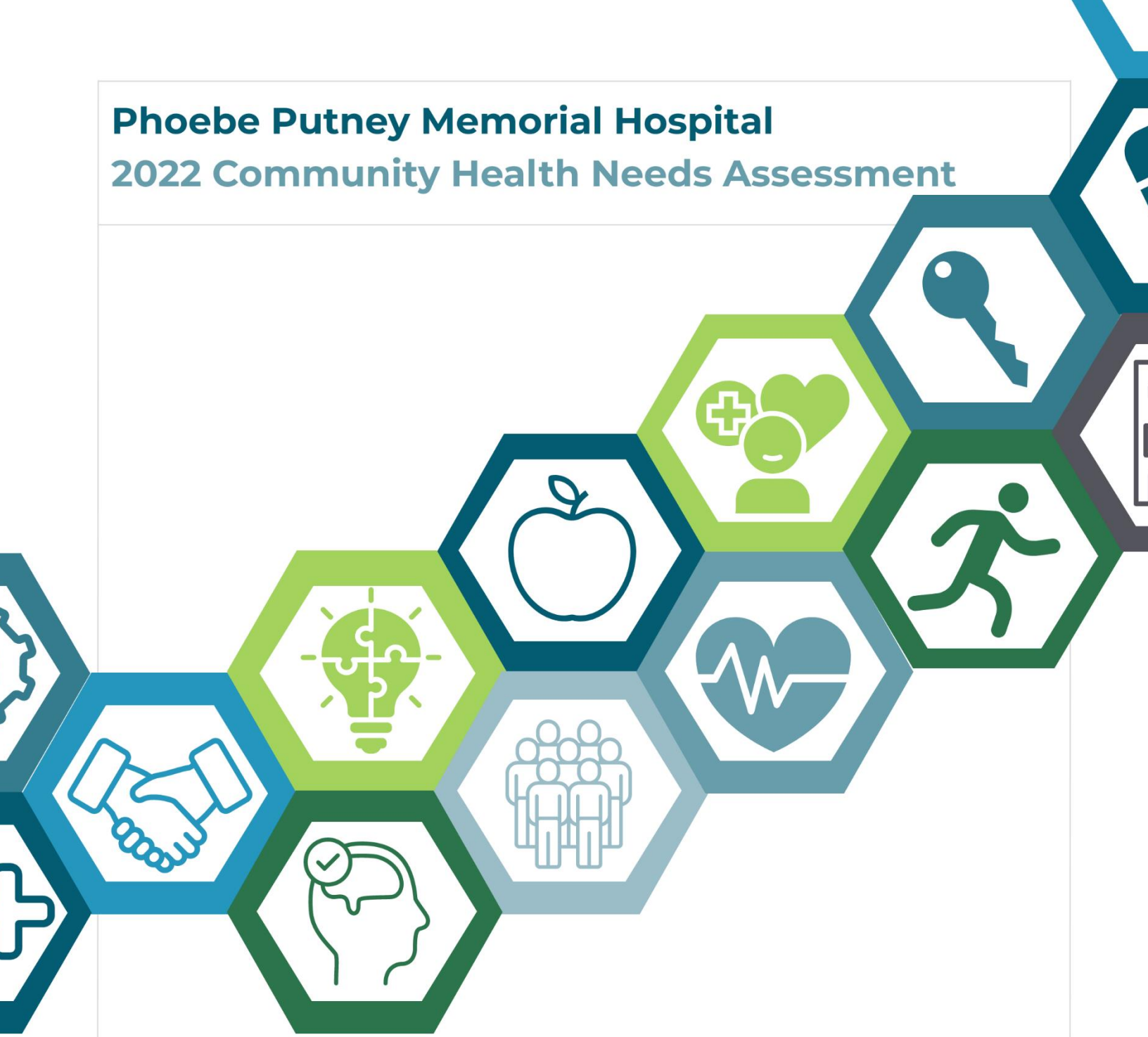
Phoebe Putney Memorial Hospital

2022 Community Health Needs Assessment



Phoebe

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SECTION 1

INTRODUCTION & PURPOSE

Phoebe's vision is to make every life we touch, better. We have been committed to that goal since 1911 when our first hospital opened with a pledge to serve everyone in need of care, regardless of their ability to pay. We have proudly cared for generations of southwest Georgians – living up to that foundational pledge while expanding services and improving access to care.

Over the last three years, our country's healthcare landscape endured monumental shifts. The COVID-19 pandemic presented challenges we have never faced and forced health systems to develop new and innovative ways to deliver the care their communities need.

When southwest Georgia became one of the world's worst COVID-19 hotspots early in the pandemic, Phoebe's response was nothing short of phenomenal. We quickly and dramatically expanded our ability to care for critically ill COVID patients – opening multiple new COVID units – and we took remarkable steps to ensure we never ran out of personal protective equipment for our staff. Phoebe led COVID-19 testing efforts in southwest Georgia, operationalized one of the state's most successful vaccination programs and invested in a massive project to protect thousands of COVID patients from serious illness by administering monoclonal antibody treatments.

This report includes a description of:

- The community demographics and population served;
- The process and methods used to obtain, analyze, and synthesize primary and secondary data;
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;
- The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.

Phoebe hastened plans to purchase and equip two mobile wellness clinics, ensuring they were ready to visit rural communities and underserved neighborhoods throughout southwest Georgia as soon as COVID vaccines became widely available. Also, early in the pandemic, the Phoebe Simulation & Innovation Center opened. It is one of the country's finest and most advanced simulation and training centers located at a hospital. When nursing students were unable to complete necessary hands-on clinical training because of the pandemic, Phoebe quickly developed the unique Nursing Simulation Training and Education Program (NSTEP), so nurse graduates could get that vital training before beginning work caring for patients.

Phoebe has also become a leader in healthcare workforce development in

Georgia, expanding partnerships with colleges throughout the region and creating innovative programs with new education partners. One example, the Phoebe Healthcare Pathway, allows high school students at 4C Academy to dual enroll at Albany State University or Albany Technical College. They can complete their core college classes and earn certified nursing assistant certification while still in high school. That can lead to a paid internship at Phoebe their senior year

and allow them to go directly into a college nursing program, saving students time and money, and helping them enter the workforce sooner.

Despite challenges created by the pandemic, Phoebe has continued to work to elevate healthcare in our region. In 2022, Phoebe plans to begin construction on a new tower on its main campus that will include a new emergency center, intensive care services. Phoebe Sumter led the creation of Healthy Sumter, a growing community collaboration designed to improve the lives and wellness of people in Sumter County. Healthy Sumter initiatives include community gardens, community food distributions, mental health outreach and colorectal cancer prevention efforts. Phoebe Worth has strengthened multiple community partnerships that have enhanced access to mental health services, expanded health education, screening and medication assistance for low-income residents and helped the Village Community Garden grow and serve more people.

As southwest Georgia's only regional, comprehensive health system, Phoebe is a vital institution in our part of the state. We have built – and continue to grow – meaningful community partnerships that keep us closely connected to the people we serve and ensure we understand their healthcare needs and strive to meet those needs with compassion, expertise, and dedication.

Phoebe Putney Memorial Hospital (PPMH) conducted a Community Health Needs Assessment (CHNA) in compliance with the provisions of the Patient Protection and Affordable Care Act (ACA). That law requires all non-profit hospitals in the United States to conduct a CHNA every three years to identify health priorities and adopt an implementation strategy to meet the identified community health needs. The assessment process requires hospitals to gather and utilize input from individuals who represent a broad interest of the community served, including those with special knowledge or expertise in public health. This work resulted in identifying four priorities that were approved by the PPMH Board of Directors at their meeting on July 6th, 2022. Those priorities are:

1. Birth outcomes and reproductive responsibility
2. Cancer prevention and treatment
3. Diabetes management and prevention
4. Mental health, alcohol & drug use and violence and injury prevention

ACKNOWLEDGEMENTS

We thank all those who helped us determine our priorities and develop our implementation strategy. We look forward to working with a broad and diverse coalition of individuals and organizations as we address these

priorities and improve the overall health and wellness of the communities we serve.

COMMUNITY HEALTH NEEDS ASSESSMENT TEAM

Dr. Dianna Grant, M.D., Phoebe Health System Corporate Medical Director, Executive Sponsor
Amber Bell, District Public Health
Amanda Clements, Marketing, Phoebe Health System
Clifton Bush, COO, Albany Area Primary Health Care (AAPHC)
Dana Glass, CEO, Aspire BH/DD/SA
Keisa Mansfield, Phoebe Cancer Center

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Lisa Schexnayder, Phoebe Behavioral Health
Shaunae Motley, CEO, United Way of Southwest Georgia
Jennifer Williams, Phoebe Health System
Cynthia George, CEO, Horizons Community Solutions
Jennifer Jewell, Phoebe Behavioral Health
Heather Dutton, AAPHC
Tennasha Gresham, AAPHC
Lori Jenkins, Phoebe Health System (Support Staff)
Mark Miller, Phoebe Health System (Support Staff)

PHOEBE PUTNEY COMMUNITY BENEFIT BOARD SUBCOMMITTEE MEMBERS- PRIORITY SELECTION COMMITTEE

Marvin Laster, Owner Legacy C+C LLC, Phoebe Putney Memorial Hospital Board Chair
Dr. Derek Heard, MD., Phoebe Physician Group, Subcommittee chair
Jay Sharp, U-Save-It Pharmacy
Scott Steiner, CEO, Phoebe Health System
Dr. Dianna Grant, Chief Medical Officer, Phoebe Health System
Dr. Jim Hotz, M.D., Albany Area Primary Healthcare
Kari Middleton, Attorney, Baudino Law Group
Tary Brown, Retired (former CEO of AAPHC)
Dawn Benson, Attorney, Phoebe Health System
Joe Austin, CEO, Phoebe Putney Memorial Hospital
Lori Jenkins, Manager of Strategy and Development, Phoebe Health System (Support Staff)
Mark Miller, Data Strategy Analyst, Phoebe Health System (Support Staff)

1.1 SERVICE AREA

Phoebe Putney Memorial Hospital's Primary Service Area (PSA) consists of Dougherty, Lee, Mitchell, Terrell, and Worth County.

FIGURE 1. PHOEBE PUTNEY SERVICE AREA

1.2 CONSULTANTS

Phoebe Putney Health System commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2022 CHNA. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. The following HCI team members were involved in the development of this report:
Maudra R. Brown, MPH CHES APM PAHM – Public Health Consultant, Dari Goldman, MPH - Senior Project Specialist, and Alison Sunahara- Delivery Management Analyst. To learn more about Conduent HCI, please visit https://www.conduent.com/claims-and-administration/community-health-solutions/.

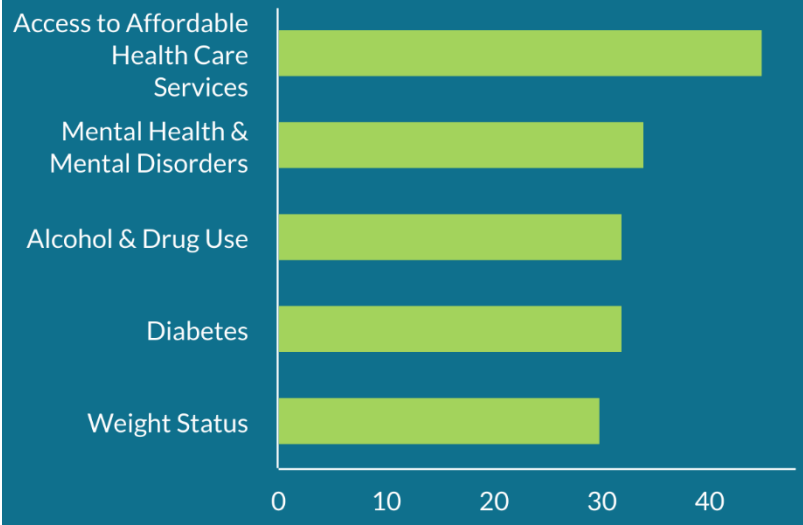
COMMUNITY HEALTH NEEDS ASSESSMENT
At a Glance: Phoebe Putney Memorial Hospital

Primary Data/Community Input

Community Health Survey

Dougherty, Lee, Worth, Terrell and Mitchell Counties had **238** Community Survey Respondents

Top Health Issues by Percentage



Focus Group Discussions & Key Informant Interviews

- **Racism**
- **Chronic Conditions** (Cancer, Diabetes, Heart Disease)
- **Exercise, Nutrition & Healthy Eating** (Access to healthy food/grocery stores, built environment/safety)
- **Healthcare Access & Quality** (Provider burnout/shortages, lack of focus on preventative health measures, cost of care)
- **Mental Health & Mental Disorders** (Collective trauma "crisis mode", economic depression/generational poverty leading to trauma)

Secondary Data

- Diabetes
- Mental Health & Mental Disorders
- Other Conditions
- Sexually Transmitted Diseases
- Wellness and Lifestyle
- Older Adults

Health Equity

Health equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

Systemic racism
Poverty
Gender discrimination

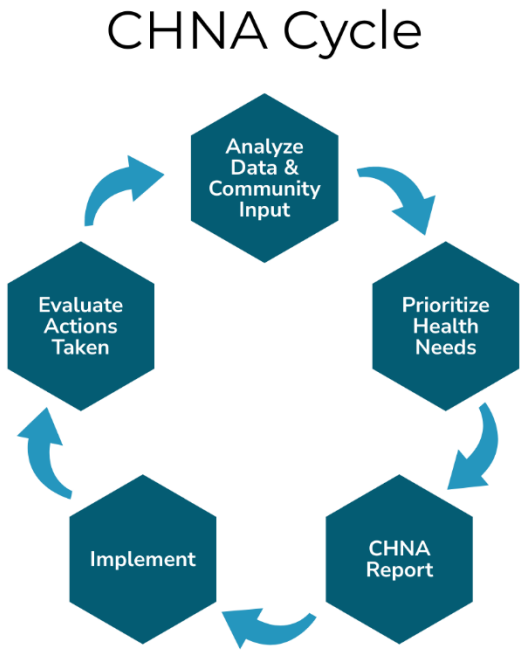
Poorer health outcomes for groups such as Black persons, Hispanic or Latino persons, Indigenous communities, people experiencing poverty and LGBTQ+ communities.

SECTION 2

LOOK BACK:

EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a three-year cycle. An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs.
By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.



2.1 PRIORITY HEALTH NEEDS FROM PRECEDING CHNA

Phoebe built upon efforts from the previous 2019 CHNA to focus on communities and populations who disproportionally experience the prioritized health challenges identified above. Of the activities or programs implemented, the most notable are below. You can see more details in the 2019-2022 Implementation Strategy Plan in the Appendix or located here.

2.1.1 BEHAVIORAL HEALTH & ADDICTIVE DISEASE ADVOCACY

1. Albany Police Department: The local police department is working with Aspire and Phoebe Putney to integrate behavioral health practices when encountering a resident with major behavioral issues.
2. Aspire BH/SA/DD: Aspire provides behavioral health, substance abuse and services to the developmentally disabled citizens in our region. They are the major behavior health stakeholder.
3. Network of Trust: Phoebe's Network of Trust with a grant from Morehouse School of Medicine provides Opioid education and awareness throughout Southwest Georgia.

2.1.2 BIRTH OUTCOMES & REPRODUCTIVE RESPONSIBILITY

1. AAPHC: Albany Area Primary Health Care (AAPHC) provides OBGYN services for women of Southwest Georgia. The Marian Worthy Center is one of few who accepts Medicaid patients. They are an important referral source to the Nurse Family Partnership.
2. Albany State University: Albany State University (ASU) is actively involved in many projects with Phoebe. They participate in a grant funded partnership with Phoebe and Morehouse School of Medicine addressing teen pregnancy reduction, provide meeting space for health fairs, as well as financial support for the Community Health Needs Assessment.
3. CareSource Foundation: The CareSource foundation provides a 20% match ($260,000) for the first three years of Phoebe's NFP.
4. Dougherty County Family Literacy Connection (DCFLC): DCFLC is part of the state family connection network. While their focus centers on adult literacy services, DCFLC is a certified Parents as Teachers (PAT) program which provides services to women from pregnancy until the child turns 5. PAT is a complement program to the Phoebe Nurse Family Partnership and refer clients to each other.
5. Dougherty County School System (DCCS): The DCCS offsets some of the cost of Phoebe providing nurses to the school system. In addition, they are a vital partner to approve adolescent based teen pregnancy prevention programs for their students.
6. Doula: Doula's are certified and provide emotional and physical support during pregnancy and childbirth. They are a main referral source for the Nurse Family Partnership.
7. Morehouse School of Medicine: Morehouse School of Medicine funds a variety of NOT adolescent initiatives centered on teen pregnancy prevention evidence- based programs such as Love Notes and Taking Time for Teens.
8. Network of Trust (Phoebe Putney Memorial Hospital): Network of Trust (NOT) is Phoebe's primary community outreach program that houses programs for Teen Moms, School Nurse Program, and Phoebe Nurse Family Partnership home visitation program for first time moms. NOT objectives are to reduce teen pregnancy (repeat), provide support and training to pregnant teen moms and provide a home visitation program to first time moms who are Medicaid or WIC eligible.

9. Nurse Family Partnership National Service Office (NFP NSO): NFP NSO is the national flagship for local NFP's throughout the United States. Through a private foundation, they provide a 40% three- year match to Phoebe NFP.
10. WIC: The Women's Infants and Child program is administered by the local health department. From many first- time moms, this is when they know they are pregnant and Medicaid eligibility is presumed. They are a major referral source to the Nurse Family Partnership.

2.1.3 CANCER PREVENTION & TREATMENT

1. Horizons Community Solutions: Horizons Community Solutions has been a vital Phoebe Partner in screening and prevention of cancer. Since the organization's inception, Phoebe has been a constant funder.
2. Local AA/Black Churches & AA Ministerial Association: Ten Area AA/Black churches committed 2 men to be trained as community lay health leaders focused on prostate cancer and prevention.
3. Peach State health plan: Peach State is a health insurance company that made just for the needs of Georgia's Medicaid and PeachCare for Kids members and sponsors the men's health fair prostate and chronic disease screenings.

2.1.4 DIABETES MANAGEMENT & PREVENTION

1. Albany Area Primary Health Care (AAPHC): As a primary provider of Medicaid patients throughout Southwest Ga, AAPHC collaborates with Phoebe Putney to minimize diabetic related inpatient admissions.
2. Dougherty County Health Department: The mission of the public health department is to prevent disease, injury, and disability, promote health and well-being, and prepare for and respond to disasters. The health department assists in screening for various diseases during Phoebe sponsored health fairs.
3. Flint River Fresh (Farmer Fredo): Farmer Fredo is the executive director of Flint River Fresh. He works with Phoebe Putney and NOT in designing and planning community gardens throughout Dougherty County and within the school system. Upkeep and maintenance are volunteer based. Community Garden funding is provided by Phoebe Putney. Fresh Fruits and vegetables are distributed throughout the neighborhoods.
4. Morehouse School of Medicine: Morehouse School of Medicine provided funding and training of lay community health workers in Albany centered on Prostate Cancer.

2.2 COMMUNITY FEEDBACK FROM PRECEDING CHNA & IMPLEMENTATION PLAN

Phoebe Putney Memorial Hospital has a feedback button on the Community Benefit landing page that allows residents to comment on the current Community Health Needs Assessment including the Implementation plan. To date, there has been no feedback to the current assessment or plan.

Upon board approval, the Community Health Needs Assessment and the Implementation plan were posted in the hospital's community benefit page located here.

SECTION 3

DEMOGRAPHICS

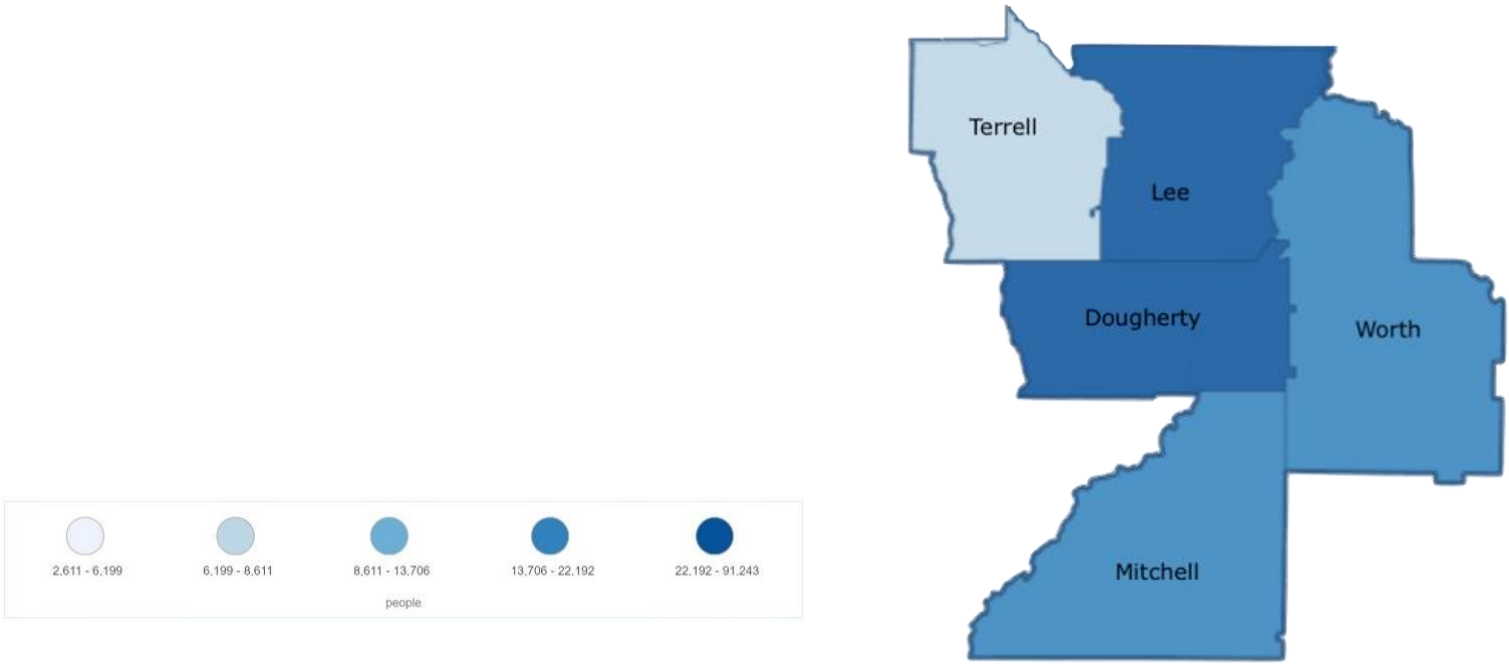
The following section explores the demographic profile of Phoebe Putney Memorial Hospitals Primary Service Area, which consists of Dougherty, Lee, Mitchell, Terrell, and Worth County. The demographics of a community significantly impact its health profile. Different race/ethnicity, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All demographic estimates are sourced from the Census Bureau Quickfacts (2021 estimated population) and American Community Survey one-year (2019) or five-year (2015- 2019) estimates unless otherwise indicated.

3.1 DEMOGRAPHIC PROFILE

3.1.1.POPULATION

The largest county is Dougherty County, with a population of 84,844 in 2021. The smallest county is Terrell County with a population of 8,964 in 2021. Figure 2 shows population size by county. The darkest blue regions represent zip codes with the largest population.

FIGURE 2: PHOEBE PUTNEY SERVICE AREA POPULATION SIZE BY COUNTY



3.1.2 AGE

The figures below show the population for the Primary Service Area by County as compared to the State and USA. [1] Lee County is the only growing county in the PSA. As shown in Figure 3, Lee County has one of the largest 0-17 populations and the fewest age 65+.

Figure 3 illustrates the change in total population from 2010 to 2020 with Lee the only county in the Primary Service to see a net gain in population from the previous 2010 census. Lee surpassed gains in Georgia and USA in the same time period. The Primary Service lost 4% of its population.

1. US Census Bureau, Quick Facts Sheet, August 2021. https://data.census.gov/cedsci/

FIGURE 3: TOTAL POPULATION BY AGE GROUPS

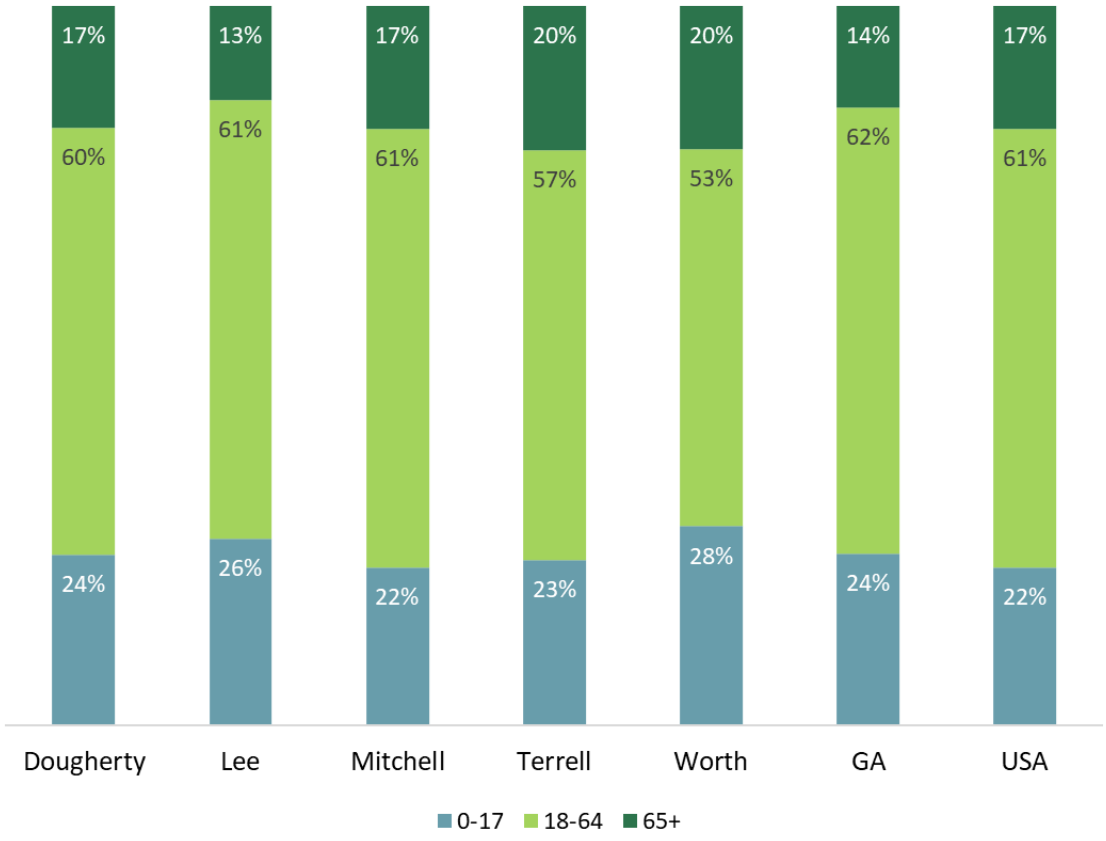
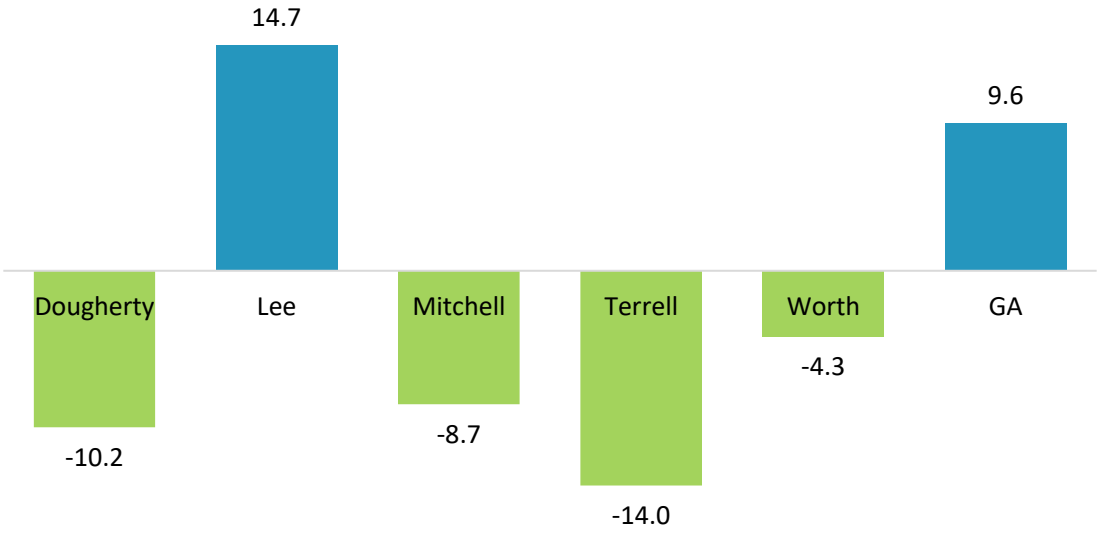


FIGURE 4: CHANGE IN TOTAL POPULATION, 2010-2020



3.1.3 RACE AND ETHNICITY

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. Figures 5 and 6 show the population by race and by ethnicity of the PSA and a breakout of all five counties. Compared to Georgia and the US, Phoebe's Primary Service Area is majority African American and has fewer residents who identify as Hispanic/Latino.

FIGURE 5: POPULATION BY RACE AND ETHNICITY ORIGIN PRIMARY SERVICE AREA (2020)

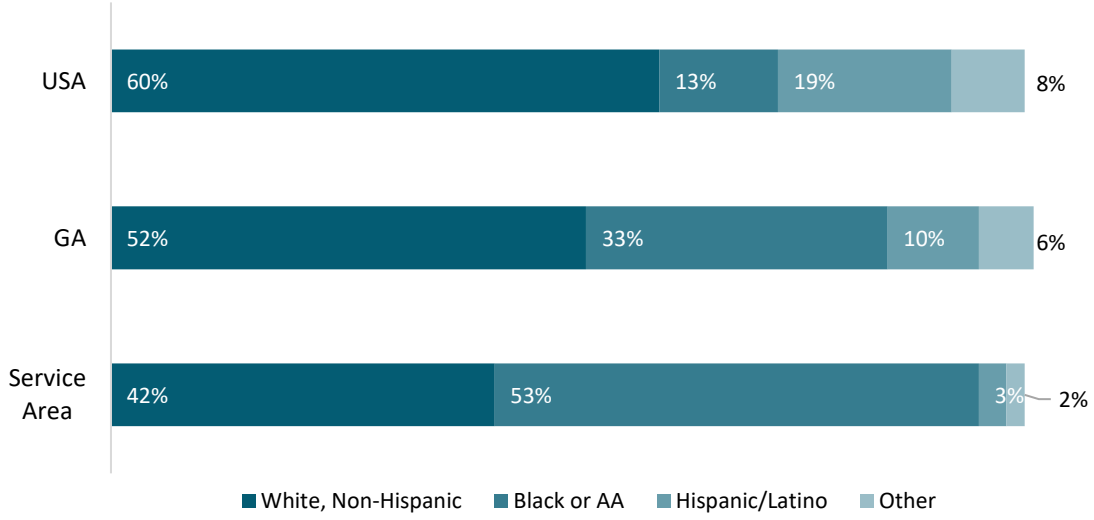
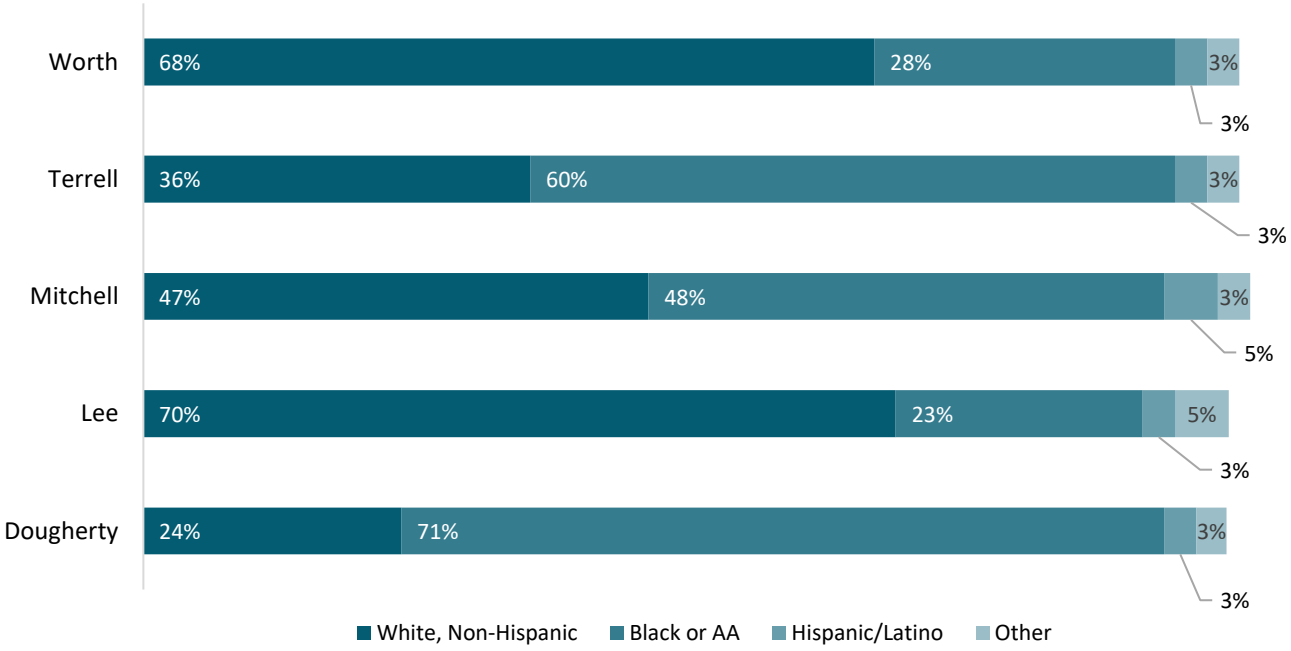


FIGURE 6: POPULATION BY RACE AND ETHNICITY ORIGIN BY COUNTY (2020)



SECTION 4

SOCIAL & ECONOMIC DETERMINANTS OF HEALTH

This section explores the economic, environmental, and social determinants of health of the Primary Service Area. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping conditions of daily life. It should be noted that county-level data can sometimes mask what could be going on at the zip code level. While indicators may be strong at the county level, zip code level analysis can reveal disparities.

4.1 INCOME

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 7 shows the Per Capita Income and Household Median Income (HHMI), displayed on the right axis and green line. Each county except for Lee County is either below or well below the Georgia or US values. The US HHMI value is $64,994 and the Georgia Value is $61,224. Likewise, there is significant Per Capita Income (Blue Bar) differences for all counties compared to the Georgia and US value.

FIGURE 7: PER CAPITA AND HOUSEHOLD MEDIUM INCOME, 2016-2020

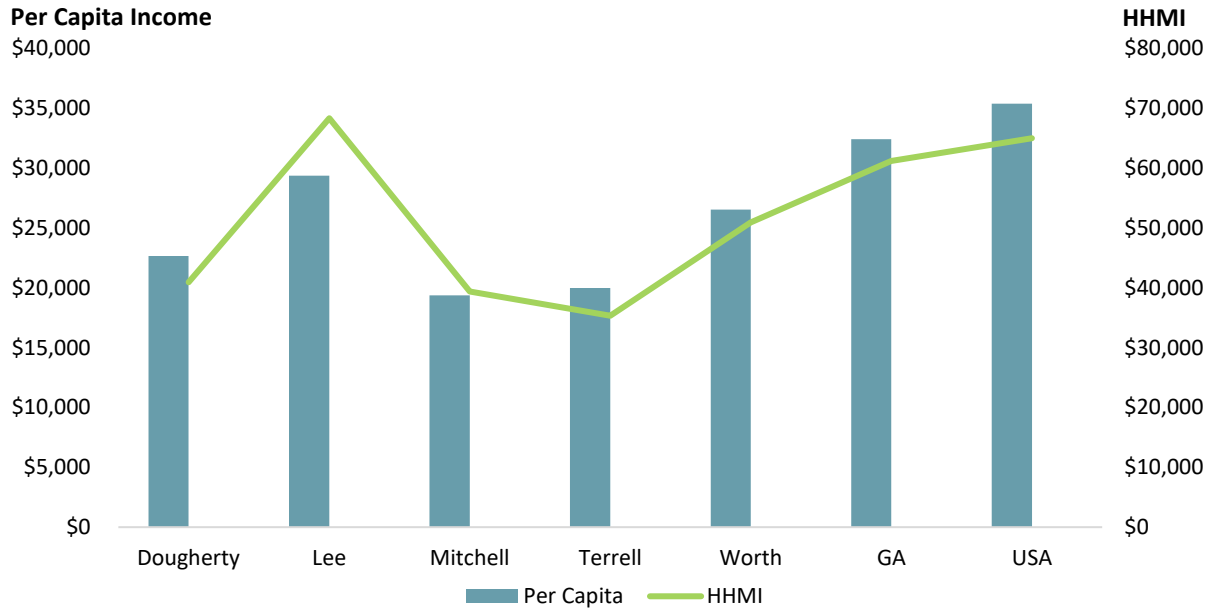
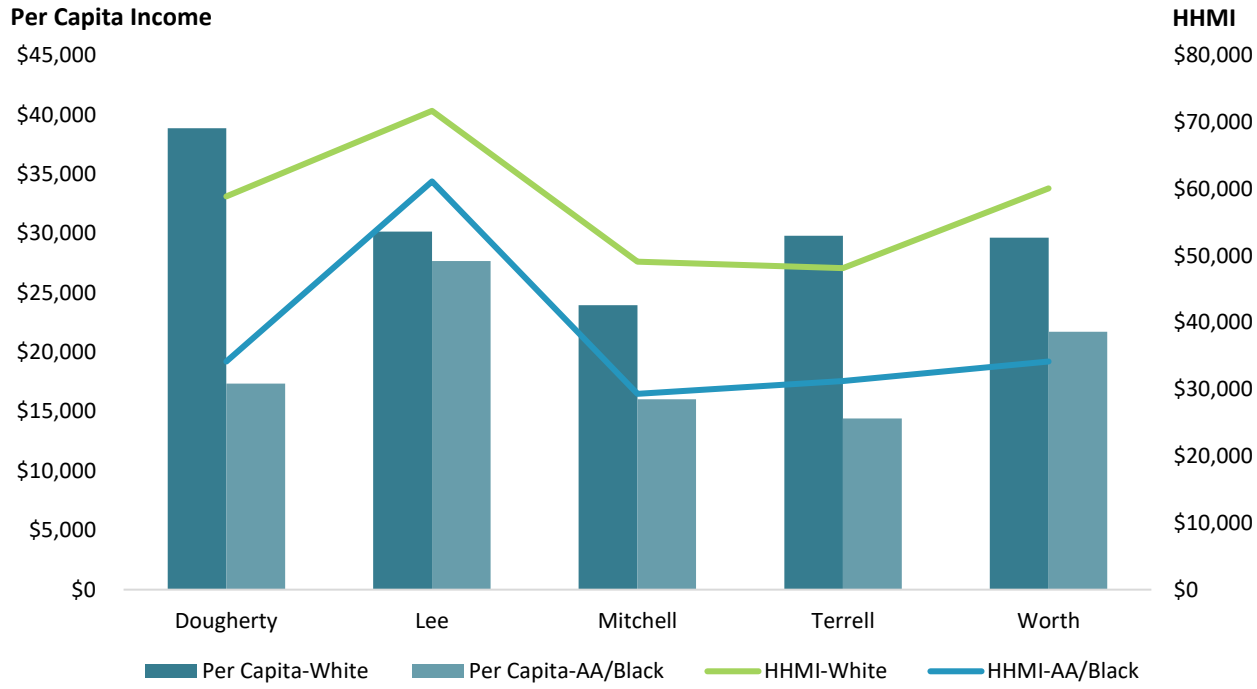


Figure 8 shows the Per Capita Income and Household Median Income (HHMI) with racial breakouts for White and African American/Black residents. As shown below, for all counties, Black or African American households have lower household median incomes as compared to White households.

FIGURE 8: PER CAPITA AND HOUSEHOLD MEDIUM INCOME BY RACE, 2016-2020

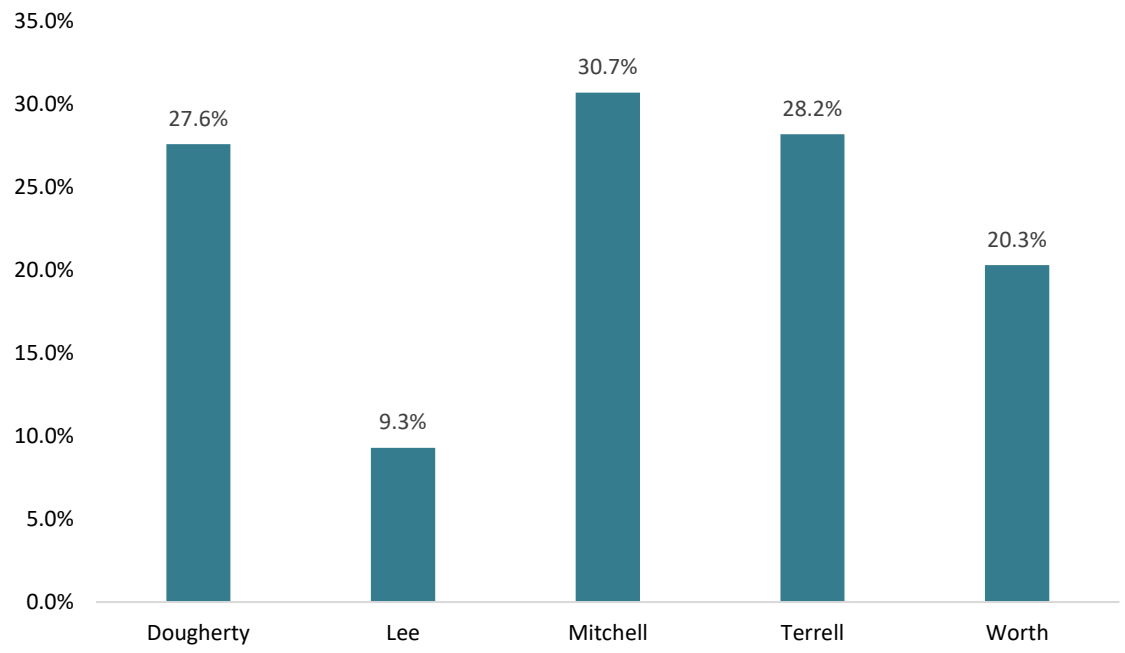


4.2 POVERTY

Federal poverty thresholds are set every year by the U.S. Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.

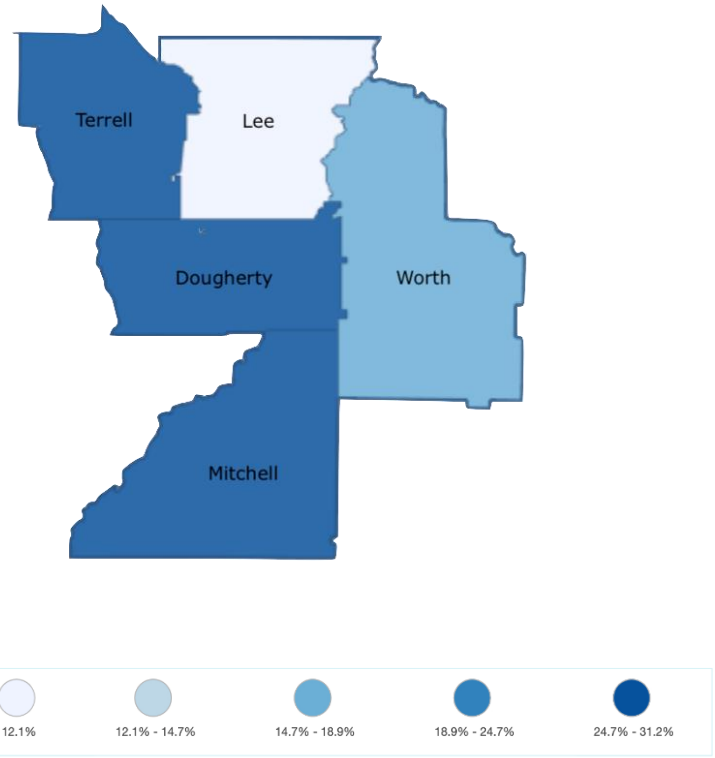
Figure 9 shows the Percentage of People Living in Poverty by county while Figure 10 shows the Percentage of People Living Below Poverty Level by county. Overall, Terrell has the highest percentage of people living below poverty (31.2%) while Lee has the lowest percentage (12.1%).

FIGURE 9: PERCENT OF PEOPLE LIVING IN POVERTY BY COUNTY



ACS, 2015-2019

FIGURE 10: PEOPLE LIVING BELOW POVERTY LEVEL BY COUNTY



4.3 EMPLOYMENT

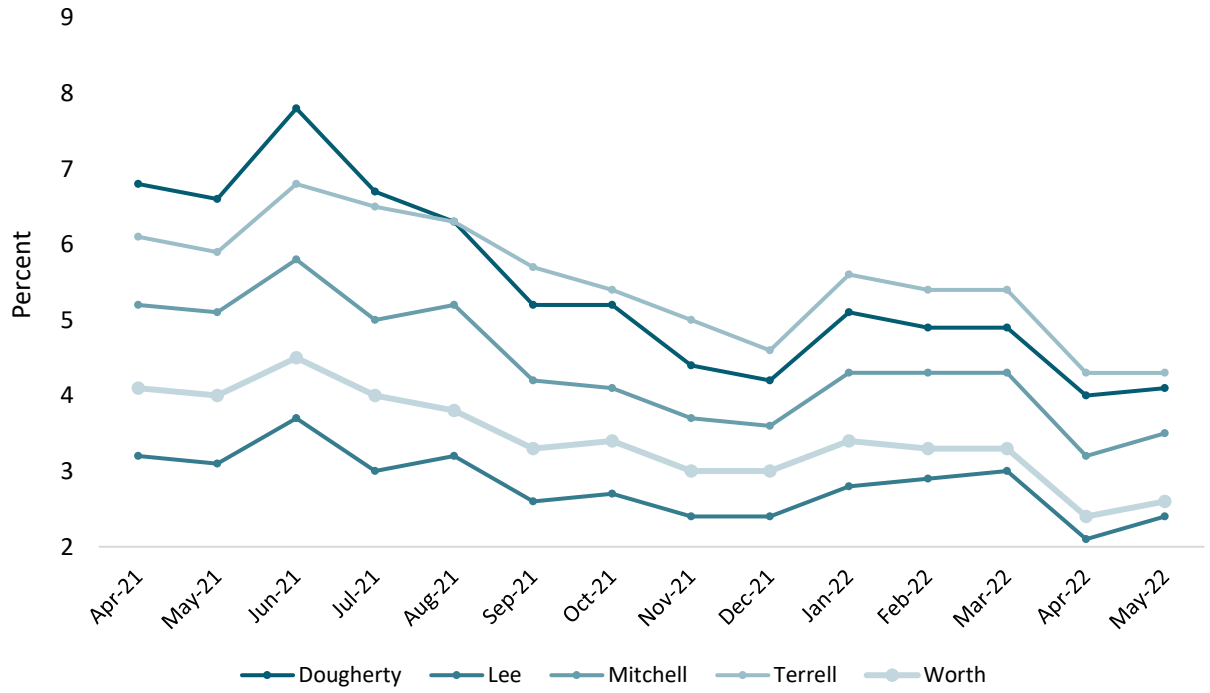
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.

Figure 11 shows the Unemployment Rate, according to the U.S. Bureau of Labor Statistics (2021), for each county within the Primary Service Area from April 2021 to May 2022.

FIGURE 11. UNEMPLOYMENT RATE (POPULATION 16+)



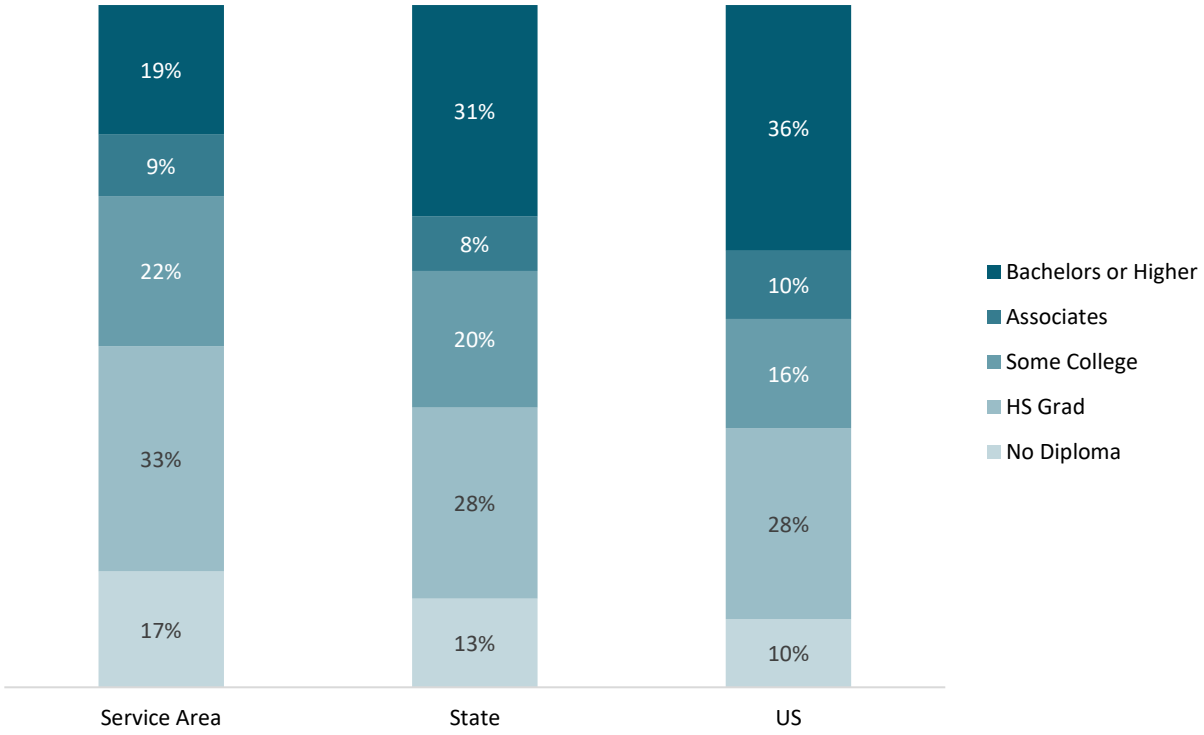
U.S. Bureau of Labor Statistics

4.4 EDUCATION

Education is an important indicator of health and well-being across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, experience better health outcomes, and practice health-promoting behaviors.

Figure 12 shows the percentage of the population 25 years or older by educational attainment. Compared to Georgia and US values, the PSA has fewer percentage of the age 25+ with a bachelor's degree than State and US counterparts with US almost 100% larger (36% vs 19%).

FIGURE 12. EDUCATION LEVEL AMONG POPULATION 25+ (2015-2019)

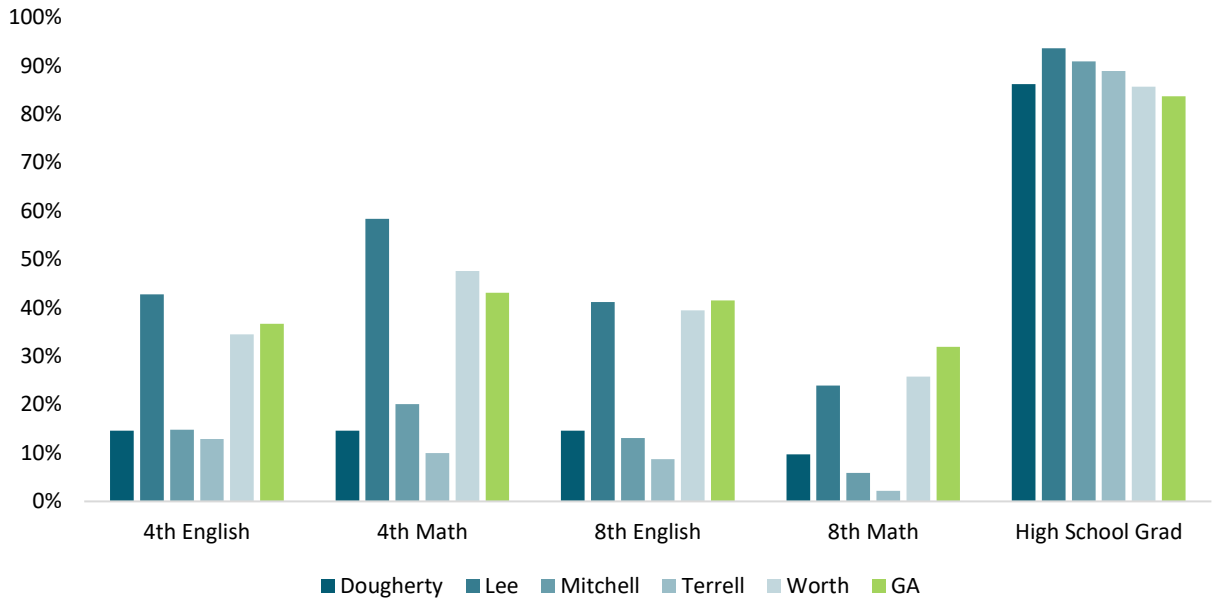


Georgia Governor's Office of Student Achievement, 2020-2021

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.

Figure 13 shows the proficiency scores for 4th and 8th grade students in both English and Math, as well as the high school graduation rate. All counties in the PSA have a higher high school graduation rate than the state value.

FIGURE 13. 4TH AND 8TH GRADE STUDENTS PROFICIENCY SCORE AND HIGH SCHOOL GRADUATION RATE



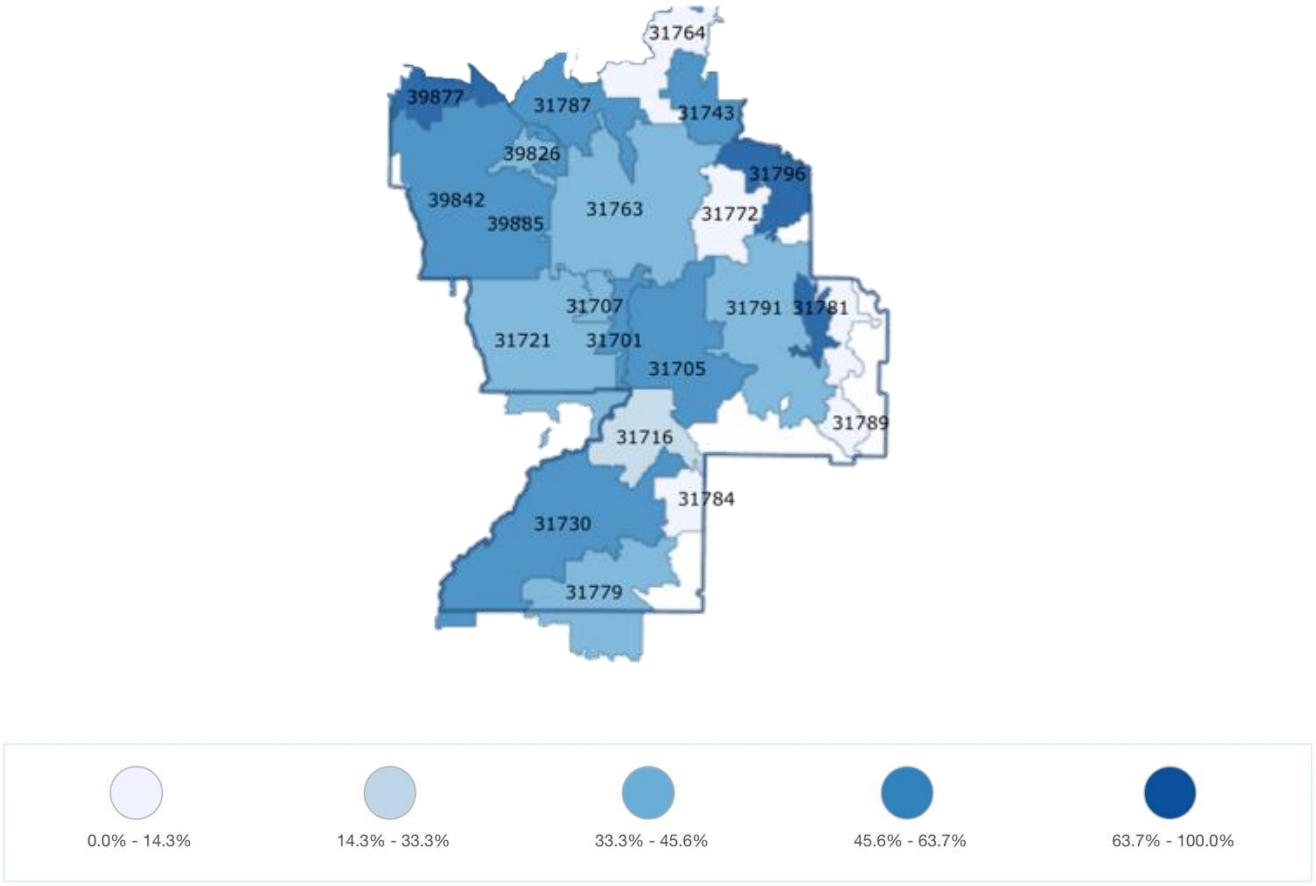
Georgia Governor's Office of Student Achievement, 2020-2021

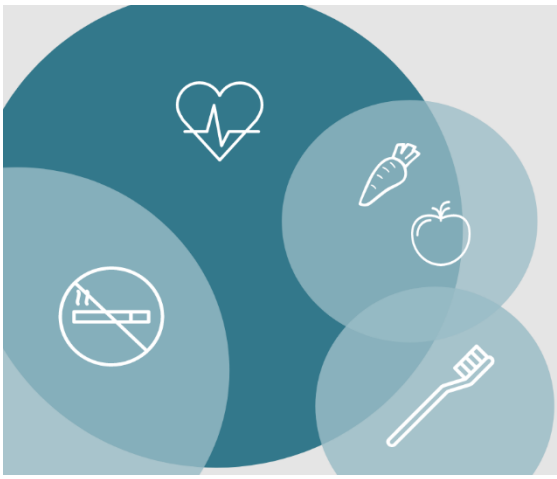
4.5 HOUSING

Safe, stable, and affordable housing provides a critical foundation for health and well-being. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health. When families must spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.

As shown in Figure 14, many renters living within Dougherty, Lee, Mitchell, Terrell, and Worth counties spend 30% or more of their household income on rent. In some zip codes, such as 39877, 31796, 31781, this is estimated to be over three-quarters of renters. As indicated by the primary data collected during the CHNA process, housing costs and affordability may have been impacted by COVID-19 in these communities. Therefore, the Percent of Renters Spending 30% or More of their Household Income on Rent may have increased since 2019 for all communities.

FIGURE 14. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT BY ZIP CODE





SECTION 5

DISPARITIES AND HEALTH EQUITY

Identifying disparities by race/ethnicity, gender, age, and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity. Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities. National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black, Indigenous, or People of Color, individuals living below the poverty level, and LGBTQ+ communities.

Primary and secondary data revealed significant community health disparities based on race/ethnicity, particularly among the Black and Hispanic communities. The assessment also found zip codes with disparities related to health and social determinants of health. It is important to note that while much of the data is presented to show differences and disparities of data by population groups, differences within each population group can be as great as differences between different groups. Information and themes captured through key informant interviews, our focus group, and the community survey have been shared to provide a more comprehensive and nuanced understanding of each community's experiences. This report includes information drawn from all aspects including both quantitative and qualitative data, analysis of health and social determinants collected through interviews, the focus group discussion, and an online community survey. The HCI team used a variety of methodologies to analyze data and provide findings that can inform decision-makers and advocates working toward creating more equity, access, and quality within healthcare.

Increasing awareness of the diverse needs and experience of communities at risk and an important step in addressing health inequities. The recognition that disparities are caused by unequal access to resources (i.e., knowledge, skills etc.) is necessary to identify the underlying causes of inequity and how they can be resolved.

5.1 DISPARITIES BY RACE AND ETHNICITY

Community health disparities were assessed in both the primary and secondary data collection processes. Table 1 below identifies notable secondary data health indicators with a statistically significant disparity for any of the counties within the Primary Service Area. A complete list can be found in Appendix A.

TABLE 1. INDICATORS WITH SIGNIFICANT RACE/ETHNIC DISPARITIES

COUNTY	HEALTH INDICATOR	GROUP(S) NEGATIVELY IMPACTED
Dougherty	People Living Below Poverty Level	Black/African American
	Children Living Below Poverty Level	Other
	People 65+ Living Below Poverty Level	Black/African American
	Per Capita Income	Black/African American, Hispanic
	Prostate Cancer Incidence Rate	Black/African American
	Medium Household Income	American Indian/Alaska Native
	People 25+ with a Bachelor's Degree or Higher	Black/African American
	Persons with an internet subscription	Hispanic/Latino
	People 25+ with a High School Degree or Higher	Hispanic/Latino
Lee	Prostate Cancer Incidence Rate	Black/African American
	Children Living Below Poverty Level	Asian
	Per Capita Income	Black/African American, Other, 2 or more races
	People Living Below Poverty Level	Asian
	People 25+ with a High School Degree or Higher	Asian, Black/African American, Other
Mitchell	People 25+ with a Bachelor's Degree or Higher	Hispanic/ Latino
	People 25+ with a High School Degree or Higher	Hispanic/Latino, Other
	Children Living Below Poverty Level	Black/African American
	Per Capita Income	Asian, Hispanic/Latino, Other
	People Living Below Poverty Level	Black/African American
	Medium Household Income	Black/African American
	Workers who Drive Alone to Work	Asian, Other
	Persons with an internet subscription	Other
Terrell	People 65+ Living Below Poverty Level	Black/African American
	People 25+ with a Bachelor's Degree or Higher	Black/African American
	People Living Below Poverty Level	American Indian/Alaska Native
	Per Capita Income	Black/African American
	Persons with an internet subscription	Other
	Workers who Drive Alone to Work	Hispanic/Latino, Other
Worth	Children Living Below Poverty	Black/African American
	People 25+ with a Bachelor's Degree or	Black/African American

S	High	
	Workers who Drive Alone to Work	Asian
	People Living Below Poverty Level	Black/African American
	Median Household Income	Black/African American, Hispanic/Latino, Two or More Races
	Per Capita Income	Hispanic/Latino, Two or More Races
	People 25+ with a High School Degree or Higher	Black/African American
	Prostate Cancer Incidence Rate	Black/African American

Focus groups and key informant interviews identified the following groups as those struggling more with social determinants of health and potentially experiencing worse health outcomes: families living on a low income, Black or African American populations, Hispanic/Latino populations, elder communities, and immigrant populations. Additionally, children were identified as groups challenged with accessing healthcare services and providers. Specifically, a lack of pediatric and specialty care providers was frequently mentioned. Transportation was consistently raised as a major barrier to accessing services for these populations, especially in rural regions.

2. Pearcy, Jeffrey, and Kenneth Keppel. *A Summary Measure of Health Disparity*. Public Health Reports, June 2002.

5.3 GEOGRAPHIC DISPARITIES

Geographic disparities were identified using the SocioNeeds ® Index Suite, including the Health Equity Index (formerly, SocioNeeds ® Index) and Food Insecurity Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need or food insecurity. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. For both indices, counties, zip codes, and census tracts with populations over 300 are assigned index values ranging from zero to 100, where higher values are estimated to highest need, critical to targeting prevention and outreach activities.

5.3.1 HEALTH EQUITY INDEX

Conduent's Health Equity Index (HEI) estimates areas of highest socioeconomic need correlated with poor health outcomes. In the HEI, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 15. According to the 2021 index, the following zip codes had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 31705 (Dougherty County) and 31701 (Dougherty County). Table 2 provides the index values for each top need zip code. See Appendix A for more detailed methodology for the calculation of Health Equity Index values.

FIGURE 15: HEALTH EQUITY INDEX

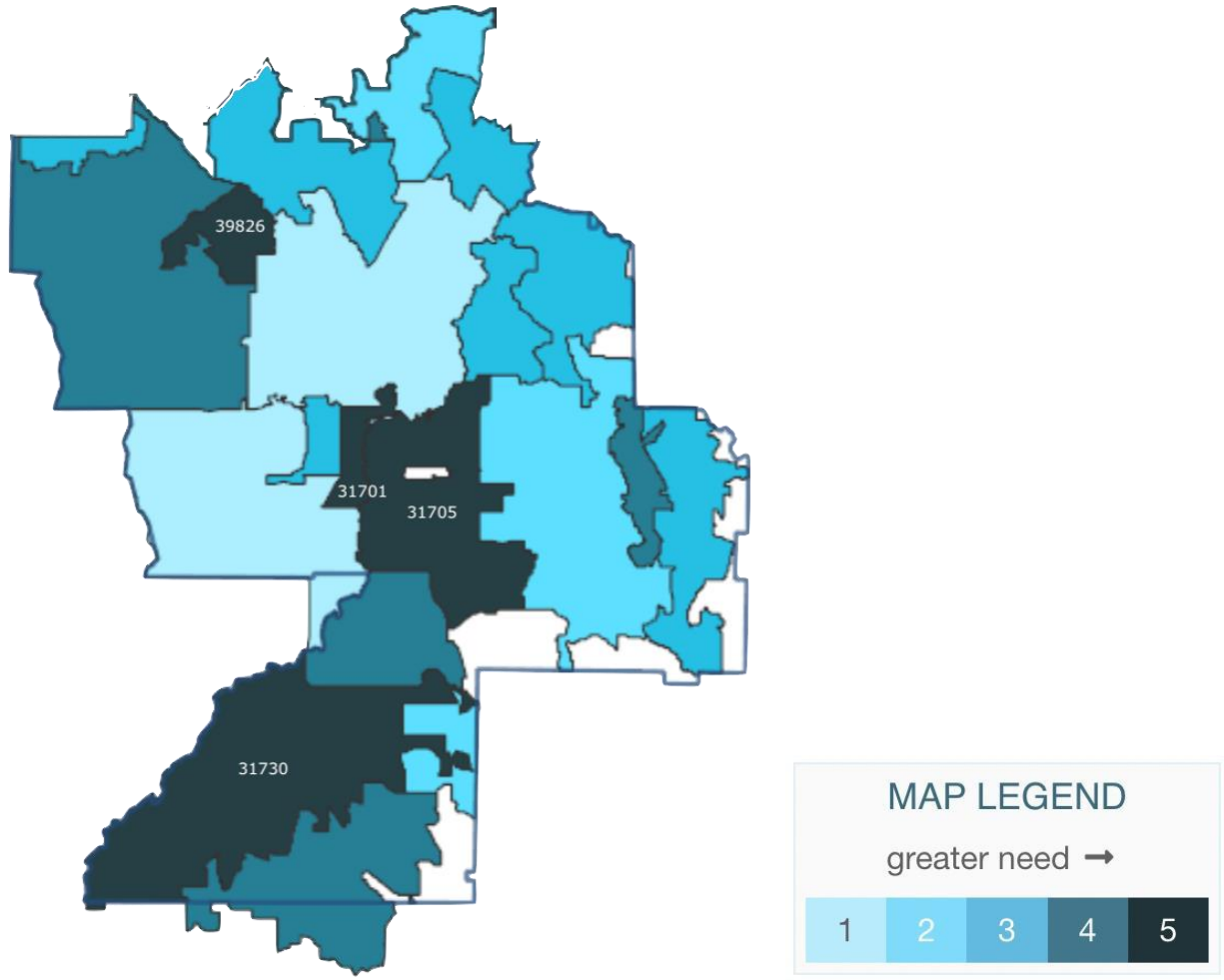


TABLE 2. HEALTH EQUITY INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	HEI VALUE	COUNTY
31705	5	98.1	Dougherty
31701	5	97.8	Dougherty
39826	5	97.4	Terrell
31730	5	96.2	Mitchell

5.3.2FOOD INSECURITY INDEX

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. In this index, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 16. According to the 2020 FII, the following zip codes have the highest level of food insecurity (as indicated by the darkest shades of green): 31701 (Dougherty County), 31705 (Dougherty County), and 31730 (Mitchell County). Table 3 provides the index values for high needs zip codes. See Appendix A for a more detailed FII methodology.

FIGURE 16. FOOD INSECURITY INDEX

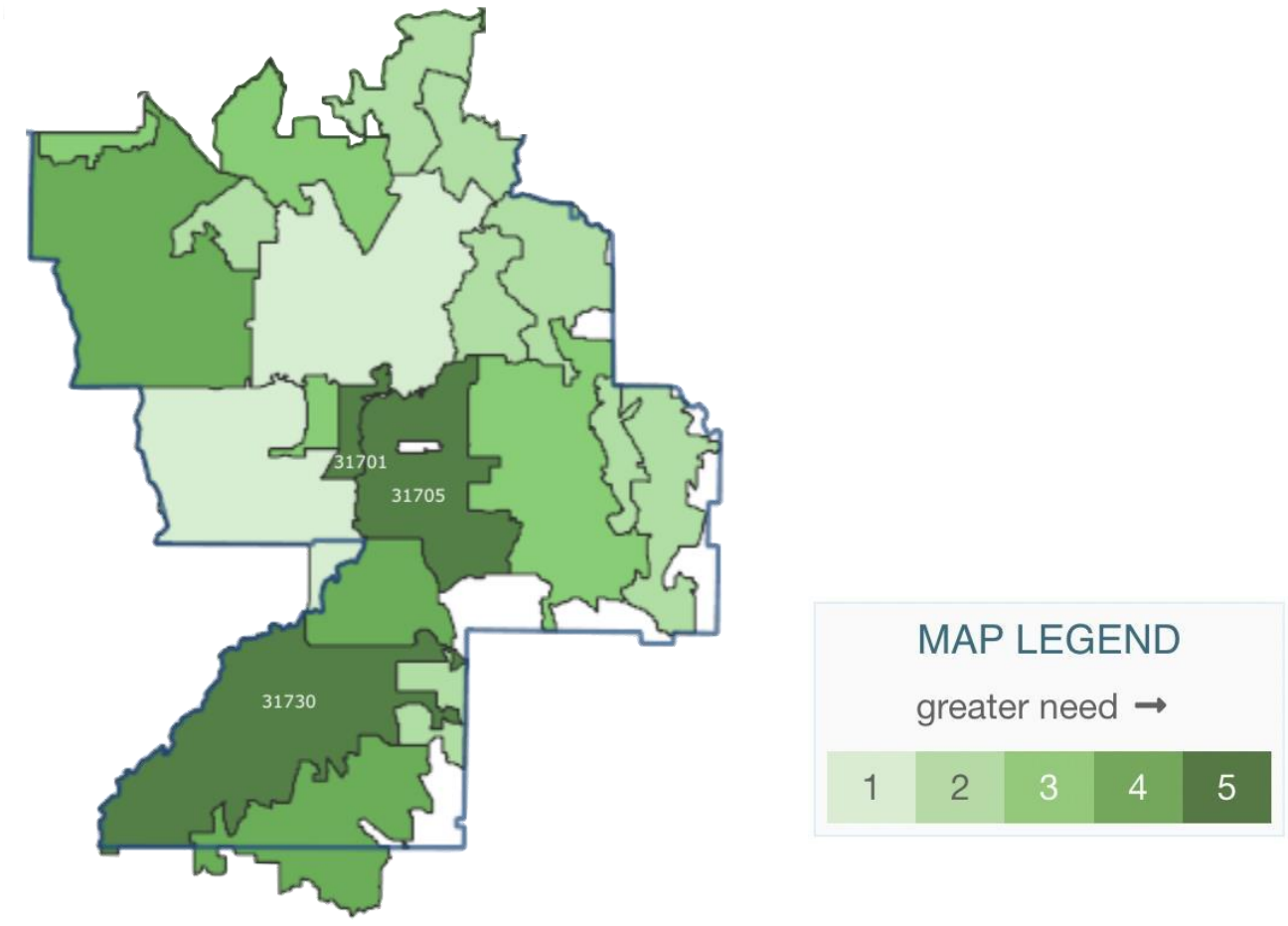


TABLE 3. FOOD INSECURITY INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	FII VALUE	COUNTY
31701	5	97.6	Dougherty
31705	5	97.5	Dougherty
31730	5	96.3	Mitchell

5.4 FUTURE CONSIDERATIONS

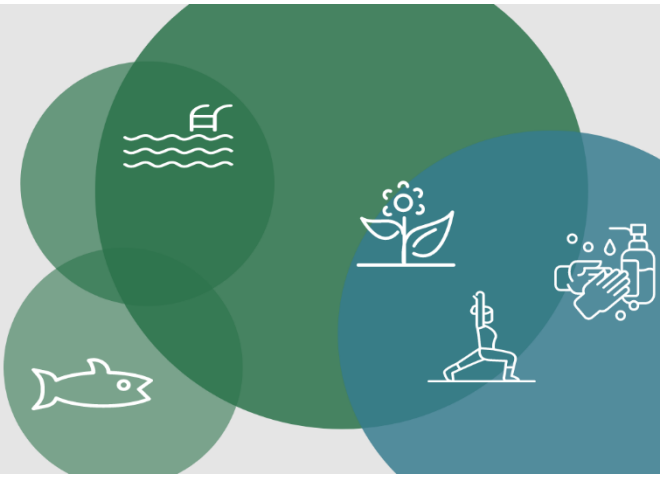
While identifying barriers and disparities are critical components in assessing the needs of a community, it is also important to understand the social determinants of health and other upstream factors that influence a community's health as well. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come together to inform and focus strategies to positively impact a community's health. The following outlines opportunities for on-going work as well as potential for future impact.

Phoebe Health System has a strong and sustained relationship with community-based stakeholders and has developed additional supports to address some of the most pressing health disparities that impact the community the system serves. So many health disparities are generational and effect previously underserved and under resourced communities. Fostering relationships and programming organizations, such as Nurse-Family Partnership will be key in transforming the landscape of future generations.

Phoebe Health System is committed to supporting community education and advocacy. Innovation is a critical component to addressing large scale social determinants that impact a community's health. New targeted funding ensures resources for local communities to address health disparities, improve health outcomes, expand access to primary care and prevention services, and help reduce healthcare costs. Key interventions will occur at the individual, community and system levels and include expansion of mobile integrated health, connections with primary care, expansion of culturally and linguistically appropriate evidence-based diabetes programming and deployment of community health workers.

SECTION 6

METHODOLOGY AND KEY FINDINGS



6.1 OVERVIEW

Phoebe Health System combined primary and secondary data to inform its Community Health Needs Assessment (CHNA). The CHNA provides an understanding of the health status, quality of life, and risk factors of a community through findings from secondary data analysis and qualitative data collection. The themes and strengths provide insights about what topics and issues community members feel are important, how they perceive their quality of life, and what assets they believe can be used to improve health.

The purpose of the Community Health Assessment process is to identify priority health needs and quality-of-life concerns of the community, including minority populations and low-income areas. The CHNA is a community tool that provides an understanding of the health status, quality of life, and risk factors affecting citizens within a geographic area. It also identifies community assets that can be used to address its health issues.

Findings from both primary and secondary data helped to inform the top community health needs. Each type of data was analyzed using a defined methodology. Primary data was obtained through a community survey, focus groups, and key informant interviews. Secondary data are health indicator data that have been collected by other sources, such as national and state level government entities, and made available for analysis.

6.2 SECONDARY DATA FINDINGS

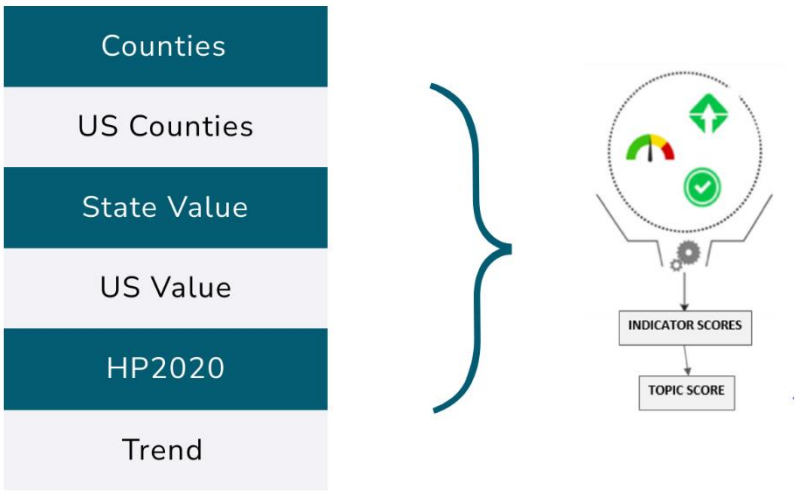


TABLE 4: SECONDARY DATA SCORING RESULTS (AVERAGE)

Health and Quality of Life Topics	Score
Other Conditions	2.37
Mental Health & Mental Disorders	2.11
Wellness & Lifestyle	2.07
Cancer	1.95
Older Adults	1.91
Oral Health	1.87
Respiratory Diseases	1.84
Maternal, Fetal & Infant Health	1.83
Diabetes	1.77
Sexually Transmitted Infections	1.76

Secondary data used for this assessment were collected and analyzed with the Conduent Healthy Communities Institute (HCI) Community Dashboard — a web-based community health platform developed by Conduent Community Health Solutions. The Community Dashboard brings data, local resources, and a wealth of information to one accessible, user-friendly location. It includes over 300 community indicators covering more than 25 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally or locally set targets, and to previous time periods.

HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard and rank indicators based on highest need. For each indicator, the county value was compared to a distribution of Georgia and US counties, state and national values, Healthy People 2030, and significant trends. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcomes and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Because Phoebe Putney Service Area includes five counties, data scoring for each individual were collated in order to determine the top health needs for the entire Service Area. We took the top 10 topic indicators for each county, averaged the rank order and score of each topic. Table 4 shows the top ten health topics for the Primary Service Area. Other Conditions is the poorest performing topic area, followed by Wellness and Lifestyle. The top ten topic areas were those that scored over the 1.84 threshold in data scoring. Health topic areas with fewer than three indicators were considered a data gap. Data gaps were specifically assessed as a part of the online community survey to ensure that, where the secondary data fell short, primary data could provide a more accurate picture of that particular health topic area.

6.3 PRIMARY DATA COLLECTION & ANALYSIS

To ensure the perspectives of community members were considered, input was collected from all Service Area counties of Phoebe Putney. Primary data used in this assessment consisted of an online community survey, focus group, and key informant interviews. The findings from this data expanded upon information gathered from the secondary data analysis to inform this Community Health Needs Assessment.

As the assessment was conducted during the COVID-19 pandemic, primary data collection methods were managed in a way to maintain social distancing and protect the safety of participants by eliminating in-person data collection.

To help inform an assessment of community assets, community members were asked to list and describe resources available in the community. Although not reflective of every resource available in the community, the list can help Phoebe Putney to expand and support existing programs and resources. This resource list is available in Appendix C.

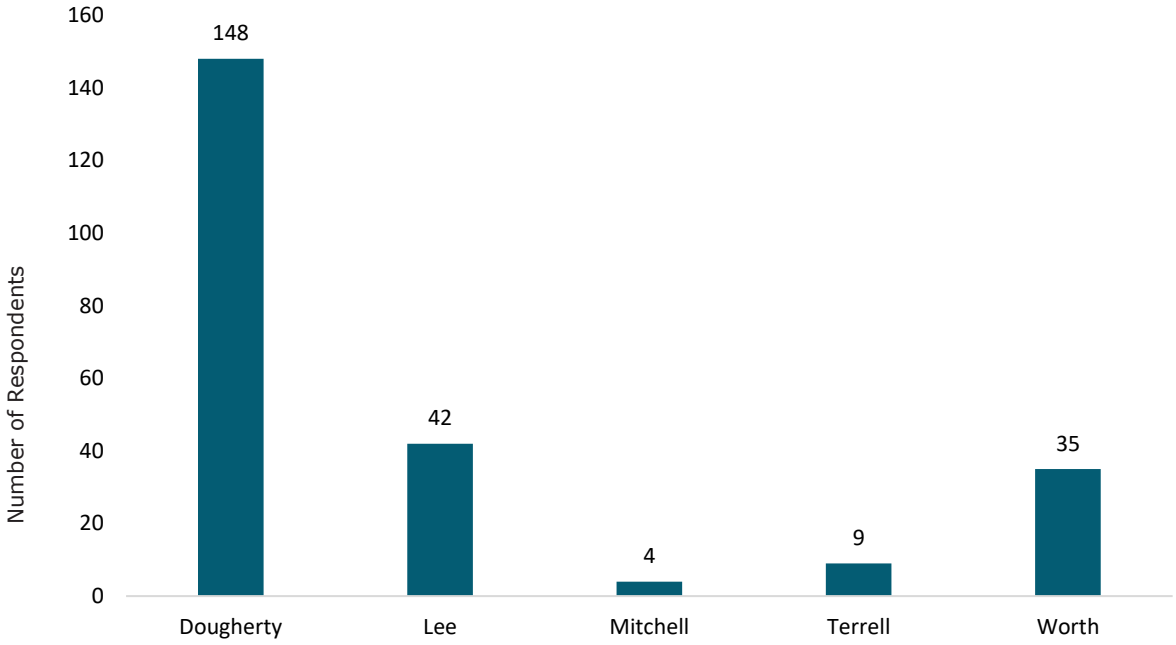
6.3.1 COMMUNITY SURVEY

Community input was collected via an online community survey available in English and Spanish, as well as paper copies available, from May 2022 through June 2022. The survey consisted of 56 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to healthcare services, as well as social and economic determinants of health. The survey was shared via health systems' websites, social media, email distribution, and other local community partners. Paper copies were also distributed at several community outreach events and directly to patients at Phoebe Health System via QR code or Care Coordination Team Members. A total of 428 responses were collected.

Demographics of Community Survey Respondents

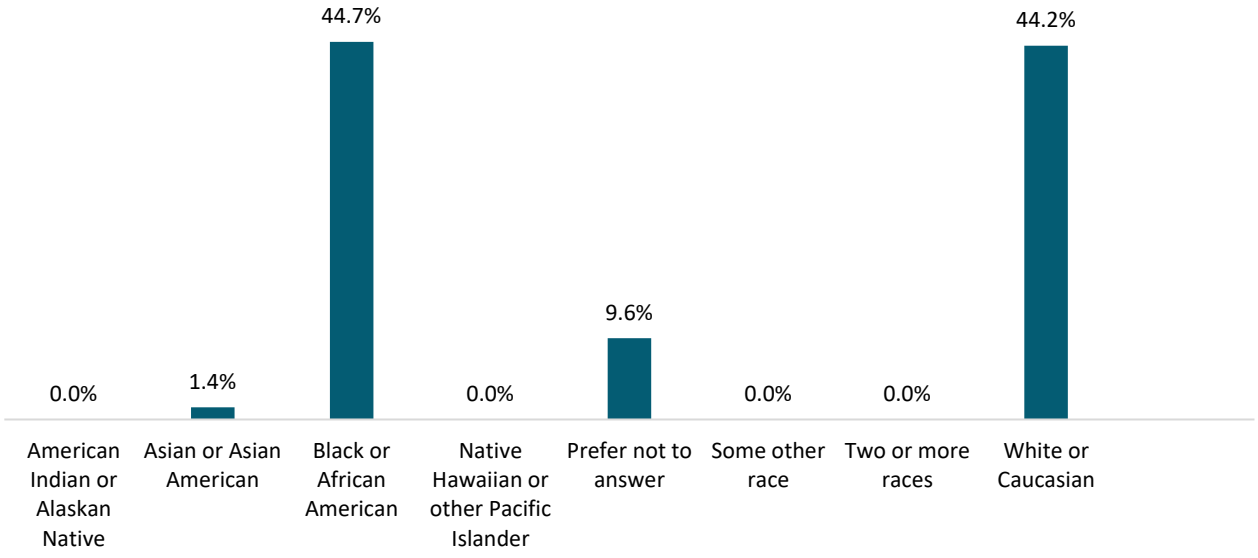
As seen in Figure 17, a majority of survey respondents reported being from Dougherty County.

FIGURE 17: RESPONDENTS COUNTY OF RESIDENCE



As shown in Figure 18, Black or African American community members comprised the largest percentage of survey respondents at 44.7%, followed by White or Caucasian community members at 44.2%.

FIGURE 18: RESPONDENTS RACE



Only 1.4% of survey respondents identified as Hispanic/Latino, while the majority, 84.1% identified as Non-Hispanic/Latino (Figure 19).

FIGURE 19: RESPONDENTS ETHNICITY

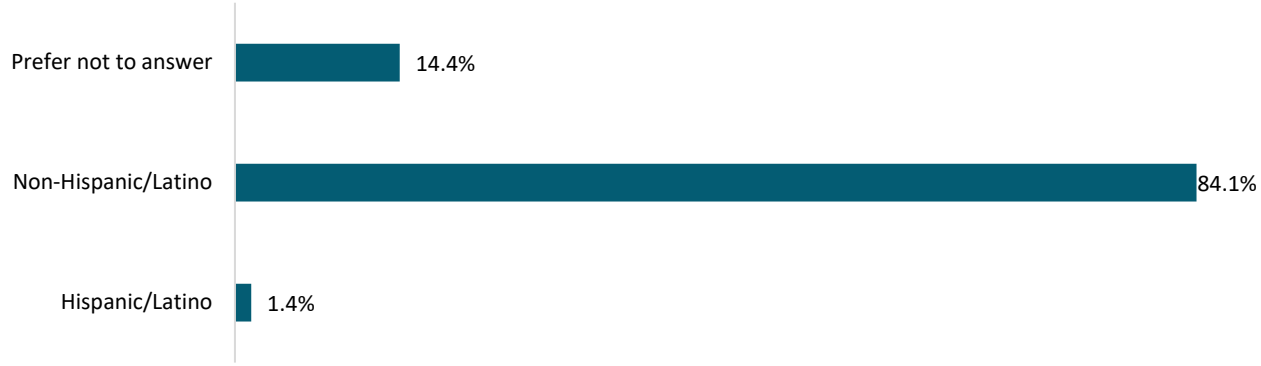
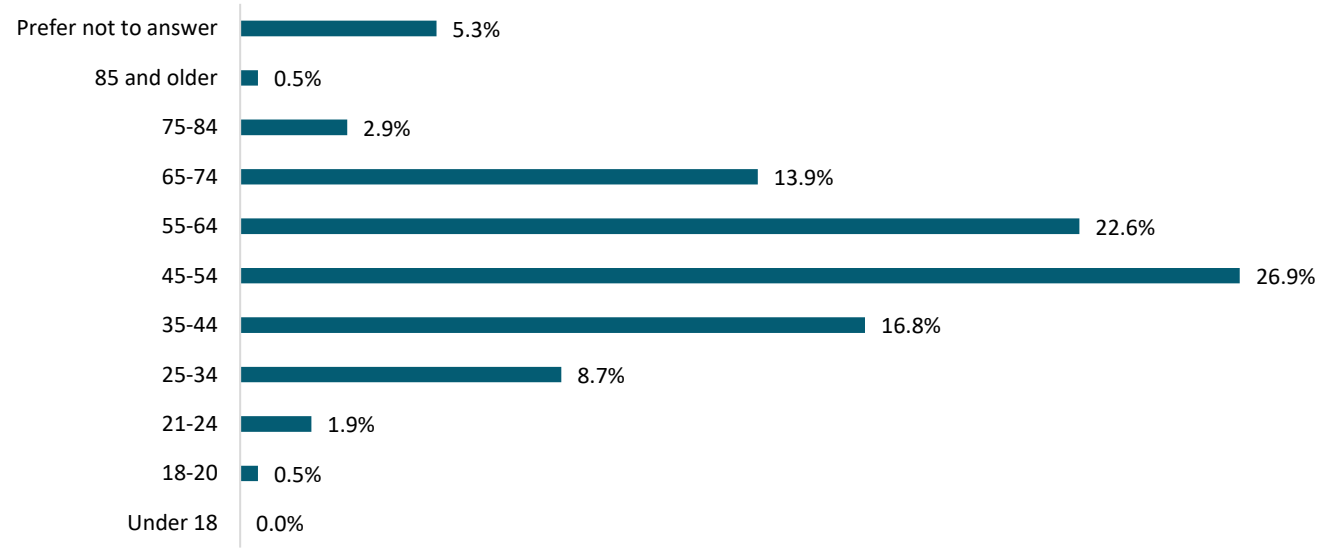


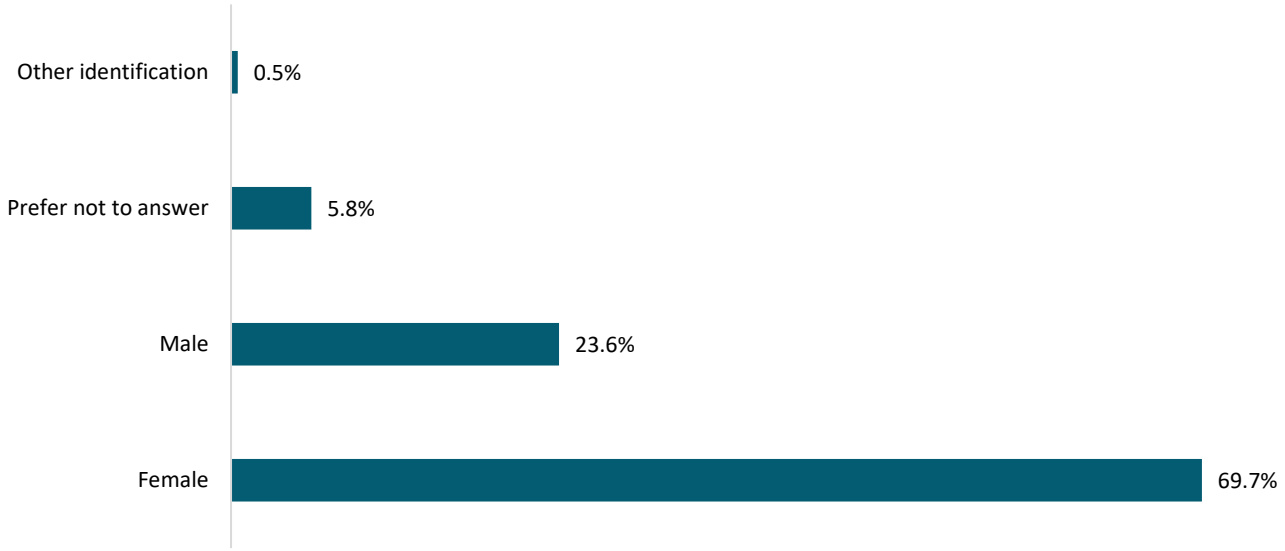
Figure 20 shows the age breakdown of survey respondents. The 45-54 and 55-64age groups comprised the largest portions of survey respondents, at 26.9% and 22.6% respectively.

FIGURE 20: RESPONDENTS AGE



The majority of survey respondents identified as female at 69.7%. An additional 23.6% identified as male, and the remaining 6.3% as other (other identification or prefer not to answer), as shown in Figure 21.

FIGURE 21: RESPONDENTS GENDER

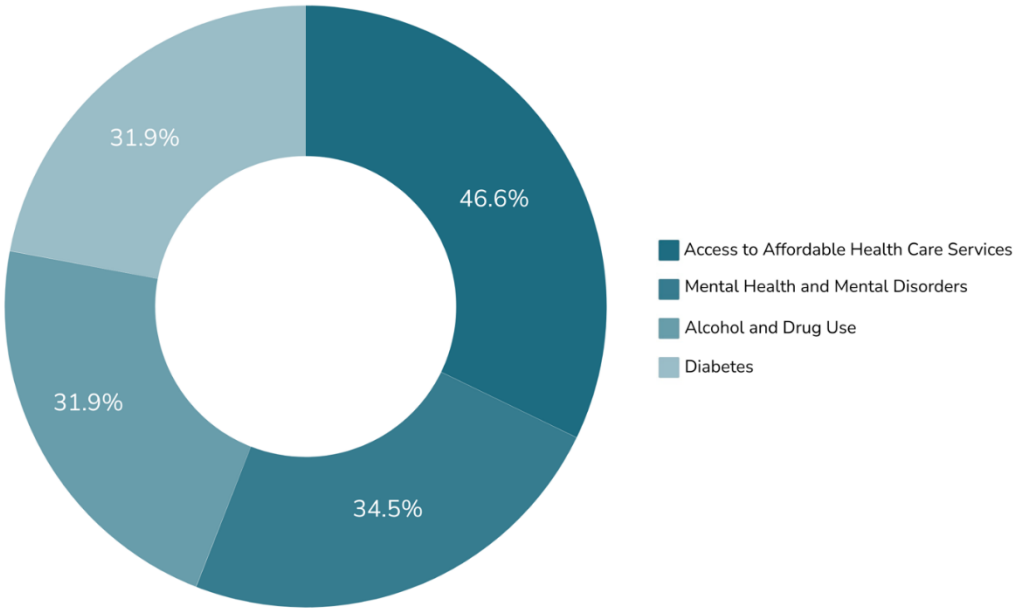


6.3.2 COMMUNITY SURVEY ANALYSIS RESULTS

In the survey, participants were asked about important health issues in the community, and which were the most important quality of life issues to address in the Primary Service Area. The top responses for these questions are shown in Figures 22 and 23 below. Additionally, questions were included to get feedback about the impact of COVID-19 on the community, which is included in the "COVID-19 Impact Snapshot" section of this report.

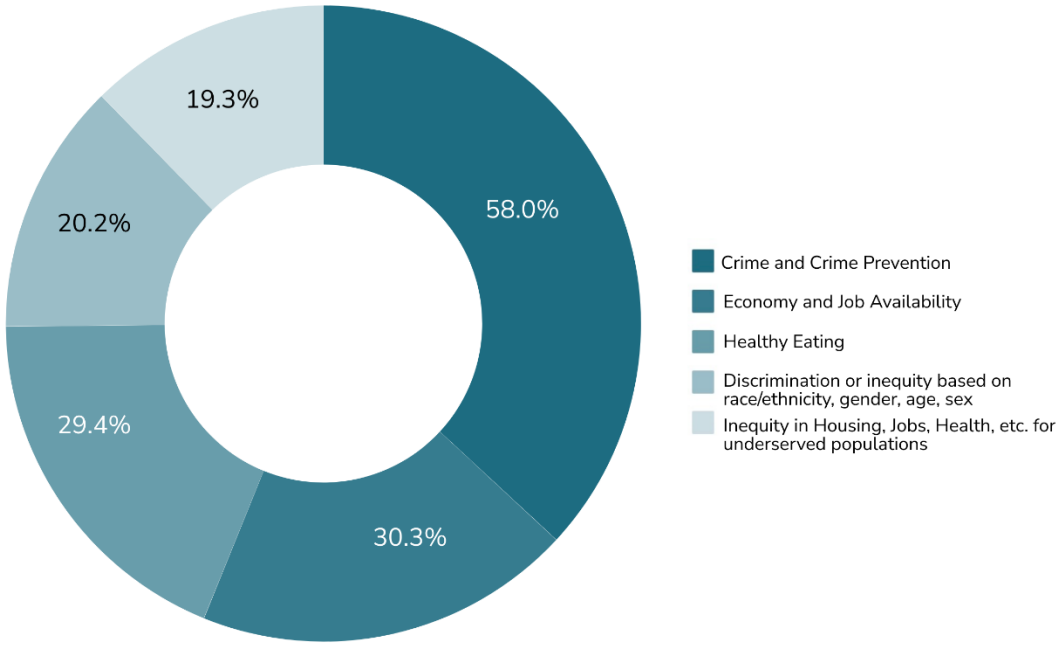
As shown in Figure 22, the "Most Important Community Health Issues" were Access to Affordable Healthcare Services (46.6%), Mental Health and Mental Disorders (34.5%), Alcohol and Drug Use (31.9%), and Diabetes (31.9%).

FIGURE 22. MOST IMPORTANT COMMUNITY HEALTH ISSUES



As shown in Figure 23 below, Crime and Crime Prevention was ranked by survey respondents as the most urgent quality of life issue needing to be addressed (58.0% of survey respondents), followed by Economy and Job Availability (30.3%), Healthy Eating (29.4%), Discrimination or inequity based on race/ethnicity, gender, age, sex (20.2%) and Inequity in Housing, Jobs, Health, etc. for underserved populations (19.3%).

FIGURE 23: MOST IMPORTANT QUALITY OF LIFE ISSUES TO ADDRESS



6.3.3 QUALITATIVE DATA (FOCUS GROUP & KEY INFORMANT INTERVIEWS)

Phoebe Health System in partnership with HCI consultants conducted key informant interviews and a key leadership focus group to gain deeper insights about perceptions, attitudes, experiences, or beliefs held by community members about their health and the health of their community. It is important to note that the information collected in an individual focus group or interview is not necessarily representative of other groups.

Focus Group

The project team developed a focus group guide made up of a series of questions and prompts about the health and well-being of residents in the Phoebe Putney Health System Service Area. The guide can be found in Appendix B. All participants volunteered. Participants were asked to speak to barriers and assets to their health and access to healthcare. A total of 15 participants took part in the key leader focus group, which each lasted approximately 45-60 minutes. Facilitators implemented techniques to ensure that everyone was able to participate in the discussions.

Key Informant Interviews

HCI consultants conducted key informant interviews to collect community input. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs, and/or represented the broad interest of the community served by the hospitals and health departments, and/or could speak to the needs of medically underserved or vulnerable populations.

A total of 18 key informant interviews were conducted during April 2022-May 2022. You can see the key informant organizations represented below in Table 5. These organizations are also current or potential community partners for the hospitals and health departments leading this assessment. Each interview included an interviewer and notetaker and lasted approximately 30 – 60 minutes. During the interviews, questions were asked to learn about the interviewee's background and organization, biggest health needs and barriers of concern in the community, as well as the impact of health issues on vulnerable populations. A list of the questions asked during the interviews can be found in Appendix B.

TABLE 5. KEY INFORMANT ORGANIZATIONS & POPULATION SERVED

KEY INFORMANT ORGANIZATION	POPULATION SERVED
Albany Area Primary Health Care	Regional
Albany State University	Regional
Albany Technical College	Regional
Aspire Behavioral Health and Developmental Disabilities	Regional
Augusta University	Regional
Bishop Clean Care	Lee County
City of Sylvester	Worth County
Council on Aging	Regional
Dougherty County Family Connection	Dougherty County
Georgia Family Connection Partnership	Regional
Lee County Schools	Lee County
NAMI Albany	Regional
Phoebe Health System	Regional
Southwest Public Health District for the Department of Public Health	Regional
SOWEGA Rising	Regional
Strive to Thrive	Regional
Sylvester Worth County Chamber of Commerce	Worth County
Wells Fargo	Regional

6.3.4 QUALITATIVE DATA ANALYSIS RESULTS

Transcripts from the focus groups and key informant interviews were uploaded to the web-based qualitative data analysis tool, Dedoose[3]. Transcript text was coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The frequency with which a health topic was discussed was used to assess the relative importance of that health and/or social need to determine the most pressing health needs of the community. The findings from the qualitative analysis were combined with the findings from other data sources and incorporated into the Data Synthesis, Top Health Needs, and COVID-19 sections of this report.

3. Dedoose Version 8.0.35, web application for managing, ana- lyzing and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Socio- Cultural Research Consultants, LLC www.dedoose.com

Themes Across Qualitative Data

Figure 24 below summarizes the main themes and topics that trended across all or almost all focus group conversations and key informant interviews.

FIGURE 24: WORD CLOUD THEMES FROM QUALITATIVE DATA

6.3.5 DATA CONSIDERATIONS

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. All forms of data have their own strengths and limitations. Each data source for this CHNA process was evaluated based on these strengths and limitations during data synthesis and should be kept in mind when reviewing this report. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, community survey respondents, focus group participants, and key informant experts as possible.

While data collection efforts aimed to include a wide range of secondary data indicators and community member voices, some limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Secondary data were limited to availability of data, with some health topic areas having a robust set of indicators while others were more limited. The Index of Disparity, used to analyze disparities for the secondary data, is also limited by data availability from data sources. Some secondary data sources do not include subpopulation data and others only display values for a select number of racial/ethnic groups.

For the primary data, the breadth of findings is dependent upon who was selected to be a key informant or who self-selected to participate in the community focus groups. Additionally, the community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. Findings from the survey were shown to have a majority of respondents who identified as White, Non-Hispanic, and/or Female. This is a limitation to consider in future assessments, specifically in targeting the qualitative data collection to better include a true representation of the Phoebe Putney Service Area. Though there were several qualitative data collection efforts with community members throughout this process (key informant interviews and focus group), the voices and experiences of individuals within the community still may not be fully reflected.

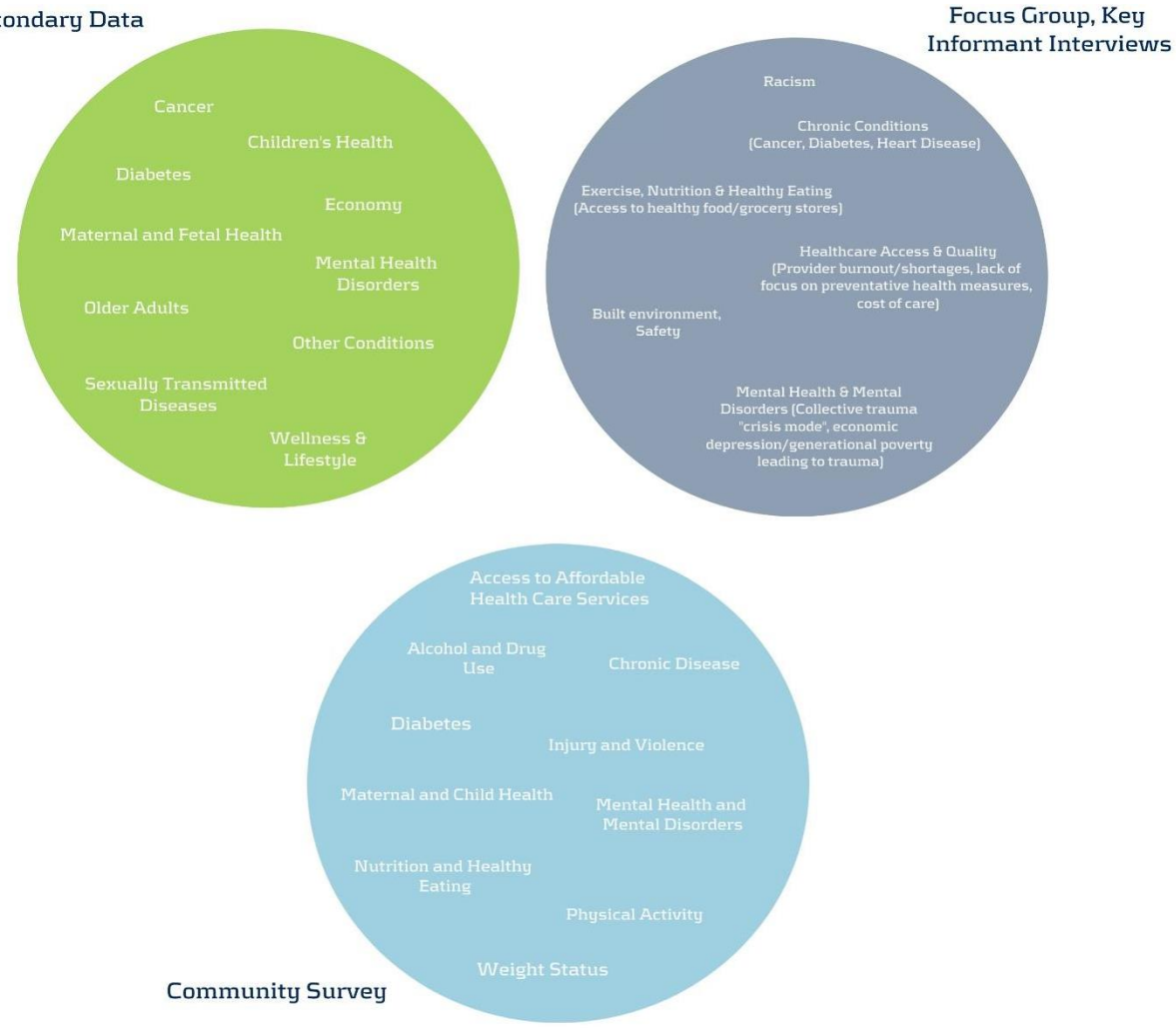
SECTION 7

DATA SYNTHESIS AND PRIORITIZATION

7.1 DATA SYNTHESIS

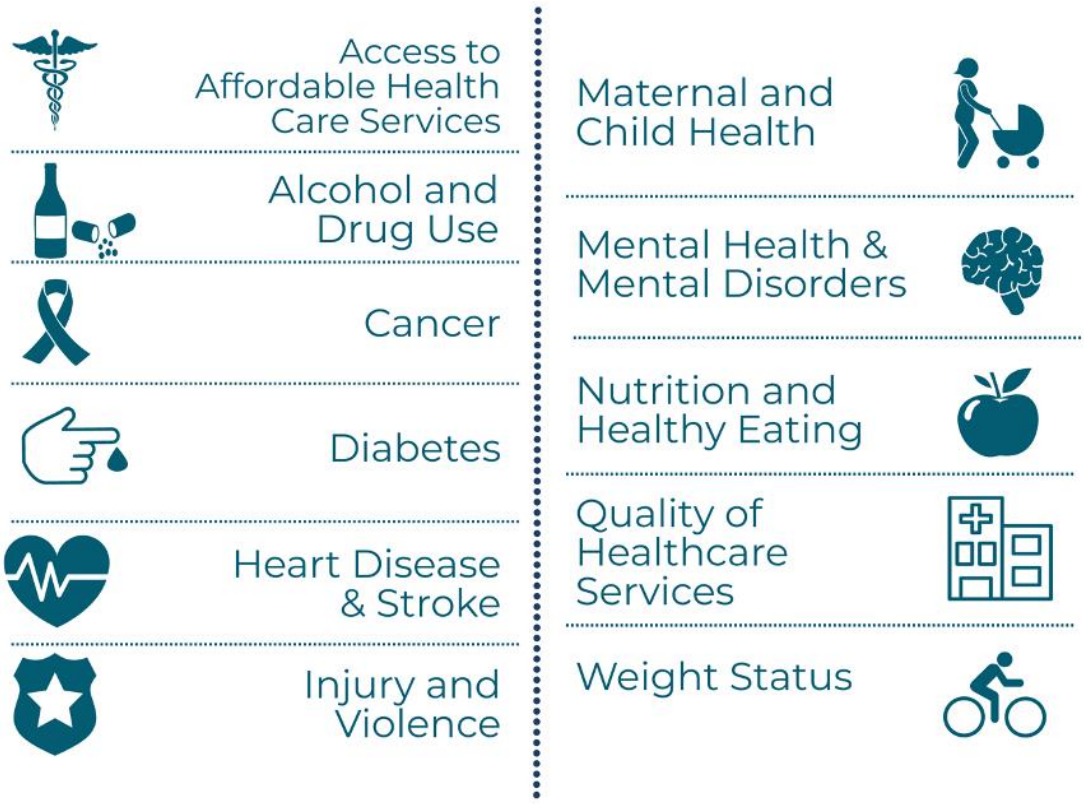
Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in the Primary Service Area. The top health needs identified from data sources were analyzed for areas of overlap.

FIGURE 25: DATA SYNTHESIS VENN DIAGRAM



Primary data from the community survey, focus groups, and key informant interviews as well as secondary data findings identified 11 areas of greater need. Figure 26 shows the final 11 significant health needs, listed in alphabetical order, that were included for prioritization based on the synthesis of all forms of data collected for CHNA.

FIGURE 26. DATA SYNTHESIS RESULTS



7.2 PRIORITIZATION

To better target activities to address the most pressing health needs in the community, Phoebe convened a group of individuals who represent a broad interest of the community served, including those with special knowledge or expertise in public health in a presentation of data on significant health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise to rank the significant health needs based on a set of criteria. The presentation and prioritization session were conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

The team reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

7.2.1 PARTICIPANTS

The following community health leaders took part in the prioritization session:

- Dr. Dianna Grant, Chief Medical Officer, Phoebe Health System
- Joe Austin, CEO, Phoebe Putney Memorial Hospital
- Brian Church, CFO, Phoebe Health System
- Christopher Kane, Chief Strategy Officer, Phoebe Health System
- Dr. Derek Heard, M.D., Phoebe Physician Group
- Dr. Suresh Lakhanpal, M.D., Chief Executive Officer, Phoebe Physician Group
- Shelley Spires, CEO, Albany Area Primary Health Care
- Kimberly Parker, Quality Improvement, Phoebe Health System
- A.L. Fleming, Albany State University

7.2.2 PROCESS

On June 28, 2022, the above-mentioned joined together for the prioritization meeting hosted by HCI. During this meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the preliminary significant health needs discussed in detail in the data synthesis portion of this report. From there, participants were given three days to access an online link
to score each of the significant health needs by how well they met the following criteria:

1. Magnitude of the Issue
   - How many people in the community are or will be impacted?
   - How does the identified need impact health and quality of life?
   - Has the need changed over time?
2. Ability to Impact
   - Can actionable and measurable goals be defined to address the health need? Are those goals achievable in a reasonable time frame?
   - Does the hospital or health system have the expertise or resources to address the identified health need?
   - Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?

The group also agreed that root causes, disparities, and social determinants of health would be considered for all health topics resulting from prioritization.

Participants scored each health area against each criterion on a scale from 1-3 with 1 meaning it did not meet the given criterion, 2 meaning it met the criterion, and 3 meaning it strongly met the criterion. In addition to considering the data presented by HCI in the presentation and on the health topic note sheet, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that particular need met the criteria for prioritization. HCI downloaded the online results, calculated the scores, and then ranked the significant health needs according to their topic scores, with the highest scoring health need receiving the highest priority ranking.

7.2.3 SIGNIFICANT HEALTH NEEDS PRIORITIZATION

The aggregate ranking can be seen in the list below. Phoebe Putney Health Systems' Team reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

PHOEBE ALBANY

Leading Topic Indicators/Data Scoring Results

Counties: Dougherty, Lee, Mitchell, Terrell, Worth

Health Topic	Indicators	Avg Score
Other Conditions	5	2.4
Wellness and Lifestyle	8	2.2
Mental Health Disorders	8	2.2
Diabetes	5	2.1
Sexually Transmitted Diseases	3	2.1
Older Adults	24	2.04
Children's Health	6	2.0
Maternal and Fetal Health	7	1.96
Economy	35	1.91
Cancer	15	1.84

The results of the prioritization session were presented to the PPMH Board of Directors where they reviewed and approved the priority areas at their July 6th, 2022, meeting. The four priority health needs are:

PRIORITIZED HEALTH NEEDS
Birth Outcomes & Reproductive Responsibility
Cancer Prevention & Treatment
Diabetes Management & Prevention
Mental Health, Alcohol & Drug Use, Injury & Violence

A deeper dive into the primary data and secondary data indicators for each of these four priority health needs is provided later in this report. Phoebe Putney Memorial Hospital plans to build upon these efforts and continue to address these health needs in their upcoming Implementation Strategies.

SECTION 8

PRIORITIZED SIGNIFICANT HEALTH NEEDS

The following section provides detailed descriptions of the four prioritized health needs. This also includes health issues, the population groups with greater needs, and factors that contribute to those needs.

8.1 PRIORITIZED HEALTH TOPIC #1: BIRTH OUTCOMES & REPRODUCTIVE RESPONSIBILITY

Birth Outcomes & Reproductive Responsibility

Secondary Data Score: **1.83** (Maternal and Fetal Health)

Key Themes from Community Input

- Infant and maternal mortality disproportionately impact Black people
- Poor birth outcomes largely associated with spacing factors, and lack of access to adequate prenatal care
- Workforce shortages: lack of obstetrical providers coupled with hospital closures, and OB units shutting down

Warning Indicators

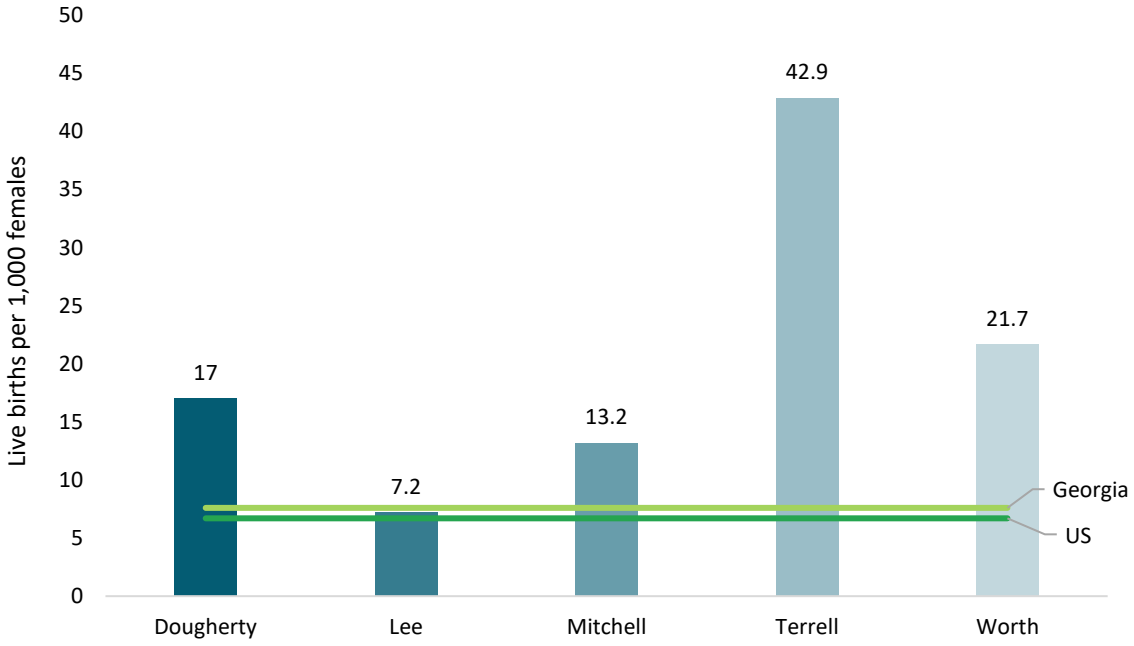
- Babies with Low Birth Weight
- Babies with Very Low Birth Weight
- Infant Mortality Rate
- Infants Born to Mothers with <12 Years Education
- Mothers who Smoked During Pregnancy
- Preterm Births
- Teen Birth Rate: 15-17
- Teen Pregnancy Rate

SECONDARY DATA

The secondary data analysis for Maternal, Fetal & Infant Health resulted in a topic score of 1.83 on a scale of 0 to 3, indicating need above average. Some notable indicators that fall within this topic area are seen in the charts below.

All counties expect Lee have a higher teen birth rate as compared to the Georgia State value, and the US (Figure 27). Terrell County has a significantly higher teen birth rate of 42.9 live births per 1,000 females aged 15-17.

FIGURE 27: TEEN BIRTH RATE:15-17 (GEORGIA DEPARTMENT OF PUBLIC HEALTH OASIS, 2021)



Georgia DPH OASIS, 2021

FIGURE 28: INFANT MORTALITY RATE (GEORGIA DEPARTMENT OF PUBLIC HEALTH OASIS, 2008-2019)

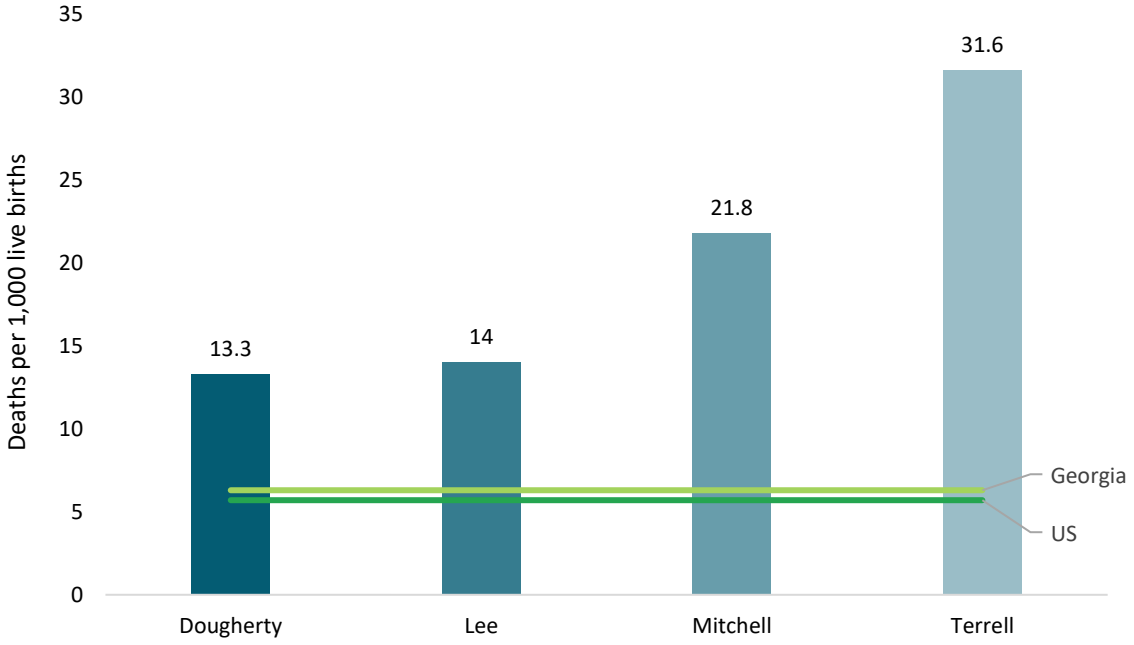
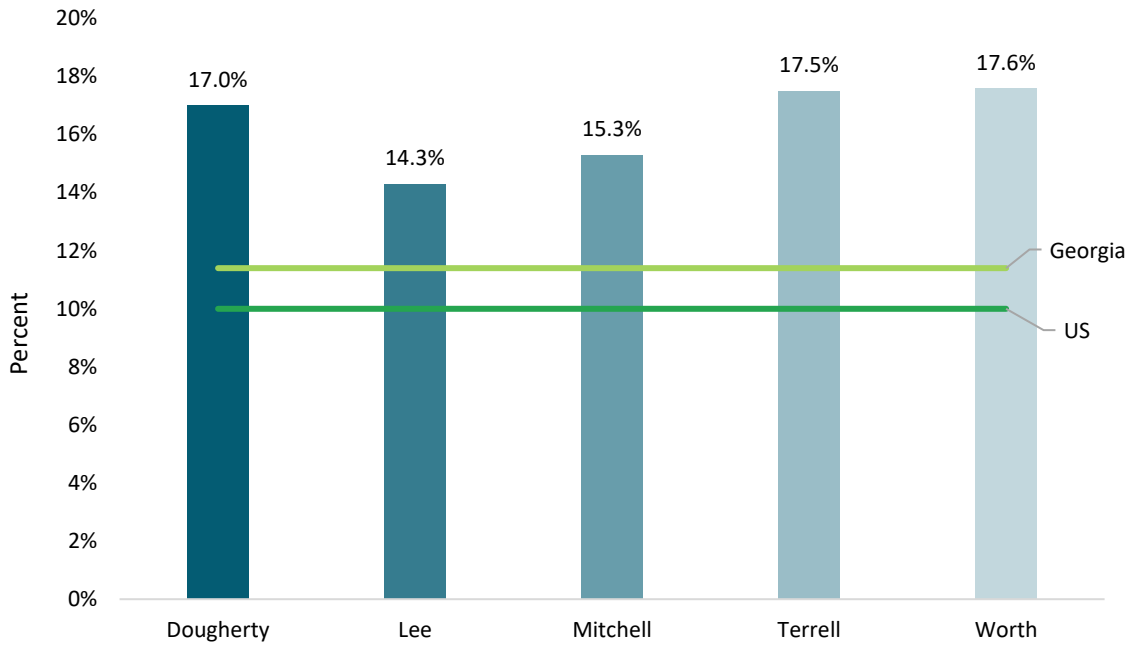


FIGURE 29: PRETERM BIRTHS (GEORGIA DEPARTMENT OF PUBLIC HEALTH OASIS, 2020)



GDPH OASIS, 2020

PRIMARY DATA

POOR BIRTH OUTCOMES

Poor birth outcomes were a top health need identified from the community survey, focus group, and key informant interviews. High incidence of maternal complications, premature births, and young mothers at high risk for complications were mentioned throughout key informant interviews and provide robust rationale for the need to improve access to prenatal care. Additionally, having effective available reproductive healthcare/family planning was a theme that emerged as a way to reduce infant mortality (spacing factors), reduction in unintended pregnancy, and a way to impact maternal deaths indirectly.

Furthermore, women are not receiving preconception counseling and education to understand delivery options, especially Black Women on Medicaid. However, poor Medicaid reimbursement for preventative services coupled with policy decisions and failure to expand Medicaid prove to be barriers to achieving optimal maternal and infant health.

Many participants spoke about the workforce shortages, particularly, OB providers, Midwives, Doulas, and Birthing Centers. Similarly, centers and physicians are overwhelmed with trying to make money to pay their staff and support their centers, which in turn allows for short OBGYN visits, often detrimental to the quality of care received.

> I have to mention our birth outcomes and improving access to adequate prenatal care. We are in a particular OB obstetrical provider dearth right now. We already had issues and now we've had three providers leave for different reasons. We've actually done a needs assessment and we're down at least five providers so OB is clearly still an issue.
>
> - Key Informant

BLACK MATERNAL HEALTH

Black maternal health was a reoccurring topic that emerged in key informant interviews and specifically, how it impacts rural communities differently from urban communities. The state of Georgia has the second highest rate of maternal mortality in the nation, with Black women more than 5 times likely to die during childbirth than White women. Thus, it is imperative to examine what is causing this, and how racial equity plays a role in that.

Several key informants mentioned ways to address this, including, the need for more Midwives of Color, teaching women how to advocate for themselves, and addressing the physician side of why Women of Color are dying at higher rates during childbirth due to the effects of implicit bias, racism, and historical patterns of disinvestment/underinvestment in Communities of Color.

> Racial equity needs to be front and center in our community. I think Phoebe has an opportunity to lead the way with that because medical care is something that is unifying. We all need it at some point in our lives. But to really understand how racial equity can work to solve a lot of problems and create solutions and also can address things like what is happening with Black maternal mortality rates.
>
> - Key Informant

8.2 PRIORITIZED HEALTH TOPIC #2: CANCER PREVENTION & TREATMENT

Cancer Prevention & Treatment

Secondary Data Score: **1.95**

Key Themes from Community Input

- **Twenty Five percent (25%)** of survey respondents ranked Cancer as the most important health issue in the community
- Lack of focus on preventative health measures i.e. immunizations (HPV) and cancer screenings
- Cultural barriers in HPV vaccination acceptance

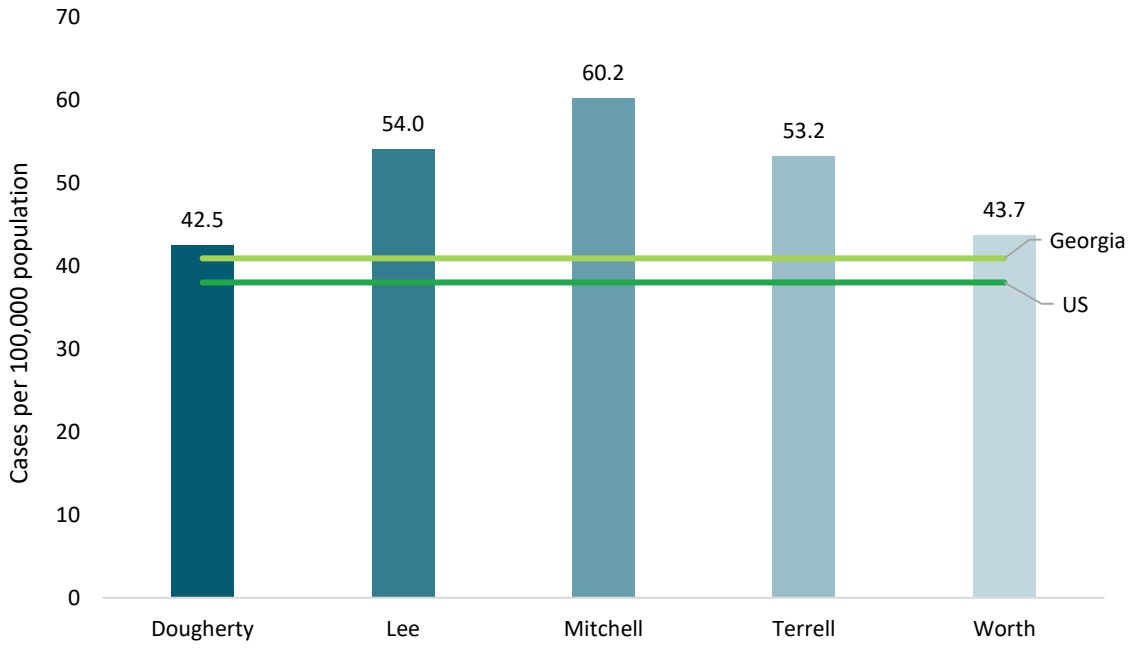
Warning Indicators

- Age-Adjusted Death Rate due to Breast Cancer
- Age-Adjusted Death Rate due to Cancer
- Age-Adjusted Death Rate due to Colorectal Cancer
- Age-Adjusted Death Rate due to Lung Cancer
- Age-Adjusted Death Rate due to Prostate Cancer
- All Cancer Incidence Rate
- Breast Cancer Incidence Rate
- Cancer: Medicare Population
- Colon Cancer Screening
- Colorectal Cancer Incidence Rate
- Lung and Bronchus Cancer Incidence Rate
- Oral Cavity and Pharynx Cancer Incidence Rate
- Prostate Cancer Incidence Rate

SECONDARY DATA

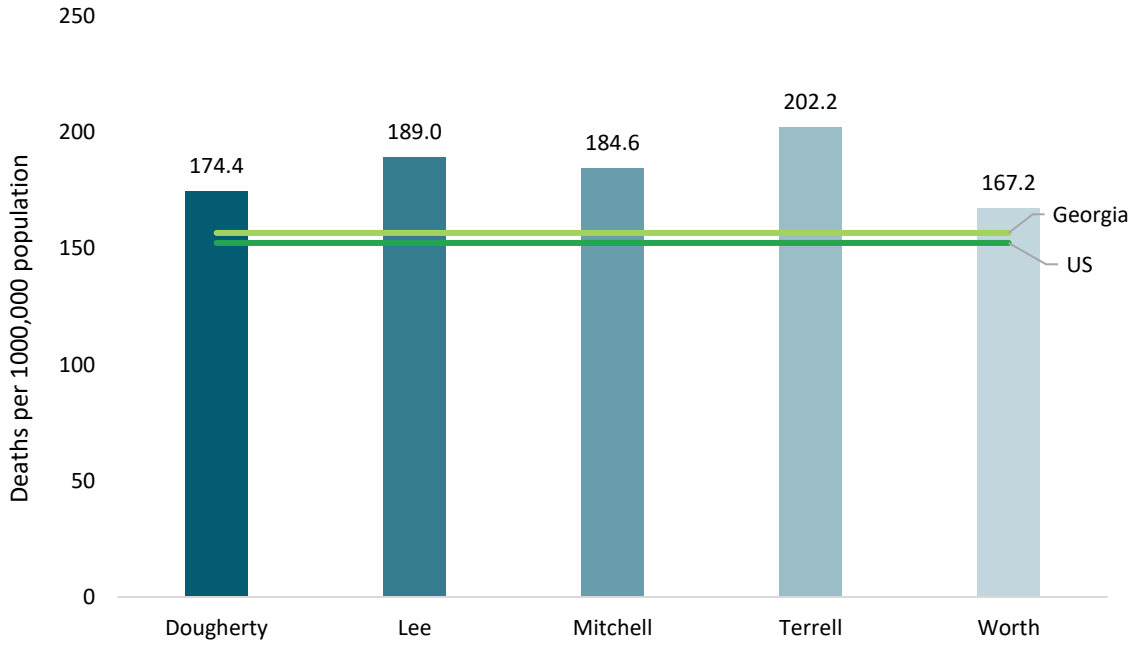
The secondary data analysis for Cancer resulted in a topic score of 1.95. Lee, Mitchell, and Terrell counties had higher individual scores for this topic area (2.24, 2.09 and 2.14, respectively). Both Dougherty and Worth counties had slightly lower individual scores for this topic are with 1.58 and 1.72 respectively. It is important to note that Cancer is affected by a variety of socioeconomic factors including access to healthy foods, housing conditions, environmental exposure, nutrition resources, and exercise opportunities.

FIGURE 30: COLORECTAL CANCER INCIDENCE RATE (NATIONAL CANCER INSTITUTE, 2014-2018)



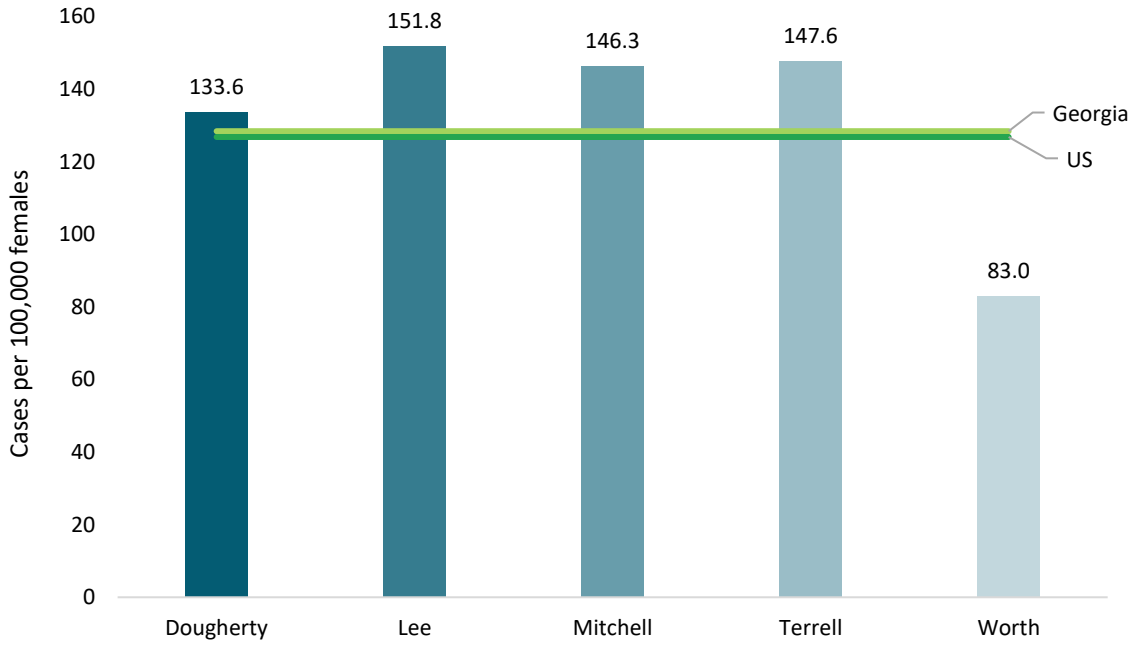
National Cancer Institute, 2014-2018

FIGURE 31: AGE-ADJUSTED DEATH RATE DUE TO CANCER (NATIONAL CANCER INSTITUTE, 2015-2019)



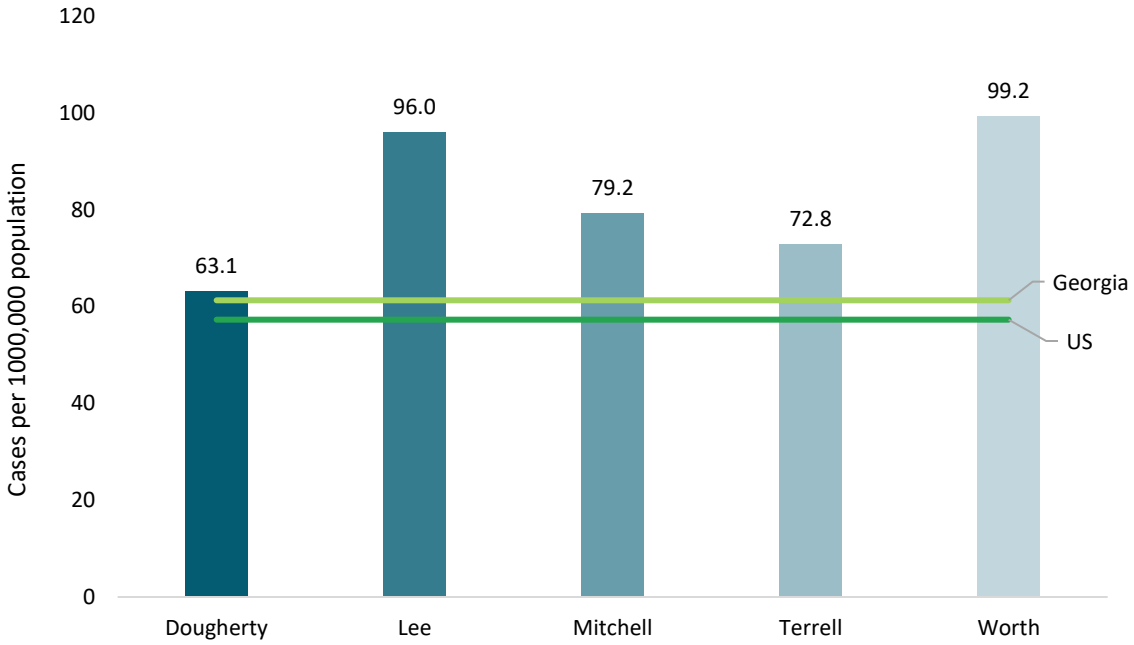
National Cancer Institute, 2015-2019

FIGURE 32: BREAST CANCER INCIDENCE RATE (NATIONAL CANCER INSTITUTE, 2014-2018)



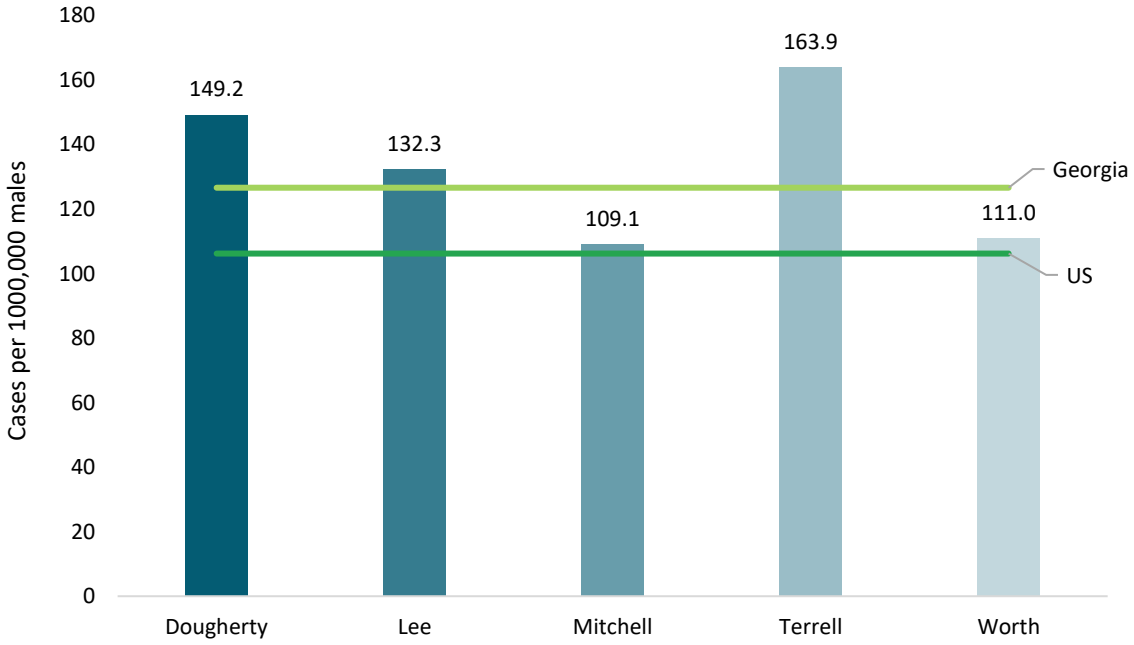
National Cancer Institute, 2014-2018

FIGURE 33: LUNG AND BRONCHUS CANCER INCIDENCE RATE (NATIONAL CANCER INSTITUTE, 2014-2018)



National Cancer Institute, 2014-2018

FIGURE 34: PROSTATE CANCER INCIDENCE RATE (NATIONAL CANCER INSTITUTE, 2014-2018)



National Cancer Institute, 2014-2018

PRIMARY DATA

CANCER

Cancer was a top health need from the community survey, focus group, and key informant interviews. When community survey respondents were asked what the "most important health problem" in the community is, 31% selected Cancer.

Lack of focus on preventative health care measures, including immunizations and screenings, was mentioned throughout the key informant interviews as tangible public health efforts to eradicate cancer in the community. More specifically, Human Papillomavirus (HPV) vaccination. Decreased rates of colorectal cancer and breast cancer screening efforts over time were also mentioned.

Another important topic mentioned regarding HPV related cancers, are the cultural barriers that exist in vaccine acceptance. Thus, presenting an opportunity for Phoebe to fill these gaps in knowledge by providing more community education.

> We know that we can eradicate cervical cancer and a lot of head and neck cancers by getting HPV vaccination rate to 80%.
>
> - Key Informant

8.3 PRIORITIZED HEALTH TOPIC #3: DIABETES MANAGEMENT & PREVENTION

Diabetes Management & Prevention

Secondary Data Score: **1.77**

Key Themes from Community Input

- **Thirty Two percent (32%)** of survey respondents ranked Diabetes as the most important health issue in the community
- Lack of access to preventative care and education, coupled with a poor population has led to health disparities in diabetes diagnoses

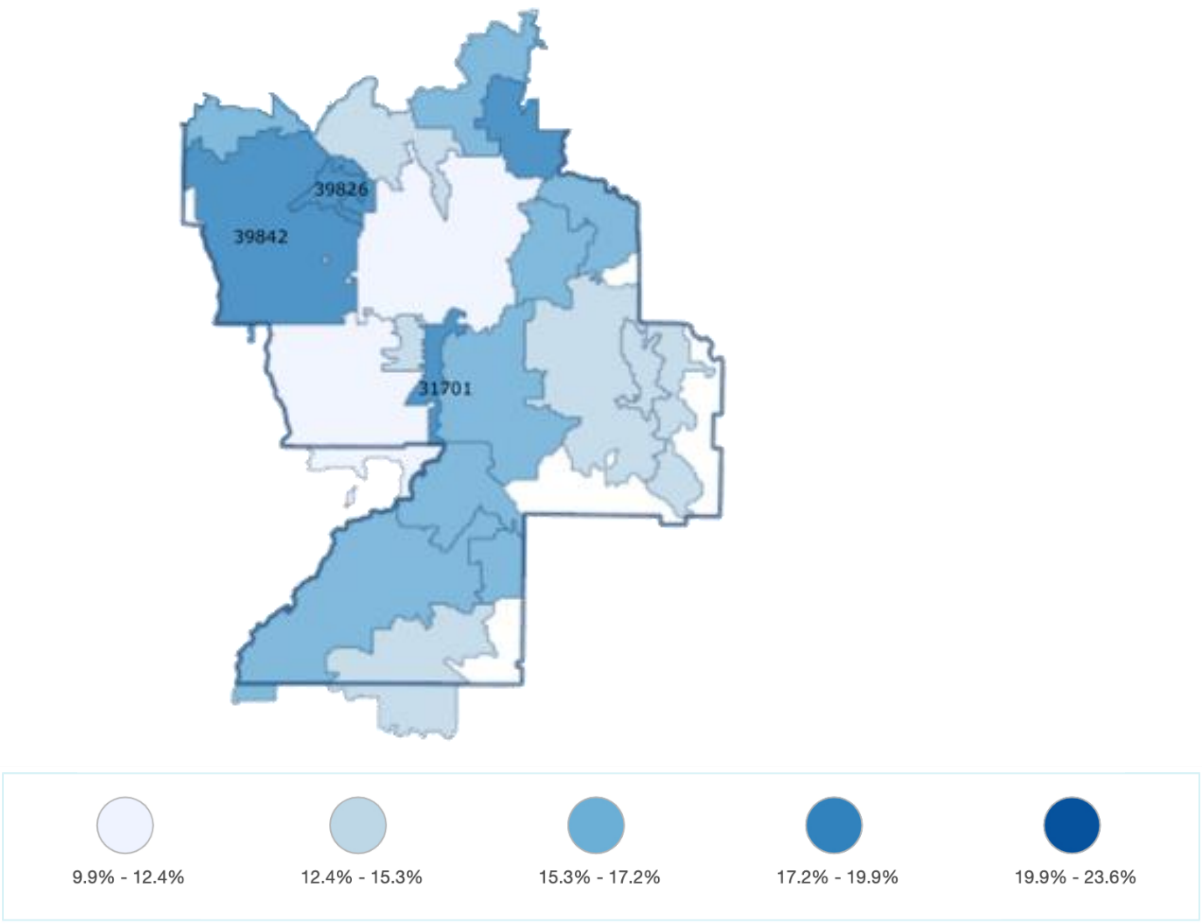
Warning Indicators

- Age-Adjusted Death Rate due to Diabetes
- Age-Adjusted ER Rate due to Diabetes
- Age-Adjusted Hospitalization Rate due to Diabetes
- Diabetes: Medicare Population

SECONDARY DATA

The secondary data analysis for Diabetes resulted in a topic score of 1.77. Figure 35 shows the Percent of Adults with Diabetes by Zip Code. The darkest blue color indicates a higher percentage of adults with diabetes within that zip code. Compared to the Food Insecurity Index map (Figure 16), there is some overlap between zip codes with higher Food Insecurity Index values and diabetes rates. This overlap can be easily seen in 39826 (Terrell) and 31701 (Dougherty). These general trends or co-occurrences can also be seen for within the highest need zip codes with the Health Equity Index (Figure 15 and Table 2, respectively). This could indicate different factors at play that affect societal and social determinants of health, such as the higher population of older adults that reside in the most affected zip codes.

FIGURE 35: PERCENT OF ADULTS WITH DIABETES, BY ZIP CODE



PRIMARY DATA

A common theme in the key informants and focus group was the need to change the environment, and the environmental factors that are leading to the high incidence of chronic diseases, specifically, Diabetes. This includes addressing things like low standards of education, poverty, a lack of transportation, inability to have healthy foods as part of one's normal diet, and inability to have a safe place to walk.

Additionally, Nutrition & Healthy Eating, specifically Access to Healthy Foods, was mentioned in almost every key informant interview. Similarly, Physical Activity and Weight Status were cited frequently when discussing overall health and wellness, and commonly co-occurring with chronic conditions like Diabetes. Key informants cited lower-income or impoverished areas having less access to healthy foods and being less likely to lead healthy lifestyles. Also mentioned was economic status, worsened by COVID-19, causing added stress and financial hardship which tend to exacerbate unhealthy habits.

> We have a very poor population, a very uneducated population. We see a lot of health disparities in our community, whether it be obesity, diabetes. We have a lot of patients in the clinic who've lost limbs due to not knowing how to control their diabetes or not having diabetes education. And it all basically comes down to education and being in a primarily very poor district that doesn't have access to a lot of services.
> - Key Informant

> Much of our community is a food desert when it comes to having grocery stores that are convenient and ways to get back and forth to those stores.
> - Key Informant

8.4 PRIORITIZED HEALTH TOPIC #4: MENTAL HEALTH, ALCOHOL & DRUG USE, INJURY & VIOLENCE

Mental Health, Alcohol & Drug Use and Violence and Injury Prevention

Secondary Data Score: **2.11**

Key Themes from Community Input

- Mental Health and Mental Disorders was ranked by survey respondents as the **second most important** health issue in the community **(34%)**
- Top 5 reasons from getting mental health services: Cost – too expensive/can't pay, privacy concerns, wait is too long, did not know where to go, lack of trust in healthcare services/providers
- Collective trauma people have been experiencing is leading people to live in crisis mode
- Many individuals are showing up in the ER with co-occurring disorders like mental health and substance use disorder

Warning Indicators

- Adults Ever Diagnosed with Depression
- Age-Adjusted Death Rate due to Alzheimer's Disease
- Age-Adjusted Death Rate due to Suicide
- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days
- Poor Mental Health: Average Number of Days

SECONDARY DATA

The secondary data analysis for Mental Health & Mental Disorders and Alcohol & Drug Use resulted in topic scores of 2.11 and 1.31, respectively. These topic areas were combined into one priority, given the relationship between mental health and substance use disorders. Prevention & Safety resulted in a topic score of 1.25.

MENTAL HEALTH AND MENTAL DISORDERS

Secondary data scoring presented Mental Health & Mental Disorders as above average, with a topic score of 2.11. Lee, Terrell, and Worth counties had higher individual scores for this topic area (2.17, 2.15 and 2.36, respectively), which could indicate a greater need for mental health services or interventions in these counties.

It is important to note that Mental Health can be affected by a variety of socioeconomic factors including income, social support, socioeconomic status, gender identity, disability status, and stress caused by structural racism and other systemic barriers. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 36. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 31701 (Dougherty County), 31705 (Dougherty County), 31730 (Mitchell County), 31707 (Dougherty County), and 39842 (Terrell County). Table 6 provides the index values for high needs zip codes. See Appendix A for more detailed MHI methodology.

FIGURE 36: MENTAL HEALTH INDEX BY ZIP CODE

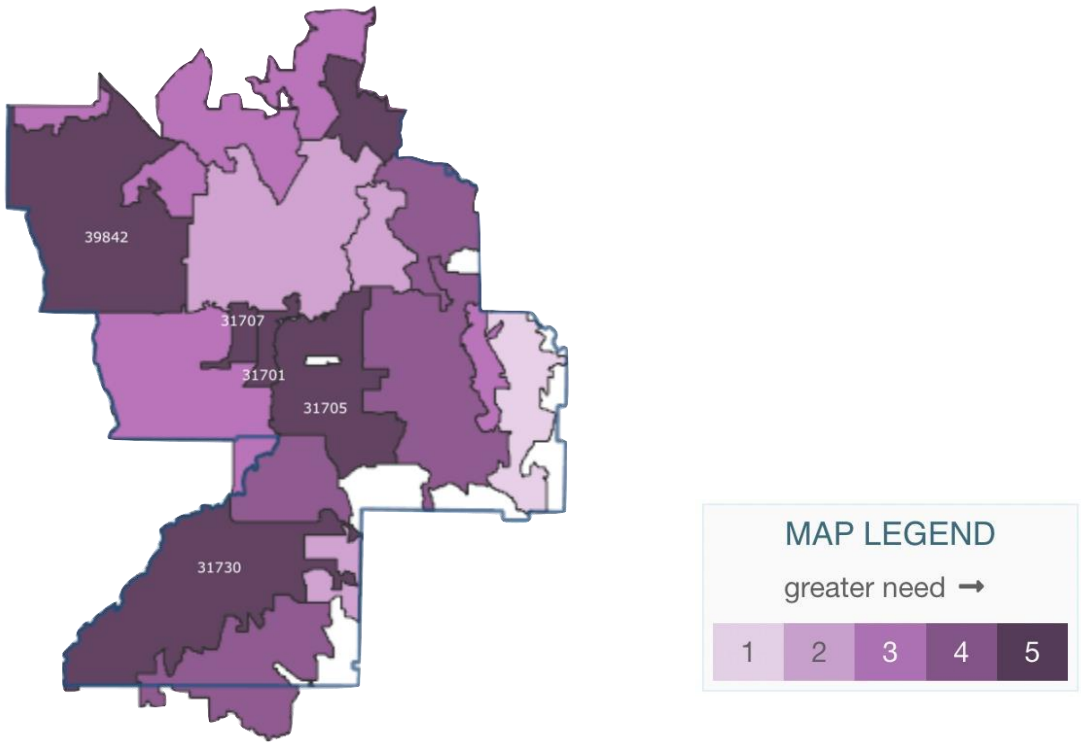


TABLE 6. MENTAL HEALTH INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	MHI VALUE	COUNTY
31701	5	99.3	Dougherty
31705	5	98.8	Dougherty
31730	5	98.3	Mitchell
31707	5	96.8	Dougherty
39842	5	95.3	Terrell

ALCOHOL & DRUG USE

Secondary data scoring presented Alcohol & Drug Use as below average, with a topic score of 1.31. There are concerning data around age-adjusted

ER rate due to opioid overdose, age-adjusted hospitalization rate due to opioid overdose, alcohol-impaired driving deaths, and liquor store density. Both Lee County and Worth County, have higher Age-Adjusted ER rates due to Opioid Overdose than their respective state value. (Figure 39). All counties aside from Dougherty County also have higher Age-Adjusted Hospitalization Rates due to Opioid Overdose than the state value of 19.1/100,000 residents (Figure 40). Additionally, both Lee County and Mitchell County have higher Alcohol-Impaired Driving Deaths than their respective state value (Figure 41). Dougherty County was the only county with available age-adjusted drug and opioid-involved overdose death rate data, which was slightly above the state value of 14.8 deaths/100,000 population. (Figure 38).

Lastly, as shown in Figure 42, Dougherty, Mitchell, and Lee Counties have a higher liquor store density, stores per 100,000 population, than both the state value and US value. Studies have shown that neighborhoods with a high density of alcohol outlets are associated with higher rates of violence, regardless of other community characteristics such as poverty and age of residents. High alcohol outlet density has been shown to be related to increased rates of drinking and driving, motor vehicle-related pedestrian injuries, and child abuse and neglect. In addition, liquor stores frequently sell food and other goods that are unhealthy and expensive.

Figure 37 Adults who Binge Drink

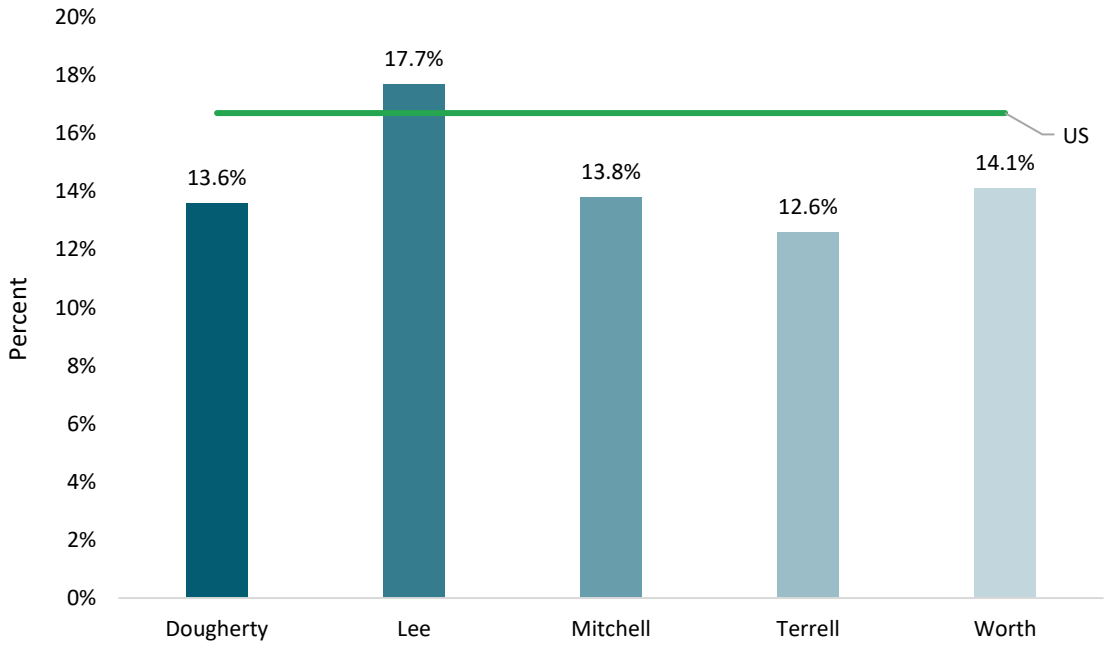


Figure 38 Age-Adjusted Drug and Opioid-Involved Overdose Death Rate

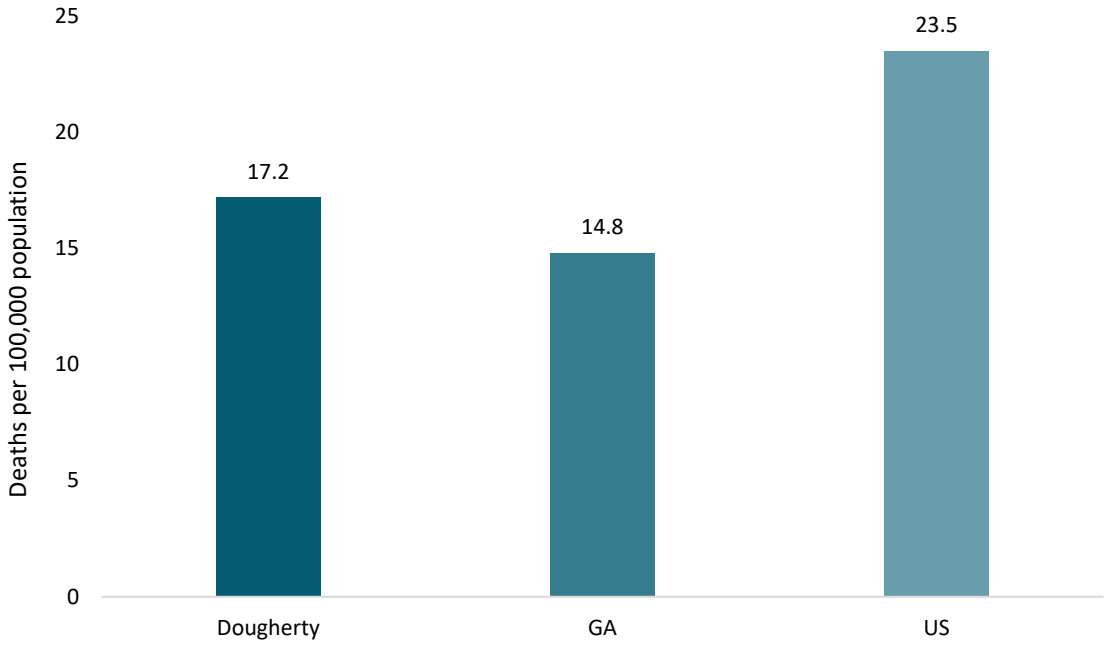


Figure 39 Age-Adjusted ER Rate due to Opioid Overdose

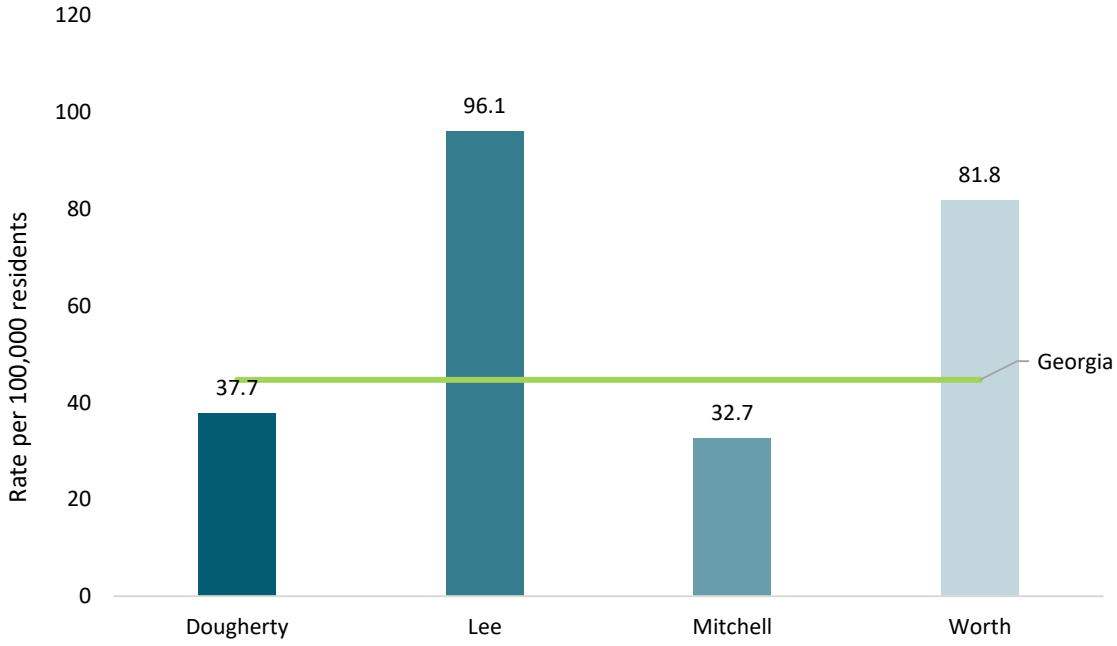


Figure 40 Age-Adjusted Hospitalization Rate due to Opioid Overdose

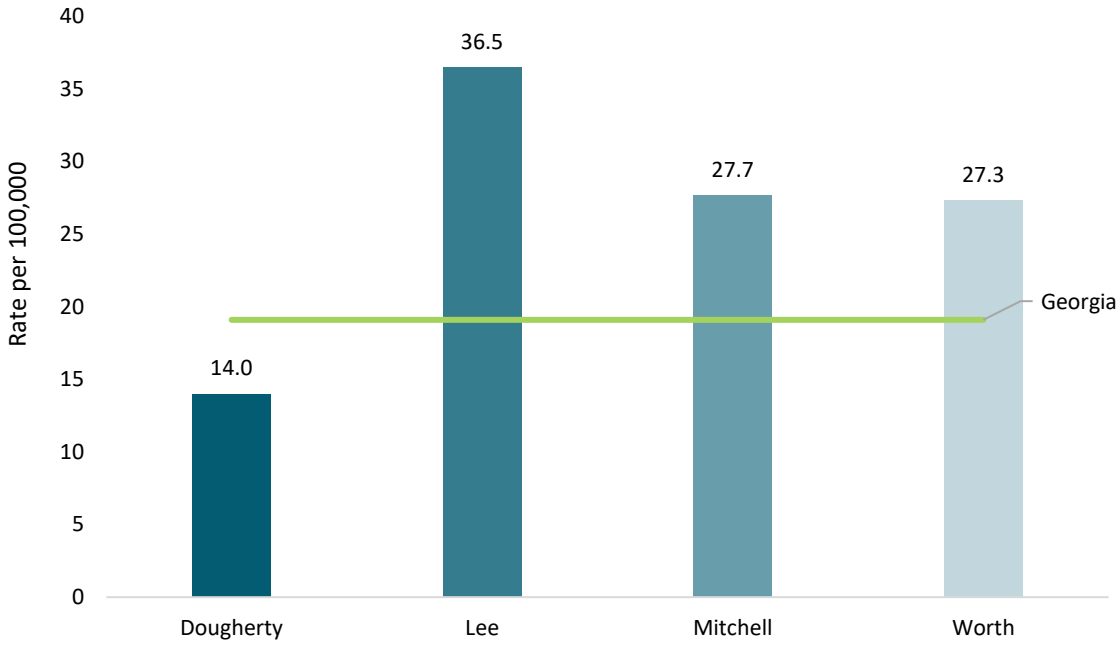


Figure 41 Alcohol-Impaired Driving Deaths

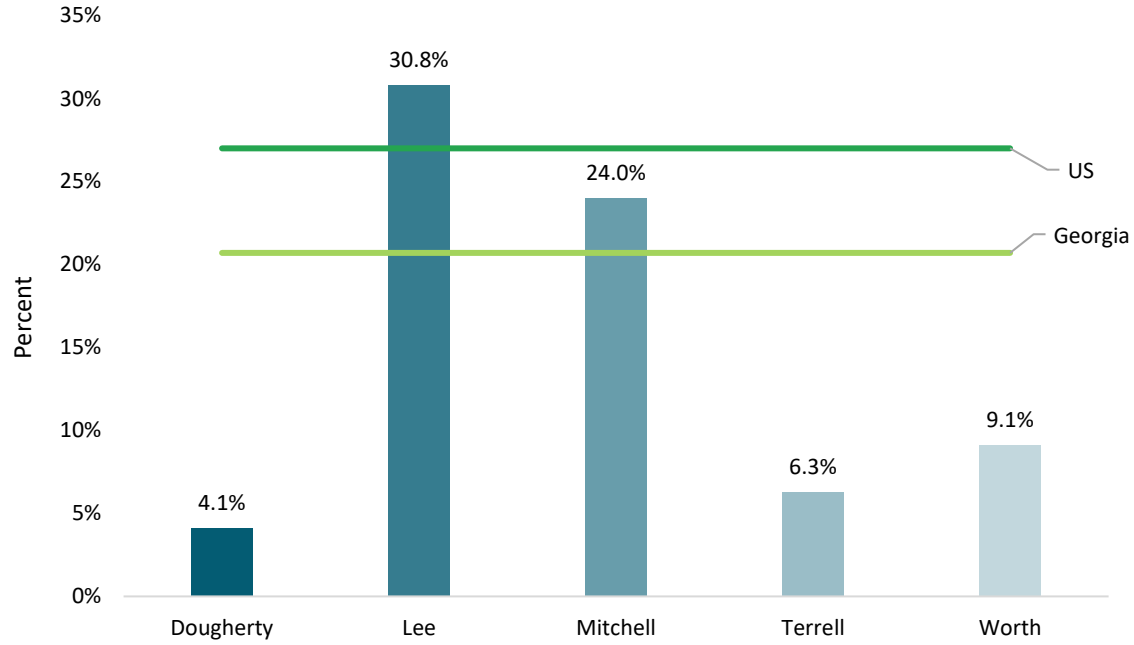
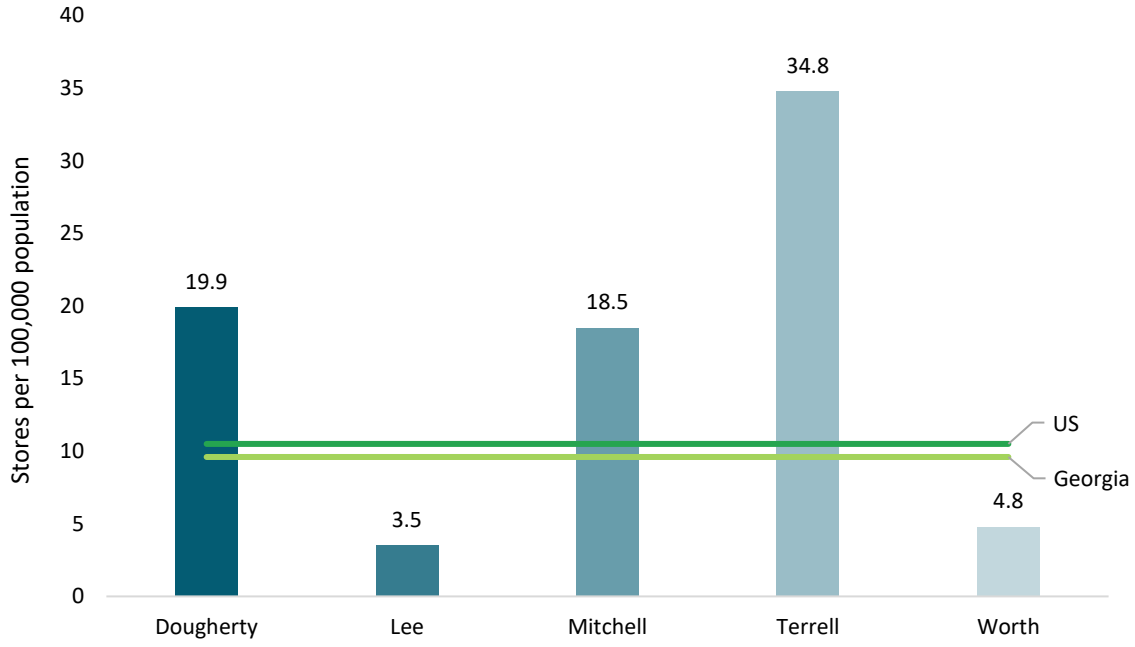


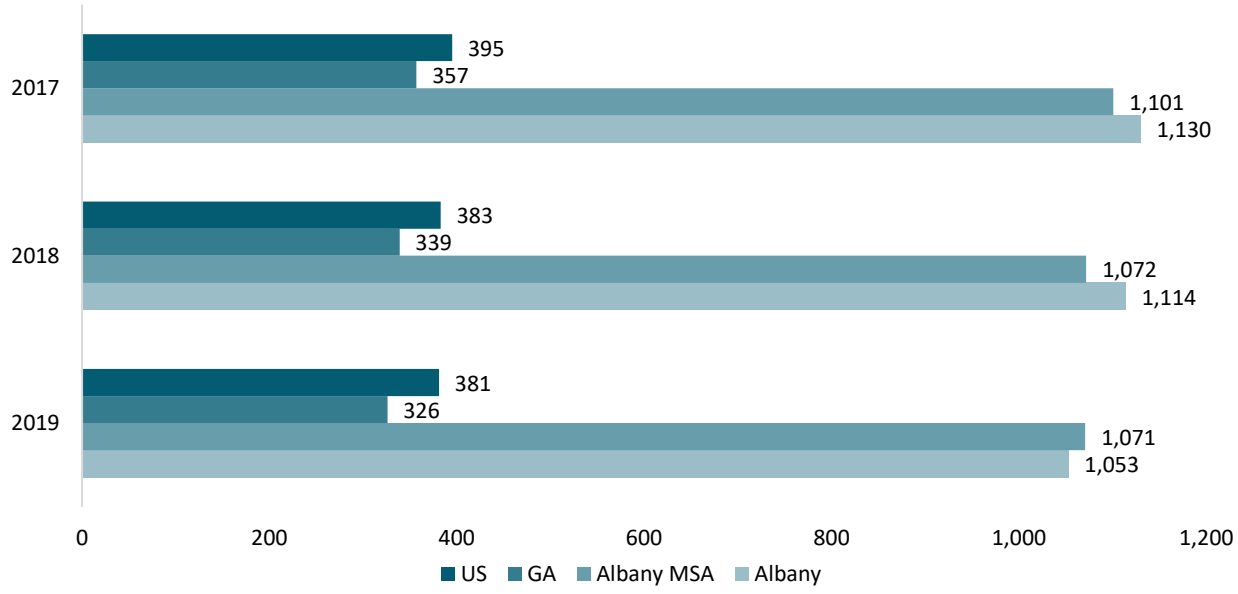
Figure 42 Liquor Store Density



VIOLENCE AND INJURY PREVENTION

Secondary data scoring presented Prevention & Safety as below average, with a topic score of 1.25. The warning indicator, Violent Crime Rate, measured crimes per 100,000 population. Violent crimes include murder, rape, robbery, and aggravated assault. Figure 43 shows the violent crime rate in 2017, 2018 and 2019. Violent Crime in Albany and the Metro Area are significantly higher than Georgia or US rates. Violence negatively impacts communities by reducing productivity, decreasing property values, and disrupting social services.

FIGURE 43: VIOLENT CRIME RATE



PRIMARY DATA

MENTAL HEALTH AND MENTAL DISORDERS

Mental Health and Mental Disorders was a top health need from the community survey, focus groups, and key informant interviews. In the community survey it was ranked as the second most pressing health need in the community (34%).

Mental health resources, and the availability of mental health providers were frequently cited as disproportionate to community need. Focus group and key informant participants mentioned stigma associated with mental health or mental disorders being a limitation for people in need to seek help or treatment. In addition to stigma, key informants mentioned the way in society treats mental health illnesses differently from chronic diseases leading to a large amount of discrimination contributing to unwillingness to seek treatment out of fear of what other people may think. Overall, cost, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers also.

Participants emphasized the need to examine the root causes leading to mental health issues within the community including poverty and an unequal playing field in terms of investment in education in low-income communities. This historical disinvestment in communities has led to the economic depression and generational trauma.

> "If we funded mental health like we fund cancer, there would be a lot more healthier people."
> - Key Informant

ALCOHOL AND DRUG USE

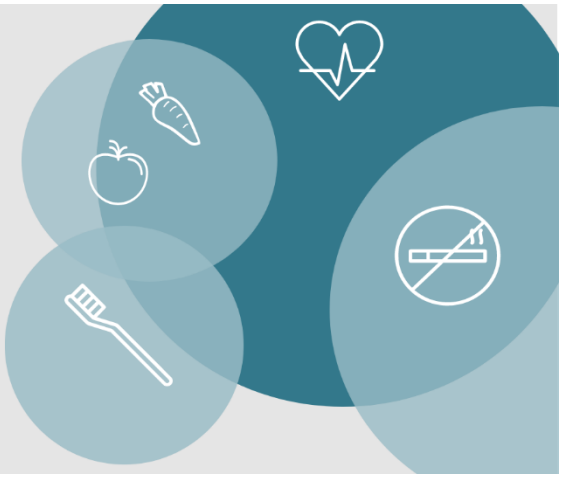
Alcohol and drug use was a top health need from the community survey, focus groups, and key informant interviews. In the community survey, 32% of survey respondents ranked Alcohol and Drug Use as the most important health issue in the community.

Substance use disorder was a recurring topic in the key informant interviews with participants mentioning substance use disorder frequently coinciding with or is a result of mental health issues. Key informants pointed out that low-income and impoverished neighborhoods typically deal with more stressors while drugs are simultaneously more accessible in those areas. Participants mentioned the opioid epidemic still affecting their community, specifically the issue of opioid overdoses. Additionally, they spoke about law enforcement often treating substance use disorder as a criminal act, rather than the serious health issue it is.

> "We really need more support when it comes to substance use disorder. Helping people deal with the trauma of life and poverty and COVID-19."
> - Key Informant

SECTION 9

NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS



The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. However, Phoebe Putney Health System will not focus directly on these topics in their Implementation Strategy/ Improvement Plans. Several of the non-prioritized needs are related to the three primary priority areas, and implementation of activities under those priorities will have an indirect impact on many of these needs.

Key themes from community input are included where relevant for each non-prioritized health need along with the secondary data score and warning indicators.

9.1 NON-PRIORITIZED HEALTH NEED #1: HEALTHCARE ACCESS & QUALITY

Healthcare Access & Quality

Key Themes from Community Input

- Access to Affordable Health Care & Quality of Healthcare Services was ranked by survey respondents as the **most important** health issue in the community **(57%)**
- Utilization of the ER for minor health issues due to lack of PCP
- Healthcare systems driven by economics
- Need for Medicaid expansion to increase coverage

9.2 NON-PRIORITIZED HEALTH NEED #2: HEART DISEASE & STROKE

Heart Disease & Stroke

Key Themes from Community Input

- **Twenty eight percent** (28%) of survey respondents ranked Heart Disease and Stroke as the most important health issue in the community
- Need for community education on exercise and healthy eating to address gaps in knowledge of how to prepare healthy food
- High poverty rates lead to poor health outcomes: higher rates of cardiovascular disease in poor rural counties

9.3 NON-PRIORITIZED HEALTH NEED #3: NUTRITION AND HEALTHY EATING

Nutrition and Healthy Eating

Key Themes from Community Input

- Primarily low-income uneducated population without access to healthy food
- Need for community education on healthy eating to address gaps in knowledge of how to prepare healthy food
- High poverty rates lead to poor health outcomes: higher rates of cardiovascular disease and diabetes in poor rural counties

9.4 NON-PRIORITIZED HEALTH NEED #4: WEIGHT STATUS

Weight Status

Key Themes from Community Input

- **Thirty percent** (30%) of survey respondents ranked Weight Status as the most important health issue in the community
- Need for community education on exercise and healthy eating to address gaps in knowledge of how to prepare healthy food
- Lack of meaningful investment in low income rural communities limiting access to fresh and healthy food
- High poverty rates lead to poor health outcomes: higher rates of obesity, cardiovascular disease and diabetes in poor rural counties

SECTION 10

OTHER FINDINGS

Critical components in assessing the needs of a community are identifying barriers to and disparities in healthcare. Additionally, the identification of these will help inform and focus strategies for addressing prioritized health needs. We previously covered disparities in the Disparities and Health Equity section of this report. The following identifies barriers as they pertain to the Phoebe Putney Memorial Hospital Service Area.

10 BARRIERS TO CARE

Community health barriers were identified as part of the primary data collection. Community survey respondents, focus group participants, and key informants were asked to identify any barriers to healthcare observed or experienced in the community.

10.1.1 TRANSPORTATION

Transportation was identified through this assessment as a major barrier to accessing health and social services within the Phoebe Putney Memorial Hospital Service Area. This geographic region is rural which exacerbates the issues of access to healthcare providers and services, especially for low-income populations and older adults who already experience barriers to access. The focus group and key informant participants stressed how important an issue transportation is across the region. There was specific emphasis about the lack of public transit options available. There is a definite need for an alternative to driving, especially in rural areas. While support from public transportation may alleviate some of these challenges, long-term solutions will require more creative approaches. Additionally, a high percentage of community survey respondents believed that transportation is a huge barrier that needs to be addressed in their community.

10.1.2 COST, HEALTH LITERACY, CULTURAL/LANGUAGE BARRIERS

In general, accessing affordable healthcare was a common problem that was discussed due to several identified barriers. For community survey respondents that did not receive the care they needed, 51.11% selected cost as a barrier to seeking the care they needed, while 74.16% selected cost as a barrier to seeking dental or oral health services. Focus group participants and key informants were concerned that low-income community members do not have access to affordable healthcare providers or medications for certain disease management. Key informants added that even when health insurance or services may be available, health literacy issues and cultural/language barriers make seeking or continuing to seek care difficult, especially for older adults and immigrant populations.

SECTION 11

COVID-19 IMPACT SNAPSHOT

11 INTRODUCTION

At the time that Phoebe Putney Memorial Hospital began its CHNA process, they were continuing to mitigate the coronavirus (COVID-19) pandemic.

The process for conducting the assessment remained fundamentally the same. However, there were some adjustments made during the primary data collection to ensure the health and safety of those participating.

11 PANDEMIC OVERVIEW

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Dougherty County was declared an early hotspot for COVID-19, and Phoebe Health System formed a COVID-19 taskforce, and Gov. Brian Kemp signed the COVID-19 executive order declaring a public health state of emergency for the state of Georgia.

Vaccinations were available to select groups of individuals since December 2020 and became more widely available to all adults in early 2021. Despite availability of vaccinations, new cases, hospitalizations, and deaths continue to occur throughout Georgia, the U.S., and worldwide. Upon completion of this report in August 2022, the pandemic was still very much a health crisis across the United States and in most countries.

Community Insights

The CHNA project team researched additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on the Phoebe Putney Memorial Service Area. Findings are reported below.

11 COVID-19 CASES AND DEATHS IN PHOEBE PUTNEY HOSPITAL SYSTEM

For current cases and deaths due to COVID-19 with the Phoebe Putney Health system visit their website at https://www.phoebehealth.com/patients-and-visitors/coronavirus/coronavirus-update.

11 COMMUNITY FEEDBACK

The community survey, focus groups, and key informant interviews were used to capture insights and perspectives of the health needs of Phoebe Putney Health System. Included in these primary data collection tools were questions specific to COVID-19. Survey respondents were specifically asked about vaccine status related to COVID-19. This question had the following answers from respondents:

- 59.73% Reported as vaccinated and boosted
- 28.92% Reported initially vaccinated (initial series only)
- 7.03% Reported not planning on getting vaccinated

Additionally, the information highlighted below summarizes insights from the focus group and key informant interviews regarding the impact of COVID-19 on their community.

TABLE 7. COVID-19 PRIMARY DATA INSIGHTS

FOCUS GROUP INSIGHTS	KEY INFORMANT INSIGHTS
Parents concerned and stressed with children attending school, possibly getting sick, or schools closing; lack of childcare services available or open	Local health departments and health services organizations experiencing burden with staffing shortages and in-turn negatively affects community need
Low-income families struggling to keep their homes and/or losing employment	Financial impact on local community has been significant
Patients who need routine healthcare or lab work are unable to get it; general access to care being worsened by closures or delays	Problems with testing coordination and availability; schools/students heavily affected
Misinformation; vaccination hesitancy/ confusion; conflicting information around vaccinations from healthcare professionals, especially for older adults and immigrant communities	Technology gap in immigrant communities specifically; lack of clear communication; hesitancy to trust/get vaccination
Emergency preparedness planning and communication with partners and specialist to navigate the pandemics and consequences associated	Lack of true and sustainable linkages within health systems and community level health care.

11 SIGNIFICANT HEALTH NEEDS AND COVID-19 IMPACT

Each of the three prioritized health needs appeared to worsen throughout the duration of the COVID-19 pandemic according to information gathered through primary data as discussed in the Prioritized Health Needs section of this report.

11.6.1 COVID-19 IMPACT SNAPSHOT DATA SOURCES

As local, state, and national data are updated and become available, these data can continue to help inform approaches to meeting existing and developing needs related to the pandemic. Recommended data sources for the Phoebe Putney Health System are included here:

National Data Sources

Data from the following national websites are updated regularly and may provide additional information into the impact of COVID-19:

- United States National Response to COVID-19 https://www.usa.gov/coronavirus
- Centers for Disease Control and Prevention: https://www.cdc.gov/
- U.S. Department of Health and Human Services: https://www.hhs.gov/
- Centers for Medicare and Medicaid: https://www.cms.gov/
- U.S. Department of Labor: https://www.dol.gov/coronavirus
- Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/us-map
- National Association of County and City Health Officials: https://www.naccho.org/
- Feeding America (The Impact of the Coronavirus on Food Insecurity): https://www.feedingamerica.org/

County and State Data Sources

Data from the following websites are updated regularly and may provide additional information into the impact of COVID-19:

- Phoebe Health System: https://www.phoebehealth.com/patients-and-visitors/coronavirus/covid-statistics
- City of Albany: https://www.albanyga.gov/about-us/advanced-components/covid-19-microsite
- Dougherty County Health Department: https://www.dougherty.ga.us/public-safety/public-resources/covid-19-resources

SECTION 12

CONCLUSION

The Community Health Needs Assessment (CHNA) provided a comprehensive picture of health in Phoebe Putney. This report helps meet IRS requirements of Phoebe Putney as a non-profit health system and is part of the essential services of local public health departments based on standards by the Public Health Accreditation Board.

This assessment was completed through a collaborative effort that integrated the CHNA process of the three hospitals and its established partners. This group partnered with Conduent Healthy Communities Institute to conduct this 2022 CHNA.

This process was used to determine the 5 significant health needs in the Phoebe Putney Health System service area. The prioritization process identified four top health needs: Birth Outcomes and Reproductive Responsibility, Cancer Prevention and Treatment, Diabetes Management and Prevention.

The findings in this report will be used to guide the development of the hospitals' Implementation Strategy Plans which will outline strategies to address identified priorities and improve the health of the community.